Dangerous ideas

Top 4 proposals presented at Family Medicine Forum

The Dangerous Ideas Soapbox is a session presented annually at Family Medicine Forum (FMF) by the College of Family Physicians of Canada's Section of Researchers. This session invites innovative ideas that might advance our profession through family medicine research. There were 67 Dangerous Ideas submitted for the 2018 FMF in Toronto, Ont. All eligible submissions were reviewed and scored by 3 reviewers. Dangerous Ideas are judged by the reviewers, and later by the audience at FMF, on 3 criteria: 1) Is the idea novel? 2) Does the idea offer a challenge? and 3) Could the idea make a difference? Dangerous Ideas are selected for presentation at FMF based on reviewers' scores, and the innovators are required to attend the Dangerous Ideas Soapbox session to present and defend their idea in person. Each innovator gets 3 minutes to convince the audience of the importance and robustness of his or her idea. Presentations are followed by an 8-minute question-and-answer period.

At the 2018 Dangerous Ideas Soapbox session at FMF, we had 4 presenters in attendance. At the end of the session the audience was asked to applaud for the best and most robust Dangerous Idea. To measure audience members' applause, an "official" applause meter app was downloaded. Audience members had a lot of fun voting for their favourite idea. All 4 ideas received "fantastic" applause based on the applause meter; however, 1 idea reached the level of "amazing" and was declared the winner.

Fantastic idea: *Use secure video to improve quality of care and access*

What if a patient could access his or her family doctor via secure video and the family doctor could "bill" for it without increasing the overall cost to the system? What if family physicians acknowledged that *comprehensive care* should mean that annual capitation payments include electronic communication with patients? What if the government required electronic medical record vendors to build this type of access into their systems for provincial validation? Imagine access to care for homebound populations of seniors and patients with mobility or mental health issues that make leaving the home difficult. Imagine access to care for new mothers who do not want to drive their babies to an office visit in the dead of winter on icy roads for a "quick check" or for patients without transportation in rural areas across Canada who need to connect with their family physicians. Imagine eliminating office visits that force patients to take time off work (or avoid booking the appointment because they cannot take time off work) when a video call would suffice during a coffee break or lunch hour. How would this help patients? I believe it would improve access immensely. How would this help physicians? No nursing or registration staff members are needed for a day of video appointments. Overhead costs drop. Will this replace a full visit where a clinical examination is required? No. However, by increasing simple access for problems that do not require a physical visit and allowing physicians to bill for (shadow bills such as A007V [ie, "intermediate visit—video"] in Ontario) and document the hard work they do, there will be more availability for physicians to see those who actually need an in-person visit. The technology already exists. Patients are looking for access that saves travel costs, parking costs, etc, and both physicians and patients want access through devices they already own and use. The Dangerous Idea is that family physicians must think

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Dangerous Ideas/Innovations Soapbox

Do you have a dangerous idea/innovation about clinical practice, faculty development, or post-graduate or undergraduate education that you think could make a difference in family medicine health services or patients' health and well-being?

The Dangerous Ideas/Innovations Soapbox at Family Medicine Forum (FMF) offers a platform for innovators to share an important idea that has not been presented or published. A dangerous idea/innovation can be controversial, completely novel, blue-sky thinking, or something that challenges current thinking. It must be ethical, include an evaluation in some form, and have the potential to stir up conversation, and have the research to back it up/present the argument. It must also demonstrate a commitment to moving the idea forward—to making a difference.

Dangerous Ideas/Innovations must be new, cannot have already been implemented, or published. The author of the Dangerous Idea/Innovation selected for presentation must be present during the session at FMF and is responsible for all expenses.

Each speaker will have three minutes to present their idea/innovation. Audience members then have an opportunity to challenge the speaker(s), critique the ideas, and cast their vote to choose the most compelling dangerous idea/innovation. All of the presented ideas will be published in *Canadian Family Physician*.

Submissions will be accepted until **June 1, 2019** and should be sent to **ideasubmission@cfpc.ca**.

Submissions are selected based on the following:
- Creativity—is the idea new?
- Challenge—is the idea innovative?
- Suitability for dissemination—has the idea been evaluated or proven to make a difference?

Submissions must meet the following criteria:
- Present your idea/innovation in a single paragraph that is no longer than 300 words
- Describe the idea/innovation and how it will make a difference to family medicine, health services, or patients' health and well-being.

What is your Dangerous/ Innovative Idea?

differently and be willing to work differently to make the system work better for all.

—*Marilyn Crabtree MD CCFP FCFP*
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Fantastic idea: *Integrate drug and test cost data with the electronic medical record*

Family physicians prescribe medications and order tests every day without any information regarding the price of these interventions. To support the Choosing Wisely campaign and to advance responsible patient care, why not integrate drug and test cost data into the electronic medical record so that family doctors will instantly know the financial ramifications of their management decisions? By including insurance benefit information, physicians can also ensure that prescribed medications will be covered by provincial drug plans and can provide the appropriate limited-use code. This will save time and obviate the back-and-forth faxing between the pharmacy and the clinic when doctors accidently prescribe medications that are not covered or are too expensive for our patients without a drug plan, or omit the correct limited-use code. Also, making visible the cost of blood and imaging tests might provide an opportunity for collaborative discussions with patients about costs and benefits of diagnostic testing.

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Fantastic idea: *Make longitudinal community-based training in care of the frail elderly mandatory for residents*

At least 30% of individuals older than 80 years of age are clinically frail.[1] Despite this, family medicine residents can graduate without ever having set foot in a nursing home or having made a housecall for someone who is frail. It is time for this to change. Our Dangerous Idea is that the College of Family Physicians of Canada make longitudinal community-based care of the frail elderly (housecalls and nursing home care) a mandatory element of training. The introduction of such programs will provide many opportunities to make a difference in family practice and health care delivery. First, learners will develop their geriatric, internal medicine, emergency medicine, and palliative clinical skills without relying on extensive laboratory tests or imaging, allowing the history and physical examination to return to centre stage in making a diagnosis. Residents will also learn to provide a blend of curative therapy and palliation following patient and family discussions—both the art and science of medicine. As homebound and nursing home patients are a captive audience, there is increased opportunity to develop longitudinal doctor-patient relationships—something that postgraduate programs struggle to provide in office-based learning environments. In addition, when residents are exposed to nursing home and homebound elder care, they must work with a team of other formal and informal providers. This allows them to develop a greater understanding of team-based care. Furthermore, service provision in these settings provides learners with opportunities to see the "context" of the patients' illness experiences, the determinants of their health, and their support systems and resources. Finally, this requirement would address a growing need for home-based and nursing home primary care as our population ages. It is time to take all trainees to the "coal face," where very frail elders reside, and allow the next generation of family doctors to develop confidence in this increasingly important work.

—*Margaret J. McGregor MD CCFP(COE) MHSc*
Vancouver, BC
—*Christopher C. Frank MD CCFP(COE) FCFP*
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Reference

1. Gale CR, Cooper C, Aihie Sayer A. Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing. *Age Ageing* 2015;44(1):162-5. Epub 2014 Oct 12.

Amazing idea: *Train lay dispensers of opioids*

Remote First Nations have no local pharmacists and the Health Canada nurses have been advised to give minimal assistance to community treatment programs. We have trained lay community members to do direct observed therapy, and they are responsible for keeping track of the buprenorphine-naloxone. If this spreads across the country, many communities will have access to opioid replacement therapy and there will be fewer overdose deaths.

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