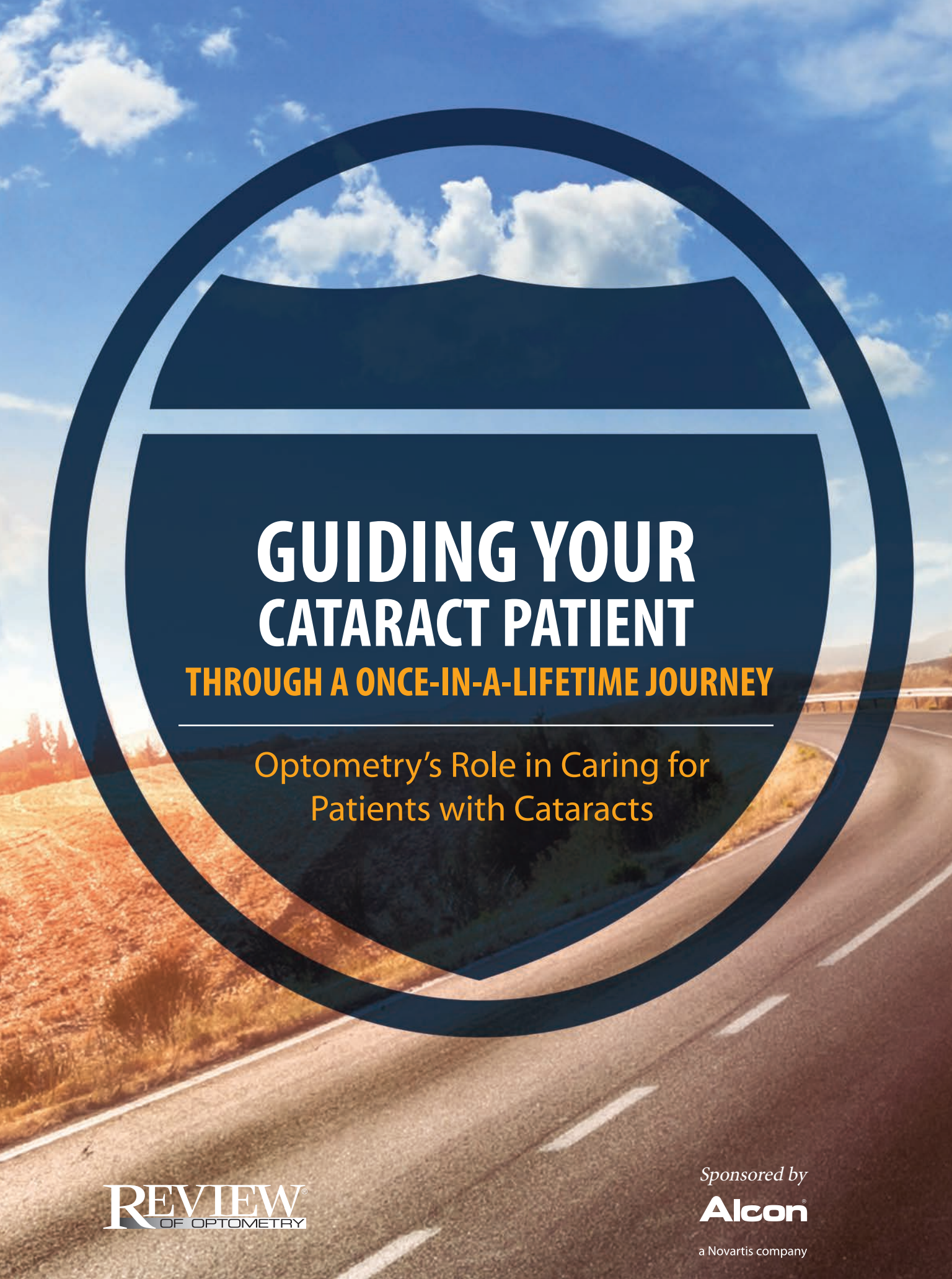

GUIDING YOUR CATARACT PATIENT

THROUGH A ONCE-IN-A-LIFETIME JOURNEY

Optometry's Role in Caring for Patients with Cataracts

REVIEW® OF OPTOMETRY

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PANELISTS

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Katie Gilbert-Spear, OD, practices at Sight & Sun Eyeworks, where she also serves as director of the practice's Visual Performance Center. She is the area director for the Special Olympics Opening Eyes program and is on the board of directors for Independence for the Blind.

Jim Owen, OD, MBA, is vice president of Business Development for nJoy Vision and owns a private optometric practice in Encinitas, Calif. He also serves as extern preceptor for the Southern College of Optometry in Memphis, Tenn.

Walter O. Whitley, OD, MBA, is the director of Optometric Services at Virginia Eye Consultants in Norfolk, Va., where his practice encompasses ocular surface disease, glaucoma, surgical comanagement, clinical research, practice development and the supervision of an extensive network.

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Why I Care™

Paul M. Karpecki, OD: In recent years, we've seen an obvious push for optometrists to become more closely involved with cataract surgery patients. How do you feel about caring for patients with cataracts and about this becoming a bigger priority for optometrists?

Jill C. Autry, OD, RPh: In primary care, the goal is to be the patient's eye care professional for virtually the entire life cycle—from the children to the elderly. Cataract is as much a part of that for optometrists as high blood pressure and diabetes is for primary care physicians.

Katie Gilbert-Spear, OD: I agree; continuity of care is so important. When we excuse ourselves from this care, we not only lose patients, we also lose the connection. With so many baby boomers approaching cataract age, this could have a significant effect.

Dr. Autry: Cataract is one of the most common maladies that you're likely to get as you age. As laser and intraocular lens (IOL) technology continue to evolve, there are more and more options that we need to understand so we are prepared to explain the choices to patients before they arrive at the surgeon's office. We need to educate the patient.

Walter O. Whitley, OD, MBA: Cataract care really is part of the essence of our profession. As primary care providers, we have been seeing these patients for years, and we know a lot about them. Walking them through this next stage is a natural progression. We can't just sit this part out. Cataract surgery can have a huge impact on our patients. I want to be a part of that by educating them and leading them down the right path so that their outcomes are as good as they can be.

Dr. Karpecki: Do you think it's an overstatement to say that cataract surgery can transform a patient's life?

Jim Owen, OD, MBA: Not at all. Most patients are amazed at what they can see afterwards. It's also important to note that this truly is a "once-in-a-lifetime" journey. You only get one shot at this decision. That's why thorough patient education is so important. Patients have an amazing opportunity, provided we make them aware of it. Modern cataract surgery truly is a life-changing event.

Prevalence

Dr. Karpecki: Now more than ever, aging patients need optometrists. The number of Americans with age-related eye disease and the vision impairment that results is expected to double within the next three decades.[1] If you have not already begun to experience the increase, you will soon. Of the total 104 million refractive eye exams performed annually by all eye-care professionals, ODs perform an estimated 88 million.[2] This presents an incredible opportunity for our profession and for our patients. But does it also create a new imperative, or a new standard, in optometric care?

Dr. Whitley: I believe it does. With the aging demographic, optometrists will be called upon to take a more active role in the care of our cataract patients. Patients look to us and want us to help guide them throughout their procedure—from preparing them for the cataract evaluation, discussing their IOL options, referring them to a surgeon who we trust, and discussing the postoperative care and expectations.

Dr. Autry: The expectations of the cataract patients are higher. There are very few complications in the hands of a good surgeon and generally, even when there are, these can be easily managed.

The Cataract Surgery Market at a Glance

- The number of Americans at risk for age-related eye diseases is increasing as the baby boomer generation ages. The number of Americans with age-related eye disease and the vision impairment that results is expected to *double* within the next three decades.[1]
- By 2020, the U.S. population over age 65 will account for 12.9% of the total population.[2]
- Beginning in 2011, the first of 78 million baby boomers (people born between 1946 and 1964) started the transition to retirement, kicking off an expansion in the number of elderly people that will continue for decades. According to the U.S. Census Bureau, one out of every nine baby boomers will live to be at least age 90.

1. Prevent Blindness America and the National Eye Institute, the 2012 "Vision Problems in the U.S." report. http://www.visionproblemsus.org/index.html. Accessed August 25, 2014.
2. http://www.allaboutvision.com/conditions/cataracts.htm

Dr. Owen: It's also important to recognize that cataract surgery has become a refractive procedure. We need to go into it with a refractive mindset, steering what we say to these patients and their surgeons to ensure that outcomes match expectations. Optometrists have an intimate understanding of each patient's individual goal, based on lifestyle, personality and functional vision.

Dr. Gilbert-Spear: We are an integrated clinic with four optometric locations and a central ophthalmology location, so I am fortunate to see both sides of the process. The key is communication between the optometrist, the patient and the surgeon.

Dr. Karpecki: To summarize our thoughts on this, it appears that the entire cataract landscape is at the brink of substantial change. On one hand, we have new technology that makes the primary care optometrist's role more vital than ever before. And, on the other hand, we are bracing ourselves and preparing for a tremendous swell in volume. I think we can all agree that if practice protocols have not yet changed, they need to—and soon. Those optometrists who act right away have a unique opportunity to truly differentiate their practices, while preparing for an inevitable future.

Here to Help

Dr. Karpecki: We've established that new technology has necessitated increased patient education and more intimate, detailed history analysis. Do you expect that ophthalmologists will continue to manage the lion's share of the preoperative and postoperative workups to the same extent they have historically?

Dr. Owen: Research shows that demand for surgical eye procedures is increasing (driven by the aging population and Affordable Care Act coverage), yet the number of practicing ophthalmologists will remain flat.[3] We're reaching a point at which the manpower in ophthalmology just doesn't exist for all of the preoperative and postoperative care that's needed.

Dr. Whitley: If you look at the math, in order to meet the needs of the growing population of patients with serious eye conditions, ophthalmologists would need to increase their productivity by an average of 17.3%.[3] While there may be exceptions in certain markets, many ophthalmologists are already maxed out, yet they are being called upon to do more surgery. The last thing these MDs want is for us to essentially dump uninformed patients in their laps. As the initial point of contact, the optometrist can be there to help patients recognize the opportunity that cataracts present so that every patient can be prepared when it is time to make a final informed decision with their surgeon.

"Optometrists who act right away have **a unique opportunity** to **truly differentiate** their practices while preparing for an inevitable future."
—Paul M. Karpecki, OD

Dr. Autry: The history and in-depth understanding of the patient is critical and we can't take shortcuts just because there are more patients walking through the door. Primary care ODs need to be there to gauge the patient or size him up, so to speak. This is an incremental process that occurs over the course of many visits.

Dr. Karpecki: What information do ophthalmologists need that can't be garnered in a 15-minute consult? What details do optometrists have that can help ophthalmologists make an IOL selection?

Dr. Autry: To begin, it's important to know how patients wear their correction now. Do they use the same correction all the time? Do they take their glasses off sometimes? What do they do for a living and how do their visual demands affect their job performance? Remember, patients aren't only living longer; they are working longer too. Lifestyle is also important. What about their current vision are they unwilling to sacrifice? What would they change if they could? The primary care provider knows the background and is the only person who can say to the surgical center, "you do not want to put a multifocal in this guy—he returns every pair of glasses three times." Poor clinical choices can be easily avoided with closer OD involvement.

Dr. Whitley: I would say unequivocally that optometry needs to play a more active role in caring for cataract patients. The quality of patient care that can be provided in our current healthcare system truly depends on it.

Dr. Gilbert-Spear: I agree. And playing a more active role also represents a great opportunity for optometry. As far as the importance of continuity of care, there's no reason for a patient to show up at the surgical center completely uninformed about their options. We're not taking anything away from the surgeon by educating our patients on laser-assisted cataract surgery and advanced technology IOLs (ATIOLs), especially toric IOLs. We're streamlining care, ensuring continuity and creating patients for life.

Dr. Karpecki: I couldn't agree more. This is an outstanding opportunity for everyone involved and we're already starting to see the beginnings of it. In fact, Market Scope reports a 24% increase in the projected number of cataract procedures (IOLs) that will be performed between 2008 and 2015.[3]

Current OD and MD Roles

Dr. Karpecki: Optometrists refer 40% of all cataract surgery patients to the surgeon.[4] Yet despite this staggering statistic, there are currently no new guidelines for the optometrist's role in cataract patient management prior to sending them. Would you say that many optometrists don't discuss lens options because they believe the ophthalmologist is having this conversation with the patient?

Dr. Whitley: That may be the assumption, but it's often not correct. In fact, research shows that patients may be acquiring more knowledge from relatives and friends (77%) as opposed to their physician (40%).[5] Furthermore, this same study shows that only 23% of patients with cataracts say different lens options had been discussed. Following surgery, 75% indicated that they understood their lens and vision options—one-quarter did not.[5] This is a gap that we, as optometrists, can fill. There is no reason why 35% of patients about to undergo cataract surgery should be reporting that there has been no discussion about the possibility of wearing glasses less often after surgery.[5] Patients are looking to us for guidance throughout their cataract journey and looking for our recommendations.

Reality Check

Most optometrists consider themselves knowledgeable on cataract surgery, however:

- < **40%** consider themselves *highly* knowledgeable on IOL options and only **42%** are comfortable making an IOL recommendation.
- >**38%** of ODs *never* make an IOL recommendation to patients being referred out for cataract surgery.

*OD and PCP Opportunity Assessment – Jan 7, 2013, + Review of Optometry Readership Study, 2013 & 2014, ^ Cataract referral Activity Report – May 29, 2014

Dr. Autry: I agree. ODs need to get in there and start doing it. It may seem awkward at first, but we shouldn't feel any hesitation about picking up the phone and calling the surgeon that we send our patients to. If you think your patient is, or is not, a candidate for a specific lens design, let the surgeon know and explain your reasoning.

Dr. Gilbert-Spear: Having a comfortable relationship with your surgeon is more important now than it ever was. We encourage our doctors and our referring doctors to spend time with our surgeons in the clinic and in the operating room.

Dr. Karpecki: Indeed, too many of our colleagues remain passive in terms of the decision-making, leaving everything up to the surgeon. Can you imagine that there are actually

patients who say they have no idea that a lens will be or has been put in their eyes? We need to step in and prevent this from happening.

Dr. Owen: We sometimes take for granted what we deal with every day—like driving home the fact that a lens will be exchanged. It sounds so simple, but it's the door to the bigger discussion about choosing a lens that will improve functional vision and why this is a critical moment in their lives that requires some decision-making.

The Easiest Place to Start

Dr. Karpecki: As a profession, we're all in different places with respect to how involved we are and what duties we perform when helping to care for cataract patients. Would you say that's okay as long as we have a solid understanding of current technology and we make sure that someone educates patients on the available options prior to surgery?

Dr. Gilbert-Spear: I would agree provided the patient absolutely knows he has a choice. The worst thing is for a patient to find out after the surgery that he had other options.

Dr. Whitley: Yes, but if you are not doing it yourself, ensuring this requires a very good relationship with the surgeon. Communication is key to ensure you and your surgeon are on the same page. You need to have spent time in the practice and know what goes on there—day in and day out—so you can be certain that every patient you send understands the choices. There also should be open dialogue and comfortable discussion between the surgeon and the referring OD. Generally though—when these good MD/OD relationships exist—optometrists are quick to discover that the surgeon would prefer that we handle initial discussions about lens and laser options. It's a big time-saver for the MD.

Dr. Karpecki: Let's talk about where optometrists currently stand. Most consider themselves knowledgeable on cataract surgery, but only about 40% would consider themselves highly knowledgeable on IOL options and comfortable making an IOL recommendation.[6]

Dr. Gilbert-Spear: Hopefully, over time, education will tip that scale in the other direction. Optometrists are ideally suited to explaining the functional vision benefits of different types of IOL options. At a minimum, some written information and resources can be provided.

Dr. Whitley: We need to talk to our patients about their IOL options and provide them education material so they can do their homework prior to their cataract evaluation. It's important to put the information in the patient's hands to get them thinking about the choices they'll be faced with when they arrive at the surgery center. In fact, research shows that patients who believe they are actively included in the decision-making process are more satisfied with their outcomes.[5]

Dr. Karpecki: Most of our colleagues aren't going to go from zero to 60 overnight. It's a process. Do you have any advice on a good place to start or an effective first step?

Dr. Gilbert-Spear: I think toric IOLs are a good way to ease in. If you've been correcting for astigmatism with spectacles or contacts, then AcrySof® IQ Toric† (Alcon) IOL is a no-brainer. It's a basic concept that we're all comfortable and familiar with, so it's a good segue into advanced technology procedures, and it gets you used to having the conversation and working it into your practice routine.

Dr. Owen: I agree, but would add that the first step is practicing

"The optometrist can be there to help patients recognize the opportunity that cataracts present so that every patient can be prepared when it is time to make a final informed decision with their surgeon."
— Walter O. Whitley, OD, MBA

†Please refer to page 11 for important product information.

optometry in accordance with the reality that cataract surgery is now refractive surgery. When you know this and make it a part of your practice, having a discussion about toric IOLs is the easiest thing to do. I simply explain that this is how we correct the distance vision.

Dr. Karpecki: Clearly, it would make no sense to put an astigmatic contact lens wearer into a spherical lens and then hand them a pair of glasses for the astigmatism. Similarly, you shouldn't mask astigmatism with a standard spherical IOL. With that in mind, shouldn't presenting a toric IOL be as standard and commonplace a practice as is selecting a toric contact lens?

Dr. Gilbert-Spear: Definitely. I think it's the same standard of care. When a toric IOL is available, recommend it. With today's technology, I feel all my patients deserve to have the best and, at minimum, they deserve to be offered the best.

Dr. Whitley: Toric IOLs can be great options for our astigmatic patients who have ≥0.75D of astigmatism. Many patients have heard about astigmatism and know that they have it corrected in their spectacles or contact lenses. This makes the discussion much easier by letting them know that we can correct it with surgery. If they don't know about it already, then we have the discussion on how astigmatism will affect their vision after cataract surgery.

Dr. Owen: The only way you're going to get the astigmatic patient to see at distance without glasses is by correcting the astigmatism. So the conversation with the patient is really very simple. All you have to say is, "If you want us to correct your distance vision, we can do that. Here's how."

Dr. Karpecki: This brings up a great point about how patients' expectations nowadays are much higher than they once were. Now, they have friends who have had cataract surgery, and they come in and tell us about how their friend no longer wears glasses.

Dr. Gilbert-Spear: I would never want a patient to learn about a technology somewhere else. I would hate for my patient to have cataract surgery and come back to me and say, "My friend had a toric IOL put in, and she sees fantastically. Why was that not mentioned to me?" The notion that some eye-care practitioners might be concerned about loosing spectacle lens sales rather than delivering the best patient care seems ludicrous when you consider the effect that patients who've missed an opportunity can have on your practice.

Dr. Whitley: One final point I'd like to add regarding toric IOLs is that, during our evaluation, it is important to obtain corneal measurements preferably with either manual keratometry or corneal topography. Although our patient's current spectacle or refraction may show some astigmatism, the only astigmatism that matters during cataract surgery is from the corneal measurements. Lenticular astigmatism is not factored into the IOL calculations because this is removed during the surgery.

Cataract Refractive Surgery: the New Normal

Dr. Karpecki: As Dr. Owen has highlighted, cataract surgery is a refractive procedure. In fact, I'd say cataract refractive surgery is the new normal. And part of this big picture is the increased use of femtosecond lasers in cataract surgery. How much patient interest do you see in your own practices for laser cataract?

Dr. Autry: When we looked at acquiring a laser for our practice, I thought, "Really? How much is this going to be used?" But, to my relief, our surgeons probably do 60% to 65% laser cataract surgery now. And, in the hands of the surgeons who I work with, the outcomes are very good. In that regard, I think it's an easy discussion with most patients as long as the price point is reasonable.

Dr. Gilbert-Spear: We were shocked to see how many of our patients wanted laser–assisted cataract surgery. I do not practice in a particularly affluent area, yet our surgeons perform most of our surgeries with the LenSx® Laser† (Alcon) now. It's a real paradigm shift because it takes cataract surgery out of the realm of a basic covered service into a premium one that almost all of our patients are interested in. It's remarkable.

Informed Decisions Are Key

- To make a truly informed decision, patients need to understand the difference between IOLs—and why ATIOLs are worth the investment.
- Remind patients that choosing their IOL is an important decision—they'll only get to make the choice once, and it will affect their vision for the rest of their life.
- To really make an impact, convey the specific benefits of the lens you've recommended, so they'll remember why this lens is right for them.

†Please refer to page 11 for important product information.

Timing is Everything

Dr. Karpecki: What stage in the disease process do you believe is the most appropriate time to start discussing cataract surgery with your patients?

Dr. Owen: It's best to bring up cataracts as soon as you begin to see a lens change—even if it's in a late 50-year-old.

Dr. Gilbert-Spear: I would agree. What if the patient sees another provider for some reason and that other doctor mentions the cataract? Your patient is going to question your knowledge and wonder why you missed it.

Dr. Karpecki: How do you feel about letting a decrease in visual acuity guide the timing of the discussion?

Dr. Owen: Even when I can correct to 20/20, I start talking about cataracts as soon as I see lens changes. I want to prepare the patient for the future and let him know that there will be a point when we can't get to 20/20. This gives the patient time to plan, learn about the technology, and weigh the options.

Dr. Whitley: Educated patients tend to be more satisfied with their outcomes,[5] so starting the discussion early definitely helps ensure this level of satisfaction postoperatively. And, also consider that a cataract does not only affect vision, it affects daily life and activities. It's important to ask patients about their vision during tasks such as reading or driving at night and factor these responses into your decision on when to recommend surgery.

Dr. Gilbert-Spear: I think perhaps some optometrists hesitate to mention it right away because they don't want to alarm their patients by delivering what, in their minds, might be perceived as bad news.

Dr. Owen: Exactly. But having cataracts is not bad news. In fact, it's great news because their once-in-a-lifetime opportunity has arrived. I let my patients know this right away and we celebrate the opportunity.

Dr. Gilbert-Spear: We recently had one of the senior executives from the local hospital in with a mild cataract that was affecting his night vision as well as his vision working on the computer. He opted for a multifocal IOL with laser-assisted cataract surgery using the LenSx® Laser†. He is ecstatic about his "new" vision, and the goodwill at the surgery center and patients he sends is fantastic.

Dr. Karpecki: In terms of the diagnosis and referral to a surgeon, would you say visual acuity has to drop to a certain level before it really begins to have an impact on quality of life?

Dr. Gilbert-Spear: Many of us were taught that 20/40 is the magic number and you don't refer until you get there. But, I think this is an outdated standard. I've had patients who clearly have symptoms, and when I perform glare testing, sure enough, they're ready for surgery. The hospital executive I mentioned earlier is a great example. I tell my patients that, when I am not able to correct their vision so that they can do everything they want to do, it is time to discuss cataract surgery. With today's active lifestyles the time is becoming earlier and earlier.

Dr. Karpecki: Yes, but the reality is that many offices don't have access to glare testing.

Timing Surgery Based on Quality of Life Concerns

Although cataracts may not affect visual acuity, it may affect quality of life. Appropriate diagnosis of cataracts includes:

- contrast sensitivity testing
- glare testing
- questioning the patient regarding the effects of vision on his or her lifestyle.

Earlier treatment of cataracts shows significant benefits in terms of both patient safety and quality of life. In fact, research shows patients wish they would have had surgery sooner, based primarily on their improved quality of life postoperatively.[1]

1. Henderson BA, Solomon K, Masket S, et al. A survey of potential and previous cataract-surgery patients: what the ophthalmologist should know. Clin Ophthalmol. 2014;(8):1595-1602.

Dr. Gilbert-Spear: True, but there are other ways to tease out that information. There are certain questions we could ask that uncover these functional vision challenges.

Dr. Autry: We give patients a questionnaire that helps us uncover this information. We ask questions such as, "Do you have more trouble driving at night than you do during the day?" and, "Do you need more light to read?"

Dr. Whitley: Another simple glare test that we can perform is using our penlight or binocular indirect ophthalmoscope. With the patients' best-corrected vision, we can shine the light into their eyes, which will give us an idea of the impact the glare can have. A common example where patients may have fairly good vision but

are affected significantly by glare are those with central posterior subcapsular cataracts or cortical cataracts. In these cases, cataract surgery may be warranted with proper documentation.

Dr. Karpecki: I think we all agree that making an early diagnosis is an achievable goal, and sharing this diagnosis with the patient can only help in the months and years ahead. After all, how many patients return and say they wish they waited longer to have surgery? On the contrary, almost everyone returns saying, "I see so much better. I wish I had this done sooner."

Patient Education

Dr. Karpecki: Considering that laser cataract surgery is such a new area of innovation, have you developed a way to present it in easy-to-understand terms?

Dr. Autry: I always begin by taking out the model and explaining what cataract is. Then, when I get to the part where I explain that we need to remove the lens, I simply add that we can do this in one of two ways. We can go in the way we've done it for years—which is with a blade that's used to make cuts on the eye so we can remove the lens—or we can use the higher technology that is available today by performing laser cataract surgery. Then, I explain the advantages that the laser has compared to using a blade. For starters, I explain that the laser is more precise than traditional cataract surgery.

Dr. Owen: As professionals, we have a tendency to overcomplicate things. I learned this from one of my patients soon after our surgeons started using the LenSx® Laser.† I went into a pretty detailed discussion, and when I finally stopped talking, the patient looked at me and said, "So, all things being equal, the laser is better." No sooner did I say, "yes" then he made up his mind: "Then, let's just go with that."

Dr. Gilbert-Spear: I agree; we have to simplify it—for patients as well as for ourselves. Yes, it's new, but I look at it and explain it in the same way I would custom laser refractive surgery, which I'm comfortable describing because we've been doing that for years. You can differentiate it the same way you did with refractive surgery. Patients are scared of blades and also take a lot of comfort in hearing that lasers are more precise. We pride ourselves on being the bladeless alternative for both cataract and LASIK surgery.

Dr. Whitley: Keeping it simple is key. When it comes to explaining the laser, we need to talk about the benefits of the femtosecond laser technology. Laser cataract surgery takes surgery to the next level by improving the consistency and predictability of the procedure during the capsulorhexis, lens fragmentation, and corneal incisions. These benefits, coupled with the toric and multifocal IOL, can provide our patients optimal outcomes. In our practice, we've compared our outcomes between manual versus laser assisted cataract surgery and the laser procedure has delivered. Nonetheless, we must remember that not everyone can have the laser procedure. It is an elective procedure, which is combined with premium IOLs.

Dr. Karpecki: We talked earlier about diagnosing the cataract early and mentioning the existence of the cataract to the patient, but is it reasonable to also educate patients about their IOL options at that time?

Have an Informed Discussion with Patients

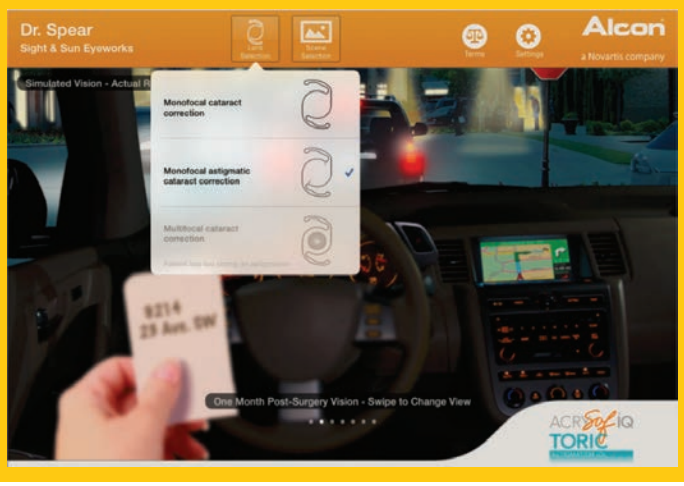
- **Mitigate** fears by explaining that cataract surgery is one of the safest and most effective outpatient procedures and that less invasive techniques have resulted in faster recovery times. Still, although cataract surgery is generally a safe and effective procedure, it's still surgery, and that comes with its own set of precautions, risks and considerations that you should discuss with your patients.
- **Communicate** that while the procedure itself isn't a huge deal, the choice of lens is a big deal and has significant impact on the outcome.
- **Inform** them about the benefits of the procedure in *patient* terms, not technical terms.
- **Highlight** stories of patients who didn't realize how much of their vision they had lost before surgery and had a positive outcome.

Dr. Gilbert-Spear: I bring it up the first time I diagnose the cataract because, by discussing it early, you can turn the whole thing into a positive instead of a negative. As you know, sometimes, the patient is shocked when you tell him he has cataract. He might look at you like you just told him he was blind. In fact, this is the best opportunity to quickly segue into why it's such a great time in history to be having cataract surgery. I get that patient excited by explaining that there are so many options now that it's like having refractive surgery. Then, I talk about either torics or multifocals, depending on the patient's individual needs and history. By the end of the talk, most patients leave the office exited about having cataracts. They

†Please refer to page 11 for important product information.

Education App Helps Doctors Simulate Vision with Various IOLs

The AcrySof® IOL Vision Simulator is an iPad-optimized tool to help eye-care professionals educate cataract patients about their different IOL options. The app uses a patient's cataract and vision diagnosis to simulate vision before and after cataract surgery using monofocal and ATIOL options. Different scenes are available to simulate near, intermediate and distance vision, and to simulate vision conditions in nighttime settings. The app is free in the iTunes store. Simply search ALCON in the iPad apps.



can't wait until that day comes when I refer them for surgery.

Dr. Karpecki: That's a great point. We can get these patients to see like they've never seen before or with less dependence on glasses than prior to surgery. Cataract development may, in fact, be the best thing that can happen to them.

Dr. Owen: It's funny. I now have patients whose first question at every exam is, "Are my cataracts bad enough for surgery yet? I was hoping I can have surgery." That's because we made them aware of what it can do. We brought up the IOL options early on and the anticipation mounted.

Dr. Karpecki: Are there any other benefits to discussing IOLs at the time of diagnosis?

Dr. Owen: I think it helps in patient selection because you have an opportunity to see the patient several more times before they undergo surgery, you can get a sense of how they perceive their options. For example, do they really understand the benefits and limitations of their preferred option? Particularly with a multifocal, it's very helpful to have time to get a better sense of the patient as opposed to being in a situation where that patient has to decide in a matter of weeks. There are also some very helpful patient education materials that you can order free at www.myalcon.com/cataractresources.

Dr. Karpecki: Do you make a specific IOL recommendation?

Dr. Autry: Yes. I've found that it's very helpful to make a recommendation.

"Like everything else, **cataract surgery and the lenses that are implanted have come a long way.** When you see the surgeon, he will discuss all the options and decide which is best for you. I will forward him my notes as well. I would recommend that you really consider the lenses that correct your astigmatism. If you were someone in my family, I would want you to have that lens."

—Katie Gilbert–Spear, OD

I write it all down on a little piece of paper that they take with them and I also include their interest in the LenSx®† Laser on this slip.

Dr. Karpecki: Do you worry that they may get to the surgeon and find out that they're not a candidate? How does that reflect on the optometrist and might that make it harder for the surgeon?

Dr. Owen: Of course our number-one fear is being contradicted. But, we're not writing a prescription. We're letting the patient know that he might be a candidate. We're simply giving a tangible reminder to the patient so they don't forget to ask the surgeon about the option we discussed. I write it on the flip side of my business card. And, of course, I always remind the patient that the surgeon will make the final decision. And most of the time, the surgeon is thrilled because he doesn't have to spend 20 minutes explaining and answering questions. He knows you've already done that because it's written on the card.

Dr. Gilbert-Spear: We do the same thing. We put in our note so the surgeon knows that we've already explained the option.

Dr. Whitley: As primary eye-care providers, we are best suited to make a recommendation as to what visual outcome will meet our patients' lifestyle demands. When it comes to personality and lifestyle, the surgeon only knows what we tell him.

Dr. Karpecki: That's an important point. Lasers and advanced technology lenses provide an exciting wealth of opportunity for patients and practitioners alike. But with those benefits come responsibilities. We need to communicate with the surgeons with whom we share care because, put simply, it's in the best interest of our patients. Cataract refractive surgery is the new normal and it can make a big difference in our patients' lives. But it is up to us, as primary care providers, to make sure that we make this once-in-a-lifetime opportunity accessible to every patient who might be a candidate.

Take Action

Dr. Karpecki: As was mentioned earlier in our discussion, sharing in the care of cataract patients will soon be commonplace in optometric practices, so getting a head start by beginning to make adjustments is a marvelous opportunity to differentiate your practice and position yourself as an expert and a leader. We spoke briefly about starting with toric IOLs. Beyond that, do you have any advice on some of the small initial steps that are key to successfully moving ahead?

Dr. Whitley: Reach out to your surgeon and talk to them about the different IOL options and ask them about the technology they are currently using. Whether it's toric, accommodative or multifocal technologies and laser cataract surgery, we need to be on the same page. We all want what is best for our patients and it is important to continuously evaluate the technologies that are currently available and discuss what is to come. Understanding who is a good candidate for toric and premium IOLs and those who would be better served by a standard IOL will help maximize outcomes and expectations. By having this discussion and understanding, it shows that we are an integral part of the cataract journey, we can provide state-of-the-art care, and we can offer our patients the best technology that is available.

Dr. Gilbert-Spear: Designate a cataract counselor or point-person. Just as we have optical staff who can educate and explain glasses, we have found that having a point-person to manage all of our referrals is valuable to the patient and the practice. Our referral coordinators track all of the outgoing patients and follow-up to ensure appointments are kept. They develop a great working relationship with other providers and are a great touch point for our patients so that they know we are coordinating their care and not getting rid of them. ■

Why Make a Recommendation?

- Patients look to optometrists to educate them on their IOL options.
- Proper education and your strong recommendation instill confidence in the patient and his IOL decision.
- The sooner you start the discussion, the more time patients have to carefully consider their options. Then they are less likely to feel as though a decision was made for them and that they had no choice in the matter.
- Educate your patients well before decision-making time.
- Patients who believe they are actively included in the decision-making process are more satisfied.[1]

1. Henderson BA, Solomon K, Masket S, et al. A survey of potential and previous cataract-surgery patients: what the ophthalmologist should know. Clin Ophthalmol. 2014;(8):1595-1602.

1. Prevent Blindness America and the National Eye Institute, the 2012 Vision Problems in the U.S. report. http://www.visionproblemsus.org/index.html. Accessed August 25, 2014.)
2. American Optometric Association and Jobson Medical Information. The State of the Optometric Profession: 2013.
3. Harmon D, Merritt J (Market Scope, LLC). Demand for Ophthalmic Services and Ophthalmologists—A Resource Assessment. April 2009.
4. IMS Consulting. Alcon Cataract Patient Journey. December 10, 2013. Data on file.
5. Henderson BA, Solomon K, Masket S, et al. A survey of potential and previous cataract-surgery patients: what the ophthalmologist should know. Clin Ophthalmol. 2014;(8):1595-1602.
6. OD and PCP Opportunity Assessment – Jan 7, 2013.

IMPORTANT PRODUCT INFORMATION

AcrySof® IQ Toric Intraocular Lenses

CAUTION: Federal (USA) law restricts this device to the sale by or on the order of a physician.

INDICATIONS: The AcrySof® IQ Toric posterior chamber intraocular lenses are intended for primary implantation in the capsular bag of the eye for visual correction of aphakia and pre-existing corneal astigmatism secondary to removal of a cataractous lens in adult patients with or without presbyopia, who desire improved uncorrected distance vision, reduction of residual refractive cylinder and increased spectacle independence for distance vision.

WARNING/PRECAUTION: Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the risk/benefit ratio before implanting a lens in a patient with any of the conditions described in the Directions for Use labeling. Toric IOLs should not be implanted if the posterior capsule is ruptured, if the zonules are damaged, or if a primary posterior capsulotomy is planned. Rotation can reduce astigmatic correction; if necessary lens repositioning should occur as early as possible prior to lens encapsulation. All viscoelastics should be removed from both the anterior and posterior sides of the lens; residual viscoelastics may allow the lens to rotate.

Optical theory suggest, that, high astigmatic patients (i.e. > 2.5 D) may experience spatial distortions. Possible toric IOL related factors may include residual cylindrical error or axis misalignments. Prior to surgery, physicians should provide prospective patients with a copy of the Patient Information Brochure available from Alcon for this product informing them of possible risks and benefits associated with the AcrySof® IQ Toric Cylinder Power IOLs.

Studies have shown that color vision discrimination is not adversely affected in individuals with the AcrySof® Natural IOL and normal color vision. The effect on vision of the AcrySof® Natural IOL in subjects with hereditary color vision defects and acquired color vision defects secondary to ocular disease (e.g., glaucoma, diabetic retinopathy, chronic uveitis, and other retinal or optic nerve diseases) has not been studied. Do not resterilize; do not store over 45° C; use only sterile irrigating solutions such as BSS® or BSS PLUS® Sterile Intraocular Irrigating Solutions.

ATTENTION: Reference the Directions for Use labeling for a complete listing of indications, warnings and precautions.

LenSx® Laser

CAUTION: United States Federal Law restricts this device to sale and use by or on the order of a physician or licensed eye care practitioner.

INDICATION: The LenSx® Laser is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, phacofragmentation, and the creation of single plane and multi-plane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during the same procedure.

RESTRICTIONS:
- Patients must be able to lie flat and motionless in a supine position.
- Patient must be able to understand and give an informed consent.
- Patients must be able to tolerate local or topical anesthesia.
- Patients with elevated IOP should use topical steroids only under close medical supervision.

CONTRAINDICATIONS:
- Corneal disease that precludes applanation of the cornea or transmission of laser light at 1030 nm wavelength
- Descemetocele with impending corneal rupture
- Presence of blood or other material in the anterior chamber
- Poorly dilating pupil, such that the iris is not peripheral to the intended diameter for the capsulotomy
- Conditions which would cause inadequate clearance between the intended capsulotomy depth and the endothelium (applicable to capsulotomy only)
- Previous corneal incisions that might provide a potential space into which the gas produced by the procedure can escape
- Corneal thickness requirements that are beyond the range of the system
- Corneal opacity that would interfere with the laser beam
- Hypotony or the presence of a corneal implant
- Residual, recurrent, active ocular or eyelid disease, including any corneal abnormality (for example, recurrent corneal erosion, severe basement membrane disease)
- History of lens or zonular instability
- Any contraindication to cataract or keratoplasty
- This device is not intended for use in pediatric surgery.

WARNINGS: The LenSx® Laser System should only be operated by a physician trained in its use.
The LenSx® Laser delivery system employs one sterile disposable Patient Interface consisting of an applanation lens and suction ring. The Patient Interface is intended for single use only. The disposables used in conjunction with ALCON® instrument products constitute a complete surgical system. Use of disposables other than those manufactured by Alcon may affect system performance and create potential hazards.
The physician should base patient selection criteria on professional experience, published literature, and educational courses. Adult patients should be scheduled to undergo cataract extraction.

PRECAUTIONS:
- Do not use cell phones or pagers of any kind in the same room as the LenSx® Laser.
- Discard used Patient Interfaces as medical waste.

COMPLICATIONS:
• Capsulotomy, phacofragmentation, or cut or incision decentration • Incomplete or interrupted capsulotomy, fragmentation, or corneal incision procedure • Capsular tear • Corneal abrasion or defect • Pain • Infection • Bleeding • Damage to intraocular structures • Anterior chamber fluid leakage, anterior chamber collapse • Elevated pressure to the eye

ATTENTION: Refer to the LenSx® Laser Operator's Manual for a complete listing of indications, warnings and precautions.

Alcon®

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