

Pick case study

[Business](#)



The fact that they were advertising based on price was bad enough, but the price they were promoting-\$900 for both eyes-was ridiculous.

PICK and its cooperating optometric physicians would not even cover their variable cost if they performed the surgery at that price. A typical PICK customer paid between \$1,750 and \$2,000 per eye for corrective laser surgery. Although Dry. Everett knew that firms in Canada had several inherent cost advantages, including a favorable exchange rate and regulatory environment, he could not understand how they could undercut Pascal's price so much without compromising service quality.

PICK was a privately held company that operated a total of 11 clinics throughout the northwestern United States and provided a range of medical and surgical eye treatments including laser vision correction.

Responding to the challenge of the Canadian competitors was one of the points that would be discussed when Dry. Everett and the other clinic coordinators and surgeons who ran PICK met next month to discuss policies and strategy. Dry. Everett strongly believed that the organization's success was based on surgical excellence and commissioned concern for its patients and the doctors who referred them.

PICK strives to provide the ultimate in patient care and consideration.

Dry. Everett had joined PICK in 1993 in large part because of how impressed he had been at how PICK treated its patients, and he remained committed to this patient-focused value. He was concerned, however, about his organization's ability to attract laser vision correction patients. He knew that

many prospective PICK customers would be swayed by the low prices and would travel to Canada to have the procedure performed, especially because most medical insurance programs covered only a small portion of the cost of this procedure.

Dry.

Everett believed strongly that PICK achieved better results and provided a higher quality service experience than the clinics in Canada offering low-priced ALASKA procedures. He also felt PICK did a much better job of helping potential customers determine which of several procedures, if any, best met the customers' long-term 'Sino needs. Dry. Everett wondered what PICK should do to win over these potential customers-both for the good of the customers and for the good of PICK. Pacific Cataract and Laser Institute Pacific Cataract and Laser Institute (PICK) was founded in 1985 by Dry.

RobertFordand specialized in medical and surgical eye treatment. The company was headquartered in Challis, Washington, and operated clinics in Washington, Oregon, Idaho, and Alaska. (Exhibit 17/1 shows a map of PICK locations.) In addition to laser vision correction, PICK provided cataract surgery, glaucoma consultation and surgery, corneal transplants, retinal care and surgery, and eyelid surgery. Dry. Ford detuned PICK on the principle that doctors must go beyond science and technology to practice the art of healing through the Christian principles of love, kindness, and compassion.

E organization had defined eight core values that were based on these principles. These core values, shown in Exhibit 17/2, guided Pascal's decision making as it attempted to fulfill its stated mission of providing the best

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possible “ co-managed” services to the profession of optometry. Co-management involved PICK working closely with a patient’s optometrists, or ODD (for doctor of optometry). In co-managed eye care, family Odds were the primary care eye doctors who diagnosed, treated, and managed certain diseases of the eye that did not require surgery.

When surgery was needed, the family ODD referred patients to ophthalmologists (e.

. , Pascal’s eye surgeons) for specialized treatment and surgery. Successful co-management, according to PICK, depended upon a relationship of mutual trust and respect built through shared learning, constant communication and commitment to providing quality patient care. Pascal’s co-management arrangements did not restrict Odds to Nor with Just PICK, although PICK sought out Odds who would use PICK as their primary surgery partner and who shared Pascal’s values. Many Odds did work exclusively with PICK unless a specific patient requested otherwise.

APPC-Spokane had developed a network of 150 family Odds in its region.

Exhibit 17/2: Pacific Cataract and Laser Institute’s Core Values We believe patients’ families and friends provide important support, and we encourage them to be as involved as possible in our care of their loved ones. We believe patients and their families have a right to honest and forthright medical information presented in a manner they can understand. En believe that a calm, caring, and cheerful environment minimizes patient stress and the need for artificial sedation. We believe that all our actions should be guided

by integrity, honesty, and courage. We believe that true success comes from owning the right things for the right reasons.

We believe that efficient, quality eye care is provided best by professionals practicing at the highest level of their expertise. We believe that communicating openly and sharing knowledge with our optometric colleagues is crucial to providing outstanding patient care. We believe that the ultimate measure of our success is the complete satisfaction of the doctors No entrust us with the care of their patients.

PICK operated its 11 clinics in a very coordinated manner. It had seven surgeons that specialized in the various forms of eye surgery. These surgeons, each accompanied by several surgical assistants, traveled from center to center to perform specific surgeries.

The company owned two aircraft that were used to fly the surgical teams between the centers. Each clinic had a resident optometric physician who served as that clinic's coordinator and essentially managed the day-to-day operations of the clinic. Each clinic also employed its own office support staff.

Pascal's main office in Challis, Washington, also employed patient counselors who worked with the referring family Odds for scheduling the patient's surgery and a finance team to help tenants with medical insurance claims and any financing arrangements (which were made through third-party sources). Dry.

Everett was the Spokane clinic's resident optometric physician and managed the day-to-day activities of that clinic. Actual surgeries were performed in

the Spokane clinic only one or two days a week, depending upon demand and the surgeons' availability. * Irish case was prepared by John J.

Lawrence and Linda J. Morris, University of Idaho, for the sole purpose of providing material for class discussion.

It is not intended to illustrate either effective or ineffective handling of a managerial situation. The authors thank Dr. Mark Everett for his cooperation and assistance with this project. The authors also thank the anonymous Case Research Journal reviewers and the anonymous North American Case Research Association 2000 annual meeting reviewers for their valuable input and suggestions. Copyright 2002 by the Case Research Journal and John J.

Lawrence and Linda J.

Morris. Laser Eye Surgery and ALASKA Laser eye surgery was performed on the eye to create better focus and lessen the patient's dependence on glasses and contact lenses. Chimer lasers were the main means of performing this type of surgery. Although research on the chimer laser began in 1973, it was not until 1985 that chimer lasers were introduced to the ophthalmology community in the United States. The FDA approved the use of chimer lasers for presbyopia (PARK) in October 1995 for the purpose of correcting nearsightedness.

PARK entailed using computer-controlled beams of laser light to permanently reduce the curvature of the eye by selectively removing a small portion on the outer top surface of the cornea (called epithelium).

The epithelium naturally regenerated itself, although eye medication was required for 3 to 4 months after the procedure. In the late sass, laser in-situ seriousness's, or ALASKA, replaced PARK as the preferred method to correct or reduce moderate to high levels of nearsightedness (I. E. , myopia).

The procedure required the surgeon to create a flap in the cornea using a surgical instrument called a micrometeorite.

This instrument used lacuna suction to hold and position the cornea and a motorized cutting blade to make the necessary incision. The surgeon then used an chimer laser to remove a microchip layer of tissue from the exposed, interior corneal surface (as opposed to moving a thin layer of tissue on the outer surface of the cornea as was the case Ninth PARK). The chimer laser released a precisely focused beam of low temperature, Invisible light.

Each laser pulse removed less than one hundred-thousandth of an inch. After the cornea had been reshaped, the flap was replaced.

The actual surgical procedure took only about 5 minutes per eye. ALASKA surgery allowed a patient to eliminate the regular use of glasses or contact lenses although many patients still required reading glasses. Although ALASKA used the same chimer laser that had been proved for other eye surgeries in the United States by the Ophthalmic Devices Panel of the FDA, it was not an approved procedure in the United States, but was under study.

ALASKA was offered by clinics in the United States, but was considered an ' off-label" use of the laser. " Off label" was a phrase given to medical services and supplies that had not been thoroughly tested by the FDA, but which the

FDA permitted to be performed and provided by a licensed medical professional.

Prescribing aspirin as a blood thinner to reduce the risk of stroke was another example of an off-label use of a medical product-the prescribing of aspirin for this purpose did not have formal FDA approval but was permitted by the FDA.

The ALASKA procedure was not without some risks. Complications arose in about 5 percent of all cases, although experienced surgeons and complication rates tot less than 2 percent. According to the American Academy of Ophthalmology, complications and side effects included irregular astigmatism, resulting in a decrease in best corrected ' Sino; glare; corneal haze; overcorrection; interconnection; inability to wear contact lenses; loss of the corneal cap, requiring a corneal graft; corneal scarring and infection; and in an extremely rare number of cases, loss of vision.

If aliasing were not perfect, a patient might develop haze in the cornea. This could make it impossible to achieve 20/20 vision, even with glasses.

The flap could also heal Improperly, causing fuzzy vision. Infections were also occasionally an issue. Although PARK and ALASKA were the main types of eye surgery currently performed to reduce a patient's dependence on glasses or contact lenses, there were new surgical procedures and technologies that were in the test stage that could receive approval in the United States within the next 3 to 10 years.

These included intraocular lenses that were implanted behind a patient's cornea, laser thermostatically (LAT) and conductive ceroplastics (KC) that used heat to reshape the cornea, and "custom" ALASKA technologies that could better measure and correct the total optics of the eye. These newer methods had the potential to improve vision even more than ALASKA, and some of these new processes also might allow additional corrections to be made to the eye as the patient aged. Intraocular lenses were already widely available in Europe.

ALASKA Market Potential Rhea market potential for ALASKA procedures was very significant, and the market was just beginning to take off. According to officials of the American Academy of Ophthalmology, over 150 million people wore glasses or contact lenses in the United States. About 12 million of these people were candidates for current forms of refractive surgery. As procedures were refined to cover a wider range of vision conditions, and as the FDA approved new procedures, the number of people who could have their vision improved surgically was expected to grow to over 60 million.

As many as 1.7 million people in the United States were expected to have some form of laser eye surgery during 2000, compared to 500,000 in 1999 and 250,000 in 1998.

Laser eye repair was the most frequently performed surgery in all of medicine. Referrals were increasingly playing a key role in the industry's growth. Surgeons estimated that the typical patient referred five friends and that as many as 75 percent of new patients had been referred by a friend. A few employers were also beginning to offer laser eye surgery benefits

through managed care vision plans. These plans offered discounts from list prices of participating surgeons and clinics to employees. Vision Service Plan's (VSP) partners, for example, gave such discounts and guaranteed a maximum price of \$1,800 per eye for VSP members.

The number of people eligible for such benefits was expected to grow significantly in the coming years. PICK did not participate in these plans and did not offer such discounts. ALASKA at PC's Rhea process of providing ALASKA surgery to patients at PICK began with the partnering ODD.

The ODD provided the patient with information about ALASKA and PICK, reviewed the treatment options available, and answered any questions the patient might have concerning ALASKA or PICK. If a patient was interested in having the surgery performed, the ODD performed a pre-exam to make sure the patient was a suitable candidate for the surgery.

Assuming the patient was able to have the surgery, the ODD made an appointment for the patient with PICK and forwarded the results of the pre-exam to Dry. Everett. PICK had a standard surgical fee of \$1,400 per eye for ALASKA.

Each family ODD added on additional fees for pre- and postoperative exams depending on the number of visits per patient and the ODD's costs. Most of the ODDs charged \$700 to \$1,200, making the total price of laser surgery to the patient between \$3,500 and \$4,000. This total price rather than two separate service fees was presented to the patient.

Once a patient arrived at PICK, an ophthalmic assistant measured the tangent's range of vision and took a topographical reading of the eyes. Dry. Everett Mould then explain the entire process to the patient, discuss the possible risks, and have the patient read and sign an informed consent form.

The patient would then meet the surgeon and have any final questions answered. The meeting with the surgeon was also intended to reduce any anxiety that the patient might have regarding the procedure. The surgical procedure itself took less than 15 minutes to perform.

After the surgery was completed, the patient was told to rest his/her eyes for a few hours and was given dark glasses and eyedroppers. The patient was required to either return to PICK or to his or her family ODD 24 hours after their surgery for a follow-up exam.

Additional follow-up exams were required at 1 week, 1 month, 3 months, 6 months, and 1 year to make sure the eyes healed properly and to insure that any problems were caught quickly. The patient's family ODD performed all of these follow-up exams. Three of Pascal's seven surgeons specialized in ALASKA and related procedures.

The company's founder, Dry. Robert Ford, had performed over 16, 000 ALASKA procedures during his career, more than any other surgeon in the Northwest. His early training was as a physicist, and he was very interested in and knowledgeable about the laser technology used to perform ALASKA procedures.

Because of this interest and understanding, Dry. Ford was an industry innovator and had developed a number of procedural enhancements that were unique to PICK.

Dry. Ford had developed an enhanced software calibration system for Pascal's lasers that was better than the system provided by the laser manufacturers. More significantly, Dry. Ford had also developed a system to track eye movements. Using superimposed live and saved computer images of the eye, PICK surgeons could achieve improved eye alignment to provide more accurate laser results of the eye. Dry.

Ford was working with Laser Sight, a laser equipment manufacturer developing what PICK and many others viewed as the next big technological step in corrective eye surgery- custom ALASKA. Custom ALASKA involved developing more detailed corneal maps and then using special software to convert these maps into a program that would run a spot laser to achieve theoretically perfect corrections of the cornea. This technology was currently in clinical trials in an effort to gain FDA approval of the technology, and Dry. Ford and PICK were participating in these trials.

Although Dry. Ford was on the leading edge of technology and had vast ALASKA surgical experience, very few of Pascal's patients were aware of his achievements.

Competition PICK in Spokane faced stiff competition from clinics in both the United States and Canada. There were basically three types of competitors. There were general ophthalmology practices that also provided ALASKA

surgeries, surgery centers like PICK that provided a range of eye surgeries, and specialized ALASKA clinics that focused solely on ALASKA surgeries.

General ophthalmology practices provided a range of services covering a patient's basic eye care needs. They performed general eye exams, monitored the health of patients' eyes, and wrote prescriptions for glasses and contact lenses.

Most general ophthalmology practices did not perform ALASKA surgeries (or any other types of surgeries) because of the high cost of the equipment and the special training needed to perform the surgery, but a few did. These clinics were able to offer patients a continuity of care that surgery centers and centers specializing solely in ALASKA surgeries could not.

Customers could have all pre- and postoperative exams performed at the same location by the same doctor. In the Spokane market, a clinic called Eye Consultants was the most aggressive competitor of this type. This organization advertised heavily in the local newspaper, promoting an \$1,195 per eye price (Exhibit 17/3). The current newspaper promotion invited potential customers to a free ALASKA seminar put on by the clinic's staff, and seminar attendees who chose to have the procedure qualified for the \$1,195 per eye price, which was a \$300 per eye discount from the clinic's regular price.

Exhibit 17/3: Eye Consultant's Advertisement Surgery centers did not provide for patients' basic eye care needs, but rather peccadillo in performing eye surgeries. These centers provided a variety of eye surgeries, including such procedures as cataract surgeries and ALASKA surgeries in addition to other

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specialty eye surgeries. PICK was this type of clinic. The other surgery center of this type in the Spokane area was Empire Eye. PICK viewed Empire Eye as its most formidable competitor in the immediate geographic area.

Empire Eye operated in a similar way as PICK. It relied heavily on referrals from independent optometric physicians, did not advertise aggressively, and did not attempt to win customers with low prices. It did employ a locally based surgeon who performed its ALASKA procedures, although this surgeon was not nearly as experienced as Dry. Ford at PICK. ALASKA clinics provided only ALASKA or ALASKA and PARK procedures. They did not provide for general eye care needs nor did they provide a range of eye surgeries like surgery centers.

These clinics generally had much higher volumes of ALASKA patients than general ophthalmology or surgery centers, allowing them to achieve much higher utilization of the expensive capital equipment required to perform the surgeries. The capital cost of the equipment to perform the ALASKA procedure was about IIS\$500,000. The largest of these firms specializing in ALASKA surgeries was TTL Laser Eye Centers, Inc. TTL was based in Mississauga, Ontario, and had 56 clinics in the United States and 7 in Canada. During the first quarter of 2000, TTL generated revenues of IIS\$49.

Million by performing 33,000 surgeries. This compared with first quarter of 1999 when the company had revenues of IIS\$41.4 million on 25,600 procedures. TTL was the largest ALASKA eye surgery company in North America and performed more ALASKA surgeries in the United States than

any other company. The losses TTL centers to Spokane were in Seattle, Washington, and Vancouver, British Columbia.

The second largest provider of ALASKA surgeries in the United States was Laser Vision Centers (LIVE), based in SST. Louis, Missouri. Its closest center to Spokane Nas also in Seattle.

Almost all of the Canadian competitors that had been successful at attracting US customers were clinics that specialized solely in ALASKA surgeries. The largest Canadian competitor was Alaska Vision Corporation (C), based in Vancouver, arthritis Columbia. LIVE operated 15 clinics in Canada and 14 in the United States, and Nas growing rapidly.

LIVE had plans to add another 21 clinics by the end of 2000. During the first quarter of 2000, LIVE generated revenues of IIS\$20. 1 million by performing 26, 673 procedures. This compared to first quarter of 1999, when the company had revenues of only IIS\$4. Million on 6, 300 procedures. In total, there Nerve 13 companies specializing in providing ALASKA surgeries in British Columbia, mostly in the Vancouver area.

One of the British Columbia firms that advertised most aggressively in the Spokane area was Lexington Laser Vision (ALVA). ALVA operated a single clinic staffed by nine surgeons and equipped with four lasers. The clinic scheduled surgeries 6 days a week and typically had a 2-month wait for an appointment. The service design process at ALVA was structured to accommodate many patients and differed significantly from Pascal's service process.

To begin the process, a patient simply called a toll-free number for ALVA to schedule a time to have the surgery performed.

Once the patient arrived at the ALVA clinic, he or she received preoperative examination to assess the patient's current vision and to scan the topography of the patient's eyes. The next day, the patient returned to the clinic for the scheduled surgery. The typical sequence was to first meet with a patient counselor who reviewed with the patient all pages of a ALASKA information booklet that had been sent to the patient following the scheduled surgery date.

The patient counselor answered any questions the patient had regarding the information in the booklet and ensured that the patient had signed all necessary surgical consent forms. Following this step, a medical assistant surgically prepped the patient and explained the postcard treatment of the eyes.

After this preparation, the surgeon greeted the patient, reviewed the topographical eye charts with the patient, explained the recommended eye adjustments for the patient, and reiterated the surgical procedure once again.

The patient would then be transferred to the surgery room, where two surgical assistants were available to help the doctor with the 5- to 10-minute operation. Once the surgery was completed, a surgical assistant led the patient to a dark, unlit room so that the patient's eyes could adjust. After a 15-minute Matting period, the surgical assistant checked the patient for any discomfort and repeated the instructions for postcard treatment. Barring no

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problems or discomfort, the surgical assistant would hand the patient a pair of dark, wraparound sunglasses. Ninth instructions to avoid bright lights for the next 24 hours.

At the scheduled postoperative exam the next day, a medical technician measured the patient's corrected vision and scheduled any additional postoperative exams.

If desired, the patient could return to the clinic for the 1-week, 1-month, and 3-month postoperative exams at either the ALVA clinic or one of the US-based partner clinics of ALVA. In some cases, the patient might opt to have these postoperative exams performed by his or her family ODD.

US patients traveling to ALVA or the other clinics in British Columbia to have the surgery performed needed to allow for 3 days and 2 nights for the surgery. A pre-exam to insure the patient was a suitable candidate for the surgery was performed the first day, the surgery itself was performed the second day, and the 24-hour postman was performed on the third day. Two nights in a hotel near ALVA cost approximately US\$100, and airfare to Vancouver, British Columbia, Canada cost approximately US\$50 from Spokane, Washington.

Lexington Laser Vision and a sister clinic in the Seattle area where patients could go for postoperative exams.

ALVA requested patients to undergo follow-up exams at 1 week, 1 month, and 3 months. These exams were included in the price as long as the patient came to either the Seattle or Vancouver clinics. Some patients outside of the

Gastrointestinal area arranged with their family Odds to perform these follow-ups at their own expense to avoid the time and cost of traveling to Seattle or Vancouver, British Columbia.

A breakdown of the estimated cost structure for each of these different competitors is shown in Exhibit 17/4. Dry.

Everett believed that both Eye Consultants and ALVA were probably incurring losses. Both were believed to be offering below-cost pricing in response to the significant price competition going on in the industry. Eye Consultants was also believed to be offering below-cost pricing in order to build meme and gain surgeon experience. Pascal’s own cost structure was fairly similar to Empire Eye’s cost structure, as both operated in a similar fashion.

Exhibit 17/4: ALASKA- Related Revenue and Cost Estimates for Pascal’s, Competitors (All Figures Are in US\$)

Competitor	Eye Consultants	Empire Eye	RL Lexington	Laser Visions	yep of Operation	General Ophthalmology Practice	Eye Surgery Center	Specialized ALASKA Clinic	Location of Operation
Spokane, WA	Seattle, WA	Vancouver, BC							
Number of Procedures	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Price to Customer, per Eye	\$1,195	\$1,900	\$1,600						
Estimated Revenues	717,000								
Estimated Expenses									
Payments for Pre- and Postoperative Care	120,000								
Royalties	150,000	250,000							
Surgeon’s Fees/Salary	300,000								
Medical Supplies	30,000	200,000							
Laser Service	125,000								
Depreciation									
Marketing	75,000								
Overhead	350,000								
Total Annual	\$925,000								

This table was developed based on a variety of public sources on both the ALASKA industry in general and on individual competitors.

In a number of cases, the figures represent aggregated “ estimates” of data from several sources.

Estimated expenses are based largely, but not entirely, on discussion of the ALASKA industry cost structure provided in “ Eyeing the Bottom Line: Just Who Profits from Your Laser Eye Surgery May Surprise You,” by James Pothooks, U. S. News & World Report, March 30, 1998, up. 80-82. B This cost structure was thought to be typical of all of the specialized ALASKA clinics located in British Columbia, Canada, that competed with PICK.

C In some cases, these costs are paid directly by the patient to the postoperative care provider; they have been included here because they represent a part of the total price paid by the customer. The Canadian Advantage ALASKA clinics operating in Canada had a number of advantages that allowed them to charge significantly less than competitors in the United States.

First, the Canadian dollar had been relatively weak compared to the US dollar for some time, fluctuating between C\$1 . 45 per US dollar and C\$1 . 50 per US dollar.

This exchange rate compared to rates in the early sass that fluctuated between C\$1 . 5 per US dollar and C\$1 . 20 per US dollar. On top of this, the inflation rate in Canada averaged only 1. 5 percent during the sass compared to 2. 5 percent in the United States.

This dual effect of a weakened Canadian dollar combined with somewhat higher inflation in the United States meant that Canadian providers had, over

time, acquired a significant exchange rate cost advantage. Second, laser surgery equipment manufacturers charged a \$250 patent royalty fee for each surgery (I. E. Each eye) performed in the United States. The legal system in Canada prevented equipment manufacturers from hearing such a royalty every time a surgery was performed, amounting to a \$500 cost savings per patient for Canadian clinics.

Competitive pressure among surgery equipment manufacturers had caused this fee to drop in recent months to as low as \$100 for certain procedures performed on some older equipment in the United States, giving US clinics some hope that this cost disadvantage might decrease over time. Third, clinics in the United States generally paid higher salaries or fees to surgeons and support staff than did their Canadian rivals.

The nationalized health system in Canada tended to limit what doctors in Canada could earn compared to their peers in the United States. ALASKA clinics themselves were not part of the Canadian national health system because they represented elective surgeries. However, Canadian ALASKA clinics could pay their surgeons a large premium over what they could make in the nationalized system, but this was still significantly less than a comparable surgeon's earnings in the United States.

This cost differential extended to the referring optometrists who provided pre- and postoperative exams and whose fees were typically included in the price quoted to customers. Many Canadian clinics