Ophthalmology MANAGEMENT
Article

A marketing plan that hinges on listening

The most effective tool for premium IOL conversion is looking at you in the mirror.

By Shareef Mahdavi November 1, 2017

Despite more than a decade of commercial availability, premium IOLs have not attracted their target audience, the patient-consumer who wants to see without glasses for most to all activities following surgery. According to *Market Scope*, market penetration has not gone beyond 10%.

The issue? The shared responsibility/self-pay aspect of the implant, used as part of cataract surgery, has been both blessing and curse. Surgeons may charge patients directly for the services required and the refractive benefits offered for the technology. However, legacy impressions ("I thought my insurance paid for cataract surgery") and the heightened expectations for a discretionary purchase place a heavy burden on the surgical practice.

Because patients cannot "sample" many implants, such as multifocals, before they make a decision, the question arises: What technologies are most essential to a refractive-cataract practice to successfully "market" the procedure? I place this word in quotes as I define marketing as both meeting the needs and exceeding the expectations of the customer, who in this case is a patient who presents with a diagnosis of cataract. The marketing function is far more complex than simply advertising or promoting the availability of a procedure.

Beyond the diagnostic workup and clinical testing to ensure candidacy, practices have several technologies at their disposal that can make a meaningful difference in the number of patients who choose a refractive outcome. Having on hand educational software that can be used to inform and educate regarding the benefits and risks is a must.

Point-of-care company CheckedUp provides e-mail links that allow patients to self-educate prior to a consultation (http://www.checkedup.com). Using software to simulate vision before and after some surgeries as does Sight Selector (https://advicemedia.com/services/sight-selector-patient-education-videos/) can help a patient appreciate what reduced dependency on glasses, at all distances, will look and feel like.

Measuring glare and halo before and after surgery also will go a long way to manage expectations, especially since patients cannot readily recall how they saw prior to surgery once they've had surgery in that eye. All these steps help set proper expectations.

NO SOFTWARE CAN REPLACE YOU

The one outside force that exceeds all others in terms of impact on a patient's decision-making process is the surgeon's guidance. In my opinion, the meager premium IOL market penetration has far more to do with ineffective surgeon communication than with surgical skill or limitations of the available lenses.

Great communication is a skill that can be learned and improved upon by the surgeon. She should begin with a short description of treatment options in clear and concise language that is easily understood. From there, the surgeon immediately shifts to listening mode, specifically to understand the goals of the patient. If she sees fine as is, don't do surgery. If he says he doesn't mind wearing glasses, don't offer a self-pay option.

If, however, a patient shares something about his or her profession, hobbies or daily life that leads you to believe this person would benefit from a refractive implant, that becomes the cue for you to move to the next step. "I now routinely ask if after cataract surgery my patient would like to be glasses free, wear reading glasses or wear bifocals," comments Steve Wilmarth, MD, a refractive-cataract surgeon in Sacramento, Calif.

From there, the surgeon and counselor move to a specific recommendation, based entirely on the available technology and the patient's goals.

AVOID THE CLOUD OF CONFUSION

The above process, which seems obvious, is not what typically takes place. What I observe is that most doctors *must* talk about the IOL's technical aspects, how it works and then adds sufficient detail to make sure they've covered the bases with the patient. Unfortunately, this creates a cloud of confusion around the patient, who typically gets lost after the first or second mentioned medical term. And while the person may nod in agreement (so as to not appear dumb), he already has lost focus with "crystalline lens."

That word and many others in doctor parlance have zero meaning to the patient. "Long-winded statements with technical terms alienate patients, who do not understand what you are trying to tell them," adds Dr. Wilmarth. As a result, the surgeon inevitably says too much and is perceived as trying to convince the patient to "buy my product." Long before the patient is asked, "Are you interested?" he or she has shut down.

A DIFFERENT APPROACH

Here is an approach I've used with a number of surgeon clients that has served as a breakthrough in terms of results. The process begins with getting a baseline of the current conversation taking place between surgeon and patient with respect to options during cataract surgery. This is handled through direct observation or a simple audio recording of the entire session for remote review. Much like coaches reviewing film after a game, we analyze and scrutinize the specific language as well as tone of the interaction.

These sessions are enlightening as doctors rarely get feedback on their communication skills. In addition, we ask the practice to tell us its current rate of acceptance of patients for some type of self-pay upgrade to their upcoming cataract surgery.

NO SUBSTITUTE

The next step is helping the surgeon (as well as the staff) develop a new set of talking points to use during the consultation — literally replacing words and phrases that were commonly spoken with ones that are more aligned to the needs of the patient.

As one surgeon told me, "It's about the patient's feelings, which he or she understands very well. In this regard, they are very smart and it's wise for me as a surgeon to tune into those feelings." Indeed, our goal in this step is to help the entire practice shift the theme of the conversation from "will you buy my product?" to one of "this can change your life."

This transition takes practice and coordination between surgeon and staff, mainly the counselor and scheduler. There is often a re-assignment of what specific topics each person covers with the patient. This change can work in a variety of environments including with referred patients and those who have heavy pre-consult education. It works because there is no substitute for the in-person, face-to-face contact with a patient, especially in an era in which so much of our human interaction has been lost to automation of services.

	April – June 2017	**July – September 2017**	**Percentage of growth vs. prior quarter**
Number of cataract cases	134	124	--
Eyes with toric implant *N (% of cases)*	6 (4%)	8 (6%)	+33%
Eyes with multifocal *N (% of cases)*	17 (13%)	32 (24%)	+85%
Eyes w/ femto cataract option *N (% of cases)*	23 (17%)	39 (31%)	+82%

Given the high need for trust for anything related to one's eyes, human interaction and solid communication become paramount.

THE RESULT

I generally recommend a full 30 days of "practice, practice, practice" before we start keeping score to see changes. What we have observed to date are conversions in three important areas:

- The doctor says far less, asks more questions and spends more time listening.
- The staff report being asked fewer questions in their sessions and receive fewer incoming phone calls with questions prior to surgery.
- Significantly more patients accept the opportunity to pay directly for services providing a refractive outcome.

In Dr. Wilmarth's practice, the transition took effect at the beginning of the third quarter. After 90 days, patient acceptance of multifocal and toric implants increased from 17% to 30%, while acceptance of fees for a refractive procedure, including use of the laser, grew from 17% to 31%. No other changes in staff, equipment or marketing were made.

His staff members indicate much less stress in the decision-naming process as their patients better integrate the information into their own specific needs and desires. The practice will continue to measure and monitor progress over the coming two quarters.

PARTING WORDS

While technology will continue to drive better visual outcomes, the larger issue plaguing consumer demand is the role that doctors play in effectively communicating with patients in a way that resonates with their needs. Refractive surgeons would be well served to take a serious and objective look at their current methods and processes for patient counseling and seek ways to improve them.

An outsized impact on patient acceptance as well as staff engagement could follow. **OM**

About the Author

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