A pure optometric vision therapy (OVT) practice is the dream of many ODs. It is also one of the best options for a recent grad who wants to avoid becoming locked into a primary or managed care rat race.

Over the past three decades I’ve seen many doctors attain this practice ideal. There are several commonalities among both those who were successful, and those doctors who failed or gave up. A doctor recently wrote us about his successful and expanding OVT-only practice.

After describing a doubling of patient visits to 100 per week in less than a year, he discussed how he’d done it: “First and most importantly, we implemented new community outreach programs, especially workshops. You strongly emphasized that a VT-only practice could not survive without these programs.”

Next, he specified the kinds of community outreach actions he’d taken.

“We have been very successful with this. For example, in May we did 10 workshops in total; I spoke at a child psychiatrist meeting at (an) Army base and to IT specialists at Exxon.”

This doctor conducts a mix of in-office and community workshops. It is extremely easy to set up workshops to community organizations, associations, support groups, clubs and other groups. You can identify possible audiences in newspapers, publications and online. Search community calendars, event listings published by local cities, chambers of commerce and by searching online using local city names followed by the Boolean search characters, + plus sign or – minus sign, and key search words, (e.g. Amarillo + learning disabilities) This simple search engine query produced pages of possible venues.

As president of a local club that presents about 70 speakers per year, I can attest to the difficulty program chairs have filling their schedules. A good presentation on vision and some aspect of life or behavior that interests a particular group will nearly always be welcome.

One common mistake made by doctors doing an OVT-only startup is focusing on public schools. It consumes considerable time and effort with limited results. What about marketing to other optometrists? The value of either of these efforts is related to the comfort level a doctor feels in handling challenging cases. Many primary care ODs and educators mostly identify and refer patients with gross visual problems. Some of these cases may be beyond the confidence level of a doctor who is new to OVT.

An active community outreach effort that emphasizes learning-related vision problems tends to produce less challenging cases and higher success rates. Success breeds more of the same because happy parents refer others, particularly if they see the doctor modeling how to get the OVT message across in simple language at a workshop. We have found that talks that use optometric terminology, or focus on educating the audience are less effective than those that dwell on the emotional impact of the problem. (For a free guide to setting up community talks, visit the download page at www.idealvt.com.)

Some ODs will be able to devote full time to a new VT-only practice, but most will have to use a different
approach. Student loans, family expenses and other costs drive most new grads to work for someone else.

We highly recommend the following sequence: Start with working 4 days for an employer. Establish an OVT office at the same time and devote 1 or 2 days per week to the private office. This means you will need to hire at least one employee. Train and educate a Vision Therapy Administrator who will answer the phone, set up community outreach workshops and even do a little therapy to start with.

As patient load increases, cut out a primary practice day and spend it in the VT office and doing community outreach. Do more workshops, enroll more therapy patients and then switch out one more day. At some point, with a fairly modest patient load (and additional staff) the OD can quit the primary care position and devote full time to building vision therapy.

The cost of establishing such a practice is fairly small. Many are able to do it with an investment of $80,000 to $100,000. Frugal budgeting is appropriate. Used equipment and a modest office location help keep startup costs down. The good news is that in a private-pay-only environment, breakeven (earnings offset costs) can occur in 6 to 8 months, not years.

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A therapy-only office may or may not include a dispensary. Doing without may make some ODs more comfortable referring (less fear of losing a patient), but that is not always the case. Since not every optical excels at working with children, you may wish to keep an inventory of good children's frames. A compromise is to set up a modest dispensary in a discreet space.

It is possible to get into financial trouble by growing too fast. A well established banking ratio predicts that a business growing faster than about 25-30 percent without new capital will go bankrupt. This is because expenses come due before income arrives to cover it. Optometric vision therapy is usually more profitable than primary care, so growth financed by cash flow can probably rise to 30 to 35 percent, but faster growth is problematic. It is important to arrange a credit line to cover growth, or to moderate growth by limiting available therapy hours.

Where will the new practitioner find financing? The American Optometric Association recently endorsed the professional financing arm of Wells Fargo Bank, once known as Matsco. We have found their personnel and printed guides to be helpful. (Lecoq Practice Development has no financial or other interest in this firm.) Some local banks and other financial institutions may be able to assist. Credit cards are another frequently used, but expensive source of back-up funds. A few doctors are able to get financial support directly from family.

Another option is to start the OVT-only operation in conjunction with an established primary care practice. Share exam room facilities and rent a room or two in the facility for therapy. This can dramatically cut startup costs, but can become complicated when the OVT caseload outgrows the space allotted to it. Be sure to cover this possibility in any contractual agreements.

To make this side-by-side setting work, it is important to train the established staff to detect potential VT cases during their initial call. The patient is prepared for what’s coming and is directed to the VT focused doctor.

The OVT doctor should not fill their schedule with primary care patients while waiting passively for VT patients to show up. Open time should be set aside for community outreach talks. Workshops should be scheduled every 2 weeks in the office so all potential VT patients, particularly those discovered by the primary care doctors, have the opportunity to hear the strongest possible OVT message.

Patient reports are a very important tool for community outreach. The report is also used to enroll parents/patients into therapy. Reports enable you to connect with high probability referral sources in the community. We recommend interviewing parents to find out what other professionals and educators are working with their child. A copy of the report should be prepared for each, and in select cases, should be presented in person by the new practitioner or an educated staff person.

Once the connection is made, keep it alive with ongoing communication. Social media can play a role in this, however, email is probably a better digital vehicle because it depends less on random sharing. A blog can be used to post information with links to it included in emails and social media posts. But
don't forget snail mail. While many people are deeply engaged with the web, many others use it lightly or not at all. Many organizations restrict work time access to the web and digital communications can be dismissed unread with a click.

What should you send? There are so many articles and studies being produced today that it won't be hard to find informative and inspiring material. Once you start publishing or distributing these, don't stop. Making contacts, then dropping the connection is one of the most common external marketing errors. Four to eight mailings or contacts per year is about right.

Perhaps the most important thing about starting an OVT-only practice is a deep commitment to being in action. As patient load grows, it is very tempting to spend less effort at marketing, community outreach, and building and sustaining a referral network. Unfortunately, reduced activity will soon result in a decline in caseload. If that happens, reviving the practice will require a repeat of the initial concentrated effort.

As doctor time is used more for patient care, staff training and education, much of the marketing effort should be transferred to the Vision Therapy Administrator (VTA). After reaching about 80 – 100 therapy visits per week, the VTA will need the help of a Marketing Assistant, who will execute the ongoing marketing effort. This assistant can be a part time employee.

In a previous article on hiring to support growth (Hire Now To Better Manage Future Practice Growth, OVD Vol. 38, No. 4, 2007) we set out this general rule: you will need to hire a full time therapist (or equivalent part timers) for every 30-32 therapy hours. You will need to hire this person about 6 weeks before you need them to allow time for basic training.

Training and staff education (how to do something and then why you do it) are principal activities for every optometrist who provides optometric vision therapy. The number one reason we've found for staff quitting is they feel their training has been insufficient. This is an ethical dilemma for many employees, particularly when it comes to working with children.

Schedule as much time as possible for training and education during the first year of practice. Enroll staff in COVD, OEP and other courses, or have an experienced therapist come to teach at your office. You will never regret having a knowledgeable and committed staff. It will be the difference between a great practice and a practice that could have been great.

Finally, invest in your own education and training. There are now many resources for learning about vision therapy. Take courses and develop a network of professional colleagues with whom you can discuss patients. Go to the annual COVD meeting, join a study group and watch for OEPF courses in your area. Sign on to ListServs, DOC-L (Contact Marc Taub, O.D., at Southern College of Optometry, mtaub@sco.edu) and VTOD (http://www.vtod.org); attend practice development courses (they are all worth the time and cost) and use resources such as MainosMemos (http://www.MainosMemos.blogspot.com) for information on the latest research and the COVD blog (http://covdblog.wordpress.com/) and VisionHelp Blog (http://visionhelp.wordpress.com/) for perspectives on a number of topic areas. Take advantage of every opportunity to ask questions, in person, by phone or email.

Perhaps the best thing about Optometric Vision Therapy is the collegial relationships that exist among its practitioners and supporters. Developmental optometry is an inclusive club of professionals whose members are eager to share whatever they can.

Thomas and Anee Lecoq are consultants with Lecoq Practice Development, located in Apple Valley, CA. A free Community Outreach Guide is available at their site, http://www.idealvt.com/downloads.htm. For questions, comments and suggestions email idealvt@verizon.net.

A personal note: 2011 marks my 30th year of helping OVT doctors build their practices. It is a pleasure to count so many optometrists among my friends and associates. Thanks to all of you who have helped us and to those who have let us help them. – Thomas Lecoq