Your Practice Website Position – Going...Going...Gone – Continued

websites. This method improved the relevance of surfer searches for quite a while, and, this method continues to be an important aspect of positioning strategy. But...

PROBLEM: Nefarious programmers (who are these people?) created programs that created "link farms." They sold access to these link farms to owners of websites. This instantly linked a website with thousands of others and improved website positioning. Unfortunately, what the surfer got was more spam and more irrelevant web search results.

SEARCH ENGINE REACTION: Changed the way they "rank" web sites (**again**).

Technology now evolved to the point of actually measuring the relevancy and quality of each individual link. The "link farms" lost their impact. As a matter of fact, those that took advantage of link farms were immediately penalized by search engines.

SO WHAT IS NEW IN 2013 AND BEYOND?
Search engines have "upped" the ante again. They have vowed to stay well ahead of nefarious programmers. From here on out (spearheaded by Google), websites will now be ranked on "*strength.*" **Those strength elements are, but are not limited to the following** (these are in priority order):

- Video
- Audio
- Flash Elements
- Stickiness (surfer time on site)
- Integration with Social Networks
- Google Earth
- Google Maps, Yahoo Maps, etc.
- Second Life

Search engines want to see:

- More engaging sites
- More entertaining sites
- More effective delivery of information
- Less spam - more relevance

HOW DOES THIS IMPACT YOU?
If you have a website but *do not* have it optimized:

- This is a fantastic time to do it once and do it right
- Make sure your website/SEO company is aware and prepared

If you do not have a website for your practice yet:

- This is your entry point. You can "leapfrog" in position quickly

If you do have a website *and* you have it optimized:

- Time to take a global look at your site and your positioning
- Time to add the elements that will add to your ranking "weight"

WHO LOSES THE MOST WITH THIS NEW TECHNOLOGY?
You know those "search consolidators" (middlemen) that call you to get you to "subscribe" to their service? They claim they have top placement in your town for 50 keywords and ask you to get listed on their site for a monthly fee? Their sites are going to drop like a stone when this new technology is fully implemented. This is good news to the search engines and surfers. Surfers don't necessarily want to go to a middleman - they want to go directly to the site they want (asked for).

Paid search results (also known as AdWords or Pay Per Click) will also become less and less relevant IF you have a well built site with the proper strength elements. Why would you pay for "ad space" in a newspaper that had you on the front page with each edition? While this might not necessarily be true for all businesses - it certainly minimizes the need for search engine pay per click for dentistry. So, if you are exhausting marketing budget $'s into PPC or AdWords - you should enjoy those savings.

SUMMARY:
Properly promoting your practice website locally through various other local mediums is definitely a tried and true way to get a big bang for your website buck! Properly positioning your site so it shows up on the first page of a search engine just became much more involved. The more progressive dentists committed to using the Internet as a primary marketing medium will win "the position wars." As soon as ten to fifteen dentists in a particular market build their sites with the strength elements above - it will take considerable work/investment to "wedge" your way into their space.

This is a new and exciting time. We suggest to each of our clients that they allocate a small percentage (usually 10% of budget or less) of their annual marketing budget each year toward their website, getting it to convert more visitors into phone calls, and getting their website competitively positioned on search engines.

If you have any questions, feel free to reach Howie Horrocks at whh@net-tpatientsinc.com or Mark Dilatush at markd@newpatientsinc.com.
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Charge for $edation... Produceanother$50,000to$100,000peryear.

by Dr. Alan Nix[2]

My journey with sedation began some 25 years ago, when Dr. Carrington, who had been practicing 30+ years, suggested I do what he did. He had been sedating patients with oral medication for most of his career, and not had a problem. The dose he routinely gave was 2.5 mg of Ativan given one to one and a half hours before treatment, on an empty stomach. This was long before the days of certification for enteral sedation were required, and I felt that if it was good enough for him, it was good enough for me. So, my journey of sedating patients began over 25 years ago.

In recent years, in Texas, we have been required to obtain training to be certified for enteral sedation if we use oral medication and nitrous together. No certification is required if we use oral medication by itself, or nitrous by itself. Only if we combine the two.

When I first heard of the requirement to monitor, I thought it was not necessary since I had been sedating for about twenty five years already. However, I decided to obtain certification immediately, and began to monitor the patient's blood pressure, pulse, and blood oxygen level.

At first I was perturbed that we had to do this, but after doing a few cases with it, I found that it was idiot proof! The monitor would beep to let us know if anything was out of normal range. My confidence level went up that things were all right, and I could measure it. This also lead to the true purpose of this paper, which is the ability to charge for sedation.

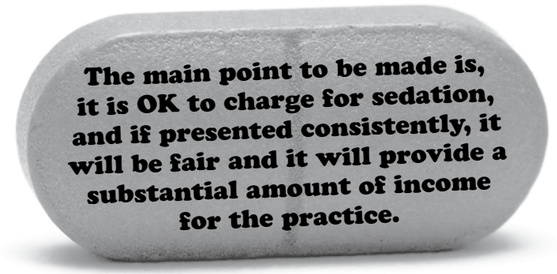
During my training, it was mentioned that the State Board suggested charging for sedation, and a figure of over $200 was suggested. Having heard this, I was somewhat shocked that the State Board would suggest charging, and even mentioning the amount! Even though I came away with this information, I still only charged for sedation on rare occasions.

After a while, I decided to charge, but we had to work out a few kinks. At first, we would only charge on some cases that I felt would be justified through either the size of the case, or the size of the apprehension of the patient. Whatever the reason, we charged only rarely. Then one day a light bulb went off. The message was, "My goodness, if the State Board says its OK, then why not?"

So, during a staff meeting, I announced that we were going to start charging for sedation on every case. After a while, I asked for the report on sedation charges, and quickly realized that we were hardly charging anyone! I looked into it, and the problem was, we were relying for the charge to be added at the front. It wasn't happening. The person who was making financial arrangements simply wasn't adding it in, for whatever reason.

We immediately changed this, and the assistants and hygiene department were to add on sedation where there seemed to be a need. After a short time, it was discovered that it was not added consistently, by overlooking it or by not adding it when needed. Therefore, we decided to reverse the thinking. Sedation was added in the back at the diagnosis, and the front was to delete it when necessary. This took care of the problem, and sedation was consistently added and charged for.

Exceptions are made when either the patient doesn't want sedation, or they don't want to pay for it, and it would not allow the case to be accepted if we charged. Sort of throw the sedation in to create some good will for the patient to proceed. Of course, if it is a two appointment case to be sedated for the second appointment, we only charge for one. Also, most doctors would rather use sedation and not charge, than to not use it if the patient objects to paying for it.



Objections typically are in the area of, "$245.00 for two little pills?" A quick, gentle response of an explanation that it "is not just for the two little pills" follows. It is explained that "it is not for the two little pills, but it is for monitoring, equipment, delays when the patient is not sedated enough, and allowing recovery time. In these cases, we have to sometimes wait for the patient to sedate more, or give more meds and wait. After treatment, recovery time is taken into consideration when the patient is monitored until they are conscious enough to leave." This explanation establishes value, and the patient is happy.

Some insurance plans cover their percentage for sedation, and this can be factored in. The main point to be made is, it is OK to charge for sedation, and if presented consistently, it will be fair and it will provide a substantial amount of income for the practice.

So, the concept I implemented in my office involves a philosophy that doesn't take any more work on my part. We simply started charging where we were giving it away before. And since this was sort of "free" income, I decided to put this amount away into a money market account. Each week, my office manager informs my wife the amount of sedation charges, and she transfers the amount into a money market. Charging one case per day equals about $50,000 per year, and charging two per day $100,000 per year!

In good times, this represents a substantial amount to put aside in a year, with no more effort on the dentist's part. So called "extra free money". In not so good times, it can be a great help in meeting those bills!

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Implant Technology at Castle Rock Oral & Facial Surgery:

With technology changing frequently, Dr. Hart sees it as a priority to not only give his patients the best care but to also use the most innovative and forward thinking technology available on the market. Here at Castle Rock Oral & Facial Surgery, Dr. Hart uses The Osstell ISQ meter for each implant surgery.

The Osstell ISQ meter (Implant Stability Quotient) stimulates a smart peg (small magnet) mounted on the dental implant through the use of magnetic pulses. This causes the smart peg to vibrate to levels dependent on the stability of the dental implant in the jawbone. The resonance is then quantified using the Osstell ISQ meter, giving Dr. Hart a number that can be tracked over time. Therefore, this technology provides the doctor a quantifiable way to judge the dental implants stability and success over time.

The Osstell ISQ meter provides accurate and reliable stability measurements that are important to allow Dr. Hart to make informed loading decisions.

OUR NEW OFFICE:

Castle Rock Oral & Facial Surgery is thrilled to soon be joining the Centura family at our new Castle Rock Adventist Health Campus location. Look for our new office to open in July of 2013!

Your Practice Website Position Going...Going...Gone

by Howie Horrocks & Mark Dilatush[1]

Those of you who are familiar with our firm know that we work in every medium known to be effective for promoting dental practices. This includes websites, search engine optimization, and First Impression Video for dental websites. Websites are one of many mediums a dentist can use to promote his/her dental office. And, we have been gathering and studying the impact of dental websites for years. Websites are *fantastic secondary mediums.* As secondary mediums, they give everyone that sees or hears your other local promotions (mail, radio, billboard, etc) - a place to "check you out" before making their first appointment phone call. Practice websites are also good *primary mediums.*

One trend that we have noticed over the past 5 years is the acceleration in dentist spending money on websites. Not only that, dentists are spending money on getting their websites competitively positioned on major internet search engines like Google, Yahoo, MSN, etc. Some of you are *over spending.*

Howie and Mark are here to tell you that how you attain (or attained) your current search engine position is **drastically** changing right before your eyes. Some of you are calling us because neither you nor your website company knows why you are losing your hard earned (and in some cases costly) positioning.

We know why. This is the focus of this article.

The following is watered down to its most basic form to allow people who are not familiar with websites or website positioning to understand the history and impact.

First, let's start with a history lesson of sorts...

About a decade ago, search engines ranked websites primarily by popularity. In other words, if a website was already visited by lots of people - it must be "popular." So, search engines ranked them higher. The more visitors you had, the higher you ranked. Does anyone remember those little "visitor counters" at the bottom of the website home page in the old days? That's what those "counters" were for – search engine positioning.

PROBLEM: Nefarious programmers created programs to make it "appear" that a website had a high traffic count. Thus, artificially gains in higher rank and "spamming" of web surfers. Search engines got upset.

SEARCH ENGINE REACTION: Change the way they "rank" web sites.

Search engines adopted some new (at the time) technology that allowed them to change the definition of "popularity." Number of visitors was still important, but the search engines decided to start looking at the number of, and validity of links on each website. They also paid particular attention to the number of websites on the internet that had reciprocal links to other