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MAY 2013

AVOID the PRESBYOPIC PRECIPICE

How many of your contact lens patients will abandon their lenses at age 40? Stop the dropouts and continue to grow your practice with multifocal contact lenses.

Participating Faculty

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Dr. Lowinger owns two retail practices in south Florida. He has received research funding from Vistakon and honoraria from Alcon.

Important information for AIR OPTIX® AQUA Multifocal (lotrafilcon B) contact lenses: For daily wear or extended wear up to 6 nights for near/farsightedness and/or presbyopia. Risk of serious eye problems (i.e., corneal ulcer) is greater for extended wear. In rare cases, loss of vision may result. Side effects like discomfort, mild burning or stinging may occur.

See product instructions for complete wear, care and safety information.

Rx only

AVOID the PRESBYOPIC PRECIPICE

How many of your contact lens patients will abandon their lenses at age 40? Stop the dropouts and continue to grow your practice with multifocal contact lenses.

John L. Schachet, OD: One bright spot in an otherwise flat contact lens market has been the multifocal category, which grew about 7 percent in dollar volume industry-wide in 2011 and 2012.[1] Driving this growth are the practitioners who embrace multifocal technology and enthusiastically present it to their patients as their best corrective option. Some of these forward-thinking practitioners are part of today's panel discussion. They will discuss how multifocals have contributed to the success of their practices and share pearls that other practitioners can use to enhance the lives of their presbyopic patients while increasing sales and profits. These practitioners are committed to giving their patients the best possible care, by providing binocular vision at all distances through the use of multifocal contact lenses.

Let's begin by discussing when and how we address the subject of presbyopia with patients and why it's important to offer the best care by providing binocular vision at all distances.

When and How Doctors Discuss Presbyopia With Their Patients

Steve Lowinger, OD: When I see a patient who's approaching presbyopic age, I like to "set the table" for future encounters, even if the patient isn't noticing any vision changes at that moment. If he's in his late 30s or early 40s, I let him know that he may start having some problems with reading in the next couple of years. At the same time, I reassure him that we have ways, such as prescribing contact lenses, to address these visual changes. When I proactively address a patient's future needs, his confidence in me grows and my value increases in his eyes.

David L. Kading, OD, FAAO: Many practitioners target people in the 40- to 45-year age range, but I believe our amplitude of accommodation starts decreasing at a younger age, especially among people who spend a great deal of time reading or working on a computer. I usually discuss presbyopia with patients when they're in their mid-30s, particularly if they're using computers for 8 to 12 hours a day.

Dr. Schachet: How do you handle the age aspect of the discussion?

Dr. Lowinger: Now that I've gotten older, having the age conversation with patients is much easier, because they look at me and say, "Well, I don't have it as bad as you." I tend to make little jokes about age without actually using the word "age." Most patients understand presbyopia is age-related. I reassure them that this is a normal change that everyone experiences.

Crystal M. Brimer, OD: When talking to young presbyopes, I don't use the words "bifocal" or "multifocal" contact lenses until after they've tried them and can see the benefits. I just say, "We have lenses that let you see up close, intermediate and far away."
Dr. Schachet: How do you explain presbyopia to your patients?
Mile Brujic, OD: Assuming the patient's eyes are healthy, I begin with that good news. Then I say, "I see that your eyes aren't focusing quite as well up close. This is a condition called presbyopia."
At that point, I use our patient-education software to show a cross-section of the eye, while explaining exactly how it functions and the reason why he's not seeing well up close.
Dr. Brimer: When I discuss the physiology associated with presbyopia, I may be more descriptive with some patients than others, depending how well I know them and how much information I think they want. I have an exaggerated analogy, but it's a good visual aid. I say, "Let's pretend you don't have a prescription. When you look in the distance, that muscle is flat like a pancake. When you look at your computer, it has to ball up like a tennis ball to see the monitor, and for reading, it has to get really tight like a golf ball." I explain that their natural lens has become less flexible so it's difficult to focus up close.
Dr. Kading: I start the conversation, particularly if the patient is symptomatic, by explaining that our focusing system has to be moldable, and every year from birth that structure gets thicker like a tree. It's not that, all of a sudden, at age 40 you can't adjust, but every year it gets thicker, making it more challenging to see up close. Then we talk about the options we have to aid that structure.

Describing the Options for Presbyopia Correction

Dr. Schachet: How do you present the options for correcting presbyopia?
Dr. Brujic: I explain that we have three options that work well: "You can use reading glasses, or we can design a pair of eyeglasses so that you can see in the distance through the top of the lenses and up close through the bottom. These can be made with or without lines. The third option is contact lenses that allow you to see far away and up close without any obstruction from the frames."

During my presentation, I always explain what patients should expect with their vision over the next several years. I want them to understand that the lenses I'm prescribing for them now will work well for a certain period, but that their presbyopia will advance, whether they're wearing eyeglasses or contact lenses. This discussion serves to encourage them to return for annual examinations, so I can make adjustments to their prescriptions, if necessary.

> **... I discuss [multifocal contact lenses] with every presbyopic patient for two reasons. First, if I don't discuss them, someone else probably will ... and then patients might lose confidence in my skills, resources and ability to stay current with technology. If that happens, I might not get another chance to show them this option.**
>
> **Second, I want patients to be wowed. I want them to be excited, and I think you can achieve that by fitting them with the latest technology.**
>
> **— Crystal M. Brimer, OD**

Dr. Kading: I have a similar discussion. When describing bifocal or progressive eyeglasses, I also mention that vision through them is monofocal, which has limitations because you can't see at all distances at once, and that peripheral vision is limited with eyeglasses. Then I discuss how multifocal contact lenses provide a full range of vision, because there are multiple focusing distances within each lens.
Dr. Lowinger: I break down the options in a slightly different way. I tell patients we have six ways to help presbyopes, three in eyeglasses and three in contact lenses, and I'll further explain each one. When I get to the contact lenses, I say they can wear contact lenses for distance and use reading glasses for close work (most patients don't like that idea). Then I briefly mention monovision. Most patients feel monovision is a very strange concept and are not real excited about the monovision idea. Finally, I talk about my preference — multifocal contact lenses.
Dr. Lowinger: When I describe how monovision works, I usually tell patients, "You may know people who have monovision correction. We used to start with monovision, but we don't start there anymore." Then I go on to describe the benefits of multifocal contact lenses.
Dr. Schachet: When patients ask me specifically for

monovision because their mom, aunt or father wore monovision, I explain that, at one time, monovision was our only option, but now we have multifocal lenses that allow them to see all the distances using both eyes, which is preferable. I reiterate that with these lenses, they can experience vision the way they used to before being affected by presbyopia.

Dr. Lowinger: Some patients — and even some practitioners — may believe that monovision is a first-choice option because it's been around so long. It hasn't been around this long because of the strength of the product or technology. We just didn't have anything better. Now we have AIR OPTIX® AQUA Multifocal contact lenses — a far better option for our presbyopic patients.

Dr. Brimer: When discussing multifocal contact lenses with patients, I think it's important to emphasize that we're using new technology. Just as we may have tried fitting old multifocal lenses 10 years ago and were disappointed with the outcomes, many of our patients may have had the same experience, and they may think we're still using that same technology.

Dr. Lowinger: I agree. The multifocal contact lenses of today far surpass the ones we were fitting 10 years ago. The new products and fitting guides address the concerns we had with older multifocals, so we can be much more successful with today's technology.

To Whom Do You Present Multifocals?

Dr. Schachet: It seems all of us are proactively discussing presbyopia with our patients much earlier in life than practitioners did years ago. Are you also presenting multifocal contact lenses earlier?

Dr. Lowinger: In most cases, yes. Sometimes patients won't tell you their true complaint unless you push and prod. By starting the conversation about presbyopia and explaining that we have options to correct it, I can usually get to the heart of the problem. People don't necessarily want to admit they're aging. By having the conversation, I can get to the, "Oh, yes. That's happening to me" moment.

We also have patients who admit they have a problem but are afraid of what I'll propose to solve it. Sometimes they're more open to correction with multifocal contact lenses, which can camouflage the fact that they're aging.

Dr. Schachet: Dr. Brimer, when do you present multifocal contact lenses as an option?

Dr. Brimer: As soon as a patient can appreciate any add whatsoever, I talk about presbyopia and multifocal contact lenses. I discuss how reading in dim light or spending hours on a computer contributes to eye fatigue, especially in presbyopes. Once I start talking about these issues, even patients who didn't have complaints often admit to struggling with these issues. When they try the multifocal contact lenses, they appreciate the difference they make, even though they might not have realized changes in their eyes were occurring.

Dr. Kading: I move patients into multifocal lenses somewhat earlier than I did in the past for two main reasons. First, I've found adaptation is easier than if I wait until there's a significant difference between a patient's distance and near vision. The second reason is because I want to be proactive in treating my patients.

Dr. Brujic: If a patient isn't complaining about his near vision and if I refract him with a certain add power and he doesn't notice a significant improvement, I won't have an in-depth conversation, other than to let him know that his visual system will continue to become weaker, and we have options for that. Telling patients about multifocal contact lenses before they need them makes them aware of the modality, so that next year, the conversation will start on a positive note.

> **It's important to set expectations from the start, I tell [patients], "The first lens may not be perfect. That's okay. I'm not fitting you in your real life. ... When you come back next week, I expect you to tell me what's working and what isn't working."**
>
> **— Steve Lowinger, OD**

Dr. Brimer: When I tell a patient that presbyopia will worsen and he may not be able to make it through a full year without coming back because of near-vision strain, his perspective changes. Many patients say, "I can already appreciate the difference. Let's just make the change now."

Dr. Lowinger: The proactive practitioner has to perform some fortune telling. We know at some point, patients will become presbyopic, whether they complain about their vision or not. Personally, when I find a doctor who prepares me for symptoms that may need to be addressed, that's the doctor I want to continue seeing.

Dr. Kading: Fortune-telling, as Dr. Lowinger calls it, is critical because it builds loyalty and brings

patients back. By telling patients what to expect, we also reassure them that we have solutions.

Dr. Schachet: Do you discuss multifocal contact lenses with all presbyopes?

Dr. Brimer: Yes, I discuss them with every presbyopic patient for two reasons. First, if I don't discuss them, someone else probably will — perhaps one of their friends — and then patients might lose confidence in my skills, resources and ability to stay current with technology. If that happens, I might not get another chance to show them this option.

Second, I want patients to be wowed. I want them to be excited, and I think you can achieve that by fitting them with the latest technology. My success rate with fitting AIR OPTIX® AQUA Multifocal contact lenses is very high, for example, but even if I have a patient who is one of the few for whom it doesn't work, he knows that I took the time and made the effort to fit him with a lens that I felt would improve his experience. That positive experience stays with a patient.

Dr. Kading: In my practice, our goal is to grow our contact lens business. So, all of our doctors offer all eligible patients contact lenses as a vision-correction option. We have such a broad portfolio of lenses, there's no reason why we shouldn't offer them to everyone.

The benefits of AIR OPTIX® AQUA Multifocal contact lenses:

- Binocular vision
- Unobstructed vision compared to eyeglasses
- Smooth transitions between near, intermediate and distance
- Comfort
- Superior deposit resistance[2*]
- Increased wettability[3**]

Patient's First Multifocal Experience

Dr. Schachet: Let's talk about a patient's first experience wearing multifocal contact lenses. What do you do and say?

Dr. Brujic: I'm all about demonstration. I outline the benefits of multifocal contact lenses, then I apply the lenses.

If the patient mentioned he was having trouble seeing his smartphone, then the smartphone becomes part of the demonstration. We black out the distance eye chart, because the first thing I want the patient to see is his phone. By showing him something he couldn't see well before, I demonstrate what multifocal lenses can do for him. Then I discuss the other attributes of the lenses.

Dr. Lowinger: Some multifocal products, for example AIR OPTIX® AQUA Multifocal contact lenses, do such a good job of correcting distance vision that I start with the distance chart. Most often, the patient looks up and can see the 20/25 or the 20/20 line and then looks down and says, "Wow! I can read."

Dr. Kading: Do you find that patients lose any distance or near vision with a multifocal contact lens when compared with their habitual lenses?

Dr. Lowinger: With the AIR OPTIX® AQUA Multifocal contact lenses, I typically don't see compromised distance or near vision, even if I increase the plus power of the lens somewhat. That's why I'm comfortable showing patients both charts.

Dr. Schachet: Dr. Kading, what's your usual procedure once a patient has multifocal contact lenses on his eyes?

Dr. Kading: In my office, I hand the patient a near card first. In most cases, that's the patient's chief complaint, so I want to show him how much better he can see up close than he could before. When we don't have an open examination room, I ask the patient to go into the reception area and experience the lenses in a real-world environment. Invariably, the patient will start looking at his phone rather than any magazines or brochures. When he returns to the examination room, I ask how the lenses are working. By improving the patient's near vision, I have a win. Then I show him the distance chart. With the AIR OPTIX® AQUA Multifocal contact lenses, the distance vision hasn't been degraded, and the patient has gained depth of vision.

Dr. Schachet: What we're doing is setting a patient's expectations through demonstration.

Dr. Brimer: Whether you show near vision or distance vision first, the key is to avoid talking about the negatives, because patients will lose confidence. I focus on the benefits, like improved near vision, smooth transitions, and comfort. I don't talk about adaptation. I don't talk about compromise. I apply the lenses, wait for the patient's reaction and address any concerns as they arise.

Managing Expectations for Week 1

Dr. Schachet: How do you proceed once you're satisfied with your initial multifocal fit?

Dr. Lowinger: I make sure patients understand the concept of simultaneous vision — that multifocal lenses provide distance and near vision at the same time — and the brain needs to sort that out. Sometimes, when I refer to multifocal contact lenses, patients think there's a line in the middle

> **If a patient mentioned having trouble seeing his smartphone, then the smartphone becomes part of the demonstration. I black out the distance eye chart, because the first thing I want the patient to see is his phone. By showing him something he couldn't see well before, I have demonstrated success and the positive attributes of multifocal lenses.**
>
> **— Mile Brujic, OD**

of the lens, so I need to correct that misconception. Then I tell them the three things I want them to pay attention to during their first week of lens wear. I want to know:

- How they're seeing in the distance
- How they're reading and
- If the lenses are comfortable.

I keep my instructions simple and not too specific, because the experience will be different for every patient, and I don't want to prejudice anyone by suggesting where they might have problems.

Dr. Kading: While the patient is wearing the lenses and experiencing that relative range of vision, I tell him, "The worst vision you'll have with these lenses is right now. Your vision will continue to improve as your brain and your eyes adjust. Go home and experience the lenses in your everyday life. When you come back to the office, if we need to make any changes, we can modify the lenses to maximize your vision in your environment — not mine.

Dr. Brimer: Explaining the design of the lens — that correction for distance and near are there all of the time and your brain sorts it out — helps patients understand that adaptation may take time, and makes them more patient with the process.

Dr. Kading: Yes, patience is another aspect of fitting these lenses for patients and practitioners. We learned about cortical adaptation in the early days of monovision, when we put lenses on patients and they wouldn't work, but patients returned later and the lenses were working. With multifocal lenses, a patient's vision may not be as good at the initial fitting as it will be at the follow-up visit, because cortically, their brain and their eyes learned to how to use the lens. That's why we have to let patients go home to experience the lenses in real life so they can adapt to them. Ensure patients have functional vision at the end of their first visit. During their follow-up visit, you will have the feedback needed to fine-tune the lenses to fit your patient's needs.

Dr. Lowinger: After years of fitting multifocal contact lenses, I've learned to impose three rules for a patient's first week:

1. Don't alternately cover your eyes. It's how both eyes work together that's important to me.
2. Don't use your reading glasses over the lenses. I'd rather hear that you needed to stretch out your arm or use more light.
3. Most importantly, even if you're not comfortable with these lenses right now, please wear them when you return for your follow-up visit, because that's when I'll be making any necessary adjustments.

When patients follow these rules, they are engaged, and they'll be specific when explaining why it's not working.

Dr. Brimer: I tell patients, "When you come back, I want you to be as descriptive as possible. I want to know exactly what problems you're experiencing." And if somebody calls before his appointment with issues, my staff is trained to say that same thing. "You need to work on figuring out exactly what's happening, so that we will know how to change it." I do that mainly to change their focus, so they realize it's a work in progress, that it's okay that their vision isn't perfect, and that they're part of the solution.

Dr. Lowinger: The examination room is the worst place to check someone's vision. Whenever I fit a patient with a multifocal contact lens for the first time, I find it's important to set expectations from the start. I say, "The first lens may not be perfect. That's okay. I'm not fitting you in your real life. I'm fitting you in a 13' dark room and telling you to go on your way. When you come back next week, I expect you to tell me what's working and what isn't." Explain to your patients the difference between their eyesight in the exam room, as opposed to their daily lives. If you don't let patients have a real-world experience with their contact lenses, they won't be happy most of the time. Once they have those real-world experiences, they may come back with issues that need to be addressed, but those are tangible issues that we can usually work through to increase satisfaction.

Time Is Money: How to Manage Both

Dr. Schachet: How do you address the extra time it takes to fit a multifocal contact lens versus a single-vision lens. Are your fitting fees higher for specialty lenses?

Dr. Lowinger: The value of a contact lens practitioner is making the difficult look effortless and patients are willing to pay for that. If I have a well-fitting multifocal, that doesn't mean I will lower my fee. If it's a specialty fit, I charge accordingly. With

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> **— John L. Schachet, OD**

the AIR OPTIX® AQUA Multifocal contact lenses Fitting Guidelines, I have the guidance I need to fit my patients easily and quickly. In fact, the small extra effort needed in fitting the lens is well worth it, especially considering the elevated specialty fitting fees, and future referrals from satisfied patients.

Dr. Kading: In our practice, we offer contact lenses to everyone, so the fitting is built into our fee, even though fitting a multifocal lens may take more time than fitting a spherical lens. If a patient wants to talk more about multifocals, that may add time to the visit, but that's similar to discussing a pair of computer glasses. Even though it takes extra time, it's in the patient's best interest. It's our responsibility to understand our patients' needs and give them the opportunity to choose what they feel is best. We can use ancillary staff to assist us in this process.

Dr. Schachet: There's always a chance a patient will decide against multifocal contact lenses after you've taken the time to demonstrate them.

Dr. Kading: That's true, but my job as a practitioner isn't to sell something to a patient, it's to educate him. If it benefits me financially, great, but if it doesn't, I've still educated the patient about the latest vision-correction options. There's also an indirect benefit. By educating a patient about these opportunities, I've planted a seed. That seed may grow next year or a year later. In the meantime, when the patient goes to dinner with friends and hears them complaining about needing reading glasses, he becomes an ambassador for our practice who can tell his friends we have contact lenses that can replace reading glasses. By having that conversation with the patient during his visit, we've made an investment in our practice whether he buys the lenses or not.

Dr. Schachet: Dr. Brujic, how do you manage your time when educating patients?

Dr. Brujic: The consultative portion of the examination is when I discuss the status of the patient's eyes and his options. It is a well-defined, predetermined time to which I commit, whether I'm talking to a 16-year-old myope, a 45-year-old presbyope or a 65-year-old glaucoma patient. The education doesn't take much extra time, because it's factored into the eye examination, as is my demonstration. For a presbyope, I'm not doing anything extra or above and beyond what I've already factored into that time frame.

Dr. Schachet: As a specialty product, multifocal contact lenses cost more than spherical lenses. How do you present that to your patients, especially in light of all the low-priced advertising in our marketplace today?

Dr. Brujic: I think it's a point of differentiation. We're offering a product that isn't available everywhere. I don't think there's any reason to shy away from the fees that we charge for that product.

Dr. Brimer: Patients can compare the price per box from various vendors or practices, but they can't compare examination fees and fitting fees, because what I offer in my examination room is different from what somebody else offers. Setting the proper price for a specialty fit is key to your success. When you keep your patients' best interests at heart, they appreciate that and they're not so price conscious.

Dr. Lowinger: Regardless of your practice setting — retail, HMO, private — certain specialty care items should cost more, because they require the expertise of the practitioner. There's a true benefit in fitting progressive eyeglasses versus a pair of bifocals, in fitting multifocal contact lenses versus spherical contact lenses.

Where do we create value? We create value with the type of eye examination we perform and the amount of information and education we provide. We also create value by fitting patients with products they don't consider run-of-the-mill, such as multifocal contact lenses. It's a higher level of expertise that we're offering them, so they can see both near and far. That builds value and loyalty in the practice.

Dr. Brimer: Most patients are more concerned with finding the best value rather than the cheapest

Grow Your Retail Practice

Dr. Schachet: Dr. Lowinger, many of our colleagues practice in retail settings, as you do. When we discuss specialty lens fitting fees, many of them feel they can't offer multifocal contact lenses because patients expect their fees to be low. How would you advise those practitioners?
Dr. Lowinger: I don't feel my practice is different from other modes of practice. I may have a slightly different model, but like most eyecare practitioners, my goal is to be busier than I was the year before while delivering excellent patient care. How am I going to build my practice if I don't fit every type of contact lens?

Let's take my retail setting out of the discussion. Let's say I'm in a primarily lower income, Medicaid-type practice, so my patients don't have the money to spend for specialty contact lenses, that is, up until the moment I present them, and then they do. By not offering multifocal contact lenses, practitioners are forcing themselves into what will be a self-fulfilling prophecy.

Some practitioners believe their scope of practice in a retail setting is limited. Meanwhile, other retail ODs are employing best practices to deliver primary and medical eye care to their patients. They're using high-end diagnostic equipment, prescribing pharmaceutical medications and fitting multifocal contact lenses for their patients because they believe in full-service eye care regardless of setting. Patients will come to see you for your expertise, whether you're in an HMO, a private practice, a Costco or a Wal-Mart.

I'll challenge anybody, wherever you practice. The day you start mentioning multifocal contact lenses to patients is the day you'll start fitting more of them, and a year from now, you'll discover that your practice has grown because of that.

price. Part of what we're charging for is the outcome. Patients pay more to not have a line in their bifocal spectacles, and most of them are willing to pay more to see distance and near with their contact lenses, because they understand and appreciate the value of that.

Dr. Lowinger: Patients are paying for our expertise. Even when we try to dial down technically how multifocal contact lenses work, they still don't completely buy into it. They buy into the results and the practitioner who can produce those results. This creates a patient loyalty that doesn't come in a box of spherical contact lenses.

Dr. Kading: I've heard that one-sixth of the population makes buying decisions based solely on price, and those folks will choose the cheapest option. They most likely will never want multifocal contact lenses, because they won't appreciate their value. We aren't here to serve that one-sixth of the population. We're here to serve people who want the opportunities that we provide, and if our fitting fees tend to be somewhat higher to justify our time, expertise and efforts, that should be understandable.

Empower Your Staff

Dr. Schachet: What role do staff members play in your contact lens practice, particularly when you're fitting multifocal contact lenses?

Dr. Brimer: Some practitioners don't delegate tasks to staff members because they're concerned it might slow patient flow, but I've found that using well-trained staff is a huge asset to the practice. I apply the initial lenses, so that I can observe the patient's first reaction and determine the starting point. I've trained my staff to perform the over-refractions. They know the guidelines for my first choice in multifocal lenses, which are AIR OPTIX® AQUA Multifocal contact lenses, so they know exactly what to do. Then, they come to me to approve the final lens selection. Basically, I'm in and out of the room at the beginning and the end of the encounter. This allows me to be a significant part of the process, but still see another patient during that time.

Dr. Brujic: One of my favorite things to do is to put contact lenses on the eyes of patients who've never worn them to see their response, so I apply the lenses initially. Our paraoptometrics are responsible for teaching patients how to apply, remove and care for their lenses. They also follow up with patients by phone a day or two after an appointment to find out how things are going. This is one of my top tips for building relationships and rapport with your patients, even after they've left the office.

Dr. Kading: In our practice, I select the lenses for the patient. Then, my technician pulls them from the diagnostic fitting set. If a patient is new to contact lens wear, I apply the lenses. If a patient is an established lens wearer, the technician will work with him to apply the lenses.

Ancillary staff is important in this process and in following up with patients later, because, as Dr. Lowinger said before, the worst place to perform

an eye exam is in the office. Nobody sees 6' away or 20' through a mirrored room. That's not how we live our lives. We really want to know what the patient is experiencing outside and in real life — driving in sunlight, driving in darkness, going to work. It's important that we prepare the patient for what they should expect and then follow up a couple of days later to see how they're doing. Again, we work with the team to manage the patient's expectations.

Dr. Lowinger: Involving ancillary staff makes them better staff members, because they want to learn. In fact, it also helps retain talented individuals, who can help your practice succeed.

Dr. Brimer: I agree. When we use their skills, we build the staff's confidence, exceed patients' expectations and grow the profit of the practice by executing specialty fits efficiently.

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>
> **— David L. Kading, OD, FAAO**

Dr. Lowinger: Also, I've found some patients are more comfortable asking questions of staff members. When your staff is prepared to answer questions, it adds to the value of your practice. Your staff is more empowered. Your patients are happier, and the result is a better outlook for your practice without doing anything other than giving someone part of the load to carry for you.

Dr. Brujic: Another fringe benefit is the more you engage your team members, the more responsibility they feel toward the patient's care. A staff member who follows up with a multifocal lens patient and hears positive feedback is likely to share those comments with other patients, preemptively educating them before you walk into the examination room.

Dr. Brimer: I've trained my staff to watch for patients who might benefit from multifocal technology and mention it to them. By the time they see me, I can simply ask, "Would you like to see distance and up close without your glasses?"

Dr. Schachet: Do you use your staff differently when fitting specialty lenses as opposed to standard spherical lenses? Do you feel you personally need to spend more time with specialty lens patients?

Dr. Kading: Do patients expect more "doctor time" because the fitting fee is higher? In my opinion, the patient is paying for the outcome, as well as the experience. As long as the doctor is involved in the process and doesn't have another team member do everything, I think it's fine to use your staff to the maximum capabilities for specialty lens fitting.

Dr. Schachet: That's an important point. Fitting multifocal contact lenses is an outcomes-based process, and if you can achieve the same outcome by using ancillary personnel versus what you do yourself, it makes good sense to do that.

Are You Ready to Begin?

Dr. Schachet: What advice would you give to colleagues who want to start fitting multifocal contact lenses? We've discussed how to educate patients and the importance of demonstrating the lenses. What else can practitioners do to achieve success?

Dr. Lowinger: First, decide to fit them. Then offer them to every patient. Start with the top lens in the category, we use AIR OPTIX® AQUA Multifocal contact lenses and use the Fitting Guidelines. We have about an 85% success rate with these lenses. Remember that not every contact lens fitting, whether it's a spherical lens, a toric lens or a multifocal lens, goes perfectly. Don't be discouraged if a small percentage of your patients don't do well or can't adapt to multifocal lenses. That doesn't mean the entire category is lost to you. It just means that like any other modality, it doesn't fit 100 percent of people. Two or three failures out of 20 successes shouldn't deter you from continuing to offer these lenses to your presbyopes. There are successes and there are challenges in anything we fit. Don't let the small challenges deter you from continuing, because as you get to 100 fits or 200 fits, you'll find many more patients are happy than are unhappy.

Dr. Brujic: I agree. You have to be committed to incorporating multifocal lenses into your practice. It's also important to make a commitment to your patients and to set some type of reference point for them. Explain that it takes about three visits for a successful multifocal fit. If by the second visit, the patient says, "This is perfect," you've exceeded his expectations and this is what happens most of the time. We all know that if you meet or exceed a patient's expectations, you'll have a happy patient. Setting proper expectations is key.

Dr. Lowinger: Practitioners new to the multifocal modality may spend a bit more time with a patient, but as they gain experience and become accustomed to the protocols in the fitting guides, chair time decreases. By the twentieth patient, or maybe sooner, what was challenging becomes effortless. The fittings become easier and the chair time — whether it's the

practitioner's or staff chair time — decreases.

Dr. Brimer: When you commit fully to fitting multifocal contact lenses, your confidence and your staff's confidence skyrockets, and your success rate increases. Everything is tied together and happens simultaneously. In addition, the patient's confidence in your abilities increases, which means more referrals.

Dr. Schachet: Essentially, what practitioners shouldn't do is draw a conclusion from a small population or single difficult fit. Are there certain patients who are more likely to be successes?

Dr. Brimer: Yes. Start with easy wins, for example, younger presbyopes. Start with your patients who are nice, the ones who have been loyal to you in the past and relate to you.

Dr. Lowinger: You may want to exclude certain patients from the conversation. For example, a patient for whom you've had to remake progressive spectacles five or six times because he's been unhappy may not be the patient with whom you should start your multifocal journey. You can easily fit a large percentage of your presbyopic patients with multifocals, but there will be certain patients who don't do well with it.

Tangible and Intangible Rewards

Dr. Schachet: What rewards have you realized from successfully incorporating multifocal contact lenses into your practices?

Dr. Brimer: Financially, of course, there are fitting fees and profits from the sales of annual supplies of contact lenses. We also see improved compliance with yearly examinations. We see real benefits, however, when patients talk about our practice in the community. When they're wowed by their experiences with us and excited by what we've done for them, they tell their friends and family members. They become evangelists for us. That attitude is easy to cultivate in a patient who's happily wearing multifocal contact lenses.

Dr. Lowinger: Referrals and loyalty may be the two most important practice-building rewards we realize from fitting multifocal contact lenses, but you'll realize other benefits, as well. For example, your communication skills will improve as you hone your multifocal message. In addition, your staff members will feel more engaged in your practice, because you're using a different modality, something that's cool and interesting for them to learn about and discuss with patients. Giving staff more responsibility empowers them to be better in every aspect of what they do. The big change in vision care is the shift to fitting new patients in multifocal contact lenses as opposed to monovision. This is essential in helping maintain your patients, as they may choose to go to a different practitioner if it's not offered to them initially.

Dr. Schachet: These are less tangible but important benefits that we've all experienced.

Dr. Lowinger: When you take on challenges — and I'm confident practitioners will find the latest multifocals aren't as challenging as they may think — and you master them, it's a high tide that floats all boats. You're building the kind of practice that you really wanted to have. To me, that's most important. It's not necessarily a particular modality that's responsible for this improvement. It has more to do with being the practitioner who does everything possible for patients. You have to try new products and make them your own, because if you don't, someone else will.

Dr. Brujic: When we optimize the patient's experience, we have practice growth. It's a simple equation: if a patient's perception of your practice and the products he acquires from you exceed his expectations, he's had a positive experience. With the AIR OPTIX® AQUA Multifocal contact lens, we have an opportunity to elevate our patients' perceptions of our care and the products we offer, which will inevitably lead to positive practice growth.

Dr. Lowinger: Here are two takeaways for anyone who is still unsure about incorporating multifocal contact lenses into practice: Number one, be patient as you start, because there's a learning curve, but it's a short learning curve. Number two, talk to your patients. Give them information. You'll be amazed at how a little bit of extra time makes a huge difference in the success of these contact lenses. By doing those two simple things, I predict a year from now, your practice will be more enjoyable and more successful than it is today.

Dr. Schachet: I want to thank our panelists for sharing their insights and practical advice on how to build and maintain a successful multifocal contact lens practice. It's often difficult to differentiate yourself in this fast-paced eyecare environment, but following these recommendations is a good way to start working toward this goal. ■

*Lipid deposit resistance compared to Biofinity^, PureVision^, ACUVUE^ OASYS^, ACUVUE^ ADVANCE^ and Avaira^ contact lenses.

**Compared to ACUVUE^ OASYS^, Biofinity^ and PureVision^ contact lenses.

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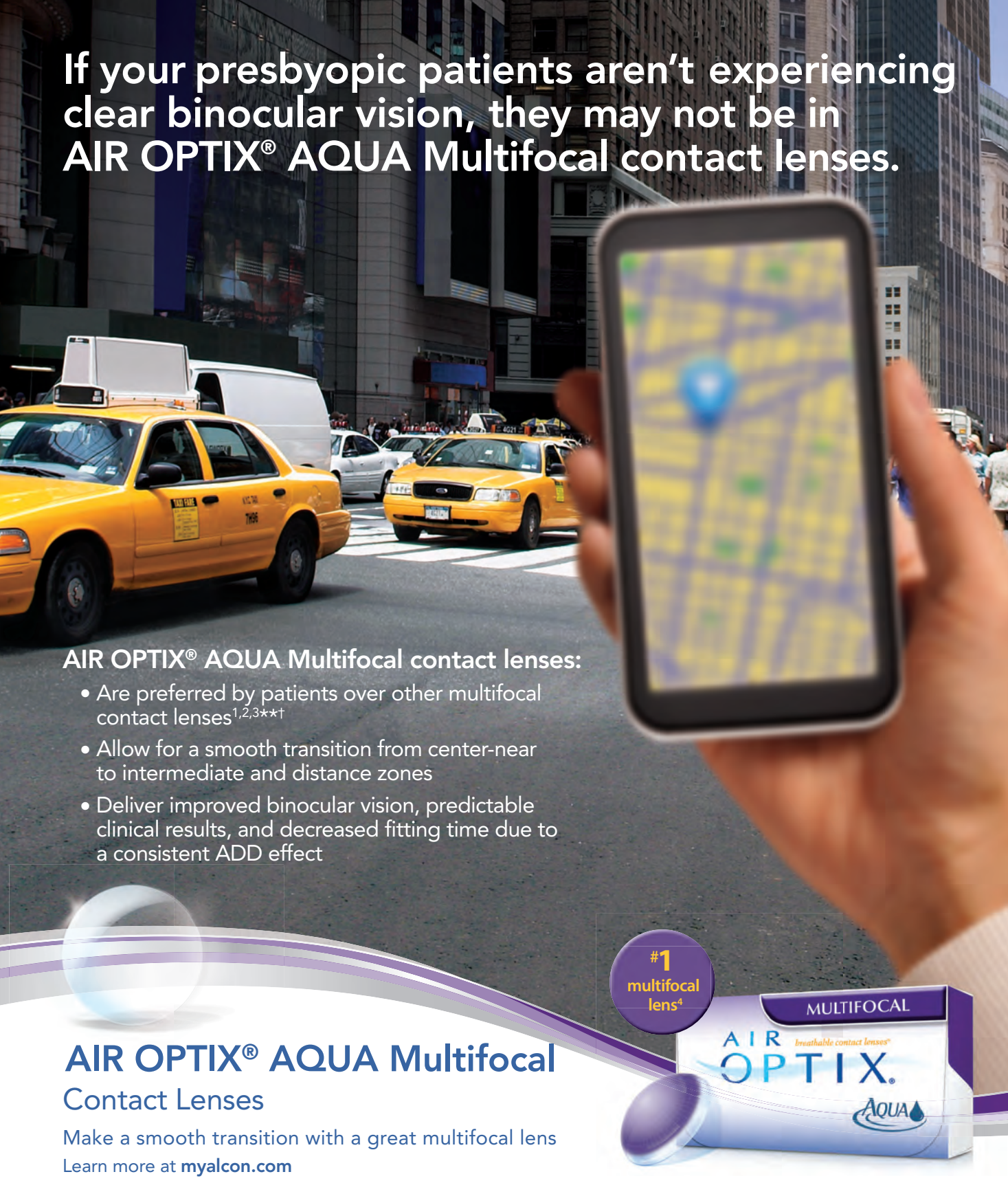
References

1. Based on third-party industry report, 15 months ending June 2012; Alcon data on file.
2. Nash W, Gabriel M, Mowrey-McKee M. A comparison of various silicone hydrogel lenses; lipid and protein deposition as a result of daily wear. *Optom Vis Sci* 2010;87:E-abstract 105110.
3. In vitro measurement of contact angles on unworn lenses; significance demonstrated at the 0.05 level; Alcon data on file, 2009.

See page 2 for Important Safety Information.

If your presbyopic patients aren't experiencing clear binocular vision, they may not be in AIR OPTIX® AQUA Multifocal contact lenses.



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References: 1. In a randomized, subject-masked clinical study at 20 sites with 252 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2009. **2.** Rappon J. Center-near multifocal innovation: optical and material enhancements lead to more satisfied presbyopic patients. *Optom Vis Sci.* 2009;86:E-abstract 095557. **3.** In a randomized, subject-masked clinical trial at 6 sites with 47 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2008. **4.** Based on a third-party industry report, 12 months ending October 2012; Alcon data on file.

See product instructions for complete wear, care and safety information.

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