

THEME 01 · DATA, MEASUREMENT & EVIDENCE

Table H1 · Defining the Healthy Worker

Measurement, before commitment.

WHY THIS TOPIC, WHY NOW

NIOSH's Total Worker Health® approach widened the lens. It now covers the health conditions workers bring with them into the workplace and the conditions the workplace creates that follow them home. The framing is now widely accepted in OEHS. The measurement systems have not kept up.

Most organizations can describe a healthy worker in general terms but can't back it up with a working definition. The pieces are scattered - occupational health, HR, benefits, EAP, ergonomics, psychosocial - across functions that don't share data, governance, or even vocabulary. This table isn't about whether to widen the lens. That's settled. The question is whether your measurement system can produce a definition you could defend in front of your workforce, your regulators, and your board.

THE FRAMING QUESTION

"What is the operating definition of a healthy worker your organization could defend on the evidence - and what would you have to measure to back it up?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a time your organization made a real OEHS decision using a broader view of worker health than the usual one. What data and systems made that decision defensible?

Listening for: *Stories where data crossed function boundaries - occupational health plus HR plus benefits - and produced one clear signal. Push past "we care about the whole person" to the actual data setup that made it work.*

Q2 · Gaps (0:20–0:30)

Where does your current measurement system miss something important about your workers' health? Why does that gap exist?

Listening for: *Listen for the moment someone names a measurement that matters but the organization can't actually produce it. That gap, and the reason behind it, is the most useful material here.*

Q3 · Needs (0:30–0:40)

What worker-health signal do you believe matters but can't currently collect? What would have to change to start collecting it?

Listening for: *Watch for technology answers ("we need better wearables"). The harder, more useful answer is usually about consent, governance, and getting functions to share - things technology alone can't solve.*

Q4 · Asks (0:40–0:50)

What would your organization need from AIHA, NIOSH, or peer companies to make a defensible working definition of "the healthy worker" possible?

Listening for: *Two kinds of asks - asks for content (research, frameworks) and asks for permission (peer examples that make the change easier to defend at home). Capture both.*

PATTERNS TO REDIRECT FROM

The wellness-program collapse. Total Worker Health® often gets read at the executive level as wellness programs - step counters, meditation apps, smoothie bars - because that's what HR is funded to do. The real measurement work is about workplace conditions that drive health outcomes, not the benefits programs sitting on top. When the room starts naming wellness vendors, pull it back to: what's the workplace condition we should be measuring?

The wearables-as-answer detour. Continuous health monitoring through wearables is real and growing. It also shows up in vendor pitches more often than its actual evidence supports, and it requires consent and governance that most organizations haven't built. When the table starts comparing devices, return to: "If you had perfect data, what's the definition you'd defend with it?" Then work backwards from there.

The privacy-as-stopper reflex. "We can't because of HIPAA / GDPR / our works council" is sometimes a real constraint and sometimes a way to dodge the harder conversation about leadership and consent. The leaders making real progress are the ones who built a consent process, not the ones who treated privacy as a wall.

WHERE THIS TABLE SITS IN THE LARGER ROOM

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CONNECTED TABLE

WHERE IT REJOINS YOURS

Human · Measuring Human-Centric Risk
(Theme 1 sibling)

The numbers side of what your table defines. They go deeper into how psychosocial risks connect to HOP.

Tech · Performance Metrics & Analytics
(Theme 1 partner)

Same theme, but through an analytics lens. Your measurement question and their analytics question are the same problem from two sides. Rotation III will thread them together.

Human · Safety Culture for 2026 & Beyond
(Theme 4)

The culture companion. Your table asks what we should measure; that one asks what culture has to look like to make worker health real.

Human · Trust & Psychological Safety
(Theme 4)

Measurement depends on consent. Consent depends on trust. If your table hits the consent question during "needs," that's the connection point.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: The measurement-system layer, not the wellness-program layer. Be familiar with the NIOSH Total Worker Health® framework and the recent work on measuring psychosocial hazards - enough to recognize when participants are reaching for them. When vendor names start getting swapped, return to: "That's a tool answer - what's the measurement-system answer?"

What this table isn't trying to produce: A defense of Total Worker Health® (the room is past that). A list of wellness programs. A single field-wide definition - the field isn't ready, and forcing one would produce a fake answer. Three lines of strength, gap, and ask is the deliverable.

THEME 01 · DATA, MEASUREMENT & EVIDENCE

Table H2 · Measuring Human-Centric Risk

The worker as the subject of risk, not the vector of hazard.

WHY THIS TOPIC, WHY NOW

Most OEHS risk frameworks come from traditional industrial hygiene, built around hazards. We've stretched them to cover psychosocial load, cumulative ergonomic strain, fatigue, and the way different life stages and demographics shape exposure. The frame works well for what it was built for and worse for everything the field has added on. The core gap: traditional frameworks treat the worker as the carrier of risk. Human-centric risk treats the worker as the subject of risk - the person who absorbs the harm, does the work, and lives with the effect.

Executives still report against the older frameworks. Psychosocial and cumulative-exposure findings don't map cleanly onto those reports. ISO 45003 (2024) has given the field a shared vocabulary for the operating committee, which is necessary but not enough on its own. The real work is in the gap between having the standard and being able to defend a number in front of the executive team.

THE FRAMING QUESTION

"Where has your organization tried to measure a human-centric risk and produced a number you could defend - and where have you stopped trying because it didn't hold up?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a human-centric risk your organization measured well enough to actually act on. What made the measurement hold up?

Listening for: *Examples where the measurement moved from OEHS into the broader operating review. The interesting condition is rarely the tool itself; it's the working relationship OEHS built with finance, operations, or legal.*

Q2 · Gaps (0:20–0:30)

Where does your current risk framework still treat the worker as the carrier of a hazard rather than the person living with the risk? What's the consequence of that framing?

Listening for: *The moment a participant catches themselves describing a worker as "exposed to a hazard" and then re-describes it as a person carrying cumulative effects over time. That re-description is the shift we're listening for.*

Q3 · Needs (0:30–0:40)

What would you need to be able to measure to make human-centric risk something you could defend in an operating review? What's blocking you from getting there?

Listening for: *The validation question. Many vendors claim to measure human-centric risk; few have published evidence that their measure actually predicts operating outcomes.*

Q4 · Asks (0:40–0:50)

What does our field need to standardize for human-centric risk to land in the executive conversation the way exposure risk does? Where's the lever?

Listening for: *The gap between ISO 45003 as a written standard and ISO 45003 as something you actually use day-to-day. The asks usually live in the translation layer - the templates, benchmarks, and examples that would let an OEHS leader put it into practice.*

PATTERNS TO REDIRECT FROM

The hazard-by-another-name collapse. “Human-centric risk” can quietly slide back into traditional hazard analysis if the table isn’t held to it. Watch for someone naming a hazard (noise, chemicals, ergonomic load) and stopping there. The substantive material is how the worker relates to that hazard over time, across life stages, and under accumulated demand – not the hazard itself.

The wearable-vendor drift. Continuous monitoring of physical signals (heart rate variability, sleep, gait) is a growing capability. Many products claim to measure fatigue or stress; few have validation that holds up when an operating decision is on the line. When the room starts trading device names, the honest question is: what’s the measurement actually validated against, and who decides what to do with it?

The surveillance-versus-care line. Human-centric risk measurement creates new consent questions. The work that lands well is built on a process that lets workers and labor reps clearly see the difference between care and surveillance. When the conversation drifts to “what we could measure if we had permission,” the consent question is where the useful work lives.

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CONNECTED TABLE**WHERE IT REJOINS YOURS**

Human · Defining the Healthy Worker
(Theme 1 sibling)

“Who is being measured?” runs underneath both tables. If your table hits the consent and systems questions, that’s the closest companion conversation.

Tech · Performance Metrics & Analytics
(Theme 1 partner)

The “what counts as proof” question through a metrics and analytics lens. Human-centric risk and executive analytics meet at the same problem: what makes a measurement defensible in an operating review.

Human · SIF/HOP, Systems, and Strategy
(Theme 2)

Risk measurement comes before decision rights. The question of which signals require which kind of governance is the natural bridge to the SIF/HOP table.

Human · Trust & Psychological Safety
(Theme 4)

The same consent process that makes human-centric measurement possible is what makes psychological safety actually work in practice. If the consent question comes up during “needs,” that table is the mirror.

WHAT THE TABLE IS AND ISN’T TRYING TO PRODUCE

What this table is holding for: A working knowledge of ISO 45003 and the recent psychosocial-risk-measurement literature – enough to recognize when participants are reaching for it. Comfort with the language of validation. The question this conversation returns to most: “What was that measurement validated against?”

What this table isn’t trying to produce: A defense of psychosocial or cumulative-risk measurement as a category (the literature is past that). A single agreed-on threshold; the field isn’t ready to set thresholds for human-centric risks, and forcing the room toward one produces a weaker conversation than naming the gap honestly.

THEME 02 · GOVERNANCE, RISK & DECISION RIGHTS

Table H3 · SIF/HOP, Systems, and Strategy

Governance for the work that acutely kills.

WHY THIS TOPIC, WHY NOW

SIF and HOP aren't new. Both have been developing inside leading OEHS organizations for more than a decade - BST/Mercer ORC surfaced the precursor concept back in 2010, and HOP's five principles were formally written into ASSP/ANSI Z10.100-2024. The literature is settled. The argument now is whether SIF and HOP work effectively, and how.

The argument is structural. SIF and HOP usually run as parallel programs in big organizations - sitting next to core OEHS governance rather than shaping it. The decision rights haven't moved. The work that actually kills people is being managed by a part of the organization that doesn't yet have the authority to change how the rest of the organization decides things. The U.S. fatal-injury rate has been flat for eleven years, and we've largely ignored the 100,000-plus occupational disease deaths that happen every year. The knowledge to move the number is already on the shelf.

THE FRAMING QUESTION

"Where has SIF or HOP work actually changed decision rights in your organization - and where has it sat parallel to the work that kills people, additive but peripheral?"

FOUR QUESTIONS

Q1 · Strengths (0:10-0:20)

Tell us about a specific decision in your organization where SIF or HOP work changed not just the outcome but who got to decide - who weighed in, with what authority, on what timeline. What made the shift possible?

Listening for: *Stories where spotting a precursor led to an actual change in procedure or capital spending. Push past "we got better at investigations" toward "we changed who decides what."*

Q2 · Gaps (0:20-0:30)

Where does HOP show up in your organization as a principle but not in your governance system as actual decision authority? What's keeping the two apart?

Listening for: *Some version of "HOP is in our learning team but not our operating committee."*

Q3 · Needs (0:30-0:40)

Name a SIF precursor from your operations that your system isn't yet set up to act on. What would have to change about who decides - not just policy - for that signal to actually land?

Listening for: *The honest answer is almost always about who reads what report, how often, with what authority to stop work. When the conversation turns to naming policies, the real question underneath is who decides.*

Q4 · Asks (0:40-0:50)

What governance change would you most want to make tomorrow if you had executive backing for it? What outside pressure could actually deliver that backing?

Listening for: *The strongest material here is what people would actually do if their CEO read the right article over the weekend and called them on Monday morning.*

PATTERNS TO REDIRECT FROM

The compliance-theater detour. This conversation slides fastest into two dead ends: “we need a new policy” (compliance theater) or “leadership doesn’t get it” (politics). Both are real, both lead nowhere here. The substantive ground is decision architecture - who has authority over which kind of signal, how often they look at it, with what accountability.

The HOP-as-blame-shift trap. HOP done badly is just blame in a different shape. “It was a system failure” can become a way to avoid the harder conversation about which leaders signed off on the system. If there’s too much warm agreement about systems thinking, the harder question is: name a HOP-style finding that pointed directly at leadership - and what happened after?

The precursor-confidence problem. Some tables will overclaim what their precursor work has actually prevented. It’s hard to count what didn’t happen, and SIF prevention is the hardest case because the absence is the win. The honest answer is usually “we don’t know what we prevented; we know we changed how we make decisions.”

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CONNECTED TABLE

WHERE IT REJOINS YOURS

Human · Leadership and Legal Risks (Theme 2 sibling)

When SIF/HOP changes decision rights, it also changes legal exposure. The legal-risk table is the closest companion; if the room reaches the “executive cover” question, that’s the mirror.

Tech · AI Ethics, Governance & Strategy (Theme 2 partner)

Same theme, Tech-leaning. SIF/HOP and AI governance are the same conversation seen from two ends - both are about who decides when a new kind of signal enters the system. Expect Rotation III to thread them together.

Tech · Performance Metrics & Analytics (Theme 1)

If your table reaches “what would change if we measured the right precursors,” the metrics conversation across the room is the mirror. Worth naming when the conversation hits the “needs” stage.

Human · Creating Actionable Learning Loops (Theme 3)

The closest sibling on the learning side. Their question is “how does learning turn into change?” Yours is “who has the authority to act on the learning?”

WHAT THE TABLE IS AND ISN’T TRYING TO PRODUCE

What this table is holding for: Be comfortable holding silence. The substantive answers in this conversation usually come four seconds after the question, not one. Working knowledge of how HOP principles are codified in ASSP/ANSI Z10.100-2024. The question to keep returning to: “That’s a policy answer. What’s the decision-rights answer?”

What this table isn’t trying to produce: A defense of SIF or HOP (the room is past that). Vendor or consultant pitches - when the conversation slides toward pitch language, the move is to surface the decision-rights conversation underneath the tool. This conversation will not produce consensus and isn’t designed to. Three lines of strength, gap, and ask is the deliverable.

THEME 02 · GOVERNANCE, RISK & DECISION RIGHTS

Table H4 · Leadership and Legal Risks

When the legal frame catches up to the OEHS decision.

WHY THIS TOPIC, WHY NOW

The legal landscape around OEHS leadership decisions has shifted in ways the field's executive playbook hasn't fully caught up with. Personal liability has grown globally - especially in Canada and Australia, and at home through the post-Volkswagen pattern of individual prosecution in U.S. federal cases that has continued. ESG disclosure rules have put OEHS data on the official record, where it can be pulled into discovery in new ways.

On top of that: AI in EHS systems creates a new problem - tracing where a decision came from. The algorithm recommends, the executive acts on it, a worker is harmed, and the discovery process has to reconstruct who decided what based on what evidence - sometimes months or years later, in front of counsel and regulators who weren't in the room. Most organizations haven't built the documentation practice that would make those decisions defensible. This table isn't a legal seminar. It's a conversation among OEHS executives about what governance practice will hold up in court.

THE FRAMING QUESTION

"What's a decision in your organization in the last twenty-four months where you could not produce a defensible record of who decided what based on what evidence?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a recent OEHS-adjacent decision in your organization where your governance produced a defensible audit trail - on purpose, not by luck. What did that practice actually look like?

Listening for: *The difference between documentation that holds up in discovery and documentation that doesn't. Participants who've built this on purpose can describe the practice in specific, operational terms.*

Q2 · Gaps (0:20–0:30)

Where in your organization is there a gap between who makes the call and who carries the legal exposure if it goes wrong? Why does that gap still exist?

Listening for: *The question of personal liability. OEHS leaders often carry exposure they don't fully see until they're in a deposition. The honest answer is sometimes uncomfortable - sit with it.*

Q3 · Needs (0:30–0:40)

What documentation, legal-counsel relationship, or governance change would you want to make to better protect your highest-exposure decisions? What's stopping you?

Listening for: *Watch for the tendency to push the answer outward ("legal would have to lead it"). The substantive material is what OEHS leadership would change about its own practice if it wasn't waiting on legal.*

Q4 · Asks (0:40–0:50)

What does the field need to turn these governance changes into a defensible business case for your CEO and board?

Listening for: *The insurance industry signal is underplayed in field conversations and is starting to bite at the edges. Watch for D&O premium pressure and changes in carrier audits - those are signals worth paying close attention to when they surface.*

PATTERNS TO REDIRECT FROM

The “legal will handle it” deferral. Counsel is reactive by nature and limited by privilege. OEHS leadership often hands exposure to legal that they’re actually carrying personally and operationally themselves. The useful examples are leaders who built the legal partnership instead of waiting to be invited into it.

The compliance-theater documentation trap. Some organizations document for the file, not for the decision. The result is paperwork that falls apart the moment someone reads it against what was actually happening on the ground. Volume of documentation isn’t defensibility. The honest practice is leaner and harder to do.

The AI-decision provenance gap. Decisions made on AI-generated recommendations - risk scoring, near-miss prediction, exposure modeling - are especially hard to reconstruct later. For organizations already running AI in EHS, the honest question is what’s actually being captured about the decision trail. The answer is often “less than we thought,” which is the most useful capture.

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CONNECTED TABLE**WHERE IT REJOINS YOURS**

Human · SIF/HOP, Systems, and Strategy
(Theme 2 sibling)

Fatality risk is where leadership legal exposure peaks. The SIF/HOP conversation about decision rights and your conversation about defensibility are the same conversation.

Tech · AI Ethics, Governance & Strategy
(Theme 2 partner)

The algorithm side of the same exposure. Your documentation and decision-trail question and their upstream design question meet at the same place: what will hold up in discovery.

Tech · AI in EHS Maturity & Frameworks
(Theme 2 partner)

Maturity frameworks for AI in EHS are the infrastructure question your governance conversation rides on. The room will reference this without naming it; worth surfacing as a connection point.

Human · Trust & Psychological Safety
(Theme 4)

What gets reported up versus hidden depends on trust infrastructure and shapes legal exposure. If your room reaches the underreporting question, that table is the mirror.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: Comfort with the personal-exposure conversation. This is uncomfortable territory and the most useful capture comes when the room is willing to name it specifically. Working familiarity with the recent legal landscape - R v. Greater Sudbury, the Australian industrial-manslaughter laws, the post-Volkswagen U.S. pattern, and how ESG disclosure makes things discoverable.

What this table isn't trying to produce: A legal opinion (the Rotation III anchor brings the legal frame; your work here is to surface the OEHS leadership practice questions that legal can then build on). Case citations as content - the cases are reference points for framing, not the substance. A defensive posture; the most useful conversations here are the ones where executives are willing to name what they can't yet defend.

THEME 03 · ADOPTION, SCALE & CHANGE

Table H5 · Creating Actionable Learning Loops

Learning that closes inside the operating cycle.

WHY THIS TOPIC, WHY NOW

Most OEHS organizations have learning systems. Few have learning that turns into action at the speed and scope the work actually needs. The gap is structural: investigation findings sit in reports, root-cause analyses cycle through committees, lessons-learned documents get filed - and the operational decisions that need to change keep getting made the same way.

HOP's contribution to the field was naming this gap as a built-in feature of how organizations are designed, not a defect of any one investigator or leader. Honest HOP implementation means the operating system has to absorb learning at the pace work actually happens - weekly, not quarterly. Most organizations haven't built that infrastructure. This table opens up: what does the operating practice actually look like for the ones who have? And what workarounds or partial fixes are working in the field?

THE FRAMING QUESTION

"Walk us through the last time learning from a real event in your organization actually changed how decisions get made. What was the loop, and why did it close?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Where in your organization does learning actually turn into changed practice within the same operating cycle - not next year's planning cycle, this one? What's the setup that makes the loop close?

Listening for: *Specific cadence. Participants who've built loops that work can describe them in terms of who reads what, how often, with what authority. Those who haven't will describe culture and tone.*

Q2 · Gaps (0:20–0:30)

Where does your learning system produce findings that everyone agrees with - and nothing changes? What's the reason behind that?

Listening for: *The agreement-without-change pattern is the most common and the most revealing. The reason is almost never "people don't care." It's usually a specific gap in authority or cadence.*

Q3 · Needs (0:30–0:40)

If you could redesign one feedback loop in your organization tomorrow, which one and why? What would have to change about authority, cadence, or who reads the signal?

Listening for: *Watch for the urge to redesign the report itself. The substantive answer is almost always about authority or cadence, not the document. When a participant starts redesigning a template, ask: "Who reads it, when, with what authority?"*

Q4 · Asks (0:40–0:50)

What would the field need to share to make fast-cycle operational learning a defensible governance practice rather than a workaround?

Listening for: *The field doesn't yet have shared language for what makes a learning loop "actionable" as opposed to "thorough." The most useful asks tend to live in that language gap.*

PATTERNS TO REDIRECT FROM

The “we have a great LMS” detour. Learning management systems aren't learning loops. The LMS sits downstream of the loop and often gets substituted for it in conversation. When the room slides into talking about training content or platform features, the question that matters is: did anything change about how the work actually gets done?

The blame-displacement trap. HOP-style learning can collapse into “the system did it” without anyone naming what actually changed about decision rights or operating practice. Warm agreement about systems thinking without operational specifics is a warning sign. The harder question: what changed about who decides what?

The lessons-learned-report cul-de-sac. A report isn't a loop. A lot of OEHS organizations define “we closed the loop” as “we published the report.” When a report gets cited as evidence the loop closed, ask what the report actually changed about operating practice. The honest answer is often “less than I thought,” which is the most useful capture.

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CONNECTED TABLE**WHERE IT REJOINS YOURS**

Human · Engagement & Risk Tolerance
(Theme 3 sibling)

The workforce-engagement side of the same theme. Learning loops that don't engage the workforce don't close. Natural companion at the “needs” stage.

Tech · Use Cases & Lessons Learned
(Theme 3 partner)

Same theme, Tech-leaning - the capture side of the loop. Your authority-to-act question and their what-to-capture question meet at the same problem. Expect Rotation III to thread them.

Tech · Moving from Pilot-to-Scale
(Theme 3 partner)

The scaling question through a different lens. A pilot that doesn't produce actionable learning doesn't scale. If your room reaches the scale question at “needs,” that's the mirror.

Human · SIF/HOP, Systems, and Strategy
(Theme 2)

The governance side of the same loop. Their question is “who has decision rights to act on the signal?” Yours is “how does the signal turn into change?” Same loop, different access points.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: Be comfortable pushing for specifics. The question this conversation returns to most: “What did that actually change about how decisions get made?” Working familiarity with HOP's learning principles and the recent literature on fast-cycle operational learning in safety-critical industries.

What this table isn't trying to produce: A defense of the learning frame (the room is past that). A single agreed-on definition of “actionable learning” - the field doesn't have one yet, and forcing the room toward one will produce a weaker conversation than the gap itself. Vendor pitches; when a tool gets named, surface the loop-closure question underneath the platform.

THEME 03 · ADOPTION, SCALE & CHANGE

Table H6 · Engagement & Risk Tolerance

The worker's answer to the rollout plan.

WHY THIS TOPIC, WHY NOW

The classical OEHS frame treats risk tolerance as a worker trait to be managed down - through training, signage, supervision, and culture. The current safety-culture literature and the HOP-adjacent work treats it instead as the worker's rational response to the operating environment the organization actually built: the gap between rules-as-written and rules-as-followed, the trade-offs the work demands, and the signals the organization sends about what it really values.

Adopting and scaling new OEHS technology or practice runs straight into this. Workers engage with what makes their work better and disengage from what makes it harder, no matter what the rollout deck says. Wearables get worn or they don't. Reporting platforms get used or they don't. Behavior-based safety programs land or they generate paperwork. The post-mortem is almost always about engagement, and almost always too late.

THE FRAMING QUESTION

“What’s an OEHS technology, practice, or system your organization tried to scale that ran straight into worker engagement reality - and what did you learn about the gap?”

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a scale-up that actually worked - where workforce engagement carried the change, not the change-management plan. What were the operating conditions that made it possible?

Listening for: *Look for the moments where workers themselves became the carriers of the change. The signal is usually that workers modified the rollout in ways the organization didn't expect, and the organization went with the modification.*

Q2 · Gaps (0:20–0:30)

Where is your organization currently misreading worker engagement or risk tolerance? What are workers doing that the metrics say they're not - or not doing that the metrics say they are?

Listening for: *The gap between survey scores and what's actually happening on the floor. The most useful signal is the specific case where the dashboard said one thing and the work was telling a different story.*

Q3 · Needs (0:30–0:40)

What feedback mechanism would you need to read workforce engagement accurately during a scale-up? Why don't you have it?

Listening for: *The answer is rarely “a better survey.” It's usually a relationship and cadence the organization hasn't built. The relationship-and-cadence answer is the substantive one.*

Q4 · Asks (0:40–0:50)

What does the field need to share about how workforce engagement actually shapes adoption - enough to make engagement a defensible part of pilot-to-scale planning instead of an afterthought?

Listening for: *The most practical asks tend to be about how to get engagement evidence into the business case for a deployment. That's the lever - and the specifics are what matter.*

PATTERNS TO REDIRECT FROM

The “they don’t understand the risk” reflex. When engagement gaps get framed as “workers don’t understand,” the alternative reading is almost always available and more useful: workers may understand the risk and the work differently than the organization assumes - and the gap is information about the work, not a deficit in the worker. The harder question: “What are they seeing that the rollout deck isn’t?”

The survey-as-signal trap. Engagement surveys reflect conditions; they aren’t the conditions. They’re also gameable, slow, and often worded to produce the answer the organization wants. When a survey score gets cited, ask what’s actually observed in the work. The gap between the survey and the observation is the substantive capture.

The off-the-shelf change-management drift. Generic change-management frameworks tend to assume engagement is a communication problem. The OEHS literature increasingly reads it as a design problem - the work was designed without the workforce in the room, and the rollout is the receipt. The useful move is from a communication frame to a design frame.

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Human · Creating Actionable Learning Loops (Theme 3 sibling)	The learning-loop side of the same theme. An engagement signal that doesn’t close a loop doesn’t change the work.
Tech · Moving from Pilot-to-Scale (Theme 3 partner)	Same loop, infrastructure side. The infrastructure that lets a pilot scale and the engagement that lets workers carry it are two halves of the same answer.
Tech · Use Cases & Lessons Learned (Theme 3 partner)	What scales and what doesn’t, from the Tech side. Worth surfacing if your conversation reaches the cross-organization pattern question.
Human · Trust & Psychological Safety (Theme 4)	Honest engagement signal requires trust. If your table asks why workers aren’t telling you something, that table is the closest companion.
Human · Workforce Development & Skills (Theme 5)	The longer arc on the same question. Engagement during a scale-up depends on how the workforce was developed to engage with the work.

WHAT THE TABLE IS AND ISN’T TRYING TO PRODUCE

What this table is holding for: Hold the workforce-as-source-of-information frame against the pull toward workforce-as-resistance. Working familiarity with the safety-culture literature. The question worth returning to: “That’s a comms answer. What’s the design answer?”

What this table isn’t trying to produce: A defense of safety culture as a frame (the room is past that). A specific change-management framework - the conversation isn’t about which framework is best; it’s about what the workforce is telling you that the framework didn’t predict. Don’t try to produce a unified theory of engagement - the room won’t, and shouldn’t.

THEME 04 · TRUST, CULTURE & THE BUSINESS CASE

Table H7 · Trust & Psychological Safety

The condition every other program quietly depends on.

WHY THIS TOPIC, WHY NOW

Psychological safety entered OEHS through a side door. The foundational 1999 work on clinical-team performance was re-popularized in 2015 as a predictor of team effectiveness, and HOP's codification in ASSP/ANSI Z10.100-2024 pulled it into the safety canon as the condition a learning team needs. It's now load-bearing in leading OEHS programs - reporting culture, near-miss capture, pSIF identification, and engagement signal all depend on it.

The structural problem is that psychological safety is still being managed as a survey construct rather than an operating condition. Organizations measure it with quarterly pulse surveys and act on the score - but the real signal is in the operating evidence: who reports what, how quickly, with what consequence. The gap between the survey score and what the operating evidence shows is where the conversation that matters lives. A second pressure is reshaping this table: AI-mediated worker monitoring and algorithmic supervision are changing trust.

THE FRAMING QUESTION

"Where in your organization does the operating evidence actually match what your psychological-safety survey says? And where doesn't it?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a moment in the last year when a worker or a team in your organization raised something hard and the organization handled it well. What were the operating conditions that made it possible?

Listening for: *Look for the operating conditions, not the culture story. Strong answers name a specific cadence, a specific authority, or a specific pattern of consequences. "Our culture is good" is not an answer.*

Q2 · Gaps (0:20–0:30)

Where in your organization is the survey saying one thing and the operating evidence saying another? What's the workforce telling you through what they don't report - that the dashboard doesn't catch?

Listening for: *The inversions. The most useful answers are the cases where psych-safety scores went up while the operating evidence went down (or vice versa). Those inversions are where the field is learning what the construct is actually measuring.*

Q3 · Needs (0:30–0:40)

AI-driven monitoring and predictive worker analytics are entering the workplace faster than the trust infrastructure can carry them. What does your workforce need to know?

Listening for: *Listen for participants whose organizations have already deployed and have honest readouts on what changed. The early-deployer evidence is the most valuable thing in the room. Some accounts will overclaim; the specific worker response is what clarifies.*

Q4 · Asks (0:40–0:50)

What does the field need to take a position on about the conditions psychological safety actually requires in 2026 and beyond? What position would give you cover to act?

Listening for: *Asks here often cluster around AI-deployment guidelines, leadership accountability standards, and frameworks for both.*

PATTERNS TO REDIRECT FROM

The culture-talk drift. Psychological safety is the OEHS topic that collapses fastest into warm agreement about culture. “Our culture is strong” is not data. The redirect: “Say we accept the culture is good - what’s the specific operating signal that tells you so?”

The canonical-citation trap. The foundational psychological-safety frameworks get cited as the answer, but the operational prescriptions inside them get skipped. When a framework gets named as the answer, the harder question is: in this organization, what does the framework actually prescribe operationally that has been implemented - and what does it prescribe that hasn’t? That gap is often the substantive capture.

The surveillance-vs-trust honesty problem. Several participants in the room will have organizations actively deploying worker-monitoring technology while also running psych-safety programs. The tension is real and the honest conversation about it is rare. When the room gets quiet at Q3, that silence is informative; the participants who can speak to the tension directly are the ones the rest of the room most needs to hear.

WHERE THIS TABLE SITS IN THE LARGER ROOM

Threads from this table connect to others through live theme mapping happening around the room. By the Rotation III handoff, what each table brings in is richer than any single one could produce on its own.

CONNECTED TABLE**WHERE IT REJOINS YOURS****Human · Safety Culture for 2026 & Beyond
(Theme 4 sibling)**

The culture companion. Your table asks what operating conditions trust requires; that one asks what culture has to become to carry trust under AI-driven work and demographic change. Load-bearing pair on the Human side of Theme 4.

**Tech · New Tools & Approaches
(Theme 4 partner)**

Same theme, Tech-leaning - what’s genuinely new in the OEHS-technology market versus what’s just rebranded. Your trust question and their new-capability question are the same conversation from opposite ends.

**Human · Engagement & Risk Tolerance
(Theme 3)**

Workforce engagement is a downstream signal of the trust infrastructure this table looks at. If a participant moves to why an engagement signal isn’t landing, the conversation routes here.

**Human · SIF/HOP, Systems, and Strategy
(Theme 2)**

HOP’s learning-team principle doesn’t work without the trust conditions this table looks at. The governance table is asking who has the authority; your table is asking under what conditions that authority gets used honestly.

WHAT THE TABLE IS AND ISN’T TRYING TO PRODUCE

What this table is holding for: Hold the operating-evidence frame against the pull of the culture-story frame.

Working familiarity with the recent operational literature on what produces psychological safety as a condition - not as a score.

What this table isn’t trying to produce: A defense of psychological safety as a construct (the room is past that). A debate about which survey is best - the conversation is downstream of the survey. A settled answer on the surveillance question: the field doesn’t have one, and the room won’t produce one.

THEME 04 · TRUST, CULTURE & THE BUSINESS CASE

Table H8 · Safety Culture for 2026 & Beyond

There were never two cultures.

WHY THIS TOPIC, WHY NOW

The field has spent forty years building “safety culture” as a separate thing - measured, funded, audited, and often staffed separately from the rest of the organization's culture. That separation was always partly fiction. The cultural conditions that produce reliable hazard reporting are the same conditions that produce reliable execution, retention, and ethical behavior. The organizations whose safety culture holds under stress are the organizations whose culture holds under stress.

Three pressures are reshaping this conversation. AI-driven work is entering workplaces faster than the cultural infrastructure can carry it; reporting and learning conditions that took two decades to build can be unwound in eighteen months by a deployment nobody flagged as a cultural intervention. The workforce now spans four generations with very different expectations, and the engagement-survey era has little fuel left.

THE FRAMING QUESTION

“What does the culture you have actually let you do in 2025 - and what does it tell you about what safety culture has to become in the post-engagement-survey era?”

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Tell us about a moment where the culture genuinely carried the safety outcome, and you can point to the specific conditions that did it. What were they, and what makes them durable?

Listening for: *Listen for conditions that show up in the rest of the organization, not just the OEHS function. Strong answers name an executive practice, a hiring discipline, or a pattern of consequences that crosses functions.*

Q2 · Gaps (0:20–0:30)

Where has the AI-and-monitoring stack already changed what the culture can hold up under? What's the workforce telling you?

Listening for: *The inversion stories. The most useful answers are the ones where a cultural condition the organization thought was solid turned out to be holding up something the deployment quietly undermined.*

Q3 · Needs (0:30–0:40)

You're staffing across four generations with different defaults on voice, technology, authority, and trust. What cultural infrastructure has to hold across that gap? What are you not yet built for?

Listening for: *Generational framing collapses fastest into stereotypes. The useful answers are specific: a meeting cadence that lands differently across cohorts, a feedback practice the early-career tier uses but the senior tier doesn't.*

Q4 · Asks (0:40–0:50)

If “safety culture” were retired tomorrow and the field had to spell out what cultural conditions an organization actually requires, what would we say? And what does the field need to build to anchor it?

Listening for: *This is the field-level deliverable. Operational language is what matters - past the abstraction. What would the articulation actually let an OEHS leader do, or refuse, in front of an executive team?*

PATTERNS TO REDIRECT FROM

The “we have a strong safety culture” reflex. Most senior OEHS leaders will reach for some version of this claim early in the conversation. It's rarely false and rarely useful. The substantive ground is what the culture has actually let the organization do that a different culture wouldn't have - and what the culture hasn't yet been tested against. The redirect: “What's the test the culture hasn't passed yet, or hasn't been put to?”

The instrument-as-culture substitution. Pulse surveys, culture audits, engagement dashboards, climate scores - these are measurements downstream of culture, and the field has spent a decade managing the measurements as if they were the thing itself. The honest captures are operational: who reports what, how leadership responds, what consequences land, what gets quietly tolerated.

The generational-as-deficit framing. Senior leaders sometimes read early-career expectations - around voice, transparency, AI use, authority - as deficits rather than as information about what the cultural infrastructure now has to support. The useful frame is symmetric: the cohorts coming in are telling the organization what culture it has to become to retain, develop, and learn from them.

WHERE THIS TABLE SITS IN THE LARGER ROOM

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CONNECTED TABLE**WHERE IT REJOINS YOURS****Human · Trust & Psychological Safety
(Theme 4 sibling)**

Load-bearing companion on the Human side of Theme 4. Their table asks what operating conditions trust requires; yours asks what culture has to become to produce those conditions under AI-driven work and demographic change.

**Tech · Building the Business Case
(Theme 4 partner)**

The funding-side companion. Cultural infrastructure is the most underfunded category in OEHS investment cases because the field hasn't agreed on language CFOs and boards will pay for. What your conversation produces is what their conversation has to fund.

**Human · Workforce Development & Skills
(Theme 5)**

The generational and workforce-pipeline question runs through both tables. If your conversation reaches the four-generations question, the “asks” stage will line up with theirs.

**Tech · AI Ethics, Governance & Strategy
(Theme 2)**

AI-driven work is reshaping the cultural conditions this table looks at. The ethics-and-governance choices on the Tech side determine whether the cultural infrastructure on the Human side can hold.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: Hold the one-culture frame against the pull of the safety-culture-as-separate frame. Forty years of field practice pull toward the separation; the useful conversation lives on the other side of it.

What this table isn't trying to produce: A defense or rejection of “safety culture” as a construct (the room is past either move). An engagement-survey methodology debate. A neat resolution: the field is in the middle of working out what culture has to become.

THEME 05 · SKILLS & THE HUMAN-TECH INTERFACE

Table H9 · Critical Thinking Under AI

What the practitioner still has to be able to do.

WHY THIS TOPIC, WHY NOW

AI is now built into the working day of most OEHS practitioners. Drafting risk assessments, analyzing incidents, interpreting regulations, writing exposure narratives, supporting hazard recognition - the tools are no longer optional and no longer hypothetical. The question isn't whether practitioners use AI. It's what they still need to be able to do without it - and what skills the field is unintentionally losing in the transition.

The cognitive-science evidence is coming in fast. Microsoft Research's 2025 work found measurable cognitive offloading in heavy AI users, strongest among workers with high tool-confidence. The automation-complacency literature predicts this pattern. OEHS has a specific exposure here: hazard recognition, exposure judgment, and incident interpretation are exactly the high-consequence, low-frequency cognitive tasks the literature predicts will erode fastest.

THE FRAMING QUESTION

“What can the senior OEHS practitioners in your organization still do that a mid-career practitioner with strong AI tools cannot - and how does the next cohort develop that skill?”

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Where in your organization is AI tooling actually strengthening practitioner judgment rather than replacing it? What's the operating discipline that produces that strengthening effect?

Listening for: *Listen for the specific discipline. Strong answers name a review practice, a calibration cadence, a deliberate piece of friction the organization built in, or a training requirement that forces the practitioner to engage.*

Q2 · Gaps (0:20–0:30)

Where is your organization already seeing skill loss, judgment shortcuts, or fading critical thinking in practitioners who lean heavily on AI tools? What are the early signals?

Listening for: *Listen for the early-career signal. The most useful answers here are about practitioners three to seven years in, where the foundational judgment is still developing and AI tools are most heavily woven in.*

Q3 · Needs (0:30–0:40)

What does the field still need to require practitioners to be able to do without AI help? What would the operating discipline have to look like to preserve it?

Listening for: *Look for the irreducibles. Some participants will have organizational answers; others will have personal-practice answers. Both are valuable. The strongest answers name the exact judgment moment.*

Q4 · Asks (0:40–0:50)

What does the field need to take a position on, build, or share about the human-tech interface and the skills the next generation of practitioners will need?

Listening for: *The credentialing question will surface. So will research questions about cognitive offloading specifically in OEHS contexts.*

PATTERNS TO REDIRECT FROM

The technophobia trap. This table isn't a vote on AI tools and shouldn't be treated as one. Practitioners who are skeptical of AI in OEHS have real reasons; practitioners who use it every day have real reasons too. The substantive ground is the cognitive-discipline question underneath, not the tooling question.

The senior-vs-junior gravity. Senior practitioners will tend to describe their own judgment as the irreducible standard. That framing is partly right and partly generational nostalgia. Press for the specific judgment elements that demonstrably matter - not for everything the senior practitioner used to do. The honest answer is harder and more useful.

The augmentation-claim overreach. Some participants will overclaim what their AI tools have done for practitioner capability. The current evidence suggests the split between augmentation and erosion depends heavily on operating discipline; without the discipline, the default is offloading. When "augmentation" gets claimed, ask what the operating discipline is. If there isn't one named, the augmentation claim is probably soft.

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CONNECTED TABLE

WHERE IT REJOINS YOURS

Human · Workforce Development & Skills (Theme 5 sibling)

The pipeline-and-credentialing side. Your table asks what skills have to be preserved; theirs asks how the field develops the workforce that has them. The two should converge at the "asks" stage.

Tech · Human-in-the-Loop Design (Theme 5 partner)

Same theme, Tech-leaning - what meaningful human-in-the-loop actually has to require in OEHS deployments. Your "what the practitioner still has to do" question and their "what the design has to require" question are two halves of the same answer.

Tech · AI Ethics, Governance & Strategy (Theme 2)

Ethical AI deployment and skill preservation are tightly linked. If your conversation reaches organizational responsibility for what AI tools do to practitioner capability, that table is the bridge.

Human · SIF/HOP, Systems, and Strategy (Theme 2)

HOP treats human judgment as a designed-in capability of the operating system, not what's left over after compliance. The skill-erosion conversation lands in HOP's frame as a system-design question.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: Working familiarity with cognitive offloading and the broader automation-complacency literature. Be comfortable holding the operating-discipline layer against the pull of the tool-quality layer. The question worth returning to: "That's a tool answer. What's the practice answer?"

What this table isn't trying to produce: A debate about which AI tools are best (your conversation is upstream of the tool choice). A defense of the practitioner role; the room isn't seriously worried about practitioner replacement - the room is worried about practitioner capability under tool dependency. A clean resolution: the field is early on this, and the honest captures will be partial.

THEME 05 · SKILLS & THE HUMAN-TECH INTERFACE

Table H10 · Workforce Development & Skills

The pipeline question the field has been quietly losing.

WHY THIS TOPIC, WHY NOW

The structural numbers on the OEHS workforce aren't where they should be. BLS projects about five percent growth in occupational health and safety roles through 2033 - below average, at a time when scope is expanding, new exposure types are emerging, and regulatory and ESG demand keeps growing. The undergraduate IH pipeline has been shrinking for over a decade; the route into the field is less defined than it was twenty years ago, even as the field's scope has gotten wider.

Inside the credentialing world, the picture is also shifting. Professional bodies have all been working on credential updates - including AI-fluency standards, broader Total Worker Health® competencies, and recognition of practitioners coming in through non-traditional paths. The field is repositioning, but the repositioning hasn't yet produced a clear pipeline story for executives building their OEHS organizations right now. The participants in this room are the ones hiring, developing, and retaining the practitioners the next decade requires.

THE FRAMING QUESTION

"If you had to describe the OEHS practitioner your organization will need in 2030, what does that look like, and how far is the current pipeline from producing them?"

FOUR QUESTIONS

Q1 · Strengths (0:10–0:20)

Where is your organization's workforce development model actually working - producing the practitioners you need, keeping them, building the right judgment at the right pace?

Listening for: *Look for the operating elements, not the program names. Strong answers name a specific rotation, a mentorship cadence, a credentialing investment, or a career path.*

Q2 · Gaps (0:20–0:30)

Where is the pipeline actually failing your organization right now? What roles are you struggling to fill, what skills are you struggling to develop, what kind of attrition is costing you the most?

Listening for: *Look for the specific role and the specific skill. The most useful answers are concrete: "we cannot hire a Total Worker Health®-capable senior IH for less than seven figures of TCOR responsibility" is the kind of specificity the room needs.*

Q3 · Needs (0:30–0:40)

What does the field need to build, share, or coordinate to produce the next practitioner?

Listening for: *Asks here often cluster around credential modernization, ABET program advocacy, apprenticeships and non-traditional path recognition, and AI-fluency standards.*

Q4 · Asks (0:40–0:50)

If credentialing and professional bodies could hear one thing from this room about what executives need from the credentialing and field-building ecosystem in 2026 and beyond, what would it be? What's the message that has to land?

Listening for: *This is the field-level deliverable for the table. What surfaces here goes directly into the leadership readout.*

PATTERNS TO REDIRECT FROM

The credentialism reflex. Senior practitioners often default to defending existing credentials as the answer to pipeline pressure. That answer is partly right and partly habit. Press the room: which credentials are actually predicting practitioner performance now, and which are just inherited? The honest answer is more useful than the defensive one.

The academia-blaming detour. It's easy and partly fair to put the pipeline problem on the shrinking of academic IH programs. It's also incomplete. The executives in this room have decision rights over hiring, development investment, recognition of non-traditional paths, and what gets funded at universities. The redirect: "What part of this is actually in this room's decision rights?"

The AI-fluency wave. AI-fluency standards are now being written into credential frameworks and competency models across the field. Some participants will overclaim what fluency means; others will underplay its importance. The substantive ground is what an AI-fluent OEHS practitioner can actually do that a non-fluent one can't - operationally, not aspirationally.

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CONNECTED TABLE

WHERE IT REJOINS YOURS

**Human · Critical Thinking Under AI
(Theme 5 sibling)**

The skill-preservation companion. Your table asks how the field develops the workforce; theirs asks what skills that workforce still has to be developed for.

**Tech · Preparing the Profession
(Theme 5 partner)**

Same theme, Tech-leaning. The practitioner of the future depends on both the workforce-development infrastructure your table looks at and the human-tech-interface skills theirs does.

**Human · Engagement & Risk Tolerance
(Theme 3)**

Keeping the workforce you develop depends on how that workforce experiences the work. If your table talks about attrition, that table is the closest companion.

**Human · Safety Culture for 2026 & Beyond
(Theme 4)**

Workforce development across four generations runs through the cultural-infrastructure question. If your conversation reaches the multi-generational pipeline question, that table is the bridge.

WHAT THE TABLE IS AND ISN'T TRYING TO PRODUCE

What this table is holding for: Working familiarity with BLS occupational projections, the credentialing landscape, and the recent conversation on recognizing non-traditional paths. Hold the executive-decision-rights frame against the pull of the academia-blaming frame. The question worth returning to: "What's in this room's authority?"

What this table isn't trying to produce: A defense of any specific credential (the room is past that). A unified theory of the OEHS practitioner of the future - the field doesn't have one and the room won't produce one. Vendor pitches on training platforms or credentialing programs; when a platform gets named, surface the workforce-development question underneath.