CASE STUDY

BETERRA HEALTH × TEXAS HEALTH RESOURCES

Orchestrating Reliability

How one of the nation's largest faith-based nonprofit health systems built a unified, trust-driven learning system for safety, guided by promise principles, fueled by psychological safety, orchestrated through systemic anticipation, and sustained by digital infrastructure.

KEY MILESTONES

Mid-2010s	Texas Health Resources begins its high-reliability journey
2023–2025	**20%** reduction in second victim experiences, **10%** improvement in support
Past 5 Yrs	Near-miss reporting grows by **83.6%** system-wide
Today	**Top-quartile** national performance in reporting culture

ABOUT THE CLIENT

Texas Health Resources

One of the nation's largest faith-based nonprofit health systems, serving millions of patients and families across North Texas through a network of hospitals, outpatient facilities, and community partnerships.

SETTING

Health System · North Texas

SCALE

30,000 Employees · 29 Hospitals

LEADERSHIP

Kristin Duncan · Sr. Dir., Safety & High Reliability

FRAMEWORK

High Reliability · Accountable Learning · ACT Platform

KEY RESULTS

+83.6%	Near-miss reporting growth over 5 years
99%	Action plan follow-up engagement
1,500	System-wide improvement projects
Top Qt.	National reporting culture performance

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Before the Shift: The Plateau

By the mid-2010s, Texas Health Resources had invested in safety training and event reporting, but progress had leveled off. The opportunity: connect meaningful improvement efforts into a unified, system-wide approach.

Safety training programs had been rolled out, and leaders often spoke of “just culture” and “zero harm.” Many meaningful improvement efforts were underway, and the opportunity lay in bringing them together in a more unified, connected approach. Local units launched their own projects but had limited visibility beyond a single department, and successes often depended on individual champions rather than a systemic approach.

Event reporting may have been perceived as one-directional, and limited feedback made it difficult for teams to see how investigations supported learning. This could create hesitation among leaders and staff, highlighting an opportunity to strengthen transparency and shared trust.

Meanwhile, the national climate fueled fear. Following highly publicized cases in which clinicians faced severe punishment, staff across the healthcare industry became hesitant to report incidents. Even the language of safety, though abundant, felt hollow without consistent reinforcement. It was essential that HRO training be recognized as a powerful driver of safer, more collaborative care rather than a compliance activity.

> *There was an awareness that Texas Health was primed to engage in reliability practices to address error-prone situations. When reliability becomes a shared rhythm, it strengthens consistency and alignment across the organization. At Texas Health, HRO wasn’t implemented simply as a framework; it represented the standard of excellence the system aimed to achieve, and the unified approach leaders committed to advancing together.*
>
> Kristin Duncan · Sr. Director of Safety and High Reliability, THR

Composing a New Movement for Change

Reliability had to become who THR is, not what THR does. What followed was a system-wide orchestration that reset focus, expectations, and the daily demonstration of safety principles.

Every leader completed a training program, and expectations were embedded in safety behaviors. Performance metrics tied success not just to clinical outcomes, but to the daily demonstration of high-reliability principles. Senior leadership established the expectations and support necessary to advance high-reliability practices across the organization.

> The leadership set the tone to open the movement to adopt error-prevention tools. What started as a structured program transformed into a shared vision.

Safety became the shared goal, and harm prevention was a collective movement. Leaders showed up with passion, and over time several key design principles emerged that reshaped how THR embedded high reliability into daily practice: a broadened definition of accountability and harm, a deeper commitment to psychological safety, the elevation of near misses as gifts, an accountable learning system, and the digital infrastructure that made it scalable.

Redefining Harm, Redefining Accountability

Corrective actions were no longer tied solely to the outcomes of medical errors; they were also influenced by system-level opportunities. Leaders were given clear accountability and expectations around speaking up and using error-prevention tools. Clinical and operational leaders were expected to drive both operational excellence and safety culture, holding themselves and their teams accountable for consistent improvements in patient outcomes and organizational trust.

At the same time, the concept of harm itself was redefined. Beyond physical outcomes, THR classified safety events with an emotional harm level. The patient's experience of care and deviations in practice standards came to represent harm. By broadening the definition, THR underscored that safety was about dignity, trust, and the whole patient experience.

From Composition to Performance

Four design principles reshaped how THR embedded high reliability into daily practice, turning safety from a stated value into an organizational reflex.

Psychological Safety, Reframed

The familiar slogan “speak up for safety” was examined through a sharper lens. The question was no longer simply whether people would speak up, but whether they felt safe to do so. Leaders recognized that genuine psychological safety was the foundation for high reliability. It required creating an environment where frontline voices were not only welcomed but also acted upon. Consistent application proved essential: leaders used safety language daily, reports were acknowledged and addressed, and the cumulative effect built trust. The result was a **20% reduction in second victim experiences** and a **10% improvement in second victim support** between 2023 and 2025.

Near Misses as Gifts

Near-miss events can easily be overlooked as inconsequential, but THR elevated them as central indicators of system health. Near-miss identification was embedded into high-reliability development. Leaders were tasked with finding and fixing a near miss during onboarding, and departments were held accountable for analyzing their top near misses through structured PDSAs. Instead of being ignored, near misses were celebrated, publicly acknowledged as evidence of proactive safety. The reporting of near misses increased by **83.6% over five years**, a tangible sign that staff trusted the system to focus on learning.

> *When you get a near miss, that is your gift. You fixed something before it reached the patient.*
>
> Kristin Duncan · Sr. Director of Safety and High Reliability, THR

Accountable Learning System

Investigations into safety events underwent a philosophical transformation. Rather than stopping at individual blame, leaders were trained to dig deeper, exhausting every “why.” Why did a team member miss a policy? Was the policy itself confusing? Was there normalized deviance in the unit? This line of questioning placed responsibility where it most often belonged: on the system rather than the individual. The guiding principle became “Did the system fail the employee, or the employee fail the process?” This reframing built a culture of shared accountability and continuous learning.

Broadened Accountability and the Definition of Harm

Accountability became the cornerstone of THR’s high-reliability design. Corrective actions were influenced not only by medical error outcomes but also by system-level opportunities. The concept of harm itself was redefined, classified with an emotional harm level that captured dignity, trust, and the whole patient experience, reinforcing THR’s Promise Principles of Reliability and Safety.

The Digital Infrastructure

If culture provided the vision, infrastructure made it scalable, reliable, and sustainable. With 30,000 employees spread across a vast geography, THR needed a unifying system to translate its safety principles into daily action.

BETERRA ACT PLATFORM

The central system supporting THR's high-reliability programming

ACT measures organizational culture, coordinates improvement actions, sends timely reminders, and integrates data into a cohesive structure. Systematic prompts ensure leaders close the loop on reports and follow through on PDSAs. Micro-learnings refresh perishable skills without overwhelming staff. Learning repositories capture both successes and process failures, allowing lessons to spread system-wide rather than remain isolated.

Equally important, the platform unifies culture data, improvement plans, and actions in one place, significantly reducing the burden on frontline leaders and giving them real-time visibility without the administrative overhead of managing multiple disconnected systems. Through human factors design, reliability became intuitive: the right action easy, the wrong action hard.

> *To prevent harm, we must design systems that make it easy to do the right thing and difficult to do the wrong thing.*
>
> Kristin Duncan · Sr. Director of Safety and High Reliability, THR

Outcomes in Motion

+83.6%
Near-Miss Reporting
Growth over 5 years

1,500
Improvement Projects
System-wide

1,000+
Leaders Engaged
Safety culture & harm reduction

99%
Action Plan Follow-Up
Engagement post-feedback

90%
Plan Success Rate
Meaningful improvement

Reporting volumes climbed steadily, indicating a positive reporting culture. Serious Safety Events (SSEs) continued to decline. Staff engagement and psychological safety scores trended upward, reflecting trust in both leadership and the reliability journey. Beyond the metrics, resiliency has supported a culture shift: leaders begin every safety briefing with safety language, and harm is viewed as a collective opportunity for mitigation rather than a reflection of individual fault.

A Living, Breathing Learning Organization

Ten years into its high-reliability journey, THR describes itself as a "living, breathing learning organization." The transformation has created a more aligned, efficient, and purpose-driven environment.

Leadership exhibits a coordinated, proactive, and reliable approach that supports sustained organizational progress. Looking forward, THR's goal is to embed resilience engineering and reliability concepts more deeply into workflows, making safe actions instinctive and unsafe actions cumbersome. People and digital infrastructure, along with their mutual interactions, will remain central, ensuring that culture does not drift into rhetoric but into sustained practice.

Through its commitment to human factors, THR is designing systems that ease cognitive and operational burdens on frontline staff, enabling them to adapt quickly and effectively to prevent errors even in high-pressure environments.

THE ROAD AHEAD

From Complexity to Clarity

For patients and families, the change means safer care. For staff, it means transparency and trust. And for healthcare at large, THR offers a roadmap: from complexity to clarity, powered by culture and sustained by the people and systems in which they operate.

Reliability is achieved through proactive anticipation and responsive adaptation.

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SIMPLIFYING HEALTHCARE IMPROVEMENT

Beterra is a healthcare technology company focused on building tools for safety, quality, and staff engagement.

Our solutions help healthcare leaders accelerate improvement through the collection, analysis, and intelligent use of safety, quality, and feedback data, reducing administrative burden while making performance data actionable across every level of the organization.

HIGH RELIABILITY & SAFETY CULTURE

HRO frameworks, near-miss elevation, psychological safety measurement, and learning repositories

ACT PLATFORM

Structured improvement tracking, action planning tools, leader engagement dashboards, and automated regulatory submissions

CAREGIVER SUPPORT & ENGAGEMENT

Second victim identification, NPS tracking, staff engagement surveys, and real-time frontline feedback loops

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