# Vet Clinic Change Management EXERCISE

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This exercise is a tactical way to manage internal pushback and ensure thorough planning before implementing a major change, such as adopting a new technology. Use this outline to help create a dedicated space for staff to share constructive, concrete feedback and break a deadlock on difficult decisions, instead of undermining the process in the background.

## How it Works

Separate the team debating a difficult decision (e.g., AI doing callbacks or booking appointments) into two groups.

**Blue Team:** Argues why the change should be made.
**Red Team:** Voices their concerns as to why the change shouldn't be made.

## The Outcomes

This process yields specific, actionable outputs, such as:

- SOPs for implementation.
- Concerns that need to be addressed through education.
- Metrics to help inform whether the change is a success.

## #1 CASE SETUP

**Compile the Blue and Red team's insights using this template to clearly present both sides to the decision owner.**

**Proposal title:** _____

*(Example: "Increase grade 3–4 dental procedure uptake.")*

**Date:** _____

**Decision owner:** _____

*(Who will ultimately decide and own the outcome?)*

**The next several pages include a template to help your Blue team and Red team complete the bulleted lists outlined below.**

### Blue Team

- Problem and Goal
- The Idea
- Strongest Case FOR the Idea
- Risks and How We Contain Them
- Simple Pilot Plan
- Blue Team Recommendation

### Red Team

- Problem Framing Check
- Assumptions to Stress Test
- Strongest Case AGAINST the Idea
- Who Pays the Price
- Alternatives and Modifications
- Evidence that Could Change Your Mind
- Red Team Recommendation

# Blue Team

**Purpose**: Build the strongest possible case that this idea SHOULD go ahead.

*(Blue team mindset: "If this works, why did it work, specifically here?" Focus on mechanisms, evidence, and a small test.)*

## PROBLEM AND GOAL

**Problem in one or two sentences:**

*(Example: "Many pets with grade 3 or 4 dental disease are diagnosed but never receive recommended dental procedures at our clinic.")*

**Why this matters in the next 6 to 18 months:**

*(Example: "Untreated advanced dental disease causes chronic pain, infection risk, and client distrust when problems are noticed later or by another clinic.")*

**One primary outcome goal:**

*(Example: "Increase completion of recommended grade 3–4 dental procedures from 35 percent to 65 percent within 12 months.")*

# THE IDEA

**What are we actually going to do or change:**

*(Example: "Standardize grade 3–4 dental recommendations, provide a clear estimate on the day, schedule a follow up call within 1 week if not booked, and add a dashboard to track outstanding recommended dentals.")*

**Who is most affected:**

*(Example: "Veterinarians: consistent grading and recommendations. Technicians: support grading and client education. CSRs: proactive follow up calls and scheduling.")*

# STRONGEST CASE FOR THE IDEA

*(Spend most of your effort here.)*

## Why it is likely to work in THIS clinic

List the 3 to 7 strongest arguments, focused on how and why it works here.

*(Examples: "We already diagnose grade 3–4 disease reliably, so the gap is follow through, not detection.", "Clients often say yes once the cost is broken down and they understand the pain component, which suggests better education and follow up would close the gap.", "We have unused dental capacity on specific weekdays, so there is operational room to increase cases without adding equipment or staff.")*

## Evidence or examples that support this

**Internal evidence:**

*(Example: "Last quarter we recommended 120 grade 3–4 dentals, but only 42 were completed. When Dr Smith personally followed up, her completion rate was over 70 percent.")*

**External examples:**

*(Example: "AAHA and other practices report that structured dental reminder programs and visual aids significantly increase acceptance of dental procedures.")*

## Why this beats the main alternatives

**Compared with doing nothing, this is better because:**

*(Example: "Doing nothing locks in chronic pain and repeat dental infections and we continue to under use an existing revenue and patient welfare opportunity.")*

**Compared with the most realistic alternative, this is better because:**

*(Example: "Compared to adding another discount plan, this focuses on communication and follow up, which we can control and sustain without permanent fee cuts.")*

## Risks and how we contain them

**Top 3 realistic risks if we proceed:**

*(Examples: "Team feels pressured to sell dentals and becomes uncomfortable in consults.", "Dentistry schedule becomes overloaded on a few high demand days and wait times increase.", "Clients perceive the clinic as money driven if messaging is not handled well.")*

**Safeguards and rules to keep risk acceptable:**

*(Example: "Use standardized medical criteria for grade 3–4 recommendations, script client education around pain and infection rather than money, and cap the number of dentals per day per doctor.")*

# SIMPLE PILOT PLAN

**Smallest useful pilot:**

*(Example: "For 8 weeks, apply this process only to dogs with grade 3–4 dental disease seen by Dr Lee and Dr Patel.")*

**Pilot duration:**

*(Example: "8 weeks to accumulate at least 30 recommended cases and follow their outcomes.")*

**One or two metrics that show it is working:**

*(Example: "Percentage of grade 3–4 cases scheduled within 30 days; average days from recommendation to procedure.")*

**Decision rule:**

*(Example: "Percentage of grade 3–4 cases scheduled within 30 days; average days from recommendation to procedure.")*

**We continue or scale if:**

*(Example: "Completion rate improves by at least 20 percentage points with no increase in client complaints or staff overtime.")*

**We stop or rethink if:**

*(Example: "No improvement in completion rate or significant increase in staff overtime or schedule bottlenecks.")*

# BLUE TEAM RECOMMENDATION

**One sentence recommendation:**

*(Example: "We recommend an 8 week pilot of a structured follow up and scheduling process for grade 3–4 dental cases because it targets a known drop off point, uses existing capacity, and has clear upside for patient welfare and revenue.")*

# Red Team

**Purpose**: Build the strongest possible case that this idea SHOULD NOT go ahead, at least not as proposed.

*(Red team mindset: "If this fails, how does it fail in our real clinic?" Focus on assumptions, failure modes, and better options.)*

## PROBLEM FRAMING CHECK

**Problem restated in your own words:**

*(Example: "We are not converting enough diagnosed grade 3–4 dental disease cases into completed dental procedures.")*

**What might be missing or misframed:**

*(Example: "We are treating this as a pure communication problem, but some clients may have legitimate financial or prioritization constraints that we cannot overcome just by pushing harder.")*

**One alternative way to define the problem:**

*(Example: "We lack a clear strategy for which dental cases to prioritize, how to stage care, and how to support clients who cannot do everything at once.")*

# ASSUMPTIONS TO STRESS TEST

**Critical assumptions that must be true for this to work:**

*(Examples: "Veterinarians and technicians will consistently and accurately grade dentals as 3 or 4 and document them.", "CSRs have enough time and training to do effective follow up calls, not just quick reminders.", "Clients mainly fail to book due to lack of understanding rather than finances or competing priorities.")*

**For each assumption, how it could fail in our real clinic:**

*(Example: "Grading is inconsistent across doctors; some under call disease severity. CSRs are already stretched and may treat calls as check box tasks. Many clients have multiple chronic issues and will choose cheaper, visible problems first.")*

# STRONGEST CASE AGAINST THE IDEA

*(Spend most of your effort here.)*

## Main arguments against proceeding

List the 5 to 7 strongest objections.

*(Examples: "We are already at or near capacity on dentistry days, so increasing uptake without rebalancing schedules will create bottlenecks and frustration.", "If communication is not done carefully, this may feel like a sales push, damaging trust with some long term clients.", "We may add follow up work for CSRs and nurses without removing anything from their current workload, driving burnout.", "Inconsistent grading and messaging between doctors will cause confusion and complaints.", "Focusing heavily on grade 3–4 dentals might unintentionally pull attention from other high impact care gaps like chronic pain or senior screening.")*

## Realistic failure modes

**For patients or quality of care**

*(Example: "Because we are trying to increase numbers, some marginal grade 2–3 cases get pushed into dentistry prematurely just to fill slots.")*

**For clients or communication**

*(Example: "Clients start to expect big dentals every time we mention tartar and begin to avoid check ups because they feel judged or pressured.")*

**For staff time, morale, or turnover**

*(Example: "CSRs feel they now own a never ending list of 'outstanding dentals' with little control over the outcome, which increases stress.")*

**For money, operations, or compliance**

*(Example: "We overbook dentistry, leading to overtime and write offs, and do not actually improve net profit.")*

## Second order effects

**If the idea "works" at first, how could it create bigger problems over 1 to 3 years:**

*(Example: "We build a culture that measures success by procedure count rather than appropriateness, and it becomes harder to question borderline recommendations later.")*

## Who pays the price

**Roles or groups that carry most of the extra work, risk, or frustration:**

*(Example: "Lead technician managing dental days, CSRs who handle follow up, and specific doctors whose schedules become dental heavy.")*

**Edge cases or vulnerable groups who might be harmed:**

*(Example: "Low income clients who feel pressured, anxious pets who struggle with hospitalization, or geriatric patients with higher anesthetic risk.")*

## Alternatives and modifications

**One or two simpler or safer ways to tackle the same problem:**

*(Example: "Start with a structured communication script and visual aids in exam rooms without adding follow up calls, to see if uptake improves.")*

**Smallest change that might capture much of the benefit with less risk:**

*(Example: "Focus only on grade 4 cases in dogs under 10 years old for the first pilot, where risk benefit is clearest.")*

**Changes to the proposal that would reduce your objections:**

*(Example: "Limit number of follow up calls per week per CSR, standardize grading training, and define a clear dental capacity plan per week.")*

## Evidence that could change your mind

**Specific data or pilot result that would make you comfortable trying this:**

*(Example: "An 8 week pilot showing at least a 20 percentage point increase in grade 3–4 dental completion with no increase in staff overtime and no uptick in client complaints.")*

**If leadership proceeds anyway, 3 leading indicators to monitor closely:**

*(Examples: "Client complaints related to pressure or fees.", "Staff overtime hours on dental days.", "Cancellation or no show rate for dentals.")*

## Red Team Recommendation

**One sentence recommendation:**

*(Example: "We recommend narrowing the initial dental uptake project to clearer high benefit cases with explicit capacity planning and messaging safeguards, because the current proposal underestimates schedule bottlenecks and communication risk.")*


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