The Economy's Impact on Refractive and Refractive Cataract Surgeons

Ophthalmologists discuss the US financial market and how it has influenced their practice and profession.

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LAWRENCE B. KATZEN, MD

Through June 2008, LASIK volume was down about 15% in our practice. Next, my colleagues and I noticed a significant drop in initial patient contacts, consultations, and procedures. Our LASIK volume from August 2008 through November 2008 was down 50%. This decline has significantly affected cash flow, total revenue, and net income.

As in most practices, payroll expenses are our No. 1 cost. In September 2008, for the first time in our practice's history, through layoffs and attrition, we had to reduce our nontechnical and technical staff by 15% and 20%, respectively.

We have proactively cross-trained most of our personnel. As a result, LASIK team members whose time was once exclusively devoted to laser vision correction are now spending 30% to 40% of their clinical days on the non-LASIK portion of our practice. Counselors are now checking patients in and out, scheduling appointments and consultations, and answering the phone. LASIK technicians are currently serving the general ophthalmology side of our practice.

In early September 2008, we terminated 90% of our external marketing for the remainder of the year. All future external marketing purchases are subject to a 2-week cancellation. Underperforming media are not being renewed in 2009. Nor are underperforming Internet listing agreements.

My colleagues and I are doing a line item review of every expense. We are bidding all supply purchases to three different vendors. We have discontinued the matching program for our 401(k) retirement plan. In an effort to boost morale, we gave all employees a $50 grocery gift card before Thanksgiving, and we will hold our traditional holiday office party.

Prior to July 2008, 50% of our practice consisted of LASIK, and the other half was devoted to cataract/IOL surgery and general ophthalmology. We had been performing IOL upgrades on 20% to 30% of our patients, but the number of those procedures decreased between August and November 2008. Patients continue to pay out of pocket for noncovered services related to refractions, perioperative refractive management, limbal relaxing incisions, and toric, aspheric, and presbyopia-correcting IOLs as well as IOL calculations for cataract patients who have had previous refractive surgery.

MARK A. KONTOS, MD

During the past 6 months, the financial crisis has profoundly affected the makeup of our practice's revenue streams. Last year, the revenue generated by the refractive and anterior segment surgery sides of the practice was about the same. This ratio started to change in April 2008, and the difference has been growing larger each month. I currently perform more cataract surgery now than at any other time in my

career. My volume of laser-based refractive surgery has steadily decreased, particularly in the last 3 months.

When talking with my patients, it is not hard to see the reasons for the aforementioned trends. More and more of my older patients are expressing a sense of urgency about cataract removal, because they fear that their benefits will be cut or that surgery will be more expensive in the future. Candidates for laser refractive surgery are not booking procedures because of financial uncertainty.

Fortunately, major changes we made to our practice during the past couple of years are helping us greatly now. Most important among them was that we opened our own cataract surgery center. Although it is a significant capital expense, the center is the reason we were more profitable in 2008 than 2007. We also assumed sole ownership of the laser surgery center and severed our franchise relationship with a large corporation. This change has allowed us greater focus and flexibility in our marketing and pricing of surgery.

In response to the economic downturn, we have spent a lot more time and energy on our staff's development. Cross-training employees has allowed us not to furlough experienced staff members. We have no plans to hire additional staff in 2009 or to raise salaries. The purchase of new equipment during the next 6 months is unlikely. We are also working harder on improving the patient's experience in our office. Because ours is predominantly a comanagement practice, we are striving to strengthen our relationships with the doctors in our network through better personal communication, visits to their practices, and the exchange of information.

In short, we are trying to focus on sound practice management strategies, to be fiscally prudent, and to take care of our employees and patients as we wait out the storm.

DWAYNE K. LOGAN, MD

Located in Long Beach, California, Atlantis Eyecare is a group practice that traditionally focused on optical and comprehensive ophthalmic medical/surgical services. Five years ago, in an attempt to participate in the laser vision correction market, we purchased a Visx Star S4 excimer laser (Advanced Medical Optics, Inc., Santa Ana, CA) and used it as a means of marketing the practice to patients 50 years old and younger.

Although we had a steady flow of patients, our monthly profit and loss statements revealed that our profit margins were tight. We entered the laser vision correction market a little late in our community. Candidly, we also did not commit the marketing resources necessary to be perceived as leaders in our area. Three years after purchasing the excimer laser, however, we were able to offer our patients premium IOLs, which allowed us to enter a new market within our community and grow as individuals into experienced surgeons and thought leaders. We found a new and important role for the excimer laser as a tool for enhancements after patients received premium IOLs. Our laser vision correction volume has remained stable during the past 2 years, as the global market decreased more than 30%, because our patients older than 55 years of age became our greatest pool of candidates for laser vision correction.

Once patients were free of their glasses and saw well at near, we noticed that they were much more aware of their periocular and facial features. It turned out that glasses hid the periocular effects of aging and exposure to ultraviolet rays from the sun. We decided to offer cosmetic eye care. We perform medical spa services, such as microderm abrasion and facials. An upper and lower eyelid cosmetic blepharoplasty combined with a midface lift has become a very common outpatient procedure that is performed by our comprehensive ophthalmologist, under local anesthesia. All of our satellite offices have counselors that offer eye care vitamins, Botox (Allergan, Inc., Irvine, CA), facial fillers to help reduce the signs of aging without surgery, and skin care products. The diversification of services has allowed our practice to expand during an economic recession.

ROBERT J. WEINSTOCK, MD

Over the past few months, I have realized that the multispecialty ophthalmic practice of which I am part is not immune to the recent downturn in the US economy. The recession apparently started in 2007, but, at that time, my refractive cataract practice was booming. All the other subspecialties were thriving as well. Then, in early October 2008, we started to see the first signs of the economic slump. The clinics were not full, the OR schedule was light, and the conversion ratio to an upgraded cataract package started to drop a few points. The past few months brought roughly a 20% decrease in the overall procedural volume of the practice. I would not be surprised to see our surgical volume dip further and not recover for some time. Eye disease, however, does not disappear when the economy is bad. At some point, patients who need care will find their way back to the doctor.

We are adjusting to the change in our business by cutting overhead and expenditures. Staffing is the largest component to a practice's overhead. We may have to lay off unproductive employees and reduce the staff in proportion to the decrease in our business. Bonuses may be

decreased, and unnecessary expenses (eg, staff lunches, parties, etc.) will be eliminated. We plan to create a budget based on last year's expenditures minus 20%, freeze capital equipment expenditures unless truly needed, and consider leasing versus buying any needed equipment. We will decrease external marketing and maximize internal marketing. We hope to improve customer service and satisfaction and patients' overall experience. We will continue to diversify our sources of income and we expect to achieve a balance between private insurance, Medicare, and cash payments. We are continuing to optimize our additional sources of income such as an optical, LASIK, skin care, hearing aids, and weight management as well as insurance-based revenue streams such as retina, glaucoma, and oculoplastics.

We will not eliminate services but will offer in-house and external financing for all cash services, including copays. Lastly, we will spend more time with patients and help them realize the benefit of the presbyopia- and astigmatism-correcting products we recommend.

DARRELL E. WHITE, MD

Located in Cleveland, my practice entered a severe economic slowdown on September 12, 2001, like other businesses across the country. In general, Cleveland never regained its pre-2001 economic vigor, especially in terms of discretionary spending (eg, luxury vehicles, furs, jewelry). The economic crisis has therefore amounted to a financial dive from the low board in my state.

At my practice, we started 2005 with reasonable goals and a need for diversification in mind. We hoped to perform 250 to 500 LASIK procedures per year and increase our cataract volume to approximately 1,000 procedures per year over time. We are on track for the latter. Only one laser group in Cleveland has been successful in the last 3 years, however, and its volume was down nearly 40% in 2008. Our premium IOL business still accounts for 20% to 22% of our lens-based surgeries; all growth in that area in our practice has been obliterated by the recession.

Our patients' behavior since the economic slowdown is best described by the words *delay* and *deprivation*. General eye care such as vision or annual diabetic eye examinations is now taking place every 18 to 24 months as patients extend the intervals between checkups. Necessary care for ongoing medical diseases, like glaucoma, which occurred every 3 to 4 months before the recession, now happens every 4 to 6 months. Furthermore, whereas patients once routinely purchased a second pair of glasses, they now buy a single lower-priced pair, often after a delay if insurance does not help cover the cost.

How have my colleagues and I reacted? We have dramatically de-emphasized refractive laser surgery but will continue to offer it, as it is a necessary complement to our premium IOL services. We have ramped up internal marketing to inform patients about premium options in all service lines (laser, IOL, and optical) at every available opportunity. We offer financing options but only to the extent that the fee we pay is reasonable. We rarely offer payment plans that extend longer 12 months, because they cut too far into our bottom line. We actively promote our optical shop, which now draws in surgical patients. The opposite was true in the past. We are postponing essentially all capital purchases and have become vicious negotiators with vendors.

We plan to seek more vision care work for our optometrists and to find exclusive optical lines to sell as ways of distinguishing our practice in the marketplace. We will look for strategic partners and shrink our office space in order to reduce fixed overhead.

Cleveland entered the recession early, and its recovery will likely lag behind that of the rest of the country. We are therefore preparing for the long term. ■

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