AMS - CM - Dr. Robert Reid - Transcript

Helen 0:00

Welcome. Nice to see you. I'm here with Dr Rob Reid, professor at the University of Toronto in family medicine and at the Dalla Lana School of Public Health.

Rob 0:09

Well, it's wonderful to be with you here today. Helen.

Helen 0:12

Thanks. So I've been looking forward to this conversation for a while.

Rob Reid 0:16

So have I.

Helen 0:16

And we've had a few interesting conversations about learning health systems, and we'll get to that. But really interested in, you know, your leadership journey and what drew you to actually moving from, you know, like private practice, into a major leadership role in the healthcare system. We'll talk later.

Rob 0:33

Yeah, it's a really good question. Helen, you know, it's been a 30 year journey, and it's been meandering, to say the least, and have had many different roles. And I started out as a primary care physician in rural Alberta. Had no intentions at all about doing research or about doing administration, or I just wanted to be a good doctor, and that was a tremendously good experience those first few years. What I realized was that the system that I was placed in, that I was working in, didn't work very well, and lots of people fell through the cracks. And actually I didn't really have much power or ability to change the system, and I actually didn't really even know how so that began my quest for doing something different and to experience different things, see different systems, and sort of move up in leadership over time.

Helen 0:34

So, I know we've talked before, you've moved around a fair bit. Yeah, talk a bit about that, because they're not ever some people to stay and do it in a jurisdiction and but you...

Rob 1:10

I actually, I've had the benefit from moving around. And maybe I think I might have ants in my pants or something, but, but it's, you know, I started out in Alberta. When I left it there, I went to, actually, Baltimore. I studied in Baltimore. I was there for a number of years. I did my PhD at that time, and came back and settled in British Columbia, in Vancouver, was there for a number of years, and then moved south into the US, and spent the majority of my career in the United States, in Seattle, actually, at a large, integrated healthcare system. And in really, that's where my really main leadership journey began, was in Seattle and working to really embed science in day to day healthcare delivery, and that was a real formative experience. And then came back to Canada about 10 years ago and brought that experience back here.

Helen 2:29

So how did you get involved in learning health systems? I think most people have an intuitive sense that we should have research connected to delivery, and that the two should toggle back and forth, and there should talk to each other and advance learning and understanding. But you've got an understanding of this at a whole different level.

Rob 2:49

Yeah, it happened from my Seattle experience, because I came to a large system that actually had an embedded research unit that was 60 years in origin, and they used that lab, that large system, as current kind of their learning lab, to learn how to deliver care to the population that they served. And coming as a scientist in Canada that working at a university that was very remote from health systems now to be embedded directly in one was a fantastic experience that was before it even was known as the learning health system, and the work the Learning Health System stuff generated after that. But in many respects, that's what group health had been doing for 60 years, and it was just learning how to do that over and over. It's not usual in healthcare at that time, anyway, to have those types of high functioning research groups embedded, well, right within a system.

And you know, I'll reflect a little bit of my own experience when I came to Group Health, they said, So Rob, can you fix these problems? We've got a few problems here, and you're a scientist, you should be able to know how to fix them. And I said, well, here I'll, you know, do a literature synthesis, and I'll tell you what to do, and then you go off and do it. And they said, Well, no, that's not what we do here. We actually experiment. So let's do something. We'll change care in one clinic or a bunch of clinics, they'll study what happens, and then we'll be we'll know whether it works or not. And that light bulb went off in my head, yeah? Like, yeah, that is the right way to do science and healthcare really applied on the ground, working right within a system.

Helen 4:34

And do you have some examples, like, of early wins, but how that made improvements in care? Because, I mean, it obviously is taken off. A lot of people have adopted the methods, right?

Rob 4:45

There are many examples I could draw from, everything from developing and testing a breast cancer screening program to working in tobacco cessation, working in in alcohol use disorder, but the one that is that I was in involved most with was the reinvigoration of the primary care infrastructure at Group Health. Primary care at that time was not working very well. Providers were dissatisfied. They were retiring early. Many people were going to the emergency room and getting admitted to hospitals because of poorly articulated primary care. And I was a primary care researcher, so I had the opportunity to come in and help them really reinvent primary care, reimagine primary care in that system, which became what we call now the patient centered medical home, right? And I had the opportunity, I was given the opportunity to really help bring science into the design of a new primary care model, a new way of doing primary care, and then really studying its effectiveness.

Helen 5:52

It must have been enormously satisfying.

Rob 5:56

It was a wonderful experience, but it wasn't without a challenges. You're trying to do science within a very complex system that's rapidly evolving. And you know, everything is shifting and changing as you go, and that takes a lot of skill to be able to produce good science in that type of environment.

Helen 6:15

That works. So I mean, if I get this right, you would have been a fairly young in your scientific career starting

Rob 6:22

Yeah, well, you know, beginning I got through my first promotion at the university, but yes, I was relatively young, and given that opportunity.

Helen 6:31

Fantastic. And how did... who helped you? Kind of mentors you have starting out?

Rob 6:35

I have been so fortunate Helen, to be so fortunate to have the best mentors in the world continuing to this day. And there were kind of, really three that stand out. First was Barbara Starfield, who was my doctoral supervisor in Baltimore, who really studied and understood

primary care and now has given primary care its meaning in the world. And Barbara was a very skilled scientist, you know, uncompromising, unflinching and demanding, but I was just so fortunate to learn so much from her around the science of primary care. The second was Ed Wagner at Seattle. You know, Ed was also a superb scientist. He was the one that invented the chronic care model at Group Health that is now adopted worldwide around how to organize chronic illness care. But his take was different. His take was, how do you actually think about and doing care in a real life system, and how do you actually make it happen in practical ways. So that was Ed. And then my third one was with Bob Evans at the University of British Columbia, my main Canadian mentor. And, you know, he was a political economist, and he taught me around the push, the pulls and that, you know, the gives and takes in healthcare and how, as you change, you're taking some things away from some people and giving it to others, and it's a tough sport, and you've got to look at all the complexities as you're moving through that to be able to deal with those complexities, and that sometimes science isn't welcomed, and you have to be a bit tough in terms of your integrity for scientific process.

Helen 8:20

And how do you pay that forward?

Rob 8:22

Yeah, I mean, this is one of my joys now, is kind of becoming an emeritus is that's how I was so fortunate to have my mentors. And now in as much as I can do, I try to mentor others, particularly younger scientists, age that I was when I was at Group Health, trying to figure out how to make things work and how to make choices. And I am so fortunate to have such incredible people in Ontario and outside Ontario as well that I mentor and I talk to and try to help them think through their strategies and their struggles.

Helen 8:57

I'm going to ask you about your team in a couple of minutes, but let's go back to the work on primary care. I mean, that's probably the biggest pressing challenge in Ontario's healthcare system, is both the adequacy and the structure of primary care. And I'm very happy that Jane Philpott has taken that on. But really thinking about the sort of the medical home as kind of the enduring big idea right behind how to deliver primary care effectively to people.

Rob 9:27

I mean, I'll give you my two bits on what the medical home is, because it's a bit of a mystery at some point, I think it's actually quite a simple concept. It's really got three or four components to it. One is, it's really reinvigorating the core attributes of primary care that Barbara Starfield taught us all so well about, access, continuity, comprehensiveness, coordination of care, the functions of primary care that need to be there every day for every person. The second is then to marry in how to deliver chronic illness care and plan care for prevention and chronic illness

care to populations of people. And so that's the work of Ed Wagner and then the third is now to use all of the new tools that we have available to do that in teams, the new information technology, to really maximize how you build both those attributes of primary care as well as the functionalities around serving populations with these new tools. In the context of teams, primary care is a team sport who's no longer an individual family doctor, you know, hanging out a shingle. It's a complex environment, and we have to have teams of people, of professionals working together to deliver that. And then the final thing is really changing payment structures to facilitate all of the other things. So the old fashioned ways of paying for primary care are no longer up to the task of how we need to do it in this environment. So in a nutshell, those are the four attributes of the patient centered medical home. And whether you call it the patient centered medical home or not, we really are talking about capable primary care.

Helen 11:07

Yeah, it's getting from here to there. That's the challenge, right?

Rob 11:10

It's getting from here to there. You know, the really good thing in Ontario is there are bits and pieces of excellence. There's bits and pieces all over that now just have to be married together, strategically oriented, and then fitting in some of the gaps that we don't have right now. And so I think the opportunity for Jane and her team, it was a golden opportunity to really deliver primary care for the residents of Ontario, because it's about the health of residents of Ontario,

and we know that primary care is essential to achieve good health status.

Helen 11:47

You know, everybody I've talked to about Jane's work, we should probably try and get Jane here someday on a podcast. But I think people are optimistic. I'm encouraged by, you know, the quality of the team of people that she's building around her and consulting with, but also, you know, the goodwill that she has, obviously, you know, from investments in the government, but also the people working in the system. We all want and need her to be successful.

Rob 12:13

Yeah, we sure do. And and I'll be there as much as she needs me and wants me in terms of any expertise I can provide.

Helen 12:20

That's terrific. So let's talk about how you lead, and we've talked about the areas that you're been most impactful for you, in platform of learning, health systems. But how would you describe your leadership style? Because you've worked with different kinds of people, and...

Rob 12:38

Interesting. Yeah, it's interesting. I there's a few things. I mean, we all take these leadership 360s over time, and there's a few things that always pop up as to where my leadership strengths are, what are good and what I can rely on, and, you know, things that maybe I need some help with. And so where I think my real strength is always in the strategic thinking part of it, it's about visioning as to where we can where we could be, figuring out where we are now and then, figuring out the mechanism to get from here to there. And so that's been my strength, is actually creating that vision for people to whether it's the medical home or the Learning Health System at drawing Health Partners, or otherwise, it's for them to kind of see where we're going and then how we might get there. So that's my main strength, I think. The second is, it's all about people, and it's about leading with people. So, you know, it's building bringing the expertise of other people who have incredible skills, whether it's health economists or a whole variety of different types of skills that you need is bringing it together to kind of on under a common vision, to get to where you need and it's about building relationships. Yeah, over time, I fully believe that. And then I think some other people would say to me, you have to be humble in this world. And probably one of my strengths is a bit of humility realize, oh, when things aren't going so well, and we need to change course, or we need to redirect, and kind of be able to understand when to do that. And then I think maybe this is an area where people maybe it's not a leadership strength, but people talked about is, I, I'm relentless, relentless. I don't, you know, give up and we don't just settle for mediocrity. You really want to get the essence of what you want to go forward. And so I think people sometimes get tired of me, because I think I'm always sparking. I'm always saying the same thing, but that relentless thing is probably a strength of mine.

Helen 14:38

Yeah, I would, you're talking, I'm thinking about my first kick at trying to develop integrated care for people and health links back in the day, and I don't remember if you were in my office, but I had the NHS change model on a banner in my office, just to remind myself to kind of think about all the levers for change and that the center of that. That is the shared vision

right the center of that is you can't get anywhere unless you somehow capture the hearts and minds of people around an idea.

Rob 15:08

You're absolutely right. And it's figuring out what their role is in it, and how they can promote it, how they can make their name in it, how they can contribute, and allowing them to do that. And, you know, creating a part of it's their own as well. So it's, it is that shared vision and then creating room for people to contribute?

Helen 15:28

Yeah, you know, I have to say, as an observer, the team that you've created at the Institute for Better Health that you're now an emeritus of, is quite a remarkable team. And, you know, full disclosure, there are many, several AMS fellows of various kinds who we have a relationship with and who are doing spectacular work. And quite often they might even start their career somewhere else and boop all of a sudden, they're, they're with you and doing fantastic work. So what's your secret to attracting talent and keeping them going? Because it's impressive.

Rob 16:07

Well, thanks, Helen, and it's been probably the in the biggest joy of my career in the last 10 years, is creating the Institute for Better Health. Because I think it is, it is a real something now in this country that this country needs. Back to my mentors. When my mentor came to me and we hadn't started the Institute for Better Health yet, I asked him, it was Ed Wagner. He said, You know, you started an institute many years ago. Give me your best advice, Ed and he said, Really, Rob, you only have one job, and it's to find the best people that are aligned with you and create and enable them to come and capture their imagination, to come and work with you. And so he was absolutely right. And so most of my efforts for the first few years was to find the right people that had the special sauce, that saw the vision, that wanted to partake, and then figuring out helping them figuring out how to get from where they are now to where they could be. And, you know, I was so lucky to have got some just fabulous people, Laura Rosella, Walter Wodchis, Kerry Kuluski just saying a few that decided to take a risk and come and spend, you know, it was a risky move for all of them to come to a brand new upstart research unit as well established researchers. But once they came and built success, could people beget good people? And all of a sudden, more and more people wanted to come and join and it was so, so fabulous to see them, and it at the Institute for Better Health. It, you know, we believe there, and I firmly believe in team based science. So it's, it's not an individual sport. We all work together. We all work on the same projects. We all contribute and bring our skills in. And so that is proud of. The learning health system model that we produced was a joint effort between all of us around bringing our best brains together to make this, figure out how to make this happen in a place like Trillium.

Helen 18:10

But this influence, and now you're being very humble and modest, like you said you were. But when I think about the influence, like Walter's work on kind of segmenting populations was really, you know, instructive behind health links for sure, right? And looking at what percentage of patient comprise, what percentage of expenditure. And then I think if you kind of look under the hood of the most recent work, which I'm pretty impressed by, which is the that OHA Dalla Lana report on the future capacity needs of the province. There's Laura...

Rob 18:45

Laura Rosella, leading that work.

Helen 18:48

Yeah! and it's, it's important work. It's important. And I think, you know, it's having an impact, both probably well, in policy circles, for sure, right? So it's an impact is systemic in nature.

Rob 18:59

All of them have just they're so special because of a variety of characteristics. One is that they are top notch scientists. Top notch scientists bring the top in their game. The second is they also believe in relationships, and they believe with working with people, so that they are trying to solve problems through research, not just study them, it's actually solving problems collaboratively with other people, and also going to where the puck is, where are the problems of the day, and we're going to help solve those problems, so being really responsive to the priorities that our system needs, rather than their individual priorities. And so that's sort of the phenotype of the people that we were able to attract to Trillium.

Helen 19:41

Well, I think they're being pretty successful. So talk to me about an emeritus role. I mean, that's kind of interesting. It doesn't mean that you're half in, half out or, well, all in. It's new title. What is...

Rob 19:55

You know, it's another transition for me, and I've had many transitions. I. Over the years. So it's not, I'm not a I'm not opposed to different transitions and figuring out different roles. So for the most part, you know, I'm taking reshaping the role. So I'm actually spending more and more time with in the mentorship capacity, spending more time with all the people that we've talked about here, plus some people outside of Trillium that are wanting to go, wanting to move in this direction of applied research. So that's spending a lot of time with that, spending a lot of time as well helping people across the country realize their aspirations around the learning health system. How would they create capacity in their systems to replicate some of the work that's done at these other places. So really helping them think through whether it's in Saskatchewan or Alberta or Quebec across the country, and then also kind of starting to do a few new things and provide some you know, expertise in other areas that heretofore, I haven't, I haven't explored. So right now, it's wonderful, but I'm not working too hard and I'm, I'm in a bit of a transition, so I'm not full on working. So that's kind of nice.

Helen 21:10

It's, yeah, I found, you know, after leaving the big job, yeah, it's nice to have a little mental space to recalibrate. But you know, wherever we go, there you are right, and so you sort of, you find your way back to doing the things that you care about, or helping the next generation learn how to step out.

Rob 21:30

I mean, I Helen, I just have to always think about the state of healthcare in our country, and that, you know, we really do have a lot of problems. We've got exceptionally good clinicians and nurses and doctors who are working at the front lines, but they're often working in a system that is not promoting the best work is not built and bring them together, is not bridging them, is not supporting them in the right ways. And so for me, you know, this has always been my passion, and to try to really organize care for Canadians so that they get better, because they actually deserve better than often they're currently getting. And you only have to look at the waiting room, at trailing Health Partners every day to see waits of three or four hours of care. Is that and people in hallways? Is that really what we want from healthcare in Canada? No, it's not,

Helen 22:23

No, no, it's interesting. I was just on a, we talked a bit about this before I was just on it, we were watching a webinar, and a lot of the focus was on health data and using data and AI to be part of the solution to the problems that you've just described. And one of the speakers said it was lacking was sort of like comprehensive, you know, capacity in learning health systems across the country that can take good ideas from research and science and have them embedded in the system at scope, scale and pace, probably, and you know, they were certainly looking for Canadian made innovations to get to market and get into the delivery system faster. So...

Rob 23:06

But I mean, I'm optimistic on this one, Helen, because in the world, there are really places where the learning health system is alive and well doing as you're saying. And I think we have most of the ingredients here in Canada now with data infrastructures, with AI talent, with embedded scientists, many of whom are actually now being trained here, who really, really now are understanding how to work with system partners around doing this type of work. And so I'm really optimistic that we can really embed this learning infrastructure now, right within systems is, you know, has it can have its puts and takes over the years, but I think it's a ripe time to do this.

Helen 23:50

Yeah, I mean, I would share your optimism. The conversations that I'm seeing is are a little bit of impatience, right? They're worried that there is a sort of window of opportunity that we need to seize as a country if we're really going to, one, I think, resolve some of the challenges in the healthcare system, and two, capitalize on the economic advantages. And of course, those two things are interrelated. They aren't two completely separate policy objectives.

Rob 24:18

I think you're right. The pace of change has to quicken, and our ability has to do it. We have to move quicker and faster, because we're the windows of opportunity are narrow to do this, so you're absolutely right on that. And we actually have to figure out how to move quicker around developing some of these infrastructures than we have in the past, and unplug some of the real problems we've had, be it data infrastructure across the country, be it funding mechanisms, a whole variety of just things that need to be unplugged to be able to actually make this wheel turn. You know, most other industries that you talk of, you know, be it IT or any other industries, have a learning and. Research and Development built right into their corporate enterprise. And healthcare, for some reason, hasn't had that for years. We haven't had a research and development arm built within our systems, and so, you know, they're much more reliant on research that's done remotely at universities, and really now we're just trying to replicate, in many respects, what's done has been done in other industries for decades.

Helen 25:25

So it's structural, it's but go back to the point you raised earlier in our conversation. Was about, you know, some people not wanting to listen to science and the idea that you probably need to be bit brave in this and resilient, right?

Rob 25:39

Yeah, you do have to be brave and resilient. And you know, you got to be able to get up if you get knocked down, which I've had been knocked down many times in my career, and relentlessly, get back up. And you know, because there are some truths in healthcare that don't go away, we know have to stay there. For instance, one of the truths in healthcare that I don't think we'll ever get away from is it's a relationship business. It's about relationships with patients and providers, and we have to enable those relationships, so we can't get away from building relationships and facilitating and so there's some real truths in healthcare that we have to relentlessly come back to and if you get knocked down, you start you get back up and you start again. The one in this country that's the probably the most challenging is, how do we integrate care? Yeah, because it it is still very siloed, and historically has been siloed, and I know we can do much better, rather than having hospitals and primary care and long term care facilities working in their own islands, for the most part, actually integrate them into a common platform.

Helen 26:52

There's some places that do better than we do, right?

Rob 26:54

Yeah. Oh, there are many, many places across the world that did, including the the place that I came from, which was an integrated system that had primary care, had home care, had specialty care, had hospital care, all within the same roof. And you could use the same

information technologies, the same personnel management strategies. You could shift people, nurses and doctors from one group to another group fairly seamlessly, because it was one system that's not what we have in Canada.

Helen 27:26

I love that vision.

Rob 27:28

I have an aspiration at some point. And you know, whether it's the OHT or another acronym for an integrated system in Canada, I have a hope that Canadians can kind of say, I work for an OHT I don't work for a hospital, I don't work for a primary care group, I don't work for a long term care I work for a system. Because right now we can't say that.

Helen 27:53

And you know when I would share that, and when I thought about OHTs, I thought I wanted, as a consumer or as a patient, to say I'm connected not to that primary care practice, but to that configuration of services that could kind of move seamlessly from one phase of life to another, as I'm on the cusp of turning 65 and that would provide all the well, not all, but most of the care that I needed, and I wasn't going to have to navigate between organizations to get that.

Rob 28:26

And it'll be done for you. It's continuous.

Helen 28:29

Yes, be like a moving sidewalk, right?

Helen 28:31

And there are many places across the world that have those types of infrastructures. I mean, even if you go to the UK, the people in the UK don't talk about working for hospital, they talk about working for the National Health Service. Yeah, amazing, right? And that's the type of idea that we need in Canada.

Helen 28:51

I think that's a great place to stop you, and I will spend the rest of our careers trying to make this happen.

Rob 28:57

Yeah, and this has been wonderful talking to you, Helen, this has been fabulous and good on you. Keep producing those fellows we need. We need a lot of them.

Helen 29:06

Well, we're up to about 85 and we're going to add another 24 this year, so they're coming.

Rob 29:12

Good. So we'll have more needs for mentorship.

Helen 29:14

Absolutely. Thank you very much