Podcast 118: The Developing World of Wound Care with John Sory

John Marchica:

Welcome to season four of Health Care Rounds. Here, we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care and attaining joy in work. I'm John Marchica host of Health Care Rounds. I'm also the CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Please, don't forget to rate and review us wherever you get your podcasts and send your questions, comments, or ideas for Health Care Rounds to podcast@darwinresearch.com. Let's get started. Today I'm speaking with John Sory, president of Vohra Wound Physicians. Sory has been an integral part of Vohra since March 2018 and brings 25 years of extensive expertise in healthcare management.

Today he's responsible for managing Vohra's core operations and key strategic initiatives formerly. He served as the chief executive Uhealth Regional Alliance for the University of Miami Health System, where he oversaw affiliations and expansion, health plan relationships and new reimbursement models. Sory received his MBA from the Tuck School of Business at Dartmouth College and earned his bachelor's from Vanderbilt University. So to kick things off, John, thank you so much for spending some time with me today. Appreciate your taking the time.

John Sory:

Oh, my pleasure.

John Marchica:

So as I always say through the magic of podcasting, I will have already read in your bio, but why don't you just tell me a little bit about your background before we get into what you're working on today?

John Sory:

Sure. Well, thank you. So I've spent about 25 years in healthcare and various forms after business school, working for Pfizer and helping to launch and run a health services business for Pfizer, which really took care of the chronically ill, both in the US and internationally, then moved into a clinical research company and expanded them into healthcare from just clinical research. Then following that, moved into the actual delivery world, working with the University of Miami Health System down here in Florida, where I am today. A little over little over two years ago, joining Vohra Wound Physicians and a classic one of these stories of seemingly a niche business. But in reality, a large business that's not well understood or well promoted. And the reality is it's a classic story of providing a very needed service for, primarily in our case, primarily for seniors who really need the care that we can provide. So we're now in 27 states and have grown quite remarkably, even though it started 20 years ago. So this is the last stop in a 25 year healthcare career.

John Marchica:

Well, I'm excited to talk to you and I want to tell everybody listening right now for those of you who said, "What? Wound care?," let me tell you something. I always do a pre-interview and found John's story and what his company is doing to be absolutely fascinating. And I knew nothing about wound care and it's a really important topic. So before you switch on to your next podcast, I suggest that you hear

John out. So, tell me more about the wound care business and the specialization and kind of like the types of wounds that they're dealing with.

John Sory:

Sure. And I had the same reaction to be honest with you. I wasn't quite sure. Wound care is not a specialty that you see in medical schools. I mean, I was most recently associated with the University of Miami Health System and the medical school there. And it's not one of the 20 clinical chairs that sit around the table that are involved in wound care specifically. But reality is, I'll say, first our physicians 60% are surgeons of various types, general surgeons, vascular surgeons, neurosurgeons even plastic surgeons, and the rest are either internal medicine or family medicine. Those are the largest groups, but wound care is really focused on several areas that you might think of. If you think of a nursing home, you're thinking of pressure ulcers. And if you've had a family member in a nursing home, you've seen these. They're sad and they can be really disconcerting as a family member, but very much if you are the patient.

And so it's pressure ulcers, decubitus ulcers, these are the ones that they can be infected and lead to all sorts of problems. Fast-growing areas in wound care are diabetic ulcers. Think of a person with diabetes, with their foot ulcers. And unfortunately they can lead to eventually having to remove the leg or the foot as they get worse. And then there are a number of venous ulcers or those related to arterial flow. In other words, not able to get the blood to the area. So it begins to create a problem. It doesn't eventually heal. A lot of our work is with those chronic ulcers that don't heal quickly and need a lot of care. I always say that healthy people don't get wounds like this. They certainly don't get ulcers like I'm talking about. They need help and support, and that's what a specialist can do.

John Marchica:

So one of the things that we talked about previously is that wounds and wound care, it's becoming a larger problem in the United States. Why is that so?

John Sory:

I'd say the big movers here are we have an aging population and as they age, a lot of seniors, their past sins catch up to them in some ways. There's a rise of chronic disease. I mean, if you think about diabetes for one, the fastest growing segment of those with diabetes is those over 75 years old. So as we see an aging population, they're living with a lot of the chronic diseases and as such does often lead to a variety of issues. And sometimes they're bed bound. And if they're bed bound, they probably, they can have a pressure ulcer or they don't move. There's not much circulation. That can lead to a wound. So the rise of chronic disease, the aging of the population, the sedentary style, the obesity of our population, a lot can lead to this. And so we see significant rises, not only in nursing homes where most of our physicians are treating people, but there's the post-surgical care. There's trauma.

There's there wounds related to oncology. You go in for cancer care, they come out, they might have wounds related to that that need attention. So again, we try to primarily treat seniors in nursing homes, but there's a whole bunch treated in wound care centers, in hospitals, even the home setting, but the primary trends really are those about demographics and chronic disease. The realities of our population.

John Marchica:

So tell me, to orient people, tell me a little bit more about Vohra Wound Physicians and what makes your business model unique.

John Sory:

Yeah. So this is a classic story of a person who sees an opportunity and that opportunity identifies a real need and tries to meet that need. So this story will sort of tell you the evolution of wound care in our country. So Dr. Vohra went to residency in Miami and was attached to the wound care center. So if any of your listeners have seen any of the population or somebody in their family, somebody they know, went to a wound care center, they're affiliated with hospitals. They typically go to a wound care center once a week and receive treatment for when they go back home again. Well, dr. Vohra was working in the wound care center and found that patients were being transported from nursing homes into the wound care center. He would treat those patients and then they go back to the nursing home and he'd lose track of what happened to them.

There wasn't really a wound care team there. He could make the best suggestions in the world and clean and dress the wound, but then when the person went back to the nursing home, he lost control or had no idea what happened. As a result, when he saw him a week later, perhaps the wound got worse, it got larger, it became infected, or for all he knew they had to be admitted into a hospital. And so he said, "Well, why don't I go there? And I'll follow the patient to the nursing home and try to take care of them there." So he actually followed the patient to the nursing home and said, "I can provide some of these services right at bedside." And from that point, what happened is he created a wound care team inside the nursing home. He was a doctor walking into the nursing home, not on staff at the nursing home, just an independent specialist. He would take care of the patient right there at bedside.

He would train a nurse and show her what to do while he was not there for the next six days. "This is what you do. This is how you change, the dressing. This is why I'm doing what I'm doing right now to attend to the wound. This is what you have to watch out for. This is how we measure it." And then when he came back, he's educated them so they know what to do. So seven days later, when he's back in there, he can see what's what's transpired. Does he have to change the dressing? Does he have to meet with a different nurse or different members of the team, so they understand what next to do? Patients liked it because of course they're not getting into a vehicle and being transported to the hospital. That has with it inherent issues with falls or infection or risk. Certainly the health plans like it, because whether you're a Medicare or a Medicare Advantage plan, or even a commercial payer, you'd like it because a hospital is a very expensive place to receive care.

And also there're issues when you go to a hospital, just as we all know, there's various risks besides cost of infection and others. So patients liked it, nursing homes liked it, the payers liked it. And so before you knew it, they were saying, 'Well, thank you for coming here. But since you've come here, would you go to our other nursing home, which is over there? And by the way, I have a friend who has a nursing home. They'd like you to come there." And before you knew it, Dr. Vohra was moving all over South Florida trying to tend to patients. And he said, "Let me try to educate some other doctors, bring them in and have them go to some of these nursing homes." And the nursing homes and the administrators loved it. The patients liked it. Their wounds were taken care of. From that humble beginning became the start of a pretty remarkable business.

And the business is really taking care of patients where they want to be treated and in this case of their home setting, and it's been growing for 20 years now. Several people have tried to emulate the model. We're in 27 states, about 300 positions, all providing the same kinds of services. We've standardized them, so there's not this huge variability where you wonder if every time I go, what's going to happen next? That's the genesis of the practice. And it's really provided a great service. Everybody always asks, "What are the results?" And so we measured the results against what standard care would look like. And the standard care was if we didn't have a doctor going in, what would happen? And the key measures

that people look at, are were they readmitted to the hospital afterwards? Did they lose a limb? Or how long did it take for that wound to heal?

All of which dramatically improved over the time that we measured this. And so that's convinced others that this is a great way to provide care going forward and not use the hospital, but use the place where they are, which is the home setting or the nursing home setting.

John Marchica:

So you've already touched on this in a couple of different ways, but I want you to sort of summarize, because everything is about the triple aim, quadruple aim, summarize the value argument here and why and why this approach makes sense.

John Sory:

Sure. And that's one of the most compelling parts of it. So first, it's patient centered, right? It's meeting the patient where they are, right there at bedside. So that itself is one of the most important places to care for somebody and care and work with those who are going to see that patient over time. So, number one, it's patient centered this way. Number two, it's accessible. I mean, we are there every week, either in person or we could also be there through telemedicine, which is a whole nother area of healthcare that we've seen a lot of growth recently, but it's accessible. It's there. Third, the outcomes are remarkable and that you can, if you're there, you're accessible, you're an expert in your field and you provide good care, you ensure physician led compliance, which means that you're helping them to do what they need to do. It's happening in real time, so that whatever is needed to be done, can be done. So the health outcomes improve.

And then finally the costs. And so often we talk about value in terms of costs. And again, it's far less expensive to have a patient treated by a physician than it is for that patient to go to a hospital. And it's far less expensive to have that patient treated at bed and heal, than have to go to a hospital and have an amputation or some other very risky procedure. So I'd say the key aims are met, and that's what's led to growth. As people have understood the model and understood wound care, it's become, I'd say, the standard. Even if you look at other industries, you're trying to get people out of the hospital into ambulatory surgery centers, as opposed to going into a hospital. And I'd say much the same way, if you can go to a doctor's office, as opposed to an ambulatory surgery center, you do that and best all, if you could be treated at home as opposed to any other facility, it's the best of all worlds.

So that's really what we're doing. We're getting them where they need it in their home setting. And for us, again, most of the home settings are the nursing homes.

John Marchica:

I'm not going to ask you if this business model is sustainable because obviously 20 years, I mean, you're growing. So you're doing something right, but I'm having a hard time understanding the economics behind it. So for a while there, Medicare had been experimenting with sending physicians in the home. I think they called it Independence at Home and very early on, it looked promising, but at the end of the day, it just wasn't cost-effective to be sending doctors or even advanced practice, APPs, and nurse practitioners into the home. So how is it that you make money doing this? What's the billing story? I'm just trying to understand the economics, as I said.

John Sory:

Sure. So I would agree with you that for a physician to go into the home is quite costly. I mean, you can drive 30 minutes for one patient and then have to drive again, another 30 minutes for another. In our

case, we're going into nursing homes. Just to give you some facts on a typical nursing home. Because the true answer to your question is that under one roof are a number of patients and that's where the economics kick in. So if you take your typical nursing home in America, about 120 beds, it's about 80% occupied. And so that's 100 filled beds and of those, expect 12 to 14 patients or residents to have a wound. So our patient goes in once a week, typically might go in more or less, depending upon medical necessity would go in and see, let's call it on average, 12 to 14 patients, round with the nurses and then leave and go to the next building, probably see about three buildings in a day.

So there's the basic economics. The more patients they see, the more procedures they do, the more encounters we have and the more the physician receives. So it's a pretty simple economic model that way. The more they do, the more they get paid.

John Marchica:

That makes sense. It makes sense. So when you're interacting with all these nursing homes, we've heard a lot about nursing homes in the last six months with COVID-19. So how has that affected your business if at all, or in what ways has it affected it, I guess is a better way to ask the question?

John Sory:

So it's a great question. And I think I jumped to a concluding statements that say some of what's happened with COVID-19 will be with us forever in terms of how it's changed healthcare. So specifically we have physicians all over the country, but if I take New York City, for example, sort of the epicenter for the COVID outbreak when we think of what we heard, our doctors were going into these nursing homes and seeing patients and finding that they might even go in on Monday and find out on Tuesday, they passed away. It was moving so quickly through some of these nursing homes. This was on the very, very early days back in, say, March 2020. So immediately we were found ourselves right on the front lines of what were the most dangerous place where COVID could spread.

So we were there very actively with our protective equipment, making sure that we were changing the gowns and changing all the gloves and the booties and face masks and everything between from room to room to try to make sure that we weren't part of the spread. But very importantly, these people who were at risk for COVID also were the ones who, if you left them alone, they would be at risk for those same wounds that they're suffering from getting worse and they'd be suffering from infections and all sorts of effects thereafter. So our doctors were being very careful about where they could go. Now, a number of buildings then went into lockdown. They said, "Nobody comes in here." We were designated often as an essential provider that we needed to go in. But sometimes these buildings saw an outbreak of COVID and they said, "I don't want anybody in here who's either not living here or not full-time staff, a nurse, say, that it's going to be here all the time."

And we found that for a while. So in that case, what we did was we would provide telemedicine services, teleconsulting. We would dial in using our technology to work together with the nurses who were there to round with them. So they would carry with them a phone and use our telemedicine app and we'd do a video consult. We'd see the wound, we get close to it, they'd measure it. We tell them what to do. And so we rounded that way. It's not ideal, but it's better than not seeing it at all. We couldn't do some of the procedures that we would do if we're there in person, but we could instruct the nurses on what they needed to do. And so that's how we helped it. So if you just take the time from March to the present what we saw as our telemedicine, which was a relatively small part of our practice, but had been part of our practice for nearly 10 years, it grew about 8000% because of the COVID impact.

And it became a pretty large part of the practice. I mean, it's still less than half, but a pretty large part, and now it's pulled back a lot. So the change with COVID is that around the country, we still do

telemedicine. We often do it in concert with an in-person visit, both nurses and buildings, as well as patients are becoming much more comfortable with it. So it becomes a way to add to the practice that we already have. The buildings, everybody understands better about how to be careful of making sure they're not, in any way, putting anybody at risk, very much changing out of all their PPE and making sure that where they go, they're aware they're being tested constantly. So they bring with them a test. And so we know sort of the rules, what we have to live by, which is working for us. So I'd say we've learned how to adjust.

And as a result, the bedside care has come back up again to be 80 plus percent of our overall practice. But we always have telemedicine to supplement what we do in person. And that's really been the quick change that's COVID related.

John Marchica:

And you see a lot in the news, not so much these days, but certainly early on about nursing homes. What's the status these days in terms of PPE, testing, like what are you seeing out there? Is it better now?

John Sory:

Oh, it's a great question. So the PPE is actually, we haven't seen issues with that. There were issues at the beginning. Sourcing that was a real challenge for a while. Fortunately we're always able to source it, so we weren't at risk. And we found ways to get it for our doctors. Today it's not nearly the concern it once was, so we have plenty of it and people have access to it. Testing has been variable around the country and even the rules that the CDC puts out and that nursing homes put out, they're changing. And so it really depends on where you are in the country as far as what rules you have to abide by. We've seen places where they say you have to have a test that's shows that you're negative that is no more than seven days old, but you couldn't get a test result back within seven days. So that was a bit of a quandary for us. And that's gotten a little bit better.

But again, that point is different wherever you go. Other places there, you have CVS Pharmacy that will do a test and you get it back quickly. A lot of places testing has improved in terms of its speed. A number of our doctors are being tested. At one facility, CMS has begun to sponsor testing inside of a nursing home. So when you go in, you're tested and you get a result from that nursing home and you can carry it with you for the next week or two weeks. And we've seen that. So I'd say it's more available. Most recently, just in the last several days, they've, they being the CDC, said it's not nearly as risky. In other words, everybody has adjusted to what it's like to be even exposed to COVID. Used to be that if you even saw a COVID patient, they didn't want you back for 14 days. Now, as long as if you've seen a COVID patient, but you've managed all your PPE and you're all protected, as long as you're asymptomatic, it's okay.

Continue to come in and see our patients. Get your test, but continue to come in. No quarantining, no 14 days away. So everything's loosened up a little bit, in part because we've all learned how to live with it. It was a lot of fear at the very beginning, a lot of uncertainty, a lot of unknowns, then it began let's manage it. And now we're in that phase of, we understand it. We know how to live with it. We know how to make sure that everybody's doing their part. So it's a different day-to-day and we're all looking forward to the day when a vaccine comes or something else, which will make it not nearly the concern that we see now.

John Marchica:

Yeah. I mean, definitely we've got to live our lives. I will say I was, at least as far as consumers go, typical people out there, I was puzzled by the latest recommendation that if you're in contact with someone who's COVID positive that you don't need a test. And the reason why it bothers me is that there's so much asymptomatic COVID out there. And if I'm asymptomatic for, let's say, two or three days, I could be walking around and spreading it. Now, if I'm walking around, as I normally am today, I've got a mask on. So at least that helps prevent some of the spread. But it just seemed to me, I mean, there are those who, who would say that it's political. I'm not going to go down that route. It just surprised me because I feel like with the research that we do for our clients, that I've been all over COVID and tracking all this stuff just every day, all day for months and months and months. Now you live it in a different way. Right?

John Sory:

Right.

John Marchica:

It just surprised me. It looked like they were relaxing maybe a little bit too soon, but maybe I'm paranoid.

John Sory:

It seemed like that for sure. I mean, our physicians are no way cavalier about this. I mean, I think they take it as, at every time, anybody that they're interacting with could be asymptomatic and COVID positive and they could be too. And so they're taking all the precautions and not leaving anything to chance. And I think that's the only way to go. And thankfully, we have had situations where physicians have been concerned that maybe they're at risk and they'll even stay home by their own admission, waiting for results and maybe waiting for a test to come back, but nobody is taking it lightly. And everybody is fully masked with the face shields, the goggles. And I think it's critical. You can't stop providing care. I mean, you've stop providing care in one place before you know it, we've seen this too, when being prevented from going into seeing the patients, the acuity level has dramatically increased for the wounds that aren't being treated.

The rounds inside the building, the time it takes to go see each patient, has dramatically increased because of all this. So everyone has to just allow more time to go through the process. And time, it's a fine defense mechanism. Take the time. Change out of the gown, put a new one on. Change your clothes. I mean, we even have physicians who will go home between buildings and change their entire clothing, including their shoes, put on new clothes, put the old into the laundry, go back in, still put the gowns on, still put the gloves on, still put the mask and the goggles on just to make certain that there's no risk. And that continues to this day. I think it's their commitment to providing good patient care. So it continues to be a very serious area of concern and management.

John Marchica:

So one of the things that you said a little while ago is you said COVID has changed healthcare forever. Now we could probably spend another half hour on this, but just what did you mean by that? What's the biggest areas where you see healthcare changing forever?

John Sory:

The primary one is one we see and read about every day now, and I'd say, it's the telemedicine results. I mean, there are many parts, I think, where people aren't taking things for granted like they used to, but

really the adoption of some of these technologies and the comfort with telemedicine. I mean, I've been in healthcare for a very long time on many sides, including the employer side. We'd often offer telemedicine consults to employees because it's a requirement, but very few people would ever take up the offer. In other words, even though it was very convenient and all the things would point to you can reach out and within 15 minutes have a consult with a primary care physician and have a prescription sent to the pharmacy, people just would not be that interested in it. And now what's happened, and for all the reasons we talked about, you can call in, work with the nurse, work with the patient. You can get the prescription sent to the pharmacy. Both employees of our organization, as well as physicians working as members of the consumer community are using telemedicine. And then we are providing telemedicine into the nursing homes and very importantly, back into the households. We'll follow some of these discharged patients into the home and work together with either home health agencies or with members of the family to consult with them about their patient who's been discharged or their family member who's been discharged about how to take care of their wounds. So you're consulting with the person or the family and it's truly different. And it's something that is, like I said, it's not going away. I mean, this is a change. And this is the adoption of real technology that provides great access in healthcare. And this wound care conversation we're having today is just one small example of a world that will be just continuing to grow, I think, in this regard.

John Marchica:

I guess it must've been about six weeks ago, I had my first telemedicine visit and it was just a Zoom. Went by pretty quickly and it was a pleasant experience. Didn't have to wait in the doctor's office. Didn't have to wait for him more than a couple of minutes and he was right on time. So yeah, it's like one of the success stories in all of this is that a new way of delivering care has kind of taken over and it's back to patient-centric, potentially lowering costs. So yeah. The last question I had for you, John, is what kind of physician chooses this practice and why do they choose to build their practice in this way?

John Sory:

I mentioned earlier, and I'll just repeat it, if we look across our 300 or so physicians, about 60% are surgeons by training, various surgical specialties or subspecialties, and the rest are internal medicine, family medicine. We have people who are interested in geriatrics. They, for various reasons, might've worked in urgent care clinics, but that's a lot of physicians who fall into those categories, but what brings them to us is a few things. One is if you're a surgeon today, it can be tough. Malpractice insurance rates are very, very high. You're on call. The amount of procedures done by your general surgeon are limited. Often the quality of life is really poor. So you put these together and say, "I'm working really hard. Not really using all my services I can use, but much the same way. It's like, there's got to be something better here." And they like the idea of working with a patient and seeing the change.

In other words, they're not just doing a procedure, a hernia operation. They send them home. They never see the patient again. They're actually seeing these patients often. So they like that part of it. There's great flexibility to it. I mean, our doctors will work with us, I'd say, three, four, maybe five days a week. They work as hard as they want. In other words, if they want to work three days, they can. If they want to go see 150 patients a week, they can. We can build a practice around them. So we take away the question of them having to build a practice. We do it with them. So they've got the support behind them. They have the flexibility of how much they want to do, how much work they want to do. They have the quality of life that often they're missing. I mean, some people have to step out of providing clinical care for a while. Maybe it's because they're raising small children.

Maybe it's some other family issues. Maybe they've moved to a new town and they have this expertise and they're not quite sure where are they going to work next and they say, "Wound care is an area. I think I can learn it." We provide extensive training to our doctors. In other words, they join us. They have training at the beginning in our one-year fellowship. So they know that they'll learn as they go. What always happens is people get involved in this and it's more complicated than they realized because the complexities of care like this even are pretty great. So it becomes intellectually very challenging. They get the time they get a serious career opportunity for them. And they can become an expert in a field that is truly emerging with a lot of demands.

John Marchica:

Wow. That's great. That's great. John Sory, this has been a pleasure. I hope our listeners enjoyed learning about this topic as much as I have. It's been great. Thanks again.

John Sory:

Thank you for the time. Thanks for the questions. It's something we believe in, so I appreciate you hearing the story.

John Marchica:

Great. Well, let's make sure to keep in touch, okay, John?

John Sory:

Okay. Thank you. Let's do it.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced by me, Kim Asciutto, and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research for provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift for value-based care. Find us at darwinresearch.com. See you next round!

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