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Collective Occupational Trauma, Health Care Quality, and Trauma-Informed Leadership

Intersections and Implications

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ABSTRACT

Managing stress, burnout, and vicarious trauma is a long-standing issue for the health and behavioral health workforce, including those in case management. Yet, the recent novel coronavirus pandemic has amplified routine burnout to record levels. Practitioners and patients are amid a new dynamic of collective occupational trauma (COT). In this realm, health and behavioral health workers (HBWs) experience the same reality as their patients, families, and support systems; professional boundaries become blurred, leading to heightened levels of emotional vulnerability that can prompt the development of more pervasive psychopathology. This reality has put the Quadruple Aim in peril, with increased workforce turnover, staff shortages, costs, and quality challenges.

Purpose/Objectives: This article:

1. Identifies the incidence and costs associated with COT for HBWs;
2. Distinguishes among terms associated with HBW burnout;
3. Describes the occupational stress–trauma continuum;
4. Defines COT;
5. Explains the connection between COT and health care quality;
6. Identifies why trauma-informed care (TIC) is relevant to address COT;
7. Applies TIC to leadership and supervision strategies; and
8. Identifies how established resources of guidance address workforce health, mental health, and professional self-care.

Primary Practice Setting(s): Applicable to all health and behavioral health settings where case management is practiced.

Findings/Conclusions: Organizational cultures must shift from a "process and roll" mindset to one that is trauma-informed. Implementation of TIC has yielded successful outcomes for the workforce via enhanced patient engagement, treatment adherence, and successful outcomes. In tandem, TIC leadership and supervision models have had promising results and should be more readily utilized; they acknowledge and address workforce trauma while prioritizing staff health, mental health, and wellness. Failure to shift the culture will result in an ongoing exodus of practitioners, leaving insufficient numbers to render safe, cost-effective, efficient, and patient-centered care.

Implications for Case Management Practice: The case management workforce comprises professional disciplines across health and behavioral health, employed in every setting. The expanding workforce presence has put them at risk of COT. Leadership strategies must shift to acknowledge workforce exposure to occupational trauma, address mental health and wellness, and address professional self-care. This shift is key to mitigating retention, sustainability, and quality challenges.

Key words: *burnout, collective occupational trauma, collective trauma, compassion fatigue, leadership, moral distress, secondary traumatic stress, trauma-informed care, trauma-informed leadership, vicarious traumatization, workforce retention, workforce sustainability*

Burnout, vicarious and posttraumatic stress and moral distress are well-explored health care occupational hazards, historically impacting clinicians at 83% of health care organizations (Agency for Healthcare Research and Quality [AHRQ], 2017). The common thread of these hazards is chronic workforce exposure to witnessing or experiencing patient trauma (Branson, 2019). The novel coronavirus pandemic has added a new tier to the burnout continuum for health and behavioral health workers (HBWs)—that of collective occupational trauma (COT).

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An already worn workforce has been forced to wrestle constant and intense levels of suffering. Grief, loss, and fear of illness morbidity and mortality are shared with patients, their families, colleagues, and society. Chronic and recurrent waves of pandemic-related illness, exhaustion, and depersonalization have kept HBWs on high alert, including those within case management.

An already worn workforce has been forced to wrestle constant and intense levels of suffering. Grief, loss, and fear of illness morbidity and mortality are shared with patients, their families, colleagues, and society. Chronic and recurrent waves of pandemic-related illness, exhaustion, and depersonalization have kept HBWs on high alert, including those within case management. Staff call out sick in droves, prompting excessive absences, coverage challenges, and plummeting retention rates. More than 50% of nurses cite the severe emotional toll from insufficient staffing, workload intensity, and being forced to deal with untenable ethical decisions such as rationing of patient care; 60%–80% are ready to leave their jobs (American Nurses Foundation [ANF], 2021; Berlin et al., 2021). Almost 75% of the interprofessional workforce is mentally and physically exhausted, with 60% of social workers barely coping with the daily rigor of their work (McFadden et al., 2021). A study of 42 health care organizations revealed almost half of all physicians (49%) admitted to burnout (Prasad et al., 2021). Suicidal ideation, gestures, and completed attempts are being reported by every profession. Add fierce societal narrative of cultural, social, and racial injustice to the equation and a trauma tsunami has been triggered, spanning the health and behavioral health sector.

This article explores the rising incidence, prevalence, costs, and consequences associated with COT. Prepandemic and pandemic-related studies are discussed, along with their impact on workforce retention and patient quality. Leadership models to address workforce trauma are presented, such as trauma-informed leadership (TIL), which has been proven to enhance workforce resilience, sustainability, and organizational return on investment. Finally, revisions to the industry's established resources of guidance are explored that highlight professional impairment, competence, and self-care.

The Evolution of Collective Occupational Trauma

Definitions and Distinctions

Over the last 50 years, the industry has seen assorted terms associated with occupational trauma, starting with stress and HBW-specific burnout through to COT. Although the verbiage is often used interchangeably, there are clear definition distinctions, which appear in Table 1. The terms span an occupational stress–trauma continuum, which appears in Figure 1.

Stress

Every practitioner experiences stress from time to time; it is a normal reaction to change that prompts some physical, emotional, and psychological response. There is good stress as readily as bad stress, such as when a person experiences that adrenaline rush from starting a new job, relationship, or even preparing for a long-awaited (and needed) vacation. There can be excitement, elation, and an elevated mood. However, positive stress can become as overwhelming as its negative counterpart, prompting a flurry of integrated care challenges that influence health across the life span (Epel et al., 2018). What starts as subtle overthinking shifts to preoccupation and insomnia. A ripple effect of cognitive consequences can impede the quality of an individual's thinking, prompting brain fog, forgetfulness, and distractibility. Increased vulnerability to physical health issues ensues, advancing to more chronic illnesses. Unmanaged stress ultimately influences the quality of personal and professional presentation, critical thinking, decision making, and clinical practice; the safety of patient intervention and treatment becomes an adverse side effect of the utmost concern.

Burnout as a Workforce Reality

Burnout first appeared amid industry-specific literature in the 1970s. Freudenberger, a clinical psychologist, witnessed an emotionally depleted staff at the clinic where he volunteered. They displayed physical and behavioral health manifestations that had the strong potential to impact morale, as well as intervention with patients:

- *Physical symptoms*: Exhaustion, fatigue, frequent headaches, gastrointestinal disorders, sleeplessness, shortness of breath;

Almost 75% of the interprofessional workforce is mentally and physically exhausted, with 60% of social workers barely coping with the daily rigor of their work. A study of 42 health care organization revealed almost half of all physicians (49%) admitted to burnout.

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TABLE 1
Definition Distinctions Associated With Occupational Stress and Trauma

Term	Definition
Stress (Lazarus & Folkman,1984)	When a person perceives the demands of an environmental stimuli to be greater than their ability to meet, mitigate, or alter those demands.
Burnout (initial) (Freudenberger, 1974)	The consequences of severe stress and high ideals for helping professions.
Burnout (formal) (Maslach & Jackson, 1981)	A formal model, framing a psychological syndrome directly associated with prolonged practitioner response to chronic interpersonal job stressors that spans three domains: emotional exhaustion, depersonalization, and diminished sense of personal accomplishment.
Secondary Traumatization (Figley, 1983)	Stress derived from helping others who are suffering or who have been traumatized.
Moral Distress (Jameton, 1984)	A phenomenon in which one knows the right, or ethical action to take, but is constrained from taking it.
Vicarious Traumatization (Pearlman & Saakvitne, 1995)	Permanent and cumulative changes of schemas based on empathetic work with trauma survivors.
Collective Trauma (Hirschberger, 2018)	Psychological reactions to traumatic or cataclysmic events that impact society on a larger scale, involving not only "loss of life but also a crisis of meaning."
Collective Occupational Trauma (Fink-Samnick, 2020)	An extension of collective trauma, where practitioners, professionals, and providers experience the same reality as their patients, families, and support systems.
	Professional boundaries become blurred, leading to heightened levels of emotional vulnerability, which can prompt development of more pervasive psychopathology.

- *Behavioral signs*: Anger, cynicism, depression, frustration, excessive use of tranquilizers and barbiturates, feelings of omnipotence or overconfidence. (Freudenberger, 1974).

During the next decade, the terminology became part of mainstream industry language. By the 1980s, Maslach evolved the concept of burnout to a measurable construct impacting workforce well-being, plus patient care quality and safety (e.g., increased incidence of medical errors, numbers of physicians involved in lawsuits, rates of patient mortality, transmission of hospital-related infections) (Reith, 2018). Her seminal work advanced the definition of burnout to a formal model, framing a psychological syndrome directly associated with "prolonged practitioner response to chronic interpersonal job stressors" spanning three domains: emotional exhaustion, depersonalization, and diminished sense of personal accomplishment (Maslach & Leiter, 2016; Reith, 2018). Maslach's Burnout Inventory (Maslach et al., 2018) remains the industry gold standard for assessing burnout of emergency physicians and other professionals. The tool uses 22 questions that are scored across the three domains and is available through the cited reference.

Although burnout does not appear as a diagnosis in the *Diagnostic Statistical Manual of Mental Disorders* (*DSM-5*), it was included as a formal, occupational phenomenon and reimbursable syndrome in the *International Statistical Classification of Diseases and Related Health Problems* (*ICD-11*) (Z73.0). The World Health Organization (2019) decision to include the terminology within *ICD-11* has elevated the significance of burnout for the workforce; the formal language for this diagnostic code appears in Box 1.

Secondary Traumatization to Moral Distress

Figley (1983) built on his predecessors' work by identifying the dynamic of secondary traumatization. This term refers to normal stress experienced by the workforce from their frequent contact with persons experiencing traumatic events, whether victims, witnesses, or survivors (Figley, 1983). Pearlman and Saakvitne (1995) evolved

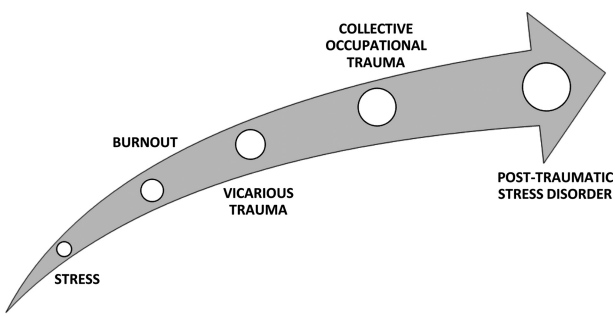

FIGURE 1
Occupational stress–trauma continuum.

BOX 1
Burnout, *International Statistical Classification of Diseases and Related Health Problems* (*ICD-11*) (Z.73.0)

A syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:

1. Feelings of energy depletion or exhaustion;
2. Increased mental distance from one's job or feelings of negativism or cynicism related to one's job; and
3. Reduced professional efficacy.

Note. From *Burnout, International Statistical Classification of Diseases and Related Health Problems* (11th ed.), by World Health Organization, 2019 (https://icd.who.int). In the public domain.

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The concept (of moral distress) was directly related to the profound emotional discomfort experienced by nurses when they knew the ethical action to take but found themselves constrained by external forces, impeding their ability to take it. There is undeniable pressure for professionals to prioritize their ethical responsibilities to patients, their families, their employer, and profession. It can become untenable to balance personal views on life and death, with patient autonomy and treatment appropriateness.

the framing to one with more enduring impact, or that of vicarious traumatization. The authors identified the profound occupational hazard for practitioners working closely and consistently with patients who ensured trauma. The alignment with trauma survivors could contribute to the development of the clinician's negative view of the world, leading to cynicism, pessimism, depression, and, eventually, burnout (Pearlman & Saakvitne, 1995).

In contrast, the term of "moral distress" was coined by Jameton (1984). The concept was directly related to the profound emotional discomfort experienced by nurses when they knew the ethical action to take but found themselves constrained by external forces, impeding their ability to take it. There is undeniable pressure for professionals to prioritize their ethical responsibilities to patients, their families, their employer, and profession. It can become untenable to balance personal views on life and death, with patient autonomy and treatment appropriateness. Organizational pressures to discharge patients or discontinue their coverage for care can feel too heavy a burden to bear. Health and behavioral health workers are forced to juggle personal, clinical, organizational, and professional ethical balls on a regular basis, which contributes to enduring distress (Fink-Samnick, 2019).

Collective to Collective Occupational Trauma

Hirschberger (2018) framed collective trauma as "psychological reactions to traumatic or cataclysmic events" that impacts society on a larger scale, involving not only "loss of life but also a crisis of meaning." Most would agree the recent pandemic aligns with this definition. However, the unique presentation of other nuances brought collective trauma to new level, warranting a shift in terminology and framing.

Collective occupational trauma is an extension of collective trauma and more invasive disruptor. The term is an all-encompassing dynamic in which practitioners, professionals, and providers experience the same reality as their patients, families, and support systems. The practitioner's traditionally steadfast professional boundaries become blurred, leading to heightened levels of emotional vulnerability that can prompt the development of more pervasive wholistic health issues (e.g., psychopathology, pathophysiology, psychosocial circumstances) (Fink-Samnick, 2020).

The fierce construct of COT is displayed in Figure 2; intense levels of collective induced stress are endured by the population and passed directly to involved professionals as collective infused trauma (Fink-Samnick, 2020). In turn, the individual's boundaries and resolve further weaken under the weight of simultaneously occurring professional and personal stressors. The immune system succumbs to psychological, emotional, and psychosocial strain. An array of disruptive symptoms manifest as neuropathophysiology, pathophysiology, and psychopathology intersect. Acute and chronic illnesses erupt, all made more complex by co-occurring anxiety, depression, and stress:

- Autoimmune (e.g., celiac, fibromyalgia, lupus, rheumatoid arthritis);
- Cardiovascular (e.g., congestive heart failure, hypertension);
- Endocrine (e.g., Addison's disease, Cushing's syndrome, diabetes mellitus, Graves' disease);
- Gastrointestinal (e.g., absorption issues, celiac, irritable bowel syndrome);
- Neurological (e.g., brain fog, focus, headaches);
- Pulmonary (e.g., asthma, emphysema, chronic obstructive pulmonary disease); and
- Rheumatology (e.g., migraines, orthopedic).

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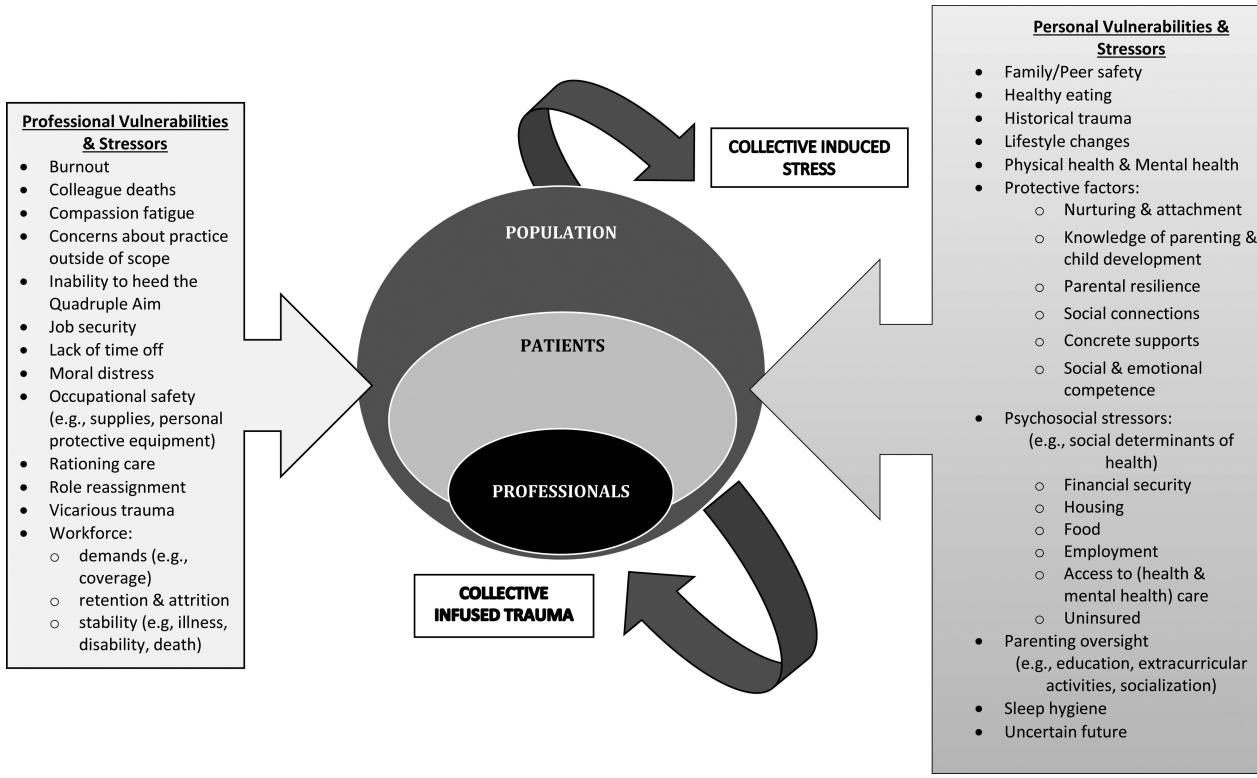

FIGURE 2
The cycle of collective occupational trauma.

In addition, substance use and behavioral health symptoms intensify and advance to formal mental health diagnoses. Ultimately, a person's capability, motivation, and desire to appropriately function become hampered, whether academically, occupationally, or socially (Fink-Samnick, 2020).

Examining the Evidence

Prepandemic and pandemic-related studies yield contextual considerations on workforce burnout incidence and risk of COT across disciplines, as well as racial, ethnic, socioeconomic, and cultural groups. Rising rates of workforce trauma across the industry translate to significant consequences for workforce wholistic health and wellness such as burnout, pervasive mental health exacerbation, onset, and chronic illness emergence (ANF, 2021; Bryant-Genevier et al., 2021; Fink-Samnick, 2020; Denning et al., 2021; Kelly et al., 2021; McFadden et al., 2021; Moitra et al., 2021; Prasad et al., 2021; Rossi et al., 2021).

Prepandemic Burnout and Practitioner Suicide

Kelly et al. (2021) explored burnout for nurses prepandemic, characterized by emotional exhaustion, depersonalization, and disengagement from work. Kelly et al. (2021) completed a quantitative nonexperimental point in time survey of more than 7,000 nursing staff members at three hospitals between March 2018 (N = 3,574) and March 2019 (N = 3,528). Roughly 51% of 2018 surveys were returned, with 46% of those completed in 2019; 54% of all respondents experienced burnout and 28% with high levels of burnout (Kelly et al., 2021).

Research by McFadden et al. (2021) used cross-sectional surveys to assess prepandemic mental health and quality of work life for social care professionals (N = 1,195) in the United Kingdom (e.g., allied health, nurses, nurse midwives, social workers). Findings revealed major workforce challenges; 75% of respondents expressed mental and physical exhaustion as major factors to impede performance, and 60% barely able to cope with daily responsibilities and citing issues including primary responsibilities of focus, attention, completion of patient follow-up, and documentation (McFadden et al., 2021).

Literature on physician burnout prepandemic revealed an incidence of 51% with frontline practitioners (e.g., emergency departments [EDs], family medicine, internal medicine, obstetrics/gynecology) at the highest risk (Reith, 2018). Marshall et al. (2020) surveyed more than 3,600 professionals, revealing female physicians had a higher prevalence of burnout than their male colleagues: 50.7% versus 38.2%. Other contributing factors included practice specialty and setting, as well as other personal and professional factors (e.g., career stage, quality of familial and peer relationships,

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satisfaction with work–life balance) (Marshall et al., 2020).

Practitioner suicide was an evolving theme in the literature prior to March 2020. Dutheil et al. (2019) completed prepandemic reviews of PubMed, Cochrane Library, Science Direct, and EMBASE databases. Incidence of physician suicide was higher in the United States than in Europe, particularly for anesthesiologists, psychiatrists, general practitioners, and surgeons: "Overall standardized mortality ratio (SMR) for suicide in physicians was 1.44" (Dutheil et al., 2019). Authors identified a significantly higher risk of suicide among male physicians than in the general population (SMR = 1.24), with females at higher risk than males (SMR = 1.94) (Dutheil et al., 2019). Female practitioners (e.g., physicians, nurses) also experienced higher rates of suicidal ideation than their male counterparts (Dutheil et al., 2019).

Pandemic-Related and Beyond: Collective Occupational Trauma

Pandemic-related research has been churning out at a swift rate, particularly literature specific to the impact on workforce wholistic health. The data comprises attention to workforce behavioral health, manifestation of more formal mental illness, somatic complaints, and longer term trauma, as in COT and posttraumatic stress disorder (PTSD).

Mental Health and Suicidal Ideation

Prasad et al. (2021) conducted surveys of 20,497 health care workers across 42 health care organizations during three COVID-19 waves: March 2020, October 2020, and March 2021. Grossly elevated levels of stress and burnout were identified for clinical and nonclinical staff (Prasad et al., 2021). More than 30% of persons employed on inpatient units of hospitals had "high or very high" daily stress scores, 61% noting "high fears of virus exposure," and 40% of respondents admitted to escalating anxiety or depression (Prasad et al., 2021). Sharifi et al. (2020) similarly found a high incidence and prevalence of chronic occupational stress for HBWs, leading to the development of more pervasive mental health conditions, such as acute stress and PTSD.

Amanullah and Ramesh Shankar's (2020) systematic review of MEDLINE and EMBASE noted research on physician burnout, specific to the onset of severe stress symptoms. Vulnerability to rigorous occupational factors (e.g., high volume of patients, rapid patient turnover, high mortality) was a major contributor to provider burnout; exhaustion, distractibility, and poor perceived efficacy were among the manifestations (Amanullah & Ramesh Shankar, 2020).

Research by Norful et al. (2021) reviewed the physical and psychological impacts of HBWs employed in high stress clinical environments during the pandemic. Rigorous work demands and extreme stressors associated with concerns for personal safety triggered respondent reports of severe insomnia, exhaustion, anxiety, and depression (Norful et al., 2021). Three key themes emerged for organizational attention to mitigate staff burnout; these included fear of uncertainty, physical and psychological manifestations of stress, and attention to morale and resilience building (Norful et al., 2021).

Bryant-Genevier et al. (2021) conducted a nonprobability-based convenience sample of frontline public health workers (N = 26,174); more than 53% had symptoms of depression (32%), anxiety (30.3%), and PTSD (36.8%). News reports of physician and other practitioner suicides occurring during the pandemic prompted researchers to assess for suicidal ideation, with 8.4% expressing passive ideation (Bryant-Genevier et al., 2021).

In contrast, the ANF (2021) assessed mental health of the nursing workforce in the United States during December 2020 (N = 12,881). Online questionnaires were emailed to survey participants, with results showing nurses suffering from symptoms associated with PTSD and other trauma-related disorders: irritability (57%), profound sadness and depression (47% and 38%, respectively), isolation (37%), feeling life had little to no meaning (35%), disassociation (25%), and increased alcohol use (19%) (ANF, 2021).

Denning et al. (2021) completed a global review of HBWs to assess psychological safety and burnout across disciplines. Through use of assorted tools (e.g., Safety Attitudes Questionnaire, Oldenburg Burnout Inventory, Hospital Anxiety and Depression Scale), researchers identified that more than 67% of HBWs experienced burnout, 20% anxiety, and 11% depression. A strong association was identified between level of behavioral health, sense of safety in the job, and redeployment of HBWs to other roles or areas of facility need (Denning et al., 2021).

Traumatic Stress

Amid the pandemic, HBWs have been exposed to intense levels of patient illness morbidity and mortality, and within relatively short periods of time. Most practitioners faced more patient deaths in a single day than would be expected over their entire careers (Fink-Samnick, 2020). The traumatic impact of massive losses of this nature is an overwhelming consideration. Yet, despite the sensory assault of these events, HBWs report feeling their mental health and well-being are not organizational priorities (Søvold et al., 2021).

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Benfante et al. (2020) completed a literature review across PubMed and PsycINFO on early pandemic response and trauma. The limited number of studies ($N = 7$) naming HBW trauma or traumatic stress still yielded key findings; mild to severe trauma-related symptoms were experienced in up to 35% of HBWs, with symptoms of psychological trauma identified including anxiety, depression, insomnia, and substance use and abuse (Benfante et al., 2020). The relevant studies ($N = 12$) on the topic identified by Sharifi et al. (2020) yielded similar conclusions on high risks of workforce trauma in response to chronic stress associated with burnout.

Braquehais et al. (2020) reviewed MEDLINE, Web of Science, and Google Scholar for studies on the mental health of HBWs employed across EDs, intensive care units, primary care, or dedicated COVID-19 units or hospitals. The authors were succinct in their findings; studies revealed a high prevalence of anxiety (30%–70%), depression (20%–40%), plus insomnia, emotional exhaustion, or other somatic symptoms (e.g., headaches, gastrointestinal, backaches) (Braquehais et al., 2020). Similar themes were identified by Zhang et al. (2020) in a review of psychological stress on medical staff in Wuhan, China, within months of the virus outbreak; insomnia, loss of appetite, and other stress symptoms (e.g., perseveration, worry) were identified in more than 36% of subjects.

Research by Arpacioglu et al. (2021) addressed secondary traumatization and mental health of health care professionals using a cross-sectional study administered via an online questionnaire; the study employed Likert scale self-reports and established tools (e.g., Patient Health Questionnaire [PHQ]-4, and Secondary Traumatic Stress Scale [STSS]). Frontline participants comprised 44% of respondents, with anxiety, depression, and secondary traumatization scores significantly higher than other members of the workforce ($p < .001$) (Arpacioglu et al., 2021). The categories of gender, age, history of trauma, anxiety, or depression, and years of employment were listed as factors impacting onset; persons employed for more than 20 years displayed fewer symptoms of trauma or PTSD (Arpacioglu et al., 2021).

Cultural Demographics and Considerations

The research by Moitra et al. (2021) was unique in its focus, exploring the occurrence of mental health and traumatic response for HBWs across low- and middle-income countries. Authors identified 51 studies through PubMed and EMBASE that addressed signs and symptoms of mental health manifestation, including depression, anxiety, psychological trauma, insomnia, workplace burnout, and fatigue; persons facing economic hardship faced more symptoms (Moitra et al., 2021). Prasad et al. (2021) also noted nuances in trauma manifestation across cultural considerations (e.g., ethnicity, gender, race, socioeconomic status); Black and Latinx workers had higher stress scores than Whites, and women of color had higher stress scores than men.

Retention Rates and Organizational Economic Burden

Exploration of staff retention rates speaks volumes to the relationship between workforce stress and trauma exposure. Decreasing retention rates perpetuate a vicious cycle of chronic quality missteps of medical errors, substandard patient care, and increasing costs. Research on COVID-19 workforce retention is emerging rapidly, with alarming trends specific to attrition, burnout incidence, and turnover. In 2020, turnover of staff increased to 18.7%, with nurses in step-down units, EDs, and behavioral health recording the highest turnover rates (NSI Nursing Solutions, 2021). Costs associated with staffing turnovers remain hefty, upwards of $90,000 annually per registered nurse, based on role, facility, and geographic location, and annual hospital losses from $3.6 million to $6.5 million annually (Kelly et al., 2021; NSI Nursing Solutions, 2021).

An adverse effect of the pandemic has been the emergence of what Klotz refers to as the "*Great Resignation*": high levels of turnover across sectors, as businesses and their employees cope with economic and emotional consequences of the times (March 2020–2021) (Kelly, 2021; LaPointe, 2021). The U.S. Bureau of Labor Statistics (2021) reports 4.4 million persons quit their jobs in September 2021 alone, the high-volume trend staying steady. The health care

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industry is experiencing a mass exodus of its battered workforce, most in pursuit of more flexible and less stressful roles: 80% of nurses, 75% of social workers, 60% of physicians, and more than 67% of other workforce members (ANF, 2021; Denning et al., 2021; McFadden et al., 2021; Prasad et al., 2021; Sharifi et al., 2020). Close to half of the physician workforce has opted for early retirement, resulting in more workforce departures than entries; 67% of health care organizations have no formal plan in place for physician succession (LaPointe, 2021). Much concern has been expressed over who will be left to render care, especially with this trend manifesting across professions.

Staff who remain employed work diligently to hold down the fort, often at the expense of their physical and behavioral health. Hospitals are reporting major fiscal losses from the inability to provide necessary staffing for key service areas. Haddad et al. (2020) noted well over $7 million in revenue from staff shortages in EDs, ambulatory services, and inpatient units.

Best et al. (2020) predicted a concerning economic impact for hospitals due to cancelled elective procedures. Using data from the *National Inpatient Sample* and the *Nationwide Ambulatory Surgery Sample*, the authors identified all elective surgical procedures performed in U.S. inpatient settings and in hospital-owned outpatient surgery departments; they defined total cost, reimbursement, and net income for all elective surgical procedures (Best et al., 2020). Estimated total annual cost of elective inpatient and outpatient surgical procedures was $147.2 billion, with estimated total hospital reimbursement at $195.4 billion to $212.2 billion; net income for the U.S. hospital system was $48.0 billion to $64.8 billion annually (Best et al., 2020). Cancellation of all elective procedures was expected to result in estimated monthly losses to U.S. hospitals ranging from $16.3 billion to $17.7 billion in revenue and upwards of $5.4 billion in net income (Best et al., 2020). Further research by Bose et al. (2021) showed the national revenue loss for major elective surgery cessation at approximately $22.3 billion. The ability of health care systems to balance the organizational priorities of recouping revenue, proper operational capacity, and staffing ratios will continue to be a balancing act and grand challenge for the foreseeable future.

A Workforce Exodus

Recent research has looked at the increasing prevalence of HBWs departing the workforce due to COT and related mental health exacerbation. Rossi et al. (2021) explored the trajectory of behavioral health for 2,856 Italian health care workers who exhibited pandemic-related depression, anxiety, insomnia, and posttraumatic stress symptoms (PTSS); women had higher rates of depression, anxiety, and PTSS, whereas men showed a larger increases over time of PTSS and insomnia (Rossi et al., 2021). Similar findings were identified for studies out of Canada, Japan, and Belgium. Ultimately, the extent of exposure to primary stressors (e.g., frontline exposure to or hospitalization for COVID-19) yielded a significant impact on HBWs' mental health; limiting exposure yielded a decreasing trend of psychopathology presentation and eased mental health exacerbation (Rossi et al., 2021).

The Quality Factor

There has been global impact of prepandemic and pandemic COT for clinical and nonclinical HBWs around the globe, impacting workforce retention, sustainability, and health and mental health wellness. These disruptors have a domino effect on quality and safety of patient care, along with the costs of that care.

The Quality–Cost Conundrum

The interconnection of quality and cost of care is a long-standing industry imperative that goes back decades. *Crossing the Quality Chasm* (Institute of Medicine [IOM], 2001) put the industry on notice; medical errors were rising yet identified to be avoidable with attention to six key aims, displayed in Figure 3: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Then came the Triple Aim, leveraging the IOM's work by forging a comprehensive view of quality that framed accountability for care across three key domains or aims: to enhance the patient experience, health of populations, and reduce per capita costs of care. A fourth aim was posed to directly address the interconnection between workforce burnout, quality, and medical errors (Bodenheimer & Sinsky, 2014).

FIGURE 3
Crossing the Quality Chasm, Six Aims. Data from *Crossing the Quality Chasm: A New Health System for the 21st Century*, by Institute of Medicine (IOM). Committee on Quality of Health Care in America, 2001, National Academies Press.

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The state of the quality conundrum has contributed to a financially imbalanced U.S. health care system, whose condition has only worsened over time. National health expenditures (NHEs) for 2019 sat at $3.8 trillion or $11,582 per person (Centers for Medicare & Medicaid Services [CMS], 2021). Traditional growth prepandemic was 5.4% annually, with NHEs expected to reach $6.2 trillion by 2028, though recent estimates expect the figure to as much as double courtesy of COVID-19 (CMS, 2021; Glied & Levy, 2020). Experts note the potential for NHEs to tally more than $7 trillion for 2020 alone due to pandemic-related expenditures, with exponential annual rises anticipated at more than 6% annually (Glied & Levy, 2020).

Quality, Workforce Trauma, and Patient Safety

Despite heightened industry attention to the occupational hazards of workforce burnout on quality, pervasive challenges continue. More than 250,000 medical errors and 100,000 deaths annually are attributed to workforce frustration, yielding poor team member communication and thus fragmented care, order entry mistakes, plus medication and treatment missteps (Garcia et al., 2019; Ozeke et al., 2019; Restauri & Sheridan, 2020). In tandem, ongoing HBW exposure to stress and trauma is associated with practitioner "dissociation, negative mood, insomnia, emotional exhaustion, and increased medical errors" (Restauri & Sheridan, 2020, p. 923).

When organizations and the industry fail to provide professionals the needed resources to cope with stressors and strains of the work, increased rates and incidence of burnout result. Provider burnout has been identified to double the rates of adverse patient safety events; the greater the levels of burnout, the poorer quality of health care overall (Panagioti et al., 2018; Salyers et al., 2017; Willard-Grace et al., 2019). For example, HBWs may experience impaired attention, memory, and executive function that can decrease recall and attention to details, including medication management and reconciliation, provider orders, patient directions, or timeliness of care. Case managers across practice settings juggle countless and, often, competing priorities. When experiencing COT, they may find themselves less organized and more prone to distraction, forgetting to enter key information in electronic health records such as medication allergies, vital family contacts, or changes in treatment plans.

Impact of Historical Trauma

Recent research is advancing the influence of historical and cultural traumas on society. These topics yield implications when considering the diverse composition of HBWs. Cultural considerations for the onset and exacerbation of stress-related mental health and COT appeared across several studies. Arpacioglu et al. (2021), Moitra et al. (2021), and Prasad et al. (2021) explored the interconnection between historical trauma and systematic racism in the context of HBW sustainability; ethnicity and race played major roles in triggering of past trauma, as well as susceptibility to current traumas associated with the pandemic.

The recent work by Subica and Link (2021) aligns cultural trauma with health disparities from the context of resource deprivation and social disadvantage; this concept refers to trauma against the culture and health-sustaining (cultural) resources of traumatized groups, including marginalized members of society (e.g., human trafficking victims, individuals with disabilities, LGBTQIA persons, racial and ethnic minorities). Cultural trauma is an overwhelming construct, stemming from consistent "physical or psychological assault (or stressor) perpetuated by an oppressive dominant group on a cultural group through force, threats of force, or oppressive policies"; it involves assaulting and damaging the innate culture of people itself (Subica & Link, 2021, p.1).

Consider the influence of hate crimes or anti-immigrant media and policies on society. Each of these factors have been identified to advance health disparities across cultural groups. The stress of these circumstances yield strong physiological and emotional responses to trauma, making populations especially vulnerable to chronic illness exacerbation and potential disability (e.g., autoimmune disorders, cancers, diabetes, obesity, respiratory ailments, rheumatoid arthritis) (Manyema et al., 2018; Pust et al., 2020; Subica & Link, 2021). The onset and exacerbation of these conditions impact a person's ability to engage in their work, prompting absences, short- and long-term disability, and other workforce challenges. The wrath of trauma exposure for HBWs becomes a vital factor in understanding factors that impact workforce attrition, including turnover, retention, and sustainability.

Trauma-Informed Practices, Organizations, and Leadership

Prepandemic industry stressors had already triggered a leadership evolution. Although servant, transformational, and inclusive models have proven popular, none of these models were developed specifically to address workforce trauma. Given the dynamics and responses associated with COT, Harris and Fallot's (2001) seminal trauma-informed care elements (TICs) are contenders for integration: safety, engagement, trust, collaboration, and empowerment. Although first, a brief primer on TIC is in order.

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Trauma-Informed Care

Trauma-informed care has been actively applied across practice settings and populations, ensuring an empathic awareness of the presence and impact of trauma, independent of how or when it was experienced (e.g., advance childhood experience; sudden illness onset, hospitalization, unexpected family death). Most of the population has been exposed to some type of trauma during their lives: physical or emotional abuse, a violent crime, and experiencing of a sudden medical (or psychiatric) event. Perhaps, an individual dealt with bullying or gaslighting behaviors. At the least, HBWs have been forced to reconcile intense traumatic experiences these past several years, whether on the front lines rendering care or as a witness to these events. An individual's brain and body remember trauma, prompting strong emotional and physical reactions (Brown, 2018; Van Der Kolk, 2014).

In TIC, Harris and Fallot's (2001) seminal concepts, shown in Figure 4, are carefully woven into every patient and family interaction. This action serves to bolster engagement with individuals who have experienced or perceived any trauma, whether a single event or ongoing experiences.

A 6th element of, Cultural, Historical, and Gender issues, has been added to recent iterations of TIC (Oral, 2020) and appears in Figure 5. This action ensures all interactions with patients and staff are culturally sensitive and free of prejudices that arise from biases and stereotypes. Imagine, approaching a patient with concern or grace versus antagonism, assumption, or stigma. Consider, providing patients a choice in:

- Which name they want to be known by;
- What pronouns are used, by themselves and others;
- Being offered options to request the gender of a provider rendering care, whether physician, therapist, phlebotomist, or x-ray technician; and
- Allowing them to define who they want in the treatment space when having a diagnostic test, laboratory work, or therapy treatment.

Implementation of TIC by health care organizations has yielded higher levels of patient (and family) engagement, satisfaction, and more successful outcomes (Brown, 2018; Oral et al., 2020).

Application of Trauma-Informed Care to Leadership

The success of TIC with patients and families has prompted its extension to the workforce through aligned leadership and supervision models. Baugh et al. (2020, p. 1044) affirmed, "Burnout (in medicine) is primarily caused by workplace factors (e.g., unmanageable workloads, unreasonable time pressures) and therefore requires solutions at an organizational level"; enter trauma-informed leadership (TIL).

Trauma-informed leadership is the antidote for COT (Fink-Samnick, 2021). The model has been associated with easing organizational burdens from practitioner burnout, high workforce turnover, and enhancing the quality of patient care (Knight & Borders, 2020; National Council for Behavioral Health [NCBH], 2019; Oral et al., 2020; Purtle, 2020). Using this novel approach, managers are encouraged to step in and support staff in distinct ways. The approach shifts the long-held, "process and roll" culture of health care organizations to a more nurturing atmosphere. In this novel workforce culture, leadership and staff relationships are nourished with actionable efforts, partnering toward meaningful, reciprocal interactions that empower (staff) resilience (Fink-Samnick, 2021). Trauma-informed leadership provides a fresh approach to leadership, incorporating not only the day-to-day tasks of management but also relationship-based skills that empower

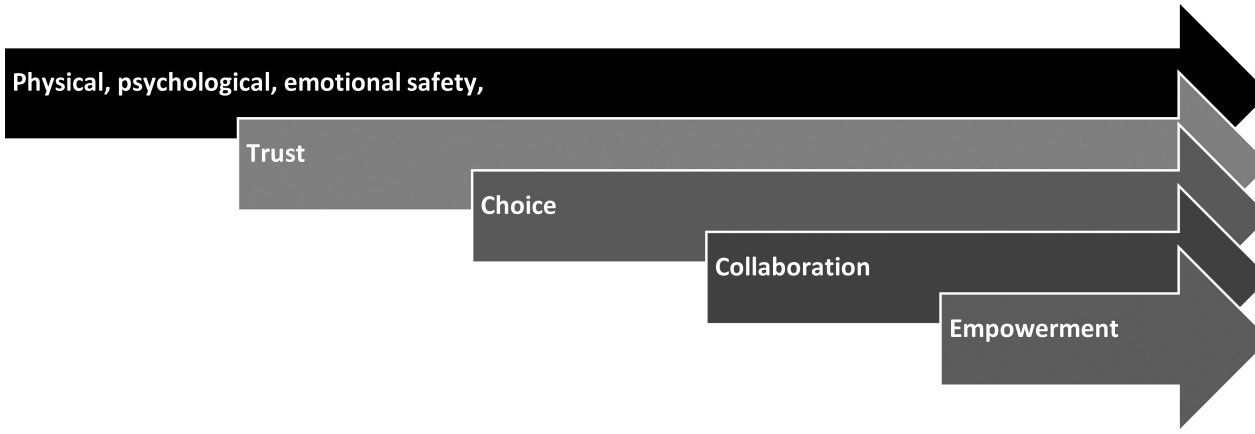

FIGURE 4
Trauma-informed care concepts. Concept names from "Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift," by M. Harris and R. D. Fallot, in M. Harris & R. D. Fallot (Eds.), *Using Trauma Theory to Design Service Systems* (pp. 3–22), 2001, Jossey-Bass/Wiley.

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staff faced with changing and challenging situations (NCBH, 2019).

Health and behavioral health organizations have never been more fluid. To be successful in evolving change, leaders must embrace vulnerability, while creating a welcoming and supportive culture. In this way, the daily rigor of work and accompanying tough conversations are provided a foundation solidified by certain elements, as displayed in Box 2. In the end, all successes are shared with the team, rather than just by the leader. This effort recognizes the mutuality of and reciprocity of work (Fink-Samnick, 2021; NCBH, 2019).

Consider the following scenario. Nadia is a case manager at a local community-based clinic associated with a large health system. Many of her patients are COVID-19 positive, with a growing number hospitalized in the last month. In addition, a large percentage of patients have delayed routine preventive care for management of their chronic illnesses, prompting exacerbations, urgent and unscheduled clinical visits, and ED admissions. Nadia works 16 hr a day. While being given the option to work virtually, Nadia comes in daily, works through lunch, returns home exhausted, and goes right to bed, often without eating dinner. She then restarts the cycle again the next day. Jorge is the clinic program director who runs a tight ship. He calls to check on Nadia and notices she looks pale and seems tense. When he asks Nadia how she is doing, her response concerns him: "I'm fine, What choice do I have?" Jorge implements a TIL approach, displayed in Figure 5. Remember, culture shifts are not achieved by a single "one-and-done" approach. Leadership must ensure a consistent TIL approach for long-term organizational and workforce sustainability.

BOX 2
Ten Tactics to Implement Trauma-Informed Leadership

1. Set a safe, nurturing, holding environment.
2. Foster interactional discussions vs. one-way mandates or reprimands.
3. Build camaraderie and trust to embrace group efforts and dialogues, where input of staff is valued vs. discouraged.
4. Get beyond the "process and roll" mentality and recognize nobody has infinite strength or ability.
5. Be accountable for missteps, frustration, or unprofessional behavior; explain these actions to staff in a way that demonstrates your own humanity and vulnerability to stress.
6. Encourage staff to "Take 10" to emphasize commitment to staff health and mental health.
7. Engage in two-way communication that informs staff of the rationale for actions.
8. Stay visible and accessible.
9. Recognize staff strengths and not just weaknesses to encourage and empower.
10. For virtual/remote roles, visibility matters; have "camera-on" meetings two to three times a week.

Note. From Brown (2018); Fink-Samnick (2020); National Council for Behavioral Health (2019).

Established Resources of Guidance and Workforce Wellness

Moving forward, there must be more formal acknowledgment of how the industry addresses workforce stress, mental health, and COT; the potential for impairment of professional competence has become a concerning adverse effect of workforce stress.

Industry Accountability

Chronic exposure to any stress taxes the reserve of even the most seasoned professional; the individual's reserve weakens and their responses (e.g., agitation, distractibility, frustration, sadness) become tougher to manage. Individuals wrestle anxiety, depression, insomnia, and a host of other symptoms, which disrupt their efforts. Common behavioral health symptoms left untreated morph into mental health diagnoses, which sets a person up for COT or, potentially, PTSD. As a result, all professionals, including case managers, have an ethical and legal obligation to the patients (and families) to heed the ethics principles of beneficence and nonmalfeasance.

Accountability for workforce mental health, wellness, and sustainability is a group effort informed by the industry's established resources of hierarchical guidance; these seminal documents set the rigor that defines academic accreditation, licensure regulation, professional credentialing, and certification and guides codes of ethics and standards of practice (Fink-Samnick, 2019). The process begins at the gateway of professional education and training with

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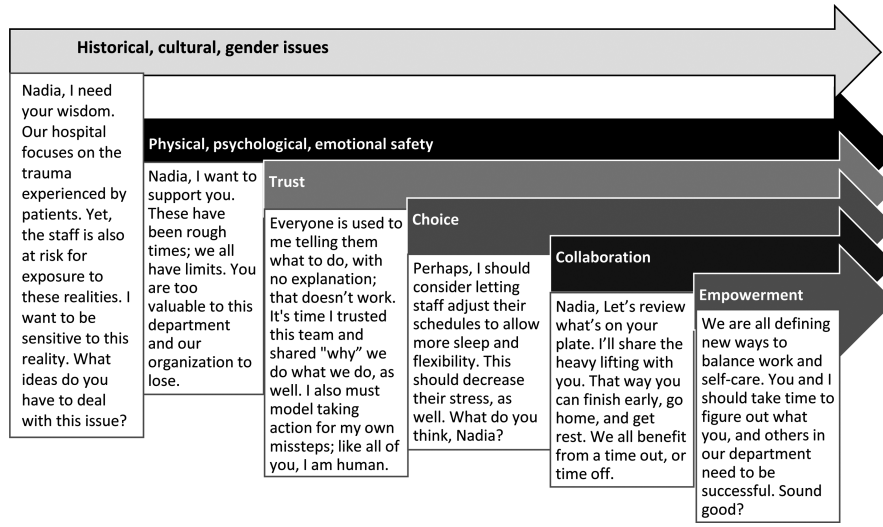

FIGURE 5
Trauma-informed leadership case scenario implementation.

establishment of the knowledge core for practice: competencies, practice behaviors, theories, and interventions. Licensure boards and credentialing entities have a duty to further inform the workforce via regulations that define and have oversight for standards of professional behavior and set reprimands for breaches to them. These entities also evolve codes of ethics and professional conduct that set distinct parameters for practice; these parameters protect the public by ensuring common expectations for the requisite professionals through shared and vetted expectations for how practice is understood. Finally, professional associations engage in a formal process to develop clear standards of practice, which define expectations for how their requisite workforce members should function. This concerted approach lays a firm professional foundation for practice accountability, one that allows minimum standards for professional practice and thus, any necessary advocacy with employers to ensure these standards are met.

Ethical Mandates for Professional Impairment and Self-Care

Historically, entities have included dedicated standards of practice on professionalism, impairment in competence (ACMA, 2020; ACA, 2014; ANA, 2021; NASW, 2021) and clear processes for management of ethical complaints against workforce members (AMA, 2016; CCMC, 2015). Yet, the themes of professional impairment and self-care are becoming more commonly called out by the industry's established resources.

The ANA (2015) has long highlighted professional self-management through language in its *Code of Ethics*, noting shared accountability for "moral respect": what nurses extend to all human beings extends to themselves. The AMA (2016) sets a vital tone in the *Principles of Medical Ethics*, stating physicians "shall uphold the standards of professionalism … and strive to report physicians deficient in character or competence." The Commission on Rehabilitation Counselor Certification ([CRCC], 2017) has explicit language in its *Code of Ethics* specific to "Functional Competence" and "Impairment" of rehabilitation counselors. Members of that workforce they are beholden to stay attuned to signs of impairment from their "own health issues or personal circumstances and refrain from offering or providing professional services when such impairment is likely to harm clients or others" (CRCC, 2017). The standard also takes a firm stance in mandating its professionals obtain support and intervention should problems reach the level of "professional impairment, and as necessary, limit, suspend, or terminate their professional responsibilities until it is determined they may safely resume their work" (CRCC, 2017).

The NASW (2021) took a bold stance with its latest version of the *Code of Ethics*, developing comprehensive language to recognize the reality posed by professional workforce challenges (e.g., demanding climates, exposure to trauma, occupational safety). Clear messaging informs the workforce of their responsibility to heed self-care needs, ensuring shared accountability for action that spans all entities, from members of the workforce to the academic institutions and practice settings that educate and hire them. This language is a model for other entities to follow and is provided in Box 3 with other industry examples. The latest versions of other established resources include similar revisions; *CMSA's* 2022 *Standards of Practice for Professional Case Management* incorporate language emphasizing the importance of professionalism

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BOX 3
Examples, Established Resources of Guidance: Professional Competence and Self-Care

American Counseling Association (ACA) (2014)

Section C. Professional Responsibility, C 2g. Impairment

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

American Nurses Association (ANA) (2015)

Provision 5:

The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

5.1 Moral self-respect:

Moral respect accords moral worth and dignity to all human beings irrespective of their personal attributes or life situation. Such respect extends to oneself as well: the same duties that we owe to others we owe to ourselves. Self-regarding duties refer to a realm of duties that primarily concern oneself and include professional growth and maintenance of competence, preservation of wholeness of character, and personal integrity.

Commission on Rehabilitation Counselor Certification (CRCC) (2017)

Section D. Professional Responsibility; D.3. Functional Competence

a. Impairment. Rehabilitation counselors are alert to the signs of impairment due to their own health issues or personal circumstances and refrain from offering or providing professional services when such impairment is likely to harm clients or others. They seek assistance for problems that reach the level of professional impairment, and if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined they may safely resume their work.

National Association of Social Workers (NASW) (2021)

Professional Self-Care Statement

Purpose:

- Professional self-care is paramount for competent and ethical social work practice.
- Professional demands, challenging workplace climates, and exposure to trauma warrant that social workers maintain personal and professional health, safety, and integrity.
- Social work organizations, agencies, and educational institutions are encouraged to promote organizational policies, practices, and materials to support social workers' self-care.

and attention to self-care by each case manager and the organizations that employ and/or contract with them.

Conclusion

The health and behavioral health workforce has a series of hefty burdens to bear, notwithstanding attention to the ethical tenets that underlie their practice. Yet, competing realities of the pandemic and societal narratives on social, racial, and cultural inequities have heightened workforce stress to untenable levels, prompting considerable challenges. Record levels of burnout, mental health exacerbation, and new trauma syndromes as COT, are yielding problems with staff retention, turnover, and organizational capacity to render safe patient care. The mandate for a shift in industry culture and implementation of TIL are clearly demonstrated through compelling research data and the literature.

The need for each HBW to ensure appropriate levels of professional competence must be a shared responsibility with the industry, including all hiring organizations and practice settings. Heeding the human condition of every member of the workforce will ensure quality attention to the human condition of persons and populations that all organizations are tasked to serve.

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