The next $2 million should not be a guess.

Fictional 50-location dental platform | Prepared for the investment committee | October 2026

Sample deliverable. This memo shows how AOX Ops structures an investment recommendation. The company, figures, records, interviews and findings are invented. AOX Ops did not conduct this investigation.

Decision requested: After two quarters below plan, management seeks **$2.0M**: marketing ($800K), sales coaching ($500K) and CRM changes ($700K).

Recommendation: REDIRECT, subject to validation

FUND	**REDIRECT**	DELAY	INVESTIGATE FURTHER

Do not authorize the full $2.0M as proposed. The most material constraint is not insufficient sales effort. It is **inconsistent lead-to-appointment execution**, compounded by informal workarounds and weak escalation of system failures. Release only a **$150K capped pilot** for workflow and integration repair, contingent on a verified baseline, named owners and measured results. **Keep $1.85M uncommitted** pending evidence.

The surprising finding

Management's explanation: sales teams need more coaching and more leads to restore full-arch conversion. **UNSUPPORTED** in the sample reviewed.

What the field work found: at several lower-performing practices, CRM tasks were marked complete even though call records and appointment histories showed missed handoffs. Stronger practices quietly corrected the same issues through experienced managers' manual tracking. The dashboard measured task completion; it did not reliably measure whether patients reached the next step.

Behavioral connection: staff described repeated unresolved issues and stopped escalating them. Leaders saw green activity metrics and concluded effort was the problem. This is a causal hypothesis supported by cross-source evidence, not proof, and it is tested by the pilot below.

What the evidence suggests

Evidence stream	Grade	Result	Investor relevance
Record reconciliation E-01, E-02	**VERIFIED**	In a purposive sample of 240 inquiries across 6 sites, 48 (20%) had a missed or delayed handoff; 32 of those were at the 4 lower-performing sites.	Potentially recoverable patient opportunity; not a population-wide rate.
Workflow observation E-03	**VERIFIED**	At 2 strong sites, managers kept manual recovery lists that do not appear in the documented SOP.	Key-person and scalability dependency.
Interviews + audit trail E-04, E-05	**PLAUSIBLE**	11 of 18 staff interviews described recurring workarounds; issue tickets were repeatedly closed without process verification.	Leadership feedback and adoption risk.
Intervention review E-06	**PLAUSIBLE**	Conversion rose during coaching weeks but showed no consistent sustained lift in the following 8 weeks.	Coaching effect not established as durable.

Verified: confirmed across independent sources in the sample. **Plausible:** supported but not yet confirmed. **Unsupported:** not supported by the evidence reviewed. Evidence IDs refer to the register on page 3.

Change the decision. Not just the dashboard.

Financial exposure (scenario, not a forecast)

Assume **80 incremental funded cases per year** could be recovered after workflow repair, at a **$20,000 average collected case value** and a **30% incremental contribution margin**. That equals **$1.6M in annual incremental collections** and **$480K in annual incremental contribution**, before pilot cost and any added fixed costs. At an illustrative 8× multiple, $480K of sustainable EBITDA-equivalent improvement implies **$3.84M of enterprise-value sensitivity**.

Pilot break-even: the $150K pilot pays back at roughly **25 recovered cases** (25 × $20,000 × 30% = $150K), less than a third of the scenario. All figures require verification against real cohort, capacity, cost and cash data before they are treated as recoverable value.

Capital decision: proposed $2M versus gated alternative

Management request	AOX Ops recommendation	Release condition
$800K marketing	**DEFER**	Show incremental collected contribution from current leads, and capacity to absorb more volume.
$500K sales coaching	**DEFER / TEST**	Demonstrate sustained conversion lift after the coach withdraws, controlling for patient mix.
$700K CRM changes	**REDESIGN**	Validate root cause; pilot fixes before replacing or expanding platforms.
$150K capped pilot (within the $700K)	**CONDITIONAL APPROVAL**	Baseline verified; owner assigned; 60–90-day observation; stop rules agreed.

Pilot success gates

1. Reconcile CRM task status with call, appointment and PMS records in a defined sample.
2. Reduce verified missed handoffs against a pre-registered baseline.
3. Show improvement in attended consultations and collected contribution, adjusted for patient mix and timing.
4. Confirm performance holds without manager-maintained shadow spreadsheets or extraordinary coaching.
5. Stop or redesign if improvement does not exceed the fully loaded pilot cost.

What could overturn this recommendation?

If broader records show the sample was atypical, if financing denials or market demand explain most of the decline, or if coaching proves to have a durable incremental effect, capital priorities should change. The conclusion stays open to contradictory evidence by design.

Investment committee decision

> **Approve: up to $150K of the proposed CRM allocation for a controlled verification-and-repair pilot.**
> **Defer: $1.85M.**
> **Require: independent 30/60/90-day reporting and a second authorization vote once the gates are assessed.**

How the conclusion was reached.

This appendix shows the evidence discipline behind the recommendation. In a real engagement, each evidence ID points to permissioned, access-controlled source records, and no patient identifiers appear in the memo.

Evidence register

ID / source	Grade	Observation	Limitation
E-01 / CRM + call logs	**VERIFIED**	48 of 240 sampled inquiries had missed or delayed handoffs, concentrated at specific sites.	Corroborated in sample; selection bias possible.
E-02 / PMS appointment history	**VERIFIED**	Some completed CRM tasks did not match a scheduled or attended visit.	Corroborated; timestamps and definitions need reconciling.
E-03 / shadowing	**VERIFIED**	Two managers used manual spreadsheets to recover patients.	Observed at 2 sites; prevalence unknown.
E-04 / staff interviews	**PLAUSIBLE**	11 of 18 interviewees reported workarounds or unresolved issues.	Self-reported; subject to recall and selection bias.
E-05 / issue tickets	**PLAUSIBLE**	Tickets closed as ‘resolved’ without end-to-end workflow validation.	Documented in sample; root cause not proven.
E-06 / coaching cohorts	**PLAUSIBLE**	Short-term lift during visits; no consistent persistence afterward.	Associational; not causal proof.

Alternative explanations tested

Hypothesis	Would support it	Would weaken it	Finding so far
Price / affordability	Financing denials and patient objections worsen by cohort.	No material change after controlling for mix.	**Weakened** — approval rates broadly stable in sample; full-cohort check pending.
Sales skill	Consultation quality and sustained post-coaching lift explain variance.	Similar skill scores but different handoff reliability.	**Weakened** — lift faded after coaching (E-06).
Lead quality	Source-level readiness, show rate and case mix deteriorate.	Comparable lead cohorts with divergent process outcomes.	**Open** — not ruled out; source mix needs review.
Workflow / integration	Missed handoffs reconcile across systems and improve after repair.	No link to patient progression or collected contribution.	**Supported** — E-01 to E-05; the pilot is the test.

Field verification protocol

Select sites independently across strong, middle and weak performers, including mature and newer locations. Review 12–24 months of site-level results, then trace a purposive sample of patient journeys. Observe authorized routine workflows, interview frontline and executive staff separately, and challenge preliminary findings with management. Record the source, timestamp, alternative causes and confidence level for every material claim.

From observation to dollars.

Financial bridge: every assumption visible

Variable	Assumption	Calculation / caution
Recovered cases	80 per year	Must be validated against missed handoffs, show rate, acceptance, financing and capacity.
Average collected case value	$20,000	Treatment mix and timing may vary.
Incremental collections	$1,600,000	80 × $20,000; not the same as EBITDA.
Incremental contribution margin	30%	After incremental variable costs; fixed costs may rise.
Annual contribution	$480,000	$1.6M × 30%, before pilot cost.
Enterprise-value sensitivity	$3,840,000	$480K × illustrative 8×, only if sustainable and EBITDA-equivalent.
Pilot cap	$150,000	One-time spend; not netted against annual recurring contribution.
Pilot break-even	~25 cases	$150K ÷ ($20,000 × 30%) = 25 recovered cases.

Why the behavioral evidence matters

A manager's workaround can conceal a system defect. A quiet escalation channel can conceal how long it persists. An activity dashboard can record compliance without successful handoffs. None of these observations proves causality on its own. Their value is that they generate testable predictions: after a targeted fix, handoff reliability should improve, manager rescue work should fall, and collected contribution should rise without constant intervention.

Decision accountability: the 90-day test

Timing	Question to answer	Required artifact
Day 0	Are definitions, baselines and ownership agreed?	Signed metric dictionary + sample plan.
Day 30	Are handoffs measurably more reliable?	Cross-system audit + exception log.
Day 60	Are patient progression and economics improving?	Cohort conversion and collections bridge.
Day 90	Does performance hold without rescue effort?	Independent verification and release recommendation.

What you receive in a real engagement

A concise decision memo, an evidence register with traceable sources, an operational dependency map, an assumption-based financial model, and a capital-release recommendation with explicit uncertainty and stop criteria.

Before you fund another solution, verify the problem.

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