



정택수 JEONG TAEKSOO

iD in

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PROFESSIONAL EXPERIENCE

2024.01

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현재

Clinical Research Coordinator

가톨릭관동대학교 국제성모병원 | 재활의학과

핵심 성과

- 3.9억 원 규모 다기관 R&D 프로젝트 총괄 관리
- SCI급 논문 공동저자 1편 게재 (Frontiers in Neurology) + 제1저자 논문 1편 투고 예정 (MDPI)
- 국내 학회 포스터 발표 2건 (대한재활의학회 추계학술대회)
- 보건복지부·한국보건산업진흥원 실증사업 중간보고회 Q&A 세션 진행

보건복지부 첨단의료지원관 국장, 의료정보정책과장, 보건산업진흥원 바이오헬스혁신본부장 등 주요 인사 참석, 디지털 헬스케어 실증 연구 관련 질의응답 진행

주요 업무

- AI 기반 디지털 인지훈련 치료제 다기관 무작위대조 임상시험(MCI·뇌졸중 대상) 총괄
- 대상자 모집·선정, IRB 심의, CRIS 등록, 연구비 집행 및 보고서 작성
- 임상시험 문서 관리, 데이터 품질 점검, 연구 진행 모니터링
- 교수진·간호사·치료사 등 다직종 협업을 통한 연구 프로세스 구축 및 개선
- 학술 논문 작성 및 학회 발표

2025.02

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2025.08

Clinical Research Associate (프리랜서)

(주)플코스킨 | 계약 만료

- 임상시험 초기 IRB 문서 검토

EDUCATION & CERTIFICATIONS

2017.03

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2023.02

전남과학대학교 | 간호학과 학사
간호사 면허 (No.494848) | 보건복지부 (2023.02)

PUBLICATIONS

1. AI-driven cognitive telerehabilitation for stroke: a randomized controlled trial

Frontiers in Neurology | Published: August 14, 2025 (공저자)

뇌졸중 환자를 위한 AI 기반 인지 원격재활의 임상 효과를 다기관 무작위 대조시험을 통해 검증한 연구로, AI 재활이 치료사 감독형 재활과 동등한 인지 개선 효과를 보였음을 입증함

2. Designing a Generative AI Framework for Cognitive Intervention in Older Adults: An Engineering Protocol for Clinical Application

MDPI | To be submitted: November 2025 (제1저자)

고령자의 인지기능 저하와 디지털 배제를 해결하기 위해 생성형 AI 기반 3중 에이전트(Coach-Teacher-Companion) 시스템을 설계하고, 일상생활 속 자연스러운 인지훈련 흐름(Context-Adaptive Cognitive Flow)을 구현

공동 제1저자: 황건휘 (훗카이도대학교 응용물리학 박사과정) | 교신저자: 김두영 교수 (가톨릭관동대 국제성모병원 재활의학과)

PROFESSIONAL DEVELOPMENT

교육 & 자격

- 임상시험 모니터요원(CRA) 신규자 과정 (1200분) | KONECT 국가임상시험지원재단 (2025.02)
- 임상연구와 AI | 고려대학교 의료원 (2024.07)
- Leadership | LinkedIn Learning (2024.05)
- Communication & Leadership | LinkedIn Learning (2024.05)

학회 참석

- 대한재활의학회 춘계·추계 국제학술대회 (2024~2025, 총 4회)

CONFERENCE PRESENTATIONS

2024 추계 대한재활의학회

Artificial Intelligence-Guided Mobile Telerehabilitation for Subjects with Cognitive Impairment

P-34

Artificial Intelligence-Guided Mobile Telerehabilitation for Subjects with Cognitive Impairment

Namso Jeon¹, Doo Young Kim², Jarkoon Jeong³, Sue Beon Kim⁴, Bium-Suk Lee⁵,
Min-Soo Kang⁶, Si-Woon Park⁷

¹Department of Rehabilitation Medicine, Inje University School of Medicine, Inje University Hospital, Incheon 22016, Korea
²Department of Physical and Rehabilitation Medicine, Seonang Hospital, Incheon

Introduction

To test feasibility and usability of Artificial Intelligence (AI) guided mobile cognitive telerehabilitation program for patients with stroke or older adults with mild cognitive impairment

Method

Design: Case series with pre-post comparison
Setting: A university hospital and a rehabilitation hospital
Participants: Thirteen subjects with cognitive impairment (Mini-Mental State Examination (MMSE) ≤ 26): 9 subjects with stroke, 4 subjects with MCI.
Interventions: Each participant was given a tablet PC on which AI-guided mobile cognitive rehabilitation program (Zenicog) was installed, and instructed to go through total 24 sessions of 30 minutes training within 6 weeks.
Main Outcome Measures: Cognitive assessments included MMSE, digit span, trail making test A & B. Usability questionnaire consisted of equitable and feasibility in use, simple and intuitive use, perceptible information, tolerance for error, low physical effort, size and space for approach and use, overall quality of product and overall satisfaction.

Results

Thirteen subjects with cognitive impairment were enrolled, including nine stroke patients in the subsacute phase and four subjects with mild cognitive impairment (MCI). Two participants withdrew after enrollment due to lack of motivation; one from the MCI group before the initial assessment and the other from the stroke group after six sessions. Eleven participants completed all 24 sessions. The average age of the participants was 68.45 ± 8.61 years, with eight females (72.7%) and three males (27.3%). The average duration of education was 10.73 ± 3.26 years. The stroke participants had experienced their condition for an average of 79.63 ± 52.3 days post-onset. (Table 1)

The MMSE score was significantly increased from 22.64 ± 3.93 at baseline to 26.18 ± 3.22 after intervention (p=0.014). Other cognitive measures, such as digit span (forward and backward) and trail making test B, showed improvement after intervention without statistical significance. Health-related quality of life, self-efficacy and depression did not show significant change. (Table 2)

Table 1. General Characteristics and Comparison between MCI and Stroke Groups

	Total (n=13)	MCI (n=4)	Stroke (n=9)
Age, n (%)	68.45 ± 8.61	77 ± 6	65.25 ± 9.92
Gender	8 (72.7%)	3 (75.0%)	5 (55.6%)
Male	3 (27.3%)	0 (0.0%)	4 (44.4%)
Female	5 (55.6%)	3 (75.0%)	1 (11.1%)
Education duration (yr)	10.73 ± 3.26	12.5 ± 2.1	9.7 ± 3.1
Stroke duration (days)	79.63 ± 52.3	-	79.63 ± 52.3

MMSE, Mini-Mental State Examination; MCI, Mild Cognitive Impairment; MMSE, Mini-Mental State Examination.

Table 2. Outcome measure analysis

	Pre-intervention	Post-intervention	p-value
MMSE	22.64 ± 3.93	26.18 ± 3.22	0.014*
Digit span	4.1 (4.1, 5.0)	5.0 (4.5, 5.5)	0.186
Trail making	2.7 (2.1, 3.3)	3.0 (2.1, 3.5)	0.188
Trail making B	31 (28.5, 33.5)	42 (35.5, 46.5)	0.477
Trail making C	110 (84, 130)	77 (64.2, 107.8)	0.534
Trail making D	6 (2.5, 18.3)	7 (4, 20.3)	0.964
Trail making E	0.7 (0.0, 2.0)	0.8 (0.0, 2.0)	0.114
Trail making F	40 ± 25.49	61.82 ± 29.60	0.171
Trail making G	26.82 ± 7.81	28.27 ± 8.46	0.791
Trail making H	1 (0.5, 1)	0 (0, 0)	0.157
Trail making I	1 (0.5, 1)	0 (0, 0)	0.157
Trail making J	58 ± 25.30	71.12 ± 22.13	0.124

Conclusion

AI-guided mobile cognitive telerehabilitation program is feasible and potentially beneficial in improving cognitive function for patients with stroke or older adults with MCI. Special consideration should be given to those who are less familiar with electronic devices to improve its usability.

Acknowledgement

This research was supported by a grant of the Korean Health Technology R&D Project through the Korea Health Industry Development Institute (KHIDI), funded by the Ministry of Health & Welfare, Republic of Korea (Grant number: RS-2024-00263387).

2024 추계 대한재활의학회

Predictive Value of Cognitive Function and ALT for Functional Ambulation Gain in MCA Stroke Patients

P-36

Predictive Value of Cognitive Function and ALT for Functional Ambulation Gain in MCA Stroke Patients

Namso Jeon¹, Jarkoon Jeong², Doo Young Kim³

¹Department of Rehabilitation Medicine, Inje University School of Medicine, Inje University Hospital, Incheon 22016, Korea

Introduction

Stroke is a leading cause of disability, significantly impacting mobility. Effective rehabilitation depends on accurate predictors of recovery. Recent studies suggest that both cognitive function and certain initial laboratory biomarkers, such as aminotransferase (ALT), could be crucial for predicting recovery outcomes. This study investigates how cognitive function and ALT levels can predict functional ambulation in survivors of middle cerebral artery (MCA) stroke.

Method

This retrospective study analyzed 87 patients who experienced a first-time middle cerebral artery (MCA) stroke and began rehabilitation within 30 days of their stroke, between June 2016 and June 2023 at a university hospital. Key covariates such as age, sex, National Institutes of Health Stroke Scale (NIHSS), Berg Balance Scale (BBS), Mini-Mental State Examination (MMSE), and low alanine aminotransferase (ALT) levels were considered.

Participants : The study included MCA stroke patients who were initially non-ambulatory and excluded those with conditions that could affect gait, such as musculoskeletal disorders, quadriplegia, or other brain region strokes. The total study population was 87 individuals.

Outcome Variable : The primary outcome was whether the patient achieved functional ambulation, measured using the Functional Ambulation Categories (FAC) scale, after short-term rehabilitation. A FAC score of 3 or higher indicated functional ambulation.

Data Analysis : To identify predictors of ambulation recovery, multivariate binary logistic regression was used. Comparing the comorbidities, stroke type, lesion size, balance, and cognitive function were factored into the model.

Results

Comparison of General Characteristics and Group Outcomes (Table 1)

The study found that individuals who did not achieve functional ambulation were older (69.4 vs. 61.2 years, p = 0.004) and had lower initial BBS and MMSE scores compared to those who regained ambulation (p = 0.001). Men were more likely to regain walking function than women (p = 0.035). Extremely low ALT levels were associated with poor ambulation outcomes (p = 0.014). Among 32 participants with aphasia, all had left-hemisphere lesions, but aphasia incidence showed no significant difference between groups.

Binary logistic regression (Table 2)

The binary logistic regression identified several key predictors of functional ambulation. Male sex, higher initial MMSE (≥20), and BBS (≥20) scores were associated with increased odds of achieving functional ambulation, while older age, higher Charlson Comorbidity Index (CCI), and extremely low ALT levels (≤10 U/L) negatively impacted recovery. Serum albumin and hemoglobin levels were positive predictors. In the multivariate analysis, male sex, MMSE, BBS scores, and low ALT levels remained significant predictors. These findings highlight the importance of cognitive function, balance, and biochemical markers in post-stroke ambulation recovery.

Table 1. General Characteristics and Functional Ambulation After Subacute Rehabilitation

	No (n=35)	Yes (n=52)	p-value
Age (mean ± SD)	69.4 ± 12.2	61.2 ± 11.5	0.004*
Sex	19 (54.3%)	33 (63.5%)	0.001*
Male	26 (75.7%)	45 (86.5%)	0.001*
Female	13 (37.3%)	21 (40.5%)	0.776
Stroke type	22 (62.9%)	34 (65.4%)	0.937
Ischemic	22 (62.9%)	34 (65.4%)	0.937
Stroke size (mm)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (cm)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (m)	22 (62.9%)	34 (65.4%)	0.125
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Stroke size (v)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (u)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (t)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (s)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (r)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (q)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (p)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (o)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (n)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (m)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (l)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (k)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (j)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (i)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (h)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (g)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (f)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (e)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (d)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (c)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (b)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (a)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (z)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (y)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (x)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (w)	22 (62.9%)	34 (65.4%)	0.125
Stroke size (v)	22 (62.9%)	34 (65.4%)	0.125