

BOARDROOM BRIEF

Enthusiasm Isn't a Market

Strong evidence.
Positive KOL feedback.
Enthusiastic early adopters.

All encouraging signals.

But none necessarily means
the market is willing to
change how it practices.

A physician can
understand your value,
believe your evidence—
and still choose what they
already know and trust.

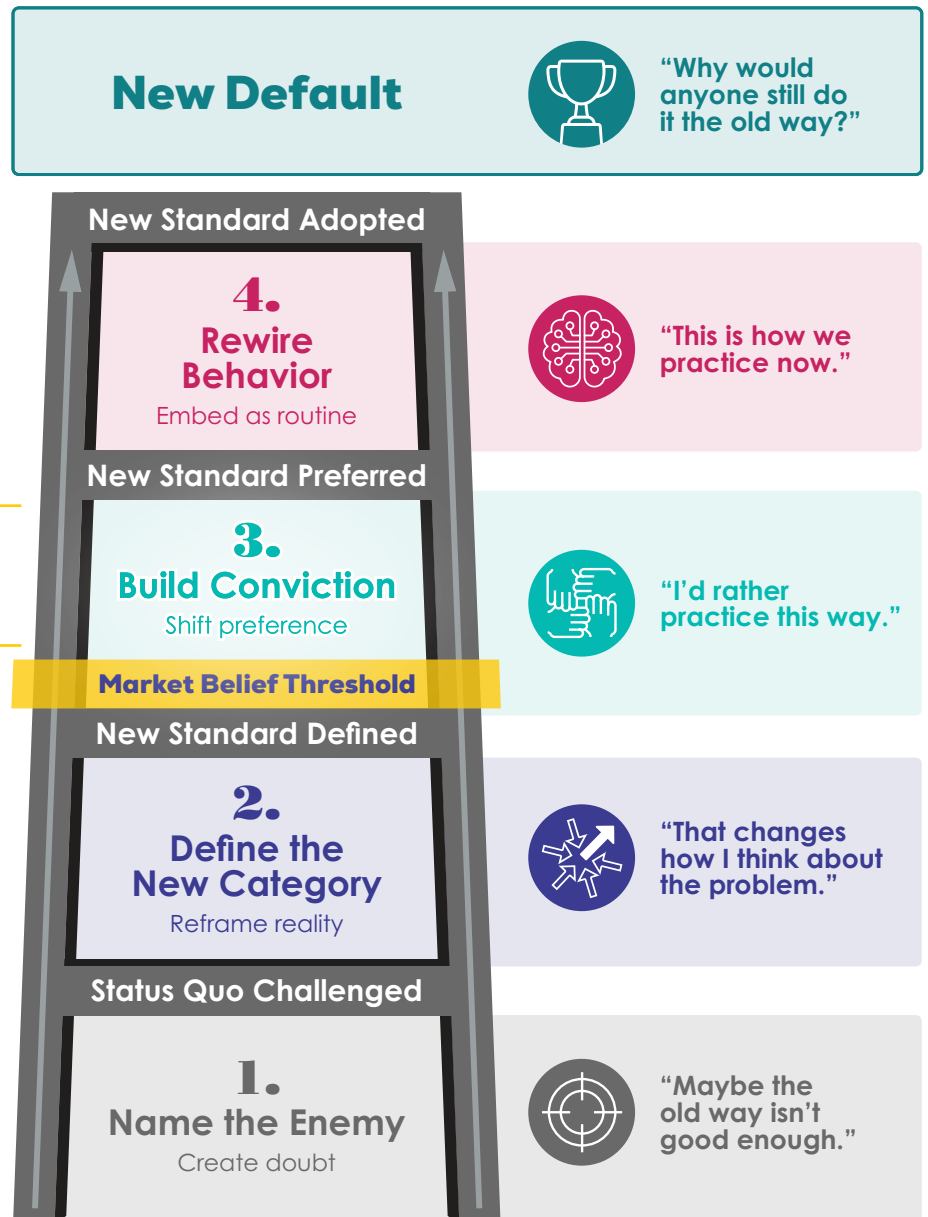
That gap is easy to miss.
Interest can increase
even when the reasons to
keep choosing the familiar
haven't changed.

Healthcare markets don't
move from questioning
the old way to adopting
a new standard in a single
leap. They move through a
progression of belief shifts.
We call that progression
the **Market Belief Ladder**.

This brief focuses on the third
move: **Build Conviction**—
when the market develops
enough confidence in the
new approach to begin
choosing it over the familiar
one.

THE MARKET BELIEF LADDER

Markets climb because beliefs change—
not because products improve



Key Takeaways

1

Positive response is not evidence of preference.

The market can understand your value and believe your evidence without being willing to change how it practices.

2

Agreement doesn't change behavior. Conviction does.

The familiar and trusted standard carries a built-in advantage that evidence alone doesn't automatically erase.

3

Preference is the first visible sign that conviction is changing decisions.

Look for what stakeholders are beginning to favor, advocate for, prioritize or choose—not simply what they say while you're in the room.

CASE STUDY

CareDx: When the Safer Decision Changed

For decades, endomyocardial biopsy was deeply embedded in heart-transplant surveillance. It was invasive and burdensome, but when the consequences of missing rejection were high, clinicians trusted it. They knew what it could tell them and how to defend the decisions they made from it.

That gave biopsy an advantage convenience alone couldn't overcome.

CareDx's HeartCare offered a fundamentally different approach, combining AlloMap to assess immune activation with AlloSure-Heart to measure donor-derived cell-free DNA associated with graft injury. A blood-based approach could reduce the burden of routine biopsy—but reducing the burden wasn't enough. Transplant teams had to trust molecular surveillance enough to make consequential clinical decisions from it.

Prospective multicenter validation helped establish that donor-derived cell-free DNA could provide meaningful information about graft injury. But the evidence had a larger commercial job than demonstrating that the technology worked. It reduced uncertainty around whether clinicians could rely on molecular surveillance when making decisions about patient care.

As transplant programs accumulated clinical experience, molecular surveillance moved from something clinicians could understand to something they could act on. Physicians could see other transplant programs incorporating molecular signals into surveillance decisions rather than automatically relying on scheduled biopsy.

The question began to change from **"Can I trust a blood test?"** to **"Does this patient need an invasive biopsy?"**

For appropriate patients, biopsy was no longer automatically the safer choice simply because it was the familiar one. Clinicians could use molecular surveillance to help determine whether and when a biopsy was necessary.

By 2022, CareDx reported that HeartCare was being used by more than 90% of U.S. heart-transplant centers.

Penetration is the evidence that conviction ultimately scaled. But conviction became visible earlier—in the decision that changed.

Lesson: Conviction isn't demonstrated by how strongly the market agrees with you. It becomes visible when that confidence begins changing what the market chooses.

The evidence didn't just make molecular surveillance credible. It made a different clinical decision defensible.

What Are You Treating as Evidence of Preference?

By the time a commercial plan reaches the boardroom, assumptions about market readiness are already embedded in the forecast.

The question is whether the evidence underneath those assumptions demonstrates

that the market is actually beginning to choose differently.

Before you scale against that assumption, pressure-test what your market signals actually prove.

Discussion Questions



Which market signals are we currently using as evidence that we're gaining traction?

Which demonstrate interest or agreement—and which demonstrate an actual change in preference?



What specific decision would a physician, payer, or health system have to make differently for us to know preference is beginning to form?

Have we defined that signal clearly enough to recognize it—or are we interpreting positive response as evidence of change?



Among stakeholders who understand and value our new approach, what still makes the familiar choice easier to trust or defend?

Where does the incumbent retain an advantage despite agreement with our value?



Where are stakeholders beginning to favor, advocate for, prioritize or choose the new standard when we're not in the room?

What observable behavior tells us preference is forming independently of our commercial activity?

Conviction becomes visible when the market begins choosing differently.

But individual choices don't create a new standard of care.

The next challenge is making that behavior **routine**—until:

"I'd rather practice this way."

become

"This is how we practice now."

Next on the Market Belief Ladder: Rewire Behavior.

Pressure-Test Your Commercial Decision Readiness

Positive market response can look like momentum long before the behaviors underneath the growth plan have actually changed.

Take the Pivotal Commercial Design Review (PCDR)

The **Pre-Commercial Decision Readiness (PCDR)** assessment helps leadership identify where critical market assumptions remain unvalidated before commercial investment scales.



Grey Matter Marketing
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