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- FREE**  **611 Conversion to Persistent or High-Risk Opioid Use After a New Prescription From the Emergency Department: Evidence From Washington Medicaid Beneficiaries** (Original Research)
ZF Meisel, N Lupulescu-Mann, CJ Charlesworth, H Kim, BC Sun
What question this study addressed: How often and what factors relate to later high-risk opioid use after emergency department (ED) discharge? *What this study adds to our knowledge:* According to 2013 to 2015 Washington State Medicaid data, for the 11.5% of patients receiving an opioid prescription within 1 day of discharge, 13.7% received ongoing or high-risk opioid prescribing in the next 12 months compared with 3.2% without initial exposure. Larger initial dosing (starting at a prescription ≥ 150 morphine milligram equivalents) had the most effect.
-  **622 Racial and Ethnic Disparities in Opioid Prescribing for Long Bone Fractures at Discharge From the Emergency Department: A Cross-sectional Analysis of 22 Centers From a Health Care Delivery System in Northern California** (Original Research)
RJ Romanelli, Z Shen, N Szwedinski, A Scott, S Lockhart, AR Pressman
What question this study addressed: For patients with one injury type, does race/ethnicity link with any opioid prescribing differences? *What this study adds to our knowledge:* Of 11,576 patients with a long bone fracture treated in 22 California emergency departments, 65.6% received an opioid prescription at discharge, with little difference in proportion among race/ethnicity. Non-Hispanic white patients received slightly higher potency aggregate prescriptions.
-  **634 Risk Factors for Misuse of Prescribed Opioids: A Systematic Review and Meta-Analysis** (Systematic Review/Meta-Analysis)
A Cragg, JP Hau, SA Woo, SA Kitchen, C Liu, MM Doyle-Waters, CM Hohl
What question this study addressed: What risk factors in opioid-naive patients are associated with subsequent opioid misuse? *What this study adds to our knowledge:* This systematic review of 67 studies found that current or previous substance use, mental health diagnoses, and younger age are associated with greater risk of developing problematic opioid use after an initial prescription.

SRS designates Systematic Review Snapshot articles.

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Annals of Emergency Medicine (ISSN: 0196-0644) is published monthly by Elsevier Inc., 230 Park Ave, Suite 800, New York, NY 10169-0901, USA. Periodicals postage paid at New York, NY, and at additional mailing offices.

POSTMASTER: Send address changes to Elsevier, Journal Returns, 1799 Highway 50 East, Linn, MO 65051, USA.

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- 647 **Starting to Think Like an Expert: An Analysis of Resident Cognitive Processes During Simulation-Based Resuscitation Examinations** (Original Research)
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What question this study addressed: Which cognitive skills related to team management and decisionmaking in emergency clinical settings distinguish residents with differing levels of expertise? *What this study adds to our knowledge:* The authors used simulated scenarios to classify crisis resource management skills of 22 Canadian emergency medicine residents of various expertise. Residents with higher performance ratings were better at anticipating, selecting information, and pursuing a nonlinear approach to directing resuscitation efforts.
- 660 **Perceptions of Emergency Medicine Residents of Multisource Feedback: Different, Relevant, and Useful Information** (Original Research)
V Castonguay, P Lavoie, P Karazivan, J Morris, R Gagnon
What question this study addressed: How do residents perceive the usefulness of feedback from nurses and patients compared with that from attending physicians? *What this study adds to our knowledge:* This mixed-methods prospective study examined the attitudes of 10 Canadian emergency residents who received feedback in the form of 255 evaluations completed by physicians, nurses, and patients. Qualitative analysis of subsequent interviews indicated that residents generally believed that feedback from nurses and patients provided unique information, particularly about interpersonal competencies.
- 670 **The Extended Supervised Learning Event (ESLE): Assessing Nontechnical Skills in Emergency Medicine Trainees in the Workplace** (Original Research)
W Townend, A Gopal, L Flowerdew, A Farrow, J Crossley
What question this study addressed: Is the reliability of the Extended Supervised Learning Event framework adequate to be used effectively with the resources available to standard emergency medicine residency programs? *What this study adds to our knowledge:* The authors analyzed reliability of the Extended Supervised Learning Event, using data from 1,390 assessments of 701 trainees in emergency residencies across the United Kingdom. Most of the variation in scores was explained by differences in trainee skills. Two assessors evaluating trainees 3 times a year could achieve acceptable reliability.
- 679 **Assessing Resident Performance: Do We Know What We Are Evaluating?** (Editorial)
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What question this study addressed: This cross-sectional survey measured prevalence of burnout symptoms among emergency medicine residents in the United States. *What this study adds to our knowledge:* A total of 1,522 residents (21.1% of all emergency medicine residents) representing 78.1% of emergency medicine programs completed the survey. Of these residents, three quarters met criteria for burnout, according to the most common definition. With a more conservative definition, 18% of residents met criteria for burnout. Burnout prevalence was higher among postgraduate year 2 and 3 residents than postgraduate year 1 residents.
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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.