Academic Emergency Medicine
Editor-in-Chief Pick of the Month

This month I am pleased to introduce our second guest writer for the EIC POTM. Please meet Esther Choo, MD, MPH. Dr. Choo is an associate professor in the Department of Emergency Medicine at Oregon Health & Science University (OHSU) in Portland. She completed medical school at Yale University, did her clinical training at Yale-New Haven Hospital and Boston Medical Center, and completed a health services research fellowship at Oregon Health & Sciences University (OHSU). She has published more than 65 research manuscripts on health disparities, gender bias, emergency care, and substance use disorders. She is the Editor for Dissemination on the Senior Editorial Board of Academic Emergency Medicine, is a past president of SAEM's Academy of Women in Academic Emergency Medicine (AWAEM), and serves on the executive board of FeminEM.org and Women Physicians for Humanity. Dr. Choo started the #DoctorsSpeakOut project capturing the opinions of physicians about the Senate health care bill. She also created the #thatsbias hashtag to advance discussions of gender bias in medicine, and #codehate to raise awareness about racism in the healthcare setting. She is mother to Benjamin, Zadie, Ezra and Thea.

Best Wishes,
Jeffrey A. Kline
Editor-in-Chief, Academic Emergency Medicine

I don't understand and I likely won't let you know

I chose the **article** by Balakrishnan, et al as the Pick of the Month. Health literacy's effect has been studied with close to 12,000 PubMed citations and 202 listed when combined with emergency department. Poor health literacy is associated with a host of poor outcomes. Balakrishnan and colleagues are the first to show the relationship between literacy and ambulatory care sensitive conditions (ACSC) resulting in preventable emergency department (ED) visits. The association of poor health literacy and ACSC controlling for the usual confounders was noteworthy. Those with poor literacy were 2.3 times as likely to be admitted after presentation with a preventable

condition. Poor health literacy in their setting was high with one-third of patients failing the health literacy test they used. The authors found 9.5 percent of visits were for ACSC, about what others have shown. They note that punitive measures such as increased copay have not worked in reducing ACSC. The question, then, is what can you do about it? While the mechanism remains in a black box, clinicians can still act. The authors used a 66-word test (REALM) for medical literacy that is not suitable for use in the ED. However, there is a short version of REALM that asks the patient to read seven words. Patients or caregivers are given five seconds per word. Maybe discharge instructions can be modified to the patient's or caregiver's literacy. This may work to reduce revisits if used in the ED, better yet if used in the outpatient setting to prevent the ACSC in the first place. It is worth investigating whether this is time well spent.

The article also contains a (perhaps more subtle) message for those who conduct and publish research. The authors used the STROBE criteria. Carpenter and Meisel[1] recently published a commentary of the value of following the EQUATOR guidelines. This publication is an excellent example of the value of adhering to the appropriate guideline for the study type.

Best regards,
Lowell W. Gerson, PhD, Northeast Ohio Medical University
Guest Editor, Academic Emergency Medicine

1. Carpenter, C. R. and Meisel, Z. F. (2017), Overcoming the Tower of Babel in Medical Science by Finding the "EQUATOR": Research Reporting Guidelines. Acad Emerg Med. doi:10.1111/acem.13225

Narrative Summary

Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:

"Those papers won't get her to the doctor. With my grandmom, you have to make it real for her." The teenager was doing her best to close the gaps between what we were trying to say with the incidental finding notification form (stating that grandma had a suspicious nodule on her lung) and the

reality that this was something that needed non-urgent follow up. Those forms, created by thoughtful quality improvement-focused nurses and doctors, filtered through various legal and hospital committees, were useless to our patient with low literacy. What she needed was context to wrap her head around the nuanced scenario (she needed a test… but didn't need it today… it was very important and could save her life… but the nodule was unlikely to be life threatening). Carden and colleagues show us that low health literacy is a risk factor *independent* of other social determinants of health for visits and hospital admissions among patients with preventable conditions. Indeed, our patient had good insurance and good follow-up, but as her granddaughter was trying to explain, it wasn't enough. So we did our best to make it real (by telling the patient a story that made sense to her). We also sent the forms back to the hospital QI group to come up with more literacy sensitive approaches to these notifications.