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Promise and Perils of Leader-Employee Check-ins in Reducing Emotional Exhaustion in Primary Care Clinics: Quasi-Experimental and Qualitative Evidence

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Abstract

Objective: To analyze the role of short (<30 minutes) and frequent (quarterly) check-ins between clinic leaders and employees in reducing emotional exhaustion.

Methods: Three interrelated studies were conducted: a 3-year repeated cross-sectional survey at 10 primary care clinics (n=505; we compared emotional exhaustion, perceived stress, and values alignment among employees of a clinic where check-ins were conducted vs 9 control clinics); interviews with leaders and employees (n=10) regarding the check-ins process and experiences; and interviews with leaders and employees (n=10) after replicating the check-ins at a new clinic.

Results: Outcomes were similar at baseline. After a year, emotional exhaustion was lower at the check-ins compared with control clinics (standardized mean difference, *d*, −0.71 [*P*<.05]). After 2 years, emotional exhaustion remained lower at the check-ins clinic, but this difference was not significant. The check-ins were associated with an increment in values alignment (2018 vs 2017, *d*=0.59 [*P*<.05]; 2019 vs 2017, *d*=0.76 [*P*<.05]). There were no differences for perceived job stress. Interviews indicated that work-life challenges were discussed in the check-ins. However, employees need confidentiality and to feel safe to do so. The replication suggested that the check-ins are feasible to implement even amid turbulent times.

Conclusion: Periodic check-ins wherein leaders acknowledge and address work-life stressors might be a practical tactic to reduce emotional exhaustion in primary care clinics.

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Emotional exhaustion, a constituting feature of burnout, refers to worn-out feelings that result from chronic work stress.[1] Emotional exhaustion and burnout afflict about a third to a half of the health care workforce.[2,3] Emotional exhaustion has been an omnipresent cloud hanging over the health care industry in the last 2 decades, and the COVID-19 pandemic has added more insult to this long-standing psychological injury.[4] Drivers of emotional exhaustion are multifactorial, including excessive charting and electronic health records demands,[5] time pressures, and inefficient workflows coupled with a lack of resources, such as staffing or equipment, to meet high demands.[6-8] Psychosocial and organizational drivers include mistrust of clinic leaders, lack of purpose or joy in work, and ineffective work teams.[9] Despite that emotional exhaustion is an industry-wide problem,[10] the burden of its solutions and consequences often falls on clinic leaders who desperately need urgent guidance to implement swift, low-effort, practical, and meaningful strategies to manage an afflicted workforce.

Even amid a volatile context such as the COVID-19 pandemic, the National Academy of Medicine highlighted the leader-worker interaction as a more predictable factor in addressing emotional exhaustion.[11] Clinic

leaders influence the organizational culture at their clinics, creating conditions that aggravate or lessen job stressors.[12,13] Studies have reported the potential of higher values alignment with clinic leaders in reducing emotional exhaustion in health care workers.[12,14] Clinic leaders have an impact on emotional exhaustion by fostering psychological safety and demonstrating care and concern for employees[15] as well as by spearheading reductions of job demands and redundant or ambiguous procedures or increasing resources.[16] Clinic leaders can also address burnout drivers by interacting with organizational leaders with more power and authority to adjust work demands,[17] advocating for or requesting more safety and well-being resources.[18,19] The impacts of COVID-19 on the health care workforce have created an imperative for robust approaches to enhance the leader-employee relationship. Leaders often need coaching and a model for optimal relational relationship behaviors, such as Wellness-Centered Leadership, which focuses on elements such as care for people, cultivating relations, and readiness for change.[20]

Workplace interventions that have trained supervisors to demonstrate more effectively emotional (eg, reflective listening) or instrumental (eg, adding resources, changing environments or procedures) support have produced improvements in mental health outcomes in many industries.[21] Likewise, evidence indicates the benefits of leadership-based training (eg, transformational, relational) on many precursors of burnout, such as teamwork effectiveness.[22] Leadership "walk rounds" to assess concerns and to provide constructive feedback to team members have effectively reduced emotional exhaustion and improved safety culture.[23] The premise of these approaches is the need for clinic leaders to create or to maintain encounters with staff to reflect themselves as empathic, humble leaders who take employees' concerns seriously and act with clear communication and expectations.[24]

Given the prevalence and consequences of emotional exhaustion, many primary care clinics have attempted solutions such as addressing workflow breakdowns, improving communication, or reducing job stressors.[25] Even when successful, these idiosyncratic approaches address clinic-specific concerns; thus, a detailed documentation is required for replications in other settings. This study presents quantitative and qualitative evidence from 3 interrelated studies of a practice focused on the leader-employee relationship. We present 3 data sources: a quasi-experimental study examining a survey conducted at multiple primary care clinics in 2017, 2018, and 2019, whose preliminary analyses signaled the check-ins as a potential explanation for reduced burnout levels; in-depth interviews with clinic leaders and staff who participated in the check-ins to detail the process and experience; and interviews with clinic leaders and employees after replicating the check-ins at a new clinic to elucidate short-term successes and barriers. We discuss the promise and perils of brief and frequent leader-employee check-ins in reducing emotional exhaustion among primary care clinic workers.

METHODS

Overall Context

We conducted the 3 interrelated studies at primary care clinics of a large academic health center in the US Pacific Northwest. The institutional review board at Oregon Health & Science University approved this study.

Study 1: Employee Surveys

We administered the survey in the fall of 2017, 2018, and 2019. In 2017, we emailed the survey to 540 email addresses, and 340 participants completed the survey (response rate of 60.9%). Of those, 330 had information regarding emotional exhaustion. In 2018, 293 of 567 participants completed the survey (response rate of 51.7%); in 2019, 288 of 600 surveys were returned (response rate of 49.4%) (two observations had missing data for emotional exhaustion). Altogether, 518 participants completed any survey, and of those, 505 had data for the three outcomes ,and 133 completed the survey in each of the 3 waves. Patient-facing employees of 10 primary care clinics (eg,

patient access specialists, medical assistants, nurses, residents, and clinical faculty) were invited to participate in the survey. Employees who did not have a supervisor at a clinic were excluded. The research team programmed the survey in REDCap; it had an approximate duration of 10 to 15 minutes, and it was sent directly to eligible participants' email addresses. No individual participation incentives were provided, but participants were allowed to complete the survey during work hours, and the clinics with the highest response rate received a catered lunch.

Emotional exhaustion was measured with the Mini Z questionnaire,[26] which has a single item that instructs participants to rate their current experience from "I enjoy my work, I have no symptoms of burnout" (1 point) to "I feel completely burned out. I am at the point where I may need to seek help" (5 points). Although this single item asks about burnout in general, it has shown strong correlations with the emotional exhaustion dimension of burnout, thus serving as a proxy.[27] The Mini Z also includes a question for perceived stress (eg, "I feel a great deal of stress because of my job") and for values alignment with clinic leaders (eg, "My professional values are well aligned with those of my clinic leaders"). These secondary outcomes were rated on a 5-point positive scale from strongly disagree to strongly agree. The survey included several items for roles at the clinic: clinical faculty (doctor of medicine, doctor of osteopathic medicine), patient care staff (medical assistants and registered nurses), and non—patient care staff (patient access specialists, billing). Likewise, the survey included questions for individual-level characteristics (eg, sex, underrepresented status in health care [in terms of race/ethnicity, socioeconomic status, disability, LGTBQ+], work hours, and tenure at the clinic; Table 1).

Study 2: In-depth Interviews

Our preliminary analyses indicated that emotional exhaustion was lower in 2018 relative to 2017 at 1 particular clinic, so we inquired with clinic leaders about potential explanations, and thus we learned about the check-ins. Consequently, we conducted several interviews to obtain details about the process, experiences, and outcomes. We conducted 30- to 45-minute interviews with all the clinic leaders who led 1-on-1 check-ins with their staff, namely, the practice manager, the medical director, the supervisors for the patient access specialists, and the medical assistants (n=4). We also interviewed a convenience sample (n=6) of employees who shared their experience with the check-ins, recruited through flyers and emails sent by the practice manager. The 10 interviews were conducted from October 2020 to April 2021. The interviews were semistructured, asking participants about the rationale for the check-ins, the logistics and process, their perceived impact, and any opportunity for improvement. However, the analysis was based on an inductive process, highlighting salient themes that emerged from the transcripts (see Table 4). All participants received a $50 gift certificate. The interviews were conducted and recorded online through WebEx and had verbatim transcription by a professional service. The main output from these interviews was a protocol with instructions to implement the check-ins in the replication study (Figure).

Study 3: Replication of Check-ins at a New Clinic

After learning about the process and experience of the check-ins, we recruited another primary care clinic to pilot test the feasibility of check-ins amid the COVID-19 pandemic, specifically during the beginning of the Delta variant outbreak (summer 2021). This study also happened amid the resignation and appointment of a new practice manager. The replication started with an overview of the check-ins with a meeting with leaders only, followed by another presentation at the all-staff regular monthly meeting. We also provided a 30-minute training to all the clinic leaders we asked to do the check-ins, which consisted of a presentation of the instructions with examples from the previous study, followed by questions and comments. We also provided a list of

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resources available to all employees (eg, employee assistance programs) to be distributed during the check-ins. We instructed clinic leaders to check in at least once every 1 to 2 months. During the study period, the clinic experienced a change of practice manager, so we provided the check-ins in an additional meeting for this new hire. Interviews were conducted in a similar strategy as mentioned before, targeting leaders and staff who had most recently participated in check-ins. We interviewed leaders after each round of check-ins (n=5; practice manager, medical directors, nursing lead, medical assistant lead, and patient access specialists lead). A convenience sample of employees (n=5 of 30 clinic staff) who participated in check-ins were interviewed after completing a check-in (ie, physician, medical assistant, nurse, patient access specialist). All participants received a $50 gift certificate for each completed interview.

Data Analyses

Study 1. We tested whether the check-ins were associated with lower emotional exhaustion, perceived stress, and higher values alignment with clinic leaders with generalized linear mixed models (GLMMs). Each GLMM estimated changes in outcomes over time between the check-ins clinics and a control group of 9 primary care clinics. We assumed an unstructured covariance matrix to address the autocorrelation of outcomes over time. Likewise, standard errors accounted for individuals clustered by clinic. The GLMM included an indicator variable for check-ins clinic vs controls clinics (reference), survey year (2017 as reference), and their respective interaction terms (check-ins × year). We conducted the GLMM with a cohort-based data set (ie, the 133 participants who completed the 3 surveys) and a complete-case data set (ie, 505 participants who completed any survey). We also examined any outcome difference at baseline between participants who did not complete more than the initial survey and those who completed each survey. Covariates were fixed individuals' characteristics whose distribution did not differ between check-ins and control clinics. Still, we examined their association with each outcome to determine which variables to include in the adjusted GLMM. As such, the GLMM controlled for sex and tenure at the clinic. To estimate the strength of the association, we computed standardized mean differences (Cohen *d*) for pre-post repeated designs.[28] Statistical analyses were conducted with SAS software (9.4; SAS Institute) and had a .05 level of significance.

Study 2. Interviews with clinic leaders and staff were analyzed with an inductive process, extracting recurring themes using Atlas.ti software. A research assistant initially coded interview transcriptions and refined coding and themes after discussion with the investigators.

Study 3. We followed a similar coding process, although the contents were analyzed in light of the study feasibility framework of Bowen et al[29] per 8 categories: acceptability (perceived appropriateness of the check-ins for the clinic), demand (difficulty in implementing the check-ins), implementation (the extent to which the check-ins were carried out as intended), practicality (whether check-ins can be implemented with clinic resources), adaptation (whether the check-ins can be adjusted to fit the clinic context), integration (whether the check-ins can be used in tandem with other procedures or resources), expansion (whether the check-ins can address multiple issues), and efficacy (whether the check-ins are expected to reduce burnout).

RESULTS

Study 1

Table 1 lists descriptive statistics of the sample per year between check-ins and control clinics. The median range of participants per clinic was 59 (range, 18 to 104). At baseline (2017), there were no differences in any outcome between those who completed the 3 surveys (n=133) and those who did not (n=385; *P*=.89 for emotional exhaustion; *P*=.36 for perceived job stress; *P*=.14 for

TABLE 1. Description of Study Participants in Employee Survey

	2017 (n=330)				2018 (n=293)				2019 (n=286)			
	Control clinics (n=277)		Check-ins clinic (n=53)		Control clinics (n=256)		Check-ins clinic (n=37)		Control clinics (n=243)		Check-ins clinic (n=43)	
	M	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD
Emotional exhaustion, 1-5	2.17	0.90	2.44	0.80	2.47	1.00	2.02	0.81	2.31	0.95	2.17	0.86
Perceived job stress, 1-5	3.18	1.19	3.28	0.95	3.35	1.19	2.83	1.02	3.26	1.19	3.20	1.05
Values alignment with clinic leaders, 1-5	4.05	0.87	3.84	0.99	3.82	0.91	4.21	0.67	3.84	0.92	4.17	0.97
Sex												
Male	18.89		21.15		21.20		33.33		18.41		34.15	
Female	75.56		67.31		68.80		55.56		73.22		48.78	
Other/nonbinary	0.74		1.92		0.40		2.78		0.42		4.88	
Declined to answer	4.81		9.62		9.60		8.33		7.95		12.20	
Underrepresented in medicine												
Yes	19.93		14.29		17.93		14.29		21.10		31.71	
No	71.31		77.14		71.31		77.14		71.73		60.98	
Declined to answer	10.76		8.57		10.76		8.57		7.17		7.32	
Role at clinic												
Clinical staff (MA, LPN, RN, social worker)	51.99		43.40		51.95		43.24		53.88		41.86	
Faculty (DO, MD, NP)	22.38		28.30		23.44		21.62		18.78		25.58	
Nonclinical staff (patient access specialist)	25.63		28.30		24.61		35.14		27.35		32.56	
Tenure at clinic												
<1 year	22.02		9.43		12.25		5.41		14.29		20.93	
1-5 years	40.07		49.06		47.83		37.84		46.53		27.91	
5-10 years	18.77		22.64		21.34		29.73		20.82		27.91	
>10 years	17.33		18.87		17.79		27.03		17.14		23.26	
Declined to answer	1.81		0		0.79		0		1.22		0	
Work hours												
<40 hours	81.18		91.43		80.81		95.65		78.26		85.71	
≥40 hours	18.82		8.57		19.19		4.35		21.74		14.29	

DO, doctor of osteopathic medicine; LPN, licensed practical nurse; MA, medical assistant; MD, doctor of medicine; NP, nurse practitioner; RN, registered nurse. Categorical variables are presented as percentage.

TABLE 2. General Linear Mixed Models Showing Differences Between the Check-ins and Control Primary Care Clinics Using a Cohort-Based Data Set (n=133)

	Emotional exhaustion				Perceived job stress				Values alignment with clinic leaders			
	b	SE	95% CI		b	SE	95% CI		b	SE	95% CI	
Intercept	2.20***	0.08	2.03	2.36	3.20***	0.10	3.00	3.41	4.12***	0.07	3.96	4.27
2018 wave vs 2017 wave (reference)	0.27**	0.08	0.10	0.44	014	0.09	−0.05	0.33	−0.26**	0.08	−0.42	−0.11
2019 wave vs 2017 wave (reference)	0.20*	0.10	0.01	0.40	0.23*	0.10	0.02	0.45	−0.26*	0.08	−0.42	−0.11
Check-ins vs control clinics (reference)	0.09	0.20	−0.30	0.49	0.10	0.19	−0.34	0.54	−011	0.18	−0.46	0.23
2018 × check-ins interaction	−0.62**	0.22	−1.05	−0.18	−0.47	0.32	−1.10	0.16	0.51**	0.15	0.20	0.82
2019 × check-ins interaction	−0.30	0.22	−0.73	0.13	−0.33	0.27	−0.87	0.20	0.60**	0.18	0.24	0.96

*P<.05; **P<.001; ***P<.0001.

values alignment). The covariate distribution was similar between check-ins and control clinics at baseline, although the check-ins clinic had a slightly higher proportion of workers who self-identified as male or nonbinary.

The results show an association between check-ins and lower emotional exhaustion. The estimates were statistically similar, including a cohort-based data set (133 participants who completed the 3 surveys; Table 2) and a repeated cross-sectional data set (505 participants who completed any survey; Table 3). In 2017, before the check-ins, the clinic at which they were subsequently implemented had higher emotional exhaustion than control clinics. However, this difference was not statistically significant (P=.35). In 2018, after the check-ins had been implemented for about 8 months (as was later established by the interviews), emotional exhaustion was reduced, whereas it increased at the control clinics (Tables 2 and 3). This difference corresponds to a Cohen d of −0.71. By 2019, the difference was not statistically significant (P=.17; Tables 2 and 3). The perceived job stress differences between the check-ins and control clinics were not statistically significant (P=.28 for 2017 vs 2019 and P=.39 for 2017 vs 2019). However, the increment in values alignment with clinic leaders was statistically significant at the check-ins clinic, whereas this variable declined at the control clinics (Tables 2 and 3). The difference between clinics increased over time

TABLE 3. General Linear Mixed Models Showing Differences Between the Check-ins and Control Primary Care Clinics Using a Complete-Case Data Set (n=505)

	Emotional exhaustion				Perceived job stress				Values alignment with clinic leaders			
	b	SE	95% CI		b	SE	95% CI		b	SE	95% CI	
Intercept	1.77***	0.07	1.62	1.92	2.69***	0.10	2.47	2.90	4.13***	0.07	3.98	4.28
2018 wave vs 2017 wave (reference)	0.20**	0.07	0.08	0.32	0.05	0.07	−0.09	0.20	−0.21**	0.06	−0.34	−0.08
2019 wave vs 2017 wave (reference)	0.10	0.06	−0.02	0.24	0.03	0.08	−0.12	0.19	−0.21*	0.07	−0.35	−0.06
Check-ins vs control clinics (reference)	0.08	0.13	−0.17	0.33	−0.07	0.16	−0.39	0.24	−0.22	0.13	−0.49	0.03
2018 × check-ins interaction	−0.52**	0.16	−0.85	−0.19	−0.40	0.84	0.03	0.12	0.51**	0.13	0.23	0.78
2019 × check-ins interaction	−0.25	0.18	−0.61	0.11	−0.06	0.20	−0.45	0.33	0.53**	0.16	0.21	0.85

*P<.05; **P<.001; ***P<.0001. Model adjusted by sex and tenure at clinic.

TABLE 4. Results From Interviews (n=10) Regarding the Core Elements of the Original Check-ins Conducted at a Primary Care Clinic

Theme	Participant	Examples
Worker centered	PAS	"Well, the first thing that I think of would be that usually there's no specific agenda for this meeting."
	Clinic leader	"If you have an agenda, do it outside, because once I go into that check-in with an agenda, my mind is not really focused on what that employee wants to talk about."
	PAS	"Never punitive, always just, 'What's going on? Do you have a good balance between your work life and your home life?' I mean, they always took ownership of your problem, and how can we make it better?"
Confidential	Clinical staff	"It's all confidential. You're there in front of your supervisor. What happens in this check-in can stay in this check-in."
Regular	PAS	"What makes the check-ins meaningful is knowing that they're going to happen, knowing that this is a space and time to bring any concerns to."
Listening opportunity	Clinic leader	"What we've learnt the hard way is, when you just talk to people, and you just give instructions, so you don't listen, people start feeling like you don't care."
	PAS	"Even if [my supervisor] can't see what I'm going through or what I'm experiencing, she always validates my experience and she doesn't question if it's true or not. That's a big thing for me."
Practical	Clinic leader	"I honestly try and make the changes that I can. I occasionally have to say no, which is just part of the job."
	PAS	"I can't think of a time where they haven't followed up on something, whether that's directly to me or to the group, because some of the things that I bring up are relevant to all the PAS staff.... When we get the weekly email, it's always there."
	Clinical staff	"Our clinic had access issues. The goal was to get people scheduled within 48 hours of getting a referral, and that just routinely was not possible. So, in my check-ins I advocated for getting more staff on the team, and that happened very quickly. Leadership just needed to know that I needed help. As soon as it was offered, it was resolved within a couple of weeks. And then it was also one of my regular feedback points."

PAS, patient access specialist.

(Cohen d=0.59 for 2017 vs 2018, d=0.76 for 2017 vs 2019).

Study 2

Interviews revealed that the practice managers initiated the check-ins shortly after their appointment in late 2017. The check-ins had the objective of listening to and validating employees' concerns. The check-ins consisted of 1-on-1 meetings between a clinic leader and an employee that lasted 10 to 30 minutes and were held in a private location. Clinic leaders mentioned spending no more than an hour per week scheduling, conducting check-ins, and sending follow-up emails. The check-ins were separate from annual performance reviews, although related work-life issues were mentioned. The leaders made clear that information disclosed in the check-ins stayed private unless it was about a reportable event. Recurrent workflow issues or system-related problems were discussed with other parties with the employee's permission. The clinic leader sent a follow-up email with a summary of the conversation and action items, including the next check-in date. The check-ins were voluntary, and interviews with these clinic leaders revealed that more than 80% of the staff did at least 1 check-in per year. Interviews with the patient access specialist and medical assistant supervisors revealed that they conducted check-ins with most staff about once every 6 weeks. However, the medical director mentioned that check-ins with physicians or other advanced practice providers were far less regular because of time constraints, with a check-in twice per year.

The clinic leader opened the check-ins with a generic "What is on your mind?" Interviews with team members revealed that

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the check-ins were an opportunity to communicate issues and improvement suggestions directly to a clinic leader. Recurrent issues discussed included scheduling conflicts, redundant or tedious clinic procedures, and ergonomic problems (Table 4).

Study 3

Table 5 lists quotes that illustrate the feasibility criteria. Clinic leaders completed at least 2 check-ins with the same employee before the interviews were scheduled, about 4 months after training. The supervisors followed the protocol with ease but mentioned the need for additional templates for follow-up emails to simplify the process as well as a handout regarding access to well-being–related resources (eg, employee assistant program, wellness initiatives). Altogether, the check-ins were deemed feasible and not too demanding to implement despite the pilot test amid turbulent times.

Interviews revealed that the check-ins help employees bring stressful issues to the attention of their supervisors, to feel listened to and appreciated, and to have a moment to acknowledge problems. In addition, the check-ins led to changes (eg, debriefing sessions after emotionally taxing cases or modifying specific duties to allow short-term projects to break routine work) that employees requested. However, interviews also revealed shortcomings of the check-ins. Employees mentioned the need to conduct them during paid time and not during meal or rest breaks. Likewise, the frequency and duration of check-ins need to be flexible, depending on follow-up items, with a recommended frequency of at least 1 check-in per quarter. Finally, the replication test also identified problems with the check-ins. An employee shared a negative experience in which a clinic leader was believed to have overstepped personal boundaries, making judgments about the employee's work-life challenges. Other problems included low morale after scheduling requests were denied because of a short-staffing situation related to the pandemic.

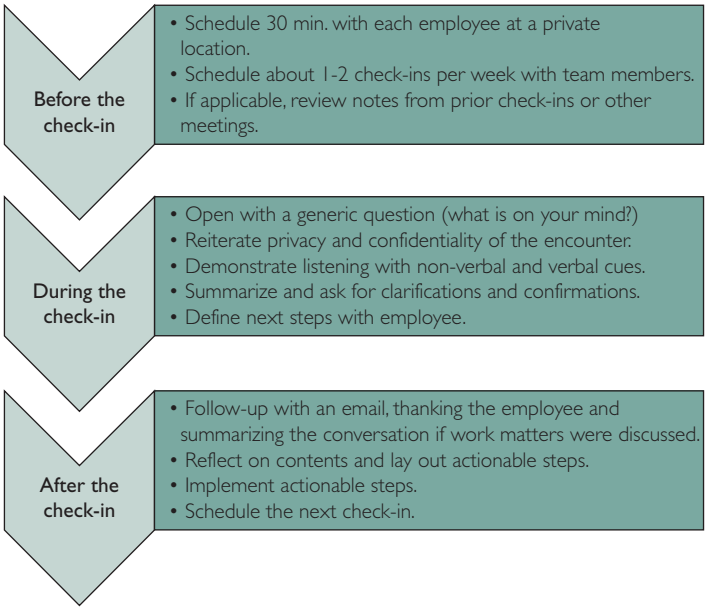

FIGURE. Steps involved in the check-ins.

DISCUSSION

The 3 interlinked studies presented here indicate that brief and frequent leader-employee check-ins were associated with reduced emotional exhaustion, especially during the next 12 months. The check-ins consisted of 1-on-1 short (less than 30 minutes) and frequent (about once every 6 weeks) meetings between clinic leaders and staff. This study adds quantitative and qualitative evidence, first documenting a practice that a primary care clinic implemented by itself and then exploring its feasibility and reproducibility in a comparable setting during a particularly challenging moment amid the COVID-19 pandemic (Delta variant outbreak).

The association between check-ins and emotional exhaustion was stronger during the first follow-up (2017 vs 2018), and although this was not sustained over time, employees at the clinic at which check-ins were conducted still had lower scores in the second year of follow-up (2019) compared with control clinics. In addition, we found a sizable and sustained association between the check-ins and higher values alignment with clinic leaders among

TABLE 5. Results From Interviews (n=10) After Replicating the Check-ins at a New Primary Care Clinic

Category	Participant No. and job title	Quote
Acceptability (fit and appropriateness of the check-ins)	Participant 11 PAS	"I'm very lucky because all of our staff has worked together for a while now. So, it was much easier, for me to say, Hey, so how's your family?"
	Participant 5 PAS Supervisor/lead	"It takes a little while to get to that point where staff are feeling okay being vulnerable and share things or raise concerns that might be a little outside their comfort zone."
Demand (intention to use)	Participant 10 PAS	"If there's a place that changes constantly, they might need [check-ins] more often. I think it really depends just on the flow of the workplace."
	Participant 5 PAS Supervisor/lead	"Once you get to a point where you're talking on a regular basis and they're bringing work things in and having conversations, you'll see them share more personal things too."
Implementation (supports and barriers; degree of execution)	Participant 3 Clinic leader	"What we've learnt the hard way is, when you just talk to people, and you just give instructions, so you don't listen, people start feeling like you don't care."
	Participant 19 Medical assistant Supervisor/lead	"It's a wellness check-in, and it's not just work related, it could be also how can we support you at work to make your home life easier?"
	Participant 6 Care coordinator	"This is nothing punitive. This is only between you and I. I want to know what is on your mind." That was the first question. It could be personal or work related or both.
Practicality (positive and negative effects on individuals)	Participant 18 PAS Supervisor/lead	"I'm not always going to be able to have an immediate solution but I want people to keep on bringing the feedback so we can know what's going on for their day-to-day work, what barriers there might be too, so if it's not an in-the-moment fix, at least I can give them some estimate of what my next steps are going to be or when they could expect an update."
	Participant 6 Care coordinator	"My supervisor gave me tips on mindfulness…to not think about what I might not get done or what might get done tomorrow. Practice that on the way home… It kind of had a cascade effect because then when I was going to work, I practiced not taking home with me and worrying about home. My husband has health issues. So, I tend to worry. So, this helped in both directions. Practicing not taking home to work and not taking work to home."
Adaptation (ability to achieve similar outcomes when tailored)	Participant 7 PAS	"I think in some cases [check-ins] might crash and burn depending on the leadership team. In family medicine, we're very much focused on the psychology and social part of medicine…. In other departments, I've noticed it's much more on the scientific level, the left brain thinking of formulas…. I think what could be implemented is training for each leadership team."
	Participant 9 PAS	"Ours [check-ins] usually are with my supervisor and the lead, which is nice. I have both of them there but I can go to each of them separately too. And they each have different kind of roles and we have different relationships. So that's kind of nice, that it's not just one person and everything is riding on the relationship with that one person."
Integration (perceived sustainability with existing resources)	Participant 9 PAS	"One thing that could be improved upon is having the check-in be a platform for highlighting some of those other [hospital] resources. Which is something that my supervisor did, she was like, oh, by the way, there's this career counseling thing that I didn't know about before."

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TABLE 5. Continued

Category	Participant No. and job title	Quote
Expansion (positive and negative effects on organization)	Participant 7 PAS	"If we want to give feedback but we don't feel comfortable doing it in-person, then we can do anonymous feedback through a weekly survey. Which I think is super helpful because personally the feedback that I want to give doesn't need to go through any of the major hospital anonymous resources."
Efficacy (maintenance and sustainability)	Participant 8 Medical assistant	"I think [check-ins] made a big difference for me. And I think it's why many people are still within the department. There's definitely less turnover within the back office because of it. And it really gets you to know who you're working with and who they are as individuals. And then the trust and stuff can be built from there."
	Participant 10 PAS	"Nobody knew that the feedback came from me specifically. I don't need that, and I didn't need that claim to credit or whatever. But it's important to have that, and it's important to give people the floor to share what's going on. And you can't make changes without hearing from the people who are doing the work."

PAS, patient access specialist.

employees of the check-in clinics, whereas this variable decreased in the control clinics. The difference in perceived stress was not statistically significant.

This study adds new evidence of how frequent and brief encounters reflect the important role of clinic leaders in reducing emotional exhaustion, as reported by other studies.[9,10] This study highlights the significance of listening to employees' concerns and obtaining direct feedback to include or to respond to organizational changes. This is consistent with leadership best practices as outlined in the Wellness-Centered Leadership model and a recent study on effective leadership walk rounds.[23] In this sense, the qualitative evidence indicated that employees deemed the check-ins a useful encounter to provide feedback about work processes and situations that may affect performance or well-being. If changes to stressors were within the purview of the clinic leader, the check-ins were key to understanding the problem and obtaining employee feedback to address a problem. If a clinic leader could not address the stressor directly, the check-ins still helped to listen to, validate, and acknowledge the problem presented by an employee.

The replication study suggested that the check-ins are relatively easy to implement even amid the COVID-19 pandemic and leadership change. For the most part, the experience of both clinic leaders and employees was positive. However, staff mentioned that they need to feel safe to disclose any information, and trust needs to be built or restored before attempting to address issues presented by each employee.[30] As a result, employees mentioned the need to reinforce or to offer more training to supervisors to demonstrate support, to respect boundaries, and to solve problems collaboratively.

Study Limitations

Whereas the Mini Z single item asks participants to use their own definition of burnout, this item correlates solely with emotional exhaustion and does not provide information about the other subdimensions of burnout, such as cynicism and low self-efficacy.[27] The response rates oscillated between 49% and 60%, which may limit the survey's

generalizability, although they are consistent with estimates for an industry with difficulties in enrolling participants.[31] Still, we offered limited participation incentives, which could have elevated the response rate. The small sample size of 20 people observed during 3 years at the check-ins clinic was underpowered to conduct stratified analyses by key sociodemographic or occupational characteristics, such as the role in the clinic or underrepresented status.

The 2 qualitative studies were conducted during a short period and were retrospective. Whereas we interviewed every supervisor, interviews with employees were voluntary, so there is a chance that employees who did not complete check-ins or had a negative experience ignored our recruitment efforts. Notwithstanding, we documented a case in which the check-ins failed to reduce stress, thus minimizing bias toward summarizing positive experiences exclusively. Finally, the replication study happened at a single clinic without a control location. Because we were primarily concerned with the reactions and experiences in starting the check-ins at a new clinic, we opted for an in-depth qualitative study with key players, although a measure of burnout would have been helpful to establish the short-term effects of the check-ins. However, an additional survey would have been difficult to carry out amid the Delta outbreak, which imposed several acute and compounded challenges to health care settings.

Practice Implications

This study presents a low-effort tactic with the potential to reduce emotional exhaustion among health care workers. The check-ins have a manageable additional administrative burden of about an hour per week. If the supervisors do not have the authority to change a work stressor (eg, scheduling or staffing levels), we find that acknowledging and validating stressors is important for preventing employee emotional exhaustion. If there are stressors that supervisors can address, asking for employees' input to co-define and to monitor an action plan can reduce burnout. However, personal boundaries need to be respected; clinic leaders should practice reflective listening and ask how the clinic can support an employee.

CONCLUSION

We presented 3 interlinked studies conducted at primary care clinics indicating that leader-employee check-ins may reduce emotional exhaustion, with more benefits during the first 12 months. The evidence presented here indicates that periodic private and confidential conversations wherein leaders listen, acknowledge, and address work stressors might be a practical step to reduce burnout and to increase values alignment with clinic leaders. Still, the check-ins' success depends on leaders' support and trust, assurances of psychological safety to disclose information, and transformative organizational changes. Although a formal randomized controlled trial is needed to provide more conclusive evidence of its impact, we believe that the check-ins could be swift, relatively easy to implement, and a practical strategy to address emotional exhaustion and burnout in primary care clinics.

POTENTIAL COMPETING INTERESTS

The authors report no competing interests.

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Abbreviations and Acronyms: **GLMM**, generalized linear mixed model

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