DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 134 Being A Physician Advisor in a Non-Hospital-Based Role

With guest Dr. Ron Hirsch

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RH: "I fell into the utilization review physician advisor world. I had no intention of ever doing this, but once I got into it, I fell in love with it. And I absolutely love what I do every single day of my job."

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 134. We have talked about the role of the physician advisor in a previous episode number 105 with Dr. Tim Owolabi. In that earlier episode, Dr. Owolabi described the work he does as a hospital-based physician advisor, which involves a variety of duties, including being a liaison between administration and the clinical staff, assisting with revenue management and utilization of services.

Today we're going to continue to learn more about what physician advisors do with a focus on the role physician advisors have when they work for a company outside of the hospital system. Our expert guest internal medicine physician, Dr. Ronald Hirsch, has had extensive experience as a physician advisor in both hospital-based and external roles.

Dr. Hirsch is currently the Vice President of Physician Advisory Solutions at R1 RCM, a third party company that provides physician advisory services. Dr. Hirsch is also on the advisory board for the American College of Physician Advisors. Ron is going to give us a lot of useful information about this expanding area of work you can do as a physician advisor, what the qualifications are, how to explore opportunities, why he is passionate about this work and more. Without further ado, I am honored and excited to welcome Dr. Ronald Hirsch to the podcast. Hi Ron. How are you?

RH: I'm doing great. Thank you. Pleasure to be on your podcast here.

HF: Yeah, I'm a big fan of yours and I've been hearing about you for a long time since I first started delving into this area of physician advising. It's one thing I've noticed about the people who go into this work is they seem to be very friendly.

RH: Well, I think that's really part of the role is you have to be able to interact on a collegial basis with people of all types, other physicians, administrators, the nurses, the patients. I think it's intrinsic within the role to be a nice person.

HF: Well, and a lot of doctors are. They like people. So I think it is potentially a good fit. I want to go back to the basics because this term “physician advisor” is confusing. A lot of my clients think, “Well, I'd love to be advising physicians by working with my colleagues.” Can you first give us sort of a 30,000 foot view of what the physician advisor does? And then we'll kind of break it down to these two different ways that they can work internally and externally.

RH: Sure. We don't really know where the term physician advisor came from. It kind of appeared many years ago. In the pre-talk, we talked about Dr. Howard Stein in New Jersey, and he's probably one of the earliest physician advisors. And one way I like to look at the physician advisor who works in the hospital is they're kind of the mini CMO. You have a chief medical officer who's kind of in charge of medical operations, but they're looking at the big picture. They're working on joint commission surveys and planning for new procedures and all kinds of stuff.

The physician advisor is the CMO who's out on the floor on a daily basis dealing with doctors one-on-one, dealing with insurance companies, dealing with patients, interacting with the nurses, the case managers, et cetera. There's no one definition in the hospital for what a physician advisor can do.

There is a list of probably 20 potential things they could be doing, and it's really the hospital who's hiring them to say, “Here's where we want you to prioritize your time and effort.” It depends on the person, depends on the hospital, depends on the points of tension within the hospital, depends on their payer mix. There's all kinds of things that could potentially happen.

One of the things when I started as a physician advisor at my community hospital, someone said our length of stay is too long. So they asked me to start looking into length of stay and seeing how we could shorten length of stay, how we could optimize patient care. That was one thing I worked on.

Certainly, we talk a lot about dealing with insurance companies, and that's become more of an issue as they're trying to do everything they can to not pay for care. And of course, the hospitals want to be paid for the care that they're providing. So, that's another big role.

HF: Those are helpful examples and it is a hard role to describe because when you do hear about it, it sounds like they're wearing a lot of different hats, and as you said, it can be sort of specific to the institution that they're in, which hats they'll wear on a particular day or even in that job.

RH: Absolutely. And it can vary day to day, hour by hour. You may be dealing with looking at level of care determinations or appeals, and you get a phone call from a case manager about a patient who's upset that they're being discharged. So now you have to put on your appeal hat and make sure that the patient received the right documents and handle that discharge appeal process.

Then you might get a call from an insurance company that wants to deny a procedure that's been performed. So now you have to discuss with that insurance company the criteria that were used and why the patient had the procedure that they had and why they should pay for it. So, it's a constantly evolving process in the hospital.

HF: It sounds like the kind of thing where someone's always knocking on your door for something.

RH: Absolutely. Absolutely. I think physicians, at least the ones I know, we tend to have the personality of, if you ask us to do something, we're going to do it. And I think to really be a successful physician advisor, if you're working in a hospital, you really need to work with administration to outline what you're going to be doing and how much time you have allotted to those things. Because what you can end up doing is being stuck with a million duties and not enough time to do any of them well.

Sometimes we just have to learn how to say no, I can't cover every patient seven days a week, 24 hours a day. We're going to have to have some backup plan when I'm not there. When I'm on vacation I don't want to be receiving phone calls from the case managers who need a physician to look at a condition code 44 change. And I think if we

don't learn to say no, we're just going to have more and more duties piled upon us. That certainly can lead to burnout in itself.

The other important thing that I'll mention is when you're working in a hospital, it is crucial that the C-suite understands what the physician advisor does and provides them the support that they're going to need. The people that bring money into the hospitals are often the surgeons, and it's just the reality of our healthcare system. And if you're trying to talk to a surgeon about their documentation or length of stay or whatever it is, and that surgeon gets upset and goes to the C-suite to complain about you, the C-suite needs to understand what that physician advisor was doing, why they were doing it, so they can provide support to that physician advisor rather than telling the physician, "Oh, don't worry, I'll get that doctor off your back."

HF: Yeah, absolutely. Because when you're a liaison working between the administrators and the clinicians, there's obviously going to be tension there, and it's probably like walking on a tightrope.

RH: Absolutely. I can give you a good example. In fact, it just came up on one of the discussion groups. A hospital in the southeast was curious about how other hospitals determine the admission status for the patients having TURPs. And this person was saying that their urologists keep their patients two days after surgery, and therefore by the rules that should be an inpatient.

The problem is, if you talk to hospitals in other parts of the country, those patients go home the same day or the next day. The message I gave them was you need to go back to your physicians, your leadership and say, "Wait a minute, why are our doctors keeping patients two days when the national standard of care is to send them home after one day?"

Now, those are not easy discussions to have. You have to prepare for it, you have to get literature, but it's necessary because that hospital is being reimbursed the same price, whether that patient goes home the same day, the next day or two days later. So understanding the nuances of things, the psychological effects of these conversations is really critical.

HF: And we're going to be talking about the physician advisor role working for a third party company to contrast them a bit, because when we think about this role, it sounds like someone who needs to have a high emotional intelligence and like interacting with people and be comfortable wearing a lot of different hats. And maybe just shifting gears a lot. So, Ron, would you mind giving us a picture of what a physician would be doing if they work for a third party vendor as a physician advisor?

RH: Absolutely. In the case of R1, we work for clients around the country, and what we do is review patients who are being hospitalized and look at the documentation, look at the patient's presentation and decide based on the rules what admission status the patient should be assigned.

And for the most part, that's a significant part of what our physicians do day in and day out. They're logging into the hospital's EMR, they're reading the notes, they're looking at the vital signs, et cetera, reading the H&P and helping the hospital make that decision.

Our kind of mission is to make the physicians be able to practice medicine and provide the administrative regulatory support that the hospitals need. I don't want to sit and go to hospitals and say there's a thousand insurance companies registered in the United States. I'm going to teach you the admission rules for all thousand companies. They're going to say, "I didn't go to medical school for this. Just tell me what to write basically." We do a lot of admission decision, reviews.

Our physicians also will do specialized audits. A hospital for example, that may think that their patients are staying longer than necessary than is medically necessary, may send us a selection of records and our physicians will read through those notes, reviewing everything and help determine from our view, did that patient require the continued hospital stay that they were in? And we may say, yes, absolutely it was appropriate. We may say, no, it looks like they could have been discharged two days earlier and here is where the delay may have been. And then give that information back to the hospital to work on addressing those issues.

We also do specialized audits. A hospital may receive a chart request from an auditor saying, we think you're doing too many defibrillator placements. Can you please review your defibrillators to make sure that they meet the national coverage determination for that procedure? Rather than having their internal people who may be a little biased, you hire a third party auditor who will look at it objectively, look at the guidelines and help decide whether there's risk there or whether everything is being done properly.

HF: You're helping to keep them out of trouble and also to not leave money on the table and to make sure that they're doing things that are as sort of fiscally responsible and rewarding as possible within the guidelines.

RH: Absolutely. Absolutely. And I don't think physicians realize it. They think it's just the hospital's money at stake. But the reality is for someone like a surgeon, if the hospital can't stay open, they have no place to operate.

It's interesting, I was just reviewing the Office of Inspector General Audit that was recently published. And while we often see hospitals fined for inappropriate admissions or inappropriate procedures, in this case, the physician who admitted the patients inappropriately had to pay a half a million dollar fine for their activity. Physicians licensing their money, their livelihood is potentially at stake if they don't get things right.

HF: Yeah. You don't want to be liable for that at all. When we think about a physician advisor who might be working for one of these third party companies such as yours, R1 RCM, what are the qualifications that they would need?

RH: We'd like to have physicians who have experience with hospital medicine. Since obviously we're looking at patients who are hospitalized, we want physicians who are current, have been practicing relatively recently, understand hospital medicine as opposed to being purely office-based. That have been keeping up with the medical literature, know the current guidelines, know how to assess patients.

We also want people who can get into an EMR and quickly pull out the information that's necessary to make those decisions. We don't want them getting bogged down reading a lot of superfluous documentation. We know there's a lot of check boxes and copying and pasting. It takes a skill to go into that chart and really pull out the crucial elements.

And then the ability to continue to learn. Understanding these rules about how to status patients and what medical necessity is isn't something that's taught in medical school. It's not taught in residency. And most physicians in practice don't have really any clue. They're going to be put through a comprehensive educational program that will teach those rules with a lot of oversight, double checking. And so, the ability to go back and kind of be a student again is really crucial.

And sometimes you interview people and you can determine those things, but other times, they've got to get into it to see whether it's something they want to do. Again, this training process takes months and months. Our physicians take sometimes six months before they're really good at doing this. And part of that again, is making sure that they're really committed to doing work like this. This is not for the physician who is just burnt out and thinks they're going to take a job and it's going to be easy money and because they have an MD after their name, they're going to get paid for it.

It takes devotion, you're going to be questioned. They're going to be talking to physicians at hospitals. They have to be able to justify their work and their decisions. So, it does take a personality to do that.

HF: That's interesting that in this job too, there can be some of that conflict with speaking with a physician who may have a different idea about what should happen with this patient versus what the physician advisor is recommending.

RH: Absolutely. At least with our company, we work with our client hospitals to decide how they want us to relate our findings back to the hospital. In many cases, the hospital says if our doctor wants inpatient and you agree, great. But if they want inpatient and you think it should be observation, we'd like you to call our physician and explain to them why you think inpatient is not appropriate.

Now, again, in most cases, those conversations are collegial. Oftentimes what happens, the doctor says, “But didn't you see that this or that?” And we say it's not in your notes. We weren't there to see that. We need it in your documentation. And it's very collegial.

Other times it's a doctor who says, “I don't care who you are, you're somewhere across the country telling me what to do. I'm not going to listen to you.” We hope that doesn't happen, but it does. And you have to be able to kind of explain that this is not about their medical care. This is about an insurance company that in three months or three years will come back and read those same notes and not pay the hospital for that admission.

HF: Right, exactly. You're just really trying to help them.

RH: Absolutely.

HF: Don't blame the messenger. I want to take a quick break to share some resources and then when we come back. I'd like to dive in a little bit more to qualifications and how to even find these jobs.

All right. My dear listeners, I wanted to remind you that for the month of June, 2023, we have a special on my LinkedIn course. You can get 10% off this course, which is full of videos, which help you build out your LinkedIn profile and learn how to network, search for and apply to jobs and establish yourself in a professional niche if that's something you're interested in.

LinkedIn is probably the number one networking platform, and my clients have found it incredibly helpful when they're navigating into a new non-clinical area and LinkedIn keeps adding on new features. And I've updated my course to add in some of these things that they have now that they didn't before.

If you're interested in learning more about this course, you can find it at doctorscrossing.com under the products tab. I'll also link to the information in the show notes, and they'll also be the discount code. You can use LINKEDIN10 to get 10% off. Now back to our guests, Dr. Ronald Hirsch.

Alright, Dr. Ron. Anyway, this is a real potential area for physicians who want to keep using their medical knowledge and being engaged in patient care and improving things. You said that it's good to have hospital experience and obviously I would assume a medical license is required. Is board certification required? And also how many years do you like a physician to have practiced clinically after residency before being a candidate?

RH: Medical licensing is required in one state, at least. In California to review cases you actually have to have a California license. Many of California does things the way they want to, and this is one of those things that they've put in place.

Board certification is especially encouraged. I can't say it's absolutely a must, but I guess the whole board certification issue is a little bit controversial these days. Many people don't like to have to pay money every year to maintain those things, but also to us maybe looks and says, "Why aren't you board certified? What is missing from your education, from your knowledge base that you are not board certified?"

And then experience-wise, again, it's going to depend on the individual. Certainly somebody coming out of residency probably doesn't have the experience to be able to look at the broad range of cases that they're going to be exposed to and to be able to make those determinations.

We do look at experience from the side of how consistently have they been in the same job? Surprisingly, there's a fair number of people out there that will switch jobs regularly. And again, for a company like ours who's going to put a lot of time and effort into training, we want someone who's going to be committed to that job.

I think maybe I'm dating myself, but in the old days you became a physician and you settled down in your practice and you were there for a lifetime. It seems nowadays with hospital-based physicians and office-based physicians and corporate employment and such, that there's a lot more transition of physicians from job to job. And if we're hiring someone and we see that they've had five jobs over the last eight years, we might be concerned is this the right person for our company?

HF: I know sometimes I see physicians doing that because they realize that clinical care is not for them. So, they keep trying a different setting hoping it will be better, and then they finally realize, "Well no, I need a nonclinical job."

RH: You're probably best at knowing that there's lots of roles for physicians in our society. Again, back in my day you did it because you wanted to take great care of patients. I fell into the utilization review physician advisor world. I had no intention of ever doing this,

but once I got into it, I fell in love with it. And I absolutely love what I do every single day of my job.

HF: Well, that was one of the questions I wanted to ask you is what makes you passionate about this work?

RH: I have fun doing it right. My job is a little unique with our company because I'm the educator for our clients. My job is to read the regulations, understand them, translate them into actionable processes, and then go talk to our clients about how to incorporate that. Just this week I was at a client in the Midwest and I spent two days doing eight hours of lectures, talks to their staff, their physicians, their case managers, their social workers about Medicare regulations and good care and determining admission status and social determinants of health and stuff. It was wonderful.

Also, honestly, I'm a little bit snarky and sarcastic. And I think that helps get the message over better when it's not just someone up there giving you this dry lecture about A, B, C, D and E.

HF: I know, I was going to say it sounds a little dry to me. So, that's great. You know how to spice it up a bit.

RH: Absolutely. And use case examples. You kind of make fun of everybody. The doctor who lets the patients stay overnight because Monday night football is on TV. That's not a necessary reason to keep a patient in the hospital. But it gets the point across because the people see it every day happening in their hospitals.

HF: I'm sure you have a lot of stories you can tell that illustrate your teaching principles. We have a few minutes left here. If a physician is interested in exploring if the physician advisor role could be feasible for them or even enjoyable, what are some steps that he or she could take?

RH: Well, I'd certainly first advise you to go to the American College of Physician Advisors website and browse around there. Lots of interesting information, some guidelines, they have a jobs board. I honestly have not been there recently to know how active it is.

You want to at least get a taste of what the job is and one way to do that is to go to your hospital and talk to your case managers and see what your hospital does and maybe there's opportunities there to get involved as a start.

One easy thing to get involved in this, again, if you're on a medical staff, is volunteer to be on the Utilization Review Committee. That's the committee that's kind of appointed by Joint Commission to review all of these things. By being on that committee, you can get a feel of that data, the information, the challenges that they face.

If I can put in a plug, if you're really into it, I was the co-author on a book called The Hospital Guide to Contemporary Utilization Review. It's available on hcpro.com. And I have to say it's a really good book. It can use as my teaching methods to really explain a lot of these processes that are involved in the world of the physician advisor.

HF: We'll absolutely link to that. Absolutely.

RH: Sure. Read it. It gives you a feel for what you may be doing. You may start reading about the two midnight rule and say, “Oh my God, I don't want anything to do with this. I want to keep treating heart attacks and strokes and sore throats and whatever else is going on.”

And then I think there's a lot of prominent companies in the industry. So, I think you probably go to their websites and look at their job boards and see what's out there. Our company, r1rcm.com has a careers page. I'm sure the others probably do also. And again, the hiring is variable depending on need. We are seeing certainly a lot more hospitals bring these services in-house. So, it's going to change. There's also some

movement with artificial intelligence, can it do these things? Honestly, I asked ChatGPT to help me determine the admission status for a chest pain patient.

HF: Oh, right. Yeah.

RH: It was as wrong as could be. It didn't understand the difference between inpatient and outpatient with observation services. So, it's not there yet.

HF: Okay. I'm glad you mentioned it because it is something we're talking about more on the podcast and I think it really is going to have a place in medicine that's increasing over time and it's pretty bright in so many ways. It's kind of scary, crazy.

RH: It's really going to be interesting. Quick little anecdote. In one of my private practice, we built our own building in 2003 or something. As we're designing the building, I said we need to wire every single room with Cat5 cables so we could have computers in our office in the exam rooms with the patients at the time.

It took two years to build the building. By the time we opened the building, wireless internet was broadly available and we never ever used those plugs that I insist to be put in every single room.

HF: Wow.

RH: I don't know where AI is going to go. I don't know. I think when it comes to the patient care developing differential diagnoses, determining the optimal treatment, there's certainly a lot of opportunity. A lot of potential.

HF: It'll be very interesting to see. And the last thing I wanted to ask you, Ron, is if you can speak a little bit about compensation.

RH: I honestly don't know what our company's paying currently. I think it depends on what specialty you're coming from and what setting you're coming from. If you look at physician compensation surveys, it tends to be family medicine and pediatrics are on the lower side and it may be comparable into that range. You're certainly not going to be compensated the way an orthopedic surgeon would who's in practice. You certainly cannot set your target too high because it's not going to be realistic. And each company's going to be a little different based on your duties, your hours, your commitment to the work.

HF: You're saying that the salary for working for a third party vendor as a physician advisor could be fairly comparable to what you'd be making if you were a primary care physician.

RH: That's a good range to say, yes.

HF: Okay. All right. Is there anything else you'd like to add that we haven't discussed yet? Or any words to these physicians out here who are just trying to figure it out for themselves?

RH: Yeah, I think being a physician advisor is extremely rewarding. You're not only doing what's right for the hospital, but it's also what's right for the patient. It's right for our healthcare system. You're getting a look at all the complexities that are involved in healthcare. A politician said "Who knew healthcare could be so complicated?"

HF: It's like the tax code. It's much worse.

RH: Yeah. Going through residency, you practice medicine, you order medications, you order treatments, you take care of patients. There's so much behind it that you can realize. And honestly this is a great way if you have a career goal of being in administrative medicine. I know physician advisors who have quickly gone on to become CEOs of

hospitals because it's that experience you're getting in every piece of healthcare that gives them the insight to move up in their careers.

HF: Yeah. And the physician advisor role seems to be expanding. Before you didn't hear about it very much and now it's something that most hospital systems I think really have to have.

RH: Absolutely. The pressure of our healthcare system with our thousand insurance companies. More than 50% of patients in Medicare Advantage is creating a whole new layer of complexity. You need that administrative liaison to help survive.

HF: All right. Well, thank you so much Dr. Ron for coming on the podcast. It's really great to finally get to meet you and get to hear more about this area, which is very intriguing.

RH: Well, thank you for having me. It was a great time.

HF: All right. Okay, my dear listeners, thank you so much for being here. Feel free to share this podcast with anyone who you think might be interested. And if you don't have my LinkedIn course yet, but you think it might be useful for you, please check out the link in the show notes or go to doctorscrossing.com website and hit the products tab and you can learn more about it. The 10% off special is good for the entire month of June 2023.

And one thing I'd just like to add is if you're interested in the physician advisor role or any other non-clinical direction or even a clinical niche, LinkedIn is great for being able to find other physicians who are actively in that role. And you can reach out to them. And if you reach out to enough, someone's going to get back to you and chat with you and help you. I've seen it time and time again.

So, I want you to have as many resources as possible to be able to carpe that diem and live the life that you're meant to live. I'll see you in the next episode. Bye for now.

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Podcast details

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