TRANSCRIPT

EPISODE 131 Finding Great Work-Life balance as a Medical Director in Health Insurance

With guest Dr. Stacie Laff

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SL: "Do I even know what to do if I'm not worrying about work and patience and patient care? And so, for me, there was those those two big fears not knowing what it would be like? And would I still feel good about what I was doing, if that makes sense."

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 and welcome back to the Doctor's Crossing Carpe Diem podcast. You're listening to episode number 131. Today we have a delightful guest here to talk about the role she has as a medical director for a health insurance company where she has the kind of work-life balance she only dreamed of when she was in full-time practice.

Our guest is pediatrician, Dr. Stacie Laff, who practiced it for more than 25 years before transitioning into working in the area of utilization management. Dr. Laff is going to

discuss what it is like to work for a health insurance company, the necessary qualifications, what she loves about her job, how to explore this area and more. We'll also learn how Stacie is able to still practice pediatrics part-time on the side while doing this nonclinical job. It is with much excitement and fanfare that I welcome Dr. Stacie Laff to the podcast. Hey there, Stacie, how are you?

SL: Hey, Heather. I'm great. Thanks for having me on today.

HF: Thank you. We've been talking about this for a bit, haven't we?

SL: We have. We have. I was excited when you asked me, I was like, cool.

HF: I love it. I love your enthusiasm and I think the listeners will too. So, would you like to take us back to the time when you reached out for coaching and you had no idea where this journey was going to go? What was happening then?

SL: Yeah. I had gone to, and actually met you at the nonclinical careers thing that they had in Chicago with SEAK. I had met you and was thinking about the idea of changing career paths. And when I had reached out to you, I kind of had the realization that owning my own practice, I had hired two young doctors to work with me was just getting harder and harder to keep afloat.

I had so many administrative things, it was just eating up my weekends, my evenings, still seeing patients Monday through Saturday. But I just would get home and have to do administrative work to keep the business afloat on the weekends when I was on vacation. And I thought I just didn't want to do it anymore. And when I've gone to the nonclinical careers, they had kind of given the idea I probably need to sell my practice and join a larger group and maybe that would help.

I reached out to you after I had sold my practice. And I had realized after I had sold my practice and was working for a larger hospital system that the administrative work was different but it was still there. And the things that I really didn't like about practicing medicine were really not a lot different when I worked for a larger organization. They just were different stresses, if that makes sense.

And so, I just had decided it was time to see what else was out there because I knew that at the rate I was going, I wasn't going to make it as long as I wanted to work. So I said it was time to find something different. I just didn't know what was out there. I had to kind of look in you and I explored why did I want to leave clinical medicine? And I really had to think a long time about that. What was making things so difficult? I remember drawing the picture of the weights on my shoulder.

HF: Oh yeah, the cartoon.

SL: The cartoon with the two big giant weights sitting on my shoulder. And I just felt like that all the time. Even when I would go out and do something fun, I was always thinking about work and I thought it would end when I sold my practice, but it really doesn't. And so, I thought, “Well, what did I love about medicine?” And when I really looked at what I didn't like about medicine and then what I did like about medicine, this idea of utilization management and working with an insurance company or for an insurance company seemed like it may be a really nice way to continue to use what I had, continue to nurture what I love to do, which is learn. But I didn't have those same stresses that I had in practicing medicine.

HF: I think those are excellent questions to ask, is “What is working, what do you like? And then what's not working for you?” Because you really start to tease apart, what's fundamentally there that you want to take into your next iteration. I'm curious, Stacie, because you practiced for a good long time, over 25 years, was there some trepidation about really just letting go of this big part of your identity?

SL: Oh my gosh, yes. Completely. First it's always the fear of the unknown. I think doctors tend to not like change. Even just going from private practice to hospital owned practice was a huge change. You not knowing what was going to be like. But I think a lot of physician friends of mine, we are all the same. We studied really hard in high school. Most of us knew in high school we wanted to be in medical school and be a doctor. I knew actually in eighth grade I wanted to be a doctor. So, I was always focused and studying always came first. I sacrificed a lot in high school and college. In medical school, you just study. In residency, you just study. And it's your whole life and it's really hard to know what you can do outside of it.

People I've talked to about changing careers, physicians, they're like, "I don't know what I would do." And I'm thinking, "Well, I know what I want to do but I don't know if I have time to do that. Never had time to do it." So I was so afraid that I wouldn't be the same person because my whole life revolved around being a doctor and that was my identity and I didn't have Stacie as anything else. As Dr. Laff, that's all I knew I was. And so that fear of "Would I like who I was outside of a doctor? Am I going to have anything else to do? Do I even know what to do if I'm not worrying about work and patients and patient care?" And so, for me there were those two big fears, not knowing what it would be like and would I still feel good about what I was doing, if that makes sense.

HF: You speak to the very common fears that so many of us have, but they didn't stop you from moving forward. You had mentioned earlier, Stacie, that when you thought about what you liked about your job, you identified some things that made utilization management seem like a good fit. I want to touch upon that but before we go there, could you just describe what utilization management is for anyone who may not be familiar with it?

SL: Yeah. This arm of the insurance company is looking at medical necessity is something that a patient needs medically necessary. And so, my job is to look at requests that may

not meet certain criteria and wouldn't meet for medical necessity. And that's really the nuts and bolts. They're getting the right care, appropriate care, but not care that they don't need, if that makes sense.
That's really kind of what we do. With that, we also work with nurses during complex care rounds and during private duty nurse, which is like a home health nurse rounds. We talk about these complex patients and work as a team, which is so nice to help these members get what they need. It's just such a nice feeling. That's what I really like is that the insurance company I work for, we are working to help the members. We're working to help them and give them what they need and support them and help the health of the community by helping these individual members.

HF: And how did when you looked at what you liked about your job, give you the indication that this might be a good direction to go in when there are so many different nonclinical avenues?

SL: I really wasn't sure. I think working with you I realized I had done some utilization management. I did an online course to kind of see if I even liked doing reviews. And I said, "Well, I kind of like this." And it reminded me a little bit of the expert witness work I had done where I just love to read cases. I love to read about them and learn about the patients and what not to do in private practice. I love that about expert witness work. Not necessarily going on a trial, but I love the reading of the case part.

And so, in utilization management you're reading cases. And so, I like that part. I like the learning part. And then the helping part, at least the organization I work for, we're helping patients. I don't know about every insurance company but this one. So, I can continue the helping of patients, but just a larger number of patients, a larger group of them, if that makes sense.

HF: You're talking about reading cases and helping patients. Can you give us a little more in-depth vision of what your day-to-day might be like?

SL: Sure, sure. I was kind of thinking about how my life is so different because I get up in the morning and have coffee with my husband and I go work out and then I go upstairs… Well, I shower, but then I go upstairs.

HF: On a good day.

SL: On a good day. Right. But I'm not stressing about fighting the traffic or is there going to be a bad snowstorm or a big thunderstorm. Am I running late for a hospital meeting? I just log in at eight in the morning. It may be a little bit before, and I start looking at the cases that are in, we call them the queues, that are in our queues. Or I may look and see, "Oh, I've got some peer-to-peers today. Let me prepare for those. Or we have rounds today and these are the patients that are going to be on rounds. Let me check and see if there's something I shouldn't learn about before rounds." I kind of prepare my day, what I have on my calendar and sit and work on cases throughout the day and go to those meetings.

And then of course, if I'm on a committee, I'll do those committee meetings. Those will be on the calendar for that day. And so, there might be more peer-to-peers on one day than others or more cases on a day than others. There may be more complex care rounds on a day than others, but that's kind of the balance of the day.

And then at five o'clock, pretty much I'm done most days. Pretty rare that I work longer than that. If there's a late review then I will of course stay. Because I'm so used to working till eight o'clock at night, that 5:15 is not a problem for me. I was like, "Hand it to me. I don't mind at all ever."

Then of course, if there's an appeal that I'm looking at and I don't know as much about it as I want, I may take the time after work to research and read about it so I can be prepared when I'm writing it up. There might be some things at the end of the day that I

said, “Oh, I didn't get a chance to look that up, let me look that up now. I just want to read about this now. I never heard of this, what is this treatment?” It may be 5:15, 5:30. Anything later than that is usually not.

HF: Yeah, it's a completely different schedule than you used to have. I remember sometimes you would tell me you were at a call at 7:00 AM going into work, they were talking about some administrative things and your day just started really early, it ended really late.

Now when doctors think about this area, the work-life balance can be very appealing. But then often thoughts come up, which could be, “Oh, I don't want to be someone denying care to patients.” And they've been on the receiving end of peer-to-peer calls and they are saying, “I don't want to be that doctor.” Or they're not confrontational and they think they need to be a confrontational person to be able to do those peer-to-peers. How would you speak to some of these concerns?

SL: Well, I'm definitely not confrontational. My very first peer-to-peer, my boss was super nice and did it with me.

HF: Held your hand.

SL: Held my hand. And then that's what's so nice about her is that she will definitely hold my hand. Could you go over this with me one more time? Yes. But no, they're really not confrontational because I know people see it as denying care. We're really not denying care. We're making sure it's appropriate care. There may be somebody that wants to try some experimental drug, but there is no research for it. Or there's somebody that wants to have, let's say an injection in a knee, but the recommendation may be to do X, Y, Z before.

And if I go look under the standard of care for something, our criteria would be the standard of care, pretty much. So, it's not like we're asking them to jump through all

these hoops that they need to do to get something that would otherwise be the standard of care. We're asking them, let's follow the standard of care of what you would do for this before we do it. And there might be an extenuating circumstance that we might not be able to have them go through step A, B, and C, but most of the time, it's just they don't want to, it's not a medical necessity, if that makes sense. It's not a convenience, it's not convenient. Well, that's not okay.

HF: Do you find many situations where you disagree with what you're supposed to be doing, and would rather be able to say, "Yes, we'll let you do this, but I really can't because of the guidelines?"

SL: I would have to say probably not. I think the hardest ones might be the cancer reviews, the chemotherapeutic agents. But most of the time they're going to a specialist, a cancer specialist. I'm just basically getting their denial and then I'm talking. They're doing the peer-to-peer. Of course, my heartstrings get pulled but when I talk to the cancer doctor ahead of time, the person that did the review, they're explaining to me why it's not recommended.

And so, it makes total sense. I would say no, I'm not really going, "Oh my gosh, I really should approve this. And this silly criteria." I don't really find that often. And if there is a time, it's most of the time because I may not understand it as well. And so, I may reach out to somebody in a different specialty and go, "Hey, this just doesn't make sense to me." And they go over it with me and they're like, "Well, this is what I'm thinking." Just like I have them reach out to me, "Hey, this pediatric case doesn't make any sense. Why should I deny this?" And then I'll explain why. Oh, okay. That makes sense. So we kind of work together helping each other when something doesn't make sense. It's pretty rare that we're just going, "Oh, this silly criteria" and not approving it.

HF: How often do you find the peer-to-peers to be uncomfortable for you?

SL: Pretty rare now that I go about them with a little bit more confidence, because I've done them now for over a year. I really try to get missing information. I said often I start out with the assumption that we probably should be approving this, so what are we missing? And then when the doctor can't give me the missing information, sometimes they go "Well, you're right." Sometimes they get upset. Sometimes they really want it for their patient and I totally get it. But I also understand that we have to be giving appropriate care to patients. And so, I feel less bad. I don't feel as bad when I can see that they really didn't follow what would be considered the standard of care and so it should be denied.

HF: All right. So let's shift gears a little bit and if someone is interested in this kind of work, what are the qualifications?

SL: Well, usually, and I can only again speak for where I work. But usually board certification is required. I think having at least five years of clinical medicine. I think the more clinical experience you have, the better only because now I can look at cases and just say "From my experience I can see why this patient needs to be admitted even if they don't quite meet." Just clinically you can understand it, but if you haven't been in practice long enough, you're not clinically going to understand it, if that makes sense.

HF: What you said is exactly right for most utilization management jobs. Not all of them, but most of them do require board certification. And typically they'd like you to have five years of post-residency experience. There are some that will do three years post-residency, but five is often a standard and for the reasons that you spoke to. You also need to have an active license in at least one state.

SL: Right. And I think the more states you have is that better. But usually they're going to want you to have an active license in the state that they're in or that you're working for. So yeah, I don't think they'd let you do it without that.

HF: And if someone meets these qualifications and then they're interested in exploring further, what do you recommend?

SL: Well, I think definitely using LinkedIn to look for jobs that are out there for utilization management and reach out to people that you know that do that at insurance companies. I know that there are people that I do peer-to-peers with that's all they do. I didn't even know that was a thing. But there's companies that just do peer-to-peers or just do appeals. And so, if you really were interested, that would be a good way to get experience. I don't know what their requirements are but I don't know if I would like to do peer-to-peers all day long. I think it'd be hard.

HF: Anything all day long is hard but peer-to-peers, I think you need to have some breaks from that.

SL: Right. And then the appeal people, they are looking at all the denials with the peer-to-peers that denied and then they decide to overturn or not overturn.

HF: Exactly.

SL: Yeah, that'd be a good thing to try if you want to get experience. And I think the little online class that I did was good for me to know personally that I enjoy this, I enjoy doing this. I don't know if it helped me get the position I have now, but it helped me know, because you wonder just like they wonder. If you've never done it before, are you going to enjoy it? And you just don't know till you start doing it. And that's always a big fear.

So, if at least you have that under your belt or like I did case reviews with expert witnessing, you know that you like that kind of work. Some people just don't like that detail oriented type of approach to things. “I don't want to deal with that. I just want to see patients and go home”, then you don't want to do this.

HF: Exactly. And one of the ways that you can test this out while you're still in practice is by doing chart review. And if you're interested in this, on my website, doctorscrossing.com, if you go to the freebies tab at the top of the page and scroll down, there's a freebie with a list of chart review companies and there's also a sample letter for when you're reaching out to these companies.

You do typically need to be in active clinical practice at least eight hours a week to do most chart reviews. Not all of them, but about 80%. Again, you can find that resource for doing some chart review at doctorscrossing.com. Just go to the freebies tab at the top and scroll down a bit.

This would be one avenue for getting started. Stacie also mentioned taking a short course in utilization management. Sometimes you can even do some utilization management for your healthcare system or get on the utilization management committee.

Now Stacie, there's one thing I was curious if you could talk about. Do you remember when I had you do a little networking on LinkedIn and what happened at first? Can you briefly just share how that all went down?

SL: I remember reaching out to a couple people that I wasn't even connected to and tried to connect to them because I got the LinkedIn, the one where you could reach out to people that you weren't connected with, whatever level that is. Expensive level of LinkedIn.

HF: Yeah, with the Premium where you get the emails that you can send. Yes, exactly.

SL: I reached out to somebody at one insurance company and he reached out and said, “Sure, I'll talk to you. He gave me a list of questions and then I gave him the list and he

never responded back." And it was like, I was just about giving up. I had reached out to a couple people, nobody responded and I didn't know anybody who was a pediatrician.

I was all dejected and you would go looking through my LinkedIn connections and you're like, "Hey, Stacie you've got a connection that not only are they a pediatrician, but they're a medical director." And come to find out that we actually went to the same residency, we both did some moonlighting at the same hospital. Somehow we were connected on LinkedIn and I have no idea how and when that happened, but when I reached out to this person, they were super nice and just spent all kinds of time with me about his nonclinical career.

And if it wasn't for you to tell me "Just reach out." No, I've had so many rejects from these. No, I'm not doing it. But he was super nice and super informative and then I kind of told him what I was looking for, and he had mentioned about the position where he was at that there were other openings there and I should look and apply. And there you go.

And so, some of it was being in the right place at the right time and having that right connection. But I think also if I hadn't talked to so many other people, I may not have been as prepared to talk with him. And maybe he would've said, "I don't know what she is, but I'm not recommending her for our group."

HF: I know, I love that story and I love hearing my client's rendition of what happened because my perspective is often different where I think it wasn't a very long period of time, it was maybe a couple days when people didn't respond to you and you were so discouraged like, "This is not working, nobody's getting back to me." And then those other people that actually hadn't gotten back to you right away, they actually end up did. I think most of them got back to you. It just takes some time.

But I totally understand how when you first go out there, as doctors, we're used to when someone wants a response from us, we're just on it, we just do it. We don't understand that people have different timeframes that they work under.

SL: That is so true. That is so true. I just emailed them like yesterday, 12 hours ago.

HF: And they are not getting back to me. So, let's see, we have a few more things to talk about before we wrap up and one is compensation. I just wanted to let people know that in general these utilization management jobs in health insurance tend to pay between $180,000 to $300,000, $330,000. Somewhere in between. And that often includes your base salary plus some bonusing. It can also include stock options.

And what I often hear from my clients is that when they get into this position, they actually get raises and they get bonuses and they feel appreciated. And I've heard that so many times that I don't think it's just a fluke.

SL: No, I agree. I have such a different sense of feeling appreciated than I've ever felt. And I used to always feel appreciated by my patients, but when you start working for other organizations, you just realize how you're just not really appreciated. But I would say, yes, you do feel appreciated, you feel compensated for what you're doing and recognized for what you're doing.

And it's a wonderful feeling. It's just very different because in medicine, especially now in practicing medicine, it's RVU based in number of patients you see. And if you take a vacation, oh my gosh, you're going to lose money that month because you took a one week vacation or a two week vacation. It's just a completely different concept to not be this RVU based kind of salary. That it's just not a way to pay people. It's awful.

HF: It's something that really bothers me. It's that my clients who love their patients would like to still practice, leave and then they end up being appreciated and often make more

money in health insurance or some of these other jobs than as practicing doctors. And there's something really wrong with that. I can't fix it. I don't condone the situation. I don't like that people have to leave medicine to feel this way, but you have to do what you have to do.

SL: Yeah, yeah. And honestly, I don't think the doctors often realize that that's what's going on. They don't often realize that they are underappreciated, but they're burned out. They talk about burnout but they can't really define what that means. And then when you get out of that environment and you're out of the toxic kind of negative thing that can happen in practicing medicine that you go to an organization where you are appreciated and you don't realize how much you've missed it.

HF: I know. Exactly, exactly.

SL: “You actually never had that?”

HF: That can be a thing. I can be appreciated. Someone can value me? Oh, it feels good.

SL: Right, exactly.

HF: So, what other things do you really love about your job, Stacie?

SL: I love to learn. I've always loved learning. I always felt like I never had enough time to look up things and I would see some of the same things day in and day out. But I still loved and I loved watching that asthma patient get better or the eczema patient get better. I love that. But now I'm learning all sorts of medicine that wasn't even around when I was in medical school or residency. And I may have had one mitochondrial defect patient in my entire 25 years. Now I see one maybe every other week on a review. So, I'm like, oh my goodness. Every rare, unusual thing it seems like we have, I don't even

understand how that could possibly be, but we seem to have the rare. And so, it's great for me. Or we see the rare presentation of something and I'm like, oh my gosh.

Where I work, I do adult and pediatric reviews. So I also am learning all this adult medicine that I either A) never learned or B) definitely don't remember from medical school. So, that's where it's like I get to learn all the stuff. I'm much quicker at looking things up too than I used to be between all the different websites and resources. When I do my mock questions it's like "Oh, my gosh, I'm so much quicker at finding this stuff now." And so, it's great. Yeah.

HF: I do hear that a lot for physicians in all sorts of different nonclinical jobs that they feel like they really get to keep learning and something that we want to keep doing and not feel like we're stagnating.

SL: Right. You have the time and energy to look and learn where in private practice you tend to just be tired and want to go home.

HF: You're just trying to get stuff done and get a few hours of sleep.

SL: Right.

HF: The last thing I wanted to ask you about, which is something really unique about this type of position, it's not in all UM jobs and I think it's just a small sector where part of your job requirement is to be clinically active for half a day a week. Is that correct?

SL: Yes.

HF: And how do you do that?

SL: Well, I was very fortunate to find a telemedicine company that I work a half a day a week on Friday mornings is when I do my telemedicine. Well, I usually have to add another hour in there during the week either on evening. One evening I may work from 05:00 to 06:00 to get the extra hour in. They require five hours a week or 20 hours a month.

But anyway, I work in a telemedicine company. It's basically pediatric urgent care. So it's great. I don't see adults, but I see the age range that I saw in private practice. And so, yeah, it's a lot of fun. I never thought I'd be that comfortable with telemedicine. I did some telemedicine during the pandemic. I think it's a little bit different if you're trying to do well visit telemedicine. I don't think that that's really what the well visit is all about in pediatrics and you definitely can't give vaccines over to telemedicine.

But to be able to help a patient parent know, yes, this is something you need to go to urgent care, you need to see your doctor for or something we can treat over the phone or they just want advice. And so, it's kind of nice because again, you're getting appreciated and you're getting paid almost for your telephone calls. A lot of them are just really like a telephone call. You're not really prescribing anything. You're just giving them really good advice and what to look for and when to go to the ER, when to see your doctor. So, it's very nice and I think the patients are usually so happy that you're able to avoid them driving in the snowstorm or missing school because they don't have that note because of their pink eye.

HF: I think that's great. And I love this combination. I wish more companies did that. To wrap up, what would you give your job that satisfaction on a scale of zero to 10, Stacie?

SL: Oh my goodness. I would have to say 10 right now. I'm super happy.

HF: Wow.

SL: It's not like every day is perfect, don't get me wrong, but more often they're more perfect than most of the days in the past.

HF: Well, that's wonderful. I'm really happy for you. I'm proud of you. And thank you so much for coming on the podcast and talking to us about being a medical director in health insurance.

SL: Well, thank you and thanks for having me. And just thank you for you being you and all you do because I couldn't have done it without you, Heather.

HF: Oh, I trust that you could but thank you so much for those kind words. It's such a joy to work with you and other physicians. Alright, my dear lovely listeners, thank you for listening and if there's someone you know who might benefit from listening to this podcast too, please share it, spread it far and wide because we don't want anybody to feel trapped. And 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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