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“Trying to put out fires with kitchen sink water”: Understanding burnout among providers and staff at Ryan White HIV Clinics in the Southeastern United States

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“Trying to put out fires with kitchen sink water”: Understanding burnout among providers and staff at Ryan White HIV Clinics in the Southeastern United States

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Abstract

“Trying to put out fires with kitchen sink water”: Understanding burnout among providers and staff at Ryan White HIV Clinics in the Southeastern United States

By Nicole Groff

Burnout, described as an extended response to chronic workplace stress, can have many downstream effects on healthcare systems, contributing to less productivity, increased turnover, lower patient satisfaction, and increased cost for health systems. Providers and staff who work at HIV clinics funded by the federal Ryan White program may be particularly prone to burnout due to the challenges that many of their patients face, such as homelessness, stigma, and histories of trauma—while often working with staffing shortages and funding changes. Studies on burnout among HIV providers and staff are limited and outdated and this study helps to address this gap. The purpose of this study is to gain a deeper understanding of the factors which may contribute to and alleviate stress and burnout, the role of patient trauma in provider and staff burnout, and existing strategies and suggestions to improve well-being at Ryan White Clinics (RWCs) across the Southeastern United States. This qualitative study is part of a larger mixed-methods study and includes twenty in-depth interviews with providers, staff, and administrators who work at RWCs in the Southeastern United States. Factors contributing to burnout included poor leadership, negative work environments, workload, and insufficient resources for patients, while factors which alleviated burnout included both formal and informal team support mechanisms, feeling supported, and years of experience. There was variation in the impact of patient trauma on providers and staff. Positively, providers often found the work rewarding to see patients make improvements, despite having experienced trauma. Negatively, many providers mentioned that hearing patients’ traumas could lead to burnout. Existing strategies included employee assistance programs, social and self-care activities, team meetings, and effective leadership, with many participants focusing on the effectiveness of the latter three. Suggestions included increased monitoring of well-being, increased team building, social activities, and trainings on patient trauma, burnout, and ways to manage well-being. This study provides opportunities for researchers and administrators in HIV care to better understand how to prevent burnout among providers and staff. Recommendations include normalizing dialogue on burnout and well-being, encouraging more effective leadership strategies, promoting team cohesion, and implementing trauma-informed care trainings.

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CHAPTER ONE: INTRODUCTION

Burnout, defined as a "prolonged response to chronic emotional and interpersonal stressors on the job" has been found across nearly every healthcare profession and in a variety of healthcare settings (Arrogante & Aparicio-Zaldivar, 2017; Klein et al., 2020; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Parola, Coelho, Cardoso, Sandgren, & Apóstolo, 2017; Rodrigues et al., 2018). Even before COVID-19 brought the topic to the forefront, burnout had become a common experience among healthcare workers. Burnout can put strain on organizations, can negatively impact the health and well-being of providers and staff, and can have detrimental effects on patient care and the trust between patients and providers (Bodenheimer & Sinsky, 2014; West, Dyrbye, & Shanafelt, 2018). The annual monetary cost of burnout, due to loss of productivity and turnover, is estimated at $7,600 per clinician, according to a 2019 cost-consequence analysis (Han et al., 2019). By preventing burnout among providers and staff, organizations could save thousands of dollars, and benefit from happier, healthier, and more productive workers.

Burnout includes three dimensions: exhaustion, cynicism, and inefficacy (Maslach, Schaufeli, & Leiter, 2001). Numerous studies have examined the factors that contribute to burnout, its prevalence across several sectors, and impact, but there remains significant gaps in research. Since the development of the term "burnout" in the 1970's, theoretical models have evolved from examining personal burnout to including organizational factors. Although research has demonstrated the larger role of organizational and situational factors in alleviating burnout, interventions have been focused at the individual level (Maslach et al., 2001). This suggests a gap between literature recommendations and implementation.

Staff of Ryan White clinics (RWCs), which provide care to over half of the country's population of people with HIV, may be particularly susceptible to burnout. RWCs are often understaffed and under-resourced, and those in the South face increasing patient volumes as they continue to respond to the increasing number of new regional infections (i.e., 19,396 new HIV diagnoses in 2018) (Centers for Disease Control and Prevention, 2020).

Few studies have examined the unique challenges of individuals working in the HIV sector in the U.S., and many of these studies are now outdated (Ginossar et al., 2014; Macks & Abrams, 1992). The nature of HIV care in the United States has changed from palliative care in the 1980s to a focus on primary care and comorbidities associated with aging now in the 2020s (Chu & Selwyn, 2011). Nevertheless, the complexity and difficulty of daily life that many persons living with HIV (PLWH) face (stigma, homelessness, poor mental health, etc.) remain present today. Trauma, defined as an adverse event or series of events experienced by an individual as physically or emotionally harmful or life threatening, and which has "lasting adverse effects on an individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014), is also pervasive among many PLWH. Experiencing trauma has been linked to an increase in mental health problems, HIV-risk behaviors, and not engaging fully in treatment protocols (Whetten et al., 2006). The complexity of serving patients who have experienced trauma, have other comorbidities and chronic illnesses, may serve as additional work stressors for providers and staff (Brezing, Ferrara, & Freudenreich, 2015; Chu & Selwyn, 2011; Gallant, Hsue, Shreay, & Meyer, 2017; Varkey et al., 2009).

Trauma-informed approaches emphasize incorporation of practices that promote staff self-care and organizational support (SAMHSA, 2014), recognizing that prevention of burnout among providers and staff is critical to assisting patients with histories of trauma. There are six

key aspects of a trauma-informed approach, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). These are: 1) safety 2) trustworthiness and transparency 3) peer support 4) collaboration and mutuality 5) empowerment, voice and choice and 6) cultural, historical, and gender issues (SAMHSA, 2014). In implementing this approach in organizations, many of these aspects involve focus not only on clients, but on the administration and staff as well. In order to build this resiliency, staff and providers must be cared for so that they may provide better care for their patients. While the link has been made to understand how trauma-informed care can help patients, little is understood of how providers and staff could be affected, and what opportunities there are to prevent burnout.

This study aims to contribute a deeper understanding of burnout, factors that contribute to burnout and the role trauma-informed care could play in preventing burnout among providers, staff, and administrators at Ryan White Clinics (RWCs) in the Southeastern United States. Through a qualitative sub-study of a larger mixed methods study assessing factors associated with the implementation of a trauma-informed model of care at RWCs across the Southeastern U.S., our goal was to examine how providers, staff, and administrators of RWCs experience burnout and opportunities to support their well-being. Specifically, the study addresses the following four aims:

1) to understand the factors which contribute to or alleviate stress or burnout for providers, staff and administrators of Ryan White clinics

2) to examine the impact of providing care to patients with histories of trauma on Ryan White (RW) providers and staff

3) to explore existing strategies utilized by RW clinics to support well-being and prevent and reduce burnout, and

4) to examine suggestions from providers, staff and administrators on methods to prevent and reduce burnout in RW clinics

This study is crucial for clinic administrators, team managers, human resources, Ryan White administrators, and policymakers to understand the factors that may contribute to and alleviate burnout and to identify enhancements to existing staff support activities and organizational culture. This study will explore opportunities to break cycles of burnout and form new cycles of support and healing for healthcare workers so they can effectively care for their patients.

CHAPTER TWO: LITERATURE REVIEW

Burnout: Definition and Prevalence among Healthcare Professionals

Burnout is defined as "a prolonged response to chronic emotional and interpersonal stressors on the job" (Maslach et al., 2001). Burnout, the antithesis of well-being, includes 3 dimensions: emotional exhaustion, depersonalization and a decreased sense of personal accomplishment or efficacy (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1986).

Burnout, while related, can be differentiated from other terms, such as stress, job dissatisfaction, depression, and compassion fatigue. Burnout results from prolonged exposure to stress at the workplace. Stress has been defined by Lazarus and Folkman (1984) as the product of a troubled relationship between the person and the environment. This can be mediated by a person's coping mechanisms, and emotional regulation restored. If the stress exceeds the person's ability to cope, this can put the person in a constant state of "fight" or "flight". This kind of prolonged stress is precisely what can lead to burnout, through decreased job satisfaction, poorer overall health, and diminished social functioning (Williams, Manwell, Konrad, & Linzer, 2007).

Some have argued that job dissatisfaction significantly leads to burnout (Williams et al., 2007), while others have argued that the causal relationship is unclear—that dissatisfaction may be a result of burnout (Maslach et al., 2001).

Burnout is separate from depression, although people prone to depression may be more prone to burnout (Maslach et al., 2001). There may be overlap of burnout and depression, but an individual may be depressed and not burned out, or vice versa (Fahrenkopf et al., 2008; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). Lastly, the terms compassion fatigue, secondary

trauma, and vicarious trauma commonly arise when discussing burnout, specifically related to the chronic stress of being exposed to another's traumatic experiences. These three terms are used by some interchangeably (Greinacher, Derezza-Greeven, Herzog, & Nikendei, 2019) while others provide distinct definitions. Sweileh (2020) describes compassion fatigue as the state by which a caretaker is unable to engage in a caring relation. Figley (1983) describes secondary traumatic stress as 'the stress derived from helping others who are suffering or who have been traumatized' and was the first to suggest that those in proximity to trauma survivors may have a traumatic stress response without having experienced the trauma themselves.

Burnout has been found across nearly every healthcare profession and in a variety of healthcare settings (Arrogante & Aparicio-Zaldivar, 2017; Klein et al., 2020; McHugh et al., 2011; Parola et al., 2017; Rodrigues et al., 2018). About 44% of U.S. physicians reported at least one symptom of burnout in a representative survey in 2017, compared to the general U.S. population prevalence of about 28% (Shanafelt et al., 2019). Primary care physicians have some of the highest rates of burnout among physician specialties, with 60% reporting high levels of burnout (Shanafelt et al., 2015). As of 2012, the specialties with the highest physician burnout were in family medicine, general internal medicine, and emergency medicine (Shanafelt et al., 2012). A survey of physicians in 2011, 2014 and 2017 demonstrated an increase in burnout and decrease in work-life integration in 2014, with levels nearly returning to that of 2011 by 2017 (Shanafelt et al., 2019).

Burnout research among advanced practice providers is limited. A study among rural physician assistants found 64% experienced high to moderate emotional exhaustion and depersonalization and 46% experienced feelings of low to moderate personal accomplishment (Benson et al., 2016).

A study among nurses identified 30% of emergency department nurses experiencing burnout (Gómez-Urquiza et al., 2017), with depersonalization being the most correlated dimension. In a systematic review of primary care nurses, emotional exhaustion was high (28%), sense of personal accomplishment was low (31%) and depersonalization was low (15%) (Monsalve-Reyes et al., 2018).

A study from a U.S. healthcare setting found that staff (nurses, behavioral health, front desk staff, medical assistants, and others) and clinicians (physicians, physician assistants, and nurse practitioners) both experienced burnout at 53% (Willard-Grace et al., 2019). More research is needed regarding staff that are not directly involved in patient care. A recent study among hospital non-healthcare staff (administrators, managers, IT, medical technicians, and laboratory technicians) in France found that burnout was very high (75%) with 15% experiencing severe burnout and more than half experiencing moderate burnout (Clinchamps et al., 2020).

Impacts of Burnout

Burnout negatively affects the individual, team, and organization. Within healthcare, burnout can put a strain on the organization, negatively impact the well-being of providers and staff, and have detrimental effects on patient care and the trust between patients and providers (Bodenheimer & Sinsky, 2014; West et al., 2018).

Organizational strain

Numerous studies in recent years have demonstrated the detrimental effects of burnout to health systems and organizations. Across the globe, provider burnout has been correlated to poor job performance, high turnover, decreased work ability, and increased number of sick days

(Azam, Khan, & Alam, 2017; Dewa, Loong, Bonato, Thanh, & Jacobs, 2014; Klein et al., 2020). A systematic review from across 14 countries stated the organizational impacts of physician burnout to be poor job performance, low organizational commitment, and turnover intention (Azam et al., 2017).

Productivity is decreased when physicians experience burnout (Dewa et al., 2014; Shanafelt et al., 2016). A global systematic review on physician burnout noted burnout was associated with intent to change jobs, low self-perceived work ability, and number of sick days. While there was variation between studies depending on the type of productivity examined, most studies revealed a negative relationship between burnout and productivity (Dewa et al., 2014). A prospective longitudinal study found that physicians who reported higher emotional exhaustion and less professional satisfaction were more likely to change to working less than full time within the subsequent 24 months. This net loss of productivity is estimated to the loss of graduating classes of seven medical schools—a net loss of approximately 1067 physicians, or 1.2% of the US physician workforce (Shanafelt et al., 2016)

A significant burden to organizations in the health care system is the impact of burnout on turnover rates. A longitudinal study of two major health systems in San Francisco examined indicators of low engagement and burnout among primary care clinicians and staff and found that clinician, but not staff, turnover rates were significantly correlated to burnout. Low engagement among clinicians, although not statistically significant, was a strong trend and predictor of turnover (Willard-Grace et al., 2019). While turnover rates are multifactorial, burnout is likely to play a significant role—especially for clinicians. It was hypothesized that the other factors involved in turnover—such as job location and career mobility—may affect staff and clinicians differently. Burnout may be experienced by staff and clinicians at the same level,

but clinicians may be more able or likely to leave a practice because of it (Willard-Grace et al., 2019).

High rates of turnover are expensive for healthcare organizations—the cost of recruiting a new physician estimated at between $500,000. The annual cost of burnout, due to loss of productivity and turnover, is estimated at $7600 per clinician, according to a 2019 cost-consequence analysis (Han et al., 2019).

While turnover rates among healthcare staff were not significantly correlated to burnout in one study (Willard-Grace et al., 2019), burnout does exist among staff, and work stress is exacerbated when either physician or staff are burned out (Bodenheimer & Sinsky, 2014). This seems to suggest that when one/some members of a healthcare team are experiencing burn out, there may be a ripple effect to the rest of the team. More studies should be conducted to examine the impacts of burnout on team dynamics and productivity.

Staff/provider well-being

Mental and physical health

Burnout can have a significant impact on the mental and physical aspects of health and well-being. While most studies on burnout have been cross-sectional, prospective studies examining the individual level effects of burnout have also been conducted. A systematic review of prospective studies identified burnout to be linked to greater odds of cardiovascular disease, pain, antidepressant use, and absenteeism (Salvagioni et al., 2017).

Additional physical consequences found included hypercholesterolemia, Type 2 diabetes, coronary heart disease, hospitalization due to cardiovascular disorder, musculoskeletal pain, changes in pain experiences, prolonged fatigue, gastrointestinal issues, respiratory problems,

severe injuries and premature death (before age 45). These have been explained through direct effects of neuroendocrine mechanisms as well as indirect effects of behaviors (poor diet and low physical activity) (Salvagioni et al., 2017). Psychological consequences of burnout include greater reporting of depressive symptoms, use of psychotropic and antidepressant medications, hospitalization for mental disorders and other mental health symptoms (Salvagioni et al., 2017).

Social/ familial health

Work-life integration is significantly lower for physicians than the general working population. After adjusting for sex, relationship status, hours worked, and age, one study found that 40% of U.S. physicians reported satisfaction with work-life integration, compared to 61% of the general U.S. population. Work-life integration was assessed with the statement “My work schedule leaves me enough time for my personal/family life” (Shanafelt et al., 2019). Burnout is also related to marital or relationship conflicts (Booth-LeDoux, Matthews, & Wayne, 2020; Lacy & Chan, 2018) and increased rates of depression, alcohol abuse, drug abuse, and motor vehicle collisions (Leiter et al., 2013; West et al., 2018; West, Tan, & Shanafelt, 2012).

Health system metrics

As the health care system in America is increasingly using patient outcomes as a key metric, it is important to understand the impact that burnout of providers and staff has on the patients they serve. A systematic review among various healthcare settings, found that the vast majority of studies confirm the association between burnout and decreased patient safety (Garcia et al., 2019). Surgeons who made a medical error within the last three months were associated with burnout and symptoms of depression (Shanafelt et al., 2010). In hospitals where nurses

experienced great levels of burnout and dissatisfaction, patients also experienced greater levels of dissatisfaction (McHugh et al., 2011).

An important mediator between individual burnout and the patient experience is the impact on the healthcare team. Physicians experiencing burnout are more likely to lash out on their staff (Bodenheimer & Sinsky, 2014). A longitudinal study found that burnout—particularly emotional exhaustion—sets into motion a cycle of a negative work environment, negative communication among members of the healthcare team, and consequently decreased patient safety (Welp, Meier, & Manser, 2016).

The MEMO (Minimizing Error, Maximizing Outcome) study was a 3-year longitudinal study among 500 physicians and 2,000 patients in the mid-West and New York City. The study found that burnout correlated with suboptimal care of patients and self-reported likelihood of error, suggesting that having clinicians who are not burned out contributes greatly to delivering quality care (Williams et al., 2007).

A study among nurses assessing patient outcomes and nursing burnout also found that job dissatisfaction and burnout among nurses in a variety of settings led to worsened patient satisfaction, after adjusting for organizational and structural factors. For every 10 percent increase in job dissatisfaction among nurses there was a two percent decrease in the likelihood that a patient would recommend the hospital to family or friends, The study reported similar findings for high levels of burnout (McHugh et al., 2011). Although not a direct component of burnout, job dissatisfaction among physicians and nurses has been found to correlate with decreased patient satisfaction (Haas et al., 2000; McHugh et al., 2011; Williams et al., 2007).

Depersonalization is a key feature of burnout and affects the way providers are able to connect to their patients. Bodenheimer and Sinsky (2014) argue that understanding the impacts

of depersonalization can be understood using the Social Exchange Theory developed by Peter Blau in 1964. In the healthcare context, depersonalization of a provider may lead to a detached patient interaction, whereby patients feel less invested in and cared for. This leads to patients having less motivation for their health, poorer health outcomes, and thereby increasingly frustrated providers and a further divide in the patient-provider relationship (Blau, 1964; Bodenheimer & Sinsky, 2014).

A systematic review and meta-analysis examined the impact of healthcare staff well-being and burnout on patient safety. The majority of studies were cross-sectional, and examined the burnout experiences of nurses. Other professions included were physicians, physicians in training, anesthetists, paramedics, pharmacists and surgeons. Hospital receptionists were excluded. Of the 30 studies on burnout, 21 found that more errors were significantly associated with burnout. Four studies found an association with only one subscale of burnout, and the remaining five found no association (Hall et al., 2016). Physician job satisfaction has been found to have a significant effect on patient treatment adherence, regarding medical, exercise and diet recommendations (DiMatteo et al., 1993). More research is needed to examine the impact of provider burnout on patient adherence.

Factors Associated with Burnout

Healthcare professionals are especially prone to burnout due to high volume of stress, lack of involvement in decision making, and time constraints (Bridgeman, Bridgeman, & Barone, 2018). Job dissatisfaction and stress have been found to be significant precursors to burnout (Williams et al., 2007). Maslach (2001) discusses both situational and individual level factors, acknowledging that burnout is more affected by situational rather than individual factors.

Situational factors: Job stressors, organizational characteristics, interpersonal characteristics

Job stressors

Job stressors include too much work for time allotted, role conflicts and role ambiguity, lack of social support from supervisors and coworkers, lack of feedback, and lack of decision-making participation (Maslach et al., 2001). Williams et al. (2007) found that less physician stress was significantly associated with alignment between leadership interests and physician interests. In advanced practice providers (APPs), job stressors of role ambiguity, work pressures and lack of autonomy were significantly correlated to burnout (Klein et al., 2020).

Another factor that may contribute to job stress is 'emotion work.' Emotion work is defined as the requirement to display organizationally desired emotions. Zapf, et al (2001) found that among service workers in various industries, emotion work factors—needing to be empathetic, requiring suppression or display of emotion, etc—were more strongly related to burnout than other job stressors. Similar findings in a study among nurses across various settings, determined that those who worked in direct patient care had higher rates of burnout than those who rarely interacted with patients (McHugh et al., 2011).

Organizational characteristics

Organizational characteristics are shaped by larger social, cultural, and economic forces. These include hierarchies, operating rules, resources, and space distribution. Maslach et al. (2001) found that organizational factors can have particularly negative influence on employees when they violate a person's basic expectation of fairness and equity.

Zapf, et al. (2001) studied correlations between emotion work and burnout, as well as the interactions with organizational and social variables. Organizational factors that led directly to

emotional exhaustion and depersonalization included time pressure and the amount of work that required concentration (concentration necessity). The study also found that emotion work is correlated to all three dimensions of burnout and can explain variances in tasks and other organizational and social stressors and resources (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001).

One aspect of emotion work, emotional dissonance, has been found to consistently lead to exhaustion. Emotional dissonance occurs when an individual feels one way but is expected to display a different emotion. For example, a provider may feel frustrated and rushed for time, while expected to appear patient and empathetic with the individual in front of them, or saddened by a patient they just saw while expected to be happy and friendly for the next patient. This can lead to alienation of one's feelings and psychological strain. Emotional dissonance, when added to organizational stressors such as uncertainty or time pressure can amplify effects on emotional exhaustion and depersonalization (Zapf et al., 2001).

Zapf, et al (2001) suggests that the high emotional demands of interacting with clients may not cause burnout if sufficient resources are present within the organization (Zapf et al., 2001). Resources such as complexity of tasks, concentration necessity, positive emotions, and sensitivity requirements (i.e. whether empathy or knowledge about a client's feelings were required of the job), were positive predictors of personal achievement, the third dimension of burnout (Zapf et al., 2001).

Burnout among physicians in the U.S. increased between 2011 and 2014 and decreased to near 2011 levels by 2017. This study involved a nationally representative random sample of U.S. physicians who completed a survey using the Maslach Burnout Inventory scale. The randomized sample was different in 2011, 2014, and 2017 although methods were consistent (Shanafelt et al.,

2019).Several hypotheses may explain this trend, such as a switch to electronic medical records in 2014, and interventions which have helped decrease levels of burnout. Other explanations include the stress of mergers and consolidation of hospitals, new regulations, and increased administration burdens. Hypotheses for the improvement in 2017 were that burned out physicians left or decreased their hours, physicians have adapted to the changes taking place in 2014, or that organizations focusing more on staff well-being, team-based care, etc has had an effect on burnout (Shanafelt et al., 2019).

Autonomy has been associated with lower levels of burnout among staff, advanced practice providers and physicians in small primary care practices across the United States. One study found that members of solo-practices reported lower levels of burnout than those who were part of Federally Qualified Health Centers or members of health-system owned practices (Edwards et al., 2018).

Interpersonal characteristics

A qualitative study among health educators and nurses in Italy exhibited four main risk factors and protective factors of well-being. The most highly discussed protective theme was "interactions"—the quality of relationships between patients, coworkers, and supervisors. Other themes included: "emotional responses to work", "competence and professional growth" and "working conditions" (Berlanda, de Cordova, Fraizzoli, & Pedrazza, 2020).

Individual factors: Demographics, Personal qualities, Work hours

Individual factors that may cause an individual to be more prone to burnout include personality, demographics, and work hours (Cañadas-De la Fuente et al., 2018; Lacy & Chan, 2018; Maslach et al., 2001; Shanafelt et al., 2019).

Demographics

Demographics including age, gender, and marital status, have each been studied in relation to burnout. Age is the only demographic with consistent evidence to suggest that younger people are more prone to burnout (Friedberg et al., 2014; Maslach et al., 2001). Among physicians, the age difference has been explained by theories such as younger physicians being more idealistic, older physicians who were dissatisfied with medicine leaving practice early, and the ability to enjoy one's job (decreasing chronic stress) may come with experience (Friedberg et al., 2014).

Gender has had mixed results and has differed between different roles. Female gender was associated with higher burnout among physicians, while male gender was associated with higher burnout among nurses. Being married and having children was associated with lower burnout (Cañadas-De la Fuente et al., 2018; Shanafelt et al., 2019).

Personal qualities

Lacy & Chan (2018) found that physicians who were most prone to develop burnout often showed "personal qualities of idealism, perfectionism, and an intense sense of responsibility." This may help to explain difficulty in maintaining personal and professional balance and prioritizing personal wellness (Lacy & Chan, 2018). All three dimensions of burnout have been related to low self-esteem (Maslach et al., 2001).

Work hours

Working more hours per week was independently associated with higher burnout and lower work-life integration among U.S. physicians from a 2017 survey (Shanafelt et al., 2019).

Work-life balance among advanced practice providers was positively associated with better work engagement and lower burnout (Klein et al., 2020).

Ryan White HIV Primary Care Clinics

While provider and staff burnout occur across fields of medicine, providers and staff of Ryan White-funded HIV primary care clinics (responsible for the care of uninsured and underinsured individuals living with HIV) may be particularly susceptible.

Description of the Ryan White HIV/AIDS Program

Background

The Ryan White federal funding program provides support for people living with HIV (PLWH) who do not have health insurance or whose insurance does not completely cover costs (Kaiser Family Foundation, 2020). The Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, named after a boy who, along with his mother, fought discrimination and the right to go to school despite having HIV, began in 1990 (HRSA, 2016).

Over half of the individuals living with HIV in the U.S. receive support from the Ryan White HIV/AIDS Program: a total of 567,803 people in 2018 (Health Resources and Services Administration, 2019). In 2019, 80.8% of individuals receiving Ryan White care were retained in care and 88.1% achieved viral suppression—up from 83.4% in 2015 (Health Resources and Services Administration, 2019). Among the general population of PLWH in the U.S. in 2019, 66% were virally suppressed (Centers for Disease Control and Prevention, 2021).

Demographics

The majority of people served at Ryan White clinics are male, people of color, and low-income. In 2018, of those who reported a gender, 71.6 % were male, 26.5% female, and 1.9% were transgender. The top three races/ethnicities reported were 47.1% Black/African-American, 26.3% White and 23.2% Hispanic/Latinx (Health Resources and Services Administration, 2019).

Ryan White clients have varied types of health care coverage. Twenty percent (20%) had no coverage, 31.5% had Medicaid, and the remaining were covered by Medicare, private employers, Medicare and Medicaid combined or other coverages in 2018. Sixty one percent (61%) of clients had an income below 100% of the federal poverty line. Eight percent (7.7%) reported living in temporary housing and 5.3% reported having unstable housing in 2018 (Health Resources and Services Administration, 2019).

Services

The Ryan White HIV/AIDS program plays a significant role in addressing common barriers to engagement in HIV care and filling in the coverage gaps for thousands of individuals living with HIV. Common barriers to care include income, transportation, mental health challenges, substance abuse, housing, and social support. Mental health, oral health, assistance with food, transportation, supportive services, health education, non-medical case management are some of the services provided through Ryan White programs that address these gaps and provide holistic care (Health Resources and Services Administration, 2020).

Burnout among providers and staff of HIV care

Emerging evidence suggests high levels of burnout among HIV care providers. While many studies were conducted in the U.S. in the 1990’s regarding burnout among HIV providers (Macks & Abrams, 1992), circumstances regarding HIV care and treatment have changed. The

HIV epidemic has shifted from palliative care and opportunistic infections (prior to 1990), to managing antiretrovirals (1990-2000), to now a focus on co-morbidities, aging, and primary care (2000-present) (Chu & Selwyn, 2011). The complexity of patients served, including co-morbid mental health conditions, chronic illness, trauma histories, low-income and minority status suggest additional work stressors for providers and staff, and many have called for a new model of HIV care (Brezing et al., 2015; Chu & Selwyn, 2011; Gallant et al., 2017; Varkey et al., 2009).

Burnout among providers of HIV care is likely high as many also provide primary care and handle co-morbid conditions (Gallant et al., 2017). Prior studies have shown that primary care physicians have some of the highest rates of burnout among physician specialties, with 60% reporting high levels of burnout (Shanafelt et al., 2015).

A recent cross-sectional study in Ryan White clinics in a southwestern state suggests that organizational culture is an important factor in burnout among providers and staff. Poor teamwork was a statistically significant predictor of emotional exhaustion, and critical appraisal (i.e. hurtful or negative evaluation) was associated with depersonalization. The study suggests that having a positive organizational culture (with good teamwork and less critical appraisal) would "provide a buffer" to the stresses of HIV care and create stability in the workplace, thereby creating a safe and compassionate setting to provide HIV care (Ginossar et al., 2014).

Staffing shortages are another factor potentially contributing to burnout among the HIV workforce, with concerns that experienced providers of HIV care are leaving or retiring and not being replaced by newly trained providers. When comparing providers of Ryan White clinics to private practices, those working for Ryan White funded agencies were more highly qualified, yet more likely to state having plans to leave HIV practice in the next five years (Weiser et al.,

2016). Providers planning to leave HIV practice were more likely to also provide primary care than those entering the practice—a concern as the prevalence of chronic comorbidities among HIV patients increases (Gallant et al., 2017).

Factors that may lead to burnout in providers of HIV care include mental health and trauma histories of the patients they serve. Poor adherence to ART has been associated with increased number of childhood traumas, sexual trauma before puberty, PTSD, and depression (Brezing et al., 2015; Pence, 2009). These factors and lack of adherence may add to the stressors that providers of HIV care experience, however, there are no studies to date that describe this link.

Other hypotheses leading to burnout among providers and staff at Ryan White clinics include funding challenges, time constraints, increased administrative tasks and high turnover rates. More research is needed to understand the extent of burnout, as well as contributing and alleviating factors of burnout among providers and staff at Ryan White HIV clinics.

Addressing Burnout: Trauma-Informed Care

Significant progress has been made in the past several decades to identify interventions to prevent burnout. These include increasing staff well-being, mindfulness, stress management, and teamwork (Zhang, Song, Jiang, Ding, & Shi, 2020). Due to the complex nature of HIV care and the high rate of trauma histories among PLWH, several studies have suggested the importance of adopting a trauma-informed model of care (Brezing et al., 2015; Pence, 2009).

What is trauma and trauma-informed care?

Trauma can be defined as an "emotionally harmful event or series of events", which may include violence, neglect, abuse, loss, war, natural disaster, and any other adverse event as experienced by the individual. Trauma often underlies many mental health illnesses, substance use disorders, and other health conditions and is a serious public health issue (SAMHSA, 2014).

The Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that applying a trauma-informed approach to systems will affect those who have experienced trauma, staff within the system, and patients who receive services. Organizations and institutions, especially healthcare organizations, have the opportunity to either exacerbate, ease or even work towards healing a patient's past experience of trauma (SAMHSA, 2014).

Trauma-informed care, as defined by SAMSHA, uses four essential approaches (the four R's). First, it "*realizes* the widespread impact of trauma and understands potential paths for recovery". It "*recognizes* the signs and symptoms of trauma in clients, families, staff, and others; *responds* by fully integrating knowledge about trauma into policies, procedures and practices"; and lastly, it "seeks to actively *resist* re-traumatization." SAMHSA suggests six key trauma-informed care principles: 1) safety 2) trustworthiness and transparency 3) peer support 4) collaboration and mutuality 5) empowerment, voice and choice and 6) recognition of cultural, historical and gender issues (SAMHSA, 2014).

Koetting (2016) describes trauma-informed care as being about "withholding judgement from negative health behaviors," providing insight and understanding into why individuals may engage in certain behaviors, and offering healing. Koetting describes safety as a key grounding feature to help patients get out of a hypervigilant (trauma) state and into a relaxed state where healing can occur. Trauma-informed care models are intentional about providing environments that feel safe to the patients they serve. Trauma-informed care provides more voice for patients

than traditional models of care, and similarly, ‘collaboration and mutuality’ means flattening the administration hierarchy as well as hierarchy between patients, staff, and providers (Koetting, 2016).

Components of burnout interventions

As discussed previously, both individual and organizational factors play large role in burnout, and therefore interventions should target both individual and organizational level factors (Trockel, Corcoran, Minor, & Shanafelt, 2020). Because organizational characteristics (such as hierarchies, operation, resources) can play such a large role in burnout, Maslach emphasizes the importance of values in an organization’s structure and policies as these can have a major effect on the emotional and mental state of employees. Maslach encourages management to focus on values such as equity and fairness, and to create a workplace setting of energy, vigor, and positive feedback. Moreover, Maslach suggests that to enhance accountability, organizational interventions should be positive: building engagement vs. treating burnout (Maslach et al., 2001).

A systematic review by Zhang et al. (2020) has found that interventions to address burnout among healthcare professionals have included those that address individual characteristics, organizational or structural characteristics, or a combined approach. Individual level interventions have included emotional regulation training, mindfulness, stress reduction techniques, yoga, massage, aromatherapy and communication skills trainings at the workplace. Massage and aromatherapy interventions have had mixed evidence, whereas interventions focusing on emotional regulation and mindfulness have been found to decrease burnout (Jackson-Koku & Grime, 2019; Li et al., 2019).

Structural interventions addressed workload or scheduling rotations, teambuilding, stress management and resiliency training, and others (Zhang et al., 2020). Another systematic review on organizational interventions suggests that "workplace interventions that improve processes, optimize EHRs, reduce clerical burden by the use of scribes, and implement team-based care can lessen physician burnout" (DeChant et al., 2019). Zhang et al. (2020) recommend implementing and evaluating a "bundled" strategy, which focuses on building resilience through combined approaches, including communication skills training, self-care workshops, stress management training, workload/schedule rotation, teamwork, and debriefing sessions.

Trockel et al. (2020) suggest a multi-level framework for advancing physician well-being, to include aligning values of employees and organization and removing barriers to getting help. These are two of many components recommended to 'foster change in professional norms and culture' (Trockel et al., 2020). The American Medical Association uses the STEPS forward program, which seeks to optimize team-based workflow, improve organizational culture, and put joy back into physician practice to enhance physician well-being and prevent burnout. Online modules allow administrators and individuals access to learn more about these interventions (American Medical Association, 2020). Lacy and Chan (2018) recommend that organizations take on the responsibility of assessing burnout and providing tools and trainings for employees, thereby empowering them to recognize burnout and have the tools and support to care for their own health and well-being. Lacy and Chan also presents five key principles in treating physician burnout: 1) learn to balance personal and professional goals 2) shape your career and identify stressors 3) nurture wellness strategies 4) become engaged and/or re-engage, and 5) build resilience (Lacy & Chan, 2018).

Booth-LeDoux et al. (2020) suggest that employees (as well as their partners/spouses) experience less burnout when they perceive their organization as being supportive of their work and family life. There is spillover and crossover between home and work stressors, and research suggests that burnout interventions should include support of family systems (Booth-LeDoux et al., 2020).

Trauma-informed care and burnout

Research on trauma-informed care approaches and the effect on an organization is limited, however, several preliminary studies have been promising in reducing burnout (Damian, Gallo, Leaf, & Mendelson, 2017; Hales & Nochajski, 2019).

A systematic review on trauma-informed care models among out-of-home care settings demonstrated few studies and a need for more evidence, especially in determining the impact of the approach on staff and organizations (Bailey et al., 2019). Hales & Nochajski's study (2019) in a large public behavioral health hospital found that collaboration and choice may increase organizational commitment and reduce burnout. A trauma-informed approach focuses on "collaboration" and "choice" throughout an organization, allowing for greater autonomy and decision making—and offering creative solutions to traditional forms of hierarchy (Hales & Nochajski, 2019).

Individuals who have participated in trauma-informed care trainings may bring back a fresh perspective to their workplace and organizations. After a training in trauma-informed care for providers who work with youth, four key themes were found during semi-structured interviews. Participants stated having a greater sense of camaraderie and empathy for colleagues and heightened awareness of own traumatic stress and need for self-care. They also reported that

they implemented more flexible and less punitive policies toward clients and adopted trauma-informed workplace designs. This study suggests that successful implementation of trauma-informed care could have a positive impact on staff by empowering staff towards being more aware of their own secondary trauma and potential for burnout (Damian et al., 2017).

Trauma-informed care approaches, as suggested by the two studies mentioned above, can increase collaboration, decision-making, empathy, and self-care among staff. Thus, it could follow that the dimensions of burnout—emotional exhaustion, depersonalization, and personal efficacy—could be addressed by trauma-informed approaches.

<u>Trauma-informed care in HIV</u>

It is well understood that people living with HIV experience high rates of trauma and recommendations have been made to implement interventions that are trauma-informed (Brezing et al., 2015; Cuca et al., 2019; Machtinger, Wilson, Haberer, & Weiss, 2012). Most of the literature focuses on the positive effect on patients; few have asked what effect there may be on staff and providers of HIV care.

While providing HIV care may be stressful and complex, preliminary research in HIV care suggests that a positive organizational climate may act as a buffer to burnout among providers and staff (Ginossar et al., 2014).

A trauma-informed healthcare model offers a promising way to address social determinants of health among patients and to boost interdisciplinary practice and well-being of staff and providers. A baseline qualitative study on the implications of trauma at an HIV clinic found that there were many opportunities for staff to benefit from trauma-informed care. A key characteristic that was highlighted was hierarchy—in which the power dynamics among the

healthcare team often created additional stressors. Having defined roles, however, mitigated stress especially in times of crisis. Additionally, a trauma-informed care model would allow for staff to have a common language as well as resources on how to understand patient trauma (Dawson-Rose, Cuca, Shumway, Davis, & Machtinger, 2019).

A study at a large Ryan White HIV treatment center in the Southern U.S. assessing implementation of trauma-informed care found that there was interest in trauma-informed care, yet lack of training and resources (Piper et al., 2020).

Gaps in knowledge

While research on burnout has been increasing exponentially in the past few decades, there remain several gaps—including burnout among providers and staff of HIV care, the impact of patient trauma histories on provider burnout, and burnout among non-physician and non-registered nursing staff (advanced care practitioners, social workers, peer-educators, medical assistants, nursing assistants, etc). More studies are needed to examine the adverse effects of provider burnout on patient outcomes, including metrics such as medication and lifestyle adherence. There is a gap in the literature on burnout and productivity among non-physician staff in the United States and a gap in understanding the role of hierarchy and communal aspects of a workplace, especially in regards to organizational interventions to prevent burnout. While most studies on burnout have been quantitative, there is a need for qualitative studies to understand the true experience of healthcare workers and burnout.

A major gap exists in the burnout literature in HIV settings. Many studies were conducted between 1992-1993. The most recent study is from 2014 and examined the impact of

organizational culture on burnout among HIV providers (Ginossar et al., 2014). There are no published studies to date comprehensively assessing burnout at Ryan White HIV clinics.

There is a lack of quality evidence for the efficacy of trauma-informed care among organizations (and even less on how it affects provider and staff burnout). Numerous articles on HIV highlight the need for trauma-informed interventions (Brezing et al., 2015; Chu & Selwyn, 2011; Cuca et al., 2019; Piper et al., 2020), but few have implemented and evaluated this approach. Other gaps include secondary trauma in healthcare workers—understanding the impact of patient trauma histories on provider and staff burnout.

Study Aims

This study will seek to address issues of burnout and strategies for prevention across Ryan White HIV clinics in the Southeastern United States. There are four aims of this study:

1. to understand the **factors** which contribute to and alleviate **stress** or burnout for providers, staff and administrators of Ryan White (RW) clinics

2. to examine the **impact** of providing care to patients with **histories of trauma** on Ryan White (RW) providers and staff

3. to explore **existing strategies** utilized by RW clinics to support well-being and reduce burnout

4. to examine **suggestions** from providers, staff and administrators on methods to reduce burnout in RW clinics

CHAPTER THREE: MANUSCRIPT

"Trying to put out fires with kitchen sink water": Understanding burnout among providers and staff at Ryan White HIV Clinics in the Southeastern United States

By Nicole Groff

ABSTRACT

Burnout, described as an extended response to chronic workplace stress, can have many downstream effects on healthcare systems, contributing to less productivity, increased turnover, lower patient satisfaction, and increased cost for health systems. Providers and staff who work at HIV clinics funded by the federal Ryan White program may be particularly prone to burnout due to the challenges that many of their patients face, such as homelessness, stigma, and histories of trauma—while often working with staffing shortages and funding changes. Studies on burnout among HIV providers and staff are limited and outdated and this study helps to address this gap. The purpose of this study is to gain a deeper understanding of the factors which may contribute to and alleviate stress and burnout, the role of patient trauma in provider and staff burnout, and existing strategies and suggestions to improve well-being at Ryan White Clinics (RWCs) across the Southeastern United States. This qualitative study is part of a larger mixed-methods study and includes twenty in-depth interviews with providers, staff, and administrators who work at RWCs in the Southeastern United States. Factors contributing to burnout included poor leadership, negative work environments, workload, and insufficient resources for patients, while factors which alleviated burnout included both formal and informal team support mechanisms, feeling supported, and years of experience. There was variation in the impact of patient trauma on providers and staff. Positively, providers often found the work rewarding to see patients make improvements, despite having experienced trauma. Negatively, many providers mentioned that hearing patients' traumas could lead to burnout. Existing strategies included employee assistance programs, social and self-care activities, team meetings, and effective leadership, with many participants focusing on the effectiveness of the latter three. Suggestions included increased monitoring of well-being, increased team building, social activities, and trainings on patient trauma, burnout, and ways to manage well-being. This study provides opportunities for researchers and administrators in HIV care to better understand how to prevent burnout among providers and staff. Recommendations include normalizing dialogue on burnout and well-being, encouraging more effective leadership strategies, promoting team cohesion, and implementing trauma-informed care trainings.

INTRODUCTION

Burnout, defined as a “prolonged response to chronic emotional and interpersonal stressors on the job” has been found across nearly every healthcare profession and in a variety of healthcare settings (Arrogante & Aparicio-Zaldivar, 2017; Klein et al., 2020; McHugh et al., 2011; Parola et al., 2017; Rodrigues et al., 2018). Even before COVID-19 brought the topic to the forefront, burnout had become a common experience among healthcare workers. Burnout can put strain on organizations, can negatively impact the health and well-being of providers and staff, and can have detrimental effects on patient care and the trust between patients and providers (Bodenheimer & Sinsky, 2014; West et al., 2018). The annual monetary cost of burnout, due to loss of productivity and turnover, is estimated at $7,600 per clinician, according to a 2019 cost-consequence analysis (Han et al., 2019). By preventing burnout among providers and staff, organizations could save thousands of dollars, and benefit from happier, healthier, and more productive workers.

Burnout includes three dimensions: exhaustion, cynicism, and inefficacy (Maslach et al., 2001). Numerous studies have examined the factors that contribute to burnout, its prevalence across several sectors, and impact, but there remains significant gaps in research. Since the development of the term “burnout” in the 1970’s, theoretical models have evolved from examining personal burnout to including organizational factors. Although research has demonstrated the larger role of organizational and situational factors in alleviating burnout, interventions have been focused at the individual level (Maslach et al., 2001). This suggests a gap between literature recommendations and implementation.

Staff of Ryan White clinics (RWCs), which provide care to over half of the country's population of people with HIV, may be particularly susceptible to burnout. RWCs are often understaffed and under-resourced, and those in the South face increasing patient volumes as they continue to respond to the increasing number of new regional infections (i.e., 19,396 new HIV diagnoses in 2018) (Centers for Disease Control and Prevention, 2020).

Few studies have examined the unique challenges of individuals working in the HIV sector in the U.S., and many of these studies are now outdated (Ginossar et al., 2014; Macks & Abrams, 1992). The nature of HIV care in the United States has changed from palliative care in the 1980s to a focus on primary care and comorbidities associated with aging now in the 2020s (Chu & Selwyn, 2011). Nevertheless, the complexity and difficulty of daily life that many persons living with HIV (PLWH) face (stigma, homelessness, poor mental health, etc.) remain present today. Trauma, defined as an adverse event or series of events experienced by an individual as physically or emotionally harmful or life threatening, and which has "lasting adverse effects on an individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014), is also pervasive among many PLWH. Experiencing trauma has been linked to an increase in mental health problems, HIV-risk behaviors, and not engaging fully in treatment protocols (Whetten et al., 2006). The complexity of serving patients who have experienced trauma, have other comorbidities and chronic illnesses, may serve as additional work stressors for providers and staff (Brezing et al., 2015; Chu & Selwyn, 2011; Gallant et al., 2017; Varkey et al., 2009).

Trauma-informed approaches emphasize incorporation of practices that promote staff self-care and organizational support (SAMHSA, 2014), recognizing that prevention of burnout among providers and staff is critical to assisting patients with histories of trauma. There are six

key aspects of a trauma-informed approach, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). These are: 1) safety 2) trustworthiness and transparency 3) peer support 4) collaboration and mutuality 5) empowerment, voice and choice and 6) cultural, historical, and gender issues (SAMHSA, 2014). In implementing this approach in organizations, many of these aspects involve focus not only on clients, but on the administration and staff as well. In order to build this resiliency, staff and providers must be cared for so that they may provide better care for their patients. While the link has been made to understand how trauma-informed care can help patients, little is understood of how providers and staff could be affected, and what opportunities there are to prevent burnout.

This study aims to contribute a deeper understanding of burnout, factors that contribute to burnout and the role trauma-informed care could play in preventing burnout among providers, staff, and administrators at Ryan White Clinics (RWCs) in the Southeastern United States. Through a qualitative sub-study of a larger mixed methods study assessing factors associated with the implementation of a trauma-informed model of care at RWCs across the Southeastern U.S., our goal was to examine how providers, staff, and administrators of RWCs experience burnout and opportunities to support their well-being. Specifically, the study addresses the following four aims:

1) to understand the factors which contribute to or alleviate stress or burnout for providers, staff and administrators of Ryan White clinics

2) to examine the impact of providing care to patients with histories of trauma on Ryan White (RW) providers and staff

3) to explore existing strategies utilized by RW clinics to support well-being and prevent and reduce burnout, and

4) to examine suggestions from providers, staff and administrators on methods to prevent and reduce burnout in RW clinics

This study is crucial for clinic administrators, team managers, human resources, Ryan White administrators, and policymakers to understand the factors that may contribute to and alleviate burnout and to identify enhancements to existing staff support activities and organizational culture. This study will explore opportunities to break cycles of burnout and form new cycles of support and healing for healthcare workers so they can effectively care for their patients.

METHODS

Study Overview

The present analysis utilizes data from a qualitative sub-study of a larger mixed-methods study assessing implementation of trauma-informed care (TIC) and readiness to implement TIC in Ryan White Clinics (RWCs) in the Southeastern United States. The mixed methods study first involved a survey examining present level of clinic TIC implementation, readiness of TIC implementation, provider and staff burnout, and organizational climate and culture. Surveys were administered to 382 providers, administrators, and clinical staff across 51 RWCs. A subsample of survey participants subsequently underwent an in-depth interview to explore inner and outer context factors associated with TIC implementation. As addressing burnout is a critical element of TIC, interviews included questions examining burnout impact, causes, and prevention strategies, which are used in the present analysis.

Study Setting

The study was conducted at Ryan White Clinics (RWCs) across rural, urban cluster, and urban settings in the Southeastern United States. RWCs are those which receive funding from the Ryan White HIV/AIDS program—a federal program providing assistance with insurance gaps, medical care, and support services for low-income individuals living with HIV. More than half of the people diagnosed with HIV in the United States receive services from the program each year (HRSA, 2016). The United States Southern states account for an estimated 51% of new HIV cases annually and is considered the epicenter of the HIV epidemic (Centers for Disease Control and Prevention, 2020). The RWCs included in this study were from the Department of Health and Human Services (DHHS) Region IV: North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Kentucky, Tennessee. Participants worked at RWCs in rural, urban, and urban cluster locations. Interviews for the present analysis were conducted from March 2020 until February 2021, during the early months of the COVID pandemic.

Participant eligibility and identification

As part of the larger study, individuals working at Ryan White Clinics (RWCs) as clinical providers, support staff, or administrators who completed the web-based survey were eligible for an interview. Clinical providers included: physicians, physician assistants, nurse practitioners, and nurses. Support staff included social workers and patient educators/coordinators/navigators. Administrators were those who provided clinic oversight, including clinic coordinators, program managers, or other administrative/ financial decision-making authority. Each participant indicated on the web-based survey whether they were open to being contacted for a one-hour follow-up interview. Out of those who were interested, attempt was made to diversify

interviewees based on state, gender, urbanicity, and role. Between March 2020 and February 2021, a total of 38 interviews were conducted.

For this sub-study, 20 of the 38 interviews were selected for the analysis. They were selected to represent a diversity of clinic roles to promote a more comprehensive understanding and explore differences in burnout among subgroups. For this sub-study, we limited participants to those employed in RWCs that were academically affiliated, in an urban setting, and working with a primarily adult population.

Participant Recruitment

Recruitment was limited to those who completed the web-based survey and indicated that they would be willing to volunteer for an interview. Participants were informed that they would receive $50 compensation for their time. To those who were interested, an email was sent, followed by a phone call to arrange an interview through Zoom.

Data collection

In advance of the interview, participants were emailed a copy of 'a brief overview of trauma-informed care' to ensure all participants shared a standard definition of practices constituting TIC to inform interview responses.

The interview guide was developed by the Emory Trauma-Informed Care (TIC) team and informed by Consolidated Framework for Implementation Research (CFIR) and SAMHSA guidelines/best practices. CFIR defines constructs identified as important for implementation success, including intervention characteristics, inner and outer setting. Utilizing CFIR allowed us to comprehensively capture multiple factors from many stakeholders' perspectives that could influence an organization's decision to adopt and implement TIC.

The interview guide was reviewed by a clinical and behavioral investigator team and individuals with research expertise on trauma against gender/sexual minorities and was revised to incorporate the feedback. The interviews were conducted by two research assistants (one note-taker and one interviewer) with one participant. The interviews were conducted via Zoom and lasted approximately 1-2 hours and were audio recorded. Research assistants were trained in qualitative research methodology. The research assistants were at minimum master level students in public health. There were four sections of the interview: Clinical Environment, Screening/ Assessment, Staff/ Provider Care, and Planning for Action.

This qualitative sub-study was focused on staff and provider care. The five questions from the guide used to inform the present analysis are listed below (question probes are not listed but can be found in the full IDI guide in the appendix):

1. *In what ways do you think working with patients with histories of trauma in your clinic has impacted you or other providers/staff positively or negatively?*
2. *Do you think staff/provider burnout is an issue at your clinic? Why or why not?*
3. *What strategies does your clinic employ to support staff emotional well-being?*
4. *What resources are available for all staff/providers?*
5. *What suggestions would you have to improve how the clinic supports emotional well-being or burn-out?*

Data Management

After completion of the interview, the interviewer downloaded the Zoom recording to a secure Emory University laptop. The audio recording was then sent to a transcription service, Verbalink or Happy Scribe. A copy of the audio recording was saved and password protected on

the study team Box Drive. Once the interview was transcribed by the designated company it was returned to the interviewer. Transcriptions were saved and password protected on the study team Box Drive. All transcripts underwent a quality check and any identifying information was removed by a study team member. These final transcripts were then saved to a new password protected folder on Box Drive.

Data analysis

The 20 transcripts analyzed for this sub-study were downloaded from Box Drive and imported to MAXQDA for coding. Transcripts were first reviewed in full, highlighting and commenting on themes. A codebook was developed based on both inductive and deductive codes examining themes around causes and prevention strategies for burnout, with some codes being pulled from the CFIR and SAMSHA codebooks of the larger study. The codebook included definitions, use for statements, and examples, and was reviewed with other members of the study team. Transcripts were then transferred to MAXQDA software for coding. A single study team member coded all transcripts for this sub-study. When questions arose around the appropriateness of a code, other members of the study team were consulted and the text was discussed until consensus was reached.

Ethics

The study team obtained IRB approval from Emory University. Each study team member completed CITI socio-behavioral certifications prior to working on the study. A verbal informed consent from each participant was obtained at the start of the interview process. During the interview participants were never asked to disclose personal traumas. They were informed they

could pause or leave the interview at any time. Participants were also reminded that any identifying information would be redacted from the interview transcript.

RESULTS

Participant Characteristics

There were twenty interviews included in this qualitative sub-study (see Table 1). Three participants identified as male and seventeen as female. There were seven states represented: five participants were from Georgia, four from North Carolina, four from Alabama, three from Tennessee, two from Kentucky, one from South Carolina, and one from Florida. All worked at hospitals or clinics with a university affiliation and in an urban setting. Eleven participants worked at a hospital-based HIV clinic, six worked at a hospital-based HIV/ID clinic, and two worked at a stand-alone HIV/ID clinic. The participant role within the workplace varied. Six were considered support staff, nine were providers, and five were administrators. Specific roles can be found in Table 1.

Four major themes were examined: 1) factors that contribute to and alleviate stress or burnout 2) the positive and negative impacts of working with patients who have experienced trauma 3) existing strategies RW clinics use to support well-being and reduce burnout, and 4) suggestions to further enhance well-being, prevent and address burnout of RW clinic staff and providers. A fifth theme emerged from the data—a sense that burnout was experienced "by others" with few acknowledging burnout in oneself.

Table 1

Clinic Role	Gender	Clinic type	State
Supervising Social worker/ Program coordinator	Male	Stand-alone HIV/ID Clinic	KY
Manager/ Center Coordinator	Female	Hospital-based HIV/ID Clinic	AL
Center Coordinator	Female	Hospital-based HIV/ID Clinic	GA
Center/ Research Coordinator	Female	Hospital-based HIV/ID Clinic	AL
Supervising Pharmacist	Female	Hospital-based HIV/ID Clinic	AL
Nurse/ Quality manager	Female	Hospital-based HIV Clinic	GA
Nurse Practitioner	Female	Hospital-based HIV Clinic	GA
Nurse/ TIC educator	Female	Hospital-based HIV Clinic	NC
Nurse/ Patient Care Coordinator	Female	Hospital-based HIV Clinic	NC
Physician	Female	Hospital-based HIV Clinic	NC
Physician	Female	Hospital-based HIV Clinic	GA
Physician	Female	Hospital-based HIV Clinic	TN
Nurse	Female	Hospital-based HIV/ID Clinic	AL
Psychiatric Mental Health Nurse Practitioner	Female	Hospital-based HIV Clinic	TN
Social work team lead	Female	Hospital-based HIV Clinic	TN
Adherence Coordinator/ Health educator	Female	Stand-alone HIV/ID Clinic	KY
Counselor/ Quality Programs Manager	Female	Hospital-based HIV Clinic	NC
Patient Support Specialist	Male	Hospital-based HIV Clinic	GA
Social worker	Female	Hospital-based HIV/ID Clinic	SC
Clinical research coordinator/ Manager of Community Health Workers	Male	Hospital-based HIV/ID Clinic	FL

Factors related to stress and/or burnout

Factors that were protective against stress or alleviated burnout included a flexible schedule and work environment, the opportunity to discuss patient issues among staff, having effective tools and resources available to help patients, tools to effectively manage one's own emotional well-being, years of work experience, and having personal strategies to alleviate stress. Factors that contributed to stress and burnout included time restraints, greater workload, documentation, working in a negative environment, increased clinic time, increased responsibilities outside of the clinic, tension between quantity and quality of patient care, poor leadership, and a lack of effective systems to meet a patient's needs.

Protective and Alleviating Factors

For many participants, having a flexible schedule and work environment, such as working from home, alleviated stress.

"In terms of administrators, though [...] it's a little more challenging because, you know, we have to work within the structure of 9:00 to 5:00, and so like there's sometimes where like we'll go out and test in the morning and like, you know, we'll deal with pretty difficult situations, and then [...] we're back in the office and we have to like kinda just like put that away in the back of our mind and focus on the office tasks. I would say as presently structured, it's easier for community health workers to take the necessary time to recover from- from potential burnout than the administrators"

-Clinical research coordinator/ Manager of Community Health Workers

In addition to work flexibility, several participants mentioned how having venues to discuss patient issues with other staff members was effective in decreasing stress.

"you know, honestly, like a little check-in meeting about all the patients [...] would be really helpful, because then the stress might not pile up so much if you knew that you could share what's going on with the patient and ask for suggestions from the outset."

-Nurse Practitioner

Several participants mentioned that having tools and resources to provide effective care was an alleviator of burnout.

"I do think there's something really positive and anti-burnout about working in the context of the Ryan White program because it's just – it's such a wonderful safety net and I will often sort of feel this like, ah, just knowing – you know, if I see a patient who doesn't have HIV before a patient who does and the person, you know, before that, I'm thinking how am I gonna get this person their IV antibiotics, I can't – you know, how do I get them the care they need, and then I walk into a room with one of my patients with HIV and I think oh, thank God we've got this wonderful program and they can see our psychologist and, you know, we can help them with gas money. And that definitely I think helps with the burnout by providing – by giving us tools to help our patients and that's definitely an anti-burnout element, I would say."

-Physician 1

Years of staff experience was also discussed as being protective of burnout, although many participants themselves were unsure of how or why.

“So, burnout with some of the older social workers isn't as much as what it has been with some of the younger ones […] And I'm wondering if it's just because the older social workers have been there the longest. And they've learned that just like I said they can't take things to heart. If a patient lashes out or is mad it's the situation instead of them being mad at them. So I think that might be part of it.”

-*Nurse*

“[Burnout] is not as common as you would think […] – a lot of times other people will ask, like, what I do, and be like, "That must be really hard," and it's not that hard. And I find that's true with most of my colleagues. And I don't know if that's because we have a good team spirit or we've been doing it for so long or we're delusional or what, but it seems like people cope fairly well.”

-*Social work team lead*

Participants mentioned personal factors that help to alleviate stress, including gardening, talking with a spouse, friends and family, and faith.

“My self-care involves my yardwork, that's how I escape from the realities of the clinic”

-Nurse/ Patient Care Coordinator

“But occasionally it just does become too much to deal with and then I mean I have my husband at home and so I'm able to talk to him to work through some things that I've heard or witnesses.”

-Counselor/ Quality Programs Manager

Trauma-informed care training has impacted some participants and helped them to manage their own well-being and prevent burnout.

"And then I think one of the things that makes… – well, becoming informed about trauma-informed care has actually helped in terms of my own well-being in managing… the downstream effects of trauma on some of our more challenging patients. So if folks act out or have issues with interacting, I have found the trauma-informed care approach to be helpful in trying to maintain empathy and minimize frustration by trying to remind myself, you know, what's happened to this person to bring them to this point in their life. So that's kind of helped me in terms of maintaining my own well-being as a provider but also maintaining an empathetic approach"

-Physician 1

Contributing factors

Workload and time restraints were major contributing factors mentioned by providers, staff and administrators that contributed to stress and burnout.

"I haven't seen any provider like, lose it, essentially because of mental burnout, for lack of a better term, but I feel like we all, at some point, get just overran, or overworked in a sense. You've got 15 patients. You've gotta do 15 notes, but you've got clinic tomorrow with another 15 patients, and that can just be mentally taxing."

-Adherence Coordinator/ Quality Programs Manager

"I would say the on the whole – I do think there are times when workload for sure increases burnout and there are times when though we have MDs that see patients and then we have two nurse practitioners and our PAs. And our nurse practitioners and our PAs definitely have a higher patient load and I do think that they experience burnout quicker."

-Counselor/ Quality Programs Manager

"So from what I hear of the medical providers, it is the increasing demand on providers in a shortened reimbursable time period. It is institutional requirements to meet a specific quota. It is knowing that there are psychosocial issues impacting that person's care, but in 15 minutes, you can't address that and their other ten complex comorbidities."

-*Psychiatric Mental Health Nurse Practitioner*

"And I know sometimes for the providers, it can be just the same, because not only are you trying to see patients, but you're trying to see patients. You're trying to satisfy them, but do it within time restraints so that you're not three hours behind, because the next patient, they're gonna be irate with you when you finally do get them in the room. So I feel like that puts a lot more pressure on a provider – which then can mentally affect them. I mean it can just be tiring sometimes."

-Adherence Coordinator/ Health educator

Some participants mentioned a negative work environment as contributing to stress.

"They specifically brought me in because the turnover was around six months to eight months and there was so much anger and negativity that they needed someone in there that could help turn it around. And it was literally, when I got there, the first week I almost was in tears because we're in a – there's five of us in a room and you would hear a patient call in and they would have significant trauma reactions and challenges and the triage nurse would slam the phone down and cuss 'em out and call 'em, you know, skanks or whores or addicts. […] so it was rough there for a while. […] That's not healthy for any of us and that's not something that I can be in an environment with for eight hours a day"

-Nurse/ TIC educator

Activities, such as paperwork and charting, seemed to detract from the joy of seeing patients, and therefore were discussed as contributing to stress and burnout.

"Certainly the billing and the documentation and, you know, all the things that aren't directly related to patient care detract from the joy of the work, which then leads to burnout."

-Physician 1

"The electronic medical record is the number one cause of burnout in medicine in the country, and certainly in our clinic. We just hate it. It's so time consuming and it takes you away from the patient instead of bringing you closer to the patient, and it's not going anywhere."

-Nurse Practitioner

"Again, I feel like a lot of the reason for burnout is stuff that's structural and beyond – if I didn't have to worry about what insurance someone had or if our politicians could make housing important. If I didn't have to spend an hour getting a prior authorization on medic – just paperwork is probably a part of it, charting"

-Physician 3

Some participants thought that balancing administrative, academic and/or patient care work added to potential burnout.

"I see providers who just in general are going from being on call in the clinics at multiple clinics, maybe both at [hospital] and [university]. They teach classes. They're running programs. They're doing research. They're writing papers. I think that because we work for an academic institution, there's lots of requirements, both academic and clinical, that are required of our providers. And sometimes that is just too much for them to be able to provide good care for their patients and then take care of themselves."

-Nurse/ Quality Manager

Several providers described the tension between quantity and quality of patient care as a contributing factor for stress and burnout.

"There's a lack of understanding of what we do and you know, why we need more time to see our patients, why we can't just churn out 24 a day, you know, because it's not all earaches and you know, strep throat. And forming a relationship with the patients helps keep them in care and

helps them, and you can't form a relationship with the patient if you have to see a patient every 10 or 15 minutes. And I think our clinic, our administrators get that, but sometimes they can't. That message just doesn't – it falls on deaf ears because [Clinic Name] is just always all about the numbers. They want us to see more and more and more, and we're trying to say, "But we're just trying to see the ones we see really well."

-Nurse Practitioner

Poor leadership, organization, clarity of job roles and accountability were described as contributing to stress and burnout by one participant.

"So it's really unorganized, and I think that the lack of organization and the lack of really having active and un-active patients contributes to the frustration and the anxiety and the burnout because they just feel overworked and like, "Well, I'm doing this and this and this. I see myself seeing six patients today, and Suzie over here, she only saw two today." […] From the top down, we need them keeping people accountable, that if your job is to do X, Y, and Z, then they should be accountable to do X, Y, and Z. […] I feel like my burnout personally would be because I pull my weight or do 110 percent and Tim over here can do absolutely nothing and still have his job and get away with it […]. When it comes to, "I'm feeling overwhelmed. I'm feeling that… I don't feel like my work is the same as someone else's," I haven't ever had a response. In the time that I have been there, I have never felt like things got – the other person got talked to or workloads got shifted or anything like that. […] That's what I would think the problem is. It comes from lack of leadership and true organization within the job roles and keeping people accountable."

-Nurse/ Quality Manager

A lack of effective systems to address the entirety of a patient's needs, emerged as a factor leading to burnout for providers and staff.

"I tend to – my burnout feelings tend to be around – more around the bureaucracy of the system and not the patients, themselves."

-Nurse/ Patient Care Coordinator

Positive and negative impacts of working with patients who have experienced trauma

Participants discussed the positive impacts of working with patients who have experienced trauma. These included unifying staff and patients, gratitude, creating deeper understanding and trust in the provider-patient relationship, providing better care, witnessing patient resiliency, and being part of rewarding and fulfilling work. The identified negative impacts included burnout, vicarious traumatization, feelings of helplessness, and impact on home life.

Positive impacts of patient trauma

Participants felt helpful, effective, and validated (i.e. that they were doing their jobs well) when patients who disclosed their traumatic histories to them and they could help them.

"That they were willing to open up to me and tell me their story and they felt comfortable enough for that is reassuring that I'm doing my job the way that I want to do my job. That I am providing care that someone feels comfortable with and that I can move forward with it and that I have the resources so that I can get them connected to the right people is reassuring."

-Nurse/ Quality Manager

"I think, it makes me feel at least a little bit better that they can find in me a person that they can trust to tell, to at least to vent these types of stories, at least that they can see in me someone that they can share their pain with. So it makes me feel useful, like, okay, I've gained this person's trust enough for them to share very painful and sometimes embarrassing and humiliating and traumatic events. […]Because I'm providing care for them, at least I feel a little bit hopeful that they have found in me a person that they can trust."

-Physician 2

Participants also discussed the ways in which patients who have experienced trauma inspired them and that it was rewarding to witness resiliency in their patients. Despite hearing difficult stories and trauma, participants found it rewarding to see patients make positive change in their lives.

"I am just constantly amazed of what experiences people go through. And maybe I have a little biased perspective because, again, I work with people, some often that want to volunteer and they want to give something back, or they want to serve on the patient advisory board. But really seeing that resiliency, especially – well, it's nice to even see it at the very beginning. When you see someone that comes in getting tested and they're just so distraught and all the things they are. And then see them three months from now and they're like, "Yeah, it's undetectable and da, da, da, da. I have housing now." So those stories are great. And then people, the long-term survivors and just what people have been through. Like, they're amazing."

-Manager/ Center Coordinator

Another positive impact of working with patients who have experienced trauma was that it was unifying for staff and patients. Participants discussed how those difficult stories can pull people together.

"The other thing is, is that it is a way of unifying, I think, some of our staff. I spend a fair – not a huge portion of every day but some portion of every day interacting with social work about patients that I am working with that are dealing with trauma. We all kinda work together, and so I think it kinda helps us in our working relationship. We teach each other, we learn different things about patients, like patients may tell me one thing and share different stuff with the social worker. So I think it calls on all of us to pull together."

-Nurse/ Patient Care Coordinator

"Well, for me, positively it is, you know, being able to see how we're all interconnected and help each other...at different points in our lives through different things"

-Nurse/ TIC educator

Other participants discussed gratefulness and how working with patients with histories of trauma fosters a sense of gratitude over personal good fortune.

"Ways that I've been positively affected is I am constantly aware of how good I have it in life and that might be a weird thing to say, but when you're working with people who are so traumatized

and who have such hardships in their life… to realize that, it gives me a sense of gratitude that I think I probably wouldn't have if I didn't have this job."

-Nurse/ Patient Care Coordinator

Participants also described the way that working with trauma shapes their understanding of disease and clinical history.

"So on a positive note, I think it is incredibly gratifying and rewarding to work addressing medical issues under the understanding of how trauma impacts that. So not just thinking of it as treating someone's, you know, diabetes, or their syphilis, or whatever it may be, what the kind of backstory is to that. So I think it's really, it's a very rewarding working population."

-Psychiatric Mental Health Nurse Practitioner

"So… from my standpoint, it's positive most days. […] it's taught me to listen more and maybe not necessarily ask more questions, but understand a patient more, or to look at things a different way, or maybe from a patient's point of view."

-Adherence Coordinator/ Health educator

For some participants, a positive impact of working with patients with histories of trauma led to greater understanding of a patient's background and therefore informed and influenced socio-political views and voting preferences as well.

"It also changes, or it should change – your professional experiences should change your political views, and how you vote. So I think that one positive is that when I go to vote, it is with real faces that are impacted by these policies far more than my life will ever be."

-Psychiatric Mental Health Nurse Practitioner

One physician and educator mentioned the positive impact that being exposed to a patient's trauma had on education of trainees.

"Certainly when we have learners present I think it's really positive from an educational standpoint because then they can see, one, I mean they can hear the stories, and two, they can start to learn how to engage with people who have experienced trauma and so that then they can take on an awareness and hopefully start, you know, learning some skills to carry with them. That's very positive."

-Physician 1

Negative impacts of patient trauma

Burnout was discussed by providers, staff and administrators as the primary negative impact of working with patients who had trauma histories. Hearing people's difficult stories for some providers was a painful and stressful experience.

"*Sometimes I use the analogy of I feel like a sponge that is completely soaked, and can't absorb any more fluid, and just wring me out, you know? I think a lot of us feel that way at times when*

we come home to our families. You know our world is we're just so emotionally exhausted from hearing the stories and seeing the lives of our patients. Sometimes it's just really painful."

-Nurse Practitioner

"Negatively I think burnout is a huge issue. I'm sure everybody talks about that. And, yeah, just being frustrated with our society causes anxiety, political [stress]. So, yeah. I mean, definitely stress, anxiety, burnout."

-*Physician 3*

"I think it's much harder for staff [than administrators] … to encounter [stories of trauma] on a daily basis. […]. I mean the negative would be burnout. So we have a lot of patients who have so much trauma, so many things that they need help with that after a year or two of a provider or a caseworker working with that patient it's kind of difficult to put everything you have into it […] when you have just seen failures or extremely slow progress over that time. So I'd say burnout is the main negative consequence."

-*Supervising Social Worker/ Program Coordinator*

Participants' perspectives varied in how much impact patients' trauma had on provider and staff burnout.

"I mean not surprisingly I think it can cause a certain amount of vicarious traumatization, compassion fatigue…, burnout…, frustration, kind of all the things that one would expect."

-Physician 1

On the contrary, other providers thought patient trauma had minimal impact on staff and provider burnout. Instead, they discussed that the burnout resulted from not being able to meet a patient's needs around trauma support. Participants discussed how the frustrating aspects of working with patients with histories of trauma only arose when they could not fully help a patient.

"For me personally, it might be traumatizing to hear at the moment, but I always feel like it's – I've never been left where I felt like I've been in a bad place afterwards because the only time I ever feel worry or angst or frustration about it is when I can't make those connections and I don't feel like the patient's gonna get what they really need. Then I start to worry and get frustrated."

-Nurse/ Quality Manager

"So I don't think burnout is related to patients', you know, trauma, itself. […] It's just what happens when you do clinical care day in and day out. There are many times that patients send me messages about things that I cannot fix. So, for example, their Social Security was denied, or they're homeless now, and their [citywide program] is going nowhere. I cannot fix those things, yet, I still feel responsible."

-Physician 2

"The burnout isn't so much about [patient's trauma/ emotional exhaustion] as it is about systems."

-Nurse Practitioner

Participants mentioned that a negative impact of working with patients with histories of trauma often resulted in them feeling helpless.

"I think the hard part is also feeling very helpless a lot of times with some of the things that our patients are dealing with and going through and wanting to be able to fix it sometimes and there just not being a good fix for everybody all the time. […] And I think that watching people struggle and still seeing people die when they don't need to, but you know, that's – it's almost harder when you know that they could live long, productive lives. But I think some of our patients don't want to live a long life because their lives are so hard. And so trying to figure out how to – what to do, you know, and how to help people in that situation sometimes it's exhausting, and there are weeks where I just am weary when I go home with just the feeling of helplessness. And it's just like the whole situation in our country right now in my opinion, so it's like the whole like inequality/ inequity that's out there and feeling like there is no way we can fix that. I mean, you know, I can't, you know, individually fix that. I can do the best I can to try to help people as much as possible but I can't fix that problem. One of our doctors said one time about a patient who had so many struggles and she said, you know, she needs a life transplant, and we can't do that. So –."

-*Nurse/ Patient Care Coordinator*

Another negative aspect of working with patients who have experienced trauma that was mentioned by several participants was vicarious and secondary trauma, emotional exhaustion, and taking on the burdens of their patients.

"The negative is the secondary trauma and the compassion fatigue. That is very real amongst people who I see you know working alongside me. And in myself. […] It is knowing that there are psychosocial issues impacting that person's care, but in 15 minutes, you can't address that and their other ten complex comorbidities. Personally, it is emotionally taxing, and at times draining to work with complex trauma as a clinician, and to carry that space and that weight for other people and not be affected by it."

-Psychiatric Mental Health Nurse Practitioner

"It's impossible, at least for me not to take these things personally, meaning, you know, someone tells you, you know, these horrible experiences, it's just hard not to feel their pain as well. It's horrible […] you know, it bums me out."

-Physician 2

Lastly, some participants briefly mentioned that the emotional exhaustion from working with patients who have histories of trauma often had a negative impact on their home life.

"In the negatively I think we all take some things home with us."

-Nurse

"Sometimes I think we all go home and we feel like we have nothing left to give"

-Nurse Practitioner

Existing strategies utilized by clinics to support well-being

Providers, staff, and administrators discussed how regular team meetings were an effective existing strategy to support emotional well-being. These meetings served different functions for different people.

Some highlighted the importance of encouragement and appreciation.

"So early when COVID started to happen, we started meeting twice a week in what we called COVID huddles. And I think, initially, it was just to provide education, and like, okay, this is now the screening protocol, and this is where people can go to get tested and all that kind of stuff. But I think a month or so into, we realized that oftentimes what we were discussing was just the uncertainty and the fear that we were carrying. And that impact on us. And we've kept on doing it because it's just kind of nice to have 30 minutes twice a week to come together and pat each other on the back and say we got this. So that's been great."

-Psychiatric Mental Health Nurse Practitioner

"We do have huddle every morning, and they do kudos every morning to try to um recognize those who do something good"

-Nurse/ Quality Manager

Some participants appreciated the opportunity to get to know coworkers better through meetings.

"I know at our staff meetings, every staff meeting, once a month, they will highlight a different group within our clinic. You know, whether it's the front desk staff, the nursing staff, the dental staff, whoever it is, and kind of tell you some things about them, like fun facts about them. You know, their background, like where they graduated from, how many years they've been there. Just to kind of let you get to know people a little bit better? Getting to know each other, I think helps a lot."

-Supervising Pharmacist

Other participants mentioned the ways that team meetings helped providers and staff to have a space to vent or to trouble-shoot and discuss difficulties.

"We also encourage them to talk. You know, whether – during your staff meetings, we're encouraged to leave, like, you know, about 15 minutes or 20 minutes or so, so people can express like, what's going on. How do you feel? And we as a group can understand each other better, and it adds a little bit more. We also have managers' meetings, which actually I had one today, and we're able to talk to each other as managers and supervisors on issues, and help each other out with issues, whether it be staff issues, patient issues, whatever, and so that has helped. And they give you know, other people give you different strategies."

-Center/ Research Coordinator

"…once a month we would have sort of like a venting session and one of our clinic psychologists would be present to help us just kind of talk through like working with personality disordered patients and boy, how tough is that."

-Physician 1

Ensuring opportunities to build familiarity within staff, such as regular check-ins and one-on-one meetings seemed to be an effective strategy for early recognition of burnout.

"Usually its, honestly, the best way to describe [how people experience burnout] without going into full detail is the person's personality. And their behavior change. […] So you know that person's mannerisms and their behavior, and temperament. You know you have some you know, like I have one of my staff members. I love her to death. She has a very bubbly personality. So if I say, "Hey, good morning," and she says, "Hi." That's not her. So at that point it's to inquire, you know, and that was the training that we also had as the trauma-informed supervisors, that we had to make sure we support our staff."

-Center/ Research Coordinator

"In every one-on-one I find out kind of what's going on with them or if I notice that there's maybe – I recently noticed one of my team is not as engaged as she was and she was just feeling really overwhelmed"

-Social work team lead

Many participants mentioned how much they enjoyed social activities, both inside and outside clinic, to support well-being.

"The happy hours, the social events do help more, though, I think, because it's kinda like – I don't know, it makes it feel more like a team than just a workplace sometimes"

-Clinical research coordinator/ Manager of Community Health Workers

"We usually have, like, 'outside, go somewhere' things that we do. We've done everything from volunteer in a soup kitchen. We've done food bank, where we bag up food for people. We've done things like go out to lunch together, you know? I try to do things like that or something fun […] so that they can have time together, and that's away from here, so we might take a half a day or a whole day away from here. And we're still at work because we're together, but you know, it just helps."

-Center/ Research Coordinator

Several participants mentioned a retreat, or getting off the clinic site to relax with other coworkers, as a previous strategy to support well-being.

"Back in the day before I was there, I know this would never happen now, but apparently they used to close the clinic once a month. And the whole staff would go up to North Georgia and just spend the day you know, picnicking on somebody's property that had a place up there. I'm not saying that that's very realistic, but just the occasional, you know, sort of all staff just rest and

relax together kind of thing I think would be bonding. We've done a couple of those for an afternoon."

-Nurse Practitioner

"They have tried to plan a retreat, a um staff retreat just to have some fun time together without having to see patients. Actually, it was planned for right when the whole corona thing happened, so we didn't get to do it. But I think they're gonna pick it back up when we get back. But at least they were planning it and thinking about it."

-Nurse/ Quality Manager

Participants also mentioned the positive impact of food at social activities.

"We celebrate a lot of birthdays and have a lot of food and parties within my staff trying to … it makes everybody very happy."

-Supervising Pharmacist

"We do have periodic gatherings that usually include some kind of food [laughter] to just spend time together usually around the holidays"

-Nurse/ Quality Manager

Other existing strategies that RW clinics used to support well-being included group self-care activities, such as yoga and meditation. Access of and effectiveness of these activities had varying responses.

"Thursday, they have like a what they call mindfulness meditation, where right before work starts on Thursday, like at 7:45, they have a meditation slash- I guess prayer, whatever it is you want to do for the first 15 minutes of the day before things get started at 8. They've done many, they've tried to do, you know we've talked about [well-being]. You know, ways that sort of implement more of that, more self-care or more sort of activities where people can get to know each other better"

-Supervising Pharmacist

"I mean they're great about setting things up for providers, meditations and yoga and you know. We know that you're stressed. We know that it's hard to do this job. Let us help you, but nobody has the time to do it"

-Nurse Practitioner

"In general, the whole like self-care modules, whatever webinars, it's kind of B. S. in general, like, not only like in the clinic. It's just… I don't know besides allowing people to work from home, I don't really know that a mindfulness webinar would really help when you're actually just overworked and need a break."

-Physician 2

While not an official strategy, informal team support mechanisms seemed to be a powerful tool for many staff members' sense of well-being. Some administrators discussed intentionality of this strategy, and others described how it occurred naturally.

"It took me a lot of trial and error to have a realization that if I take out the first 20 minutes of my day, instead of going to my office, turn my computer on and start working, that I go to each one of my members and say, How was your evening? What is wrong with you? How was your weekend? Even the small talk to just get them engaged, each one of them individually, and that has changed things, because they know I'm here."

-Center/ Research Coordinator

"I would say just the fact that we generally care about one another and support one another when we're going through something, that it even though it's not a formal strategy, we do a really good job of being there for one another if we need to."

-Supervising social worker/ Program Coordinator

Some participants mentioned that this informal support with co-workers was so strong that they felt they did not need to take advantage of the other institutional support strategies offered.

"We do have just kind of our own counseling kind of deal, support group that we can take advantage of if we want to or feel like we need to. That's offered. I'm not sure who's taken

advantage of that because like I said us nurses just kind of take care of each other. […] But, you know we're even, we're close enough that even on holidays we have a group text where we, you know, send out the holiday well wishes and birthday wishes and all that to each other. And we keep up. You know, we're a close-knit group."

-Nurse 1

Leadership was a theme brought up by many participants. Leadership who set a good precedent for self-care, who showed appreciation for staff, and who provided a team approach were effective at promoting well-being.

"…it takes not just me but also my manager who, you know, did go and get the trauma-informed care training, and then our medical director, you know, setting that precedent that this is not just about the patient, this is about our well-being, so that we can continue, you know, to be here for ourselves, for our families, for our patients, for our community."

-Nurse/ Trauma-informed care educator

"I think our clinic leadership is really outstanding. That's part of the reason I've been here for so long, too, is I think there's just some really outstanding leaders that practice what they preach. And our physicians are really great and easy to work with. And I think we have people who are supportive of staff around here. I mean, I've always felt valued. It's a hard job, but I've always felt valued for what I've done."

-Supervising Pharmacist

An administrator discussed how important the team approach was to effectively working together as a team and reducing burnout.

"I've done a lot of leadership training; John Maxwell's my favorite leadership trainer. And he talks about the team approach, you know, having everyone buy in. So, that's my most – and I think since I have employed that, my staff has gotten much more cohesive and work as a team, and he also says that the leader should not always express that they're the leader. So they know that I'm their supervisor. They know that. I don't have to always say that. And then they have to also know that their leader and their supervisor are always willing to help. So, you always have to be willing to be there."

-Center/ Research Coordinator

Flexibility of taking time off when requested, especially for mental health days, was an effective strategy in supporting well-being for some support staff and administrators.

"I've had staff members who've just, you know, literally text me that morning and said, "Look. I need a mental health day." And we say, "Yeah," because you wanna make sure that your staff is healthy to be able to help the people that they need to. I'm really grateful that the people here understand when someone says, "I need a mental health day."

-Center/ Research Coordinator

“I will certainly encourage my team that we get three personal days a year, but like if you need to take it as a mental health day, or you need to take a sick day as a mental health day that that’s strongly encouraged.”

-Manager/Center Coordinator

Gaps in existing strategies

Participants mentioned appreciation of meetings as an existing strategy to promote well-being but mentioned them as a thing of the past. Trouble-shooting and the space to vent was an important part of team meetings, and they expressed some regret over not having the space for those things anymore. Additionally, some participants also did not feel supported by their administrators in having these meetings.

“I mean we have case presentations sometimes, like if you have a difficult case and you don't know what to do with them medically – usually it's medically. We can have provider meetings where you can present your case and then ask for ideas. So, we do have that, but it's not been as common lately, and we used to have it in sort of an administrative meeting every month with the clinical staff [...] Sometimes it was a bit of a bitch session, but a lot of times we addressed things and said, "How can we fix this?" or, "What we can we do with this?" or, "This is a problem." And we haven't been doing those in a long time. We've mostly just been having didactics at our time together[...] we have sort of lost the time where we can all kind of just talk about how we're doing and what's messed up in the clinic and what's not. I mean from a provider's point of view, those meetings were essential. I think the administration got really sick of it, because it wasn't fun to hold those meetings, and I think that we're a lot less trouble to the administrators

now that we don't have those meetings, because they don't have to listen to us talk about that stuff, to be honest."

-Nurse Practitioner

"We've also had in the past – it didn't last very long, but it was I thought it was a useful– time well spent. We have case conferences where we review specific HIV cases and it was similar to that but it was more a time for providers and staff to voice feelings of being overwhelmed or feelings of burden and so it was like a safe space for folks to come together and just to express like frustration or to vent. It didn't last very long but it was nice."

-Counselor/ Quality Programs Manager

Participants discussed the need for more venues to openly discuss issues surrounding burnout.

"I think we need to talk about [addressing burnout]. I think the biggest barrier is admitting to it. You know just talking about it. Without feeling, as if you're not doing your job or whatever, I just think that that's something healthy to talk about. The only barrier I see is, it not being discussed."

-Center Coordinator

Despite leaders encouraging well-being, some participants discussed how it is still up to individuals to practice it.

"…nurses seem to be the holdup. This is just an insight that I've had over the years that nurses, nurse assistants will not take care of themselves and do what they should or that the leaders encourage them to do. There is always a, well, I'll be viewed negatively or if I do that then I'm gonna come back and have double work or they see themselves as not valuable if they don't just put in straight eight hours. And I will say I'm bad to do that myself. My family gets onto me, where, you know, I'm an hour ten and they say did you go eat today, and I'm like no, I didn't."

-Nurse/ TIC educator

One participant mentioned feeling appreciated but seemed to suggest that more intentional or cohesive strategies could be employed to support well-being.

"Our office manager always made us feel appreciated, absolutely, but when they're being, like, cohesive and doing a retreat kind of thing just to have a mental time, or just a mental shutdown, a breakdown, no, we didn't."

-Adherence Coordinator/ Health educator

Others discussed poor leadership modeling, not feeling supported by the administration, and the difference in priorities and perspective between leadership and staff regarding effective strategies for promoting well-being.

"Our director is the most hard working, dedicated person you can imagine, but he also works like maybe 80 hours every week. He's a poor role model. [He is] healthcare over taking the mental health days. So I do think that, again, it's, the dedication model is there. And it's not like

he won't encourage it of other people, but I know sometimes I've felt like, "Okay, well my boss is doing this." And I'm already like a hard worker, but –"

-Manager/ Center Coordinator

"It's like- it feels like right now especially, but for the last couple of years that things just kind of fall on deaf ears. They have their own priorities, and that's what their priorities are. And if you're the squeaky wheel, you're just the squeaky wheel. You don't necessarily get greased. That's how it feels."

-Nurse Practitioner

"Because the leadership and the majority of the folks in the hospital are not trauma-informed, they are running in circles trying to put out fires with, you know, your kitchen sink water and not realizing that they're not getting to the root and it's just causing us to repeat cycles of, you know, staff being overwhelmed, patients not being seen, staff not being heard, you know, staff reacting to patients' trauma as a personal [inaudible] and then it becomes a workplace violence issue. And then that gets escalated – and it's just a repetitive cycle and it needs to be changed."

-Nurse/ TIC educator

A Nurse/ Quality Manager talked about differing perspectives between staff versus administrators around staff being supported in the clinic:

"Oh, yeah. I would say the majority of staff would say that we are not supported. They [administrators] would say, "Oh, yeah, they are greatly supported."

-Nurse and Quality Manager

When asked about task sharing and reducing patient load as strategies used by the clinic to promote well-being, responses to the use of these strategies were mixed.

"So I had a navigator come to me a couple of years ago who was expressing burnout and feeling overwhelmed. And so we were able to shift some of his work load so that it wasn't so heavy in clinic and then we referred him to the employee assistance program so that he could get additional support."

-Counselor/ Quality Programs Manager

One participant stated that they did use some task shifting and job sharing among patient care providers, but that reducing patient load was not within their control.

"So, for example, the patient care load stuff is way above our paygrade. We get 15 minutes with a return patient, and a lot of times at least two-thirds of the time we're their primary care doctor"

-Physician 3

Another participant discussed why role shifting was not an effective strategy for them, but it was for other clinical staff.

"For me personally, no, [role shifting] never happens. There's just some of us within the Ryan White team that I feel like our role is very specific and we know how to do it and no one else has

been taught to do it. We're each supposed to have a backup person, but really that backup person doesn't know what to do, so they can't back us up. So that is false for the Ryan White team members. I think within the clinic, when it comes to nursing or if someone's out, they do shift, rearrange, and take different roles. They share responsibilities so that we have nursing patients that come in just for regular routine checks of STIs or getting a vaccination and their doctor just says, "Make a nurse appointment." So instead of one nurse always having that responsibility every day of the week, one nurse is assigned a day of the week so that that responsibility is shared. They…If somebody is out or feeling overwhelmed, they usually do try to accommodate and rearrange."

-Nurse/ Quality Manager

In response to task shifting and reducing patient load as a strategy for promoting staff well-being, some providers felt supported by their clinic leadership, but not by the larger administration.

"I think that our clinic administrators do their best to advocate for us, but I think that the problem is larger than our clinic. I think it's at the big, high, administrative level, at the main, you know, at the top of the health system"

-Nurse Practitioner

Participants also mentioned resources available for staff to help promote well-being, including the employee assistance program (EAP), counseling, and other resources offered by

the university or institution. Opinions on effectiveness and usability of these staff support outlets as strategies for well-being varied. Some participants stated that they used the resources, others were aware of them but did not use them, and others were unaware of what resources were available.

"So again, a lot of the [university] resources as far as the employee assistance program, as far as the general wellness programs that exist. And then, again, the support group that we have at the clinic. All those things are available. And it really depends on each person sort of whether they need those, or they feel like they have time to take advantage of them, but I would say they're certainly encouraged."

-Manager/Center Coordinator

"I started seeing a therapist through our EAP during this. And, that's been wonderful"

-Psychiatric Mental Health Nurse Practitioner

"I know there's a counseling hot line and there's counselors available through [university] for staff members, and we have been encouraged to use them if needed"

-Nurse/ Quality Manager

"I'm sure there's some [resources] offered, but what they are, I have no clue. And I mean it's just something. It's not that I don't care. It's just not something that I would utilize, essentially. So if those resources were put out there, and I'm sure there are plenty of them. It's just not something

that I'm familiar – made myself familiar with. Like, I know that [university] offers, like, counseling in a sense, like six visits just with – I don't even think they're a psychologist, but like a CSW (clinical social worker) or something along those lines that they offer, like, as a sounding board kind of."

-Adherence Coordinator/Health educator

"I mean, well, I'm clearly a talker, so you know, I do find it helpful to talk with colleagues and friends and kind of debrief. But I don't take advantage of like any of the formal institutional programs – I guess I have my own outlets outside of those settings."

-Physician 1

"I would say that – because even like with the mental health counseling that's offered through the university, it's still a day out of the week that you kinda have to put aside for that."

-Clinical research coordinator/ Manager of Community Health Workers

Some administrators mentioned university level resources as a primary strategy and others mentioned university level resources as a place to go if staff did not want to find support from within the clinic group.

"So there's dieticians, smoking cessation, there's a gym that you can enroll in and all these health classes like yoga. They also do mindfulness-based stress reduction classes and things like that that are offered either for free or like the gym membership is $7.00 a month and it's brand

new, really nice gym. And so there's a lot of things like that that we can leverage without having to do something within our specific department."

-Supervising social worker/ Program coordinator

"[The university hospital] as a whole has our resource centers, our Patient Resource Center, which has – it's fully staffed with therapists, counselors, psychiatrists, and where our supervisors encourage that if someone's having home issues or something like that, to go talk to them if they don't wish to talk to us. We also encourage them to talk. You know, whether – during your staff meetings, we're encouraged to leave, like, you know, about 15 minutes or 20 minutes or so, so people can express like, what's going on. How do you feel? And we as a group can understand each other better, and it adds a little bit more"

-Center/ Research Coordinator

Several individuals thought the available resources for addressing well-being were in excess and not addressing the underlying causes of burnout.

"So there are plenty of resources. We have the employee assistance program, […], we have a huge chaplain team, we have peer advocates. You know, we have our internal folks that have always open doors and say if you want to come to us to vent. I don't necessarily know that there are preemptive strategies, meaning let's think in advance how to take care of ourselves. It's more of a reactive. Once there is something that bubbles up, it's, oh well, we need to attend to this"

-Nurse/ TIC educator

"[The university hospital] provides a lot of workshops and WebEx on topics like this. There's a big abundance of them. Sometimes too many to me. So I think those are in place."

-Patient Support Specialist

"One of our social workers has like a meditation thing at least once a week, where – it's like a meditation session almost, it's like a brief like 15-minute thing, but a time where people can kinda come back and do a – usually she likes to use the Calm app and just will do a meditation with that. We don't do enough, to be honest with you, to try to –. There are also things that the hospital offers itself for emphasizing self-care, different groups that meet, different exercise programs, things like that, that they offer."

-Nurse/ Patient Care Coordinator

One particular strategy for promoting well-being was having self-care coaches; this participant stated that there could be more resources put toward this initiative.

"And I think it's a great idea, they go around to teach you how to self-regulate, how to take breaks, if you're working at a desk how to not end up with carpal tunnel, you know, whatever. Um But as with almost anything in a large institution, if you only give five or ten Best Health coaches to 17 to 20,000 employees –."

-Nurse/ TIC educator

Suggestions to further promote well-being

Participants suggested more opportunities for team bonding as well as meetings to discuss patients as ways to further promote provider and staff well-being.

"I think – and this is something that we've been trying to do and we haven't done it yet, but I think having like team meetings to – as a group with nursing and social work, especially, to problem solve together certain patients who are struggling more than others with trauma and with the way they're dealing with trauma and their healthcare would be helpful if we can ever get that undertaken. And a lot of the abilities that interfere with that is just time."

-Nurse/ Patient Care Coordinator

Several participants discussed the ways in which they would like their clinic to promote well-being in more preventative and proactive ways, instead of providing resources after staff were feeling burned out. Some participants mentioned doing this through more structured self-care at work.

"Maybe we just need to be a little bit more proactive in looking out for staff. I mean we look out; you know we are focused – we're client focused – making sure that we can find services for our clients but not staff focused. I guess being more proactive in trying to see if there are resources out there may be the answer, I guess."

-Center Coordinator

"I wish there was an appreciation and recognition of that [emotional] toll. And that self-care was something that is built into our work week and is recognized that it is our job to take care of ourselves so that we can take care of others […] I would venture to say that everyone agrees that we should have time built into our work schedule to take care of ourselves. Just like we do, continuing education, there's time built into my schedule to, you know, expand my professional, [inaudible] you know […] I mean I would start just like I think we should have a bit more of a European framework for vacation and time off. I think studies show that you're a better professional because of that. But that's - I would suffice with just being able to go to therapy once a week [laughter] during my work hours."

-Psychiatric Mental Health Nurse Practitioner

Another participant suggested more on-site support to promote well-being.

"I think we probably could offer more available times for our, you know, on-site like support, peer support, among us. So because mostly it's during lunch. So and a lot of us end up working during lunch and eating at the same time."

-Nurse

"I think we probably need to have um some more structured self-care within our clinic 'cause we don't have that."

-Supervising Social Worker/ Program Coordinator

Some participants suggested taking mental health days to promote well-being, but continued to suggest the cultural reasons that make it difficult to do so.

"*I mean, I think everyone needs a mental health day here and there. I think we're in healthcare very much, at least before COVID, you go to work every day even when you're maybe not feeling well physically or emotionally. I think it's cultural. And people don't want to put things off on their peers."*

-Physician 3

Participants suggested improving well-being by changing organizational culture; taking the responsibility off of the individual and sharing it among the organization.

"I think we need to do – like one thing we're interested in doing more with our trauma informed stuff is really more like trauma informed supervision, so that's going to be a part of some upcoming training for our leaders and managers. I think I would like to see more organizational care, so the sort of responsibility isn't all on the individual. And what that exactly looks like I'm not sure, but that is more sort of "shared care" I guess, if you will."

-Manager/Center Coordinator

"And so if they could expand [self-care training resources] and make it a culture of we want to take care of us, I think that would go a long way."

-Nurse/ TIC educator

Culture was another overarching theme that was expressed as a barrier to addressing burnout.

"Sometimes just if we get so bogged down in our – as a supervisor – stuff to do, and not noticing. So, I think the biggest barrier is, like, what do you call it? Your head in the sand kind of thing? And you're not realizing the other people around you? And then another barrier is that people don't feel like they can talk to somebody, and they don't wanna express their thoughts and opinions, so you always have to have an avenue or an environment that will allow that person to express their true selves."

-Center/ Research Coordinator

Participants also discussed a desire for capacity-building, such as team-building experiences and trainings on how to manage trauma, in order to better promote well-being and address burnout.

"I think, you know, maybe having some guidance from the psychiatrist that works with our patients, and this is what they're working on, it hasn't really started happening yet, but having periodic times to have that person help train us, you know, how to deal with our emotions and feelings around working with patients who have trauma. Some, you know, just some helpful things that we can do when we get to feeling burned out and frustrated. I think that having that option for staff would be helpful."

-Nurse/ Patient Care Coordinator

"I would like to have some sort of regular um…retreat or teambuilding exercise or something like that within our department that shows a regular, dedicated focus to um…self-care or caring for our staff, something where we are at work but are not working and we're taking care of ourselves as a team."

-Supervising Social Worker/Program Coordinator

"I think it should be standard training or like a staff – what's it called -- like team building, something like that is mandated. And something that again, I mean similar to the trauma-informed care, I don't think it should be something that you breeze through in two hours or half a day. You know maybe some sort of a retreat like a, you know, a Thursday-Friday kind of thing where you're learning valuable steps to guard your own emotional well-being."

-Counselor/ Quality Programs Manager

Active monitoring of well-being was suggested as a method of preventing burnout and supporting emotional well-being.

"I would just think doing more check-in […]. Maybe monthly – not monthly, maybe but quarterly, have staff fill out assessments on just how they feel and their experiences. I don't think that's done enough."

-Patient Support Specialist

Increasing time with patients and increasing staffing was a suggestion on how to improve well-being among staff and providers.

"If we're able to get more staff then that opens up more time for everyone to be able to- to get better trained, and also it helps- it would help them personally get less burnout."

-Clinical research coordinator/ Manager of Community Health Workers

"I think that—I mean a big thing would be giving us more time per patient encounter, at least for me. I feel like, you know, that would just be huge… to not feel that time crunch."

-Physician 1

Besides offering suggestions for promoting well-being, participants also discussed time constraints and workload as barriers to implementing other burnout prevention strategies.

"The institution does offer trainings for provider burnout. I haven't attended one of those and a lot of that is just I mean due to workload and it's difficult to schedule the time to attend those types of trainings."

- Counselor/ Quality Programs Manager

A flexible work environment and flexible schedule was a helpful tool for some providers and staff to prevent burnout.

"A lot of the work – some of the work can be done from home and I think that in terms of mental health and preventing burnout um, it would be helpful for our staff to be able to do that more often. […] it kinda limits the given stressors of just having to go into the office sometimes and it allows you to just like work in a more relaxed state."

-Clinical research coordinator/ Manager of Community Health Workers

"[Burnout is an issue at the clinic], but it's not for me"

An additional finding of this qualitative research was that many participants discussed how "others" were experiencing burnout, while few discussed their personal experiences of burnout. This resulted in varying opinions over who was experiencing burnout and why. Despite expressing significant emotional exhaustion, cynicism and inefficacy (components of burnout), some participants stated that they themselves did not experience burnout.

Participants mentioned noticing psychiatrists, nurses, and social workers getting especially burned out.

"We have psychiatrists that are designated to see our patients and they seem like they get burned out."

-Center Coordinator

"I think [social workers] feel overworked and burned out… I think that is true of most of our social workers"

-Nurse/ Quality Manager

“The nurses just because, I mean, they're just dealing with enormous amounts of patient requests and constantly – I think they bear the brunt of when patients are upset and feeling like their needs aren't being addressed. Then the mental healthcare team, I don't know, just 'cause of even more, again, just difficult situations I guess, difficult patients”

-Physician 3

Some participants mentioned that providers who spend a lot of time in clinic experience more burnout.

“We have one provider who is in the clinic five days a week. All the other providers are only there maybe one or two days out of the week. And that particular provider is very busy. He's there five days a week, and I think he gets burned out.”

-Nurse/ Quality Manager

“I think for APPs, in particular, that are there all day, every day, five days a week, it’s just a lot. It’s a lot of clinical care […] And that’s just me being in clinic once a week. Imagine what it must be for people who are there five times a week, and I bet you guys are on interviewing APPs that are doing clinical work as full-time. So I bet you’re gonna get answers from them much better than you’re getting from me.”

-Physician 2

In contrast, an APP, claims to not be experiencing burnout.

“[Burnout is an issue at the clinic], but it's not for me, and I think I can speak for… many of my colleagues.”

-Nurse Practitioner

DISCUSSION

The participants of this study have highlighted the need for prevention of burnout among providers and staff in RWCs across the Southeastern U.S. Burnout prevention may be of particular importance in the unique context of HIV care, where patients have higher rates of comorbidities and higher rates of trauma (Brezing et al., 2015; Cuca et al., 2019; Gallant et al., 2017). Further, Ryan White clinics are often poorly funded and short-staffed. Studies on burnout in the HIV sector in the U.S. are limited and outdated, and this qualitative study is vital to elevate the voices of those who care for people living with HIV (PLWH).

Figure 1 (see below) represents the main results of this study, including factors that contribute to burnout, factors that alleviate burnout, and strategies and suggestions to address and prevent burnout. Overall, the factors alleviating and contributing to burnout were consistent with other research, which has demonstrated that poor organization and increased workload contribute to burnout whereas positive relationships and teamwork can alleviate burnout (Berlanda et al., 2020).

Additionally, our results demonstrated that factors protective against stress and burnout included team and leadership support, being equipped with time, tools and resources for effective care, having personal coping strategies, and greater years of experience. All these findings have correlated with prior research (Berlanda et al., 2020; Cull, Frintner, Starmer, & Leslie, 2019; Friedberg et al., 2014; Maslach et al., 2001).

Factors that contributed to burnout included systemic, organizational, clinical and personal factors. Some participants experienced stress and frustration from working in broken systems and seeing politics of inequity (such as homelessness) play out in their patients' lives.

This was exacerbated by an inability to fully meet a patient's needs or provide them with the tools and resources for their success. Factors most frequently discussed were at the organizational level. The tension between quantity and quality was brought up by many participants, especially providers, who seemed to have more pressures placed on them, such as needing to meet a certain patient quota. At a clinic level, not feeling supported by supervisors, working in a negative environment, younger age, time restraints and higher workload played a large role in burnout. A majority of these factors have all been identified previously in the literature in non-HIV care settings (Bridgeman et al., 2018; Trockel et al., 2020).

A distinct theme that has not been identified in other literature is the impact of not being able to adequately address systemic or national level factors affecting patients - such as homelessness, lack of adequate transportation, issues with health insurance, etc. Several participants mentioned how their work would be much more straightforward if they did not have to assist patients in navigating complicated systems (housing, healthcare, transportation, etc.). It is hypothesized that this may not have emerged as a factor contributing to burnout in other healthcare settings because RWCs see a disproportionately high number of patients who are below the poverty line (61% in 2019) (Health Resources and Services Administration, 2019).

Results were mixed as to how much a patient's experience of trauma was a component leading to burnout in providers and staff. For some, hearing patients' traumatic experiences fueled burnout. For others, however, it was not solely the patient's experiences of trauma, but rather the sense of inefficacy and helplessness that providers faced when caring for these patients in the setting of inadequate time and resources. It was the sense of working in a broken system and being unable to fully help a patient that seemed to drain providers and staff. Others described the positive impacts of working with patients who have experienced trauma—including unifying

staff and patients, providing deeper understanding of patients, and being part of rewarding and fulfilling work. Consistent with these findings, prior literature suggests that seeing tremendous growth and resilience in patients is one reason that many providers stay in HIV care despite the burnout (Garrett, 1999). As participants in these interviews expressed, it may not be the trauma that directly leads to burnout, but a myriad of other factors, such as inefficient systems, time pressures, and inability to meet a patient's complex needs, that can contribute to chronic stress.

Existing strategies currently employed by the clinics to promote well-being included providing access to resources through the larger institution and other clinic-level strategies. Many participants mentioned the employee assistance program (EAP), counseling and fitness or lifestyle classes that were available at the institution. Within the clinic, strategies included supportive leadership, regular team meetings and check-ins, flexibility with time off, group social and self-care activities, and informal support mechanisms. These strategies are similar to those employed in other healthcare settings (American Medical Association, 2020; West, Dyrbye, Erwin, & Shanafelt, 2016; Zhang et al., 2020).

Suggestions built off of effective existing strategies, namely: fostering leadership support, informal team support and cohesion. As several participants stated, they see an opportunity for burnout to be prevented rather than reacted to after the fact. This is consistent with recommendations to frame organizational burnout interventions as positive (building engagement) vs reactive (treating burnout) (Maslach et al., 2001). As one participant stated, they would like to see more "shared care", where the responsibility falls on teams in place of individual healthcare workers. This was supported by others who highlighted how important it was to have social events and meetings to support each other.

There were also gaps in existing strategies and suggestions. Despite good leadership, there may be resistance to self-care practices due to personal or cultural factors. Some participants stated that task shifting and reducing patient load were effective methods for addressing burnout, while others, especially providers, disagreed— stating those decisions were out of their control. Participants reported variety in their level of awareness and use of institutional level resources, such as the EAP, mentioning that informal team support, social activities and teambuilding were more effective ways to prevent burnout than providing access to resources outside of the clinic (which required more effort and time away from work). Lastly, some participants suggested changes at the greater health system level, or national level, and therefore felt out of reach.

To further promote well-being and prevent burnout, participants mentioned the need for more venues to share, discuss, socialize, provide feedback, and increase team cohesiveness. Many participants mentioned a needed cultural/mindset shift, the need to bring more attention and conversation to staff and provider well-being, and the need for organizations to be more involved in preventing burnout rather than leaving self-care up to the individual. Participants also discussed their desire for more team-building activities and capacity building activities, such as trainings on how to manage trauma and their own emotional well-being. Lastly, participants discussed the need for increased time per patient, decreased workload, and increased flexibility, such as the ability to work from home sometimes.

Many participants suggested having support from a psychologist, or trainings and tools to better regulate emotions. Another participant expressed improvement in her own well-being after having been trained in the trauma-informed approach due to improved emotion regulation. This is consistent with a systematic review that found that those interventions which focused on

mindfulness, emotion regulation, and social support had the most significant effect (Huang, An, & Li, 2020; Jackson-Koku & Grime, 2019). The negative social emotions that can result from empathy may be mediated by compassion training, which brain studies have found to use different neurological pathways than empathy training (Klimecki, Leiberg, Ricard, & Singer, 2014). One study on the implementation of trauma-informed care found that ‘choice’ and ‘collaboration’ may reduce burnout (Hales & Nochajski, 2019). Providers and staff of this study also expressed the need to be heard and expressed desire for change, as well as the importance of working with others when faced with difficult patients.

An additional, overarching theme was that participants often noted burnout in other roles and suggested reasons for their burnout. This is a key finding as it suggests that self-awareness of burnout may require additional training and support, and that it may be easier for people to see burnout in others than in themselves. This study intentionally diversified participants according to clinic role, anticipating differences. There were only minimal differences in how people in different roles experienced burnout and these differences were subtle. While nurses and social workers seemed to have strong internal support and cohesion, physicians, APPs, and administrators seemed to have less. This is congruent with prior research which found nurses and social workers to experience less burnout than physicians (Garrett, 1999).

Limitations:

There were several limitations of this study. First, the recruiting method for in-depth interviews were limited to those who first completed the survey, which was sent out by email. There could be bias in who decided to sign up for an interview—perhaps those who were less familiar with trauma-informed care, those who were too busy and perhaps more burned out, and/or those whose personalities were less social or less talkative were less likely to participate.

There was diversity of role, however, no physician assistants and no front desk staff were represented. There is a larger gap in the literature on burnout among front-desk staff and future studies should assess this, especially in the context of interacting with patients who experience trauma. Front-desk staff often are first in the clinic to encounter challenging, irate patients, and thus would benefit from burnout prevention and trauma-informed care as well. Additionally, it would be important to include physician assistants in future studies, as several participants noted that they thought advanced practice providers were more likely to experience burnout.

The interviews were conducted from March 2020 through February 2021, with the majority of the interviews conducted in May 2020. A nation-wide state of emergency due to the COVID-19 pandemic went into effect in March 2020. The exact impact of the pandemic likely varied between clinics and between participants. While participants were encouraged to answer questions regarding how things were prior to the pandemic, many participants found this difficult and answers were very likely to be impacted by the state of the pandemic. Some participants mentioned strategies used in the past (such as meetings) which helped promote well-being. It was unclear whether these strategies no longer existed due to an administration change, COVID-19, or something else. Suggestions for social activities, team meetings, opportunities to talk/vent may be an extrovert bias or may have been influenced by a general feeling of isolation during peak pandemic times.

Lastly, the in-depth interviews were about one hour in duration, and the section of the interview on staff and provider well-being was near the end. If interviewees were pressed for time, they may not have answered in as much depth as they would have otherwise. A single coder was used for this research and when questions arose, the researcher consulted her advisor.

Although reflexivity was practiced throughout the coding process to minimize personal bias, the single coder likely had her own bias due to her personal experiences, training, and worldview.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

Burnout is placing significant strain on the healthcare system and on individuals. This study highlights the need for action to prevent burnout among providers and staff at RWCs and suggests that a trauma-informed model of care is a particularly well-suited framework to address this pertinent topic. While it has been established that PLWH have experienced high rates of trauma (Brezing et al., 2015; Cuca et al., 2019), this study is the only known qualitative study in the HIV context in the United States to assess the impact patient trauma has on providers and staff.

Strategies that depend on the individual to take the initiative are likely going to be less effective than strategies that are built into an existing work structure, especially if individuals cannot identify burnout in themselves. A major finding was that patient trauma does not have to result in secondary trauma and burnout—that with the time, training, tools, and resources, addressing a patient's experience of trauma can be transformed into a positive encounter for the provider and staff (i.e., compassion satisfaction). A dissertation published in 1999 discussed the gap in burnout literature in understanding the unique experiences of HIV care providers and focused on understanding secondary traumatic stress (Garrett, 1999). This gap still exists today and it is recommended that more research be conducted to fully understand the implications of secondary traumatic stress and ways to build resiliency of staff.

Burnout is a major public health issue as the impacts of provider and staff burnout have significant implications on not only personal health, but also on productivity and the health of the patients they serve. The impacts of burnout include high turnover, decreased productivity, increased number of sick days, increased medical errors, and decreased patient satisfaction and

adherence (Azam et al., 2017; Dewa et al., 2014; DiMatteo et al., 1993; Hall et al., 2016; Klein et al., 2020; Shanafelt et al., 2010).

This study calls on policy makers, organizational leaders, and funding organizations to prioritize the well-being of employees. This holistic approach may have numerous downstream effects, providing for happier and more productive workers, more efficient health systems, and effectively healthier patients.

Future implementation research should prioritize assessment of the positive impacts of promoting well-being and the effects this may have on healthcare systems—including provider and staff turnover, patient satisfaction, health outcomes, cost to health systems, etc. Future research should also focus on burnout experiences for front desk staff and medical assistants. It is recommended to monitor the well-being of providers and staff and continually assess the impacts of various strategies of burnout prevention (monetary and otherwise) on the clinics. It is recommended to invest in social support, effective leadership strategies, and team cohesion rather than on individual-level treatment of burnout, thereby focusing on a sense of "shared care" and prevention of burnout.

Recommendations

• Normalize dialogue on burnout and well-being
• Encourage Effective Leadership:
    o Model well-being practices
    o Show appreciation
    o Be familiar with staff through regular check-in and monitoring
    o Create safe environment to express needs
• Promote team cohesion
    o Plan retreats, group social and self-care activities, team-building activities, meetings
• Allow for schedule flexibility and mental health days off when possible

- Implement Trauma-Informed Care Training
    - Including burnout, secondary traumatic stress, and ways to protect emotional well-being
- Future research
    - Assess burnout among front desk staff and medical assistants
    - Implementation research: evaluate impacts of promoting staff/provider well-being on patient outcomes, cost-saving, staff turnover, etc

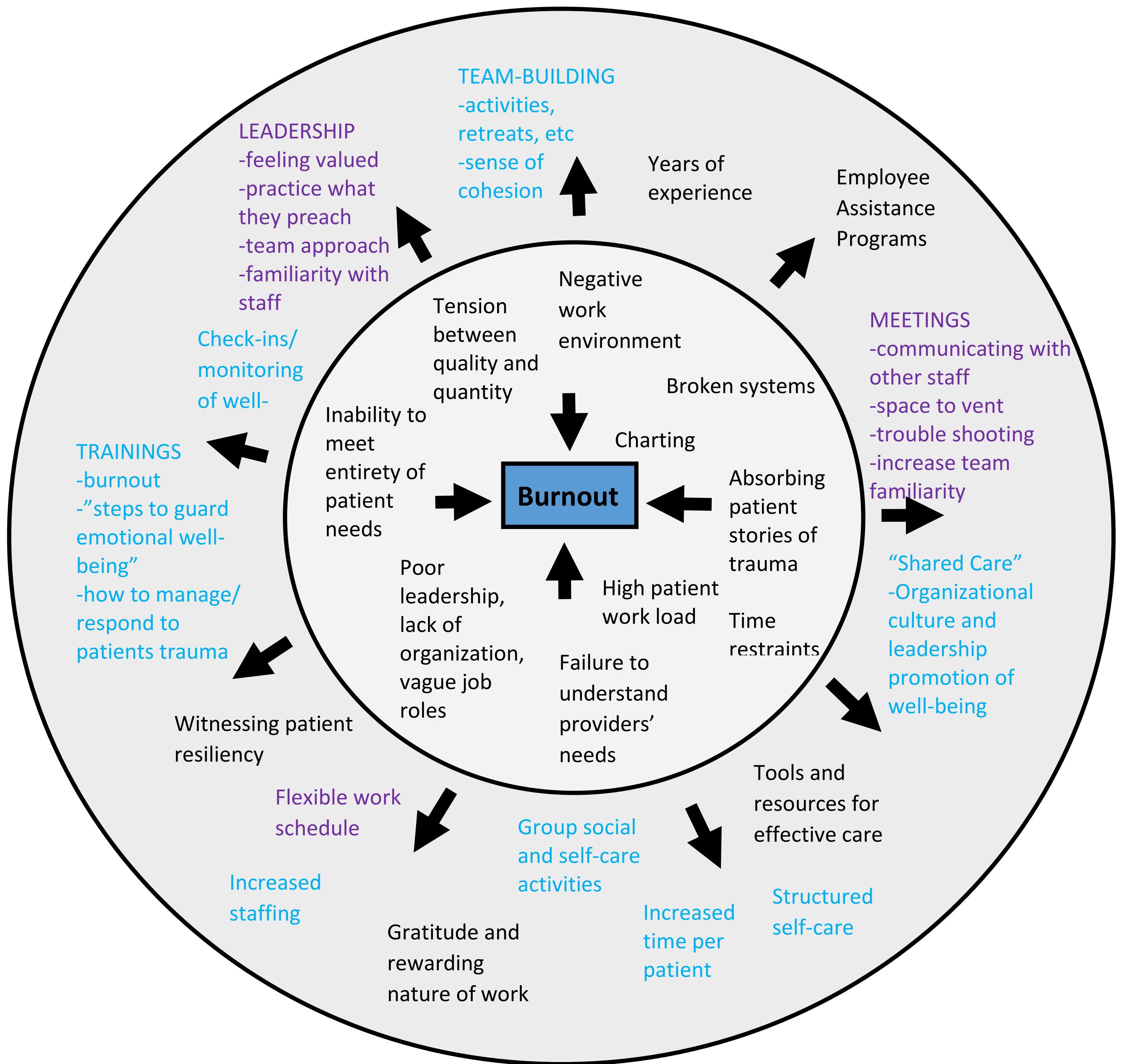

Figure 1. Factors that contribute to and alleviate burnout. The inner circle describes the contributing factors of burnout. The outer circle includes factors that alleviate burnout (black), existing strategies (purple) and suggestions (blue) for promoting well-being.

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APPENDICES

In-depth interview guide for Staff/ Providers

Qualitative Guide: TIC Staff / Provider Interview Guide (60 mins)
Study Title: Ryan White Trauma-Informed Care

Interviewee Information:

Age: _______________ Gender: _______________ Race: _______________________

State: ___________________________________ Urban/Rural: _________________________

Clinic Role: ______________________________ Time in role: __________________________

Introduction
Thank you for agreeing to an interview with me today. My name is _______________, and I am a Research Assistant with Emory University's Trauma-Informed Care (TIC) Study.

I am part of a research team that is conducting interviews with providers and staff at Ryan White Primary Care Clinics (RWPCCs) across the Southeast Region IV to understand the ways in which RWPCCs address patient trauma and are incorporating trauma-informed services in patient care at their clinics. We feel that it's important to speak directly with providers and staff to understand your experiences and perspectives.

During this interview, I will be asking questions aimed at identifying current protocols, policies, and practices related to implementation of TIC, as well as resources for providers and staff that interact with patients with complex needs. Additionally, we seek to gain your perspective on best practices for integrating services into care and how RWPCCs can create a safe environment for patients that have experienced trauma.

Because your perspective is important to us, please feel free to share your honest opinion. Information shared during this interview will be kept confidential within the research team, however, I would like to record our conversation in order to best capture your responses. For reporting purposes, we will redact any information that could identify you or your practice, and only report results in aggregate.

The interview will last about an hour. Before we get started, do you have any questions? **[Wait for a response and answer any questions.]**

Thank you for agreeing to participate in this interview. I will begin recording now. **[Turn on the recorder.]**

Warm Up

6. I'd like to begin by asking you to describe your clinic, as well as your role(s) and responsibilities.

7. Can you tell me about the patients that you see at your clinic? (probe if necessary, age, gender, race, ethnicity, and sexuality)

8. Thinking about what you see in your clinic, how do you define trauma as it relates to your patients?

9. Please tell me about your experience treating patients that have been exposed to trauma. ***[Note for interviewer: Suggested response if participant brings up COVID-19 early in interview:*** *"Thank you for raising COVID-19 as a form of trauma. I'm going to ask you to hold that thought for now and think back to the pre-COVID-19 epidemic period first. Thinking about other common forms of trauma experienced by your patients living with HIV, let's work through the next set of questions. We'll come back COVID-19 at the end."]*

    a. How well prepared did you feel to manage that situation?

    b. What would have made you feel more prepared?

    c. Have you ever participated in a training in trauma-informed care?
    [If "yes"]:

        i. What worked well?

        ii. What didn't work well?

Section I: Clinic Environment

Feeling physically and emotionally safe while seeking health care is important, especially for patients with trauma histories. As many people served by RWCs have histories of violence and trauma, we would like to ask you some questions about TIC at your clinic.
Interviewer Note: *For Questions 4-6, we would like you to probe for nuances relating to age, gender, sexuality, race, and ethnicity.*

10. In your words, what might emotional/physical safety look like for a trauma survivor?

    a. Does that differ by age, gender, sexuality, race, or ethnicity? How so?

11. How does your clinic ensure that patients feel physically safe when they are seeking care? *[Probe, if necessary: well-lit spaces, comfortable examination rooms, gender neutral bathrooms, ability to accommodate patient's choice of gender-of provider, special considerations for gender, sexual, racial/ethnic minorities, etc.]*

    a. What barriers has your clinic encountered related to creating a safe environment for patients? *[Probe, if necessary: availability of gender concordant providers/staff members?]*

        i. What do you think would need to happen to overcome these barriers in your clinic?

12. **How does your clinic create an environment that makes patients feel emotionally safe?** ***[Probe, if necessary: establishing patient-provider relationships based on mutual trust and respect, creation of a safe space where patients can speak freely without judgment, setting ethical and professional boundaries, etc.]***

    a. What barriers has your clinic encountered related to creating an emotionally safe environment for patients?

        i. What do you think would need to happen to overcome these barriers in your clinic?

13. When an issue is identified or raised by patients, providers, or staff about the safety of the clinic environment, how is the issue handled by the clinic?

    a. Is this something that you as ___________ would be involved in?

        i. If not, who would be involved?

    b. What roles can/do patients play as support systems for other patients?

        i. How is patient involvement organized? *[Probe, if necessary: is patient involvement formally or informally organized?]*

14. When changes have been made to create a safer physical or emotional environment for patients, what facilitated that change?

    a. How are new policies/procedures/protocols developed?

    b. Are patients ever involved in conversations about changing clinical protocol to respond to safety issues/concerns?

i. In what ways can/do patients provide feedback about their experience with the clinic?

ii. Are special efforts made to ensure gender, sexual, racial, ethnic minorities are part of the process?

iii. What roles can/do patients play in ensuring the care provided by the clinic meets their needs and is not re-traumatizing/triggering?

Section II: Screening/Assessment

We would like to know more about how your clinic learns about patient experiences of trauma (i.e., violence, loss, HIV-related trauma). However, sometimes clinics and staff have limited resources and screening for trauma can be difficult to implement. These next questions are related to your clinic's current screening practices. We define "screening" as either formal (scale or tool) and/or informal (probing questions) about trauma.

15. Please describe what formal (scale or tool) and/or informal (probing questions) trauma screenings (e.g., IPV or other types of trauma) are conducted at your clinic. **[NOTE: If no screenings are conducted for trauma, skip to Question 10c, then go to 11.]**

    a. Are screenings done systematically (e.g., an established screening protocol for all patients or in specific circumstances)? Why or why not?

        i. How often are patients screened? *[Probe, if necessary: only at intake, routinely, at provider/staff discretion]*
        ii. Do screening practices differ by gender/sexuality and race/ethnicity *[Probe, if necessary: ask about hate crimes? Use screening tools validated for people of different gender?]*

    b. Are these screening practices consistent across all areas of your clinic services? Why or why not?
        i. Are these screening practices consistently conducted by providers/staff?

    c. What barriers has your clinic experienced related to screening for violence? *[Probe, if necessary: lack of knowledge/training, time, lack of resources, legal concerns (i.e. mandatory reporting), providers/staff discomfort with asking, competing clinical priorities, insufficient evidence base to support screening, etc.]*

        i. What do you think would need to happen to overcome these barriers in your clinic?

d. When the screening goes well, what were the things that make it go well?

e. When someone screens positive for having experienced violence, what happens next?

   i. How are positive screens of violence communicated to other providers/staff in the clinic so that they are aware of this information when interacting with the patient?

   ii. How are they documented (i.e., form, patient note, etc.)?

   iii. Please describe the communication chain.

      1. To what extent is it adhered to?

f. What barriers has your clinic experienced related to following up on a positive screen for someone who needs mental health support? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]*

   i. What do you think would need to happen to overcome these barriers in your clinic?

g. What are barriers your clinic has experienced related to following up on a positive screen for someone who needs housing or social/legal services? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]*

   i. What do you think would need to happen to overcome these barriers in your clinic?

h. When the linkage to services goes well, what are the things that make it go well? [*Probe, if necessary: facilitators related to internal and external linkages, gender, sexuality, race, or ethnicity]*

16. If systematic screening does not already exist at your clinic, how should it be implemented in your clinic? **[NOTE: If systematic screening exists, skip to Question 12.]**

   a. Who should conduct it and why? *[Probe, interviewer role, characteristics, should the individual conducting the screening be of the same gender/sexuality/race/ethnicity as the patient being screened?]*

   b. How should it be conducted (e.g., when or how often) and why?

   c. What infrastructure would need to be in place to make sure it is done right and why?

d. How should results be communicated to other providers/staff involved in patient care and why?

e. How should it impact their subsequent approach to the patient, and why?

17. What protocol is in place to address when patients disclose they are experiencing or have experienced trauma outside of the usual screening process (e.g. during the patient encounter)? [*Probe, if necessary: issues related gender, sexuality, race, or ethnicity]*

Section III: Staff/Provider Care

Another key component to trauma-informed care is recognizing that working with individuals with complex lives and trauma histories can take a toll on providers. Thus, trauma-informed settings sometimes put practices into place to address the impact this can have on staff/providers.

18. In what ways do you think working with patients with histories of trauma in your clinic has impacted you or other providers/staff positively or negatively?

19. Do you think staff/provider burnout is an issue at your clinic? Why or why not? *[Probe, if necessary: feeling overwhelmed by the experience of supporting patients with histories of trauma and complex needs.]*

20. What strategies (e.g., task shifting/sharing, reducing patient load, protecting time for addressing personal needs) does your clinic employ to support staff emotional well-being?

    a. Do you find these strategies effective? Why or why not?

        i. Do you think most providers/staff at your clinic share your opinion? Why or why not?
        ii. Do you think administrators at your clinic share your opinion? Why or why not?

21. What resources (e.g., services) are available for all staff/providers?

22. What suggestions would you have to improve how the clinic supports emotional well-being or burn-out? *[Probe, if necessary: self-care classes, changes to workload, social events, etc.]*

Section IV: Planning for Action

23. Would you describe enhancing trauma-related practices and services as a current/future priority? Why or why not?

a. Do you think most administrators/providers/staff at your clinic share your opinion? *[Probe, if necessary: differences between admin vs providers/staff.]*

    i. If not, why?

24. Would you describe the provision of a clinic-wide trauma training for providers and staff as a current/future priority for your clinic? Why or why not?

    a. Do you think most administrators/providers/staff at your clinic share your opinion? *[Probe, if necessary: differences between admin vs providers/staff.]*

        i. If not, why?

25. How can administrators/providers/staff advocate for trauma-related practices?

    a. Are there administrators/providers/staff in your clinic that currently serve as advocates?

    b. Are there administrators/providers/staff in your clinic that are not/would not be supportive of TIC? Why do you think that is?

<u>COVID-19 Questions</u>:

As many participants have raised community experience of COVID-19 as a form of collective trauma, we'd like to ask you some specific questions about your experience as an HIV care provider or clinical staff during the COVID-19 pandemic.

1. Can you please describe how COVID-19 has impacted your clinic (i.e. operations, culture)?
2. Can you please describe how COVID-19 has impacted providers at your clinic? Other staff at the clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: Are there things your clinic is doing to support the emotional well-being of providers and staff during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?
3. Can you please describe how COVID-19 has impacted the patients who receive care at your clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: are there things your clinic is doing to support the emotional well-being of patients during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?

4. Has COVID-19 epidemic shaped how your HIV clinic may prioritize trauma-informed care (i.e. once it returns to normal operations)? How so? (probe: perceived as more/less important, new TIC ideas or implementation strategies)

Closing

26. Overall, how does trauma-informed care fit with existing care infrastructure at your clinic?

    a. How easy or difficult will it be to integrate TIC in clinic practice?

27. Overall, what do you think your clinic is doing well in terms of providing trauma-informed care?

28. Overall, what are some things that your clinic could do to improve the provision of trauma-informed care?

In-depth interview guide for Administrators

Qualitative Guide: TIC Administrator Interview Guide (60 mins)
Study Title: Ryan White Trauma-Informed Care

Interviewee Information:

Age: _______________ Gender: _______________ Race: __________________

State: _____________________________ Urban/Rural:______________________

Clinic Role: ______________________________ Time in role: _________________________

Introduction

Thank you for agreeing to an interview with me today. My name is _______________, and I am a Research Assistant with Emory University's Trauma-Informed Care (TIC) Study.

I am part of a research team that is conducting interviews with administrators at Ryan White Primary Care Clinics (RWPCCs) across the Southeast Region IV to understand the ways in which RWPCCs address patient trauma and are incorporating trauma-informed services in patient care at their clinics. We feel that it's important to speak directly with administrators to understand your experiences and perspectives.

During this interview, I will be asking questions aimed at identifying current protocols, policies, and practices related to implementation of TIC, as well as resources for providers and staff that interact with patients with complex needs. Additionally, we seek to gain your perspective on clinic priorities and how RWPCCs can create a safe environment for patients that have experienced trauma.

Because your perspective is important to us, please feel free to share your honest opinion. Information shared during this interview will be kept anonymous, however, I would like to record our conversation in order to best capture your responses. For reporting purposes, we will redact any information that could identify you or your clinic, and only report results in aggregate.

The interview will last about an hour. Before we get started, do you have any questions? [Interviewer Note: Wait for a response and answer any questions.]

Thank you for agreeing to participate in this interview. I will begin recording now. [Interviewer Note: Turn on the recorder.]

*[Note for interviewer: **Suggested response if participant brings up COVID-19 early in interview:** "Thank you for raising COVID-19 as a form of trauma. I'm going to ask you to hold that thought for now and*

think back to the pre-COVID-19 epidemic period first. Thinking about other common forms of trauma experienced by your patients living with HIV, let's work through the next set of questions. We'll come back COVID-19 at the end."]

Warm Up

1. Thank you for agreeing to participate in this interview. I'd like to begin by asking you to introduce yourself and describe your role(s) and responsibilities at the clinic.

2. Please tell me a little bit about your clinic. *[Probe, if necessary: number of staff, providers, patient population [age, race, ethnicity, gender, sexuality], location, estimated burden of trauma, etc.]*

3. In your words, how would you define trauma as it relates to the patients your clinic serves? *[Probe, if necessary: differences related to age, gender, sexuality, race, or ethnicity]*

4. In your words, how would you define trauma-informed care in the clinic setting?

    a. What do you believe is/are most important to its implementation?

Thank you for sharing that with me. Now I'd like to shift and learn about your clinic environment.

Section I: Policies/Practices Related to Trauma-Informed Care and the Clinic Environment

Feeling physically and emotionally safe while seeking health care is important, especially for patients with trauma histories. As many people served by RWPCCs have histories of violence and trauma, we would like to ask you some questions about TIC at your clinic.

5. What are your clinic's policies/practices relating to the care of patients that have experienced trauma?

    a. Are the policies/practices you mentioned clinic-specific or Ryan White-mandated?

    b. Can these policies/practices be adapted to meet patients' needs? If not, why not? *[Probe, if necessary: policies related to gender, sexuality, race, or ethnicity]*

6. What policies/practices do you have in place that create a safe environment? *[Probe, if necessary: policies/practices related gender, sexuality, race, or ethnicity]*

    a. What policies/practices do you have in place to create a **physically safe** environment for patients seeking care *[Probe, if necessary: well-lit spaces, comfortable examination rooms, gender neutral bathrooms, gender-appropriate provider, special considerations for gender, sexual, racial/ethnic minorities, etc.]*

b. What policies/practices do you have in place to create an **emotionally safe** environment for patients (e.g., establishing patient-provider relationships based on mutual trust and respect, creation of a safe space where patients can speak freely w/o judgment, setting ethical and professional boundaries, policies for patient safety vs. provider/staff safety)?

7. Please tell me about a time when implementation of policies/practices for creating safe environments worked well. What made it work?

8. What barriers has your clinic encountered related to creating a safe environment for patients?

    a. If barriers: What do you think would need to happen to overcome these barriers in your clinic?

9. When an issue is identified or raised by patients, providers, or staff about the safety of the clinic environment, how is the issue handled by the clinic?

    a. Is this something you as an administrator would be involved in?

    b. If not, who would be involved?

        i. What roles can/do patients play as support systems for other patients?

            1. Is this formally or informally organized?

10. When changes have been made to create a safer (physical or emotional) environment for patients, what facilitated that change (e.g., types of events)?

    a. How are new policies/procedures/protocols developed?

    b. Who is involved in the process?

    c. Are patients ever involved in conversations about changing clinical protocol to respond to safety issues/concerns?

        i. Are special efforts made to ensure gender, sexual, racial, ethnic minorities are part of the process?

        ii. What roles can/do patients play in ensuring the care provided by the clinic meets their needs and is not re-traumatizing/triggering?

Section II: Screening/Assessment

We would like to know more about how your clinic learns about patient experiences of trauma (i.e., violence, loss, HIV-related trauma, etc.). However, we also know that screening for trauma is difficult to implement. These next questions are related to your clinic's current screening practices. We define "screening" for trauma as either formal (i.e., scale or tool) or informal (i.e., questions asked during the patient encounter or prompted by concern for patient).

11. What screenings are currently conducted at your clinic? (Probe: Does this include screening for trauma?)

    a. Are screenings for trauma done systematically (e.g., all patients, in specific circumstances, etc.)? Why or why not?

[Interviewer Note: If no formal screenings are conducted, skip to Q11c, then go to Q12.]

<table>
<tr><th>YES SYSTEMATIC SCREENING</th><th>NO SYSTEMATIC SCREENING</th></tr>
<tr><td>[11.a.]
i. How often are patients screened (e.g., only at intake, routinely, at provider/staff discretion, etc.)?

ii. Do screening practices differ by gender/sexuality and race/ethnicity [Probe, if necessary: racial discrimination or experience of hate crimes, gender-specific validated screening tools, etc.]

iii. Are these practices consistent across all areas of your clinic services? Why or why not?

iv. How do you ensure that patients are being screened by providers/staff?

[11.b.] When someone discloses that he/she/they have experienced violence, what happens next?

i. How are positive screens for violence communicated to other providers/staff in the clinic so that they are aware of this information when interacting with the patient?

1. How are they documented (i.e., form, patient note, etc.)?</td><td>[11.c.]

What barriers has your clinic experienced related to screening for violence? [Probe, if necessary: lack of knowledge/training, time, lack of resources, legal concerns (i.e., mandatory reporting), providers/staff discomfort with asking, competing clinical priorities, etc.]

If barriers: What do you think would need to happen to overcome these barriers in your clinic?

12. What protocols or standard practices are in place to address when patients disclose they are experiencing or have experienced trauma outside of the screening process (e.g., during the patient encounter)?</td></tr>
</table>

2. Please describe the communication chain. 3. To what extent is it adhered to? [11.c.] What barriers has your clinic experienced related to screening for violence? *[Probe, if necessary: lack of knowledge/training, time, lack of resources, legal concerns (i.e., mandatory reporting), providers/staff discomfort with asking, competing clinical priorities, etc.]* If barriers: What do you think would need to happen to overcome these barriers in your clinic? [11.d.] What barriers has your clinic experienced related to following up on a positive screen for violence for someone who needs mental health support? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]* If barriers: What do you think would need to happen to overcome these barriers in your clinic? [11.e.] What are barriers your clinic has experienced related to following up on a positive screen for violence for someone who needs housing or social/legal services? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]* ii. If barriers: What do you think would need to happen to overcome these barriers in your clinic? [11.f.] After a patient is referred to internal/external services (i.e., mental health, housing, or social/legal services), how is the patient's use of services conveyed back to your clinic?	

What system is in place to document/track what the outcomes of the referral were? [11.g.] What are the barriers in this process? If barriers: What do you think would need to happen to overcome these barriers in your clinic? 12. What protocols or standard practices are in place to address when patients disclose they are experiencing or have experienced trauma outside of the screening process (e.g., during the patient encounter)?	

Section III: Staff Well-being

Serving patients that have experienced trauma can take an emotional toll on administrators/providers/staff. We are interested in learning more about how your clinic supports administrator/provider/staff well-being.

13. In what ways do you think working with patients with histories of trauma in your clinic has impacted administrators/providers/staff positively or negatively?

14. Do you think administrator/provider/staff burnout is an issue at your clinic? Why or why not? *[Probe, if necessary: feeling overwhelmed by the experience of supporting patients with histories of trauma and complex needs; limited time and resources.]*

    a. What barriers to addressing staff burnout do you encounter?

15. What strategies does your clinic employ to support staff emotional well-being? *[Probe, if necessary: self-care classes, changes to workload, social events, etc.]*

    a. Do you find these strategies effective? Why or why not?

        i. Do you think administrators at your clinic share your opinion? Why or why not?

        ii. Do you think most providers/staff at your clinic share your opinion? Why or why not?

16. What resources (e.g., services) are available for all staff/providers?

17. What would you like to do to promote staff well-being that you are not currently doing?

Section IV: Internal Priorities

18. What is the current capacity at your clinic for providing TIC on site?
    a. What kinds of resources (e.g. funding, space, time, training, etc.) do you have available to support adopting more trauma-informed practices at your clinic?
    b. Would you describe enhancing trauma-informed practices and services as a current/future priority? Why or why not?
        i. Do you think most staff/providers/administrators at your clinic share your opinion?
            1. If not, why?
19. What informs your decisions when balancing competing priorities at your clinic?
    a. In what ways are staff/providers at your clinic involved in establishing priorities?
        i. How can administrators/providers/staff advocate for trauma-informed practices?
        ii. Are there staff or providers in your clinic that currently advocate for trauma-informed practices?
        iii. Are there staff or providers or administrators in your clinic that are not/would not be supportive of TIC?
            1. If so, why do you think they feel that way?
20. Would you describe the provision of a clinic-wide trauma training for staff and providers as a current/future priority for your clinic? Why or why not?
    a. If not, what are barriers to incorporating TIC training into current priorities?
    b. Do you think most staff/providers/administrators at your clinic share your opinion?
        i. If not, why?

Section V: Relationships with External Partners/Incorporating External Priorities

21. Please describe your clinic's relationships with partner organizations (e.g., government, private, community, nonprofit, etc.) that currently/may be able to contribute to your ability to provide comprehensive TIC to patients. *[Probe, if necessary: mental health services, legal services, safe housing, etc.]*

    a. What is the nature of your clinic's relationships with these organizations?

    b. To what extent does your clinic interact/collaborate with these organizations?

        i. To what extent have these external relationships influenced your clinic's internal practices?

<u>COVID-19 Questions</u>:

As many participants have raised community experience of COVID-19 as a form of collective trauma, we'd like to ask you some specific questions about your experience as administrative staff during the COVID-19 pandemic.

22. Can you please describe how COVID-19 has impacted your clinic (i.e. operations, culture)?
23. Can you please describe how COVID-19 has impacted providers at your clinic? Other staff at the clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: Are there things your clinic is doing to support the emotional well-being of providers and staff during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?
24. Can you please describe how COVID-19 has impacted the patients who receive care at your clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: are there things your clinic is doing to support the emotional well-being of patients during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?
25. Has COVID-19 epidemic shaped how your HIV clinic may prioritize trauma-informed care (i.e. once it returns to normal operations)? How so? (<u>probe</u>: perceived as more/less important, new TIC ideas or implementation strategies)

Closing

26. Overall, how well does trauma-informed care align with existing care infrastructure at your clinic?

    a. How easy or difficult will it be to integrate TIC in clinic practice?

27. Overall, what do you think your clinic is doing well in terms of providing trauma-informed care? *[Probe, if necessary: suggestions for other clinics]*

28. Overall, what are some things that your clinic could do to improve the provision of trauma-informed care?

Codebook

For all codes, only use in context of staff/providers/administrators. Do not use for discussion of patients (unless related to staff). Also do not code topics related to COVID (unless also applicable to pre-COVID times).

1. Stress factors

- Financial

Use for mention of finances, financial pressures, meeting quota, numbers, etc.

Example: “that message just falls on deaf ears because [Clinic Name] is just always all about the numbers. They want us to see more and more and more patients."

- Personal life

Use for mention of spouse, family, home, garden, etc. May be positive or negative.

Examples: a husband who provides a listening ear after a long day at work; having a difficult home life and bringing that stress to work.

- Flexible schedule and work environment

Use for mention of the ability to adjust daily schedule, such as hours worked or needing to take a breathing break in the middle of the day, or working from home.

Do not use for mental health days or entire days off. For this use “time off”.

- Joy

Use for mention of fun, happiness, laughter, celebration, morale, etc. May also use for things that take away joy, for example “charting takes away the joy of seeing patients”.

- Positive communication

Use for mention of positive communication in regards to work, interdisciplinary work, communicating well across roles, feeling comfortable to communicate needs/concerns, encouragement, being shown appreciation, talking as a way to alleviate stress, etc.

Example: “I think it's all part of the, if you're communicating as well. So if you're just not coming in I'm sure that's not a positive thing. If you're not talking to your supervisor or someone about what you're going through.”

Do not use for informal support (ex- “we nurses support each other”). For this use “Team support”

- Negative communication

Use for mention of problems in workplace, not being attuned to coworkers, negativity, misunderstanding, poor communication among staff or with patients, as well as lack of communication.

Example—“there was so much anger and negativity”

- Documentation

Use for mention of EMR, documentation, billing, coding, or other administrative tasks in relation to stress/burnout.

- Ryan White program

Use for ways that the Ryan White program may contribute to or alleviate stress/burnout.

Example—knowing that a patient's antibiotics will be paid for

- Consistency

Use for familiarity, consistency, seniority, and longevity of staff. Staff knowing each other well, having worked somewhere for a long time.

Do not use for administrator knowing staff well. For this, use "familiarity with staff"

- Workload

Use for mention of workload, being overworked, sensing that others are overworked. Also use for being short staffed.

Example—"we have a large number of patients for the number of providers"

Do not use for specific mention of not enough time. For this, use "time restraints"

- Lacking ability/capacity to help

Use for mention of provider or staff not feeling that they have the ability, knowledge, resources, or capacity to truly help a patient in need. Use also when a participant feels they have tried hard to meet a patient's needs, but their needs are so complex.

Do not use for lack of time. For this, use "time restraints".

- Job roles

Organization of job roles, having a clear role, knowing one's role and responsibilities, being confused on one's role, or feeling that another is not doing their job.

Example—'my burnout comes from not having clearly defined roles'

- Lack of effective systems

Use for lack of organization at workplace or working in a broken system (clinic, regional, state, national level).

May double code with "job roles".

- Time restraints

Use for not having enough time with patients, time for self-care, or not enough time to address trauma related topics.

Example—'we want to care for ourselves, but don't have enough time to do so'

<u>2. Trauma-</u> *All are in relation to working with patients who've experienced trauma.*

- Feeling helpful, effective, and validated

Use for alleviating another's suffering, through listening, taking the burden off the patient, providing a safe space, etc. Use also for the feeling of doing one's job correctly.

- Inspired by witnessing patient resiliency

Use for mention of resiliency, success stories in patients, being amazed at what people go through.

- Unifying

Use for creating a sense of interconnectedness with patients and/or staff, feeling support of other staff, mention of staff coming together as a result of hearing patients' traumas.

- Sense of gratitude

Use for mention of rewarding work, feeling grateful, being made aware of or reminded how good one's own life is.

Also use for increasing clinical understanding, and learning from patients.

- Deeper empathy

Use for mention of understanding a patient better, improving empathy between provider/staff and patient, feeling honored that they shared their stories, building trust.

- Burnout

Use for mention of "burnout" in regards to working with patients with histories of trauma. For burnout proxies, such as vicarious trauma or exhaustion, use separate codes.

- Feeling helpless

Use for not knowing how to help and/or not being able to help in response to a patient's trauma, not having all the resources, being unable to make the connections a patient needs to succeed.

May double code with "lacking ability/capacity"

- Vicarious trauma

Use for mention of vicarious trauma, secondary trauma, compassion fatigue. Use for preoccupation with stories/ trauma experienced by patients, when participants take on the pain of a patient.

- Exhaustion

Use for mention of being exhausted, mentally and emotionally drained, overwhelmed, etc. For example, being tired of hearing people's difficult stories all day.

- Impact on home life

Use for mention of taking difficulties home from work, venting to a family member/spouse, etc.

3. Strategies used by RWCs to address/prevent burnout

- Time off

Use for sick days, vacation days, holidays, mental health days. Planned or unplanned time off work.

- Familiarity with staff

Use for mention of how familiar an administrator is (or is not) with their staff, importance of knowing staff.

Example—"I can tell when my staff are burnt our because their personality changes"

- Meetings

Use for staff/team meetings, informational sessions, 'lunch and learn', support groups, etc. Do not use for yoga, mindfulness, etc. For this use "activities". For informal support, use "team support".

- Staff support outlets

Use for institution-sponsored or hosted (during working hours) services and\or promoted resources and outlets for staff support such as EAP, counselling, gym memberships, group sessions, and wellness programs.

Do not use for clinic-level activities. For this use "activities".

Do not use for staff support groups. For this use "meetings".

- Activities

Use for any kind of planned activities including: retreats, mindfulness, yoga, group exercise, walking, social events, or other opportunities for staff to get to know each other better**.**

May double code with 'food' (ex, eating lunch together?) Informal support should be coded as "team support"

- Food

Use for mention of eating together, having lunch together/ going out for lunch, having food provided.

May double code with 'activities' or 'meetings'.

- Team Support

Use for mention of coworkers in a positive light, being supported by the team, having team cohesiveness, informally caring for each other, talking or venting with each other.

- Leadership

Use for any mention of leadership, leadership styles or methods, administrators, managers, supervisors. Use also for discrepancies or agreements between administration and staff opinions.

Example—"our office manager always made me feel appreciated"

- Task shifting

Use for mention of the effectiveness of task shifting as a strategy to reduce burnout. Task shifting may include changing schedules, job sharing, reducing patient load.

Example— a staff member was feeling overwhelmed, so his schedule was adjusted.

- Other self-care

Use for mention of self-care, caring for each other, etc. Not related to other codes for strategies of burnout prevention.

4. Suggested strategies for RWCs to employ to improve well-being

- Meetings

See "strategies" section

- Barriers

Use for mention of barriers to addressing burnout or self-care. For example, a barrier may be time or admitting to burnout.

- Strategic/Proactive self-care

Use for stated need for structured self-care time, mandated events, formal strategies or policies to increase well-being.

Example—wishing there was time built into the day for self-care at work

- Structural/cultural change

Use for need of structural, organizational, cultural, political change, such as socialized medicine, solutions to housing, etc. Use for the need of change in culture surrounding burnout, well-being or self-care (may be clinic level or nationwide) as well as suggestions for organizational change.

- Monitoring well-being

Use for mention of needing more check-ins, time for feedback, assessments to express how staff are doing, or being more aware of staff and how they are doing.

- Capacity building

Use for mention of the need for more resources, trainings, tools, etc that would increase resiliency against burnout and/or help a participant do their job well.

Do not use for meetings.

Example— 'I would appreciate more training on trauma'

- Leadership setting precedent

Use for mention of wanting leadership to set a precedent, be better role models, etc.

- Increase Time or Staffing

Use for mention of wanting to increase time per patient or to increase staffing, in order to prevent burnout.

5. Other findings (over-arching themes, or did not fit clearly into one of the research categories)

- Culture

Use for mention of culture among staff, leadership and/or patients in relation to staff. Culture may include environment, consistency, a set precedent, modeling by leadership, or expectations about a workplace.

Use separate codes for “positive communication”, “negative communication”, “team support”. Also, do not use for mention of culture related to patients only (not staff).

Example: “you always have to have an avenue or an environment that will allow that person to express their true selves.”

- Trauma-informed care and well-being

Use for mention of trauma-informed care or trauma-informed training in relation to well-being, self-care, or burnout. May include how a trauma-informed care approach has helped them see the importance of self-care, for example.

- Discussion of how others are affected by stress/burnout

Use for participant discussion of how stress, burnout, traumas affects someone (or a group of people) other than the participant themselves. For example, when asking a nurse about burnout, they mention burnout being prevalent among physicians.

Also use for what others need (example—'providers need a mental health counselor who has been on the medical side of things’)