PREMIUM PRACTICE TODAY

April 2014
Volume 5, No. 4

eyetube.net

TAKING THE PULSE OF ELECTIVE EYE CARE

Being in the "elective" mindset is quite different from being in the insurance mindset.

By Rochelle Nataloni, Contributing Editor

ENHANCED PEARLS
Audio
Video
Website
bmctoday.net/crstoday/premiumpractice

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

Taking the Pulse of Elective Eye Care

Being in the "elective" mindset is quite different from being in the insurance mindset.

BY ROCHELLE NATALONI, CONTRIBUTING EDITOR

Early in my career, I made the jump from marketing reimbursed products (Humphrey Field Analyzer; Carl Zeiss Meditec) to self-pay devices (Visx excimer laser). The approval of laser vision correction marked the modern era in self-pay elective medicine for ophthalmology. Although LASIK volumes are at half their previous peak, the procedure is still the most commonly performed elective surgery in the United States and worldwide (China now exceeds the United States in annual procedures). Cataract surgery is the most commonly performed surgical procedure in the United States, giving ophthalmology the top spot in both categories.

Although the demographics strongly favor the opportunity for refractive lens surgery over refractive corneal surgery, this will switch back to more parity as the Millennials (children of baby boomers) get older and want to see without glasses. For now, the smart investment of time and money is in refractive cataract surgery, and we see that with increasing adoption of the femtosecond laser.

However, two axioms are worth putting forward to help even those at premium practices understand why their numbers are not as high as they would like them to be in self-pay elective medicine. Axiom No. 1: nobody wants eye surgery. Axiom No. 2: you are not your customer. I will leave the explanations of these for another time (hint: there is an article covering the first axiom in the CRST *archive). For now, enjoy the commentary provided by coeditor James Dawes and a number of other experts in practice.*

—Section Editor Shareef Mahdavi

There are specialties dedicated to elective procedures, there are specialties dedicated to insurance-covered procedures, and then there is ophthalmic surgery, which straddles the two spheres not only within the same practice but increasingly within the same procedures. Gone are the days when practices could thrive on Medicare-covered monofocal cataract surgery. The LASIK boom, too, is a distant memory. Eye care professionals who have been riding the waves of change long enough to sink or swim suggest that looking back is pointless. They say that, with the newest IOLs and laser phaco technology and a generation of prospective patients who are more than willing to pay out of pocket to stave off the aging process, opportunities for practice growth in the elective and semielective markets are boundless.

MISSION ACCOMPLISHED

According to James D. Dawes, chief administrative officer at Center for Sight in Sarasota, Florida (ⓘ www.centerforsight.org), and an editorial advisor to *Premium Practice Today*, "Providing patient lifestyle choices and creating a better patient experience [have] become my mission in life; the byproduct of that has been growth of elective revenue." He has been with the practice for a decade. When he started, 11% of The Center for Sight's revenue came from out-of-pocket services (including eyeglasses and hearing-related services). That figure has since increased to 50%. "As patients become more aware that they have lifestyle choices, I think 65% to 70% of our revenue will ultimately come from elective services," he says. In addition to semielective "advanced-technology"

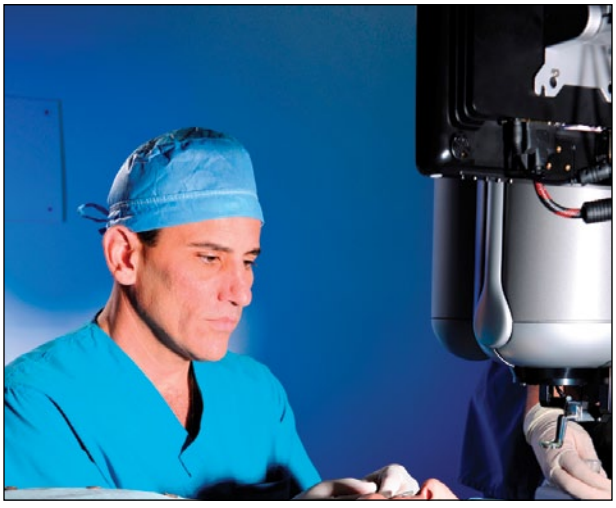
IOLs combined with laser cataract surgery, glasses, and hearing services, the Center for Sight's elective services include onabotulinumtoxinA (Botox; Allergan), dermal fillers, cosmetic skin care products, skin care treatments, nutritional supplements, and blepharoplasty as well as a full menu of facial cosmetic surgery procedures performed by an oculoplastic surgeon on staff.

Mr. Dawes' relentless efforts to provide patients with lifestyle choices and an improved patient experience allows surgeons to enjoy a more positive work environment. He says, "Nobody would agree to a job where they knew coming in that they would get a pay cut every year, but all of us who are providers with Medicare have accepted that deal, and in turn, I see a lot of very unhappy health care providers. And, more importantly, the current boomer population of patients with Medicare wants to have a choice regarding their surgical outcome; they want something better than just what the government will cover. So if we want to be able to continue to provide the level of patient care that we do, achieving the outcomes that we achieve using advanced technology, and providing our patients with a choice, then we have to be in the elective business. It's the only way to continually deliver the level of service to which we are committed."

How he has gone about increasing the elective side of the Center for Sight's business is equally simple. "What we know for sure is, when someone is paying out of pocket for a procedure, they [had] better have a great experience, and they [had] better have a great outcome, or they are not going to be happy," Mr. Dawes remarks. "We are totally focused on delighting the patient, making sure that the patient experience is second to none, and at the same time, we are focused on achieving the best possible outcomes."

Being in the "elective" mindset is quite different from being in the insurance mindset, Mr. Dawes points out. "This has required a lot of internal staff training, because it's not all about volume; it [is] truly about the experience—eliminating wait times, talking to our patients, getting their feedback, and making changes based on what the patients tell us they want changed," he comments.

He says blaming the economy for lost elective revenue is of no value. "The economy is the economy," he remarks. "It's going to fluctuate, and we have little control over macroeconomics. If we focus on providing our patients with choice, a great outcome, and making the patient experience wonderful, the patient is going to keep on coming back."



William L. Soscia, MD, of the Center for Sight uses a femtosecond laser for cataract surgery.

BLEPHAROPLASTY

The Center for Sight accrues approximately 15% of its overall revenue from dermatologic and plastic surgery procedures—including blepharoplasty—which James Dawes describes as "significant." According to the American Academy of Facial Plastic and Reconstructive Surgery (ⓘ www.aafprs.org), blepharoplasty was the second most popular cosmetic surgical procedure performed in 2012. According to the American Society for Aesthetic Plastic Surgery (ⓘ www.surgery.org), blepharoplasty was the fourth most popular elective cosmetic procedure. The American Society for Aesthetic Plastic Surgery also reported that, for people 51 and older, blepharoplasty was the most popular cosmetic surgery. Regardless of which association's data you find most compelling, blepharoplasty is clearly in high demand.

Jacqueline Griffiths, MD, of New View Eye Center (ⓘ www.newviewlasereye.com), Reston, Virginia, offers aesthetic services in her ophthalmic surgery practice and suggests that, in the coming years, others in her specialty who have the ability should focus on that market. "I believe [the volume of] cosmetic procedures such as Botox, incobotulinumtoxinA (Xeomin; Merz Pharma), and fillers as well as cosmetic blepharoplasty will rise due to the aging

population and the sheer number of baby boomers," she says. "Many of these patients want a quick 'freshen up' to compete in the working world. Even when the economy was at its worst, patients would still come in or make impulse decisions during their appointment for these elective services." Dr. Griffiths adds, "In my very urban area, however, there is plenty of competition for these services, so it's difficult to increase your numbers. We try to generate more patients through internal marketing."

Blepharoplasty, of course, is a procedure that straddles the elective/nonelective arenas. Mr. Dawes and Dr. Griffiths are among those who have a plan in place to educate patients about getting the lower lid treated, too, when they present with vision-related complaints because of a droopy upper lid. Dr. Griffiths explains, "Each patient who comes for a regular insurance visit is given a welcome sheet to check off if they are interested in any of our elective procedures, and we list all of our elective options. It opens the door to start a discussion to convert [patients to] some of our elective services. This has worked extremely well for us over the years, because it introduces the patient to the full offerings in the office, and even if they are not interested, they can let their friends or family members know that we offer certain services they may have expressed interest in."

As cofounder and marketing partner of Aesthetics 360 (ⓘ www.aesthetics360.com), near Boston, Christine Lapointe is a consultant to both ophthalmic and cosmetic surgery practices. She agrees that blepharoplasty and facial aesthetics offer ophthalmic practices an opportunity for revenue generation. She says that ophthalmic practices tend to be handicapped, however, by an inability to properly integrate ancillary aesthetic services. "We see a lot of practices doing insurance-covered blepharoplasties, but those doctors often have a difficult time talking to the patients and getting them to get their lower eyelids done," she notes. She adds, "When we talk to oculoplastic surgeons, it seems that a lot of them have worked in an environment where the patients have been fed to them, so they don't have a problem doing the uppers."

Ms. Lapointe sees this inability to take things to the next level in all but the most committed practices. "With Botox and fillers, more often than not, there is a lack of a system in place designed to have patients return for treatment," she explains. "This is a problem

ELECTIVE VERSUS COVERED: CHALLENGES AND FRUSTRATIONS

A 2012 survey of more than 13,500 doctors from around the country found that 50% plan to cut some access to their services, and about 7% plan to switch to cash-only practices.[1]

Meanwhile, the vast majority of physicians continues to accept private health insurance and Medicare/Medicaid despite growing frustration with increased governmental regulations and unsatisfactory reimbursement. Most continue to do so because it guarantees a steady flow of patients, while some consider it ethically questionable to discontinue seeing patients who cannot afford to pay out of pocket for medically necessary procedures.

This is not a concern with elective and semielective procedures. Paying extra for an upgrade to a premium level of service is the American way, after all. James Khodabakhsh, MD, of the Beverly Hills Vision Institute (ⓘ www.beverlyhillsvision.com) prefers the simplicity of the elective side of his practice. "There is no third-party involvement," he says. "One does not have to wait to get paid—usually at a much reduced rate—and the decision is between the doctor and the patient. The challenge is to bring the patient in the door. If the work that is being done is good and the patients are happy with the results, they will continue to come and refer their family and friends. The greatest thing about living in the United States is that good ethical work is rewarded."

Of course, there are difficulties even in the elective arena. When patients are paying out of pocket, they expect more attention, says William J. Fishkind, MD, of Fishkind, Bakewell, Maltzman Eye Care and Surgery Center in Tucson, Arizona (http://eyestucson.com). "The immediate gratification mindset of patients adds to physician 'handholding' in recovery," he comments. Rather than dial down the elective side of his practice, Dr. Fishkind and team are ratcheting things up a notch. "We are making an increased effort to educate patients about premium-channel management and IOLs with the goal of increasing the number of patients who opt for noninsurance-covered procedures," he says. "We find that many patients are sorry they did not have their astigmatism corrected because they just didn't understand it. Some regret that they don't have reading vision after monofocal surgery." The practice has created a new position of surgery educator, and this person will speak to all patients preoperatively, either before they are seen or after they are seen and scheduled. "[This employee] will educate all patients who are candidates as to the benefits of astigmatism management, multifocal IOLs, and laser cataract surgery," Dr. Fishkind explains.

Jacqueline Griffiths, MD, of New View Eye Center practices in an area populated by power brokers and politicos just outside the nation's capital. She has a thriving ophthalmic surgery practice despite not having jumped on the laser phaco bandwagon yet. Dr. Griffiths has a generally positive outlook, but she feels a mounting sense of frustration. "Since I opened my practice, I have had multiple [ancillary aesthetic, etc.] offerings," she says. "This has been a very successful model for me. Like many of my colleagues, however, I am growing extremely tired of all the regulatory changes coming all at once on the insurance side. I understand why physicians would want to get out, retire early, or change careers altogether. I have noticed patients getting more and more upset when they find out their copays and deductibles are higher. They often don't understand the complexities of their own insurance. They expect us to be their de facto insurance concierge service and explain it to them. We do try, but unfortunately, their wrath is often taken out on the office and not on their insurance company when something isn't covered or it goes to the deductible. This has become burdensome and tiring. I'm not ready to throw in the towel yet, but the frustration is certainly rising."

1. Survey conducted on behalf of The Physicians Foundation by Merritt Hawkins. Completed September, 2012. Copyright 2012, The Physicians Foundation.

because these are procedures that are supposed to be repeated and maintained." One practice that does an excellent job in this regard is Center for Sight in Florida, she says. "They get out of it what they put into it," she remarks. "They have a plan, and they execute it, and they measure their results, and they don't roll out any new service or procedure unless they are 100% ready to do it right."

LASER PHACOEMULSIFICATION, IOLs, AND LASIK

As surgeons become increasingly comfortable implanting a variety of premium IOLs, and as outcomes reflect this learning curve, volume is rising. Meanwhile, femtosecond lasers are poised for growth beyond early adopters as the economy continues to rebound. At this stage, the growth in laser premium

> "What we know for sure is, when someone is paying cash for a procedure, they [had] better have a great experience, and they [had] better have a great outcome, or they are not going to be happy."
> —James Dawes

IOL surgery may be more responsible for LASIK's lingering malaise than the economy.

Ms. Lapointe says, "There are factors other than the economy affecting the LASIK dip. One of them is that there are other vision correction options; another is the inappropriate marketing of LASIK. People still buy things that they feel there's a value for regardless of economic fluctuations. So, if LASIK's value has not been conveyed appropriately, that's a problem. When you look at it over time, plenty of women spend a couple thousand dollars yearly on hairstyle and color maintenance. Clearly, they feel it's important to spend the money on that. It's all about showing patients the value of how something is going to benefit them. I think that, too often, the surgeons forget that and they have the knee-jerk reaction of discounting prices. Then, they end up doing three times the number of procedures and earning the same amount of money as they would have if they [had] kept the price steady."

Cary Silverman, MD, of EyeCare 2020 in East Hanover, New Jersey (ⓘ www.eyecare2020.com), appears to be having an experience reflective of the typical overachieving premium practice ophthalmologist in Anytown, USA. "In my practice, LASIK has been on a spiral downhill since the economy crashed, and that is the case in just about every practice that I see except for a few rare outliers," he says. "However, refractive lens surgery and [laser] cataract surgery [are] a whole different animal. That's doing very well. I think this is because it's a whole different population set, older people who have more money. Plus, insurance is paying for part of it, and they like that." He says people who are willing to pay for the uncovered portion of premium IOL surgery don't get hung up on the fact that part of it isn't covered. Instead, they are pleased that part of it is. "They understand that they only have

> "Laser cataract surgery is a savior. It is picking up the slack from the fall in LASIK revenue."
> —Cary Silverman, MD

one shot at getting their cataracts removed, and they want to get it right," he explains.

Dr. Silverman acquired a femtosecond laser about a year ago, and he says it is saving his practice. "When I first started doing laser cataract surgery, it probably represented 20% to 30% of all of my cataract cases," he says. "Today, that's up to 70%. Laser cataract is a savior. It is picking up the slack from the fall in LASIK revenue. At its peak, I was doing well over 100 LASIKs a month. Now, we're doing 20 a month." He adds that people seem to "get" laser cataract surgery. "They understand that it's less invasive, that it can correct their astigmatism, that it's a safer procedure, and that they get a premium lens, and because they understand this, they are willing to spend money for it," he says.

A 65-year-old today is not the same as a typical 65-year-old 20 years ago, Dr. Silverman points out. "People are willing to spend money on cosmetic procedures to look younger, and they're willing to spend money to be able to stop wearing glasses," he says.

HERE COMES THE BOOM

Beverly Hills ophthalmic surgeon James Khodabakhsh of the Beverly Hills Vision Institute (ⓘ www.beverlyhillsvision.com) sees laser phacoemulsification as ophthalmology's next big boom. "In our practice, Botox, fillers, and LASIK have had a very slight upward shift, remaining almost steady over the past few years," he says. "What has really shifted upwards in my practice is premium cataract surgery. With the addition of the femtosecond laser, I now have an 85% to 90% conversion to premium lens surgery. I'm very optimistic about how the next 10 years will look. Barring another disaster to the economy, like the housing collapse, we are going to see steady rises in both premium lens surgery and cosmetic procedures as the baby boomers age. Staying and feeling young are priceless to them."

Cindy Haskell is marketing director of Gordon-Weiss-Schanzlin Vision Institute (ⓘ www.gwsvision.com) in San Diego, a practice headed up by veteran refractive surgeons Michael Gordon, Jack Weiss, and David Schanzlin. Ms. Haskell says LASIK and other nonvision procedures are flat in her practice but that refractive laser cataract surgery is up 20%. "The demographic shift and new technologies are creating greater demand for refractive laser cataract surgery, and improved IOLs and more precision are driving improved outcomes for patients," she comments. "The boomer generation is demanding the best possible treatments, and with surgeon buy-in, we are delivering what patients want."

Ms. Haskell predicts that the demand for refractive laser cataract procedures will continue to grow and says, "As the economy continues to improve, hopefully, the demand for LASIK will pick up as well." She remains optimistic, pointing out, "The Millennials are being cautious with their purchases at this point, but they seem to appreciate the lifestyle benefits of LASIK." ■

James D. Dawes may be reached at (941) 480-2105; jdawes@centerforsight.net.

William J. Fishkind, MD, may be reached at (520) 293-6740; wfishkind@earthlink.net.

Jacqueline Griffiths, MD, may be reached at (703) 834-9777; jgriffiths@newviewlasereye.com.

Cindy Haskell may be reached at (760) 815-1255; chaskell@gwsvision.com.

James Khodabakhsh, MD, may be reached at (310) 550-7888; lasereyedoc@aol.com.

Christine Lapointe may be reached at (954) 770-2599; christine@aesthetics360.com.

Cary M. Silverman, MD, MBA, may be reached at (973) 560-1500; csilverman@eyecare2020.com.

Rochelle Nataloni welcomes ideas for future articles about innovative strategies that are helping you elevate your practice to the "premium" level. She may be reached at rnk2020@comcast.net