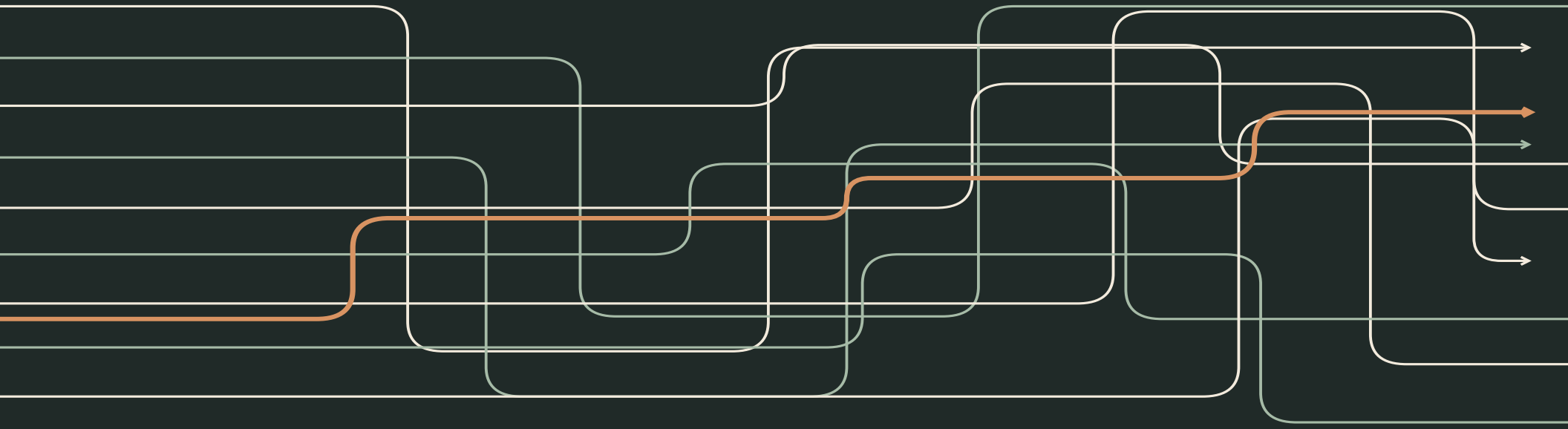
PRACTICE NOTE

Pharma’s Realization Revolution

Completing the therapeutic value chain

Pharma’s Essential New Growth Discipline

Realizing the patient and commercial value of prescribed medicines



THE Customer Excellence AGENCY

mamahealth

NOVEMBER 2026

EXECUTIVE SUMMARY

Value realization depends on what patients experience

REALIZE VALUE THROUGH THE PATIENT EXPERIENCE

Value leakage is the potential left unrealized between prescription and appropriate treatment. The realization lever addresses its avoidable causes by improving how patients and healthcare professionals experience that journey.

Customer consciousness means allowing that understanding to shape decisions. A prescription may bring hope while leaving someone to chase an authorization, absorb an unexpected cost or face an injection alone. These experiences affect whether the person can take the next appropriate step. Journey thinking connects those steps across the functions and organizations responsible for them.

The strategic case for customer experience in pharma is growth and value creation, judged by material, measurable effects on patient and commercial outcomes. Net revenue and contribution depend on treatment received; clinical benefit needs its own evidence. Mamahealth’s descriptive research helps explain the concerns and practical burdens behind interruption, directing leaders toward the experience improvements worth testing.

EMBED THE DISCIPLINE IN EVERYDAY WORK

Realization Management gives this work a commercial discipline: identify avoidable barriers, assign responsibility for resolving them and establish whether the response helped patients progress and realized additional value.

The Realization Layer supplies the operating infrastructure. Shared decision rights and workflows connect patient and HCP insight with accountable action across functions. Technology supports that work; its usefulness depends on whether a team can act on the information and follow the issue through.

This Practice Note develops the response through patient accounts, handoff design and leadership decisions. The economic illustration distinguishes unrealized value from the portion a feasible intervention might recover. CEA’s Player-Coach approach supports employees as they put the discipline into practice; Value Unlocked helps leaders agree where to begin.

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This paper stands alone. The companion Research Paper provides additional published evidence and the full economic derivation.

THE CASE FOR CHANGE

Experience activates the realization lever

Customer consciousness changes what leaders ask; journey thinking changes what they manage.

In an illustrative QBR, a brand team reviews share of voice, engagement and field vacancies. Someone asks how many patients prescribed the therapy last quarter actually started it and continued appropriately. Answering requires several sources and a follow-up that nobody clearly owns. The review can explain activity more readily than the patient’s progress.

Customer consciousness begins with that imbalance. Leaders need to understand what patients and HCPs must do to obtain and use treatment, then let those circumstances influence priorities. A service can complete its task while leaving the person confused, uncertain or unable to proceed.

Mamahealth’s patient and caregiver accounts expose unclear instructions, unanswered concerns and failed handoffs. [2] Operational records help establish how often these problems occur and who can address them. Together, they provide a fuller explanation than either source alone.

Journey thinking follows the connections between those events. It asks whether one team’s completed work enables the next team, and ultimately the patient, to move forward.

The management consequence is shared responsibility for transitions that cross functional boundaries. Leaders must agree who accepts unresolved work, what information travels with it and how a delay reaches someone with authority to respond. The Realization Layer supports those arrangements.

An approved patient, for example, may never start because an affordability referral fails. The access decision succeeded, but the journey stalled. Fixing the referral requires an accepted handoff and confirmation of the patient’s next step. Initiation establishes a milestone; subsequent clinical benefit and commercial value require their own evidence.

The companion Research Paper illustrates the stakes: 9,600 patients represent $436.8 million in modeled Earned Value, of which $241.9 million is realized and $194.9 million remains unrealized over one year. [1] This note examines how experience can help explain that gap and inform a response.

COMMERCIAL ECONOMICS

The cause of value leakage determines the investment

Following the same patients gives functions a shared problem to investigate.

A clinical concern, a coverage restriction and a failed pharmacy handoff can each precede non-initiation. Each requires different expertise. An aggregate conversion rate identifies where to look, but choosing a response requires understanding what happened to the patient and why the journey stalled.

Friction is the effort, uncertainty, delay or rework that makes an appropriate next step harder. Its commercial effects can include delayed receipts, a missed start or less time on treatment within the observation period. Repeated calls and duplicate work also raise service costs. Experience therefore matters both to treatment progression and to the resources required to support it.

Functional categories such as access, affordability and tolerability remain useful for diagnosis. Journey thinking connects their consequences. It prevents a resolved authorization from being mistaken for a completed start, or a delivered medicine from being mistaken for a patient ready to use it.

The patient’s account may overturn the first explanation. A missed start coded as an affordability problem might also involve uncertainty about taking the medicine. Reconstruct the sequence with the patient and relevant records before deciding which clinical or service team should respond.

That explanation determines the investment case. Estimate the population a response can reach, the improvement supported by evidence and the full delivery cost. Leaders can then compare its expected contribution with other uses of the budget. Page 8 illustrates the value requiring investigation.

The same reasoning applies to technology. Summarizing missing documentation is useful only if an access team can use the summary to complete a submission. The investment question concerns the work and the outcome the technology could change.

RESPONSIBILITY IN PRACTICE

Define responsibility around the patient’s next step

Clinical, access and commercial teams contribute different expertise to a shared progression account.

Understanding why a medicine was prescribed does not ensure that a patient can obtain it. Approval can arrive before affordability is resolved; delivery can precede readiness to start. Designing support around the journey means anticipating these gaps and making the next step understandable and achievable.

Patient accounts supply context that transactions can miss. Access staff may need to locate a document, pharmacy colleagues to clarify delivery, or qualified clinicians to address a treatment concern. Assigning responsibility requires enough context to send the problem to someone able and authorized to resolve it.

A written prescription, dispensing and initiation are different events. The medication-adherence taxonomy developed by Vrijens and colleagues also distinguishes initiation, implementation and discontinuation. [3] Use those distinctions to specify what each team is expected to confirm.

An effective handoff preserves that context. The receiving role needs to accept the issue, understand what remains unresolved and know when to escalate it. Patients and caregivers should not have to coordinate the organizations involved or repeat their history at every contact.

Patient choice and clinical judgment govern starting, continuing and stopping treatment. A clinically appropriate change is a legitimate outcome. The organization’s responsibility is to address avoidable friction and unmet support needs within its influence.

A useful first test is a transition where ownership is uncertain. Compare what each team regards as complete with what the patient still needs. The discrepancy gives leaders a concrete service problem to address.

PATIENT EVIDENCE

Patient questions reveal friction between clinical encounters

Descriptive research from mamahealth helps identify what patients need to understand or do next.

The consultation ends before the treatment experience begins. Patients may still be unsure why a medicine was selected, when benefit should become noticeable or whom to contact about side effects. At home, those questions meet practical and emotional circumstances that a prescription record cannot describe.

In mamahealth’s research, US patients living with psoriasis described limited participation in treatment decisions, uncertainty about time to benefit and insufficient preparation for side effects. Participants connected those experiences with anxiety and early stopping. A patient living with lupus described going home "in the dark." [2]

Among respondents prescribed specialty therapies, one in eight described a prescription they never started. In the psoriasis research, 90% cited a healthcare professional as a key information source and around one in five also used digital sources. [2] These figures describe the participating samples.

The physician remains central. Between appointments, patients need help understanding the treatment decision and reaching qualified advice. A reliable contact can matter as much as another explanation.

Questions in mamahealth’s patient companion app provide another view of the interval. Roughly one conversation in four concerned effectiveness or side effects, while close to one in five concerned obtaining an answer from a doctor. [2] These themes can help teams identify where explanations or routes to clinical support need attention.

Patient and caregiver accounts can connect an unopened letter, uncertainty about an injection and a call that restarts the entire discussion. Read alongside dispensing or refill records, they help explain how separate events became an interruption.

The management value of listening lies in the decisions it changes. A team that discovers an unmet clinical concern should respond differently from one investigating a routing error. Customer consciousness becomes operational when patients’ circumstances influence that diagnosis and the service subsequently provided.

Descriptive mamahealth research. Sample sizes, recruitment periods and complete methods are unavailable; the percentages describe participating samples or coded conversations, not population prevalence. See page 33. [2]

ONE-YEAR ECONOMICS

A one-year view connects patient progression and value leakage

Realization Rate and Realization Yield answer different questions.

PATIENT PROGRESSION

9,600	8,160	7,507	5,555	4,000
Written	Filled	Started	Day 90	Month 12
100.0%	85.0%	78.2%	57.9%	41.7%

Realization Rate **41.7%**

COMMERCIAL VALUE | $ MILLIONS

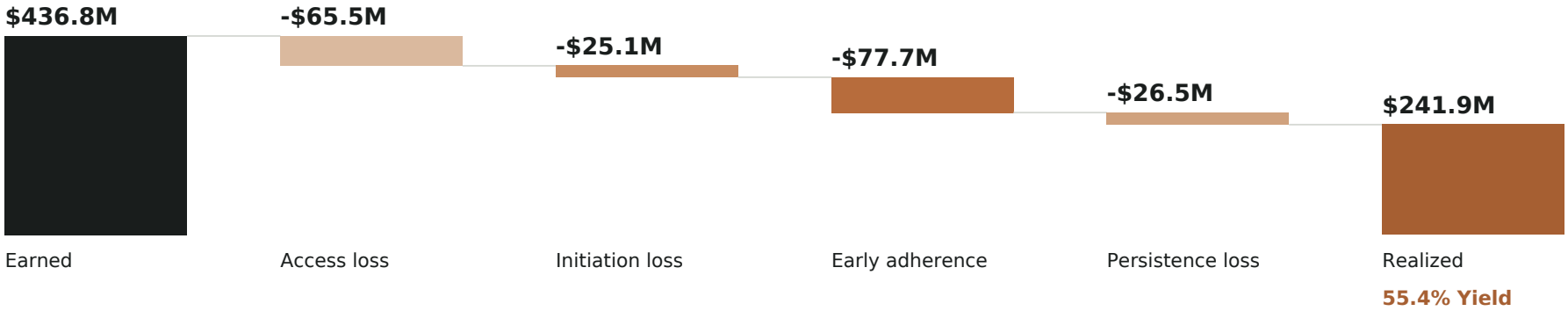

Exhibit 1. Illustrative CEA one-year economics. The same 9,600 patients underlie both views. Loss rates apply to patients entering each stage. Assumptions are on page 33. [1]

Follow 9,600 patients for one full year. At $45,500 per patient, modeled Earned Value is $436.8 million. Approximately 4,000 reach month twelve, a 41.7% Realization Rate.

Realized Value is $241.9 million, including value before some patients stop. Yield is 55.4%; $194.9 million remains unrealized. Evidence about addressable causes and feasible interventions establishes the recoverable share. Clinical benefit requires separate evidence.

INTERPRETING VALUE LEAKAGE

Loss timing changes the economic importance of a barrier

The largest attrition percentage alone cannot determine where to invest.

The Value Leakage Ladder locates changes within the original prescribed population. Each transition directs investigation toward the experience, support and decisions that preceded the observed result.

The illustrative loss rates apply to patients entering each stage: 15% at access, 8% at initiation, 26% at early adherence and 28% at persistence. Applied in sequence, they leave approximately 4,000 of the original 9,600 patients at month twelve. [1]

Persistence has the highest conditional loss rate, yet early adherence carries the largest modeled financial gap: $77.7 million of $194.9 million. Patients who stop later have already contributed more value within the horizon. Timing is therefore part of the economic diagnosis.

Size alone cannot establish investment priority. A small handoff failure that is readily corrected may offer more incremental contribution than a larger gap whose causes are costly or difficult to change.

The financial account retains value realized before interruption. Patients who stop after several months still contribute during the year, so the persistence endpoint cannot stand in for annual value. Page 33 specifies the timing assumptions, including the possibility that a paid fill generates receipts before a start is confirmed. [1]

A brand must replace the illustrative inputs with its own net price, dose, duration and observation horizon. It must also distinguish missing status from confirmed discontinuation and choose clinically suitable milestones for finite treatment courses.

Mamahealth’s participants are separate from the modeled population, and their experiences do not establish its loss rates. The two sources serve different decisions: the model locates economic exposure, while patient accounts suggest explanations to investigate. Conflating them would weaken the case for action.

Patient experience makes the sources of value leakage visible and gives teams a practical basis for action.

PATIENT EXPERIENCE

Patient accounts reveal what transaction records leave unexplained

Each account points to a different question about the source of friction.

BEFORE ACCESS Understanding the prescription	"He said it targets the inflammation differently. I nodded. I still don't know what that means."	**Crohn's disease**
ACCESS Waiting for authorization	"Prior authorization took seven weeks. By then I'd stopped calling."	**Pulmonary fibrosis**
ACCESS Facing the cost at collection	"At the counter it was four hundred dollars. I left it there."	**Type 2 diabetes**
INITIATION Preparing for the first dose	"The pens have been in my fridge for a couple of weeks. I'm scared of doing the first injection alone."	**Psoriasis**
EARLY ADHERENCE Waiting for benefit	"Nobody told me it could take three months. By week six I thought it had failed."	**Lupus**
PERSISTENCE Deciding whether to continue	"I was still falling asleep at work or at dinner. I didn't see the point in carrying on."	**Narcolepsy**

Exhibit 2. Exact patient quotations from mamahealth, analytically mapped to journey moments. The accounts are descriptive and come from separate conditions and participants; see the evidence note on page 33. [2]

Fear of an injection suggests preparation and qualified support; an authorization delay suggests coordination. Both can end in non-initiation, but the useful intervention depends on the experience behind it.

These accounts come from separate participants and conditions, independently of the model on page 8. Their value is diagnostic: they give the responsible team a specific question to investigate before treating the recorded endpoint as a sufficient explanation.

INTERRUPTION IN CONTEXT

The patient can struggle before the dashboard registers a loss

An illustrative patient narrative shows how completed tasks can leave a need unresolved.

In this illustrative account, a patient reaches week nine without noticing the benefit she expected. Early side effects have become wearing. She has explained her circumstances to several people since receiving the prescription, yet each conversation requires much of the same history.

She misses a dose on Tuesday and plans to resume at the weekend. A week later, restarting feels harder: she now expects to explain the interruption as well as the original concern. No service has recognized what is developing.

The pharmacy’s next contact is days away. The hub has completed enrollment, the field team has no patient-level clinical visibility, and the physician will hear about the stop at a later appointment. Each function can report that its assigned work was done while the patient’s concern remains unanswered.

A missed refill may eventually reveal the interruption. The earlier opportunity lies in understanding when the concern began, whom the patient contacted and what followed. That sequence helps determine whether continuity, clearer information or timely clinical support could have made a difference.

Clinical judgment remains decisive: side effects or an informed preference may justify stopping. Commercial teams can remove barriers within their influence and connect the patient with qualified help; they cannot assume that continuation is always the right outcome.

In this case, the support service needs to preserve the patient’s account and keep the concern open until a receiving team accepts it. Success would first mean less repetition and timely qualified help. The subsequent treatment milestone would then show how the journey developed. This is the practical connection between experience design and progression.

ACCOUNTABILITY

Functional labels can leave cumulative leakage unexplained

Keep the distinct causes while connecting their consequences in a shared review.

Familiar label	Where responsibility often sits	Question for a realization review
Access barrier	Payer and market access	What restriction applies, what can the enterprise influence, and who owns the next authorized step?
Affordability problem	Benefit design, employer and patient	Is benefit-specific navigation or eligible support available, and did the patient reach it?
Prescription abandonment	Pharmacy and fulfillment processes	Was the cause routing, cost, preference, clinical change or a missing observation?
Nonadherence	Medication-taking behavior	What beliefs, burden or practical circumstances contributed to the interruption?
Tolerability discontinuation	Clinical care and product experience	Was the stop clinically appropriate, and were questions or support needs addressed?

Exhibit 3. CEA accountability questions. These prompts support investigation; actual responsibilities depend on the brand, market and support model.

Functional labels become limiting when they end the inquiry. “Access” may identify a department without explaining the patient’s unresolved next step. A shared review follows the consequences across boundaries to establish where action remains possible.

WHO’s adherence work emphasized care systems and the support patients need. [4] That perspective broadens the commercial diagnosis beyond medication-taking behavior to the conditions that make appropriate treatment manageable.

REGIMEN BURDEN

Treatment burden can change the questions raised with payers

An anonymized mamahealth case connects regimen design with the patient and caregiver experience.

A company described a leading therapy for a chronic condition available in different formulations of the same molecule. The specialist formulation required two pills a day; an alternative required six to deliver the same reported total daily dose. Health plans increasingly preferred the six-pill formulation on unit-price grounds, according to the case. [2]

For the company, the issue was coverage and formulation choice. At home, it was managing a daily regimen. Refill records could reveal an interruption while leaving the schedule, caregiver involvement and practical burden unexplained.

Through AI-moderated conversations run by mamahealth, patients and caregivers described their regimen, missed or interrupted doses and the circumstances around hospital admissions. The case reports adherence of around 95% for the two-pill regimen and 70% for the six-pill regimen. One in four participants linked a hospitalization to a missed or interrupted dose. [2]

Participants described forgetfulness, confusion and daytime sleepiness as obstacles to managing six pills a day. Some relied on a spouse or adult child to manage the schedule. One participant said her sister had "practically become my caregiver." [2]

The company reports using the findings in payer and health-system discussions and in access advocacy through a national patient organization. Those conversations could now consider the daily burden of treatment alongside unit price and raise further questions about adherence and total cost of care.

The case illustrates how customer consciousness can change the question brought to a decision maker. Patients’ descriptions exposed consequences that a price comparison omitted. The reported outcome was a different discussion; the research does not establish that coverage, adherence or hospitalization changed as a result. Further evidence is needed to support those conclusions.

Descriptive mamahealth case. Sample sizes, recruitment details and a common adherence measure were unavailable for validation. The comparison does not establish that formulation caused better adherence or fewer hospitalizations. [2]

HANDOFF STANDARDS

A handoff needs a responsible team and a confirmed next step

A handoff is complete when the receiving role has what it needs and the next step is confirmed.

Prescription received	Access route resolved	Pharmacy connected	Start supported	Continuity reviewed
Receiving role				
Prescribing team	**Authorized access team**	**Pharmacy and support**	**Qualified support route**	**Care and support teams**
Evidence of completion				
Required information accepted	Next authorized step confirmed	Receipt and patient contact confirmed	Relevant preparation and escalation available	Unresolved concerns routed and followed up

Unresolved transition → Named escalation owner → Confirmed next step

Exhibit 4. Illustrative handoff design. Responsibilities and information access must fit the authorized support model.

A patient should not have to discover who owns a stalled transition. Handoff standards make responsibility visible across organizations, including the point at which the receiving team accepts the work and the route for resolving a delay.

The standard must also describe what the patient should experience: a clear explanation, preserved context and a dependable next contact. Those expectations help teams judge whether their coordination is useful to the person relying on it.

DESIGNING THE RESPONSE

Match the intervention to the source of friction

Patient accounts help explain the problem; operational evidence determines the response to test.

Barrier to investigate	Work that could address it	Evidence to examine
Missing authorization information	The access team requests the specific missing item and confirms that the receiving organization accepts it.	Time to a complete submission, repeat requests and the next access decision.
Unexpected cost at collection	An authorized team explains the benefit-specific options and eligible support, with a clear follow-up route.	Whether the patient received usable guidance and whether the dispensing issue was resolved.
Uncertainty about a first injection	Route the concern to qualified support and arrange preparation suited to the patient’s needs.	Patient-reported understanding and the relevant initiation milestone.
Repeated explanations across services	Preserve the permitted context in the handoff and name who owns unresolved questions.	Repeated contacts, accepted handoffs and the patient’s account of whether the concern was addressed.
Difficulty fitting treatment into daily life	Investigate practical and caregiver burden and connect treatment concerns with the clinical team.	Support used, remaining burden and the agreed continuation or treatment-change outcome.

Exhibit 5. Proposed responses to reported or observed friction. These are design options to investigate, not measured intervention effects.

A response should address the particular difficulty the patient encounters. Before scaling it, establish whether the receiving team could deliver the service and whether the intended next step became easier to complete. The result should inform both service design and the next investment decision.

INFORMATION BETWEEN APPOINTMENTS

Unanswered questions can become a source of friction

Information helps when it connects patients to the right next step.

An unfamiliar term in a plan letter or a pharmacy call from an unrecognized number can leave a patient uncertain about what to do. Communication design belongs in the treatment journey because an explanation has practical value when the person can use it to take the next appropriate step.

Levy and colleagues found that formulary-related rejections for single-source branded drugs rose from 24.3% in 2018 to 40.7% in 2024. Among initially rejected attempts, 48.4% had no observed same-class fill within 90 days. [5] These are US fill-attempt measures, not a percentage of all written prescriptions. They show why the subsequent disposition belongs in the access account.

Patients increasingly seek information beyond appointments. In KFF’s March 2026 poll, 32% of US adults reported using AI for physical or mental health information or advice in the prior year. Among those users, 41% reported uploading personal medical information. Pew separately found that 22% of US adults had used chatbots to learn about treatments and the same share to learn about a doctor’s diagnosis. [6,7]

These surveys establish use, while the effect on treatment progression remains uncertain. Information may help someone recognize a stalled process or prepare a clinical question. Resolving the authorization or deciding whether therapy remains appropriate still requires the responsible service or clinician.

Horne and colleagues associated stronger beliefs in medicines’ necessity and fewer concerns with better adherence. [8] This supports examining patients’ understanding and worries when designing support. It provides no estimate of the effect of a particular information tool.

The route must fit the question. Access problems require process support; symptoms and treatment decisions require qualified clinical care. Manufacturer-supported information also needs appropriate review, privacy and safety-reporting arrangements. Consented patient accounts can expose confusing explanations or referrals that lose context, giving teams a specific design problem to test.

YIELD AND THE GROWTH DECISION

Realization Yield adds a growth decision to the patient account

The financial measure includes value realized before a patient stops treatment.

Realization Rate measures patients reaching a specified milestone as a share of those originally prescribed. Realization Yield is Realized Value divided by Earned Value for the same patients and horizon. Earned Value is modeled commercial potential at prescription. In the one-year illustration, month-twelve Rate is 41.7% and Yield is 55.4%. [1]

The distinction matters because patients who stop before month twelve may already have contributed commercial value. An endpoint-only measure omits that contribution. Report the two measures for the same original population and period so leaders can interpret the difference correctly.

With potential value unchanged, a rise in Yield from 55% to 60% increases realized value by about 9.1%, calculated as 60 divided by 55, less one. This is an economic sensitivity, not a forecast of an intervention’s effect.

Yield gives leaders a reason to investigate the underlying journey. Repeated access delays may call for a coordination change; later interruptions may reflect burdens that emerge during treatment. In either case, the investment decision rests on whether a feasible response can address the cause.

A higher Yield alone cannot explain which intervention helped. Establish whether the response reached the intended patients and changed the targeted process, then compare its contribution with delivery cost. Expansion should depend on that evidence and the uncertainty that remains.

Patient accounts sharpen the interpretation. They can reveal why a referral failed, a service went unused or a practical change helped. This evidence informs the diagnosis and design; the financial account measures value over the agreed period. Both belong in the review, with their different roles understood.

FUNDING THE RESPONSE

Fund responses to barriers the organization can change

Within Prioritize barriers, assess the likely improvement, the people it can reach and the full cost.

Evidence before funding	What leaders need to establish
A barrier we can change	Identify the friction behind the loss and explain how the proposed response would reduce it. Separate avoidable delays from appropriate treatment changes and constraints outside the organization’s influence.
People the response can reach	Estimate how many patients face this barrier and how many the service can realistically help, given its permissions, capacity and timing.
A credible improvement	Use available evidence to estimate the additional progression the response could produce. State the assumptions and what a pilot must test.
Value after delivery costs	Compare the expected additional commercial contribution with staffing, technology, partner and oversight costs over the same period. Count each benefit once.
A decision that fits the evidence	Fund a test when the case is credible. When the cause or likely benefit remains unclear, investigate further before committing to expansion.

Exhibit 6. CEA funding criteria within Prioritize barriers. The illustrative $194.9 million value gap is not a recovery forecast.

The $194.9 million gap sets the scale of the investigation. Recovery depends on the barrier the organization can change and the cost of doing so. Economic analysis guides investment in better processes and services; necessary clinical support remains governed by patient need.

Consider an authorization service proposing clearer documentation requests and a named follow-up owner. The case depends on how many delays arise from incomplete information, whether offices can respond and the staffing required. A pilot should first test acceptance and resolution time, then follow the relevant patient milestone. These findings determine whether expansion is justified.

BRAND INVESTMENT

Let the source of lost value guide the next investment

Compare promotion and friction reduction using the same period, expected benefit and full cost.

The realization lever complements demand creation by addressing what happens after prescribing. Limited appropriate prescribing may justify better evidence and engagement; poor fulfillment may warrant access or support investment. Following the journey lets leaders compare both opportunities before committing the next dollar.

The constraint can move. Additional prescribing may expose a weak pharmacy handoff; resolving access may reveal a difficulty with starting treatment. Following patients through the journey allows leaders to revise priorities as the limiting problem changes.

Compare proposals over a common period, using expected incremental contribution and full delivery cost. Show how reach and effectiveness could alter the result. Leaders can then revise allocations as evidence improves.

Payer decisions, treatment changes and patients’ circumstances can also affect results. A suitable comparison helps distinguish the intervention’s contribution from those other influences. Promotional investments should meet the same evidentiary standard.

Reduced rework and appropriate treatment may both create value. Estimate each on a clear basis and check for overlap. A simpler patient experience may cost less to deliver, but the financial account must demonstrate it.

Earlier acquisition spending helps explain the concern about leakage, but it is already committed. Each new investment must justify its prospective benefit and cost, within treatment decisions governed by clinical judgment and patient choice.

PRESCRIBER EXPERIENCE

Repeated friction may weaken prescriber confidence

An illustrative practice experience shows a relationship that leaders can investigate.

Consider a rheumatologist who has prescribed a biologic for years. Repeated authorization delays, misdirected pharmacy contacts and unanswered requests create extra work for the practice. The physician still values the clinical profile but becomes more cautious about the demands obtaining treatment places on patients and staff.

That experience may affect decisions involving patients with limited support or demanding schedules. Listening to the practice can expose the burden before prescribing changes become visible. Clinical evidence and competing treatments must also remain part of any explanation.

Field colleagues can report recurring process problems through approved channels without accessing individual clinical records. Their contribution connects the HCP’s experience with the team able to investigate and correct the underlying service problem.

Evaluate the immediate change first: did the handoff improve or the delay shorten, and how did patients and staff experience the response? A claim about prescriber confidence or subsequent choices requires separate analysis that accounts for competing treatments and changes in clinical evidence.

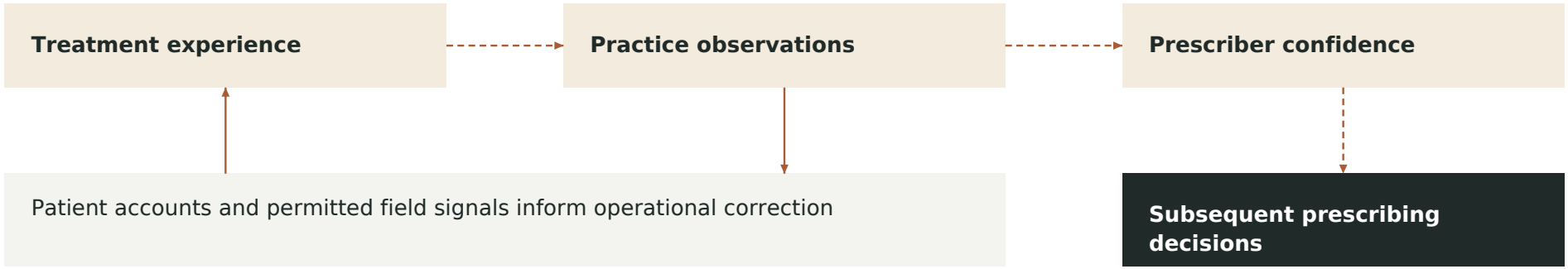

Exhibit 7. Dashed arrows show hypotheses about prescribing; solid arrows show a proposed operational feedback route. Clinical judgment and patient choice remain central.

CONTINUING RESPONSIBILITY

Keep support responsive as patients’ circumstances change

The Realization Layer applies wherever a patient needs help, including when new difficulties arise during treatment.

Patient situation	Responsibility to establish	What to confirm
Preparing to start treatment	Coordinate access, pharmacy contact and the support needed for an appropriate start. Agree who follows up when a step remains unresolved.	The patient understands the next step and knows where to take practical or clinical questions.
Managing treatment in everyday life	Make practical support and qualified clinical advice accessible. Listen for confusing instructions, caregiver burden and difficulties fitting treatment into daily routines.	The concern reaches the right team, and the response addresses the patient’s circumstances.
Facing a new access or practical difficulty	Check whether changes in coverage, cost, pharmacy or personal circumstances have created a barrier. Assign an authorized team to coordinate the response.	Responsibility is accepted, the issue is followed through and any interruption is investigated.
Considering a pause, change or stop	Keep treatment decisions with the patient and clinical team. Provide appropriate routes for discussing concerns and record the support team’s permitted follow-up.	An appropriate treatment change is distinguished from an unresolved support need.

Exhibit 8. Illustrative patient situations, not additional operating steps. Needs may recur or overlap; responsibilities depend on the therapy, market and support model.

Continuing responsibility after acquisition offers a useful lesson from consumer businesses. In pharma, a person’s needs can change throughout treatment. Support designed around the first fill alone leaves later difficulties outside the service’s attention.

Journey thinking therefore requires more than a map of the initial route. It requires a way to recognize changed circumstances and reconnect the patient with appropriate help. Patient and caregiver accounts show whether that support remains understandable, accessible and useful as the treatment experience develops.

AI INVESTMENT

Use AI to help teams address the friction behind value leakage

Review AI projects and investments for their contribution to patient progression as well as prescribing.

AI investment should follow the patient journey. Preparing field visits and content may support informed prescribing. Leaders should also examine work that helps patients obtain and continue appropriate treatment, where unresolved friction can limit the value of additional demand.

A useful proposal begins with work that repeatedly fails or consumes scarce time. An access team may search for missing documents; a support team may receive questions that earlier contacts left unanswered. AI could assemble records or suggest an approved action. The business case must explain how that assistance changes the service the patient receives.

The receiving team is decisive. A summary or alert has little practical value unless someone has the authority and capacity to respond. The Realization Layer connects the proposed technology with that responsibility and preserves human accountability for consequential decisions.

Cost estimates must include the work created downstream. An alert that arrives too late, reaches the wrong team or repeatedly proves false can make the experience worse. Compare proposals on the burden they remove as well as the new tasks they introduce.

Evaluation should follow the change through to the patient’s next step. Examine false alerts, delay and unnecessary contacts alongside progression and commercial value. Clinical questions retain qualified review, and consequential decisions require the appropriate human authority.

Customer consciousness keeps this assessment grounded in lived experience. Consented, de-identified accounts may reveal confusing instructions or repeated explanations absent from a structured record. Use them to design the service and interpret its results. The applications proposed here still require evidence of their effect on value leakage.

A handoff is complete when the receiving role has what it needs and the next step is confirmed.

COMMERCIAL INFRASTRUCTURE

The Realization Layer makes the discipline operational

Shared roles, decision rights, workflows and technology connect intelligence to accountable action.

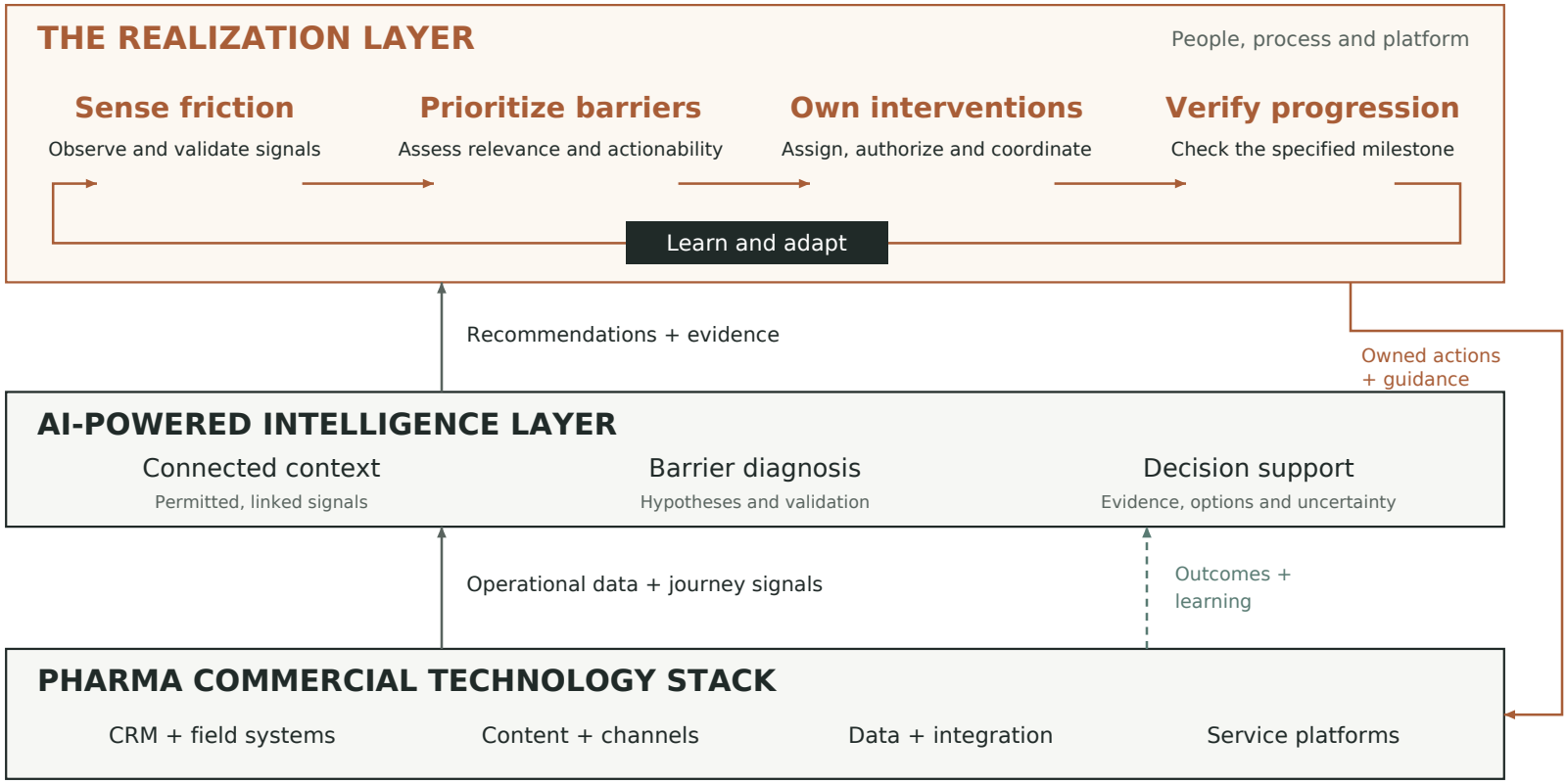

Exhibit 9. Universal CEA Realization Layer. Arrows indicate intended operating and information flows, not measured causal effects.

Customer consciousness keeps this architecture grounded in patients' circumstances. Journey thinking connects work across organizational boundaries. Accountable teams use that understanding to improve the next transition, then examine both the experience and the result.

EQUIPPING THE OPERATING LOOP

Teams need the capability to carry out the Realization Layer

These capabilities provide the skills, rules and tools needed to perform the operating steps.

Capability	What it enables	Where it supports the operating loop
Experience architecture	Design clear instructions, useful support and handoffs that patients and teams can complete.	Informs Prioritize barriers, the design of interventions and the standards used to Verify progression.
Journey governance	Agree who can decide, who acts and how an unresolved issue moves across teams.	Sets authority for Prioritize barriers and Own interventions, including who checks the result.
Field barrier resolution	Help field colleagues report recurring problems through approved channels and receive feedback.	Connects Sense friction with Own interventions and returns information about the response.
Real-time detection and intervention	Recognize a relevant warning and coordinate help while it can still be useful.	Supports Sense friction and Own interventions; Verify progression checks what followed.
Behavioral and continuity infrastructure	Provide practical support for using treatment and routes to qualified clinical help when concerns arise.	Supplies services and processes used in Own interventions and Verify progression.
Continuous improvement	Test responses and change the work when results reveal a better approach.	Carries Learn and adapt across the operating loop.

Exhibit 10. CEA capability relationships, proposed for implementation. A capability can support several steps. These are not a one-to-one mapping to Customer Excellence Activation’s MOBILIZE domains.

The capability requirement follows from the operating problem. A visible access delay with no coordinator calls for clearer decision rights. A well-owned process with long queues may need capacity. Distinguishing the two avoids buying a tool or launching a program that leaves the real constraint untouched.

Build the capability that the next useful response requires. Experience design sets the standard patients should encounter; governance and frontline practice make it deliverable. Evidence from implementation then shows where further investment is warranted.

CUSTOMER VALUE AT RISK

Separate unrealized value from value still at risk

The completed-period gap and future exposure answer different management questions.

UNREALIZED VALUE

A completed period

Earned Value − Realized Value

Commercial potential that was not realized during the period being reviewed.

PROSPECTIVE CVaR EXPOSURE

The remaining period

Σ (remaining value × probability of loss)

Commercial value that may still be lost, based on validated estimates of future risk.

The simple risk formula assumes each amount is either fully lost or retained, with no value counted twice. Partial losses or several competing risks require a more detailed estimate.

Exhibit 11. CEA retrospective and prospective measures. CVaR means Customer Value at Risk here; it is different from Conditional Value at Risk in finance. [1]

Unrealized Value measures the completed-period gap between Earned and Realized Value for the same patients. The recoverable portion depends on addressable causes, eligible reach and the expected effect and cost of a feasible intervention.

Prospective CVaR Exposure estimates remaining commercial value at risk using probabilities validated against relevant patient outcomes. An overdue refill is a signal to investigate; it does not supply the probability of loss.

A forecast loss may later enter the recorded gap. Combining both as separate opportunities would count the same value twice. Keep the patient, period and valuation basis aligned when comparing future exposure with completed-period results.

Use the estimate to assess a service or process investment. Necessary care remains governed by patient need and clinical judgment; an individual’s modeled commercial value must never determine access to that care.

RESPONDING TO AN EARLY WARNING

An overdue refill needs a checked record and an accountable response

A risk signal is an early warning of possible interruption. The Realization Layer connects that warning to a response.

Illustrative example: a refill appears overdue in a service record. The sequence below describes a proposed response, not a measured result.

Sense friction

The authorized team first establishes what the record means. The patient may have filled elsewhere, agreed a treatment change or encountered a problem; a late data update can also resemble an interruption. Checking the context prevents unnecessary contact and inappropriate assumptions.

Prioritize barriers

A confirmed delivery problem requires a judgment about urgency and what the organization can change. Repeated cases may justify a service redesign. Validated estimates of future exposure can inform that investment, while the individual alert remains a prompt to establish the patient’s need.

Own interventions

The receiving team accepts responsibility, obtains the information needed and tells the patient what to expect. Treatment concerns go to qualified clinical support. The handoff should spare the patient another round of explanations while making responsibility clear.

Verify progression

Confirm supply and the relevant next step, recording any remaining barrier or appropriate treatment change. A completed call establishes contact. Evidence of a refill, continued use or clinical benefit must come from the corresponding observation.

Learn and adapt

Repeated delivery failures should lead to changes in instructions, coordination or capacity. Evaluate the resulting response against a suitable comparison before attributing improvement to it, since supported patients may differ from others. The aim is to correct the recurring source of difficulty.

The resulting record connects a warning with a verified problem, an accountable response and what followed. Leaders can use it to improve service accuracy and timing, then assess cost and commercial value. The patient’s experience helps explain whether the operational correction was useful.

COMMERCIAL SYSTEM AND CULTURE

Culture makes customer consciousness consequential

Culture determines whether experience influences the commercial plan.

Dimension	Existing demand-oriented responsibility	Additional realization responsibility
Field model	Relevant engagement, evidence and appropriate prescribing support.	Recognize recurring barriers and route them through authorized resolution teams.
Success measures	Prescribing, share and activity measures interpreted within their definitions.	Patient progression, Realization Yield and separately defined prospective exposure.
Investment	Evaluate the contribution of demand generation.	Compare that contribution with the expected value and cost of addressing downstream constraints.
Governance	Assign ownership of brand objectives and promotional investment.	Assign journey accountability and govern consequential handoffs across functions and partners.

Exhibit 12. CEA responsibilities for embedding Realization Management. The starting position varies by organization and brand.

A persistent gap in realization reflects the commercial model, mindset and ethos together. When leaders reward functional output without following the patient’s progress, experience remains peripheral to decisions about growth.

Closing the gap requires shared accountability, funding and authority after prescribing. Leaders reinforce that commitment when they act on unresolved patient and HCP experiences, reward cooperation across functions and treat appropriate progression as part of commercial success.

LEADERSHIP AND THE FIRST TEST

Leadership turns the leakage diagnosis into an intervention

The first test should improve the decision as well as the operating response.

Choose a consequential barrier within a defined patient population and value horizon. Patient accounts help reconstruct what happened; operational and financial records establish scale. Identify the uncertainty most likely to change the decision before commissioning more analysis.

Give the response to the functions able to alter the constraint. Its owner needs authority to coordinate partners and resolve escalation, with enough capacity to deliver the work. Otherwise a shared measure will reveal a problem that nobody can act on.

Agree the eligible population, comparison and follow-up before implementation. A phased or randomized design may be feasible; other settings require a justified comparison. Early before-and-after movement can guide inquiry, but it cannot establish the response’s effect by itself.

First examine whether the service was delivered as intended. Did eligible patients receive support, did teams have sufficient capacity and did handoffs occur? Failure to deliver calls for an operational correction. A delivered service that produces no useful effect requires reconsidering the diagnosis or design.

Report progression, value and delivery cost consistently, with missing status and clinical exceptions visible. Patient accounts explain the experience of change; the defined population, period and valuation basis support the economic conclusion.

Realization becomes a brand growth strategy when experience improvements produce measurable patient and commercial value. Evidence should determine whether to expand, redesign or stop a response. Record how the diagnosis changed and amend operating standards accordingly, so customer consciousness shapes the next investment and the organization learns how to create greater value.

THE QBR AS AN OPERATING WORKFLOW

Extend the QBR into an always-on realization workflow

The meeting sets priorities; the commercial infrastructure carries decisions into action.

The QBR should establish what happened after the previous decision. Between meetings, unresolved barriers need owners, deadlines and escalation. An agentic workflow can help retain context and coordinate permitted tasks, while people remain accountable for consequential decisions. This makes the review part of a continuing management process.

Operating requirement	Agentic workflow between reviews	Leadership accountability
Visibility into progression	Combine permitted patient signals with consented, de-identified patient and caregiver friction themes; surface delays and changes in value exposure.	Set population, period, milestones and data access; check missing observations and whose experiences the accounts represent.
Collaboration across handoffs	Organize patient-reported friction into barrier hypotheses; route exceptions to named owners and track acceptance, dependencies and overdue actions.	Assign decision rights, response windows, escalation routes and capacity across functions and partners.
Action within defined authority	Agents coordinate multistep tasks, retrieve evidence and propose or execute permitted routine actions.	Set permissions, approval gates and audit requirements; retain human authorization for consequential decisions and clinical ownership of treatment decisions.
Verification and learning	Check disposition against milestone evidence; update the intervention register and return results to the next decision.	Distinguish task completion from patient progression; evaluate effects, cost and uncertainty before scaling.

Exhibit 13. Proposed QBR design within the Realization Layer. Agentic workflows coordinate multistep tasks within defined permissions; their effects on progression and Yield require evaluation.

An intervention register preserves the connection between the barrier, the agreed response and the evidence of its effect. The next review can then examine delivery and results before reopening the investment decision. Priorities survive beyond the meeting because responsibility and follow-up remain visible.

Evaluate whether the workflow improves response time, handoff completion and patient progression, then assess Yield over the agreed period. A pilot charter should specify the population, mechanism, comparison and costs, together with the evidence required to continue or expand.

LEADERSHIP ALIGNMENT AND ACTIVATION

Activate Realization Management as a growth discipline

Pharma’s Essential New Growth Discipline begins with leadership alignment and employee-owned action.

Value Unlocked executive brief

The 60-minute Value Unlocked executive brief helps leaders examine value leakage within the decisions they already make in brand planning and commercial reviews. It connects patient progression and Realization Yield with the organization’s ability to respond.

Patient accounts and operational evidence establish a shared starting point: where the journey stalls, which responsibility is missing and what current data can explain. The intended outcome is an agreed case for change, a sponsor and a specific next decision.

Leaders leave with a common view of the problem and the work needed to investigate it, connecting customer consciousness with a practical commercial commitment.

Value Unlocked Masterclass

The applied Masterclass brings commercial, brand, field, access, patient-services and relevant medical leaders together around a brand or market. Teams examine the journey through patient experience and operational evidence, separating observation from hypothesis.

Participants develop a case for change, clarify who can act and design an initial response. They agree what the next review must learn from the test. The activation agenda records the priority barrier, responsible roles and evidence needed to support the next investment decision.

Through CEA’s Player-Coach approach, Wayne Simmons works alongside employees as they implement and improve the response. Leaders supply direction and authority; teams develop the capability through practice. The objective is a commercial system in which customer understanding consistently shapes decisions and experience contributes to patient progression and value realization.

To arrange the executive brief or Masterclass: cxedna.com | wsimmons@cxedna.com

EVIDENCE AND DEFINITIONS

The evidence supports distinct patient and commercial conclusions

The model, patient material and proposed infrastructure each have a defined role.

The one-year economic illustration

The analysis follows 9,600 prescribed patients for twelve months each. This defined group is a cohort. Patients enter during a six-month intake; the results describe a full year for each patient. Stage-entry loss rates of 15%, 8%, 26% and 28% leave 3,999.836 patients at month twelve, shown as 4,000 and 41.7%. [1]

Earned Value is modeled commercial potential at prescription over that horizon. At $7,000 net value per fill and 6.5 annual fills, it is $45,500 per patient and $436.8 million for the cohort. Access, initiation, early-adherence and persistence gaps are $65.5200 million, $25.1328 million, $77.7089 million and $26.5406 million. Total Unrealized Value is $194.9023 million; Realized Value is $241.8977 million and Yield is 55.3795%.

The scenario credits no value before an access loss, one paid fill before an initiation loss, 1.5 months before an early-adherence loss and 7.5 months before a persistence loss. These calibrated assumptions include inferred inputs, not measured treatment durations. The account is separate from mamahealth’s samples and calendar-year booked revenue. Clinical benefit and recoverable value require additional evidence.

Patient research and conceptual application

Patient quotations, conversation findings and the anonymized regimen case come from mamahealth’s unpublished descriptive research. Complete sample sizes, recruitment periods, coding rules and some measure definitions were unavailable for validation. The regimen percentages do not establish a causal formulation effect. These materials identify experiences and possible mechanisms for investigation. Population estimates and causal conclusions require additional evidence.

The QBR scene, week-nine patient narrative and rheumatologist account are explicitly illustrative. The architecture, mechanism maps and decision frameworks are CEA operating propositions. Their application requires adaptation to the brand and market and evaluation of the resulting work.

Published studies and surveys retain their own populations and denominators. They do not form a synthetic industry realization rate. Patient progression, commercial value and clinical benefit require distinct evidence. The full economic derivation and wider published evidence are developed in the companion Research Paper. [1]

SOURCES

References

Numbered citations connect the analysis to its published and conceptual sources.

[1] Simmons W. Pharma’s Realization Revolution: Research Paper. Realization Management. Pharma’s Essential New Growth Discipline. The Customer Excellence Agency; November 2026.

[2] mamahealth. Patient interviews, patient-companion conversation findings and anonymized regimen case. Unpublished partner research; 2026. See evidence and definitions, page 33.

[3] Vrijens B, De Geest S, Hughes DA, et al. A new taxonomy for describing and defining adherence to medications. British Journal of Clinical Pharmacology. 2012;73(5):691–705.

doi: 10.1111/j.1365-2125.2012.04167.x

[4] World Health Organization. Adherence to Long-Term Therapies: Evidence for Action. Sabaté E, ed. Geneva: WHO; 2003.

Source publication

[5] Levy JF, Alexander GC, Vabson B, Ippolito BN. Formulary-related insurance denials of single-source branded drugs in the United States. JAMA. 2026;336(8):664–672.

doi: 10.1001/jama.2026.8702

[6] Montero A, Montalvo J III, Kearney A, et al. KFF Tracking Poll on Health Information and Trust: Use of AI for Health Information and Advice. 25 March 2026.

Source publication

[7] Kikuchi E, Pasquini G, Yam E. From Diagnoses to Treatments, Why Americans Use AI Chatbots for Health. Pew Research Center; 25 August 2026.

Source publication

[8] Horne R, Chapman SCE, Parham R, Freemantle N, Forbes A, Cooper V. Understanding patients’ adherence-related beliefs about medicines prescribed for long-term conditions: a meta-analytic review of the Necessity-Concerns Framework. PLOS ONE. 2013;8(12):e80633.

doi: 10.1371/journal.pone.0080633

[9] mamahealth. About mamahealth. Official company description. Accessed 3 November 2026.

www.mamahealth.com/about

[10] mamahealth. Patient engagement and intelligence for pharma. Official partner website. Accessed 3 November 2026.

partners.mamahealth.com/

ABOUT THE CONTRIBUTORS

About the Agency and mamahealth

Commercial systems expertise and patient research inform complementary parts of the realization question.

The Customer Excellence Agency

The Customer Excellence Agency helps pharmaceutical and life sciences companies bring customer experience into commercial performance. Its work connects an understanding of patients and HCPs with the systems, field practices and culture that support progression and value realization.

Under its Player-Coach model, Wayne Simmons works alongside client teams through strategy and implementation. FieldOS and Customer Excellence Activation help employees recognize recurring friction, coordinate a response and use the results to improve the customer experience and commercial system.

Wayne Simmons, CCXP, is the Agency's Founder and Commercial Systems Architect and author of The Customer Excellence Enterprise (Wiley, 2024). He is founding faculty in the MS in Customer Experience Management at Michigan State University's Broad College of Business and a former senior customer experience and commercial leader at Pfizer and Bayer. He is a United States Army Intelligence veteran.

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About mamahealth

mamahealth provides a free app for people living with chronic and rare conditions, helping them explore health information, understand medical documents and prepare questions for clinical conversations. Its information services are intended to complement care from healthcare professionals. [9]

For life sciences organizations, mamahealth uses AI-moderated patient conversations to help explain treatment decisions, unmet needs and barriers across the patient journey. Its partner offering organizes consented, anonymized patient accounts into insights that teams can examine alongside clinical, claims and other research data. Medical and scientific review support the interpretation of those accounts. [10]

Mamahealth supplied the interviews, conversation findings and regimen case. These accounts bring patients’ circumstances into management decisions. Their descriptive nature and limitations are stated with the relevant findings and in the methods note.

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Pharma’s Realization Revolution | Practice Note, revised November 2026. CEA analytical constructs and text © 2026 Wayne Simmons and The Customer Excellence Agency. Patient research credited to mamahealth. Original conceptual progression artwork created for this edition.

Put the realization lever to work.

Examine where the patient journey is breaking down, what it means for brand growth and where your leadership team can act.

Executive Brief

60-MINUTE LEADERSHIP SESSION

Build a shared understanding of value leakage and the decisions needed to make realization part of the brand growth strategy.

Masterclass

APPLIED SESSION FOR YOUR LEADERSHIP TEAM

Apply realization economics and journey thinking to a brand or market. Develop a case for change and agree priorities for activation.

Arrange a Value Unlocked Executive Brief or Masterclass for your leadership team.

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