FIXING THE TOPICAL WOUND-CARE **BRAND CHOICE** DRIFT

A clinic-embedded case-study playbook to make Brand UMI the default in everyday wound care

Executive Summary

THE DRIFT DEFINITION

Brand UMI sits in a category where clinical pathways are largely standardized.

Minor wound care is among the most common use cases in primary care. Cuts, scrapes, abrasions, and minor burns are clinically straightforward. The science is settled, the therapeutic intent is clear, and there is little debate at the point of care.

On paper, this should make brand choice predictable. In reality, it makes it fragile.

Brand UMI operates in a high-volume environment where wound-care decisions are made quickly and with minimal cognitive load. Advice is brief, largely verbal, and rarely revisited. Once a doctor decides that topical wound care is required, the category decision is complete – and brand choice is resolved almost immediately. At that moment, Brand UMI is not rejected or questioned. It is simply not anchored.

Brand selection defaults to what feels standard, familiar, and already embedded in the doctor's routine – a default that is often reinforced later by pharmacy substitution or parental assumptions. As a result, Brand UMI loses not on science, not on trust, and not on clinical suitability, but on absence from the period where defaults are reinforced. That period begins the moment the patient leaves the clinic.

Traditional brand responses do not correct this. Additional product messaging, reminder cards, or wound-care education raise confidence in the category as a whole, but disproportionately strengthen entrenched defaults. From the brand's perspective, this means paying for category lift while competitors capture habit.

The issue does not lie in knowledge or persuasion. It lies in how Brand UMI's value is carried forward once care leaves the clinic.

The strategic question for Brand UMI is therefore narrow and specific:
How can Brand UMI be experienced by doctors as the default wound-care brand – not through more messaging, but by owning the follow-up phase where outcomes and habits are actually formed?

This is not a scientific limitation or a persuasion gap. It is a brand choice challenge shaped by workflow, follow-up, and default reinforcement – and it must be addressed at that level.

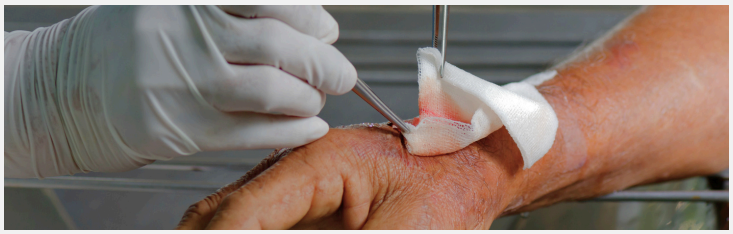
Market Reality

THE GUIDELINE-REALITY GAP

For Brand UMI, the clinical framework for wound care presents no constraint. Standard guiFor Brand UMI, the clinical framework for wound care presents no constraint. Standard guidance is well established and consistently applied during the consultation. The challenge lies in what follows after the patient leaves the clinic.

In real-world practice:

- advice is delivered once,
- execution shifts to the home,
- follow-up depends on parents recognising and reporting change,
- and early infection signals are frequently missed or delayed.



Guidelines define what good care looks like. They do not govern how reliably it is carried out after the visit.

Once the patient leaves the clinic, wound care becomes parent-dependent. Healing, deterioration, or infection unfolds outside the doctor's view — and outside the brand's line of sight. When healing is uneventful, Brand UMI remains invisible. When problems emerge, the brand is often judged retrospectively, without having had any role in monitoring or intervention.

This creates a structural disadvantage for the brand:

- Correct advice is given in-clinic,
- but brand value is constructed post-visit, without clinic or brand visibility.

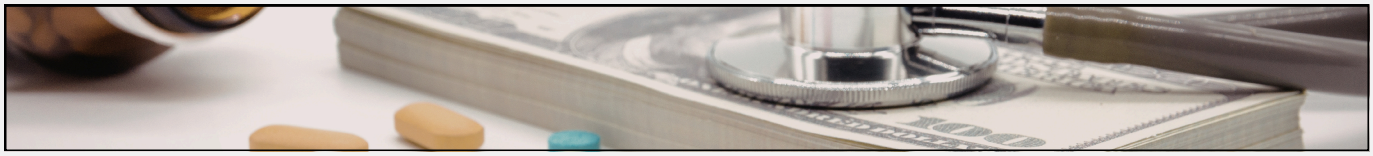
Brands that do not participate in this follow-up window struggle to become default, regardless of whether they were initially recommended. Over time, this reinforces substitution, habit drift, and weak brand stickiness.

For Brand UMI, the gap is not educational. It is operational and behavioral, concentrated in the Day 1 to Day 5 window - where outcomes are shaped, habits are reinforced, and brand choice gradually shifts.

Problem Framework

THE BRAND PAIN

For Brand UMI, wound care creates three specific brand risks.



1. Brand choice dissolves after the consult

In minor wounds, the decision moment is brief. Once advice is given, the brand rarely reappears in the doctor's mind. Execution shifts entirely to the home.

Without structured follow-up, brand choice loses reinforcement.

2. Outcomes are judged without brand visibility

When wounds worsen or get infected, the brand used becomes associated - fairly or unfairly - with the outcome. But the brand had no role in monitoring adherence or early warning.

Brand UMI bears outcome risk without outcome presence.

3. The default is set outside the clinic

Parents revisit advice through chemists, family, or the internet. Substitution happens quietly. The clinic has no structured signal until a problem appears.

By the time the patient returns, the brand choice has already drifted.

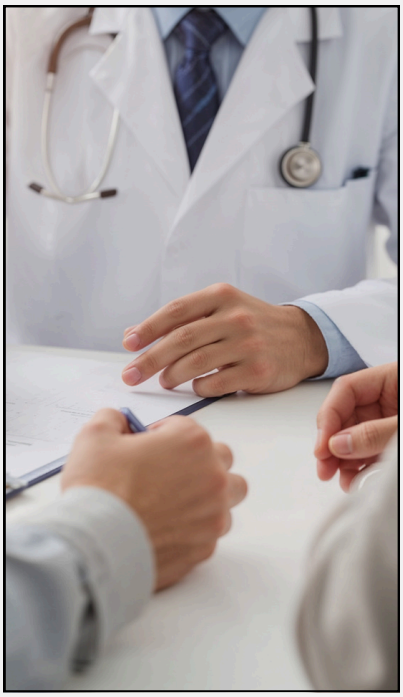
The commercial consequence

In wound care, brand leadership is not created at the moment of advice. It is created by owning what happens next.

Until Brand UMI is structurally present in the follow-up window, it will remain replaceable - regardless of trust or reputation.

The Behavioural Moment Map

Brand choice in wound care is shaped across three moments, but only one is influenceable.



MOMENT 1: IN-CLINIC ADVICE (LOW LEVERAGE)

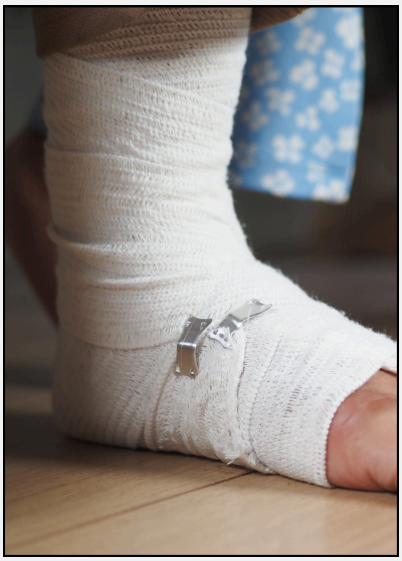
Advice is given quickly. Multiple instructions compete for attention. Brand differentiation here is weak.

MOMENT 2: AT-HOME CARE & EARLY HEALING (CRITICAL)

Days two to five determine outcomes:

- adherence to cleaning and dressing,
- correct application,
- early infection recognition.

This is where brand value is experienced.



MOMENT 3: RETURN VISIT OR ESCALATION

If things worsen, the brand is judged – but the decision has already played out.

Correction must happen in Moment 2, not at the desk and not after failure.

The Clinic-Centred Solution Framework

EXTEND → MONITOR → DEFAULT

The objective is not to change how doctors treat wounds. It is to extend clinic ownership into the follow-up period, where brand defaults are formed.

EXTEND → MONITOR → DEFAULT

EXTEND
(Clinic ownership beyond the visit)

Every wound patient receives a clinic-branded "Wound Care After-Visit Link" via QR or WhatsApp.

This turns wound care into a clinic service, not a one-time instruction. Brand UMI does not appear to patients. The content is Academy approved and hence trusted by doctors.

MONITOR
(Early signal, zero effort)

Day-2 and Day-5 check-ins:

- capture adherence,
- detect early infection,
- trigger doctor alerts only when red flags appear.

The clinic stays in control without chasing follow-ups.

DEFAULT
(Brand association through utility)

Brand UMI appears only in doctor-facing layers:

- red-flag email footer,
- doctor briefing,
- service support attribution.

Over time, Brand UMI becomes associated with:

- better outcomes,
- fewer surprises,
- smoother follow-up.

Brand choice shifts through experience, not messaging.

Replication Blueprint

IMPLEMENTATION MODULES

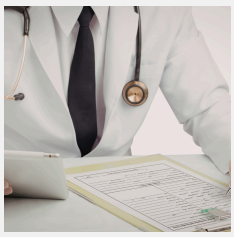
Module	What is implemented	How it works in practice	Brand UMI Impact (Brand Choice)
Clinic-Branded Wound-Care Microsite - with Academy approved content	QR / WhatsApp after-visit link	Parents access standardized wound-care steps and short videos	Extends clinic authority into home care
Day-2 / Day-5 Check-ins	Brief red-flag screens	Any red flag triggers a doctor notification	Anchors Brand UMI to safety and vigilance
Doctor Red-Flag Email	Auto-generated summary	Clear, action-oriented signal without noise	Repeated exposure in a high-trust context
Clinic SOP + Doctor Brief	One-page operational guides	Staff aligned on when and how to deploy	Enables consistency across clinics
Minimal Field Enablement	One-time setup	Installed and sustained without ongoing detailing	Brand choice driven by workflow, not promotion

Brand Choice Execution Checklist

THIS CHECKLIST DEFINES THE NON-NEGOTIABLES FOR REPLICATION. IF ANY ELEMENT FAILS, BRAND CHOICE REVERTS TO DEFAULT DRIFT.

01.

✔Functions as a clinic service, not a brand message

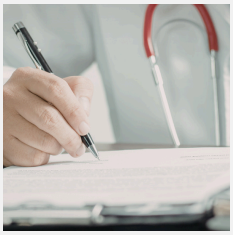


02.

✔Brand visibility limited to the doctor interface

03.

✔Designed for high-frequency patient interaction



04.

✔Requires no incremental doctor time

05.

✔Outcomes reinforced through follow-up behavior, not claims

Brand Outcome

MEASUREMENT LOGIC

Measurement Layer	What is Tracked	What it Indicates for Brand UMI
Clinic Adoption	Clinics live with the service	Integration into routine wound-care workflows
Usage Frequency	Percentage of wound patients receiving the link	Staff-level default behavior
Patient Engagement	Video views and check-in completion	Ownership of post-visit follow-up
Clinical Signals	Red-flag incidence and recurring themes	Perceived utility and trust in the service
Brand Choice Proxy	Improvement in “default topical” recall or brand-of-use in pilot clinics	Directional shift in brand preference

Strategic Opportunity & CTA

Brand UMI's opportunity in wound care does not lie in increased visibility or message frequency. It lies in structuring the part of care that most directly shapes outcomes. By enabling wound-care follow-up as a clinic-owned service, Brand UMI becomes associated with safe healing, early signal detection, and reduced uncertainty for both doctors and caregivers.

THE NEXT STEP IS NOT EXPANDED PROMOTION, BUT FOCUSED OWNERSHIP OF THE EARLY POST-VISIT PERIOD WHERE OUTCOMES AND BRAND PREFERENCE ARE FORMED.

Email

AMIT@INDITECH.CO.IN

Website

WWW.INDITECH.CO.IN