Closing pharma's intent-to-impact gap

Why pharma's value leakage problem is a field effectiveness problem — and how AI-powered journey operations solves it

EXECUTIVE SUMMARY EDITION

A JOINT PAPER BY

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Executive summary

How does a $1 billion blockbuster become a $450 million reality?

Not through failed science, and not through commercial neglect. The therapy works. The launch performs. Physicians are persuaded, prescriptions are written, and every dashboard the commercial organization watches confirms that the brand is succeeding. Then the arithmetic of the modern healthcare system begins. Roughly 30 percent of prescriptions are never filled, and the $1 billion opportunity becomes $700 million. Early discontinuation claims another tranche, reducing it to approximately $560 million. Adherence erosion takes a further 20 percent. What remains is close to $450 million in realized value. In many specialty categories, 40 to 55 percent of written prescriptions never convert into long-term persistence. More than half of the value the organization spent a decade earning quietly fails to materialize, without a single competitor taking it.

This value does not disappear because physicians stop prescribing. It disappears because prescribing intent fails to survive the operational realities of modern healthcare: reimbursement variability, prior authorization, affordability shock at the pharmacy counter, specialty pharmacy handoffs, documentation burden, and the accumulated friction of a downstream system that no function owns end to end. The prescription is a promise made in the exam room. Whether that promise is kept is decided later, in places the commercial model was never designed to see, by processes it was never designed to govern. The distance between the promise and the outcome is the intent-to-impact gap.

The gap persists because of a paradox at the heart of commercial excellence. Marketing succeeds by its measures. Sales succeeds by its measures. Medical, market access, and patient services each succeed by theirs. Every function can hit its numbers while the enterprise misses its outcome, because the patient experiences one continuous journey while the organization manages a collection of separately optimized functions. The industry has become expert at winning the moment and remains structurally unequipped to win the journey. This is not a failure of talent or effort. It is a failure of architecture, and architecture does not respond to exhortation.

The basis of competition is shifting in a way that makes this architecture untenable. In an era of experiential commerce, outcomes are shaped less by clinical uncertainty and more by how reliably patients move through access, affordability, and treatment pathways. Experience is the mechanism that carries intent forward or causes it to fail. Clinical acumen earns consideration and promotional excellence earns the decision. Neither carries the decision through what follows. The physician navigating prior authorization is the same person accustomed to real-time logistics tracking and immediate service resolution everywhere else in life, and digitally native competitors are being architected from inception around realization rather than persuasion. An organization optimized for influence increasingly competes against organizations optimized for follow-through.

Previous responses to the gap were sincere and insufficient. Retraining field teams, intensifying coaching, and importing customer experience frameworks from retail and hospitality all operated within the same underlying architecture. They strengthened the discipline of persuasion without redesigning the system that determines whether persuasion converts into initiated and sustained therapy. Experience was measured with increasing sophistication, but it was never given authority over the pathways where intent becomes impact. Measurement without governance produces awareness without change.

This paper proposes the alternative: make journey progression, not prescribing activity, the unit of commercial performance, and govern it through a discipline called journey operations. The discipline is operationalized through FieldOS™, a proven reference architecture for field intelligence and activation. Intelligence is the sensing half: what the field observes about barriers, friction, and progression risk, captured and structured into decision grade signal. Activation is the mobilization half: that signal converted into coordinated intervention by the function best placed to act. Together they turn the field organization into the enterprise's friction and barrier mitigation engine, running a closed loop that captures what the field observes, classifies the barrier, assigns the owner best placed to act, intervenes with full journey context, measures whether progression resumed, and sharpens detection with each cycle.

TheyDo enables the coordination this requires. It is the connected multidisciplinary operating environment that makes journey progression visible, coordinated, governable, and measurable across commercial functions, so that field, access, brand, medical, and omnichannel leaders work from a single progression reality rather than a dozen partial ones.

Artificial intelligence runs throughout this argument, but it is the enabling capability rather than the story. AI makes journey governance operable at scale: it surfaces friction patterns invisible at the level of individual cases, links signals across geographies, payer dynamics, and access conditions, and turns progression into something the enterprise can observe, diagnose, and correct. Prior field effectiveness models could not do this work, which is why they plateaued. The deeper point cuts against the prevailing anxiety: as AI levels informational access and scientific differentiation narrows, the human field organization becomes more consequential, not less, because how the enterprise shows up through its people becomes the brand in motion.

The conclusion is a redefinition of commercial excellence itself. The organizations that win the next decade will not simply be those that communicate most convincingly. They will be those whose systems ensure that clinical conviction consistently becomes care, for the patient and for the enterprise alike. Prescribing was never the finish line. It is the midpoint, and the second half of the race is currently being run by no one.

> A $1 billion brand is a $450 million reality, and no competitor took the difference.
>
> Roughly $550 million evaporates downstream of decisions the organization had already won: prescriptions never filled, therapies discontinued early, adherence eroded over time.

THE ARGUMENT IN ONE SENTENCE

The organizations that win will not be those that communicate most convincingly. They will be those whose systems ensure that conviction consistently becomes care.

SECTION 1

The intent-to-impact gap

Commercial performance in pharma has long been measured at the point of prescribing. It is a rational convention with a hidden cost: it locates success at the moment of greatest vulnerability. A prescription is not a product delivered. It is an intention declared, and from the instant it is written that intention travels through a gauntlet the prescriber does not control, the manufacturer does not manage, and the patient rarely understands. Benefit verification, prior authorization, step edits, specialty pharmacy routing, financial clearance, onboarding, first fill: each is administered by a different actor with different incentives, and each is a point where a justified decision can stall or quietly die.

The convention also explains why organizations believe they are succeeding while value leaks downstream. Every instrument on the commercial dashboard points up and to the right precisely when leakage is at its worst, because the dashboard measures the formation of intent rather than its survival. Clinical conviction is formed. Scripts are written. Share of voice, call quality, and engagement scores confirm effectiveness. Nothing registers the script that was never submitted, the approval that arrived after the patient gave up, or the therapy abandoned at a $400 copay. The organization is not misreading its data. It is reading the wrong data, faithfully.

The consequences run in two directions. For patients, nearly half of clinically justified treatment decisions fail to be fully realized in the person they were intended to help, a quiet clinical failure hiding inside an apparent commercial success. For the enterprise, a significant share of associated revenue never materializes, forecasts degrade, and lifetime value erodes. Industry estimates suggest that improving adherence alone could reduce avoidable healthcare costs by more than $100 billion annually in the United States. None of this is inevitable friction. It is the predictable output of a structural breakdown that no one has been assigned to prevent.

The diagram opposite traces the six stages through which intent must pass. Read it less as a process map than as an actuarial table: every stage carries a measurable probability of loss, and the losses compound. Each dropout point is experiential rather than clinical or promotional. The physician did not change their mind. The evidence did not weaken. The system failed to carry the decision forward, and no function was accountable for noticing.

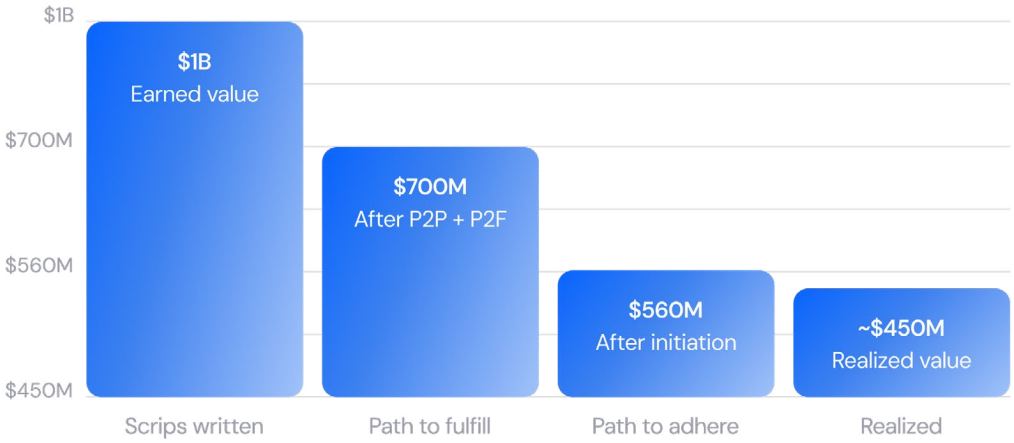
When prescribing intent does not translate into patients starting and staying on appropriate therapy, patient outcomes stall and commercial value is lost

together. This is the intent-to-impact gap. It is not a single point of failure or variability at the margins. It is a system level failure to carry clinical intent through to realized impact. The front end performs. The end-to-end system does not.

> The prescription is not where value is realized. It is where value becomes vulnerable.

The value leakage ladder

How compounding drop-off reduces $1B in earned value to ~$450M realized



$300M
20–50% of scrips go unfilled P2F

$140M
30% discontinued within 90 days P2A initiation

$300M
Long-term adherence averages ~50% P2A persistence

Sources : Fischer et al., Annals of Internal Medicine; Journal of managed care & Specialty Pharmacy; World health organization

The Value Leakage Ladder shows how compounding breakdowns across fulfillment, initiation, and adherence reduce $1 billion in earned value to roughly $450 million realized: not through failures in clinical science or commercial execution, but through a system that was never designed to govern progression.

The ladder deserves more than a glance, because it compresses the argument of this paper into four bars. One billion dollars of earned value, value the organization legitimately created through science, evidence, and effective commercial work, steps down to roughly $450 million of realized value through three compounding mechanisms: prescriptions that go unfilled, therapies discontinued within the first ninety days, and long-term adherence that averages near 50 percent. Each mechanism on its own looks like a familiar, tolerable industry statistic. Compounded, they halve the brand.

Why does this happen? Because the commercial model is optimized to influence decisions, not to safeguard progression. Whether patients start and stay on therapy is governed by reimbursement variability, prior authorization, affordability barriers, specialty pharmacy coordination, documentation burden, and fragmented handoffs, and adherence challenges compound every one of these breakdowns. Nearly 50 percent of patients with chronic conditions do not take medications as prescribed, and prior authorization requirements alone affect more than 80 percent of covered lives in the United States, introducing delay, fulfillment challenges, and abandonment risk into the ordinary course of care.

Why do executives not see it? Because the leakage is distributed, delayed, and denominated in absence. No invoice arrives for the unfilled script. Each function sees only its own segment of the ladder, and within that segment its numbers look defensible. The losses surface months later as forecast variance and are explained away as market conditions. A competitor taking half a brand's revenue would trigger a war room. The system taking it triggers a footnote.

Why does this change commercial strategy? Because the ladder reprices every commercial investment the organization makes. If only 45 cents of every dollar of created intent survives to realization, then the marginal dollar spent creating additional intent competes against the marginal dollar spent protecting intent that already exists, and in most portfolios the second dollar now earns more. Increasingly, drop-off is driven less by clinical uncertainty or promotional shortfall and more by experiential friction, which means the leakage is addressable, and what is addressable and unaddressed is a strategy decision whether or not anyone recognizes it as one.

The ladder explains where the value goes. It does not explain how to stop it. The architecture that closes the gap, and the operating model required to govern it, are set out in the sections that follow.

What the full paper covers

This is the executive summary edition. The full paper carries the argument from diagnosis through to the operating model, the architecture, and the questions a leadership team should be able to answer about its own commercial system.

2 | Why the commercial model breaks

The commercial excellence paradox. Every function succeeds while the journey fails, with a table setting what each function optimizes against what no one owns.

Editorial | Customer experience in pharma looks different

Why customer experience was never wrong, only imported without being redesigned, and why the next decade asks pharma to augment clinical and promotional acumen with experiential prowess.

3 | The shift to journey-based performance

How other industries govern Order-to-Cash and Plan-to-Produce as structural backbones, the three realization journeys, and why the brand team owns the outcome without holding the instruments.

4 | The reemergence of the field organization

Why the human field organization becomes more consequential as AI levels informational access, not less.

5 | From intent to impact through journey operations

The discipline itself, and what changes for field teams when progression becomes visible and governed.

6 | FieldOS: field intelligence and activation

The reference architecture, the six step closed loop from captured signal to sharpened detection, the five building blocks, and the shift from activity metrics to progression metrics.

7 | What changes when progression becomes governable

Diagnosis before intervention, and a maturity ladder for locating where a commercial system actually sits.

8 | Field effectiveness in practice

What changes in every interaction, and what the field becomes once its observations are structured.

Key takeaways and diagnostic questions

Ten takeaways for a leadership team, and nine questions that surface whether an organization is optimizing for activity or governing progression.

> Fill out the short form to get the full paper.

About the authors

Wayne Simmons

Wayne Simmons is a global thought leader in customer centric transformation and the founder of The Customer Excellence Agency, where he provides advisory, training, and insights to the pharma and life sciences industries. He is the author of The Customer Excellence Enterprise: A Playbook for Creating Customers for Life (Wiley, 2024) and brings more than two decades of commercial leadership experience, including senior global roles at Pfizer and Bayer, where he operated at the intersection of brand strategy, field effectiveness, commercial operating models, and customer experience.

He is a founding faculty member of North America's first graduate level Master of Science in Customer Experience Management program at Michigan State University, where he created the customer experience strategy course, the first of its kind to teach future leaders how to architect experience led growth in complex enterprises. Earlier, he was an Inc. 500 awarded founder and CEO and a U.S. Army Intelligence veteran.

Wayne focuses on helping pharma and life sciences organizations turn customer excellence into a working part of the commercial model. His approach brings brand, product, and experience together into a unified system that carries intent into realized care. Through FieldOS™, he provides a practical blueprint for governing how journeys unfold, improving field experience, and strengthening downstream commercial and patient outcomes through continuous journey improvement.

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TheyDo

TheyDo is the experience context platform that helps enterprises connect fragmented data into a shared understanding of how experiences actually unfold. Organizing customer, employee, and operational signals within the journey context creates a single source of truth for decision making across the business.

This enables organizations to move beyond static reporting and disconnected insights toward continuous, governed improvement. Teams can identify where value is lost, align across functions, and take coordinated action to improve progression across complex journeys. By making journeys the system of record, TheyDo serves as the connected multidisciplinary operating environment for journey governance, helping enterprises turn fragmented signals into clear context, better decisions, and measurable business impact.

Contact: TheyDo.com

Sources

1. NEHI / Annals of Pharmacotherapy estimates on adherence impact (improving adherence could reduce avoidable healthcare costs by more than $100 billion annually in the United States).

2. World Health Organization. Adherence to Long-Term Therapies: Evidence for Action. 2003.

3. American Medical Association. 2022 Prior Authorization Physician Survey.

4. Fischer et al., Annals of Internal Medicine; Journal of Managed Care and Specialty Pharmacy; World Health Organization.

FieldOS™ is a reference architecture of The Customer Excellence Agency.

Thank you

for taking the time to read this whitepaper. We hope the insights and frameworks shared here will help drive your organization forward.

THE Customer Excellence AGENCY

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