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an example of a qualitative study using the delphi method is presented by shankar et al. (2013). in their study, the researchers used the delphi method to measure readiness for change and quality improvement among health care providers [ 176 ]. the researchers identified three concepts of readiness for change, namely, 'readiness for change in providers', 'readiness for change in organizations', and 'readiness for change in health care systems'. the study sample consisted of 109 health care providers with at least one year experience in an academic medical centre. two rounds of surveys were used to achieve consensus. in round 1, participants indicated the degree of their agreement or disagreement with 38 statements in relation to readiness for change in providers. in round 2, participants rated how confident they felt about the effectiveness of different strategies to improve outcomes in patients. the researchers also collected demographic data, and analysed participants' opinions regarding readiness for change. out of the 109 participants, 101 completed at least three of the four round questionnaires. the results from the delphi were used to create structured guidelines to help health care providers develop plans to achieve a specific goal, thereby leading to improved patient outcomes [ 176 ]. an example of a mixed-method study using the delphi method is presented by landgraf et al. (2008). in this study, the researchers used the modified delphi approach to identify characteristics of participants for a clinical trial on the subject of ivf. for this study, the researchers aimed to identify the characteristics of patients who are willing to participate in a treatment decision-making process involving ivf. the researchers developed a 14-item questionnaire to measure women's preferences for participation in an ivf treatment decision-making process [ 87 ]. round 1 of the modified delphi process consisted of a two-phase survey. the first phase was designed to elicit the views of all participants on whether the items in the questionnaire were acceptable for the item, and also to generate additional items for the final questionnaire.

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it is important to ensure that the attributes that are being prioritised are relevant and meaningful to patients, clinicians and other stakeholders. it also needs to be remembered that what matters most is the combined individual scores from patients, clinicians, researchers and other stakeholders. it is not the individual scores of each stakeholder, but the differences between their scores that should be measured against the relative importance of other attributes. in order to achieve this, a cos project would likely need to involve many stakeholders to gather their views and experiences with an outcome. some recent studies have established different levels of physical activity in sedentary adults (e.g. vujasinovic et al. 2010). studies addressing a range of outcomes relating to physical activity have concluded that there is consensus on the measurement of these outcomes in adults [60,61,63,67,69,70,71,72,73]. however, there is less consistency in terms of the measurement of higher levels of activity. for example, some studies have concluded that there is consensus in measuring vigorous physical activity and some have defined this as a score of 10 and above [ 60,61,72]. other studies have used the term 'vigorous physical activity' to refer to a frequency of activity that is 'near maximum intensity' or 'that gives large increases in oxygen uptake' [61,69,70,71,73]. assessing outcomes for patients with rheumatic diseases has also been debated, particularly for rheumatoid arthritis. several outcomes have been proposed and recommended for use in ra, for example, the das28 (28-joint count disease activity index) for monitoring disease activity in rheumatoid arthritis patients [134,135]. 5ec8ef588b

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