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The Value of Written Planning in All Human Endeavors

Virtually all human achievements are exquisitely planned in advance on paper in minute detail. Ships, planes, sky scrapers, city parks, Danish furniture and machinery of every stripe are created on blueprints or computer screens before they are ever created in reality. Circuit boards are diagrammed before they're welded, and potential new autos are modeled in clay. Diplomacy and wars are waged from written, branched contingency plans. And even the most artistic chefs do their best work when working from a written recipe. Symphonic music, another wonderful human construction, is played from written sheets of music. Movies are scripted. Novels are outlined. Professional athletes adhere to a formal, written training program and playbook. Even some paintings, and certainly most sculptures, are thumb-nailed on paper before they ever become real. But what about your surgical practice? In most settings, practice development is about as unstructured as fishing or writing poetry: there's not much advance planning, and certainly little thought given to how you want things to turn out. If we plan and build our practices like we plan and build our homes, we're more likely to achieve our goals.

2

Fast Facts on Your Market and Service Area

The first and easiest place to go for a breakdown of your practice's service area is on the web. The best site is www.factfinder.census.gov, where you'll find for any chosen zip code, city, county or state a treasury of data from the last census. This data is already sorted in the way that's most useful to practice planners, with economic and age breakdowns, as well as social and ethnic characteristics. Of course, the deeper into each intervening decade we go, the less accurate the data becomes. But there's much to extrapolate by clicking on www.epodunk.com/top10/countyPop, which shows growth rates for any selected county in the nation.

3

Subspecialty vs. Comprehensive/General Ophthalmology

The bloom of applied clinical science over the past several decades has created a mild tension within ophthalmology...and certainly in the minds of any surgeon trying to divine his career path...between the so-called "comprehensive" ophthalmologists, and those (with or without formal subspecialty fellowship training) who pursue a subset of eye care. Those who choose the mile-wide-inch-deep path of comprehensive care are rewarded in terms of intellectual diversification, but will probably find some loss of traction, both economically and in terms of professional depth. Of course, this tension is as natural as that which once caused Eye-Ear-Nose-Throat to become two distinct specialties. In the years ahead, I suspect that this tension will lead to a continuation of the tendency for subspecialists of every stripe to partition themselves off into smaller interest groups, particularly urban providers, who will find it more practical to find a niche than their rural colleagues.

4

The Spectrum of Possible Relationships Between Practices

As you scan your own marketplace, you can simplistically and grossly divide your local colleagues into "friends," "enemies" and "neutrals." But at a deeper level, there is a more subtle continuum of possible doctor-to-doctor and practice-to-practice interactions and models:

- Razor Wire...Frank antipathy, marked by active, reciprocal efforts to advance at the expense of the competition...a very uncomfortable way to practice for all but the alpha doctors in a market.
- Good, But Wary, Neighbors...Respectful, friendly (but not particularly embracing) competitors, who either work to become eventual “Trusting Colleagues” or at least not devolve into “Razor Wire”...again, quite isolating.
- Trusting Colleagues...Partially collaborative and periodically cross-referring (as by a general ophthalmologist referring to a difficult patient to a fellow generalist with a subspecialty interest in glaucoma)...doctors in such arrangements trust each other to return patients.
- Unconflicted Specialist-Subspecialist Alliances...Not competing; collaborative and cross-referring (as by a general ophthalmologist referring to a dedicated retinal subspecialist.)
- Independent Practice Association...doctors collaborating, usually with a narrowly defined mission, such as group contracting with managed care. Usually involves minimal investment and commitment, and is subject to rapid disintegration as soon as the sponsoring threat or opportunity dissolves.
- Management Services Organization/Facility Joint-Ventures...Like an IPA in terms of lower commitment levels, but involves higher capital/debt commitments; can include active joint venturing (as by doctors developing an ASC or laser center or central billing service together, and sharing a significant group investment.) If successful, can be the precursor for deeper projects and the eventual economic integration of selected members.
- Physician-Hospital Association...now falling from favor; doctors and hospitals form a loose alliance to ultimately develop a contracting alliance or an insurance product.
- Expense Sharing Associates...(two or more doctors in the same building who share staff and certain other expenses, but who maintain separate entities) Like two lovers living together rather than marrying, can be successful or fraught with discord, depending on the maturity of the involved parties and the stresses in the environment.
- Classic Single-Specialty Group Practice...The doctors are partners or shareholders in a common entity and the group is economically integrated.
- Multi-Specialty Group Practice...Often formed or grown through consolidation with soloists and single-specialty groups; once favored because of expected better access to managed care contracts, now troubled by significant diseconomies of scale and partner opposition—especially along low-producer/high-producer lines
- Integrated Delivery System...Inserts a multi-specialty provider into the context of an in-patient institution, with the ability to provide a full-spectrum of care...often includes one or more insurance products and competes with other third-party payers for a share of the employer premium dollar.

5

Money and Happiness

A U.S. Census question some years back asked the public what it costs to live the American Dream. The surveys asked rich families and poor families. People who made millions and people living below the poverty line. The result? Just about everyone answered, “It takes roughly twice what I’m making today—THAT would make me happy and allow me to live the American Dream.” Ophthalmologists (and their spouses) too often step into the same happiness trap, locked in a professional setting they dislike, because they’ve become addicted to the belief that life would be less happy making \$230,000 a year (the rough national average income for eye surgeons) instead of \$500,000. That’s not to say you shouldn’t strive to grow and develop your practice and to improve in every dimension, including higher economic ground...but be clear about why you are striving. Is it for the thrill of professional competition, or the fear of others having a larger practice than yours? Is it for the deep personal satisfaction of doing your best

work possible, or are you polishing your surgical skills out of some recurring, residency-inspired nightmare of criticism and failure? Are you economically fruitful as a by-product of giving your patients real value, or are you so fearful of falling behind that you're cutting corners?

6

The U.S. Economy As the Ultimate Driver for Domestic Health Reform

About five years ago I prepared an article for EyeWorld discussing what might happen to ophthalmology one day if the general economy started to flutter. I wrote then, *“If you thought that health reform efforts under Clinton, or losing a few percent of revenue from Medicare each year were onerous, wait until the next turn of the business cycle combines with wage inflation, a clamp-down on consumer spending for elective surgery, and the rapidly aging population. What’s been termed a ‘health care cost and access crisis’ will be called a real emergency, and the regulatory wheels will spin in earnest. We have likely not yet lived through the toughest times.”* As this book goes to press, federal deficit spending mounts, the international balance of trade is sharply against us, inflation is starting to creep up, and as a result of all this the value of the dollar is down about one-third against the rest of the industrial world’s currencies in just the past couple of years. At the same time, employers are rapidly shifting employee health benefit costs to beneficiaries, which will inevitably give voice to louder calls for health reform. It’s an unfortunate and frustrating paradox that market demand (in the form of a rapidly aging population) and product sophistication (in the form of the myriad new ways in which we can help these and other patients today) could well be trumped by a lack of money to pay for it all. How should you apply these murky macro-economic trends to your own practice? There are several appropriate guidelines for breath-holding times such as these:

- Work hard on developing marginal revenue. In this fixed-cost, service-based profession, the profit margin is essentially 100% on the last few dollars you earn every hour. Said another way, 100% of every marginal dollar you don’t collect is swept from your paycheck.
- Add any missing ancillary services. For example, even if you don’t have enough cataract cases personally to develop a free-standing ASC, you can still partner with others and gain \$300 or more in lost profits for each case you perform.
- Examine your practice production statistics closely for habit-driven under-utilization patterns. Are you performing sufficient visual field exams? Angiographies? Are you treating conditions like dry eye that may seem clinically ho-hum to you, but rank high in patient demand? Are you referring out care that you could just as competently handle in-house?
- Avoid investments with uncertain return...unless there is a clear-cut economic incentive or standard-of care-demand, put your wallet away and count to 100. Don’t purchase new equipment, facilities, or staffing on a whim.
- Don’t shy away from investments that increase your productivity...for example, it’s false economy to hold off adding an exam room or technician or technology if these resources will allow you to serve a backlog of patients.
- Keep your ear to the ground. It’s unlikely that the next stages of national economic malaise or health reform will happen overnight. Scan nationally and locally for trends that will impact your practice. Examples of important signposts: Orchestrated policy trial balloons out of Washington, the likes of which preceded the recent Medicare drug bill. News that two locally competing hospitals are now merging. News of the consolidation of influential primary care providers in your market. The development of a local, employer-sponsored health cost containment panel.
- Keep asking yourself: “Who in my market has control over my share of the specialty care premium dollar?” At present, the overwhelming answer is the patient, who can call for your

services at a whim...but a potential future trend will be to shift this control back to payers and primary care providers.

7

Discriminate Between Regret-Free and Regret-Laden Practice Activities

Some tactics and strategies are a one-way street—once begun, they are hard or at least expensive to reverse, and thus very dependent on your advance critical judgement and deep vetting. Examples would be the development of a large office building, or establishing a free-standing LASIK satellite. Poor judgement will result in lots of regrets. By contrast, there are far more numerous opportunities for “no regrets” strategies and tactics in your business. Example would be those projects easily halted and reversed: a trial marketing effort, a visiting subspecialist or a new piece of equipment taken on trial for 60 days. The next time you and your managers are discussing a possible new direction, ask yourselves, is this strategy or tactic potentially regret-free or laden with the potential for regret? If the latter, but sure to apply extra due diligence before proceeding.

8

Motivations for Higher Cataract Volumes

High-output surgeons achieve their volumes in a variety of ways, including long tenure in their respective markets, providing a superior experience for patients, developing regional referral networks and paying for direct-to-consumer advertising. Few such surgeons reach these higher volumes overnight. One common thread among these surgeons is a competitive drive to invest many years and much capital to achieve leading status in their markets. Most importantly, though, given the fallen rates of professional fee reimbursement now for surgery, higher-volume surgeons are driven by a desire to reach those case volumes needed to support a private surgery center (in the range of 50 or more cases per month.) An inefficient, low-volume cataract surgeon can only generate about \$800 in revenue per hour and perhaps \$300 in profit per hour in the OR...which is not much more than can be generated in an office practice. By contrast, an efficient and especially gifted cataract surgeon can generate \$7000 or more in hourly revenue and bring nearly \$3000 to the bottom line.

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Cataract Surgery Incidence on the Rise

Compared to a decade ago, the incidence of cataract surgery appears to be up. We once performed about 50 surgical cases per 1000 seniors (65+ years of age) per year in a non-capitated environment. We now perform about 60 surgical cases per 1000 seniors per year, up about 20%. I'd venture that at least a part of this elevation is due to improving outcomes and the growing realization among both patients and providers that the cost-benefit and risk-benefit ratios are very favorable. These expected future case volumes may be leveraged upward by the increasingly poor health and dietary habits of Americans, and the observation that obesity may significantly increase cataract risk, even among individuals who are not diabetic. With new technologies now coming on line, one can expect case volumes to rise at least as fast as the growing senior population, unless, of course, there are successful efforts in the years ahead to ration care. How bad could it get? In pre-paid HMO settings, the typical utilization rates are down around 25 surgical cases per 1000 seniors per year.
