CHIME Digital Health most wired Survey | DHA

2026 EDITION

NATIONAL TRENDS REPORT

Digital Health Most Wired 2026

Insights, Benchmarks, and Trends Shaping Digital Health Maturity



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dhanalytics.org/digital-health-most-wired-survey

INTRODUCTION

From Adoption to Assurance

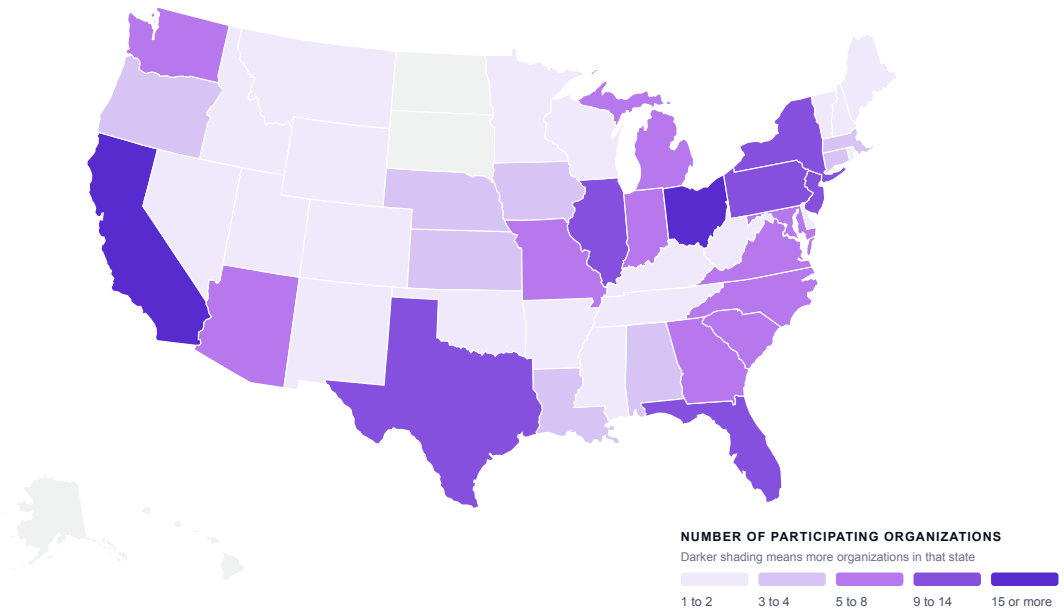
The 2025 report highlighted that the value of technology lies not simply in its adoption, but in how effectively it is used. The 2026 findings build on that insight, revealing what drives meaningful differences in Digital Health Maturity. Organizations are increasingly distinguished not by the technologies they acquire, but by how effectively those technologies are governed, measured, and integrated into care delivery, and the value these technologies deliver to patients, providers, and organizations.

The gap that matters most is the one between having technology and being able to show that it is working safely. Documented governance behind the committee, interpretation behind the dashboard, and monitoring behind the deployed system are the clearest examples. Nowhere is this more visible than in artificial intelligence: use has risen sharply over the past year, while the processes that evaluate, monitor, and correct AI across its lifecycle have not kept pace.

Why This Report Matters

The Digital Health Most Wired survey benchmarks Digital Health Maturity, measures progress and identifies where to advance next. Participants are senior digital health leaders and multidisciplinary teams across acute, ambulatory and long-term and post-acute care, evaluated within defined peer groups so that comparisons account for size, scale and care delivery environment.

DHMW Organization Demographics



235
participating organizations

5
countries represented

United States	229
India	2
Saudi Arabia	2
United Kingdom	1
Italy	1

Shading shows the number of participating organizations in each state, and the panel to the right gives the split by country. Alaska and Hawaii are shown as insets and had no participants in 2026.

Looking Ahead

Digital Health Maturity continues to evolve, with increasing emphasis on the core capabilities that support sustainable performance. The findings identify four priorities for future investment: governing AI across its full lifecycle; strengthening cybersecurity, operational resilience and rehearsed recovery; integrating clinical devices and decision support into care delivery; and building trusted data and analytics capabilities. The findings throughout this report offer actionable insights to help healthcare leaders develop digital strategies to prepare for the next phase of Digital Health Maturity. The Priority Investments section and the closing Call to Action translate those findings into steps leaders can take now.

EXECUTIVE SUMMARY

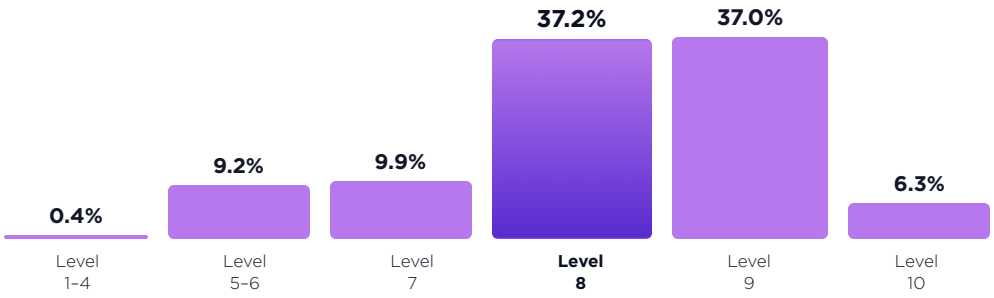
The State of Digital Health Maturity in 2026

Digital adoption no longer separates health systems. In 2026, 93.2% of participating organizations use AI, and fully adopted generative AI rose from 31.0% to 54.8% in a single year. What now distinguishes the leaders is the ability to show that technology is working safely: documented oversight of the models in use, rehearsed recovery when systems fail, and measured value from every major investment. The mean Level of Achievement rose from 7.90 to 8.13 on the acute arm. The gap that matters most is the one between having technology and being able to show that it is working safely.

THE 2026 SNAPSHOT

Where DHMW participants stand now

2026 DIGITAL HEALTH MATURITY: DISTRIBUTION BY LEVEL OF ACHIEVEMENT



N = 476 submissions · Acute 228 · Ambulatory 218 · Long-Term and Post-Acute 30. Each care setting is scored against its own peer group.

8
Average Level of Achievement, on a scale of 1 to 10

80.5%
of submissions reach Level 8 or above

7.90 → 8.13
mean Level of Achievement since 2025, acute arm

BEYOND THE SCORE: WHAT THE DATA REVEALS

Six findings from the 2026 survey

93.2%
report using AI in clinical or operational processes, 219 of 235

50.2%
of analytics programs track the return on their own projects, 117 of 233

42.9 pt
gap in tracking cost savings from digital engagement, 80.0% of leading organizations against 37.1%

59.7%
of clinical and operational data reported as labeled, standardized and prepared for AI use

39.1%
report recovery of every assessed system class within four hours, 92 of 235

16.4%
have a fully structured, documented process for monitoring an AI model after it is deployed

WHAT HEALTHCARE LEADERS SHOULD KNOW

01 AI Is Scaling Faster Than Its Oversight
93.2% of organizations use AI, but only 42.0% of AI users have fully documented pre-deployment evaluation and 16.4% fully documented post-deployment monitoring. Even among Advanced organizations only 24% have fully documented monitoring.

02 Measuring Outcomes Distinguishes Digital Leaders
Across 17 measures of return in revenue cycle and workforce technology, 17% of Advanced organizations cannot quantify the result, against 37% of the rest.

03 Safe AI Adoption Demands More than Technology
Respondents estimate that 59.7% of clinical and operational data is ready for AI, and 38.7% have master data management for critical domains. Sustainable AI depends on trusted data, effective governance and ongoing monitoring, not deployment alone.

04 Resilience Is Foundational to High-Reliability Digital Ecosystems
Only 39.1% can restore all four critical system classes within four hours, and 23.6% run full-scale failover exercises at least semi-annually. Recovery must be rehearsed, not assumed.

Source: Digital Health Most Wired 2026 benchmark. Figures cover all 476 submissions unless stated.

235 ORGANIZATIONS | 476 SUBMISSIONS | 10 SEGMENTS | 5 COUNTRIES

CONTENTS

Inside the 2026 National Trends Report

01 Introduction 02
Why the report matters, how digital maturity has moved on, and who took part

02 Executive Summary 03
The state of Digital Health Maturity in 2026, the numbers to know, and what matters now

03 What Changed in 12 Months 05
Where digital practices advanced between 2025 and 2026, on comparable items

04 Methodology & Benchmarking 06
How the 2026 benchmark was developed, who participated, and how to interpret the results

05 2026 DHMW Top 10 Trends 08
What the data says about the direction of digital maturity, with one chart for each trend

06 *Special Feature: What the Most Advanced Digital Health Leaders Do Differently* 15

07 *Special Feature: The AI Governance Gap* 17

08 *Special Feature: Who Is Using AI, and Who Is Helping Govern It* 22

09 *Special Feature: Digital Foundations for High Reliability* 24

10 Segment Deep Dives 29

1 Infrastructure 29
2 Security 30
3 Supply Chain 31
4 Administration 32
5 Analytics and Data Management 33
6 Interoperability 34
7 Population Health 35
8 Patient Engagement 36
9 Clinical Quality and Safety 37
10 Innovation and Emerging Technologies 38

11 Ambulatory and Long-Term and Post-Acute Care: Digital Maturity Insights 40

12 Bringing it All Together 41
What the 2026 data says

13 Priority Investments 43
Where the largest capability gaps are, and what closing each one would be worth

14 Call to Action 45
Ten priorities ordered by urgency, and where to begin

15 About CHIME, Digital Health Analytics, and Our Sponsors 47

16 Appendix 48

ABOUT THE DATA

Unless otherwise noted, findings reflect responses from all three care settings in the 2026 Digital Health Most Wired survey. Where results are based on a subset of respondents, the applicable sample size is provided alongside the figure. The 2026 survey drew 476 submissions from 235 organizations across 46 US states and 5 countries, scored on 10 segments.

SECTION 03

03 What Changed in 12 Months

Digital health capabilities continued to advance among organizations participating in both the 2025 and 2026 Digital Health Most Wired surveys. Among comparable survey items, AI-related practices showed stronger adoption gains than the broader set of digital health capabilities. At the same time, the overall Level of Achievement changed modestly among returning organizations.

Two things stand out. AI is the one area with a lot of room left and a lot of ground already covered. Everywhere else, organizations are finishing work they had already started, which is why the field's mean Level of Achievement moved from 7.90 to 8.13 while 168 individual practices improved.

WHAT MOVED

+4.4

Points, the 34 Comparable Artificial Intelligence Items

Starting from a 2025 median of 33.3%, the 34 comparable AI items gained 4.4 points. The other 263 items gained 2.4 points from a median of 77.3%. AI is the only area that combines a low starting point with a large gap still to close.

31.0 to 54.8

Generative Artificial Intelligence, Fully Adopted

Fully adopted generative AI rose from 31.0% to 54.8% in a single year (197 and 188 organizations), the fastest move among all comparable items. Ambient listening rose from 42.9% to 62.1%.

+7.1

Points, the 11 Artificial Intelligence Items Inside Security

The largest gains were in AI-driven incident response and threat intelligence, which rose from 44.1% to 59.4% (202 organizations in both years). AI is moving into the security operations center and the clinic at the same time.

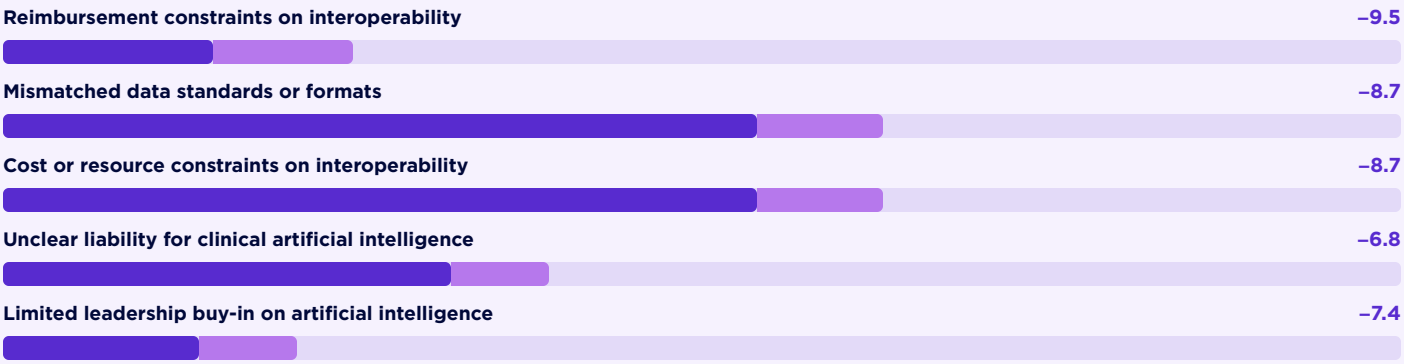
7.90 to 8.13

Mean Level of Achievement, 2025 to 2026

The official figures: 259 submissions in 2025, 228 in 2026. Different cohorts, so this is the level of the field. Among the 204 returning organizations, 58 moved up, 108 held and 38 moved down.

FEWER ORGANIZATIONS REPORT SELECTED BARRIERS TO DIGITAL ADVANCEMENT

Solid bars show 2026; the paler band shows the ground given up since 2025. These are research questions with no score, and they measure what organizations report as an obstacle, so a fall is good news. This reverses the usual direction of the other figures in this section.



Questions 6.4 and 9.30. Bases 196 organizations to 205 organizations.

WHERE DIGITAL HEALTH MATURITY GOES NEXT

The question for 2027 is not whether organizations will advance, but where the biggest opportunity remains. Most of the survey sits near the top of the scale, where a year of work buys about a point. Two areas have real room left: AI, which moved further in one year than anything else and is still only about half adopted among the most advanced organizations, and practices organizations have started but not finished. The core capabilities, above all clinical quality and safety integration and analytics and data management, make the second the priority. The organizations with the most room are closing the gap fastest, and the distance between advanced and mid-range peers is narrower than a year ago.

None of the figures in this section compare a 2025 segment score with a 2026 one. Movement is measured on comparable items only, see the Appendix.

Year over year figures run on the 205 organizations that answered in both 2025 and 2026, a subset of the 235 in the rest of this report.

METHODOLOGY

How the 2026 Benchmark Was Built

The 2026 Digital Health Most Wired (DHMW) survey assesses Digital Health Maturity across ten segments, examining how healthcare organizations adopt, integrate, and use digital technologies to support care delivery, operational performance, and organizational outcomes. Each submission receives scores for the ten segments and an overall Level of Achievement from 1 to 10. Organizations may submit results for up to three care settings (Acute, Ambulatory, and Long-Term and Post-Acute Care), with each setting evaluated against its respective peer group. As a result, the number of submissions exceeds the number of participating organizations. Unless otherwise noted, findings reflect all three care settings, with respondent counts provided where applicable.

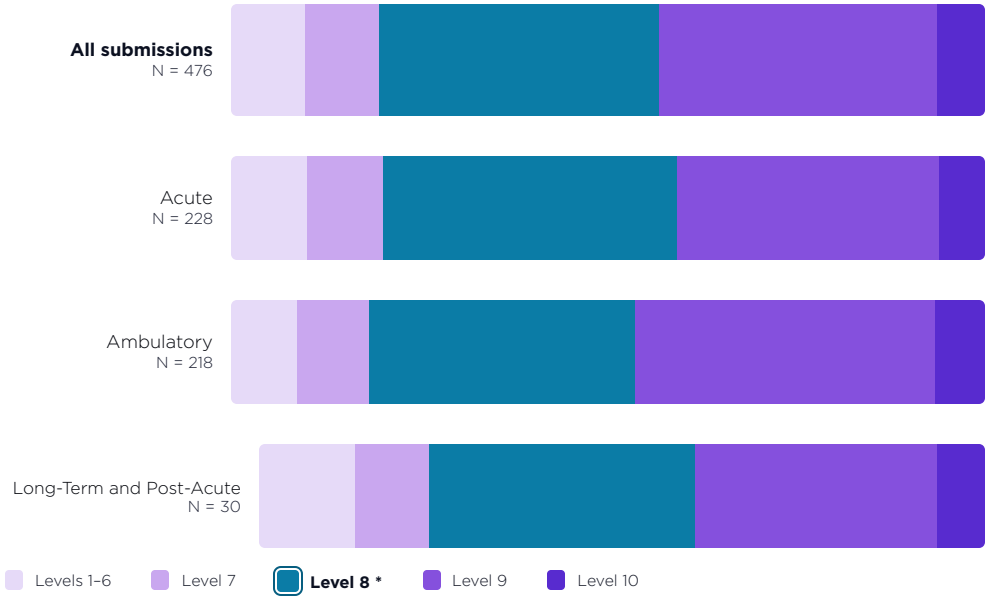
THE 2026 PARTICIPANTS

Organizations	**235**
Submissions	**476**
Countries	**5**
US states	**46**



LEVEL OF ACHIEVEMENT BY CARE SETTING

Share of submissions at each Level of Achievement, by care setting



Capabilities matter more than geography. Across the 465 United States submissions, the spread between the highest and lowest census division is **7.1 points**, against **13.3 points** between the highest and lowest of the ten DHMW segments. The division table is in the Appendix.

HOW TO READ THIS REPORT

Every figure prints the base it is drawn from, because many questions reach only some participants. A share of organizations and a share of submissions are different measures: a question asked once of each organization has a base of 235, while a measure scored per care setting has a base of 476. Where this report compares the most advanced organizations with the rest, Advanced means a mean Level of Achievement of 9 or 10 across the care settings an organization submitted, 95 organizations, and all others means the remaining 140. Research questions carry no score and are labelled wherever they appear; they measure what organizations report, not what was measured. Self-reported capability is not demonstrated performance. Figures from outside this survey are named in the text and cited in full in the Appendix.

COMPARING 2025 WITH 2026

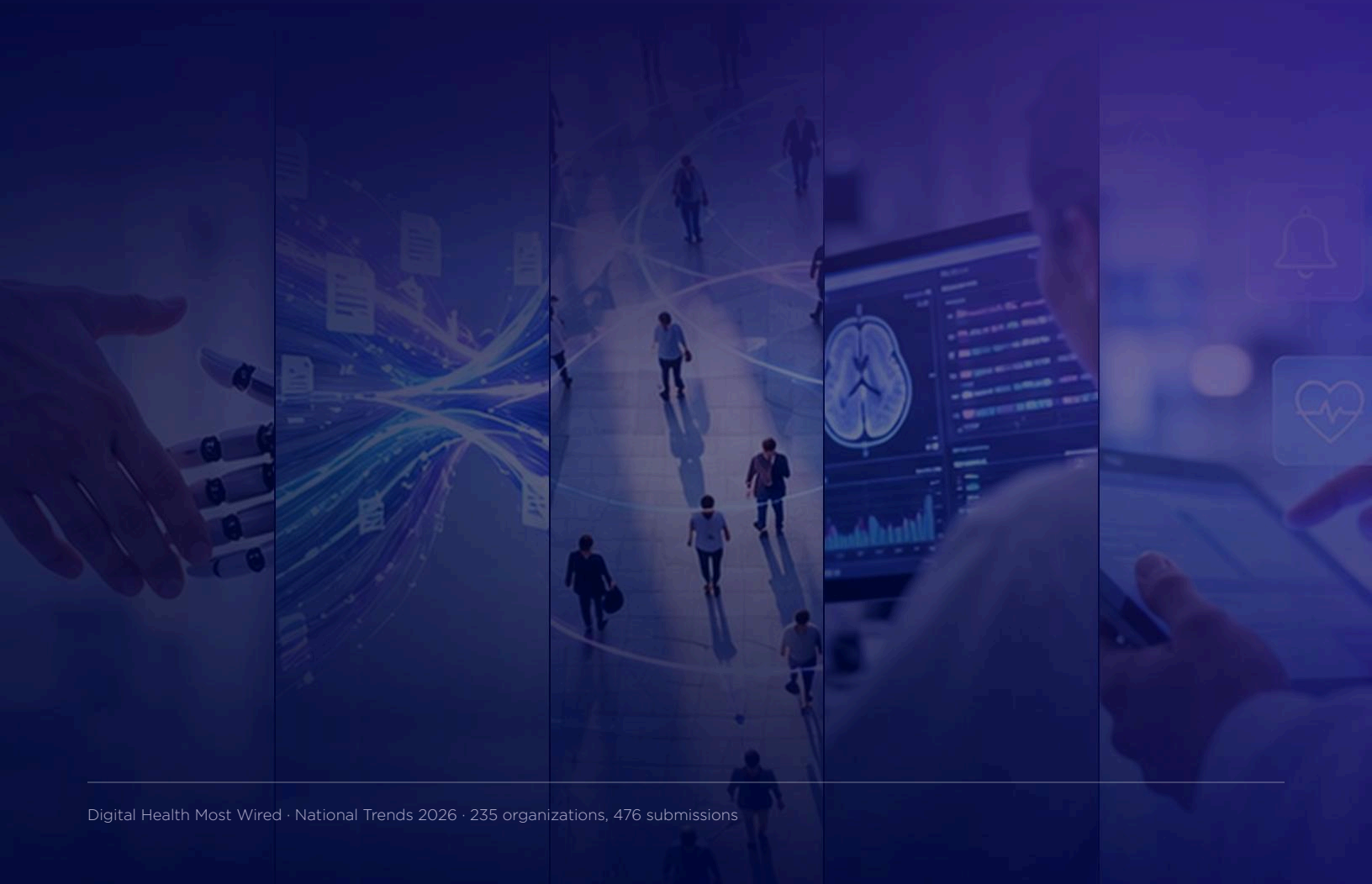
The survey was restructured between the two years, so segment results are not compared across years anywhere in this report, and year-over-year movement is measured on comparable items only. The mean Level of Achievement moved from 7.90 to 8.13 on the acute arm, 259 submissions in 2025 and 228 in 2026, which is the level of the field rather than the progress of any one participant. The Appendix sets out what is and is not comparable, and why.

PART ONE · 2026 DHMW NATIONAL TRENDS REPORT

DHMW Top 10

The Trends Shaping Digital Health Maturity in 2026

Ten trends for executives planning the next investment cycle. Together they describe a market that has largely finished adopting technology and is now learning to govern it, prove its value and sustain it under pressure. Each trend shows where the field stands, how far the most advanced organizations have moved ahead, and where leaders should act.



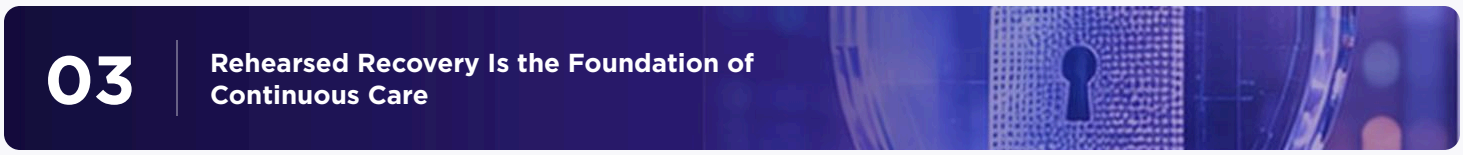
DHMW Top 10

Ten Trends Shaping Digital Health Maturity in 2026

The 2026 DHMW Top 10 identifies the trends that matter most for digital health executives planning their next investment cycle. Together they describe a market that has largely finished adopting technology and is now learning to govern it, prove its value and sustain it under pressure. Each trend shows where the field stands, how far the most advanced organizations have moved ahead, and where leaders should act.



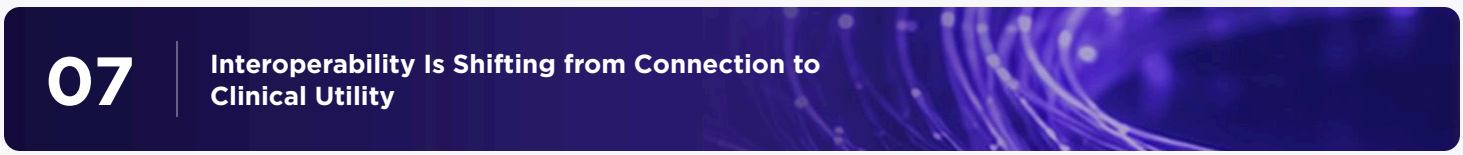


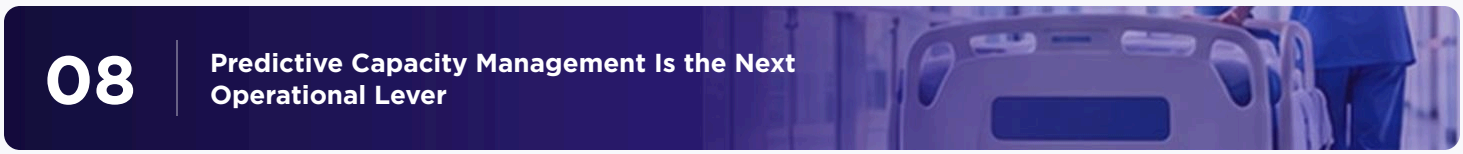


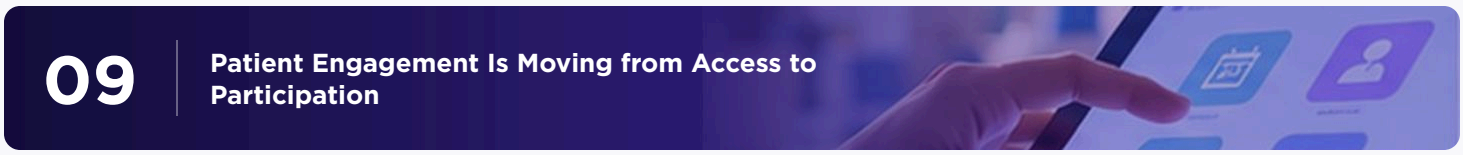














01 AI Is Mainstream; Lifecycle Oversight Is the Next Differentiator

AI is now part of everyday operations. 93.2% of participating organizations use AI in clinical or operational processes, and among returning organizations fully adopted generative AI rose from 31.0% to 54.8% in a single year.

Oversight has not kept pace. Among AI users, 65.3% keep a current model inventory, 42.0% have fully documented evaluation before deployment, and 16.4% have fully documented monitoring after it.

The organizations that pull ahead will be those that can show their models remain safe and effective long after go-live. The wider market is moving the same way: the American Medical Association's 2026 physician survey found 81% of physicians using AI in practice, up from 38% in 2023.

16.4% ALL PARTICIPANTS | **24.5%** ADVANCED | **10.4%** ALL OTHERS

of AI users have a fully structured, documented post-deployment monitoring process

Question 5.23.C, 36 of 219 AI users. Advanced organizations: 24.5%, against 10.4% of all others.



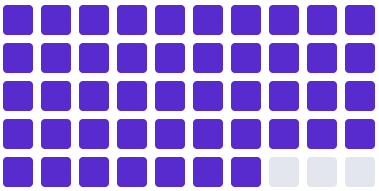
THE LEADERSHIP TAKEAWAY

Treat AI oversight as an operating discipline, not a launch checklist. Give every deployed model, including vendor-embedded tools, a named owner, and report monitoring results to the governance committee on a fixed schedule.

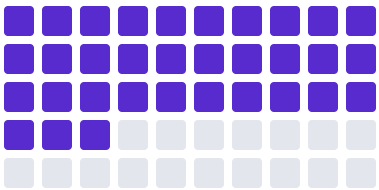
AI Use and Governance Practices

AI use: base 235 organizations. Governance measures: base 219 organizations using AI. Each measure reflects a separate survey question, so the difference between any two of them is not a drop-off.

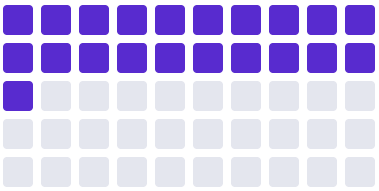
93.2% 219 of 235
AI in clinical or operational use



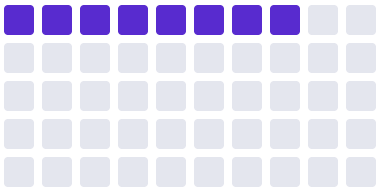
65.3% base 219
Comprehensive and current inventory of deployed AI models



42.0% base 219
Fully established and documented evaluation before deployment



16.4% base 219
Fully structured and documented monitoring after deployment



Reported | Not reported | One tile is 2 percentage points of that measure's own base

Year over year, among organizations answering in both years: generative AI fully adopted rose from **31.0% to 54.8%**, on bases of 197 organizations and 188 organizations.

02 Proven Value Separates Digital Leaders

The most mature organizations decide in advance how they will judge an investment and then go back to check. Advanced organizations are more than twice as likely to monitor cost savings from digital engagement, and far less likely to answer unknown when asked what technology returned.

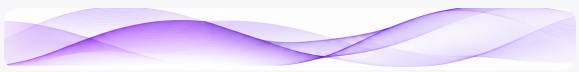
Across the field the evidence base is thin: half of analytics programs track their own return, and 38.7% evaluate innovation with a formal framework and standardized metrics.

With margins under pressure, the ability to show value is becoming the condition for continued investment. The Congressional Budget Office estimates that the Medicaid provisions of the 2025 reconciliation law will reduce federal Medicaid spending by about $990 billion over ten years, fiscal years 2025 to 2034.

38.7% ALL PARTICIPANTS | **52.6%** ADVANCED | **29.3%** ALL OTHERS

use a formal framework with standardized metrics to evaluate innovation

Question 10.7, 91 of 235 organizations. Advanced organizations: 52.6%, against 29.3% of all others. 77.0% name financial constraints and return uncertainty as the top innovation barrier, 177 of 230.



THE LEADERSHIP TAKEAWAY

Set the outcome measures for a digital investment before it is approved, assign an owner to report against them, and review results at six and twelve months. Stop or change what is not delivering.

Can Organizations Show What Technology Returned?

Four separate questions on four separate bases, printed with each bar. These are not stages of one process and they do not sum.



03 Rehearsed Recovery Is the Foundation of Continuous Care

Only 39.1% of organizations report that clinical, administrative, network and employee communication systems can all be restored within four hours of losing the primary data center. Tested failover makes the difference: organizations with it are about twice as likely to meet that bar, 45.7% against 23.5%.

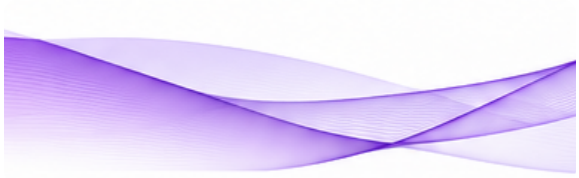
Yet organizations rehearse what is easy. Phishing simulations run at least semi-annually at 95.3% of organizations; full-scale exercises with actual failover at 23.6%.

Third-party risk, the most cited barrier to running a cyber risk function at 82.1%, extends that exposure beyond the organization's walls. The February 2024 ransomware attack on the claims processor Change Healthcare affected an estimated 192.7 million individuals, the largest health care data breach on record in the United States.

39.1% ALL PARTICIPANTS | **70.2%** ADVANCED | **45.3%** ALL OTHERS

report four-hour recovery across all four critical system classes

Question 1.16, 92 of 235 organizations. Self-reported capability. On annual role-based continuity training beyond IT, Advanced organizations: 70.2%, against 45.3% of all others.

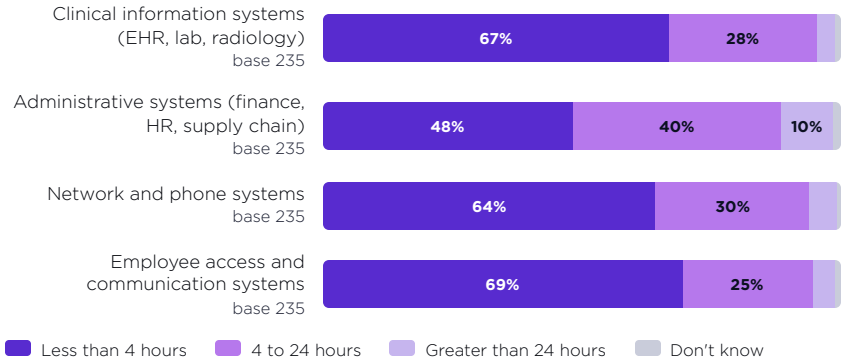


THE LEADERSHIP TAKEAWAY

Set recovery time objectives by system class, run full-scale failover exercises at least semi-annually with clinical leaders taking part, and extend recovery testing to the third parties that critical care depends on.

Reported Recovery Time After Complete Primary Data Center Loss

Reported ability to restore mission-critical operations following complete loss of the primary data center. Question 1.16, base 235 organizations.



Self-reported capability, not demonstrated performance. All four classes inside four hours is the 39.1% headline figure.

ORGANIZATIONS REHEARSE WHAT IS CHEAPEST TO REHEARSE

Share conducting each exercise at least semi-annually. Question 2.8.D, base 233 organizations.



04 AI-Ready Data Is the Constraint on Scale

AI can only be as reliable as the data beneath it. Respondents estimate that 59.7% of their clinical and operational data is labeled, normalized and interoperable, leaving roughly two in five data elements not yet ready for AI.

Organizations are further along in finding data than in reconciling it. Data catalogs reach 66.5% and automated quality monitoring 60.0%, but master data management for critical domains such as patient, provider and location reaches 38.7%.

Without a single trusted definition, analytics and AI can disagree across systems, and the disagreement surfaces in front of a clinician rather than in the data team.

38.7% ALL PARTICIPANTS | **50.5%** ADVANCED | **30.4%** ALL OTHERS

have master data management for critical domains

Question 5.8.E, 89 of 230 organizations. Advanced organizations: 50.5%, against 30.4% of all others, computed for this edition. Separately, 59.7% of data is reported as AI-ready, a respondent estimate on a base of 214.

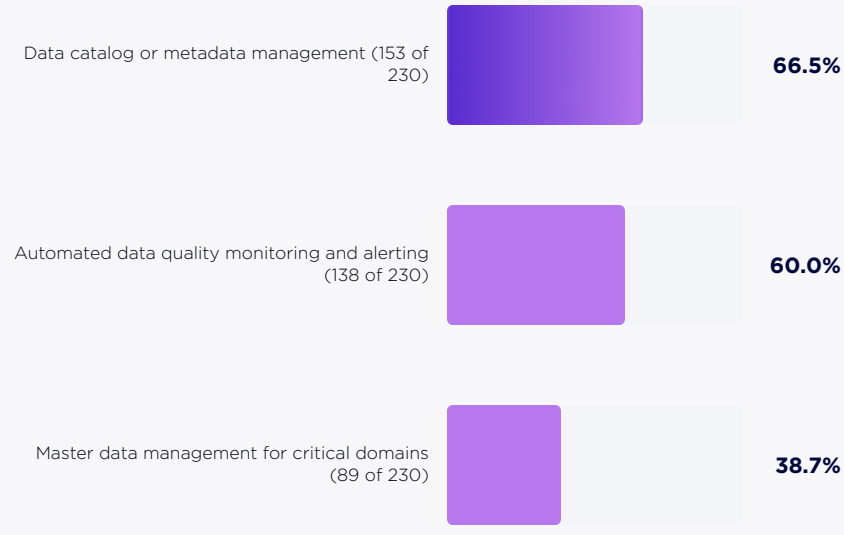


THE LEADERSHIP TAKEAWAY

Fund data foundations as part of every AI business case. Master data for patient, provider and location is the quiet prerequisite for AI that clinicians and executives can trust.

Finding Data Is Further Along Than Trusting It

Share with each capability in place. Question 5.8.E, base 230 organizations. Separate capabilities, not stages.



59.7% of clinical and operational data is reported as labeled, normalized and interoperable, median 65.1%, base 214 organizations. A respondent estimate, not a measurement.

05 Workforce Data Literacy Determines Whether AI Is Trusted

Clinicians are well represented in digital governance, but the wider workforce is not equipped to question what analytics and AI tell them. Only 15.7% of organizations have a comprehensive, role-based data literacy program, and 76.2% name end-user data literacy as a barrier to adopting analytics.

Lack of AI expertise and workforce readiness is cited at every maturity level.

Adoption is also uneven across professions: ambient listening is fully adopted for physicians and advanced practitioners at 60.8%, and for nursing, the largest clinical workforce, at 9.5%. In the AMA's 2026 survey, 85% of physicians want to be consulted or directly involved in AI adoption decisions.

15.7% ALL PARTICIPANTS | **72.3%** ADVANCED | **56.8%** ALL OTHERS

have a comprehensive, role-based data literacy program

Question 5.6, 37 of 235 organizations. On assigning AI testing and validation to a multidisciplinary committee that includes clinical leadership, Advanced organizations: 72.3%, against 56.8% of all others, question 5.20, base 219 AI users.

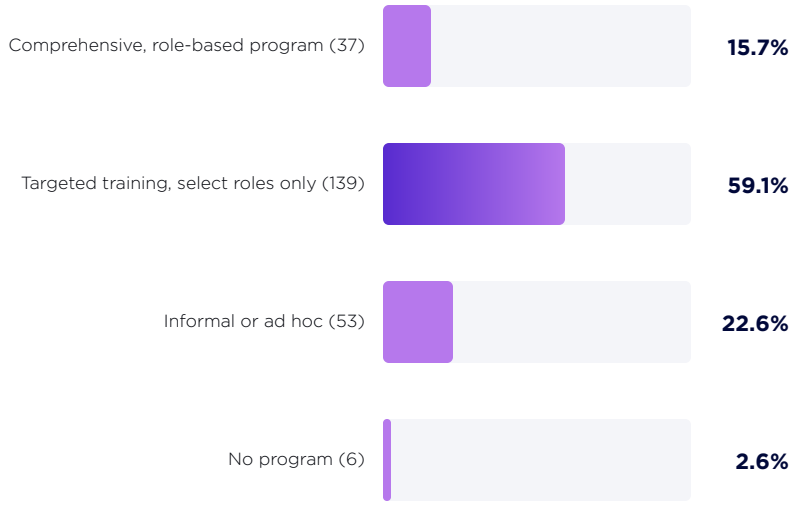


THE LEADERSHIP TAKEAWAY

Treat data and AI literacy as a standing workforce program with role-based paths for clinicians, nurses, managers and executives, and fund it as part of every AI business case. Seat nursing explicitly on AI governance.

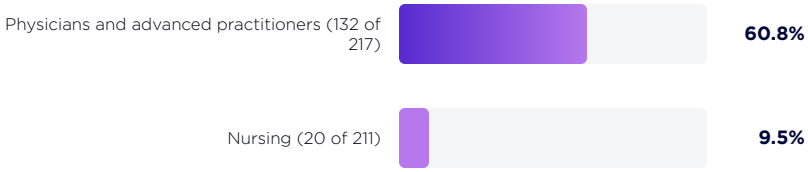
The Data Literacy Program Gap

Share of organizations at each level of programme. Question 5.6, base 235 organizations, single choice.



AMBIENT LISTENING REACHES PHYSICIANS FIRST

Share fully adopted. Question 5.22, each on its own base.



06 Predictive Population Health Is the Widest Maturity Divide

Knowing who is at risk is largely solved: 77.4% of organizations maintain internal registries and 68.1% use risk stratification. Acting earlier is not.

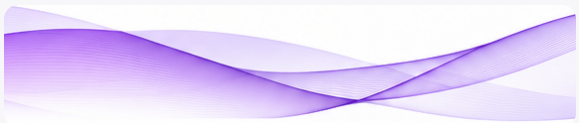
Tailored predictive and prescriptive analytics are fully adopted by 42.6%, the lowest of the population health capabilities and the widest gap between Advanced organizations and the rest of any finding in this Top 10. It is also the most selected priority for new population health investment, at 68.8%.

Environmental risk is almost absent from the picture: heat index data is fully adopted by 5.6%. Globally, heat was associated with an estimated 710,000 deaths in 2023, and older adults now experience an average of 11.5 heatwave days a year, up from 7.2 a decade earlier.

42.6% ALL PARTICIPANTS | **69.5%** ADVANCED | **24.3%** ALL OTHERS

have fully adopted tailored predictive and prescriptive analytics

Question 7.2.A, 100 of 235 organizations. Advanced organizations: 69.5%, against 24.3% of all others, the widest gap in this Top 10.



THE LEADERSHIP TAKEAWAY

Turn registries into early-warning systems. Prioritize predictive models that trigger outreach before an admission, and include environmental risk such as extreme heat when identifying the patients who need it most.

Identifying Risk Is Solved; Acting Earlier Is Not

Share reporting full adoption of each capability. Question 7.2.A, base 235 organizations. Separate adoption measures, not sequential stages.



07 Interoperability Is Shifting from Connection to Clinical Utility

National exchange is now mainstream: 80.3% of United States organizations have joined a TEFCA Qualified Health Information Network. The next test is whether exchanged information arrives in a form clinicians can use.

56.8% have full two-way, real-time exchange with non-affiliated community providers, and 81.5% say those partners lack the capability to connect. Manual processes persist where they matter: 81.2% maintain behavioral health referral directories by hand, and prior authorization is automated by 49.4%, falling to 28.9% among the smallest organizations.

From 1 January 2027 the CMS Interoperability and Prior Authorization Final Rule requires impacted payers to implement Prior Authorization, Provider Access and Payer-to-Payer APIs. Providers that have not automated prior authorization will capture less of the benefit.

56.8% ALL PARTICIPANTS | **74.7%** ADVANCED | **44.6%** ALL OTHERS

have full two-way, real-time exchange with non-affiliated community providers

Question 6.2, base 234 organizations. Advanced organizations: 74.7%, against 44.6% of all others.

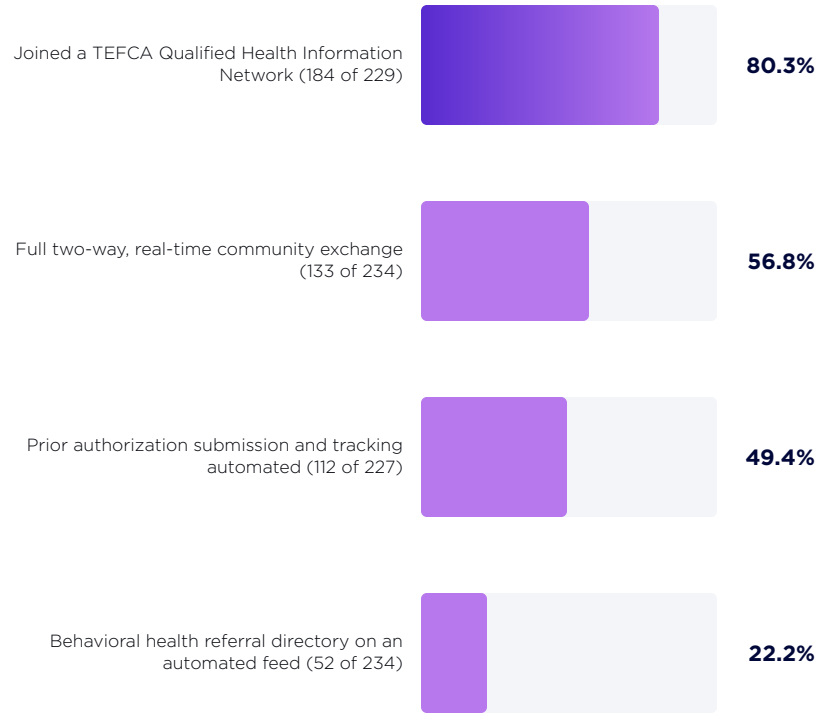


THE LEADERSHIP TAKEAWAY

Measure interoperability by what reaches the clinician, not by the number of connections. Prioritize automated prior authorization ahead of the 2027 payer API deadline, and automated feeds for behavioral health referrals.

Connection Against Utility

Four separate questions, each on its own base, printed with the bar. Connection is further along than what clinicians can act on.



08 Predictive Capacity Management Is the Next Operational Lever

Most organizations manage capacity with real-time visibility; few can see it coming. Integrated patient logistics is fully adopted at 64.1% and intelligent bed management at 54.3%, but predictive bed demand forecasting reaches 33.0% and AI-driven patient flow 14.8%.

62.3% of hospitals operate or are piloting a command center, which is where forecasting, capacity, alarms and disaster response converge.

Predictive capacity management determines how early leaders can act on surge, boarding and diversion, and it is the difference between managing a full hospital and anticipating one.

33.0% ALL PARTICIPANTS | **70.1%** ADVANCED | **51.6%** ALL OTHERS

have fully adopted predictive bed demand forecasting

Question 4.4, 76 of 229 organizations. Among the 141 organizations running a command center, 61.7% use predictive analytics for capacity and demand forecasting; Advanced organizations: 70.1%, against 51.6% of all others, question 9.26.B.

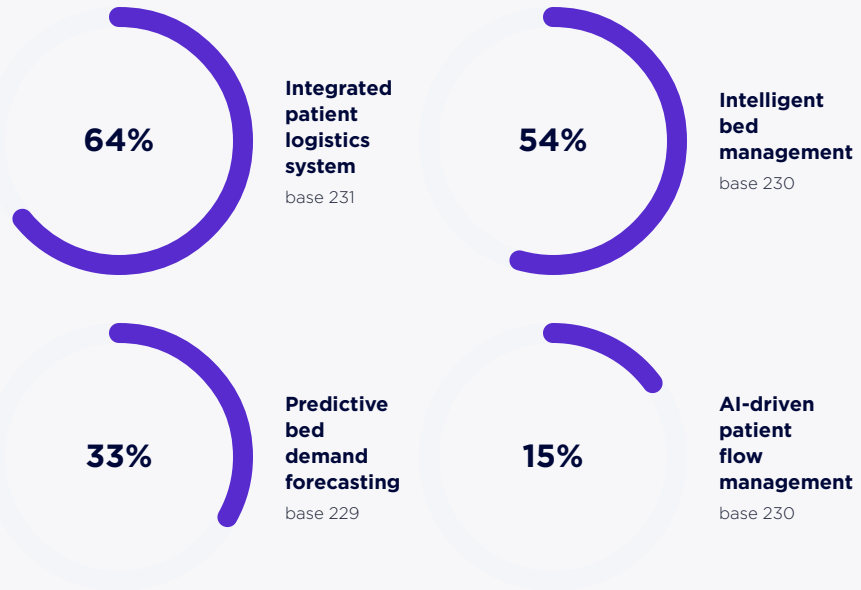


THE LEADERSHIP TAKEAWAY

Pair real-time visibility with forecasting, and connect both to a command center that can act on them. Track forecast accuracy, boarding time and diversion hours to show the return.

PATIENT FLOW TECHNOLOGY MATURITY

Share fully adopted. Question 4.4, base 229 to 231 organizations



Four independent capabilities, not four stages of one pipeline. Question 4.4.

09 Patient Engagement Is Moving from Access to Participation

The digital front door is open at almost every organization: appointment reminders reach 97.0%, care summaries 94.0%, and secure messaging and video visits 92.3% each.

Two-way participation is the next stage. Shared care planning is fully adopted at 56.2%, patient-reported outcomes at 50.6%, integration of patient-generated health data at 35.2% and shared decision-making tools at 22.4%.

Fewer than half of organizations, 48.1%, monitor digital literacy by population segment, which matters if digital engagement is not to widen the gaps in access it was meant to close.

72.3% ALL PARTICIPANTS | **88.4%** ADVANCED | **61.4%** ALL OTHERS

have a fully approved and adopted patient engagement strategy with goals and metrics

Question 8.1, 170 of 235 organizations. Advanced organizations: 88.4%, against 61.4% of all others.

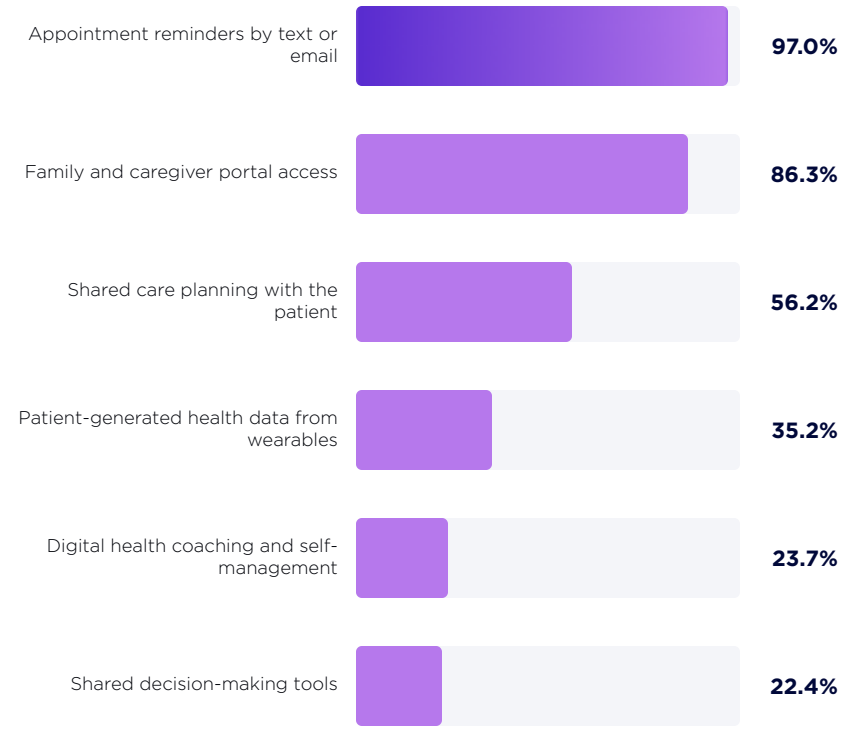


THE LEADERSHIP TAKEAWAY

Measure engagement by what patients contribute, not only by what the organization sends. Prioritize tools that put patient input in front of care teams in a form they will act on.

DIGITAL ENGAGEMENT: ACCESS AGAINST ONGOING SUPPORT

Share fully adopted. Questions 8.3 and 8.4, bases 232 to 235 organizations



10 Device Integration Is the Remaining Medication-Safety Gap

The software side of medication safety is largely in place: 65.0% of organizations have comprehensive closed-loop medication administration, and 88.0% report barcode scan compliance above 90%. The devices are not.

Bidirectional integration between IV smart pumps and the EHR reaches 41.1%, and bidirectional cardiac monitoring data 26.3%. Where device data must be entered by hand, nurses carry the transcription burden and early-warning models lose the data they depend on.

A 2025 systematic review found that smart pump and EHR interoperability reduces intravenous medication administration errors. A companion economic model estimated that for a six-hospital system with 1,500 staffed beds it would prevent 56 preventable adverse drug events a year and recoup about $2.4 million in outpatient infusion charges. Both estimates are modeled and exclude implementation costs.

41.1% ALL PARTICIPANTS | **52%** ADVANCED | **33%** ALL OTHERS

have bidirectional or closed-loop integration between IV smart pumps and the EHR

Question 9.4, 92 of 224 hospitals. Advanced organizations: 52%, against 33% of all others. On continuous cardiac monitoring, 36% against 21%.



THE LEADERSHIP TAKEAWAY

Make device integration part of the medication safety program, not a biomedical engineering project. Prioritize infusion pumps and physiologic monitoring, the data streams that early-warning AI depends on.

The Software Is Connected; the Devices Are Not

Share with each capability in place, each on its own base, printed with the bar.



PART TWO · 2026 DHMW NATIONAL TRENDS REPORT

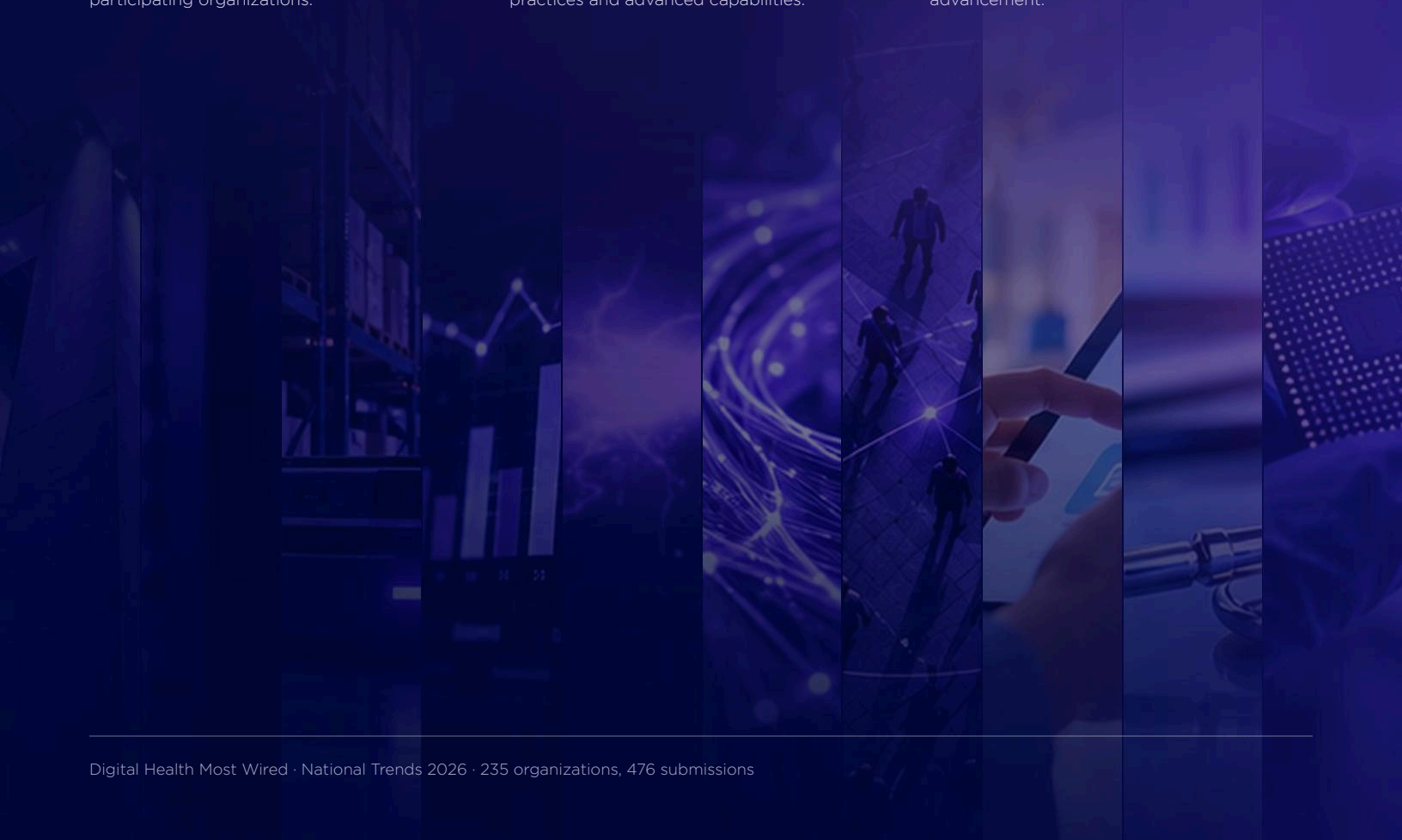
Special Features

Three closer looks at what separates the most advanced organizations: the habits they share, how far AI oversight has kept pace with AI adoption, who in the workforce is equipped to use it, and the digital foundations that keep care running when systems fail.

Benchmark Performance
Understanding Digital Health Maturity across participating organizations.

Maturity Gaps
Identifying differences between established practices and advanced capabilities.

Leadership Opportunities
Highlighting priorities for continued digital advancement.



What the Most Advanced Digital Health Leaders Do Differently

Digital maturity is not a stack of technology. The organizations at the top of the 2026 benchmark are set apart by habits: they measure what technology delivers, rehearse for failure, assign clear ownership, listen to patients and engage with the bodies shaping AI oversight. This section compares three groups of organizations to show what changes as maturity rises, and where even the most advanced organizations have further to go.

Three Stages of Maturity

Each organization is placed by its mean Level of Achievement across the care settings it submitted. Building organizations (below Level 8) number 49, Leading organizations (Level 8) number 91, and Advanced organizations (Levels 9 and 10, Highly Advanced or Exemplar) number 95. Across all 476 submissions, 19.5% sit at Level 7 or below, 37.2% at Level 8 and 43.3% at Levels 9 and 10 (206 submissions). Groups are counted by organization here because most survey questions are asked once per organization.

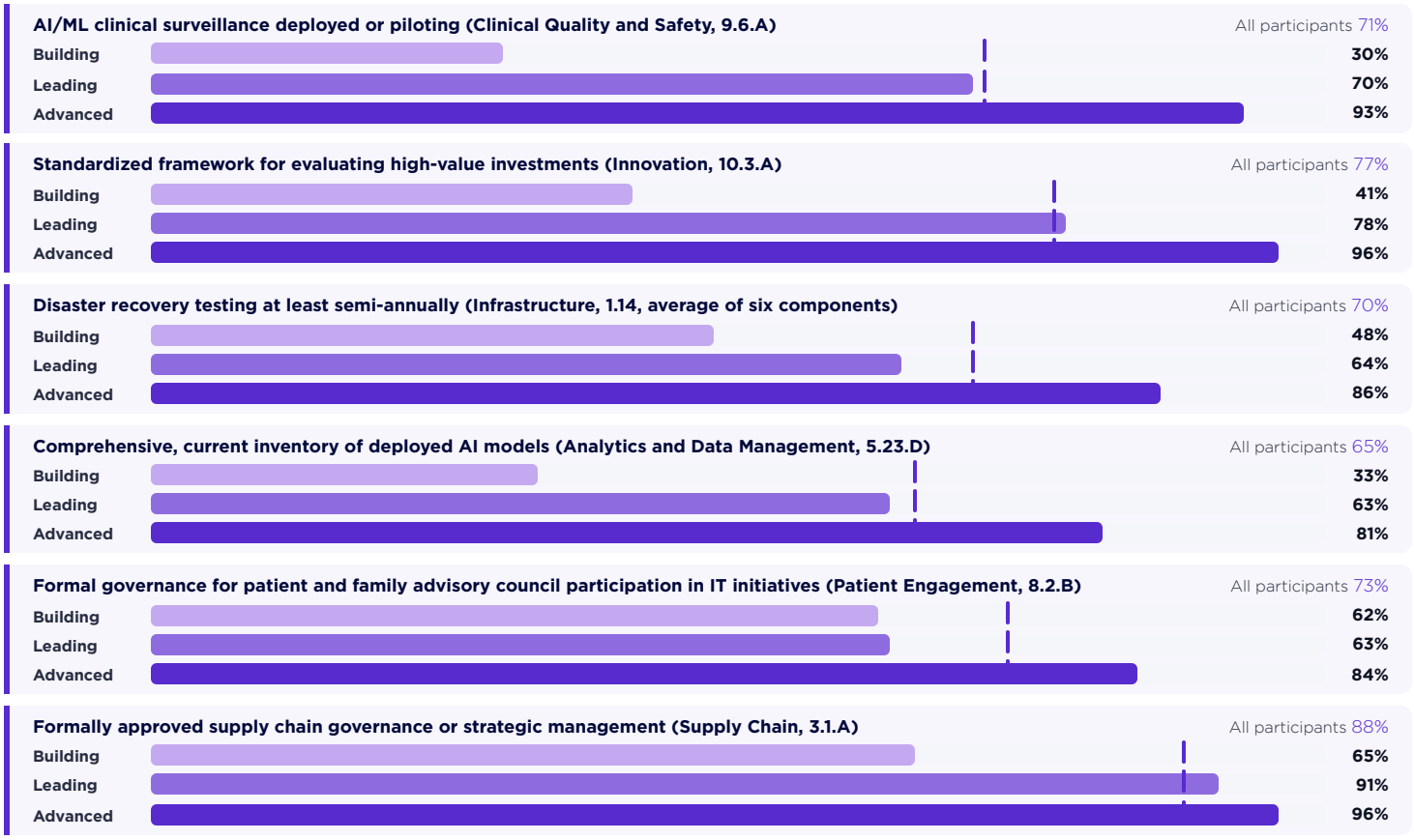
Very few submissions sit at the earliest Levels (0.4% at Levels 1 to 4), so the Building group is organizations still short of Level 8, not organizations at the start of their journey.

Six Practices That Rise with Maturity

Six practices rise steadily from Building to Advanced. The widest gap is AI clinical surveillance, deployed or piloting at 93% of Advanced organizations. The narrowest is supply chain governance, which is close to universal at the top.

SIX PRACTICES THAT RISE WITH MATURITY

Share with each practice in place, by maturity group. Every one of the six rises from Building to Advanced.



Building Leading Advanced All participants Bars are on a 0 to 100 scale.

Building 49 organizations, Leading 91, Advanced 95; the tick on the right is all 235 participants.

Against organizations outside the Advanced group the gaps are wider; for example, AI clinical surveillance is 93% for Advanced and 57% for all others.

Where Even Advanced Organizations Fall Short

The gap in AI oversight does not close at the top. Among AI users, 66% of Advanced organizations have a fully documented process to evaluate models before deployment, but only 24% have fully documented monitoring after deployment, so about three in four of the most advanced organizations still lack it. Regular bias testing reaches 50% of Advanced organizations. For Building organizations the figures are 18%, 3% and 10%. The AI Governance Gap feature that follows sets out the lifecycle and a pathway to close each gap.

AI USERS AMONG ADVANCED ORGANIZATIONS, AGAINST BUILDING

66%
Fully documented evaluation before deployment
Building 18%

24%
Fully documented monitoring after deployment
Building 3%

50%
Regular bias testing
Building 10%

The Habits Behind Best Practice

Research questions, which carry no score, point to the habits behind these practices. Each paragraph pairs a practice with what organizations told us.

Measure
Standardized way to judge investments

96%
Building 41%

Advanced organizations are far more likely to have a standardized way to judge investments (96%, against 41% of Building organizations), and far less likely to say they cannot quantify what AI and analytics returned. Across 17 measures of return in revenue cycle and workforce technology, 17% of Advanced organizations answer "Unknown," against 37% of the rest. For predictive workforce planning the share is 29% for Advanced and 70% for Building organizations.

Rehearse
Scenario-based drills at least semi-annually

52%
The rest 25%

Testing recovery is common, but rehearsing it against specific scenarios separates leaders. 52% of Advanced organizations run scenario-based drills at least semi-annually, against 25% of the rest, and organizations that drill that often are more likely to restore all four critical system classes within four hours (48%, against 25% of those who drill ad hoc or not at all).

Own
Current inventory of AI models

81%
Building 33%

81% of Advanced organizations keep a current AI model inventory, against 33% of Building organizations. Asked which safeguards they still want, only 11% of Advanced organizations ask for a designated accountable leader for governance, against 38% of the rest, which suggests the role is already in place at the top.

Listen
Formal governance for patient and family advisory input

84%
Building 62%

84% of Advanced organizations have formal governance for patient and family advisory council participation in IT initiatives, against 62% of Building organizations. Advanced organizations are also more likely to ask for patient and community perspectives in AI governance (23%, against 7% of the rest), though even there fewer than one in four do.

Engage
Take part in the Coalition for Health AI

53%
The rest 25%

53% of Advanced organizations take part in the Coalition for Health AI, against 25% of the rest, and they are also more likely to take part in NIST, the AMA, CMS and the AHA.

Deploy and Confront
Cite post-deployment monitoring as a barrier

37%
The rest 17%

AI is moving into clinical practice fastest at the top (93% deploy or pilot clinical surveillance), and so is the difficulty of governing it: 37% of Advanced organizations cite monitoring and auditing models after deployment as a governance barrier, against 17% of the rest. Those furthest along are meeting the monitoring problem first.

Advanced organizations | Comparison group: Building organizations, or all others where stated

Method. Differences between groups are associations, not proof of cause. Maturity and organization size are related, with the largest organizations more often Advanced; most of the differences shown remain after controlling for organization size. Research questions are unscored, so these patterns are not built into the Level of Achievement. Sources: DHMW 2026 response data, 235 organizations.

> "Reaching the top of the Most Wired benchmark was never about buying more technology. What changed was how we operationalized it: we decided what success looked like before we invested, created accountability for that success, and measured the outcomes. Those habits, more than any single technology, became the platform for a culture of innovation and truly using IT to make a difference for our teams and our patients. While we will never be done with the journey, this foundation enables us to sustain Level 10 year after year and provide excellent, innovative care for our patients."
>
> **Steve Hess**
> CIO, UCHealth
> DHMW Level 10 achieving site for 11 consecutive years.

SPECIAL FEATURE · AI GOVERNANCE

The AI Governance Gap: AI Is Scaling Faster Than the Oversight Around It

Artificial intelligence is now part of everyday operations at nearly every participating organization. What has not kept pace is the governance that keeps it safe: knowing which models are running, proving they work for local patient populations, testing them for bias, watching them after go-live and correcting them when performance drifts. This feature follows AI across its lifecycle, shows where oversight thins out, names the risks that follow and sets out a practical pathway to close each gap.

Momentum: Adoption Is Accelerating

Among organizations that answered in both 2025 and 2026, AI-related practices moved further than anything else in the survey. Generative AI that is fully adopted rose from 31.0% to 54.8%, and ambient listening from 42.9% to 62.1%. The 34 assessed comparable AI items gained a median of 4.4 points, compared with 2.4 points for the other 263 items, and the 11 AI items in Security gained 7.1 points.

The wider market shows the same pattern. The American Medical Association's 2026 physician survey found 81% of physicians using AI in practice, up from 38% in 2023, and the average physician now uses 2.3 AI use cases, up from 1.1.

Sources: DHMW 2025 to 2026 comparable items (Year Over Year section); American Medical Association, 2026 Physician Survey on Augmented Intelligence, March 2026.

Adoption is not uniform across use cases. The two that put AI in front of a clinician, ambient listening for physicians and predictive models, are furthest along; the two that put it behind one, workflow and resource optimization, are roughly a third as far. Where organizations say the benefit shows is a separate question, and one they answer about themselves.

WHERE AI IS BECOMING PART OF HEALTHCARE WORKFLOWS

Six use cases, ranked by full adoption. The two at the top put AI in front of a clinician; the two in the middle put it behind one.



Share reporting FULLY ADOPTED. DHMW 2026 question 5.22. Each use case carries its own respondent base, shown in brackets, so the bars are not shares of one cohort. Bars are on a 0 to 100 scale.

FROM AI INVESTMENT TO REPORTED IMPACT

80.4% of AI users track and report the benefits of AI investment, 176 of 219. Of those that answered where the benefit shows, these are the three most reported areas.



DHMW 2026 questions 5.24.A (base 219 AI users) and 5.24.B (base 172 answering). Self-reported improvement, not a measured outcome: organizations report where they see benefit, not what it was worth. Bars are on a 0 to 100 scale.

Readiness is the constraint under all of it. Organizations estimate that 59.7% of their clinical and operational data is labeled, normalized and interoperable, with a median of 65.1% across 214 organizations. That is a respondent estimate rather than a measurement, but it puts roughly two in five data elements outside what a model can safely be trained on, which is a limit on scaling that no amount of governance removes.

The AI Governance Lifecycle

Adoption is the middle of the lifecycle, not its first or last step: governance should begin before go-live and continue after it. The table follows an AI model from use-case definition through monitoring and retirement. It shows how much of the field has each control fully in place. Each row is a separate survey question with its own base, so read the rows as coverage at each stage rather than as a funnel.

DHMW 2026 MEASURE	RESULT	KEY FEATURES THAT REPRESENT DIGITAL MATURITY
BEFORE GO-LIVE		
1 **Define the use case and risk tier** Committee reviews and approves AI risk prediction models (adjacent) (base 177)	**78.5%** 139 of 177	Every proposed tool has a stated purpose, intended population and risk tier before any pilot, with clinical sponsorship for high-risk uses
2 **Evaluate and validate** Fully established and documented evaluation: risk assessment, validation testing, performance tracking, bias detection (base 219 AI users)	**42.0%** 92 of 219	Local validation on the organization's own patients before deployment, reviewed by a multidisciplinary committee that includes clinical leadership (63.5% assign testing and validation this way)
3 **Test for bias and equity** Regular bias or discrimination testing during development and after deployment (base 219)	**33.3%** 73 of 219 14.6% do not test	Subgroup performance reviewed at go-live and on a schedule, including administrative tools
GO-LIVE		
4 **Adopt** Use AI in clinical or operational processes (base 235)	**93.2%** 219 of 235	Go-live is a decision gate: launch only after evaluation sign-off, with a named owner and a rollback plan
5 **Register and assign an owner** Comprehensive, current inventory of deployed models with versioning and maintenance logs (base 219)	**65.3%** 143 of 219	Every model, including vendor-embedded tools, is registered with a named owner
AFTER GO-LIVE		
6 **Monitor** Fully structured and documented monitoring: drift detection, bias auditing, periodic revalidation (base 219)	**16.4%** 36 of 219	Named owner, defined thresholds, override and incident capture, scheduled revalidation
7 **Demonstrate value** Track and report the benefits of AI investment (base 219)	**80.0%** 176 of 219	Benefits tied to clinical, operational and financial measures, compared with intent
8 **Correct or retire** Models recalibrated as populations or care patterns change (adjacent) (base 177)	**56.5%** 100 of 177	Rollback and retirement criteria defined for every model

Results are the share reporting the practice fully in place. "Fully established and documented" is a deliberately high bar; many more organizations report evaluating tools in some form. Use of AI is a share of all 235 organizations; all other rows are shares of the 219 that use AI. Stages are ordered as they should happen, not as the survey asks. Reading down, the share with documented evaluation before go-live (42.0%) is far below the share that have gone live (93.2%). Two stages are not measured directly; where a nearby question comes close it is marked adjacent, on its own base of 177 organizations using AI risk prediction (9.27.C).

HOW MATURITY CHANGES THE LIFECYCLE

Advanced organizations are further along at every stage, yet post-deployment monitoring is the weakest link at every level.



Groups are mean Level of Achievement: Building below 8, Leading 8 to below 9, Advanced 9 to 10. DHMW 2026 questions 5.23.A to 5.23.D, base 219 AI users.

The groups here count AI USERS, 39, 86 and 94, against 49, 91 and 95 organizations in the maturity feature: 16 of the 235 do not use AI and 10 of those are Building organizations. Even among Advanced organizations, about three in four lack fully documented monitoring after deployment.

The pipeline is a window. In AI clinical surveillance, 50.2% of hospitals have deployed in multiple areas, 21.2% are piloting, 17.3% are planning and 11.3% have no initiative. In AI imaging, 53.2% routinely integrate it, 29.0% have a single application or pilot, 10.8% are evaluating and 3.9% do not use it. Organizations still piloting are less likely to have documented evaluation (38.3% of surveillance pilots against 53.0% of those with deployments; 26.2% of imaging pilots against 55.9%), so evaluation practice is still building behind deployment. That leaves a window to put governance in place before AI spreads.

Three Patterns Behind the Gap

1 **Governance on paper, not yet in operation.**

In Security and in Clinical Quality and Safety, governance scores exceed operational maturity by 12.4 and 19.0 points. In Innovation (–15.5) and Interoperability (–7.0) the order reverses and operations have run ahead of governance. Committees and charters exist, but the day-to-day controls beneath them do not yet reach every model.

2 **AI is the weakest capability in three segments.**

The lowest-scoring dimension in Security is AI and Emerging Technology Adoption (59.0). In Supply Chain it is AI in Supply Chain Management (26.2). In Clinical Quality and Safety it is Advanced AI and Clinical Risk Operations (53.7), with Clinical Decision Support and AI Surveillance next lowest (55.1).

3 **Breadth and depth tell different stories.**

The AI Governance, Adoption and Readiness dimension averages 74.2, reflecting the breadth of governance practices in place. The lifecycle measures count only fully documented processes, and here 16.4% of AI users report fully documented post-deployment monitoring. Leaders should track both: breadth shows the structure exists; depth shows it is operating.

What the Gap Puts at Risk

CARE DELIVERY
44% of hospitals evaluated predictive models locally for bias (national data, 2023)

THE WORKFORCE
9.5% ambient listening fully adopted for nursing, the largest clinical workforce, against 60.8% for physicians

THE ORGANIZATION
33 healthcare AI laws enacted in 21 states by the end of 2025, with 177 bills pending in 2026

Care delivery. Models that are not validated on local patients or watched after go-live can drift as workflows, data and populations change, and unrecognized bias can widen disparities. In national hospital data for 2023, about 65% of hospitals used predictive models but only 44% evaluated them locally for bias. Among DHMW organizations with AI or machine learning clinical surveillance deployed or piloting, sepsis prediction (61.8%) and readmission risk (56.4%) are fully adopted at the highest rates, yet only 16.4% of AI users have fully documented monitoring.

The workforce. Unmonitored tools add hidden workload, alert burden and over-reliance, and unsanctioned tools put patient data and clinical judgment outside any control. Physicians report concern about skill erosion and want a voice in adoption decisions, yet nursing, which is the largest clinical workforce, is the least likely to have AI deployed in its workflows or a core seat on governance committees.

The organization. The Joint Commission and the Coalition for Health AI issued joint guidance in September 2025 built on seven elements: governance, privacy and transparency, data security, quality monitoring, safety event reporting, risk and bias assessment, and training. The voluntary certification program was released by The Joint Commission in May 2026. Regulation is moving in parallel: by the end of 2025, 21 states had enacted 33 healthcare AI laws, with 177 bills pending across 31 states in 2026, and federal preemption remains unsettled. Most hospitals source predictive tools from their EHR vendor (79% in 2023), so vendor oversight is part of the exposure. More recent federal data show the same pattern: in 2024, 80% of hospitals using predictive AI sourced it from their EHR developer, and overall use of predictive AI had risen to 71% of hospitals (ASTP/ONC, 2025).

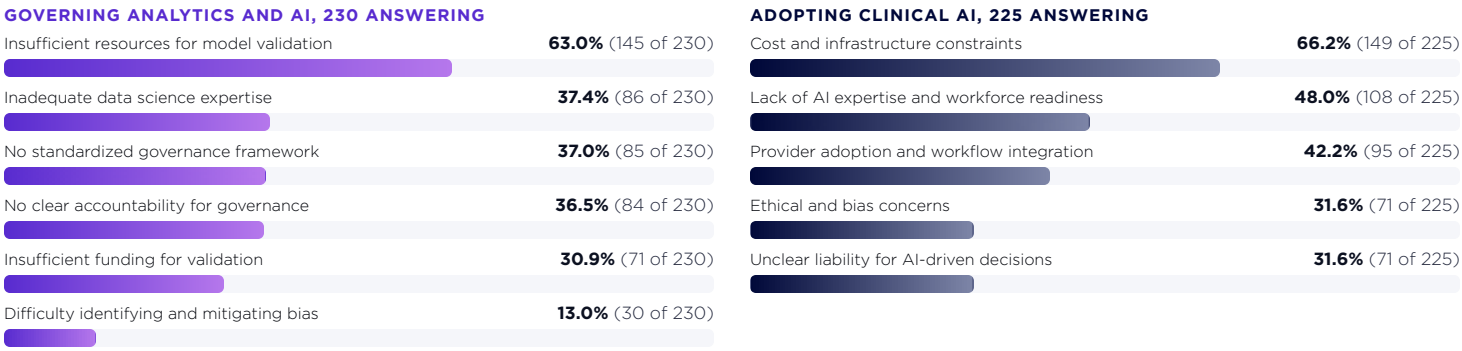
Sources: Nong et al., Health Affairs, January 2025 (2023 American Hospital Association survey data); ECRI Top 10 Health Technology Hazards for 2026; Joint Commission and Coalition for Health AI, Responsible Use of AI in Healthcare, September 2025; Palmieri, Robertson and Cohen, JAMA; Dickinson Wright PLLC, State of AI Regulation in Healthcare, 2026, citing National Conference of State Legislatures tracking. Full references follow in the Appendix.

What organizations say is in the way. Asked about barriers to governing analytics and AI, 63.0% name insufficient resources (skills, staff and time) for comprehensive model validation, far more than name insufficient funding (30.9%). Next come inadequate data science expertise (37.4%), the lack of standardized governance frameworks (37.0%) and the lack of clear accountability (36.5%). Barriers to clinical AI follow the same pattern: cost and infrastructure (66.2%) and lack of AI expertise and workforce readiness (48.0%) outrank ethical and bias concerns (31.6%) and unclear liability (31.6%). In cybersecurity, cost (75.7%) and regulatory uncertainty (59.1%) lead, and 56.5% cite lack of trust in AI decision-making.

Bias is rarely named. Only 13.0% name difficulty identifying and mitigating bias as a governance barrier, even though 14.6% of AI users never test for bias and only 33.3% test regularly. Bias is one of the least-cited barriers and one of the least-tested risks. Untested bias carries real risk, because models trained on historical data inherit the inequities already in health care. The National Academies' 2024 update to Unequal Treatment concludes that unequal treatment persists in clinical care, access and coverage. In a widely cited example, an algorithm that used past health care costs as a proxy for need cut the number of Black patients identified for extra care by more than half, because less had historically been spent on their care (Obermeyer et al., Science, 2019). Bias testing is also an opportunity: well-designed testing can surface and correct disparities that already exist in the system, so that models reduce them instead of repeating them.

TOP BARRIERS TO GOVERNING AI AND TO ADOPTING CLINICAL AI

Resources, skills and cost lead both lists. Bias is named least often on the governance side.



DHMW 2026 questions 5.17 (base 230 organizations) and 9.30 (base 225 organizations), both select up to six. Research questions carry no score. Bars are on a 0 to 100 scale.

Sources: DHMW 2026 research questions 5.17 (base 230 organizations), 9.30 (base 225 organizations) and 2.12.B (base 230 organizations). Research questions are unscored and measure perception; respondents selected up to six options.

Pathways to Closing the Gaps

The Joint Commission and Coalition for Health AI elements give leaders a common frame. The pathway below maps each DHMW gap to a practical first step, a progress measure and a realistic time frame.

1 Inventory 65.3%; unsanctioned use unmeasured — 90 days

Build one enterprise AI registry covering vendor-embedded, third-party and clinician-adopted tools. Assign an owner and risk tier to every entry and publish an approved-tools list.

Progress measure: Share of deployed models with owner and risk tier

2 Pre-deployment evaluation 42.0% — 6 months

Require local validation on the organization's own data before go-live for high-risk tools. Standardize a vendor evidence pack: intended use, training data, known limits, bias results.

Progress measure: Share of high-risk models with documented validation

3 Bias testing 33.3%; 14.6% none — 6 months

Add subgroup performance review to validation and to every scheduled review. Include administrative and revenue cycle tools, not only clinical ones.

Progress measure: Share of models with subgroup results

4 Monitoring 16.4% — 12 months

Name a monitoring owner for each model. Define drift and performance thresholds, capture clinician overrides and safety events, and schedule revalidation.

Progress measure: Share of models with owner, thresholds and override capture

5 Workforce voice and training — 12 months

Seat nursing, patient and family voices in AI governance. Train by role on intended use, limits and escalation, and address skill retention.

Progress measure: Core nursing seat on AI governance; share of users trained

6 Vendor accountability — 12 months

Add AI terms to contracts: disclosure of model changes, revalidation on material change, performance reporting and data-use limits. Update business associate agreements.

Progress measure: Share of AI contracts with revalidation clause

7 Board oversight — 12 months

Report AI inventory, performance and incidents to the board at least quarterly.

Progress measure: Quarterly board AI report in place

Pathways are recommended practices aligned to the Joint Commission and Coalition for Health AI guidance, not DHMW scoring requirements.

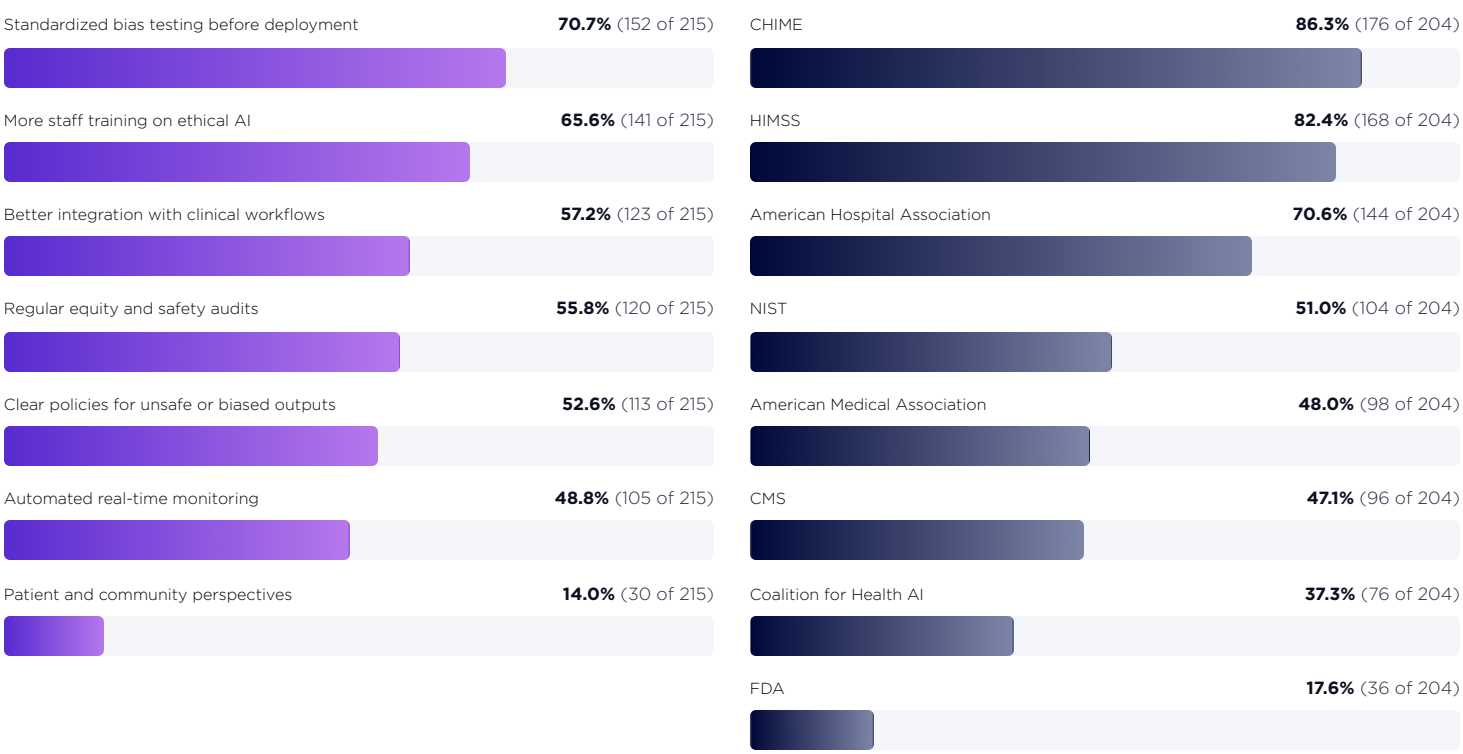
WHAT ORGANIZATIONS SAY WOULD HELP

The top requests are standardized procedures for testing models for bias before deployment (70.7%), more staff training on ethical AI and data governance (65.6%) and better integration with clinical workflows (57.2%), followed by regular equity and safety audits (55.8%), clear policies for unsafe or biased outputs (52.6%) and automated real-time monitoring (48.8%). Patient and community perspectives in governance are requested by 14.0%.

Few organizations sit alongside the guidance writers. Participation in the bodies shaping AI oversight is uneven. CHIME (86.3%), HIMSS (82.4%) and the AHA (70.6%) lead, NIST reaches 51.0%, the AMA 48.0% and CMS 47.1%, while the Coalition for Health AI reaches 37.3% and the FDA 17.6%. What it means for providers: Providers carry the clinical and legal responsibility for the AI they deploy, yet most are not at the table where the guidance is written. Joining the bodies that set expectations, starting with the Coalition for Health AI and NIST, gives organizations early sight of what accreditors and regulators will ask for and a say in making it workable at the bedside. It is also a mark of advanced organizations: 53% of Advanced organizations take part in CHAI, against 25% of all others.

SAFEGUARDS ORGANIZATIONS WANT AND THE BODIES THEY TAKE PART IN

The safeguards most asked for are testing and training. Participation concentrates in the provider associations rather than the bodies writing AI guidance.



DHMW 2026 questions 5.26 (base 215 organizations, select up to six) and 5.25 (base 204 organizations, select all that apply). Research questions carry no score. Bars are on a 0 to 100 scale.

Sources: DHMW 2026 research questions 5.26 (base 215 organizations; select six) and 5.25 (base 204 organizations). Research questions are unscored. Several 5.25 options are new in 2026, so no year-over-year comparison.

Who Is Using AI, and Who Is Helping Govern It

AI is reaching clinicians faster than the training, the data literacy and the governance seats that would let them use it well. This feature sets out who is using it today, who is in the room when it is governed, and what the workforce says is in the way.

AMBIENT LISTENING, FULLY ADOPTED



CORE SEAT ON CYBER RISK GOVERNANCE



88%

of physicians concerned about loss of skills

AMA, 2026

40%

of staff have met unsanctioned AI at work

Wolters Kluwer Health, Dec 2025

AI is reaching physician workflows first.

Ambient listening is the widest split in the use-case chart above: 60.8% for physicians and advanced practitioners against 9.5% for nursing. Ambient listening for nursing is only now becoming reliable, so this is early-stage adoption, but it is already a marker of advanced performers: 62% of Advanced organizations use or are piloting it, against 23% of Building organizations, and 13 of the 14 organizations with a Level 10 submission use it or are piloting it (2 have fully adopted it). Intent runs well ahead of deployment: in the 2025 survey, 88.1% of organizations reported past or planned investment in AI tools for nursing workflows (Plover, 2026), while in 2026 ambient listening for nursing is fully adopted at 9.5% and in use or piloting at 46.9%. The two measures differ (broad AI tools and intent against one named tool), so read the gap as direction, not trend.

> **Leadership takeaway:** Put nursing on the ambient listening roadmap now, and judge pilots by nurses' documentation burden, not only physician time saved.

Nursing has a thinner seat at the governance table.

Nursing is a core member of cyber risk and security governance at 38%, compared with 55% for clinical operations. Patient, family and consumer representatives are core members of innovation governance at only 17.1%. Nursing and allied health are core members of innovation governance at 76.3% of organizations (171 of 224), compared with 61.0% in the 2025 survey in an independent analysis by Dr. Colin Plover (University of Massachusetts Amherst), which also found that organizations with nursing on core committees had stronger governance maturity. The 2026 data replicate part of that finding: organizations with nursing in core governance are more likely to have a standardized evaluation framework (85.4% against 60.4%). They are not clearly more likely to have fully documented AI evaluation before deployment (44.7% against 38.3%) or monitoring afterwards (18.6% against 12.8%). Nursing in innovation governance does not automatically extend to AI oversight, so AI governance committees should include nursing explicitly.

> **Leadership takeaway:** Make nursing, and patient and family representatives, core voting members of AI governance, not only of innovation and cyber committees.

Clinicians are concerned and want a say.

In the AMA's 2026 survey, 88% of physicians were concerned about loss of skills and 85% wanted to be consulted or directly involved in decisions about AI adoption. The governance implication is to give frontline clinicians, including nurses, a formal voice in approving and monitoring AI tools, and to treat deskilling as a monitored risk rather than an afterthought.

> **Leadership takeaway:** Ask clinicians each year which AI tools help and which add burden, and report the results to the AI governance committee.

Who Is Using AI, and Who Is Helping Govern It

Unsanctioned AI is already in the building.

A Wolters Kluwer Health survey of 518 professionals (December 2025) found 40% had encountered unauthorized AI tools at work and nearly 20% had used them, about one in ten for direct patient care. The governance implication is that an approved-tools list and a simple intake route are essential: unsanctioned use signals unmet clinical demand and sits outside every control in the lifecycle (inventory, validation and monitoring), so policy should be paired with sanctioned alternatives that meet the need and a risk-tiered intake process that allows for variable levels of review according to the use case.

Leadership takeaway: Within 90 days, publish an approved-tools list and a risk-tiered intake route, and ask staff what they use today.

Workforce readiness is a stated barrier at every maturity level.

Lack of AI expertise and workforce readiness is cited as a barrier to clinical AI by 48.0% of organizations (45% of Building, 48% of Leading, and 49% of Advanced organizations). However, only 15.7% report comprehensive, role-based data literacy programs.

Leadership takeaway: Fund role-based AI and data literacy training as part of every AI business case, so clinicians and managers can question what the tools tell them.

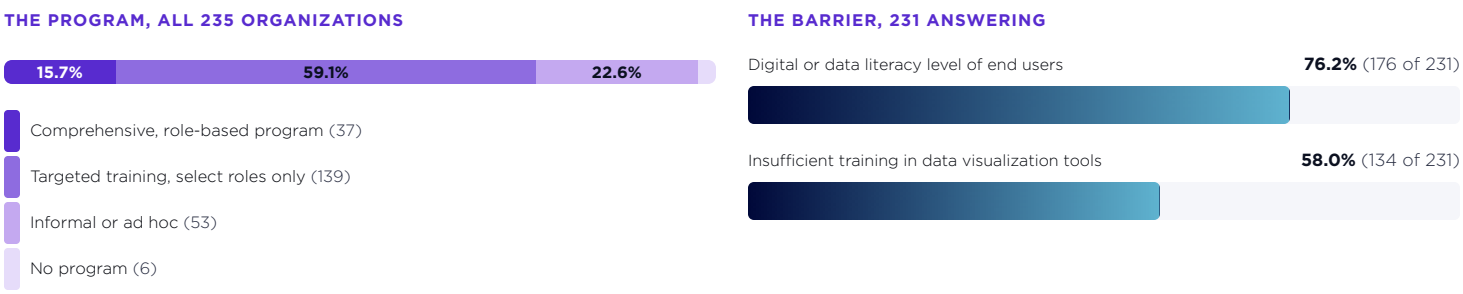
Data literacy is the most common barrier to analytics adoption.

76.2% cite end-user digital or data literacy as a barrier to adopting analytics, and 58.0% cite insufficient training in visualization tools. Training and engagement for end users is the second investment priority for analytics programs (68.1%), behind adoption of AI and advanced analytics (86.6%). These measures cover data literacy, not AI literacy, and the barrier is reported at every maturity level. Only 15.7% have a comprehensive, role-based data literacy program for the broader workforce; 59.1% train select roles only, 22.6% offer informal or ad hoc access and 2.6% have no program (question 5.6, base 235 organizations).

Leadership takeaway: Treat data literacy as a standing workforce program, with role-based paths for clinicians, managers and executives, before scaling self-service analytics and AI.

DATA LITERACY: THE PROGRAM GAP AND THE ADOPTION BARRIER

Four in five organizations train some of the workforce or none of it, and end-user literacy is the most cited barrier to adopting analytics.



DHMW 2026 questions 5.6 (base 235 organizations, single choice) and 5.16 (base 231 organizations, select up to six). Research questions carry no score.

Sources: DHMW 2026 research questions 5.16 (base 231 organizations) and 5.15 (base 232 organizations). Research questions are unscored and measure perception; respondents selected up to six options.

> "Nurses are the largest clinical workforce and often the first to know whether an AI tool helps or adds burden. A seat on the innovation committee is not the same as a voice when AI is approved, validated and monitored. AI governance needs nursing written into its charter, not assumed from other committees."
>
> **Colin Plover PhD, MBA, MPH, MSEd, RN**
> Thomas Jefferson University

Digital Foundations for High Reliability

The digital capabilities that help health systems anticipate, withstand and learn from disruption.

High reliability organizations operate in complex, high-hazard settings for long periods without serious failures. The Agency for Healthcare Research and Quality describes five habits of mind behind them: preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise and commitment to resilience. Health care has adopted the idea because standardization alone cannot manage complexity. Digital systems now sit under almost every one of those habits. They are how organizations see what is happening, how they recover when something breaks and how they learn afterwards.

The pressure is real. ECRI ranked unpreparedness for a sudden loss of electronic systems second on its 2026 list of health technology hazards. In September 2024, flooding from Hurricane Helene closed a single North Carolina plant that supplied about 60% of the country's sterile IV fluids, and hospitals nationwide rationed supply for months.

The DHMW survey cannot show whether an organization practices high reliability, because it does not measure culture, near-miss reporting or leadership behavior. It measures the digital foundations that make high reliability possible. Read across the ten segments, those foundations are strong where governance and routine operations are involved, and thinner where the system must be practiced, tested or shared under stress.

Ten Segments, Ten Reliability Measures

Each segment answers one reliability question. The table shows what is widely in place and where the largest gap sits. A final cross-segment line covers climate and disaster preparedness, which spans Analytics, Population Health and Clinical Quality and Safety.

SEGMENT AND RELIABILITY QUESTION	WHAT IS IN PLACE	WHERE THE GAP IS
Infrastructure Can we keep operating and recover? Commitment to resilience	Tested failover 70.7%; immutable backups 84.5%	Only 39.1% report four-hour recovery for all four critical system classes
Security Can we withstand attack and learn from it? Preoccupation with failure	Automated threat intelligence 87.6%; phishing simulations at least semi-annually 95.3%	Full-scale exercises at least semi-annually 23.6%; only 50.6% trend lessons from every incident quarterly
Supply Chain Do we see disruption coming? Sensitivity to operations	Inventory metrics monitored 94.0%	Resilience and risk metrics monitored 78.5%, the least of six categories; AI critical-item disruption monitoring 9.8%; robotic emergency stockpiling 0.9%
Administration Can capacity and workforce flex with demand? Sensitivity to operations	Intelligent bed management 54.3%; workforce analytics used extensively 57.5%	Predictive bed demand forecasting 33.0%; AI-driven patient flow 14.8%; retention-risk analytics 38.7%
Analytics and Data Management Do we trust what we see? Reluctance to simplify	Analytics in clinical workflows 82% and operational workflows 85%	Master data management for critical domains 38.7%; sustainability and resilience analytics used extensively 15.6%
Interoperability Does information move when it counts? Commitment to resilience	Joined a TEFCA QHIN 80.3%; syndromic surveillance data fully adopted 53.8% (adjacent)	Full two-way real-time exchange 56.8%; 81.5% say community partners lack capability
Population Health Do we know who is most at risk? Sensitivity to operations	Registries 77.4%; risk stratification 68.1% (adjacent)	Predictive and prescriptive analytics 42.6%; heat, air quality and weather data fully adopted 5.6% to 12.9%
Patient Engagement Can patients reach us and take their information with them? Commitment to resilience	Reminders 97.0%; secure messaging 92.3%; care-summary access 94.0% (adjacent to portability)	Patient-generated data integration 35.2%; digital literacy monitored by population 48.1%
Clinical Quality and Safety Do technology and clinicians catch risk early? Preoccupation with failure	76.3% of hospitals use AI in at least one high-risk care domain; barcode scan compliance above 90% at 88.0%	Only 16.4% of AI users fully monitor models after deployment. Decision support for high-risk care is partial: safety bundles (including sepsis) fully enabled 53.9%, AI-assisted alerting fully adopted in the ED 60.1%. Closed-loop medication administration is comprehensive at 65.0% and IV pump integration at 41.1%
Innovation Do we learn before we scale? Deference to expertise	Clinical medicine a core member of innovation governance 82.3%, nursing 76.3%; standardized review framework for high-value investments 77.4%	Patient and family representatives core 17.1%; formal evaluation framework with standardized metrics 38.7%
Climate and disaster preparedness (cross-segment) Do we see environmental hazards coming and respond? Sensitivity to operations	Disaster response coordination in 74.5% of command centers; 89% of organizations reporting climate resilience as an investment area plan to invest in the next two years	Heat, air quality and weather data fully adopted at 5.6% to 12.9%; only 27.7% have even one of five environmental data sources fully adopted; environmental analytics dashboards 30.6%

Sources: DHMW 2026 segment pages and questions 1.12.B, 1.16, 2.8.D, 2.7.F, 3.x, 4.4, 5.4.D, 5.8.E, 5.21, 6.1.A, 6.2, 7.2, 7.3, 8.3, 8.4, 9.3, 9.4.B, 9.5, 9.22, 9.25, 10.3 and 10.4. For how these practices differ by maturity tier, see What the Most Advanced Digital Health Leaders Do Differently.

Three Stories Behind the Table

The Recovery Gap

Infrastructure is where governance and operations are most closely aligned, yet the ability to recover is not demonstrated for most organizations. 70.7% have fully adopted and tested failover, but only 39.1% report that all four critical system classes (clinical, administrative, network and employee communications) can be restored within four hours. Failover testing matters: organizations that have it are about twice as likely to report four-hour recovery for all four systems (45.7%, against 23.5%), and the link holds after controlling for organization size. But 54.3% of those with tested failover (89 of 164) still do not report four-hour recovery for every system. Alternative communications are nearly universal (78.0%) but are not associated with recovery speed. They keep people coordinating; they do not keep systems running.

Self-reported capability, not demonstrated performance; the four-hour band is a survey response category, not a standard. Sources: DHMW 2026 questions 1.12.A, 1.12.B and 1.16 (bases 232 to 235 organizations).

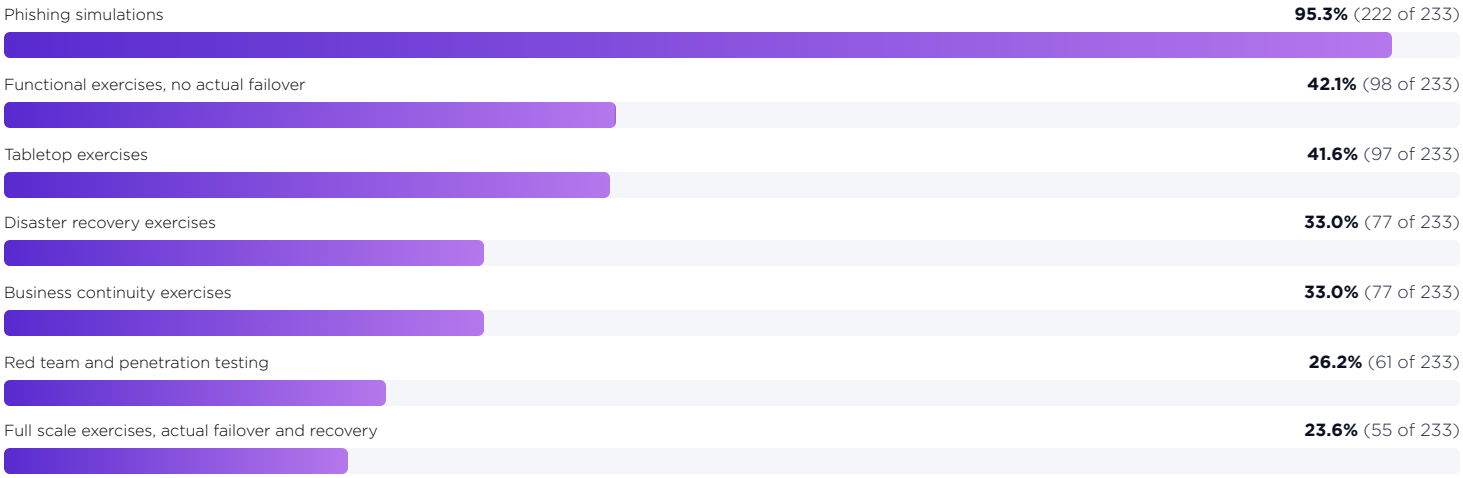
Hazards compound. Climate hazards rarely arrive one at a time. In California, extreme heat alone raised all-cause mortality by about 6% and extreme fine-particle pollution by about 5%, but together they raised it by about 21%. Events also cascade: in 2024, power disruption from Hurricane Beryl cut access to cooling during the week-long heatwave that followed. With only 39.1% of organizations reporting four-hour recovery for all four critical system classes, recovery time during a heat event is a patient safety measure.

The Rehearsal Gap

Organizations rehearse what is easy. Phishing simulations at least semi-annually reach 95.3%, but full-scale exercises with actual failover reach only 23.6%, and 17.6% never run one. The learning loop closes on paper (96.1% document lessons learned and 93.9% review within 30 days), yet only 50.6% review every incident and exercise and trend the findings quarterly. And the people closest to patient care are partly outside the loop. Clinical leaders take part in 81.8% of exercises but only 55.6% receive a quarterly security report, while the board receives one at 85.5% and takes part in 24.2% of exercises.

CYBERSECURITY EXERCISES CONDUCTED AT LEAST SEMI-ANNUALLY

Seven exercise types, ranked. The one that costs least to run is near universal; the one that proves recovery is last.



Share answering Quarterly or more often, or Semi-annual. DHMW 2026 question 2.8.D, base 233 organizations. Bars are on a 0 to 100 scale.

Sources: DHMW 2026 questions 2.8.D (base 233 organizations), 2.9.A and 2.9.C (base 231 organizations), 2.7.F (base 233 organizations) and 2.5 (base 234 organizations).

Two Continuity-critical Operations: the Command Center and Virtual Care

62.3% of hospitals operate a command center or are piloting one (142 of 228). Among the 141 that answered, real-time bed capacity management is a function at 92.2%, critical care bed coordination across facilities 86.5%, emergency department demand forecasting 79.4%, disaster response coordination 74.5% and integrated alarm management 66.7%. Supply chain monitoring and critical resource allocation is in 53.2% and environmental monitoring of critical areas in 44.7%. The command center is where capacity, alarms and disaster response converge, and where environmental and supply signals are least often connected.

The Lancet Countdown identifies impact-based heat-health warning systems, triggered by expected hospital admissions or deaths rather than by temperature alone, as the stronger model for protecting health. Command centers are the natural home for this: 74.5% already coordinate disaster response, but only 44.7% monitor environmental conditions in critical areas.

Virtual care shows the dependency. Real-time virtual visits are fully adopted at 92.3% of organizations, but only 64.3% report that network and phone systems can be restored within four hours and 69.4% employee access and communication systems. Third-party risk, the most cited barrier to running a cyber risk function (82.1%), reaches the platforms virtual care relies on. The survey does not measure telehealth continuity or command center failover directly, so these are dependencies, not scores. Investment in inpatient virtual nursing is widespread (78.1% of organizations reported past or planned investment in 2025), but nurses' experience is mixed. In a December 2025 JAMA Network Open survey of 880 bedside nurses, 57% said virtual nursing does not reduce their workload and 10% said it increases it, while 53% reported better quality of care (11% substantially). Evaluating these models with bedside nurses at the table is a workforce and safety question.

Environmental Hazards: Adaptation Is a Reliability Question

Sensitivity to operations includes seeing the environment a hospital operates in. Environmental risk data is rarely built into decision support or patient messaging. Syndromic surveillance, which many organizations already receive, is fully adopted at 53.8%. Heat index, air quality and weather data are each fully adopted by fewer than 13%, and only 27.7% have at least one of the five environmental data sources fully adopted. Investment is about to change that. Among organizations reporting climate resilience and adaptation as an innovation investment area, 55% invested in the past two years and 89% plan to in the next two, while information technology disaster preparedness is flat (91% to 90%).

Sources: DHMW 2026 questions 7.3 (bases 232 to 234 organizations) and 10.5.G (base 170 organizations for climate resilience and adaptation; 221 for information technology disaster preparedness).

Among the 61 organizations that delivered environmental risk analytics projects, 93.4% focused on syndromic surveillance, but far fewer on heat index alerts (34.4%), air quality (27.9%) or wildfire smoke (18.0%). The tools to see hazards exist; they are not yet connected to the workflows that protect patients.

From hazard data to clinical action. Extreme heat is now one of the largest climate-related threats to health. The 2026 Lancet Countdown report links heat to an estimated 710,000 deaths globally in 2023, 71.5% of them attributable to climate change, and finds that average annual heat-related deaths rose 35.8% after the Paris Agreement entered into force. The patients most at risk are the ones health systems already know: older adults now experience an average of 11.5 heatwave days a year, up from 7.2 a decade earlier, and infants 8.8, up from 5.1. Yet heat index data is fully adopted by 5.6% of DHMW organizations, and only 27.7% have even one environmental data source fully adopted.

The clinical opportunity is specific. When a heat alert is issued, decision support and population health worklists can identify the patients most at risk, including older adults, infants, people with cardiovascular, respiratory or kidney disease, and patients taking medications that impair thermoregulation or fluid balance, such as diuretics, anticholinergics and some antipsychotics. The same data can trigger outreach and patient messaging before the emergency department sees the consequences.

EXTREME HEAT INDICATOR

5.6% of organizations have fully adopted heat index data. 23,200 estimated heat-related deaths among United States adults aged 65 and older in 2022, up 88% from 2000–2004. A modeled estimate of all deaths associated with heat, not only those recorded as heat deaths on a death certificate. Source: Lancet Countdown 2023 United States Brief.

Surveillance is building climate in; hospitals are not yet. Public health is moving faster than hospital decision support. Among WHO Member States reporting to the 2025 global survey, 65.5% have at least one health surveillance system that incorporates climate information, and heat-related illness and mortality is the second most common type. Inside DHMW organizations, syndromic surveillance is fully adopted at 53.8%, but heat, air quality and weather data each sit below 13%.

Globally, the death rate linked to wildfire smoke fell 7% between 2006–15 and 2016–25, but in North America it rose 49%. Wildfire smoke features in 18.0% of the environmental analytics projects DHMW organizations delivered.

What Closing the Gaps Would Mean

If 80% of the organizations answering each question had these capabilities in place, the gains would be large. The Priority Investments section sets out what closing each gap would be worth, capability by capability, with the outcomes to track.

Where to Act

1 Rehearse the real thing (full-scale exercises 23.6%)

Run full-scale failover exercises at least semi-annually that include clinical leaders, facilities and supply chain, and use one definition of a drill across the organization

12 months

Progress measure: Share running full-scale exercises; clinicians taking part

2 Close the recovery gap (39.1%; runbooks for all critical components 58.0%)

Set recovery time objectives by system class, document runbooks and test restoration across clinical, administrative, network and communications systems together

6 to 12 months

Progress measure: Share meeting objectives

3 Bring clinicians into the loop (55.6% receive quarterly security reports)

Add clinical and operational leaders to security and resilience reporting and trend after-action findings quarterly

6 months

Progress measure: Report distribution; trending in place

4 See disruption coming (resilience metrics monitored 78.5%)

Monitor resilience and risk metrics alongside inventory, map single-source dependencies for critical drugs and fluids, and extend command center supply monitoring (53.2%)

6 to 12 months

Progress measure: Resilience metrics monitored

5 Connect hazards to operations (hazard data 5.6% to 12.9%)

Feed heat, air quality, weather and disaster incident data into command center views and patient messaging for at-risk populations

12 months

Progress measure: Hazard data sources fully adopted

6 Monitor AI where the stakes are highest (16.4%)

Document an owner, thresholds and revalidation for AI used in high-risk care, following the AI Governance Gap pathway

12 months

Progress measure: Models with documented monitoring

Pathways are recommended practices, not DHMW scoring requirements.

"High reliability starts with asking, 'What could we miss?' At Baptist Health, an AI-supported screening tool helped our emergency department nurses screen 125,861 potential adult and 60,607 potential pediatric victims of human trafficking as of June 2026. Of those, 314 screened positive. The same discipline has to apply to AI itself. If we deploy models at scale, we need surveillance for how they fail, not just evidence that they were adopted."

Aaron Miri, MBA, DHA, FCHIME, CHCIO
EVP, Chief Digital & Innovation Officer

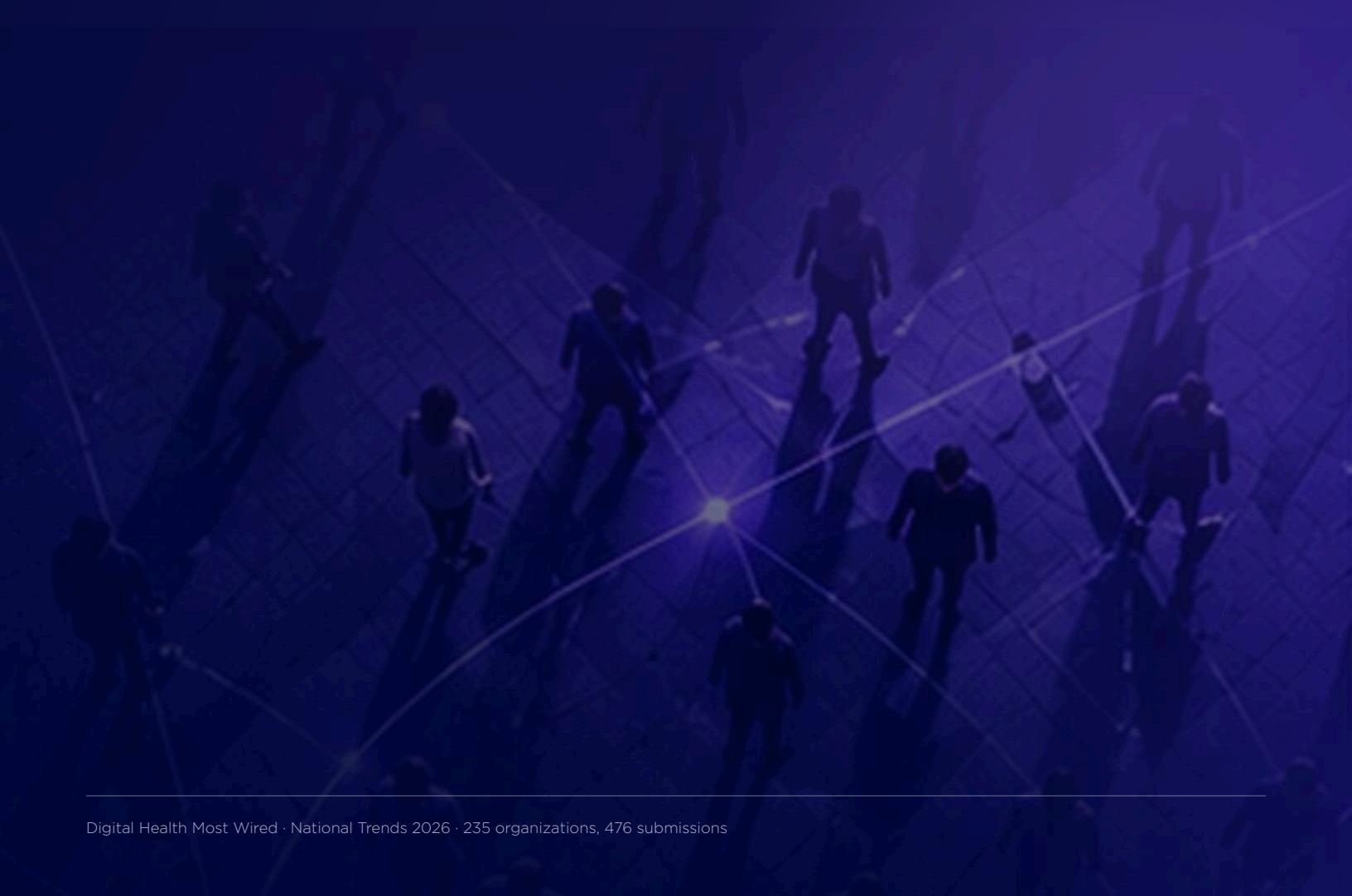
THE SUSTAINABILITY FOOTPRINT

Global health-care greenhouse gas emissions have risen 25.5% since 2016, and the supply chain accounts for most of them in almost every country. Yet only 11.1% of DHMW organizations track supply chain (Scope 3) emissions. The data to act is arriving: 30.7% of medical products and pharmaceuticals now have decision-ready carbon footprint data. AI adds a new line to the footprint: energy demand from AI data centres grew 17% in 2025 and could triple by 2030, but only 3.4% of DHMW organizations monitor the energy their AI consumes.

PART THREE · 2026 DHMW NATIONAL TRENDS REPORT

Segment Snapshots

Digital Health Maturity is shaped by the capabilities, practices and performance of healthcare organizations across ten key segments. This section examines where organizations demonstrate strength, where maturity gaps remain, and how performance varies across the national benchmark. Each segment provides a closer look at the findings and opportunities that can help healthcare leaders prioritize investments and advance Digital Health Maturity.



DHA DIGITAL HEALTH ANALYTICS

SEGMENT SPONSOR | Spectrum BUSINESS

SEGMENT 01 OF 10

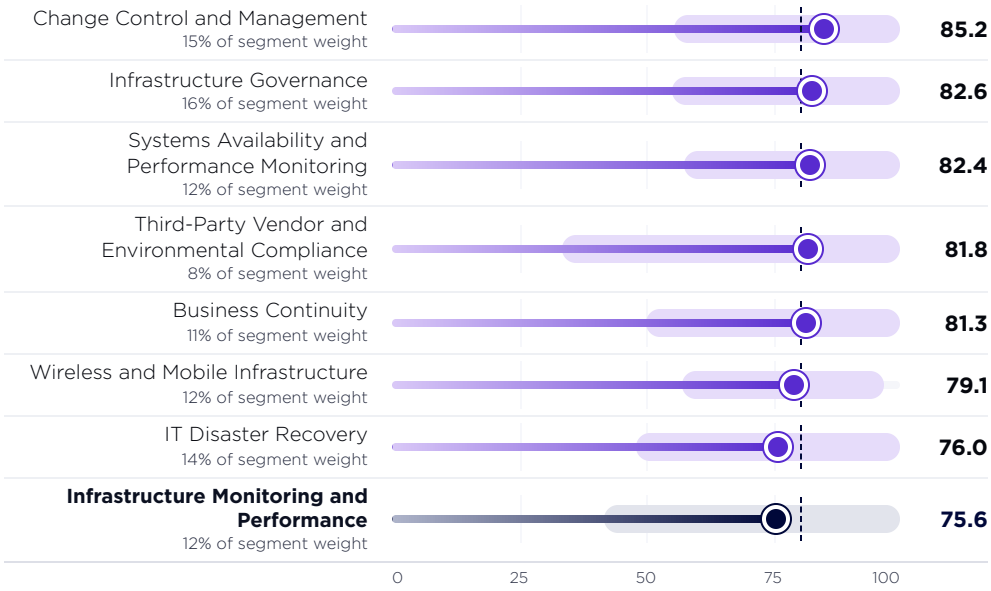
Infrastructure

80.5 pts
NATIONAL MEAN
out of 100 points

Infrastructure remains a foundational strength in Digital Health Maturity, achieving a national mean score of 80.5 out of 100. Organizations demonstrate established capabilities in governance, change control, and system availability monitoring. Yet the next level of maturity depends on more than maintaining uptime. It requires the ability to restore critical clinical systems, sustain operations during disruptions, and use intelligent automation to identify and respond to emerging infrastructure risks. The 2026 findings highlight a shift in focus from infrastructure availability toward operational resilience and recovery readiness.

INFRASTRUCTURE DIGITAL HEALTH MATURITY BY DIMENSION

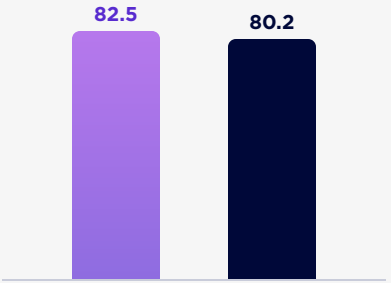
Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Mean score · Greatest opportunity in the segment · Middle 80% of organizations (10th to 90th percentile) · Segment mean, 80.5

Scores are raw dimension achievement, comparable between dimensions. Weight is the dimension's share of the segment score, so a low score on a lightly weighted dimension moves the segment less than its distance suggests.

INFRASTRUCTURE GOVERNANCE VS. OPERATIONAL MATURITY



Scale 0 to 100 points

Governance 82.5 pts
Operational Maturity 80.2 pts

+2.4 points

The smallest governance-to-operations gap of the ten segments: oversight and operational capability are closely aligned here. Monitoring and disaster recovery are where that alignment is weakest.

Governance reflects the Infrastructure Governance dimension score. Operational maturity represents the unweighted mean of the remaining seven infrastructure dimensions. The gap is calculated using unrounded values.

WHAT THE DATA SHOWS

Three findings from the Infrastructure segment, each with the share, the base it is drawn from, and what it means for healthcare.

70.7%

Tested infrastructure failover

Organizations report fully adopted and tested failover capabilities to alternative infrastructure, including secondary data centers, cloud recovery environments, or hot sites. Base 232 organizations. What it means: A tested alternate site is the strongest recovery signal in the data: organizations with it are about twice as likely to report four-hour recovery for all four systems (**45.7%**, against **23.5%**). Even so, more than half still do not meet that bar for every system.

78.0%

Alternative communications during outages

Organizations have fully adopted alternative collaboration and communication tools to maintain essential operations when primary systems are unavailable. Base 232 organizations. What it means: Alternative communication tools keep care teams coordinating when systems go down, but they are not associated with faster recovery. They complement tested failover; they do not replace it.

25.9%

Fully adopted AI-assisted infrastructure triage

Organizations have fully adopted AI-augmented tools to automatically triage high-criticality infrastructure alerts, signaling the emergence of more intelligent IT operations. Base 232 organizations. What it means: AI-assisted triage is where infrastructure teams can gain early warning of failures, but at one in four organizations it is still early. The value depends on alerts being acted on, not only generated.

WHERE TO ACT

Two moves. First, extend failover testing to the systems it does not yet cover: 70.7% have tested failover, and an untested one only shows itself during an outage. Second, write the alternative communication tools 78.0% already own into the downtime procedure, so staff reach for them by habit rather than find them on the day.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DIGITAL HEALTH ANALYTICS

SEGMENT SPONSOR zscaler Healthcare

SEGMENT 02 OF 10

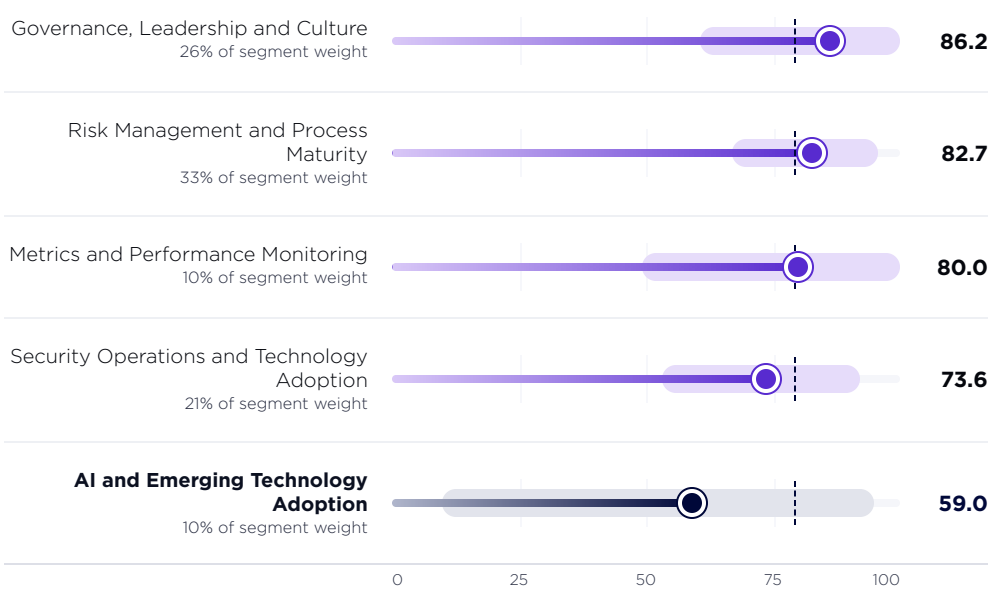
Security

79.1 pts
NATIONAL MEAN
out of 100 points

Security demonstrates established Digital Health Maturity in governance and risk management, with a national mean of 79.1 out of 100. Yet operational security and AI-enabled capabilities remain less mature and more unevenly adopted. The 2026 findings reveal a shift from documenting cybersecurity controls toward integrating threat intelligence, deploying AI where risks are greatest, measuring defensive effectiveness, and routinely validating recovery readiness.

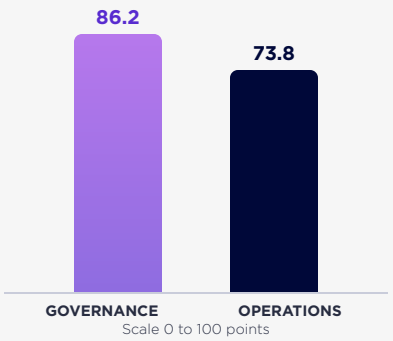
SECURITY DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement, comparable between dimensions. Weight is the dimension's share of the segment score, so a low score on a lightly weighted dimension moves the segment less than its distance suggests.

SECURITY GOVERNANCE VS. OPERATIONAL MATURITY



Governance 86.2 pts
Operational Maturity 73.8 pts

+12.4 points

Security governance exceeds the mean of the other four security dimensions by 12.4 points. This gap suggests that established oversight and risk-management structures have not yet translated consistently into operational capabilities, particularly in AI and emerging technology adoption.

Governance reflects the Governance, Leadership and Culture dimension. Operational Maturity is the unweighted mean of the other four Security dimensions. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Security segment, each with the share, the base it is drawn from, and what it means for healthcare.

87.6%

From threat intelligence to action

Automated, real-time threat intelligence feeds adopted and integrated into routine security operations. 204 of 233. What it means: Detection inputs are largely in place, so the next gains lie in acting on them faster and in measuring how quickly threats are contained.

79.3% ENDPOINT SECURITY · 20.8% THIRD-PARTY RISK

AI adoption is uneven across cyber defense

AI deployed for endpoint security, 184 of 232, against supply-chain and third-party risk monitoring, 48 of 231. What it means: AI is concentrated in endpoint defense, while third-party and supply chain monitoring, the area most exposed to vendor risk, has the least AI support. Third-party risk is the most cited barrier to running a cyber risk function (**82.1%**). The February 2024 ransomware attack on the claims processor Change Healthcare reached an estimated 192.7 million individuals, the largest health care data breach on record in the United States.

35.6%

Cyber recovery testing frequency

Testing recovery procedures at least semi-annually with quarterly reviews. 83 of 233. A combined testing-and-review category, not frequency alone. What it means: About one in three organizations practice recovery from a cyber incident at least semi-annually, and **8.2%** have never formally tested it. An untested plan is an assumption, not a capability.

WHERE TO ACT

Two moves. First, take Zero Trust past identity: 11.2% apply it across identity, devices, networks, applications and data, so for most organizations the data layer is still open once an attacker is inside. Second, point AI at the exposure that is least defended rather than the one already best served: 79.3% use it on endpoints against 20.8% on third-party and supply chain risk, which is the risk 82.1% name as their most cited barrier.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 03 OF 10

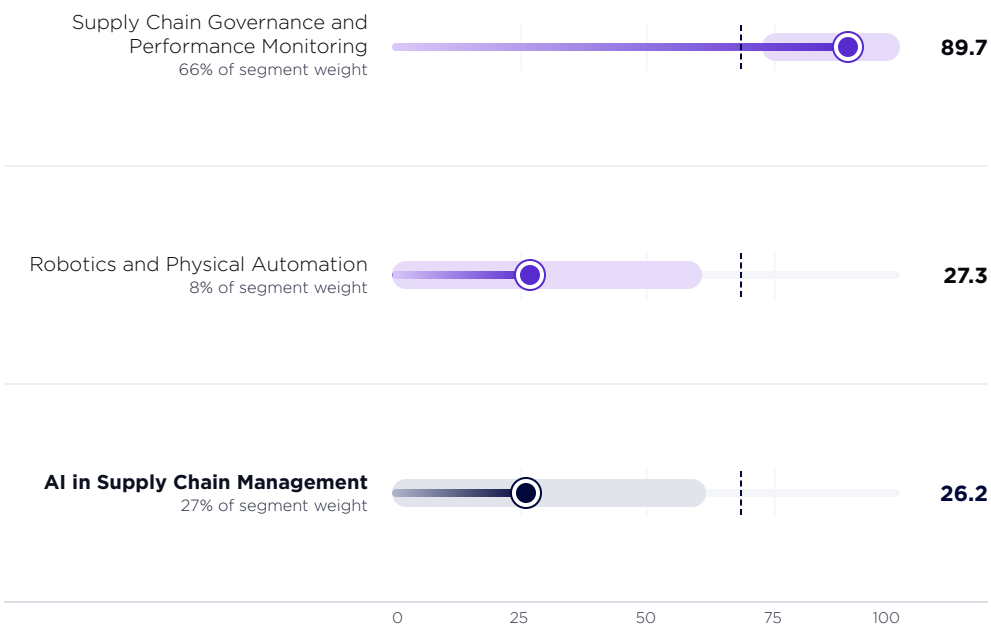
Supply Chain

68.5 pts
NATIONAL MEAN
out of 100 points

Supply Chain Digital Health Maturity reflects a strong foundation in governance and performance monitoring, while predictive analytics, AI, and robotics offer opportunities to advance operational intelligence. Organizations can prioritize capabilities that strengthen supply availability, patient safety, resource stewardship, and resilience according to their size and operational needs.

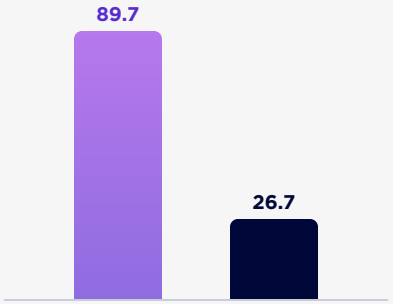
SUPPLY CHAIN DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement. The segment mean is weighted: governance carries 66% of it, which is why 68.5 sits above all three dimension scores, whose unweighted mean is 47.7. Supply Chain also renormalizes weight when a dimension does not apply, so the shares shown are averages rather than fixed constants. No 2025 comparison is available for this segment, see the Appendix.

GOVERNANCE AND ADVANCED AUTOMATION



Governance 89.7 pts
Operational Maturity 26.7 pts

+62.9 points

The widest gap in the report. The oversight structure needed to run supply chain automation safely is already in place for most participating organizations, ahead of the automation itself. Governance first is a strong position from which to expand.

Governance is the Supply Chain Governance and Performance Monitoring dimension. Operational Maturity is the unweighted mean of the other two. Supply Chain redistributes weight when a dimension does not apply, so weights are averages across organizations rather than constants. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Supply Chain segment, each with the share, the base it is drawn from, and what it means for healthcare.

32.9%

Forecasting a smarter Supply Chain

Fully or partially adopting AI-enabled demand forecasting and planning, which anticipates supply needs and supports proactive planning. 77 of 234. What it means: Forecasting is where AI can help most with supplies that are hard to stockpile, such as short-dated drugs and IV fluids, yet two in three organizations still plan on historical patterns.

78.5%

Expanding Supply Chain performance visibility

Resilience and risk management is the least monitored of the six metric categories, 183 of 233, against **94.0%** for inventory. The opportunity is to strengthen operational visibility and data-informed decisions. What it means: Organizations watch inventory more closely than the risk of running out. After Hurricane Helene closed a plant making about **60%** of U.S. IV fluids, seeing disruption risk early became a patient care issue.

17.6% INSTRUMENT HANDLING · 12.0% WASTE SORTING

Advancing robotics in sterile processing

Fully or partially adopted robotic arm-assisted instrument handling, 41 of 233, and automated waste sorting and disposal, 28 of 233. Two different capabilities, reported separately. What it means: Robotics are concentrated in sterile processing and waste handling. Robotic emergency stockpiling is rare (**0.9%** fully adopted), so automated support for emergency supply readiness is limited.

WHERE TO ACT

Two moves. First, forecast where a stockout reaches a patient rather than across the whole catalogue: 32.9% have adopted AI-enabled demand forecasting, and a narrow, measured start is what makes the case for the next one. Second, raise resilience and risk monitoring to the standard already set for inventory: 78.5% monitor it against 94.0% for inventory, and it is the category that gives warning of the next Helene.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 04 OF 10

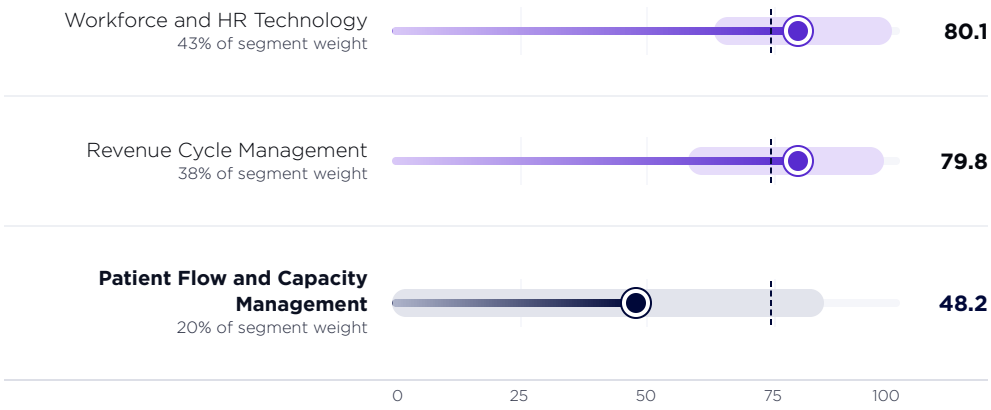
Administration

74.3 pts
NATIONAL MEAN
out of 100 points

Administration Digital Health Maturity is built on transactional work that is already largely automated, with a national segment mean of 74.3 points. Employee self-service, eligibility verification and bed management are established almost everywhere. The predictive layer above each is not: retention risk analytics, denial prevention and AI-driven patient flow run at roughly a third that rate. The opportunity is to use foundations that already exist to decide ahead of events.

ADMINISTRATION DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement. Questions 4.3 and 4.8 are research questions: they carry no score and record how an organization characterizes value. The instrument records no dollar figure, no percent saved and no return-on-investment amount anywhere, so nothing here is evidence of a realized saving.

ESTABLISHED CAPABILITIES AND PREDICTIVE INTELLIGENCE

WORKFORCE AND HR TECHNOLOGY

95% Apply to internal positions, employee self-service

31% Internal talent marketplace

REVENUE CYCLE MANAGEMENT

94% Real-time eligibility verification at registration

43% Predictive analytics for denial prevention

PATIENT FLOW AND CAPACITY MANAGEMENT

54% Intelligent bed management

15% AI-driven patient flow management

Transactional Predictive

Administration is the only segment with no dimension named Governance, so the governance and operations comparison does not apply. The pattern it usually reveals shows up inside each dimension instead. Matrix figures are the fully adopted share. Bases 220 to 235 organizations.

WHAT THE DATA SHOWS

Three findings from the Administration segment, each with the share, the base it is drawn from, and what it means for healthcare.

38.7%

Run retention risk analytics

Against **83.0%** with employee recognition platforms and **75.3%** with voice-of-employee tools. Organizations gather staff feedback widely; predicting who is at risk of leaving is the next opportunity. What it means: With workforce shortages constraining capacity, predicting who is likely to leave is a direct lever on access to care. Fewer than four in ten organizations use it.

49.4%

Automate prior authorization submission and tracking

A long-standing administrative burden, and half of participants still manage it manually. What it means: automation rises sharply with size, **28.9%**, **46.6%** and **70.7%** across small, mid-sized and large organizations, leaving smaller organizations most exposed. From 1 January 2027 the CMS Interoperability and Prior Authorization Final Rule requires impacted payers to run prior authorization APIs, and providers that have not automated will capture less of the benefit.

23.5%

Have fully adopted artificial intelligence in the operating room

Operating room scheduling is a widely cited operational priority, and more than three quarters still schedule it on historical averages. Base 230 organizations. What it means: Operating room time is among the most valuable and constrained assets in a hospital. AI scheduling can raise throughput, but three in four organizations still schedule on historical averages.

WHERE TO ACT

Two moves. First, automate prior authorization submission and tracking: 49.4% have, and the 41.8 point spread from the smallest organizations to the largest means the burden falls hardest where there is least capacity to absorb it. Second, turn the staff feedback already being gathered into prediction: 38.7% run retention risk analytics against 83.0% with recognition platforms, so the data is in hand and the model is not.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA DIGITAL HEALTH ANALYTICS

SEGMENT SPONSOR Everpure

SEGMENT 05 OF 10

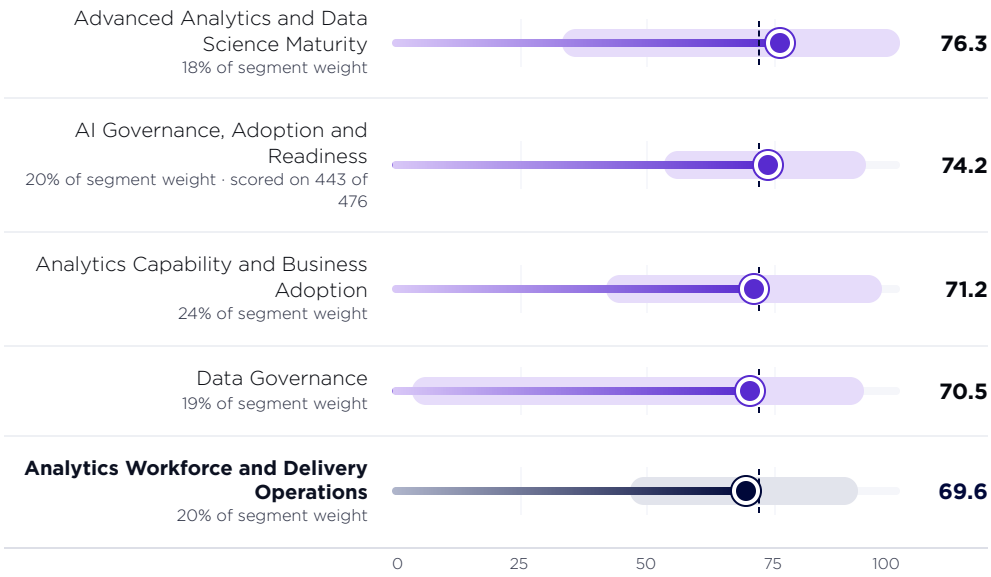
Analytics and Data Management

72.1 pts
NATIONAL MEAN
out of 100 points

Analytics and Data Management provides the foundation for advancing Digital Health Maturity, connecting data across clinical, operational, and administrative systems to support more informed decision-making. As healthcare organizations expand their analytics capabilities, maturity increasingly depends on how effectively data is integrated, made accessible, and translated into actionable intelligence. Strong data foundations, embedded analytics, and workforce capabilities help organizations move beyond reporting toward predictive insights and measurable improvements in care delivery and operations.

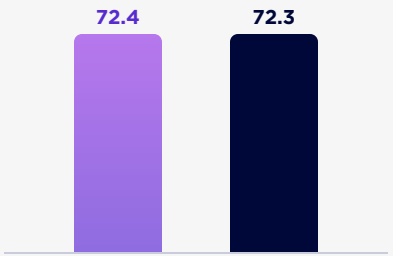
ANALYTICS AND DATA MANAGEMENT DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Raw dimension achievement. AI Governance is scored on 443 submissions: it is excluded for the 16 organizations with no AI in use.

GOVERNANCE AND ANALYTICS OPERATIONS



Governance 72.4 pts
Operational Maturity 72.3 pts

+0.0 points

The only segment where the two sit level. Analytics has two dimensions named Governance and they average 72.4 against an operational mean of 72.3. Nothing here is running ahead of anything else; the whole segment is mid-table together.

Governance is the mean of the two dimensions named Governance. Operational Maturity is the unweighted mean of the other three. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Analytics and Data Management segment, each with the share, the base it is drawn from, and what it means for healthcare.

39.9%

Making analytics accessible across the enterprise

Run a comprehensive self-service analytics ecosystem, 93 of 233. With the tier below it, **85.8%** offer self-service in some form. What it means: Self-service moves analysis closer to clinical and operational decisions, but only when users can interpret results. **76.2%** of organizations name end-user data literacy as a barrier.

38.7%

Building trust in enterprise data

Have master data management for critical domains, 89 of 230. Catalogs reach **66.5%** and automated quality monitoring **60.0%**: finding data is further along than reconciling it. What it means: Without a single trusted definition of a patient, provider or location, analytics and AI results can disagree across systems. Master data is the quiet prerequisite for AI at scale.

50.2% RETURN TRACKED **49.4%** FORECAST ACCURACY

Measuring the value of analytics

Track return on investment or financial impact, 117 of 233, and forecast accuracy, 115 of 233. Only half of analytics programs measure their own ROI. What it means: Half of analytics programs cannot show their own return, which weakens the case for continued investment as AI competes for the same funding.

WHERE TO ACT

Two moves. First, reconcile the data rather than only catalogue it: 38.7% have master data management for critical domains while catalogs reach 66.5%, so finding data is further along than trusting it. Second, measure the return on analytics itself: 50.2% track the return on their own projects, and a program that cannot show its value competes badly for the next round of funding.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 06 OF 10

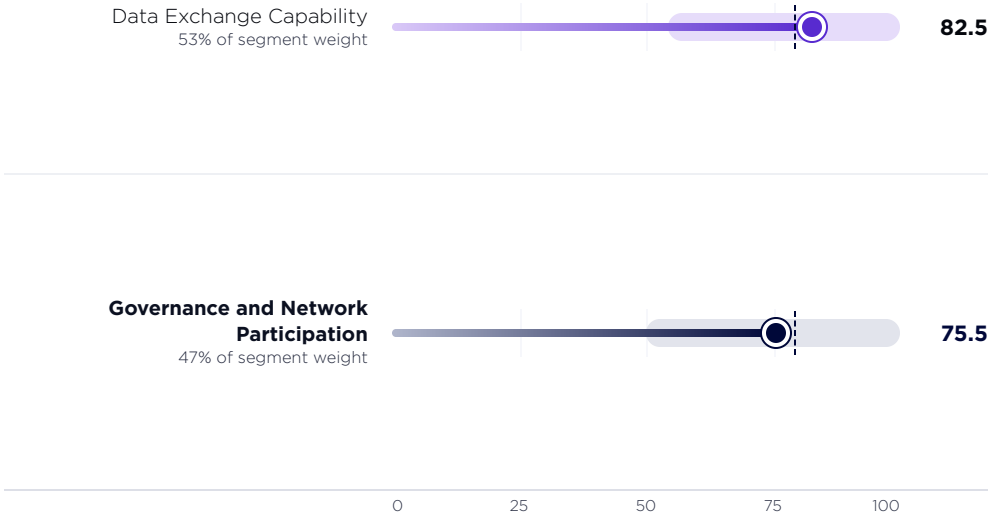
Interoperability

79.2 pts
NATIONAL MEAN
out of 100 points

Interoperability continues to be a foundational strength of Digital Health Maturity, enabling healthcare organizations to exchange clinical information across systems, providers, and care settings. As connectivity becomes more established, the opportunity is to advance how exchanged information is integrated into everyday clinical workflows. Interactive access, structured data integration, and reliable referral information can help transform interoperability from a technical capability into a practical resource for care coordination, clinical decision-making, and continuity of care.

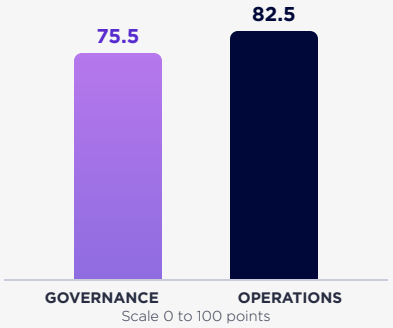
INTEROPERABILITY DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement. This is the smallest segment in the program: four scored questions. Question 6.1.A is United States only, so its base is 229.

GOVERNANCE AND EXCHANGE OPERATIONS



Governance 75.5 pts
Operational Maturity 82.5 pts

−7.0 points

Exchange capability runs ahead of governance. Organizations have built the connections, often to meet federal interoperability requirements. The next step is the governance that decides who sees what, when, and how quickly.

Governance is the Governance and Network Participation dimension. Operational Maturity is the Data Exchange Capability dimension. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Interoperability segment, each with the share, the base it is drawn from, and what it means for healthcare.

84.9%

Strengthening governance of provider access

Manage affiliated-provider EHR access through a formal framework: **58.0%** structured, **26.9%** risk-stratified. 186 of the 219 granting any access. What it means: Governed access is nearly universal. The open question is whether the framework puts the right information in front of the right clinician quickly enough, including in an emergency.

80.3%

Advancing participation in trusted exchange networks

Have joined a TEFCA Qualified Health Information Network, 184 of 229 United States organizations. A further **15.3%** are actively exploring options. What it means: Participation in national exchange networks is now mainstream, which puts nationwide record retrieval within reach of most organizations. The value depends on whether retrieved data reaches clinicians in their workflow.

81.2%

Modernizing behavioral health referral information

Maintain behavioral health and substance use referral directories by hand, 190 of 234, against **22.2%** using an automated feed. Directory accuracy depends on how entries are maintained. What it means: Behavioral health referrals depend on directories maintained by hand, which go stale. Automating them is a low-cost way to shorten waits for patients in crisis.

WHERE TO ACT

Two moves. First, automate behavioral health and substance use referral directories: 81.2% are maintained by hand, and stale directories lengthen waits for patients in crisis. Second, route records retrieved through national exchange into the clinician's workflow rather than a separate viewer, so that 80.3% network participation becomes information used at the point of care.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 07 OF 10

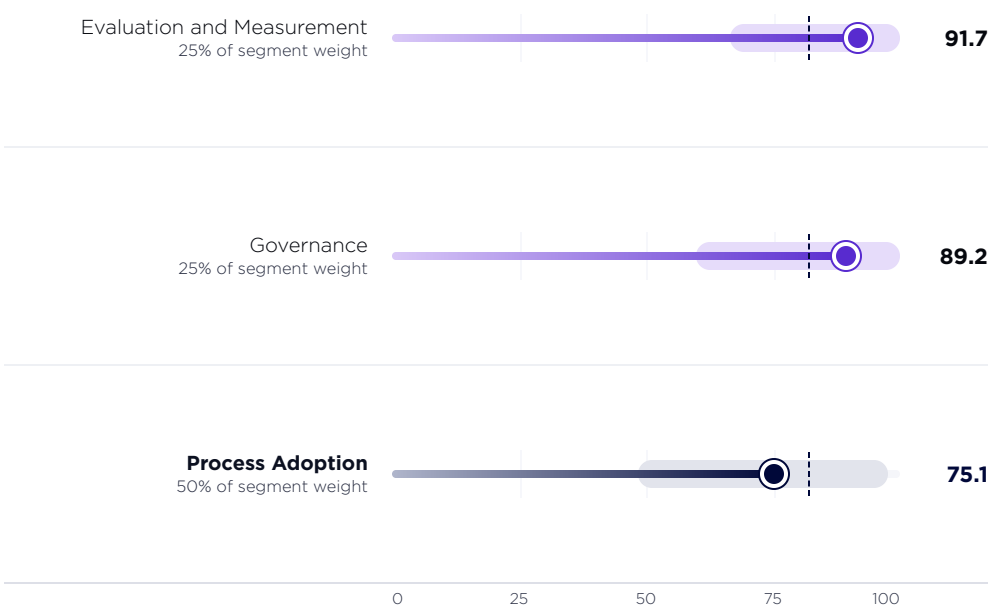
Population Health

81.8 pts
NATIONAL MEAN
out of 100 points

Population Health is the highest-scoring of the ten 2026 Digital Health Most Wired segments, with a national Digital Health Maturity mean of 81.8. Strong governance and performance measurement capabilities provide a foundation for identifying patient populations, tracking outcomes, and supporting coordinated care. As healthcare organizations advance their digital capabilities, the opportunity is to translate population-level insights into timely, personalized interventions through predictive analytics, intelligent care management workflows, and continuous monitoring across the care journey.

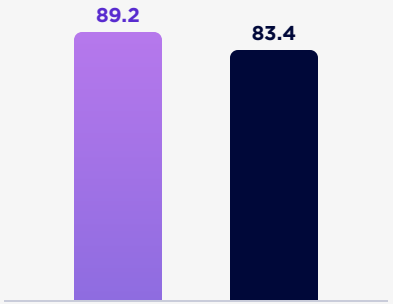
POPULATION HEALTH DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement. Process Adoption carries half the segment weight, so the 16.6-point gap below Evaluation and Measurement is what holds the segment at 81.8.

GOVERNANCE AND POPULATION HEALTH OPERATIONS



Scale 0 to 100 points

Governance 89.2 pts
Operational Maturity 83.4 pts

+5.8 points

Population Health measures itself better than it acts on what it measures. Evaluation and Measurement reaches 91.7 while Process Adoption sits at 75.1, a gap of 16.6 points on the dimension that carries half the segment weight.

Governance is the dimension named Governance. Operational Maturity is the unweighted mean of Evaluation and Measurement and Process Adoption. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Population Health segment, each with the share, the base it is drawn from, and what it means for healthcare.

51.1% TOTAL COST OF CARE **41.8%** RISK SCORES TO PAYERS

Connecting Population Health to value-based care

Fully adopt total cost of care analytics, 120 of 235, and report risk scores to payers, 97 of 232. The least adopted part of the segment. What it means: The financial case for population health depends on cost and risk data shared with payers, the least adopted part of the segment. Without it, organizations carry risk they cannot fully see or price.

85.5%

Bringing Population Health insights to clinicians

Fully adopt quality measures at the physician level, 200 of 234. Care-gap decision support reaches **77.8%** and high-risk dashboards **63.9%**. What it means: Quality performance reaches the physician level at most organizations, but high-risk dashboards trail. Insight is further along than the targeting of the patients who most need intervention.

68.8%

Prioritizing predictive Population Health

Name predictive analytics and risk stratification as a priority for new investment, 161 of 234: the most selected of fourteen options. What it means: Predictive population health is the top investment priority in the segment, signalling that the field wants to move from identifying risk to intervening earlier. Only **42.6%** have fully adopted predictive and prescriptive analytics today.

WHERE TO ACT

Two moves. First, close the value-based care gap: 51.1% fully adopt total cost of care analytics and 41.8% report risk scores to payers, the least adopted part of the segment and the part contracts are written against. Second, fund the predictive work leaders have already named: 68.8% select predictive analytics and risk stratification as their first priority for new investment, the most selected of fourteen options.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 08 OF 10

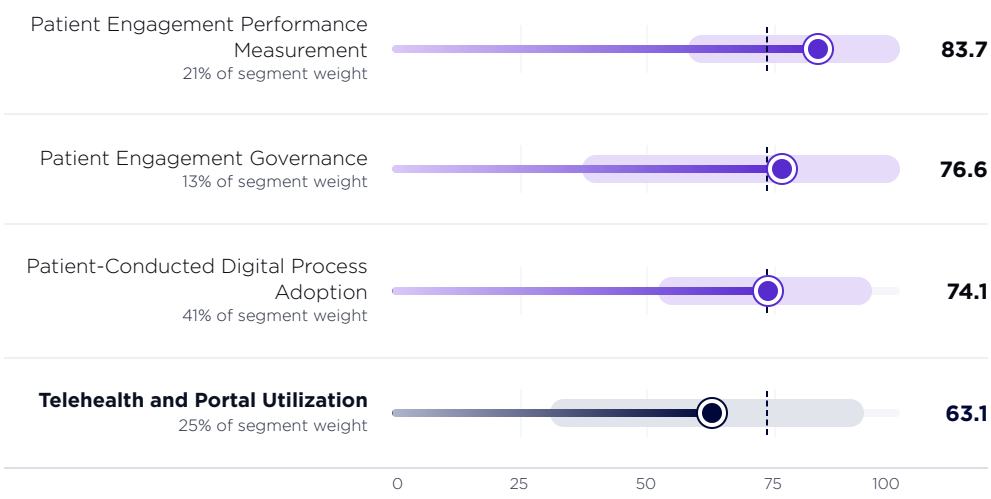
Patient Engagement

73.8 pts
NATIONAL MEAN
out of 100 points

Patient Engagement Digital Health Maturity reflects widespread adoption of digital access and communication capabilities, including appointment reminders, secure messaging, and patient-facing information tools. As these foundational capabilities become more established, the opportunity is to advance meaningful, two-way participation in care. Shared care planning, patient-reported outcomes, personalized engagement, and the measurement of digital adoption across patient populations can help organizations move beyond providing digital access toward more connected, responsive, and patient-centered care.

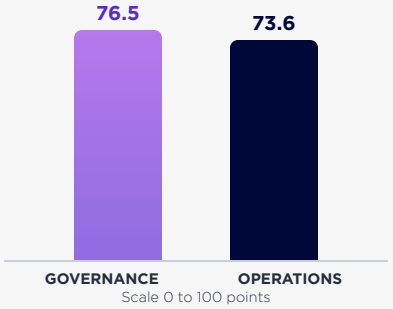
PATIENT ENGAGEMENT DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Scores are raw dimension achievement. Telehealth and Portal Utilization measures how much these capabilities are used, not whether they exist.

GOVERNANCE AND ENGAGEMENT OPERATIONS



- Governance 76.5 pts
- Operational Maturity 73.6 pts

+2.9 points

A narrow gap, so the weighting matters more than the gap itself: the two dimensions with the most room carry 66.4% of the segment.

Governance is the Patient Engagement Governance dimension. Operational Maturity is the unweighted mean of the other three. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Patient Engagement segment, each with the share, the base it is drawn from, and what it means for healthcare.

35.2%

Making patients partners in care

Fully adopt patient-generated health data integration, 82 of 233. Health coaching reaches **23.7%** and shared decision aids **22.4%**. What it means: Wearable and home-collected data change care only when clinicians can see it in the record. With about a third integrating it, most patient-generated data stays in a separate app.

72.8% ACCESSIBLE TOOLS **48.1%** LITERACY BY SEGMENT

Measuring engagement across patient populations

Monitor adoption of multilingual and accessible tools, 171 of 235; only **48.1%** monitor digital literacy by population segment. What it means: Most organizations monitor multilingual and accessible tools, but fewer than half track digital literacy by population segment. Without that, digital engagement can widen gaps in access.

23.9%

Understanding where telehealth delivers access

Median share of behavioral health appointments by telehealth. No other line reaches **10%**: primary care **8.0%**, chronic disease **6.1%**. What it means: Telehealth has settled into behavioral health but remains marginal elsewhere, which shows where virtual access is genuinely changing who can be reached.

WHERE TO ACT

Two moves. First, bring patient-generated health data into the record: 35.2% fully adopt it, and without it engagement stays one-way. Second, measure engagement by population rather than in aggregate: 72.8% monitor adoption of multilingual and accessible tools but 48.1% monitor digital literacy by population segment, so the groups being left behind are the ones least visible in the numbers.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA DIGITAL HEALTH ANALYTICS

SEGMENT SPONSOR Epic

SEGMENT 09 OF 10

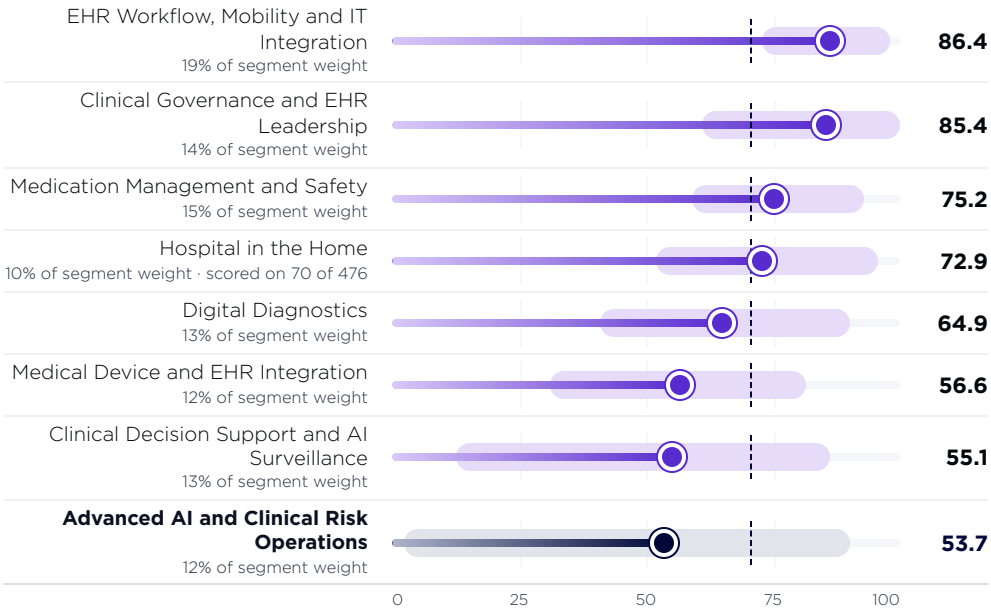
Clinical Quality and Safety

70.3 pts
NATIONAL MEAN
out of 100 points

Clinical Quality and Safety Digital Health Maturity reflects strong clinical governance and established electronic health record capabilities, with a national segment mean of 70.3. As healthcare organizations advance their digital capabilities, opportunities remain to strengthen the integration of medical devices, clinical decision support, digitally enabled safety protocols, and AI-supported clinical surveillance. Progress increasingly depends on translating governance and technology investments into reliable, integrated workflows that support clinicians in delivering safe, effective, and coordinated care.

CLINICAL QUALITY AND SAFETY DIGITAL HEALTH MATURITY BY DIMENSION

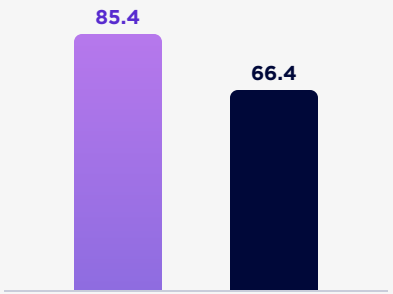
Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Mean score · Greatest opportunity in the segment · Middle 80% of organizations (10th to 90th percentile) · Segment mean, 70.3

Hospital in the Home applies to 70 of 476 submissions; its weight is redistributed.

CLINICAL GOVERNANCE AND TECHNOLOGY INTEGRATION



Scale 0 to 100 points

Governance 85.4 pts
Operational Maturity 66.4 pts
+19.0 points

The committee exists, the charter is reviewed and the line of accountability reaches the executive. What is uneven is the practice underneath.

Governance is the Clinical Governance and EHR Leadership dimension. Operational Maturity is the unweighted mean of the other seven. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Clinical Quality and Safety segment, each with the share, the base it is drawn from, and what it means for healthcare.

41.1%

Closing the loop on medication safety

Have bidirectional or closed-loop integration between IV smart pumps and the EHR, 92 of 224. What it means: Smart pumps that cannot exchange data with the EHR leave nurses transcribing orders and doses by hand, the step where programming and documentation errors occur. Closing the loop is among the most direct digital medication safety gains.

26.3%

Connecting medical devices to clinical workflows

Have bidirectional integration for cardiac monitoring numeric data, 60 of 228. Another **44.3%** are real-time one-way only. What it means: Telemetry data that must be entered manually is slower, less complete and absent when it matters, so device integration decides whether early-warning models have usable data.

53.2%

Radiology AI: widely governed, rarely tested for bias

Routinely integrate AI imaging across multiple applications, 123 of 231. Of the 186 using AI imaging, **76.9%** have a governance committee, **69.4%** formal clinical validation and **58.6%** performance monitoring, but only **36.0%** assess performance across patient demographics. What it means: Radiology shows what mature AI oversight looks like and is a model for other specialties. Bias assessment is the missing piece, and the monitoring measured here is a lower bar than the fully documented monitoring counted elsewhere.

WHERE TO ACT

Two moves. First, close the loop between IV smart pumps and the record: 41.1% have bidirectional or closed-loop integration, and the published evidence puts the benefit in preventable medication administration errors. Second, monitor clinical AI after it is live: 16.4% of AI users have a fully structured post-deployment process against 42.0% evaluating before deployment, so most models are checked once and then trusted.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

DHA
DIGITAL HEALTH ANALYTICS

SEGMENT 10 OF 10

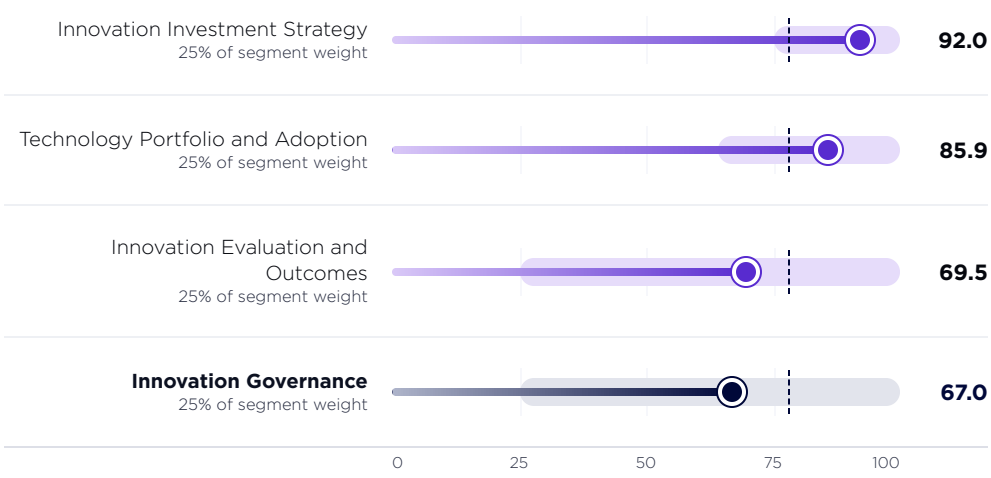
Innovation and Emerging Technologies

78.1 pts
NATIONAL MEAN
out of 100 points

Innovation and Emerging Technologies Digital Health Maturity reflects strong organizational commitment to digital advancement, with a national segment mean of 78.1. Innovation investment strategies and technology portfolios demonstrate established capabilities, while governance and evaluation practices present opportunities for further development. As healthcare organizations expand investments in emerging technologies, maturity increasingly depends on defining success before implementation, engaging the appropriate clinical and operational stakeholders, and consistently measuring whether innovations deliver their intended value.

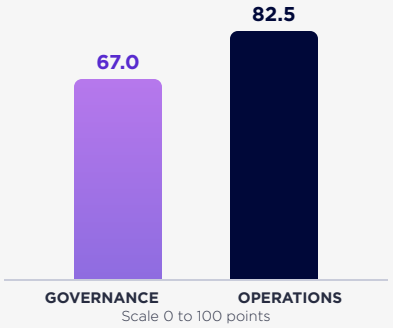
INNOVATION AND EMERGING TECHNOLOGIES DIGITAL HEALTH MATURITY BY DIMENSION

Mean score for each dimension out of 100. The shaded band runs from the tenth to the ninetieth percentile, so a wide band means results vary widely across peers. Colours are keyed below.



Questions 10.11 to 10.15 are research questions: they carry no score and measure perception. Questions 10.3.B to 10.3.G are conditional on 10.3.A, base 180 organizations.

INNOVATION INVESTMENT AND OVERSIGHT



Governance 67.0 pts
Operational Maturity 82.5 pts
–15.5 points

Investment runs ahead of evaluation. Organizations commit to innovation more readily than they build the frameworks that show whether it delivered.

Governance is the Innovation Governance dimension. Operational Maturity is the unweighted mean of the other three. The gap is calculated from unrounded values.

WHAT THE DATA SHOWS

Three findings from the Innovation and Emerging Technologies segment, each with the share, the base it is drawn from, and what it means for healthcare.

93.2% STRATEGIC AND BUSINESS RISK
42.6% ENVIRONMENTAL AND SOCIAL

Defining success before innovation begins

Of the 180 with a standardized evaluation framework, **93.2%** assess strategic and business risk in it. Environmental and social risk is in **42.6%**. Everything except ESG sits above **87%**. What it means: Strategic and business risk are almost always considered before investment, but environmental and social risk is considered by fewer than half, which matters as resilience and community impact become investment criteria.

82.3% MEDICINE
17.1% PATIENTS AND FAMILIES

Bringing clinical voices into Innovation Governance

Medicine is a core member of innovation governance in **82.3%** of organizations and nursing in **76.3%**. Patient, family and consumer representatives are core members in **17.1%**. Bases 218 to 226 organizations. What it means: Clinicians shape innovation decisions at most organizations, but patients and families are core members at only about one in six. The people who live with the technology are the least represented in choosing it.

89.4%

Measuring innovation beyond financial ROI

Use clinical outcomes to assess return, 210 of 213 answering. Patient satisfaction reaches **82.1%** and workforce retention **70.2%**. Real-time patient experience feedback is lowest at **57.0%**. What it means: Most organizations judge innovation by clinical outcomes, not only dollars. Real-time patient experience feedback is the least used measure.

WHERE TO ACT

Two moves. First, put patients on the governance that decides what gets built: medicine is a core member of innovation governance in 82.3% of organizations and patient, family and consumer representatives in 17.1%. Second, hold environmental and social risk to the standard this segment already sets elsewhere: it sits in 42.6% of evaluation frameworks while every other risk category is above 87%, and 89.4% already assess return on clinical outcomes.

A deep-dive report on this segment, with the full question set and peer comparisons, follows this publication.

PART FOUR · 2026 DHMW NATIONAL TRENDS REPORT

Care Settings

Digital Health Maturity looks different across care settings. This section examines how scoring priorities vary across ambulatory and long-term and post-acute care, revealing opportunities to advance digital capabilities and performance.

- Understanding Care-Setting Scores
- What Drives Digital Maturity
- Telehealth Adoption and Utilization

06

SECTION 11

Ambulatory and Long-Term and Post-Acute Care

Where the ambulatory front door is already digital and where the patient is still waiting on the organization to act first, and whether the record follows a patient who moves into long-term and post-acute care.

218
AMBULATORY ARMS

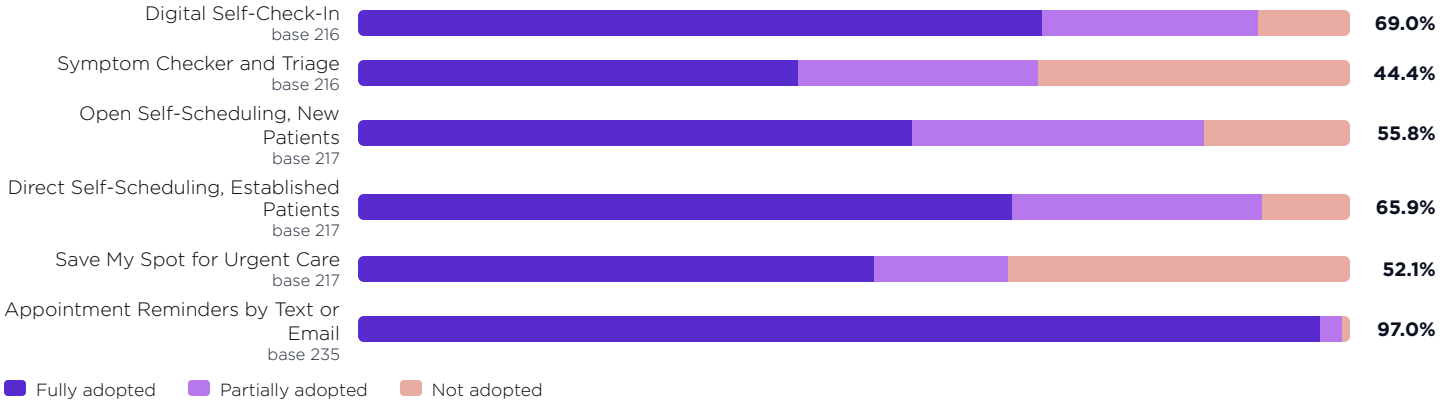
30
LTPAC ARMS



Ambulatory care is where most patients meet a health system, and 218 of the 476 submissions are ambulatory arms. Care setting is a scoring lens, not a separate group of organizations: the scores below are the same answers weighted for ambulatory practice.

DIGITAL ADOPTION ACROSS THE AMBULATORY PATIENT JOURNEY

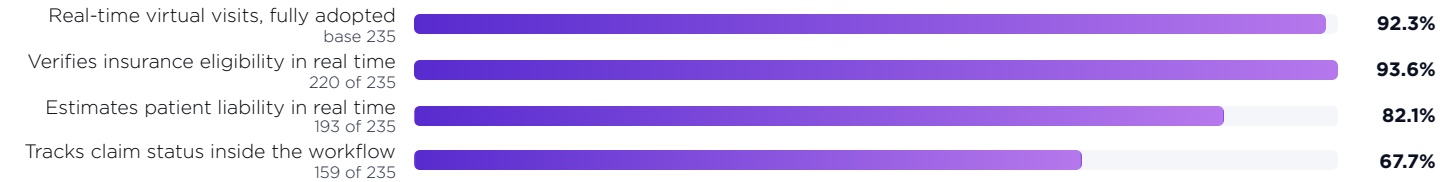
Share of organizations at each stage of adoption, for the six scheduling and intake items the instrument marks for ambulatory practice.



Appointment reminders are asked of every organization, which is why that row carries a base of 235 while the five marked ambulatory items reach roughly 216. Maturity under the ambulatory lens also varies with organization size: across the 208 ambulatory arms reporting an employee count, the spread between the smallest and largest third is 22.1 points in Patient Engagement, 20.5 in Analytics and Data Management and 17.7 in Innovation, against 8.5 in Security. These comparisons do not establish size as the cause.

VIRTUAL CARE AND REVENUE CYCLE CAPABILITIES

Every figure in this block covers all participating organizations. Each row prints its own base.

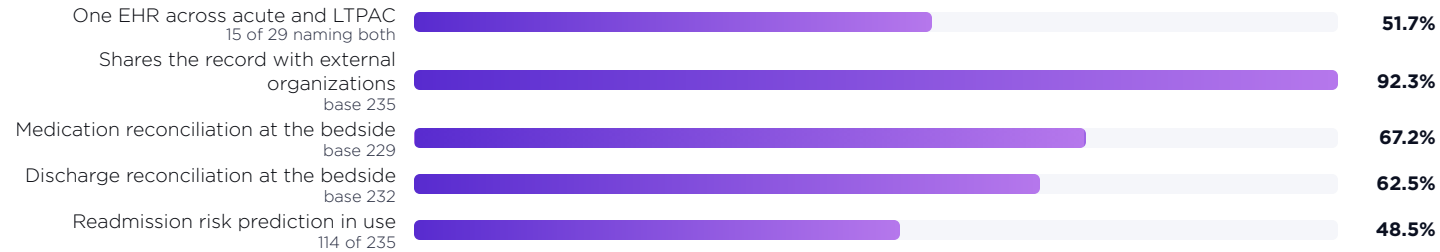


Virtual visits are a single adoption item; the three revenue cycle rows are a multi-select, so an organization can appear on all three or on none. Nine selected none of them. The 2026 instrument asks no question about electronic prescribing, so no figure for it appears in this report.

LONG-TERM AND POST-ACUTE CARE

The Data Must Follow the Patient

Thirty of the 476 submissions are LTPAC arms, and every organization that ran one also ran an acute arm. The question is therefore not how long-term and post-acute providers score, but whether the record, the medication list and the care plan survive the move between settings.



Share with each capability fully in place. The two bedside rows are question 9.2.B, which asks WHERE a task can be done: these are the organizations where it works on mobile as well as a fixed workstation, because a transition happens at a bedside. External finding, not from this survey: ONC reports only 16% of hospitals send summary of care records to most or all post-acute providers (Data Brief 71, 2023).

WHAT TO WATCH

The gap between pushing and pulling. Appointment reminders reach 97.0% fully adopted, a message the organization sends. Where the patient initiates, the figures fall: open self-scheduling at 55.8% and a symptom checker at 44.4%.

DIGITAL HEALTH ANALYTICS

IN CLOSING

What the 2026 Data Says

Breadth has stopped separating organizations. What separates them now is depth, oversight and evidence.

The 2026 Digital Health Most Wired findings reflect continued progress in digital health adoption, with participating organizations demonstrating established capabilities across infrastructure, interoperability, clinical technology and emerging innovation. Yet digital maturity increasingly depends on what organizations do with these capabilities. Integration, governance, resilience and measurable outcomes are becoming important differentiators as healthcare leaders move beyond initial implementation. Year-over-year findings reinforce this evolution, showing progress across comparable digital practices while highlighting opportunities to strengthen the foundations that support sustainable digital transformation.

01

Digital Maturity Is Defined by Depth, Not Just Adoption

Digital technologies are widely established across participating healthcare organizations. The next stage of maturity depends on how effectively these capabilities are integrated into clinical and operational workflows, supported by governance and evaluated for performance. The findings highlight opportunities to strengthen real-time information exchange, clinical technology oversight and operational resilience. As organizations expand their digital portfolios, the emphasis is shifting from the presence of technology toward its reliability, usability and demonstrated value.

The next investment priority is strengthening the depth and effectiveness of existing digital capabilities, not simply adding more technology.

02

Artificial Intelligence Is Advancing Faster Than Its Oversight

Artificial intelligence is among the fastest-advancing areas of digital health. Across comparable survey items, AI-related capabilities showed stronger year-over-year adoption gains than the broader set of digital practices. Generative AI, clinical applications and AI-enabled cybersecurity illustrate the expanding role of these technologies. As adoption grows, healthcare organizations have opportunities to strengthen model governance, post-deployment monitoring, evaluation and accountability. Establishing consistent oversight processes can help ensure that AI capabilities remain aligned with clinical, operational and organizational priorities. The gaps are widest where the stakes are highest: only 16.4% of AI users report fully documented post-deployment monitoring and 33.3% test models for bias regularly. The AI Governance Gap feature sets out the lifecycle view and a pathway to close each gap.

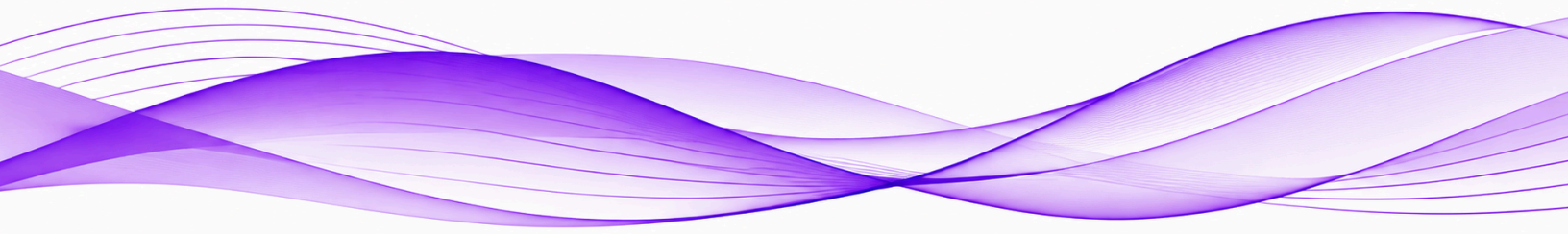
Sustainable AI maturity requires continuous oversight, not adoption alone.

03

Governance and Evaluation Help Differentiate Digitally Mature Organizations

Advanced organizations do not just own more technology; they run it differently. They define what success looks like before they invest, assign clear accountability, and check the results afterwards. They test clinical AI for bias and equity, and they watch how patients actually experience digital access. The data shows the pattern: 96% of Advanced organizations have a standardized framework for evaluating major technology investments, against 41% of Building organizations; they are about half as likely to say they cannot quantify what AI and analytics returned (17% against 37% of the rest); and half of them test AI models for bias regularly, against 10% of Building organizations. Leaders can act on this in three steps. First, set the outcome measures for a project before it is approved, not after it launches. Second, give every technology a named owner who reports on results. Third, review results on a schedule, and stop or change what is not working. These are practices, not purchases, so organizations of any size can start now.

Consistent leadership practices and measurable outcomes are essential components of digital maturity.



The 2026 Digital Health Most Wired findings point toward a more integrated, accountable and outcomes-focused era of Digital Health Maturity. Participating organizations have made meaningful progress in establishing digital capabilities. The opportunity ahead is to make those capabilities more connected, resilient, measurable and effective. As healthcare organizations prepare for the next phase of digital transformation, continued progress will depend on strengthening core capabilities, supporting clinical and operational workflows, and translating digital investments into meaningful value for patients, clinicians and healthcare systems.

PART FIVE · 2026 DHMW NATIONAL TRENDS REPORT

Looking Ahead

The 2026 findings show where investment will matter most in the year ahead. This section identifies the core capabilities with the largest gaps, estimates what closing them would mean, and sets out the actions leaders can take now.

Priority Investments **Turn Insights into Action**



DIGITAL HEALTH ANALYTICS

LOOKING AHEAD

Priority Investments: Strengthening the Foundations

Where to invest first, what 80% adoption would be worth, and what to track.

> These four are ordered by what a gap costs a patient, not by which scores lowest. Clinical Quality and Safety comes first because its gaps sit between a device and a medication; data comes next because every clinical decision and every model rests on it; security and infrastructure follow because they decide whether care continues when something fails.

WHERE TO INVEST FIRST

1 Clinical Quality and Safety

National mean 70.3

- IV pump to EHR closed loop 41.1% (92 of 224)
- Bidirectional cardiac monitoring data 26.3% (60 of 228)
- Fully documented AI monitoring 16.4% (36 of 219)

PRIORITY INVESTMENT

Connect devices and decision support to the EHR, close the medication safety loop, and document monitoring of clinical AI

IF 80% HAD IT

About 87 more hospitals with closed-loop IV pumps, 122 more with bidirectional cardiac monitoring, and 139 more AI users with documented monitoring

OUTCOMES TO EXPECT

Fewer manual transcription steps and programming risks; earlier detection of model drift; documented safety oversight of clinical AI

Track: device-integrated beds, AI incidents detected and corrected, time to detect drift

WHAT IT WOULD MEAN FOR PATIENTS Smart pump and EHR interoperability reduces intravenous medication administration errors; a modeled six-hospital system would prevent 56 preventable adverse drug events a year. Modeled, excluding implementation costs (Borrelli et al., 2025; see Appendix).

2 Analytics and Data Management

National mean 72.1

- Master data management for critical domains 38.7% (89 of 230)
- Track ROI or financial impact 50.2% (117 of 233)

PRIORITY INVESTMENT

Build trusted, AI-ready data and tie analytics to measured outcomes

IF 80% HAD IT

About 95 more organizations with master data management and 69 more tracking return on analytics

OUTCOMES TO EXPECT

Consistent data across systems with fewer manual reconciliations; analytics investments tied to outcomes

Track: share of data labeled and standardized for AI (59.7% self-estimated today), analytics products with defined outcome measures

WHAT IT WOULD MEAN FOR PATIENTS One trusted definition of a patient means a care team sees the same record and the same risk score wherever the patient presents.

3 Security

National mean 79.1

- Cyber recovery testing at least semi-annually with quarterly reviews 35.6% (83 of 233)
- AI for supply chain and third-party risk monitoring 20.8% (48 of 231)

PRIORITY INVESTMENT

Make recovery rehearsed and tested; deploy AI where cyber risk is concentrated

IF 80% HAD IT

About 103 more organizations testing recovery at that cadence and 137 more using AI for third-party risk

OUTCOMES TO EXPECT

Faster, rehearsed recovery from ransomware and third-party incidents

Track: time to detect and respond, recovery test results, third-party risk coverage

WHAT IT WOULD MEAN FOR PATIENTS Rehearsed recovery is the difference between an outage a patient never notices and one that cancels their procedure.

4 Infrastructure

National mean 80.5

- Recovery of all four critical system classes within four hours 39.1% (92 of 235)
- Tested failover 70.7%

PRIORITY INVESTMENT

Validate recovery and downtime communications by system class

IF 80% HAD IT

About 96 more organizations restoring all four system classes within four hours

OUTCOMES TO EXPECT

Shorter downtime and clinicians working through outages with practiced procedures

Track: recovery time by system class, downtime hours, downtime drill completion

WHAT IT WOULD MEAN FOR PATIENTS Four hours is roughly one shift: medication, results and communication return before the next handover rather than care continuing on paper.

The 80% benchmark is illustrative, set near where the strongest foundational practices in this report already sit (87.6% automated threat intelligence, 78.0% alternative communications during outages). Each count is 80% of that question's own base (all organizations, AI users or hospitals, as shown) less the organizations that already have the capability, rounded. DHMW records adoption and self-reported practice, not dollars or clinical outcomes; the outcomes listed are what leaders should expect to see and measure, not results the survey has demonstrated.

LOOKING AHEAD

What Advanced Organizations Show Is Possible

The same four foundations, as the Advanced group already runs them.

Advanced means a mean Level of Achievement of 9 or 10 across the care settings an organization submitted: 95 of the 235. They are not a different kind of organization; they are further along the same four foundations, and the distance is measurable.

Organizations at Level of Achievement 9 and 10 already perform differently on these foundations. Among hospitals, two-way EHR integration of IV infusion pumps reaches 52% at Advanced organizations against 33% for the rest, continuous cardiac monitoring 36% against 21%, and pulse oximetry 30% against 17%. In Security, 66% of Advanced organizations track threat coverage against 41% of the rest, and 80% track mean-time metrics against 55%.

Applied to the roughly 130 remaining hospitals, matching the Advanced group would add about 25 hospitals with closed-loop IV pumps and about 20 with bidirectional cardiac monitoring. Applied to the 139 organizations outside the Advanced group in Security, it would add about 35 tracking threat coverage and 35 tracking mean-time metrics. These are associations, not proof of cause.

Rehearsal shows the same pattern. 52% of Advanced organizations run scenario-based recovery drills at least semi-annually, against 25% of the rest, and organizations that drill that often are more likely to restore all four critical system classes within four hours (48%, against 25% of those who drill ad hoc or not at all). This is an association and holds across smaller and mid-sized organizations.

THE DISTANCE, MEASURED



The bar is the Advanced group and the upright mark is every other participant. Hospital rows are the subset asked the device questions. These are associations, not proof of cause.

"Healthcare has reached an inflection point where technology adoption is giving way to a powerful new focus on how effectively organizations put it to use," said Russ Branzell, President and CEO of CHIME. "AI and other digital technologies are advancing at extraordinary speed, but lasting value depends on the leadershivp, governance and infrastructure surrounding them."

Russ Branzell
President and CEO
College of Healthcare Information Management Executives

DIGITAL HEALTH ANALYTICS

LOOKING AHEAD

Turn Insights into Action

Ten priorities, each with an owner, a horizon and a measure of progress.

Use this priorities map to inform your 2027 digital strategy, in context of your organizational goals, priorities and resources. Start with items 1 through 3: they are where the data shows the widest distance between how much AI is in use and how much control exists around it, and they require governance, not new technology.

1 Inventory every AI tool

START HERE

Including vendor-embedded and unsanctioned tools; assign an owner and risk tier to each.

CMIO or Chief AI Officer, with CIO — 90 days

Progress measure: Share of models with owner and risk tier

2 Validate locally before go-live

START HERE

Including subgroup performance; require a standard vendor evidence pack.

CMIO, CNIO — 6 months

Progress measure: Share of high-risk models with documented validation

3 Monitor every deployed model

START HERE

Owner, thresholds, override and incident capture, scheduled revalidation.

CMIO, Chief Data and Analytics Officer — 12 months

Progress measure: Share of models with documented monitoring

4 Prove you can recover

Including from third parties: test by system class against a four-hour objective and run full-scale exercises with clinical leaders.

CIO, CISO — 6–12 months

Progress measure: Share of system classes meeting objectives

5 Measure value before you scale

Define outcome measures at approval and compare intended with actual outcomes.

CFO with CIO or CDO — Next budget cycle

Progress measure: Share of major investments with defined outcome measures

6 Make data AI-ready

Master data for critical domains, labeled and standardized data, analytics in the workflow.

Chief Data and Analytics Officer — 12 months

Progress measure: Share of data labeled and standardized

7 Bring the workforce into governance and build data and AI literacy by role

CNIO, CMIO, CHRO — 12 months

Progress measure: Core nursing seat on AI governance; share of staff trained

8 Put AI governance at the board table with quarterly reporting aligned to Joint Commission and CHAI guidance

CEO and CIO — Next board cycle

Progress measure: Quarterly board AI report in place

9 Close the safety loop

Integrate infusion pumps and physiologic monitoring with the EHR.

CNIO, CMIO, Biomedical Engineering — 12–24 months

Progress measure: Device-integrated beds

10 Benchmark and commit

Register for the 2027 DHMW survey at dhanalytics.org/digital-health-most-wired-survey.

CIO — Now

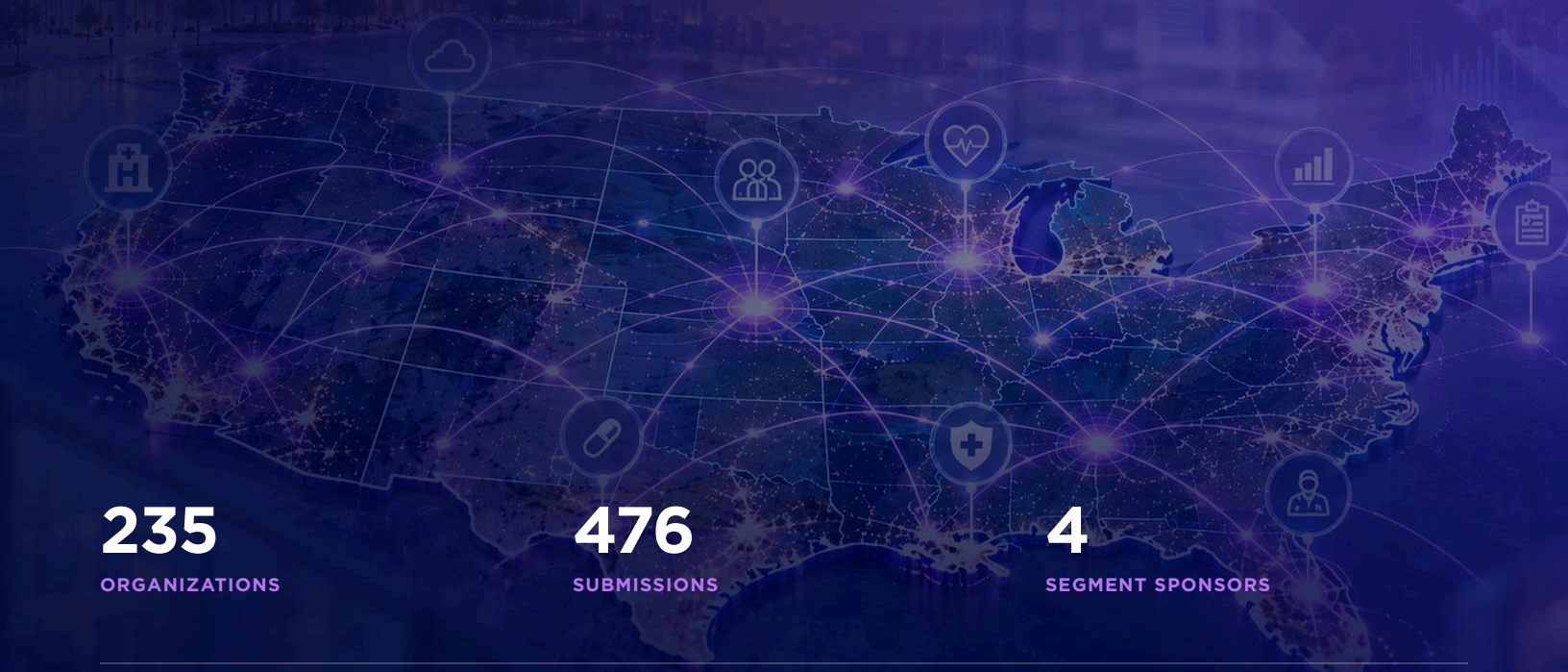
Progress measure: Registration complete

PART SIX · 2026 DHMW NATIONAL TRENDS REPORT

Reference

Everything behind the numbers: who runs Digital Health Most Wired, who backs each segment of it, and the definition of every term used in these pages.

About CHIME and DHA | Our sponsors | Every term defined



235
ORGANIZATIONS

476
SUBMISSIONS

4
SEGMENT SPONSORS

09

SECTION 15

The Organizations Behind This Report

Who runs the Digital Health Most Wired program, who built this year's analysis, and who sponsors each segment of it.

About CHIME

chimecentral.org

The College of Healthcare Information Management Executives (CHIME) is the leading professional organization for digital health executives and leaders. CHIME provides a trusted, collaborative environment where members and partners connect, share best practices, advance professional development, and advocate for the effective use of information and technology to improve health and care in the communities they serve. For more information, please visit chimecentral.org.

About Digital Health Analytics

dhanalytics.org

Digital Health Analytics (DHA) is the data and analytics engine of the DHX ecosystem, one of three CHIME organizations advancing digital health transformation. Alongside Digital Health Insights (DHI) and the Digital Health Community (DHC), DHA gives healthcare leaders the intelligence and analytical depth to drive meaningful change. The X in DHX represents the exponential impact of community, analysis and insight working together.

About Revolutional

revolutional.com

Revolutional combines expertise in artificial intelligence, data science and advanced analytics to transform complex data into clearer insights and informed action. As the research and analytics partner for the 2026 Digital Health Most Wired program, Revolutional worked with CHIME and Digital Health Analytics to identify national trends and develop meaningful benchmarks and actionable insights for healthcare leaders.

How to Cite This Report

CHIME Digital Health Analytics. *Digital Health Most Wired National Trends Report 2026*. Figures computed from the 2026 response set: 476 submissions from 235 organizations in 5 countries.

Our Sponsors

FOUR OF THE TEN SEGMENTS ARE SPONSORED

Digital Health Analytics, powered by CHIME, is grateful to our sponsoring organizations for making our research and this report possible.

Each sponsor supports one segment of the Digital Health Most Wired program. For information on how to become a sponsor of the 2027 DHMW, contact your CHIME representative or go to chime.foleon.com/chimeconnect/06-media-and-marketing-services/digital-health-analytics.

Spectrum Business	zscaler Healthcare	Everpure	Epic
SEGMENT 01 Infrastructure	**SEGMENT 02** Security	**SEGMENT 05** Analytics and Data Management	**SEGMENT 09** Clinical Quality and Safety

Sponsor profiles are to be supplied by each sponsor and are not drafted here.

This report is published by CHIME. Every figure in it is computed from the 2026 Digital Health Most Wired response set and is reproducible from the analysis scripts that produced it. Where a figure reaches only some participants, the number of organizations or submissions answering is printed beside it.

SECTION 16

10

Terminology and Abbreviations

Every term a reader of this report meets, in plain English. Acronyms are also spelled out on first use in the body of the report.

Definitions of terms and abbreviations used in this report are available in the DHMW glossary of terms on the DHMW website, dhanalytics.org/digital-health-most-wired-survey.

COMPARING 2025 WITH 2026

The survey was restructured between the two years: nine segments became ten, several were rescored, and Supply Chain was rebuilt on a new weighting, which is why it has no 2025 comparison. A change in a segment score can therefore reflect the rule rather than the behavior, so this report never compares a 2025 segment score with a 2026 one. Year-over-year movement is measured on comparable items only: questions asked the same way in both years. Level movement is measured on the uncapped Level of Achievement, because the capped Level reflects a transitional requirement that does not exist in 2025.

Every source cited outside this survey, with the page that cites it.

EXTERNAL SOURCES

Trusted Exchange Framework and Common Agreement

Office of the National Coordinator for Health Information Technology and The Sequoia Project, as Recognized Coordinating Entity. Cited for TEFCA and for Qualified Health Information Network membership.

2026 Physician Survey on Augmented Intelligence

American Medical Association, Center for Digital Health and AI, March 2026. 1,692 physicians surveyed January to February 2026. Cited for physician AI use, skill-loss concern and involvement in adoption decisions.

Use of AI-based predictive models in US hospitals

Nong P, Adler-Milstein J, Apathy NC, Holmgren AJ, Everson J. Health Affairs, January 2025, using the 2023 American Hospital Association Annual Survey IT Supplement. Cited for hospital use and local evaluation of predictive models and for vendor sourcing.

Healthcare shadow AI survey

Wolters Kluwer Health, conducted by CITE Research, December 2025, 518 healthcare professionals. Cited for unsanctioned AI use.

Top 10 Health Technology Hazards for 2026

ECRI, January 2026. Cited for AI chatbot misuse and unpreparedness for a digital darkness event.

Responsible Use of AI in Healthcare

The Joint Commission and the Coalition for Health AI, September 2025. Cited for the seven elements of responsible AI use and the planned certification program.

New guidance on responsible use of AI

Palmieri S, Robertson CT, Cohen IG. JAMA, AI in Medicine commentary, 2026. Cited for the guidance's possible influence on standard of care.

The State of AI Regulation in Healthcare: Still Complicated

Dickinson Wright PLLC, 2026, citing National Conference of State Legislatures tracking. Cited for state healthcare AI laws and pending bills.

High Reliability primer

Agency for Healthcare Research and Quality, Patient Safety Network. Five characteristics of high reliability organizations. Cited in Digital Foundations for High Reliability.

Hurricane Helene and the IV fluid supply chain

Healthcare Purchasing News, "Hurricane Helene's Supply Chain Shock," and Healthcare Finance News, "Feds shore up healthcare supply chain in wake of Hurricanes Helene and Milton," October 2024.

Nurse-led innovation in the digital era: measuring governance and technology investment across health systems

Plover C. Advancing Medical-Surgical Nursing, 2026;2:100080. Secondary analysis of the 2025 DHMW survey. Cited for nursing representation in innovation governance and nursing technology investment.

Virtual nursing for the care of hospitalized patients

Muir KJ, Maye A, McHugh MD, Aiken LH, Vo V, Lasater KB. JAMA Network Open, December 2025. Survey of 880 bedside nurses. Cited for nurses' experience of virtual nursing.

WHAT THE SURVEY CANNOT YET SHOW

Several dimensions of high reliability are not measured directly in the 2026 survey. Where the survey came close, this feature uses an adjacent measure and says so: syndromic surveillance (53.8%) for public health data exchange, care-summary access (94.0%) for record portability and risk stratification (68.1%) for identifying vulnerable patients. Candidates for the 2027 instrument or additional study:

- Data sharing with public health and other organizations in disasters and pandemics
- Portability of patient records across sites and applications
- Identification of patients most vulnerable to climate and other hazards
- Workforce surge capacity and redeployment
- Telehealth continuity during outages, and command center failover
- Culture measures such as near-miss reporting and speaking up
- AI governance steps before and after go-live: use-case intake and approval, vendor due diligence, pilot evaluation criteria and retirement criteria for models

SECTION 16

10

External Sources, Continued

The remaining sources cited outside this survey, and the regional detail behind the one-line finding on the Methodology page.

Hospital Trends in the Use, Evaluation, and Governance of Predictive AI, 2023-2024

ASTP/ONC Data Brief, 2025, using the American Hospital Association Annual Survey Information Technology Supplement. Cited for predictive AI use and sourcing from EHR developers.

Dissecting racial bias in an algorithm used to manage the health of populations

Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Science, 2019;366(6464):447-453. Cited for algorithmic bias arising from a cost proxy for health need.

Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All

National Academies of Sciences, Engineering, and Medicine, 2024. Update to the Institute of Medicine's 2003 report Unequal Treatment. Cited for persistent inequities in health care.

The 2026 report of the Lancet Countdown on health and climate change: a decade of escalating health harms and a decisive moment for all

Romanello M, Walawender M, Israelsson J, et al. The Lancet, published online 28 October 2026. doi:10.1016/S0140-6736(26)01779-4. lancetcountdown.org/2026-report. Figures cited are health indicators and are global unless stated: heatwave exposure, heat mortality, compounding hazards and Hurricane Beryl, climate-informed surveillance and warning systems, nursing education, AI data-centre energy, health-care emissions and product carbon data, and wildfire smoke. Cited in Digital Foundations for High Reliability and in the sustainability sidebar.

The 2023 Lancet Countdown on Health and Climate Change: Policy Brief for the United States of America

Beyeler NS, et al. Lancet Countdown U.S., November 2023. lancetcountdownus.org. Cited for the United States heat mortality estimate: 23,200 heat-related deaths among adults aged 65 and older in 2022, up 88% from 2000 to 2004. A modeled estimate of all deaths associated with heat, not only those recorded as heat deaths on a death certificate. This is the most recent United States brief carrying a mortality estimate; the 2024 data sheet reports exposure only.

Interoperability and Prior Authorization Final Rule (CMS-0057-F)

Centers for Medicare and Medicaid Services, January 2024. Sets prior authorization decision timeframes and payer application programming interface requirements, which apply from 1 January 2027. Cited on the Interoperability trend, the Administration segment and Priority Investments.

Change Healthcare Cybersecurity Incident

United States Department of Health and Human Services, Office for Civil Rights, incident frequently asked questions and Breach Portal entry. hhs.gov and ocrportal.hhs.gov. Cited for 192.7 million individuals affected, as reported to the Office for Civil Rights on 31 July 2025. Accessed 3 November 2026.

Public Law 119-21: Title VII, Subtitle B, Chapter 1, Medicaid. Cost estimate

Congressional Budget Office, for the law as enacted 4 July 2025. cbo.gov/publication/61837. Cited for a reduction in federal Medicaid outlays of about $990 billion over fiscal years 2025 to 2034 ($989.7 billion). Cross-checked against Congressional Research Service report R48633, 18 August 2025. Accessed 3 November 2026.

Evaluating the impact of smart infusion pump interoperability on reducing medication administration errors: a systematic literature review

Borrelli EP, Lucaci JD, Wilson NS, Taneja A, Weiss M, Beer I. Medical Devices: Evidence and Research, 2025;18:247-260, published 15 April 2025. doi:10.2147/MDER.S522534. Independent research with no competing interests. Cited on the medication safety trend and in Priority Investments.

Enhancing patient safety and charge capture through smart infusion pump interoperability: a health economic analysis for US health systems

Borrelli EP, Taneja A, Abdallah S, Weiss M, Wilson NS, Beer I, Lucaci JD. ClinicoEconomics and Outcomes Research, 2025;17:507-518, published 22 July 2025. doi:10.2147/CEOR.S534748. Independent research with no competing interests. Its figures, 56 preventable adverse drug events and about $2.4 million in outpatient charges a year, are modeled and exclude implementation costs.

DIGITAL HEALTH MATURITY BY US CENSUS DIVISION



Average overall DHMW score by census division. Census divisions with fewer than 20 submissions are grouped for reporting. International submissions are excluded from regional comparisons. The green dot marks the highest reportable division average and the orange dot the division with the most room to grow.

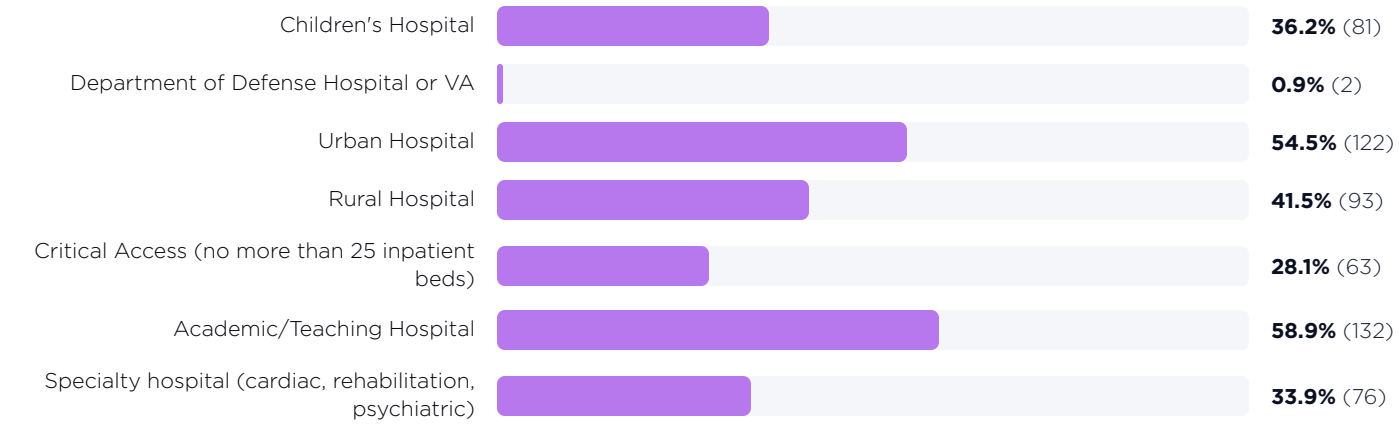
PARTICIPANT PROFILE

Who Participated in the 2026 Benchmark?

A submission may include up to three care settings, with separate responses from each entity. The three charts below therefore run on three different bases, and a single organization can appear in more than one of them.

Acute Care: Types of Participating Facilities

Share of eligible acute-care submissions reporting each facility type (select all that apply).



Base 224 submissions

Ambulatory Care: Types of Participating Facilities

Share of eligible ambulatory-care submissions reporting each facility type (select all that apply).



Base 217 submissions

Long-Term and Post-Acute Care: Types of Participating Facilities

Share of eligible LTPAC submissions reporting each facility type (select all that apply).



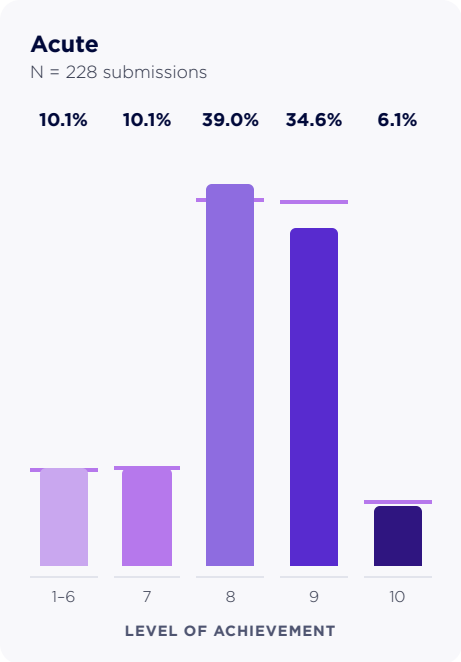
Base 29 submissions

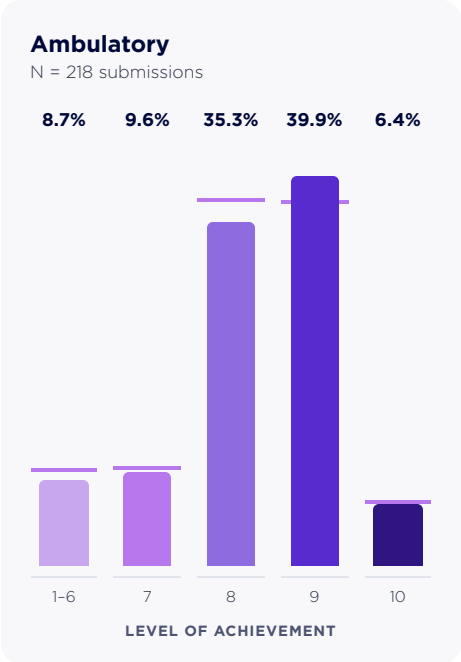
Facility categories reflect the care settings represented in survey submissions. Respondents could select multiple facility types, so percentages may total more than 100%. Percentages use the valid respondent base for each care-setting question and are not calculated from the total number of participating organizations.

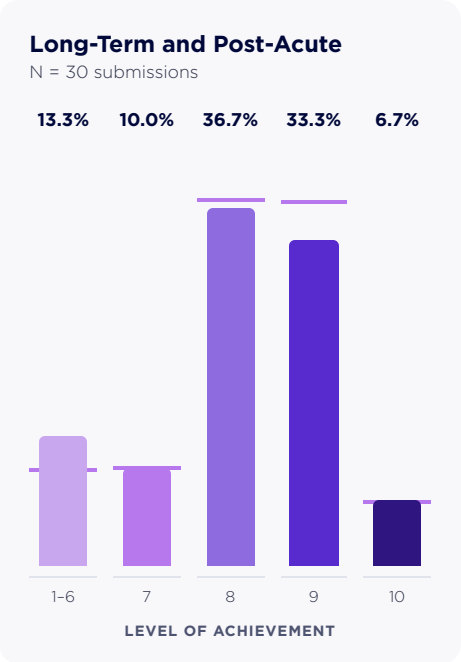
PARTICIPANT PROFILE

Level of Achievement by Care Setting

An organization may submit for up to three care settings, and each submission is scored against its own peer group, so a care setting is a scoring lens rather than a separate group of organizations. Ambulatory submissions peak at Level 9; acute and long-term and post-acute submissions peak at Level 8. Long-term and post-acute care carries the largest share below Level 7.







WHERE EACH CARE SETTING SITS AGAINST THE FIELD

Read the same three distributions as one number. Across all 476 submissions 80.5% reach Level 8 or above, so a setting above that is ahead of the field and a setting below it has the most room.

79.8%
of Acute submissions reach Level 8 or above
182 of 228

81.7%
of Ambulatory submissions reach Level 8 or above
178 of 218

76.7%
of Long-Term and Post-Acute submissions reach Level 8 or above
23 of 30

The rule across each column is all 476 submissions at that Level, so a column standing above its rule is a care setting ahead of the field.

Share of each care setting's own submissions at each Level of Achievement. Acute 228 submissions, Ambulatory 218, Long-Term and Post-Acute 30, all submissions 476. Levels 1 to 6 are grouped because 0.4% of submissions sit below Level 5. Peer groups differ by care setting, so a Level is comparable within a setting rather than across them.

APPENDIX

A

Comparable Items, 2025 to 2026

Appendix exhibit. Of the 205 organizations that answered in both years, 297 survey items can be compared across the two. Among these items, 168 show increased adoption. This exhibit supports What Changed in 12 Months; see the comparability note on the preceding pages for what is and is not comparable.

Because the 2026 survey introduced significant changes to its structure, questions and scoring methodology, segment and dimension scores should not be interpreted as direct measures of year-over-year improvement. Instead, this analysis focuses on comparable survey items to identify where adoption has advanced and where opportunities remain. Items were considered comparable when their response options, answer scales and underlying measures remained consistent across both years.

CHANGES IN COMPARABLE DIGITAL PRACTICES: 2025 TO 2026

Built from individual survey items, not from segment or dimension scores, because those are not comparable between the two years. An item qualifies only if its option text, answer scale and option menu are unchanged and at least 120 of the 205 panel organizations answered it in each year. 297 scored items survive.

	ALL COMPARABLE ITEMS	STILL BEING BUILT under 80% in 2025	ALREADY STANDARD 80% and above in 2025
Infrastructure	**+0.7** 42 items	**+1.3** 16 items	**+0.3** 26 items
Security	**+3.4** 75 items	**+3.7** 41 items	**+2.8** 34 items
Supply Chain	**+1.1** 13 items	**NA** 1 item	**+1.1** 12 items
Administration	**+2.0** 24 items	**+2.1** 12 items	**+1.8** 12 items
Analytics and Data Management	**+2.7** 57 items	**+3.0** 43 items	**+1.9** 14 items
Interoperability	**NA**	**NA**	**NA**
Population Health	**+2.1** 35 items	**+2.3** 30 items	**+2.0** 5 items
Patient Engagement	**+4.7** 28 items	**+4.9** 18 items	**+4.0** 10 items
Clinical Quality and Safety	**+0.3** 10 items	**NA** 1 item	**+0.1** 9 items
Innovation and Emerging Technologies	**+5.5** 13 items	**+6.3** 10 items	**NA** 3 items
All ten segments	**+2.5** 297 items	**+3.3** 172 items	**+1.6** 125 items

KEY: below 0.0 | 0.0 to 1.0 | 1.0 to 2.5 | 2.5 to 4.0 | 4.0 and above | NA, not comparable — Median change in points, 2025 to 2026

WHAT THE COMPARISON SHOWS

Progress Is Concentrated in Capabilities Still Maturing

+3.3

Percentage Points, Practices Still Developing in 2025

Among comparable survey items, practices with adoption below 80% in 2025 increased by a median of 3.3 percentage points, compared with 1.6 percentage points for practices already at or above 80% adoption.

+0.7

Percentage Points, Infrastructure Shows More Limited Change

Infrastructure practices improved by a median of 0.7 percentage points between 2025 and 2026. Most were already widely adopted in 2025, so there was little room left to grow.

SIX CELLS CARRY NO NUMBER

None is a zero and none is an average of a smaller set of items. Interoperability has zero comparable scored items: all four of its scored questions were rewritten for 2026. Three other cells fall below the five-item floor. A cell is suppressed under five comparable items and a row under eight.

Cells without a number are not zeros. Interoperability has no comparable scored items, because all four of its scored questions were rewritten for 2026. Three other cells have fewer than five comparable items. A result is shown only when at least five items can be compared (eight for a full row). Each cell shows the median change, in percentage points, in the share of organizations at the top of an item's own answer scale. No segment declined this year, so the orange band is not used. Population Health items can be compared because the questions stayed the same, even though Population Health and Interoperability were one segment in 2025.

Year over year figures run on the 205 organizations that answered in both 2025 and 2026, a subset of the 235 in the rest of this report.

THANK YOU

To Every Organization That Took Part in 2026

Digital Health Most Wired exists because healthcare organizations are willing to measure themselves honestly and share what they find. Every figure in this report was contributed by a team that set aside the time to answer carefully, and the benchmark is only as useful as that effort makes it.

The findings of 2026 point toward a more integrated, accountable and outcomes-focused era of Digital Health Maturity.

Organizations have built the capability. The opportunity ahead is to make it more connected, more measurable, more secure and more effective for patients, clinicians and the systems that serve them.

THE NEXT CYCLE

Register for the 2027 DHMW Survey

Putting the next cycle in the plan now means the improvements made through 2027 are captured in that benchmark rather than the one after it. Registration dates, the survey timeline and the scoring methodology are published together.

REGISTER AND SEE DATES

SCAN TO REGISTER

235
PARTICIPATING ORGANIZATIONS

476
SUBMISSIONS SCORED

10
SEGMENTS MEASURED

46
US STATES REPRESENTED

SPONSORED BY

revolutional

Spectrum BUSINESS | zscaler Healthcare | Everpure | Epic

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