Advisory Board


# Three Trends Medical Leaders Need to Know about How Customers Are Making Decisions

Across the last year, Advisory Board spoke with 50+ medical and HEOR executives, as well as 100+ decision-makers across the health care ecosystem to understand the impact of key trends and market disruptions. Through these conversations, we identified three trends that are influencing customers' decision making and impacting how medical leaders should approach 2021.

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# 01 Health technology assessment organizations are no longer "emerging" stakeholders. They have become entrenched sources of influence in U.S. payer and provider decision-making.

Over the last few years, a growing number of loosely-termed health technology assessment (HTA) organizations are increasingly evaluating evidence, conducting cost/benefit analyses, and opining on the value of drugs, devices, and diagnostic technologies. Key players in this space are now core stewards of medical value—exerting significant influence on product use and value decisions among payer and provider customers.

ICER is a prominent example. Its assessments of value for new medical treatments, measured in cost-per-QALY,[1] reliably generate buzz among a cross-section of industry stakeholders. In 2020, ICER played a key role in how Gilead Sciences priced Remdesivir during its Covid-19 rollout. But ICER is not the only organization weighing in on medical value. Other key players in this space, such as Innovation and Value Initiative (IVI), ECRI, and Lumere, are prominent voices in conversations about the clinical benefits and relative value of new treatments and medical supplies in the U.S.

In practice, payers and providers typically use HTAs to aggregate data and support a range of decisions—like product purchasing, formulary coverage, and clinical guideline development. Increasingly, HTAs are also used to support appropriate use at the point of care. For example, Lumere provides clinical decision support tools that HCPs can embed directly in the EHR. And ICER recently launched ICER Analytics and The ICER Evidence Compendium, both of which enable payers, providers, patient groups, and regulators to more readily access ICER's reports during clinical decision-making.

With Covid-19 intensifying the debate over medical value, we expect these stakeholders to become even more influential than they are today. Consequently, medical and health economics and outcomes research (HEOR) executives should develop holistic, proactive, cross-functional HTA engagement strategies. Organizations that fail to account for HTAs in their evidence generation, medical communication, and customer engagement plans risk heightened barriers to adoption and patient access.

1) Quality-adjusted life year.

# 02 The growing use of physician-to-physician communication platforms is diffusing and diversifying medical influence across a broader—and harder to control—network of voices.

Medical leaders have long recognized that key opinion leaders (KOLs) are "dying." That is, the traditional academic key opinion leader is no longer the only source, or even the primary source, of medical influence. In the last few years, medical leaders have shifted their focus from traditional KOLs toward those with localized influence, such as Pharmacy and Therapeutics (P&T) and Value Analysis Committee (VAC) leaders. But the pace of change in digital communications means that even this strategy is no longer sufficient.

Today, nearly all HCPs rely on information-sharing platforms and digital physician networks like Doximity, epocrates, UpToDate, and Sermo. These platforms provide access to real-time, tailored medical information and evidence synthesis, as well as robust online forums for HCPs to share insights and opinions with their peers. For example, HCPs on Sermo can "rate" individual drugs. HCPs on Doximity can discuss individual patient cases, seek second opinions, and weigh in on new clinical evidence.

The upshot is that medical information—and in particular, medical opinion—has become ubiquitous. The network of voices influencing clinical decisions is much more diffuse than before. And influence is shifting away from prominent academic opinion leaders toward physicians who feel like peers. Utilization data from Doximity show that HCPs increasingly prefer insight from peers with similar educational backgrounds, similar training experiences, or who treat similar patients. Many times, Doximity users will even vet information they hear from KOLs by conferring with their peers online. In short, the very notion of who counts as an opinion leader or influencer is evolving.

Of course, this new landscape of medical influence will have a profound impact on medical communication strategy. Medical leaders must identify and understand the new patterns of influence that result from online communication platforms. This includes not only who has influence, but also what kind of evidence matters in these spaces and what formats of information resonate most. For example, early evidence suggests that influence patterns vary by specialty and that video-based information is easier for busy audiences to understand and retain.

# 03 Patient voices are getting louder and stronger, causing other health care stakeholders to shift their thinking about what constitutes value and meaningful evidence.

Despite the industry's buzz around patient-centricity, true patient-centeredness remains more aspiration than reality. This isn't due to lack of effort. Like many aspects of health care, complex and competing incentives can hinder stakeholder alignment on basic definitions, methods, and objectives for patient-centeredness. But while many stakeholders continue to wrestle with a shared definition of patient-centricity, several are finding new and impactful ways to incorporate patients' voices into clinical development processes, regulatory guidelines, and analytical methods. As a result, those stakeholders are poised to significantly influence conversations about value and appropriate treatment selection.

For example, health technology assessment organizations like ICER and IVI are creating value frameworks designed specifically to help payers and providers elevate the patient voice in value assessments. FDA is developing guidance on how to capture patient-centered and patient-reported endpoints in clinical trials, potentially expanding the role of patient preference in new product approvals and label expansions. Research organizations, like PROMIS and PCORI, are educating stakeholders about the value of patient-centered and patient-reported data. And some payers and providers have even developed outcomes-based contracts that incorporate patient-reported outcomes, like quality of life metrics, thereby tying reimbursement to measures that truly matter to patients.

The pandemic and its aftermath will only exacerbate consumer anxiety about the clinical, financial, and quality of life trade-offs among different treatment options. Payers, IDNs, individual HCPs, and even digital information-sharing platforms will face new pressure to incorporate patient perspectives into the formularies, frameworks, and tools that guide patient/provider decisions.

To ensure medical evidence and value messaging resonate with these diverse stakeholders, medical leaders must monitor how the voice of the patient influences customers' priorities and decision-making processes, and develop evidence that directly supports patient-centered decision-making.

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