Issue 6
JuLY 2017

THE SECRETS OF A HIGH PERFORMANCE TEAM part 2

# THE PROTOCOL MAGAZINE™

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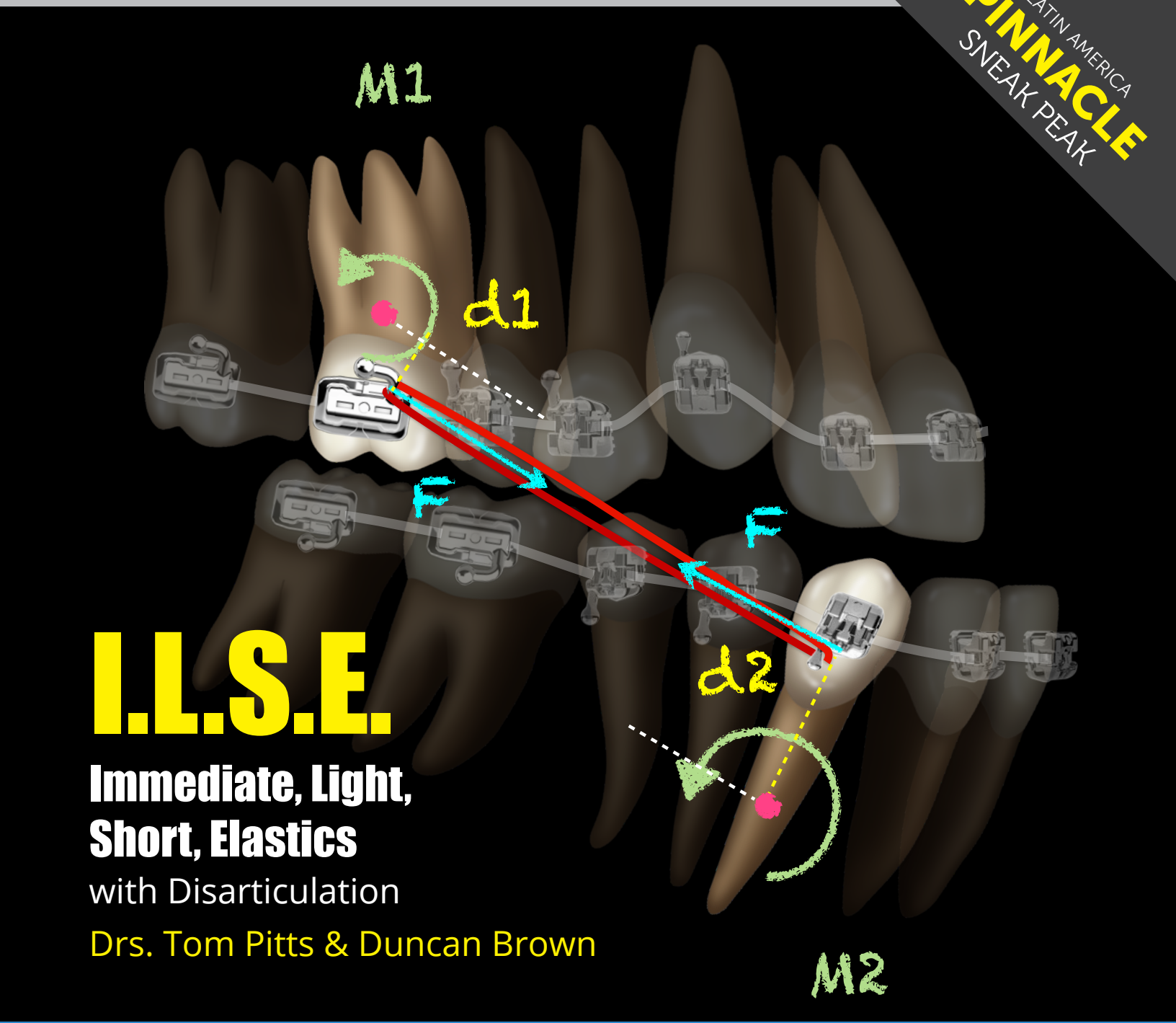
LATIN AMERICA PINNACLE SNEAK PEAK




# I.L.S.E.

## Immediate, Light, Short, Elastics

with Disarticulation

Drs. Tom Pitts & Duncan Brown

PRACTICE SPOTLIGHT - DR. JEFF HASKINS

# CONTRIBUTORS

## Thomas Pitts D.D.S., M.S.D.
*Ortho Country Orthodontics*

Dr. Pitts is a world renowned lecturer and clinician. He is highly recognized for his continued teaching of orthodontic finishing and clinical excellence. Dr. Pitts is an associate clinical professor at the UNLV and founder of the well-respected Pitts Progressive Study Club.

Dr. Pitts has been published in multiple journals and clinical publications. He has been actively teaching the orthodontic community in a variety of settings both nationally and internationally since 1986.

## Duncan Brown B.Sc., D.D.S., D. Ortho
*Smile Zone Orthodontics*

Dr. Duncan Brown is a highly regarded international speaker and educator in passive ligation bracket systems. Dr. Brown teaches regularly at the University of Alberta and University of Manitoba and is also a Kodak/Carestream Dental speaker and consultant.

Dr. Brown has made large contributions to the orthodontic community including creating effective hygiene programs for patients and much more!

## Jeff Haskins D.D.S., M.S., P.C.
*Village Orthodontics*

Dr. Jeff Haskins graduated from the University of Nebraska Medical Center with a Doctorate in Dentistry in 1981. He then attended Washington University in St. Louis where he earned a Masters Degree in Orthodontics in 1983. Dr. Haskins moved to Colorado following graduate school and established Village Orthodontics in Aurora the same year. Dr. Jeff was featured as a TOP DOC in 5280 Magazine, nominated by his peers every year from 2004 to 2015. In 1991, Dr. Haskins became a Diplomat of the American Board of Orthodontics, joining the top 20% in his field.

## David Herman D.D.S., M.S., M.P.H.
*Four Corners Orthodontics*

Dr. David Herman is credited with having one of the largest single office practices in the United States. He is known for being years ahead of the curve—foreseeing industry changes and adapting with success. Dr. Herman was one of the pioneers in implementing same-day starts, passive self-ligation, staff-driven management and adding dental and hygiene departments to an orthodontic practice. Professionals from all over the United States come to observe Dr. Herman's staff-driven management concept and see the success of his marketing campaign that brings in patients from more than two hours away.

# THE PROTOCOL™

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orthodontics

# PRACTICE SPOTLIGHT

# BE PROACTIVE AND STAY RELEVANT

## Jeff Haskins D.D.S, M.S., P.C

I am the youngest son of four, born into a family of hard working mid-west parents. We had a lot of love and encouragement, but not a lot of money. This was a great combination to encourage me to become a high achieving, hard-working student.

Growing up I aspired to be an architect. My dad told me long ago, 'if your family name is not on the architect firm building, you will end up only a draftsman'; advice I truly took to heart. My father was a mechanical engineer and my mother was a nurse with a Masters in Guidance. I am also one of 5 eagle scouts in my family; my mother earned all five of them (along with her sons) with her 'never quit' drive in a time when being a scout was not considered being one of the cool kids. I worked in hospitals during my summers and made the decision early on to look seriously into dentistry and medicine.

A funny story, just for the experience, I applied to dental school midway through my junior year in college. Low and behold, I was accepted early for the next fall. The dilemma: accept the challenge and go to dental school? Then, if I didn't like it, apply to medical school? Well, the rest is obvious; I graduated from dental school and after attending the orthodontic program at Washington University in St. Louis, I entered the work force at the young age of 27.

It was during my junior year at the University of Nebraska Dental College, that I met a young instructor, Dr. Clarke Stevens. Dr. Stevens took me under his wing and was the driving force in my applying to orthodontic residencies. Dr. Clarke Stevens has been an outstanding OGS (Orthognathic Surgery) instructor

Dr. Haskins with Dr. Pitts

at the University of Nebraska medical center as well as an orthodontic innovator. You may know him for his 'Wild Smiles' brackets or from his cutting edge ortho meeting "Ortho Voice" which is held every September in Las Vegas. I have been in private practice in the Denver metro area since 1983. I am a solo cowboy opening three scratch offices plus adding three pediatric specialists in 2008. What a game changer for a 52 year old


orthodontist who was experiencing somewhat of a plateau in production; more dialog to come on how to integrate pedo into your practice at a future Pitts meeting.

Dr. Tom Pitts' OC Protocol is the first written journal that actually teaches you the most innovative way to create amazing 'Smile Arcs' vs the previous 'flat smile lines'. Additionally, his 14 protocols serve as a great reference as you progress through your first H4 and H4 GO cases. In March of 2016, I was fortunate to attend Dr. Pitts' first in-office course at the McMinnville, Oregon OC Orthodontics production plant, now home for Tom's Ortho Country orthodontic clinic. I actually had H4 GO brackets placed and now am experiencing firsthand the game changing arch expansion and 'Smile Arc' changes in less than 12 months of treatment. I also attended the 2016 OC Pinnacle in Portland, Oregon and have hosted and attended several of Dr. Pitts' one day protocol seminars.

This past August, Dr. Pitts was generous enough to spend a day with me in my Centennial office treating H4 patients - talk about learning first hand from the master! Finally, I am part of Dr. Pitts and Dr. Duncan Brown's 2017 two-year H4 Masters course starting this spring in Reno.

**I have had the honor of having three special dentists influence my career path:**

- **Dr. John Seberg**, my family dentist in Hastings, NE. He encouraged me to apply to dental school.

- **Dr. Clarke Stevens** of Omaha, he gave me the confidence to apply to orthodontic programs.

- **Dr. Tom Pitts** started molding me in 1987. After 33 years, he continues to be my clinical mentor in helping me dramatically change my practice staying relevant and competitive with OC H4 and Pitts 21 bracket systems.

One of the most satisfying aspects of my job is helping my patients gain a confident outlook on life impart due to their new amazing smiles along with being thanked every day for doing a job I truly love. At Village Orthodontics, we try and do all the little things that enable us to have a thriving practice. You need to have fun but make sure it comes from your heart and not manufactured. The addition of in-house pediatric specialists along with a staff that is

trained daily by a former Peniche warrior, enables us to not only enroll 90% of our initial exams, but start them the same day.

Private practice orthodontics is alive and well. To compete today with all the delivery systems for braces and Invisalign, you have to be a cut above. Incorporating the innovative Dr. Pitts' protocols to get that "WOW" smile and offering Invisalign are ways to keep your office cutting edge. The final component to practice success, in my opinion is, if you are going to be competing for the same piece of the pie as 85% of the orthodontists in your communities, you have to be different but exceptional. We have in-house pediatric dentistry, offer retainers for life, and have an active progressive SEO program. In addition, we offer non-extraction treatment, utilize PSL bracket systems and try to keep everything very patient friendly. Use progressive and innovative appliances such as keyless expanders, Carriere, and occlusal bite ramps greatly reduce the need to use appliances similar to a Herbst. Talk less and listen more, to offer the patient treatment plans and outcomes they are looking for and not a treatment plan you assume they want. Always practice with the mantra, "if your son or daughter was my child, this is what I would recommend." 33 years later, my Village Orthodontics practice in Colorado, still feels relevant in our competitive orthodontic markets.

### Dr. Haskins' Top Tips:

- Hire, train and reward your staff - verbal and financial appreciation goes a long way
- Know what you are good at, don't dilute your strengths by adding things like sleep apnea (unless you have passion for it)
- Align with pediatric dental specialist
- Realize that excellent on-time treatment will fill your exam slots faster than gifting your colleagues
- Don't be afraid to try new things such as scheduling, satellite offices, SEO marketing, bracket systems, scanners, associates etc.
- Always strive to be debt free and keep overhead low
- Give the patient / parent more value than they expect

## Meet Our Orthodontist


facebook.com/VillageOrthodontics
Instagram.com/villageorthoco
@VillageOrthoCO
www.youtube.com/user/VillageOrtho

**Undergraduate**: University of Nebraska
**Dental School:** University of Nebraska
**Orthodontic School:** Washington University in St. Louis

**Past President:** Summit Orthodontic Study Club
**Member:** Diplomat, American Association of Orthodontists
Rocky Mountain Society of Orthodontists
American Dental Association
Colorado Dental Association
Metro Denver Dental Society

**Awards/Honors**
Elite Invisalign Provider since 2011
5280 Top Doc every year since 2004
Pitts Masters Course, 2017-2018

**Charitable Foundations**
Dr. Jeff and his wife Kristina founded an Orthodontic ministry in 2008 called 'Ortho 127' to provide "no charge" orthodontic treatment to adopted children in the Denver area.

He also hosts a '911' campaign every fall to honor first responders with a sizeable ($911) treatment discount for their children.

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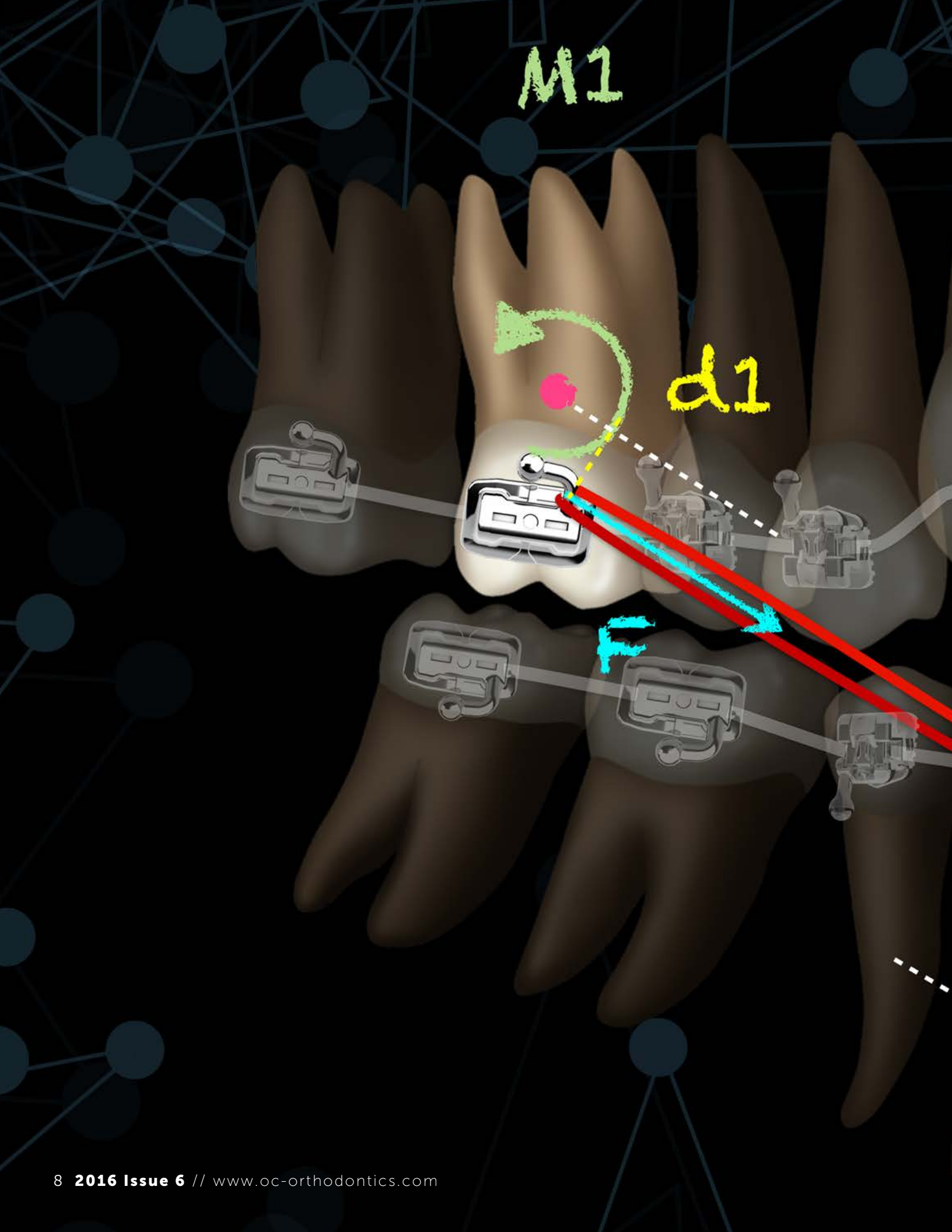
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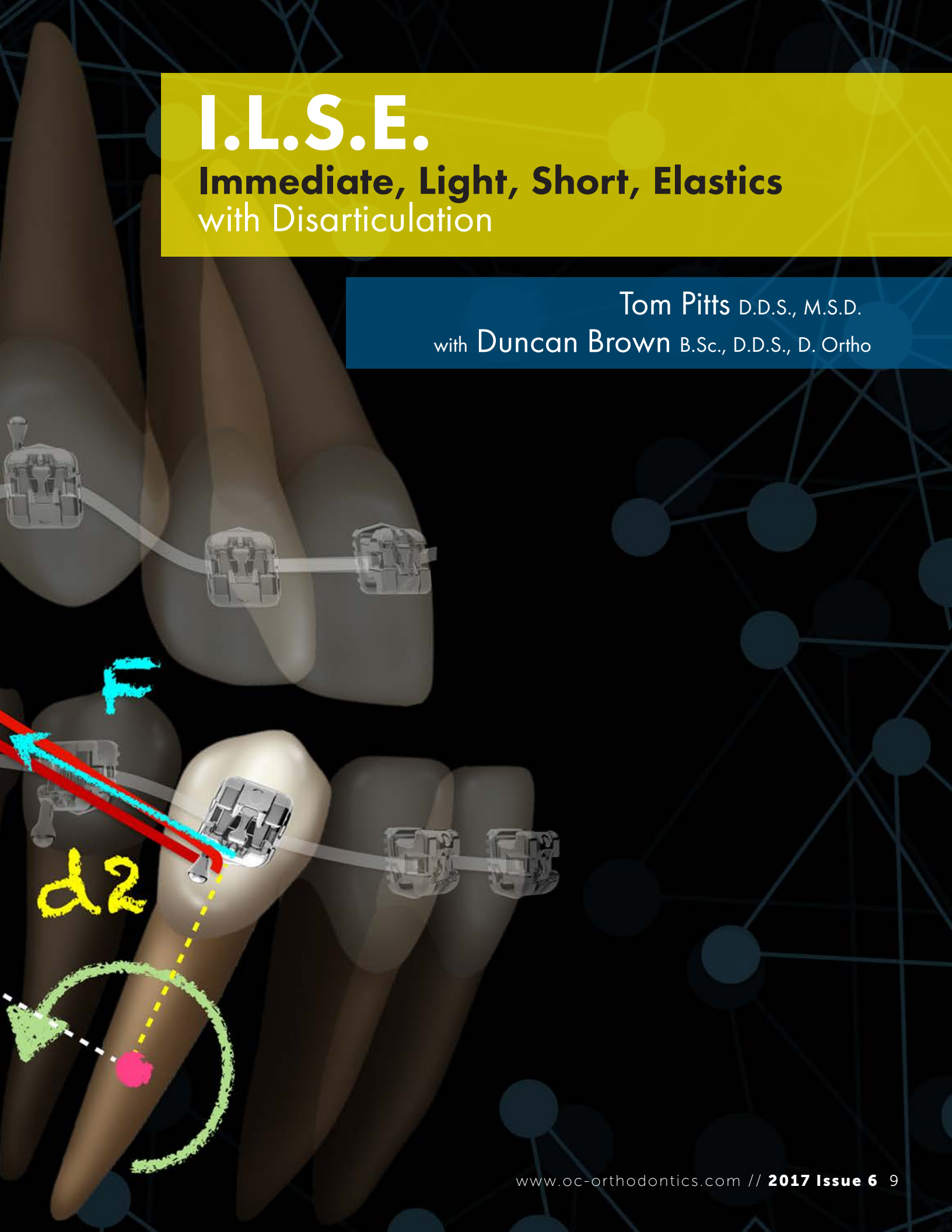
# I.L.S.E.

## Immediate, Light, Short, Elastics
with Disarticulation

Tom Pitts D.D.S., M.S.D.
with Duncan Brown B.Sc., D.D.S., D. Ortho



# *"Knowledge is a process of piling up facts; Wisdom lies in their simplification" – Martin Fischer*

Historically, the use of orthodontic elastics for the treatment of inter-arch tooth discrepancies dates back to the dawn of orthodontics when Calvin Case and Henry Baker used natural rubber products as "inter-maxillary anchorage"[1] prior to the 1900's. Edward Angle first described the technique before the New York institute in 1902[2], and most orthodontic patients treated since then have used either inter-maxillary or intra-maxillary elastics at some point in their treatment.

Despite their obvious significance in orthodontic mechanics, little research and only very basic articles regarding the use of elastics has been done. Today we'd like to give an introduction to our current approach when using elastics (usually with disarticulation) as an adjunct in "Active Early"[3] treatment protocols.

## Exact forces required to move teeth are not known

The force magnitude for "optimal tooth movement" has been one of the holy grails of orthodontics since Schwartz[4] advanced the concept of "the force leading to a change in the tissue pressures that approximated the capillary blood pressure, thus preventing their occlusion in the compressed periodontal ligament". While there has been a good deal of animal research, human studies have been very limited. Reitan's study in the 1960's suggested that the optimal force level for tooth movement was 5 N (approximately 50 gms) of force. Clinically, it has been obvious to me that teeth will move with forces that are much smaller than commonly used if they are precisely applied[5].

For years orthodontists, have had to resort to heavier forces than we needed. Once we began using passive self-ligation and taking IO photos every visit, I was able to see that we could use very light elastics at the very first appointment to attain desired changes (Figure 1-6). This is far more comfortable for the patient, and we achieve better cooperation, as a rule.

With the widespread adoption of PSL approximately 20 years ago, clinical protocols have been developed that reduce the level of applied forces to increase patient comfort while improving clinical efficiency for me. Our ILSE (Immediate Light & Short Elastics)

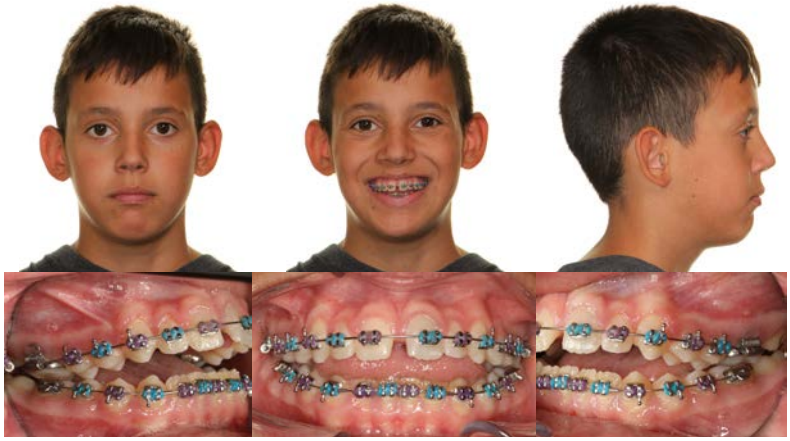


Figure 1: Transfer cases 18 months into treatment - Courtesy Tom Pitts 2017

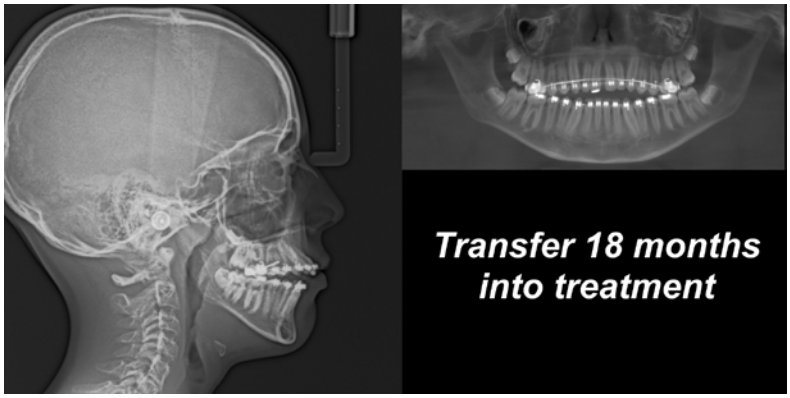



Figure 2: Transfer cases 18 months into treatment - Courtesy Tom Pitts 2017

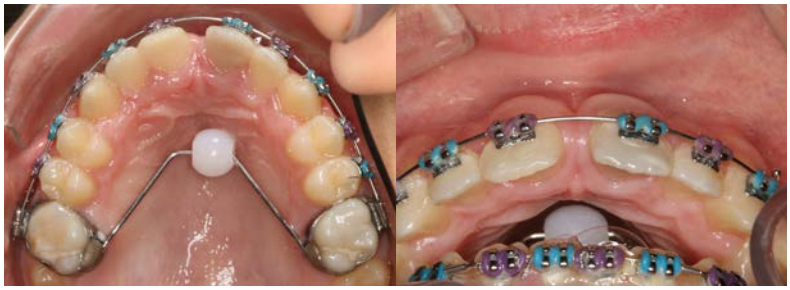


Figure 3: Popular "blue grass" roller did not provide resolution of the AOB or tongue thrust - Courtesy Tom Pitts 2017

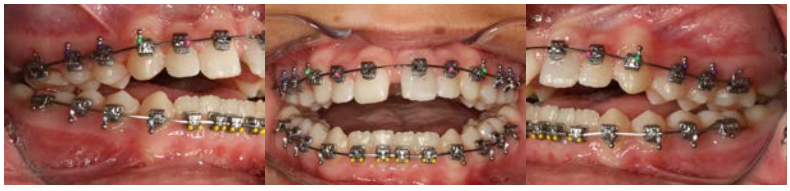


Figure 4: Pitts "Active Early" protocols: SAP bracket position, "Flipped" upper anterior brackets, Pitts Broad AW's, ISLE (triangle elastics), NMI (squeeze exercises, lower tongue tamers) are applied - Courtesy Tom Pitts 2017

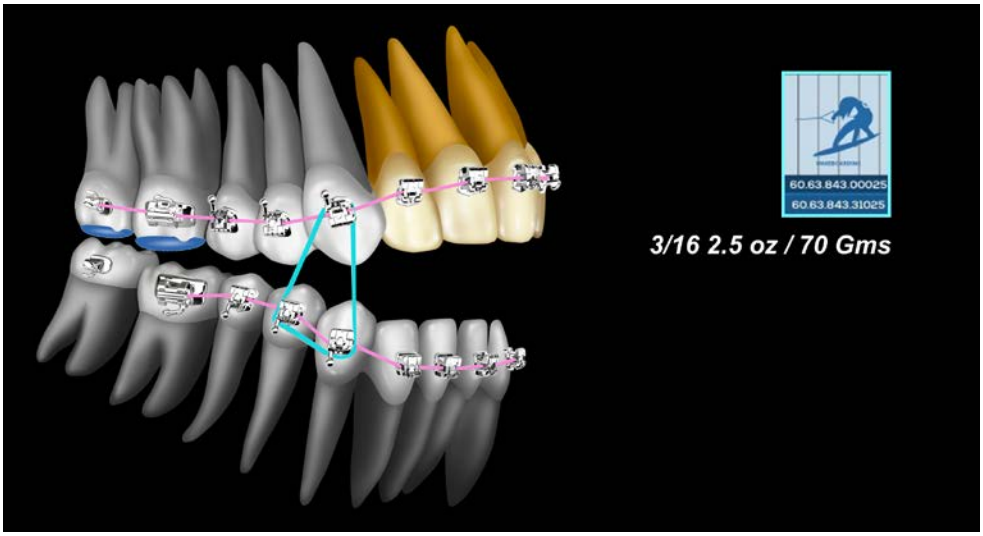



Figure 5: ISLE protocols involved wear of "Vertical Triangle" elastics full time, and Pitts P.T. squeeze exercises.

protocols deliver light, precise forces in support of mechanics. ILSE and PSL are great marriage. In contrast to some contemporary protocols where inter-maxillary elastic forces of 4.5 to 6.0 oz. are commonplace, "Active Early" approaches seldom employ elastic forces greater than 4.5 oz. and frequently 2.5 or 3.5 oz.

To minimize inventory and simplify elastic selection, our protocols use mainly six elastic types, and most our treatment can be accomplished with only four. We have 2 sizes, 3/16 and 5/16 and 3 forces levels of each of these sizes 2.5, 3.5, 4.5 ounces.

## There are a variety of factors that degrade elastic force over time

Both Latex and Synthetic (non-latex) elastics and elastomers display a reduction in loss of strength when stretched over a period of time, and exposed to various fluids that may be ingested during in vitro testing. Force degradation during function approximates 25% in the first 24 hours[6], with most of effect occurring in the first 3 to 5 hours[7].

With this in mind, we suggest changing elastics after each meal, which applies a more consistent level of force supporting mechanics.

## Elastic compliance is critical to attain a designed result

With "active early" esthetic treatment planning protocols, elastic wear is critical to achieve the desired results. "Every patient/every appointment" photos supports patient compliance, and fully involves the patient/parent in the treatment process by revealing progress from the previous appointment.

## Routine intra-oral photos every visit

"Active Early" case management protocols are very efficient, and it is important to keep this in mind during esthetic orthodontic treatment. This is not a "set it and forget it" approach. Every appointment requires a regular routine of photography, review of patient progress, and adjustment of case management (where it is required). Use of treatment milestones allows this process to be systematic - PRACM (Pano reposition adjust case management). Progress IO photos are most important for adjusting case management and mechanics.

## Derivation of ISLE - Immediate, Short, Light, Elastics

As with many other clinical advances, ISLE and disarticulation protocols were developed as a combination of luck and experience. In 1977, when I was testing lingual appliances, I found that in deep overbite cases with lingual appliances, the posterior teeth were disarticulated. The posterior teeth came together by eruption and no intrusion of the upper anterior teeth was necessary to reduce the overbite. Leveling naturally occurred, but on some cases it took some months for the posterior

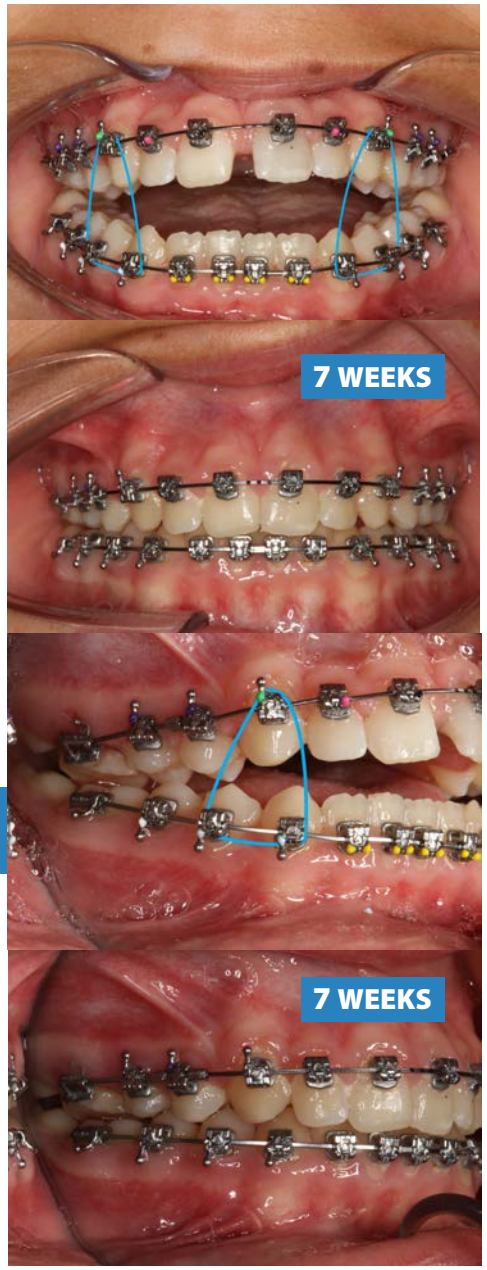



Figure 6: Excellent patient co-operation in elastics wear, and Pitts PT exercises contributed to the progress to date in just 7 weeks. Notice the improvement in incisor inclination due to "Active Early" case management - Courtesy Tom Pitts 2017

## Supported by NMI

**Mechanism was supported by neuromuscular intervention, tongue tamers, and Pitts PT squeeze exercises.**

Figure 7: In many Class II div 2 patients, incisor exposure is near ideal prior to treatment - Courtesy Tom Pitts 2017

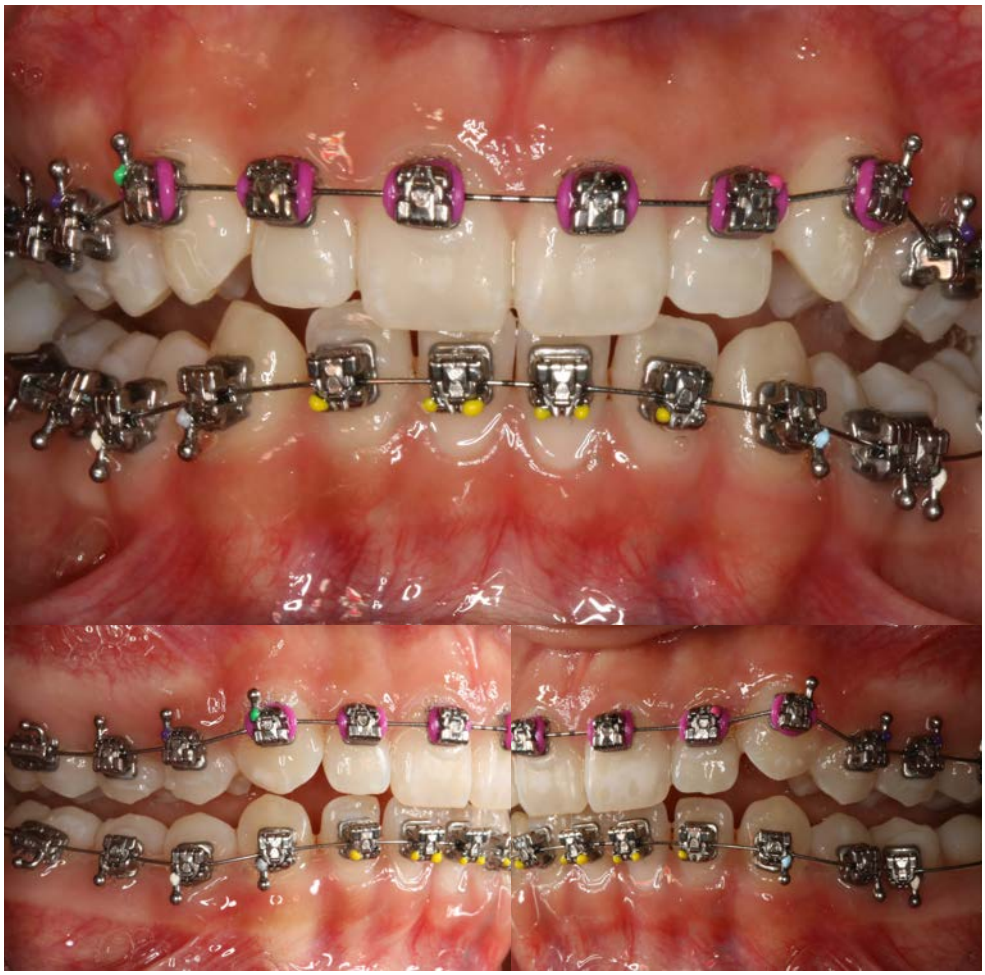


Figure 8: Protection of existing smile arc and incisor display is critical to esthetics. Eruption of the lower posterior teeth and protection of upper incisor position by SAP bracket position is supported by disarticulation and ISLE - Courtesy Tom Pitts 2017 Pitts "Active Early" protocols: SAP bracket position, Pitts Broad AW's, ISLE (Short Class II), anterior disarticulation are applied - Courtesy Tom Pitts 2017

teeth to begin occluding. I began using composite bite buttons behind the upper centrals, which became known as bite turbos (derivation of the name turbos is unknown). However, not only did some patients take a long time to erupt the buccal segments, some would return on their first visit biting behind the bite buttons with the lower anteriors. I added some short light elastics to mitigate against this, using the lightest forces possible (2 oz., 3/16") to close the posterior bite. When patients wore the elastics (full time), starting with the first appointment, from the lower 6 to the upper 4, the posterior teeth were touching in 6 to 8 weeks and biting behind the turbos was no longer a problem. By observing the IO photos, the AP corrected slightly. There were no deleterious effects. Today, we have developed ISLE protocols and combined groups of elastics designed to increase VIP (Vertical Incisor Position; this acronym was suggested by Dr, Dwight Frey) cant the occlusal plane, and broaden arches-improving occlusion and esthetics from the first appointment. This is a major factor in being able to treat more cases non-extraction with "WOW" esthetics.

## A Practical Clinical Approach

"Active Early" treatment protocols are designed to apply lighter forces for longer durations earlier in the treatment cycle to improve efficiency for the Orthodontist and gentleness for the patient. Each of the parameters of pre-bonding coronoplasty, SAP/VIP bracket placement, use of precise PSL bracket slots, practical torque values, (inverting brackets as needed), combined with appropriate disarticulation, early elastics, and NMI (neuromuscular intervention) improves esthetic and occlusal results quickly with very light force levels.

By clinical trial and error, we've found less need to distalize molars of many crowded cases, due to our esthetic positioning of incisors, torque control, and arch development providing needed space. Light inter-arch elastics save a tremendous amount of time and effort in treating all different types over malocclusions, with attendant esthetic enhancement. Yes - we begin most treatments with light elastics at the **first appointment**.

## Disarticulation and Early Elastics

The most frequent questions that we are asked when teaching involves the case management techniques with elastics and disarticulation. One of the subtleties of case management of continuous arch wires in fixed mechanics is flaring associated with relief of crowding and is counter to esthetic or occlusal outcomes. We do not need to use reverse curve wires with our technique. With our active early protocols we can generally treat non-extraction cases and end up with proper inclination of the anterior teeth.

We advocate approaches that are simple, efficient, effective, and predictable; for that reason we do not use MEAW mechanics (Figures 1-6). That is only needed when using twin-tie brackets.

## Disarticulation

ILSE and disarticulation work together in "active early" case management. Disarticulation removes the occlusal influences of malocclusion and permits selective eruption and intrusion of teeth and arch development to meet esthetic and occlusal goals.

**We use either Bandlock (blue) or Pink Triad gel for posterior turbos (pillows) or Triad rope (pink) for anterior turbos.** These materials are easily adjusted (reduced or increased), distinguishable from natural teeth (facilitating removal), and wear more easily than enamel (preventing tooth wear).

Adjustment of the position or size of bite turbos requires constant management, in response to treatment response for maximum benefit. "Setting and forgetting" disarticulation is a common error.

Disarticulation strategies have evolved considerably to improve efficiency and patient comfort.

**Anterior Bite Turbos:** We use disarticulation that is more anterior in deeper bite cases, reducing overbite through selective eruption of the lower posterior teeth, and intrusion of the lower anterior teeth, supported by SAP bracket placement and ILSE. Where good upper incisor display is present, anterior turbos **behind the upper anterior**

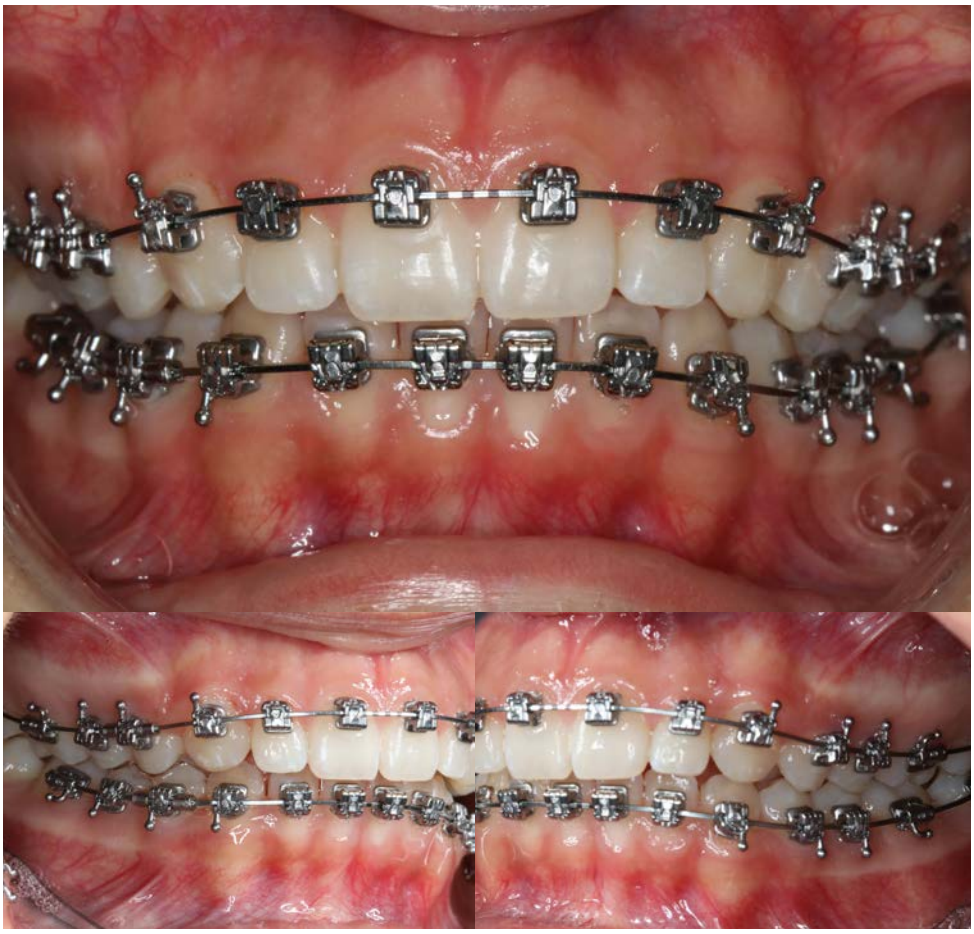


**Figure 9: Great improvement in only 6 weeks. "Every appointment imaging" reinforced the progress with the patient/parent, and advancement of wires to 018X016 UltraSoft TA NiTi was possible. Today, I would place the bite openers (turbos) on the upper first bicuspids with a bite ramp to let the lower jaw come forward. - Courtesy Tom Pitts 2017**

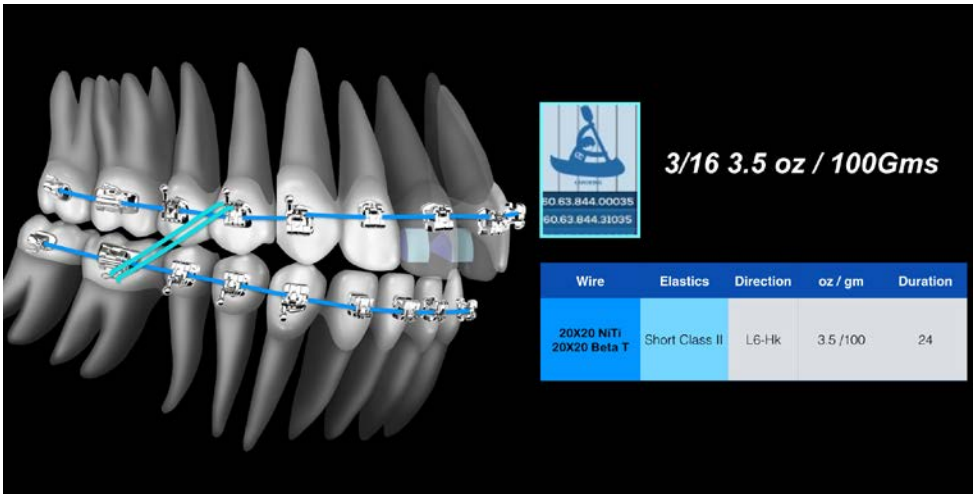



**Figure 10: Great improvement in only 6 weeks. "Every appointment imaging" reinforced the progress with the patient/parent, and advancement of wires to 018X018 UltraSoft TA NiTi was possible - Courtesy Tom Pitts 2017**

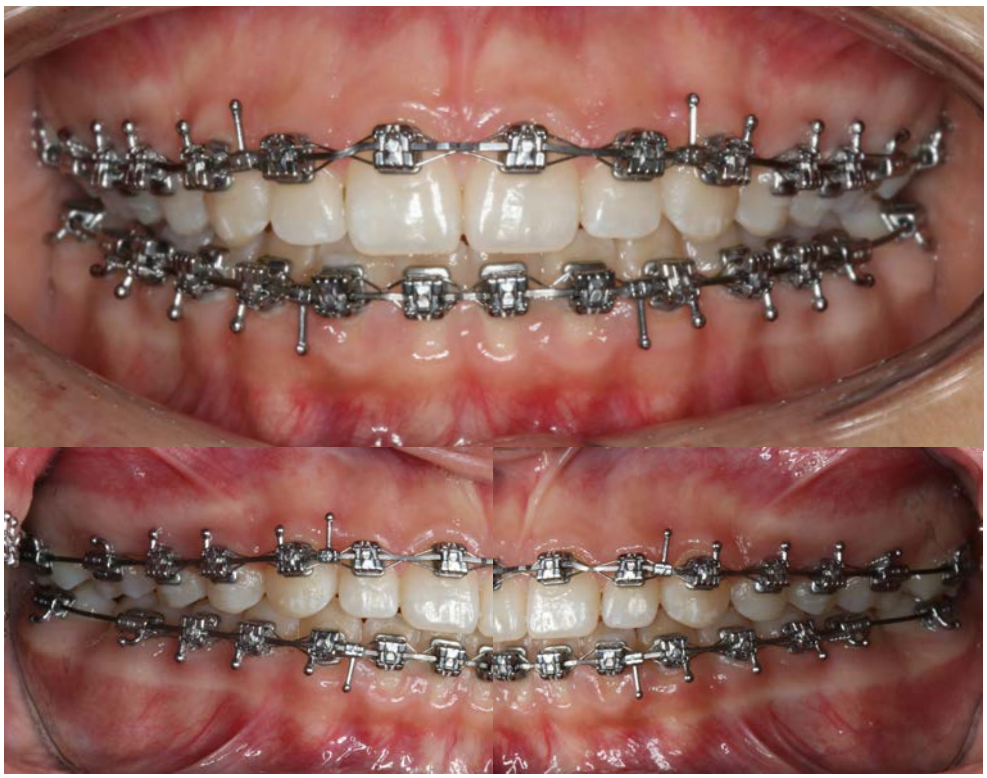


Figure 11: Continued improvement. As most rotations were completely resolved, finishing was possible with 020X020 Beta T with a minimum of AW adjustments, further adjustment of occlusion as the posterior teeth seat into occlusion. 8 months from beginning of treatment. - Courtesy Tom Pitts 2017

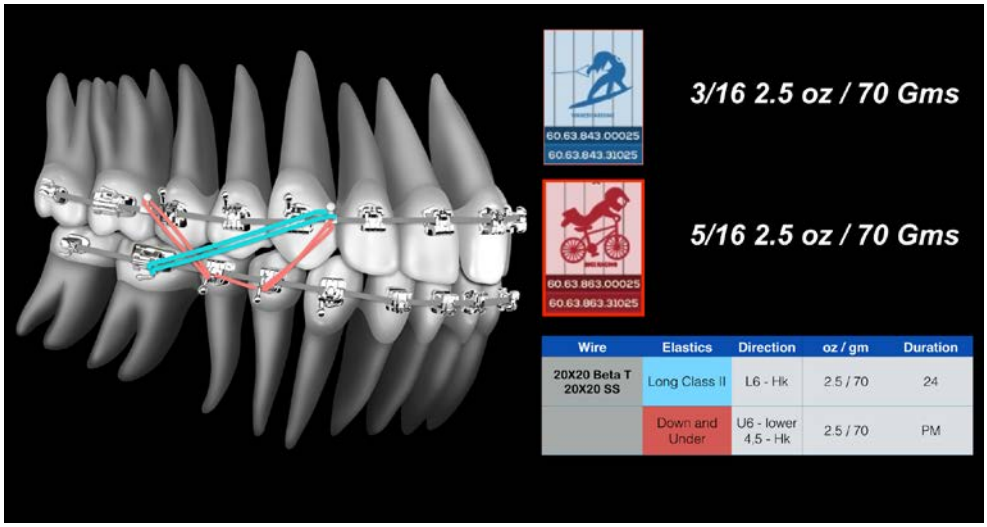



Figure 12: Finishing procedures involved continue wear of the light Class II elastic, and Down and Under elastics to complete seating of the occlusion. The anterior disarticulation can be removed once the posterior occlusion is fully seated.

**teeth**, provides rapid reduction of overbite, while preserving enamel display. Several years ago we found that placing turbos on the upper cuspids, was more comfortable for the patient, and still effective early in treatment. Most recently, we have adapted an approach suggested by others, including Dr. Keith Sellers in Charlotte, using bite turbos **on the upper first bicuspids** incorporating bite ramps to encourage forward mandibular positioning (similar to "planas direct tracks"). These turbos are still anterior enough to allow eruption of lower molars with light elastics, and clockwise tipping of the upper occlusal plane for esthetic gain. With the bite ramps on maxillary first bicuspids it allows for more eruption of lower molars than upper molars. **When the cases are nearly leveled, cuspid or bicuspid turbos are repositioned anteriorly to the maxillary incisors**, allowing ideal overbite protection, while maintaining incisor display, and seating the buccal segments. Anterior bite turbos are maintained until near the end of treatment, ensuring over-correction of the deep-bite. As an aside, uprighting of the anteriors is easier when the anterior teeth are not in occlusion.

**Posterior Bite Turbos/Pillows** have evolved considerably, directed towards positive adjustments of the occlusal plane, and molar intrusion. They are used in anterior open bite cases as well as high angle cases. Upper or lower posterior bite turbos are **supplemented with PT exercises** (squeezing pressure on molar pillows, activating the posterior fibers of the temporalis muscles) to encourage favorable rotation of the occlusal plane and intrude molars. We suggest placing posterior turbos in the depth of the occlusal fossa rather than the cusp tips, frequently on the upper first and second molars, and adjusted to balance the occlusion. Posterior bite pillows are **removed when the ideal overbite relationship is attained**, so that the buccal segment relationships can be developed with finishing elastics and refined through coronoplasty. We can expect to intrude the molars 2+ mm with PT exercises.

## Patient Compliance

The only way we achieve "WOW" esthetics is wearing light elastics full time, immediately, and then continuing excellent compliance throughout treatment, to minimize treatment time and achieve esthetic goals. I think that Dr. John Campbell's esthetic treatment explanation to his patients says it best, "Elastics is not a part of your treatment, **it is your treatment!**" We use any and all efforts that develop a collaborative relationship with patient/parent in elastic wear, explaining the impact of elastic wear on esthetic/occlusal results, describing the adverse effects of failure to comply. We also empower the patient/parent role in achieving excellent results. Matt Brunner approaches this with NIMIT discussion (Now Is the Most Important Time) to reinforce the importance of elastic wear throughout the treatment process, using clinical photography both monitor progress and provide positive patient reinforcement.

**In Summary, as our guiding principles of ILSE:**

- Shorter elastic stretch is better than longer
- Groups of elastics are better than individual
- Full time wear is absolutely necessary (except for rainbow)
- Immediate (first appointment) is a must
- Lighter is better than heavier

## To Summarize:

We strive to develop protocols that are effective, efficient, predictable, and produce outstanding results with a more accurate and tightened slot. In "Active Early" case management, ILSE and disarticulation are critical contributors. We hope that this article will reduce some of the confusion that has existed regarding their role in our case management.

Look for more innovations on both the technology and case management sides, that we will be releasing soon as the Pitts 21 system.

Until next time...

Drs. Tom Pitts and Duncan Brown

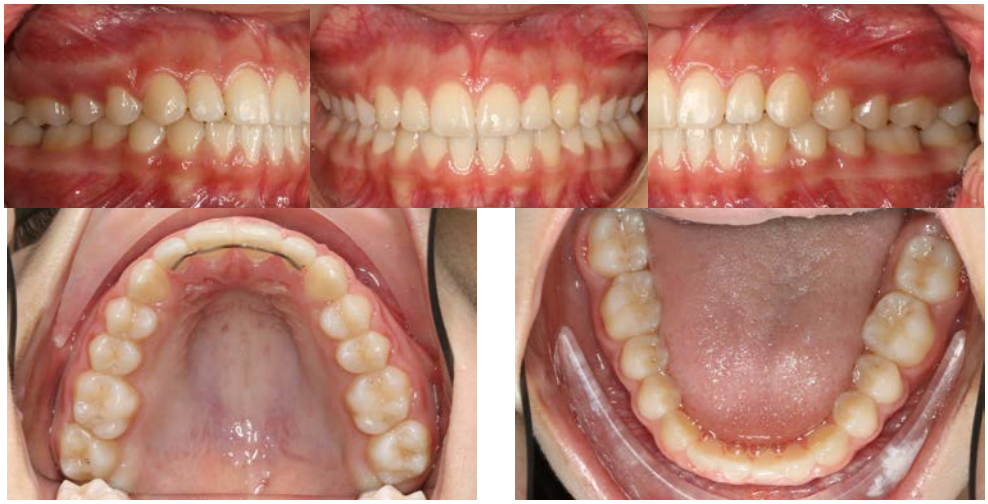


Figure 13: Very nice final result attained in only 9 months with this approach - Courtesy Tom Pitts 2017


Figure 14: Very nice final result attained in only 9 months with this approach - Courtesy Tom Pitts 2017

Figure 15 & 16: Very nice final result attained in only 9 months with this approach - Courtesy Tom Pitts 2017

## Author's Comments

Dr. Tom Pitts

Dr. Duncan Brown

*"Efficiency of treatment and the quality of the final result is highly dependent on elastic wear and disarticulation. Mastering ILSE (immediate, light, short, elastics) and disarticulation will shorten treatment times, and improve the quality of your esthetic results. With the introduction of Pitts 21 appliance system, and its revolutionary slot design, using ILSE and disarticulation will be even more effective! Look forward to showing it to you!" - Tom Pitts*

## REFERENCES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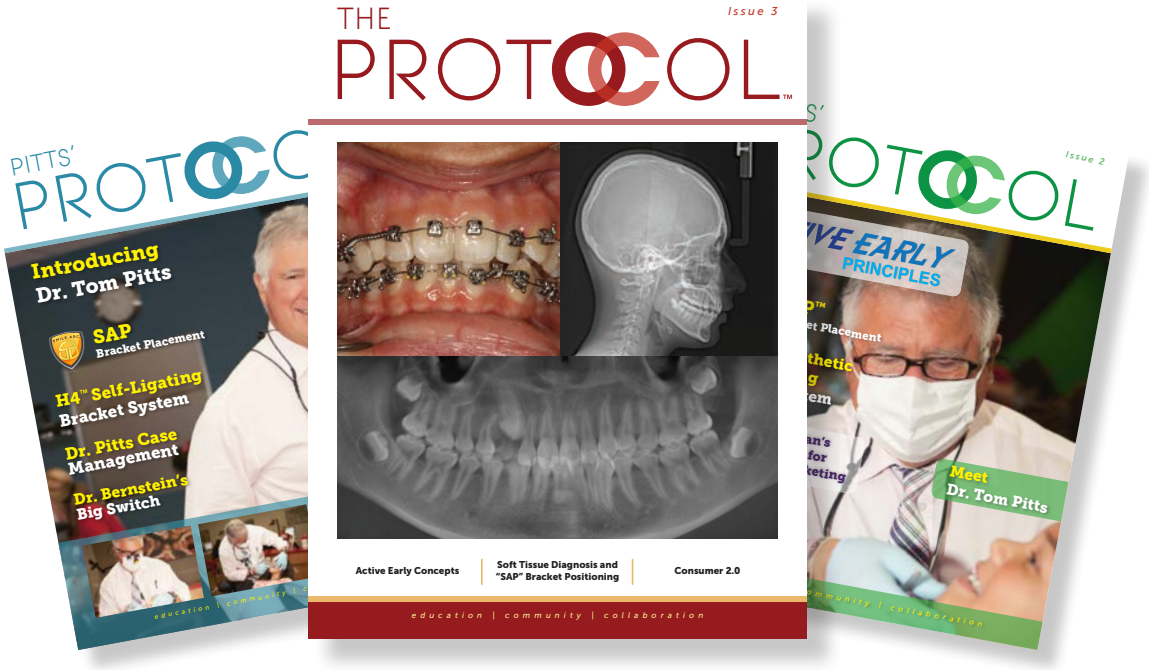


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# Developing a High Performance Team

*Teams Succeed based on the Strength of their Leadership.*

By David Herman D.D.S., M.S., M.P.H.

**PART 2 OF 2**

*For part 1 of this article see Protocol Issue 5*

"Clients do not come first. Employees come first. If you treat employees right they will take care of your clients." - Richard Branson

## What you see is what you coached: Training, maturation, problem solving, conflict resolution.

The biggest complaint I hear from new staff about their old job was poor training. My training process is integrated in with my team's maturation process. Mature teams train faster and can handle more complex skill sets than less mature teams. New staff learn faster when placed on a mature team. In this section, I will discuss the relationship between training and the team maturation process.

Training requires teaching, practice, and monitored execution. Training starts with teaching new skill sets and requires hours to accomplish. Practice can require at least 35 work days to reach minimum competency. Practice is replication of what was taught to increase self-confidence, discipline and consistency of performance. Monitored execution is evaluation of what the trainee learned and practiced. This is followed by re-teaching and more practice until maximum competency is achieved. I recommend about four hours of practice to every hour of teaching. I find that teaching without sufficient amounts of practice results in too many negative outcomes. Outcomes that severely impact the trainee's self-confidence and sense of well-being.

All teams go through a maturation process. The stages of this maturation process are: **forming, storming, norming, and performing.** Forming is about starting out. It tends to be a short honeymoon period were all is good and expectations are high.

Storming is the point where control, significance, and openness issues cause friction within the team. It can be short or endless. Norming is the stage that a large majority of teams operate within. In this stage your team performs well but quickly reverts back to a storming stage if conflicts or problems arise. The performing stage is what a team strives to mature into. It is a stage where performance is consistently good and conflict and problems are handled without reverting back to a storming stage. Do not expect to have a consistently high performing team unless your team is at a performance maturation level. Because storming results in inconsistent performance, and is a stage needed to be minimized, I want to discuss the causes of storming behavior in some detail.

Storming is the stage we all dislike and it usually is due to three root causes. First is Control: who bosses who around?, who decides the course of action?, who controls situations?. Second is Significance: how do I feel when I am in your presence? In your presence, do I feel better or worse about myself? Third is Openness; how much information does someone share? Too much communication too little communication? These three root causes all have a range, and those team members that tend to be at the more extreme ends of these ranges are often involved in the most storms.

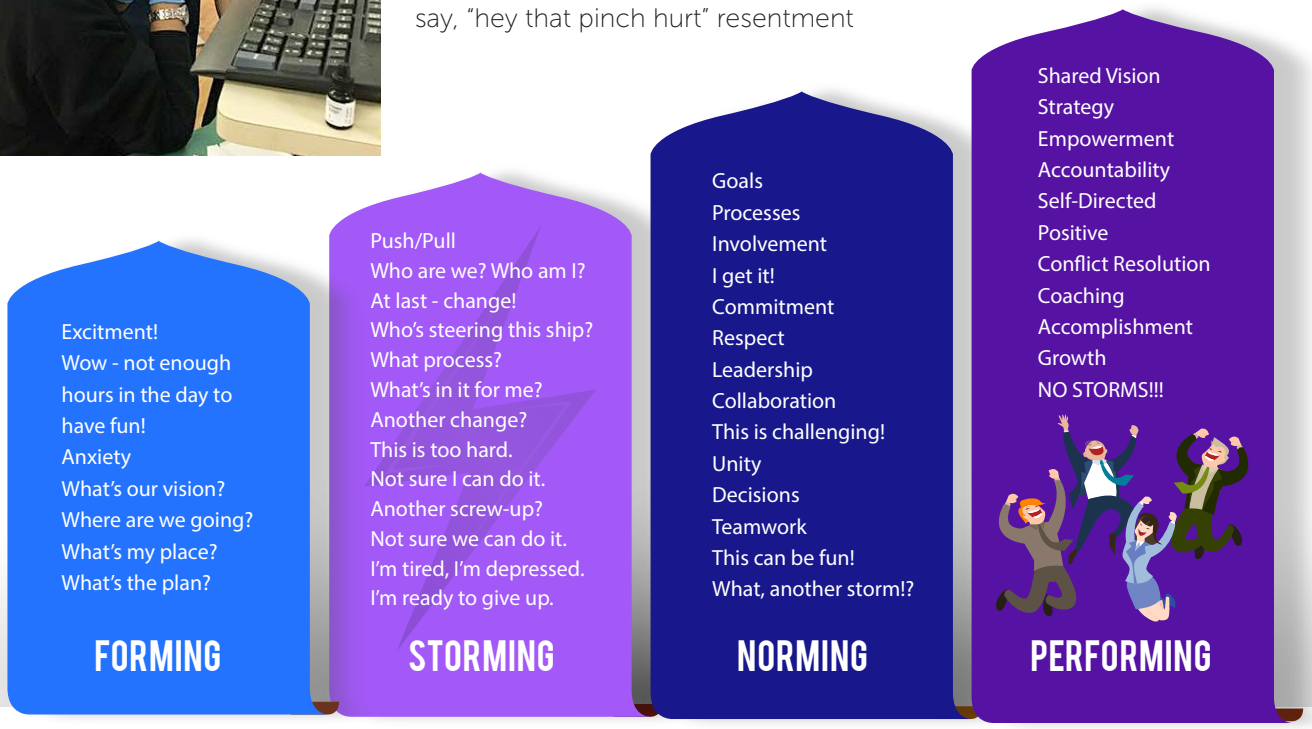
To get a team to a performance maturation level, they need to be trained in problem solving and conflict resolution. Training in these two areas are of paramount importance in my training process. Problem solving is

about "things" and conflict resolution is about "people." There exists many books on these two subjects. Having great problem solving skills mean that all variables are assessed before identifying solutions. The greatest reason for poor problem solving is jumping to solutions. The biggest reason for jumping to solutions is not identifying the root cause(s) of a problem. The second reason for poor problem solving skills is letting blame assessment into the process.

Conflict resolution is different than problem solving because it gets personal. We use the pinch theory for conflict resolution. The pinch theory has been used for years in couples counseling. It is based on the belief that little pinches that go uncalled lead to a crunch. When someone does not say, "hey that pinch hurt" resentment starts to build. A series of pinches that go uncalled eventually result in an emotional outburst and a crunch occurs. At this point, emotion rather than rational response rules the day. My staff is trained to avoid crunches by calling pinches. My assistant coaches are involved most times in this process unless I am part of the problem or part of the solution. It would be rare for me to be involved in this process. Most pinches are in their control.

### Discipline: Players first concept

One of the main reasons my staff has so much empowerment and control is due to the fact that they are well disciplined in behavior and performance. My staff stays focused while performing, takes corrective



action intuitively and responds positively to coaching. Training a team to be self-disciplined starts for me with my "players come first" philosophy. As a coach (leader), my players (staff) are the most important part of my practice and my staff knows it. As stated in part 1 of this article, it is as a team, coaches and players combined, that the patients become most important, When you put your players first you develop a unique relationship with each player that shows him or her how much you care and how important it is to you that they achieve success. In return, I expect my players to be coachable and part of being coachable is having the self-discipline to "do what's right."

Doing what is right is another one of our ten core values. In my practice, undisciplined behavior stands out and the team has pretty close to zero tolerance of such behavior. As I added staff to my team it became easier to hire people who were a good fit, and eliminate early in the try out period those who were a poor fit. For my team, the prima-dona, or self-centered applicants, were a poor fit. I have had the prima-dona type make the team but he or she had to change to be more giving and less self-centered. I want team members with diverse personalities, and I strive to achieve a balance of personality types in the office. Too heavy of one personality over another creates problems. When we are looking for a new team member, we hire for personality fit and train for needed skill sets. Training someone with the needed skill sets but wrong personality is more difficult and time consuming.

In my "players come first" environment, fighting between staff has been significantly reduced. To reduce such behavior, all staff have leadership responsibilities. We all conduct informal performance evaluations on each other. The evaluations are based on four main areas. I call the process TLC +P, Trust, Loyalty, Commitment, Passion. First, are you trusted to do the right thing and not over commit or under deliver? Second, are you loyal? Does the team know that you are there for them and have their back? Third, are you committed to the team? How committed does the team feel you are? This includes attendance and timeliness, as well as being present in the moment when performing. Fourth, are you passionate about what you do? Does it show through to teammates, patients and parents that you really love being at the practice and performing your skills? I have a very responsive team to coach so when a team member needs to adjust behavior in any of the TLC+P areas it can be achieved with minimum drama.

## Great Leaders don't create followers they create more leaders

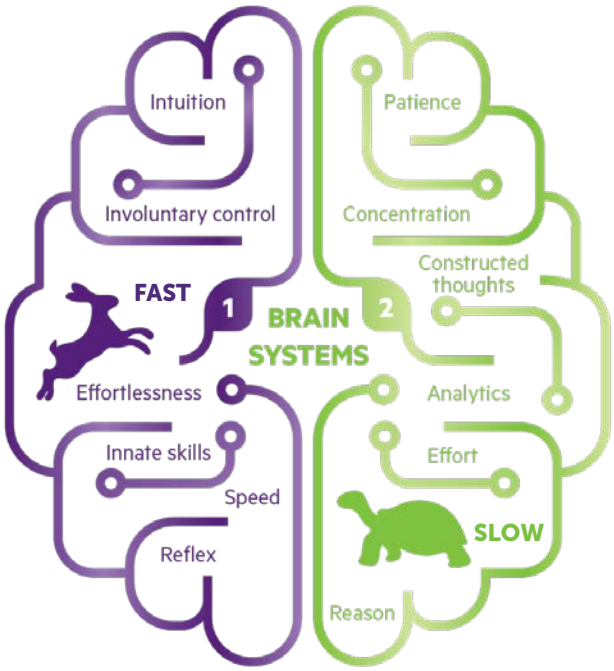
As my practice grew, decentralization of the leadership was required. Studies show the ideal leader to team ratio is about six to one. I have 36 staff members, so I have five assistant coaches. I trained these coaches to be extensions of me and I chose coaches that would balance out my areas of weakness listed in part 1 of this article, on the question, "Why not work with me?" So, I chose assistant coaches who demonstrated good listening and nurturing characteristics. This meant that assertive type personalities were not a good fit for this position. Next, I took a firm stance with my assistant coaches that if I was not part of a problem or part of a solution then I would not be involved in the problem solving or conflict resolution processes. I developed this coaching staff into my core management group. The more relevant my coaches became to the team, the more my quality of life improved. Each coach has responsibility for a five or six person work unit. Once these work units matured into performance level teams it was the core management group's responsibility to integrate these work units into one larger functioning operation. Because I want to create more leaders than followers, I am goal or objective-oriented rather than process-oriented. I understand there are usually different processes that can be followed to achieve a goal or an objective. I encourage my leaders to think for themselves about the process he or she wants to use. This is the same critical thinking process that most of us learned as residents. Most of us had several attendees teaching us their way to achieve treatment outcomes. A residency director did not tell the attendees to teach just

one methodology. Leaders who are process-oriented are called micro managers, poor idea if you want your leaders to be critical thinkers. The better method is to evaluate a process based on its ability to efficiently and effectively reach a goal or objective and not on if it fits into the way you would have done it.

## Creating an Environment of Transparency and Options

Years ago I found that being opaque about information hurt the team, and being transparent allowed the team to make better decisions about their destiny. Controlling one's own destiny eventually became one of our core values. When we first moved toward transparency it took some desensitization of the staff. Being direct wasn't as easy for a staff member to take as dancing around the bush. As the staff embraced transparency, meetings became extremely efficient and effective because we took a more open, honest approach to solving problems and conflict. Part of the desensitization process includes training my staff to have long term memory about the teaching moment surrounding mistakes or failures, and short term memory about the emotional distress accompanying such a mistake or failure. Learn from mistakes and get over making them. Training staff to own up to mistakes or failures made "throwing someone under the bus" a serious breach of trust to the team and hence, a rarely attempted tactic.

Adding to the environment of transparency is creating an environment of options. My staff are trained that the locus of control of one's destiny is improved if one thinks in terms of options when looking at solutions to problems or conflict. If one has multiple options, one rarely has to compromise to reach solutions. My staff recognizes that compromising has a negative slant because it is an outside-in approach. You are being forced to give in by outside influence. If one learns to explore options from other people's points of view then an inside-out solution is possible and the locus of control remains within each staff member.




## Thinking Fast and Slow

I incorporated the process of slow thinking to improve my leadership abilities. Daniel Kahneman's book, "Thinking Fast and Slow," explains in detail how the two modes of thinking are different. Eight years ago I began working three weeks on and one week off every month. I did this for a few reasons, but one main reason was to slow my thinking process down and improve my leadership capabilities. As I moved on from a resident to an orthodontist everything sped up. As my office went from six chairs and eight staff members to 14 chairs and 25 staff members, it sped up more. Twenty-five chairs and 36 staff members, that included a dental department and a dental hygiene department, faster yet. My world and what I had to handle expanded greatly. I developed a strong, fast thinking mode of operation. It was easy to make reactive decisions that needed to be made quickly. It was difficult for me to get out of this mode.

I want to emphasize that this schedule had a huge impact on improving the operation of my entire practice. Think of it as a bye week, it affords my staff time to conduct training, refine systems and catch up on larger projects that cannot be done during a busy patient schedule. It allows outside the office marketing activities. It also provides staff time to handle personal activities without missing patient days. I am out of the office during this week, which takes me emotionally out of the day to day operations. I get out of my reactive mode and into a slow thinking mode. I spend time assessing practice management issues. I reflect on where we are and where we are going. I spend

time thinking about my relationship with each team member and where that needs to go. I read coaching or management books and take time to think how theory in those books can be applied to what I want to accomplish. Lastly, I spend time recharging my batteries so that I am ready to go for another three weeks of strong performances.

The slow thinking process requires a huge amount of energy to accomplish. I start the process with a scenario in my head or sometimes written down, and over an extended period of time this scenario goes through a series of small changes, or sometimes large wholesale changes. The slow thinking process requires a lot of time to reach a quality result. It is the time issue that makes us all prefer to use the fast thinking process for so many of our management activities. I plan for, and I need, a couple of days to decompress from a busy three weeks of being in the practice before I feel up to tackling an issue that requires a slow thinking process.

### Final Words: Turnover Kills

Turnover kills. I have had the good fortune of having many long term staff members. Out of 36 staff members, I usually have a turnover rate of two or three per year. While staff leave for a variety of reasons, it is rare that a staff member leaves due to work related issues. If you significantly reduce turnover, have a great training program, a strong core management team and can solve problems or conflicts with efficiency you are well on your way to developing a staff driven practice, and well on your way toward having a high performance team.

## Author's Comments

### Dr. David Herman

It is my hope that this article will stimulate discussions on effective practice promotion. As a health-care provider, I believe that maintaining the public's trust in my practice is my top priority. In order to do this, I must consistently deliver on the promises I make to the public, invest in the further development of my staff's skills, and always keep my staff's wellbeing in mind when making decisions.

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