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Annals of Emergency Medicine

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13A GLOBAL RESEARCH HIGHLIGHTS

HEALTH POLICY

213 Changes in Reimbursement to Emergency Physicians After Medicaid Expansion Under the Patient Protection and Affordable Care Act (Original Research)

JM Pines, R Ladhania, BS Black, CK Corbit, JN Carlson, A Venkat

What question this study addressed: Did implementation of the Patient Protection and Affordable Care Act, with its variable embrace across states, alter reimbursement for emergency department (ED) care? *What this study adds to our knowledge:* For paid claims during 3 years (2012 to 2015), involving 6.7 million ED encounters from one large multistate emergency care provider group, reimbursement per visit increased in full-expansion states compared with nonexpansion states, more so with commercially insured patients.

225 Disparities in Emergency Department Visits Among Collocated Racial/Ethnic Medicare Enrollees (Original Research)

AD Hanchate, KS Dyer, MK Paasche-Orlow, S Banerjee, WE Baker, M Lin, WD Xue, J Feldman

What question this study addressed: This study examined differences in emergency department (ED) utilization according to race/ethnicity in a national Medicare population. *What this study adds to our knowledge:* Within zip codes with racial and ethnic diversity, blacks and Hispanics with Medicare had more ED visits per person than whites with Medicare.

237 A Quality Framework for Emergency Department Treatment of Opioid Use Disorder

(Concepts)

EA Samuels, G D'Onofrio, K Huntley, S Levin, JD Schuur, G Bart, K Hawk, B Tai, CI Campbell, AK Venkatesh

Emergency clinicians are on the front lines of responding to the opioid epidemic and are leading innovations to reduce opioid overdose deaths through safer prescribing, harm reduction, and improved linkage to outpatient treatment. Currently, there are no nationally recognized quality measures or best practices to guide emergency department quality improvement efforts, implementation science researchers, or policymakers seeking to reduce opioid-associated morbidity and mortality. We describe a multistakeholder quality improvement framework with specific structural, process, and outcome measures to guide an emergency medicine agenda for opioid use disorder policy, research, and clinical quality improvement.

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- 📄 **248 Waterfalls and Handoffs: A Novel Physician Staffing Model to Decrease Handoffs in a Pediatric Emergency Department** (Original Research)
H Yoshida, LE Rutman, J Chen, ML Shaffer, RT Migita, BK Enriquez, GA Woodward, SS Mazor
What question this study addressed: Does a new, overlapping, emergency physician staffing model decrease the proportion of handoffs in the emergency department? *What this study adds to our knowledge:* This quality improvement retrospective study demonstrated a 25% decrease in the probability of patients' handoff after the implementation of a new overlapping staffing model in a tertiary care pediatric hospital.
- 📄 **255 Oral Ondansetron Administration to Nondehydrated Children With Diarrhea and Associated Vomiting in Emergency Departments in Pakistan: A Randomized Controlled Trial** (Original Research)
SB Freedman, SB Soofi, AR Willan, S Williamson-Urquhart, N Ali, J Xie, F Dawoud, ZA Bhutta
What question this study addressed: In a middle-income country, does oral administration of a single dose of oral ondansetron reduce the rate of intravenous fluid administration in children with vomiting and diarrhea but without dehydration? *What this study adds to our knowledge:* In this trial of 626 children, a single dose of oral ondansetron did not reduce intravenous fluid use. No serious adverse events were reported.
- 📄 **266 Oral Ondansetron to Reduce Intravenous Fluid Rehydration: Context Matters** (Editorial)
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- 269 Nebulized Tranexamic Acid Use for Pediatric Secondary Post-Tonsillectomy Hemorrhage** (Case Report)
W Schwarz, T Ruttan, K Bundick
- 📄 **272 Can the Probiotic *Lactobacillus reuteri* Be Used to Treat Infant Colic?** (Systematic Review Snapshot)
K FitzGibbon, NR Ju

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- 📄 **274 Comparison of 30-Day Serious Adverse Clinical Events for Elderly Patients Presenting to the Emergency Department With Near-Syncope Versus Syncope** (Original Research)
A Bastani, E Su, DH Adler, C Baugh, JM Caterino, CL Clark, DB Diercks, JE Hollander, SE Malveau, BA Nicks, DK Nishijima, MN Shah, KA Stiffler, AB Storrow, ST Wilber, AN Yagapen, RE Weiss, BC Sun
What question this study addressed: Do rates of death or serious clinical events at 30 days differ between patients who present to the emergency department (ED) with near-syncope versus syncope? *What this study adds to our knowledge:* Among 3,581 patients from 11 US EDs, rates of death or serious clinical events were similar for patients with near-syncope (18.7%) versus syncope (18.2%). Adjustment for other risk factors did not alter this finding.
- 📄 **281 Age-Related Characteristics and Outcomes for Patients With Severe Trauma: Analysis of Japan's Nationwide Trauma Registry** (Original Research)
M Kojima, A Endo, A Shiraishi, Y Otomo
What question this study addressed: How does the accuracy of commonly used measures of injury severity for predicting mortality vary by age? *What this study adds to our knowledge:* In this retrospective analysis of 121,000 patients in the Japan Trauma Data Bank from 2004 to 2015, the Revised Trauma Score accurately predicted mortality in younger adults but was a poor predictor in older adults.

291 The Applied Mathematics of the Geriatric Trauma Evaluation (Editorial)

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J Abbott

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The Peer Review Process at *Annals of Emergency Medicine*

Most readers highly value the fact that articles in a journal like ours have undergone formal peer review. Many readers also have a relatively simple understanding of that term as describing a single well-defined process of review by expert reviewers, but it is a lot more complicated and nuanced than that. We therefore provide a very brief summary of our procedures to provide appropriate levels of review for most (but not entirely all) the journal content.

Although we try to be a model among journals for the rigor of our peer review process, like most of them (including the most prestigious) this does not mean that all content is peer reviewed in the same way. All original content (particularly research content) in the journal is peer reviewed by one of the many experts on our editorial board, but additional peer review of every submission by members of our reviewer panel is not always necessary or appropriate. Many submissions are not appropriate for the journal for one fairly obvious reason or another (eg, target audience), so like most other journals we reject many manuscripts after review by an editor. For those which are not obviously inappropriate, however, we receive far more submissions than we can publish, so our further process seeks to identify the best of the best.

The vast majority of scientific content that we publish is critically reviewed first by members of our editorial board with specific expertise, and then gets additional scrutiny from our expert reviewers. Our most stringent level of review is reserved for original research, which will form the basis of the scientific record in the future. These submissions are reviewed by at least two of our expert reviewers who are blinded to the identity of the authors. Quite a few papers are reviewed more than once, and sometimes in particularly complex cases 5 or 6 reviewers and editors may be involved, including deputy editors. During this process there is much consultation and discussion between editors, reviewers, and authors and recommendations are made to the authors. Sometimes that discussion exceeds the length of the original paper itself, and it certainly is a laborious and time-consuming process. Editors and reviewers must disclose potential conflicts of interest which are managed as per a rigorous policy (<http://www.annemergmed.com/content/policies-coi>). Virtually no original research is accepted with no revisions whatsoever, and our authors strongly agree that in general the process improves the quality of the final manuscript. Once it has been discussed, revised, and received the final stamp of approval from the supervising editor (whose name is always published with the manuscript for transparency), all original science content in the journal undergoes a final review by the editor in chief before acceptance.

None of this means the final article is irrefutable truth; such a thing does not exist in science where our state of knowledge is (we hope) constantly evolving and no study should be judged in isolation. But it does mean that we've asked all the appropriate questions we could think of, made suggestions, and required revisions to make the paper as complete and transparent to replication as possible.

This process for original research is the most rigorous and is probably what most readers think of as "formal peer review," but the journal contains much other content of a factual and scientific nature which does not lend itself to this approach. For example, we have a number of regular journal features (like News & Perspective, CDC Update, NHTSA Notes, etc) that are updates written by selected topic experts on a routine basis. These are also reviewed by an editor but not sent out for additional review. A very few items, such as ACEP Clinical Policies, are published verbatim from the experts that develop them and are not revised (for obvious reasons); this fact is published along with each.

There are always some exceptions to the above processes as we develop new types of content or relatively unique contributions occur. We try to describe the particular variants of peer review that were used for each of these, or if there was none, that is made clear as well. Our goal is to provide as much oversight as is needed and logistically practical, and to enable readers to determine what that level of oversight was as conveniently as possible.