

## Felix Ankel

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From: Felix Ankel [ankel001@tc.umn.edu]  
Sent: Friday, March 11, 2005 11:00 AM  
To: 'robert knopp'; 'Brent.R.Asplin@HealthPartners.com'  
Cc: 'Won.G.Chung@HealthPartners.com'  
Subject: RE: clinical variation among staff

This is an area close to my heart and one that Brad G and I have been discussing from time to time. Brad calls this nodes of expertise. To get on my soapbox

"My vision is to increase the amount of medical knowledge that is effectively translated from what is known and what is practiced. My goal is to develop curricula and lead educational systems that are learner centered, multi-disciplinary, web based, "open source", continuously available and accessible, experientially focused, and outcomes based. I believe creating innovative curricula, continuously mentoring students, residents, and faculty, and systematically capturing the wisdom of learners and teachers for dissemination best achieve this."

I think this translation piece is the rate limiting factor for quality care and have been setting the groundwork for a Regions EM defined best practice in care (rather than relying on interpretation of former clinician of external proprietary guidelines)

This is what is set so far.

1. EMREL library to archive and search residency wisdom (e.g. can search Knopp + UTI)
2. Emres listserve that facilitates dialogue between practitioners inside and outside the department
3. 18 month curriculum that addresses breadth of EM content
4. 20+ faculty with defined core content "expert" designation

This is what we have but haven't tapped into for this

Education volunteer willing to focus speakers to ensure didactics are of appropriate breadth AND depth and facilitate wisdom posted on emrel in organized manner  
2. EMR implementation with ability to link potential diagnosis to Regions defined best practices

These are thoughts I've considered

1. Each resident (27) is a core content expert when they start the residency and is paired with the core content expert faculty. One of their administrative projects is to develop one best practice guideline/per year with their faculty expert. They also review the other guidelines with their faculty on a yearly basis. This will allow each graduating resident to have the breadth of EM knowledge with and area of specified depth plus the experience of writing clinical guidelines
2. The clinical guidelines are living documents where proposed updates are presented on the emres list. Residents and faculty can be instructed to use JADE for this (journal articles delivered electronically) in a push me method.
3. The regions clinical guidelines are cross referenced and linked to our EMR
4. All 27 areas are reviewed in conference as a state of the art panel with the resident and faculty. E.g. we would have a state of the art panel every two weeks (state of the art panels would be 10-15% of all conference time, this will still allow for "core" board type material)

I think great discussion piece for strategic plan. This is one way of reducing MD variation and falls in nicely within the IOM, IHI, Leapfrog, ?Partners for health indicatives (the GE leapfrog equivalent). I think it would be more robust than milliman or Interqual, it addresses acgme issues such as systems based practice and practice based learning, it ultimately will help patient care and health care education, and can serve as the foundation of our academic research, educational, and operational initiatives for our department.

Thoughts??

Felix

-----Original Message-----

From: robert knopp [mailto:knopp003@umn.edu]  
Sent: Tuesday, March 08, 2005 11:43 AM

To: Brent.R.Asplin@HealthPartners.com  
Cc: Felix Ankel; Won.G.Chung@HealthPartners.com  
Subject: clinical variation among staff

Over the past six months, a recurring question has been posed to me: a resident or staff indicates that they recently reviewed a state of the art paper or attended a conference that reviewed best practices in a certain area and that there is substantial variation in how we do things in our ED regarding clinical condition X such that we are not achieving what we should be doing. Most recently the issue raised was management of CHF. But examples of other issues include aspects of trauma care, mesenteric ischemia, appropriate use of heparin for PE, airway management, antibiotic use.

I know that there are other issues consuming a lot of time. However, I do think for the more common clinical problems we need a strategy to narrow the variability and increase the frequency with which patients are treated with the latest information.

Bob