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

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. 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 operational rather than clinical. 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.

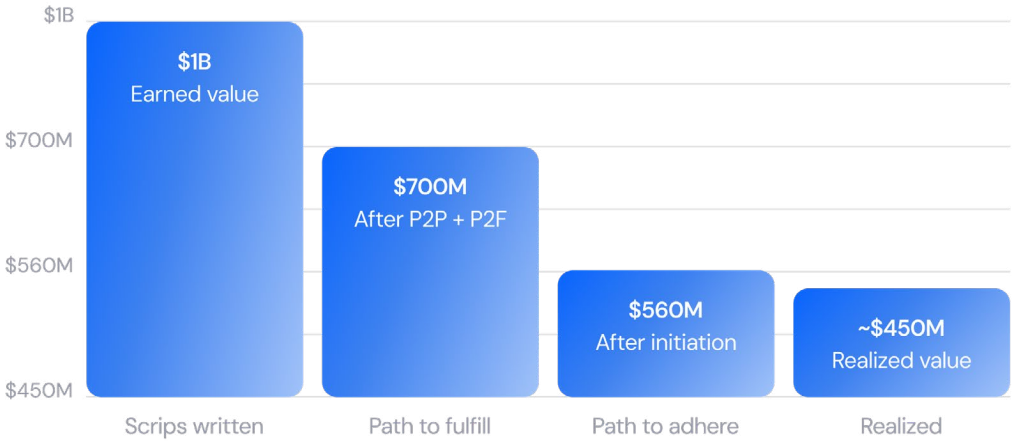
When prescribing intent does not translate into patients starting and staying on appropriate therapy, patient outcomes stall and commercial value is lost

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 and more by operational 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.

SECTION 2

Why the commercial model breaks

If the gap between intent and impact is structural, the cause is not commercial execution. It is the design of the commercial model itself, and the clearest way to see the design flaw is through a paradox most executives recognize the moment it is named: the organization wins the moment and loses the journey.

This is not marketing language. It is a structural description of how well run functions produce a poorly served customer. Marketing succeeds: awareness, engagement, and message recall meet plan. Sales succeeds: reach, frequency, and call quality meet plan. Medical succeeds on scientific exchange, market access on coverage secured, patient services on enrolled patients supported to target service levels. Every leader in the room can defend their numbers, yet providers and patients continue to experience friction, delay, and abandonment, because every function measures success at its own moment while the customer experiences one continuous journey.

Patients experience one journey. Organizations manage many functions.

Patients live a single story. Organizations manage many chapters, each with its own author, and no one edits the book. Competitive advantage belongs to the companies that close this gap, not because closing it is fashionable, but because it is where the money already is.

Every function can hit its number while the enterprise misses its outcome.

Marketing, sales, medical affairs, market access, and patient services each optimize a different moment. The patient experiences the sum of those moments, and no function is accountable for the sum.

The paradox has a history. Pharma commercial models were designed to influence prescribing decisions because, for decades, influence was the binding constraint on growth. Field engagement, marketing, and omnichannel investment were industrialized around shaping clinical conviction and driving script volume, and the model performed. That constraint has now shifted. Prescribing no longer secures value; it marks the midpoint at which value becomes exposed. Once made, the decision must pass through a system the commercial model was never designed to govern, one shaped by reimbursement variability, prior authorization, affordability constraints, specialty pharmacy coordination, and fragmented handoffs. That downstream system is critical infrastructure for the enterprise, and it is not governed as infrastructure. Ownership of its moments is diffuse, spread across functions with different incentives, metrics, and systems of record.

The result is a fundamental mismatch. The model is highly effective at generating influence and structurally incapable of ensuring progression. It can shape the decision but cannot reliably carry the decision through. So the front end of the commercial system is industrialized, measured, and continuously optimized, while the downstream system, where value is actually realized or lost, remains fragmented and largely ungoverned.

Why the industry response to the gap has not been enough

When performance pressure rises, commercial organizations reach for familiar levers: retraining, coaching, field restructuring, sharper messaging, recalibrated targeting, adjusted incentives. Each improves execution within the system. None changes the system. Increasing activity inside a model that leaks value buys short-term momentum, because effort applied to the front end cannot repair breakdowns downstream of it.

Customer experience initiatives came closer to the real problem and still missed it, for reasons the following page examines. Imported largely intact from other industries, they measured sentiment in a system whose failures were operational. Applied without redesigning commercial authority, they captured experience without operationalizing it where value is realized. The commercial model stayed anchored in promotional effectiveness while prescribing conversion, fulfillment

reliability, and adherence continuity ran through legacy structures.

A second paradox layers on the first: customer experience as a function has stalled for lack of measurable impact at precisely the moment the enterprise needs it most. The requirement is not a transplanted version of customer experience. It is a pharma specific form of customer experience aimed at the journeys where value is won or lost: the path to prescribe, the path to fulfill, and the path to adhere. Until progression across the full journey becomes the unit of governance, realization remains structurally vulnerable. No degree of persuasion, personalization, or artificial intelligence compensates for an operating model that does not own the pathways where intent becomes impact.

TABLE 1 | THE COMMERCIAL EXCELLENCE PARADOX

Every function succeeds. The journey still fails.

Function	What it optimizes	How it declares success	What no one owns
Marketing	Awareness and message resonance	Reach, engagement, recall	Whether the script is ever filled
Sales	Prescribing conviction	Calls, frequency, script lift	What happens after the decision
Medical affairs	Scientific understanding	Exchanges and evidence delivered	Administrative burden created in the practice
Market access	Coverage and formulary position	Lives covered, tier secured	Whether covered patients actually start
Patient services	Support for enrolled patients	Enrollment and service levels	Patients who never reach enrollment
The enterprise	Realized therapy	No shared measure exists	Progression itself

EDITORIAL

Customer experience in pharma looks different

Customer experience was never wrong. It was imported without being redesigned.

In retail, hospitality, and financial services, the organization controls the full transaction from promise to fulfillment. When a hotel measures satisfaction, it is measuring a journey it owns end to end, which is why sentiment metrics such as Net Promoter Score can serve as reasonable proxies for loyalty and revenue. Pharma enjoys no such control. The prescribing decision is made by a physician, funded by a payer, adjudicated by a pharmacy benefit manager, dispensed by a specialty pharmacy, and lived by a patient, and the manufacturer directly controls none of these actors. Imported intact, customer experience could describe this ecosystem but could not act on it. It measured how the journey felt while holding no authority over whether the journey progressed.

The lesson is not that experience matters less in pharma. It is that experience in pharma is operational before it is emotional. The moments that define how a healthcare provider or patient experiences a brand are prior authorization turnaround, benefits clarity, affordability at the counter, and continuity between handoffs. Improving them requires governance of progression, not measurement of sentiment.

FieldOS represents customer experience adapted specifically for pharmaceutical commercial excellence: designed for an ecosystem no single organization fully controls, anchored to the three journeys where pharma value is won or lost, and empowered to remove barriers rather than merely record them.

SECTION 3

The shift to journey-based performance

Closing the intent-to-impact gap requires a change in how performance itself is defined. Across industries, value is no longer determined at the moment of decision but by how reliably that decision translates into real-world use, a shift often described as experiential commerce. Experience becomes the mechanism through which value is either realized or lost. In pharma this means the value of a therapy is realized not when it is prescribed but when patients can access it, initiate treatment, and remain on it over time. As access, affordability, and administrative complexity increase, experience becomes the deciding factor in whether therapy actually happens: it shapes how clinicians navigate reimbursement constraints, how patients begin treatment, and how frontline teams resolve friction.

The future of commercial excellence is not creating more intent. It is realizing more of the intent already created.

Why leading industries already architect around journeys

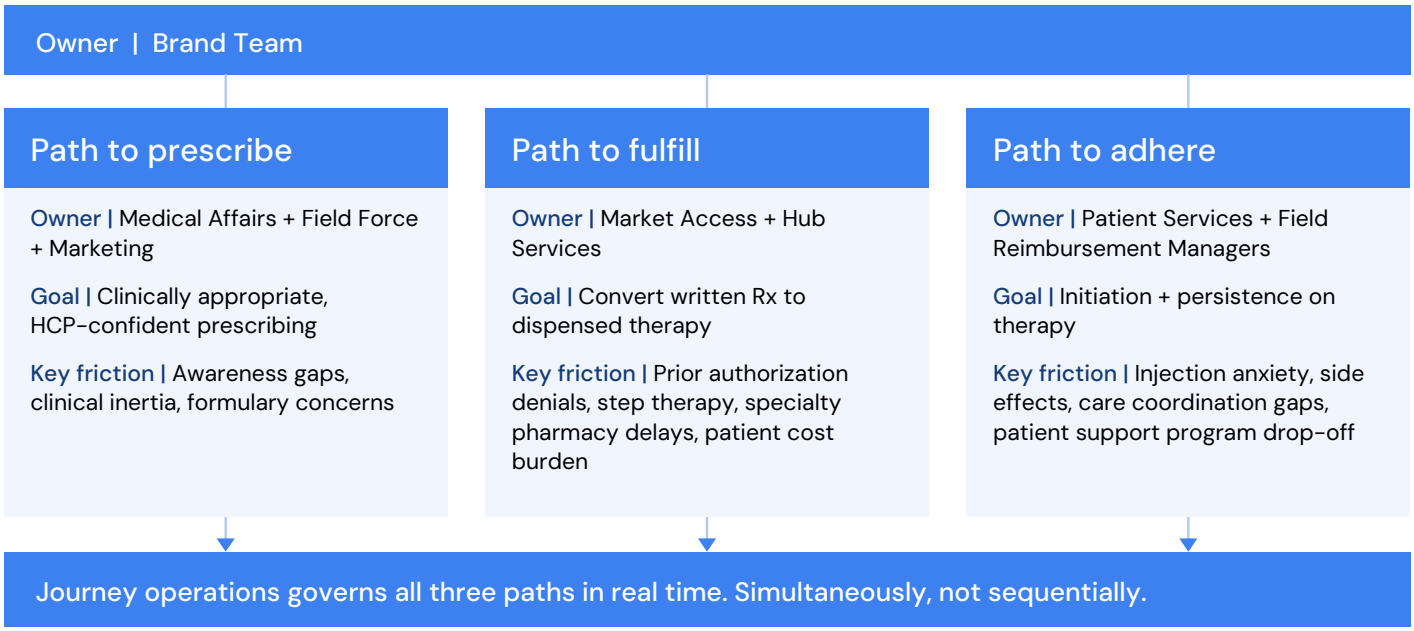
The structural pivot toward journeys is not theoretical. It reflects how high performing industries have evolved wherever consumer grade expectations shape competition. In finance and enterprise operations, Order-to-Cash governs liquidity and revenue reliability from value exchange through payment collection. In supply chain management, Plan-to-Produce protects margin and continuity across sourcing, production, and settlement. In digital commerce, the onboarding, fulfillment, and issue resolution journeys determine conversion, retention, and lifetime value. These are not conceptual maps. They are structural backbones: explicitly defined, measured end to end, assigned ownership, and continuously optimized, because they determine whether economic value is secured or leaked. No chief financial officer would tolerate Order-to-Cash being run as a set of disconnected functional activities with no owner. Pharma runs its equivalent that way every day.

Healthcare providers and patients now carry those same expectations into care. The physician navigating prior authorization complexity is the same individual accustomed to seamless digital commerce, real-time logistics tracking, and immediate service resolution in every other domain of life. Expectations do not reset at the clinic door. Meanwhile, digitally native healthcare platforms such as Hims and Hers Health, Ro, and Amazon Clinic have been architected from inception around integrated access, affordability, prescribing, fulfillment, and follow-up, and established players such as CVS Health are reconfiguring care delivery around end-to-end continuity. In each case the competitive design principle is realization: ensuring clinical intent converts smoothly into initiated and sustained therapy. An organization optimized primarily for persuasion increasingly competes against organizations optimized for realization, and the asymmetry compounds with every therapeutic area they enter.

This is what an outside-in commercial operating model means in practice. The organization is arranged around the sequence the customer actually experiences rather than the sequence the org chart finds convenient, and promotional excellence is extended rather than replaced: the discipline that creates intent remains essential, and it is joined by a discipline that carries intent through to realization.

FIGURE | THREE MASTER JOURNEYS. ONE OPERATING SYSTEM.

The FieldOS three-path framework



Journeys as the unit of performance

Pharma commercial performance has historically been organized around influencing prescribing decisions, a model that reflects a world where the primary constraint was influence. Today the constraint is progression. Value is realized only when prescribing intent progresses through access, fulfillment, and sustained adherence, which shifts the unit of performance itself. Sales calls, promotional details, omnichannel campaigns, and activity metrics remain foundational, but they are no longer sufficient. Performance must extend to the reliability of movement across the full pathway from prescribing decision to sustained therapy.

Pharma's clinical and commercial performance ultimately depends on three interconnected journeys. The path to prescribe, where clinical conviction is formed and translated into prescribing intent. The path to fulfill, where prescribing intent becomes initiated therapy. The path to adhere, where therapy is sustained over time. Together these journeys form the pathways through which clinical intent becomes real-world impact. When they are governed with discipline, value is realized. When they are left to fragmentation, value is lost.

Who owns the journey, and who can actually see it

The bar across the top of that figure names an ownership most organizations already assert. The brand team is accountable for the brand end to end, which in practice means accountable for the number the three paths produce together. Ownership on paper is not the same as visibility in practice. The instruments the brand team actually holds are concentrated almost entirely in the first path: prescribing data, market research, message testing, share and volume tracking, promotional response. Those instruments describe how conviction forms. They say very little about what happens to conviction afterward, which is where the larger share of the value is decided.

This produces a specific and correctable asymmetry. Market research is retrospective, sampled, and abstracted. It reports what a panel of prescribers recalled weeks or months ago, sorted into categories the questionnaire chose in advance. Field intelligence is none of those things. It is observed rather than recalled, specific to a named account rather than averaged across a sample, current rather than lagged, and it arrives already attached to the moment where progression broke. Where market research reports that access is a concern, the field reports which payer, which policy, which step edit, which practice, and what the office tried before it gave up. That is what makes the field the most unimpeachable source of intelligence in the commercial system, and the only one that is actionable on the day it is captured. Section 6 sets out how FieldOS converts it from anecdote into an enterprise asset.

SECTION 4

The reemergence of the field organization

Despite accelerating sophistication in data infrastructure, omnichannel orchestration, and artificial intelligence, the human-to-human work of the field organization has not diminished in relevance. It has become more consequential, for a reason that is structural rather than sentimental. In therapeutic markets where scientific claims increasingly converge and digital capabilities are broadly democratized, sustainable differentiation no longer rests on reach and frequency. Information asymmetry has narrowed. Technology has leveled access. What remains differentiating is how the enterprise is experienced in practice.

Even in a data and AI centric environment, the human interface of the field, including sales representatives, access teams, and other customer facing roles, carries disproportionate weight in shaping that experience. The way the organization shows up does not merely reinforce scientific claims or echo brand positioning. It becomes the brand in motion, defining how the enterprise is experienced not only at the prescribing moment but across the administrative, operational, and financial realities that follow as intent advances into initiation, fulfillment, and sustained care.

This is why the model that follows keeps the human in the loop with AI rather than substituting one for the other. Machines are better at detecting pattern, recurrence, and concentration across thousands of journeys. People are better at interpreting a specific account, judging what an observation means in context, and carrying an intervention through a relationship. A system that automates the first and elevates the second outperforms a system that attempts to automate both.

The field effectiveness value chain has therefore not receded. Its mandate has expanded, and it now operates at the intersection of influence and realization. With that expansion comes greater responsibility and greater opportunity: to create meaningful differentiation, earn preference, and convert scientific excellence into durable enterprise value. Yet this expanded mandate collides with a commercial architecture designed for a different era, one that equips the field to shape decisions and gives it neither the visibility nor the authority to protect what happens after. The sections that follow describe the architecture that resolves the collision.

> ## Access on paper is not access in practice.
>
> Prior authorization requirements alone affect more than 80 percent of covered lives in the United States, introducing delay, fulfillment failure, and abandonment risk into the ordinary course of care.

The field organization is not a legacy cost to be optimized away. It is the enterprise sensing capability, and it is the only one that reports in real time.

SECTION 5

From intent to impact through journey operations

If journeys are the mechanism through which value flows, they must be actively governed, and journey operations is the discipline that enables this. It shifts commercial focus from isolated moments to continuity, ensuring outcomes are realized across end-to-end journeys so that what begins as intent translates into real-world use. The discipline is only viable now because AI makes it operable at scale. Governing thousands of provider and patient journeys in real time, detecting where friction concentrates, why it propagates, and where to intervene, is work no previous field effectiveness model could perform.

In pharma, journey operations means governing the progression from prescribing intent to therapy initiation and sustained adherence, and commercial accountability expands accordingly. The focus moves beyond shaping conviction to protecting continuity, which requires infrastructure that makes the identification and removal of barriers continuous and systemic. Journey operations treats progression as a system property: something that can be designed, measured, and improved with discipline rather than hoped for.

At its core, the discipline creates a shared analytical foundation across commercial, field, access, brand, medical, and omnichannel teams. It aligns them on where journeys break, where risk concentrates, and how progression actually unfolds, establishing a living source of truth that reflects how experience plays out across prescribing, fulfillment, and adherence. Performance measurement changes with it. Instead of tracking volume of activity, the organization tracks progression reliability: do decisions translate into outcomes? Breakdowns stop being treated as isolated incidents and start being read as patterns within a system. Advanced analytics surface clusters of abandonment linked to payer dynamics, initiation delays tied to documentation burden, and persistence risks driven by affordability transitions, so the organization operates on structured signals that show where value is lost and why, rather than on anecdote and escalation.

From friction to action: how FieldOS closes the loop

Three steps. One system. No friction left unaddressed.

Barrier 01.

A point of friction occurs in the patient or HCP journey. The barrier is detected at the frontline by a field rep, hub coordinator, or system trigger.

Signal 02.

TheyDo captures and structures the friction data against the relevant journey stage as a structured signal anchored to a specific moment in the path to prescribe, fulfill, or adhere. Patterns surface in real time.

Intervention 03.

The right function is mobilized to resolve the barrier with full context of where the patient or HCP sits in their journey. The intervention is documented and fed back into the journey model, improving future detection.

FieldOS doesn't just map the journey. It governs progression through it.

The case level loop: one barrier, one patient or prescriber, carried from detection to resolution with full journey context. Section 6 sets out the same logic as the enterprise cycle that runs across the whole portfolio.

Implications for field operations

Journey operations is not only technical. It changes how the field operates and what the roles of representatives, field enablement, and frontline teams mean. When representatives lack visibility into downstream barriers or the authority to address them, their work becomes reactive: administrative burden increases, rework accumulates, healthcare providers face unnecessary complexity, and credibility erodes exactly where influence should be strongest. When progression is visible and governed, the dynamic reverses. Representatives and the broader field organization act with clarity and authority, healthcare providers encounter fewer barriers to follow-through, initiation improves, persistence stabilizes, and revenue becomes more predictable. Influence becomes more effective because outcomes become more reliable.

This reflects a broader principle: experience is not a byproduct of the system. It is produced by it. Embedding barrier detection, prioritization, and removal into the operating fabric of the enterprise turns experience from something measured into something managed, and when progression reliability is built into the system, journey operations becomes a repeatable commercial capability rather than an aspiration.

Journey operations is what turns experience from something the enterprise measures into something the enterprise manages.

SECTION 6

FieldOS: field intelligence and activation

Journey operations only delivers value when it is embedded in how the organization actually works, and that requires more than insight. It requires an operating system. FieldOS is that system: a proven reference architecture for field intelligence and activation, the two capabilities through which journey progression becomes governable across the path to prescribe, the path to fulfill, and the path to adhere.

The pairing is deliberate, and each half is inert without the other. Field intelligence is the sensing capability: the systematic capture and structuring of what the field observes about barriers, friction, and progression risk, converted from anecdote into decision grade signal. Activation is the mobilization capability: the disciplined conversion of that signal into coordinated intervention by whichever function is best placed to remove the barrier.

> Intelligence without activation produces well documented frustration. Activation without intelligence produces energetic guessing.

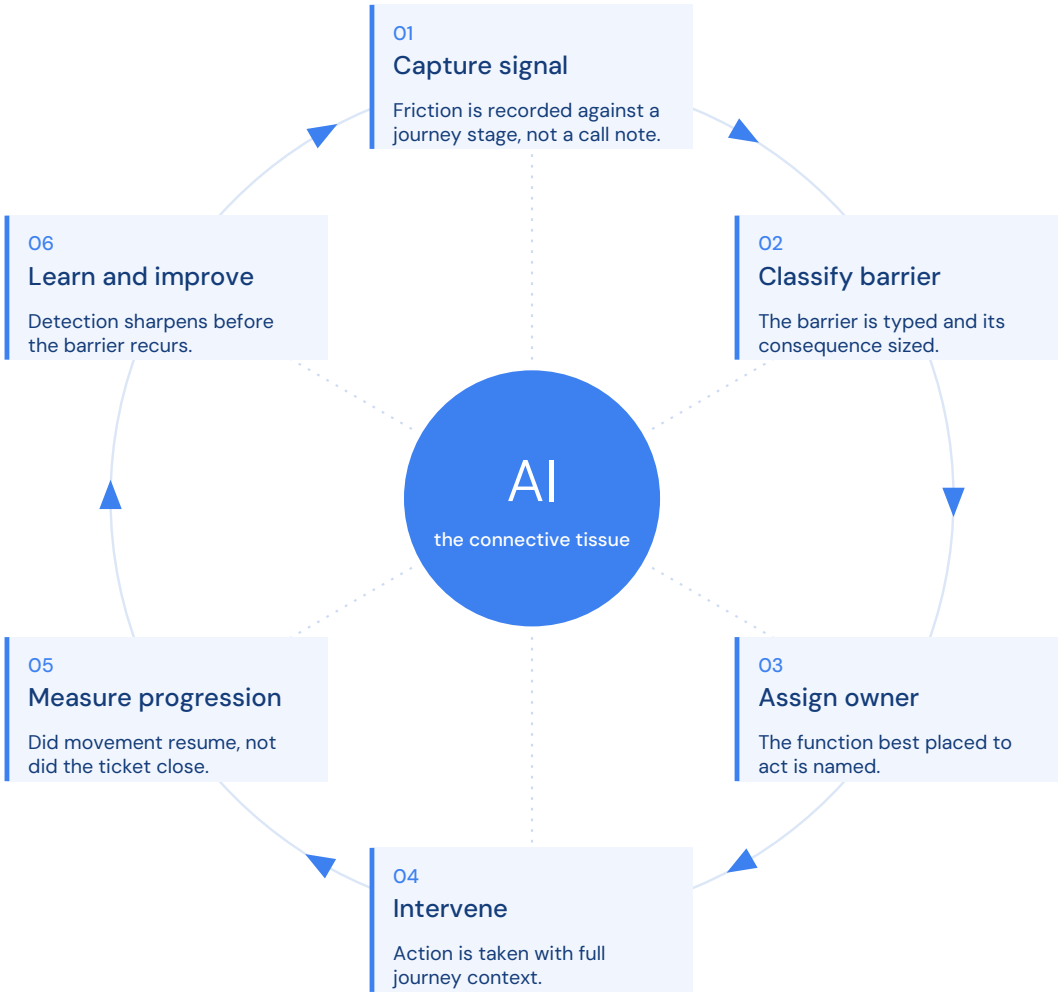
The distinction matters because most field technology today lives on the other side of the conversation. It helps representatives talk better: next best action, pre-call planning, message optimization. FieldOS is built on the opposite premise, that the larger untapped value lies in helping the enterprise listen better and act on what it hears.

The loop that joins them has six steps, and the two in the middle are what separate it from generic feedback. A signal is captured when the field observes friction and records it against a specific journey stage rather than in a call note. The barrier is classified: typed, sized, and connected to the progression it threatens. An owner is assigned, because a barrier that belongs to everyone is addressed by no one, and the right owner is frequently not the person who found it. Someone intervenes, with full journey context rather than a fragment of it. Progression is measured, which asks whether movement actually resumed and not whether the ticket closed. The system then learns, so the same barrier is detected earlier and resolved faster the next time it appears.

Section 5 showed this at the level of a single case: one barrier, one patient or prescriber, resolved in context. The figure below shows the same logic as the enterprise cycle, running across thousands of cases at once. At that scale, classification and ownership stop being administrative steps and become the mechanism that converts scattered observation into portfolio level intelligence. FieldOS transforms the field from a promotion delivery channel into the enterprise capability that runs both levels at the same time, which is what distinguishes an operating system from a program.

FIGURE | THE FIELDOS CLOSED LOOP

Six steps that turn field intelligence into removed barriers



The loop runs on a single case and across the whole portfolio at the same time.

FieldOS functions as a living system of record for progression, reflecting how movement actually unfolds across prescribing, fulfillment, and adherence rather than how the organization chart assumes it does. It is architected as an AI powered model from the ground up. AI is not a layer applied to the framework; it is the connective tissue that makes the framework operable, linking structured operational data with unstructured frontline signals and turning progression into a governed system rather than a stated ambition. Prior field effectiveness models could not deliver this because they predated the technology that makes it possible.

The architecture rests on five interdependent building blocks. They are presented in sequence but operate as a system: each strengthens the others, and removing any one returns the organization to reactive execution.

Building block 1 | Customer excellence as an operating premise

The customer sits at the center of the model, which in pharma means the provider, the patient, and the care team treated as one connected system rather than three separate audiences. Customer experience moves from aspiration to accountability, embedded as the fourth pillar of commercial excellence alongside the established disciplines. Field effectiveness is no longer defined solely by engagement quality but by the reliability with which prescribing intent progresses into initiation and sustained care. Journeys become the shared language across field, brand, access, and medical teams, aligning decisions around barrier removal rather than isolated activity. The performance dialogue changes accordingly: influence remains necessary, but it is repositioned as the beginning of a

progression chain rather than the endpoint of value creation.

Building block 2 | The voice of the frontline as structured intelligence

Every commercial organization already owns the most valuable sensor network in healthcare, and most have never switched it on. The field is the richest, most timely, most credible, and most unimpeachable source of truth the enterprise possesses about what is actually happening in the market: about provider behavior and the administrative burden reshaping practice, about patient barriers and the affordability cliffs that end therapy, about access issues as they emerge rather than as they surface in claims data months later, about competitive dynamics in the clinic, about operational friction and workflow breakdown inside accounts, and about real-world therapeutic progression no dashboard captures. Syndicated data and market research describe the market in aggregate and in arrears, sorted into categories chosen before the question was asked. The field observes it specifically and in the present tense, from inside the room where the friction occurs.

Historically, this intelligence disappeared. It was trapped in anecdote, buried in disconnected call notes, exchanged in hallway conversations at national meetings, and lost entirely when a representative changed territories. The enterprise paid for the sensing and discarded the signal, then purchased inferior substitutes for the same information from third parties. This is among the largest unexploited information asymmetries in the industry, and it has persisted for a simple reason: unstructured human observation could not previously be converted into structured, decision grade intelligence at scale.

> The field is no longer simply the voice of the customer. It is the enterprise sensing capability.

FieldOS converts it into enterprise learning. Qualitative signals from field teams and other customer facing colleagues are anchored to specific journey stages and friction points within the hierarchical journey model defined by the reference architecture, where they combine with operational data to create a real-time view of where progression breaks down. Artificial intelligence strengthens the capability by detecting patterns invisible at the level of individual cases: connecting signals across geographies, segments, and access conditions, revealing where friction concentrates, how it propagates, and where intervention will have the greatest impact. The representative's own experience becomes a leading indicator of provider burden and downstream realization instability. Listening shifts from passive collection to engineered signal acquisition embedded within commercial workflows, and the field's observations become institutional memory: codified, compounding, and retained when people move on.

Building block 3 | Measurement that reflects progression economics

Performance measurement shifts from engagement metrics to progression metrics. Barrier density, initiation delay, abandonment, and persistence become measurable within the journey itself and directly linked to business impact. By integrating structured operational data, including initiation timelines, abandonment rates, reimbursement delays, and milestone volatility, with unstructured frontline signals, AI makes friction economically legible: breakdowns in progression are translated into revenue exposure, forecast instability, and lifetime value compression. Operational delays that once appeared isolated are quantified in terms of therapeutic substitution risk and initiation attrition. What was previously anecdotal becomes measurable, and what is measurable becomes fundable.

TABLE 2 | THE MEASUREMENT SHIFT

From activity metrics to progression metrics

Conventional measure	Progression measure	What the progression measure exposes
Calls and reach	Barrier density per account	Where friction concentrates, and which accounts are structurally harder than they look
Script volume	Script to initiation conversion	Value lost between the decision won and the therapy started
Formulary wins	Time to first fill	Whether access on paper is becoming access in practice
Program enrollment	Initiation delay	Where onboarding, documentation, and financial clearance stall
Refill counts	Persistence at 90 and 180 days	Whether therapy survives affordability transitions and side effect windows
Campaign response	Recurrence of resolved barriers	Whether interventions hold, or the same friction returns unnoticed

Building block 4 | Operating model integration

Journey operations becomes embedded in how the business runs. Governance, ownership, and review cadences are structured around progression rather than function: the FieldOS reference architecture defines how journey progression is reviewed, how hypotheses are tested, how ownership is assigned, and how corrective actions are sustained, while TheyDo provides the connected multidisciplinary operating environment in which field, access, brand, medical, and omnichannel leaders work from a single progression reality. Artificial intelligence supports the cadence by continuously surfacing emerging risks, validating hypotheses against real-world progression data, and enabling faster, evidence based decisions across teams. Field effectiveness evolves from persuasive execution to disciplined stewardship of progression.

Building block 5 | Continuous journey improvement

Improvement becomes systematic rather than episodic. Instead of reacting to isolated issues, the organization identifies recurring breakdown patterns, redesigns the upstream conditions that produce them, and scales the learning across brands and markets. AI enables the shift by revealing recurrence and tracking the impact of interventions over time, so the enterprise moves from fixing instances to engineering progression reliability. Learning is codified, cross-functional collaboration shifts from reactive escalation to systemic redesign, and each cycle raises the baseline the next cycle starts from.

Taken together, the five building blocks make experience measurable and governable within the system itself. Friction is identified, quantified, and addressed within defined journey stages. Decision making moves from reactive intervention to structured, evidence based correction. The operating model, not any individual initiative, becomes the source of advantage.

SECTION 7

What changes when progression becomes governable

In clinical practice, symptoms are observed, potential causes are evaluated, and interventions are validated against outcomes. Persistent instability is addressed through structured diagnosis, never through repetition of the same treatment at higher doses. Journey operations applies the same logic to commercial progression. When prescribing momentum slows, initiation timelines lengthen, or persistence weakens, the response becomes investigation rather than intensified activity. What appears as prescriber resistance may reflect reimbursement friction. What appears as hesitation may stem from documentation burden. What appears as nonadherence may signal affordability instability. Diagnosis precedes intervention, which is precisely the discipline the commercial model has historically skipped.

Decision making as a governed system

The operational shift changes how decisions are made. Hypotheses are explicitly defined, tested against structured and unstructured journey signals, and validated against progression outcomes. Artificial intelligence sharpens managerial judgment by revealing systemic patterns, risk concentrations, and progression instability across geographies and access conditions, linking initiation delays to documentation burden or persistence decline to affordability transitions, so that what appears as isolated friction is understood as a system condition. Leadership reviews become hypothesis driven rather than anecdotal, cross-functional collaboration shifts from reactive escalation to coordinated redesign, and learning is codified within the system and reused across markets, brands, and teams.

From activity optimization to progression reliability

The impact becomes visible over time. Initiation stabilizes, abandonment declines, and persistence strengthens. Commercial investment delivers greater downstream return because journeys hold together, and productivity improves not through increased activity but through stronger progression integrity, as the system continuously detects, interprets, and corrects breakdown patterns across the journey.

FIGURE | JOURNEY GOVERNANCE MATURITY

Where the commercial system actually sits

A new definition of commercial excellence

When execution becomes system performance, when progression is continuously observed, diagnosed, and corrected, the operating model itself becomes a source of advantage. Commercial excellence is no longer defined solely by how effectively an organization drives decisions, but by how reliably it ensures those decisions become outcomes. That is a different competition, with different winners.

SECTION 8

Field effectiveness in practice

In practice, this shift changes what field teams do in every interaction: how they listen, what they capture, and how the intelligence they generate flows back into the system. Interactions with healthcare professionals expand in scope. Clinical conversations are complemented by structured inquiry into what happens next: reimbursement feasibility, documentation burden, therapy affordability, and continuity of care. These signals reveal where progression is at risk and where intervention is needed, and over time their capture becomes systematic, anchored to specific journey stages and types of friction within a shared system of intelligence.

Instead of solving isolated problems, field teams begin to surface patterns that point to upstream issues addressable at scale. Management practices evolve in parallel: performance assessment extends beyond coverage and engagement toward progression indicators, milestone stability, and recurrence patterns. Hypotheses are defined, tested against journey signals, and refined on outcomes, with artificial intelligence identifying patterns and risks across geographies, access conditions, and patient populations so teams focus where intervention will matter most.

The shift extends across the operating model. Field, access, brand, medical, and omnichannel teams operate within a shared view of the journey, aligning on barrier removal rather than isolated activity, and collaboration becomes proactive, improving the conditions that shape outcomes rather than reacting to issues after they occur. Enablement adapts in parallel: training expands from messaging and execution toward diagnostic capability, equipping teams to recognize progression breakdown, interpret signals in context, and contribute to coordinated system improvement.

Over time this produces a more precise and more valuable field model. Field teams become a primary source of structured progression intelligence, enabling targeted intervention and continuous learning across brands, markets, and therapeutic areas. Field effectiveness is no longer defined solely by the ability to influence decisions or provide support after the fact. It is defined by the organization's ability to ensure that those decisions translate into real-world outcomes, consistently moving patients from prescribing intent to initiation and sustained care.

> ## Half of the decisions already won never become therapy.
>
> Up to 50 percent of written specialty prescriptions never become initiated therapy. Every one of them began as clinical conviction the commercial organization had already earned.

Key takeaways

1. The constraint is not influence. It is what happens after.

Pharma has optimized to shape prescribing decisions, yet a significant share of those decisions never translate into initiated and sustained therapy. The primary limitation is not front end effectiveness. It is progression.

2. Prescribing is the midpoint, not where value is realized.

Commercial success has long been measured at the moment of prescribing. In reality, value is realized only when patients start and stay on therapy. What happens after the decision determines both patient outcomes and commercial performance.

3. Experience now determines whether therapy actually happens.

As access, affordability, and administrative complexity increase, operational friction rather than clinical uncertainty has become the primary driver of drop-off. In an era of experiential commerce, experience is what carries intent forward or causes it to fail.

4. The model breaks because it was never designed to govern progression.

The commercial engine is highly optimized to generate decisions, but the downstream system that determines whether decisions become outcomes remains fragmented and largely ungoverned. The constraint is structural, not behavioral.

5. The unit of performance must shift from activity to progression.

Calls, campaigns, and engagement metrics are no longer sufficient. The journey, and the reliability of progression across prescribing, fulfillment, and adherence, must become the unit of commercial governance.

6. Journeys must be governed as infrastructure.

Closing the gap requires a system that makes progression observable, measurable, and correctable, treating journeys as managed infrastructure rather than disconnected touchpoints. AI is what makes that infrastructure operable at scale.

7. Performance improves when progression is diagnosed and managed.

Once journeys are observable, the organization operates differently. Progression is diagnosed, interventions are tested, and learning is codified. Decisions shift from activity driven to evidence based within a governed system.

8. Field effectiveness is defined by progression, not influence alone.

The role of the field expands beyond shaping decisions to ensuring those decisions translate into initiation and sustained care. Field teams become a primary source of insight into where progression breaks down and how to improve it.

9. AI makes the next generation field organization possible, and the human field matters more because of it.

AI surfaces friction patterns invisible at the individual case level and links signals across geographies and access conditions, which is why FieldOS works where prior frameworks could not. As technology levels access and scientific differentiation narrows, the enterprise shows up through its people: when the employee experience of the field is coherent and supported, customer experience strengthens and commercial performance follows.

10. This is a system redesign, not a tactical fix.

Improving performance is not about doing more. It is about ensuring that intent consistently becomes outcome, which requires redesigning how the commercial system operates: from generating decisions to governing progression across the end-to-end journey.

Diagnostic questions for leaders

Closing the intent-to-impact gap requires more than new metrics or tools. It requires leaders to examine how the commercial system actually performs, from prescribing intent through initiation and sustained care. The following questions surface whether the organization is optimizing for activity or governing progression.

1. Are we optimizing for prescribing activity or therapy realization?

Is success defined by reach, frequency, and engagement, or by how reliably prescribing intent translates into initiation and sustained therapy?

2. Where do prescriptions break down, and do we measure those points?

What percentage of written scripts convert to initiated therapy? How many patients persist over time? If these are not consistently measured, value leakage remains invisible.

3. Who owns what happens after the scripts are written?

Is there clear accountability for progression across the path to fulfill and the path to adhere, or are reimbursement, affordability, and access treated as downstream variability outside the commercial mandate?

4. Is the downstream system governed or left to fragmentation?

Are prescribing, fulfillment, and adherence managed as connected journeys with defined ownership and performance metrics, or as disconnected processes across functions?

5. Are friction signals structured and acted on, or anecdotal?

When the field surfaces access barriers, documentation burden, or affordability challenges, are those signals captured within a shared framework and translated into action, or do they remain isolated notes, escalations, and workarounds?

6. Does AI improve targeting or make progression visible and governable?

Are AI investments primarily focused on refining persuasion, or on detecting friction patterns, identifying progression risk, and guiding interventions across real-world care pathways?

7. Are we diagnosing progression or reacting to outcomes?

When initiation slows or persistence declines, do teams investigate root causes and test interventions within a structured system, or default to increasing activity and reinforcement?

8. Is field effectiveness defined by influence or realized impact?

Do performance reviews stop at prescribing intent, or do they assess whether those decisions translate into initiation, persistence, and sustained value?

9. Are we improving the system or compensating for it?

When performance gaps emerge, does the organization redesign the conditions that create friction, or rely on more effort, more messaging, and more activity to offset structural weaknesses?

Next steps | From diagnosis to action

Field effectiveness has centered on shaping decisions. Its next evolution is governing the journey from intent to initiation, fulfillment, and adherence through journey operations.

If the questions above reveal gaps in your commercial architecture, the next step is structured action. Wayne Simmons and TheyDo work with pharma commercial leaders to map current state journey progression, identify the highest value friction points, and design the operating model required to govern them.

This is not a software demonstration. It is a working session focused on how prescribing intent becomes initiated, fulfilled, and sustained therapy in practice.

If you are ready to explore what this could look like in your organization

Get in touch with Wayne Simmons at The Customer Excellence Agency, or see the FieldOS framework in action in TheyDo.

THE WORKING SESSION

Three steps from diagnosis to a governed journey

01 Map

Establish current state progression across the path to prescribe, fulfill, and adhere, and locate where value actually leaves the system.

02 Quantify

Size the friction. Translate barrier density, initiation delay, and persistence loss into revenue exposure and forecast risk.

03 Design

Define the operating model, ownership, and review cadence required to govern progression rather than report on it.

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.

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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