



A number of outcomes and measures have been used in previous studies (Table 2) (126-152). To provide a starting point for the discussion, and because a major purpose of the Rational Rose Enterprise Edition V 70 13 is to provide an accessible and clear listing of outcomes, we provide a few examples here and select most appropriate outcome measures and measures to assess them. We also provide explanations for measures that are not included in this listing but should be considered for inclusion. 160. See, e.g., *Rosenfeld v. Southern Pacific Trans. Co.*, 444 F.2d 1219, 1226 (9th Cir. 1971). The court of appeals stated that, "In this instance, whereas a white female who testified by deposition against all defendants was not allowed by the trial judge to enter the courtroom during the trial to view the courtroom and defendants' photographs, defendants' counsel were allowed to follow the plaintiff into the courtroom." *Id.* Virtually all of the consumers buying these products belonged to what economist Robert Merton called the middle three-quarters of American society in the 1960s. Middle-class Americans were increasingly wedded to middle-class lifestyles. Families and young professionals made up the fast growing suburban consumer base. The working class, meanwhile, remained stuck in southern mill towns and urban centers like Detroit and Flint, Michigan. Between 1940 and 1960, the percentage of city dwellers in America dropped from 59 percent to 44 percent, while the percentage of suburban and suburban-over-urban Americans increased from 30 percent to 46 percent. The proportion of American adults that lived in the Midwest rose from 38 percent in 1950 to 47 percent in 1960, while those living in the South grew from 43 percent to 51 percent. By the end of the 1950s, 57 percent of Americans lived in the suburbs.

And, perhaps most importantly, the average income for America's middle-class remained roughly constant while middle-class consumption more than doubled. In 1960, American middle-class families earned around \$8,600 in income, purchased around \$2,800 in consumer durables, and consumed around \$2,300 in services. In 1970 the figures were \$12,600 in income, \$6,200 in durables, and \$3,000 in services. Economic mobility remained very low. In the early 1950s, only 37 percent of Americans could expect to find themselves in the middle class by the end of their lives; by the end of the 1960s, only 33 percent of Americans could expect to wind up there. In the first decade of the twenty-first century, roughly 50 percent of Americans could expect to remain in the middle class.

Postwar prosperity and Cold War investments created a strong rationale for government investments in basic biomedical research in the United States, which in turn led to enormous increases in the amount of medical research that the federal government funded.

One major step in the development of the guidelines was a needs assessment.* To better understand stakeholders' current knowledge, perceptions, and practices related to screening, diagnostic, and treatment strategies for opioid-associated harm, CDC and Rational Rose staff conducted a mixed methods assessment (167). This needs assessment identified stakeholder knowledge gaps and established the methods used to develop the guideline recommendations. The comprehensive needs assessment included in-depth interviews with stakeholders, an anonymous online survey, and telephone and in-person focus groups. At the development stage, stakeholders were not asked to consider preferences over different implementation strategies, and the choice to focus on opioid-associated harm was due to the burden of the epidemic on patients with other chronic conditions (eg, cancer, stroke, diabetes) who use opioids. The decision to develop specific recommendations targeted to the need for accessible and appropriate implementation strategies was made during stakeholder workshops and in consultation with the guideline development team (formerly the Rational Rose Prevention, Intervention, Management, & Evaluation panel). The guideline development team considered recommendations for multilevel initiatives, such as the use of data to link patients with PDMPs, electronic prescribing systems, and PDMPs. The needs assessment findings provided evidence to help develop the recommendations. As part of this process, stakeholders, including health care providers, patients, state and local public health officials, law enforcement, and regulatory agencies, took part in a guideline development workshop to identify priority needs and develop recommendations. The guideline development team then reviewed and revised the draft recommendations that were identified as being needed by stakeholders. The draft recommendations underwent a second review and revision by a multidisciplinary panel of stakeholders including providers, nurses, patients, medical product developers, law enforcement, and regulatory agencies. Stakeholder feedback was collected via email and through onsite workshops and conference calls. The process was iterative; stakeholders provided written feedback on the draft recommendations and revised them. On the basis of the needs assessment, stakeholders identified key knowledge gaps and wrote recommendations as a commentary to the draft recommendations, providing evidence-based arguments to support each recommendation. 5ec8ef588b

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