DOCTOR'S CROSSING
CARPE DIEM PODCAST
TRANSCRIPT

EPISODE 50 From Surgeon to CDI Specialist with Guest Dr. Jenn Jolley

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JJ: "Especially the surgery. It's like a whole nother world. It's a very small world. We go to meetings in our specialties and we make a lot of different friends in that world. And so, when you move to a nonclinical position, you feel like you're out of that world, but I don't think there is any reason to be embarrassed or ashamed. You got your doctor degree and your MD, and you still have a lot to offer people".

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So pull up a chair, my friend, and let's carpe that diem.

Hello, hello and welcome back to the Doctor's Crossing Carpe Diem podcast. You are listening to episode number 50. Right out of residency I purchased a small dermatology practice in Austin, Texas. Back in those days, before the EMR, as residents, we didn't need to know anything about coding or billing.

Before starting my practice, I needed a crash course in these topics. Fortunately, there was this coding guru for dermatology named Inga Ellzey. I promptly signed up for her

course and support service. She really opened my eyes to this complex world of coding and how important it is to understand the nuance and get it right, both from a patient care perspective, as well as for billing purposes. Whenever I had a challenging coding situation, I would fax Inga. That was before we had email and she would always get right back to me with an answer.

The complexities of coding and documentation can be frustrating and time consuming for sure, but they can also create job opportunities. Today, I have the great pleasure of speaking with Dr. Jenn Jolly, a board-certified general surgeon and mother of two who transitioned out of practice to work in CDI - Clinical Documentation Improvement.

In her job, she helps hospitals accurately reflect the clinical truth through proper coding and documentation. We're going to be hearing about why she left surgery, what her day-to-day job is like, and some steps you can take to explore this area if it sparks your curiosity. I'm very happy and excited to welcome Dr. Jenn Jolly to the podcast. Hey Jenn, how are you?

JJ: Good. Thanks. Thanks for having me on.

HF: Yeah, it's great to have you here and finally get to meet you so to speak and get to see you.

JJ: Yeah, for sure. Likewise.

HF: Thank you. Thank you. As I often do in these podcasts, I love to begin with your story and have you paint the picture for the listeners of what it was like for you as a surgeon and then how this transition happened?

JJ: Sure. Well, we have talked about this extensively as you helped me with the transition, but basically, I was let go during the pandemic. Our hospital system was making several changes and due to some lack of volume, a few of the surgeons were let go.
And so, that forced me into looking around for what else I could do. I certainly looked at some clinical positions, but also had in the back of my mind looking at nonclinical positions. And I had been thinking for several months that I might want to make a drastic change, not just from the specific hospital where I was, but maybe even bigger than that and moving into a nonclinical position. That is what got the process started, so to speak, and then I ended up here.

HF: Yeah. I call it the COVID cattle prod because it did push a lot of physicians out of practice, both from being let go from downsizing and also from sheer burnout and disillusionment. So, you have a lot of company out there. Would you like to tell us a bit about how long you had been in practice and if you have been considering doing something different even before that?

JJ: Sure. I took the normal path - Medical school, five years of general surgery residency. I did a year of laparoscopic training, for fellowship, for MIS, and then came out to where I am now and started working in the hospital system. It's a community hospital, employed by the hospital, but as a private practice type surgeon, that's kind of the feeling we had. We worked with each other as kind of a private practice group, but we were hospital employed.

Over the next few years, things started to change a lot within the hospital system in the specific hospital we were in. There were just a lot of changes that made me start to question whether or not I wanted to continue at that specific hospital. In general, personally, I started a family and just wanted to have a little bit more time with them.

HF: What was it like for you being a surgeon? What was really working for you and what wasn't?

JJ: I love being in the operating room. I love helping patients. All those things were great. The camaraderie, the teamwork, and then just the satisfaction or gratification of people getting better. Simply put, those are the things that I really love about it. The things that weren't working, for me personally, were being kind of very anal about my patient care, spending too much time outside of the hospital, thinking, worrying, talking to patients and not really present at home.

Some of the things within the hospital system itself were starting to change. We were having less communication or input into the changes that were being made. And that was frustrating. I think that happens to a lot of people in various professions, but there were just things that built up that made me start to consider that maybe there was something else that I wanted to do. I always said going into surgery that if you don't love it, then you shouldn't do it. And I had kind of lost some of my passion for it overall.

HF: I think you echo what a lot of physicians feel is that they like the work itself, like taking care of patients and surgeons often like being in the OR but then it's sort of everything else has enough of a negative component to it that it outweighs the joy and the satisfaction that you are getting. So, it ends up being less than a zero-sum game. It's a negative net.

JJ: I agree.

HF: How did you feel after you were let go?

JJ: You go through the different phases. Denial and guilt, shame. I don't know what they are.

HF: Anger, bargaining.

JJ: Anger, bargaining. Right. Sadness. But at the end of the day, I realized that maybe it was the best thing because it pushed me to look for something else that I'm very satisfied doing. And also, it seemed like it ended up being the best move for my family. Especially during a very tough time in the pandemic, since we don't really have family around us to help. It seemed like a good move for us.

HF: Yeah. And your kids are very young. I'm sure there was a lot you wanted to do and be able to be at home and be able to be present. And worrying about patients like Mrs. Robins after her appendectomy and not being able to really enjoy your time off can really take a toll.

JJ: Yeah, for sure. And we're finding that I have much more time to do things outside of work hours and I don't have to make sure my phone is on me 24/7. So, I'm happy about that.

HF: Yeah. Let's shift into talking about what you're actually doing now. Could you put a big umbrella over the work that you do? And then we'll get more into the details.

JJ: Sure. I'm working with a company now that works with many hospital systems nationally. I work remotely from home and basically, it's a chart review to figure out what we call the true clinical picture to help with documentation and billing for the various hospital systems.

HF: And what does this actually do for the hospitals?

JJ: It allows them to bill more appropriately and more accurately based on the actual clinical picture of the patient during their inpatient hospitalization. Overall, they're able to get the appropriate funds that they should be getting just based on the fact that we are able to enhance the billing at times, simply based on what the documentation is

there, but maybe it's not saying specifically what needs to be said to get the codes correct and the billing correct.

HF: You're helping them to optimize the coding so that they can have the maximum return. Now they can get paid as much as possible, but also make sure that it's accurate so they don't get subject to being audited or a fraud that is committed.

JJ: Absolutely, Heather. Yeah, there is quality to it. And I think optimization is the best word for it.

HF: Now I know some physicians tell me that in their job, they get pressure to code a certain way and they're told if they're not coding optimally. And some of them feel that they're being asked to do things that really aren't appropriate to what they're doing clinically. Do you feel any of that kind of pressure in the work that you're doing?

JJ: No, not at all. In fact, we are told to "downgrade" the billing if necessary. If it is not accurate of what the clinical picture is. And we actually have clinical criteria that we check to make sure that the diagnoses that are already coded are accurate and clinically appropriate. We are first validating what is already coded and making sure that that's appropriate and accurate and checking clinical criteria to make sure things like sepsis are appropriate. And then if not, we may ask to validate it with a query to the physician. There definitely is no pressure to do something that's not accurate.

HF: One thing that I think is really helpful for listeners is to get that microscopic view of what your day is like. What time do you start? How are you actually doing this work? Maybe skills that you're using. Would you like to go down into the weeds for us?

JJ: Sure. There are various kinds of what we call shifts. Basically, it's like an eight-and-a-half-hour day with 30 minutes for lunch. And then two 15-minute breaks.

Once you're in the system for a while, you can kind of adjust as you want to. There are lunch hour lectures, maybe once a week or an afternoon meeting once a week.

But basically, my shift is from 08:00 to 04:30. And then one weekend out of every month, we have to work an eight-hour shift, which they've allowed me to split up actually into four hours on two different days. So, it's not just taking up a whole Saturday or a whole Sunday. That's really nice. And it's kind of like banking hours, I guess. When it's done, it's done. I'm not worrying about coding overnight.

HF: Right, exactly. You're not going to kill anybody if you miss code.

JJ: And basically, it's just myself working with a coder. We're both remote on our computers, working via the computer to look through a chart together and review it. Well, they're looking with the help of a billing system and putting codes in, and then I'm looking more at the clinical picture and the clinical criteria and stuff.

HF: Okay. So, you have this coder. Are you working with this person most of the time, or does it change?

JJ: Once you have been working there for a while and if you find someone that you work well with and they work well with you and you're both happy with each other, then you can just pair up with that person. For a while now, I'm just working with the same coach and that can continue for as long as we are both working there.

HF: This person typically, would they be a nurse who is trained in coding?

JJ: They may have a nursing background. They may just have a coding background. I'm not sure exactly what the criteria are for coders, but definitely they've done a lot of coding and billing previously. We call them coaches. My coach has a nursing background and

has done a lot of auditing and coding billing since then. But I don't think all of them necessarily have a nursing background.

HF: All right. Let's go even more specific. You're there, you're looking at the chart. Can you give it an example of something that you might see needs attention and then how you go about through that process?

JJ: Sure. For instance, especially from a surgical standpoint, I look at the operation and make sure that everything going on in the operating room is actually coded in procedure diagnosis. I think that's something that I can bring to the table. Or for instance, we've had charts where it's been said that it's an appendectomy, but maybe they have to take part of the cecum because it's a necrotic appendix and very gangrenous appendicitis or whatnot so part of the cecum is taken.

So, I've pointed that out. And that adds another procedure code to where maybe the surgeon didn't actually say cecestomy was performed or wasn't very specific in their overall words, but it's within the operative note. And that actually changes the billing process. So, it's little things like that.

Or if we think the patient meets clinical criteria for sepsis, but maybe sepsis was never actually stated, but they're obviously treating a patient for an infection and the patient is tachycardic and is febrile and has a very high white count and they're getting antibiotics. Well, then they have sepsis and we query or recommend to query for sepsis and that'll change the billing usually.

HF: Those are some really excellent examples. Then you'll send in a query to the physician and then will they decide if they want to make those changes?

JJ: Yeah. What happens, the way that company has it is we're all kind of separated and there's different levels of checks and balances, I guess. We make a suggestion from what

we call our tower, my coach and I. That goes to a different tower, and that coding tower reviews it, and they either agree or don't agree. And if they agree, then they develop a query and they send that onto the physician.

And within the query the physician has the option to choose sepsis or say no sepsis or whatnot. There are several options usually in queries. And then the physician will choose whichever they think is appropriate. And then that becomes part of the clinical documentation and the chart so that is allowed to then be billed for.

HF: Got it. Now some people may be wondering. She was a surgeon and she was in the OR, and you are kind of queen in the OR. How does it feel to be working on a computer most of the time and doing this very different kind of work?

JJ: Well, it's obviously very different. I'm sitting a lot more than I used to. But at the same time, it's a game. I guess a lot of surgeons like to win at things as most physicians do. I think there is some challenge to it in terms of finding diagnoses that aren't coded or clinical scenarios that just aren't documented appropriately so that the coder can pick it up.

I think that there are challenges to it. It's still medical related. It still keeps me in the medical game of medicine, I think. And while I always intended to be a surgeon, I also really like just medicine in general. And so, I really like reading through charts and seeing what's going on and how patients are treated. And it's certainly taking me back to medical school in some ways, because I'm not just doing charts, I'm doing all kinds of medical charts. So, some ways that's really interesting to renew my medical knowledge a little bit.

HF: Do you feel like you're learning on the job, that it's intellectually challenging?

JJ: Yeah, for sure. It's a totally different mindset for one thing. Learning about the coding system and the billing system in general, that's something that certainly in my surgical residency, and in a lot of residencies, we don't get a lot of teaching about. And so, it's learning that system itself. And then also, like I said, it's just intellectually stimulating to review diagnoses and patient situations. Those were things that I haven't been involved with in a number of years.

HF: Let's look at if a physician is interested in doing this kind of work, who do you think might be a good fit?

JJ: If it's people who would like to move into the nonclinical world, but also stay close to medicine, because I think it allows us to keep our medical knowledge up to date and accurate. Also, for me, it helps to work remotely with what I was trying to achieve by being more present at home. So, that's really nice, but at the same time I'm not working just completely by myself. It's nice to have a colleague there throughout the day so that you're not just totally independent, because that would be a complete change for me going from having a surgical team. I do occasionally like to socialize, so that is good.

And then most physicians are pretty detail oriented, but certainly it fits kind of anal OCD aspect of the surgeon mindset in turn of really looking closely at the chart and at the documentation, at the labs, at the vital signs, the imaging to try to figure out if there's any part of the clinical picture that's being missed in the current coding or documentation that is there.

HF: Yeah. And one of the things I hear physicians say when they learn about this kind of job is, "Oh, so I don't have to do peer to peer calls". Because they might like being in the chart and things that are more like utilization management, but they're conflict-averse. And they like this kind of position where you're not on those phone calls with an angry doctor, potentially.

JJ: Yeah. We don't have to make any of those phone calls. I'm not necessarily conflict-averse, but I think it is hard. You do have kind of a change of mindset in that. Or I have had one, I should say in terms of I don't feel like not a practicing physician currently. I think that is a little bit of a change in mindset to approach a practicing physician and kind of discuss their documentation or their thoughts about what was occurring. I could see why that might frustrate someone who's actually on the front lines working with the patients. So, we don't have to do that. I'm happy we don't have to do that. But yeah, that's not part of this job.

HF: And in terms of income, often when a primary care physician goes into a nonclinical job, they may stay at the same salary, but they often go up in salary. For surgeons and some specialists, they can take a hit. Are you able to speak to that at all?

JJ: Yes, it's definitely a decrease in my salary by a fair amount. But at the same time, I think there's a lot to be said for maybe a dollar per hour that I'm gaining.

HF: And stress per dollar per hour.

JJ: Exactly. And the extra time that is spent as a surgeon that isn't billed and isn't paid for. I'm not dealing with that. While there is definitely a decrease in salary, it's still a reasonable medical salary, I think for a lot of physicians and certainly sufficient for myself and my family.

HF: Yeah, and it's always a tradeoff. And I think each individual makes that decision for themselves. And there is a lot of value to not being anxious and being able to be who you want to be for yourself and your loved ones. I don't know how you put a price tag on that, but it's important.

JJ: Absolutely.

HF: All right. If you want this job, what are the qualifications that you need to have?

JJ: All our physicians are board-certified and we do actually get a stipend to actually keep our licensure and CME requirements and whatnot. So that is really nice. The other requirement was to have been a practicing physician outside of residency for five years, I believe. And they actually do support some of the physicians continuing to practice. I don't know what that schedule entails. I don't know if they're part-time or if they're just doing locums or whatnot, but that is an option.

HF: All right. So, they need board certification, five years of clinical practice, have an active license and be interested in this job. Are there certain specialties that are more in demand that you know of?

JJ: I don't know which specialties this company is looking for. I know they certainly branched out a lot in the past several months, but in terms of trying to get specialties, like we added a neurosurgeon. I know we've added like a couple of pediatricians. I know specialties are valued, but I don't know that they're looking for one specifically right now.

HF: Yeah. It sounds like quite a varied group. I know an anesthesiologist who work there too, so quite the range. And how about experience? You didn't have to have any specific coding experience or CDI training?

JJ: No, I didn't have any at all. And I know a couple of the physicians that I interviewed with didn't have any prior to joining the company. That's certainly not something that's necessary. At least the first month or two are spent on training and also just with reading and learning practice materials, but also shadowing physicians in a tower. So that is very helpful to getting started.

HF: Now, if a physician is considering doing this work, is there anything you'd recommend them doing to try to figure out if they might like it or not?

JJ: I don't know if there's something that you can do. I guess you could, while you're still in your current position, seek out either physician advisors, or if there are any physicians in the hospital that work closely with the billing charting department. That might be someplace to start.

HF: Yeah. They could go and see if they do have a physician advisor and I've heard about just volunteering to help them out sometimes - the coders or the billers. If they have a difficult case, they could run it by you. And that might give you some taste of the work.

On a previous podcast, number 44 with Dr. Tim Owolabi, when he was in practice as a family physician, he got his coding certification and he started helping other doctors in his practice. So, if that is a real interest that you have, you could get a coding certification if you wanted to. But as Jenn is saying, it wasn't necessary at all for this job.

There is also this association for clinical documentation called ACDIS. And I'll link to that in the show notes. You can join them. You can go to their annual meeting that they have. You can even take a course through them. That's another possibility. And talking to physicians who are doing this work, to find out what the day to day is like. I think that's always helpful.

JJ: Yes.

HF: All right. Now we've covered a lot of what you do and about your transition and some steps physicians can take. There is this question in my mind going on, which is have you had thoughts of "Okay, I've been out of surgery about a year or so" - do you have thoughts of, "Oh, am I going to lose skills? Should I consider going back before it's too late?"

JJ: I definitely had those thoughts when I was even first initially looking at nonclinical positions and I looked into locums and I thought about that. But that wasn't really going to help my goal, which was to be more present with my family. So, I thought I'd just give this a few months and see whether or not it was a good fit and whether or not I liked it. And it was satisfying to me. So far it has been, and I've been working here for about eight or nine months now. I'm pretty happy with what I'm doing and how it's helped me outside of work. I don't feel just defined by my work all the time.

From my personal standpoint, I think it is important if someone wants to get back into surgery, that they keep their clinical skills up, that they find a way to maybe do locums or something like that. But personally, for me, I think that I've unofficially retired from the surgical practice. I don't have that concern or that worry because I don't think I will be trying to go back into clinical practice.

HF: What kind of response did you get from your colleagues?

JJ: Somewhat limited. People want everyone to be happy and that's at first a surprise obviously, and kind of like, "Well, what are you going to do?"

HF: Right. right. The big question.

JJ: Yeah. I think that some people initially, and I had the same thoughts, what exactly are you going to do? Because we have a single mindset when we go into medicine and we choose our specialties that we're not really sure what else is out there. And I certainly didn't know a lot about what other nonclinical jobs were out there. And you helped me a lot to see some different ones. And so, I think initially there is a lot of surprise from colleagues. And maybe some people are disappointed, I don't know, but most people are supportive. You always have to surround yourself with people that are supportive and certainly my family has been, and they're happy if I'm happy.

HF: And that's what really matters. So, that's good. If you feel like there are people who are disapproving of you, it's really about their own journey and what this is bringing up for them, and you don't want to let that stop you.

This has been terrific. I'd love to see if there is a final word or two that you'd like to share.

JJ: Yeah. I think it goes to what you were just asking about, because I think it is really hard and especially, I'm sure at times I still do and will struggle with it. Especially with surgery, it's like a whole nother world. It is a very small world. We go to meetings in our specialties and we see our friends and we make a lot of different friends in that world. And so, when you are moved to a nonclinical position, you feel like you're out of that world, but I don't think there is any reason to be embarrassed or ashamed. You still have medical knowledge, you got your doctor degree and your MD. You still have a lot to offer people.

I think there is no reason to think less of yourself or be nervous. Just go for it. If you need to just make that big change, just make it for yourself and don't worry what everyone else thinks.

HF: That is a big, beautiful, fat permission slip that you gave people. Thank you for those words, Jenn. I can tell they really come from the heart and they're going to go to other people's hearts and help them find their way. Thank you so much. And listeners, I appreciate you being here. If this is of interest to you at all, please check out the links on the website in the show notes for some further guidance. And as always, don't forget to carpe that diem, and I'll see you in the next episode. Bye for now.

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Podcast details

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