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Sara ataxia outcome measure pdf

J Anal Res Clin Med, 2017, 5(4), 110-1.
doi: 10.15171/jarcm.2017.021, *http://journals.tbzmed.ac.ir/JARCM*

Editorial

A call for routine outcome monitoring in Iran

Sara Farhang[1], Richard Bruggeman*[1]

[1] University Medical Center Groningen, University Center for Psychiatry, Rob Giel Research Center, University of Groningen, Groningen, The Netherlands

Assessment is a crucial part of randomized clinical trials (RCTs) that give us evidences for decision making in clinical evidence-based practice. However, the process of evaluation does not end with results of a trial. Clinicians should use similar assessments to evaluate treatment modalities and to improve the quality of the care in routine practice. There has been a growing notice for feedback systems similar to assessment technology developed for RCTs. Such a system should not only evaluate the patient at the end of treatment, but also provide information on severity of pathology prior to treatment, as well as feedback on progress made in treatment.[1] Evaluations can involve both symptoms and (social) functioning.

Routine outcome monitoring (ROM) refers to the assessment of treatment outcome at regular intervals, setting up a feedback loop to improve the clinical process. A comprehensive ROM-assessment can be successful in several domains[2] and should meet the following criteria. The very first aim is to be positively effective in (i) clinical process by continually optimizing treatment decisions using repeated assessments. This feedback system can give accurate information about treatment progress[1] by systematic evaluation of patients' response during the treatment. Most importantly, it can pick up signals to identify patients that do not show a favorable response.[3] This regular feedback could also improve the quality of practice by professionals.[4]

From a (ii) managerial perspective, a comprehensive ROM provides an orderly appraisal for all patients receiving the care and yielding valuable information for managers to optimize strategic choices.[5] Data are gathered by standard assessment tools which will be available for both professionals and patients to improve transparency and generate information for external (iii) accountability for parties, such as insurance companies and policy makers. An inclusive ROM takes account of all eligible patients and uses valid and proper instruments. ROM-data can add value to care-consumption data by giving insight in who is profiting from the care provided and who is not.[2] Finally, a good ROM should contribute to (iv) research by providing naturalistic "real-world" data about disorders, needs of care, and outcome.[6]

Hurdles are to be expected in the implementation of ROM. Standard tools leave little room for personal treatment aims. Monitoring and comprehensive assessment can be time consuming and very costly. The referral process -where patients are referred back and forth between primary, secondary, and tertiary care centers- challenges the continuity of the monitoring system; especially for those care systems that advocate general practitioners to provide low intensity care to eligible patients. Confidentiality might also be an issue. Clinician may criticize the process of ROM as a burden for patients.

In the field of somatic diseases like diabetes, there have been long standing monitoring initiatives such as Mayo Clinic

* **Corresponding Author:** Richard Bruggeman, Email: r.bruggeman@umcg.nl

BMJ Open

Development of a 'universal-reporter' outcome measure (UROM) for patient and healthcare professional completion: a mixed methods study demonstrating a novel concept for optimal questionnaire design

Rhiannon Macefield,[1,2] Sara Brookes,[1] Jane Blazeby,[1,2,3] Kerry Avery,[1,2,4] On behalf of the Bluebelle Study Group*

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For numbered affiliations see end of article.

Correspondence to
Rhiannon Macefield;
R.Macefield@bristol.ac.uk

ABSTRACT

Objectives To describe the novel concept of, and methods for developing, a 'universal-reporter' outcome measure (UROM); a single questionnaire for completion by patients and/or healthcare professionals (HCPs) when views on the same subject are required.

Design A mixed methods study with three phases—phase I: identification of relevant content domains from existing clinical tools, patient questionnaires and in-depth interviews with multistakeholders; phase II: item development using a novel approach that considered plain language in conjunction with medical terminology; and phase III: pretesting with multistakeholders using cognitive interviews.

Setting A case study in surgical wound assessment undertaken in two UK hospital trusts and one university setting.

Participants Patients who had recently undergone general abdominal surgery and healthcare professionals involved in post-surgical wound care.

Results Phase I: In the example case study, 19 relevant content domains were identified from two clinical tools, two patient questionnaires and 19 multistakeholder interviews (nine patients, 10 HCPs). Phase II: Domains were operationalised into items and subitems (secondary components to collect further information, if relevant). The version after pretesting had 16 items, five of which included further subitems. Plain language in conjunction with medical terminology was applicable in nine (27%) items/subitems. Phase III: Pretesting with 28 patients and 14 HCPs found that the UROM was acceptable to both respondent groups. An unanticipated secondary finding of the study was that the combined use of plain language and medical terminology during questionnaire development may be a useful, novel technique for evaluating item interpretation and thereby identifying items with inadequate content validity.

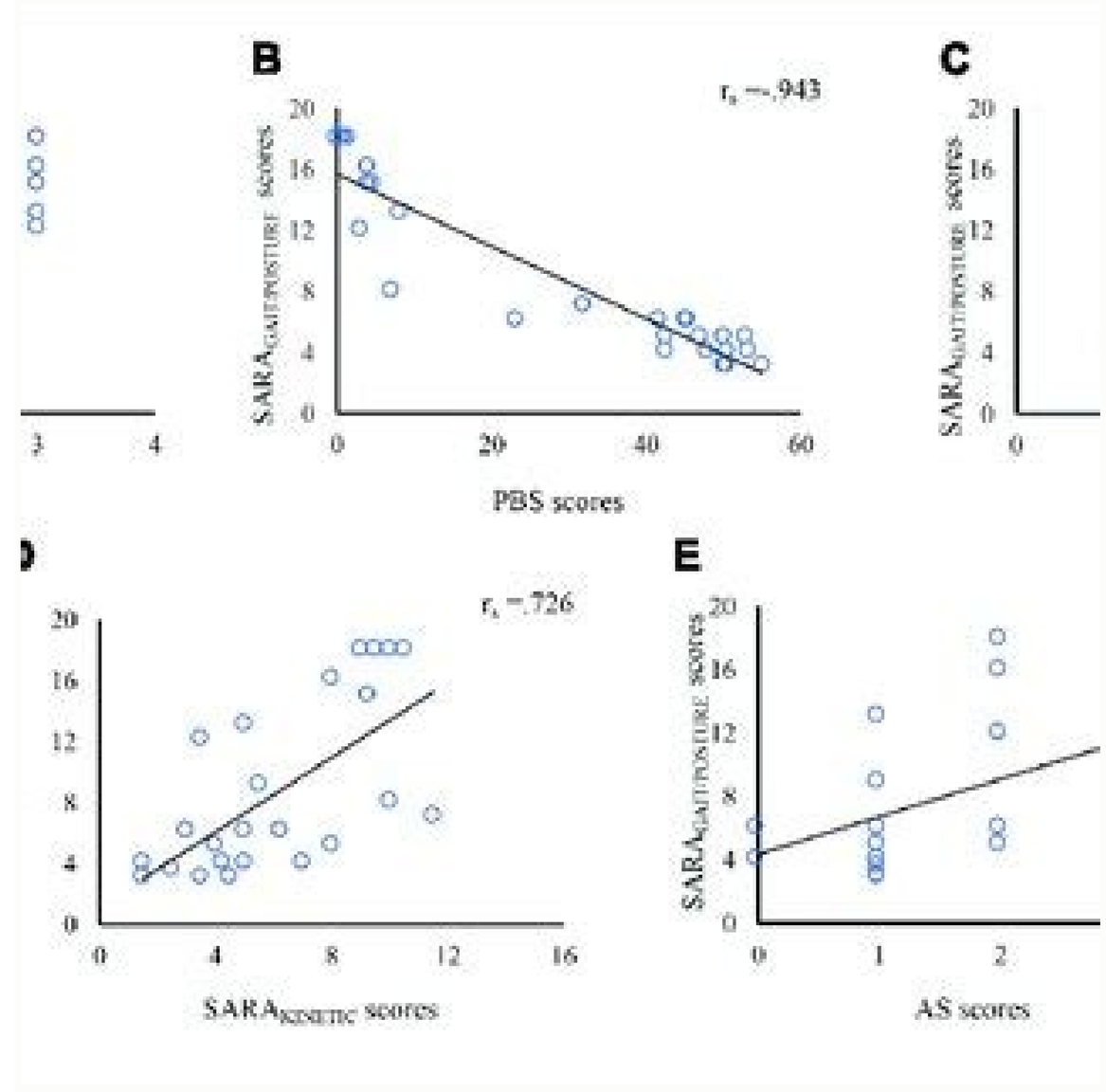
Conclusion UROMs are a novel approach to outcome assessment that are acceptable to both patients and HCPs. Combining plain language and medical terminology during item development is a recommended technique to improve accuracy of item interpretation and content validity during questionnaire design. More work is needed to further validate this novel approach and explore the application of UROMs to other settings.

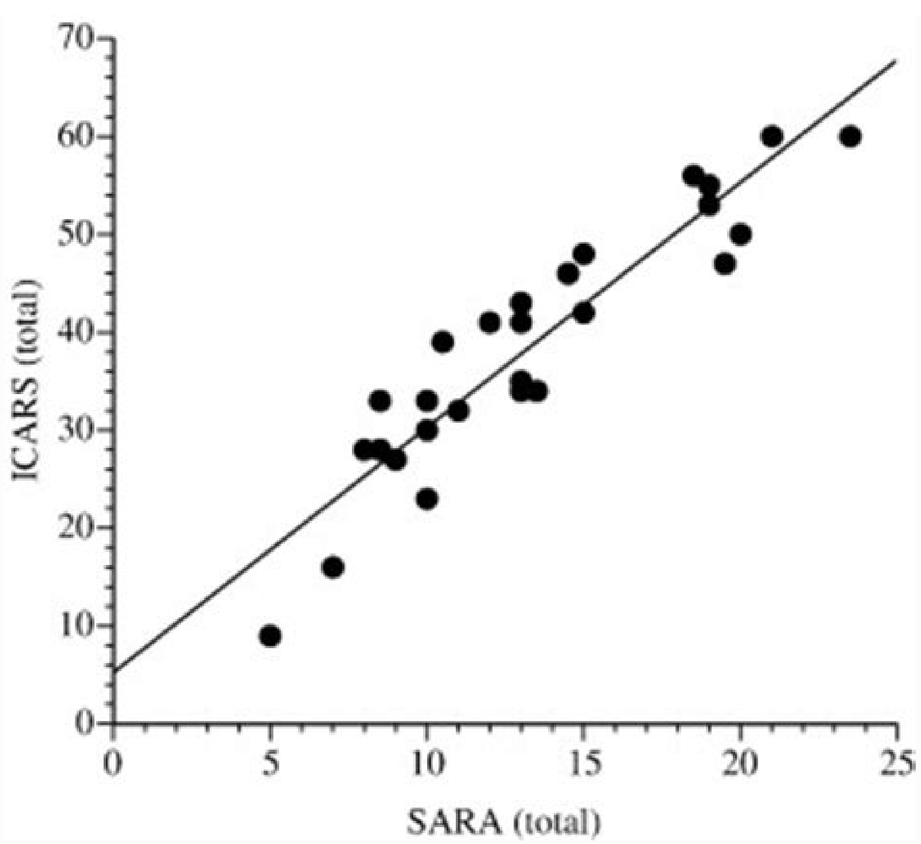
Strengths and limitations of this study

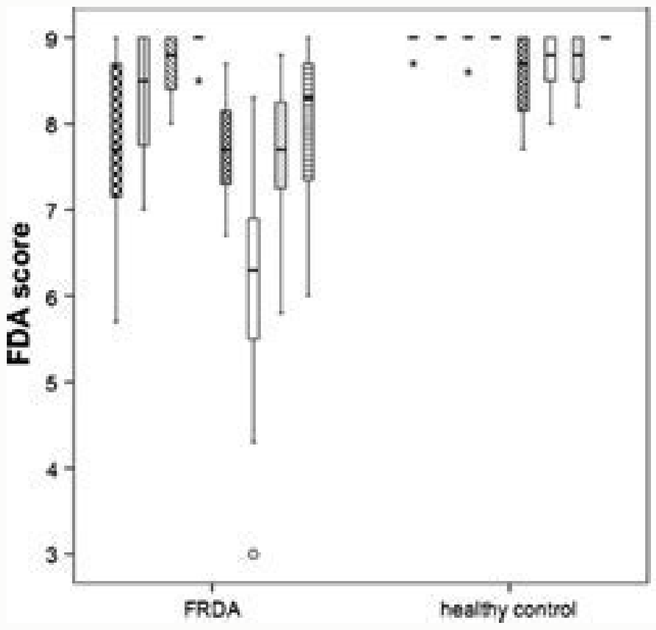
- A novel approach to outcome assessment is described, comprising the use of plain language alongside medical terminology in questionnaire items to develop a single measure for completion by patients and/or healthcare professionals.
- Multiple stakeholders were considered in all phases of development of the new universal-reporter outcome measure (UROM).
- Combined use of plain language and medical terminology in items presents a novel technique for evaluating item interpretation and improving content validity during questionnaire development.
- Evaluation of this novel method is limited to the findings from a single case study. Further work is warranted to explore the applicability of UROMs to other settings.

BACKGROUND

Research often requires views from different stakeholders on the same subject. Reasons may be to combine different stakeholder responses to obtain comprehensive information to better answer the research question. Other reasons may be to compare stakeholder responses and explore any similarities or differences in perspectives, opinions or behaviours. Alternatively, there may be logistical reasons for obtaining views from different stakeholders to enable important data to be collected irrespective of who is available to provide it. In a clinical trial, for







Frenchay item	FRDA	Healthy control	*p* value	r_s
Frenchay (total score)	7.9 ± 0.6	8.9 ± 0.1	0.000*	−0.932
Reflexes	7.6 ± 1.1	9.0 ± 0.1	0.000*	−0.8
Respiration	8.3 ± 0.8	9.0 ± 0.0	0.002*	ns
Lips	8.6 ± 0.4	9.0 ± 0.1	0.004*	−0.559
Jaw	9.0 ± 0.1	9.0 ± 0.0	0.334*	ns
Palate	7.7 ± 0.6	8.6 ± 0.5	0.000*	−0.743
Voice	6.2 ± 1.4	8.7 ± 0.3	0.000*	−0.648
Tongue	7.7 ± 0.8	8.7 ± 0.3	0.000*	−0.643
Intelligibility	7.9 ± 1.1	9.0 ± 0.0	0.001*	−0.595

Scale for the assessment and rating of ataxia (sara). Sara ataxia score. Sara ataxia scale scoring. Sara ataxia outcome measure pdf. Interpretation of sara ataxia scale.

Doi: 10.1016 / S0960-8966 (01) 00193-6 Pubmed Summary | Full text of Crossref | Brandsma, R., Kremer, R., Kremer, H. In the present study, aimed at elucidating the validity and reliability of the construction of EOA Saragait / posture scores subcomes in children and young adults. According to the Dutch Méstica Law, both parents and children over 12 years of age provided a written informed consent. Figure 3. First, patients with EOA that meet the requirements for the inclusion of the patient are rare, implying that the number of patients was limited. However, Saragait / posture parameters are insufficiently discriminate between influence on ataxia and muscle weakness. In 24/28 (86%) patients, ataxia was independently recognized as the main movement disorder of the three pediatric neuronologists. This explains why the characteristics of Sara Puntuación may differ between the AOA and EOA patient groups (Suvels and Brunt, 2009, Sival et al., 2011, Brandsma et al., 2014a, 2016b). The X axis indicates the ASMK scores (A), the PBS scores (B), the GMFCS-E & R (C) rates, the Sarakinética scores (D), such as scores (E). (2010). 53, 529-534. The remaining subgroup Ã ¢ â, ¬ involved 13 patients, without Ã ¢ â, ¬ "Myoclonic 'co-morbidity. Before Sara's scores can be interpreted analogous in patients with AOA and EOA, it is important to take into account the effect of possible group differences. Doi: 10,1097 / 01.PEP.0000068117.48023.18 Pubmed Abstract | Full text of Crossref | Google Scholar Hartley, H., Pizer, B., Lane, S., Sneadura, C., Pratt, R., Bishop, A., et al. Qualification of scale scores by EOA group. In patients with Pediatric EOA, we investigated the validity of the construction of Saragait / Posture when determining: (1) Reliability Observers, (2) convergent validity, and (3) discriminant validity. Analyze the inclusion of the patient from the EOA MIPATHIC cohort, revealed most of the patients with FA. The boxes represent lower, medium and upper quartile; superior; Represents the minimum and maximum relative score in% -Sub. (1998). A., Pougels, M. In the children, it was demonstrated that the reliability of this method is very high (FranceJoine et al., 2003). We determine the total muscle strength (Mftetal), the muscle strength of the upper limb (MFUE), the muscular force of the lower extremity (MFLE) and the proximal muscle force (MFProx). L. However, as the current data is obtained in a specialized movement disorder center during a 5-year study period (with an inclusion rate of 100%), the investigation of a patient cohort more Large will not be easily achieved. L., KOTT, K., and Young, B. B. B. B. B. The MU (Binder Fiders, Right Férons and Tibial Previous Muscles) were obtained according to a standard protocol and configuration (Sively et al. , 2011, Brandsma et al., 2012). We apply the Bonferroni correction to adjust the p value for multiple comparisons in the same data. Lancet Neurol. The boxes represent lower, medium and upper quartile; The mustaches represent the minimum and maximum sub-promotion of% relative. Statistics Analysis We perform a statistical analysis using SPSS 22.0 statistics. We determine the normality of age, time differences between evaluations, SARA medium scores, ASMK scores, PBS scores, GFMCS-E & R scores, such as scores and MF scores, both graph Film as by Shapiro's Wilk test. With regard to the incomplete discriminant validity of the scores, it is advisable to interpret the scores of Saragait / Posture for the muscular weakness. R., DRR, N., HELD, S. (2017). 22, 350 â, ¬ 359. This implies that the discriminant validity of Sara Gait / Posture Sub-Parts between muscle weakness and ataxia is incomplete. Schenk, C. This group revealed a child Neuropathic alterations and substantial muscle weakness, revealing a similar association between Saragait / posture scores and muscle weakness as the myopathic group. Correlations between SARA scores and other coordination measurements. In addition, one must be That the correlations between muscle weakness and SARA scores would require subgroups of patients with a sufficient variety in MF. Doi: 10.1007 / S00381-015-2650-5 PubMed Summary | Full text of Crossref | Google Scholar Klockgether, T., LÃ¼dtke, R., Kramer, B., Abele, M., BÃ¼rk, K., SchÃ¶ls, L., et al. H., Fock, J. F., Kuiper, M. Phys. Misopathic anomalies are characterized by homogenely increasing the density MU and / or muscle atrophy in a distal proximal distribution. The reference values of the maximum isomenal muscle strength obtained in 270 children from 4 to 16 years with hand dynamometry. The Protocol was approved by the "Medical Committee of the Médico Center of the Groningen University (UMCG), Netherlands. The rating scale of international cooperative ataxia shows a strong dependence on age in niã ± OS. This is contrasted by the total SARA scores in patients with EOA, which are also attributed to: (1) pediatric age (ie, cerebellar maturation; Long et al., 2003; SIVENT and BRUND, 2009; Brandsma et al., 2014a), (2) Comorbid muscle weakness [in FA (Sively et al., 2011)], and (3) Motion disorders ComoBidos (Brandsma et al., 2016b). To elucidate The Saragait / posture test construct, we also investigate the potential effects of co-morbidity factors in Saragait / posture scores. In all patients, we reported the presence of secondary movement disorder features when at least 2 from every 3 independent observers had evaluated the same character Secondary Erástica, according to the clinical phenotype. Doi: 10.1016 / S1474-4422 (16) 00131-9 Crossref Full text | BRANDSMA DE GOOGLE SCHOLAR, R., LAWERMAN, T. DECLARATION OF CONFLICT OF INTERESTS The authors declare that the investigation was carried out in the absence of any commercial or financial relationship that could be as a possible conflict of interest. Van Den Bosch, G. Under the premise that the parameters for Saragait / Posture depend on the integrated cerebellar processing of Visual, Vestibular, and and Signs of the extremities and the trunk (Sivels, 2012, Dellabasita et al., 2016, Takakusaki, 2017), it would be expected that Saragait / Posture subscales will be correlated with biomarkers for dynamic and passive balance , such as: the scale for ASMK [Klockgether et al., 1998)] and the PBS (Static Balance, Franjoine et al., 2010). MOV Saragait / posture scores were associated with ASMK, PBS, GMFCS-E & R, Sarakintic scores and as scores. Saragait / Posture was also correlated with Sarakinética (cinnetic function of the upper and lower extremities; RS = 0.726, p

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