DR. ADAM STRIKER:

Welcome back to Central Line. I'm Dr. Adam Striker, your host and editor. And I'm welcoming today Dr. Mary Dale Peterson, who is chief operating officer and executive vice president of Driscoll Children's Health System in Corpus Christi, Texas. And she's also ASA's past president and also a repeat guest. And so certainly no stranger to our show. She's joined me today to discuss how health care leaders are expanding and monitoring the use of existing capacity, how they're using anesthesiologists and surgical teams to improve perioperative performance and exploring new practice models. So, Mary Dale, welcome to the show.

DR. MARY DALE PETERSON:

Thank you, Adam.

DR. STRIKER:

Well, I think it goes without saying, you're a successful health care executive, so let's just really briefly start off with your experiences. We know many hospitals are struggling with the surgical backlog and demand. Do you mind talking a little bit about the challenges your organization faces -- staffing shortages, bed availability, capacity, etcetera? And then also, what are the main obstacles when it comes to what you think are facing health care organizations now?

DR. PETERSON:

Sure. So I'm in a children's health system, but I've been involved in the American Hospital Association and Texas Hospital Association, and I don't think we're unique. I think adult systems across the board are experiencing similar challenges. And, you
know, for us, I don't think it's necessarily a backlog. We just have a large increase in demand for our services. It's interesting to me how ENT in kids have just exploded and that's partly it went way down during the pandemic and it wasn't really pent up demand. But all of a sudden when we started unleashing all these viruses again and people were going back to school and work, kids were getting a lot sicker and necessitated ENT procedures is just one example.

I know some facilities are still experiencing the backlog from delayed endoscopies and other things, so it is a supply and demand issue. And so at the same time we're seeing demand increase for anesthesia professionals and ORs or procedural rooms. That's really the big explosion is in the non OR locations.

You know, we've also had some challenges, I believe, with our workforce. And we know that every day with the nursing workforce. And it goes beyond nursing. It's, you know, respiratory therapy, it's x ray technicians, you know, you name it. And workforce has been a challenge. So where did they all go? You know, some people took early retirement. Certainly anesthesiologists we saw four years of retirements and one year. I think that's stabilized now. But that's a loss. That's an attrition of people that we could use now. As far as pipeline, the good news is, is that we have a lot of people interested in practicing anesthesia and becoming anesthesiologists. So we've got more people coming into the pipeline. Actually, we have more anesthesiologists being produced than surgical specialists. But once again, on that demand side, we've got this imbalance because of all the non OR proceduralist requesting our services. So and it varies by facility. I mean every facility is different in what they're most short of.

DR. STRIKER:

Regarding the imbalance between supply and demand, what are the financial implications of this? We know that the operating room certainly generates a lot of revenue for health care organizations. How how does this imbalance affect that?

DR. PETERSON:

Well, I think we want to make sure our main economic engines are still running well. And I think that's why hospital executives need to be involved in helping with the solutions. And that means ensuring that you've got the right leaders in place that can either look at different models of care or where we're lacking in resources or where a change in, you know, what you would normally have in your FTEs could be helpful in either creating a more efficient or Nora environment, you know, or it could be that you don't have enough ICU beds. It may not even be an O.R. problem. It may be a problem
in another part of your system that's creating an impasse where you can't schedule
certain high intensity cases.

DR. STRIKER:

Are practice models evolving because of this demand and the workforce shortages.
What do you see?

DR. PETERSON:

Well, I think, first of all, there's been a change in practice models that has affected us
that I think we're just now realizing. Adam And that's that a lot of the proceduralists
coming out of training, whether it's cardiology, nephrology, GI, whatever, they're not
trained in providing procedural sedation. And on the pediatric side, we've been dealing
with this for a while and where I am in South Texas, we've always had, you know, a
relative shortage of, you know, physicians and other providers. And so I've pretty much
said, no, there are certain things that a cardiologist or a nephrologist or, you know,
oc oncologists especially, you know, that they can learn to do and we can teach them how
to do it safely if we provide the right resources, things like sedation nurses, the training,
the protocols and, you know, support them. And so I do think that when you're looking at
an issue with resources like anesthesiologists or crn as an anesthesia professionals and,
you know, some of your locations and your ORs, the constraints that we have right now,
looking at other professionals in your organization who could be upskilled with the
appropriate support to provide safe care is something hospital systems should be
looking at.

DR. STRIKER:

How do you feel that's received by anesthesia practices or specifically
anesthesiologists? The idea of maybe shifting a little bit of what was traditionally
practiced for the anesthesia team to other health care individuals?

DR. PETERSON:

A lot of it depends, obviously, on economics and governance. But I firmly believe that
your anesthesia department should direct and oversee the quality of all sedation care in
your hospital system. Now, how it's provided, you know, there can be a lot of different
ways of doing that that I think are safe. But the anesthesiologist or director of
anesthesia needs to ensure that you have the right quality improvement processes, the
right way of credentialing physicians, training them, as well as your nursing staff and
setting up the protocols to do that. So I think it's, once again, creating alignment where,
you know, a CEO or a COO or whatever says, look, you know, we have a bandwidth issue but how can we work with other people in our organization to make sure that people have appropriate, timely access to care? So people are part of the solution and they're not penalized economically or some other way by doing the right thing. I mean, it was our group that suggested we use pediatric intensivists to help us with some procedures requiring sedation. You know, whether it was, you know, the bear hearing test exam or some types of MRIs, they were the ones that said we will train them and we can we can do that. But you've got to align the economics and the incentives to make sure that everybody wins.

DR. STRIKER:

What do you think the role is of burnout in the workforce shortages?

DR. PETERSON:

I think it plays a role in what I worry about more is pressure to do more with who we already have. So I think it's making sure that as we have the demands that we don't burn out the people we currently have and burnout rates are already reported to be high by saying, Oh, we're just going to work people harder, longer start Saturday shifts, all those kinds of things. At a certain point, it doesn't matter how much you pay people, they reach a burnout or a breaking point. And so I think we have to be really careful. And this is another, I think, message to hospital executives is be careful about stretching people too much because then you may lose the good people you already have. And I think this is especially true with the aging anesthesiologist or perhaps people who have other challenges with caregiving or whatever and their families that you need to have those conversations with people. And I would rather have people working half time or 80% or whatever. And even though it's a management challenge to figure it out, but I'd rather work to do that than to have them quit entirely.

DR. STRIKER:

Are there any other tactics or strategies that our listeners should be aware of when it comes to the burnout issue? Or is it simply that a time versus money thing?

DR. PETERSON:

No, I don't think it's just time versus money. I think it goes beyond that. I think that's part of it. But I think it's also feeling appreciated. It's the workplace environment. I think sometimes operating rooms can be toxic environments and that creates a huge stress factor. A lot of times people will work longer hours. If it's a pleasant environment, you're
working with people you enjoy working with. So I think it's making sure that you have good relationships with all of your staff, your surgeons and ensuring that you have an environment of respect. That's a big part of it, I think. And then showing how much you appreciate it. You know, from a leadership, I try to meet with people individually and as a group and share that. You know, a lot of times people can easily get into a negative mindset. And of course, we we know that sometimes with surgeons, sometimes they're never happy about things. And so I think trying to change people's mindset and celebrate, you know, what's going well and appreciate the people around you can go a really long way.

DR. STRIKER:

Well, I do have some more questions for you, but first, we're going to take a short break. Please stay with me.

(SOUNDBITE OF MUSIC)

DR. DEBORAH SCHWENGLE:

Hi, this is Dr. Deborah Schwenge, chair of the ASA patient safety editorial board. Perioperative hypothermia continues to be a common occurrence, despite extensive knowledge of its ill effects and the common practice of warming patients during surgery. The amount of time a patient experiences hypothermia matters work to prevent heat loss, reducing the percentage of time patients experience hypothermia and ensure the patient is normothermic upon arrival to the PACU, it's essential that all team members understand the importance of pre warming patients prior to entering the operating room and then actively warming during surgery. A team-based approach with the anesthesiologist who's responsible for ensuring patients remain normothermic as the team leader improves perioperative temperature management.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. STRIKER:

We're back with Dr. Mary Dale Peterson and talking about, well, surgical backlogs, but really it's more of a imbalance between supply of workforce and the demand for workforce. Dr. Peterson, what role do you think value-based care plays here? Things like new perioperative practice models? Do those make a difference?
DR. PETERSON:

Yes, I think they do make a difference because the worst thing that can happen for scheduling is when you have to cancel a patient on the day of surgery because of either inadequate preoperative workup or preparation or prehabilitation. I think we still see disconnects between surgeon scheduling patients and appropriate counseling, you know, before surgery. And we, you know, patients now are older, sicker. They're on a lot more medications, some of which people shouldn't be taking right before surgery, some that they should be taking right up until surgery. Those anesthesia practices that work closely with their surgeons and have preoperative clinics or high risk clinics, especially as you get into more complex procedures that may take up three, 4 or 5 hours or plus in a day, you definitely don't want those cancelled on the day of surgery. So that's just one example. There's a lot of others, but I think that's a big one.

DR. STRIKER:

How do you analyze efficiency when it comes to all of this? Is there anything different, I suppose, than before?

DR. PETERSON:

Yeah, there's plenty of papers published out there on that. I'm certainly not the leading expert. There's plenty of literature on that. But I think it's, you know, we know what your key performance indicators or KPIs could be that people look at, you know, like, okay, did you start on time? You know, did you schedule for the right amount of time? You know, what your cancellation rate, what's your turnover time between cases, those kinds of things. But you know, we've got that. But the more important thing is really, I think having a governance structure and a model where there's transparency and alignment where there's consequences. So if you have somebody that can't seem to show up for 730 start time consistently, then it really is about saying, look, you know, maybe. 730 start time isn't a good thing for you for whatever reason. And maybe they get started later in the day. Or you have another surgeon who can at least book one case before them. But it's really getting alignment with your leadership and your hospital organization to make that happen.

I recently started a smaller work group that's under our governance structure and efficiency task force really, you know, taking the chair of anesthesia who is an efficient anesthesiologist and our one of our most efficient surgeons as a team, and we branded it out with other people on this group. But to really look at that, we've got policies and procedures. But are we really following them and enforcing them when people don't open up their block schedules, when they haven't filled them? And, you know, how are
we enforcing all of that? And so as they start to make decisions and it's important for everybody in the administration to be aligned, if a particular surgeon isn't happy with that outcome, that we're supportive of those leaders.

DR. STRIKER:

Well, speaking of that, talk a little bit about the importance of having anesthesiologists in leadership positions, both perioperative as well as hospital leadership positions.

DR. PETERSON:

Well, I don't think you can do it without the leadership of your anesthesiologists, whether it's in perioperative care. Our surgeons have really embraced that. You know, we say, look, we don't want to cancel your cases on the same day. If you have a patient that has chronic conditions or you think is high risk, we will see that patient ahead of time and we'll make sure that the appropriate workup is done and that, you know, there won't be, you know, hopefully a cancellation. I think it's about having your key people maybe not rotating it, but everybody in your group has certain skill sets. And having the right leaders run your board with your nurse leadership every day is key. And some people are better than others. I mean, let's face it, Adam, the ORs are dynamic places. You can have your schedule that you think you're going to have and then stuff happens. You know, you've got your add ons, you've got your emergencies, got people that don't show up and you're having to move things around. And so having somebody who is really good at thinking on their feet and understanding scheduling and what they can safely move around and having all the right pieces in an O.R., all those specialized people can be really a huge improvement in efficiency. And I think not necessarily being egalitarian, but giving the right jobs to the right people and finding those leaders is key to making an O.R. run smoothly, just like your nursing staff are as well.

DR. STRIKER:

Well, and we've talked about this so many times about the importance of being involved in leadership as anesthesiologists because of the skill set that most anesthesiologists possess. But to demonstrate the value to your health care organization and how vital it is just to participate at the organizational level.

DR. PETERSON:

Yeah, it it really is key because we've got, you know, the food and medicine, the food and surgery. We work with our medical proceduralist colleagues. We work with our consultant physicians making sure patients are prepared for surgery, especially
cardiology or pulmonology. We, of course, interface with our surgical colleagues. And I think, you know, they do appreciate when anesthesiologists are working with them to find solutions, whether it's on a particular patient or scheduling patients, trying to juggle emergencies with their elective cases. I think when anesthesiologists step up and communicate well, there's a huge value and respect to that.

DR. STRIKER:

So ASA recently co-hosted an executive dialogue event online with the American Hospital Association and produced a related book to share thoughts on this issue. You were involved in that. Do you mind talking about that experience a little bit?

DR. PETERSON:

It was an interesting experience. We were oversubscribed. They had to cut off having people participate because they like to keep it in a relatively small group of 30 to 40. And what I found the most fascinating, we had people from all across the country, hospital leaders in various types of hospital systems, small, medium, large, academic, private and in different roles. When we talked about anesthesia or resources, really it varied really across the board. And anesthesia, or OR resources really, it varied across the board. And anesthesia, Arizona was like, oh, just so short of anesthesiologists. But in the Northeast, it was a little bit different. I need our nurses, I need x ray techs. So what we're shortages were different in each facility. But what was clear to me is it does take a village to safely provide, you know, care for our surgical patients and patients undergoing complex procedures. And we're one part of that equation. And certainly, you know, if you don't have people that can get patients and bringing the operating room or people to help you clean the rooms between cases or anesthesia techs, it slows down everybody. So, you know, the whole workforce is necessary. And I think, you know, when we have certain shortages in our workforce, like recently, we've had a crisis in our sterile processing. You know, you don't realize how important all of these units are until you have a staffing shortage. And so I think that's where people really need to come together and say, okay, how can we temporarily help this particular area while we're trying to fill these gaps?

DR. STRIKER:

And this book is available to members, right?

DR. PETERSON:

It is available. It's on the ASA website.
DR. STRIKER:

Okay, great. Well, before we wind down here, you know, we've talked a little bit about staffing shortages before the two of us on this podcast. Is there anything you've learned since we've talked last about this issue that you think it's important for for our listeners to know?

DR. PETERSON:

I think it's hard to come up with one thing, Adam, But if I had to come up with one thing, I think what I love about some of my leaders is a can do attitude, and that accomplishes a lot. It means that in the face of adversity, you are still going to look for a solution. Doesn't mean you have it right now, but it means you're going to work towards that solution. And that attitude goes a long way with either hospital leaders or your surgical colleagues. It might be saying, you know, Doctor, I don't feel comfortable providing anesthesia for your patient right now because of X, Y, or Z. I'm concerned about. But I'm going to do this or that and I'm going to get this consultant in and we're going to keep going with our schedule. And I'm hoping that we can get this patient worked in later today. That's what I call the can do attitude. It's how do we accomplish something and find creative solutions together. It's how you communicate and it's being flexible that's part of that can do attitude.

DR. STRIKER:

Well stated, and I think that probably contributes to the environment and the culture that you were talking about earlier that I think makes it just more appealing to be at work and work with your colleagues, you know, with with that attitude.

DR. PETERSON:

Yes, I've just seen that go a long way. It's how you phrase something. It's kind of like when they asked me to, you know, a long time ago to have our anesthesiologists put an I'V lines. And it was like, no, I can't do that. But what I can do is I can train nurses how to do this and we will get it done. But it's going to be not maybe in the way you had imagined.

DR. STRIKER:
Dr. Peterson, thank you so much for joining us again and sharing your insight. You're a valuable resource when it comes to this topic, and it's really enjoyable to talk with you about it.

DR. PETERSON:

Always a pleasure to visit with you, Dr. Striker.

DR. STRIKER:

To access the information we were talking about earlier, please visit asahq.org/madeforthismoment/health-care-executives. And there's a hyphen between health and care and executives that should lead you to the resources the ASA is providing, but also the link to the ASA and the American Hospital Association discussing this together. So thanks for listening to this episode and please tune in again to Central Line next time. Take care.

(SOUNDBITE OF MUSIC)

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