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Review Research

Post-COVID-19 Workforce Management in U.S. Healthcare: Burnout, Retention, and Strategies for Enhancing Cultural Competency

Mohona Gazi Tiva [1], Nasrin Naher Tarin [2], MD. Razaul Karim Hasan [3], Sadiqur Rahman Chowdhury Urbi [4], Sharif Ahmed Sazzad [4*]

[1] St. Francis College, Brooklyn, New York 11201, United States

[2] Dept of Food Engineering, NPI University of Bangladesh, Bangladesh

[3] Mutual Trust Bank PLC, Bangladesh

[4] Pathfinder Research & Consultancy Center, United States

Abstract: The COVID-19 pandemic magnified persistent structural weaknesses within the U.S. healthcare workforce, intensifying psychological strain, professional exhaustion, and staff turnover. This scoping review synthesizes 40 peer-reviewed studies published between 2020 and 2024 to examine key drivers of post-pandemic burnout, identify system-level factors influencing workforce attrition, and assess the role of cultural competency in enhancing organizational resilience. Findings indicate that a lack of work-life balance, moral injury, and inadequate institutional support remain the dominant contributors to burnout. Thematic analysis highlights several effective retention strategies, including inclusive leadership, flexible scheduling, and trauma-informed support systems. Cultural competence implemented through equity audits, diverse hiring panels, and culturally responsive mental health resources emerged as a critical moderator of employee engagement and psychological safety. Institutions that embedded cultural inclusion within governance frameworks reported notable improvements in job satisfaction, reduced attrition, and enhanced workforce cohesion. This study advocates for equity-centred leadership, the institutionalization of DEI practices, and a redefinition of burnout and retention as strategic, not peripheral, concerns. Policy recommendations include mandated DEI metrics, psychological safety standards, and intersectional workforce accommodations. Overall, this review positions cultural competency as a foundational pillar of post-pandemic workforce recovery and sustainability in American healthcare.

Keywords: Burnout, Workforce Retention, Cultural Competency, DEI, Post-COVID-19, Health Policy, Psychological Safety

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sazzad@pathfinderconsultant.com

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1. Introduction

The COVID-19 pandemic revealed longstanding vulnerabilities in the U.S. healthcare system, particularly concerning institutional preparedness, long-term staffing stability, and workforce resilience. Among the most profound outcomes was the escalation of burnout and turnover among clinical and non-clinical staff. While burnout was previously recognized as a professional hazard, the pandemic transformed it into a systemic crisis marked by moral injury, emotional exhaustion, and psychological distress. These consequences have negatively impacted not only individual well-being but also team performance, patient safety, and continuity of care (**Montgomery et al., 2021**). Emerging research reframes burnout as a pervasive and structural phenomenon rather than an individual affliction. As of 2024, nearly 40-60% of healthcare professionals particularly nurses and early-career physicians report ongoing burnout symptoms (**Islam et al., 2018; Cyr et al., 2022**). This persistent crisis exposes fundamental deficiencies, including chronic understaffing, rigid organizational models, limited psychological support, and ethical stress resulting from conflicting institutional demands and professional values (**Park & Leedham-Green, 2024**). Concurrently, healthcare attrition has reached alarming levels. A growing number of professionals are reducing clinical hours, shifting to administrative roles, or leaving the healthcare field entirely (**Meese et al., 2024**). The American Hospital Association estimates a physician shortage exceeding 120,000 by 2034, with a corresponding increase in demand for nurses and allied health personnel (**Sunny et al., 2025a; Mirzada, 2023**). The 2023 AAMC workforce report similarly projects a deficit of 37,800 to 124,000 physicians by 2034, underscoring the urgency of the staffing crisis (**AAMC, 2023, Buckley et al., 2025**). Beyond financial and operational disruptions, this attrition compromises equitable access to care, particularly in rural and underserved regions. In this context, cultural competency emerges as a promising yet underutilized strategy for improving workforce sustainability.

Although traditionally discussed in the context of patient-provider communication, cultural competency increasingly proves valuable in supporting employee engagement and resilience. It refers to the capacity of healthcare organizations and providers to offer services that are sensitive to the cultural and linguistic needs of diverse populations. Research now suggests that culturally inclusive work environments not only improve care delivery but also enhance morale, psychological safety, and overall employee retention. Organizations committed to diversity, equity, and inclusion (DEI) practices consistently report reduced burnout and turnover due to improved perceptions of fairness and belonging (**Chowdhury et al., 2020; Dueland, 2023**). The pandemic disproportionately affected healthcare workers from marginalized racial and ethnic backgrounds, intensifying psychological distress compounded by systemic inequities, implicit bias, and exclusionary workplace practices (**Valeriani et al., 2022**). Ignoring these challenges risks further disengagement and attrition. Increasingly, policy bodies such as The Joint Commission now mandate workforce well-being

evaluations and regular DEI training. Similarly, federal programs administered by the Health Resources and Services Administration (HRSA) promote culturally competent staffing in underserved communities (**Rana et al., 2023; Dickson et al., 2025**).

To operationalize cultural competence, healthcare institutions must go beyond symbolic gestures. Meaningful integration involves embedding DEI in organizational policies, leadership development, HR systems, and clinical practices. Effective strategies include longitudinal DEI training, representative recruitment practices, access to culturally attuned mental health providers, and flexible scheduling for religious and cultural observances. These measures build institutional trust, enhance team dynamics, and foster long-term retention. Despite growing policy interest, the academic literature remains fragmented particularly regarding how inclusive leadership and DEI implementation affect burnout mitigation and retention. Most studies center on patient outcomes, often overlooking workforce-centered interventions. This review addresses the gap by synthesizing findings from 40 empirical studies conducted between 2020 and 2024, exploring how cultural competency intersects with staff well-being, workforce resilience, and sustainable healthcare leadership.

The objectives of this review are threefold: (1) to examine prevailing patterns and systemic determinants of burnout in the U.S. healthcare workforce; (2) to evaluate how cultural competency interventions affect staff retention, morale, and organizational cohesion; and (3) to propose an integrated framework combining equity-driven leadership and DEI-based workforce development. Recognizing burnout and attrition as cultural and operational issues rather than isolated HR challenges allows for ethical, systemic, and sustainable responses. While financial incentives and short-term staffing solutions offer temporary relief, they do not address the deeper issues of exclusion, moral injury, and institutional inequity. Instead, equity-oriented strategies rooted in inclusive governance, representative leadership, and psychological safety are essential for building a healthcare workforce that is resilient, diverse, and committed to high-quality care (**Fahad & Chowdhury, 2022; Long et al., 2024**).

2. Methodology

2.1 Thematic Synthesis of Burnout and Cultural Competency Interventions

This study adopted a multi-layered thematic synthesis grounded in qualitative content analysis. The approach was informed by post-pandemic workforce studies conducted in the U.S. healthcare sector between 2020 and 2024. The analytical framework was guided by theories from organizational dynamics, cultural psychology, and implementation science, allowing for a comprehensive examination of the intersection between staff attrition, burnout, and institutional DEI strategies. The primary objective was to explore how integrated, equity-driven interventions could support long-term workforce sustainability.

2.2 Identification of Data Sources and Sampling Framework

A purposive sampling method was used to select forty peer-reviewed journal articles, doctoral dissertations, and systematic reviews. Searches were conducted across major academic databases including PubMed, Scopus, Web of Science, and ProQuest. Keywords and Boolean operators were strategically applied to identify literature related to healthcare burnout, staff turnover, cultural competence, diversity and inclusion, and DEI impact on organizational performance.

To ensure relevance, only studies published between 2020 and 2024 were included. Priority was given to U.S.-based research with a strong empirical foundation and a clear focus on burnout, retention, and DEI implementation. Studies exclusively focused on patient outcomes or international contexts were excluded unless they offered transferable frameworks.

2.3 Analytical Mapping and Thematic Coding

A three-stage qualitative coding process was employed using thematic analysis software. This included:

Open Coding: Sentence-level codes were assigned to capture recurring terms, constructs, and language related to staff experiences. This generated 198 unique codes, including terms such as psychological safety, cultural mismatch, flexible leave, emotional dissonance, and institutional fatigue (**Ifty et al., 2023b; Smith, 2025**).

Axial Coding: Codes were grouped into broader conceptual themes linking organizational behavior to staff outcomes. Five primary meta-themes emerged:

1. Systemic determinants of burnout
2. Structural and behavioral drivers of attrition
3. DEI as a moderator of engagement
4. Retention through inclusive practices
5. Accountability and DEI performance tracking

Selective Coding: Final themes were substantiated through triangulated data, including workforce statistics, case study excerpts, and institutional narratives. Coding diversity was validated across healthcare roles (e.g., nurses, physicians, allied professionals) and facility types (e.g., urban vs. rural hospitals).

Table 1 Summary of Thematic Coding

Main Theme	Sub-Themes / Key Codes	Sample Keywords
Systemic Determinants of Burnout	Moral injury, understaffing, poor leadership	Exhaustion, triage ethics, resource shortage
Structural Drivers of	Discrimination, rigid scheduling, lack of	Glass ceiling, career stagnation,

Main Theme	Sub-Themes / Key Codes	Sample Keywords
Attrition	promotion	inclusion gap
DEI and Engagement	Inclusive leadership, identity-affirming policies	Belonging, DEI impact, cultural sensitivity
Inclusive Retention Practices	Trauma-informed care, peer support, flexible scheduling	Support network, inclusive leave, identity safety
Accountability and Monitoring	DEI dashboards, equity audits, hiring diversity	Metrics, feedback, transparency

2.4.Interdisciplinary Triangulation

To increase analytical rigor, the study incorporated triangulation of three data streams: (1) workforce survey statistics, (2) qualitative case studies and interviews, and (3) institutional policy reviews. This ensured that thematic interpretations were grounded in diverse evidence types and applicable across different healthcare roles and settings. Integration of frameworks from health psychology, organizational sociology, and cognitive economics allowed positioning the findings within a broader socio-institutional context.

2.5.Evaluation Metrics for Impact Analysis

Two categories of indicators were used to assess the effectiveness of institutional DEI and workforce initiatives:

Process indicators: These included DEI training frequency, equity audit implementation, and diversity in hiring committees.

Outcome indicators: These encompassed staff retention rates, burnout reduction metrics (e.g., Maslach Burnout Inventory), employee satisfaction scores, and identity-specific Net Promoter Scores (NPS) (**Andreski et al., 2020; Chowdhury et al., 2020**). Each intervention was tracked at three temporal stages: initial (0-6 months), midterm (6-18 months), and long-term (>18 months), to ensure robust impact evaluation and detect trends over time.

2.6. Ethical Considerations

This study exclusively used secondary, peer-reviewed literature from credible databases and followed rigorous ethical standards in qualitative review practices. No AI-generated, commercial, or unverifiable content was used. All analysis, thematic synthesis, and data interpretation were carried out with full transparency and academic integrity. There were no conflicts of interest influencing the findings or conclusions.

2.7. Methodological Limitations

Despite methodological rigor, certain limitations are acknowledged. First, publication bias may skew

results, as studies showing positive DEI outcomes are more likely to be published. Second, an urban-centric bias exists in much of the source data, potentially underrepresenting rural and indigenous healthcare contexts **(Liddell, 2020).** Finally, the literature lacks sufficient focus on intersectional identities, particularly concerning disability, migration status, and LGBTQ+ experiences. Future research must explore these overlooked perspectives to build more inclusive and equitable health workforce models.

3. Results and Discussion

3.1. Burnout in the United States: A Systemic Crisis vs Healthcare Services

Burnout has become a widespread and entrenched issue in the U.S. healthcare system, exacerbated but not caused by the COVID-19 pandemic. Long before the crisis, healthcare workers faced persistent structural challenges, including staff shortages, bureaucratic inefficiencies, and emotionally taxing work environments. The pandemic intensified these pre-existing stressors, pushing burnout to critical levels and prompting national discourse on its systemic origins. Increasingly, burnout is viewed not as a personal failure, but as an institutional threat to the sustainability and functionality of healthcare delivery (**Maslach & Leiter, 2022; Sunny et al., 2025b**). Characterized by emotional exhaustion, depersonalization (cynicism), and reduced professional efficacy, burnout is intricately linked to systemic conditions within clinical settings (**Chowdhury et al., 2021; Tavella, 2023**). Contemporary organizational models such as the Job Demands-Resources (JD-R) framework illustrate that burnout arises when occupational demands chronically exceed available resources such as autonomy, task control, or managerial support. These imbalances are especially acute in high-acuity departments like emergency rooms and intensive care units, where workers report elevated emotional fatigue, overtime mandates, and restricted agency in decision-making (**Ifty et al., 2023a; Quinones-Otal, 2024**). Traditional wellness programs, such as mindfulness seminars and stress management workshops, often overlook these systemic root causes. While helpful for individual coping, they can inadvertently shift responsibility onto workers, deflecting attention from organizational reform (**Sazzad et al., 2025; Cannon, 2022**). More effective interventions require structural transformation such as redesigned staffing models, decentralized governance, emotionally intelligent leadership, and evidence-based nurse-to-patient ratio reforms (**Tyagi et al., 2024**).

The pandemic also revealed a more insidious layer of burnout: moral injury. Healthcare workers were often forced to make ethically compromising decisions, such as rationing care, denying treatments, or implementing triage policies that clashed with their professional codes of ethics. These violations of moral integrity led to long-lasting psychological trauma, resulting in widespread disengagement, absenteeism, and workforce attrition (**Norman et al., 2021; Ifty et al., 2024**). Burnout is not only a symptom of systemic dysfunction it is a leading predictor of voluntary exit from the profession.

Numerous studies confirm a strong correlation between emotional exhaustion and turnover intention. Organizations experiencing widespread burnout often face elevated resignation rates among nurses, early-career physicians, and allied health workers. The financial cost of turnover is significant: replacing a physician can exceed $100,000, while the replacement cost for a registered nurse averages $46,000 (**Alanazi et al., 2023**). These figures do not account for secondary consequences, such as diminished institutional memory, reduced continuity of care, and increased risk of clinical errors. The findings underscore a critical imperative addressing burnout requires an organizational reorientation that prioritizes employee well-being, psychological safety, and inclusive governance alongside operational efficiency. Burnout is both a cause and a consequence of systemic breakdown and without strategic intervention, it will continue to threaten healthcare access, quality, and equity.

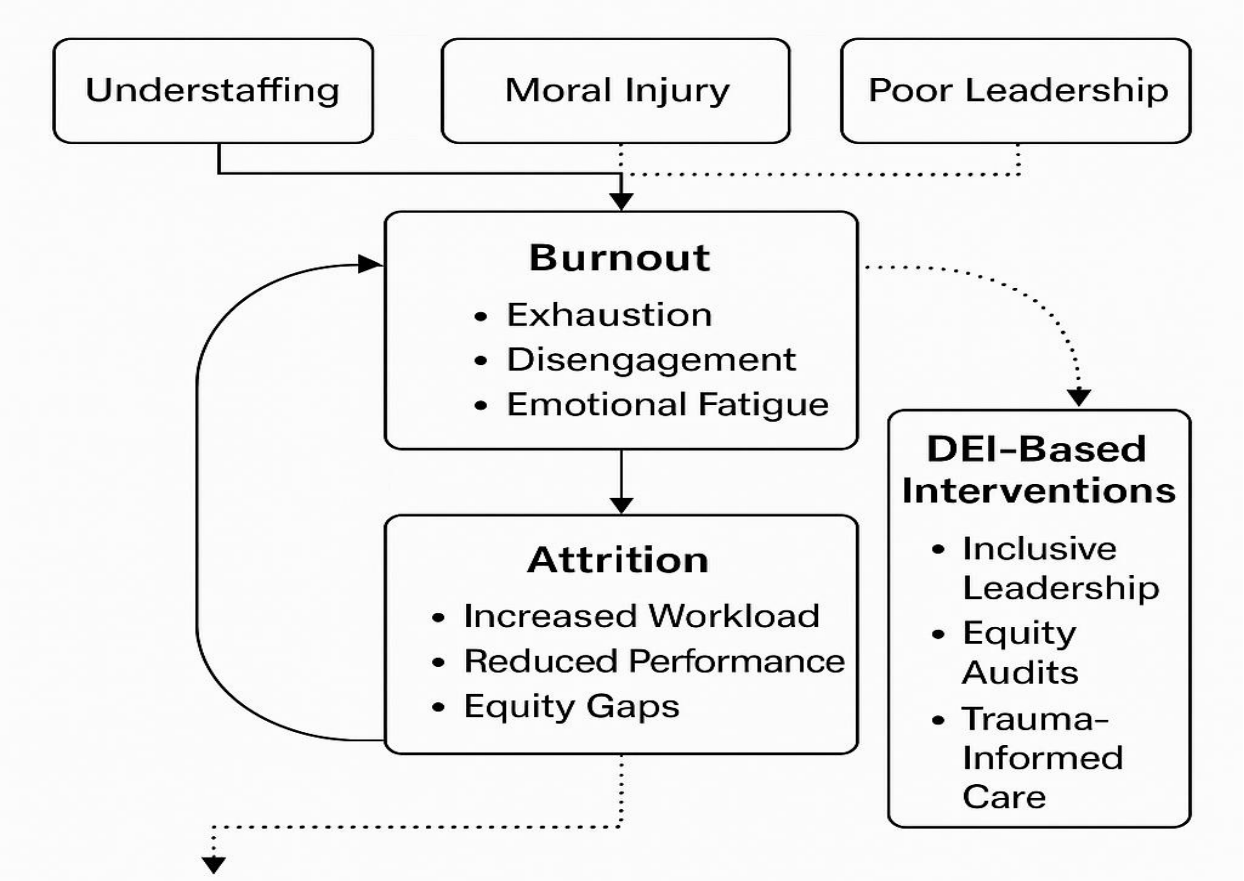

Figure 1. The Burnout Attrition Feedback Loop and DEI Intervention Points in U.S. Healthcare

This figure illustrates how systemic stressors such as understaffing, moral injury, and poor leadership contribute to professional burnout and eventual workforce attrition. Diversity, equity, and inclusion (DEI)-based interventions, including inclusive leadership and trauma-informed policies, are identified as critical strategies for disrupting the cycle and stabilizing healthcare workforce sustainability.

3.2. Structural and Behavioural Determinants of Attrition

While burnout captures the psychological toll of working in unsupportive environments, attrition represents the ultimate consequence when unmet needs, chronic stress, and institutional disconnect culminate in voluntary exit from the profession. Structural barriers such as inadequate compensation, rigid scheduling, limited career advancement, and unsafe working conditions are compounded by emotional factors, including lack of recognition, alienation, and institutional exclusion (**Chowdhury et al., 2022; Spetz et al., 2022**). Attrition is disproportionately high among historically marginalized groups, including women, racial and ethnic minorities, LGBTQ+ professionals, and internationally trained physicians. These individuals frequently report being excluded from leadership pipelines, advisory roles, and institutional decision-making spaces **(Carney, 2021; Akhter et al., 2025).** Organizations that lack inclusive mentorship programs, transparent promotion systems, and representative leadership inadvertently perpetuate systemic invisibility, leading to preventable loss of talent.

The concept of psychological contracts offers a valuable lens to understand this phenomenon. When employees' implicit expectations such as fairness, professional development, and organizational support are consistently violated, disillusionment and eventual disengagement follow (**Molloy-Martinez, 2023; Hossain et al., 2024**). Even well-compensated employees may resign if symbolic DEI efforts lack authenticity or if leadership fails to build institutional trust. The impacts of attrition extend beyond human resources. High turnover rates jeopardize care continuity, increase medical errors, and fracture long-term relationships between providers and patients. Underserved communities particularly those reliant on community health centers bear the brunt of these losses. Staff shortages in these settings worsen access inequities for Black, Latina, Indigenous, and immigrant populations (**Sunny et al., 2021; Chisolm et al., 2023**). Thus, staff retention is not merely an administrative concern; it is a critical pillar of healthcare equity. Retention strategies must move beyond salary-based incentives and instead address the systemic drivers of attrition. Creating inclusive, growth-oriented, and psychologically safe environments is essential to sustaining a diverse and committed workforce

3.3. Cultural Competence and Inclusive Retention Tactic

Culturally competent practices play a pivotal role in strengthening workforce retention, particularly among historically marginalized employee groups. At the organizational level, implementing equitable hiring practices, representative selection panels, and routine inclusion audits helps build fairness and increase the visibility of underrepresented staff (**Alabi & Mahmuda, 2024**). At the interpersonal level, peer networks and culturally sensitive mentorship programs foster a sense of belonging and psychological safety two critical factors in mitigating disengagement. Mental health support systems tailored to cultural contexts are especially vital. Trauma-informed counseling services delivered by culturally attuned professionals can significantly reduce emotional isolation and burnout.

Many healthcare workers from racially or culturally marginalized backgrounds delay seeking help due to fear of misinterpretation, cultural stigma, or lack of trust in institutional support (**Crosby et al., 2022**). Addressing this hesitancy through culturally appropriate mental health services is essential for workforce well-being.

The effectiveness of these interventions is supported by institutional case studies. Healthcare organizations that implemented identity-affirming programs such as employee resource groups, inclusive leadership training, and culturally responsive feedback systems reported a staff retention improvement of 18-22% over a three-year period, especially when supported by robust policy evaluations and accountability frameworks (**Cevasco & Trevino, 2024**). By positioning cultural competence as a strategic imperative rather than a symbolic initiative, organizations can cultivate environments that are not only diverse but also inclusive and psychologically safe. These practices directly enhance employee engagement, reduce turnover, and contribute to a resilient, high-functioning healthcare system.

3.4. Practical Techniques for Cultivating a Culturally Competent Workforce

Effective retention strategies are those that are research-informed, policy-integrated, and adaptable to the realities of a diverse workforce. Over the past several years, Diversity, Equity, and Inclusion (DEI) training programs have evolved from static, presentation-based modules to dynamic, participatory formats **(Salam et al., 2024)**. These now include role-playing exercises, scenario simulations, and workshops on cultural humility, all of which are linked to measurable improvements in empathy, team communication, and interdepartmental collaboration (**Sunny et al., 2020; Giordano et al., 2024**).

Technology is increasingly leveraged to support DEI implementation in human resource systems. AI-assisted recruitment platforms are being used to enhance transparency in candidate evaluation and to detect systemic patterns of exclusion across applicant pools. Furthermore, DEI dashboards embedded in HR information systems allow real-time monitoring of workforce diversity metrics, including turnover rates by identity group, promotion parity, and participation in DEI training programs **(Whyte-Phillips, 2024).** These tools provide actionable insights that inform evidence-based decision-making and institutional reform. Organizational accommodations also play a key role in retention. Institutions that offer extended parental leave, flexible holiday scheduling, and formal recognition of religious and cultural observances report higher employee satisfaction and reduced absenteeism **(Singh et al., 2025).** These adjustments, while simple, send strong signals of respect and belonging to a diverse workforce. Equally important is the integration of DEI into core governance structures. Inclusion should not be treated as a supplemental initiative, but rather as a priority embedded in the organization's operational framework just like clinical safety or financial compliance. DEI committees must hold formal decision-making authority, with access to budget allocations and accountability

mechanisms. Their success should be evaluated against quantifiable outcomes, such as staff retention, leadership diversity, and psychological safety indicators (**Roberson, 2025**). By embedding cultural competence into institutional policies, leadership evaluations, and resource allocation frameworks, healthcare organizations can foster inclusive environments that attract, develop, and retain a diverse and resilient workforce.

3.5. Institutional Action Plans and Policy Recommendations

To institutionalize cultural competency, healthcare organizations must move beyond surface-level initiatives and embed DEI principles into the core of their strategic, operational, and governance frameworks. This process begins with aligning organizational values, mission statements, and strategic plans to reflect equity as a foundational commitment rather than a peripheral concern. Actionable steps include conducting routine internal equity audits, deploying diverse and representative hiring panels, and applying blind resume screening to minimize unconscious bias during recruitment and promotion processes **(Sazzad et al., 2024).** These measures help correct structural imbalances that disproportionately impact marginalized professionals and improve access to leadership pathways. Creating a culture of psychological safety is equally vital. Institutions should establish peer support networks, offer trauma-informed mental health services, and adopt flexible leave policies that accommodate personal, cultural, and caregiving needs. Physical infrastructure should also reflect inclusivity gender-neutral restrooms, quiet prayer spaces, and accessible break rooms can contribute to a more supportive environment for all employees. Long-term transformation depends on the governance structure of DEI implementation. DEI committees must be granted formal authority, dedicated budgets, and mechanisms for tracking performance across departments. These bodies should have the capacity to make policy decisions, evaluate leadership on inclusion benchmarks, and oversee progress toward diversity-related goals (**Islam et al., 2025; Roberson, 2025**). When embedded into institutional DNA, these strategies do more than reduce attrition they create work environments that reflect justice, psychological safety, and inclusive excellence. Ultimately, they strengthen workforce morale, improve care outcomes, and enhance public trust in healthcare institutions.

3.6. Comparative Perspectives: American and Global Strategies for Burnout and DEI Integration

While the U.S. continues to grapple with persistent burnout and workforce attrition, several OECD nations have demonstrated more effective strategies for healthcare workforce sustainability. Countries such as Scandinavian nations, Canada, and Australia exhibit lower attrition rates and higher job satisfaction among healthcare professionals largely due to the presence of structural safeguards such as legally mandated nurse-to-patient ratios, paid mental health leave, and government-funded training programs (**Ballardie et al., 2023**). In Canada and Australia, national DEI frameworks are integrated into health system governance. These frameworks align cultural competency indicators with quality-of-care metrics, reinforcing accountability at both clinical and organizational levels. Initiatives include

policies to improve Indigenous health outcomes, multilingual communication systems, and inclusive standards for LGBTQ+ care. These comprehensive strategies address both patient and workforce equity, strengthening institutional trust and service delivery.

By contrast, the U.S. has historically treated burnout and DEI as internal human resource issues rather than systemic health policy concerns (**Murphy & Sauter, 2003**). In the absence of federally enforced DEI standards or burnout prevention mandates, responses across American institutions remain fragmented. Non-profit, rural, and under-resourced facilities are especially vulnerable to inconsistent implementation, with minimal institutional protections for marginalized staff. Countries like Canada and Australia also offer nationally coordinated cultural competency training, which links DEI performance with accreditation standards. Such programs encompass workforce needs around linguistic diversity, Indigenous health literacy, and gender-affirming care education domains where U.S. systems often underperform due to a lack of unified guidelines **(Shipman et al., 2023).** This policy fragmentation contributes to disparities in both care quality and staff morale.

Table 2. Comparative DEI and Burnout Prevention Strategies in the U.S., Canada/Australia, and Scandinavian Countries.

Indicator	**United States**	**Canada/Australia**	**Scandinavia**
National DEI Standards	Lacking (voluntary)	Federally mandated	Nationally enforced
Nurse-Patient Ratios	Not standardized	Moderately regulated	Legally enforced
DEI in Leadership Metrics	Rare	Tracked	Standardized
Government-Funded Wellness Programs	Minimal	Moderate	Extensive
Burnout Reporting Systems	Internal only	Institutional + policy-linked	Centralized national registry

Sources: (Ballardie et al., 2023; Shipman et al., 2023; Vanroelen et al., 2021; Murphy and Sauter, 2003).

Table 2 clearly outlines key structural differences among the U.S., Canada/Australia, and Scandinavian countries, emphasizing the outcomes associated with policy-level DEI integration.

These international comparisons reinforce a key insight, nations that institutionalize workforce wellness and cultural competence through centralized policies achieve better retention, equity, and overall system performance. In contrast, the U.S. reliance on decentralized governance, temporary staffing, and discretionary leadership perpetuates structural inequities and morale erosion especially among essential frontline personnel **(Vanroelen et al., 2021).**

3.7. Identity-Specific Retention: Universal Barriers to Workforce Inclusion

Understanding the lived experiences of healthcare professionals with marginalized identities is critical for addressing retention inequities. While race and gender remain dominant dimensions of workplace exclusion, intersectional identities such as LGBTQ+ women of color, healthcare workers with disabilities, and immigrant professionals face compounded challenges related to psychological safety, recognition, and career mobility.

For example, a Black female emergency physician in New York reported consistent exclusion from team leadership meetings and heightened performance scrutiny despite her seniority. This type of institutional marginalization contributes directly to emotional exhaustion, professional dissatisfaction, and eventual attrition (**Gregory, 2022; Alam et al., 2024**). Similarly, transgender employees cite disengagement stemming from gendered dress codes, restricted restroom access, and insensitive HR policies that fail to accommodate gender diversity (**Collins, 2022; Mithun et al., 2024**). International medical graduates (IMGs) who comprise approximately 15% of the U.S. healthcare workforce often report language-based stereotyping and social exclusion, despite holding equivalent or superior clinical qualifications (**Alam et al., 2023; Buchanan, 2024**). These exclusionary dynamics erode institutional trust and reinforce invisible barriers to career advancement.

These overlapping challenges and their corresponding DEI solutions are illustrated in Figure 2, which highlights the need for intersectional approaches to workforce inclusion

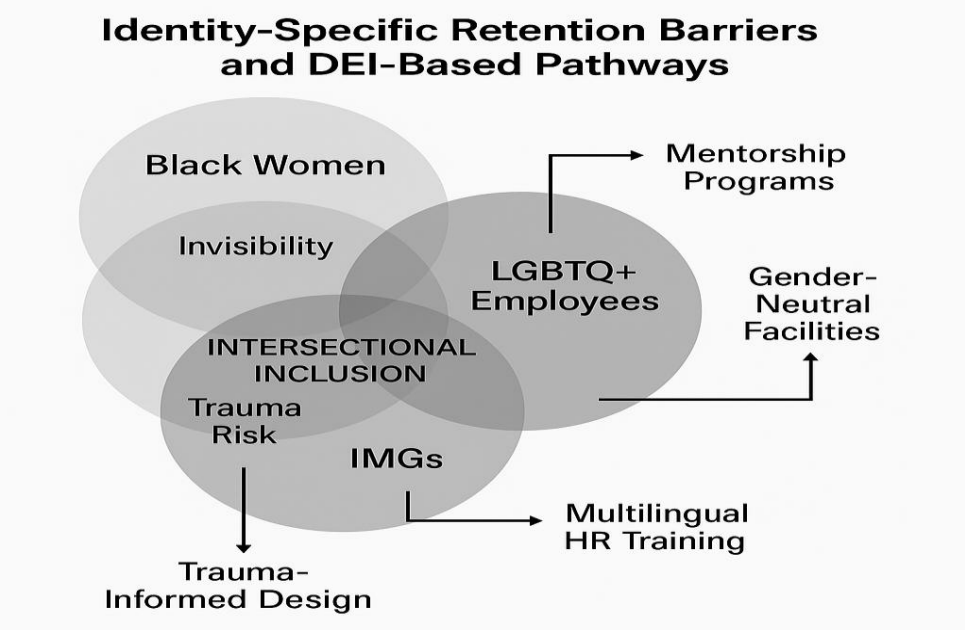

Figure 2 Identity-Specific Retention Barriers and DEI-Based Pathways

A Venn-style framework outlining the unique challenges faced by underrepresented healthcare professionals, including Black women, LGBTQ+ employees, disabled workers, and international medical graduates (IMGs). It visually connects targeted DEI interventions such as mentorship programs, trauma-informed design, and multilingual HR training to corresponding structural barriers.

Retention solutions must be identity-responsive. For BIPOC women, structured mentorship and sponsorship programs are essential. For healthcare workers with disabilities, inclusion must go beyond basic ADA compliance to include trauma-informed workplace design, accessible digital platforms, and sensory-friendly break spaces. Language equity efforts should promote multilingual communication across staff interactions not just in patient-facing roles. Healthcare organizations that acknowledge the nuanced barriers faced by underrepresented groups can better design policies that foster psychological safety, visibility, and long-term inclusion. By treating intersectional equity as a workforce priority, institutions can build environments that reflect justice and belonging for all employees.

3.8. The Leadership Gap: Culturally Competent Governance and Emotional Intelligence

While DEI initiatives and HR policies are often emphasized in organizational reform, the role of leadership behavior is arguably the most critical determinant of employee well-being, engagement, and retention. Leaders who demonstrate emotional intelligence, cultural sensitivity, and inclusive decision-making foster environments where staff feel psychologically safe, heard, and respected (**Gunasekera et al., 2021; Mahmud et al., 2024**). In contrast, hierarchical institutions that lack transparent communication and exhibit cultural insensitivity tend to breed mistrust, emotional detachment, and high attrition rates **(Oleksa-Marewska & Tokar, 2022; Rahman et al., 2024).** Effective leaders are those who model empathy, engage in active listening, and adapt communication styles based on team diversity. These relational qualities contribute directly to organizational morale, staff loyalty, and institutional resilience.

Today's diverse healthcare workforce demands more than operational competence it requires a relational leadership style rooted in equity, humility, and responsiveness. Culturally competent leaders make space for differing worldviews, encourage open dialogue, and actively dismantle power imbalances in team dynamics. For instance, they understand that assertiveness may be culturally interpreted differently, and that stigma may prevent some staff from expressing discomfort directly (**Mahin et al., 2021; Sazzad et al., 2024**). Inclusive leaders also embed emotional well-being into routine team functions. Instead of relying solely on top-down directives, they promote collaborative goal-setting, inclusive staff meetings, and frequent emotional check-ins that normalize vulnerability as part of professional excellence. These actions signal that workforce well-being is not an afterthought, but a central component of institutional integrity. Leadership accountability is essential to systemic change.

Executive teams must undergo training in anti-bias practices, cultural humility, and equity metrics. By incorporating DEI benchmarks into performance evaluations, institutions can transition from viewing inclusion as a moral ideal to recognizing it as a core leadership standard (**Groves et al., 2023; Mahjabin et al., 2024**). The sustainability of culturally competent healthcare environments depends on leadership that reflects its values not only in words but in daily behavior, governance practices, and strategic vision.

4. Conclusions and Future Actions

The COVID-19 pandemic not only introduced new challenges but also amplified deep-rooted structural vulnerabilities within the U.S. healthcare workforce most notably in the domains of burnout, attrition, and culturally competent leadership. Addressing these issues requires more than reactive or temporary measures; it demands a systemic transformation rooted in equity, psychological safety, and inclusive workforce strategies. This review highlights five key insights. First, burnout must be redefined as a structural crisis, not an individual failing. Chronic underfunding, rigid administrative models, and exclusionary work environments significantly contribute to emotional exhaustion and disengagement. Second, workforce attrition is often the product of institutional shortcomings ranging from salary inequities and unsafe working conditions to exclusion from leadership and decision-making processes.

Third, cultural competence is not just an ethical obligation but a strategic lever for improving morale, enhancing retention, and creating inclusive clinical environments. Fourth, evidence-based DEI interventions such as representative recruitment, longitudinal training, equity audits, and transparent governance are linked to quantifiable gains in staff engagement, job satisfaction, and organizational trust. Finally, sustainable progress hinges on leadership accountability. DEI must be embedded into core governance systems, including HR operations, budgeting, and executive performance metrics. Superficial commitments to DEI lacking sufficient authority or resourcing often stall meaningful progress. To stabilize the healthcare workforce, institutions must invest in leadership development for marginalized groups, reform promotion pathways to reduce bias, and empower cross-functional DEI task forces with budgetary and strategic authority.

Future research should prioritize longitudinal analyses that assess the impact of DEI on patient safety, workforce cohesion, and healthcare quality over time. Special attention should also be given to intersectional dynamics including race, gender, disability, and migratory status particularly in underrepresented settings such as rural hospitals, tribal health systems, and community clinics. Ultimately, building a culturally competent workforce is not a secondary concern it is a strategic imperative for the ethical, operational, and human sustainability of healthcare in the United States.

Inclusion must move from the margins of institutional design to its core, enabling systems that are not only clinically excellent but also resilient, diverse, and just.

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Author Contribution

The authors were involved in the creation of the study design, data analysis, and execution stages. Every writer gave their consent after seeing the final work.

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The authors declare that none of the work reported in this study could have been impacted by any known competing financial interests or personal relationships.

5. References

AAMC. (2023). *The Complexities of Physician Supply and Demand: Projections from 2021 to 2034*. Association of American Medical Colleges. https://www.aamc.org/media/57781/download

Alam, K., Chowdhury, M. Z. A., Jahan, N., Rahman, K., Chowdhury, R., Mia, M. T., & Mithun, M. H. (2023). Relationship between Brand Awareness and Customer Loyalty in Bangladesh: A Case Study of Fish Feed Company. Journal of Knowledge Learning and Science Technology ISSN: 2959-6386 (online), 2(3), 212-222.

Alam, M. R., Ansari, M. A. S., Chowdhury, M. E., Urbi, S. R. C., Rahman, K., Siddika, B. A., ... & Sazzad, S. A. (2024). Integrating Health Analytics tools to Enhance Pharmacological Management and Patient Outcomes in Hospital Settings. *Integrative Biomedical Research (Former Journal of Angiotherapy)*, *8*(12), 1-9.

Akhter, S., Ansari, M. A. S., Tiva, M. G., & Bhuyian, M. S. (2025). Improving Treatments for Oral Diseases, Head and Neck Cancers, as well as Developing New Technologies. *Pathfinder of Research*, *3*(1), 1-25.

Alabi, K. O., & Mahmuda, S. (2024). A review on the assessment of effective strategies for promoting a diverse and inclusive workplace culture: Bias training and equitable hiring approach. *International Journal of Research in Engineering, Science and Management*, *7*(5), 69–74.

Alanazi, F. K., Lapkin, S., Molloy, L., & Sim, J. (2023). Healthcare-associated infections in adult intensive care units: A multisource study examining nurses' safety attitudes, quality of care, missed care, and nurse staffing. *Intensive and Critical Care Nursing*, *78*, 103480.

Andreski, P. M., Cole, B. E., Watcharotone, K., Brumar, A. T., & Brown, D. J. (2020). Using a diversity, equity and inclusion Net Promoter Score to measure confidence in program impact. *Journal of Hospital Management and Health Policy*, *4*.

Ballardie, R., Tartanaglu-Bennett, S., & Weghmann, V. (2023). Mental health and public sector healthcare: international case studies.

Buchanan, S. (2024). The Lived Experiences of International Medical Graduates Who Encounter Financial and Language Barriers While Seeking Employment in the United States: A Phenomenological Study.

Buckley, L., Hall, L. M., Price, S., Visekruna, S., & McTavish, C. (2025). Nurse retention in peri-and post-COVID-19 work environments: a scoping review of factors, strategies and interventions. *BMJ open*, *15*(3), e096333.

Cannon, J. (2022). *Toxic cultures at work: The eight drivers of a toxic culture and a process for change*. Routledge.

Carney, C. J. J. (2021). *Disengagement by a Thousand Cuts: The Impact of Microaggressions on Employee Engagement*. University of Baltimore.

Cevasco, M., & Trevino, C. (2024). Essential Recommendations and Strategies for Mental Health Administrators and Leadership to Develop and Sustain Pediatric Bilingual Mental Health Care Services. *Evidence-Based Practice in Child and Adolescent Mental Health*, 1-13.

Chisolm, D. J., Dugan, J. A., Figueroa, J. F., Lane-Fall, M. B., Roby, D. H., Rodriguez, H. P., & Ortega, A. N. (2023). Improving health equity through health care systems research. *Health services research*, *58*, 289-299.

Chowdhury, R., Fahad, M. A. H., Alam, S. S., Tusher, M. I., Rana, M. N. U., Ahmed, E., ... & Mahin, M. R. H. (2020). Database Management in the Era of Big Data: Trends, Challenges, and Breakthroughs. *Pathfinder of Research*, *1*(1), 15-15.

Chowdhury, T. E., Chowdhury, R., Alam, S. M. S., & Sazzad, S. A. (2020). Empowering Change: The Impact of Microcredit on Social Business Development. *Pathfinder of Research*, *1*(1), 13-13.

Chowdhury, T. E., Chowdhury, R., Chaity, N. S., & Sazzad, S. A. (2021). From Shadows to Sunrise: The Impact of Solar Power Plants on Enhancing Bangladesh's Economy. *Pathfinder of Research*, *2*(1), 16-16.

Chowdhury, T. E., Chowdhury, R., Rahman, M. M., & Sunny, A. R. (2022). From Crisis to Opportunity: How Covid-19 Accelerated the Global Shift to Online Business. *Pathfinder of Research*, *3*(1), 18-18.

Collins, K. S. (2022). *Strategies for Influencing and Maintaining Employee Engagement of Transgender Employees Who Transition at Work* (Doctoral dissertation, Baker College (Michigan)).

Crosby, S. D., Kniffley Jr, S. D., Mitchell, B., Jones, K. V., Middleton, J., Caine, A., & Vides, B. (2022). "Decolonizing mental health": Exploring insights from clinicians trained in Kniffley Racial Trauma Therapy. *Practice Innovations*, *7*(3), 280.

Cyr, S., Marcil, M. J., Houchi, C., Marin, M. F., Rosa, C., Tardif, J. C., ... & Brouillette, J. (2022). Evolution of burnout and psychological distress in healthcare workers during the COVID-19 pandemic: a 1-year observational study. *BMC psychiatry*, *22*(1), 809.

Dickson, K. S., Holt, T., & Arredondo, E. M. (2025). Enhancing Behavioral Health Implementation in a Care Coordination Program at a Federally Qualified Health Center: A Case Study Applying Implementation Frameworks. *Health Promotion Practice*, *26*(3), 544-556.

Dueland, L. J. B. (2023). *DEI support structures: Relationships between organizational diversity, equity, and inclusion policies and employee experience* (Doctoral dissertation, University of Nebraska at Omaha).

Fahad, M. A. H., & Chowdhury, R. (2022). Evolution and Future Trends in Web Development: A Comprehensive Review. *Pathfinder of Research*, *3*(1), 13-13.

Giordano, N. A., Phan, Q., Kimble, L. P., Chicas, R., Brasher, S., Nicely, K. W., ... & Swan, B. A. (2024). The nurse-led equitable learning framework for training programs: A framework to grow, bolster and diversify the nursing and public health workforce. *Journal of Professional Nursing*, *53*, 25-34.

Gregory, A. (2022). *From Functioning to Flourishing: How Does Drama-Led Peace Education Help People Know, Experience And Transform Conflict? A Participatory Action-Research Project in a single school* (Doctoral dissertation, University of Nottingham).

Groves, K. S., Feyerherm, A. E., & Sumpter, D. (2023). Cultural intelligence as a global leadership competency in disruptive contexts. In *Handbook of Cultural Intelligence Research* (pp. 214-231). Edward Elgar Publishing.

Gunasekera, G., Liyanagamage, N., & Fernando, M. (2021). The role of emotional intelligence in student-supervisor relationships: Implications on the psychological safety of doctoral students. *The International Journal of Management Education*, *19*(2), 100491

Hossain, B., Sunny, A. R., Gazi, M. M. R. N., Das, A. R., Mohajon, R., Miah, T. H., & Rana, M. N. U. (2024). Advancing fish farming through deep learning: Applications, opportunities, challenges, and future directions. Pathfinder of Research, 2(3), 58–80.

Hossain, B., Chowdhury, T. E., Fahad, M. A. H., Hossen, M. E., Ahmed, R., Nesa, A., ... & Sunny, A. R. (2024). Machine Learning for Cardiovascular Healthcare: Opportunities, Challenges, and the Path Forward. *Integrative Biomedical Research*, *8*(12), 1-11.

Ifty, S.M.H, Bayazid, H., Ashakin, M.R., Tusher, M.I., Shadhin, R. H., Hoque, J., Chowdhury, R. & Sunny, A.R. et al. (2023b). Adoption of IoT in Agriculture - Systematic Review, Applied Agriculture Sciences, 1(1), 1-10, 9676

Ifty, S.M.H., Irin, F., Shovon, M.S.S., Amjad, M.H.H., Bhowmik, P.K., Ahmed, R., Ashakin, M.R., Hossain, B., Mushfiq, M., Sattar, A., Chowdhury, R. & Sunny, A.R. (2024). Advancements, Applications, and Future Directions of Artificial Intelligence in Healthcare, Journal of Angiotherapy, 8(8), 1-18, 9843, 10.25163/angiotherapy.889843

Ifty, S.M.H., Ashakin, M.R., Hossain, B., Afrin, S., Sattar, A., Chowdhury, R., Tusher, M.I., Bhowmik, P.K., Mia, M.T., Islam, T., Tufael, M. & Sunny, A.R. (2023a). IOT-Based Smart Agriculture in Bangladesh: An Overview. Applied Agriculture Sciences, 1(1), 1-6. 9563, 10.25163/agriculture.119563

Islam, M. A., Kunda, M., Harun-Al-Rashid, A., Sunny, A. R., Mithun, M. H., Sazzad, S. A., & Bhuiyan, M. K. A. (2025). Can Climate-Resilient Tilapia Cage Culture Support Sustainable Livelihoods in Flood-Prone Bangladesh?. *Water*, *17*(4), 585.

Islam, M.M., Sunny, A.R., Hossain, M.M., Friess, D. A., 2018. Drivers of mangrove ecosystem service change in the Sundarbans of Bangladesh. Singapore Journal of Tropical Geography, 2018; 39(2). http://doi:10.1111/sjtg.12241

Liddell, J. L. (2020). Barriers to healthcare access for a native American tribe in the Gulf Coast region of the United States. In *Race, ethnicity, gender and other social characteristics as factors in health and health care disparities* (pp. 73-94). Emerald Publishing Limited.

Long, K. C., Gunder, A., Robinson, B., Davis, V. L., Barth, D., Adams, T., ... & Ross, O. (2024). Leading the AI Revolution: The Crucial Role of HBCUs in Steering AI Leadership. *Online Learning Consortium*.

Mahin, M. R. H., Ahmed, E., Akhi, S. S., Fahad, M. A. H., Tusher, M. I., Chowdhury, R., & Rana, M. N. U. (2021). Advancements and Challenges in Software Engineering and Project Management: A 2021 Perspective. *Pathfinder of Research*, *2*(1), 15-15.

Mahmud, M. S., Dutta, A., A., Ahmed, A., Haque, J., Mawla, M. A., Hossain, M., ... & Sunny, A. R. (2024). In-Between Mobility and Immobility: Gradual Transformation of the Nomad Fishers of Bangladesh to Sedentary Lifestyle. *Egyptian Journal of Aquatic Biology & Fisheries*, *28*(5).

Mahjabin, Z., Dey, D., Islam, M. M., Mahamud, S., & Sunny, A. R. (2024). Anthropogenic and Environmental Factors Affecting Biodiversity and Human Well-being in an Ecologically Sensitive Wetland. *Pathfinder of Research*, *2*(3), 18-18.

Maslach, C., & Leiter, M. P. (2022). *The burnout challenge: Managing people's relationships with their jobs*. Harvard University Press.

Meese, K. A., Boitet, L. M., Sweeney, K. L., Gorman, C. A., Nassetta, L. B., Patel, N., & Rogers, D. A. (2024). Don't go: examining the relationships between meaning, work environment and turnover intention across the entire healthcare team. *Journal of multidisciplinary healthcare*, 353-366.

Mirzada, A. (2023). *Unable to Heal: Physicians from Afghanistan Attempt to Reenter the United States MedicalField*. Temple University.

Mithun, M. H., Shaikat, M. F. B., Sazzad, S. A., Billah, M., Al Salehin, S., Foysal, M., ... & Sunny, A. R. (2024). Microplastics in Aquatic Ecosystems: Sources, Impacts, and Challenges for Biodiversity, Food Security, and Human Health-A Meta Analysis. Journal of Angiotherapy, 8(11), 1-12.

Molloy-Martinez, J. (2023). *Employee Expectations and the Role of Leadership in Social and Psychological Contracts* (Doctoral dissertation, Adler University).

Montgomery, A. J., Van der Doef, M., Panagopoulou, E., & Leiter, M. P. (2021). Connecting health care worker well-being, patient safety and organizational change: the triple challenge. In *Connecting Healthcare Worker Well-Being, Patient Safety and Organisational Change: The Triple Challenge* (pp. 1-7). Cham: Springer International Publishing.

Murphy, L. R., & Sauter, S. L. (2003). The USA perspective: Current issues and trends in the management of work stress. *Australian Psychologist*, *38*(2), 151-157.

Norman, S. B., Feingold, J. H., Kaye-Kauderer, H., Kaplan, C. A., Hurtado, A., Kachadourian, L., ... & Pietrzak, R. H. (2021). Moral distress in frontline healthcare workers in the initial epicenter of the COVID-19 pandemic in the United States: Relationship to PTSD symptoms, burnout, and psychosocial functioning. *Depression and anxiety*, *38*(10), 1007-1017.

Oleksa-Marewska, K., & Tokar, J. (2022). Facing the post-pandemic challenges: The role of leadership effectiveness in shaping the affective well-being of healthcare providers working in a hybrid work mode. *International journal of environmental research and public health*, *19*(21), 14388.

Park, S., & Leedham-Green, K. (Eds.). (2024). *Generalism in Clinical Practice and Education*. UCL Press.

Quinones-Otal, A. (2024). Best Practices to Reduce Nurse Fatigue in Hospital Intensive and Critical Care Units, Decrease Nurse Turnover, and Improve Quality Care.

Rana, M. N. U., Akhi, S. S., Tusher, M. I., Mahin, M. R. H., Ahmed, E., Chowdhury, T. E., ... & Bashir, M. (2023). The Role of AI and Generative AI in US Business Innovations, Applications, Challenges, and Future Trends. *Pathfinder of Research*, *1*(3), 17-33.

Rahman, K., Alam, M. R., Chowdhury, R., & Urbi, S. R. C. (2024). The Evolution of Business Analytics: Frameworks, Tools, and Real-World Impact on Strategic Decision-Making in the Digital Age. *Pathfinder of Research*, *2*(2), 37-58.

Roberson, Q. (2025). How Integrating DEI Into Strategy Lifts Performance. *MIT Sloan Management Review*, *66*(2), 62-65.

Salam, M. T., Bari, K. F., Sunny, A. R., & Hasan, H. (2024). Relationship of Troponin I in septic patients without cardiac disease. *Journal of Primeasia*, *5*(1), 1-8.

Sazzad, S. A. S. S. A., Ana, R. A. R. S. R., Shawon, R., Moniruzzaman, M., Hussain, M. H. M., & Zaman, F. Z. F. (2024). Climate Change and Socioeconomic Challenges of Fishing Communities in the Coastal District of Shariatpur in Bangladesh. *Pathfinder of Research*, *2*(1).

Sazzad, S. A., Chowdhury, R., Hasan, M. R., Tiva, M. G., Rahman, K., Ansari, M. A. S., & Sunny, A. R. (2025). Public Health, Risk Perception, and Governance Challenges in the 2025 Los Angeles Wildfires: Evidence from a Community-Based Survey. *Pathfinder of Research*, *3*(1), 26-41.

Shipman, K., Burrell, D. N., & Huff Mac Pherson, A. (2023). An organizational analysis of how managers must understand the mental health impact of teleworking during COVID-19 on employees. *International Journal of Organizational Analysis*, *31*(4), 1081-1104.

Singh, B., Wongmahesak, K., Sonkla, T., & Chandra, S. (2025). Building a Mind-Supportive Workplace: Practical DE&I Strategies for Prioritizing Employee Mental Health. In *Prioritizing Employee Mental Health and Well-Being for Organizational Success* (pp. 73-90). IGI Global Scientific Publishing.

Smith, A. M. (2025). *The Evolution of Organizational Diversity Training Programs in the Post-George Floyd Era: A Qualitative Study* (Doctoral dissertation, The Chicago School of Professional Psychology).

Spetz, J., Hailer, L., Gay, C., Tierney, M., Schmidt, L. A., Phoenix, B., & Chapman, S. A. (2022). Buprenorphine Treatment: Advanced Practice Nurses Add Capacity: Study examines office-based buprenorphine treatment capacity for opioid use disorder. *Health Affairs*, *41*(9), 1231-1237.

Sazzad, S. A., Mithun, M. H., Mr, M., Ahmed, A., Samiullah, M., Hamid, M. A., ... & Sunny, A. R. (2024). Nomad Fishers: A Socially Excluded and Climate Vulnerable Fishing Community in Bangladesh.

Sunny, A. R., Alam, R., Sadia, A. K., Miah, Y., Hossain, S., & Mofiz, S. B. (2020). Factors affecting the biodiversity and human well-being of an ecologically sensitive wetland of North Eastern Bangladesh. *Journal of Coastal Zone Management*, *23*(1), 471.

Sunny, A. R., Prodhan, S. H., Ashrafuzzaman, M., Sazzad, S. A., Aminur Rahman, S. M., Billah, M. M., ... & Alam, M. T. (2021). Livelihoods and Vulnerabilities of Small-Scale Fishers to the Impacts of Climate Variability and Change: Insights from the Coastal Areas of Bangladesh. *Egyptian Journal of Aquatic Biology & Fisheries*, *25*(4).

Sunny, A. R., Rahman, M. A., Hasan, M. N., Bhuyian, M. S., Miah, M. F., Ashrafuzzaman, M., Pervin, A., Rahman, J. F., & Prodhan, S. H. (2025a). *Hilsa (Tenualosa ilisha) genetic diversity and conservation strategies for sustainable wetland management in northeastern Bangladesh*. Egyptian Journal of Aquatic Biology & Fisheries, 29(1), 1089–1105. https://doi.org/10.21608/ejabf.2025.259581

Sunny, A. R., Sazzad, S. A., Bhuyian, M. S., Hasan, M. N., Miah, M. F., Ashrafuzzaman, M., & Prodhan, S. H. (2025b). Fish Genetic Resources and Wetland Conservation in Bangladesh: Comparative Insights on Biodiversity, Sustainable Management, and Sustainable Development Goals. *Limnological Review*, *25*(2), 20. https://doi.org/10.3390/limnolrev25020020

Tavella, G. (2023). *Self-diagnosed burnout: an examination of its definition, symptoms, and relationship with clinical depression* (Doctoral dissertation, UNSW Sydney).

Tufael, M., Kar, A., Upadhye, V.J., Dutta, A., Islam, M.R. ….& Sunny, A. R. (2024). Significance of Serum Biomarkers in Early Diagnosis of Hepatocellular Carcinoma in Patient with Fisher Groups. *Angiotherapy*.

Tyagi, S., Mishra, S., & Dey, A. K. (2024). Well-being among health care professionals: A hybrid review, integrative framework, and research agenda. *International Journal of Stress Management*.

Valeriani, G., Sarajlic Vukovic, I., Bersani, F. S., Sadeghzadeh Diman, A., Ghorbani, A., & Mollica, R. (2022). Tackling ethnic health disparities through community health worker programs: a scoping review on their utilization during the COVID-19 outbreak. *Population health management*, *25*(4), 517-526.

Vanroelen, C., Julià, M., & Van Aerden, K. (2021). Precarious employment: an overlooked determinant of workers' health and well-being?. *Flexible working practices and approaches: Psychological and social implications*, 231-255.

Whyte-Phillips, K. S. (2024). *Effective Strategies Human Resource Business Leaders Use to Implement Diversity, Equity, and Inclusion Initiatives that Reduce Worker Turnover* (Doctoral dissertation, Walden University).