

Marketing Refractive Lens Exchange as a Surgical Treatment for Presbyopia

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From a consumer perspective, 2 of the most significant events for an aging adult also happen to be the result of changes in one's vision. One in 3 Americans are presbyopic and that ratio is moving towards 1 in 2 as the population ages (Figure 20-1). They are, of course, the onset of presbyopia ("I'm getting older") and the diagnosis of cataracts ("I'm old") (Figure 20-2). Because the onset of presbyopia is so frustrating to the person experiencing it, there has been a multitude of procedures developed in an attempt to satisfy this patient population's near blur.¹⁻⁴ Because of the sheer number of options for presbyopes, they are often confused by the research they do when considering a surgical treatment. It is important to keep this in mind when you are working on creating a program that is designed to attract, educate, and gain the confidence of this patient population.

MARKETING TO THE PRESBYOPIC PATIENT POPULATION

Marketing lens extraction can be confusing for surgeons, their practice, their referring doctors, and the patients. Many practices have never mounted a presbyopic surgery campaign. Besides the numerous challenges of creating a presbyopic marketing plan, one needs to realize that creating demand for any new offering requires time, patience, work, and money. It is also important to first look inside the current operational standards of the practice in

terms of people (your staff), place (the environment and flow that new and established patients experience), and technology. With regards to technology, investing in a laser for the most delicate steps of implant procedures, for example, can be an overwhelming decision for you, your practice, and your ASC. As is fairly obvious, there is a lot of information to consider when considering the technology utilized at each step: ocular coherence tomography-guided femtosecond lasers, intraoperative wavefront aberrometry, high-definition/3-dimensional surgical viewing/alignment technology, microscope-mounted landmark identifying devices, multifocal/accommodating implants, excimer laser enhancements, and so on. We will leave it to the other chapters in this book to discuss the merits of each technology option for optimal refractive outcomes for presbyopic surgery, but suffice to say the technology decisions are often more intuitive to the surgeon than creating a comprehensive marketing program that speaks to this patient population. The primary intention of this chapter is to focus your energy once you have decided to offer these advanced techniques and technologies in your program, and explain how to best do so through modern day marketing.

Finally, the authors of this chapter strongly believe that "marketing" as a stand-alone term leaves a lot to be desired. Simply advertising your new procedure (or the technology used to perform it) will generate interest, but will not alone make up for deficiencies in the overall marketing process that is required to successfully generate and capture interest in seeing up close without glasses. Instead, consider

Age Groups in United States Population (as of 2012)		
Select Age Groups Affected by Onset of Presbyopia		
Total United States Population	308,827	100%
Age 40 and older	144,219	47%
Age 45 and older	23,432	40%
Age 50 and older	101,849	33%
Source: US Department of Commerce, www.census.gov		

Figure 20-1. Select age groups affected by onset of presbyopia.

the term *marketing* to be one that is used to represent all the “touchpoints” that influence and affect your patients’ perception of your practice, as well as their willingness to spend their time and money in it. To make it easy, marketing can be thought of more holistically as marketing operations.

In this light, marketing has become so much more than just ad placement and flashy taglines. What information goes on your website? How does your staff answer the phone? Marketing becomes how you open the front door and how the patient is greeted. What is your waiting room (we do not even like the phrase “waiting room”) experience? Is the patient flow with your technician choreographed to build confidence and educate why these tests are performed? And how will the provider talk about the technology and the offering at the point of care with your patient-customers? Do your financial forms make sense and are they communicated in a very understandable way? Without question, marketing operations are far more exhaustive (and exhausting) than traditional advertising promotions. You want to look at every aspect of your operations when preparing to serve this refractive patient population with standards and education levels that are often high.

As we enter into this discussion, it is worth adding that working hard to add or grow this area of your practice can be one of the most rewarding journeys you could ever take. Technology has advanced to the point that we can truly address a patient’s presbyopic problem at its root cause—his or her stiffening lens. And because of these technology advancements allowing us to improve our patient’s quality of life through distance, intermediate, and near vision functioning with no or minimal dependence on external optical devices, a lot of patients are seeking this technology. The practice that best answers these presbyopic patient needs will be the practice that maximizes its health and success into the future.

WHAT’S IN A NAME?

Before diving too deep into your marketing operations analysis of deploying a new offering such as refractive lens exchange (RLE) or redeploying this offering in your program, consider what you are going to call the procedure you use to address presbyopia. For example, in the laser cataract surgery category, many practices try to come up with some catchy or pithy term to describe the technology. Many use terms such as LARX, FLACS, or worse. In most cases, the suggestion of professionals is to try to use the simplest term possible without creating something brand new for the consumer to remember. In this case, laser cataract surgery certainly wins today. However, there are problems with using the term *laser cataract surgery* to describe the category, the first of which is that patients correctly believe that cataract surgery is a covered service, whereas the laser is not. The second problem is the labeling of the technology itself. As you know, femtosecond lasers have been labeled by the US Food and Drug Administration (FDA) for use in capsular, the breaking up of the lens, and incisions for astigmatism correction.

Simply calling the category “laser cataract surgery” suggests that what we might be billing for is the laser being used for the cataract surgery portion of the work. This is fraught with errors when it comes to patient-customers understanding of how the dollars and cents work as a part of their care. As an alternative, many are adopting the new term ReLACS (refractive laser-assisted cataract surgery) to better summarize the category. This helps frame in practices’ and patients’ minds that it is the refractive nature of the technology that carries the advanced care and, therefore, the advanced billing.

SAME STORY, DIFFERENT PAY

Much like the disparity found amidst nomenclature relating to laser-based cataract surgery, new language should be created to describe the RLE category. Terms such as *clear lens extraction* or the new *dysfunctional lens syndrome* are growing in popularity. Perhaps it is time to pause and consider what is actually at issue with the RLE patient. For example, we know that, in most patients, the cornea has positive spherical aberration (SA).⁵ We also know the positive SA from the cornea is compensated mainly by the negative SA of the crystalline lens in younger patients, which leads to great image quality in our younger years. However, in our thirties, our lens starts to shift towards positive SA, which results in an overall increase in our eyes’ total SA,⁶ which results in a reduction in contrast sensitivity⁷⁻⁸ and the patient subsequently experiences an increase in low light issues, such as halos and glare, along with a reduction in image quality and resultant nighttime complaints.⁹

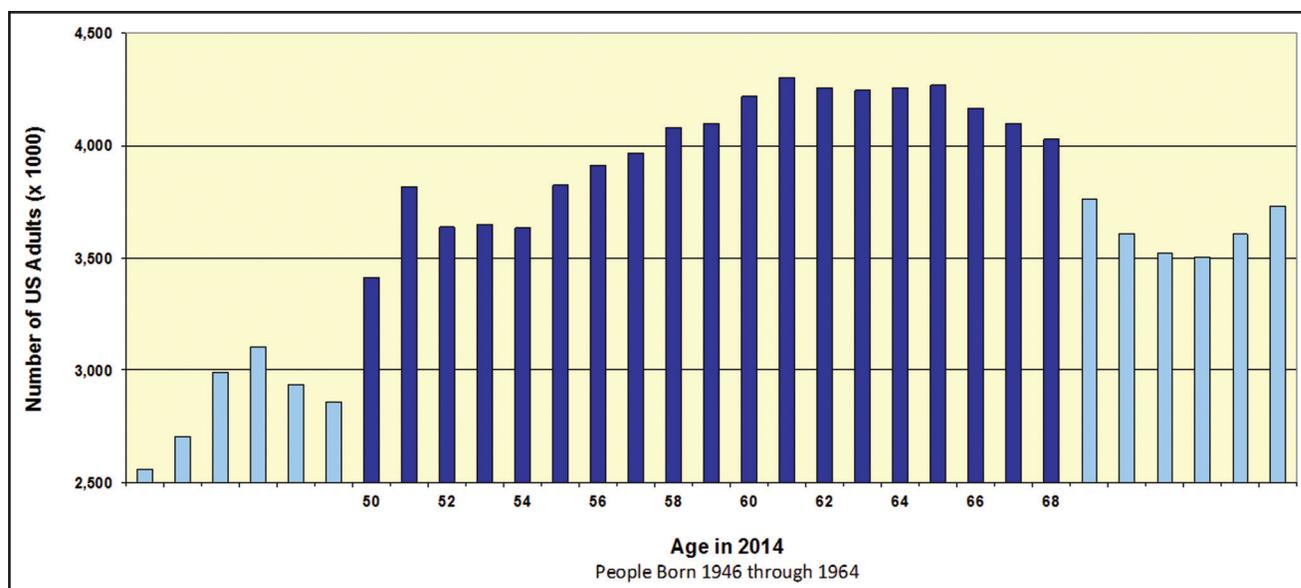


Figure 20-2. Impact of visual milestones on the aging population (baby boomer demographic in dark blue). (Adapted from US Census Data; Harry Dent, *The Next Great Bubble Boom*.)

As the patient becomes presbyopic, it is worth considering these image quality-reducing aberrations that occur far before we would call a lens cataractous.

Thus, we know lens exchange procedures are rarely truly “clear” lens exchanges. Something exists within the lens that triggers the patient. There is a challenge to the patient’s vision or he or she would not have inquired about the options to correct it, much less respond to your marketing efforts. It may be a significant refractive error that requires attention, or the loss of accommodation connected to the loss of ideal functioning of the natural lens. Whatever the case, the solution is not quite as simple as removing a clear lens. More is amiss here.

What about the dysfunctional lens syndrome? This may be the more accurate term. It certainly articulates that something is amiss with the natural lens of the eye. However, for all of the same reasons outlined with the term ReLACS, patient education and informed consent begins with the marketing. Therefore, how we discuss a category can create expectations related to outcomes, risk, and financial responsibility. The term “syndrome” carries with it an expectation that it is an insurance reimbursable procedure. Syndromes are sicknesses. Insurance covers sickness.

The term “refractive” has always carried with it a golden ability to articulate that the procedure is elective in nature. Refractive procedures have never been a covered service, and how we talk about the space sets the tone for how the offering will hit the patient-customer’s pocketbook.

In short, clear lens extraction is an outdated term that falls short of the full intention of the procedure as well as the true desire of the patient-customer. Dysfunctional Lens Syndrome also carries overtones and expectations of insurance coverage. To keep your story clear, keep “refractive”

procedures and “syndromes” separate. Dysfunctional Lens as a diagnosis and Dysfunctional Lens Replacement as a refractive procedure can work for most practices until a better name emerges. Finally, RLE to treat a dysfunctional lens is what some practices have chosen.

CHARGING FOR THE REFRACTIVE TECHNOLOGY AND SERVICES TO ACHIEVE A REFRACTIVE LENS OUTCOME

So, now you have decided to focus on incorporating presbyopic correcting technology and a quality patient experience inside your four walls and you’ve decided what you’re going to call the offering at the point of service. It’s now time to take a look at how your practice currently operates related to advanced refractive lens and cataract surgery. In reality, the refractive cataract surgery offering sets the stage for extending the offering by making a presbyopic counterpart available to the patient, simply earlier in the process and before a full-blown cataract has emerged.

The refractive cataract offering required surgical practices to more carefully and thoughtfully define what services and activities are being charged for as part of the service. Some, including this author, charge for the advanced diagnostics used to determine the state of refractive error (such as refraction, corneal topography, corneal wavefront/angle kappa measurement, macular ocular coherence tomography, intraoperative aberrometry, and more) with hopes

of reducing said error as a part of their surgical goal and experience. Meanwhile, others are simply charging for the arcuate incision as part of an astigmatic treatment. In any case, determining how you charge for presbyopic refractive surgery should harmonize with the refractive charges associated with your refractive cataract as well as laser vision correction offering. In other words, how you charge for “refractive” components of implant surgery should be consistent within your 4 walls.

So what does your practice currently do for its advanced cataract diagnostics? These same tactics can be used to set your economic modeling for your RLE program and are a high priority in the marketing operations of your program.

TRAINING FOR YOUR OFFICE STAFF

Training can be one of the most important and labor-intensive steps in rolling out your presbyopic surgery program. How your team talks about and discusses the patient-customer’s procedural options is critical to their understanding of this advanced technology. Much care should be directed towards bringing the team along in the conversation. It is important to schedule plenty of time early on to educate your team about their important role in the communication process.

Let us begin by discussing the phones. Adding surgery for presbyopia means a whole new set of scheduling options. New templates, new counseling information, new pricing information, and new explanations related to how the procedure works as opposed to your more standard options is all part of the ongoing training of your staff.

Many practices resist the use of scripts to train their phone team. Whether or not your practice adopts such a strategy, they should at least deploy the tactic of role-playing when training on this new technology offering. Questions that should be rehearsed and have ready answers could include the following:

1. What are the costs of presbyopic surgery?
2. What is included?
3. How is it different than cataract surgery?
4. Is it performed with a laser or manually?
5. How long is the aftercare?
6. What about fine-tune adjustments?
7. Are there any scheduling considerations to make?
8. Why didn't my referring provider tell me about the offering?

Assuring that your team understands the answers to these questions and adding to this list of questions daily will ensure that you and your new staff members are set up for success.

TRAINING—CLINIC AND PROVIDER

Once the patient is in the exam room with either the technician or the provider, attention should be paid to a line of questioning that will help patient-customers make the best decision possible according to their preferred vision after surgery. A series of simple questions can help in determining the patient’s desire to have refractive-like outcomes after surgery. Questions like: “Am I ready to consider surgery?” “How do I want to see when I’m done with surgery?” “Do I mind wearing reading glasses?”

For the “frustrated presbyope,” the answers to these questions will assist the doctor and his or her team in determining if presbyopic surgery will achieve patients’ goals, as well as matching the patient with the best technology offered at that center for their vision.

TRAINING—FINANCIAL INFORMED CONSENT

Now that the patient has selected the technology of their choosing, it is time to schedule the surgery. There are 2 important elements within the counseling and scheduling office that can contribute to the patient’s overall satisfaction. First, the patient needs to understand the financial ramifications of the selected surgery option, with the understanding that presbyopic surgery most likely will not have any third-party reimbursement. Not only is the center responsible for the patient understanding the costs associated with the refractive portion of the care, but also *why* the procedure is not considered a covered service by the patient’s insurance.

TRAINING—MEDICAL INFORMED CONSENT

In addition to understanding the financial informed consent, patient-customers need to understand the medical informed consent. Medical informed consent covering risks, benefits, and other options should begin with conversations with the provider and documentation within the exam room. Fully understanding medical informed consent will give the patient-customers confidence that they have chosen and are educated about the best procedure for them. A good informed consent will not only educate your patients about their best options, but will also educate them about the other options they had at their disposal at the time of their counseling, including not having surgery.

For example, a good informed consent should educate the patient about the many ways (blade or laser) to make

an incision or capsulotomy during the surgery. It should also educate about the many different advanced diagnostics (topography, aberration measurement, angle kappa analysis, macular OCT, and more) that are used to match the patient with the best technology available. A good informed consent will talk about lens removal and lens replacement options. In addition, a good informed consent should allow a patient-customer to opt into or out of the particular program. For example, the patient could select astigmatic correction as part of his or her RLE and purposefully unselect presbyopia correction as part of his or her cataract surgery. A good informed consent can help bolster this discussion in a way that improves the memory of both the patient and the practice.

THE STRONGEST NETWORK

Now that your house is in order, you are ready to turn around to your community and begin to promote your new technology and offering to the providers who share in the care of your patient-customers. The real question is, how do you properly communicate the offering? Your communication with primary eye care providers is as important as how you stage the communication with your own team.

Begin by communicating the offering the same way you might notify the press in your community. This could be a letter or fax outlining the capabilities of the technology, its associated advanced diagnostics, the full-service refractive package which may or may not include laser fine-tune post-operatively, and any other service that may be offered in addition to a total and complete refractive package. Sending this out in hard copy form is only step one with this method of communication. Many offices use robot email systems to communicate with the referral network. It is suggested to communicate via email about this offering as well. Many centers have sophisticated fax technology, which is another way to communicate your message. In short, referring providers need to hear about your new offering 3 to 5 times before they will operate their clinic with full knowledge of the category.

While that outlines some of the communication angle associated with communicating RLE, there is nothing better than immersing the referring provider in the technology itself. After you and your center have had a few days to figure out the choreography of the offering, consider hosting an event where referring providers can come and observe the procedure live. This event may or may not be associated with a lecture. The idea is simply to put them in front of the offering. This is to get them excited and give them first-hand knowledge of what their patients are going to go through. This is a helpful advantage for them at the point of service when discussing the options with patients.

Lastly, consider posting half-day or full-day sessions during which providers not only see how the technology

works on 1 or 2 patients, but also see the entirety of the flow of your clinic from counseling and scheduling to the examination, surgery, and postoperative care. When they have full knowledge of your commitment to advanced technology and doing the right thing for your patients at every step of the patient journey, they will feel very confident in sharing their patients with you for optimal care and outcomes.

MARKETING—THE LAST STAGE

The last stage of marketing your RLE program is often the easiest. Demand creation is something that can almost always be safely outsourced. You want to align yourself with professionals who are immersed in understanding the technology. However, we always suggest going directly to consumers last. This is because the fundamental rules of marketing suggest that the intent of marketing and advertising is to make a logical prospect inquire about your product or service. However, if your operations are not set up properly to receive those inquiries, you can never expect that patient-customer back. You have one shot. Always be sure to get your house in order before spending excessive dollars in marketing.

Now that we have covered that advertising your laser program will become one of the easiest messages you will ever put out in your community, how should we do it? Patient-customers already want to believe that technologies and practices like ours are world-class. Communicating the advantages and predictability of laser precision during the most delicate steps of cataract surgery is a message that continues to resonate with the market.

Much like communicating with the optometric network, prepare your market message by first going to the media. You may use similar letters and communications to the media that you used with the referring doctor core. The idea here is to invite the media to a live surgery event as well. To be clear, always begin with public relations and earned media before going to advertising or bought or paid media. In most markets, several stations will pick up the story and want to feature your technology and what it means to their community. When talking to the media, some messages may include:

- Description of a new category growing among the active, aging population.
- That this procedure uses many of the same advanced technologies that have made LASIK as predictable as it is today.
- Video and high-resolution imagery of the procedure while it is taking place at the microscopic level.

CONCLUSION

You have taken an important step in developing yourself and your team, making efforts to bolster a new category in your program. This program is very appealing to the baby boomer population that desires refractive, functional vision prior to a covered procedure. By paying special attention to how you talk about the RLE and presbyopic surgery offerings with your team, your patients, your local eye care providers, and your community, you can build a program that properly educates about all of the options to correct vision.

REFERENCES

1. Repose JS, Qazi MA, Chu R, Stahl J. A prospective randomized clinical evaluation of 3 presbyopia-correcting intraocular lenses after cataract extraction. *Am J Ophthalmol.* 2014;158(3):436-446.
2. Lindstrom RL, Macrae SM, Pepose JS, et al. Corneal inlays for presbyopia correction. *Curr Opin Ophthalmol.* 2013;24(4):281-287.
3. Gifford P, Kang P, Swarbrick H, et al. Changes to corneal aberrations and vision after Presbylasik refractive surgery using the MEL 80 platform. *J Refract Surg.* 2014;30(9):598-603.
4. Charman WN. Developments in the correction of presbyopia II: surgical approaches. *Ophthalmic Physiol Opt.* 2014;34(4):397-426.
5. Krueger RR, Applegate RA, MacRae S. Wavefront Customized Visual Correction: The Quest for Super Vision II. Thorofare, NJ: SLACK Incorporated; 2004: 368.
6. Glasser A, Campbell MC. Presbyopia and the optical changes in the human crystalline lens with age. *Vision Res.* 1998;38:209-229.
7. Guirao A, Artal P. Corneal wave aberration from videokeratography: accuracy and limitations of the procedure. *J Opt Soc Am A Opt Image Sci Vis.* 2000;17:955-965.
8. DeValois RL, DeValois KK. *Spatial Vision.* New York: Oxford University Press;1988: 147-175.
9. Beiko GHH, Haigis W, Steinmueller A. Distribution of the corneal spherical aberration in a comprehensive ophthalmology practice, and whether keratometry can predict aberration values. *J Cataract Refract Surg.* 2007;33(5):848-858.