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

TRANSCRIPT

EPISODE 153 Surgeon Finds Meaning In His Career in Population Health and Account Management

With guest Dr. Ian Hamilton Jr.

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IH: "Helping populations of people, for me personally, is as gratifying as helping an individual patient with a vascular diagnosis. It's just different. It's a different level of satisfaction, but it is still very profound for me personally."

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.

Hi there and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host Heather Fork, and you're listening to episode number 153. We've been talking a fair amount on the podcast about the more entry level medical director jobs for physicians working in the health insurance sector. However, we have not devoted an entire episode to opportunities beyond doing the bread and butter utilization management work that has been featured.

Our very special guest today, Dr. Ian Hamilton Jr, is going to help us have a better understanding of the interesting work he has been doing for almost a decade in the health insurance sector. Dr. Hamilton Jr. is a vascular surgeon who has an MBA as well as a master's in population health.

During the 20 plus years he was in practice, he was very interested in the delivery of healthcare as well as his surgical work, participating on committees, doing his MBA and taking on leadership roles.

When Dr. Hamilton first transitioned into the health insurance sector, he began working in utilization management, which is the most common entry point. However, because he already had an MBA and wanted to diversify what he was doing, he advanced into new roles and responsibilities, which has led to his current position in population health and account management for a major health insurance company.

Ian is going to help us better understand the opportunities for physicians working in the health insurance sector once they're comfortable with doing utilization management and would like to take on a new challenge.

He will talk about what is rewarding about this type of work, qualifications, who would make a good fit, compensation and more. I am truly honored and excited to welcome Dr. Ian Hamilton Jr. to the podcast. Hi, Ian.

IH: Hi, Heather. How are you doing?

HF: I'm great. I am so excited to have you here.

IH: Well, I'm excited to be with you today and to talk about some of these issues. I look forward to it.

HF: Thank you. And it's so interesting because we first met back in 2011 when I had only been doing this for a year, and it's really nice to see where your career path has gone. And I know you have a lot of value to add.

IH: Well, it's nice to see how you've grown and prospered in your space also. So congratulations to you as well.

HF: Well, thank you. And it's true. When we find something that really resonates with us, we tend to expand into it rather than look for the exit door.

IH: That's right. Yeah. And that's happened with me also.

HF: Yes, I'm excited to be able to share with the audience your story. Would you like to take us back to 2011 when you were a vascular surgeon and you were not sure exactly what direction you wanted to take your life and career in?

IH: I'm happy to, Heather. It's a circuitous story. If I go down a rabbit hole, be sure to pull me back out. But I left academia and went into private practice in 2003. I was running a small private practice in vascular surgery and also functioning as a medical director in a moderate sized hospital. And soon found myself dealing with HR and capital budgets and all sorts of things that didn't have a whole lot to do with vascular surgery.

And so, I went to the Auburn Executive MBA program, which is hybrid, and I finished that program in 2009. But before I finished, I knew I was going to leave clinical medicine at some point, because the exposure I had to issues around patient safety, waste in the healthcare system, cost of care, and just how inefficient the US healthcare system can be. It really spoke to me as an opportunity.

I started preparing myself. I didn't know how or when I was going to leave, but I knew that I needed some additional experience. I started seeking board of director

opportunities and became involved in a local physician hospital organization, and ultimately, felt like I needed some coaching.

I needed some guidance on how to make this transition where my opportunities for personal development might be. And I met you and you were very helpful in 2011 in additionally helping me prepare for this transition into a nonclinical role. It was invaluable, and I greatly appreciate that assistance, Heather.

From 2011, we go forward, and around 2012 or 2013, the hospital offered to buy my vascular surgery practice. By that point, we had grown to two vascular surgeons. The other one was hospital employed. And we came to an agreement on the sale of the practice, but we couldn't come to an agreement on the employment contract. And the long story short is after almost two years in negotiation, I decided to sell the practice, and the hospital was then free to hire somebody straight out of practice, which is probably what they really wanted.

After 11 years of private practice and seven years of academic practice prior to that, I had some time off. I had been on call either every night for five years or every other night for six years of that 11. And kind of reunited with my family.

And then I started looking, I had a sense of what I wanted to do, but I didn't know exactly. And so, I was open-minded. An opportunity presented itself with a large managed care organization. It was to perform UM and CM for one of the state's retiree population. I did that for about a year and kind of cut my teeth in the payer space. And then another payer gave me a call and offered me another opportunity.

HF: There's so much I want to dive into in your story, and I want to first thank you for your kind words. It was a real honor for me to work with you. And I remember Ian, back at that time when you were trying to decide what to do and should you sell this practice. It

is often top of mind for any physician, but especially surgeons, "Should I leave? What are the risks of letting go of my surgical skills? Can I get back in?"

And some have done as much clinical practice as you with almost 20 years, but others I see maybe just two years in, they have young children and they really aren't getting sleep at night because of babies. And then they're on call and they love their job, but they're really afraid. They're caught. They say "I can't keep doing this job physically, but I also don't want to leave and not be able to come back for this job I trained so hard to do." Do you have any insights you'd like to offer for physicians in this dilemma?

IH: Yeah, I'm happy to, Heather. I remember having those same emotions, sentiments and feelings. I think it's important to follow your gut, so to speak. If you have a new passion to explore it, give it some time and make sure that it's real. In the case of surgeons leaving clinical medicine, there are a couple of comments. One is the American Board of Surgery has a nonclinical board certification status. You can still maintain your board certification, but it's qualified as nonclinical.

You still have to meet all of the requirements for board certification, except for the case counts that you have to turn in. They obviously don't ask you to do that. You do have to have a letter from your supervising physician, which in a payer organization would probably be the chief medical officer, and you have to maintain the continuing medical education hours.

The other comment is after you've been nonclinical for a year, there is a reentry pathway back into clinical surgery if you wanted to do that. The American Board of Surgery has specified the requirements for this reentry program, and it is basically a residency that is somewhere between one and two years at an approved location, and then you can come back into clinical activity as if you never left.

HF: Yeah, it's always good to know their options. And there's a podcast I did a while back where we talked about reentry programs, for example, KSTAR, and sometimes it can be a three month reentry, sometimes a six month reentry where you're going and being immersed in your specialty.

Now, when you think about your own situation, did you know that you were headed towards doing something in the health insurance sector, or were you thinking about a whole bunch of different things?

IH: I was not seeking out a payer organization, but what I was really interested in was an opportunity to try to address the issues around cost of care to reduce the waste in the US healthcare system. And ultimately that became an interest in population health. There was still an ongoing transition in the interest space, but it was still very much related to cost of care, waste, patient safety, and then ultimately population health.

HF: Now, you started out in utilization management, which we've talked a fair amount on the podcast, so I'm not going to go into a lot of detail about that. But do you want to give maybe a one or two sentence description of what you were doing in UM?

IH: Sure. It's when requested services for beneficiaries of a healthcare plan come in with a request for approval. We match that request in the clinical information associated with that request against existing medical policy. And if the circumstances around the request meet medical policy criteria, then the request is approved. And if the clinical criteria do not meet the medical policy, then the request is denied. That's UM in a nutshell.

HF: And I have to ask this question. A lot of doctors feel that working in health insurance is going to the dark side. What are your thoughts on this?

IH: Well, I completely understand that. When I was in practice, I viewed insurance companies largely as the enemy. And I think most physicians currently view them that

way, but they're only seeing one rather small part of what payer organizations do. And that is utilization management and the denials for requested service. But once you get on the inside of a payer organization, you quickly come to realize that they're very, very interested in trying to keep their members, their patients as healthy as possible. It's in their best interest to take good care of their insured lives because the healthier those insured lives are, the lower the spend.

And so, they have a very, very sincere desire to improve the health and the wellbeing of their insured lives, their members. And that's the space that I'm in right now. And it's very rewarding to be able to participate in those aspects of wellness and health improvement activities for our members.

HF: Very briefly, how would you interpret that denial when physicians get upset and think that they're just being denied what is right for their patient?

IH: Well, there has to be some standard in care. Evidence-based care is critical. It's part of providing appropriate care for patients in different regions of the country, for example. And the medical policies that exist are all based in evidence-based care. The insurance companies don't create those policies. They get them from specialty societies and national organizations that put practice recommendations out.

And so, when there's a denial for a service, it's because it doesn't meet the medical criteria that have frequently been put in place by physicians themselves, by professional organizations, subspecialty societies that have put evidence-based recommendations out into the public venues.

The long and the short is go to your payer, get their medical criteria, their medical policies, they're available to all participating physicians, and become familiar with those services that you frequently request. As you get to know those policies, you'll be able to predict whether the requested service is going to be approved or not yourself.

HF: Okay. Well, thank you for sharing that. I know we could have a whole episode on this, and it's something that is controversial, but I see a lot of physicians who initially feel what you did, when they work on the inside, on the other side, they have a different perspective. So thank you for that.

IH: Yeah, absolutely.

HF: You went very quickly from UM into population health, and I have a former client who is a go-getter, and she started out in UM. And when she was in this company for a little bit, she started asking, "I want to advance, I'm very interested in population health, what do I need to do?" And she was basically told, "Cool your heels. It's going to take a couple years and there's nothing you can do."

And she was very discouraged by that advice, and she on her own, went and looked into doing an MPH, doing an MBA and seeing what are her alternatives rather than just sit there and feel like she's just biting time. How would you speak to a physician with a kind of interest in knowing what you know in your path?

IH: I think there are increasing numbers of physicians that are leaving clinical medicine and going into related areas that are nonclinical. The competition for these jobs has increased over the years. And although it's not mandatory, it is very helpful to have another advanced degree such as an MBA or a master's in health administration. Those educational processes really do have a lot of relevancy in these nonclinical positions. And so, I do think that that's helpful.

The other thing is to look broadly and sometimes to have a willingness to relocate to a new job opportunity. Now, today, in the virtual world that we live in, a lot of those jobs that used to be on site are now either hybrid or in fact virtual. The threshold to entry has lowered because of the virtual aspects of these jobs now. Those are a couple of points that I would have in that space.

HF: We've been talking about population health, we haven't really defined what are you doing in your current role, and you also do account management. I'd love it if you could take us into this world where you're helping out in a different way than when you did UM.

IH: Yeah, I'm happy to, Heather. Every managed care organization that has a commercial line of business sells to large self-insured companies. And what they're selling is their network of physicians and hospitals. They're selling care management, claims processing and all of the details that go into being a managed care organization, but the self-insured companies take the financial risk and they actually pay the claims.

There's a process of the managed care organizations selling their services to self-funded companies. And then after the sale is completed, then there's a management requirement there. You want to continue to make sure that the self-funded client is happy, and that anytime they have a question or a concern that the managed care company has the resources to address and answer those questions. That's where the account management comes in.

Now, behind that is the population health. Using big data, we analyze each population individually. We look for example, disease states that are higher than our benchmarks, and then we look for solutions to bring those disease states back down to the benchmark. And that's where the population health aspect comes from.

HF: Do you have a specific example, Ian, of where you've helped a company with their population health sector?

IH: Yeah, we do it all the time, Heather. The data analysis is continuous. If there's a concern or a desire, we can pull the data anytime. And then we also have large reporting packages back to the client on a regular basis, no less frequently than a year. But to your point, diabetes is a very prevalent and very expensive diagnosis these days. There's a lot

of specialty medication spent on diabetes, and as you know diabetes is responsible for a lot of expensive disease states.

Diabetes is always a topic of discussion. And we can look at an employer's population, and if their diabetes is above benchmark, we have a pre-diabetes program that we can make available to them. It's a virtual program, but it gets into issues around diet, exercise, portion control, nutrition, et cetera, et cetera. It's a yearlong program. It's certified by the CDC.

We also have a diabetes management program for people that actually have diabetes. That similarly is CDC certified and the goal is to get the hemoglobin A1C down to a normal range.

Diabetes educators are intimately involved in one-to-one interactions with the members in these virtual programs. There's a Bluetooth scale that downloads to an app, and then all the activity monitors download to the app also, like Fitbit, et cetera, et cetera. So, there's a lot of emphasis on exercise in both programs as well as understanding the food intake and portion control and things like that. Those are two of many examples in a very prevalent disease state where we actually have the ability to sell a product to a self-insured client to very specifically address a given disease state.

HF: I know a lot of physicians would like to work on those kind of programs or see new ones developed. And I want to ask you a few more questions about your work in this area, but I'm going to take a quick break to share some resources and I'll be right back.

If you're at the crossroads and you're not sure which way to go, I have a very hefty physician transition starter kit that you can download for free on the Doctor's Crossing website. There will be a link in the show notes that you can click on, or if you prefer, simply go to the doctorscrossing.com website, go to the freebie tab at the top of the page, and you'll see the starter kit right there.

Returning here to my lovely guest, Dr. Ian Hamilton Jr. and we've been talking about his work in population health in a major health insurance company. Ian, this area of population health is so interesting. Do you have a couple more examples of groups of patients that you help with these programs?

IH: Absolutely, Heather. Musculoskeletal diagnoses and procedures are routinely an area of high spend for these self-insured employers. And so, we have a virtual musculoskeletal physical therapy program that we make available. It deals with chronic pain, it also deals with preoperative needs, postoperative needs, and then specific joint requirements. There are subsets that actually go all the way down to the joint that needs the physical therapy.

It's interesting that virtual physical therapy has been found to be as effective as in-person physical therapy in peer-reviewed studies. This is actually a very popular program. It involves placing sensors on the body and then videoing one's self with an iPad, with a caricature on the iPad that is showing the patient the range of motion activities that they need to participate in for their physical therapy. And then the sensors are recorded, analyzed, and used to improve the next session. So, it's really quite high tech.

HF: I love that, Ian, because I just had meniscus repair surgery on my knee, and it takes a lot of time to go to PT and get there and do the PT and come back. So, that's interesting. And do you have another area of the population health?

IH: Behavioral healthcare has also become a very high spend, high need area. And across the United States, we have an inadequate number of behavioral healthcare practitioners. And so, working with vendors, we now have two or three programs that are virtual, that can address specific behavioral healthcare needs such as depression and anxiety.

And one of those three virtual programs actually has physician prescribing capability inside the program. So, if there's a need for a prescription medication, then we can provide that virtually also. It's an area of high utilization, high need and we're quite happy to be able to offer these programs to our self-funded clients.

HF: One thing we had talked about in the intro is who would be a good fit for the work in this area and what are the qualifications? We have about five minutes left for the podcast. I'd love to have a lot more time. But in this short period of time, could you talk a little bit about what's rewarding, who might be a good fit and some of the qualifications?

IH: Yeah. Once again, a master's is very helpful in this space. It's important to understand the issues around the financing, for example. Having an interest in population health, you need to want to do it. It needs to appeal to you, and you have to kind of take a long range approach to the outcomes because reversing diabetes in a large population isn't going to take place in three or six months. It may take a couple of years. So, there needs to be an understanding that there are long range goals associated with some of these activities. But any specialty would be a fine fit for this. The issue is having the MD first and there's no MD specialty or subspecialty that would be inappropriate for this type of work.

HF: If a physician is thinking, "All right, first I need to do utilization management and do that for a period of time, and then I could be eligible for working in this area, potentially." Should they get more experience while they're in clinical practice? For example, joint committees. You were on a lot of committees, you had leadership responsibilities, you even did your MBA before.

How did they think about "What do I need to do in advance?" versus "Could I come into a UM position without any of these things and then do my MBA, maybe be on committees within the health insurance company and grow from that point?"

IH: Yeah. I think either of those is appropriate. There are part-time positions available for UM. So, you could continue to actively practice and then do utilization management cases either at night or on weekends and start to get experience even before somebody transitions.

The committee work on both sides, and I mean within the clinical space and within the payer space is critical in my humble opinion. I think it's important to understand the operational aspects of a hospital system and also the operational aspects of a payer organization. And they're both very complimentary sets of knowledge.

HF: Now those are really helpful recommendations. I'd also mentioned we're going to touch upon compensation. Are you able to give some guidance here, Ian?

IH: Yeah, I think for starting in utilization management, the numbers that I've seen are in the high $180,000s, $190,000s, maybe $200,000. And then most organizations are going to have a bonus that's based on both organizational as well as personal performance that can be somewhere in the 20, 25 or maybe even as high as 30% of the base salary. And then overtime, increasing levels of responsibility, particularly when you begin to manage other physicians, could potentially increase that salary by 50 or maybe even 100%.

HF: I think that's absolutely spot on. That's what I see with my clients and often with a compensation package. They're in the mid twos, even up to three, sometimes a little bit higher for that entry level position. Really depends on the company and other factors, but you're absolutely right. And then there's, as you mentioned, a growth opportunity as you continue with the organization.

I'd love to ask you, Ian, what do you find rewarding about your work? Especially when you think about the rewards that you had being a vascular surgeon. I'm sure you had profound effects on a lot of your patients' lives and function.

IH: Yeah, it's different. As I said, the MBA program really pulled at some heartstrings in me looking at a much larger aspect of the US healthcare system. And that was important. The interest has to equal or exceed the personal satisfaction associated with your clinical activities. And I feel like those opportunities are everywhere within the US healthcare system. Sometimes you have to look for them, sometimes you have to do some self-education, but those opportunities are there. And helping populations of people, for me personally, is as gratifying as helping an individual patient with a vascular diagnosis. It's just different. It's a different level of satisfaction, but it is still very profound for me personally.

HF: How would you describe your work-life balance in the current job that you have?

IH: It's much better.

HF: You're not on call every night or every other night and running off just to save lives.

IH: Yeah. There's really minimal to no call. And the call that's associated with being a medical director in a payer organization is helping with after hours and weekend requests for services, which are usually emergency requests that the nurses cannot approve. So, if the nurse can approve it, then the request never gets to a physician. If the nurse cannot approve it, then they need to have a physician that they can reach out to and discuss the case and see if there may be extenuating circumstances that would allow the physician to approve it.

But that really does not take much time or effort. And sometimes you go months at a time without having any nurses reach out to you at all. It's an eight hour workday, it's five days a week, generally. It's a normal work life as opposed to the abnormal work life of being a vascular surgeon.

HF: Where would you put your job satisfaction on a scale of zero to 10?

IH: I would say in the eight range. There's still opportunities for me to be happier, but it's a pretty nice situation.

HF: What would you say is in the gap?

IH: For me, personally, I'm still hungry for advancement. What I'm basically interested in is a vice president or chief medical officer position. And those are kind of rare birds and the timing has to be right and the connections are very important. That's something that may come along with additional time for me. And payer organizations, much like hospitals, are big. They don't get redirected quickly. If there's a problem, you have to be persistent in trying to fix it or improve it. You have to have the support that's needed to make those changes and it's still going to take time and effort. So, you have to be persistent in both types of organizations.

HF: Well, thank you for sharing that. And if it's okay with you, I wanted to mention a couple things that you said when we first met about yourself, which pertains to what you just described.

IH: Sure.

HF: You had listed your personal and professional strengths, and you had described your endurance and inner strength, your unique work ethic, and you are a type one on the Enneagram, and they're very much about doing what's right, even if it takes a long time and you need to suffer along the way.

You said you're calm and dependable, truthful, dutiful, you take your responsibility seriously and you have a joy of taking care of others. You also said that you live to achieve goal. So, it makes sense that even though you're here at this higher level, you still have further aspirations.

IH: That's right. As you're reading through that, I remember it now and it's quite interesting more than 10 years later, how much that still applies to me personally.

HF: Yeah, it's your core. I want to thank you so much Ian Hamilton for coming on the podcast. This is a true, lovely reunion to get to see where you're at and have you help others who I know will be grateful for your sharing.

IH: Well, thank you Heather. I've really enjoyed reconnecting with you and I appreciate the invitation to participate in this podcast with you. It's really quite an honor.

HF: I am truly honored, Ian, and I'm sure we'll be keeping in touch and have you back in the future. I want to thank my audience too, for listening. I really appreciate you and love it when you share the podcast. Please think of someone who this might be helpful for and share away.

And don't forget, if you would like some free resources, you can find that starter kit on the Doctor's Crossing website. I'll link to it. And there's also a free chart review guide, which has a bunch of companies where you can do chart review. And that's a great way to see if you might be interested in utilization management and this work that you do for health insurance companies. You can also find the chart review resource on the Doctor's Crossing website under the freebie tab.

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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