

The Four-Stage Framework

Coaching and process design for dental teams, in a suggested thirty-day starting cycle.

Coaching can change the conversation. Process design can change the conditions. This is the method from the FDI session, laid out so a team can run it without the slides.

One line for a congress about tomorrow's dentistry. A faster tool inside an unchanged workflow produces a faster version of the same problem. Whatever technology a practice adopts next, it will be adopted by a team, into a workflow. The better that workflow is understood, the more the technology is worth.

Start here

Three questions, in your next team meeting. They take ten minutes and they prevent the two most common errors: trying to coach away a process defect, and imposing a process solution on a team that cannot discuss the problem honestly.

1. **Where does the team repeatedly lose time, clarity or control?**
2. **What makes the problem difficult to discuss openly?**
3. **Which small process change can the team test together?**

A suggested thirty-day test cycle

Four stages. Every cycle returns to Surface, because new information should improve the diagnosis rather than defend the original solution.

Thirty days is a pragmatic starting window, not an evidence-derived threshold or a project plan. Adjust the timing to local complexity, governance and available data.

01 SURFACE

DAYS 1 TO 5

Hear the concern and observe the work before proposing a solution.

ASK

- Where does the team repeatedly lose time, clarity or control?
- Who experiences the problem differently?
- What happens immediately before and after the failure?
- What is difficult to say openly?

DO

- Select one repeated friction point. One, not four.
- Observe the work at least twice, at the time it actually happens.
- Include clinical and non-clinical roles. Administrative and clinical roles may observe different parts of the same failure.
- Write a neutral problem statement.
- Confirm what data already exist before creating any new collection.

OUTPUT A neutral problem statement grounded in observable work.

02 DIAGNOSE

DAYS 6 TO 10

Separate human and relational contributors from system conditions and potential causes.

ASK

- If no individual were at fault, what in the system would we examine?
- If the process were perfect, what conversation would still be needed?
- Where are role expectations different?
- What are people currently doing to compensate?

DO

- Map the current workflow step by step, with the role at each step.
- List human and process contributors in two separate columns. Do not merge them.
- Test each assumption against what you observed, not against what you believe.
- Choose a contributing condition the team can influence and test.

OUTPUT A combined working hypothesis that does not reduce a system problem to individual blame.

03 REDESIGN

DAYS 11 TO 14

Co-design the smallest useful test.

ASK

- What is the smallest change that would teach us something?
- Who owns it?
- What burden could the change create?
- When will we review and decide?

DO

- Co-design one small change with the people who do the work.
- Define an outcome measure, a process measure and a balancing measure.
- Name one owner and one review date.
- Identify and assess patient-safety, regulatory, privacy and workforce risks. Obtain required local approval before testing.

OUTPUT A small, reversible test rather than a permanent policy announcement.

04 SUSTAIN

DAYS 15 TO 30

Review results, exceptions, ownership and unintended consequences.

ASK

- Did the intended result improve?
- Was the new process used as intended?
- Did burden move to another role?
- What did exceptions teach us?
- Should we adopt, adapt or stop?

DO

- Run the change on a limited scale for ten to fourteen days.
- Record exceptions and adaptations as they happen, not from memory.
- Ask affected roles directly what burden changed.
- Decide: adopt, adapt, stop, or run another test.
- Assign ownership for the next cycle and share what was learned, including unintended effects.

OUTPUT A learning decision and a named next cycle.

Stop and escalate. Do not continue a local test if it creates an unmitigated patient-safety, privacy, regulatory or workforce risk. Use established incident, compliance, employment or safeguarding routes when required.

Stage 1 and 2 tool: the coaching conversation

These questions reflect coaching behaviors including agreements, active listening, trust and safety, evoking awareness and facilitating growth. Using them does not replace formal ICF education or credentialing.

Set the agreement

- What would make this conversation useful?
- Which part of the problem is within our influence?
- What should remain confidential, and what must be shared for safe operations?
- Who needs to participate before a change is made?

Surface perspectives

- What are you noticing that others may not see?
- At what point does the work become difficult?
- What assumption are we making about the cause?
- What are people currently doing to compensate?
- What concern is hardest to raise?

Evoke awareness

- If no individual were at fault, what in the system would we examine?
- If the process were perfect, what conversation would still be needed?
- Where are role expectations different?
- What is the smallest change that would teach us something?

Facilitate action

- What will we test?
- Who owns the test?
- What evidence will tell us whether it helped?
- What burden could the change create?
- When will we review and decide whether to adopt, adapt or stop?

Stage 2 tool: workflow and contributing-condition analysis

Map the current workflow step by step, naming the role, the information or material required, the common failure, and the delay or rework it creates. Then work the five domains below.

People

Are knowledge, communication, workload or role expectations contributing?

Tasks

Is the sequence clear, realistic and standardized where appropriate?

Tools and technology

Do the tools support the task, or do they create workarounds?

Environment

Do space, noise, access or interruptions affect performance?

Organization

Do policies, schedules, staffing or incentives conflict with the desired process?

Causal discipline. Complex healthcare work commonly has several interacting contributors. For each proposed contributor, record four things: what evidence supports it, what evidence would disconfirm it, whether it is a cause or a contributing condition or a symptom, and whether the team can influence it.

Stage 3 tool: the small-test canvas

Aim. By _____, we aim to improve _____ for _____ from _____ to _____.

If no reliable baseline exists, say so and let the first cycle establish one rather than inventing a target.

Plan

Change to test · Location or shift · Start and end date · Owner · Roles involved · Prediction · Review date

Study

- Did the outcome move in the predicted direction?
- Was the process completed reliably?
- Did workload, delay or risk move elsewhere?
- What did the exceptions reveal?

Act

☐ Adopt ☐ Adapt ☐ Stop ☐ Run another test

Stage 4 tool: measurement and balancing

An efficiency gain without a balancing measure may simply move burden.

Outcome measure

Did the intended result change? · Example: Percentage of sessions starting within the agreed window

Process measure

Was the redesigned work actually completed? · Example: Percentage of sessions with the readiness check done

Balancing measure

Did burden or risk move elsewhere? · Example: Assistant preparation time, or duties omitted

Exception log and review

What can the occasions when the process did not work as intended teach us? · Example: A reason code and brief review for each missed start

Operational definition. For every measure, specify the numerator, denominator, inclusion and exclusion rules, data source, collection frequency, accountable role, baseline period and review method. Avoid choosing a measure only because the data are easy to obtain.

Information handling. Completed worksheets may contain sensitive operational or workforce information. Store and dispose of them under local policy. Do not send completed worksheets or identifiable operational information to Energized Vision.

About the presenter

Amardeep Bains is a dentist, healthcare executive, ICF Professional Certified Coach and Lean Six Sigma Black Belt, and the Founder and CEO of Energized Vision.

His work is operational design and leadership development in **public and institutional healthcare**, meaning settings where an organization does not choose its patients, its staffing or its schedule.

He serves on the Board of Managers of the California Dental Association and holds active dental licenses in the United Kingdom, Oregon, California and Australia. He speaks on coaching and process design for clinical teams, workforce design and burnout, and psychological safety in constrained healthcare settings.

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