

AMS - CM - Dr. Tara Kiran - Transcript

Helen 0:00

Well, I'm here with Dr. Tara Kiran, just delighted to be able to spend time with you today. You are a family doctor, a renowned primary care researcher, and I would say, having watched you in action, both at the Unity board and at conferences, a highly influential person in shaping the future of primary care, not only in Ontario, but in the country. So it's especially a privilege to be here with you.

Tara 0:26

Thanks, Helen. It's great to be here.

Helen 0:28

Maybe you can just remind people listening, because you have a whole bunch of different perches. That's the right word in terms of at the University at St Mike's, maybe just introduce us to some of those roles that you have.

Tara 0:42

I'm a family doctor, and my practice is at the health centre at ad bond, which is at St Michael's Hospital here in Toronto. And then I also do research. My research is based at St Mike's, but I'm also affiliated with ice, which houses lots of big data that we get to play with here in Ontario. And then I also have a role at the university as the vice chair for quality and innovation, and so there I hold the Fidani Chair in Improvement and Innovation. And that just gives me some flexibility to have my own protected time to do work, but also for our team to try and advance quality care for everybody.

Helen 1:16

Wonderful. So why don't we start with our care? Because I've seen you present on it. It's a pretty compelling vision, and you started it. So how did that come about? And maybe then we can talk about some of the findings. What do Canadians want from their primary care health system?

Tara 1:33

I mean, I've been a doctor for more than 20 years and a researcher for over 15 years, and during that time, I've had the privilege of being involved in lots of different conversations about health care reform, and I noticed, though, that there was often an important voice missing at the table, and that was the voice of patients in the public, the very people that our system should be designed around at the same time. You know, I also observed that there are many interest holders around the tables discussing reform, although there are things that they agreed on often, there were also a lot of different perspectives that would kind of get in the way of consensus in moving forward. And so my hope was that through doing our care, we would bring that voice of patients and the public forward. Center the system on those people that the system should be serving, but also help to bring all our different interest holders out of the silos and help them to connect to a vision that everybody can get behind. Importantly, you

know, I think also, I've been in the space trying to advocate for better for a long time, and, you know, I can understand why policy makers, why politicians may be reluctant sometimes to jump on the latest research, but they are elected to enact the voice, to enact the desires and to address the needs of the public. And so it was my goal, too, to bring that voice right to the forefront, to draw attention to important issues and to galvanize our policy makers to act on something that we could see was a problem in the system and that I think needed more focus. And then last thing I'd say is, you know, I'd had, before I started our care, I'd been doing some patient public work, and every time I did it, I always learned something new, and it always helped me to think about issues differently. And I'd say that's that was true with our care too.

Tara 1:33

Yeah, it's interesting. And the work that we've been doing around AI and sponsoring, I see some real points of light in terms of engaging with patients and families, and it actually does. It changes the conversation and it builds trust, which is absolutely essential to implementing anything in healthcare, AI included. But any reforms or any changes of policy, yeah, so maybe just talk a little bit about what it both the, I guess, the process of engagement a little bit more, yeah, and then we'll get to sort of, you know, how is that in the current time, with all this focus on primary care, how is it shaping what the response so, you know, both Ontario, but perhaps beyond,

Tara 4:10

Yeah. So our care was really a collaboration between myself and our research team and Peter MacLeod, who leads this really wonderful organization, a small organization called MASS LBP. LBP stands led by the people. And he really believes in this idea that ordinary people can solve complex problems. You just need to give them the right education and facilitation to do so. And so together, we co conceived of OurCare. And this was, I'd say, back in 2021 so just into the pandemic, we knew things weren't going well. We did it in three stages. So the first stage was really a survey. We heard back from more than 9000 people. That was in 2022 fall. But the second and third phases, I think, were really where the magic of our care is, and those were the dialogs we had with people. People. In the second phase, we conducted five provincial priority panels. So these are really citizen reference panels, where we pulled together like 35, 36 randomly selected people, strangers who never knew each other, and they spent 30 to 40 hours together, really learning about primary care and then coming up with recommendations for a better system. And then following that, we did 10 community roundtables, two in each of five provinces, and these were in partnership with community organizations that held relationships with marginalized communities. And so they brought together members of marginalized communities for one day, and we were really able to do a deep dive with them around their experiences of care and what they wanted to see done differently. And so I'd say, like over that 16 month period, we heard from nearly 10,000 people, all told. And although we heard from a wide range of people across the country, the same themes kept cropping up again and again. And you know, that's why, in our final report, we put forward something we call that our care standard, which are really six statements that describe what every person in Canada should be able to expect from the primary care system. It starts with

everybody having a clinician that's connected to a team that's publicly funded, care that's timely and ongoing, care that's wellness oriented, so primary care connected to community and social services, having access to one's own health records that you can share it with clinicians and caregivers, having a system that's culturally safe, meets all the needs, and ideally, is delivered from a workforce that reflects the diversity of the community. And finally, having primary care being accountable to the communities it serves, and by that transparent, engaging patients in the way that we designing services, but also empowering and educating patients so that they know how to navigate the system.

Helen 6:55

So how far away are we actually from that? There probably are places where we're closer than others. Are there any exemplars that are used?

Tara 7:05

Yeah, you know, I think that we are far away from that very core of it, which is everybody having a family doctor or nurse practitioner or team, right? You know, our our care data from 2022 estimated that there are more than six and a half million adults that didn't have access to primary care. And we have some updated data that we'll be actually releasing at the end of the year, just a note that I think there's going to be some some positive messages there. So I think there are signs of things getting better across the country, and I do think, you know, some governments have been taking note of of what it is that patients said, and really embracing that in the way that they are putting their reforms forward. And so I think about actually Nova Scotia as an example of that. They've launched an app, for example, Nova Scotia, Scotia Health app where people really do have much better access to their records now than they did, I'd say a few years ago, they're working really hard to try and get everyone access to primary care, and they're doing it through a variety of ways, some of which aren't necessarily providing that ongoing, continuous care, but my understanding is it's sort of a stop gap to try and get to that vision. And then, of course, here in Ontario, you know, we were really lucky to have a government that decided that they were going to invest in primary care and appointed an amazing leader, Dr Jane Philpott, to lead the primary care Action Team. Jane and her team are committed to getting everybody a primary care doctor by 2029 really fantastically, they've embedded the our care standard into legislation. So Ontario's Primary Care Act was passed in June 2025 and it's the first of its kind in the country, and it has six objectives that it lays out for the primary care system, and those six objectives mirror the our care standard.

Helen 8:52

So you must feel pretty good about that.

Tara 8:54

Yes, I mean, it was beyond what we ever imagined in terms of impact when we started out doing that work.

Helen 9:01

Sometimes that happens, and fantastic. I must say, I'm, you know, I'm also struck by some of the workarounds as well. I mean, well, first of all, you know, it was fantastic to see the numbers of people waiting on Healthcare Connect halved. I think you see some real improvement in metrics. So that work is having an impact and the legislation that underpins it, but we're also seeing some pretty interesting, maybe not optimal, solutions to the standard that you've described, but some pretty good workarounds that are trying to connect people to care who otherwise would have very little access to care. I happen to have listened to your podcast yesterday with Dr. Jonathan Fitzsimon in Renfrew County, but he's really in Petawawa, right?

Tara 9:48

That's right. I think his practice might be based in Anne Pryor, but the work they do is also in Petawawa and other parts of Renfrew County. Their goal is really to serve the whole. County and support the whole county to have access to care. And yeah, he's a example of an innovator here, right here in Canada, who's trying to make things better for his community using the tools that they have available,

Helen 10:16

Which is great anyway. We can talk a little bit about that. I would recommend your podcast. A little bit of a promo here.

Tara 10:24

Yeah. So, I mean, I started the podcast, launched it this past April. The podcast is called primary focus, and for me, it's a way of trying to move forward the our care standard, by sharing stories about how this is possible, not just in countries around the world, but also here in Canada. And so we're drawing lessons from places globally and here in Canada about how is that systems are trying to serve everybody, but also specific aspects of our care standard. How are, you know, primary care clinics or systems accountable, for example, to communities. How are they integrating virtual and in person care? How are they ensuring they're culturally safe? So, yeah, I love telling these stories, as we were talking about, it's a lot of work, but that also challenges me to understand the different contexts in which care is being provided, even here in Canada and all their different provinces and territories, the different challenges people are experiencing, but also just the amazing people who are out there who are doing innovative, great work.

Helen 11:42

What I liked about it was it really peeled the onion like you got into the level of detail that as a policy maker, I would want to understand before I would be prepared to recommend the scale up of a particular intervention. So you started with a patient's story and then really unpacked how this service was working for the people of Renfrew.

Tara 12:06

You know, I think that's why I love the podcast format. First of all, it allows me to actually bring people with me. So we've done a few that are like audio documentary

styles. So we actually bring people on the journey and have different voices that we can feature. But importantly, it just like, really enables us to, like, go deep in on an issue in a way that is really hard these days. For example, on, you know, with our propensity to have conversations on social media, often things are reduced to a headline. Even a really in depth research paper is often reduced to a headline, whereas in the podcast, I can bring in different perspectives and help people really think through the complexities of what we're talking about.

Helen 12:50

Yeah, I really, I'm a fan. I really like that. And, you know, my world is, maybe, has been a little bit different, but somehow the distillation of something that is that complex and thought through and then thoughtfully executed never finds real life in a slide deck. Right? Somehow, PowerPoint never quite captures it. So to listen to people's stories and to have the voices of the patients and others in the community really kind of struck a chord with me. So thanks for that. So I'm going to change gears a little bit, and you and I've talked about this on other occasions, but I was pretty busy with the covid response in my last job, and every Friday morning I would hear your voice on the call, mostly because my husband was a family doctor, and they were thirsty for information and knowledge, and you organized to provide it to them. I don't know how many people you maxed out at in terms of, like a regular podcast, but you know, they were about the state of the pandemic, emerging risks, novel therapeutics. How did you come up with that idea, and what did it take to implement something like that so faithfully and rigorously for quite a long time?

Tara 14:10

Yeah, it's a great question. I mean, just like our care, it started with the kernel of an idea and, you know, a collaboration among a small group, and then it just grew beyond what we had imagined. And to your point, I think it did take a lot of care and thought and sustained, focused and energy, and part of that was motivated by what we could see was clear impact that it was having, and the importance, I mean, so just to take us back before the pandemic, I had always been interested in this idea of, how do we bring groups of family doctors and clinicians together to think about how we can work differently. How can we work better together to serve our patients better? And I had been in conversation already with the Ontario College of Family Physicians about the idea of like a community of practice that was online and virtual. Well, they'd actually experimented with doing a little bit of this already, and then. So when the pandemic hit, you know, I went back to my colleagues at the Ontario College also pitched this idea to my colleague, David Kaplan at Ontario Health. And so Leanne Clark was the ed at the college at the time. So we agreed that this was something that we wanted to move forward with together. I guess, from my own perspective, part of that impetus came from knowing that I had brilliant, dedicated colleagues who were making great contributions clinically, and then I also, but I had this other role with other resources. And so thinking about, how is it that I could contribute with the resource and the expertise that we have that's different from maybe the what the work that my other colleagues were doing. And so that's where we came you know, we came up with this idea of bringing people together around working differently. And so the idea was we

would have maybe some expert discussing at the beginning, perhaps something very topical about like, what is, what's going on with covid, but then also pairing that with a family doctor that is specifically sharing how they had changed their own clinical workflow, or how they were serving patients. And so we would be really trying to be practically oriented in terms of providing the right information and also inspiration and ideas. And I think what you know, in the beginning, we had like 200 people attend the first one, and maybe it went down then to 100 150 But then what happened was the need became greater and greater in terms of doing things differently and learning from each other. And I remember in the fall, we had to we struggled with, how do we give flu shots, given that we needed to socially distance? And that's when we started to get, you know, 300 attendees, very regularly. We brought in experts like Jeff Kwong and Allison McGeer. And then in January was the covid vaccine came. And of course, there was a huge amount that we needed to learn as family doctors there. And so then we started to have five, 600 people join regularly. And again, we brought in some experts, as well as pairing that with family doctors who are doing work on the ground that could inform people. And then there was Omicron, yeah. And then our numbers went up to 1000 I remember, like, I think it was December 30 of 20, whatever the year was at that time. Yeah. Anyway, so yeah, we it was, yeah, it was like the the holiday break, right? And our team scrambled to get something there with experts in the field, so that people had the information. And that's when we hit, like 1000 and then there was paxlovid, and by then we had 1300 people who were joining. And so it just grew and grew and grew because it ended up being a space for family doctors to come together and learn and have safety and community and know that they were getting the right information. But it also ended up being a space where policymakers could come and know that they could clearly communicate to family doctors, not just for example, through a media release or through a reporter, but directly and so anyway, lots to talk about there, but just to say it was such an evolution, and we would never have imagined where we went to.

Helen 18:36

It was it was fascinating to me, because you imagine what The work that we were doing on the pandemic was working on distribution schedules of vaccines and sort of high level guidance on priorities, and then, you know, the science table, and you taking it down to the ground, to where clinicians meet patients, the translation of that, you know, we would see a guideline for, you know, where does methotrexate fit in, okay? And then you guys would be having conversation with, you know, family doctors almost right away. And it was actually very heartening to see that work happening, even if I was kind of listening with one ear.

Tara 19:17

I didn't know you were listening! I didn't know that at the time. Even now, I think it's still one of my most impactful endeavours, because, like, I will be, like, at a random place and see a family doctrine. I won't know them, but they'll recognize me because I moderated the first 50 calls. And yeah, they so they're they, they're often very grateful. And just to your point, I think, you know, often when we're creating policies, we don't really think about the impact and translation on the ground. And so this was also, we

did, actually, a lot of work behind the scenes before we actually had the session to meet with our presenters to ensure that they were presenting something. That was very clear, and that they had agreement among themselves. Because, you know, at one point, you know, during Omicron, I think, for example, that was a good example, where we had folks from maybe Ontario Health, the ministry, the science table, and, you know, independent infectious disease experts, and they didn't all necessarily agree on, you know what the message should be to family doctors about what our role is and what we should do. So it was really important that we had brought them together, and then when they get on the call, they get all these questions from the doctors, and they're really good questions, and I think it helps them understand the translation of what it is that they're saying. And often they would go back and realize, okay, actually, we have to clarify X, Y and Z, or this implementation piece, it's not working.

Helen 20:46

So have you written this up? This would be, it's a great, you know, case study and how to achieve kind of clinical change at scale, because it was a constantly evolving set of circumstances and treatments and criteria and everything else. It really was remarkable.

Tara 21:04

So much in the pandemic that needs to be written up, but I think so many of us also blocked it out.

Helen 21:12

Let's talk about some of the work that you've done making positive change for the most vulnerable in society. I find that sort of common thread when I look at, you know, the research that you've done, and why don't you describe some of your research and where you think you've made a difference? One of the ones I'm most interested in is some work that says on your website is in progress, which is about screening, because spent 10 years in cancer. So interested in cancer screening and how to raise the screening rates and appropriate screening for the most vulnerable. But where do you think what you're most proud of in that work? Because it's quite a book of work there. Yeah.

Tara 21:47

I mean, I guess I'll just start by saying, you know, serving the most underserved to those with the most needs, has really been my focus from medical school, and it was my focus clinically, actually, to begin with. So actually, when I finished medical school and residency, I didn't have an intention to be a researcher. So, you know, I worked. At first, I really wanted to work globally, but then I met someone who is, you know, it ended up being that we ended up being in Toronto. But before we settled in Toronto, I did a lot of rural work, and then I ended up doing more urban, inner city work. I did work, you know, traveling to First Nations communities in Ontario. So I would just say that it was, like, always grounded in my own clinical practice. When I started doing research, I think I started to try and understand gaps in quality of care. So I think about research we did, for example, looking at who is enrolled formally to primary care, and

those left behind, there were often more likely to be people who were new to Canada and living in lower income neighbourhoods. And of course, those left behind also have much poorer quality of care. So that's just an example of like shedding light on it, on a gap. But then as as you know, the work went forward, I also tried to think about interventions and how we can actually improve the care. And of course, as my career developed, I was doing more and more quality improvement work, and so I tried to focus some of those quality improvement initiatives in areas that I thought would have the biggest impact for those who were most vulnerable or most structurally marginalized. And as an example, you know, I start to think about like, what are the biggest contributors to mortality? And you know, opioids was definitely one at the time. Another big one pre pandemic, actually, is hepatitis C. And so we did work in both of those areas. For example, our team did a large quality improvement intervention that's quite was quite rigorous to try and improve hepatitis C treatment rates within our practice, understanding that if we can get someone on treatment, we can cure Hep C, and that can actually really have a massive impact on their on their length of life. I also wanted to directly work with patients and communities to try and improve things. And so cancer screening, as you mentioned, that's like a great example, where I collaborated a lot with Dr Aisha lofters. And you know, it started with both of us doing a lot of understanding work and the system showing gaps in care. And then we took it more to our practice level, and we saw even in our social justice oriented practice, we had gaps in care. And then we dove deeper. Where are those gaps? Okay, we did some work really trying to improve cancer screening rates for people who are trans in our practice. And then we also looked at people who had a low income. And we did some qualitative work there to understand some of the barriers and unpacked, okay, some of this was competing priorities, and some of this was actually a history of trauma. And then we did focus groups. Okay, how can we support you to actually get these tests? And they were, well, we, you know, we want these potentially group sessions wellness oriented. So we tried to design something that was really based on their input. All this to say, I think we were marginally successful in that work locally. And one of the things that I've reflected on a lot through my work trying to address inequities is only so much can be done, I think within the primary care practice. It goes beyond that, and we need to really engage with the community and do things at a community level in order for us to truly address inequities in health, and, of course, also address some of the provincial and federal policies that ultimately leave people you know with not enough means to be able to address some of the basic needs of life.

Helen 25:40

Yeah, I think one of the most, and I probably talked about this on this podcast before, but when we saw the vaccine rollout and the neighbourhood deciles and how the wealthiest neighbourhoods had the lowest covid rates and the highest vaccine uptake, and the poorest neighbourhoods had the highest covid and the lowest vaccine uptake, which was not the idea behind the vaccine rollout, and realizing that there was a level of intervention that needed to happen that was much more engaging in the community ambassadors and other things that really deeply respected where people were coming from and understood some of The, you know, historical reasons for vaccine hesitancy

and how it just needed a community based approach that was not, let's open up an arena and hope people come.

Tara 26:29

Yeah, we need to do things differently. We needed to empower communities importantly, and we needed to put more resources to balance out the fact that often those communities actually have fewer resources, and are, for example, less likely to have access to things like primary care. And so that's our challenge is, you know, Julian Tudor Hart coined the inverse care law back in the decades ago. It posits that the areas of highest need often have the lowest resources. And I think we've done work after work that shows that that continues to be true even in the Canadian context. And so, you know, part of addressing inequities means addressing the resource distribution.

Helen 27:13

Yeah, and at AMS, we think quite a lot about, you know, technology and how can we start out with introducing, whether it's digital scribes or, you know, other technologies, into primary care and beyond, in a way that actually doesn't exacerbate inequities? And I'm not a health services researcher, but certainly there are people in our community who are paying attention to that, because as the as that becomes integrated into practice, those equity concerns are certainly top of mind for many people.

Tara 27:47

Yeah, absolutely. You know, I think about actually, what are our care panelists said. So when we talk to patients in the public, you know, for example, about virtual care, they were very clear that they wanted virtual care to be integrated into with in person care, but also to be used to actually enhance equity and access. And so the example that they put forward, in particular was about how virtual care can improve care for people in rural and remote communities. And that, I think, circles back to the Renfrew example we were talking about, where Jonathan and his team have really used virtual care to try, and I think, address a resource distribution issue, and, you know, have some doctor time from doctors in big cities caring for and supporting patients in underserved community that's rural.

Helen 28:37

So I want to talk a bit about you. I've seen your present your work on a number of occasions, including to the board at Unity Health. And you are knowledgeable and compelling. And as I'm listening to our conversation, I think, you know, some people see a problem, and you know, like to throw darts at the wall, and some people actually go and try and create solutions, and you are clearly amongst the latter group who are really in there and trying to make change happen at scale. How did you prepare to do that? Was it just kind of who you are, or did you set out to develop certain skills? Tell me about your leadership journey.

Tara 29:19

Yeah, I think this is a hard question for me to answer, but you know, when I reflect back on it, I think I have always been motivated to try and make the world more fair, and I'll be honest, that I think actually some of the emotional motivation there is anger. Like I feel angry when I see things that are unjust. I feel like I was exposed to some of that in different ways through my childhood. I felt like medicine was a profession where I could be constructive in the way that I addressed injustice, and I think what I've done is try and hone that anger to be productive, if that makes sense. And not that I always feel angry, but I think sometimes I do, and sometimes I feel angry and frustrated. But I think there's a silver lining to those emotions, if I can channel them in a really productive way. So I didn't intend to do all these things. I think it really came one at a time. You know, at first I wanted to just explore and understand and serve as a clinician, and then I evolved. I ended up doing a master's for different reasons, and then I got interested in research and describing problems clearly and evaluating policy. I applied for different jobs, and those led to other jobs, which led to other opportunities that I would never have imagined when I started out. The focus has always been on, how can I do better? How can I, how can I help our system be better, and what specific skill sets and experiences and expertise do I have, and where is it that I can best apply them, and then I will say I enjoy thinking creatively and out of the box. I didn't actually perceive this of myself, but others have pointed out that I am good at building community and good at bringing people together who don't necessarily work together, and I think that's been some of the success is that we've been able to build some wonderful collaborations with people who have different expertise, and working together, we can do something that we wouldn't have been able to do alone. And I guess the last thing I'll say is that I have also been told that I'm very driven and work very hard.

Helen 31:35

Well, you're incredibly productive. So I imagine that is absolutely true, right?

Tara 31:41

So yeah, and I guess just to say is I don't think any of this stuff is done easily. It takes persistence and hard work. And again, I think some of that was honed in me as a person, and we can go back to my childhood as to why that is, but I think I actually have always enjoyed work. Work is a place that centres me, yeah, and I enjoy the feeling of being able to do something well, and so I think that also motivates me is that it's a work is a place where I know that I can contribute and do something important.

Helen 32:17

I think in that way, we're not very different. But I think having fire in your belly, whether it's anger, whether it's a big vision or both, is probably a pretty central ingredient to many people's success, but yours, in particular, think that you know what you've been able to achieve. I just can't wait to see what you're going to do next.

Tara 32:40

Me too Helen! Sometimes... Yeah, I don't know. I feel like, in some ways, I feel like I've done the biggest thing that I could have done in my career with OurCare. But then also,

I launched a podcast, and that was something new and different that I, you know, wasn't expecting to so I think what I've also learned about myself is that I have to be patient. I'm both an impatient person that has to also be patient with allowing the ideas and the creativity to come when it does.

Helen 33:11

Fantastic, delightful to spend time with you. And for those listening, it's called Primary Focus.

Tara 33:16

yeah, if you want to check out my podcast, it's called primary focus. It should be available anywhere that you get your podcasts, just search my name, Tara Kiran or Primary Focus and click on the follow button so you don't miss an episode.

Helen 33:28

Fantastic.