Received: 5 April 2023 | Revised: 13 July 2023 | Accepted: 21 July 2023

DOI: 10.1002/lrh2.10383

EXPERIENCE REPORT

Learning Health Systems

Developing a relational playbook for cardiology teams to cultivate supportive learning environments, enhance clinician well-being, and veteran care

Heather M. Gilmartin[1,2] | Brigid Connelly[1] | Edward Hess[1] | Candice Mueller[3] | Mary E. Plomondon[2,3] | Stephen W. Waldo[3,4] | Catherine Battaglia[1,2]

[1]Denver/Seattle Center of Innovation for Veteran-Centered and Value Driven Care, VHA Eastern Colorado Healthcare System, Aurora, Colorado, USA

[2]Department of Health Systems Management and Policy, University of Colorado, School of Public Health, Aurora, Colorado, USA

[3]CART Program, Office of Quality and Patient Safety, Veterans Health Administration, Washington, DC, USA

[4]Department of Medicine, Division of Cardiology, University of Colorado, Aurora, Colorado, USA

Correspondence
Heather M. Gilmartin, Denver/Seattle Center of Innovation for Veteran-Centered and Value Driven Care, VHA Eastern Colorado Healthcare System, 1700 N. Wheeling St, Aurora, CO, USA.
Email: heather.gilmartin@va.gov

Funding information
United States Department of Veterans Affairs Health Services Research & Development Service of the VA Office of Research and Development, Grant/Award Number: 1IK2HX002587-01A1

Abstract

Introduction: Despite the Veterans Health Administration (VA) efforts to become a learning health system (LHS) and high-reliability organization (HRO), interventions to build supportive learning environments within teams are not reliably implemented, contributing to high levels of burnout, turnover, and variation in care. Supportive learning environments build capabilities for teaching and learning, empower teams to safely trial and adapt new things, and adopt highly reliable work practices (eg, debriefs). Innovative approaches to create supportive learning environments are needed to advance LHS and HRO theory and research into practice.

Methods: To guide the identification of evidence-based interventions that cultivate supportive learning environments, the authors used a longitudinal, mixed-methods design and LHS and HRO frameworks. We partnered with the 81 VA cardiac catheterization laboratories and conducted surveys, interviews, and literature reviews that informed a Relational Playbook for Cardiology Teams.

Results: The Relational Playbook resources and 50 evidence-based interventions are organized into five LHS and HRO-guided chapters: Create a positive culture, teamwork, leading teams, joy in work, communication, and high reliability. The interventions are designed for managers to integrate into existing meetings or trainings to cultivate supportive learning environments.

Conclusions: LHS and HRO frameworks describe how organizations can continually learn and deliver nearly error-free services. The Playbook resources and interventions translate LHS and HRO frameworks for real-world implementation by healthcare managers. This work will cultivate supportive learning environments, employee well-being, and Veteran safety while providing insights into LHS and HRO theory, research, and practice.

This content was presented at the Academy Health Dissemination & Implementation Annual Meeting, December 12, 2022. Washington, D.C.

KEYWORDS
high-reliability organization, learning health system, veterans, workforce

1 | INTRODUCTION

Despite the Veterans Health Administration (VA) efforts to become a learning health system (LHS) and high-reliability organization (HRO), evidence-based interventions for managers to build supportive learning environments within teams are not reliably implemented.[1] Learning environments are the educational approaches, cultural context, and settings in which teaching and learning happen and are crucial to the creation of LHSs and HROs.[1] Supportive learning environments, the ideal learning environment, build capabilities for teaching and learning, empower teams to safely try new things, and adopt highly reliable work practices (eg, debriefs). The importance of supportive learning environments has been amplified by the effects of the COVID-19 pandemic, including crisis levels of clinician exhaustion, burnout, and turnover. Recent research has increased our understanding of how learning environments designed using LHS and HRO frameworks relate to learning, quality of care, and well-being.[2] Such an approach is characterized by multi-year, single-site implementation of organization-directed assessments and system-wide training.[3] It will take a fundamentally different approach to rapidly build the U.S. healthcare workforce back stronger post-COVID-19.

The next step in the LHS and HRO journey is developing innovative approaches for managers to cultivate supportive learning environments in a post-pandemic healthcare system. The purpose of this *Experience Report* is to describe the Relational Playbook for Cardiology Teams (Playbook), a compilation of LHS and HRO-guided resources and interventions designed by and for VA cardiology teams. The Playbook provides brief and simple interventions that can be implemented without significant training, adapted to the local context, and integrated into existing trainings and meetings. The Playbook practices, when woven into the flow of work, will cultivate supportive learning environments that enhance clinician well-being and ensure patient safety.[4]

2 | METHODS AND FRAMEWORKS

We used a longitudinal, sequential, mixed-methods design, the Learning Organization Model,[4] and the Reliability Enhancing Work Practice and Patient Safety Model (REWP)[5] to guide the identification of evidence-based interventions to create supportive learning environments. The Learning Organization Model (Figure 1) describes three factors that support learning and outcomes: a supportive learning environment, concrete learning processes, and practices, and leadership that reinforces learning.[4,6] The model was proposed by Garvin et al.,[6] validated in the VA by Singer et al., and operationalized as the Learning Organization Survey-27.[4]

The Learning Organization Model postulates that the first building block, a supportive learning environment, includes four key characteristics: psychological safety, appreciation of differences, openness to new ideas, and time for reflection. The second building block, concrete learning processes and practices, are activities necessary for knowledge to be shared in a systematic and clearly defined way. The third building block, leadership behavior that reinforces learning, occurs through active listening, dialogue and debate with employees, and prioritization on problem identification, knowledge transfer, and reflective post-audits.[6] Each building block makes contributions to the ability of teams to learn, with the combination producing supportive learning environments, which are foundational to LHSs[4] (Figure 1). Abundant evidence supports the influence of these concepts on organizational learning, through the implementation of innovations or new technologies (eg, checklists or clinical decision tools),[4,6] be it in the operating room,[7,8] intensive care unit,[9,10] or other healthcare settings.[11]

The REWP Model[5] was selected to provide a deeper understanding of the learning processes and practices concept within the Learning Organization Model.[4] The REWP model outlines five factors that have been shown to positively influence patient safety through fewer medication errors and patient falls.[5] These are the presence of REWPs (eg, communication training, preceptor program), respectful interaction, mindful organizing, affective commitment (eg, personal meaning, attachment to team), and organizational citizenship behaviors (Figure 2). This model was proposed by Vogus and Iacobucci[5] and operationalized as the REWP survey. The lack of tools to measure these concepts has inhibited healthcare organizations' ability to diagnose gaps and implement new learning processes and practices to become HROs. The model proposes that high reliability is achieved through the systematic use of REWPs, training to build interpersonal skills, forums to share expertise and make recommendations for improvement, and dedicated resources for local adaptations and front-line work control.

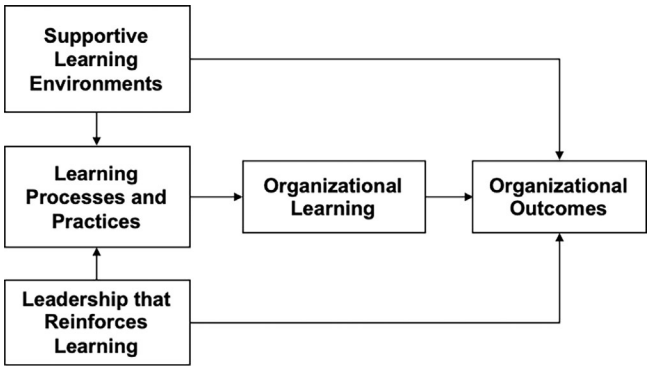

FIGURE 1 Learning Organization Conceptual Model.

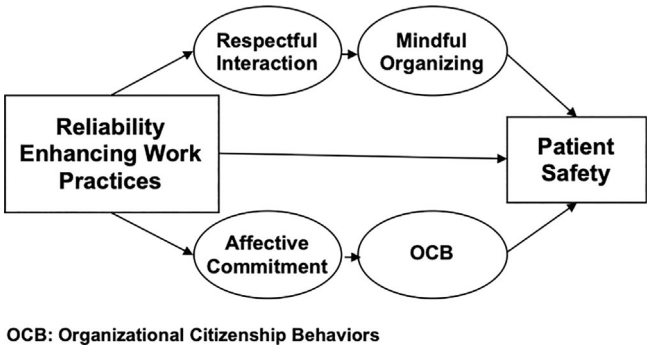

FIGURE 2 Reliability Enhancing Work Practice and Patient Safety Model.

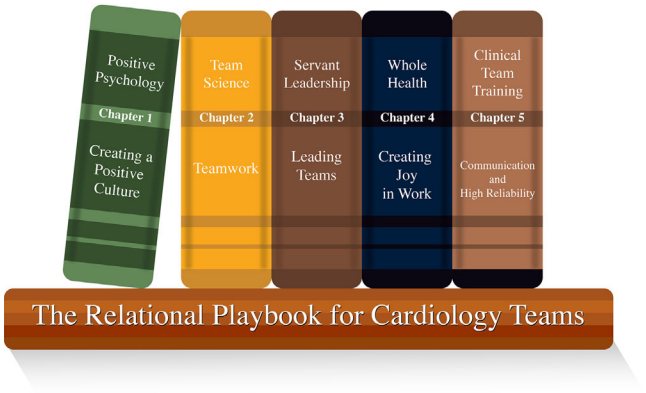

FIGURE 3 Relational Playbook for Cardiology Teams.

In 2018, we partnered with the 81 VA cardiac catheterization laboratories (CCLs) to examine factors that cultivate supportive learning environments (eg, high-quality relationships, communication, innovation, and high reliability). VA CCLs were selected because they are staffed by highly skilled multidisciplinary teams while providing life-saving coronary procedures to over 60 000 Veterans annually. The Learning Environment Survey in VA CCLs, a validated 64-item instrument based on the Learning Organization Model and REWP model was administered to CCL managers, physicians, nurses, fellows, and technicians to collect data on the presence or absence of learning environment factors[1] (Supplemental Digital Appendix 1). In 2020, we repeated the survey and identified positive relationships between more supportive learning environments and increased job satisfaction, lower burnout, lower intent to leave, lower CCL turnover in the previous 12 months, and increased perceived safety climate.[12] These findings suggest supportive learning environments exist in the VA and are new avenues to support satisfaction and safety climate while lowering burnout, intent to leave, and turnover.

In 2021, we interviewed 13 CCL leaders and staff to understand how and why learning environments were created. Participant responses were coded to the Learning Organization Model and REWP Model. Our analyses revealed that concepts and practices that cultivate and sustain supportive learning environments are grounded in the fields of positive psychology, team science, servant leadership, the VA Whole Health, and Clinical Team Training Models. These five concepts informed the development of the five related Playbook chapters (Figure 3).

2.1 | LHS and HRO concepts informing the development of the Relational Playbook

2.1.1 | Positive psychology

Positive psychology is the scientific study of positive experiences, positive individual traits, and the institutions that facilitate their development.[13] Hundreds of articles and books have been written on the topic of positive psychology and the interventions to move individuals from a negative focus into the positive. Using this perspective, the creation of a positive team culture can be facilitated through well-being assessments and targeted use of interventions, including gratitude, kindness, curiosity practices, and appreciative inquiry. Sustained use of these strengths-based interventions enhances the skill of recognizing where aspects of work and life are good. In Chapter 1 of the Playbook, managers are guided to adopt appreciative inquiry[14] to develop the skill of identifying where clinical care is best and how to provide such care reliably, vs the traditional focus on the negative aspects of work (Figure 3). The positive psychology literature suggests that individuals and teams that seek positive work and life experiences can cultivate a positive culture where clinicians, trainees, and patients can flourish and find meaning.[13]

2.1.2 | Team science

Team science is an interdisciplinary field that empirically provides a better understanding of how teams connect and collaborate to achieve breakthroughs that would not be attainable by individual efforts. Factors such as self-awareness, emotional intelligence, trust, shared vision, communication, effective leadership, mentoring, and conflict management have been identified as necessary to build high-performing teams. Due to the complexity of clinical practice, interaction between healthcare professionals, trainees, and non-clinical staff from diverse backgrounds with differing skill sets and practice cultures is required. An additional challenge is the integration of clinicians and trainees who are temporary members of a team. Given these challenges, healthcare managers would benefit from the translation of team science concepts into clinical practice. In Chapter 2 of the Playbook, teams are provided guidance on the theory and practice of relational coordination[15] to enhance the quality of relationships and communication within and between teams (Figure 3). The team science literature suggests the strongest teams are those that create shared values and agile team processes that foster trust, psychological safety, high-quality relationships, communication, and fun at work.[16]

2.1.3 | Servant leadership

Servant leadership is a philosophy and practice that emphasizes caring, authenticity, and putting colleagues, and customers ahead of other goals. The goal of a servant leader is to serve, rather than be served, and to share power broadly. In comparison, hierarchical leadership models advocate for a top-down structure where power belongs to the leader and subordinates take direction. A servant leader is expected to display several attributes including empathy, self-awareness, persuasion, stewardship, and commitment to the growth of people. A hierarchical leader is expected to command and control. The servant leadership mindset and skills can be learned and have been associated with a broad range of outcomes. These include enhanced commitment, trust, satisfaction, well-being, lower burnout, and turnover intentions. In Chapter 3 of the Playbook, managers are provided guidance on the wellness-centered leadership model proposed by Shanafelt et al,[17] which can guide leaders to cultivate relationships and inspire change within teams (Figure 3). What makes servant leadership an appealing approach for healthcare managers is the promise it holds to grow people, to develop team spirit and organizational unity, and to shift the purpose of leadership from the quest for power and authority to the understanding and fulfilling of the needs of those they serve.[18] The VA is creating a culture of servant leadership by offering assessment tools, trainings, and resources to support the delivery of Veteran-centered care by engaged and collaborative teams.

2.1.4 | VA Whole Health Model

VA Whole Health empowers and equips people to take charge of their health and well-being and live their life to the fullest. Whole Health centers around the question, "What matters to you?" and not, "What is the matter with you?" The approach is designed to help clinicians get to know Veterans to develop a personalized health plan based on their values, needs, and goals. The VA Whole Health model has expanded to Employee Whole Health to offer evidence-based programming to support the health and well-being of VA leaders, clinicians, and staff. The education and trainings include leadership resources to reconnect employees with the VA mission and values, along with gratitude, servant leadership, stress management, burnout prevention, and social wellness tools. In Chapter 4 of the Playbook, managers are provided guidance on how to identify the "pebbles in my shoes"[19] a Whole Health approach to identify what frustrates employees and steals the joyful moments of work (Figure 3). Since 2008, the VA Employee Whole Health Model has demonstrated positive impacts on employee engagement and lower burnout and turnover.[20]

2.1.5 | VA Clinical Team Training program

The VA Clinical Team Training program focuses on enhancing patient safety by improving communication and teamwork. The multidisciplinary program is based on Crew Resource Management principles developed for aviation and is designed specifically for VA teams. The education and resources teach team safety behaviors aimed at managing human error and mitigating threats to safe care. The curriculum covers HRO principles that contribute to a culture of safety, leader behaviors that encourage teamwork and honest communication, and situational awareness as a foundation for individual and team mindfulness. In Chapter 5 of the Playbook, teams are instructed on the golden rules of communication, and active listening skills[21] (Figure 3). Teams that participate in the VA Clinical Team Training program report enhanced patient safety culture, improved communication and teamwork, and decreased mortality and complication rates.[22]

2.1.6 | Theoretical implications

Across these fields and programs, the common message is that the creation of supportive learning environments, where managers support relationships, communication, learning and high reliability, is a complex process. Implementing LHS and HRO best practices requires an approach that attends to (1) the unique needs of individual teams; (2) local context; and (3) a manager's ability to practice self-awareness and stewardship while implementing interventions that foster trust, high-quality relationships and communication, and Whole Health for all team members.

2.2 | The Relational Playbook: Description

The Playbook was completed in 2022. The Playbook includes resources, and 50 evidence-based interventions that managers can incorporate, as brief, asynchronous modules, into team meetings or training to cultivate supportive learning environments (see Table 1). An excerpt from Chapter 1 is available in Supplemental Digital File 2. Six clinical, LHS, and HRO experts reviewed the Playbook and deemed it acceptable, appropriate, and feasible for implementation. Playbook implementation is facilitated by a clinical manager or educator.

2.3 | Logistics of implementation

The Playbook resources and interventions provide guidance on how managers can create a positive culture (positive psychology), intentionally build, and manage their teams (team science), purposefully lead their team (servant leadership), create joy in work (VA Whole Health), and practice effective communication and high-reliability (VA Clinical Team Training) (Figure 3). The Playbook addresses existing VA priority areas, including enhancing learning and clinician engagement to reduce burnout, turnover, and increase Veteran safety. The alignment of the Playbook content with VA priorities is designed to enhance the adoption and sustained use of the Playbook interventions to achieve organizational mission-critical goals. We developed four steps for managers to take to

TABLE 1 Relational Playbook for Cardiology Teams: Chapters, resources and interventions.

LHS and HRO concept	Chapter titles	Resource topics	Examples of evidence-based interventions
Positive psychology	Creating a positive culture	Positive culture	Three good things practice
		Assessing team well-being	Measurement of well-being
		Appreciative inquiry	Appreciative inquiry questions
Team science	Teamwork	Building a team	Relational coordination practices
		Relationships at work	Walk in my shoes exercise
		Difficult relationships	Ice breaker questions
		Hiring for high-performing teams	
Servant leadership	Leading teams	Wellness-centered leadership	Caring about people always approach
		Servant leadership	Cultivate relationships approach
		Essential leadership skills	Inspire change approach
VA Whole Health	Creating joy in work	Burnout	Measurement of team stress
		Joy and happiness	Understanding what matters
		Gratitude	The pebbles in our shoes practice
VA Clinical Team Training	Communication and high reliability	Effective communication	The golden rules of communication
		High-reliability practices	Active listening method
			Support of speaking up behaviors

TABLE 2 The Relational Playbook learning environment assessment tool.

Survey questions	Response options
The cath lab team demonstrates trust and mutual respect for each other.	1–5 Ascending Likert Scale Rarely to Almost Always
The cath lab team has a good understanding of each other's talents and skills.	
The cath lab team recognizes and values humor, joy, and celebration in the workplace.	
Cath lab managers and staff are comfortable having difficult conversations.	
The cath lab team talks about their mistakes and ways to learn from them.	
The cath lab team is comfortable asking for help and feedback from others.	
Cath lab managers and staff exhibit active listening skills, curiosity and are willing to take part in team-building activities.	
The cath lab team can control their own practice and regularly participate in decisions about their work.	
The cath lab team regularly uses huddles or debriefs to identify problems and reflect on past performance.	
The cath lab team trains as a team and conducts dry runs to improve performance.	
Cath lab management hires new employees based on their willingness to learn, work, and communicate well with others.	
The cath lab team uses highly reliable communication skills.	
The cath lab team discusses their well-being and levels of stress and burnout.	

Key: The 13 survey items were selected from the validated Learning Environment Survey in VA CCLs. Scoring: All items are summed. Higher scores suggest more supportive learning environments.

assess the current learning environment, select areas for improvement, implement and adapt Playbook interventions, and evaluate the impact.

Step 1: Assess the current state. The manager proactively assesses the current learning environment through the completion of an abbreviated version of the validated Learning Environment Survey in VA CCLs.[1,12] The 13-item Qualtrics-hosted assessment tool uses a 1-5 ascending Likert scale (**see** Table 2). The assessment results are automatically summed in Qualtrics, with higher scores suggesting more supportive learning environments. Results are linked to the five Playbook chapters and include guidance on how to interpret the results (eg, areas of strength or improvement).

Step 2: Select areas for improvement. The manager works with their team to identify areas of strength and opportunities for improvement. The selection of Playbook practices is driven by the team's sense of importance and urgency to address an area for improvement. This is gauged by the amount of time and resources members are willing to invest in a new practice.

Step 3: Implement and adapt interventions. The manager works with their team to develop an implementation and adaptation plan, based on quality improvement methods such as Plan-Do-Study-Act (PDSA). The ideal implementation team is an engaged, interdisciplinary group invested in creating a supportive learning environment through the adoption of the Playbook interventions. Fidelity to the Playbook interventions is maintained to ensure the critical aspects of each practice are delivered. However, the delivery method of the interventions can be adapted to local needs and contexts. The delivery of the Playbook interventions is iteratively revised as part of the PDSA method.

Step 4. Evaluate the impact. The manager develops feedback loops to monitor the performance of the Playbook interventions. The team reflects routinely on what they are learning, gauge impact, and acknowledge any challenges. They proactively identify emerging problems, implement solutions, and adapt the implementation process accordingly. The manager can use existing organizational data to monitor the impact of the Playbook interventions. For example, the manager could identify quality improvement metrics, such as timeliness and accuracy of services, collected by their quality department or clinician and trainee metrics, such as learning, satisfaction, burnout, and turnover, collected in employee-focused surveys. The manager could also use 360° review leadership metrics, such as the Servant Leader Index, and monitor for any unintended or adverse consequences using error reporting systems.

3 | SUMMARY AND NEXT STEPS

The Learning Organization and REWP models describe how organizations can continually learn and deliver nearly error-free services. In healthcare, the process of learning and high-reliability is important for the development of high quality, equitable and safe care systems, and employee well-being. The Playbook resources and interventions translate LHS and HRO frameworks for real-world implementation by healthcare managers and educators. The next step in this work is to implement the Playbook interventions with clinical teams who have the necessary investment, energy, and resources to act as champions, and facilitate the integration of practices into existing workflows (i.e., early adopters). Additional research is needed to identify and test strategies, including leadership coaching and learning collaboratives, to support Playbook implementation with disengaged, burned-out, and overworked teams. This will provide insights and direction for LHS and HRO theory, research, and practice.

ACKNOWLEDGEMENTS

The authors would like to thank the VA staff who shared their insights and wisdom to create the Relational Playbook.

The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs.

FUNDING INFORMATION

Dr. Gilmartin is supported by Career Development Award Number 1IK2HX002587-01A1 from the United States Department of Veterans Affairs Health Services Research and Development Service of the VA Office of Research and Development.

CONFLICT OF INTEREST STATEMENT

The authors report no potential or actual conflict of interest regarding this study.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request, though will be subject to the stringent data privacy rules of the VA Healthcare System and the United States Government.

ETHICS STATEMENT

This study was deemed an exempt, non-human subjects research study by the Colorado Multiple Institutional Review Board (17-1153).

ORCID

Heather M. Gilmartin https://orcid.org/0000-0002-0264-4059
Brigid Connelly https://orcid.org/0000-0002-7196-8997
Mary E. Plomondon https://orcid.org/0000-0002-8616-4916
Stephen W. Waldo https://orcid.org/0000-0003-0678-4873
Catherine Battaglia https://orcid.org/0000-0002-1606-3116

TWITTER

Heather M. Gilmartin *@hgrnepi*

REFERENCES

1. Gilmartin HM, Hess E, Mueller C, Plomondon ME, Waldo SW, Battaglia C. A pilot study to assess the learning environment and use of reliability enhancing work practices in VHA cardiac catheterization laboratories. *Learn Health Syst*. 2020;5:1-6. doi:10.1002/lrh2.10227
2. Tawfik DS, Scheid A, Profit J, et al. Evidence relating health care provider burnout and quality of care: a systematic review and meta-analysis. *Ann Intern Med*. 2019;171(8):555-567.
3. Sculli GL, Pendley-Louis R, Neily J, et al. A high-reliability organization framework for health care: a multiyear implementation strategy and associated outcomes. *J Patient Saf*. 2022;18(1):64-70.
4. Singer SJ, Moore SC, Meterko M, Williams S. Development of a short-form learning organization survey: the LOS-27. *Med Care Res Rev*. 2012;69(4):432-459.
5. Vogus TJ, Iacobucci D. Creating highly reliable health care: how reliability-enhancing work practices affect patient safety in hospitals. *ILR Rev*. 2016;69(4):911-938.
6. Garvin DA, Edmondson AC, Gino F. Is yours a learning organization? *Harv Bus Rev*. 2008;86(3):109-16, 134.
7. Edmondson AC. Speaking up in the operating room: how team leaders promote learning in interdisciplinary action teams. *J Manag Stud*. 2003;40(6):1419-1452.
8. Conley DM, Singer SJ, Edmondson L, Berry WR, Gawande AA. Effective surgical safety checklist implementation. *J Am Coll Surg*. 2011;212(5):873-879.
9. Tucker AL, Nembhard IM, Edmondson AC. Implementing new practices: an empirical study of organizational learning in hospital intensive care units. *Manag Sci*. 2007;53(6):894-907.

10. Dixon-Woods M, Bosk CL, Aveling EL, Goeschel CA, Pronovost PJ. Explaining Michigan: developing an ex post theory of a quality improvement program. *Milbank Quart*. 2011;89(2):167-205.
11. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quart*. 2004;82(4):581-629.
12. Gilmartin HM, Hess E, Mueller C, et al. Learning environments, reliability enhancing work practices, employee engagement, and safety climate in VA cardiac catheterization laboratories. *Health Serv Res*. 2022;57(2):385-391.
13. Duckworth AL, Steen TA, Seligman ME. Positive psychology in clinical practice. *Annu Rev Clin Psychol*. 2005;1(1):629-651.
14. Bushe GR, Kassam AF. When is appreciative inquiry transformational? A meta-case analysis. *J Appl Behav Sci*. 2005;41(2):161-181.
15. Bolton R, Logan C, Gittell JH. Revisiting relational coordination: a systematic review. *J Appl Behav Sci*. 2021;57(3):290-322.
16. Bennett ML, Gadlin H, Marchand C. *Collaboration Team Science: Field Guide*. US Department of Health & Human Services, National Institutes of Health, National Cancer Institute. https://www.cancer.gov/about-nci/organization/crs/research-initiatives/team-science-field-guide/collaboration-team-science-guide.pdf
17. Shanafelt T, Trockel M, Rodriguez A, Logan D. Wellness-centered leadership: equipping health care leaders to cultivate physician well-being and professional fulfillment. *Acad Med*. 2021;96(5):641-651.
18. Zubairu UM. Servant leadership in the last decade: a systematic review. *J Corp Resp Leadership*. 2019;6(1):53-76.
19. Maslach C, Leiter MP. *The Burnout Challenge: Managing People's Relationships with Their Jobs*. Cambridge, MA: Harvard University Press; 2022:261.
20. Reddy KP, Schult TM, Whitehead AM, Bokhour BG. Veterans health administration's whole health system of care: supporting the health, well-being, and resiliency of employees. *Glob Adv Health Med*. 2021;10:21649561211022698.
21. Luntz F. *Words that Work: It's Not What you Say, it's What People Hear*. New York: Hyperion; 2007.
22. Schwartz ME, Welsh DE, Paull DE, et al. The effects of crew resource management on teamwork and safety climate at veterans health administration facilities. *J Healthc Risk Manag*. 2017;38:17-37.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Gilmartin HM, Connelly B, Hess E, et al. Developing a relational playbook for cardiology teams to cultivate supportive learning environments, enhance clinician well-being, and veteran care. *Learn Health Sys*. 2024;8(2):e10383. doi:10.1002/lrh2.10383