

Premium Services: a Conversion Rate Study With Consideration to Sex and Age

An analysis of conversion rates for premium services reveals significant patterns based on sex and age.

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Strategies for boosting conversion rates for premium services abound, ranging from increasing the surgeon's time spent with patients to hiring sales personnel to make the pitch.¹ Practices need an accurate system to define and track their conversion rates. Therefore, I undertook this study to measure my true conversion rate for premium services. I excluded those for whom premium services were not an option and analyzed the choices made by the remaining eligible patients to opt for or decline premium services. The goal was to determine the precise conversion rate for premium services in my practice.

STUDY DESIGN AND PATIENT POPULATION

I was the sole practitioner who personally examined, documented, counseled, and performed surgery on 325 consecutive patients who met the only inclusion criterion of requiring cataract surgery. The age range of the cross-sectional sample was 46 to 100 years, with the largest number of patients falling into the age range of 61 to 75 years. The sample was 39% male and 61% female. I evaluated and recorded preexisting ophthalmic conditions and defined and applied exclusion criteria for limbal relaxing incisions (LRIs), toric, and presbyopia-correcting implants.



For potential LRI patients, the exclusion criteria were insufficient corneal cylinder (0-0.50 D), opting for toric lenses instead of LRIs for patients with corneal cylinder ranging between 0.90 D and 1.5 D (in which case those patients were grouped in the potential toric implant sample), having irregular astigmatism, or a corneal scar. These excluded patients were then categorized by age.

For potential toric implant patients, exclusions were choosing to be considered for LRIs (this option was only offered for patients who had between 0.90 D and 1.50 D of astigmatism, in which case those patients were grouped in the potential LRI sample), the lack of sufficient corneal cylinder (0-0.89 D), nonsymmetrical astigmatism, objecting to the yellow chromophore, or presenting with advanced exfoliation syndrome. These excluded patients were then categorized by age.

For potential presbyopia-correcting IOLs, exclusions were posterior pole pathology; refractive issues including amblyopia, astigmatism greater than 1.50 D, irregular astigmatism, miotic pupil(s), strabismus corrected with prisms, and unavailable IOL power due to high myopia; corneal pathology; and a positive angle kappa. These patients were then categorized by age.

Patients who were excluded from multifocal IOLs because of a positive angle kappa were offered the option of an accommodating implant and categorized by their choice with respect to sex.

I gave identical clinical counsel to all patients

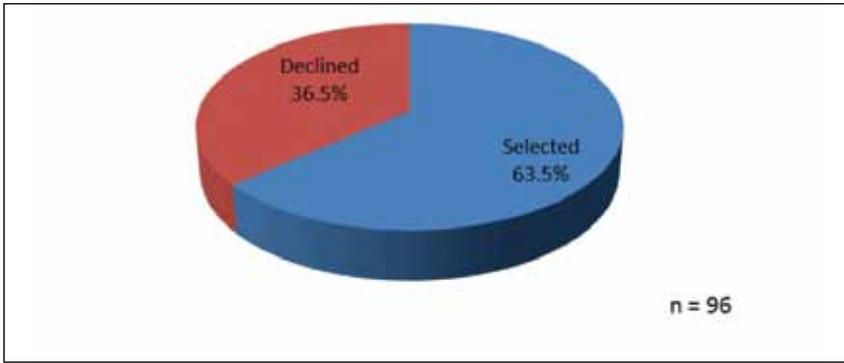


Figure 1. Percentage of eligible patients who chose toric IOLs.

undergoing cataract surgery. For the patients who were eligible for premium services, I explained the fees (data from Market Scope) associated with their option(s). For those patients who were eligible for premium services but declined, I asked if their decision to stay with spectacles was part of their identity or a cost consideration.

Patients with natural monovision or those who wore monovision contact lenses and who were eligible for presbyopia-correcting IOLs were offered presbyopia-correcting IOLs versus monofocal monovision implants. If these patients declined presbyopia-correcting IOLs, I asked them if their decision was due to the cost of the premium service or a personal preference to continue with monovision.

Finally, I documented and analyzed by sex the reasons patients cited for not choosing a premium option and classified them by the choices they made to select or decline those options, thereby determining a precise conversion rate for each premium option.

More than half of the study population (52.6%) was ineligible for LRIs, with insufficient corneal cylinder (0-0.50 D) identified as the most prominent factor (59.6%). I categorized these excluded patients by age, which revealed a marked downgrade in eligibility for LRIs in patients aged 66 through 100 years (71%-100%).

Of those patients deemed eligible for LRIs, the majority (84.4%) selected them, with no statistically significant sex preference. Patients who rejected LRIs did so largely due to cost (70.8%),

but a sizeable remainder of 29.2% rejected LRIs out of a preference for glasses.

Nearly three-quarters of the patients were ineligible for toric implants, with insufficient corneal cylinder (0-0.90 D; 49.0%) cited as the most prominent factor. I categorized these excluded patients by age, which reflected a gradual decrease in eligibility across all age groups (nonagenarians were 100% ineligible).

Among patients who were eligible for toric IOLs, the majority (64.2%) chose them (Figure 1), with no statistically significant sex preference. Of those who declined toric lenses, most (87.5%) cited cost as their reason, yet almost 12.5% cited a strong preference for glasses.

I noted that of the 78 patients eligible for both LRI and toric IOLs (astigmatism ranged between 0.90-1.50 D), 25 chose LRIs, yet 53 patients chose toric implants, despite the greater cost.

About 40% of the study population was ineligible for presbyopia-correcting IOLs, with posterior pole pathology (43.9%) being the most prominent exclusion factor. The refractive reasons that rendered the patients ineligible for presbyopia-correcting IOLs included astigmatism greater than 1.50 D as the most prominent factor. I then categorized this population of ineligible patients by age, which showed a gradual decrease in eligibility with advancing age (nonagenarians 100% ineligible).

Patients who were excluded from multifocal IOLs because of a positive angle kappa were offered an

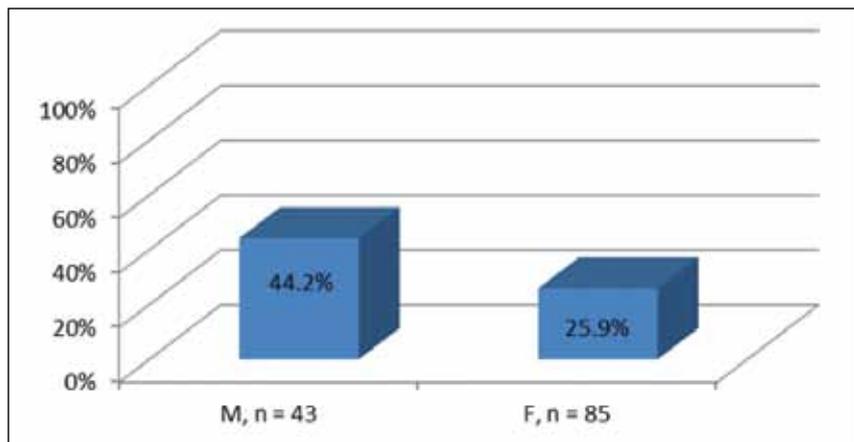


Figure 2. Breakdown of patients by sex who rejected presbyopia-correcting IOLs because they prefer glasses.

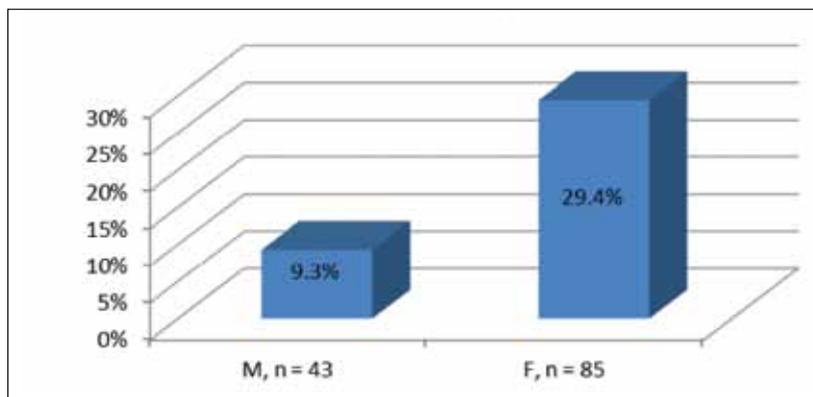


Figure 3. Sex breakdown of patients who rejected presbyopia-correcting IOLs because they prefer monovision implants.

accommodating implant. A total of 61.9% of these patients declined the accommodating IOL, while 38.1% selected that option. Of these patients, 35.3% of the men and 40.0% of the women chose the accommodating IOL option, showing no statistically significant sex preference.

Almost 75% of patients eligible for presbyopia-correcting IOLs rejected that premium option. Only about half cited cost as their main reason, and a total of 28.5% preferred to wear glasses. Of all eligible men who declined presbyopia-correcting IOLs, 46.5% did so due to cost, 44.2% preferred glasses, and 9.3% chose monovision IOLs. Of all eligible women who declined presbyopia-correcting IOLs, 44.7% did so due to cost, 25.6% preferred glasses, and 29.4% chose monovision IOLs. There was a statistically significant difference for men preferring glasses to women and women preferring monovision IOLs to men (Figures 2 and 3). Patients who opted for monovision who had concomitant astigmatism selected either LRIs or toric IOLs to correct their corneal astigmatism based on the criteria listed previously.

DISCUSSION

Taking into consideration the exclusions outlined and the uncertain national economic conditions during which this research was conducted,² this study revealed a conversion rate of 84.4% for LRIs, 63.5% for toric IOLs, and 25.4% for presbyopia-correcting IOLs among eligible patients in my practice.

Clearly, the percentage of patients whose underlying ocular conditions render them ineligible for premium services can significantly influence a practice's conversion rate. Among the patients examined in this study, more than half of those who were excluded from presbyopia-correcting IOLs for refractive reasons

presented with astigmatism (cylinder) greater than 1.5 D. I do not perform LASIK, I correct astigmatism with LRIs for corneal cylinder ranging between 0.51 D to 1.5D and/or with toric IOLs for corneal cylinder greater than 0.90 D. This subgroup of patients may benefit from toric presbyopia-correcting IOLs, which may be available in the not-too-distant future.

Furthermore, a patient population skewed toward individuals with advanced age can also contribute to a low conversion rate for premium services. Although cost does appear

to be a deterrent to conversion, a patient's preference for glasses or for monovision implants is statistically noteworthy and appears to be influenced by sex.

Therefore, calculating a practice's premium services conversion rate based on the percentage of patients selecting toric IOLs and presbyopia-correcting implants from the total population of patients in that practice (eligible or not) seeking cataract surgery does not provide a precise conversion rate. Conversion rates factoring only those patients who are eligible for these options will give the most accurate rate.

Finally, attributing a patient's rejection of premium services to price alone neglects the statistically significant influence that a preference for glasses or monovision implants has on the choice to accept or decline those premium services.

CONCLUSION

Although duplicating this study in their own practices might be prohibitive for most surgeons, and the demographics and price points certainly vary, practitioners can use this comprehensive study to better interpret and understand the conversion rates for premium services in their practices. ■

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