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NEW PARADIGMS in Premium Practice Development

This is not your father's cataract practice.

BY ROCHELLE NATALONI, CONTRIBUTING EDITOR

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Premium Practice Today is a monthly feature section in **CRSToday** providing articles and resources to assist surgeons and their staff in the pursuit of premium practice development to facilitate exceptional experiences for patients and business success.

New Paradigms in Premium Practice Development

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I am often asked what it takes to change a practice, and the answer I give is that the first thing that must change is the mindset. Change is hard, both personally and professionally. Resistance to change is all around us, and this resistance keeps us from making progress.

This month, we have interviews with three surgeons who have adopted the proper mindset and use that to change their practices, not just once but continually. Drs. Hovanesian, Gulani, and Trattler all understand that having and maintaining a premium practice requires them to treat patients as customers, to communicate early and often, and to approach with confidence every interaction with patients.

Their commitment and resultant success will serve them well as the Medicare crisis unfolds. Specifically, they are building a culture in their practice that demonstrates value in their services to the extent that patients willingly pay for them and for the overall experience that they receive. I predict that the future of medicine will create a huge fork in the road, where doctors will choose a path of premium care or one of no-frills, efficient care. Congratulations to these three surgeons for choosing the premium path; they are role models from whom we can learn (and who want to continue to learn themselves).

—Section Editor Shareef Mahdavi

Few truths are more reliable than the old yarn that change is the only constant. Although change is the great equalizer, the way that surgeons and practice administrators deal with it is what separates those who embrace—and even invent—the future from those who remain steeped in the past.

Premium refractive IOL surgery, dry eye clinics, hearing centers, and even spas dedicated to aesthetic procedures are ubiquitous in practices committed to thriving in the new millennium. Is your practice one step ahead of this exciting evolution or barely keeping pace? Ask yourself, am I a surgeon who dreads change, bemoaning cuts in Medicare reimbursement and mandates with regard to the use of electronic health records, or am I a surgeon who courts change armed with proactive strategies and preemptive maneuvers? Your response predicts if your practice will be a victim or a victor. Perhaps more importantly, it reflects whether you are the physician to whom patients refer their friends and family or the physician whom patients see only until they can find someone new.

WILLINGNESS TO CHANGE

The surgeons interviewed herein consider themselves fully prepared for what health care in general and cataract and refractive surgery specifically have in store for them. They point to patients' heightened expectations and technological developments as two of the leading variables that demand flexibility and a willingness to change. One obvious similarity between these surgeons is a commitment to personalizing patients' care. Most see the conversation about an upgrade to a premium IOL as one that should take place between the surgeon and the patient, as opposed to a task relegated to a refractive consultant.

John A. Hovanesian, MD, of Harvard Eye Associates (ⓘ www.harvardeye) in Laguna Hills, California, says

that having a staff member dedicated to providing education works for LASIK but is flawed with respect to refractive cataract surgery: "When a person comes in with questions about LASIK, they are there to learn about LASIK. When [patients come in] for cataract surgery, they are there to get their vision fixed. If you want to educate them about something that they did not come in to hear about, I think the surgeon should invest a fair amount of their time in that."

Dr. Hovanesian has designed his practice in such a way that he can spend more time with pre- and postoperative patients, because he wants to educate them himself about what they should expect from premium IOLs. "I am more credible," he says. "They are much more likely to make an informed choice after talking to me. I think, if anybody else talks to them about premium implants, it sounds like a sales pitch. When I talk to them, it sounds like education."

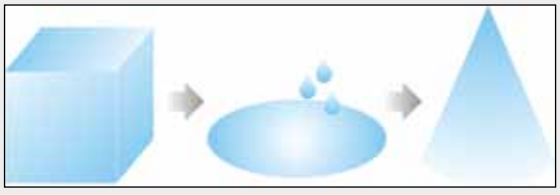
TALK THE TALK

The challenge of leading one's practice into the future, says Dr. Hovanesian, is twofold. "The first one is technical; you have to have the skills to be able to deliver the outcome," he explains. "The second is all about communication. You have to be able to talk the talk. You have to be able to communicate the value proposition before surgery and then talk to patients afterward—whether they are happy or unhappy. It is the things you say and do both verbally and nonverbally that get a patient to 20/happy and get a patient to refer their friends." Minimizing "chair time" is not the goal, he points out. "I make the time to do this because it is important," he says. "We are charging a premium for these technologies, so it is not as if we are not getting paid for our time."

Dr. Hovanesian's insights fit right in with the philosphy currently espoused by organizational change pundits who say that the era of continuous improvement is behind us and that it is time to welcome the era of continuous change. Flexibility instead of rigidity and adaptation instead of adherence are the behavioral transitions that business leaders and practice managers must recognize as critical to future growth and sustainability. No longer are successful leaders thinking in terms of doing things faster or cheaper because "things" have changed. The continuous improvement model, once so cutting edge, is no longer economically viable. Today's marketplace is driven by the consumer, who dictates the value of goods and services, accept-

PARDON ME WHILE I CHANGE

Kurt Lewin, often called the father of modern social psychology, is credited with saying, "If you want truly to understand something, try to change it." His observations on how organizations change are worth a look, as individual practices and the entire ophthalmic surgical specialty are transforming to keep pace with patients' evolving expectations and to thrive in challenging economic times. Mr. Lewin's three-step model is often described as unfreeze—change—refreeze.[1] The analogy of changing the shape of a block of ice is used to explain the stages (www.strategies-for-managing-change.com).



First, you must melt the ice to make it amenable to change (unfreeze). Then, you must mold the ice water into the shape you want (change). Finally, you must solidify the new shape (refreeze).

Unfreeze. Everyone needs to get ready or "softened up" for change, which entails challenging the status quo and identifying ways to "melt" the resistance to change.

Change. This is the stage when the change takes place, but it is also a period when confusion and fear flow freely. There is an awareness that things are changing, but no one is clear about how things will turn out.

Refreeze. This is the stage everyone wants to rush through. Change is firming up, but it takes time for everyone to get comfortable with the new state of affairs. Pull away the support too soon, and the newly hoped-for "shape" will not be complete.

1. Strategies for managing change. http://www.strategies-for-managing-change.com/kurt-lewin.html. Accessed December 29, 2011.

WHAT'S IN AND WHAT'S OUT	
IN	**OUT**
Cataract surgical education	IOL sales pitch
WiFi in the waiting room	Prohibiting smartphone use
A vision solution for every patient	The phrase "not a candidate"
Generous pre-and postoperative time	Minimizing chair time with premium IOLs
Addressing patients' expectations	Weeding out demanding patients
Courting change	Dreading change
Flexibility	Rigidity
Adaptation	Adherence

able performance levels regarding the delivery of goods and services, and where he or she wants to purchase goods and services.

Dr. Hovanesian says cataract surgery is becoming a consumer-driven process rather than a medical treatment for a disabling disease. "Patients are going to seek out surgeons in whom they have high confidence," he comments. "Patients' expectations are based on what they have heard about 20-year-olds who have had LASIK surgery. We have spoiled the world of potential patients by giving them spectacle freedom in a 5-minute procedure that causes no pain and has rare complications, so people expect the same thing of cataract surgery. We cannot deliver that, but we have to look at everything in our practice from the perspective of an uneducated patient and ask ourselves, how do I make this experience build the patient's confidence in me and in the technology that I am going to offer? How do I make them comfortable with me and the best procedure that I can provide them even if it involves extra cost?"

Some physicians truly get it, says Dr. Hovanesian, and they are mostly succeeding with the new paradigm. Then, there are the others. "Unfortunately, a large number of surgeons who are using premium IOLs and premium technology do not even understand the importance of meeting the consumer demand mindset," he says. "They think that, if they bring in this more expensive lens, then they can add a big upcharge for it, and all they have to do is implant this lens instead of a monofocal lens and that the premium lens will do the rest. However, that is completely flawed, because the patient is not buying a lens; the patient is buying good vision. The burden is on the physician to do everything possible to achieve that result."

TECHNOLOGY AND EXPECTATIONS

Arun C. Gulani, MD, director of the Gulani Vision Institute (▶ www.gulanivision.com) gets it. Based in Jacksonville, Florida, this surgeon says he has appointments almost daily with patients who fly in from near and far to see him. He says that, when he asks why they did not choose someone local, patients tell him that their research revealed information about him and his professional accomplishments that motivated them to seek him out regardless of his location. Dr. Gulani offers 40 distinct vision correction procedures to address unique needs, including those of previous refractive surgery patients who now have cataracts and want spectacle-free vision. "When I explain how I will correct their vision, I do not go into detail about how an IOL works," he says. "I explain what I will do and how that will improve their vision—whether it is a combination of laser surgery and IOL surgery or IOL surgery and corneal cross-linking [not FDA approved]. I explain the steps, and they understand."

Dr. Gulani says he stays ahead of the curve by investing in advanced technology and perfecting new skills to satisfy patients' evolving expectations and goals. "From my perspective, the future is driven by technology and revolves around patients' changing expectations," he says. "The future is our present patients but with future expectations, which is vision [of] 20/20 or better at distance and near and everything in between. They want it all with the least amount of intervention. Our strategy to satisfy this demand is to provide the

> "The future is driven by technology and revolves around patients' changing expectations."
> —*Arun C. Gulani, MD*

highest level of care, charge the appropriate fee, and avoid discounts, deals, or gimmicks, because that hurts the practice in the long run."

Dr. Gulani has a 90% conversion rate and says this is a reflection of satisfying the demands of this new breed of patient. "When you use technology to communicate with patients before meeting them, use technology to explain the available procedures to patients once they present, and they learn that you will use the newest IOL technology and the newest technology to implant the IOL, it sends a message that they are getting the best," he comments. "That is what today's savvy patients expect, and that is what I deliver."

SO MUCH HAS CHANGED

William B. Trattler, MD, of The Center for Excellence in EyeCare in Miami (www.centerforeyecare.com), has a lifelong perspective on the evolution of cataract and refractive procedures. He grew up the son of an ophthalmic surgeon with whom he now works in a practice with 12 doctors and nine cataract surgeons. "So much has changed," he observes. "We have better implants, more efficient phacoemulsification technology, better postoperative drugs, and better preoperative testing, among other things." Despite all of these innovations, Dr. Trattler says it is no secret that not all surgeons take advantage of all options. "There is a range of surgical techniques and thought process[es] regarding surgery," he says. "Some surgeons see a cataract patient and remove the cataract and think anything else is superfluous. They want the patient to do well, but they are not interested in doing much preoperative testing, primarily because there are costs associated with these tests, but there is no upcharge. I do not make my decision based on how much it will cost me. I like to perform preoperative tests, because they provide me with the extra information I need to optimize my results."

ENHANCED PEARLS

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Audio Video Web site

Harvard Eye Associates
(www.harvardeye.com)

Strategies for Managing Change
(www.strategies-for-managing-change.com)

The Center for Excellence in Eye Care
(www.centerforeyecare.com)

Gulani Vision Institute
(www.gulanivision.com)

According to Dr. Trattler, another important variable in the developmental paradigm of the modern cataract and refractive surgical practice is that "patients are presenting earlier, with less advanced cataracts, and they are coming in with higher expectations, because they have friends who have had surgery and are seeing really well. They expect amazing results. It is up to us to help the patients get excited about potentially great results but to also help them understand that not everybody gets these results."

Dr. Trattler points out that the future of the specialty leaves room for advances in surgery. "A lot of cataract patients are seeing well, but they are not seeing as well as patients who have had LASIK surgery," he notes. "So, there is still a lot of room for improvement for us to all get better results with better management of the ocular surface, better IOL calculations, and better preoperative testing. We are not at 100% 20/20 yet, and that has to be conveyed to the patient in order to effectively manage expectations." ■

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