

1. REHAB MEASURES: ACTION RESEARCH ARM TEST

Available at the Internet Stroke Center (External Link)

Title of Assessment	Action Research Arm Test
Acronym	ARAT
Instrument Reviewer(s)	Initially reviewed by the Rehabilitation Measures Team in 2011; Updated by Cara Weisbach, PT, DPT and Wendy Romney, PT, DPT, NCS and the SCI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA with references from the chronic stroke population in 2012; Updated by Irene Ward, PT, DPT, NCS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012; Updated by Maggie Bland PT, DPT, NCS and Nancy Byl PT, MPH, PhD, FAPTA and the STROKEDGE II Task Force of the Academy of Neurologic Physical Therapy - a component of APTA in 2016.
Summary Date	4/4/2016
Purpose	Assesses upper limb functioning using observational methods
Description	The ARAT's is a 19 item measure divided into 4 sub-tests (grasp, grip, pinch, and gross arm movement). Performance on each item is rated on a 4-point ordinal scale ranging from:3: Performs test normally
	2: Completes test, but takes abnormally long or has great difficulty
	1: Performs test partially
	0: Can perform no part of test
	Lyle's decision rule: Patients who achieve a maximum score on the first (most difficult) item are credited with having scored 3 on all subsequent items on that scale. If the patient scores less than 3 on the first item, then the second item is assessed. This is the easiest item, and if patients score 0 then they are unlikely to achieve a score above 0 for the remainder of the items and are credited with a zero for the other items. The maximum score on the ARTS is 57 points (possible range 0 to 57).
	Items can also be summed (van der Lee et al, 2002)
	A standardized scoring protocol has been published by Yozbatiran 2008



Area of Assessment	Activities of Daily Living; Coordination; Dexterity; Upper Extremity Function
Body Part	Upper Extremity
ICF Domain	Activity
Domain	Motor
Assessment Type	Observer
Length of Test	06 to 30 Minutes
Time to Administer	10 minutes, dependent on number of items performed
Number of Items	19
Equipment	Various sized wood blocks
Required	Cricket ball
	Stone
	Jug and glass
	Tube
	Washer and bolt
	Ball bearing
	A marble
Training Required	None
Type of training required	No Training
Cost	Purchase of the kit ~ \$600
Actual Cost	Free
Age Range	Adolescent: 13-17 years; Adult: 18-64 years; Elderly adult: 65+



Administration Mode	Paper/Pencil						
Diagnosis	Multip	Multiple Sclerosis; Stroke; Traumatic Brain Injury					
Populations Tested	Stroke Multip Traum	roke ultiple Sclerosis aumatic Brain Injury					
Standard Error of Measurement (SEM)	(Simps post s	 Simpson, 2013) A literature review identifying responsiveness data in patients post stroke (van der Lee, 2004 and Hsueh, 2002). 1.3 Note: effect size for perceived effect (e.g. MAL) were 1.66.2 times larger than the functional changes (measured ARAT or Wolf) 					
Minimal Detectable Change (MDC)	(Simps • •	son, 201 MDC ₉₀ MDC ₉₅	3) = 3.0 = 3.5				
Minimally Clinically Important Difference (MCID)Chronic Stroke: (van der Lee et al, 2001; n = 20; mean age = 62 (IQR = 52.5- years; median time since stroke = 3.6 years; mean ARAT score = 29.2 points)MCID = 10% of the measures total range (i.e. 5.7 points)Chronic Stroke: (van der Lee et al, 2001; n = 22, mean age = 58.5 years; me time since stroke = 3.6 years; Median baseline ARAT score = 38.0 points)MCID = 5.7Acute Stroke: (Lang et al, 2008; mean age = 64 (14); time between stroke a assessment = 9.5 (4.5) days)MCID Raw Score:				52.5–71.8) points) ;; mean ts) bke and first			
		MCID if	Dominant Side Af	fected	MCID if	Nondominant Sid	e Affected
		Value	Scale	Size	Value	Scale	Size
	ARAT	12	21	0.78	17	30	1.10



(Simpson, 2013)6 points total s	core;1-1.2% of maximum <i>time</i> score					
Not Established						
Chronic Stroke: (van der Lee et al, 2001) Mean (SD) intake ARAT score 29.2 (12.5) Mean (SD) intake Fugl-Meyer Assessment score 49.2 (9.9)						
Subtest:	Item	Time Limit (s)				
Grasp	Block 2.5cm	3.6				
	Block 5cm	3.5				
	Block 7.5cm	3.9				
	Ball 7.5cm	3.8				
	Stone	3.6				
	Block 10cm	4.2				
Subtest:	ltem	Time Limit (s)				
Grip	Tube 2.25cm	4.2				
	Tube 1cm	4.3				
	Place washer over bolt	4				
	Pour water from glass to glass	7.9				
Subtest:	Item	Time Limit (s)				
Pinch	Large marble first finger and thumb	3.8				
	Large marble second finger and thumb	3.8				
	Large marble third finger and thumb	4.1				
	(Simpson, 2013)	(Simpson, 2013) • 6 points total score;1-1.2% of maximum <i>time</i> score Not Established Chronic Stroke: (van der Lee et al, 2001) Mean (SD) intake ARAT score 29.2 (12.5) Mean (SD) intake Fugl-Weyer Assessment score 49.2 (9.9) Item norms (based on bealthy elderly adults): Subtest: Item Grasp Block 2.5cm Grasp Block 5cm Gloce Block 7.5cm Block 7.5cm Block 10cm Subtest: Item Grip Tube 2.25cm Grip Tube 2.25cm Grip Tube 2.25cm Fuen Comment of the fuent of the f				



	Small marble first finger and thumb	4
	Small marble second finger and thumb	4.1
	Small marble third finger and thumb	4.4
Subtest:	Item	Time Limit (s)
Gross Movement	Move hand to mouth	2.4
	Place hand on top of head	2.7
	Place hand behind head	2.7

Time limits (mean + 2 SD of the performance times of 20 healthy elderly subjects)

If performance is slower than the time limit or if the patient loses contact with the back of the chair during performance, the score is 2 instead of 3.

Acute Stroke: (Beebe and Lang, 2009; mean age = 56.9 (10.2), times since stroke
onset = 18.6 (5.6) days)

Normative Data:

	1 month	3 months	6 months
ARAT	26.4 (23.9)	39.5 (19.7)	41.3 (20.8)
Grip Strength (kg)	9.2 (9.6)	14.0 (10.3)	15.4 (11.4)
9HPT (sec)	88.8 (40.2)	67.8 (41.7)	60.8 (39.7)
SIS: Hand function	19.9 (28.0)	48.4 (32.7)	43.9 (34.2)
9HPT = 9-Hole Peg SIS = Stroke Impac	Test t Scale-Hand	d	

Test-retest Reliability Chronic and Acute Stroke, Multiple Sclerosis & Traumatic Brain Injury: (Platz et al, 2005; n = 23)

Interrater Reliability (between 2 raters)

Action Research Arm Test:



		Rating	ICC	rho
	Grasp	Excellent	0.949	0.965
	Grip	Excellent	0.947	0.955
	Pinch	Adequate	0.894	0.897
	Gross movement	Excellent	0.976	0.976
	Total score	Excellent	0.965	0.968
	Fugl-Meyer Test, arm section		1	1
	Motor function	Rating	ICC	rho
	A Shoulder/elbow/forearm	Excellent	0.954	0 944
	B Wrist	Excellent	0.973	0.961
	C Hand	Excellent	0.958	0.941
	D Co-ordination/speed	Excellent	0.936	0.947
	Total motor score	Excellent	0.965	0.951
	Sensation	Adequate	0.806	0.672
	Passive joint motion/joint pain	Excellent	0.946	0.883
	Box and Block Test:		<u> </u>	<u> </u>
		Rating	ICC	rho
	Total	Excellent	0.963	0.973
Interrater/Intrarat er Reliability	Acute Stroke: (Nijland et al, 201 ARAT score = 38; times since st	L0; n = 40; roke onset	mean < 6 m	age = 6 onths;
	Excellent interrater reliability (I	CC = 0.92)		
	Chronic Stroke: (Van der Lee ef	t al, 2001)		

Excellent Interrater Reliability (ICC = 0.995)

Excellent Intrarater Reliability (ICC = 0.989)



Chronic and Acute Stroke, Multiple Sclerosis & Traumatic Brain Injury: (Platz et al, 2005; n = 44)

Interrater Reliability (between 2 raters)				
Action Research Arm Test:				
	Rating	ICC	rho	
Grasp	Excellent	0.997	0.999	
Grip	Excellent	0.964	0.958	
Pinch	Excellent	0.999	0.999	
Gross movement	Excellent	0.984	0.984	
Total score	Excellent	0.998	0.996	
Fugl-Meyer Test, arm section				
Motor function	Rating	ICC	rho	
A Shoulder/elbow/forearm	Excellent	0.989	0 984	
B Wrist	Excellent	0.987	0.983	
C Hand	Excellent	0.987	0.984	
D Co-ordination/speed	Excellent	0.971	0.971	
Total motor score	Excellent	0.997	0.995	
Sensation	Excellent	0.979	0.969	
Passive joint motion/joint pain	Excellent	0.983	0.980	
Box and Block Test:				
	Rating	ICC	rho	
Total	Excellent	0.993	0.993	

Chronic Stroke: (Yozbatrin et al, 2008)



Interrater Reliability

Action Research Arm Test					
	Rating	ICC	rho		
Grasp	Excellent	0.9992	1.0		
Grip	Excellent	0.996	0.99		
Pinch	Excellent	0.997	0.98		
Gross Movement	Excellent	0.978	0.93		
Total Score	Excellent	0.9986	0.96		

Intrarater Reliability

Action Research Arm Test				
	Rating	ICC	rho	
Grasp	Excellent	0.98	0.93	
Grip	Excellent	0.97	0.93	
Pinch	Excellent	0.99	0.98	
Gross Movement	Excellent	0.93	0.91	
Total Score	Excellent	0.99	0.99	

(Page, 2015) Patients an average of 4.6 years since stroke with moderate upper extremity paresis

• Excellent Intrarater reliability (ICC = 0.99, 95% CI 0.98-0.99)

(Page, 2012) Patients greater than 12 months post-stroke with minimal upper extremity paresis enrolled in trial. Measurements were madebefore starting the trial, approximately 1 week apart.

• Adequate Intrarater reliability (ICC = 0.71, 95% CI 0.53-0.89)



Acute Stroke: (Nijland et al, 2010)
Excellent Internal Consistency (alpha = 0.985)
Chronic Stroke: (van der Lee et al, 2001) Evidence of concurrent validity confirmed by comparison with the upper limb subtest of the Fugl- Meyer Assessment and the Motor Assessment Scale. Chronic Stroke: (Yozbatiran et al, 2008) Excellent correlation between ARAT and arm motor score of the Fugl-Meyer (r = 0.94, p<0.01) (Chen, 2012) Patients seen an average of 17.19 (±15.29) months post-stroke • Adequate predictive validity with the composite physical domain and hand domain of the Stroke Impact Scale (ρ = 0.45 and 0.58, p<0.001, respectively) • Excellent predictive validity with the performance time and functional ability scale on the Wolf Motor Function Test (ρ = -0.66 and 0.76, p<0.001, respectively), Motor Activity Log Amount of Use (30) and Quality of Movement (30) (ρ = 0.62 and 0.66, p<0.001, respectively)
 (Page, 2015) Patients an average of 4.6 years since stroke with moderate upper extremity paresis Excellent concurrent validity with the Wrist Stability and Hand Mobility Subscales of the Fugl-Meyer Assessment (0.67-0.74, p < .001) (O'Dell, 2014) Community-dwelling volunteers seen an average (mean (SD)) of 4.1 (4.5) years post-stroke for upper extremity robotics training Excellent concurrent validity (0.79, p = 0.001) with the 9-item version of the Arm Motor Ability Test. (Wei, 2011) Twenty-seven stroke participants with moderate motor impairment in their affected upper extremity, an average of 4.92 ±0.45 years post-stroke. Excellent concurrent validity (0.81 – 0.96, p < 0.01) with the Fugl-Meyer Assessment and Motor Status Scale. (Lin, 2010) Fifty-nine stroke participants an average of 16.14 ± 13.95 months post-stroke engaging in upper extremity training or placebo.



 Adequate concurrent validity (0.31 – 0.54, p < 0.05) with the Fugl-Meyer Assessment, Motor Activity Log-Amount of Use and Quality of Life, and Stroke Impact Scale Hand Function Domain.

(Chuang, 2012) Sixty-seven participants an average of 21.12 ± 13.63 months poststroke had functional state of upper extremity skeletal muscle assessed with a Myoton-3 myometer to measure tone, elasticity and stiffness. Pretreatment

- Poor concurrent validity of the ARAT with muscle tone, elasticity and stiffness of the flexor carpi radialis (0.27, [p < 0.05], 0.02 [P>0.06], and 0.30 [p<0.05])
- Poor concurrent validity with the ARAT and muscle tone, elasticity and stiffness of the extensor digitorum (-0.01 to -0.03) and the flexor carpi radialis (-0.07 to 0.10).

Posttreatment

- Poor to Adequate concurrent validity of the ARAT with muscle tone, elasticity and stiffness of the flexor carpi radialis (0.29 [P<0.05], 0.03 [P>0.05) and 0.36,[<0.01])
- Poor concurrent validity with the ARAT and the muscle tone, elasticity and stiffness of the extensor digitorum(-0.-8 to 0.19) and the flexor carpi ulnaris (-0.18 to 0.11)

(Edwards, 2012) Fifty-one subjects as part of the VECTORS (constraint induced movement therapy) study assessed at Day 0 (9.5 \pm 4.5), Day 14 (24.9 \pm 10.6), Day 90 (110.8 \pm 20.7).

 Adequate to Excellent concurrent validity with the Wolf Motor Function Test, Functional Ability Score (WMFT FA)

(see time frame above)	Day 0	Day 14	Day 90
WMFT FA Function Score	0.745	0.827	0.863
WMFT FA Time Score	-0.641	-0.825	-0.772
WMFT FA Grip Score	0.702	0.631	0.553

(Lee, J., 2015) Fifteen subjects an average of 3.1 ± 2.3 years post-stroke who wore accelerometers while completing the ARAT

• Poor concurrent validity (0.24) on the affected side, and Excellent concurrent validity on the non-affected side (0.91).



(Lee, G., 2015) Forty-three participants were recruited a mean 15.21 ± 3.32 months post-stroke for assessment.

- An Adequate negative correlation was found (-0.41;p<0.05) with hypertonia (defined as a Modified Ashworth Scale Score of > 1+)
- Adequate predictive validity (Cut-off ≤ 15.50/57 points, AUC .76 (95% Cl 0.61-0.90, p <0.01). If a person had an ARAT score of ≤ 15.50/57 points, they had a 1.359 increased risk of having a Modified Ashworth Scale score of ≥ 1+ (p = 0.051, 95% Cl 1.01-1.82)

(Li et al, 2015) A study with 95 individuals with first time stroke greater than one month post, < 2 on the Modified Ashworth and good mental status (MMST >24) reported significant and adequate concurrent and predictive correlations between arm kinematics (movement time) and the ARAT during reaching (with and without trunk constraint).

Regression	Kinematic Variable	Adjusted R2	P value
Concurrent Validity			
Before Intervention			
Trunk constraint	MT Pre	0.29	<0.001
Trunk Unconstraint	MT Pre	0.40	<0.001
Concurrent validity			
After Intervention			
Trunk constraint	MT Pre	0.38	<0.001
Trunk Unconstraint	MT Pre	0.34	<0.001
Predictive Validity ARAT Post			
Trunk constraint	MT Pre	0.33	<0.001
Trunk Unconstraint	MT Pre	0.36	<0.001

(Page, 2012) Patients greater than 12 months post-stroke with minimal upper extremity paresis enrolled in trial.

• Excellent concurrent validy with the Wrist/Hand Subscales of the Fugl-Meyer Assessment.



(Hsieh, 2009) A cohort of 57 stroke participants (an average of 12.98±7.62 months post-stroke) with assessments completed prior to and after treatment in an effectiveness trial examining distributed constraint-induced therapy and bilateral arm training.

 Poor predictive validity (Spearman ρ (95% CI)) between the ARAT and the Functional Independence Measure-Total Score (0.22 (-0.04, 0.46, not significant)) and the Functional Independence Measure-Motor Score (0.26 (0.00, 0.49, not significant)).

Construct ValidityChronic and Acute Stroke, Multiple Sclerosis & Traumatic Brain Injury: (Platz et al,
2005; n = 56; mean age = 54, range = 13-92 years)minant)

Construct Validity: correla	tional analysis (S	Spearman's rho)	
	Fugl-Meyer motor	Action Research Arm Test	Box and Block Test
Action Research Arm Test	0.925	1	0.951
Fugl-Meyer motor	1	0.925	0.921
Fugl-Meyer sensation	0.239	0.298	0.285
Fugl-Meyer joint motion/pain	0.470	0.421	0.433
Box and Block Test	0.921	0.951	1
Motricity Index	0.861	0.811	0.798
Ashworth Scale	-0.422	-0.296	0.383
Modified Barthel Index	0.086	0.049	0.044
Correlational analysis wer	e based on the (first) assessment of 56	patients

The above table indicate the ARAT's is strongly related to the:

Fugl-Meyer motor

Box and Block Test

Motricity Index



Negatively related to the Ashworth Scale, moderately related to the Fugl-Meyer sensation and joint motion/pain scales and Not related to the Modified Barthel Index

(Awert et al (2015) 50 patients post first stroke (< 5 years), participating in outpatient rehabilitation, capable of completing a self assessment questionnaire Michigan Hand Outcomes Questionnaire (MHOQ) and strength testing (ARAT).

• Excellent correlations between the MHOQ and the ARAT for all patients (0.64; p<0.001) and for patients with arm impairments (0.60; P<0.000).

(Houwink, 2011) Twenty-one participants admitted to rehabilitation, with a stroke diagnosis occurring less than six weeks prior to admission.

 Excellent cross-sectional (0.91, p < 0.001) and longitudinal, 3 months in between assessments, (0.71, p < 0.001) correlations with the Stroke Upper Limb Capacity Scale.

Rabadi and Rabadi 2006) A study of 104 patients in an acute stroke rehabilitation (16±9 days on average post stroke) measured the performance on the ARAT within 72 hours of admission and 24 hours before discharge as well as the FMA National Institutes of Health Stroke Scale, FIM instrumental total score and FIM activities of daily living.

• The Spearman rank correlation of ARAT was excellent with the FMA (rho=0.77 on admission and 0.87 on discharge, P<0.001), adequate with the FIM-ADL on admission and discharge (0.32; P<0.001) and adequate to poor for the FIM (0.33 admission and 0.21 discharge; P<0.001)

(Hsieh, 2009)

	 Excellent construct validity was found between the ARAT and the Fugl-Meyer Assessment (0.73-0.74, p<0.01) and the Wolf Motor Function Test-Functional Ability Scale (0.68-0.77, p<0.01). Adequate to Excellent construct validity was found between the ARAT and the Wolf Motor Function Test-Performance Time (0.58-0.63, p<0.01). Poor construct validity was found between the ARAT and the Functional Independence Measure-Motor Score (0.27-0.39, p<0.01).
Content Validity	The ARAT is a modified version of the Upper Extremity Function Test (UEFT)
Face Validity	Not Established



Floor/CeilingAcute Stroke: (Lin et al, 2009; n = 53; mean age = 64; Taiwanese sample)Effects

% of Individuals who Experienced Floor and Ceiling Effects:			
Days Post Stroke	Floor	Ceiling	
14	41.5	9.4	
30	17.0	20.8	
90	11.3	20.8	
180	11.3	22.6	

Acute Stroke: (Nijland et al, 2010)

Floor effects for scores < 3

Ceiling effects for scores > 54

(Edwards, 2012)

% of Individuals who Experienced F	loor and Ce	iling Effects:
Days Post Stroke	Floor	Ceiling
Day 0 (see time frame above)	5.9	3.9
Day 14	2	22
Day 90	2.1	33

(Hsueh, 2002) Forty-eight participants undergoing rehabilitation. At admission it was a median of 24 days (range 7-53) post-stroke.

% of Individuals who Experienced Floor and Ceiling Effects:			
	Admission to rehabilitation Floor	Discharge from rehabilitation Ceiling	
ARAT Total	52.1%	7%	
ARAT Grasp	70.8%	27.1%	



	ARAT Pin	ch			7	2.9%			16.7%
	ARAT Gro	oss Mov	emer	nt	5	52.1%			29.2%
Responsiveness	Chronic Stroke: (van der Lee et al, 2002; n = 31 (RIQ = 52–66) years; mean baseline AARAT score = 30.27; > 1 year post stroke) 1.2 points (using Lyle's decision rule) 1.7 points (summing items) Acute Stroke: (Lin et al, 2009; n = 53; mean age = 64; Taiwanese sample)								
	Days Pos	t Stoke	Effec	t Rating	Interpr	etation	Effect Size		
	14–30		Smal	l	Poor		0.49	_	
	14–90		Moderate		Adequ	ate	0.70	_	
	14–180		Moderate		Adequate		0.79	_	
	Acute Stroke: (Beebe and Lang, 2009)								
	Responsiveness:								
	Measure	1–3 mo	onths	1–6 mo	nths				
	ARAT	0.55		0.63					
	9НРТ	0.52		0.66					
	SIS-Hand	1.02		0.86					
	Acute Stroke (Lang et al, 2006; mean age = 64 (14), Admission NIHSS = 5.3 (1.8); time between stroke and first assessment = 9.5 (4.5) days)								
	Responsiveness of the ARAT								
	Method	hod Day 0 to			Day 14	l Day 0	to Day 90		
	Single po	pulatior	n all c	lemonst	rated la	arge eff	ect sizes		
	ARAT tot	al score		1.018		1.390			
	ARAT gro	ss subso	core	0.729		0.984			



ARAT grasp subscore	1.042	1.224
ARAT grip subscore	1.017	1.324
ARAT pinch subscore	0.854	1.494

(Edwards, 2012)

Responsiveness:			
Measure (see time frame above)	Day 0-14	Day 0-90	
ARAT Total Score	1.017	1.390	
ARAT Gross Motor Score		0.729	0.984
ARAT Grasp Score		1.042	1.224
ARAT Grip Score			1.324
ARAT Pinch Score			1.494
(Murphy et al, 2013) Kinematic m meaningful improvement in the u with kinematic movement analysi in 51 subjects 9 days and 3 month			
Kinematics			
Movement Time			
Movement Units			
Trunk Displacement			

(Wei, Tong and Hu, 2011) Twenty seven patients chronic post stroke (avg.4.92 years) with low level arm function participated in a robotic training paradigm and responsiveness was measured with the FMA, MSS and ARAT using the standardized response mean (SRM) and the Guyatt's Responsiveness Index (GRI).

• There were no significant gains in the scores on the ARAT after treatment (25.00 [11.25] to 25.86 [10.82])



• The responsiveness was low with SRM 0.22 and GRI 0.81

The responsiveness was lower for the ARAT than the FMA and MSS. In addition, the responsiveness was lower than 0.85 reported in a previous Hseih study (2009) The ARAT may not be as responsive in patients with greater upper limb impairments (e.g. baseline ARAT score for the Hseih study was 42.72 ± 12.11 compared to the Wei study with a baseline score of 23.48 ± 11.62).

(Rabadi and Rabadi 2006)

- The SRM was 0.68 (admission score of 23 \pm 24 and discharge score 36 \pm 23
- This SRM was lower than reported by vanderLee and Roord (2002) which included subjects with a higher level of upper limb function (ARAT score 30.27 at baseline with subjects > 1 year post stroke)

(Hsieh, 2009)

- The standardized response mean (95% CI) of the ARAT was found to be 0.95 (0.75, 1.20, Wilcoxon Z = 4.64, p<0.01).
- The ARAT had a smaller standardized response mean (difference in SRM (95%CI) when compared against the Fugl-Meyer Assessment (0.47 (0.09, 0.89, p<0.05)) and the Wolf-Motor Function Test-Functional Ability Scale (0.35 (-0.01, 0.78, p = not significant)). However, the ARAT had a greater standardized response mean when compared to the Wolf-Motor Function Test-Performance Time (0.57 (0.28, 0.86, p<0.05)).

(Lin, 2010)

 The standardized response mean (95% CI) was found to be 0.79 (0.63-1.10, Wilcoxon Z = 5.76, p<0.001).

ProfessionalRecommendations for use of the instrument from the Academy of NeurologicAssociationPhysical Therapy of the American Physical Therapy Association's MultipleRecommendationsSclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal CordInjury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE), Traumatic Brain InjuryTaskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. Theserecommendations were developed by a panel of research and clinical expertsusing a modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>



Abbreviatio	ns:
HR	Highly Recommend
R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(Vestibular < 6 months post)	(SCI 3 to 6 months)	
SCI EDGE	LS	LS	LS
StrokEDGE II	R	R	R

Recommendations based on level of care in which the assessment is taken:

	Acute	Inpatient	Skilled	Outpatient	Home
	Care	Rehabilitation	Nursing Facility	Rehabilitation	Health
StrokEDGE II	R	R	R	R	R
TBI EDGE	LS	LS	R	R	R

Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	LS	LS



Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant
TBI EDGE	N/A	N/A	N/A

Recommendations for entry-level physical therapy education and use in research:

	Students	Students	Appropriate for	Is additional
	should learn	should be	use in	research
	to administer	exposed to	intervention	warranted for
	this tool?	tool? (Y/N)	research	this tool (Y/N)
	(Y/N)		studies? (Y/N)	
SCI EDGE	No	No	No	Not reported
StrokEDGE II	No	Yes	Yes	Not reported
TBI EDGE	Yes	Yes	Yes	Not reported

Considerations The ARAT an

The ARAT and WMFT are highly correlated and as such may not provide significant levels of incremental validity

(Chen, 2012)

A Rasch Analysis suggested revising the original 4-point scale into a 3-point scale. Tasks of "place hand behind head" and "place hand on top of head" showed poor item fit and item bias relevant to participant's ages.

(Sivan, 2011)

This study examined outcome measures that are currently being used in robotassisted exercise trials in stroke. They rated the ARAT as having high/excellent test-retest reliability and inter-rater reliability, moderate construct validity and responsiveness, poor with respect to floor and ceiling effects, and a moderate burden overall. Also, for patients both less than or more than six months poststroke with Moderate impairment (Fugl-Meyer >25) the ARAT was a recommended measure of activity and participation.



(Norain, 20.

	This study examined percent intra- and inter-rater reliability across 35 participants a median of 22 months post-stroke. Items 10, 11, 14, and 19 had some systematic disagreement within raters and items 1, 4, 17, and 19 between raters. Item 19 (hand to mouth) had the most disagreements. In general the greatest difficulties were deciding between a score of 2 or 3.
	(Croarkin, 2004)
	This evidence-based literature review ranked different tests of upper extremity function based on their psychometric properties. They ranked the ARAT as Level II: Established by evidence for inter-rater reliability and concurrent and convergent validity.
	(Velstra, 2011)
	In this systematic review, the authors examined how multiple measures of upper extremity function related to the International Classification of Functioning, Disability, and Health. The ARAT addressed the mobility at several joints category under the Body Functions and Body Structures domain 17 timess. Under the Activities and Participation domain 1 time fine hand use was covered, 6 times for grasping, 1 for turning or twisting the hands or arms, and 1 for drinking. One item was found not linked.
	Do you see an error or have a suggestion for this instrument summary? Please <u>e-</u> <u>mail us</u> !
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Year published	1981
Instrument in PDF Format	Yes
Approval Status	Approved



2. REHAB MEASURES: ARM MOTOR ABILITY TEST

Link to instrument			
Title of Assessment	Arm Motor Ability Test - 13		
Acronym	AMAT		
Instrument Reviewer(s)	Initially reviewed by Jane Sullivan PT, DHS, MS and the Stroke EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA. Updated by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto- Zipp, PT, EdD of the StrokEDGE II, Academy of Neurologic Physical Therapy - a component of APTA, in 3/2016		
Summary Date	8/30/2013; March 2016		
Purpose	To evaluate disabilities in upper extremity function in activities of daily living (ADL) using a quantitative and qualitative measure.		
Description	The test consists of 13 ADL activities involving one to three component tasks or movement segments. As in the case of most ADL, the components within each compound task either involve differential contributions from the two arms, or of the distal and proximal musculature of an affected arm, or are not of equal difficulty. This, the task components in this assessment are measured separately. However, each compound task is performed continuously, as a unit, without the patient's awareness of component parcellation. One is therefore able to quantify ADL in the manner of a laboratory test without interfering with the natural flow of movement characteristic of everyday activity. Each of tasks is timed and rated according to quality of movement and ability to perform each component part of a compound task. Tasks have either a 1 or 2 minute performance time limit.		
Area of Assessment	Activities of Daily Living; Upper Extremity Function		
Body Part	Upper Extremity		
ICF Domain	Activity		
Domain	ADL		
Assessment Type	Performance Measure		



Length of Test	31 to 60 Minutes		
Time to Administer	30-40 minutes		
Number of Items	28		
Equipment Required	 Shoe Telephone Shirt In order to assure a standard placement of test objects, a laminated template is used. This can be constructed according to directions or purchased by contacting: Edward Taub, Ph.D, Department of Psychology, 415 Campbell Hall, University of Alabama at Birmingham, Birmingham, AL 35294 		
Training Required	Reading an article/manual		
Type of training required	Reading an Article/Manual		
Cost	Not Free		
Actual Cost	\$25; A test template can be obtained from the address below: Edward Taub, Ph.D, Department of Psychology, 415 Campbell Hall, University of Alabama at Birmingham, Birmingham, AL 35294		
Age Range	Adults		
Administration Mode	Paper and Pencil		
Diagnosis	Stroke		
Populations Tested	Stroke		
Standard Error of Measurement (SEM)	Not Established		
Minimal Detectable Change (MDC)	Stroke:		



(Kopp et al, 1997; n = 33 subacute stroke inpatients with moderate to mild upper extremity motor deficit; median age = 66 years; sex = 12 females; median Motricity Index Arm Score = 89; median chronicity = 43 days)

• In individuals with subacute stroke and mild to moderate movement deficits, the AMAT detected the difference in change occurring as a result of the passage of 1 versus 2 weeks.

Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Not Established
Normative Data	Not Established
Test-retest Reliability	Stroke: (Kopp et al, 1997) • Excellent test-retest reliability (ICC = 0.93 - 0.99)
Interrater/Intrarater Reliability	Stroke: (Kopp et al, 1997) • Excellent interrater reliability (ICC = 0.95 - 0.99)
Internal Consistency	Not Established
Criterion Validity (Predictive/Concurrent)	Stroke: (Kopp et al, 1997) • Adequate to excellent concurrent validity with the Motricity- Index-Arm (correlation coefficient = 0.45-0.61) (Chae et al, 2003) • Excellent concurrent validity with the Fugl-Meyer Assessment (correlation coefficient = 0.92-0.94)
Construct Validity (Convergent/Discriminant)	<u>Stroke:</u> (Kopp et al, 1997)



	 Adequate to excellent correlation with Motricity-Index-Arm (r = 0.45 - 0.61) 		
	(Chae et al, 2003; <i>n</i> = 30 chronic stroke survivors)		
	• Exc	ellent correlation with Fugl-Meyer Assessment	
Content Validity	Not Established		
Face Validity	Not Established		
Floor/Ceiling Effects	Stroke:		
	The AMAT time of performance exhibited significant ceiling and floor effects with respect to the Fugl-Meyer Assessment (Chae et al, 2003).		
Responsiveness	Stroke:		
	In individuals with subacute stroke and mild to moderate movement deficits, the AMAT detected the difference in change occurring as a result of the passage of 1 versus 2 weeks (Kopp et al, 1997).		
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.		
	For detailed information about how recommendations were made, pleas visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>		
	Abbreviations:		
	HR	Highly Recommend	
	R	Recommend	
	LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	



Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 months post)		
StrokEDGE II	NR	R	R

Recommendations based on level of care in which the assessment is taken:

	Acut e Care	Inpatient Rehabilitatio n	Skilled Nursin g Facility	Outpatient Rehabilitatio n	Home Healt h
StrokEDG E II	NR	R	R	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE II	No	Yes	Yes	Not reported



Considerations	Limitations: Very lengthy to complete
	Client should have some active movement capacity in the involved arm
	 The AMAT has been used in post stroke UE intervention trials examining constraint induced movement therapy, electrical stimulation, and repetitive task training
	• Original version of AMAT had 17 items, was created by McCulloch et al, at the University of Alabama for use in the CIMT research.
	• AMAT-9 version as been proposed by O'Dell, M., et al, (2013) which only includes tasks that are seated, for those patients with more severe deficits limiting mobility and balance in standing.
Bibliography	Chae, J., Labatia, I., et al. (2003). "Upper limb motor function in hemiparesis: concurrent validity of the Arm Motor Ability test." Am J Phys Med Rehabil 82(1): 1-8. <u>Find it on PubMed</u>
	Kopp, B., Kunkel, A., et al. (1997). "The Arm Motor Ability Test: reliability, validity, and sensitivity to change of an instrument for assessing disabilities in activities of daily living." Arch Phys Med Rehabil 78(6): 615-620. <u>Find it on PubMed</u>
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	O'Dell, M., Kim, G., et al. (2013) " A psychometric evaluation of the arm motor ability test." J Rehabil Med 45(6): 519-527. Find it on PubMed
Year published	1997
Instrument in PDF Format	No
Approval Status	Approved



3. REHAB MEASURES DATABASE—ASSESSMENT OF LIFE HABITS

Link to instrument	Find Information for the LIFE-H at iNDCP							
Title of Assessment	Assess	Assessment of Life Habits						
Acronym	Life-H							
Instrument Reviewer(s)	Initially PT, MS Acade Update in 11/2 Review force of 2016.	ially reviewed by the Rehabilitation Measures Team; Updated by Sue Saliga, , MS, DHSc, Anna de Joya, PT, MS, NCS, and the TBI EDGE task force of the ademy of Neurologic Physical Therapy - a component of APTA in 2012; dated by Ashley Marrapode, SPT, Taylor McCulloch. SPT, Kristy Samra, SPT 1/2012. viewed by Rie Yoshida and Heather Anderson as part of StrokEDGE II task ce of the Academy of Neurologic Physical Therapy - a component of APTA in 16						
Summary Date	4/15/1	6						
Purpose	Assesses participants on 77 life habits from daily activities to social participation across 12 domains. It is a self-report based on one's perception of difficulty and assistance required.							
Description	The LII The firs Th Th	FE-H is composed of two sca st assesses accomplishment e degree of difficulty experie e kind of assistance required arrangements) Accomplishments Scale:	ales. s rated across two dimensions: nced I (help, technical assistance, physical					
	Score	Level of Difficulty	Type of Assistance					
	9	Accomplished with no difficulty	No assistance					
	8	Accomplished with no difficulty	Assistive device or adaptation					
	7	Accomplished with difficulty	No assistance					
	6	Accomplished with difficulty	Assistive device or adaptation					
	5	Accomplished with no difficulty	Human assistance					
	4	Accomplished with no difficulty	Assistive device or adaptation and human assistance					



3	Accomplished with difficulty	Human assistance
2	Accomplished with difficulty	Assistive device or adaptation and human assistance
1	Accomplished by a proxy	
0	Not accomplished	
N/A	Not applicable	

The second scale assesses the patient's satisfaction with daily activities or social roles. The satisfaction can range from 1 to 5 (with 5 indicating a high level of satisfaction)

Life-H Daily Activities	Domain:
Category	Items example
Nutrition	Preparing your meal
	Eating in restaurants
Fitness	Sleep
	Participating in physical activities to maintain or improve your health
Personal care	Attending to your personal hygiene
	Using a bathroom or toilet other than those in your home
Communication	Communicating with another person at home or in the community
	Written communication
Housing	Maintaining your home
	Doing major household tasks
Mobility	Getting around on slippery or uneven surfaces
	Driving a vehicle
Social Roles Domain:	
Category	Items example
Responsibility	Making purchases
	Taking care of your children
Interpersonal relationships	Maintaining friendships
	Having a sexual relationship
Community life	Getting to public buildings in your community
	Participating in spiritual or religious practices
Education	Participating in educational activities or vocational training
	Undertaking vocational training
Work	Holding a paid job
	Carrying out familial or home-making tasks as your main occupation



	Recreation Participating in sporting or recreational activ					
		Taking part in outdoor activities				
Area of Assessment	Activities of Daily Living; Communication; Eating; Executive Function; Life Participation; Quality of Life					
Body Part	Not Applicable					
ICF Domain	Activity; Participation					
Domain	ADL					
Assessment Type	Performance Measure					
Length of Test	06 to 30 Minutes					
Time to Administer	LIFE-H 3.1 short form: 2	20-40 minutes; LIFE H 3.0 long form: 20-120 minutes				
Number of Items	General long form 242 it 12 domains; Children lor	General long form 242 items over 12 domains; General short form 77 items over 12 domains; Children long form 240 items; Children short form 62 items				
Equipment Required	Find a sample of the ma	anual here				
Training Required	None. Test manuals are	available from iNDCP.				
Type of training required	No Training; Reading an	Article/Manual				
Cost	Not Free					
Actual Cost	Information about purch	asing the LIFE-H can be found at the iNDCP				
Age Range	Infant: birth-23 months; Adolescent: 13-17 years	Preschool Child: 2-5 years; Child: 6-12 years; ; Adult: 18-64 years; Elderly adult: 65+				
Administration Mode	Paper/Pencil					
Diagnosis	Cerebral Palsy; Multiple S	Sclerosis; Spinal Cord Injury; Stroke				
Populations Tested	Cerebral Palsy					
	Geriatrics					
	Multiple Sclerosis					
	Older adults with dis	abilities				
	Pediatrics					



	SCI						
	Stroke						
	Traumatic Brain Injury						
Standard Error of Measurement	Older Adults:						
(SEM)	(Lemmens et al, 2006; n =	85 adults with f	unctional limitations and $n = 40$ healthy				
	adults; sample included va	rious chronic illr	nesses; dutch sample, Older Adults)				
	Life-H Standard Error of	Measurement					
	LIFE-H categories	SEM					
	Nutrition	1.25					
	Fitness	1.51					
	Personal care	0.89					
	Communication	0.89					
	Residence	1.25					
	Mobility	1.60					
	Responsibility	1.38					
	Social relations	1.60					
	Community	0.99					
	Education	N/A					
	Employment	N/A					
	Recreation	1.56					
	Daily activities	0.78					
	Social roles	0.92					
	Total score	0.76	0.76				
		SEM = standard error of measurement					

(Noreau et al, 2004; n=40; mean age = 76.5(8.6) years; calculated from standard deviation and ICC values given in Table 4)

LIFE-H	SEM
Personal care	0.47
Nutrition	0.70
Housing	0.56
Mobility	1.03
Communication	0.55
Fitness	1.34
Daily Activities Sub-score	0.24
Responsibility	0.40



Community life Recreation0.78 2.15 Interpersonal relationshipsItinimal Detectable hange (MDC)Older Adults with Disabilities: (Noreau et al, 2004; $n = 40$; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities)LIFE-HMDC Personal care1.30 Nutrition1.93 HousingHousing1.56 MobilityAdult Sub-score0.68Mobility2.85 CommunicationItinimally Clinically ifference (MCID)Not EstablishedInterpersonal relationships Education/EmploymentNot EstablishedNot EstablishedUt-Off ScoresNot EstablishedInterpersonal relationships Interpersonal relationshipsInterpersonal relationships Interpersonal relationshipsIter Adults: (Desrosiers et al, 2009; $n = 350$ randomly recruited community-dwelling adults, Older Adults)Life-H Norms by Age Group: RegensibilishedLife-H Norms by Age Group: RegensibilityLife-H Norms by Age Group: RegensibilityLife-H Norms by Age Group: RegensibilityLife-H Norms by Age Group:								
Recreation 2.15 Interpersonal relationships Education/Employment N/A Social Roles Sub-score 0.49 Total Score Minimal Detectable Change (MDC) Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities) LIFE-H MDC Personal care 1.30 Nutrition Personal care 1.30 Nutrition 1.93 Housing Housing 1.56 Mobility 2.85 Communication Communication 1.52 Fitness 3.71 Daily Activities Sub-score Interpersonal relationships		Community life	0	78				
Interpersonal relationships Education/Employment N/A Social Roles Sub-score 0.49 Total Score 0.25 Winimal Detectable Change (MDC) Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities) LIFE-H MDC Personal care Nutrition 1.30 Nutrition Nutrition 1.56 Mobility Communication 1.56 Communication Daily Activities Sub-score 0.67 Responsibility Daily Activities Sub-score 0.68 Winimally Clinically Important Difference (MCID) Not Established Social Roles Sub-score 1.36 Total Score Not Established Social Roles Sub-score Vormative Data Older Adults: (Desrosiers et al, 2009; n = 350 randomly recruited community-dwelling adults, Older Adults) Life-H Norms by Age Group: Ife-H Norms by Age Group: Interpessonal care 0.06 Daily activities p 65-69 70-74 Daily activities p 0.68 Social Roles (0.9) 8.6 (0.9) 8.6 (0.5) 8.7 (0.5) 8.4 (0.8) Personal care		Recreation	2	.15				
Education/Employment N/A Social Roles Sub-score 0.49 Total Score 0.25 Winimal Detectable Change (MDC) Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities) LIFE-H MDC Personal care 1.30 Nutrition Mobility 2.85 Communication 1.52 Fitness Gordan Zare 1.40 Nutrition 1.93 Housing Housing 1.56 Mobility 0.67 Responsibility Mobility 2.85 Communication 1.52 Fitness Community life 2.17 Responsibility 1.10 Community life Correstore 0.67 Responsibility 1.10 Community life Correstore 0.68 Virial Score Minimally Clinically Important Difference (MCID) Not Established Cut-Off Scores Not Established Normative Data Older Adults: (Desrosiers et al, 2009; n = 350 randomly recruited community-dwelling adults, Older Adults) Life-H Norms by Age Group: Age Range Daily activities p Daily activities p 65-69 70-74 75-79 80-84 Nutrition Dialy activities <t< td=""><td></td><td>Interpersonal relationships</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>		Interpersonal relationships						
Social Roles Sub-score 0.49 Total Score Minimal Detectable Change (MDC) Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities) LIFE-H MDC Personal care 1.30 Housing Hurrition 1.93 Housing 1.56 Mobility Housing 1.56 Mobility 2.85 Communication Communication 1.52 Fitness 3.71 Daily Activities Sub-score Daily Activities Sub-score 0.667 Responsibility 1.10 Community Ife Social Roles Sub-score 0.68 Minimally Clinically Important Difference (MCID) Not Established Normative Data Older Adults: (Desrosiers et al, 2009; n = 350 randomly recruited community-dwelling adults, Older Adults) Life-H Norms by Age Group: Daily activities Fe-69 Fo-69 Fo-74 Fo-79 F		Education/Employment	N	I/A				
Total Score0.25Minimal Detectable Change (MDC)Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities)LIFE-HMDC Personal care1.30 Nutrition1.93 HousingHousing1.56 MobilityMobility2.85 CommunicationCommunication1.52 FitnessFitness3.71 Daily Activities Sub-scoreDaily Activities Sub-score0.667 ResponsibilityResponsibility1.10 Community lifeCommunity life2.17 RecreationRecreation/EmploymentN/A Social Roles Sub-scoreNot EstablishedDifference (MCI D)Cut-Off ScoresNot EstablishedNormative DataOlder Adults: (Desrosiers et al, 2009; n = 350 randomly recruited community-dwelling adults, Older Adults)Life-H Norms by Age Group:Daily activitiesp65-6970-7475-7980-84 Rol (1.3) 7.9 (1.2)Nutrition0.978.1 (1.3) 7.9 (1.2)8.0 (1.4)Baily activitiesp65-6970-7475-7980-84 Rol (1.3)Nutrition0.978.1 (1.3) 7.9 (1.2)8.0 (1.4)8.0 (0.3) 8.8 (0.3)8.4 (0.3)8.1 (0.4) 8.6 (0.4)8.0 (0.4)Personal care< 0.001		Social Roles Sub-score	0.	.49				
Minimal Detectable Change (MDC) Older Adults with Disabilities: (Noreau et al, 2004; n = 40; mean age = 76.5 (8.6) years; calculated fro standard deviation and ICC values given in Table 4, Older Adults with Disabilities) LIFE-H MDC Personal care 1.30 Nutrition 1.93 Housing 1.56 Mobility 2.85 Communication 1.52 Fitness 3.71 Daily Activities Sub-score 0.67 Responsibility 1.10 Community life 2.17 Recreation 5.95 Interpersonal relationships - Education/Employment N/A Social Roles Sub-score 1.36 Total Score 0.68 Not Established Not Established Normative Data Older Adults: (Desrosiers et al, 2009; n = 350 randomly recruited community-dwelling adults, Older Adults) Life-H Norms by Age Group: Age Range Daily activities p 65–69 70–74 75–79 80–84 Nutrition 0.97 8.1 (1.3) 7.9 (1.2) 8.0 (1.4) 8.0 (1.4) 80.1 (4.9) 80.1 (4.9) 80.1 (4.		Total Score	0.	25				
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$\begin{tabular}{ c c c c c c c } \hline Community life & 2.17 \\ \hline Recreation & 5.95 \\ \hline Interpersonal relationships & \\ \hline Education/Employment & N/A \\ \hline Social Roles Sub-score & 1.36 \\ \hline Total Score & 0.68 \\ \hline \hline Total Score & 0.68 \\ \hline \hline Not Established \\ \hline \hline Not Established \\ \hline \hline Cut-Off Scores \\ \hline Not Established \\ \hline \hline Cut-Off Scores \\ \hline Not Established \\ \hline \hline Cut-Off Scores \\ \hline \hline Interpersonal relationships & \\ \hline \hline Cut-Off Scores \\ \hline \hline Interpersonal relationships & \\ \hline \hline Interpersonal Roles & V \\ \hline \hline \hline Interpersonal relationships & \\ \hline Interpersonal relationships & \\ \hline \hline Interpersonal relationships & \\ $		Responsibility	1.	10				
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Life-H Norms by Age Group: Daily activities p 65–69 70–74 75–79 80–84 Nutrition 0.97 8.1 (1.3) 7.9 (1.2) 8.0 (1.4) 8.0 (1.4) Fitness 0.06 8.6 (0.9) 8.6 (0.5) 8.7 (0.5) 8.4 (0.8) Personal care < 0.001			. 550 Tan	donny n		Jonning	wenng	Ciù
Life-H Norms by Age Group: Daily activities p 65–69 70–74 75–79 80–84 Nutrition 0.97 8.1 (1.3) 7.9 (1.2) 8.0 (1.4) 8.0 (1.4) Fitness 0.06 8.6 (0.9) 8.6 (0.5) 8.7 (0.5) 8.4 (0.8) Personal care < 0.001		adults, Older Adults)						
Daily activities p 65-69 70-74 75-79 80-84 Nutrition 0.97 8.1 (1.3) 7.9 (1.2) 8.0 (1.4) 8.0 (1.4) Fitness 0.06 8.6 (0.9) 8.6 (0.5) 8.7 (0.5) 8.4 (0.8) Personal care < 0.001		Life-H Norms by Age Gro	oup:					
Daily activities p 65–69 70–74 75–79 80–84 Nutrition 0.97 8.1 (1.3) 7.9 (1.2) 8.0 (1.4) 8.0 (1.4) Fitness 0.06 8.6 (0.9) 8.6 (0.5) 8.7 (0.5) 8.4 (0.8) Personal care < 0.001						Age Rang	ge	
Nutrition0.978.1 (1.3)7.9 (1.2)8.0 (1.4)8.0 (1.4)Fitness0.068.6 (0.9)8.6 (0.5)8.7 (0.5)8.4 (0.8)Personal care< 0.001		Daily activities	p	65–69	70–74	75–79	80–84	
Fitness0.068.6 (0.9)8.6 (0.5)8.7 (0.5)8.4 (0.8)Personal care< 0.001		Nutrition	0.97	8.1 (1.3) 7.9 (1.2	2) 8.0 (1.4)	8.0 (1.4)	7.9
Personal care < 0.001 8.9 (0.2) 8.8 (0.3) 8.8 (0.3) 8.7 (0.3)		Fitness	0.06	8.6 (0.9) 8.6 (0.5	5) 8.7 (0.5)	8.4 (0.8)	8.4
		Personal care	< 0.001	8.9 (0.2) 8.8 (0.3	8) 8.8 (0.3)	8.7 (0.3)	8.6
Communication < 0.001 8.8 (0.3) 8.6 (0.6) 8.7 (0.4) 8.5 (0.7)		Communication	< 0.001	8.8 (0.3) 8.6 (0.6	6) 8.7 (0.4)	8.5 (0.7)	8.3
Housing $0.003 - 7.6 (0.9) - 7.3 (0.9) - 7.2 (0.8) - 7.5 (0.9)$		Housing	0.003	76(00)73(00)	(0,1)	75(09)	7 1



						1		
	Mobility	< 0.001	8.6 (0.7)	8.6 (0.6)	8.2 (1.1)	7.9 (1.2)	7.5 (1.7)	
	Daily activities subscore	< 0.001	8.4 (0.3)	8.3 (0.3)	8.3 (0.4)	8.2 (0.4)	8.0 (0.5)	
	Social roles	р	65–69	70–74	75–79	80–84	85+	
	Responsibilities	0.09	8.3 (0.8)	8.3 (0.8)	8.5 (0.7)	8.5 (0.9)	8.2 (1.0)	
	Interpersonal relationships	0.46	8.5 (0.8)	8.6 (0.8)	8.5 (1.0)	8.7 (0.7)	8.4 (1.0)	
	Community life	< 0.001	8.8 (0.7)	8.7 (0.6)	8.6 (0.8)	8.5 (1.0)	8.1 (1.6)	
	Leisure	< 0.001	7.5 (1.5)	7.9 (1.3)	7.0 (2.2)	7.4 (2.0)	6.4 (2.5)	
	Social roles subscore	< 0.001	8.4 (0.5)	8.5 (0.5)	8.3 (0.6)	8.4 (0.7)	7.9 (1.0)	
	Total score	< 0.001	8.4 (0.3)	8.4 (0.3)	8.3 (0.4)	8.3 (0.5)	8.0 (0.6)	
Test-retest Reliability	Children and Adults with	impairn	nents:					
Kenabinty	(Noreau et al, 2002; Review	v of stud	ies regar	ding socia	al particip	ation with	ר various	
	impairments in adults and c	hildren;	<i>n</i> = 24 ch	hildren & 2	25 adults	with SCI,	, Children	
	and Adults with Impairment	s)						
	Short form total score							
	Adequate for c	hildren (ICC = 0.0	67)				
	Excellent for adults (ICC = 0.83)							
	Long form total score							
	Excellent for c	hildren (ICC = 0.8	30)				
	Excellent for a	adults (IC	C = 0.89)				
	Children with Cerebral Pa	lsy:						
	(Sakzewski et al, 2007; Rev	view of p	articipatio	on measu	ires for c	hildren wi	th CP	
	aged 5 to 13; $n = 48$, Childr	en with	CP)					
	Total Score Short Form	n	,					
	Poor ICC = 0.6	67						
	Total Score Long Form							
	Adequate ICC= 0.73							
	Elderly Poonle with Disabilities							
	(Noreau et al. 2004: test-ret	test stud	v <i>n</i> = 40:	mean ad	e = 76.5	(8.6): aer	nder =	
	female 29 (72.5): interval between 2 time frames $= 5.10$ days. Elderly Decole							
	with Disabilities)							
	Total Score: ICC = 0.95	5 (Excell	ent)					
	Daily Activities Subscor	re: ICC =	= 0.96 (E)	(cellent)				
	Social Roles Subscore:	ICC = 0).76 (Ade	quate)				
	LIFE-H Categories				ICC			
	Daily Activities							
	Dorsonal Cara		Evee	llopt	0.07			
	reisonal care		EXCE	nent	0.97			



Nutrition	Excellent	0.90
Housing	Excellent	0.78
Mobility	Excellent	0.76
Communication	Excellent	0.75
Fitness	Poor	0.30
Subscore	Excellent	0.96
Social Roles		
Responsibility	Excellent	0.89
Community Life	Excellent	0.83
Recreation		0.55
Interpersonal Relationships	Limited info	
Subscore	Excellent	0.76
Total Score	Excellent	0.95

Myotonic Dystrophy:

(Gagnon et al, 2006; n = 28; mean age of 52.7 (10.01) years; diagnosed with myotonic dystrophy confirmed by DNA; 2 weeks between assessments, Myotonic Dystrophy)

LIFE-H Test re-test Reliability					
Category	T1 Mean (SD)	T2 Mean (SD)	Strength	ICC	
Nutrition	8.1 (2.1)	8.4 (1.9)	Excellent	0.92	
Personal Care	8.8 (1.4)	9.0 (1.1)	Adequate	0.86	
Mobility	6.2 (3.4)	6.5 (2.8)	Adequate	0.79	
Housing	6.1 (1.9)	6.7* (1.4)	Poor	0.73	
Fitness	8.5 (1.5)	9.1* (1.2)	Poor	0.20	
Communication	9.5 (0.6)	9.6 (0.4)	Poor	0.12	
Daily Activities Subscore	8.0 (1.3)	8.3* (1.0)	Adequate	0.80	
Interpersonal Relationships	8.6 (1.6)	8.6 (1.7)	Adequate	0.87	
Community Life	6.6 (3.6)	6.6 (3.5)	Adequate	0.83	
Recreation	6.3 (3.0)	7.4* (3.5)	Adequate	0.79	
Responsibility	8.1 (2.2)	8.5 (1.7)	Adequate	0.76	


Social Roles Subscore	7.2 (2.2)	7.4 (1.9)	Excellent	0.91
LIFE_ (total score)	7.7 (1.6)	7.9* (1.3)	Adequate	0.86
*p < 0.05				

Older Adults with Disabilities:

(Poulin & Desrosiers, 2009; n = 30; mean age 79.4 (7.1); 56.7% female; having significant functional disabilities according to SMAF; recruitment from inpatient rehab unit or short-term geriatric care unit of HSSC-UIGS (Canadian sample) in last 5 years, Older Adults with Disabilities)

(100

Excellent test-retest reliability for total score (ICC = 0.88)

Categorical test-retest reliability:

Excellent for communication (ICC = 0.88)
Excellent for fitness (ICC = 0.76)
Excellent for housing (ICC = 0.75)
Adequate for personal care (0.73)
Adequate for nutrition (ICC = 0.69)
Adequate for mobility (ICC = 0.69)
Excellent for daily activities (ICC = 0.84)
Excellent for leisure (ICC = 0.87)
Excellent for interpersonal relationships (ICC = 0.87)
Excellent for responsibilities (ICC = 0.80)
Adequate for community life (ICC = 0.65)

Excellent for social roles (ICC = 0.85)

Older Adults with Stroke :

(Lemmens, et al, 2007; n = 35; mean age = 59 (7.7); gender = male 49%, Older Adults with Stroke)

The Dutch LIFE-H showed excellent test-retest reliability (ICC = 0.80) for the total score

ICC values for subscale scores varied: ranging from 0.21 for social

relationships to 0.88 for personal care

LIFE-H Categories		ICC
Nutrition	Adequate	0.72
Fitness	Adequate	0.47
Personal Care	Excellent	0.88
Communication	Excellent	0.81
Residence	Adequate	0.57
Mobility	Adequate	0.55



Responsibility	Adequate	0.68
Social Relations	Poor	0.21
Community	Excellent	0.87
Education		NA
Employment		NA
Recreation	Adequate	0.66
Daily Activities	Excellent	0.78
Social Roles	Excellent	0.78
Total Score	Excellent	0.80

Spinal Cord Disorders (Adult and Pediatrics):

	(Fougeyrollas et al. 1998; $n = 49$, children $n = 24$, adults $n = 25$; mean age years										
	= children: 10.9 (4	= children: 10.9 (4.7), adults: 42.5 (13.1); duration of injury = children: 10.9 (4.7)									
	vears adults: 12	2 (8 2) vears:	gender – chil	dren: 16 female	8 male: adults: 3						
		2 (0.2) years,	gender – enn	idicit. To ternale,	o maie, addito. o						
	Ternale, 22 male,	Spinal Cold D	isorders)								
	Adequate level of reliability for the children and the adult samples (ICC =										
	0.73 and	0.74, respecti	vely).								
	Taken individ	ually, a majori	ty of life habi	t categories have	shown a adequate						
	to excelle	nt reliability le	vel (ICC >= (0.50) while a few	life habit categories						
	such as t	he internersor) al relationshi	in or nutrition sho	wed a noor						
	roliability										
	Adults with Sp	oinal Cord Inju	ry: ICC = 0.8	33-0.95							
Interrater/Intrarat	Children (Cerebr	al palsy, my	elomeningo	coele. sensorv-n	notor neuropathy.						
er Reliability	traumatic brain i	niury develo	nmental del	av).	<u> </u>						
	(Norsey et al. 200		oto Childron	with Dischilition)							
	(Noreau et al, 200	n, n=91 pare	ns, children	with Disabilities)							
	D '		100		100						
	Dimensions										
	Daily Activities	E	0.05	— ———————————————————————————————————	0.01						
	Communication	Excellent	0.95	Excellent	0.91						
	Personal Care	Excellent	0.94	Excellent	0.92						
	Housing	Excellent	0.93	Excellent	0.93						
	Mobility	Excellent	0.91	Excellent	0.88						
	Nutrition	Excellent	0.86	Excellent	0.82						
	Fitness	Excellent	0.83	Excellent	0.80						
	Social Roles										
	Recreation	Excellent	0.92	Excellent	0.87						
	Responsibility	Excellent	0.90	Excellent	0.91						
	Education	Excellent	0.90	Excellent	0.82						



Community Life	Excellent	0.78	Excellent	0.78
Interpersonal Relationships	Adequate	0.58	Adequate	0.63
Relationships				

Children with Cerebral Palsy:

(Sakzewski et al, 2007; Review of participation measures for children with CP

aged 5 to 13; n = 48, Children with CP)

Intrarater ICC

Daily Activities 0.82-0.96 Excellent

Social Roles > 0.90 Excellent

Interpersonal relationships 0.64 Adequate

Interrater ICC

0.70-0.91 Adequate to Excellent

Interpersonal relationships 0.62 Adequate

Elderly with Physical Disabilities:

(Noreau et al, 2004; n = 44; mean age = 80.0(7.7) years, Elderly with Physical Disabilities)

Excellent interrater reliability (ICC = 0.89)

LIFE-H	ICC	Level of Reliability
Nutrition	0.72	Adequate
Fitness	0.33	Poor
Personal Care	0.95	Excellent
Communication		
Housing	0.49	Adequate
Mobility	0.61	Adequate
Daily activities sub-score	0.91	Excellent
Responsibilities	0.72	Adequate
Interpersonal relationships		
Community life	0.70	Adequate
Leisure/Recreation	0.55	Adequate
Education/Employment	N/A	N/A
Social roles sub-score	0.64	Adequate
Total Score	0.89	Excellent

Myotonic Dystrophy:

(Gagnon et al, 2006; n = 26; mean age of 52.7 (10.01) years; diagnosed with myotonic dystrophy confirmed by DNA; 2 weeks between assessments)

LIFE-H Inter-rater reliability								
Category	T2 Mean (SD)	T3 Mean (SD)	Strength	ICC				
Personal care	9.0 (1.1)	8.7 (1.4)	Adequate	0.87				
Mobility	6.2 (2.8)	6.3 (2.7)	Adequate	0.84				
Housing	6.6 (1.4)	6.7 (1.8)	Adequate	0.76				



	Nutrition	8.3 (1.9)	8.5 (1.6)	Poor	0.68			
	Communication	9.6 (0.4)	9.5 (0.6)	Poor	0.47			
	Fitness	9.1 (1.2)	8.4* (1.3)	Poor	0.21			
	Daily activities subscore	8.3 (1.0)	8.0 (1.3)	Adequate	0.86			
	Responsibility	8.5 (1.7)	9.2* (1.0)	Poor	0.56			
	Interpersonal relationships	8.6 (1.7)	8.7 (1.7)	Adequate	0.84			
	Community life	6.5 (3.5)	6.5 (3.7)	Excellent	0.93			
	Recreation	7.0 (3.7)	6.8 (3.4)	Adequate	0.75			
	Social roles subscore	7.4 (1.9)	7.6 (1.9)	Excellent	0.92			
	LIFE-H (total score)	7.9 (1.3)	7.8 (1.5)	Excellent	0.90			
	* <i>p</i> < 0.05		, , ,					
Internal Consistency	Children and Adults with (Noreau et al, 2002; Review	Impairments: w of studies reg	arding social p	participation	n with			
	and Adults with Impairments) Short form Cronbach alpha ≥ 0.82 Excellent Long form Cronbach alpha ≥ 0.90							
	Excellent							
	(Sakzewski et al, 2007; Rev aged 5 to 13; <i>n</i> = 48, Childr Daily Activities Excellent alph Social Roles Excellent alph Categories	view of participa ren with CP) a 0.97 a 0.90	ation measure	s for childre	en witt			
	Moderate to Excellent alpha 0.73-0.90 Interpersonal relationships							
	Poor alpha 0.40							
	(Noonan et al, 2009; Review of SCI instruments, SCI) Excellent: Internal Consistency (= 0.83)							
	<u>Stroke</u> : (Tse et al, 2013; Systematic stroke; n = 119 studies) Excellent: Short Form	c review of 36 p Internal Consis	participation m	easures for ach alpha (c	[.] pers ᡘ) <u>></u> 0			
Criterion Validity (Predictive/Concur	Children with Cerebral Pa	alsy:						
rent)	(Sakzewski et al, 2007; Revaged 5 to 13; $n = 48$, Childr	view of participa ren with CP)	ation measure	s for childre	en wit			



	Domains of	PEDI, WeeFIM, Life-I	ł			
	Self	-care <i>r</i> = 0.83-0.94				
	Edu	cation/recreation: 0.7	9-0.91			
Construct Validity (Convergent/Discri minant)	Children and Adults with impairments : (Noreau et al, 2002; Review of studies regarding social participation with various impairments in adults and children, Children and Adults with Impairments) Between Life-H and CHART; N = 482 Adults SCI Spearman's rho Physical independence: • Excellent 0.76 Occupation • Adequate 0.36 Mobility • Adequate 0.33 Social integration • Poor 0.14 Between Life-H and CIQ N = 30 adults TBI Home integration • Adequate 0.56 Social integration • Adequate 0.54 Productive activities • Excellent 0.75 Children with Disabilities (Cerebral palsy, myelomeningocoele, sensory-motor neuropathy, traumatic brain injury, developmental delay): (Noreau et al, 2007; n = 91 parents, Children with Disabilities)					
	 H Personal care and Housing dimensions (0.79 < <i>r</i> < 0.88) and PEDI Social function was strongly associated with LIFE-H categories, Communication and Responsibility (<i>r</i> = 0.80-0.81) High correlations between LIFE-H Housing and Personal care with Functional Independence Measure for Children (WeeFIM) Self-care, <i>r</i> = 0.90-0.94; LIFE-H and WeeFIM communication, <i>r</i> = 0.89) Divergent validity: Associations of all PEDI dimensions with some LIFE-H dimensions were weaker (Interpersonal relationships and Community life), supporting a distinctiveness between the two constructs: activities of daily living (ADL) and social roles WeeFIM cognitive dimensions (communication and social cognition) showed a 					
	lower association with LIFE-H motor dimensions (i.e. mobility, <i>r</i> = 0.43-0.49 respectively). <u>Children with Disabilities</u> : Convergent Validity					
	females; mean a LIFE-H for Children	age 8y 10mo (2y 6),C PEDI Functional Skills	hildren with Disabilities PEDI Caregiver Assistance			



	Self-	Mobility	Social	Self-	Mobility	Social
	Care		Function	care		Function
Nutrition	0.71	0.67	0.70	0.71	0.64	0.69
Fitness	0.68	0.69	0.63	0.70	0.73	0.56
Personal care	0.79	0.82	0.61	0.88	0.80	0.57
Communication	0.76	0.61	0.81	0.75	0.62	0.79
Housing	0.79	0.88	0.61	0.81	0.84	0.55
mobility	0.56	0.68	0.40	0.63	0.65	0.32
Responsibility	0.70	0.67	0.80	0.71	0.66	0.76
Interpersonal Relationships	0.51	0.50	0.66	0.50	0.48	0.63
Community Life	0.54	0.53	0.47	0.58	0.52	0.44
Education	0.69	0.69	0.60	0.74	0.65	0.56
Recreation	0.68	0.71	0.60	0.74	0.68	0.53
Associations bo	twoo		I for child	Iron c	nd DED	1

Associations between LIFE-H for children and PEDI (Pediatric Evaluation of Disability Inventory) as measured by Pearson's correlation coefficient; n = 94;

Multiple diagnosis (Neurologic, amputation, coronary, pulmonary, rheumatic disorder, other):

Convergent Validity

(Lemmens, et al, 2007; n = 63, mean age = 69 (7.7), chronic illness n = 66 (7.9); gender = male 56%, Multiple Diagnoses)

The correlations between the LIFE-H categories and total scores and the Impact on Participation and Autonomy Questionnaire (0.80-0.82) and London Handicap Scale (0.89-0.92) were excellent.

Discriminant Validity

(Lemmens, et al, 2007; n = 120, healthy older adults n = 40, patients with chronic illness n = 80; mean age healthy adults = 69 (7.7), chronic illness n = 66 (8.3); gender = healthy adults male 60%, chronic illness male 55%, Multiple Diagnoses)

Significant differences between the healthy and ill subjects for the 10

separate categories (P < 0.01) and the total score (P < 0.001)

Older Adults with Functional Limitations:

Convergent Validity

(Desrosiers et al., 2004; n = 87; mean age = 78.0 (8.2), Older Adults with Functional Limitations)

Adequate correlations found between LIFE-H and the Functional Autonomy Measurement System (SMAF) total scores (0.70, p < 0.0001)

Discriminant Validity

(Desrosiers et al., 2004; n = 87; mean age = 78.0 (8.2), Older Adults with Functional Limitations)

Participants living in private nursing homes obtained higher scores, followed by those living at home and finally by those living in long-term care units. These variations in scores between the living environments, which are supported by differences in disability levels (SMAF scores), indicate a good level of discriminant validity for the nLIFE-H, particularly in the daily activities.

Spinal Cord Injury:

(Dumont et al, 2003; *n* = 1771; current mean age = 44.5 (15); gender=male 81.4%, SCI)



- Rasch analysis showed satisfactory measurement properties (person reliability = 0.91), and high agreement with expert opinion (items hierarchy r = 0.89)
- Item difficulty hierarchy from spinal cord injury experts differed from hierarchy from traumatic brain injury experts, suggesting that the construct varies across impairment groups

Convergent Validity

(Noreau et al, 1998; n = 482; mean age = 42 (12) years; no other information available; information from abstract, SCI)

Convergent validity was demonstrated by correlations between grouped LIFE-H items and corresponding CHART dimensions: 0.14 for social integration, through 0.33 and 0.36 for mobility and occupation, to 0.76 for physical independence

Stroke:

(Desrosiers et al, 2003; n = 132; mean age = 69.9 (13.5); mean rehab stay = 79.0 (45.5) days; 2-week (T3) and 6 month (T4) post rehabilitation, Acute Stroke)

LIFE-H, SMAF & FIM Correlations:									
	Time	e 3 (n = 118)	Time	e 4 (n = 102	<u>?)</u>			
LIFE-H Domain	SMAF (total score)	FIM (total score)	p value	SMAF (total score)	FIM (total score)	p value			
LIFE-H (total score)	0.85*	0.79	0.001	0.89	0.85	0.006			
Personal care	0.87	0.85	0.13	0.92	0.90	0.08			
Housing	0.70	0.65	0.02	0.77	0.74	0.11			
Nutrition	0.69	0.63	0.009	0.63	0.61	0.17			
Mobility	0.59	0.52	0.005	0.62	0.58	0.08			
Communication	0.52	0.52	1.00	0.56	0.56	1.00			
Fitness	0.38	0.38	1.00	0.58	0.58	1.00			
Daily activities subscore	0.89	0.85	0.007	0.91	0.88	0.03			
Responsibility	0.68	0.63	0.03	0.72	0.64	0.001			
Community	0.66	0.57	0.001	0.74	0.67	0.001			
Education/ employment	0.45	0.35	0.001	0.49	0.43	0.02			
Leisure	0.22	0.21	0.73	0.32	0.31	0.71			
Interpersonal relationships	0.06	0.05	1.00	0.30	0.33	0.26			
Social roles subscore	0.66	0.57	0.001	0.77	0.71	0.006			

SMAF = syste`me de mesure de l'autonomie fonctionnelle

FIM = functional independence measure

* Pearson correlation coefficients: at time 3, all significant at the 0.001 level



Stroke :

(Desrosiers et al, 2005; n_{stroke} = 46, n_{healthy} = 46; mean age_{stroke}= 72.5 (11.5) years, mean age _{healthy}= 73.0 (11.4)years; time post stroke = 4-6 years; French and English sample, Stroke)

LIFE-H- Comparison	Difference (1-ratio)
between stroke patients and	<u>and (95% CI)</u>
healthy elderly	
Nutrition	0.45 (0.35-0.55)
Fitness	0.25 (0.18-0.31)
Personal Care	0.39 (0.30-0.47)
Communication	0.21 (0.09-0.32)
Housing	0.31 (0.22-0.39)
Mobility	0.33 (0.21-0.44)
Daily activities sub-score	0.33 (0.26-0.39)
Responsibilities	0.19 (0.09-0.28)
Interpersonal relationships	0.01 (-0.08-0.06)
Community life	0.47 (0.35-0.48)
Leisure/Recreation	0.38 (0.12-0.63)
Education/Employment	0.69 (0.44-0.95)
Social roles sub-score	0.24 (0.16-0.31)
Total Score	0.29 (0.22-0.36)

Content Validity

Evaluated by an extensive development process involving consultation with 12 international experts including researchers, services providers, and consumer representatives. Experts concluded that the LIFE-H items covered most of a person's life habits (ADL and social roles) and it could be used to determine the appearance of handicap situations. The instrument was refined based on clinical evaluation (Fougeyrollas et al, 1998)

LIFE-H for children (Cerebral palsy, myelomeningocoele, sensory-motor neuropathy, traumatic brain injury, developmental delay) :

(Noreau et al, 2007, Children with Disabilities)

Content validity was established with the help of an expert panel (n = 29), comprising parents of children with functional limitations (n = 11), experienced pediatric clinicians (n = 15), and researchers (n = 3)

The panel reviewed the content of the LIFE-H for its overall relevance for children from 5 to 13 years old



	They assessed the comprehensiveness and clarity of the wording of the measure
	Acording to Tse et al (2012) the LIFE-H has content validity because it is based on the Disability Creation Process Model and was developed and reviewed by experts
Face Validity	Acording to Tse et al (2012) the LIFE-H has face validity because it is based on the Disability Creation Process Model and was developed and reviewed by experts
Floor/Ceiling Effects	Children With Congenital Hemiplegia: (Sakzewski et al, 2011; <i>n</i> = 64; mean age = 10.2 (2.7) years, Children with Congenital Hemiplegia) Ceiling effects were observed with LIFE-H categories including community life and interpersonal relationships
	SCI: (Noreau & Fougeyrollas, 2000; <i>n</i> = 482; mean age = 42.4 (12.1); time since injury = 13 (6.8) years; type of injury = Complete Tetraplegia 24.6%, Incomplete Tetraplegia 19.5%, Complete Paraplegia 38.0%, Incomplete Paraplegia 18.3%Chronic SCI) The LIFE-H has demonstrated low ceiling effects
Responsiveness	Spouses of Individuals with First Time Stroke: (Rochette et al, 2007; $n = 54$ spouses; time periods of assessment = before stroke (retrospectively), at 2 weeks, and at 6 months post stroke, Spouses of Individuals with First Time Stroke)At 2 weeks (T1): moderate effect size for LIFE-H total score (0.53), small for ADL sub core (0.0) and large for social roles subscore (0.90)At 6 months post stroke (T2): small effect side for LIFE H Total score (0.38), ADL subscore (0.13), and moderate for Social role subscore (0.76)Changes in participation were larger for personal relationships (T1 = 0.67; T2 = 0.83),, employment (T1 = 0.68; T2 = 0.63), and recreation (T1 = 1.16; T2 = 0.93) , showing moderate to large effect sizesStroke: (Rochette et al, 2007 ($n = 35$; mean age = 72.3 (10.5); gender = male 42.9%; time periods of assessment = before stroke (retrospectively), at 2 weeks, at 3 months, and at 6 months post stroke, Mild Stroke) At 2 weeks: Large effect size for LIFE-H total score (1.21), ADL (1.15) and Social Roles (1.24) subscores6 months post stroke and 2 weeks post stroke: moderate effect sizes for LIFE-H total score (0.60), ADL sub sore (0.64) and Social role sub score (0.56)6 months post-stroke and before the stroke: moderate effect sizes for LIFE-H total score (0.62), ADL sub score (0.58) and Social role sub score (0.70)(Rochette et al, 2007; $n = 35$; mean age = 72.3(10.5) years; time post stroke = 2-3 weeks (T1), 3 months (T2), and 6 months (T3); severity > 8.5 on Canadian Neurological Scale; French and English sample, Stroke)



	LIFE-H		Effect Size T3-T1		
	Nutrition		0.35		
	Fitness		0.54		
	Personal Ca	re	0.67		
	Communica	tion	0.35		
	Housing		0.67		
	Mobility		0.44		
	Daily activit	ties sub-score	0.64		
	Responsibili	ties	0.29		
	Interpersona	al relationships	0.33		
	Community	life	0.60		
	Leisure/Rec	reation	1.41		
	Education/E	mployment	0.14		
	Social roles	s sub-score	0.56	_	
	Total Score		0.60		
Association Recommendations	Physical The Sclerosis Ta Injury Taskfo Injury Taskfo below. These clinical expe For detailed visit: http://w outcome-me	erapy of the American skforce (MSEDGE), P orce (PD EDGE), Strok orce (TBI EDGE), and e recommendations we rts using a modified De information about how ww.neuropt.org/go/he asures-recommendati	Physical Thera arkinson's Tas a Taskforce (S Vestibular Tas ere developed elphi process. r recommendat althcare-profe ons	apy Associat kforce (PD I StrokEDGE) kforce (VED by a panel o sions were n ssionals/neu	tion's Multiple EDGE), Spinal Cord , Traumatic Brain OGE) are listed of research and nade, please urology-section-
	Abbreviati	ons:			
	HR	Highly Recommend			
	R	Recommend			
	LS/UR	Reasonable to use, Recommend	but limited stud	dy in target o	group / Unable to
	NR	Not Recommended			
	Recommend	lations for use based of Acute (CVA < 2 mont post) (SCI < 1 month p (Vestibular <	n acuity level Sul hs (CV) mo oost) (SC 6 mo	of the patier bacute A 2 to 6 bonths) I 3 to 6 bonths)	nt: Chronic (> 6 months)

The LIFE-H is able to detect changes (total score effect size = 0.60)



Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	NR	R	R	R	R
TBI EDGE	NR	NR	NR	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant
TBI EDGE	N/A	N/A	N/A

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE II	No	Yes	Yes	Not reported
TBI EDGE	No	Yes	Yes	Not reported

Considerations

Evidence Based Review for Research (Magasi et al, 2007). The group identified the following considerations:

Low ceiling effects

The satisfaction scale appears to have little empirical support

Limited use in clinical practice and research

Conceptual foundation not widely known

Translations Available:

Danish

French

German

Italian

Swedish

Stroke:

(Poulin and Desrosiers, 2008; $n_{stroke} = 40$, $n_{proxy} = 40$; mean age of stroke patients = 73.6 (8.4) years; mean time post stroke = 43.5 (32.0) months; French sample, Stroke)

Excellent level of agreement between stroke patients and their proxies (ICC = 0.82) suggests that proxies are able to complete LIFE-H when stroke patients are unable to respond



	LIFE-H	<u>ICC</u>	Level of Reliability	
	Nutrition	0.76	Excellent	
	Fitness	0.61	Adequate	
	Personal Care	0.93	Excellent	
	Communication	0.59	Adequate	
	Housing	0.83	Excellent	
	Mobility	0.86	Excellent	
	Daily activities sub-score	0.87	Excellent	
	Responsibilities	0.63	Adequate	
	Interpersonal relationships	0.41	Adequate	
	Community life	0.92	Excellent	
	Leisure	0.82	Excellent	
	Education/Employment	N/A	N/A	
	Social roles sub-score	0.73	Adequate	
	Total Score	0.82	Excellent	
Bibliography	Do you see an error or have a suge e-mail us!	gestion f	or this instrument summ	hary? Please
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Year published	1997
Instrument in PDF Format	Yes
Approval Status	Approved

4. REHAB MEASURES DATABASE: BALANCE EVALUATION SYSTEMS TEST

Link to instrument	BESTest here (other languages below)
Title of Assessment	Balance Evaluation Systems Test
Acronym	BESTest
Instrument Reviewer(s)	Initially reviewed by Kirsten Potter, PT, DPT, MS, NCS and the MS EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 3/2011; Updated with the TBI population by Katie Hays, PT, DPT, and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 5/2012; Updated for PD population by Cathy Harro MS, PT, NCS and the PD EDGE Task Force of Neurology Section, APTA 3/2013. Updated for the Vestibular EDGE task force of the Academy of Neurologic Physical Therapy by Diane Wrisley PT, PhD, NCS and Elizabeth Dannenbaum MScPT 11/2013. Updated by Evan Papa DPT, PhD for the University of North Texas Health



	Sciences Center, DPT class of 2015. Updated by StrokEdge II Task Force: Dorian Rose, PhD, PT and Carmen Capo-Lugo, PhD, PT; May 2016.
Summary Date	8/25/2015
Purpose	The Balance Evaluation Systems Test (BESTest) serves as a 36-item clinical balance assessment tool, developed to assess balance impairments across six contexts of postural control: mechanical constraints, limits of stability, APAs, postural response to induced loss of balance, sensory orientation, and gait.
Description	 36 items Grouped into 6 systems (biomechanical constraints, stability limits/verticality, anticipatory postural adjustments, postural responses, sensory orientation, stability in gait) Total score of 108 points total, calculated in to a percentage score (0-100%). Also total sub-scores exist for each above listed system. Item-level scores range from 0 (severe impairment) to 3 (no impairment). Subjects are to be tested with flat heeled shoes, or with shoes and socks off. Subjects who must use an assistive device should be scored one category lower for that item. Training DVD available for purchase (http://bestest.us/) Administration instructions can be found at http://bestest.us/training/ Shortened into mini-BESTest and brief BESTest
Area of Assessment	Balance Non-Vestibular; Gait; Strength
Body Part	
ICF Domain	Body Structure; Body Function; Activity
Domain	
Assessment Type	Performance Measure
Length of Test	06 to 30 Minutes
Time to Administer	20-30 minutes, 30 minutes if untrained raters
Number of Items	36
Equipment Required	Stop watchMeasuring tape mounted on wall



	 Approximately 60 cm x 60 cm block of 4 inch, medium density, Tempur® foam 10 degree incline ramp (at least 2 x 2 ft) Stair step, 15 cm (6 inches) in height 2 stacked shoe boxes (for 9 inch obstacle height) 2.5 kg (5-lb) free weight Firm chair with arms with 3 meters in front marked with tape Masking tape to mark 3 m and 6 m lengths on the floor
Training Required	A training DVD is available for purchase. Workshops are available to become skilled in using the BESTest to differentiate complex balance disorders in neurological patients. Workshop participants develop the ability to design a more specific rehabilitation plan of care for balance retraining. A web portal is available through http://bestest.us/ containing instructional videos and scoring samples of each BESTest item, as well as explanations of the six main balance categories.
Type of training required	Reading an Article/Manual; Training Course
Cost	Free
Actual Cost	Training DVD is \$200. The BESTest protocol is free, but is subject to copyright.
Age Range	Elderly adult: 65+
Administration Mode	
Diagnosis	Geriatrics; Parkinson's Disease
Populations Tested	 Balance deficits Cerebellar Infarct Parkinson's Disease (PD) Peripheral neuropathy Vestibular dysfunction Subacute Stroke Multiple Sclerosis



Standard Error of Measurement (SEM)

Community dwelling adults with and without balance dysfunction: (Unilateral and bilateral dysfunction, Parkinson's disease, peripheral neuropathy, total hip arthroplasty):

(Horak et al, 2009; n = 19; age range 50-88; Session 1 n = 12, mean age = 63 (10); 5 female and 7 male; 3 Parkinsons, 2 unilateral vestibular loss, 3 bilateral vestibular loss, 1 peripheral neuropathy and total hip arthroplasty, 3 controls; Session 2 n = 11, mean age = 75 (7.6); 5 female, 6 male; 2 Parkinsons, 1 unilateral vestibular loss, 1 bilateral vestibular loss, 1 peripheral neuropathy and total hip arthroplasty, 6 controls)

• SEM calculated = 3.21

Parkinson's Disease:

(Leddy et al, 2011; n = 80; mean age = 68.2 (9.3) time since diagnosis = 8.5 (0.54) years; mean MDS-UPDRS score = 72.6 (25.1); mean Hoehn and Yahr scale stage = 2.45 (0.64), separated into fallers vs. nonfallers; subset of n = 15 used for interrater reliability testing, subset of n = 24 used for test retest reliability testing)

• SEM calculated = 2.35

(Leddy et al, 2011a; subset of subjects n = 24, MDS-UPDRS = 71 (21.9), disease duration mean 6.9 (3.38), 21% fallers)

• SEM calculated = 5.78

Subacute Stroke (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months)

SEM was not provided by this study, but was calculated.

- Standard Deviation = 28.19
- ICC = 0.99
- SEM = 2.819

Minimal Detectable Change (MDC) Community dwelling adults with and without balance dysfunction: (Horak et al, 2009)



	• MDC calculated = 8.9
	Parkinson's Disease:
	(Leddy et al, 2011)
	• MDC calculated = 6.5
	(Leddy et al, 2011a)
	• MDC calculated = 16.02
	<u>Subacute Stroke</u> (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months))
	MDC was not provided by this study, but was calculated.
	• MDC = 7.81
Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Balance Deficits:
	(Padgett PTJ 2012 ; 1^{st} cohort: n = 20 varied Dx (4 PD, 1 CVA, 4 MS, 1 PN, 1 tremor) and 9 healthy; 5 with positive fall history. 2^{nd} cohort: n = 13 with MS, mean age 50, EDSS < 6 (range 0-4.5), 7 fallers)
	 69% cut off score differentiated fallers from non-fallers, and healthy from those with neurologic diagnoses. Adequate ability to detect fallers (sensitivity = 0.86, specificity = 0.95, LR+ = 17.2, LR- = 0.46, accuracy = 92%)
	Parkinson's disease:
	(Leddy et al, 2011)
	 69% cut off score (sensitivity = 0.84, specificity = 0.76, LR+ = 3.49, LR- = 0.21, AUC = 0.85) to identify individual as a faller vs. non-faller



• Sensitivity higher for BESTest as compared to Functional Gait Assessment and Berg Balance Scale

(Duncan RP 2013 PTJ; Comparative utility of BESTest, Mini BESTest, and Brief BESTest; n = 80 with idiopathic PD, mean age = 68.2 (9.7), mean MDS-UPDRS 41.3 (14.7), H & Y stage [1=4, 2=27, 2.5=30, 3=13, 4=6]; retrospective fallers n = 25 (31%), 6 month prospective fallers n = 14 (27.5%), 12 month prospective fallers n = 13 (32.5%))

69% cut off score to detect fallers; Adequate for detecting retrospective fallers (sensitivity = 0.84, specificity = 0.76, LR+ = 3.49, LR- = 0.21, AUC = 0.84); Adequate for predicting 6 month prospective fallers (sensitivity = 0.93, specificity = 0.84, LR+ = 5.81, LR- = 0.08, AUC = 0.89); Poor for predicting 12 month prospective falls (sensitivity = 0.46, specificity = 0.74, LR+ = 1.77, LR- = 0.73, AUC = 0.68

(Duncan 2012 (Accuracy of fall prediction in PD); Baseline n = 80 PD, six-month evaluation n = 51 {mean age = 67.5 (8.8), years post diagnosis 7.7(3.9), H & Y stage 2.4 (0.6), UPDRS 37.8 (13.1), 27% fallers}; 12-month evaluation n = 40 {mean age 67.3 (9.5), years post diagnosis 7.2 (4.1), H&Y stage 2.3 (0.6), UPDRS 39.3 (13.3), 37% fallers})

69% cut off score; Adequate prediction of fallers at 6 months (sensitivity = 0.93, specificity = 0.84, LR+ = 5.81, LR- = 0.08, AUC = 0.89 (CI 0.74-0.95)); Poor prediction of fallers at 12 months (sensitivity = 0.46, specificity = 0.74, LR+ = 1.77, LR- = 0.73, AUC = 0.68 (CI = 0.45-.83))

Subacute Stroke (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months))

The following cut off scores help distinguish high functional ability from low functional ability:

- >49% indicates those with high functional ability
- Mini-Best > 9 indicates high functional ability
- BBS > 19 indicates high functional ability

Normative Data <u>Subacute Stroke</u> (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months))



	Mean (SD) BESTest score for all participants = 41.7 (28.19)				
	 Low Functional Ability Mean (SD) = 23.89 (18.87) 				
	•	High Functional Ability Mean (SD)	= 59.52	(24.82)	
Test-retest Reliability	Parkins	son's disease:			
	(Leddy	et al, 2011a)			
	•	Excellent test-retest reliability for	r total BE	ST score (ICC = 0.88) a	across
		the group. Adequate test-retest	reliability	for individuals (ICC = ?))
	•	Adequate to Excellent test-rete	st reliabili	ty for sections of the tes	st (ICC
		= 0.63-0.87 - see table below)			
		 Biomechanical Constrair 	nts (ICC =	= 0.69)	
		 Stability Limits/verticality 	' (ICC = 0	.63)	
		 Anticipatory Postural Co 	ntrol (ICC	c = 0.83)	
		 Postural Responses (IC) 	C = 0.87)		
		 Sensory Orientation (ICC) 	C = 0.72)		
		 Stability in Gait (ICC = 0 	.72)		
		Test Section	ICC	Rating	
		Total BEST Score	0.88	Excellent	
		Section 1: Biomechanical	0.69	Adequate	
		Constraints	0.02	Adamuata	
		Section 2: Stability	0.63	Adequate	
		Adjustments	0.00	LAGenenit	
		Section 4: Postural Adjustments	0.87	Excellent	
		Section 5: Sensory Orientation	0.72	Adequate	
		Section 6; Stability in Gait	0.72	Adequate	
	(Leddy	et al, 2011)			
	•	Excellent test re-test reliability (CC = 0.9	1 for PT students, 0.88	for PTs)
Interrater/Intrarat er Reliability	<u>Commu</u> 2009)	unity dwelling adults with and v	<u>vithout b</u>	alance deficits: (Horak	k et al,
	•	Excellent interrater reliability for	total sco	re (ICC = 0.91)	
	•	Excellent interrater reliability for	test subs	ections (range of ICC 0	.79-
		0.92)			
		 Biomechanical constrain 	ts (ICC =	0.80)	



- Stability limits / vertically (ICC = 0.79)
- Anticipatory postural adjustments (ICC = 0.92)
- Postural responses (ICC = 0.92)
- \circ Sensory orientation (ICC = 0.88)
- Stability in gait (ICC = 0.91)

(Padgett 2012: 1st cohort: n = 20 varied Dx (4 PD, 1 CVA, 4 MS, 1 PN, 1 tremor) and 9 healthy; 5 with positive fall history.)

• Excellent inter-rater reliability ICC = 0.985 (CI 0.959-0.994)

Parkinson's Disease (PD): (Leddy et al, 2011a, n = 15 people with PD; mean disease duration = 6.8 (3.26) years; MDS-UPDRS mean score = 74.2 (18.6); Hoehn and Yahr scale stage 1 = 2, stage 2 = 7, stage 2.5 = 3, stage 3 = 2, and stage 4 = 1)

- Excellent interrater reliability total score (ICC = 0.96, 95% CI = 0.89-0.99)
- Excellent Inter-rater reliability of subsections range from ICC= 0.79-0.96:

Test Section	ICC	Rating
Total BESTest Score	0.96	Excellent
Section 1 Biomechanical Constraints	0.81 (0.61- 0.92	Excellent
Section 2 Stability	0.79 (0.58- 0.92)	Excellent
Section 3 Anticipatory Postural Adjustments	0.91 (0.81- 0.97)	Excellent
Section 4 Postural Adjustments	0.91 (0.81- 0.97)	Excellent
Section 5 Sensory Orientation	0.96 (0.91- 0.95)	Excellent
Section 6 Stability in Gait	0.86 (0.62- 0.95)	Excellent

Parkinson's Disease:

(Leddy et al, 2011, subset of 15 participants)

• **Excellent** inter-rater reliability ICC = 0.96



	Subacute Stroke (Chinsongkram et al., 2014; n=12; mean age 58.2; time since stroke: 1.1±2.0 months))
	 Excellent interrater reliability: ICC= .99 Subsection ICCs = .9599 Excellent intrarater reliability: ICC= .99 Subsection ICCs = .8798
Internal Consistency	Balance Deficits:
	(Padgett 2012; 1^{st} cohort: n = 20 varied Dx (4 PD, 1 CVA, 4 MS, 1 PN, 1 tremor) and 9 healthy; 5 with positive fall history)
	• Excellent Average Cronbach's Alpha for 5 out of 6 BESTest subsections; poor for stability limits/verticality:
	 Biomechanical constraints = 0.830 Stability limits/verticality = 0.621 Anticipatory Postural adjustments = 0.874 Postural responses = 0.863 Sensory orientation = 0.813 Stability in gait = 0.920
Criterion Validity (Predictive/Concur rent)	Concurrent Validity: Community Dwelling with and without Balance Deficits:
	 (Horak et al, 2009) Excellent correlation between total BESTest and Activities-specific Balance Confidence Scale (ABC) (<i>r</i> = 0.636, p < 0.01) Adequate to excellent correlation between BESTest sub-section scores and ABC (<i>r</i> = 0.41-0.78) Parkinson's Disease (PD): (Leddy et al, 2011) Excellent correlation between total BESTest and ABC (<i>r</i> = 0.757) Excellent correlation between total BESTest and Berg Balance Scale (<i>r</i> = 0.873) Excellent correlation between total BESTest and Functional Gait Assessment (<i>r</i> = 0.882)



	(Leddy et al, 2011a)
	• Excellent correlation with miniBESTest (r = 0.955)
	Multiple Sclerosis (Jacobs and Kasser, 2012)
	 Excellent concurrent validity of the EDSS scores (r²= 0.85, P< 0.0005) Adequate concurrent validity for center of pressure displacements during leaning (r²=0.55, P<0.005)
	 Adequate concurrent validity of step velocity during step initiation (r²= 0.48, P<0.01)
	 Excellent concurrent validity for center of pressure displacements during postural response tasks (r²= 0.76, P<0.0001)
	 Peak anticipatory postural adjustment (APA) amplitudes do not significantly correlate with BESTest total scores (r²= 0.17, P= 0.16)
	 Peak anticipatory postural adjustment (APA) amplitudes do not significantly correlate with BESTest sectional scores (r²= 0.26, P= 0.074) Predictive Validity:
	Subacute Stroke: (Chinsongkram et al., 2014)
	 Adequate sensitivity (71.4%) in classifying high or low functional ability High specificity (91.4%) in classifying high or low functional ability Moderate positive likelihood ratio (LR+) (8.33) in classifying high or low functional ability
	 Moderate negative likelihood ratio (LR-) (0.31) in classifying high or low functional ability
	Multiple Sclerosis (Jacobs and Kasser, 2012)
	 High sensitivity (86%) to identify fallers High specificity (95%) to identify non-fallers
Construct Validity (Convergent/Discri	Community Dwelling Adults with and without Balance deficits:
	(Horak et al, 2009)
	 Subjects with balance deficits score significantly lower than healthy controls (p = 0.36)
	 Discriminated between people with different balance deficits: Poorer performance on Section V: Sensory orientation in subjects with vestibular disorders; Section IV: Postural Responses in those with PD; and Section III: Anticipatory Postural Adjustments in subjects with neuropathy
	Parkinson's Disease:
	(Leddy et al, 2011, FGA and BEST):
	Excellent correlation with:
	 Modified Hoehn and Yahr Scale (r = -0.736)



- MDS-UPDRS-3 (r = -0.758)
- MDS-UPDRS (r = -0.780)
- Discriminates fallers from non-fallers (scores < 69%) sensitivity 84%, Specificity 76%, area under curve 0.84

(Leddy et al, 2011, Utility of the mini-BEST):

- **Excellent** correlation with mini-BEST (r = 0.955)
- Statistically significant difference between BESTest scores in fallers (n = 25, mean score= 57.1% (15.4) and nonfallers (n = 55, mean score= 76.4% (13.6)

Parkinson's Disease:

(Duncan 2013; excellent correlation between BESTest and Brief BESTest r = 0.95)

Balance deficits:

(Padgett 2012)

	 1st cohort: (n = 20 varied Dx (4 PD, 1 CVA, 4 MS, 1 PN, 1 tremor) and 9 healthy; 5 with positive fall history). BESTest scores significantly differentiated between healthy and those with balance deficits; 2nd cohort: (n = 13 with MS, mean age 50, EDSS < 6 (range 0-4.5)_, 7 fallers) BESTest scores differentiated those with self-reported fall history (mean score = 77 and those without fall history (mean score = 96)
	Subacute Stroke: (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months)) Excellent correlation with the BBS (r = 0.96)
	• Excellent correlation with the PASS $(r = 0.96)$
	 Excellent correlation with the CB&B (r = 0.91)
	 Excellent correlation with the Mini-BEST (r = 0.96)
Content Validity	Not Established
Face Validity	Not Established
-	



Floor/Ceiling Effects

Ceiling effects:

Parkinson's Disease:

(Leddy et al, 2011; FGA & BESTest)

- Lack of ceiling effect (no perfect score, only 6.4% of subjects scored in • top 10%; Specificity = 0.76; Sample BESTest scores were normally distributed representing range of H&Y disease severity)
- No floor effect •

Subacute Stroke: (Chinsongkram et al., 2014; n=70; mean age 57.0±12.2; time since stroke: 1.1±2.0 months))

- Excellent, no floor effects were observed with the BESTest
- Excellent, no ceiling effects were observed with the BESTest

Not Establis	ned		
Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Coro Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE, StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.			my of Neurologic tion's Multiple EDGE), Spinal Cord StrokEDGE II), r Taskforce eveloped by a panel ess.
For detailed visit: http://v outcome-me	information about how reco www.neuropt.org/go/healthca easures-recommendations	mmendations were r are-professionals/ne	nade, please urology-section-
HR	Highly Recommend		
R	Recommend		
LS/UR	Reasonable to use, but lir Recommend	nited study in target	group / Unable to
NR	NR Not Recommended		
Recommend	dations for use based on act Acute (CVA < 2 months post) (SCI < 1 month	uity level of the patien Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	nt: Chronic (> 6 months) Vestibular > 6 weeks
	Not Establisis	Not Established Recommendations for use of the instrum Physical Therapy of the American Physic Sclerosis Taskforce (MSEDGE), Parkins Injury Taskforce (PD EDGE), Stroke Tast Traumatic Brain Injury Taskforce (TBI E (VEDGE) are listed below. These recommons of research and clinical experts using a stress For detailed information about how reconvisit: http://www.neuropt.org/go/healthcatoutcome-measures-recommendations Abbreviations: HR Highly Recommend R Recommend LS / UR Reasonable to use, but lint Recommend NR Not Recommended NC Recommendations for use based on act (SCI < 1 month post)	Not Established Recommendations for use of the instrument from the Academ Physical Therapy of the American Physical Therapy Associa Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE, Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibula (VEDGE) are listed below. These recommendations were de of research and clinical experts using a modified Delphi proc For detailed information about how recommendations were r visit: http://www.neuropt.org/go/healthcare-professionals/ne outcome-measures-recommendations Abbreviations: HR Highly Recommend R Recommend LS / UR Reasonable to use, but limited study in target Recommend NR Not Recommended Subacute (CVA < 2 months)



	(Vestibular < 6 weeks post)		
SCI EDGE	NR	NR	LS
StrokEDGE II	UR	R	UR
VEDGE	LS	LS	LS

Recommendations Based on Parkinson Disease Hoehn and Yahr stage:

	I	II	III	IV	V
PD EDGE	R	R	R	R	NR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	UR	UR	UR	UR	UR
StrokEDGE II	UR	R	R	R	R
TBI EDGE	NR	LS	LS	LS	NR

Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant
TBI EDGE	LS	LS	LS

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 - 7.5
MS EDGE	UR	UR	UR

Recommendations based on vestibular diagnosis

	Peripheral	Central	Benign Paroxysmal Positional Vertigo (BPPV)
VEDGE	LS	LS	LS

Recommendations for entry-level physical therapy education and use in research:

Students	Students	Appropriate	Is additional
should learn	should be	for use in	research
to	exposed to	intervention	warranted
administer	tool? (Y/N)	research	for this tool
		studies? (Y/N)	(Y/N)



		this tool? (Y/N)					
	MS EDGE	No	No	No	Yes		
	PD EDGE	No	Yes	Yes	Not reported		
	SCI EDGE	No	No	No	Not reported		
	StrokEDGE II	No	Yes	Yes	Not reported		
	TBI EDGE	No	No	No	Not reported		
	VEDGE	No	Yes	Yes	Yes		
Considerations	 The BESTest is suitable for assessing balance in individuals with subacute stroke across many levels of functional ability, demonstrated by the distribution of BESTest scores. The BESTest allows the clinician to tailor their intervention to specific postural control systems, due to the instrument's ability to provide information regarding particular balance systems underlying balance impairments. The BESTest may be preferred to the BBS and Mini-BESTest for functional classification due to its slightly larger LR+. The BESTest may be more preferable than other balance scales due to its lack of floor and ceiling effects. Unknown whether or not the BESTest may be generalizable to patients with chronic stroke, cognitive impairment (Mini-Mental State Exam < 24), lesions involving the brainstem or cerebellum, aphasia, or presence of material state effects. 						
	 Strong psychometric studies in PD population with ability to detect retrospective fallers and predict falls over 6 month period with 68% cut off score Limited evidence of its utility in directing treatment Time to complete BESTest may not be feasible in all clinical settings, but is a strong tool for more in depth diagnostic assessment of balance impairment in PD 						
	Balance Evaluation Systems Test translations:						
	Danish: http://fysio.dk/fafo/Maleredskaber/Maleredskaber-alfabetisk/BESTest/						
	Brazilian Portuguese:						
	Rodrigues LC, Marques AP, Barros PB, Michaelsen SM. Reliability of the Balance Evaluation Systems Test (BESTest) and BESTest sections for adults with hemiparesis. Brazilian journal of physical therapy. 2014;18(3):276-81.						



	Intra- and inter-rater reliability and concurrent and convergent validity evaluated in the Adult Stroke population
	These translations, and links to them, are subject to the Terms and Conditions of Use of the Rehab Measures Database. RIC is not responsible for and does not endorse the content, products or services of any third-party website, and does not make any representations regarding its quality, content or accuracy. If you would like to contribute a language translation to the RMD, please contact us at rehabmeasures@ric.org.
	e-mail us!
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	Leddy, A. L., Crowner, B. E., et al. (2011). "Functional gait assessment and balance evaluation system test: reliability, validity, sensitivity, and specificity for identifying individuals with Parkinson disease who fall." Physical Therapy 91(1): 102-113. Find it on PubMed
	Leddy, A. L., Crowner, B. E., et al. (2011). "Functional gait assessment and balance evaluation system test: reliability, validity, sensitivity, and specificity for identifying individuals with Parkinson disease who fall." Phys Ther 91(1): 102-113. Find it on PubMed
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	Padgett, P. K., Jacobs, J. V., et al. (2012). "Is the BESTest at its best? A suggested brief version based on interrater reliability, validity, internal consistency, and theoretical construct." Physical therapy 92(9): 1197-1207.
Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



5. REHAB MEASURES DATABASE—BOX AND BLOCK TEST

Link to instrument	Box and Blocks Test Instructions					
Title of Assessment	Box and Block Test					
Acronym	BBT					
Instrument Reviewer(s)	Initially reviewed by Jason Raad, MS of the Rehabilitation Measures Team and Dorian Rose, PT, PhD of the StrokEdge Taskforce of the Academy of Neurologic Physical Therapy - a component of APTA in 9/2011; Updated with references for Stroke and Fibromyalgia populations by Denise Toombs, SPT and Marina Yusupova, SPT in 2011; Reviewed and updated by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto-Zipp, PT, EdD, of the StrokEDGE II Neurology Section, APTA, in 4/2016.					
Summary Date	4/26/2012					
Purpose	Assesses unilateral gross manual dexterity					
Description	 Individuals are seated at a table, facing a rectangular box that is divided into two square compartments of equal dimension by means of a partition. One hundred and fifty, 2.5 cm, colored, wooden cubes or blocks are placed in one compartment or the other. The individual is instructed to move as many blocks as possible, one at a time, from one compartment to the other for a period of 60 seconds. Standardized dimensions for the test materials and procedures for test administration and scoring have been provided by Mathiowetz et al, 1985. To administer the test, the examiner is seated opposite the individual in order to observe test performance. The BBT is scored by counting the number of blocks carried over the partition from one compartment to the other during the one-minute trial period. Patient's hand must cross over the partition in order for a point to be given, and blocks that drop or bounce out of the second compartment onto the floor are still rewarded with a point. Multiple blocks carried over at the same time count as a single point. 					



Area of Assessment	Activities of Daily Living; Coordination; Dexterity; Upper Extremity Function					
Body Part	Not Applicable					
ICF Domain	Activity					
Domain	Motor					
Assessment Type	Observer					
Length of Test	05 Minutes or Less					
Time to Administer	2-5 minutes					
Number of Items	1					
Equipment Required	 Stopwatch Wooden box dimensioned in 53.7 cm x 25.4 cm x 8.5 cm Partition (should be placed at the middle of the box, dividing it in two containers of 25.4 cm each) 150 wooden cubes (2.5 cm in size) 					
Training Required	No Training					
Type of training required	No Training					
Cost	Not Free					
Actual Cost	Commercially produced versions of the test can be purchased for approximately \$200.00 (as of 2011) http://www.wisdomking.com/product/box-block-test http://www.pattersonmedical.com/app.aspx?cmd=get_product&id=79848 http://www.medicalsuppliest.com/box-and-block-test-1					
Age Range	Child: 6-12 years; Adult: 18-64 years; Elderly adult: 65+					
Administration Mode	Paper/Pencil					
Diagnosis	Multiple Sclerosis; Stroke; Traumatic Brain Injury					
Populations Tested	 Stroke Multiple Sclerosis Traumatic Brain Injury (TBI) 					



	 Neuromuscular Disorders Geriatric Spinal Cord Injury (SCI) Fibromyalgia 				
Standard Error of Measurement (SEM)	Acute and Chronic Stroke: (calculated from statistics in Chen et al, 2009; $n = 62$ volunteer participants who had sustained a stroke; mean age = 61 (9.9) years; median time post-stroke = 8 months)				
	(**Note: To calculate the Smallest Real Difference (SRD; aka Minimal Detectable Change MDC) the authors averaged the standard deviations from time points 1 & 2 rather than using the baseline standard deviation; thus, to calculate the SEM, an average standard deviation was used).				
	• BBT More Affected Hand: SEM= 1.99				
	• BBT Less Affected Hand: SEM= 2.84				
	BBT Spectic Crown SEM 2.02				
	BBT Spastic Group: SEM= 2.92 BBT Non-spastic Group: SEM= 2.23				
Minimal Detectable Change (MDC)	Acute and Chronic Stroke: (Chen et al, 2009)				
	MDC: 5.5 blocks per minute				
	Percentage change: 18%				
	Spastic Hemiplegia: (Siebers et al, 2010; $n = 17$ patients with spastic				
	hemiplegia; median age = 54(22-67) years; 2 week training program; 6 month follow-up)				
	 MDC for 2 week training program: 4 blocks per minute 				
	MDC for 6 month follow-up: 6 blocks per minute				
Minimally Clinically Important Difference (MCID)	Not Established				
Cut-Off Scores	Not Established				
Normative Data	Normal adults: (Mathiowetz et al, 1985; $n = 310$ normal adult males, 318 normal adult females; aged 20 and up)				



Average Number of Cubes Transferred in One Minute						
		Male		Female		
Age	Hand	Mean	SD	Mean	SD	
40-44	R	83.0	8.1	81.1	8.2	
	L	80.0	8.8	79.7	8.8	
45-49	R	76.9	9.2	82.1	7.5	
	L	75.8	7.8	78.3	7.6	
50-54	R	79.0	9.7	77.7	10.7	
	L	77.0	9.2	74.3	9.9	
55-59	R	75.2	11.9	74.7	8.9	
	L	73.8	10.5	73.6	7.8	
60-64	R	71.3	8.8	76.1	6.9	
	L	70.5	8.1	73.6	6.4	
65-69	R	68.5	7.1	72.0	6.2	
	L	67.4	7.8	71.3	7.7	
70-74	R	66.3	9.2	68.6	7.0	
	L	64.3	9.8	68.3	7.0	
75+	R	63.0	7.1	65.0	7.1	
	L	61.3	8.4	63.6		

Normal children: (Mathiowetz et al, 1985; n = 471 normal children, 231 males, 240 females; age range = 6-19 years)

Average Number of Cubes Transferred in One Minute							
		Male		Female	Female		
Age	Hand	Mean	Mean SD		SD		
6-7	R	54.4	6.6	57.9	5.3		
	L	50.7	6.3	54.2	5.6		
8-9	R	63.4	4.3	62.8	5.1		
	L	60.1	4.9	60.4	5.2		
10-11	R	68.4	6.9	70.0	7.6		
	L	65.9	6.8	67.6	8.6		
12-13	R	74.6	8.3	73.6	8.1		
	L	72.4	8.2	70.5	6.2		
14-15	R	76.6	8.7	75.4	8.5		
	L	74.6	7.9	72.1	7.6		
16-17	R	80.3	8.7	77.0	9.0		
	L	77.6	5.1	74.3	9.1		



	18-19	R	79.9	8.9	77.9	9.4	
		L	79.2	8.8	76.0	8.5	
Test-retest Reliability	 Acute and Chronic Stroke: (Chen et al, 2009) Excellent test-retest reliability when tested on more affected (<i>r</i> = 0.98) and less affected hand (<i>r</i> = 0.93) 						
	Upper Limb Impairment: (Desrosiers et al, 1994; $n = 35$ able bodied subjects; mean age = 71.7(60-89) years; $n = 34$ subjects with impairment; mean age = 74.5(65-87) years)						
	 Excellent test-retest reliability of the right hand for able bodied subjects (ICC= 0.97) Excellent test-retest reliability of the left hand for able bodied subjects (ICC= 0.96) Excellent test-retest reliability of the right hand for subjects with impairment (ICC= 0.90) Excellent test-retest reliability of the left hand for subjects with impairment (ICC= 0.89) 						
	Upper Extremity Paresis: (Platz et al, 2005; $n = 56$ people with upper limb paresis as a result of stroke, Multiple Sclerosis (MS), and traumatic brain injury (TBI); median age = 54(13-92) years; $n = 37$ for stroke; median age = 62(22-92) years; $n = 14$ for MS; median age = 43(28-60) years; $n = 5$ for TBI; median age = 34(13-50) years) • Excellent test-retest reliability (ICC = 0.96) Spastic Hemiplecia: (Siebers et al. 2010)						
	• Excellent test-retest reliability (ICC = 0.95)						
Interrater/Intrarat er Reliability	Normal Ad • Ex • Ex	lults: (Math cellent inte cellent inte	niowetz et a errater reliat errater reliat	I, 1985) bility for bility for) the right h the left ha	and (<i>r</i> = nd (<i>r</i> =	= 1.00) 0.99)



	Upper Extremity	<u>/ Paresis:</u> (Platz et al, 2005)		
	• Excellent interrater reliability (ICC = 0.99)			
	Spastic Hemiplegia: (Siebers et al, 2010)			
	• Excellent interrater reliability (<i>r</i> = 0.95)			
	Fibromyalgia: (Canny et al, 2009; $n = 30$ participants with fibromyalgia; mean age = 46.9(range 20-68) years; $n = 30$ healthy participants; mean age= 41.2(29-52) years)			
	 Excellen 0.90) Excellen 0.85) Excellen 	nt intrarater reliability for partic nt intrarater reliability for healt nt interrater reliability for partic nt interrater reliability for healt	pipants with fibromyalgia (ICC = hy participants (ICC = 0.98) bipants with fibromyalgia (ICC = hy participants (ICC = 0.80)	
Internal Consistency	Not Established			
Criterion Validity (Predictive/Concur rent)	Stroke: (Lin et al, 2010; <i>n</i> = 59 patients with stroke; sex = 47 males, 12 females; mean age = 55.5(11.66) years)			
	Measure	Pretreatment (r)	Posttreatment (r)	
	NHPT	-0.80 (Excellent)	-0.71 (Excellent)	
	ARAT		0.64 (Excellent)	
	FMA			
	MAL-AOU	-0.37 (Adequate)	0.49 (Adequate)	
	MAL-OOM	0.52 (Adequate)	0.52 (Adequate)	
	SIS	0.59 (Adequate)	0.52 (Adequate)	
	ARAT = Action Research Arm Test, BBT = Box and Block Test, CI = confidence interval, FMA = Fugl-Meyer Assessment, MAL-AOU = Motor Activity Log-Amount of Use, MAL-QOM = Motor Activity Log-Quality of Movement, NHPT = Nine-Hole Peg Test, SIS = Stroke Impact Scale			
Construct Validity (Convergent/Discri minant)	 Upper Limb Impairment: (Desrosiers et al, 1994) Excellent convergent validity with the Action Research Arm Test (r = 0.80) 			



 Adequate convergent validity with Functional Autonomy Measurement System (r (right hand) = 0.47; r (left hand) = 0.51)

Upper Extremity Paresis: (Platz et al, 2005)

- Excellent convergent validity with the Action Research Arm Test (r = 0.95)
- **Excellent** convergent validity with the Fugl-Meyer Test (r = 0.92)
- Excellent convergent validity with the Hemispheric Stroke Scale (r = -0.67)
- Adequate convergent validity with the Passive Joint motion/Joint pain sub-scale of Fugl-Meyer Test (r = 0.43)
- **Poor** convergent validity with the Modified Barthel Index (r = 0.04)

<u>Central Paresis:</u> (Platz et al, 2008; n = 33 neurological patients with central paresis due to stroke, ischemic/anoxic brain damage, traumatic brain injury, or spinal cord injury; n=3 patients with SCI(C3,C4,T8), 6 patients with TBI, and 23 patients with stroke; sex = 20 males, 13 females; mean duration of disease = 19.4 months; mean age = 49.7(17.3) years)

Excellent convergent validity with Resistance to Passive Movement (r = -0.680)

Content Validity	Not Established		
Face Validity	Not Established		
Floor/Ceiling Effects	Not Established		
Responsiveness	Not Established		
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.		
	For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations		


Abbreviations:	
HR	Highly Recommend
R	Recommend
LS/UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute (CVA < 2 months post) (SCI < 1 month post) (Vestibular < 6 months post)	Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	Chronic (> 6 months)
StrokEDGE II	R	R	R

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	R	R	R	R	R
StrokEDGE II	R	R	R	R	R

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5
MS EDGE	R	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	No	Yes	Yes	No
StrokEDGE II	No	Yes	Yes	Yes

Considerations

 Changing block surfaces to rubber, improved BBT scores 8% for controls and stroke survivors (both paretic and non-paretic hands), by reducing movement time for "finger closing" and "contact-to-lift". This study suggests the need to modify daily objects with rubber and indicate need for therapy to focus on goal directed reaching and object grasping/releasing. (Slota et al, 2013)



	Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
Bibliography	Canny, M. L., Thompson, J. M., et al. (2009). "Reliability of the box and block test of manual dexterity for use with patients with fibromyalgia." Am J Occup Ther 63(4): 506-510. Find it on PubMed
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	Mathiowetz, V., Volland, G., et al. (1985). "Adult norms for the Box and Block Test of manual dexterity." Am J Occup Ther 39(3160243): 386-391. Find it on PubMed
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	Platz, T., Vuadens, P., et al. (2008). "REPAS, a summary rating scale for resistance to passive movement: item selection, reliability and validity." Disabil Rehabil 30(1): 44-53. Find it on PubMed
	Siebers, A., Oberg, U., et al. (2010). "The effect of modified constraint-induced movement therapy on spasticity and motor function of the affected arm in patients with chronic stroke." Physiother Can 62(4): 388-396. Find it on PubMed



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surfaces and identification of difficult movement post stroke in the Box and Block
Test." Applied Ergonomics 45: 833-838. Find it on PubMedYear published1957

	1957
Instrument in PDF Format	Yes
Approval Status	Approved



6. REHAB MEASURES DATABASE—CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

Link to instrument	Available for purchase at the Canadian Association of Occupational Therapists (external link)
Title of Assessment	Canadian Occupational Performance Measure
Acronym	СОРМ
Instrument Reviewer(s)	Initially reviewed by the Rehabilitation Measures Team; Updated with references from the TBI population by Anna de Joya, PT, DSc, NCS, Coby Nirider, PT, DPT, and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012; Updated with references for Arthritis, Pediatrics, and Ankylosing Spondylitis by Brianna DeBois, SPT, Samantha Dillon, SPT, and Jennifer Kick, SPT in 11/2012. Updated by Maggie Bland PT,DPT,NCS and Nancy Byl PT,MPH,PhD, FAPTA and the StrokEdge II task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2016.
Summary Date	4-19-2016
Purpose	Assesses an individual's perceived occupational performance in the areas of self-care, productivity, and leisure.
Description	 The assessment involves a 5-step process nested within a semi-structured interview, typically conducted by an Occupational Therapist. Interview focuses on identifying activities within each performance domain that the client wants, needs, or is expected to perform. Following Step 3, the patient and therapist create goals for therapeutic interventions. The interviewer may need to supplement information gathered during the COPM interview through other techniques including direct observation, administration of standardized tests, or an assessment of the patient's environment (Law et al, 1990). Has been translated into 24 languages and is used in over 35 countries. Also available in Pediatric, French, Hebrew, Icelandic, Japanese, German, Danish, Swedish, Greek, Spanish, Mandarin Chinese, Korean, Russian, Slavic, Italian, Portuguese and Norwegian versions.



 Caregiver/proxy may respond on the patient's behalf, but they
may not identify the same deficits or problems as the patient
would and there may be differences in option in regard to the
importance of activities.

Area of Assessment	Activities of Daily Living; Functional Mobility; Life Participation; Occupational Performance
Body Part	Not Applicable
ICF Domain	Participation
Domain	ADL; General Health; Motor
Assessment Type	Patient Reported Outcomes
Length of Test	06 to 30 Minutes
Time to Administer	10-20 minutes
Number of Items	Not applicable
Equipment Required	None necessary
Training Required	None necessary
Type of training required	Reading an Article/Manual
Cost	Not Free
Actual Cost	A 45-minute DVD and Workbook with COPM manual and 100 Forms is \$225.45 (Canadian) or a Manual/Form Kit for \$52.45 (Canadian) can be purchased from the Canadian Association of Occupational Therapists (cost determined in November, 2012)
Age Range	Child: 6-12 years; Adolescent: 13-17 years; Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Arthritis; Cerebral Palsy; Chronic Obstructive Pulmonary Disease; Pain; Parkinson's Disease; Spinal Cord Injury; Stroke; Traumatic Brain Injury
Populations Tested	The COPM was designed for use with all clients regardless of diagnosis (Law et al, 2004). The COPM has been validated with patients drawn from the following populations: • Stroke



	 COPD Pain Cerebral Palsy Traumatic Brain Injury Parkinson's Disease Arthritis Pediatrics Ankylosing Spondylitis
Standard Error of Measurement (SEM)	Ankylosing Spondylitis: (calculated from statistics in Kjenken et al, 2005; Rescore by personal interview, <i>n</i> =17, mean age 46.4 (12.8) years; Rescore by telephone, <i>n</i> =25, mean age 48.7 (13.3) years; Rescore by mail, <i>n</i> =24, mean age 46.6 (12.5) years; 2 weeks between assessments, Ankylosing Spondylitis) • Personal interview • SEM for performance=0.66 • SEM for satisfaction=0.84 • Telephone interview • SEM for performance=1.41 • SEM for satisfaction=1.86 • Mail • SEM for performance=0.99 • SEM for satisfaction=1.13 Stroke: (calculated from statistics in Cup et al, 2003, Acute Stroke) 2 to 6 months post onset • SEM for performance=1.2 points • SEM for satisfaction=1.9 points
Minimal Detectable Change (MDC)	Ankylosing Spondylitis: (calculated from statistics in Kjeken et al, 2005) • Personal interview • MDC for performance=1.59 • MDC for satisfaction - 1.80 • Telephone interview • MDC for performance=2.33 • MDC for satisfaction=2.63 • Mail • MDC for performance=1.95 • MDC for satisfaction=2.08 Osteoarthritis: (calculated by MacDermid et al, 2009 from Kjeken et al, 2005; <i>n</i> =87, women, mean age=62.7 (5.4) years, Hand Osteoarthritis) • MDC= 5 Stroke: (calculated from statistics in Cup et al, 2003, Acute Stroke) 2 to 6 months post onset • MDC for performance=1.7 points • MDC for satisfaction=2.7 points



Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Not Established
Normative Data	Acute Stroke:(Cup et al, 2003; n=26; mean age=68 (15) years; mean time between assessments=8 days (2.5) days, range 5–16 days, Acute Stroke)Mean performance and satisfaction scores Mode number of problems identified over two assessments 3 to 5• Interview 1: mean performance score 3.5 (SD 1.8, range 1.0– 7.0)• Interview 2: mean performance score 3.7 (SD 1.9, range 1.0–6.8) • Interview 1: mean satisfaction score 3.3 (SD 1.9, range 1.0–7.5) • Interview 2: mean satisfaction score 3.5 (SD 2.1, range 1.0–7.4)
Test-retest Reliability	 Adults with impairment in 1 or more ADL: (Eyssen et al, 2005; n=95; mean age 47 (15) years; various diagnoses; COPM administered twice, 7 days between assessments) Adequate test-retest reliability (ICC=0.67 performance and 0.69 satisfaction) Ankylosing Spondylitis: (Kjenken et al, 2005) Excellent test-retest reliability by personal interview (ICC=0.92 performance and ICC=0.93 satisfaction) Adequate test-retest reliability by telephone (ICC=0.73 performance and ICC=0.73 satisfaction) Adequate test-retest reliability by mail (ICC=0.90 performance and ICC=0.73 satisfaction) Excellent test-retest reliability by mail (ICC=0.90 performance and ICC=0.90 satisfaction) Excellent test-retest reliability (ICC=0.81 performance and ICC=0.76 satisfaction)
Interrater/Intrarater Reliability	 <u>Acquired Brain Injury:</u> (Jenkinson et al, 2007; Community dwelling individuals; n=34 (TBI=21; CVA=11; Others=2); total of 15 patients with ABI were involved in the stability study, ABI) <u>Consistency of self- and relative ratings for no intervention group:</u>



	 No significant difference in COPM satisfaction ratings for participants (M=4.24(1.89)) and relatives (M=5.01 (1.57)); <i>t</i>=-1.79, <i>p</i>=0.078) Participants rated their functional abilities on the Patient Competency Rating Scale (PCRS) (M=111.92 (17.58)) at a higher level than their relatives (M=105.75 (20.46)); however, no significant difference (<i>t</i> (62)=1.29, <i>p</i>=0.20) Participants' self-ratings relatively consistent with their relatives' ratings Test-re-test reliability coefficients for the COPM ratings over the 8-week interval were all significant Excellent (<i>r</i>=0.75–0.86) for relative ratings; Adequate (<i>r</i>=0.53–0.67) for self-ratings Stroke: (Cup et al, 2003; n=26; mean age=68 (15); gender; 11 males, 15 females; time post stroke; 24 patients 6 months post stroke, 2 patients 2 months post stroke, Stroke) Test retest reliability: interval=8 days Spearman's rho correlation coefficient for the performance scores=0.89 (<i>p</i> <0.001) and for the satisfaction scores 0.88 (<i>p</i> < 0.001)
Internal Consistency	 <u>Cerebral Palsy</u>: (Cusik et al, 2007; <i>n</i>=42; mean age=3.9 years; time post diagnosis unknown; GMPM Level 1, Spastic Hemiplegic Cerebral Palsy) Using an adapted form of the COPM competed by a parent proxy (deleted the categories of "paid/unpaid work" and "household management"), internal consistency reliability was found to be acceptable for Performance (Cronbach's α=0.73) and Satisfaction (Cronbach's α=0.83). <u>Stroke:</u> (Cup et al, 2003, Acute Stroke) 26 participants were asked to identify problems over the course of two interviews. During the initial COPM interview 115 problems were identified. In the second interview 112 problems were identified. 64 problems (56%) mentioned in the first interview were also mentioned in the second interview.
Criterion Validity (Predictive/Concurrent)	 Arthritis: (Ripat et al, 2001; n=13, stage 2 or stage 3 RA, Rheumatoid Arthritis) Total Perfomance Scores on the COPM were not significantly correlated to total scores on the disability index of the Health Assessment Questionnaire (HAQ) r =-0.37*, p=0.22 36 out of 50 activities identified on the COPM exactly matched activities included in the disability dimension of the HAQ. Individual performance scores on the COPM were significantly related to scores on the matched HAQ components and matched HAQ activities r=-0.52*, p<0.01



• *r*=-0.67*, *p*<0.01

*Pearson product-moment correlation coefficient

Community Dwelling Disabled Individuals:

(McColl et al, 2000; *n*=61; disability unspecified, Community Dwelling Disabled Individuals)

- Participants identified 481 problems on the COPM and the Perceived Problem Check List (PPCL)
- 54 similar problems were identified on both measures:
 - 24% of PPCL problems were similar to COPM
 - 21% of COPM problems were similar to PPCL
- Problems mentioned on both measures include:
 - Transportation and errands
 - Dressing
 - Toileting
 - Climbing stairs
 - Cooking
 - Cleaning
 - Socializing

(Martini et al 2014) Adults post stroke (6 community dwelling,> one year post stroke) and children post stroke (8 children performing below the 15th% on the Movement Assessment Battery for Children) were videotaped and rated twice (separated by two weeks) by 3 different raters (research assistant, Occupational Therapist [OT] and OT student). The objective was to determine responsiveness, inter rater and test retest (2 weeks) reliability for the PQRS (Operational Definitions [OD] and Generic systems-[G]) as well as convergent validity between the PQRS-OD, the PQRS-G and the COPM Performance Scores. In terms of convergent validity there was:

- PreTest
 - Poor, virtually no convergent validity between PQRS-G or PQRS-OD with COPM Performance (-0.37 to 0.10) and COPM Satisfaction (-0.23 to -0.07)
- Post test:
 - Poor to Adequate convergent validity based on multiple raters for PQRS-G and PQRS-OD and COPM Performance (0.20 to 0.53)
 - Poor convergent validity for PQRS-G and PQRS-OD and COPM Satisfaction (0.04 to 0.29)



- Change scores
 - Poor to Adequate correlations between PQRS-G and PQRS-OD and COPM Performance (-0.12 to 0.35) and COPM Satisfaction (017-0.58)
 - Correlations between change scores on the PQRS and the COPM were higher for research assistant raters (-0.14 to 0.58) and OT student raters (-0.20 to - 0.47) compared to licensed OT's (-0.12 to -0.21)

(Hill et al, 2014). This study evaluated 49 community dwelling individuals (mean age of 59.67 (14.14), 72 (58.8) months post stroke to determine if there was a correlation between sensory discrimination (Touch-Test, similar to Semmes Weinstein Monofilaments) and valued activities (functional performance on the COMP).

٠	Good to excellent correlations were found between individuals who
	scored high on the COPM (5.9-9.6) and low on the Touch-Test
	(X ² =9.80 (P<0.05);
٠	No significant relationships were reported between the COPM scores
	below the median (1.2-5.8) and overall hand sensation ((X^2 =.523;
	P=0.97)

- Little to no correlations were reported between touch sensation of the hand and performance of *valued* activities for those who scored low on the COPM
- No significant relationships were reported for subjects scoring above or below the median for specific hand testing locations and COPM scores
- Subjects with minimal to moderate sensation impairments did not report speech or communication as a *valued* activity
- Subjects with severe impaired sensation did not report exercise as a *valued* activity.

Construct Validity	Discriminant \	/alidity:			
t)	Acquired Brain Injury:				
	(Jenkinson et a	l, 2007; Comm	unity dwelling i	ndividuals;	n=34 (TBI=21;
	CVA=11; Other	s=2) , ABI)			
		PCRS	HADS	HADS	Health and
		Discrepancy	Depression	Anxiety	Safety
					Subtest of



				the Independent Living Scale
COPM Performance	0.21	-0.23	-0.30	0.18
COPM Satisfaction	0.20	-0.33	-0.42*	-0.02

**p*<0.05, two-tailed (PCRS: Patient Competency Rating Scale; HADS: Hospital Anxiety Depression Scale)

- Lower self-ratings of satisfaction were associated with higher levels of anxiety
- No significant difference between self-ratings of satisfaction with measures of awareness, depression and cognitive function
- No significant difference between self-ratings of performance with awareness of deficit, mood state, and cognitive function

Mixed Population (Disorders of wrist, hand and arm, Central neurological disorder, neuromuscular diseases, other diagnosis): (Eyssen et al, 2011; Dutch version; n=138; mean age=51 (13), Mixed Population)

 Significant positive correlations between the COPM scores and the Sickness Impact Profile (SIP68), Disability and Impact Profile (DIP), and Impact on Participation and Autonomy (IPA) scores

Pediatrics:

(Cusick et al, 2006, Pediatrics) **Stroke**:

(Cup et al, 2003, Acute Stroke) COPM performance scores:

- **Poor** correlation with Barthel Index $r=-0.225^*$
- **Poor** correlation with Frenchay Activities Index *r*=–0.115*
- Poor correlation with the Stroke Adapted Sickness Impact Profile (SA-SIP30) r=0.102*
- Poor correlation with the Euroqol 5D (EQ-5D) r=0.143*
- **Poor** correlation with the Rankin Scale *r*=0.209*

In other words, standardized performance measures **did not correlate with the COPM** indicating strong evidence of discriminate validity. *(Spearman rho)

- Poor correlation with the Goal Attainment Scaling (GAS) measure compared to COPM Performance score, *r*=-0.16 and COPM Satisfaction score, r=-0.13
- COPM performance and satisfaction scores are highly correlated, *r*=0.5, p=0.0012

Content Validity

The COPM assessment focuses on measuring a mismatch between a person's abilities and the demands of a task leading to functional impairment. (Macedo et al, 2009)



Face Validity	Not Established
Floor/Ceiling Effects	Not Established
Responsiveness	 Research (Law et al 2004) suggests: A change of 2 or more points is clinically significant Changes in scores from assessment to re-assessment tend to be meaningful Acquired Brain Injury: (Phipps et al, 2007; n=155 (TBI=38, CVA=117); Time from admission to discharge (TBI=141.26 (85.10); Right CVA=97.45 (72.99); Left CVA=96.47 (65.97), ABI) Significant change in performance ratings and satisfaction ratings
	 from admission to discharge for entire sample and also for each diagnostic group (Jenkinson et al, 2007; Community dwelling individuals; <i>n</i>=34 (TBI=21; CVA=11; Others=2); total of 10 patients involved in an 8-week intervention group, ABI) Significant improvement in COPM performance self-ratings (<i>p</i>=0.018) and satisfaction self-ratings (<i>p</i>=0.013) between the preand post-assessment Significant improvement in relatives' ratings of performance between the pre- and post-assessment (<i>p</i>=0.008) Improvement for relatives' ratings of satisfaction between the preand post-assessment (<i>p</i>>0.05)
	 Arthritis: (Macedo et al, 2009, Rheumatoid Arthritis) Means Changes in Satisfaction and Performance were found to be both clinically and statistically significant Cerebral Palsy: (Cusick et al, 2007, Spastic Hemiplegic Cerebral Palsy) The adapted COPM demonstrates an ability to detect change above the published minimum clinically important difference of 2 points Mixed neurologic sample: (Bodium, 1999; in-patient rehabilitation; n=17; admission to discharge=10 weeks, Mixed Neurologic Sample) significant differences in improvement in self-ratings of portarements and extinct and ex

Mixed neurological, orthopedic and cardiology sample:



(Wressle et al, 2002; n=155 experiment group and 55 in control group within geriatric, stroke and home rehabilitation; median age=80 experiment group and 79 control group; assessment after discharge=2-4 weeks with 88 patients in control group; 30 in control group, Mixed patients)

 Significant differences between groups: more patients in the experiment group perceived that treatment goals were identified, were able to recall the goals, felt that they were active participants in the goal formulation process, and perceived themselves better able to manage after completed rehabilitation compared with patients in the control group

Mixed Population (Disorders of wrist, hand and arm, Central neurological disorder, neuromuscular diseases, other diagnosis): (Eyssen et al, 2011; Dutch version; *n*=138; mean age=51 (13), Mixed Population)

- Significant differences between assessment and reassessment scores (*p*<0.001)
- The AUC ranged from 0.79 to 0.85, and the optimal cut-off values for the performance scores and satisfaction scores ranged from 0.9 to 1.9

Neuro Rehabilitation:

(Chenq et al, 2002; *n*=12, 7=cerebrovascular accident, 2=spinal cord injuries, & 3=TBI; mean age 42.5; Taiwanese sample, Neuro Rehabilitation)

• Mean changes in Satisfaction and Performance were found to be both clinically and statistically significant

Pain:

(Carpenter et al, 2001; *n*=87 completed the COPM at baseline, end of program and 3 month post intervention; mean age=44, range=19 to 72 years, Pain)

• Changes in satisfaction and performance scores were found to be statistically and clinically significant

Traumatic Brain Injury:

(Trombly et al, 1998; Outpatient therapy services; *n*=16; gender=7 female and 9 male; mean age=43 (12.6); time since injury=22 (5.4), TBI)

- Performance self-ratings were significantly better (*p*<0.001), and satisfaction self-ratings were significant as well (*p*=0.001) after treatment than before (discharge: 4-23 weeks after admission; mean=12.3 weeks)
- No significant difference from discharge to follow up (4-8 weeks after discharge)



	taken:	Acut e Care	Inpatient Rehabilitatio n	Skilled Nursin g Facility	Outp Reha	patient bilitatio n	Home Healt h
				R	h the c	ŀ	R in
	StrokEDGE	(SC (Ve mo	stibular < 6 boths post)	(SCI 3 t month	io 6 is)		
		(CV/	Acute A < 2 months post)	Subace (CVA 2 month	ute to 6 us)	Chro (> 6 m	onic onths)
	Recommenda	ations for	use based on a	cuity level	of the p	atient:	
	NR	Not Recommended					
	LS/UR	Reasonable to use, but limited study in target group / Unable to Recommend					
	R	R Recommend					
	Abbreviations:						
	For detailed i visit: http://w section-outco	nformatic ww.neurc pme-meas	on about how re- opt.org/go/health sures-recomme	commendat ncare-profes ndations	ions we	ere made s/neurolog	, please gy-
	experts using	a modifi	ed Delphi proce	SS.	sesure		
	Neurologic Pl Association's Taskforce (Pl Taskforce (Si (TBI EDGE), recommenda	hysical T Multiple D EDGE) trokEDGE and Vest	herapy of the Ar Sclerosis Taskf , Spinal Cord In E, StrokEDGE II ibular Taskforce e developed by	nerican Phy orce (MSEI jury Taskfor), Traumatic e (VEDGE) a papel of J	/sical T DGE), P rce (PD c Brain are liste	herapy Parkinson' EDGE), Injury Tas ed below. h and clir	's Stroke skforce These pical
Professional Association Recommendations	Recommenda	ations for	use of the instr	ument from	the Aca	ademy of	
	(12.16); gend onset less tha • Perfo p<0.0 • Satis p<0.0	ler=75% an equal prmance s 001, <i>r=0.8</i> faction se 001, <i>r=0.8</i>	male; onset mon to 3 months=19 self-ratings: sigr 34, during the tro elf-ratings: signit 39 during the tre	re than equa %; mixed le hificantly grea eatment ver ficantly grea	al to 12 vel of s ater ga sus no ater gair	months= everity, T in $t(10)=$ treatmen treatment	55%; BI) 5.029, t periods 325, : periods

UR

UR

UR

UR

UR

MS EDGE



StrokEDG E II	NR	UR	UR	UR	UR
TBI EDGE	NR	NR	NR	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely	Mildly	Moderately	Severely
	Independent	Dependent	Dependent	Dependent
TBI EDGE	N/A	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 –	EDSS 4.0 –	EDSS 6.0 –	EDSS 8.0 –
	3.5	5.5	7.5	9.5
MS EDGE	UR	UR	UR	UR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	No	No	No	Yes
StrokEDGE II	No	Yes	Yes	Not reported
TBI EDGE	No	Yes	Yes	Not reported

Considerations

- The COPM can be time consuming and difficult to administer (Toomey et al, 1995)
- Requires that the therapist using the tool be comfortable with a client-centered approach to both assessment and practice (Law et al, 1994)
- The interview process is of critical importance both in eliciting relevant information and devising patient-centered therapeutic interventions. However, the interview process is not standardized and both the quality and adequacy of information obtained from interviews may vary considerably between interviewers
- Initially was not considered appropriate for children under 8 years of age, but more recent research supports it use with children

(Galvin et al 2010). Twenty six children with ischemic or hemorrhagic stroke (5-16 years of age) participated in this study to identify the functional tasks of concern and identify the



	 most valued functional activities as measured by the COPM when completed by the children and by the parents). The satisfaction and performance parts of the COPM were not administered. A total of 103 goals were identified. Preschool aged children had the most concerns about self care (45%) and productivity (36%) with less concern about leisure (19%) School aged children had the most concerns about self care (46%) and leisure activities (36%)
	 Parents had concerns about their children's self care (47%), productivity (27%) and leisure activities (26%)
	Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
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Year published	1991
Instrument in PDF Format	Yes
Approval Status	Approved



Link to instrument	Chedoke Arm and Hand Activity Inventory - 13		
Title of Assessment	Chedoke Arm and Hand Activity Inventory - 13		
Acronym	CAHAI – 13		
Instrument Reviewer(s)	Initially reviewed by Dorian Rose, PhD, PT and the Stroke Edge Taskforce of the Academy of Neurologic Physical Therapy - a component of APTA, Updated by Maggie Bland PT,DPT,NCS and Nancy Byl, PT, MPH, PhD, FAPTA and the StrokEdge II Task Force of the Academy of Neurologic Physical Therapy - a component of APTA in 2016.		
Summary Date	2/29/2016		
Purpose	The purpose of this measure is to evaluate the functional ability of the paretic arm and hand to perform tasks.		
Description	The CAHAI is a performance test using functional items. It is not designed to measure the client's ability to complete the task using only their unaffected hand, but rather to encourage bilateral function. The original test consists of 13 functional tasks to complete (open jar of coffee, call 911, draw a line with a ruler, put toothpaste on toothbrush, cut medium consistency putty, pour a glass of water, wring out washcloth, clean pair of eyeglasses, zip up a zipper, do up 5 buttons, dry back with towel, place container on table, carry bag upstairs). Additional shorter versions exist as well: CAHAI-7, CAHAI-8, and CAHAI-9.		
Area of Assessment	Activities of Daily Living; Upper Extremity Function		
Body Part	Upper Extremity		
ICF Domain	Activity		
Domain	ADL; Motor		
Assessment Type	Performance Measure		
Length of Test	06 to 30 Minutes		

7. REHAB MEASURES: CHEDOKE ARM AND HAND ACTIVITY INVENTORY



Time to Administer	30 minutes.		
Number of Items	13		
Equipment Required	 Jar of coffee Phone Ruler and pen Toothpaste and toothbrush Knife Fork Putty Glass of water Wet washcloth Eyeglasses Jacket and zipper Shirt with 5 buttons Towel Rubbermaid 38 liter container (50x37x27cm) with 10 lb. weight Plastic grocery bag with 4 lb. weight 		
Training Required	Read the administration and scoring manual		
Type of training required	reading an article/manual		
Cost	Free		
Actual Cost	\$0.00		
Age Range	Not specified		
Administration Mode	Paper/Pencil		
Diagnosis	Movement Disorders		



Populations Tested	Upper Extremity Paralysis		
Standard Error of Measurement (SEM)	Not Established.		
Minimal Detectable Change (MDC)	Upper Extremity Paralysis (Barreca et al, 2005) • MDC (90) = 6.3 points		
Minimally Clinically Important Difference (MCID)	Upper Extremity Paralysis (Siven et al, 2011) Systematic Review • MCID (chronic) = 6.3 points		
Cut-Off Scores	Not Established.		
Normative Data	Not Established.		
Test-retest Reliability	Upper Extremity Paralysis: (Barreca et al, 2005) • Excellent reliability (ICC = 0.96)		
Interrater/Intrarater Reliability	Upper Extremity Paralysis: (Barreca et al, 2005) • Excellent reliability (ICC = 0.98)		
Internal Consistency	Upper Extremity Paralysis: (Barreca et al, 2006) Comparison of the CAHAI-13 to other measures in people 20-108 days post-stroke ("Psychometric properties: Reliability") • Excellent reliability (ICC = 0.98) • Excellent Internal consistency: r=0.98		
Criterion Validity (Predictive/Concurrent)	Not Established.		



Construct Validity	Stroke:				
(Convergent/Discriminan t)	(Barreca et al. , 2006)				
	 Excellent correlation with Action Reach Arm Test: r=0.93 Excellent correlation with Chedoke-McMaster Stroke 				
	(Baker, et al 2011) Systematic review of key assessment of hand/arm outcome tools to measure change following robotic therapy in stroke rehabilitation (45 measures identified)				
	 Chedoke Arm and Hand Inventory was one of 3 measures that met all domains of the ICF framework and incorporated a mixture of clinical-rated and patient reported outcome measures None of the scales were considered to be sufficient on their own to capture all important outcome domains 				
Content Validity	Not Established.				
Face Validity	Not Established.				
Floor/Ceiling Effects	Not Established.				
Responsiveness	Not Established.				
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE, StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.				
	For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>				
	Abbreviations:				
	HR Highly Recommend				



R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCl < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 months post)		
StrokEDGE II	NR	LS / UR	NR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	NR	NR	NR	NR	NR

Recommendations for entry-level physical therapy education and use in research:

Students	Students	Appropriate	Is additional
should	should be	for use in	research
learn to administer this tool? (Y/N)	exposed to tool? (Y/N)	intervention research studies? (Y/N)	warranted for this tool (Y/N)



	StrokEDGE II	No	Yes	No	Not reported
Considerations	Stroke: (Schuster et al, 2010; n = 23 post stroke patients with minimal motor function in the upper extremity, 26 days to 8 years post-stroke, validation of the CAHAI in German; CAHAI-G)				
	 Excellent correlation between the chedoke MeMaster Stroke Assessment subscale hand and CAHAI-G 13 (r = .74) Excellent correlation between the Chedoke-McMaster Stroke Assessment subscale arm and CAHAI-G 13 (r = .67) Excellent reliability (ICC = 0.99) for CAHAI-G 13 				
	These translat <u>Conditions</u> of for and does r party website quality, conte translation to	tions, and links Use of the Reha not endorse the , and does not i nt or accuracy. the RMD, pleas	to them, are s ab Measures I content, pro- make any rep If you would I se contact us a	subject to the <u>Terr</u> Database. RIC is n ducts or services o resentations rega like to contribute at <u>rehabmeasures</u>	<u>ms and</u> ot responsible of any third- rding its a language s <u>@ric.org</u>
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Year published	2004
Instrument in PDF Format	Yes
Approval Status	Approved



8. REHAB MEASURES: CHEDOKE MCMASTER STROKE ASSESSMENT MEASURE

Link to instrument	<u>Chedoke-McMaster Stroke Assessment Measure Manual and Scoring</u> Form (other languages available below)		
Title of Assessment	Chedoke-McMaster Stroke Assessment Measure		
Acronym	CMSA		
Instrument Reviewer(s)	Reviewed by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto-Zipp, PT, EdD of the StrokEDGE II, Neurology Section, APTA in 3/2016		
Summary Date	March 2016		
Purpose	Assesses physical impairment and disability in clients with stroke and other neurological impairment		
Description	 The CMSA is composed of two inventories: 1. <u>Impairment Inventory</u>: Used to determine the presence and severity of common physical impairments. It has six dimensions: Recovery stage of the arm Hand Leg Foot Postural control Shoulder pain 		
	Each dimension is measured on a 7-point scale, each point corresponds to seven stages of motor recovery. The 7-point scale for shoulder pain is based on pain severity.		
	2. <u>Activity Inventory</u> measures clinically important changes in the client's functional ability. This Activity Inventory is made up of a gross motor function and walking subscale.		
	• <u>The Gross Motor Function</u> index consists of the 10 following items:		
	1. Supine to side lying on strong side		
	2. Supine to side lying on weak side		
	3. Side lying to long sitting through strong side		
	4. Side lying to sitting on side of the bed through strong side		



- 5. Side lying to sitting on side of the bed through weak side
- 6. Standing
- 7. Transfer to and from bed toward strong side
- 8. Transfer to and from bed toward weak side
- 9. Transfer up and down from floor to chair
- 10. Transfer up and down from floor and standing.
- <u>The Walking Index</u> consists of the 5 following items:
 - 1. Walking indoors
 - 2. Walking outdoors, over rough ground, ramps, and curbs
 - 3. Walking outdoors several blocks
 - 4. Stairs
 - 5. Age and sex appropriate walking distance in meters for 2 minutes.
- Impairment Inventory is scored on a 7-point scale, where:
 - 1 = Flaccid paralysis
 - 2 = Spasticity is present and felt as a resistance to passive movement
 - 3 = Marked spasticity but voluntary movement present within synergistic patterns
 - 4 = Spasticity decreases
 - 5 = Spasticity wanes but is evident with rapid movement at the extremes of range
 - 6 = Coordination and patterns of movement are near normal
 - 7 = Normal movement.
- The 7-point scale corresponds to seven stages of motor recovery. The 7-point scale for shoulder pain is based on pain severity.
- The minimum score for the Impairment Inventory is 6 and the maximum score is 42 (Gowland et al, 1993).



	• The Activity Inventory is also scored on a 7-point scale, based on the amount of assistance the individual with stroke requires. It is categorized by:
	• The need for assistance from another person
	• The need for equipment, or
	• The need for extra time to accomplish a task.
	 For the Activity Inventory, the scoring key from the Functional Independence Measure is used, where:
	 1 = The client needs total assistance
	 2 = Maximal assistance
	 3 = Moderate assistance
	• 4 = Minimal assistance
	 5 = Clients needs supervision
	 6 = Client is modified independent (needs assistance from devices)
	• 7 = Client is timely and safely independent.
	• The maximum score is 100, where higher scores reflect normal function (Finch et al, 2002; Gowland et al, 1993).
	• The maximum score for the gross motor function index is 70
	• The maximum score for the walking index is 30 (Gowland et al, 1993).
	 A 2-point bonus should be assigned for those who walk appropriate distances in meters based on norms for the patient's age and sex, on item 15 (the 2-Minute Walk Test) (Huijbregts at al, 2000)
Area of Assessment	Functional Mobility
Body Part	Not Applicable
ICF Domain	Body Function; Activity
Domain	Motor



Assessment Type	Observer		
Length of Test	31 to 60 Minutes		
Time to Administer	45-60 minutes		
Number of Items	Not applicable		
Equipment Required	 An adjustable table Chair with armrests Floor mat Pillows A pitcher with water A measuring cup A ball 2.5 inches in diameter A footstool A 2m line marked on the floor Stopwatch 		
Training Required	The administrative guidelines can be used to learn how to administer the test. However, a training workshop is recommended to increase confidence in the ability to administer and score the measure accurately. A training workshop is also recommended if the measure is intended to be used to collect data for research purposes. Further information about training can be found at the <u>instrument's website</u> .		
Type of training required	Reading an Article/Manual		
Cost	Free		
Actual Cost	Free		



Age Range	Adult: 18-64 years; Elderly adult: 65+		
Administration Mode	Paper/Pencil		
Diagnosis	Stroke		
Populations Tested	 Stroke Brain Injury Other Neurological Disorders 		
Standard Error of Measurement (SEM)	Not Established		
Minimal Detectable Change (MDC)	Not Established		
Minimally Clinically Important Difference (MCID)	 Acute Stroke: (Gowland et al 1993; n = 32; mean age = 64; mean time since stroke onset = 9 months) MCID = 8 points (total CMSA via stroke patients) and 7 points (total CMSA via caregivers of stroke patients). 		
Cut-Off Scores	> 9 on the leg and postural control scores indicates that the individual is able to ambulate independently. (Stevenson, 1999)		
Normative Data	Not Established		
Test-retest Reliability	 Acute Stroke: (Gowland et al, 1993) Excellent test-retest reliability, Disability Inventory (ICC = 0.98) 		
Interrater/Intrarater Reliability	 Acute Stroke: (Gowland et al, 1993) Excellent inter-rater reliability, Impairment inventory ICC = 0.97 Excellent inter-rater reliability, Disability inventory ICC = 0.99 Excellent intra-rater reliability, Impairment inventory ICC = 0.98 		
Internal Consistency	 Acute Stroke: (Gowland et al, 1993) Excellent internal consistency, Total scale ICC = 0.98 		



Criterion Validity (Predictive/Concurrent)

Acute Stroke: (Gowland et al, 1993)

- **Excellent** concurrent validity: Fugl-Meyer (*r* = 0.95)
- **Excellent** concurrent validity: FIM (*r* = 0.79)
- Excellent concurrent validity: Barthel Index of ADLs (r = 0.75 -0.87 *Disability Index)
- **Poor** concurrent validity with, Barthel Index: areas of shoulder pain & eating and bowel incontinence (*r* <0.30)
- **Excellent** predictive validity, Physical Impairment Scale Leg postural control scores of >9 showed 100% sensitivity and 80% specificity in prediction of independent ambulation.
- Excellent predictive validity, Total outcome of CMSA stroke assessment could be predicted by 7 items on the Barthel Index (R-2 = 0.75)

Predictive Equations:

Predicting Clinical Outcomes following Stroke Rehabilitation (Gowland et al, 1995):

Outcome Variables	R squared	Equation	CI
Discharge Destination	0.38	5.97 – (0.06 x Gross Motor Function) – (0.21 x Bladder)	±3.5
Length of Stay	0.38	22.03–(1.18 x Leg)–(0.05 x Adult FIM [™])–(0.06 xAge)	±6.9
Adult FIM sm	0.65	39.23+(0.73 x Adult FIM SM)	±29.6
Activity Inventory	0.73	17.45+(0.88 x Gross Motor Function) + (4.30 x Leg)	±23.3
Gross Motor Function	0.7	24.94+(0.76 x Gross Motor Function)– (0.30 x Weeks)	±16.1
Walking	0.71	(Gross Motor Function x 0.28)+(Postural Control+Leg x 1.23)–4.55	±9.2
Shoulder Pain	0.55	2.33+(0.44xShoulder Pain) + (0.28 x Arm)	±1.6



	Postural Control	0.60	2.23 + (0.35 x Postural Control) + (0.3 x Leg)	±1.3
	Arm	0.80	0.82+(1.03 x Arm)-(0.03 x Weeks)	±1.5
	Hand	0.78	0.53+(0.98 x Hand)	±1.5
	Leg	0.69	1.83+(0.77 x Leg)-(0.02 x Weeks)	±1.5
	Foot	0.73	1.11+(0.90 x Foot)-(0.03 x Weeks)	±1.3
	Predictive Equati	ions for St	roke Acute Care can be found <u>HERE</u>	
Construct Validity (Convergent/Discriminant)	 Acute Stroke: (Gowland et al, 1993) Excellent convergent validity with subscales of the Fugl-Me Assessment (FMA) Excellent convergent validity with the CMSA Arm and hand Impairment Inventory and FMA shoulder, elbow, forewrist and hand scale (r = 0.95) Excellent convergent validity with the CMSA Leg and foot Impairment Inventory and FMA hip, knee, foot and ankle sc 0.93) Excellent convergent validity with the CMSA Postural contraFMA balance scale (r = 0.84) Excellent convergent validity with the CMSA Shoulder pain Impairment Inventory and FMA upper limb joint pain scale 0.76) CMSA Activity Inventory and the Functional Independence Measure convergent validity evidence: Excellent convergent validity with the CMSA gross motor fuindex and the FIM Mobility subscale (r = 0.90) Excellent convergent validity with the CMSA malking index 		/er arm, ale (<i>r</i> = bl and (<i>r</i> = (FIM) nction and	
Content Validity	Moreland. Gowla	and, Van H	ullenar, and Huijbregts (1993) performed	d a
	literature review Chedoke-McMas had enough scier	to gather ster Stroke ntific evide	evidence for a theoretical basis of the Assessment. All items from both invento ence supporting its assumptions. Thus, th	ries e



authors were able to establish a theoretical basis underlying the content of the Chedoke-McMaster Stroke Assessment.

Face Validity	Not Established			
Floor/Ceiling Effects	Not Established			
Responsiveness	The CMSA Disability Inventory is more sensitive to the FIM at detecting clinically important change. (Gowland et al, 1993)			
Professional Association Recommendations	Recomment Neurologic Association Taskforce (Taskforce (Vestibular were devel modified D For detailed visit: <u>http://section-out</u>	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology- section-outcome-measures-recommendations</u>		
	Abbreviations:			
	HR	Highly Recommend		
	R Recommend			
	LS / UR Reasonable to use, but limited study in target group / Unable to Recommend			
	NR	NR Not Recommended		

Recommendations for use based on acuity level of the patient:

Acute	Subacute	Chronic
(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)



	(SCI < 1 month post) (Vestibular < 6 months post)	(SCI 3 to 6 months)	
StrokEDGE II	R	R	R

Recommendations based on level of care in which the assessment is taken:

	Acut e Care	Inpatient Rehabilitatio n	Skilled Nursin g Facility	Outpatient Rehabilitatio n	Home Healt h
StrokEDG E II	R	R	UR	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE	Νο	Yes	Yes	Not reported

Considerations

Chedoke-McMaster Stroke Assessment Measure translations:

French:

http://www.physiotherapy.ca/Practice-Resources/Orders

These translations, and links to them, are subject to the <u>Terms and</u> <u>Conditions of Use</u> of the Rehab Measures Database. RIC is not responsible for and does not endorse the content, products or services of any thirdparty website, and does not make any representations regarding its



	 quality, content or accuracy. If you would like to contribute a language translation to the RMD, please contact us at <u>rehabmeasures@ric.org</u>. Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u>!
Bibliography	Gowland, C., Stratford, P., et al. (1993). "Measuring physical impairment and disability with the Chedoke-McMaster Stroke Assessment." Stroke 24(1): 58. <u>Find it on PubMed</u>
	Huijbregts, M., Gowland, C., et al. (2000). "Measuring clinically-important change with the activity inventory of the Chedoke McMaster Stroke Assessment." Physiotherapy Canada 52(4): 295-304.
	Morland, J., Gowland, C., et al. (1993). "Theoretical basis of the Chedoke- McMaster Stroke Assessment." Physiotherapy Canada 45: 231-231.
Year published	1993
Instrument in PDF Format	Yes
Approval Status	Approved


9. REHAB MEASURES DATABASE—DASH

Link to instrument	DASH Website
Title of Assessment	Disabilities of the Arm, Shoulder, and Hand Questionnaire
Acronym	DASH
Instrument Reviewer(s)	Initially reviewed by Jill Smiley, MPH and Allison Todd in 5/2012; Updated by Franco Calabrese, SPT, Adam Fagan, SPT, and Patrick Galvin, SPT in 11/2012. Updated by Melissa M. Eden PT, DPT, OCS. Reviewed by Dorian Rose, PhD, PT StrokEDGE II Task Force November 2017.
Summary Date	8/7/2014
Purpose	The DASH is designed to evaluate disorders and measure disability of the upper extremities, and monitor change or function over time.
Description	Developed jointly by the Institute for Work & Health and the American Academy of Orthopaedic Surgeons (AAOS). The DASH was first published in 1996. It has 2 shortened versions, the QuickDASH and the QuickDASH-9. The DASH has been formally translated into 41 versions. There are 18 translations in progress.
	The DASH is a 30-item self-report questionnaire designed to assess musculoskeletal disorders of the upper limbs. It has two, 4-item, optional modules used to measure symptoms and function in athletes, artists, and workers who require a high level of function. Scoring the DASH:
	 The 30-item disability/symptom section (item responses range from 1 (e.g. no difficulty, not at all, not limited, none, strongly disagree) to 5 (e.g. unable, extremely, unable, strongly agree)) Scoring: [(sum of n / n) - 1] x 25; n = number of completed responses (see test sheet for more information) The DASH should not be scored if more than three items are missing Optional 4-item high performance section Add values of each response, then divide by 4, subtract 1 and multiply by 25: [((sum of values/4) - 1)*25] Optional modules should not be scored if items are missing



•	More information, including a PDF of the DASH, can be found on
	the <u>DASH website</u>

Area of Assessment	Upper Extremity Function
Body Part	Upper Extremity
ICF Domain	Body Structure; Body Function; Activity; Participation
Domain	ADL; Motor
Assessment Type	Patient Reported Outcomes
Length of Test	06 to 30 Minutes
Time to Administer	05 to 30 Minutes
Number of Items	30 (34, if option high performance section is needed)
Equipment Required	None
Training Required	No Training
Type of training required	No Training
Cost	Free
Actual Cost	Free
Age Range	Adult: 18-64 years
Administration Mode	Paper/Pencil
Diagnosis	Arthritis; Geriatrics; Movement Disorders; Multiple Sclerosis; Pain; Stroke
Populations Tested	 Adults with wrist, hand, elbow and should disorders Rheumatoid Arthritis Psoriatic Arthritis and Inflammatory Disease Athletes Carpal Tunnel Syndrome Elbow Arthroplasty Neck Pain Proximal Humeral Fractures Trauma Disorders Post-Operative Upper Extremity Surgery Multiple Sclerosis Adhesive Capsulitis



	 Non-traumation symptoms Shoulder Imple Stroke 	c neck (ingeme	compla nt	aints v	with Up	per Ext	remity
Standard Error of Measurement (SEM)	Intercollegiate Athle (Hsu et al, 2010; <i>n</i> = 32) physical, Intercollegiate • 3.61 (Calculated 1.96 x SEM x so Osteoarthritis: (Vermeulen et al, 2009; Osteoarthritis; evaluated Analysis of the Change Evaluations	$\frac{\text{tes}}{1; \text{ mean}}$ Athletes d from N quare ro $n = 19,$ d at 0, 3, in DASH	age 19 i) IDC = 1 ot of 2) Primary 6 and I Score).4 (17 .96 x / Thun 12 mo From	.6-22.6) SEM x s nb Carpo onths, Os Preope	years; F quare ro ometaca steoarthi rative Cl	Pre-competition bot of 2; 10 = arpal ritis) linical
		Mean	SD	SEM	Lower	Upper	
	DASH 0 to DASH 3	-14 93	9.63	2 27	-10 14	-19 72	
	DASH 0 to DASH 6	-20.54	14.58	3.26	-13 71	-27.36	
	DASH 0 to DASH 12	-20.83	20.09	4.49	-11.42	-30.23	
	*Paired differences of th preoperative, DASH 3 is DASH score at 6 month Proximal Humeral Frac	e DASH s mean [s, and D ctures:	l scores DASH s PASH 12	s. DAS core a 2 is m	SH 0 is n at 3 mon ean DAS	nean DA ths, DAS SH score	∖SH score SH 6 is mean ∋ at 12 months.

(Slobogean et al, 2010; n = 61, mean age = 69, Proximal Humeral Fractures)

- Calculated using SEM = Standard Deviation of first outcome * square root (1-ICC)
- SEM = 21.7 * square root (1 0.928) = 5.82

Adults with musculoskeletal upper extremity problems:

(Schmitt J.S., Di Fabio R.P., 2004)

• SEM = 5.22

(Beaton D.E., Katz J.N., Fossel A.H., Wright J.G., Tarasuk V., Bombardier C., 2001)



	• SEM = 4.6
Minimal Detectable Change (MDC)	Intercollegiate Athletes:
	(Hsu et al, 2010; $n = 321$; mean age 19.4 (17.6-22.6) years; Pre-competition physical, Intercollegiate Athletes)
	• MDC = 10
	Proximal Humeral Fractures:
	(Slobogean et al., 2010; n = 61, mean age = 69, Proximal Humeral Fractures)
	 Calculated from MDC = 1.96 * SEM * (square root of 2) MDC = 1.96 * 5.82 * (square root of 2) = 16.1
	Adults with musculoskeletal upper extremity problems:
	(Schmitt J.S., Di Fabio R.P., 2004)
	• MDC90 = 12.2
	(Beaton D.E., Katz J.N., Fossel A.H., Wright J.G., Tarasuk V., Bombardier C., 2001)
	 MDC90 = 10.7 MDC95 = 12.75
Minimally Clinically Important Difference (MCID)	 Intercollegiate Athletes: (Hsu et al, 2010; n = 321; mean age 19.4 (17.6-22.6) years; Pre-competition physical, Intercollegiate Athletes) MCID = 10 Pre-operative and Post-operative change in UE Function: (Gummesson, Atroshi and Ekdah; 2003; n = 109; patients had surgery for a variety of upper extermity conditions; assessed prior to surgery then again 6 to 21 months later; Swiss sample) Patients (n = 53) reporting "much better" or "much worse" Mean Change = 19 (15 to 23) points Patients (n = 21) reporting "somewhat better" or "somewhat worse"



	• Patients (n = 9) reporting "no cha	ange"					
	• Mean change = -3 (-3 to	3.0) points					
	Total Elbow Arthroplasty:						
	(Angst et al, 2012; <i>n</i> = 65; 61.9 (13.0), To	otal Elbow Ar	throp	lasty)			
	• Standard Response Mean = 0.55	5, Effect Size	= 0.2	20)			
	Adults with upper extremity musculos	keletal com	olain	ts undergoing			
	surgery:			<u> </u>			
	(Angst F., Schwyzer H.K., Aeschlimann A	A., Simmen B	.R.,	Goldhahn J., 2011)			
	• MCID = 10.2						
	Adults with musculoskeletal upper ext	tremity prob	lems	<u>;;</u>			
	(Schmitt J.S., Di Fabio R.P., 2004)						
	• MCID = 10.2						
Cut-Off Scores	Not Established						
Normative Data	Elbow Disorders:						
	(Angst et al, 2005; <i>n</i> = 79; mean age = 64	4.1 (13.3) yea	ars; t	ime since surgery =			
	11.2 (3.0) years; Function following total	elbow arthrop	blast	y; Swiss sample,			
	Elbow Disorders)						
	1-		1				
	Instrument	Mean (SD)	n				
	DASH	55.3 (23.2)	77				
	DASH function	51.1 (25.2)	77				
	DASH symptoms	66.1 (22.8)	79				
	SF-36 physical functioning	48.7 (28.4)	79				
	SF-36 role physical	45.1 (44.7)	76				
	SF-36 bodily pain	59.1 (27.5)	79				
	SF-36 general health	56.0 (25.7)	78				
	SF-36 vitality	48.4 (22.4)	78				
	SF-36 social functioning	80.7 (22.8)	79				
	SF-36 role emotional	74.8 (41.9)	72				
	SF-36 mental health	71.4 (20.6)	78				
	SF-36 physical component summary	37.2 (12.0)	75				
	SF-36 mental component summary	52.3 (11.5)	69				
	SF-36: Short Form 36						



DASH: Disabilities of the Arm, Shoulder, and Hand Questionnaire

Osteoarthritis:

(MacDermid et al, 2007; n = 122; mean age = 65.4 (8.1) years; time since surgery = 54.2 (23.1) months, Osteoarthritis)

Arthroplasty of the ca osteoarthritis	arpometac	arpal joint	for	
	Minimum	Maximum	Mean	SD
DASH	0	90.8	36.7	24.03
PRWHE	0	92	41.5	28.33
SF-36 Mental Component Summary	21.9	66.7	47.9	11.67
SF-36 Physical Component Summary	12.0	61.5	34.6	11.38
PRWHE: Patient-Rated DASH: Disabilities of A Questionnaire SF-36: Short Form 36	d Wrist Har Irm, Should	nd Evaluatio der, and Ha	on nd	

Rheumatoid Arthritis:

(Chiari-Grisar et al, 2006; n = 37; Function following finger joint arthroplasty in patients with rheumatoid arthritis; study performed in Austria; grip strength scores measured with a Martin vigorimeter, Rheumatoid Arthritis)

Instrument	Mean (SD)	Median	Min	Мах
DASH (German version) score	44.52 (19.14)	44.2	5	82.5
HAQ score	1.12 (0.76)	1.06	0	2.88
DASH: Disabilities of Arm, Questionnaire HAQ: Health Assessment	Shoulder, ar Questionnair	nd Hand e		

Wrist Disorders:

(Imaeda et al, 2010; n = 117; adapted by the Japanese Society for Surgery of the Hand, Japanese sample, Wrist Disorders)

Score for PR	WE,	DASH	-JSS	H, and	VAS:	
Instrumenta I Scale	No.	Mean	SD	Media n	Minimu m	Maximu m
DASH-JSSH	116	44.2	28.2	39.5	0(a)	100(b)



	PRWE	112	58.7	24.3	61.5	5	99	
	VAS	111	59.3	24.3	60	6	100(b)	
	PRWE: Pati DASH-JSSH version of th (DASH) que VAS: Visual Maximum H	ent-Re I: Disa e Disa stionn Analo ealth \$	elated \ bility/S abilities atire gue So Status	Wrist Sympt of th cale fo Score	Evaluatio om scale e Arm, Sl or Pain (0 es (Ceiling	n of the Ja _l noulder, a -10 Scale g)	panese nd Hand :)	
Test-retest Reliability	Overhead A (Alberta et al • Ade Proximal Hu (Slobogean	thlete , 2010 quate <u>umera</u> et al, 2	<u>s:</u>); <i>n</i> = 2 test-re <u>I Fract</u> 2010; <i>n</i>	52 m test r <u>ures</u> = 61	ean age = eliability (, mean ag	= 23.7, Ov (ICC = 0.5 ge = 69, P	verhead A 536) Proximal H	thletes) Iumeral Fractures)
	Instrument	ICC (§ CI)	95%	Mea	enability (in erence	Limits of Agreen	of nent	
	EQ-5D	0.773 to 0.8	(0.604 75)	0.03	6 (0.00 to 5)	-0.18 to	0.24	
	HUI3	0.471 to 0.6	(0.184 86)	0.04 0.11	(-0.03 to)	-0.37 to	0.45	
	SF-6D	0.794 to 0.8	(0.634 89)	0.01 0.04	(-0.02 to -)	-0.17 to	0.19	
	DASH	0.928 to 0.9	(0.860 63)	0.4 3.1)	(-2.3 to	-15.2 to	15.9	
	Total Elbow	Arthr	oplast	: y:				
	(Angst et al, 2012; <i>n</i> = 65; 61.9 (13.0), Total Elbow Arthroplasty)							
	• Exc	ellent	test-re	test re	eliability (ICC = 0.9	6)	
	Rheumatoid Arthritis:							
	(Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008)							
	• ICC = 0.97							
	<u>Swedish Pa</u>	<u>tients</u>	with F	Rheur	<u>matoid A</u>	<u>rthritis:</u>		
	(Bilberg A., E	Breme	II T., M	anne	rkorpi K.,	2012; <i>n</i> =	- 67)	
	• ICC	= 0.99) (95%	CI, 0	.98-0.99)			
	Adults with	musc	uloske	eletal	upper ex	xtremity p	oroblems	<u>.</u>
	(Schmitt J.S.	, Di Fa	abio R.	P., 20	004)			



	• ICC = 0.91
	(Beaton D.E., Katz J.N., Fossel A.H., Wright J.G., Tarasuk V., Bombardier C., 2001)
	• ICC = 0.96 (95% CI, 0.93-0.98)
	Patients Post-Stroke (n=32; 27.9±14.4 days post-stroke)
	(Dalton E, Lannin NA, Laver K, Ross L, Ashford S, McCluskey A, Cusick A., 2016)
	• ICC=0.56 (95% CI 0.05-0.79)
Interrater/Intrarater Reliability	Proximal Humeral Fractures:
	(Slobogean et al, 2010; $n = 61$, mean age = 69, Proximal Humeral Fractures)
	See Test-retest reliability in Proximal Humeral Fractures for format
Internal Consistency	Rheumatoid Arthritis:
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008)
Internal Consistency	 <u>Rheumatoid Arthritis:</u> (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) Cronbach's alpha = 0.97
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery:
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003)
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97 Adults with Multiple Sclerosis:
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97 Adults with Multiple Sclerosis: (Cano S., Barrett L., Zajicek J., Hobart J., 2011)
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97 Adults with Multiple Sclerosis: (Cano S., Barrett L., Zajicek J., Hobart J., 2011) • Cronbach's alpha = 0.98
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97 Adults with Multiple Sclerosis: (Cano S., Barrett L., Zajicek J., Hobart J., 2011) • Cronbach's alpha = 0.98
Internal Consistency	Rheumatoid Arthritis: (Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008) • Cronbach's alpha = 0.97 Adults with upper extremity musculoskeletal complaints undergoing surgery: (Gummesson C., Atroshi I., Ekdahl C., 2003) • Cronbach's alpha = 0.92-0.97 Adults with Multiple Sclerosis: (Cano S., Barrett L., Zajicek J., Hobart J., 2011) • Cronbach's alpha = 0.98 General Population: (Hunsaker F.G., Cioffi D.A., Amadio P.C., Wright J.G., Caughlin B., 2002)



(Dalton E, Lannin NA, Laver K, Ross L, Ashford S, McCluskey A, Cusick A., 2016)

• Cronbach's alpha = 0.92, SEM = 6.65

Criterion Validity (Predictive/Concurre nt)	Neck Pain:							
,	(Mehta	et al., 2	010; <i>n</i> =	66, me	an age=	40.6 (14	.2), Neck	Pain)
	•	Both ve	ersions o	of the DA	ASH sho	wed high	correlatio	on (0.82-0.84) with
		the ND	l and mo	oderate	correlati	on with th	ne CSOQ	and VAS.
	Correlation Between Self-Report Measures							
		CSOQ Neck Pain	CSOQ Shoul der and Arm Pain	CSOQ Physic al Sympt om	CSOQ Functi onal Disabil ity	CSOQ Psychol ogical Distress	VAS	
	DASH	0.61*	0.55*	0.67*	0.58*	0.56*	0.55*	
	*Correlation is significant at the 0.01 level (2-tailed); CSOQ= Cervical spine outcome questionnaire; VAS= Visual Analog Scale							
	Patients Post-Stroke (n=32; 27.9±14.4 days post-stroke)							
	(Dalton E, Lannin NA, Laver K, Ross L, Ashford S, McCluskey A, Cusick A., 2016)							
	Spearman's rho between DASH and Patient Rated Wrist Evaluation (PRWE)							
	$r_s=0.4 \ (p=0.023)$							
Construct Validity (Convergent/Discrimi nant)	Neck Pain:							
	(Huisstede et al., 2009; <i>n</i> = 679; 41.0 (23.0), Neck Pain)							
		SF-12 Comp	Physic onent	al SF- Cor	12 Men nponen	tal Sev	verity	
		Correl	ation	Cor	relation	n Co	rrelation	



S-A-H	0.62	0.15	0.55
N-S- A-H	0.61	0.16	0.52
N-S- A-H	0.63	0.19	0.5
Ν	0.62	0.27	0.44
S-A- H- only	0.61	0.1	0.56
N- only	0.57	0.33	0.44

Osteoarthritis:

(MacDermid et al, 2007; n = 122; function following arthroplasty of the carpometacarpal joint of the hand for osteoarthritis; Osteoarthritis)

Correlations of the SF-36 component summary
scores with PRWHE and DASH Scores

SF-36 Subscale	PRWHE	DASH		
Physical Component Summary	-0.35	-0.49		
Mental Component Summary	-0.45	-0.49		
All correlations significant at the 0.01 level (2-tailed) SF-36: Short Form 36 PRWHE: Patient-Rated Wrist Hand Evaluation				

Correlation between self-report function scores and measured impairments*					
	PRWHE total DASH				
Strength					
Grip	-0.45**	-0.43**			
Tripod pinch	-0.45**	-0.44**			
Key pinch	-0.36**	-0.40**			
Wrist flexion	-0.39**	-0.44**			
Wrist extension	-0.39**	-0.37**			
Dexterity					
NK small objects	0.32**	0.30**			
NK medium objects	0.39**	0.48**			
NK large objects 0.44** 0.48**					
Range of Motion					
Wrist flexion -0.26** -0.23*					
Wrist extension -0.05 -0.07					



Radial deviation	-0.15	-0.12		
Ulnar deviation	-0.23*	-0.12		
Pronation	-0.05	-0.03		
Supination	0.00	-0.01		
Thumb IP flexion	0.03	-0.08		
Thumb MCP flexion	0.03	0.05		
Thumb IP extension	0.12	0.06		
Thumb MCP extension	-0.10	-0.02		
Thumb CMC extension	-0.12	-0.11		
Thumb abduction	0.01	0.03		
Thumb opposition	0.11	0.10		
Hand Span	-0.34**	-0.25**		
*Impairments measured using the NK Hand Assessment System ** Correlation significant at 0.01 (2-tailed). *Correlation significant at 0.05 (2-tailed) PRWHE: Patient-Rated Wrist Hand Evaluation DASH: Disabilities of Arm, Shoulder, Hand				

Proximal Humeral Fractures:

(Slobogean et al, 2010; n = 61, mean age = 69, Proximal Humeral Fractures)

Spearman Correlations between Study Instruments						
Self Function	1					
SF-12 PCS	0.49	1				
DASH	-0.76		1			
EQ-5D	0.53	0.73	-0.75	1		
HUI3	0.38*	0.63	-0.58	0.63	1	
SF-6D	0.45	0.83	-0.73	0.74	0.59	1
All correlation	s are sig	gnificar	nt to P «	< 0.01.	except	t

Self Function, HUI3 where P < 0.02.

Rheumatoid Arthritis:

(Chiari-Grisar et al, 2006; n = 37; Function following finger joint arthroplasty in patients with rheumatoid arthritis; study performed in Austria, Rheumatoid Arthritis)

SF-36	Mean	Correlation to DASH
Subscale	(SD)	(German version)



Physical functioning	47.16 (24.17)	-0.73 (<i>P</i> < 0.01)
Role-physical	32.43 (44.04)	-0.53 (<i>P</i> < 0.01)
Bodily pain	43.92 (22.37)	-0.53 (<i>P</i> < 0.01)
General health	51.41 (18.62)	-0.43 (<i>P</i> < 0.01)
Vitality	46.08 (22.36)	-0.51 (<i>P</i> < 0.001)
Social functioning	81.42 (21.77)	-0.35 (<i>P</i> < 0.03)
Role-emotional	72.97 (41.45)	-0.31 (<i>P</i> < 0.05)
Mental health	71.24 (18.66)	-0.57 (<i>P</i> < 0.001)

SF-36: Short Form 36

DASH: Disabilities of Arm, Shoulder, Hand

(Raven E.E.J., Haverkamp D., Siervelt I.N., et al., 2008)

- Correlation of DASH and other outcome measures: (Pearson correlation)
 - Health Assessment Questionnaire r = 0.88
 - \circ SF-36 r = 0.70
 - Arthritis Impact Measurement Scale r = 0.85
 - \circ Disease Activity Score r = 0.42
 - \circ Grip Strength r = 0.41-0.48
 - Visual Analog Scale r = 0.60-0.65

Swedish Patients with Rheumatoid Arthritis:

(Bilberg A., Bremell T., Mannerkorpi K., 2012; *n* = 67)

- Correlation of DASH and other outcome measures: (Spearman correlation)
 - Health Assessment Questionnaire -r = 0.80
 - \circ Active shoulder-arm motion r = -0.38 to -0.50
 - Handgrip force -r = -0.46 to -0.59
 - Activity-Induced pain r = 0.66
 - \circ Disease Activity Score in 28 joints r = 0.63



Adults with musculoskeletal upper extremity problems:

(Schmitt J.S., Di Fabio R.P., 2004)

• Global Disability Rating – Spearman r = 0.67-0.71

(Beaton D.E., Katz J.N., Fossel A.H., Wright J.G., Tarasuk V., Bombardier C., 2001)

- SPADI pain Pearson r = 0.79, Spearman r = 0.76
- SPADI function Pearson r = 0.85, Spearman r = 0.83

Adhesive Capsulitis:

(Staples M.P., Forbes A., Green S., Buchbinder R., 2010)

- SPADI r = 0.55
- Croft Index r = 0.65
- Visual Analog Scale r = 0.31
- Health Assessment Questionnaire r = 0.54

Shoulder Arthroplasty (Switzerland, German-language):

(Angst F., Pap G., Mannion A.F., et al., 2004; *n* = 43)

- SF-36 (PCS) r = 0.67
- SF-36 (MCS) r = 0.06
- SPADI r = 0.93
- pASES r = 0.79
- cASES r = 0.59
- Constant Shoulder r = 0.82

Discriminative Validity:

Adults with musculoskeletal upper extremity problems:

(Beaton D.E., Katz J.N., Fossel A.H., Wright J.G., Tarasuk V., Bombardier C., 2001)



	 Partici were a those Simila could 47.1, t 	ipants who were working with their upper limb condition and able to continue to work had a significantly lower disability than unable to work (26.8 vs. 50.7, t=-7.51, p<0.0001). rly, the DASH was able to discriminate between those who do everything they wanted to vs. those who could not (23.6 vs. =-5.81, p<0.0001).					
Content Validity	Not Establishe	d					
Face Validity	Not Establishe	d					
Professional Association Recommendations	Recommendati Therapy of the (StrokEDGE II) clinical experts.	ons for use of the instrument from the Academy of Neurologic Physical American Physical Therapy Association's Stroke Taskforce These recommendations were developed by a panel of research and					
	Abbreviations:						
	HR	Highly Recommend					
	R	Recommend					

 LS / UR
 Reasonable to use, but limited study in target group / Unable to Red

 NR
 Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
StrokEDGE II	NR	LS	LS

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	NR	NR	NR	LS	LS

Recommendations for entry-level physical therapy education and use in research:

Students	Students	Appropriate	Is additional research
should learn	should be	for use in	
to administer	exposed	intervention	warranted for



	this tool? (Y/N)	to tool? (Y/N)	research studies? (Y/N)	this tool (Y/N)
StrokEDGE II	N	Ŷ	Y	Y

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disabilities of arm, shoulder and hand questionnaire in adults following stroke.
Disability and Rehabilitation. 2017; 39:2504-2511. Find it on PubMed



10. REHAB MEASURES DATABASE-DYNAMOMETRY

Link to instrument		
Title of Assessment	Hand-held Dynamometry	
Acronym		
Instrument Reviewer(s)	Originally reviewed by StrokEDGE task force Re-reviewed by Heather Anderson and Rie Yoshida of the StrokEDGE II	
	task force.	
Summary Date	4/28/16	
Purpose	A quantitative and objective measure of isometric muscular strength	
Description	 Clients are asked to maintain an isometric contraction (for either a "make" or "break test") for 2-5 seconds. During a "make" test the client pushes the body segment into the dynamometer. During a "break" test, the examiner asks the client to maintain a static position while the examiner applies resistance. This instrument is scored using force production: kilograms, Newtons or pounds of force Kilograms (0-90), Pounds (0-200) 	
Area of Assessment	Muscle strength	
Body Part	UE, LE	
ICF Domain	Body Structure; Body Function	
Domain	Motor	
Assessment Type	Performance based	
Length of Test	05 Minutes or Less	
Time to Administer	Variable depending on the number of muscles being tested and the number of trials performed. Standard is up to 5 seconds per muscle tested.	
Number of Items	1	
Equipment Required	Requires purchase of a hand-held dynamometer	
Training Required	Reading of the instruction manual, familiarizing oneself to the dynamometer features	



Type of training required	Reading an Article/Manual			
Cost	Approximately \$1000 or more for each dynamometer			
Actual Cost	Cost of instrument varies depending on the manufacture			
Age Range	Pediatric-adult			
Administration Mode	Therapist conducts motor strength testing with dynamometer instrument			
Diagnosis	Geriatrics; Stroke			
Populations Tested	GeriatricsHealthy AdultsStroke			
Standard Error of Measurement (SEM)	Chronic Strol (Bertrand, et a as a result of a trials with time not fixed; parti Session/Tria 1,1 1,3 2,1 2,3	ke: al, 2007; n = 17; a unilateral stroke intervals betwee cipants were not Paretic SEM 28.78 (20%) 26.15 (18%) 20.35 (14%) 18.49 (13%)	mean age 53.7(1 (e that occurred > een two sessions a ot involved in a ref Non-paretic SEM 22.27 (8%) 17.10 (6%) 16.07 (6%) 12.23 (4%)	3.0); paresis of the arm one year earlier; three as well as the time of day nabilitation program)
	 SEM = 0.10 (19%) session 1 SEM = 0.07 (13%) session 2 			
Minimal Detectable Change (MDC)	Not Establishe	ed		
Minimally Clinically Important Difference (MCID)	Not Established			
Cut-Off Scores	Not Established			
Normative Data				
Test-retest Reliability	Stroke:			



(Bertrand et al, 2007, Chronic Stroke)

• Excellent test-retest reliability (ICC 0.80 to 0.89)

<u>Community Dwelling Older Adults:</u> (Abizanda, et al., 2012, n=281; mean age = 74.3 (4.9) years, healthy older adults)

• **Excellent** test-retest reliability (ICC = 0.9874)

Stroke and TBI:

(Riddle et al 1989; measurements at wrist, elbow, shoulder, hip, knee and ankle)

• **Excellent** test-retest reliability (ICC = 0.79-0.97)

Stroke, TBI, SCI and peripheral neuropathy

(Bohannon 1986; measurements at wrist, elbow, shoulder, hip, knee and ankle)

• **Excellent** test-retest reliability (ICC = 0.97-0.98)

<u>Children</u>: (Effgen & Brown, 1992; long-term stability of hand-held dynamometric measurements of shoulder, elbow and wrist in children with myelomeningocele

• Moderate to Excellent test-retest reliability (0.60-0.98)

(Taylor et al, 2004; children with cerebral palsy (CP))

• Excellent test-retest reliability (0.81-0.96) ankle PF, quads (0.81), hip flex, hip AB and hip ext tested

(Crompton et al, 2007; muscle strength measurement with hand-held dynamometry for children with CP)

• Low to moderate test-retest reliability (0.26-0.89) for LE strength testing without stabilization



	 Moderate to excellent test-retest reliability (0.62-0.91) for LE strength testing with stabilization
Interrater/Intrarater Reliability	<u>Stroke and TBI</u> : (Riddle et al 1989; measurements at wrist, elbow, shoulder, hip, knee and ankle)
	• Excellent intra-rater reliability (ICC = 0.88-0.98)
	(Katz-Leurer et al, 2008; children with TBI)
	• Excellent intra-rater reliability (0.91-0.99)
	Healthy Subjects: (Sullivan et al 1988 healthy subjects; shoulder
	• Excellent intra-rater reliability (0.98)
	(Bohannon and Andrews, 1987; healthy subjects; shoulder)
	• Excellent inter-rater reliability (0.84-0.94)
	<u>SCI</u> : (May et al, 1997; isokinetic measures of shoulder IR/ER rotator strength in persons with SCI
	• Excellent intra-rater reliability (0.89-0.96)
	(Larson et al, 2010; assessment of postural muscle strength in sitting for persons with SCI
	 Excellent intra-rater reliability (79-0.99) Excellent inter-rater reliability (0.96-0.99)
	Children with Cerebral Palsy: (Crompton et al, 2007; muscle strength measurement with hand-held dynamometry for children with CP)
	 Moderate to Excellent intra-rater reliability (0.63-0.96) ankle PF & DF, hip flex, & quads (0.63) and hip ext tested

Not Established



Criterion Validity (Predictive/Concurrent)	Stroke: (Piao et al, 2004; quadriceps femoris muscle strength on affected side)				
	 Excellent relationship with isokinetic dynomometry (Pearson r = 0.99) 				
	Huntington's disease: (E	Busse et al, 2008; LE stre	ength)		
	 Adequate to Good correlation to Unified Huntington's Disease Rating Scale (UHDRS) motor scale (Spearman's r = 0.49-0.74) Adequate to Good correlation to functional independence measure (Spearman's r = 0.59-0.74) 				
Construct Validity (Convergent/Discriminant)	Stroke:				
	(Boissy et al, 1999, stroke >1 yr, Chronic Stroke)				
	 Adequate correlation with Fugi-Myer upper limb performance test (r = 0.84) Adequate correlation with TEMPA upper limb function test Adequate correlation with Box and Block affected upper limb score 				
	(Piao et al. 2004; stroke; measured affected quadriceps)				
	 Excellent convergent validity (r = 0.99) (Dorsch et al. 2012, chronic stroke with time since stroke of 1-6 years) 				
	Correlation between strength of the muscle groups of the affected lower limb (adjusted to body weight) and walking speed (10MWT)				
	Muscle Group	Correlation with 10MWT (Pearson correlation coefficient)	Strength of correlation		
	Ankle dorsiflexors	0.50	Large		
	Hip flexors	0.35	Medium		
	Ankle evertors	0.33	Medium		
	Knee flexors 0.30 Medium				



			1
	Hip internal rotators	0.30	Medium
	Hip extensors	0.29	Small
	Hip adductors	0.29	Small
	Ankle plantarflexors	0.29	small
	Knee extensors	0.27	Small
	Ankle invertors	0.25	Small
	Hip abductors	0.24	Small
	Hip external rotators	0.22	small
Content Validity	Not Established		
Face Validity	Not Established		
Floor/Ceiling Effects	Not Established		
Responsiveness	 Healthy Adults : (Nitschke et al, 1999; n = 42; mean age 32.3 (7.3) healthy female subjects & 42.6 (11.8) nonspecific regional pain in upper arm female subjects; Jamar dynamometer) A change of more than 6 kg (13.2 lb) is necessary to detect a genuine change in grip strength 95% of the time. (Reddon et al., 1985) Small change: effect size 0.01 for men's non-preferred and women's preferred hand and 0.13 for men's preferred and 0.14 for women's non-preferred hands over 10 week trial Stroke: (Roberts et al, 2011) Recovery after a stroke estimate the differences in repeat measures of hand grip strength to be between 4.7 kg and 6.2 kg. 		
Professional Association Recommendations	Recommendations for a Neurologic Physical The Association's Stroke Tas recommendations were experts using a modifie	use of the instrument fro grapy of the American Ph skforce (StrokEDGE II) ar e developed by a panel o d Delphi process.	om the Academy of hysical Therapy e listed below. These of research and clinical



For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-</u>professionals/neurology-section-outcome-measures-recommendations

Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
StrokEDGE II	R	R	R

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	NR	R	NR	R	NR

Recommendations for entry-level physical therapy education and use in research:



		Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	ls additional research warranted for this tool (Y/N)
	StrokEDGE II	Νο	Yes	Yes	Yes
Considerations	 This c streng Prope al, 200 Gendo to stal reliabi group Dynar deper Client 	locument reflect of thesting er stabilization r 07) er, body weigh bilize a hand-h bility when "sma s (Wadsworth mometers are e nding on the se must be able t	cts hand-held must occur to t and grip stru- eld dynamon ller" testers a et al, 1992) expensive an tting to follow instr	dynamometry n improve reliabili ength can affect a neter and can infl are testing strong d not always ava uctions to comple	ot grip ty (Compton et a rater's ability uence er muscle illable ete
Bibliography	Abizanda, P., hand-held dyn dwelling older PubMed Bertrand, A. M strength meas Rehabil 21(3): Bohannon RW dynamometry Bohannon RW single session	Navarro, J. L., namometry for persons." Arch 4., Mercier, C., surements of th 248-257. Find V, Andrews AW . Phys Ther 19 V. Test-retest ro of strength as	et al. (2012) measuring m o Gerontol Go et al. (2007). le arms in su l it on PubMe /. Interrater ro 87; 67(6):931 eliability of ha sessment. P	. "Validity and us uscle strength in eriatr 54(1): 21-2 . "Reliability of ma bjects with hemip ed eliability of hand- I-933. and-held dynamo hys Ther 1986; 6	efulness of community- 7. Find it on aximal static baresis." Clin held metry during a 6(2):206-209.



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Wadsworth C, Nielsen DH, Corcoran DS, Phillips CE, Sannes TL. Interrater reliability of hand-held dynamometry: effects of rater gender, body weight, and grip strength. J Orthop Sports Phys Ther 1992; 16(2):74-81.

Year published	
Instrument in PDF Format	Yes
Approval Status	





11. REHAB MEASURES DATABASE—EURO-QUALITY OF LIFE

Link to instrument	Instrument available at EuroQol.org (other languages available below)
Title of Assessment	Euro-QOL
Acronym	EQ-5D
Instrument Reviewer(s)	Initially reviewed by Sue Saliga, PT, PHSc, CEEAA and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 10/2012 Updated by Rie Yoshida and Heather Anderson of the StrokEDGE II task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2016.
Summary Date	4/15/16
Purpose	EQ-5D [™] is a standardized instrument for use as a measure of health for clinical and economic appraisal.
Description	 Applicable to a wide range of health conditions and treatments, the EQ-5D health questionnaire provides a simple descriptive profile and a single index value for health status. Measures the dimensions of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Original EQ-5D (EQ-5D-3L) is described by three possible levels of problems (no, mild to moderate, and severe). The five dimensions measuring health status can be converted to a single utility value (EQ-Index score) A five-level version, the EuroQoL 5-Dimensions Questionnaire EQ-5D (EQ-5D-5L) also exists where each dimension is described by five possible levels of problems (1, no problem; 2, slight problem; 3, moderate problem; 4, severe problem; and 5, unable to/extreme problem) instead of the original 3 The EQ-ED also includes a visual analog scale (EQ-VAS) which measures subjective health status on a vertical 0- to 100 point VAS scale.
Area of Assessment	Health status
Body Part	NA
ICF Domain	Body Structure; Body Function; Participation
Domain	Cognitive, emotion, motor function and general health
Assessment Type	Self-report questionnaire

Assessment Type	Self-report questionnaire
Length of Test	05 Minutes or Less
Time to Administer	A few minutes
Number of Items	6 items
Equipment Required	Paper and pencil or electronic version on computer/tablet
Training Required	No formal training, information available on line



Type of training required	No Training				
Cost	Not Free				
Actual Cost	Fee involved for licensing				
Age Range	Adults (18-16) and older adults (65+)				
Administration Mode	Self-report				
Diagnosis	Arthritis; Chronic Obstructive Pulmonary Disease; Concussion; Pain; Stroke				
Populations Tested	 Rheumatoid Arthritis Eye pathology COPD Irritable Bowel Syndrome Chronic low back pain Stroke 				
Standard Error of Measurement (SEM)	Not Established				
Minimal Detectable Change (MDC)	Not Established				
Minimally Clinically Important Difference (MCID)	Chronic Stroke: (Chen et al, 2015; n=65; media mean age 52.8 <u>+</u> 11.6 years) MCID (EQ-5D-5L) Anchor-based: SIS recovery score (10-15%) Distribution-based: 0.5 SD Those exceeding MCID [n (%)] Anchor-based: SIS recovery score (10-15%) Distribution-based: 0.5 SD SIS = Stroke Impact Scale, SD = standard devi	EQ-Index 0.10 0.10 22 (33.8) 22 (33.8) iation	EQ-VAS 8.62 10.82 27 (41.5) 21 (32.3)	months (range 0.4-94);	
Cut-Off Scores	Not Established				
Normative Data	Not Established				



Test-retest Reliability	Traumatic Brain Injury: (Van Agt et al., <i>n</i> =208; mean age=49.3 (18.3); gender=43.3% female; Dutch population)
	Generalizability Theory was used for test-retest reliability assessment; results interpreted as there are some respondents who value some health states very differently the first or the second time, hence, good test retest reliability
Interrater/Intrarat er Reliability	Not Established
Internal Consistency	Not Established
Criterion Validity (Predictive/ Concurrent)	<u>Chronic Stroke</u> : (Chen et al, 2015; n=65; median time since stroke 19.7 months (range 0.4-94); mean age 52.8 <u>+</u> 11.6 years)
	Measures of predictive validity for the 5 item version (EQ-5D-5L):
	 Fair predictive validity (ρ = 0.25; P <0.05) between EQ-Index at the pre-intervention session with the Stoke Impact Scale (SIS)-ADL at the post-intervention session Fair predictive validity (ρ = -0.27; P <0.05) between the mobility dimension of the EQ-5D and the Functional Independence Measure (FIM) Fair predictive validity between the pain/discomfort dimension of the EQ-5D and the following SIS subscales: -strength (ρ = -0.28; P <0.05) -emotion (ρ = -0.27; P <0.05) -mobility (ρ = -0.33; P <0.05) -physical score (ρ = -0.34; P <0.05) Fair predictive validity (ρ = -0.26; P <0.05) between the anxiety/depression dimension of the EQ-5D and the SIS hand function
	Measures of concurrent validity for EQ-Index, EQ-VAS and individual dimension of EQ-5D
	 Fair to good concurrent validity between EQ-Index with FIM, SIS-ADL, SIS mobility and SIS physical scores (ρ = 0.255-0.703, P < 0.05) Low to fair concurrent validity between EQ-VAS with FIM, SIS mobility and SIS physical scores (ρ = 0.249-0.345, P < 0.05) Fair to good concurrent validity between mobility and self care dimensions with physical function criterion measures (SIS strength, SIS mobility and SIS physical scores) and ADL criterion measures (FIM and SIS ADL) (ρ = -0.249 to -0.771, P < 0.05)



	Fair concur and SIS physical dimensions and SIS physical dimensions and set of the	r ent validity sical scores a and SIS emot	between usι is well as be ion (ρ = -0.2	ual activi tween pa 98 to -0.	ty dimensi ain/discom 412, P < (ion and FI nfort and a).05)	IM, SIS-ADL, SIS mobility anxiety/depression
Construct Validity (Convergent/ Discriminant)	General Population previous 2 weeks, at physical health probl	<u>(British sam</u> tended outpa em)	tient in previ	er et al., ous 3 m	<i>n</i> =1453; v onths, inpa	visited ger atient in p	neral practitioner in revious year, chronic
	• The Spearman Rank correlation coefficients of the total score and the UK SF-36 dimensions were found to be in the range 0.48-0.60 (p < 0.01)					I the UK SF-36	
	Traumatic Brain Inj	u ry: (Klose e	t al.; <i>n</i> =104;	mean ag	ge=41; gei	nder=male	e n=78)
	cores on the c hypopituitar	EuroQoL Vis ism 12mo a	sual Ana fter injur	log Scale ⁄	(VAS) in j	patients with	
	 <u>Traumatic Brain Injury</u>: (Bell et al, 2005; <i>n</i>=171; telephone intervention <i>n</i>=85 and standard follow up <i>n</i>=86; mean age = 36 (15) significantly increased EuroQoL scores as an effect of a scheduled telephone intervention 						
	 <u>Stroke</u>: (Golicki et al, 2015; <i>n</i>=112; mean age 70.6 (SD=11.0); patients assessed at 1 week and 4 months post stroke with the modified Rankin Scale (mRS), Barthel Index (BI) and both the EQ-5D-5L and EQ-5D-3L, including the EQ-VAS. Spearman's rank correlation coefficient between change scores of studied measures: 						
		EQ-5D-5L	EQ-5D-3L	EQ	Barthel	mRS	
	EQ-5D-5L Index	1.00	Index	•70	Index		
	EQ-5D-3L Index	0.74	1 00				
	EQ VAS	0.48	0.41	1.00			
	Barthel Index	0.43	0.56	0.27	1.00		
	mRS	-0.31	-0.41	-0.32	-0.42	1.00	
	Interpretation of extent of correlation: Absent (< 0.20), poor (0.20 - 0.34), moderate (0.35 - 0.50) or strong (> 0.50)						
Content Validity	Not Established						
Face Validity	Not Established						



Floor/Ceiling	General populatio	n (British	n sample): (Bra	azier et al, 199	93; <i>n</i> =1463; age rai	nge=16-74; male	
Encots	gender=655)						
	 Ceiling effe 	Ceiling effects were larger for the EuroQOL dimensions than for the SF-36 dimensions					
	Domoino	0/ at apil	ling 0/ of floor				
	Domains						
	Solf-Care	97.0	0.1				
	Main Activity	99.1	3.5				
	Family/leisure	90.0	1.8				
	Pain/discomfort	90.Z	4.0				
		04.1 81.1	20.0				
	Total Score	54.6	0				
		54.0	0				
Responsiveness	Chronic Stroke: Che	en et al, 2	2015; n =65; m	iean age 52.8	+ 11.6; median mo	nths since stroke onset	
	19.7 (range 0.4 – 94	4)					
	Measures of respor	nsiveness	for the 5 item	version (EQ-5	5D-5L):		
	• Small effect size (ES) (observed change in scores between pre-intervention and post-						
	intervention divided by the standard deviation of the baseline score) for both the EQ-Index						
	(0.40) and the EQ-VAS (0.30)						
	Moderate \$	• Moderate Standardized Response Mean (SRM) (the change in scores between pre-					
	intervention measures divided by the SD of the change scores) for the EQ-Index (0.63)						
	• Limited SRM for the EQ-VAS = 0.34						
	• Small criterion-based responsiveness (determined using the Stroke Impact Scale (SIS)						
	3.0 as a criterion by calculating the Spearman correlation between the change in EQ-5D						
	and the change in perceived recovery score of the SIS 3.0) for the EQ-Index (0.46)						
	Limited criterion-based responsiveness for the EQ-VAS (0.29).						
	Stroke: (Golicki et a	Stroke: (Golicki et al, 2015; n=112; mean age 70.6 (SD=11.0); patients assessed at 1 week and 4					
	months post stroke with the modified Rankin Scale (mRS), Barthel Index (BI) and both the EQ-5D-						
	5L and EQ-5D-3L, i	5L and EQ-5D-3L, including the EQ-VAS.					
	ES calculated as th	ES calculated as the ratio of the mean change to the Standard Deviation of initial measurement					
	Moderate t	o large E	ES (0.63-0.82)	for the EQ-5D	-3L		
	Moderate I	• Moderate ES (0.51-0.71) for the EQ-5D-5I					
	Moderate I	E S (0.51-	0.65) for the E	Q VAS			
		- (,				
	SRM calculated as	the ratio	of the mean ch	nange to the S	Standard Deviation	of that change	



Moderate to large SRM (0.69-0.86 Moderate SRM (0.59-0.69) for the tic Brain Injury (moderate and se d standard follow up <i>n</i> =86; mean ag Small treatment effect: 0.10 nendations for use of the instrumen rican Physical Therapy Association e (PD EDGE), Spinal Cord Injury T ic Brain Injury Taskforce (TBI EDG) ecommendations were developed b	i) for the EQ-5D-5L EQ VAS <u>vere):</u> (Bell et al, 2005; <i>n</i> =17 ge =36 (15) t from the Academy of Neurola I's Multiple Sclerosis Taskforce askforce (PD EDGE), Stroke E), and Vestibular Taskforce (1; telephone intervention ogic Physical Therapy of e (MSEDGE), Parkinson's Taskforce (StrokEDGE II) VEDGE) are listed below			
Moderate SRM (0.59-0.69) for the tic Brain Injury (moderate and se d standard follow up <i>n</i> =86; mean ag Small treatment effect: 0.10 mendations for use of the instrument rican Physical Therapy Association re (PD EDGE), Spinal Cord Injury T ic Brain Injury Taskforce (TBI EDG) ecommendations were developed b	EQ VAS <u>vere):</u> (Bell et al, 2005; <i>n</i> =17 ge =36 (15) t from the Academy of Neurole 's Multiple Sclerosis Taskforce askforce (PD EDGE), Stroke E), and Vestibular Taskforce (1; telephone intervention ogic Physical Therapy of e (MSEDGE), Parkinson's Taskforce (StrokEDGE II) VEDGE) are listed below			
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Delphi process. iled information about how recomm p://www.neuropt.org/go/healthcare- endations	y a panel of research and clin rendations were made, please professionals/neurology-secti	ical experts using a on-outcome-measures-			
viotiona					
Highly Recommend	Highly Recommend				
Recommend	Recommend				
Reasonable to use, but limit Recommend	Reasonable to use, but limited study in target group / Unable to Recommend				
Not Recommended	Not Recommended				
	I Delphi process. iled information about how recomm p://www.neuropt.org/go/healthcare- endations viations: Viations: Recommend Recommend Recommend Not Recommended Not Recommended	I Delphi process. iled information about how recommendations were made, please p://www.neuropt.org/go/healthcare-professionals/neurology-secti endations viations: Viations: Highly Recommend Recommend Reasonable to use, but limited study in target group / Una Recommend Not Recommended hendations for use based on acuity level of the patient:			

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitatio n	Skilled Nursing Facility	Outpatient Rehabilitatio n	Home Health
StrokEDGE II	NR	R	R	R	R
TBI EDGE	NR	LS	NR	LS	LS

Recommendations for use based on ambulatory status after brain injury:



		Completely Independent	Mildly Dependent	Moderately Dependent	Severely Dependent]
	TBI EDGE	N/A	N/A	N/A	N/A	
	Pacammandat	ions for ontry loval	nhycical tharapy o	ducation and use in res	oarch:	
	Recommendat	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)	
	StrokEDGE II	No	Yes	Yes	Yes	
	TBI EDGE	No	Yes	Yes	Not reported	
	 Translations available in over 150 languages Recommended by the Core Data Elements Workgroup as a supplemental measure in TBI research (Wilde et al, 2010) In TBI, the instrument has been used in some outcome studies with good success EuroQOL translations: Other languages available at http://www.euroqol.org/eq-5d-products/eq-5d-3l.html These translations, and links to them, are subject to the Terms and Conditions of Use of the Rehab Measures Database. RIC is not responsible for and does not endorse the content, products or services of any third-party website, and does not make any representations regarding its quality, content or accuracy. If you would like to contribute a language translation to the RMD, please contact us at rehabmeasures@ric.org.					
Bibliography	Bell, K. R., Ter outcome after Rehabil 86(5): Brazier, J., Jon SF-36 health s Chen, P., Keh- difference of E 10.1007/s1113 Golicki D., Niev EQ VAS in stro	nkin, N. R., et al. (2 moderate to severe 851-856. Find it on hes, N., et al. (1993) urvey questionnaire Chung L., et al. (20 Q-5D-5L in stroke p 66-015-1196-z. Find wada M., et al. (201 oke patients. Qual L	005). "The effect of traumatic brain in PubMed). "Testing the valid e." Qual Life Res 2 (15). "Validity, resp patients undergoing it on PubMed 5). "Comparing re ive Res 24:1555-1	of a scheduled telephone jury: a randomized trial. dity of the Euroqol and o 2(3): 169-180. Find it on ponsiveness and minimu g rehabilitation." Qual Li sponsiveness of the EQ 1563. Find it on PubMed	e intervention on ' Arch Phys Med comparing it with the PubMed Im clinically important fe Res. DOI -5D-5L, EQ-5D-3L a	, nt and



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	Wilde, E. A., Whiteneck, G. G., et al. (2010). "Recommendations for the use of common outcome measures in traumatic brain injury research." Arch Phys Med Rehabil 91(11): 1650-1660 e1617. Find it on PubMed
Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



12. REHAB MEASURES: FUNCTION IN SITTING TEST

Link to instrument	Training and documentation available from Samuel Merrit University's website
Title of Assessment	Function in Sitting Test
Acronym	FIST
Instrument Reviewer(s)	Initially reviewed by Heidi Roth, DHS, PT, NCS and the TBI EDGE task for of the Academy of Neurologic Physical Therapy - a component of APTA i 5/2012; Reviewed by Michele Sulwer, PT, DPT, NCS and Maggie Bland, P DPT, of the StrokEDGE II Task Force of the Neurology Section, of the APT 02/2017.
Summary Date	11/27/2012; 2/2/2017
Purpose	Bedside evaluation of sitting balance stated to evaluate sensory, motor, proactive, reactive and steady state balance factors.
Description	 14 items Ordinal Scale (0-4) for each test item: 4: Independent, Completes the task independently and successfully 3: Needs Cues, Completes the task independently and successfully; may need verbal / tactile cues or more time 2: Upper extremity support, Unable to complete task without using upper extremities for support or assistance 1: Needs assistance, Unable to complete task successfully without physical assistance 0: Complete assistance, Requires complete physical assistance to perform task successfully, is unable to complete task successfully with physical assistance, or dependent
	 One trial of each item is allowed


0	Verbal directions and demonstration are given as needed by the therapist
0	Standard Position: Individual seated at edge of hospital bed with half of upper leg supported
	(neutral abd/adduction / rotation), hips and knees at 90 degrees and feet flat in support
	be degrees and recently explore

- Hands are placed in lap unless needed for support
- See Gorman et al, 2010 for measure

Area of Assessment	Balance Non-Vestibular
Body Part	
ICF Domain	Activity
Domain	
Assessment Type	Performance Measure
Length of Test	06 to 30 Minutes
Time to Administer	Less than 15 minutes
Number of Items	14
Equipment Required	Standard hospital bed (without air mattress)Stopwatch
Training Required	
Type of training required	
Cost	Free
Actual Cost	Free
Age Range	
Administration Mode	



Diagnosis	Stroke; Traumatic Brain Injury
Populations Tested	 Acute Stroke Population-based, inpatient sample of adults with sitting balance dysfunction, excluding persons with SCI, signigicant bracing/orthotics, and inability to perform testing safely
Standard Error of Measurement (SEM)	 <u>Acute Stroke:</u> (Gorman et al, 2010; <i>n</i>=31, age 61.5 (10.9) years, <=3 months post stroke, Modified Rankin Scale of moderate / moderately severe / severe) SEM= 2.03
	 Adults With Sitting Balance Dysfunction: (Gorman, Harro, Platko and Greenwald, 2014, n=125, age=60.0 (16.6) years) SEM= 1.40 Balance Participants: (Gorman, Rivera, and McCarthy, 2014) (n=6; Mean Age= 68.7) ***Medical diagnoses of the balance participants included Parkinson's disease (n=1), multiple sclerosis (n=1), and cerebrovascular accident (n=5). SEM= 3.58
Minimal Detectable Change (MDC)	 <u>Acute Stroke</u>: (Calculated from Gorman et al, 2010) MDC=5.63 <u>Adults With Sitting Balance Dysfunction</u>: (Gorman, Harro, Platko & Greenwald, 2014) MDC=5.5
Minimally Clinically Important Difference (MCID)	 Adults With Sitting Balance Dysfunction: (Gorman, Harro, Platko & Greenwald, 2014) MCID≥ 6.5
Cut-Off Scores	Not Established
Normative Data	Not Established
Test-retest Reliability	Balance Participants: (Gorman, Rivera, and McCarthy, 2014), n=6; mean age = 68.7



	 ***Medical diagnoses of the balance participants included Parkinson's disease (n=1), multiple sclerosis (n=1), and cerebrovascular accident (n=5). Excellent: ICC=0.97 		
Interrater/Intrarater Reliability	Balance Participants:(Gorman, Rivera, and McCarthy, 2014), n=6;mean age = 68.7***Medical diagnoses of the balance participants includedParkinson's disease (n=1), multiple sclerosis (n=1), andcerebrovascular accident (n=5).Intra-rater Reliability:Excellent ICC=0.99Inter-rater Reliability:Excellent ICC=0.991		
Internal Consistency	 Acute Stroke: (Gorman et al, 2010) Excellent internal consistency (Cronbach's alpha = 0.98) 		
Criterion Validity (Predictive/Concurrent)	Adults With Sitting Balance Dysfunction:(Gorman, Harro, Platko & Greenwald, 2014)Concurrent Validity:Good to Excellent concurrent validity with the Berg Balance Scale and Functional Independence Measure at both admission and discharge (Spearman ρ=.71–.85).		
Construct Validity (Convergent/Discriminant)	Not Established		
Content Validity	Not Established		
Face Validity	Not Established		
Floor/Ceiling Effects	Not Established		
Responsiveness	Adults With Sitting Balance Dysfunction:(Gorman, Harro, Platko and Greenwald, 2014, n=125, age=60.0 (16.6) years)Responsiveness:Strong as evidenced by the large effect size (.83), standardized response mean (1.04), and index of responsiveness (1.07).		
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy		



Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-</u> professionals/neurology-section-outcome-measuresrecommendations

Abbreviations:			
HR	Highly Recommend		
R	Recommend		
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend		
NR	Not Recommended		

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatien t Rehabilit ation	Skilled Nursing Facility	Outpatie nt Rehabilit ation	Home Health
MS EDGE	UR	UR	UR	NR	UR
TBI EDGE	LS	LS	LS	LS	LS
STROKE EDGE II	LS	LS	LS	UR	UR



Recommendations for use based on ambulatory status after brain injury:

	Complet ely Indepen dent	Mildly dependan t	Moderate ly Dependan t	Severely Dependan t
TBI EDGE	NR	LS	LS	LS

Recommendations based on EDSS Classification:

	EDSS 0.0	EDSS 4.0 –	EDSS 6.0 –	EDSS 8.0 –
	- 3.5	5.5	7.5	9.5
MS EDGE	NR	NR	NR	UR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administe r this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	No	No	No	Yes
TBI EDGE	No	No	No	Not reported
STROK E EDGE II	No	Yes	No	Yes



Considerations	Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u> .
Bibliography	Gorman, SL, Radtka, S, et al. "Development and validation of the function in sitting test in adults with acute stroke." Journal of Neurologic Physical Therapy 34(3)(2010): 150-160. <u>Find it on PubMed</u>
	Gorman, SL, et al. "Examining the Function in Sitting Test for Validity, Responsiveness, and Minimal Clinically Important Difference in Inpatient Rehabilitation." Archives of Physical Medicine and Rehabilitation 95.12 (2014): 2304-11.
	Gorman SL, Rivera M, McCarthy L. "Reliability of the Function in Sitting Test (FIST)." Rehabilitation research and practice. 2014;2014:593280.
Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



13. REHAB MEASURES DATABASE—FUNCTIONAL INDEPENDENCE MEASURE (FIM)

Uniform Data System for Medical Rehabilitation (external link)
FIM [®] instrument (FIM); FIM [®] is a trademark of the Uniform Data System fro Medical Rehabilitation, a division of UB Foundation Activities, Inc.
Initially reviewed by the Rehabilitation Measures Team; Updated by Eileen Tseng, PT, DPT, NCS, Rachel Tappan, PT, NCS, and the SCI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012; Updated by Tammie Keller, PT, DPT, MS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA; Updated by Deb Kegelmeyer, PT, DPT, MS, GCS and the PD EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA; Updated by Deb Kegelmeyer, PT, DPT, MS, GCS and the PD EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2013. Updated by Maggie Bland, PT, DPT, NCS and Nancy Byl PT, MPH, PhD, FAPTA and the Stroke Edge II Task Force in 2016.
10/6/2015; 9/27/16
Provides a uniform system of measurement for disability based on the International Classification of Impairment, Disabilities and Handicaps; measures the level of a patient's disability and indicates how much assistance is required for the individual to carry out activities of daily living.
Contains 18 items composed of:
13 motor tasks
5 cognitive tasks (considered basic activities of daily living)
Tasks are rated on a 7 point ordinal scale that ranges from total assistance (or complete dependence) to complete independence
Scores range from 18 (lowest) to 126 (highest) indicating level of function
Scores are generally rated at admission and discharge
Dimensions assessed include:
Eating
Grooming



Bathing

Upper body dressing

Lower body dressing

Toileting

Bladder management

Bowel management

Bed to chair transfer

Toilet transfer

Shower transfer

Locomotion (ambulatory or wheelchair level)

Stairs

Cognitive comprehension

Expression

Social interaction

Problem solving

Memory

FIM Instrument Scoring Criteria: (refer to the users manual for more information)

FIM Instrument Scoring Criteria:

No Helper Required

Score Description

7 Complete Independence

6 Modified Independence (patient requires use of a device, but no physical assistance)

Helper (Modified Dependence)

Score Description

5	Supervision or Setup
4	Minimal Contact Assistance (patient can perform 75% or more of task)



3	Moderate Assistance (patient can perform 50% to 74% of task)
Helpe	er (Complete Dependence)
Score	Description
2	Maximal Assistance (patient can perform 25% to 49% of taks)
1	Total assistance (patient can perform less than 25% of the task or requires more than one person to assist)

Area of Assessment	Activities of Daily Living
Body Part	Not Applicable
ICF Domain	Activity
Domain	ADL; Cognition; Motor
Assessment Type	Observer
Length of Test	31 to 60 Minutes
Time to Administer	30-45 minutes
Number of Items	18
Equipment Required	May vary based on level and impairment category measured.
Training Required	Yes, certification in administering the FIM instrument is required prior to use. Training is available through UDSMR at: www.udsmr.org.
Type of training required	Reading an Article/Manual
Cost	Not Free
Actual Cost	A license to use the FIM instrument may be obtained at: http://www.udsmr.org.



	Fees vary depending upon type of use.
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Geriatrics; Multiple Sclerosis; Pain; Spinal Cord Injury; Stroke
Populations Tested	Brain Injury
	Geriatrics
	Multiple Sclerosis
	Orthopedic Conditions including Low Back Pain
	Parkinson's Disease
	Spinal Cord Injury
	Stroke
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established
Minimally Clinically	Stroke:
Important Difference (MCID)	(Beninato et al, 2006; n = 113; mean age = 63.9 (14.3) years; mean FIM score at admission = 63.4 (24.4) points, Acute Stroke)
	FIM Total Score = 22 points
	FIM Motor Subscale = 17 points
	FIM Cognitive Subscale = 3 points
Cut-Off Scores	Not Established
Normative Data	SCI: (Hall et al, 1999; cross-sectional data from SCI Model Systems National Database; average of 8 days post injury [SD = 13 days]; sample size varying pending time post injury, Acute SCI)



Mean (SD) Motor FIM Scores at Rehabilitation Admission, Discharge, and	11,
2, and 5 Years Post Injury: All Cases at AIS Grades A, B, C	

FIM Motor	Admission	Discharge	1 yr status post	2 yr status post	5 yr status post
C1-C3	14.1(4.7)	18.6 (7.8)	25.4 (22.2)	26.5 (26)	22.1 (15.0)
01 00	n = 156	n = 115	n = 29	n = 17	n = 18
C4	14.9 (6.1)	23.1 (11.6)	26.9 (19.6)	25.4 (17.0)	24.9 (14.9)
	n = 517	n = 458	n = 118	n = 87	n = 52
C5	16.0 (7.9)	31.3 (15.0)	35.6 (20.7)	37.5 (22.7)	38.5 (22.6)
	n = 578	n = 433	n = 91	n = 81	n = 67
CC	16.9 (7.8)	37.4 (14.3)	39.7 (19.6)	46.7 (21.9)	42.2 (20.2)
0	n = 313	n = 394	n = 89	n = 75	n = 63
C7	19.6 (9.0)	50.2 (15.8)	59.6 (22.3)	58.3 (22.6)	56.9 (20.5)
C/	n = 177	n = 236	n = 56	n = 46	n = 42
۲8	22.6 (8.2)	61.9 (16.4)	68.7 (18.7)	68.4 (16.4)	73.3 (17.2)
0	n = 55	n = 76	n = 21	n = 14	n = 14
Thoracic	32.5 (12.0)	69.3 (13.1)	72.2 (14.4)	74.7 (12.8)	77.4 (10.0)
	n = 1718	n = 1869	n = 402	n = 320	n = 256
Lumbar/	36.7 (12.6)	73.2 (11.9)	79.8 (12.4)	83.2 (5.9)	82.4 (5.5)
Sacral	n = 457	n = 452	n = 97	n = 72	n = 58

Divide the score by 13 (i.e. 13 motor items) to obtain the average ratings on the 1 to 7 scale

Mean (SD) Cognitive FIM Scores at Rehabilitation Admission, Discharge, and 1, 2, and 5 Years Postinjury: All Cases at AIS Grades A, B, C

FIM Motor	Admission	Discharge	1 yr status post	2 yr status post	5 yr status post
C1 C2	26.8(9.7)	29.8 (8.2)	33.8 (2.4)	33.4 (2.1)	34.5 (1.2)
	n = 131	n = 95	n = 17	n = 10	n = 12



C4	29.0 (7.2)	32.2 (4.8)	33.2 (5.2)	34.3 (1.7)	34.3 (1.4)
	n = 456	n = 380	n = 67	n = 47	n = 37
C5	29.5 (7.3)	32.5 (4.9)	33.8 (4.2)	34.4 (1.7)	34.1 (2.1)
	n = 541	n = 371	n = 55	n = 55	n = 55
C6	29.4 (7.1)	32.9 (3.5)	33.5 (3.5)	34.2 (3.3)	34.6 (1.3)
	n = 290	n = 351	n = 56	n = 53	n = 48
C7	30.1 (7.1)	32.9 (4.4)	34.7 (0.8)	34.9 (0.3)	34.6 (0.8)
	n = 165	n = 212	n = 40	n = 27	n = 30
C8	30.5 (6.8)	32.3 (4.5)	34.5 (0.9)	35.0 (0.0)	35.0 (0.0)
	n = 52	n = 70	n = 14	n = 6	n =7
Thoracic	31.2 (5.9)	33.3 (3.5)	34.4 (2.0)	34.5 (1.5)	34.8 (0.9)
moracic	n = 1594	n = 1644	n = 249	n = 199	n = 180
Lumbar/	32.1 (5.2)	33.5 (3.4)	34.6 (1.5)	35.0 (0.2)	34.1 (4.2)
Sacral	n = 431	n = 405	n = 59	n = 41	n = 38

Divide the score by 5 (i.e. 5 cognitive items) to obtain the average ratings on the 1 to 7 scale

Mean Motor FIM Scores at Rehabilitation Admission and Discharge by Level and Completeness of Injury

	Admission*			Discharge*		
Level	AIS A	AIS B	AIS C	AIS A	AIS B	AIS C
C1-C3	13.2 (n = 88)	13.0 (n = 14)	15.8 (n = 54)	17.7 (n = 75)	21.0 (n = 13)	20.0 (n = 27)
C4	13.6 (n = 288)	14.5 (n = 73)	17.5 (n = 156)	20.9 (n = 288)	24.8 (n = 54)	27.8 (n = 116)
C5	14.3 (n = 310)	16.2 (n = 127)	19.7 (n = 141)	28.3 (n = 236)	31.1 (n = 96)	38.4 (n = 101)
C6	15.3	17.8	21.1	35.6	37.6	43.9



	(n = 173)	(n = 89)	(n = 51)	(n = 238)	(n = 93)	(n = 63)
C7	18.5	18.8	23.6	49.4	48.7	53.5
	(n = 90)	(n = 52)	(n = 35)	(n = 123)	(n = 56)	(n = 57)
CS	22.3	22.4	23.3	64.1	58.6	63.0
	(n = 27)	(n = 17)	(n = 11)	(n = 34)	(n = 27)	(n = 15)
_	32.2	31.5	35.5	69.1	67.2	71.7
Thoracic	(n = 1324)	(n = 202)	(n = 192)	(n = 1482)	(n = 163)	(n = 224)
Lumbar/	35.8	36.6	37.3	71.5	74.8	74.0
Sacral	(n = 147)	(n = 105)	(n = 205)	(n = 161)	(n = 74)	(n = 217)

*All cases with level and completeness data available; These are not all the same sample of individuals across admission and discharge

(Kay et al, 2010; n = 1780; discharged from one of 479 inpatient rehab facilities in US; age 65-74 years; diagnosed with incomplete paraplegia, Acute SCI)

Demographic, rehabilitation stay, and discharge FIM self-care and mobility subscore by etiology of incomplete paraplegia

Characteristics	Degenerative Spinal Disorder	Benign Spinal Tumor	Malignant Spinal Tumor	Spinal Abscess	Vascular Ischemia
Subjects, n	1203	81	295	54	147
Age, mean	70.2	70.1	69.2	69.4	69.7
LOS in rehab, mean (SD)	13.2 (7.7)	17.2 (9.9)	17.8 (8.4)	21.3 (10.8)	26.4 (10.8)
Discharge self- care, mean (SD)	32.7 (5.8)	33.0 (6.2)	29.0 (6.9)	27.8 (7.9)	29.3 (6.6)
Discharge mobility, mean (SD)	22.5 (5.6)	22.1 (5.9)	17.4 (6.5)	16.9 (6.8)	17.1 (6.3)
Stroke:					



(Inouye et al, 2001; n = 243; mean age = 64 (11) years; assessed at admission and discharge, Acute Stroke)

FIM scores of > 73 at admission were significantly younger (58 + 11 [SD] yr) than patients with FIM scores of 37 to 72 (64 + 11 yr) or scores < 36 (66 + 12 yr)

FIM total scores of 37 to 72 at admission showed higher gains (37 + 15) than patients who scored > 73 (20 + 10) or < to 36 (29 + 23)

(Tur et al, 2003; n = 102; mean age = 61.6 (10.9) yeas; 45-60 minutes of daily physical and occupational therapy, speech therapy daily as needed; Turkish sample, Acute Stroke)

	Admission Mean (SD)	Median	Discharge Mean (SD)	Median
FIM Total Score	69.2 (27.4)	69	83.2 (25.7)	86
FIM Motor	43.8 (20.7)	40	55.9 (20.3)	60
FIM Cognitive	25.9 (10.7)	31	27.2 (9.5)	32.5

Parkinson's Disease:

(Ellis et al, 2008; n = 68; mean age - 74 (8) years; H&Y stages II - V, number in each stage: II - 1, III - 18, IV - 37, V - 2)

Mean Score (SD) at:					
Measure	Admission	Discharge			
FIM Total Score	45.5 (13.7)	77.0 (18.6)			
FIM Motor	27.1 (10.4)	54.8 (14.0)			
FIM Cognitive	18.0 (5.6)	22.1 (5.8)			

(Marciniak et al, 2011; n = 89; mean age = 74.26 (9.38) years)

	Mean Score (SD) at:	
Measure	Admission	Discharge
FIM Total Score	54.2 (17.4)	75.29 (21.9)
FIM Motor	34.47 (12.4)	51.45 (17.1)
FIM Cognitive	19.73 (7.0)	23.84 (6.8)



Test-retest Reliability	Elderly Adults:
	(Pollak et al 1996; n = 49 elderly residents of a continuing care retirement community; mean age 89.7 years; assessed twice 3 to 8 days apart, Elderly Adults)
	 Excellent FIM Motor test-retest reliability (ICC = 0.90) Excellent FIM Cognitive test-retest reliability (ICC = 0.80) scores (Hobart et al, 2001; Elderly Adults)
	 Excellent test-retest reliability (ICC = 0.98 for total FIM, 0.95 and 0.89 for FIM Motor and FIM Cognitive, respectively)
Interrater/Intrarater Reliability	Orthopedic Diagnoses and Stroke:
	(Kohler et al, 2009; n = 143 patients (63% orthopedic and 13% stroke); mean age = 76 years; transferred and assessed from one Rehab unit to another; 1 to 3 days between assessments, Orthopedic Diagnoses and Stroke)
	 Adequate to Poor item-level interrater reliability (ICC = 0.124 to 0.661) Poor agreement on 4 items: Stairs Dressing Walking Bowel management
	SCI:
	(Grey and Kennedy, 1993; n = 40; mean age at time of injury = 29.6 (9.57) years; mean time post-injury at discharge = 24.75 (8.57) weeks, Chronic SCI)

• Excellent correlation between total FIM scores taken by clinician discharge report and self-report at one month (r = 0.828)



- Poor to Excellent correlation between FIM subscales scores taken by clinician discharge reort and self-report at one month:
- Self care: r = 0.841 (Excellent)
- Sphincter control: r = 0.710 (Adequate)
- Mobility: r = 0.733 (Adequate)
- Locomotion: r = 0.454 (Adequate)
- Communication: r = 0.029 (Poor)
- Social cognition: r = 0.085 (Poor)

(Karamehmetoglu et al, 1997; n = 50; mean age = 33.94; 22% with tetraplegia and 78% with paraplegia, SCI)

• Excellent intrarater correlation of FIM scores obtained by questioning the patient and by observation of patient performing the activity (r = 0.94)

(Kucukdeveci et al, 2001; FIM in Turkey; n = 62; mean age = 32.7; mean time since injury = 16.4 months; with cervical injury 21%; with thoracic injury 42%; with lumbar 37%, Chronic SCI)

- Excellent FIM Motor interrater reliability (ICC = 0.90)
- Excellent FIM Cognitive interrater reliability (ICC = 0.98)

(Segal et al, 1993, n = 57, discharging from acute care and admitting to rehab hospital; data collected within a max of 6 days, Subacute SCI)

- Excellent interrater reliability for total FIM scores across two settings (r = 0.83)
- Poor to Excellent interrater reliability for individual items (r = 0.02 0.77)
- Excellent interrater reliability for patients with complete quadriplegia (n = 14, r = 0.87), complete paraplegia (n = 13, r = 0.74), and incomplete paraplegia (n = 9, r = 0.85)
- Adequate interrater reliability for patients with incomplete quadriplegia (n = 17, r = 0.49)

TBI:



	 (Donaghy & Wass, 1998; TBI) Excellent interrater reliability (ICC = 0.85 for total FIM Scores, 0.92 for FIM Motor, and 0.69 for FIM Cognitive) Various Diagnoses (meta analytic findings): (Ottenbacher et al, 1996; n = 11 studies published between 1993 and 1995; total sample size = 1,568 participants, Various Diagnoses) Excellent overall consistency (median interrater reliability = 0.95) between raters across patients with different diagnosis and levels of impairment
Internal Consistency	 General Rehab: (Dodds et al, 1993; n = 11,102 (52% Stroke, 10% Orthopedic; 10% Brain Injury); mean age = 65 years, General Rehab) Excellent internal consistency (Cronbach's alpha = 0.93 admission; 0.95 discharge) Multiple Sclerosis: (Sharrack et al, 1999; n = 64; mean age = 40 years, MS)
	 Excellent internal consistency (Cronbach's alpha = 0.98) Neurological Disorders: (Hobart et al, 2001; Neurological Disorders) Excellent internal consistency (Cronbach's alpha = 0.95 FIM Total Score; 0.95 FIM Motor; 0.89 FIM Cognitive) SCI:
	 (Hobart et al, 2001; Neurological Disorders) Excellent internal consistency (Cronbach's alpha = 0.95 FIM Tota Score; 0.95 FIM Motor; 0.89 FIM Cognitive) SCI:



(Kucukdeveci et al, 2001; FIM instrument version in Turkey, Chronic SCI)

- Excellent internal consistency at admission and discharge for FIM
- Motor (Cronbach's alpha = 0.934 0.953) and FIM Cognitive (Cronbach's alpha = 0.930 0.983)

(Stineman et al, 1996; with nontraumatic SCI, n = 2,609, mean age = 64.6 years; with traumatic SCI, n = 1,831, mean age = 43.0 years, sample from Uniformed Data System for Medical Rehabilitation [UDSMRSM], SCI)

- Excellent internal consistency for nontraumatic spinal cord diagnosis (Cronbach's alpha for total = 0.91; for FIM Motor = 0.91; for FIM Cognitive = 0.90)
- Excellent internal consistency for traumatic spinal cord diagnosis (Cronbach's alpha for FIM Total Score = 0.92; for FIM Motor = 0.94; for FIM Cognitive = 0.90)

Stroke:

(Hsueh et al, 2002; n = 118; mean age = 67.5 (10.9) years; measured at inpatient rehab admission and discharge, Acute Stroke)

 Excellent internal consistency (FIM Motor Subscale) (Cronbach's alpha = 0.88 admission; 0.91 discharge)

Criterion Validity (Predictive/Concurrent)	Predictive Validity Evidence:
	Neurologic Disorders:
	(Ng, et al., 2007; n= 1502; mean age of total = 61.3 ± 15.0 years; mean acute LOS = 14.5 ± 17.5 days; mean inpatient rehab LOS = 21.5 ± 19.0 dayss for patients with neurological disorders)



• Admission motor FIM scores (β = 0.55) and admission cognitive FIM scores (β = 0.38) had the highest impact on discharge total FIM scores

Stroke:

(Inouye et al, 2001; n = 243; mean age = 64 (11) years; assessed at admission and discharge, Acute Stroke)

 Patients with FIM total scores of 37 to 72 at admission showed higher gains (37 + 15) than patients who scored > 73 (20 + 10) or < to 36 (29 + 23)

(Denti et al. 2004; n = 359; mean age = 80.8 (4.7) years; time between stroke onset and admission = 22.3 (14.6) days, Acute Stroke)

 FIM total scores at admission were found to be the most powerful predictor of Montebello Rehabilitation Factor Scores (Beta coefficient = 0.42)

(Salter et al, 2010) 134 patients, a mean age of $68.64 (\pm 14.2)$ years old, and an average of $31.84 (\pm 59.2)$ days post-stroke, receiving care in an inpatient rehabilitation setting, were tested with the FIM at admission and discharge.

- There was excellent, positive and significant correlations with performance on the FIM (total and motor) with the Clinical Outcome Variables Scale [COVS] (0.823 and 0.771 respectively).
- The COVS and FIM had excellent correlation (-0.61,-0.69)) with length of stay (P<0.01), such that lower scores at admission meant shorter length of stay.

(Ward et al, 2011) Thirty inpatients with first ischaemic stroke were evaluated with the FIM, the SIS-16 and the STREAM at admission:

- The FIM score was significantly (P<0.001) and highly correlated (excellent) with the *predicted* length of stay (-0.9438) and the *actual* length of stay (-0.6846)
- The validity of the FIM for *predicting the LOS* was higher (-0.9438) than the SIS-16 (-0.6743) and the STREAM (-0.8011)
- The validity of the FIM associated with the actual LOS was lower (-0.6846) compared to the SIS-16 (-0.7953) and the STREAM Total (-0.7972).

(Yang et al, 2013). In a prospective observational study of 122 patients with a first time stroke admitted to a rehabilitation center over a 12 month period:



- The FIM score on admission and discharge significantly predicted the Pittsburgh Rehabilitation Participation Scale [PRPS] (0.53; P<0.0001 and 0.40; P<0.001 respectively)
- The level of participation on discharge (PRPS score) was predicted by functional status on admission (FIM; 0.309), cognitive impairment (Elderly Cognitive Assessment Questionnaire-ECAQ; 0.249) and fatigue (Fatigue Severity Scale-FSS; -0.304).
- Patients with lower levels of participation were more likely to be functionally dependent, cognitively impaired and have more fatigue.

(O'Brien et al, 2013). A sample of 371,211 Medicare beneficiaries who were receiving services in an inpatient rehabilitation facility (IRF) within 60 days post stroke (> 65 years of age, 43.7% male, 41.7% right sided impairment, 796% white) were evaluated with the FIM at admission and discharge. In addition, the change in LOS at the IRF and community discharge was compared over time with the implementation of a prospective payment system (PPS) for individuals on Medicare.

- Average LOS decreased a total of 3.8 days (from 17.9 in 2002 to 16.1 days in 2007)
- Mean admission FIM scores decreased a total of 4.4 points (from 57.2 to 53.8 points)
- The mean discharge FIM sores decreased a total of 3.6 points (from 80.1 to 76.5 points) in 4 of 5 years with no significant decline in 2004.
- Frequency of community discharges declined steadily with an average overall decrease of 5.4 % (from 6.6% to 61.2%) over the 5.5 years of study
- Controlling for study year and covariates, each day in IRF was associated with an increase of 0.50 discharge points (95% CI = 0.48, 0.52)
- The association between LOS and discharge destination was excellent, averaging 0.997 (95% CI = 0.994, 0.999) based on the co-variates of admission FIM, age, gender, ethnicity, side of lesion, complications and year.

(Van Heugten et al, 2015) Systematic review of studies (51) investigating convergent, criterion and predictive validity of cognitive dysfunction in patients in the acute phase (4 weeks) post stroke using multi-domain instruments .



• The Conistat, Montreal Cognitive Assessment [MOCA] and Functional Independence Measure-Cognitive showed adequate predictive validity

(Bates, 2015-Part 1) A retrospective analysis of 4020 veterns receiving consultative or comprehensive rehabilitation care post-stroke. The study examined initial characteristics of veterans predictive of grade IV achievement on the FIM.

The final model contained the following variables: age, initial physical grade, initial cognitive stage, renal failure, nutritional compromise, type of rehabilitation services, and recovery time between admission and discharge assessments. A point system was assigned to each of the above variables, such that the clinician could enter in the above information and determine the likelihood of a patient achieving a grade IV. The area under the ROC curve was adequate of the derivation and validation cohorts (0.84 and 0.83, respectively). The Hosmer-Lemeshow statistic was not significant (p = 0.93).

(Bates, 2015-Part 2)

- The above model (Bates, 2015-Part1) was enhanced to become a prognostic index, predicting likelihood of recovery to or above the grade VI benchmark (Modified Independent). There was adequate fit with a non-significant Hosmer-Lemeshow statistic of P = 0.38 and Adequate area under the curve of 0.83 in the derivation cohort and 0.82 in the validation cohort. A similar predictive equation was derived with the sum score quartiles slightly modified.
- (Huang, 2010) Fifty-eight participants an average of 17.85 (range, 7-88) months post-stroke participated in distributed constraint induced therapy two hours per day, five days a week for three weeks. Assessments were administered prior and after therapy, and a Chi-squared Automatic Interaction Detector method was used to identify the strongest predictors of change on the Stroke Impact Scale. Participants with an initial Total FIM score ≤ 109 at admission, improved significantly more (p = 0.006) on the Stroke Impact Scale and on measures of activities of daily living and instrumental activities of daily living at completion of the intervention.

(Lin, 2010) Seventy-four participants an average age of $54.11 (\pm 11.44)$ years old and $17.46 (\pm 17.67)$ months post-stroke were seen for upper extremity intervention. Participants received constraint-induced movement therapy, bilateral arm training, or conventional rehabilitation for two hour sessions,



five times per week for three weeks. Assessments were done at baseline and post-intervention.

- Poor to excellent predictive validity was found between the domains of the Stroke Impact Scale and the FIM (0.26-0.70, p < 0.05)
- Poor to excellent predictive validity was found between the domains of the Stroke Specific Quality of Life Scale and the FIM (0.22-0.63, p < 0.01). The language, personality, thinking, and vision domains were not significant.

Concurrent Validity Evidence:

Rehabilitation Patients:

(Heinemann et al, 1994; Rehabilitation Patients) Admission FIM Motor Scores accounted for 52% of variance in discharge motor function among TBI patients, admission FIM Cognitive Scores accounted for 46% of variance in discharge cognitive function – admission motor FIM was the most significant predictor of length of stay.

(Montecchi et al, 2013) In 59 patients with mean age of 48.90 (± 14.01) years old, admitted to the intensive care unit acutely post acquired brain injury (from trauma, hypoxia, hemorrhage or ischemia), a new Trunk Recovery Scale (TRS) was developed.

• Excellent correlation between the FIM-Motor and the TRS (0.849)

Stroke:

(Hsueh et al, 2002; Acute Stroke)

Excellent correlation between the FIM Motor Subscale and the 10-item version of the Barthel Index (BI) (r = 0.92 (at admission) - 0.94 (at discharge))

Excellent agreement between the FIM Motor Subscale and 5-item version of BI (r = 0.74 (at admission) - 0.94 (at discharge)

(Ward et al 2011) On admission to the acute rehabilitation ward, the FIM and the STREAM were found to be highly correlated in thirty patients acute post ischemic stroke.(0.7766; P<0.0001)

(Shindo et al, 2015) To explore the concurrent validity of the FIM scale with the Simple Test of Evaluation Hand Function [STEF], 34 inpatients (33-86



	years of age) sub acute post stroke (less than 60 days post episode) were evaluated at admission. The STEF had statistically significant, adequate correlations with the FIM TM : FIM Total score (0.444;P<0.009), FIM motor (0.411;P<0.016) and FIM self care (0.402; P<0.019).
	(Sasaki et al, 2014) The aim of this study was to explore the validity of the Cognitive Behavioral Rating Sale (CBRS) with the FIM discharge data on 100 patients, mean age of 72.2 (± 10.9) years old and 61.0 (±61.2) days post-stroke. The Spearman Rank Correlation Coefficient was excellent between the CBRS and the FIM total Score (-0.70; p<0.01), the Cognitive FIM (-0.72; P<0.01), and the Motor FIM (-0.63; p<0.01) for patients post stroke.
	(Caglar, 2014) A retrospective analysis on 142 patients post-stroke that went to an IRF. A linear regression was run to determine which factors contributed to Motor-FIM (M-FIM) gain and Cognitive-FIM (C-FIM) gain.
	 The adjusted R² was 0.173 (p = 0.000) for M-FIM gain and the significant factors were the admission M-FIM (B = 0.809, SE = 0.199, β = -0.446, p = 0.000) and if the patient had diabetes Mellitus (B = 14.269, SE = 6.775, β = -0.177, p = 0.037). The adjusted R² was 0.146 (p = 0.001) for C-FIM gain and the significant factors were the admission C-FIM (B = -4.068, SE = 1.048, β = -0.369, p = 0.000) and if the patient had diabetes Mellitus (B = 36.226, SE = 17.904, β = -0.175, p = 0.045).
	(Cooke, 2010) One hundred and ninty-seven, first stroke participants were included an average of 45.4 ± 67.6 days post-stroke to examine the relationship of clock drawing post-stroke.
	 A significant relationship was found between the FIM-Motor and the Clock Drawing Test (Exp (B) = 0.984, p = 0.030).
Construct Validity (Convergent/Discrimina nt)	Convergent Validity Evidence (extent to which the screening instrument corresponds to similar instruments measuring the same function (expressed as a correlation):
	(Ditunno, et al., 2007; n = 141, mean age = 32 years; Entered into study within 8 weeks of onset of SCI; data taken at entry, 3 and 6 and 12 months, subjects required to have score of < 4 on the Locomotor FIM (LFIM) at entry, Acute SCI)
	 Excellent correlation between total FIM score and WISCI at 3,6, and 12 months (Spearman's r = 0.73 - 0.77)



- Excellent correlation between total FIM score and Berg Balance Scale (Spearman's r = 0.72 0.77) at 3, 6, and 12 months
- Excellent correlation between LFIM score and Walking Index for Spinal Cord Injury (WISCI) at 3, 6, and 12 months (Spearman's r = 0.88 - 0.92)
- Excellent correlation between LFIM score and Berg Balance Scale (Spearman's r = 0.86 0.89) at 3, 6, and 12 months
- Excellent correlation between LFIM score and 50-Foot Walk Test at 3, 6, and 12 months (Spearman's r = 0.66 - 0.80)
- A comparison of simultaneous performance of the WISCI and the LFIM indicated 1 FIM level per multiple WISCI levels

(Donnelly et al, 2004; n = 41; mean age = 49(118.1); mean time since injury = 52 (73.1) days; with paraplegia, n = 18; with tetraplegia, n = 20; Incomplete, n = 27; complete, n = 11, SCI)

- Adequate correlation between admission and discharge scores of the FIM Total Score and the Canadian Occupational Performance Measure (COPM) Performance (r = 0.388 - 0.452) and COPM Satisfaction (r = 0.513 - 0.514)
- Adequate correlation between change scores of the FIM Total Score and FIM motor with COPM Performance (r = 0.364, r = 0.351) and Satisfaction (r = 0.497, r = 0.497) from admission to discharge
- (Fujiwara et al, 1999; n = 14; C6 level of injury, mean age = 30.7 years; mean length of time from injury = 462.0 days, Chronic SCI)
- Excellent correlation of FIM motor score and AIS motor score (Spearman's rank correlation coefficient = 0.73)
- Excellent correlation of shoulder strength (sum of MMT for serratus anterior, upper pectoralis major, and latissiums dorsi) and FIM motor score (Spearman's rank correlation coefficient = 0.95)
- Excellent correlation of AIS shoulder strength score (deltoid) and FIM transfer score (Spearman's r = 0.93)

(Saboe et al, 1997; n = 160; mean age = 30 (13) years; assessed at admission, discharge, and 2 years post injury; Length of stay at tertiary care hospital 144 (111) days Chronic SCI)

• Excellent correlation of FIM score 2 years post injury with admission and discharge ASIA motor (Spearman's r = 0.68 - 0.80), ASIA light



touch (Spearman's r = 0.75 - 0.76), ASIA pinprick (Spearman's r = 0.73 - 0.76), and Computed Vibration (Spearman's r = 0.64 - 0.67)

- Adequate correlation of FIM score 2 years post injury with admission bony injury level (Spearman's r = 0.53) and admission and discharge ASIA Impairment (Spearman's r = 0.50 - 0.53)
- 56% of the variance of FIM scores 2 years post injury is accounted for with ASIA admission light touch scores with age being the next largest contributing factor
- (Yavuz et al, 1998; n = 29; mean age = 37 years; mean time between onset and rehab admission = 20 weeks, mean length of stay in inpatient rehab = 18 weeks, Subacute SCI) Excellent correlation of FIM score with ASIA motor (r = 0.91)
- Adequate correlation of FIM score with ASIA light touch (r = 0.58) and ASIA pinprick (r = 0.55)
- Excellent correlation of Quadriplegia Index of Function and FIM (r = 0.97)

Stroke:

(Tur et al, 2003; Acute Stroke)

- Adequate correlation with length of hospital stay (r = -0.39)
- Adequate to Excellent correlation with Brunnstrom's motor recovery stages in upper extremity, lower extremity, and hand at admission and discharge (r = 0.51 - 0.68)

(Van Heugten et al, 2015) Systematic review of studies (51) investigating convergent, criterion and predictive validity of cognitive dysfunction in patients in the acute phase (4 weeks) post stroke using multi-domain instruments .

- No instrument (including the FIM) assessed all of the commonly affected cognitive domains after a stroke
- Strong significant intercorrelations were found between the Occupational Therapy Cognitive Assessment (LOTCA), the MMSE and the FIM-Cognitive subscale

(Canbek, 2013) Fifty-five participants who experienced their first-ever stroke and went to an IRF an average of 8± 5 days post-stroke.

 Poor to Excellent construct validity was seen between the FIM-Motor and the Tinetti POMA

Tinetti POMA	Balance Domain	Gait
		Domain



Admission FIM-	0.688	0.616	0.610
Motor			
Discharge FIM-	0.609	0.588	0.536
Motor			
Change FIM-Motor	0.389	0.277	0.396

(Kucukdeveci, 2013) One hundred and eighty-eight community dwelling participants (mean age 63.1 ±12 years), a median of 27 (range 3-240) months post-stroke were evaluated on the FIM and the World Health Organization Disability Assessment Schedule (WHODAS-II).

 Adequate to Excellent convergent validity was found. All correlations significant at p < 0.001.

	FIM Motor	FIM Cognitive
WHODAS-II understanding and	-0.54	-0.74
communicating		
WHODAS-II getting around	-0.86	-0.45
WHODAS-II self-care	-0.88	-0.46
WHODAS-II getting along with people	-0.55	-0.71
WHODAS-II life activities (work items	-0.74	-0.45
removed)		
WHODAS-II participation in society	-0.72	-0.52
WHODAS-II total (work items removed)	-0.85	-0.68
WHODAS-II activities	-0.85	-0.64
WHODAS-II participation	-0.77	-0.67
WHODAS-II -12 (work items removed)	-0.86	-0.65
WHODAS-II-10	-0.83	-0.65

(Ottiger et al A new multidisciplinary observation scale for inpatients post stroke based on the ICF model of activity and participation was created to document outcomes post stroke (LIMOS). This scale included four components of the ICF:1). interpersonal activities, [mobility and self-care,; 2}. Communication; 3} Knowledge and general tasks; 4) domestic life. The activities were rated as limitations or restriction in domains as: none, slight, moderate, severe or complete. This new scale was correlated with FIM scores.

- Excellent convergent validity was found between the LIMOS and the FIM (r=0.89; P<0.0001)
- An excellent association was reported between the FIM mobility subscale and the LIMOS mobility subscale (r=0.90; P<0.0001)
- Adequate to excellent associations were found between the subscales of the LIMOS (self care, general tasks, domestic life) and the subscales of the FIM (r=0.36-0.79)



Discriminate Validity Evidence:

Rehabilitative patients:

(Hobart et al, 2001; n = 169; neurological rehab patient: MS, stroke, TBI, other)

- FIM total and FIM motor scores correlated more strongly with OPCS disability scores, LHS scores, SF-36 physical component scores and WAIS – verbal IQ, than with measures of mental health status or psychological distress (SF36 mental component, General Health Questionnaire)
- FIM Cognitive Scores correlated most strongly with OPCS Disability scores and WAIS-verbal IQ scores and weakly with LHS, SF-36 physical and mental components, and the General Health Questionnaire (ABIEBR)

Stroke:

(Brock et al, 2002; Rasch analysis; n = 106; mean age = 68.7 (11.3) years; median time since onset = 11 days, Acute Stroke)

- Difficult items on motor portion of the scale discriminated better among higher functioning patients
- Raw FIM scores (as opposed to score subjected to Rasch analysis) may underestimate change

(Cavanagh et al, 2000; ischemic and hemorrhagic stroke patients, Stroke)

- Simple 2-factor model of the FIM instrument may not be sufficient to describe disability following stroke (66% of variance)
- May not adequately measure within patient change whereas a 3factor model (self-care, cognition and elimination) accounted for more variance (74.2%)
- Content Validity The FIM instrument was based on the results of a literature review of published and unpublished measures as well as input provided by an expert



	panel. Face and content validity were determined using subject matter experts (Granger, Hamilton, Keith, Zielezny, & Sherwins, 1986).
	Content validity was established through a pilot study done at 11 centers (n = 110 patients evaluated; Keith & Granger, 1987).
	SCI:
	(Jackson et al, 2008; n = 54 expert raters assessed locomotion measures as: 1) valid or useful, 2) useful but requires validation or changes/improvements, or 3) not useful or valid for research in SCI, SCI)
	FIM – Locomotion item was rated as Valid/Useful by 6%, Useful But Requires Validation or Changes by36% , and Not Useful or Valid for Research in SCI by 58%
	Traumatic Brain Injury:
	(Hall et al, 2001; TBI)
	Although the FIM instrument is reliable and key validity characteristics have been established, it has only 5 items directly addressing cognitive, behavioral, and communication issues, which limits its content validity for TBI
Face Validity	SCI:
	(Grey and Kennedy, 1993; Chronic SCI)
	Face validity was evaluated by asking clinicians specific questions addressing:
	 Difficulty of understanding (88% had no difficulty) Unnecessary items (97% reported no unnecessary items Items that should be added (83% felt no extra items needed)
Floor/Ceiling Effects	Rehabilitation Patients:
	(Coster et al, 2006; n = 516 subjects with neurologic, orthopedic, or complex medical conditions; mean age = 68.3 (14.97) years; discharged from tertiary care or rehab hospital, Rehabilitation Patients)



• Ceiling effect on the FIM cognitive scale after discharge for 70% of subjects at 1 month, reducing to 53% at 12 months

SCI:

(Grey and Kennedy, 1993; Chronic SCI)

- 92% of subjects and 88% of clinicians reported a max score on communication
- 75% of subjects and 73% of clinicians reported a max score on social cognition

(Hall et al, 1999; Acute SCI)

Percentage of Floor and Ceil	ing FIM Sco	res by Level	of Inju	ıry	
	Admission	Discharge	1 yr	2 yrs	5 yrs
High Tetraplegia: C1 (no mo	tor ceiling e	ffect)			
Motor Floor effect(%)*	86	21	28	25	13
Cognitive Ceiling effect(%)~	59	80	89	96	98
Low Tetraplegia: C5-C8	1	-			
Motor Floor effect(%)*	61	3	5	4	3
Motor Ceiling effect(%)~	0	4	15	18	16
Cognitive Ceiling effect(%)~	67	86	95	99	96
Paraplegia (no motor floor e	ffect)				
Motor Ceiling effect(%)~	0	36	55	66	75
Cognitive Ceiling effect (%)~	76	90	97	98	99
* Floor effect: Score of 1; Ceiling effect: Score of 6 or 7					
Stroke:					

(Brock et al, 2002; Acute Stroke)



	 Minimal ceiling effect: 16% achieved ceiling on FIM Motor Subscale during inpatient rehabilitation
	(Dromerick et al, 2003; n = 95, Acute Stroke)
	No floor or ceiling effects at either time using the FIM instrument
	(Hsueh et al, 2002; Acute Stroke)
	FIM Motor subscale:
	 Minimal floor effect at admission to inpatient rehab (5.8%) and at discharge from inpatient rehab (3.5%) No ceiling effect at admission to inpatient rehab (0%) and at
	discharge from inpatient rehab (0%)
Responsiveness	Rehabilitation Patients:
	(Coster et al, 2006; Rehabilitation Patients)
	 Small, positive effect size observed for FIM motor (SRM = 0.73 to 1.05) and FIM cognitive (SRM = 0.34 to 0.35) Small to Moderate, negative effect size observed for FIM motor (SRM = 1.3 to 1.31) and FIM cognitive (SRM = 1.34 to 2.24)
	• For FIM motor, 15-36% of subjects presented with positive change exceeding the MDC and 15- 25% with negative change exceeding the MDC
	 For FIM cognitive, 8-9% of subjects presented with positive change exceeding the MDC and 20-24% presented with negative change exceeding the MDC
	SCI:
	(Spooren et al, 2006; n = 60; mean age = 38.9 years old; first measurement taken when subjects were first able to sit up in a chair for 3 hours, Acute SCI)



- Large effect size for all subjects regardless of AIS classification between initial measurement (T1) and 3 months later (T2) as well as between initial measurement (T1) and discharge from rehab (T3)
- Small to moderate effect size for subjects between T2 and T3 (ES = 0.37-0.79)

Stroke:

(Hsueh et al, 2002; Acute Stroke)

Motor subscale:

• Large effect size with standardized response mean = 1.3

(Ward et al, 2011) A prospective cohort study of 30 subjects newly diagnosed with ischemic stroke (mean days since stroke onset 7.8 days (± 3.5)) was designed to demonstrate sensitivity of the FIM to change in an acute rehabilitation setting.

- The FIM score on admission was significantly associated (adequate to excellent correlations) with discharge destination as well as predicted and actual length of stay.
- The SRM (admission to discharge change score) was 2.34 for the motor FIM (P<0.0001). This FIM SRM was greater than the SRM for the SIS-16 and SRM for the STREAM.

(Salter et al, 2010) Following admission and discharge of 292 patients post stroke (134 with complete data and 158 with incomplete data, respectively an average of 31.8 and 67.3 days post stroke), FIM[™] scores improved significantly (P<0001) from admission to discharge from a mean of 73.86 (24.13) to 95.70 (24.65). The SRM was 1.36.

Professional Association Recommendations for use of the instrument from the Academy of Recommendations Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.



For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations

Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post) (Vestibular < 6 weeks post)	(SCI 3 to 6 months)	
SCI EDGE	R	R	R
StrokEDGE II	HR	HR	UR

Recommendations Based on Parkinson Disease Hoehn and Yahr stage:

	1	II	111	IV	V
PD EDGE	NR	NR	LS/UR	LS/UR	LS/UR

Recommendations based on level of care in which the assessment is taken:



	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	NR	R	R	NR	NR
StrokEDGE II	UR	HR	UR	UR	UR
TBI EDGE	LS	R	LS	LS	LS

Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	R	R

Recommendations for use based on ambulatory status after brain injury:

	Completely	Mildly	Moderately	Severely
	Independent	Dependent	Dependent	Dependar
TBI EDGE	LS	R	R	R

Recommendations based on EDSS Classification for MS:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5	EDSS 8.0 – 9.5
MS EDGE	R	R	R	R

Recommendations for entry-level physical therapy education and use in research:



	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	Yes	Yes	Yes	No
PD EDGE	No	No	No	Not reported
SCI EDGE	Yes	Yes	Yes	Not reported
StrokEDGE II	Yes	Yes	Yes	No
TBI EDGE	Yes	Yes	Yes	Not reported

Considerations

Motor items in the FIM instrument have been shown to have crossdiagnostic Differential Item Functioning (DIF), indicating varying level of difficulty of items pending diagnosis which reduces comparison between patients. (Lundgren-Nilsson, 2006; Kucukdeveci A, 2001)

Subjective reports of pain (15.5%) and loss of strength (17.9%) were most frequently identified as causes of change in FIM instrument activities and quality of life for individuals with chronic SCI (Price et al. 2004)

For assessment of individuals with SCI, Rasch analysis indicates a fourcategory rating scale vs. the original seven-category scale has increased reliability (Nilsson, et al. 2005)

With Rasch analysis, the FIM instrument had decreased cross-cultural validity of raw motor scores with 7 of 13 items suggesting that FIM Motor Subscale scores should not be pooled in their raw form or compared between countries. (Lawton et al, 2006)

Rasch analysis indicates decreased correlation for difficulty of bladder and bowel management and individuals' ease of performing tasks. (Lundgren-Nilsson, 2006)

Rasch Analysis of FIM

Questions on the uni-dimensionality of the FIM Motor Scale have been raised. Thus, data from 340 patients involved in post stroke rehabilitation were fitted to a Rasch model. The FIM Motor Scale satisfied Rasch model expectations including the uni-dimensionality assumption without requiring



deletion of any of the 13 items. This analysis reinforces that the FIM Motor Scale contains clinically important items. (Lungren Nilsson et al 2011)

A secondary Rasch analysis combning the FIM and the Nottingham Extended Activities of Daily Living (NEADL) assessment was done on 188 participants (average of 19.45 ± 15.96 months post-stroke) from an upper extremity intervention trial. The scoring on the FIM was recoded to a 3-point scale to indicate degrees of independence and the final model (from both assessments) contained 36-items, the bowel management item was removed as it was highly correlated (0.81) with the bladder management item (Chen, 2013).

The Barthel Index is commonly administered by nursing and medical staff to measure functional recovery following an inpatient stay for patients post stroke or neurologic disorders while the rehabilitation staff use the FIM. The Barthel Index can be measured directly or estimated from the Northwick Park Dependency Scale (NPDS) or the FIM. Following hospital discharge of 717 patients (TBI and stroke), there was excellent agreement of intra-class correlations between the total scores on the FIM and the NPDS (0.93; P<0.001; 95% CI 0.92-0.94). Item by item agreement ranged from adequate (0. 41;dressing) to excellent (0.77;mobility) with the average absolute item % agreement from 71.1% (Dressing) to 90.6% (transfers). (Turner et al, 2010)

Comments from StrokEdge Task Force Members

The FIM instrument must be administered by a trained and certified evaluator and ideally scored by consensus with a multi-disciplinary team. Although the FIM instrument was originally developed to address issues of sensitivity and comprehensiveness for Barthel Index (BI), subsequent studies demonstrated that psychometric properties of the FIM instrument and BI are similar (Hsueh et al, 2002; Stroke EDGE task force)

"The FIM instrument does not contain key activity or participation elements of patient recovery important for measuring outcome and burden of illness (e.g., return to work, relationships, social and recreational pastimes, etc.)"(Nichol et al., 2011) The FIM instrument is appropriate for patients at all levels of EDSS; rating reflects limited responsiveness data, training required, and copyright issues (MS EDGE task force)

Diversity Sensitivity of FIM

The FIM instrument was examined in white, black, and Hispanic people poststroke that were admitted to inpatient rehabilitation. FIM scores were



tracked at admission, discharge, three and 12 months after discharge. At three months, black and Hispanic patients had lower FIM totals when compared to whites. In addition, total FIM ratings increased for all three group form discharge to three months post, but then showed little change after. Racial/ethnic group, age, length of stay and medical comorbidities were significant predictors of total FIM ratings over the four time points. (Berges et al, 2012; Stroke EDGE task force)

FIM converted to other Languages

(Miki et al, 2015). Internal consistency and reliability were measured with the Japanese FIM+FAM-J in 42 patients a mean 30.2 (\pm 21.2) days post CVA .

- Excellent internal consistency was observed for the FIM+FAM-J (full scale [0.968], motor scale [0.954] and cognitive subscales [0.949])
- Excellent intra rater reliability was observed within the FIM+FAM-J full scale, motor subscale and cognitive subscale ((0.83, 0.80 and 0.98 respectively).
- Excellent criterion validity was measured between the FIM+FAM-j full scale and the Motor Scale with the Barthel Index [BI], the National Institutes of Health Stroke Scale [NIHSS], modified Rankin Scale [mRS] and Brunnstrom Recovery State [BRS L/E] (r=0.83, -0.75, -0.82 and 0.79 respectively with the total scale and 0.88, -0.77, -0.87, and 0.83 respectively for the motor scale)
- Adequate criterion validity of the FIM+FAM-J cognitive scale with the BI, NIHSS, mRS and BRSL/E (0.56, -0.53,-0.54 and 0.53 respectively)
- Adequate correlations with the Mini Mental Status Examination [MMSE] and the Frontal Assessment Battery [FAB] (0.60 and 0.58) but a floor effect with the Catherine Bergego Scale [CBS].

(Naghdi et al, 2016) Two raters administered the Persian FIM and the Barthel Index to 40 patient, mean age of 60 (\pm 14.9) years old and an average of 21 (\pm 23) months post first stroke .

- Excellent intra-rater reliability was measured {0.88-0.98}
- Internal consistency of the PFIM was excellent, ranging from 0.70 to 0.96
- Construct validity was supported by a significant Pearson Correlation between the PFIM and the Persian Barthel Index (r=0.95)

Systematic Reviews

In a systematic review of outcome measures used with patients post stroke participating in robot-assisted exercise trials (RAET), the FIM[™] Motor Scale


	was used as a measure of activity level in 9 of 28 RAET trials. With scores ranging from 13-91, the MCID was 11. The FIM Motor Scale had high/excellent reliability (test-retest and inter-rater reliability) and high/excellent validity (>0.75) However, the FIM Motor Scale had only moderate responsiveness (0.4-0.74), with chronic stroke survivors with severe impairments (persisting beyond 6 months) demonstrating little change on the FIM Motor Scale. As a measure of global physical activities, the FIM Motor Scale may be impacted by many other factors beyond specific arm function. The CAHAI or the ARAT may be a more appropriate arm outcome measure for stroke survivors with severe impairments. (Sivan et al, 2011) Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
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Year published	1983
Instrument in PDF Format	Yes
Approval Status	Approved



14. REHAB MEASURES: FUGL-MEYER ASSESSMENT OF MOTOR RECOVERY AFTER STROKE

Title of Assessment	Fugl-Meyer Assessment of Motor and Sensory Recovery after Stroke				
Acronym	FMA				
Instrument Reviewer(s)	Updated by Carmen Capo-Lugo, PT, PhD and Dorian Rose PT, PhD of the Stroke Edge II Task Force in 2016.				
Summary Date	11/12/16				
Purpose	 Evaluates and measures recovery in post-stroke hemiplegic patients Used in both clinical and research settings One of the most widely used quantitative measures of motor impairment (Gladstone et al, 2002) 				
Description	 Items are scored on a 3-point ordinal scale 0 = cannot perform 1 = performs partially 2 = performs fully Maximum Score = 226 points The Five domains assessed include: Motor function (UE maximum score = 66; LE maximum score = 34) Sensory function (maximum score = 24) Balance (maximum score = 14) Joint range of motion (maximum score = 44) 				
	 Joint pain (maximum score = 44) Subscales can be administered without the using the full test Modified (abbreviated) versions have been developed (Hsueh et al, 2008) 				
Area of Assessment	Activities of Daily Living; Functional Mobility; Pain				
Body Part	Not Applicable				



ICF Domain	Body Function			
Domain	Motor; Sensory			
Assessment Type	Observer			
Length of Test	06 to 30 Minutes			
Time to Administer	30 minutes (shortened versions \geq 10 minutes)			
Number of Items	226 items across 5 domains			
Equipment Required	 The FMA Motor Test requires: Tennis ball A small spherical shaped container A tool to administer reflex tests Enough space is needed for a patient to move around freely If possible, space should be a quiet, private room with few distractions 			
Training Required	Review of manual			
Type of training required	Reading an Article/Manual			
Cost	Free			
Actual Cost	Nominal - cost of equipment only			
Age Range	Adolescent: 13-17 years; Adult: 18-64 years; Elderly adult: 65+			
Administration Mode	Paper/Pencil			
Diagnosis	Stroke			
Populations Tested	The FMA was designed for post-stroke hemiplegic patients of all ages			
Standard Error of Measurement (SEM)	<pre>Stroke: (Sanford et al, 1993; n = 12; mean age = 66 years; stroke onset < 6 months, Acute Stroke)</pre>			



	• F1	MA total	scores: 9.4				
Minimal Detectable Change (MDC)	Stroke: (Wagner e average 1 • Fi	et al, 200 4 (6.5) m MA = 5.2	8, <i>n</i> = 14, m onths post points for t	hean age = 5 stroke, Chr he Upper E	59.9 (14.6) y onic Stroke xtremity po	vears, asses) rtion of the	sed on assessment
Minimally Clinically Important Difference (MCID)	Stroke: (Shelton e days of str FMA Moto FI • 10 FI	et al, 200: roke, Acu or Scores D point ir M D point ir M	1; n = 171; i ite Stroke) from Admi ncrease in F ncrease in F	mean age 7 ission to Dis MA Upper I MA Lower I	0 (11) years scharge Extremity = Extremity =	; assessed v 1.5 change 1.9 change	within 17 (12) in discharge in discharge
Cut-Off Scores	<u>Stroke</u> : (Duncan e 14 days, A Six month	et al, 2000 Acute Stro	0; <i>n</i> = 459; r oke) es by modi	mean age = fied Rankin	70 (11.4) y	ears; stroke	onset within
	Rankin	1	2	3	4	5	6
	Fugl- Meyer	99.31 (1.49)	91.76 (9.51)	82.94 (17.18)	62.58 (24.04)	39.15 (25.42)	16.69 (23.89)
	NIH	0.07 (0.27)	0.78 (1.12)	2.06 (1.63)	3.93 (2.55)	7.94 (4.80)	18.71(11.74)
	Barthel	99.23 (1.88)	98.97 (2.83)	96.52 (5.08)	83.40 (13.50)	42.83 (18.25)	6.43 (8.86)
	SF36-PFI	85.38 (9.46)	70.12 (21.06)	54.23 (22.98)	29.38 (21.04)	8.68 (11.87)	1.67 (4.08)
Normative Data	Stroke:					1	

(Duncan et al, 2000, Acute Stroke)



	Percent	Percent of cohort that achieved recovery						
		NIH <u><</u> 1	Fugl- Meyer>90	Barthel>90	SF36 Femal PFI>66	SF36 e Male 5 PFI>75	Rankin <u><</u> 1	Rankin <u><</u> 2
	Baseline	10.46	13.07	8.06	0.00	0.00	1.74	12.20
	1 Month	16.78	12.85	26.14	9.44	12.08	5.45	21.57
	3 Month	11.11	7.84	13.94	10.73	11.59	9.80	12.85
	6 Month	6.54	3.05	9.15	3.86	4.83	7.41	7.19
	Never	55.10	63.20	42.70	76.00	71.50	75.60	46.20
	patients; • E • E	assesso xceller xceller xceller	ed twice wit It Total Mot It Sensation It Passive Jo	hin a 7 day i or Score (ICC (ICC = 0.81) int motion (interva C = 0.9 ⁻ ICC = 0	I, General Re 7) 1.95)	ehab Samp	le)
Interrater/Intrarater Reliability	Stroke: (Duncan o occasions	Stroke: (Duncan et al, 1983; n = 19; mean age = 56 (13) years; same PT rating on 3 occasions each 3 weeks apart; VA sample, Chronic Stroke)						
	Interrate	Interrater Reliability						
	Rating	Doma	in	Pearson's <i>i</i>	-			
	Excellent	: FMA t	total score	<i>r</i> = 0.98-0.9	99			
	Excellent	: Uppe	r Extremity	<i>r</i> = 0.995 -	0.996			
	Excellent	: Lowei	r Extremity	<i>r</i> = 0.96				
	Excellent	: Sensa	tion	<i>r</i> = 0.95 - 0	.96			



Excellent	Ioint Range	/ Pain	r = 0	86 - 0 996
Excellent	JUILL RAILE	/ Faiii	1 - 0.	60 - 0.990

Excellent	Balance	<i>r</i> = 0.89 - 0.98

Excellent Interrater Reliability:

(Duncan et al, 1983; 4 PT's using the above sample)

FMA Domain	Pearson's r
Upper Extremity	r = 0.98 - 0.995
Lower Extremity	<i>r</i> = 0.89 - 0.95

(Sanford et al, 1993; *n* = 12; mean age = 66 (11.5) years; 0 to 6 months post stroke, Acute Stroke)

• **Excellent i**nterrater reliability, FMA Total Score: (ICC = 0.96)

Rating	FMA Domain	ICC
Excellent	Upper Extremity	0.97
Excellent	Lower Extremity	0.92
Adequate	Sensation	0.85
Adequate	Joint Range of Motion	0.85
Poor	Pain	0.61

Sullivan et al, 2011; n=15 patients (10- 71 days post- stroke; mean age 62.8 yrs. One expert PT rater compared to 17 trained PT's using standardized procedures	Intra-rater Reliability	Inter-rater Reliability
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developed for LEAPS trial.				
FM Domain	ICC (3,1)	95% CI	ICC (2,1)	95% CI
Motor: Total	0.99	0.83-1.0	0.98	0.93-0.99
Motor: UE	0.95	0.66-1.0	0.99	0.97-1.0
Motor: LE	0.99	0.91-1.0	0.91	0.69-0.97
Sensory: Total	0.96	0.70-1.0	0.93	0.83-0.98
Sensory: Light Touch	1.0	1.0-1.0	0.87	0.69-0.95
Sensory: Proprioception	0.95	0.63-1.0	0.96	0.90-0.99

See et al, 2013; n=31 patients (54±47 mo post-stroke; mean age 61.1yrs. Three therapist raters. Testing was conducted on the UE FMA only. Performance for the total UE FMA, proximal arm subsection, and distal arm (wrist/hand) were examined separately. Reliability was assessed utilizing standardized procedures developed for a Phase II RCT.

Test	UE FMA Total Score	UE FMA Proximal Subscore	UE FMA Hand/Wrist Subscore
Intrarater reliability			
Spearman's r ²	0.99	0.99	0.94
ICC	0.99	0.99	0.99
MDC ₉₀	3.2 pts	1.7 pts	1.7 pts
Interrater reliability			
Spearman's r ²	0.97	0.95	0.85
ICC	0.99	0.98	0.98
MDC ₉₀	3.2 pts	1.6 pts	2.5 pts

Internal Consistency

<u>Stroke</u>:

(Lin et al, 2004; *n* = 176; mean age = 67.9 (10.9) years; assessed 14, 30, 90 and 180 days after stroke, Acute Stroke)

• **Excellent** internal consistency: alpha = 0.94 to 0.98 across 4 administrations

Subsection to FMA Total Score Correlations:

(Wood-Dauphinee et al, 1990; *n* = 167; assessed at admission and 5 weeks)

- **Excellent** correlation : Upper Extremity & FMA Total (*r* = 0.97)
- **Excellent** correlation: Lower Extremity & FMA Total (*r* = 0.90)
- Adequate correlation: Balance & FMA Total (*r* = 0.88)



Criterion Validity (Predictive/Concurrent)

<u>Stroke</u>:

(Malouin et al, 1994; *n* = 32; mean age = 60; mean time since stroke = 64.5 days, Acute Stroke)

- **Excellent** FMA & Motor Assessment Scale (MAS) total score correlations (*r* = 0.96)
- **Poor** FMA & MAS sitting balance item correlations (*r* = -0.10)
- Motor and sensory FMA scores 5 days post-stroke were the strongest predictor of motor recovery 6 months post-stroke (Duncan et al, 1992)

Gait Speed (Nadeau et al, 1999; n = 16; mean age = 47.9 (15.6) years; mean number of months post-stroke = 43.9, Chronic Stroke)

- **Poor correlations** between FMA Sensation and Gait speed (*r* = 0.05) and comfort (*r* = 0.14)
- Excellent correlations between FMA total motor scores and gait speed (m = 1.09 meter per second; r = 0.61); and comfort (m = 0.76 meters per second; r = 0.61)

See et al, 2013; n=12 .These exams were performed on 12 patients (of the cohort of 31 described under Reliability testing above), 4 separate visits across a treatment period, for a total of 48 exams. Testing was conducted on the UE FMA only. Performance for the total UE FMA, proximal arm subsection, and distal arm (wrist/hand) were examined separately.

Test	Baseline Value	Correlation with UE FMA Total Score	Correlation with UE FMA Proximal Score	Correlation with UE FMA Hand/Wrist Subscore
Max. Grip force, affected/nonaffected	0.29±0.22	0.74	0.73	0.73
Max. Pinch force, affected/nonaffected	0.40±0.30	0.88	0.87	0.85
Box & Blocks (no. Of blocks)	0 (0-29)	0.86	0.79	0.88
ARAT score	27.2±22.5	0.93	0.88	0.89
9-hole peg (no. Of pegs placed)	0 (0-7)	0.75	0.64	0.80
SIS hand subscore	2.3±1.3	0.86	0.79	0.88



	ARAT = Action Research Arm Test; SIS = Stroke Impact Scale. Baseline values are mean ± SD except for Box & Blocks and 9-hole peg scores, which are median. Correlation values are Spearman r values which in all cases were significant with p < 0.0001.			
	(Wei et al, 2011; n=27 with chronic stroke (4.92±0.45 yrs post-stroke)			
	Excellent correlations were observed both pre-training and post-training among the Upper Extremity Fugl-Meyer Assessment , the Motor Status Scale and the Action Research Arm Test (β =0.91-0.93). Modified Ashworth Scale and the UE FMA were fairly to moderately correlated (β =0.42-0.62)			
Construct Validity	<u>Stroke</u> :			
(Convergent/Discriminant)	Acute Stroke:			
	 Excellent correlation: modified Balance Subscale on FMA and the Barthel Index; r = 0.86 - 0.89 (Mao et al, 2002) 			
	 Excellent correlation: FMA and Functional Independence Measures (FIM) administered to 172 inpatients who had recently had a stoke; r = 0.63 (Shelton et al, 2000) 			
	 FMA effectively distinguished between three levels of self care (Independent, Partly Dependant, and Dependant) in a sample of 109 recent (< 90 days) stroke survivors (Bernspang et al, 1987). 			
	 FMA was a better measure of higher-level recovery than the MAS (Malouin, et al, 1994) 			
	Chronic Stroke			
	(Dettmann et al, 1987; <i>n</i> = 15; mean age = 64 years; mean time since stroke, 2 years, Chronic Stroke)			
	 The FMA and the Barthel Index were used to assess a group of 15 participants at an average of 2 years post stroke. Correlations between the measures were excellent (<i>r</i> = 0.67). The strongest correlations were observed in the Balance subscore (<i>r</i> = 0.76) the Upper Extremity subscore of the motor domain (<i>r</i> = 0.75) and FMA Motor total score (<i>r</i> = 0.74) 			
	(Hsieh et al, 2009; onset > 6 months, Chronic Stroke)			
	FMA Construct Validity (Spearman's rho followed by 95% CI)			



	 Excellent correlation between FMA and Action Research Arm Test: 0.73** (0.58, 0.83)
	• Excellent correlation between FMA and Wolf Motor Function Test- TIME: 0.76** (0.63, 0.86)
	• Excellent correlation between FMA and Wolf Motor Function Test- Functional Ability Scale: 0.71** (0.56, 0.82)
	 Adequate correlation between the FMA and FIM-motor: 0.49** (0.27, 0.66)
	*P < 0.05 **P < 0.01
Content Validity	<u>Stroke</u> :
	(Woodbury et al, 2008; <i>n</i> = 377; men age = 69.2 (11.2) years, Acute Stroke)
	Upper extremity (modified version, 3 reflex items removed)
	Administered at admission and 6-months post stroke
	 Rasch Analysis demonstrated adequate fit for each of the 30 items <i>except</i> the hook grasp item
	 Results suggest items contained in modified FMA, (except the hook grasp item) were assessing the same underlying construct
	(Crow et al, 2008; <i>n</i> = 62; retrospective analysis, Chronic Stroke)
	Upper and lower-extremity (excluding balance) portions of FMA:
	Items within a scale are valid, unidimensional and cumulative
	 Results suggest that if a patient is able to successfully complete an item of a certain difficulty, that same patient should be able to complete less difficult items, implying that a shortened administration of the FMA may produce valid results
Face Validity	Gladestone et al, 2002:
	• Face and content validity for the motor domain are "very good"
	Scaling is heavily weighted for the upper extremity
	Reflexes may be overrepresented in the scoring system



Floor/Ceiling Effects

<u>Stroke</u>: (Lin et al, 2004, Acute Stroke)

• **Ceiling effects** have been observed with the Sensation subscore. The following percentages of acute stroke patients reaching the highest possible score:

Days Post Stroke	% Highest Possible Score
14-30 days	44.4%
14-180 days	72.1%
30-90 days	48.9%
90-180 days	48.9%
90-180 days	62.7%

- Possible ceiling effects on hand and lower extremity items (Gladstone, et al, 2002).
- Floor effects have been reported for the modified Balance domain. The strongest effects were observed 14 days post stroke with 29.3% of participants not able to achieve the lowest possible score on the measure (Mao et al, 2002)

Responsiveness	<u>Stroke</u> :			
	(Mao et al, 2002, Acute Stroke)			
	• Excellent on the modified version of the FMA Balance score			
	 Between assessments at 14, 30, 90 and 180 days post-stroke 			
	 Responsiveness decreased as the time between stroke and assessments increased 			
	Moderate to Low: (Lin et al, 2004) responsiveness was found for the Sensation subscale of the FMA as assessed by Standardized Response Means (SRM).			
	Means were low at:			
	 14-30 days: SRM = 0.42 			
	 30-90 days: SRM = 0.43 			
	 90-180 days: SRM = 0.27 			



Moderate responsiveness when assessed from 14 to 180 days (SRM = 0.67)

(Hsueh et al, 2009, Chronic Stroke)

- Small to moderate effect sizes were observed on the FMA, the Stroke Rehabilitation Assessment of Movement instrument (STREAM) and each of the measures shortened versions.
- **Moderate** effect sizes on the shortened version of both measures (0.53 and 0.51)
- Small effect sizes on the long version of the measure (0.045 and 0.38)

(Wei et al, 2011; n=27 with chronic stroke (4.92±0.45 yrs post-stroke

Pre- and post-training which consisted of 20 sessions of UE robotic training that could be completed in 4-7 weeks.

	SRM	GRI*
UE FMA	0.85	3.62
Shoulder & elbow	0.84	2.70
	(large responsiveness)	
Wrist & Hand	0.67	3.45
	(moderate responsiveness)	

*GRI has no recommended value. Bigger GRI values mean larger effect size and more responsiveness. SRM = Standardized Response Mean; GRI= Guyatt's Responsiveness Index

Professional Association
RecommendationsRecommendations for use of the instrument from the Academy of Neurologic
Physical Therapy of the American Physical Therapy Association's Multiple
Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord
Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain
Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below.
These recommendations were developed by a panel of research and clinical
experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>

Abbreviations:		
HR	Highly Recommend	



R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute (CVA < 2 months post) (SCI < 1 month post) (Vestibular < 6 weeks post)	Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	Chronic (> 6 months)
StrokEDGE II	HR	HR	HR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	UR	HR	HR	HR	HR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE II	Yes	Yes	Yes	Not reported



Considerations	Limitations: (Gladstone et al, 2002)			
	 The Sensation, Balance, Joint Range of Motion and Joint Pain domains have been criticized as less well suited for this instrument given its intended purpose 			
	 Joint Range of Motion may be a confounding variable, so the inclusion of the Joint Pain domain may be unnecessary 			
	Distal fine motor functions may be underrepresented			
	• Finger movement not assessed (but gross hand function is included)			
	Arm scores are more heavily weighting the leg scores			
	Better measure of balance are now available			
	 Inclusion of subjective items on the Sensation and Joint Pain domains may reduce the measures reliability 			
	• The Sensory Scale's psychometric properties suggest that is should NOT be used to assess stroke patients (Lin et al, 2004)			
	Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u> !			
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Year published	1975
Instrument in PDF Format	Yes
Approval Status	Approved



15. REHAB MEASURES DATABASE—MODIFIED ASHWORTH SCALE

Link to instrument	Modified Ashworth Scale Instructions (other languages below)
Title of Assessment	Ashworth Scale / Modified Ashworth Scale
Acronym	AS / MAS
Instrument Reviewer(s)	Initially reviewed by the Rehabilitation Measures Team; Updated by Phyllis Palma PT, DPT and Christopher Newman PT, MPT, NCS and the SCI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 9/2012; Updated with references for the TBI population by Irene Ward, PT, DPT, NCS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012; Updated with references for Pediatrics and Cerebral Palsy by Anna Wetzel, SPT, Brian Baranyi, SPT, and Stephanie Johnson, SPT in 11/2012; Updated by Dorian, Rose, PhD, PT and Carmen Capo-Lugo, PhD, PT of the StrokEdge II Task Force, Academy of Neurologic Physical Therapy - a component of APTA.
Summary Date	5/26/2016
Purpose	Originally developed to assess the effects of antispasticity drugs on spasticity in Multiple Sclerosis Modified Ashworth: measures spasticity in patients with lesions of the Central Nervous System
Description	Original Ashworth Scale: Tests resistance to passive movement about a joint with varying degrees of velocity Scores range from 0-4, with 5 choices A score of 1 indicates no resistance and 5 indicates rigidity Modified Ashworth Scale : Similar to Ashworth, but adds a 1+ scoring category to indicate resistance through less than half of the movement. Thus scores range from 0-4, with 6 choices (Bohannon & Smith, 1987)



Score	Ashworth Scale (1964)	Modified Ashworth Scale Bohannon & Smith (1987)
0 (0)	No increase in tone	No increase in muscle tone
1 (1)	Slight increase in tone giving a catch when the limb was moved in flexion or extension	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the affected part(s) is moved in flexion or extension
1+ (2)		Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the reminder (less than half) of the ROM (range of movement)
2 (3)	More marked increase in tone but limb easily flexed	More marked increase in muscle tone through most of the ROM, but affected part(s) easily moved
3 (4)	Considerable increase in tone - passive movement difficult	Considerable increase in muscle tone passive, movement difficult
4 (5)	Limb rigid in flexion or extension	Affected part(s) rigid in flexion or extension

Area of Assessment	Spasticity
Body Part	Not Applicable
ICF Domain	Body Structure; Body Function
Domain	Motor
Assessment Type	Observer
Length of Test	05 Minutes or Less



Time to Administer	< 5 minutes, dependent upon the number of muscles/joints tested
Number of Items	AS uses a 5 point scale (range 0 to 4); MAS uses 6 point scale (range 0 to 4)
Equipment Required	Mat Table
Training Required	None
Type of training required	No Training
Cost	Free
Actual Cost	Free
Age Range	Child: 6-12 years; Adult: 18-64 years
Administrati on Mode	Paper/Pencil
Diagnosis	Cerebral Palsy; Multiple Sclerosis; Spinal Cord Injury; Stroke; Traumatic Brain Injury
Populations	Adults and children with lesions of the Central Nervous System
Tested	Cerebral Palsy
	Multiple Sclerosis
	Pediatric Hypertonia
	Spinal Cord Injury
	Stroke
	Traumatic Brain Injury
Standard Error of	Not Established



Measuremen t (SEM)	
Minimal	Stroke:
Detectable Change (MDC)	(Shaw et al, 2010; n = 333; adults with upper limb spasticity at the shoulder, elbow, wrist or hand and reduced upper limb function due to stroke more than 1 month previously.)
	Response to Botox: the magnitude of initial change in muscle tone/spasticity was approximately a one-point decrease on the MAS which reflects a clinically significant improvement.
Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Not Established
Normative Data	Not Established
Test-retest	Modified Ashworth Scale
Reliability	Children with Cerebral Palsy:
	(Mutlu et al, 2008; n = 38; mean age = 52.9 (19.6) months, Children with CP)
	Poor to Excellent test-retest reliability (ICC = 0.36-0.83)
	(Fosang at al, 2003; n = 18; mean age = 6.4 years, Children with CP)
	Adequate to excellent test-retest reliability for hamstrings (ICC = 0.66-0.80)
	Poor to adequate test-retest reliability for calf (ICC = 0.21-0.72)
	Adequate to excellent test-retest reliabilty for hip adductors (ICC = 0.59-0.82)
	SCI:
	(Tederko et al, 2007, n = 30; 5 = unable to sit up, 14 = adapted to sitting position, 11 patients = adapted to standing position or able to walk; mean age = 33.9 (range = 17-65); mean time since injury 14.1 months, Chronic SCI)



	Adequate reliability for individual muscle groups (ICC = 0.56), however the MAS may be a more appropriate measure of global muscle tone.
	The reliability of muscle tone assessments were weaker among younger patients
	Joint contractures decreased the reliability of the MAS
	Stroke:
	(Gregson et al, 2000; n = 32; median age = 74 years; median Barthel score = 8; median time since onset = 40 (IQR = 19 - 78) days. Blackburn et al, 2002; n = 32; mean age = 76.1 (7.89) years; assessed 12 weeks post-stroke, Acute Stroke)
	Excellent intra-rater reliability for elbow (kw = 0.84) (Gregson et al, 1999)
	Adequate intra-rater reliability for elbow (kw = 0.77 – 0.84); ankle (kw = 0.59 – 0.64); wrist (kw = 0.80 – 0.88) and knee (kw = 0.77 – 0.94) (Gregson et al, 2000)
	Adequate intra-rater reliability in the lower extremity of 73.3% (Kendall tau-b = 0.567) (Blackburn et al, 2002)
	Traumatic Brain Injury:
	Adequate test-retest reliability for the Shoulder, elbow, wrist, hip, knee and ankle (kappa = 0.47-0.62) (Mehrholz et al, 2005)
	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996)
Interrater/In	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale:
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions:
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions)
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001)
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001) Patients with severe cerebral damage:
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001) Patients with severe cerebral damage: (Mehrholz et al, 2005, patients with severe cerebral damage)
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001) Patients with severe cerebral damage: (Mehrholz et al, 2005, patients with severe cerebral damage) Poor to adequate Inter-rater reliability (kappa = 0.16 to 0.42)
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001) Patients with severe cerebral damage: (Mehrholz et al, 2005, patients with severe cerebral damage) Poor to adequate Inter-rater reliability (kappa = 0.16 to 0.42) SCI:
Interrater/In trarater Reliability	Excellent test-retest for the ankle (r = 0.82; k = 0.422) (Allison et al, 1996) Modified Ashworth Scale: Patients with central nervous system lesions: (Bohannon & Smith, 1987, n = 30, mean age = 59.3 (17.6) years, patients with centeral nervous system lesions) Excellent interrater reliability between two experienced raters (Kendall's tau = 0.847, p < 0.001) Patients with severe cerebral damage: (Mehrholz et al, 2005, patients with severe cerebral damage) Poor to adequate Inter-rater reliability (kappa = 0.16 to 0.42) SCI: (Haas et al, 1996, n = 30, mean age = 40.3 years, mean time since injury = 17.23 months; Frankel Grade A = 18, B = 3, C = 2, D = 6, E = 1, Chronic SCI)



(Craven et al, 2010, n = 20, C5-T10, AIS A-D > 12 months, Chronic SCI)

Inter-rater reliability was poor to adequate (Kappa < 0.6) for all muscle groups

Inter-session reliability for a single rater was adequate (0.4 < ICC < 0.75) for all muscle groups

MAS not reliable as an intrarater tool for all raters, and showed poor inter-rater and adequate inter-session reliability.

MAS has poor reliability for determining lower extremity spasticity between raters (interrater) or over time (intersession)

(Toderko et al, 2007; n = 30 (16 complete & 14 with incomplete); mean age = 33.9 (14.7) years; time since injury = 4-66; rated by 6 independent observers, Acute SCI)

Adequate interrater reliability (ICC = 0.56)

Stroke:

(Blackburn et al, 2002, Acute Stroke)

Adequate intrarater reliability. Agreement ranged from 57.5% (Kendall Tau-b = 0.44) to 85% (Kendall Tau-b = 0.66)

Poor interrater reliability. Agreement ranged from 50% (Kendall Tau-b = 0.20) to 42.5% (Kendall Tau-b = 0.16)

The authors concluded that the MAS was a reliable measurements for lower limb assessments made by a single rater, with highest agreement at the grade of 0. However, reliability between examiners was poor.

(Li et al, 2014; chronic stroke (3.7 +/- 4.30 months post-stroke); n=51)

This study assessed intra- and inter-rater reliability for the MAS.

Reliability		Карра	Standard	T-value	P-values	Interpretation
			error			
Inter- rater	Elbow	0.66	0.00	6.64	<0.001	Substantial
	flexors	0.00	0.09	0.04		agreement
	Plantar	0.48	0.09	5.73	<0.001	Moderate
	flexors					agreement
Elbow Intra- flexors rater Plantar	Elbow	0.60	0.00	7.06	<0.001	Substantial
	flexors	0.69	0.09	7.06	<0.001	agreement
	Plantar	0.49	0.10	E 40	<0.001	Moderate
	flexors	0.40	0.10	5.42	NO.001	agreement

TBI:



(Allison et al, 1996, n = 30, mean age = 28.3 (10.8) years; mean time since injury = 56 (48.4) months, Chronic TBI)

Adequate interrater reliability (r = 0.727) for plantar flexor spasticity

Original Ashworth Scale:

Children with Cerebral Palsy:

(Mutlu, 2008, Children with CP)

Excellent interrater reliability for measures hamstrings (ICC = 0.76, 0.73)

Excellent interrater reliability for measures of hip adductors (ICC = 0.83, 0.87)

Adequate to excellent interrater reliability for measure of hip internal rotators (ICC = 0.61, 0.84)

Adequate interrater reliability for measures of hip flexors (ICC = 0.71, 0.74)

Adequate interrater reliability for measures of gastrocnemius (ICC = 0.64, 0.68)

Poor to excellent intrarater reliability:

Lowest intrarater reliability found for hip internal rotators (ICC = 0.36)

Highest intrarater reliability found for hip flexors (ICC = 0.83)

Authors concluded that assessments of spasticity using the Modified Ashworth Scale are not very reliable for this population and should be used with caution

(Fosang, 2003, Children with CP)

Hamstrings

Poor to adequate interrater reliability (ICC = 0.37-0.48)

Adequate to Excellent intrarater reliability (ICC = 0.66-0.80)

Calf

Poor to Adequate interrater reliability (ICC: 0.27-0.45)

Poor to Adequate intrarater reliability (ICC: 0.21-0.70)

Adductors

Adequate interrater reliability (ICC = 0.54-0.56)

Adequate intrarater reliability (ICC = 0.59-0.72)

(Yam, 2005; n = 17, mean age=7.9 years, Children with CP)

Poor to adequate interrater reliability for hip adductors, knee flexed (ICC = 0.41)



Adequate interrater reliability for hip adductors, knee extended (ICC = 0.73)

Adequate interrater reliability for ankle plantarflexors, knee extended (ICC = 0.56)

Adequate interrater reliability for ankle plantarflexors, knee flexed (ICC = 0.46)

The authors caution the use of this test in this population due to none of the measures possessing excellent interrater reliability (ICC > 0.75)

Pediatric Hypertonia:

(Clopton, 2005; n = 17, mean age = 7 years, Pediatric Hypertonia)

Excellent interrater relibility for elbow flexors and hamstrings (ICC > 0.75)

Poor to adequate interrater reliability for other muscles (ICC < 0.50)

Lower than clinically acceptable

Excellent intrarater reliability for hamstrings (ICC > 0.75)

Adequate intrarater reliability for other muscles (ICC 0.50-0.75)

Potentially lower than clinically acceptable

Stroke:

(Kaya et al, 2011, n = 64, mean age = 60.5 (11.9) years; mean time since stroke = 15.7 (10.2) weeks, Stroke)

Excellent for both MAS and modified MAS (Ansari et al, 2006), with weighted kappa values of 0.868 and 0.892

MAS and MMAS have very good inter-rater reliability for assessment of poststroke elbow flexor spasticity

Neither scale is superior to grade spasticity in patients with hemiplegia for this particular muscle group

(Brashear et al, 2002, n = 10, mean age = 59.9 (16.17) years, Chronic Stroke)

Adequate intrarater reliability (across 10 raters)

	Elbow	Wrist	Fingers	Thumb
Overall weighted K	0.668	0.740	0.740	0.680
р	0.998	0.972	1.000	0.985

Adequate to excellent interrater reliability (depending on joint)

Mean of evaluations 1 and 2 (Kendall W)



Elbow	Wrist	Fingers	Thumb
0.765	0.598	0.792	0.611

TBI:

(Ansari et al., n = 15; mean age of 57.3 (14.4) years. They had brain injury on average of 33.3 (26.2) months earlier, Chronic TBI)

Adequate: the weighted Kappa (kappaw) values were calculated for reliability. The kappaw was 0.61 (adequate) for elbow flexor and 0.78 (excellent) for wrist flexor. Results support the adequate to excellent interrater reliability of the MMAS for persons with upper limb spasticity

Internal Consistency	Not Established
Criterion Validity (Predictive/C	Modified Ashworth Scale:
oncurrent)	Children with Children:
	(Alhusani, 2010; n = 27, mean age = 7 (1.9) years, Children with CP)
	Percentage of Exact Agreement with lab measurement (stretch-induced electromyographic activity) in identifying spasticity
	81.5% non-significant fair agreement (K = 0.24)
	P = 0.057 non-significant
	Pearson Correlation with lab measurement to identify the severity of spasticity
	R = 0.009 not a significant correlation
	P = 0.7 not a significant correlation
	Traumatic Brain Injury:
	(Allison & Abraham, 1995, n = 34, mean age = 30.4 years, TBI)
	Adequate concurrent validity with:
	Timed toe tapping (r = -0.042)
	Reflex Threshold Angle (r = 0.49)
	H-reflex during dorsiflexion (r = 0.47)
	H-wave during vibration (r = 0.39)



Construct	Modified Ashworth Scale:
Validity (Convergent/	SCI:
Discriminant)	(Smith et al, 2002; n = 22; 14 quadriplegia (3 incomplete), 8 paraplegia (1 incomplete); mean age = 33.4 (12.5) years, SCI)
	Excellent: Correlation with the Wartenberg Pendulum Test & MAS (r = -0.69)
	Stroke:
	(Katz 1992, n = 10; Lin & Sabbahi, 1999, n = 10, mean age = 59 (4) years, Chronic Stroke)
	Excellent convergent validity with:
	Fugl-Meyer (r = -0.94)
	Electromyography (r = -0.79)
	Box-Block Test (r = -0.83)
	Active Range of Motion (r = -0.74)
	Grip Strength (r = -0.86)
	Pendulum test (r = -0.67)
	(Min et al, 2012; acute stroke (32.2 +/- 7.3 days post-stroke); n=21)
	The Spearman correlation coefficients showed a high correlation between MAS and amplitude of T-reflex of the biceps (Rater 1 = 0.464, Rater 2 = 0.573). No correlation was found between MAS and latency of the biceps' T-reflex .
	(Lee et al, 2015; chronic stroke (15.21 +/- 3.32 months post-stroke); n=43)
	This study assessed correlation between outcome measures using Pearson correlations coefficients. MAS was negatively correlated with Fugl-Meyer Upper Extremity (FM-UE; -0.72, p<0.05), FM-wrist/hand (-0.34, p<0.05), and Action Research Arm Test (ARAT; -0.41, p<0.05).
Content	Theoretical basis of the Modified Ashworth Scale:
Validity	Implicit Assumptions:
	(Pandyan et al, 1999, Implicit Assumptions)
	Changes in the resistance to passive movement are due to changes in spasticity



	Stretch mech repeated mea	anoreceptors in the muscle would elongate with similar velocity during asures	
	Range of mov	rement on each joint during repeated measures is unaltered	
	These authors	s suggested:	
	Caution is req spasticity	uired when stating that the Modified Ashworth Scale is a measure of	
	Evidence sugg of spasticity	gests that the resistance to passive movement is not an exclusive measure	
	Resistance wi agonist and a	ll vary according to the level of activity in the alpha motor neuron of ntagonist muscles, the viscoelastic properties of soft tissues and joints.	
Face Validity	Not Establish	ed	
Floor/Ceiling Effects	Not Establish	ed	
Responsiven ess	Not Establish	ed	
Professional Association Recommend ations	Recommendations for use of the instrument from the Academy of Neurol Therapy of the American Physical Therapy Association's Multiple Sclerosis (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce Stroke Taskforce (StrokEDGE, StrokEDGE II), Traumatic Brain Injury Taskfo EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recomm were developed by a panel of research and clinical experts using a modifie process.		
	For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations		
	Abbreviation	ns:	
	HR	Highly Recommend	
	R	Recommend	



LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 months post)		
SCI EDGE	NR	NR	NR
StrokEDGEII	UR	NR	NR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGEII	UR	UR	NR	NR	NR

Recommendations for entry-level physical therapy education and use in research:

	Students	Students	Appropriate for	Is additional
	should learn	should be	use in	research
	to administer	exposed to	intervention	warranted for
	this tool?	tool? (Y/N)	research studies?	this tool (Y/N)
	(Y/N)		(Y/N)	
SCI EDGE	No	No	No	Not reported
StrokEDGEII	No	Yes	Yes	Not reported

Ashworth Scale, Modified

Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE),



Stroke Taskforce (StrokEDGE, StrokEDGEII), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations

Abbreviatior	ns:
HR	Highly Recommend
R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCl < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 months post)		
SCI EDGE	LS	LS	LS

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	UR	UR	UR	UR	UR
TBI EDGE	LS	R	R	R	R



Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant	Seve
TBI EDGE	N/A	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5	EDS
MS EDGE	UR	UR	UR	UR

Recommendations based on vestibular diagnosis

Peripheral	Central	Benign Paroxysmal	Oth
		Positional Vertigo	
		(BPPV)	

Recommendations for entry-level physical therapy education and use in research:

	Students	Students	Appropriate for	Is additional
	should learn to	should be	use in intervention	research
	administer this	exposed to	research studies?	warranted for
	tool? (Y/N)	tool? (Y/N)	(Y/N)	this tool (Y/N)
MS EDGE	No	No	No	Yes
SCI EDGE	No	Yes	No	Not reported
TBI EDGE	Yes	Yes	Yes	Not reported

Consideratio

ns

Adequate training is required to ensure inter-rater reliability

Reliability differs from muscle to muscle

Assessment technique must be standardized


Some critics question the validity of the Ashworth scale and Modified Ashworth Scale in measuring spasticity. It may be a description of resistance to passive movement. Therefore, measuring only one aspect of spasticity, not a comprehensive assessment. (Salter et al, 2005)

It was concluded that the Ashworth scale is of limited use in the assessment of spasticity in the lower limb of patients with SCI

The Ashworth scale produces a global assessment of the resistance to passive movement of an extremity, not just stretch-reflex hyperexcitability. Specifically, the Ashworth score is likely to be influenced by non-contractile soft tissue properties, by persistent muscle activity (dystonia), by intrinsic joint stiffness, and by stretch reflex responses (Kamper et al., 2001)

Ambiguity of wording and lack of standardized procedures limit the scale's usefulness for comparison across studies as well as reliability

The Modified Ashworth scale does not comply with the concept of spasticity (a velocitydependent increase in muscle tone) (Scholtes, 2007)

The Modified Ashworth Scale measures muscle tone intensity at one, unspecified, velocity which can make comparisons difficult (Scholtes, 2007)

Translated Modified Ashworth Scale:

Chinese (simplified): http://www.haodf.com/zhuanjiaguandian/liubaoqiong_1077075591.htm

French:

http://www.cofemer.fr/UserFiles/File/ECH.1.2.2.Asworth.pdf

German:

http://www.patientensicherheit.ch/dms/de/themen/3126_sturz_testbeschreibung_ch edoke_master_d/Testbeschreibung%20chedoke%20MC%20Master.pdf

Italian (p103): http://www.iss.it/binary/publ/cont/08-39%20web.1233562284.pdf

Japanese (p2): https://www.jstage.jst.go.jp/article/jkpt/12/0/12_1/_pdf

Korean: http://blog.naver.com/PostView.nhn?blogId=3c273&logNo=10000521558

Spanish (p40):

http://www.tdx.cat/bitstream/handle/10803/3840/nml1de1.pdf;jsessionid=1CF6D8957 E26C2A044019951FEBF24F2.tdx2?sequence=1



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	Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
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Year published	1964
Instrument in PDF Format	Yes



Approval Approved Status



16. REHAB MEASURES DATABASE—MODIFIED FATIGUE IMPACT SCALE

Link to instrument	Download the MSQLI: A User's Manual (PDF)			
Title of Assessment	Modified Fatigue Impact Scale			
Acronym	MFIS			
Instrument Reviewer(s)	Initially reviewed by Tammie Johnson, PT, DPT, MS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 9/2012. Updated by Genevieve Pinto-Zipp of the StrokEdge II task force, Neurology Section, APTA 2016.			
Summary Date	1/20/2017			
Purpose	The MFIS is a modified form of the Fatigue Impact Scale (Fisk et al, 1994) based on items derived from interviews with MS patients concerning how fatigue impacts their lives. This instrument provides an assessment of the effects of fatigue in terms of physical, cognitive, and psychosocial functioning.			
Description	 The full-length MFIS has 21 items while the abbreviated version has 5 items. The full-length version has the advantage of generating subscales. The MFIS is a 21-item shortened version of the 40-item FIS and has been recommended for use by the Multiple Sclerosis Council for Clinical Practice Guidelines. It assesses the perceived impact of fatigue on the subscales physical, cognitive and psychosocial functioning during the past 4 weeks (Rietberg et al., 2010). The MFIS is one of the components of the MSQLI. Description of scoring: Likert scale. Participants rate on a 5-point Likert scale, with 0 = 'Never' to 4 = 'Almost always' their agreement with 21 statements. Total score (0-84) and subscales for physical (0-36), cognitive (0-40) and psychosocial functioning (0-8). The 5 item version is scored (0-20). Higher numbers indicate greater fatigue. Rasch analysis revealed that the 21-item scale was found to contain a "physical" and a "cognitive" dimension (the original 2 social items were found to be part of the physical dimension). Scoring for Standard 21-item version: either represented as a total score by summing the totals from each subscale or by each individual subscale (see below). Physical subscale: range from 0-36 			



	 Cognitive subscale: range from 0-40 Add raw scores on items: 1+2+3+5+11+12+15+16+18+19 Psychosocial subscale: range from 0-8 Add raw scores on items: 8+9 Scoring for 5-item version: Total score is the sum of items 1+9+10+17+19 Range from 0-20 		
Area of Assessment			
Body Part			
ICF Domain	Body Structure; Body Function; Activity; Participation		
Domain			
Assessment Type			
Length of Test	05 Minutes or Less; 06 to 30 Minutes		
Time to Administer	Administration time is approximately 5-10 minutes for the full-length version and 2-3 minutes for the abbreviated version.		
Number of Items	The standard version of the MFIS consists of 21 items. The abbreviated version of the MFIS consists of 5 items.		
Equipment Required	QuestionnairePen		
Training Required	Training can be done by downloading and reading the MSQLI document on the MS site.		
Type of training required	Reading an Article/Manual		
Cost	Free		
Actual Cost	Free		
Age Range			
Administration Mode			
Diagnosis	Traumatic Brain Injury		

o Add raw scores on items: 4+6+7+10+13+14+17+20+21



Populations Tested	Multiple Sclerosis
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established
Minimally Clinically Important Difference (MCID)	<u>Multiple Sclerosis</u> : (Rietberg, 2010; <i>n</i> = 43; ambulatory patients with MS (mean age 48.7 years; SD 7 years; 30 women; median Expanded Disability Status Scale score 3.5)
	 Smallest Detectable Change (SDC) = 16.2 Minimal Detectable Change (MDC) % = 19.3%
Cut-Off Scores	Not Established
Normative Data	 Multiple Sclerosis: (Tellez et al, 2005; 231 MS patients and 123 healthy controls, 164 patients with relapsing-remitting, 47 with secondary progressive, 12 with primary progressive) Median MFIS score= 33.0 (range 0-82) Traumatic Brain Injury: (Sendroy-Terrill et al., 2010, <i>n</i>=243, 73% men, less than 5% of participants unconsciousness of < 1 day, 41 % showed LOC 1 day to 1 week, 31 % LOC from 1 week to 1 month, 24% had LOCs from 1 month to 1 year. Recived treatment in a comprehensive inpatient rehabilitation hospital. Cohorts based on years postinjury (1 to >30 years)) Mean for total MFIS = 23.7±21.1 Mean for MFIS - Physical= 10.2±9.6 Mean for MFIS - Cognitive=11.4±10.4 Mean for MFIS - Psychosocial= 2.0±2.0
Test-retest Reliability	Multiple Sclerosis:(Rietberg, 2010; n= 43; ambulatory patients with MS (mean age 48.7 years; SD 7 years; 30 women; median Expanded Disability Status Scale score 3.5)• Excellent test-retest reliability (ICC =0.85)



Interrater/Intrarat er Reliability	 Multiple Sclerosis: (Amtmann et al, 2012; n=1271 individuals with MS living in the community, 80% female, 36.2% reported being employed 20 or more hours a week; mean age 50.7, mean disease duration 13.2 years, MS severity as minimal (EDSS≤4.0) for 32.4% and intermediate (EDSS 4.5-6.5) for 47.9% and advanced (EDSS≥7.0) for 19.7%) Excellent reliability: Cronbach's alpha = 0.94-0.96 for total MFIS 			
Internal Consistency	Multiple Sclerosis: (Kos et al, 2005)			
	 MFIS has been found to show change after intervention. After a 4-week rehabilitation program, the MFIS did change, but the FSS did not. 			
Criterion Validity (Predictive/Concur rent)	Concurrent validity: <u>Multiple Sclerosis:</u> (Rietberg, 2010; <i>n</i> = 43; ambulatory patients with MS; mean age 48.7 years; SD 7 years; 30 women; median Expanded Disability Status Scale score 3.5) • Excellent: MFIS vs. Fatigue Severity Scale (FSS): r = 0.66; MFIS vs. the Checklist Individual Strength (CIS20R): r = 0.54 <u>Multiple Sclerosis:</u> (Tellez et al, 2005; (231 MS patients and 123 healthy controls, 164 patients with relapsing-remitting, 47 with secondary progressive, 12 with primary progressive)			
	 Excellent: between MFIS and FSS (<i>r</i>=0.68, p<0.0001) Adequate to Excellent: between MFIS subscale and FSS MFIS-physical: <i>r</i>=0.75, p<0.0001 MFIS-cognitive: <i>r</i>=0.44, p<0.0001 MFIS-psychosocial: <i>r</i>= 0.62, p<0.0001 Predictive Validity: Traumatic Brain Injury: (Sendroy-Terrill et al., 2010, <i>n</i>=243, 73% men, less than 5% of participants unconsciousness of < 1 day, 41 % showed LOC 1 day to 1 week, 31 % LOC from 1 week to 1 month, 24% had LOCs from 1 month to 1 			



	year. Recived treatment in a comprehensive inpatient rehabilitation hospital. Cohorts based on years postinjury (1 to >30 years))
	 MFIS-physical: with each additional decade of age at time of injury, there was a 2 point increase on the MFIS-physical score (P=.02) MFIS-psychosocial: with each additional decade of age at time of injury, there was a 0.5 point increase (P=.01)
Construct Validity (Convergent/Discri minant)	Multiple Sclerosis: (Mills et al, 2010; <i>n</i> =415)
	 Given the Rasch analysis, Mills et al. suggested that the physical and cognitive subscales should be used separately eliminating questions 4, 14, 17 from the physical and questions 1-3, 5, and 11. In addition, the authors suggest the total score not be used.
Content Validity	<u>Multiple Sclerosis:</u> (Amtmann et al., 2012; $n=1271$ individuals with MS living in the community, 80% female, 36.2% reported being employed 20 or more hours a week. Mean age 507, mean disease duration 13.2 years, MS severity as minimal (EDSS≤4.0) for 32.4% and intermediate (EDSS 4.5-6.5) for 47.9% and advanced (EDSS≥7.0) for 19.7%)
	 Validity: Spearman Rank Correlation Fatigue Severity Scale to MFIS: Excellent for MFIS total and subscales of physical and psychosocial (0.69-0.77) Adequate for MFIS cognitive subscale IRT analyses indicate that the FSS is less precise in measuring both low and high levels of fatigue, compared with the MFIS. For those interested in measuring both physical and cognitive aspects of fatigue, and whose sample is expected to have higher levels of fatigue, the MFIS is a better choice even though it is longer.
Face Validity	Not Established
Floor/Ceiling Effects	Multiple Sclerosis: (Amtmann et al., 2012; $n=1271$ individuals with MS living in the community, 80% female, 36.2% reported being employed 20 or more hours a week; mean age 50.7, mean disease duration 13.2 years, MS severity as minimal (EDSS≤4.0) for 32.4% and intermediate (EDSS 4.5-6.5) for 47.9% and advanced (EDSS≥7.0) for 19.7%)
	 Floor effects: (number of respondents with the lowest possible score)



		• MEIS total= 1.1%				
		• MFIS-phy=1.6%				
		• MFIS-cog=2.7%				
		• MFIS-psychosocial=7.4%				
	• Colling offects (number of representants with the bigheet passible cases					
	Ceiling effect: (number of respondents with the highest possible score)					
		• MFIS total= 0.7%				
		o MFIS-phy=1.6%				
		• MFIS-cog=0.9%				
		 MFIS-psychosocial=9.0% 	6			
Responsiveness	Not Establis	hed				
Professional	Recommen	dations for use of the instrum	ent from the Acader	ny of Neurologic		
Association Recommendations	Physical Th	erany of the American Physic	al Therany Associat	tion's Multiple		
Recommendations		uskforce (MSEDGE) Parkins	on's Taskforce (PD I	EDGE) Spinal Cord		
	Injury Taskf	orce (PD EDGE), Stroke Tas	kforce (StrokEDGE	II) Traumatic Brain		
	Injury Taskf	orce (TBI EDGE), and Vestib	ular Taskforce (VEC	GE) are listed		
	helow Thes	e recommendations were de	veloped by a papel (of research and		
	clinical evo	rte using a modified Delphi p		or research and		
	chinear expe	ats using a mouned Delpin p	100633.			
	For detailed	information about how reason	amandationa wara n			
				lade, please		
		www.neuropt.org/go/nealthca	re-protessionals/net	Irology-section-		
	outcome-me	easures-recommendations				
	Abbreviat	ions:]		
	HR	Highly Recommend				
	R	Recommend				
	LS/UR	Reasonable to use, but lim	ited study in target of	group / Unable to		
	NR	Not Recommended				
	Recommend	dations for use based on acui	ity level of the patier	nt:		
		Acute	Subacute	Chronic		
		(CVA < 2 months	(CVA 2 to 6	(> 6 months)		
		post (SCI < 1 month post)	(SCI 3 to 6			
		(Vestibular < 6	months)			
		weeks post)				
	StrokEDG	E NR	UR	UR		
	Recommend	dations based on level of care	e in which the asses	sment is taken:		



	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	R	R	R	R	R
StrokEDGE II	NR	NR	UR	UR	UR
TBI EDGE	NR	LS	LS	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Mildly dependa Independent		Moderately Dependant
TBI EDGE	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 - 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5
MS EDGE	R	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	No	Yes	Yes	No
StrokEDGE II	No	No	Yes	Not reported
TBI EDGE	No	No	No	Not reported

Considerations	 The MFIS is a shortened modification of the Fatigue Impact Scale, designed as a self-report measure to rate fatigue in Multiple Sclerosis. The MFIS cannot be used to generate a single overall score of fatigue. The conceptual interaction between the two dimensions remains unclear, which poses problems when interpreting change scores in these individual scales. Studies in which a global MFIS score was used as either an outcome measure or selection tool may need to be reevaluated (Mills et al., 2010). Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
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Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



17. REHAB MEASURES DATABASE—MODIFIED RANKIN HANDICAP SCALE

Link to instrument	Measure available at Strokecenter.org (external link)			
Title of Assessment	Modified Rankin Handicap Scale			
Acronym	mRS			
Instrument Reviewer(s)	Maggie Bland, PT, DPT, NCS and Nancy Byl, PT, MPH, PhD, FAPTA and the StrokEdge II Task Force of the Academy of Neurologic Physical Therapy - a component of APTA updated the review in 2016			
Summary Date	April 2016			
Purpose	Categorizes level of functional independence with reference to pre-stroke activities			
Description	 A single-item global outcomes rating scale Assessment is carried out by asking the patient about their activities of daily living, including outdoor activities Information about the patient's neurological deficits on examination, including aphasia and intellectual deficits, should be obtained All aspects of the patient's physical, mental performance, and speech should be combined in the single MRS score One MRS grade should be assigned based on the following criteria (Dromerick, Edwards, & Diringer, 2003): No significant disability despite symptoms; able to carry out all usual duties and activities Slight disability: unable to carry out all previous activities but able to look after own affairs without assistance Moderately severe disability: unable to walk without assistance Moderately severe disability: unable to walk without assistance Severe disability: bedridden, incontinent, and requiring constant nursing care and attention 			



	Measure	Mean Change*	Percent of Subjects Changed (%)	Median Change	Floor Effect, Admission	Ceiling Effect, Discharge
Normative Data	<u>Acute Stroke</u> : (Table from Dromerick et al, 2003; $n = 95$, length of rehabilitation was 19.5 (8.3) days)				gth of	
Cut-Off Scores	Not Established					
Minimally Clinically Important Difference (MCID)	Not Established					
Minimal Detectable Change (MDC)	Not Established					
Standard Error of Measurement (SEM)	Not Established					
Populations Tested	Stroke					
Diagnosis	Stroke					
Administration Mode	Paper/Pencil					
Age Range	Adult: 18-64 years; Elderly adult: 65+					
Actual Cost	Free	Free				
Cost	Free					
Type of training required	No Trainin	No Training				
Training Required	None nec	None necessary				
Equipment Required	None nec	None necessary				
Number of Items	1					
Time to Administer	5-15 minu	tes				
Length of Test	06 to 30 M	linutes				
Assessment Type	Patient Re	atient Reported Outcomes (self report or interview)				
Domain	ADL; Moto	ADL; Motor				
ICF Domain	Activity	Activity				
Body Part	Not Applicable					
Area of Assessment	Activities of Daily Living; Functional Mobility					



	MRS	-	47	1 level (0-2)	17 (18%)	0 (0%)
	ISTM	-	24	0 level (0-1)	95 (100%)	0 (0%)
	BI	28 ± 16.2	100	30 points (0-70)	5 (5%)	26 (27%)
	FIM	23.2 ± 10.6	100	22 points (4-55)	0 (0%)	0 (0%)
	*Data are score. Da	mean ± sta ta are med	andard deviation	on. Percent es in parent	of subjects wit heses.	h a change of
	BI = Barth FIM = Fu ISTM = Ir MRS = M	nel Index nctional Ind nternational odified Ran	ependence Me Stroke Trial M ikin Scale	easure easure		
Test-retest Reliability	Acute Str	oke: (Wolfe	e et al, 1991)			
	• E	xcellent tes	st-retest reliabi	lity (Kappa	w = 0.95)	
	Post-Stro	oke- 6 mon	<u>ths</u> : (Wilson et	al, 2005)		
	• E	xcellent tes	st-retest reliabi	lity		
	(F R	Rater 1: Kap ater 2: Kap	opa = 0.81; 0.9 pa = 0.95 [,] 0.99	4 and		
			pu 0.00, 0.00	·)		
Interrater/Intrarater Reliability	Acute Str	oke:				
	<u>(Wolfe et</u>	<u>al, 1991)</u>				
	• E	xcellent int	ra-rater reliabil	ity (Kappa	w = 0.95)	
	• E	xcellent int	er-rater reliabil	ity (Kappa	range 0.75 - 0.	96)
	<u>(van Swie</u>	eten et al, 1	<u>988):</u>			
	• E • A	xcellent int dequate in	er-rater reliabil ter-rater reliabi	ity (Kappa lity (Kappa	= 0.82, out-pat = 0.51, in-pati	ient) ent)
	(Wilson et	<u>t al, 2002, 2</u>	<u>2005):</u>			
	E	xcellent_int	er-rater reliabil	ity (Kappa	= 0.78)	
	(Shinohar	a et al, 200	6)			



Excellent inter-rater reliability (ICC = 0.95 neurologists; 0.96 nurses)

(Quinn et al, 2008))

• Adequate inter-rater reliability (Kappa = 0.67, overall)

(Quinn et al, 2010)

- The longer the interview, the more variability in rater consistency
- With focused assessment, patients struggle to answer categorically leaving room for rater interpretation
- Further study of reliability is needed on the modified, *simplified* modified Rankin score and the standard mRS

(Bruno et al 2010; 50 patients post stroke having treatment in an outpatient setting were rated with the simplified mRS (smRS) (yes/no questions) by 9 mRS web-certified raters with repeat testing within 20 minutes of the first rating)

- Excellent test re-test reliability of the simplified mRS questionnaire with a non-structured interview (smRS) had a k statistic of 0.72 (Cl₉₅ 0.58-0.85) with 78% agreement between raters (compared to previous research on the mRS with a structured interview with adequate reliability r=0.62 with 73% agreement)(Quinn et al, 2009;Cincura et a, 2009, Shinohara et al, 2006)
- Administration time was1.67 minutes(less time than the structured interview format for the mRS (@15 minutes)

(Ghandehari, K., et al. 2012) Five raters administered the Asian Stroke Disability Scale (ASDS) and compared it to the interrater reliability of the modified Rankin Scale (mRS) for 25 subjects post stroke (65.5 years of age, 56% males).

The difference in scores between the raters on the ASDS and the mRS were not significant (F = 1.061, p=0.379)The Interrater variability for the mRS did not differ significantly(X² = 1.758, p = 0.780).. The paired interrater variability of the mRS did also not vary significantly (X² = 0.553, p = 1.000)



(Fearon, et al 2012;Bruno et al 2012)

- In a study of 74 stroke survivors (median age = 72 years [IQR = 62-79]; median time since stroke = 5 days [IQR = 3-0]), prestroke measures of the mRS and the standard mRS with interview had only adequate inter rater reliability (pw= 0.55; with 55% agreement and pw=0.70 with 70% agreement respectively) (Fearon et al, 2012)
- The mRS cannot be used as a prestroke measure. It must only be used as a post stroke measure because some of the items cannot be scored as 0, 1 or 2 because the patient needs to compare post stroke function with pre stroke function; thus before the first stroke, there are no stroke symptoms. (Bruno et al letter, 2012)

(Bruno et al 2011) With 50 consecutive outpatients $4.83 (\pm 3.00)$ months post stroke, 9 paired raters administered the msRSq by a standard interview twice (one 20 minutes after the first) and then repeated test administration over the telephone 1-3 days later .

- The average estimated time to administer the smRSq in person was 1.29 minutes (range, 0.50 to 2.25 minutes).
- The In-person raters agreed 78% of the time (k= 0.71; Cl, 0.57 to 0.86 with weighted Kw_0.86; Cl, 0.79 to 0.94).
- The first in-person and telephone raters agreed 82% (k= 0.76; Cl, 0.63 to 0.90 and Kw= 0.87; Cl, 0.79 to 0.95).
- The second in-person and telephone raters agreed 82% (k=0.77; CI, 0.63 to 0.90 and Kw= 0.89; CI, 0.82 to 0.96).

(Zhao, et al, 2010) 56 participants, mean age = 71 years old (\pm 13.6), less than 4 days post-stroke were administered the mRS by three trained rater groups (experienced (Exp), inexperienced (Inexp), and inexperienced with a decision tool (Inexp+DT).

 Adequate reliability was found across all groups (ICC = 0.675, 95% CI = 0.559-0.791)



- Adequate reliability was found between each of the groups
 - Exp vs. Inexp (K_w = 0.686, 95% CI = 0.541-0.819, p = 0.032)
 - Exp vs. Inexp+DT (K_w = 0.568, 95% CI = 0.359-0.724, p = 0.553)
 - $\circ \quad \mbox{Inexp+DT (K_w = 0.736, 95\% Cl = 0.557-0.859,} \\ p = 0.121) \label{eq:prod}$

Sub-Acute Stroke:

(Saver, 2010) n = 50 patients, average 71.5 years old (range 43-93). Participants received the Rankin Focused Assessment to derive the mRS (administered by two coordinators) at their 90 day assessment as part of the Phase III National Institutes of Health Field Administration of Stroke Therapy-Magnesium Trial.

<u>Among all participants the percent agreement was 94% (Kw = 0.99, 95% CI = 0.99-1.00; K = 0.93, 95% CI = 0.85-1.00). Among the 43 participants living at the 90 day assessments the percent agreement was 93% (Kw = 0.99, 95% CI = 0.98-1.0, Kw = 0.91, 95% CI 0.82-1.00)</u>

Telephone Administration: (Janssen, 2010; Dennis, 2011)

Acute

(Dennis, 2012) compared two postal versions of the mRS: one with a tick box for the five descriptions, the other was the simplified modified Rankin questionnaire (smRSq) that has yes/no responses and derives the mRS score. Both were followed-up with a telephone interview using the Rankin Focused Assessment

- Adequate reliability (Kappa = 0.44, Kappa w = 0.68) between the two postal versions of the mRS
- **Adequate** reliability (Kappa = 0.47, Kappa w = 0.66) between the tick box version of the mRS and the telephone interview
- Adequate reliability (Kappa = 0.55, Kappa w = 0.73) between the smRSq and the telephone interview

(Savio et al 2013) 131 patients post stroke were interviewed by 2 certified



nurses. Half of the patients were randomized to be interviewed by telephone followed by face to face assessment and half the reverse order.

- Telephone assessment of stroke disability with the modified Rankin Scale is similar in reliability in comparison to direct face to-face assessment.
- The median value of the modified Rankin Scale score was 4 (IQR 3-5) by telephone as well as by face-to-face assessment (p = 0.8).
- Excellent reliability between the two methods was K_w = 0.82 (Cl ₉₅:0.77-0.88).
- Sensitivity of the telephone assessment was lower for scores 2 and 3 (17% and 46%, respectively) than for scores 4-5 (range 67-90%).

Subacute

(Janssen, 2010) compared mRS scores for 83 participants a median of 5 months post-stroke comparing administration face to face to over the telephone.

Adequate reliability (Kappa = 0.41, 95% CI 0.26-0.55; Kappa weighted = 0.71, 95% CI 0.59-0.82).

Internal Consistency	Not established
Criterion Validity (Predictive/Concurrent)	Predictive Validity
	(Bruno et al, 2013) Forty subjects, documented in severity with the
	National Institutes of Health Stroke Scale (NIHSS) post treatment with
	intravenous tissue plasminogen activator in the ER Department were
	followed up to assess functional outcomes using the simplified Modified
	Rankin Scale (smRSq) . The participants averaged 69 years of age
	(±14), represented 45% males, had an average initial NIHSS score of
	10 and were, on average, 3-7 months post stroke.
	 Median follow up score on the smRSq was 3 (IQR = 1-6).



- The correlation of the NIHSS and the smRSq had an excellent and significant correlation (r=0.69; p<0001).
- The smRSq is simple and brief and can be administered over the phone and still preserve validity

(Fearon et al, 2012)

- In a data set of 231 stroke survivors, the prestroke mRS and the Rockwood Fraility Index had a correlation of 0.82 (Cl₉₅ 0.78-0.86) and 0.50 (Cl₉₅ 0.40-0.59) for the Charlson comorbidity index
- There was no association between the prestroke mRS and need for caregivers (correlation = 0.10)

(Bruno et al 2011)

 In a sample of patients receiving rehabilitation in an outpatient setting approximately 5 years post stroke, the smRSq correlated adequately with the physical component of the SF Short Form 12 (r= 0.50, P< 0.005) and the mental component (r_=0.36, P< 0.048).

(Gorelick et al, 2012)

This review of randomized clinical trials of stroke intravenous thrombolytic studies (rt-PA) was carried out to determine the relationships between baseline stroke severity associated with efficacy (based on functional outcomes of the NIH Stroke Scale [NIHSS] and the modified Rankin Scale [mRS] and safety.

Summary of Findings Acute Post Stroke (5 major RCT's)

Variable	Outcome
t-PA treatment	Better outcomes
Age x NIHSS	Higher age , worse NIHSS outcomes Maintained outcomes for young (OR =1.42)
mRS score at 3 months	Better outcomes than no t-PA



	-
History of diabetes	Worse outcomes
Age x admission	Higher age and MAP: better
	oucomes
Mean Arterial Pressure	Better outcomes
	14/
Early CT Findings	Worse outcomes
Female	Better outcomes
Very elderly	Maintained outcomes: (Very
	olderly OP = 1.24
	eideny, OR = 1.34)

(Bruno et al, 2013)

Thirty two of 60 subjects post stroke enrolled in a reliability study met the criteria to participate in the current study (mean age 59.6 years (\pm 15), 53% men) to correlate stroke size (acute ischemic stroke) with smRSq scores .The patients had either computed tomography or magnetic resonance imaging to confirm an ischemic stroke and were scored on the smRSq at least 3 months post stroke. Stroke volume was computed and strokes were classified into 2 size categories: *lacunar type* measuring \leq 6.28 cm³, which corresponds to a cylinder with a maximum diameter and height of 2.00 cm, *or strokes* >6.28 cm³. The Spearman correlation analysis compared the smRSq between the lacunar type and the larger strokes.

- Acute stroke size correlated well with the smRSq supporting the validity of the smRSq for assessing functional outcomes after stroke
 - Lacunar stroke volumes (n = 17) ranged from 0.03 to 4.58 cm³, and the larger stroke volumes (n =15) ranged from 11.52 to 250.02 cm³.
 - Lacunar strokes were associated with lower smRSq scores (median 1) compared to the larger strokes (median 4) '
 - There was an adequate correlation of stroke size with the smRSq score (r=0.68; P<0.001)



- (Tilson et al, 2010; n =283; mean age 63. 5 (± 12.5) years; assessed patients approximately 20 and 60 days post-stroke); data is from the Locomotor Experience Applied Post Stroke study, and the mRS was used as the anchor for determining the minimally clinically important difference. A poor, but substantial relationship was found between the mRS and comfortable gait speed
- The area under the curve was calculated as 0.69 (95% CI = 0.63-0.75).

Concurrent Validity

Acute Stroke:

<u>(Cup et al 2003;</u> *n* = 26; mean age 68 (15) years):

- Excellent concurrent validity with: Barthel Index (r = - 0.81) Frenchay Activities Index (r = - 0.80) EQ-56 (r = 0.68)
- Adequate concurrent validity with: SA-SIP-30 (*r* = 0.47)

(Kwon et al, 2004, n = 459; mean age = 70 (11.4) years):

Excellent concurrent validity with:

Barthel Index (r = -0.89) FIM-motor dimension (r = -0.89)

(Weimer et al 2004, n = 4246; mean age = 67.1 (69) years):

- Excellent concurrent validity with:
 - SF-36 Physical Function (r = 0.84)
 - Barthel Index (r = 0.82)

(Liotta et al, 2013, to determine readmission of patients with ICF as measured by the Rankin Scale (mRS) at 14 days, 28 days and 3 months post stroke)



Retrospective evaluation of 246 patients readmitted 30 days following treatment of acute intracranial hemorrhage on the ICU. Of 246 patients with a mean age of 65 years:

- 78% survived discharge. Of these, 22 (11%) were re-admitted 4-15 days post ICU discharge.
- The most common reason for readmission was infection (n = 10) and vascular event (n = 6)
- Readmitted patients had similar mRS scores to those not readmitted at 14 days (median 4 [IQR = 4-5], median 5 [IQR = 4-5], respectively), but those who were readmitted had higher mRS scores at three months post stroke (median 5 [IQR = 3-6] for those readmitted and 3 [IQR = 1-4] for those not readmitted.

(Kerr et al, 2012)

Within the Virtual International Stroke Trials Archive, the rt-PAtreated patients were compared to the non rt-PA treated patients (10,000 samples).The end points of the mRS at 30 and 90 days and NIHSS at 7 and 90 days post stroke were studied.

- The smallest sample sizes to generate statistical power greater than 80 % were 620 and 480 respectively for the mRS and 370 and 420 respectively for the NIHSS
- The 7 day NIHSS was the most sensitive outcome measurement to detect differences in the rt-PA treated patients.

(Ali, 2013; n = 3787 with complete data available, n = 3872 Stroke Impact Scale data available at 3 months; mean age for those selfreporting 68 (58-76) years and those requiring proxy 75 (66-80). Authors examined outcomes data from the Virtual International Stroke Trials Archive.

- Excellent concurrent validity of the mRS at three months poststroke with the European Quality of Life Scale-5D (EQ-5D)
 Weighted Scores (-0.75, p<0.0001), the EQ-5D Visual Analog Scale (-0.64, p<0.0001), Stroke Impact Scale Recovery (-0.73, p<0.0001), and Stroke Impact Scale-16 (-.083, p<0.0001).
- The mRS was used to examine the proportion of patients classified as having a good primary outcome (mRS ≤ 1), but a poorer quality of life and was found to be superior.

Subacute Stroke



(Goldie, 2014; n= 12, 370, mean age of 69.5 years old (range = 18-
130), from a systematic search and review across 11 studies.
Coefficients reported from assessments completed at 90 days post-
stroke.

•	The mRS explained 80.8% (p = 0.000) of the variance in the
	National Institutes of Health Stroke Scale (NIHSS), 87.6% (p =
	0.000) of the variance in the Barthel Index (BI), 83.0% (p =
	0.000) of the variance in the Stroke Impact Scale-16 (SIS-16),
	and 76.9% (p = 0.000) of the variance in the Scandanavian
	Stroke Scale(SSS) at 90 days post-stroke.

 Once the Baseline age and NIHSS were adjusted for, the mRS explained 56.6% (p < 0.001) of the variance in the NIHSS, 75.2% (p < 0.001) of the variance in the BI, and 80.5% (p
 0.001) of the variance in the SIS-16 at 90 days post-stroke.

Close Head Injury

(Schaefer et al, 2004)

	 Excellent concurrent validity with: Signal-intensity abnormal volume on diffusion weighted images (r = 0.77) Number of lesions on images (r = 0.66) Adequate concurrent validity with: Lesion location in the corpus callosum (r = 0.51)
Construct Validity (Convergent/Discriminant ;	 Stroke Berzina, 2015; n= 266, Median age = 65 years old (IQR = 57.5-77), Median time post-stroke = 8 months (IQR = 1-12), participants were interviewed with the Comprehensive International Classification of Functioning, Disabilities, and Health (ICF) Core Stroke Set, and then this information was used to score the mRS and mRS-Systematic Interview (mRS-SI). Poor to Adequate significant correlations were found between the mRS and the sum of problems in 'Body Function' (0.59, p < 0.001), 'Body Structures' (0.23, p < 0.001), and 'Activities and Participation' (0.69, p < 0.001) of the ICF. Authors found that the mRS is mostly associated with problems under "Activities and Participation,' specifically "Self-Care' and 'Walking.' Owolabi, 2010; n= 100, mean age = 58.9 (± 10.7) at least one month post-stroke were administered the mRS, the health-related quality of life for stroke patients (HRQOLISP) and the SF-36.



	 The physical domains of the HRQOLISP were found to differ among the mRS strata (p <0.006), however the domains of the spiritual dimension did not (0.217 ≤ p ≤ 0.906). All SF-36 subscales differed among mRS strata (p ≤ 0.023) Golicki, 2015; n = 408, mean age = 69.0 (± 12.9), median time poststroke 8 days; participants completed the mRS, EuroQol-5 dimensions-5 levels of severity (EQ-5D-5L), the EuroQol-5 dimensions-3 levels of severity (EQ-5D-3L) as well as additional measures. Adequate to Excellent convergent validity was found between the mRS and the dimensions of the EQ-5D-5L (0.42-0.79) and the EQ-5D-3L (0.36-0.78)
Content Validity	Not Established
Face Validity	Not Established
Floor/Ceiling Effects	Acute Stroke: (Dromerick et al, 2003)
	 Adequate Floor Effect in 18% of stroke sample at admission to rehabilitation (see normative data for more information).
Responsiveness	 Acute Stroke: (Dromerick et al, 2003) Poor at detecting change compared to the FIM (C = 0.59)*
	*see normative data for more information
	(Batcho, C.S., et al. 2014) 68 subjects participated in a 2 month longitudinal study to evaluate responsiveness of patients receiving early versus late intervention post stroke.
	 Across subject groups, there was a change of 1 point on the mRS from before to after therapy (p<0.001) There were no significant changes in the mRS scores (mean score of 2 (with range of 2-3.5 pre and post; p=0.99) in patients who had delayed intervention post stroke (mean 10.3 months [± 7.7 months]) There was a significant one point change in the mRS score (P<0.001) for the patients who received early intervention post stroke (average at 2.01 months [±2.6 month]) There was a significant, adequate positive correlation (p=0.64; p<0.001) between the pre-post test change scores



	on rep of	the mRS and the ACT ported Rasch built que stroke patients to per	IVLIM-Stroke Score estionnaire that me form daily living ac	e (a 20 item self easures the ability tivities).
Professional Association Recommendations	Recommen Neurologic Association Taskforce Stroke Tas Taskforce below. The research a For detailed please visit professiona	ndations for use of the Physical Therapy of t n's Multiple Sclerosis ⁻ (PD EDGE), Spinal Co kforce (StrokEDGE, S (TBI EDGE), and Vest se recommendations nd clinical experts usin d information about ho t: http://www.neuropt. als/neurology-section- tions:	e instrument from th the American Physic Taskforce (MSEDG ord Injury Taskforce StrokEDGE II), Trau tibular Taskforce (V were developed by ng a modified Delph ow recommendation org/go/healthcare- outcome-measures	e Academy of cal Therapy E), Parkinson's e (PD EDGE), matic Brain Injury (EDGE) are listed r a panel of ni process. ns were made, s-recommendations
	HR	Highly Recommend		
	R	Recommend		
	LS/UR	Reasonable to use, but limited study in target group. Unable to Recommend		
	NR	Not Recommended		
	Recommer	Acute Acute (CVA < 2 months post) (SCI < 1 month post) (Vestibular < 6 weeks post)	d on acuity level of Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	the patient: Chronic (> 6 months)
	StrokED GE II	R	R	R
	_			

Recommendations based on level of care in which the assessment is taken:

tion Facility tion		
StrokEDGERRRRIIRRRR	R	



Recommendations for entry-level physical therapy education and use	
n research:	

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE II	No	Yes	Yes	Not reported

Considerations

The categories within the MRS have been criticized as being broad and poorly defined, left open to the interpretation of the individual rater (Wilson et al, 2002).

Bruno, A., Switzwer, J.A. (2013 Letter to Editor), The authors reinforce that the mRS is not designed to determine pre-stroke ability. More research is needed to further examine the new mRS instruments or in evaluating other clinometric assessments for use in determining function pre-stroke.

Dromerick, Edwards, and Diringer (2003) administered the MRS to 95 stroke rehabilitation inpatients and reported that the MRS displayed an adequate floor effect (18%) at admission to rehabilitation.

Harrison, et al. 2013 reviewed the clinometric properties of several stroke assessments. They noted that care should be taken with respect to validity and reliability when the mRS is administered by proxy or used to determine pre-stroke scores.

Rivero-Arias, et.al. (2010; n = 1283 stroke and TIA patients) examined the association between the mRS and EuroQol (EQ-5D) tariff values and the mRS and EQ-5D question responses. Patients were followed up at 1,6,12, and 24 months post. For the ordinary least squares regression model $R^2 = 0.4503$, suggesting 45% of the variability in the EQ-5D tariff was explained by the mRS scores and the Pseudo-R² for the multiple regression model range from 0.0667-0.4061

Tilson, et al. (2010) found a significant shift of mRS category (meaningful improvement defined as \geq 1 improvement of mRS scores) between days 20 and 60 post-stroke for participants in the Locomotor Experience Applied Post Stroke study.



	Do you see an error or have a suggestion for this instrument summary? Please e-mail us!
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Year published	1957
Instrument in PDF Format	Yes
Approval Status	Approved





18. REHAB MEASURES: MOTOR ACTIVITY LOG

Link to instrument	
Title of Assessment	Motor Activity Log
Acronym	MAL
Instrument Reviewer(s)	Initially reviewed by Jane Sullivan, PT in 2013. Updated by Maggie Bland PT,DPT,NCS and Nancy Byl PT,MPH,PhD, FAPTA and the StrokEDGE II task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2016.
Summary Date	7/24/2014; 3/2016
Purpose	Semi-structured interview to assess arm function.



Description

Individuals are asked to rate Quality of Movement (QOM) and Amount of Movement (AOM) during 30 daily functional tasks (original MAL), 28 functional tasks (MAL 28) or 14 tasks (MAL 14). Target tasks include object manipulation (e.g. pen, fork, comb, and cup) as well as the use of the arm during gross motor activities (e.g. transferring to a car, steadying oneself during standing, pulling a chair into a table while sitting).

Items scored on a 6-point ordinal scale.

Scoring on Amount of Use Scale:

0. The weaker arm was not used at all for that activity (never)

1. Occasionally used weaker arm, but only very rarely (very rarely)

2. Sometimes used weaker arm but did the activity most of the time with stronger arm (rarely)

3. Used weaker arm about half as much as before the stroke (half prestroke)

4. Used weaker arm almost as much as before the stroke (3/4 pre-stroke)

5. The ability to use the weaker arm for that activity was as good as before the stroke (normal)

Scoring on Quality of Movement Scale:

0. The weaker arm was not used at all for that activity (never)

1. The weaker arm was moved during that activity but was not helpful (very poor)

2. The weaker arm was of some use during the activity but needed help from the stronger arm or moved very slowly or with difficulty (poor)

3. The weaker arm was used for the purpose indicated but movements were slow or were made with only some effort (fair)

4. The movements made by the weaker arm were almost normal, but were not quite as fast or accurate as normal (almost normal)5. The ability to use the weaker arm for that activity was as good as before the stroke (normal)

Area of Assessment



Body Part	Upper extremity	
ICF Domain	Participation	
Domain	Activity	
Assessment Type	Patient Reported Outcomes	
Length of Test	06 to 30 Minutes	
Time to Administer	Approximately 20 minutes	
Number of Items	30, 28 or 14	
Equipment Required	Survey Instrument	
Training Required	Students should be aware of this as an example of self-report arm function measure. This measure is often used in outcome studies of arm intervention most commonly for patients post stroke.	
Type of training required	Reading an Article/Manual	
Cost	Free	
Actual Cost	Free	
Age Range	Adult: 18-64 years; Elderly adult: 65+	
Administration Mode	Paper/Pencil	
Diagnosis	Stroke; Head injury with hemiparesis	
Populations Tested	Stroke	
Standard Error of Measurement (SEM)	Not Established	
Minimal Detectable Change (MDC)	 (Simpson, 2015; systematic review of articles for patients post stroke)⁴ MDC₉₀ = 0.56- 1.06 MDC₉₅ = 0.67- 1.27 	


Minimally Clinically Important Difference (MCID; Responsiveness Ratio)	<u>Stroke:</u> (Simpson, 2015) ⁴ • MCID = 1.0−1.1
Cut-Off Scores	Not Established
Normative Data	Not Established
Test-retest Reliability	<u>Stroke:</u>
	(Van der Lee JH et al, 2004 ³ ; $n = 56$ chronic stroke patients
	• Excellent test retest reliability for MAL AOU (<i>r</i> = 0.70 to 0.85)
	• Excellent test retest reliability for MAL QOM (<i>r</i> = 0.61 to 0.71)
	 (Uswatte G et al, 2006 ¹; n = 41 chronic stroke patients complete MALs before and after CI therapy or a placebo control; n = 27 in second study for chronic stroke patients who complete MALs and wore accelerometers that monitored their arm movements for 3 days outside the laboratory before and after an automated form of CI therapy) Excellent test retest reliability for MAL 14 QOM (r > 0.91)
	 Participant AOU and caregiver QOM and AOU scales were not reliable
Interrater/ Intrarater Reliability	Not Established
Internal Consistency	<u>Stroke:</u>
	(Van der Lee JH et al, 2004) ³
	• Excellent internal consistency for AOU (alpha = 0.88)
	• Excellent internal consistency for AOU (alpha = 0.91)
	 Limits of agreement for AOU and QOM (r = -0.70 to 0.85 and 0.61 to 0.71)
	(Uswatte G et al, 2006) ¹
	• Excellent internal consistency of the MAL 14 (alpha > 0.81)



Criterion Validity (Predictive/Concurrent)

Stroke:

Note: concurrent validity is reported as a correlation which is interpreted in terms of strength. Squaring the correlation value tells you how much of the variance in the test 2 score can be explained by the score on test 1.

(Uswatte G et al, 2005)²

- **Excellent** concurrent correlation between QOM (MAL 28) and Stroke Impact Scale Hand Function scores (*r* = 0.72)
- Adequate concurrent correlation between QOM (MAL 28) and accelerometry (r = 0.52) (Van Der Lee JH et al, 2004)³
- **Excellent** concurrent correlation between the Action Research Arm Test and MAL 28 (*r* = 0.63)

(Uswatte G et al, 2005^2 ; n = 106 post stroke patients with mild to moderate paresis of upper extremity who took MAL before and after treatment; n = 116 took MAL an equivalent no-treatment period)

- **Excellent** concurrent correlation between the participant QOM scale (MAL 14) and caregiver COM scale (*r* = 0.70)
- Excellent concurrent correlation between the participant QOM scale (MAL 14) and caregiver MAL amount of use (AOU) scale (r = 0.73)
- **Excellent** concurrent correlation between participant QOM scale (MAL 14) and accelerometer recordings (*r* = 0.91)

(Hammer AM, Lindmark B, 2010⁵; n=30 subacute patients post-stroke underwent CIMT training)

• **Poor to Adequate** concurrent correlations of the MAL (30) AOU and QOM scales (MAL 30) compared to the FMA-UE, ARAT, MAS-UE amd Grippit ratio for 30 subjects 1-6 months post-stroke., explaining minimal variance:

	MAL	AOU	MAL QOM	
	Rho R ²		Rho	R ²
Pre- Intervention	0.50-0.53	0.25-0.28	0.45-0.50	0.20-0.25
Post- Intervention	0.23-0.45	0.05-0.20	0.31-0.48	0.10-0.23



3 Month	0.41-0.52	0.17-0.27	0.32-0.54	0.10-0.28
Follow-Up				

• **Poor to Adequate** correlations of intervention *change* scores were seen with the MAL AOU (30) and MAL QOM (30) compared to FAM-UE, ARAT, MAS-UE, and Grippit ratio with most variance in change scores pre to 3 month post intervention. **Excellent** correlations at 3 months post intervention were seen between the MAL AOU (30) and the 16 Hole Peg Test, explaining 41% of the variance:

	MAL AOU		MAL QOM				
	Rho	R ²	Rho	R ²			
FAM-UE, ARA	FAM-UE, ARAT, MAS-UE, Grippit ratio						
During Intervention	0.12-0.44	0.01-0.20	0.05-0.67	0.00-0.45			
Pre- intervention to- 3 Month follow-up	0.26-0.53	0.07-0.28	0.17-0.43	0.03-0.18			
Sixteen hole p	beg test with N	ЛАL					
Pre- Intervention	-0.44	0.19	-0.41	0.16			
Post- Intervention	-0.30	0.09	-0.41	0.16			
3 Month Follow-Up	-0.64	0.41	-0.67	0.45			

(Lin K, et al, 2010 ⁶; n=59 chronic stroke pa tients (16.1±14.0 months) receiving either constraint induced therapy or bilateral arm training)

• **Poor to Adequate** correlations for concurrent validity were seen with the MAL AOU (30) and MAL OQM (30) with Box and Block Test, Nine Hole Peg Test, and Action Research Arm Test, explaining minimal variance.

MAL-AOU	Pre-Intervention	Post-Intervention
(30)		



	Rho	R ²	Rho	R ²
	(95% CI)		(95% CI)	
BBT	0.13-0.57 (0.37)	0.134	0.27-0.66 (0.49)	0.24
NHPT	-0.40-0.10 (- 0.16)	0.03	-0.46- 0.03 (-0.23)	0.05
ARAT	0.06-0.52 (0.31)	0.10	0.07-0.53 (.0.32)	0.10
MAL- QOM (30)	Pre-Intervent	ion	Post-Interv	ention
BBT	0.31—0.68 (0.52)	0.27	0.31- 0.68 (0.52)	0.27
NHPT	-0.48-0.01) (-0.26)	0.07	-0.54 0.08 (- 0.33)	0.11

- (Lin K, et al, 2010⁷; n= 74 chronic stroke patients (17.5±17.7 months post-stroke) who received either distributed constraint induced movement therapy, bilateral arm training, or conventional rehabilitation. This study measured criterion-related validity of the Stroke Impact Scale, SIS and Stroke-Specific Quality of Life Scale, SS-QOL)
 - **Poor to Excellent** correlations (0.24-0.68) were seen across each SIS domains. The highest correlations between SIS Hand function (0.58-0.59 for MAL AOU and 0.65-0.68 for MAL QOM).
 - **Poor to Adequate** correlations (0.25-0.39) between the MAL-AOU and MAL QOM with the SS-QOL for UE function, self-care, work/productivity, family roles, social roles, and mobility.

(Wu C, et al, 2011⁸; n= 70 chronic stroke patients (19.9±12.5 months poststroke) received either distributed constraint induced movement therapy, bilateral arm training or control treatment for three weeks)

• **Poor to Adequate** concurrent validity.



			Pre-Intervention (95% CI)		Post-Intervention (95% CI)		
			Modified	Frenchay	Modified	Frenchay	
			Nottingham	Activities	Nottingham	Activities	
			Extended	Index	Extended	Index	
			Scale	0.2	Scale	0.4	
		(20)	0.3	0.3	0.3	(0.2, 0.6)	
			0.1-0.3)	0.1-0.3	0.1-0.3)	0.2-0.0)	
		(3)	(0.1-0.5)	(0.1-0.5)	(0-0.4)	(0.1-0.5)	
Construct Validity (Convergent/Discriminant)	Not I	Established					
Content Validity	Not I	Established					
Face Validity	Not I	Established					
Floor/Ceiling Effects	Not I	Established					
Responsiveness	Strol	ke:					
(MDC; effect size)							
	(Van Der Le JH et al, 2004) ³						
	 In individuals with subacute chronic stroke undergoing constraint induced movement therapy, improvement on the MAL during the intervention was only weakly related to a global change rating and to the improvement on the Action Research Arm Test (Spearman rho = 0.16 to 0.22; responsiveness ratio = 1.9 (AOU) and 2.0 (QOM)) 						
	 (Unswatte G et al, 2005)² For the MAL 14, the responsiveness ratio > 3 of the participant QOM scale was supported 					articipant	
	(Sin	npson and En In this sy <i>Patient J</i> larger th Wolf) ⁴	ng 2013) ⁴ ystematic revie <i>perception</i> of c nan <i>lab-based f</i>	ew across 68 st hange (MAL) v functional perf	udies, the effect vere 1.6 to 6.2 (formance measu	tt size for (mean 1.66) <i>ures</i> (ARAT or	
		Effect size months	zes were large post stroke ve	r with greater v rsus patients >	variance for pat	ients 1-2 stroke ⁴	



	Effe at 1	ect sizes were larger for patients with less severe impairments -2 months post stroke. ⁴			
	Effe bas tha divi me	ect sizes calculated based on change score divided by eline standard deviation (population effect size) were lower n standardized response mean (based on change score ded by the change score standard deviation) for the same asure.			
	(Hammer a • Eff Eff an mo	nd Lindmark, 2010) ⁵ ect Size fect Size: .51 MAL-AOU and .54 MAL-QOM during intervention d 1.02 MAL-AOU and 1.17 MAL-QOM pre intervention to 3 o F/U ⁵			
	SR an	M: 1.28 MAL-AOU and 1.03 MAL QOM during intervention d 1.14 MAL-AOU and 1.19 MAL-QOM 3 mo after treatment ⁵			
	• Re: RR: 2.4	sponsiveness Ratios : 1.22 MAL-AOU and 1.23 MAL-QOM during intervention and 4 MAL-AOU and 2.69 MAL-QOM 3 month after treatment ⁵			
Professional Association Recommendations	Recommend Neurologic F Association' Taskforce (P Taskforce (S Vestibular T were develo modified De	dations for use of the instrument from the Academy of Physical Therapy of the American Physical Therapy s Multiple Sclerosis Taskforce (MSEDGE), Parkinson's D EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke trokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and askforce (VEDGE) are listed below. These recommendations ped by a panel of research and clinical experts using a lphi process.			
	For detailed information about how recommendations were made, pleas visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-</u> <u>section-outcome-measures-recommendations</u>				
	Abbreviati	ons:			
	HR	Highly Recommend			
	R	Recommend			



LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute (CVA < 2 months post)	Subacute (CVA 2 to 6 months)	Chronic (> 6 months)
	(SCI < 1 month post) (Vestibular < 6	(SCI 3 to 6 months)	
	weeks postj		
StrokEDGE II	NR	HR	HR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	NR	NR	NR	UR	UR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
--	---	---	---	--



	StrokEDGE II	Νο	Yes	Yes	Yes; There are no studies on content or construct validity
Considerations					
Considerations Bibliography	 Uswatte, G. daily use of th 1194. Find it c Uswatte, G. extremity Mod 36(11): 2493-2 Van der Lee the motor act patients." Stroc Simpson L Capturing cha Neural Repair Hammer A Motor Activis stroke Disab Find it on Pu Lin K-c, Ch validity of the rehabilitation 2010;47 (4): 1 Lin K-C, Fu 	, Taub, E., et al e hemiparetic a <u>on PubMed</u> , Taub, E., et al tor Activity Log 2496. <u>Find it on</u> e, J., Beckermar ivity log for the oke 35(6): 1410 A, Eng JJ Funct anges in upper r 2013: 240-250 AM, Lindmark B ity og in patient ility and Rehab ibMed uang L-l, Wu C- ree dexterous f n. J of Rehabilita 563-572 <u>Find it</u>	. (2006). "The arm after stro . (2005). "Reli -14 for measu <u>PubMed</u> a, H., et al. (20 assessment of -1414. <u>Find it</u> ional recover extremity fun). <u>Find it on P</u> . Responsiver ts during the ilitation 2010 -y, Hsieh Y-w. unction mease ation Researce <u>on PubMed</u> eh Y-W, Chen	e Motor Activity Lo oke." Neurology 6 iability and validit uring real-world a 004). "Clinimetric of arm use in hem on PubMed y following stroke uction Neurorehak ubMed hess and vaidity of subacute phase a y; 32 (14):1184-11 Responsiveness a sures in stroke h and Developme C-L, Lee P-C.	og-28 Assessing 7(7): 1189- y of the upper- rm use." Stroke properties of liparetic e: oil f the fter 93 and ent:
	 Psychometric comparisons of the Stroke Impact Scale 3.0 and Stroke-Specific Quality of Liv Scale. Research 2010; 29 (3):435- 443 <u>Find it on PubMed</u> 8. Wu C-y,Chuang L-I Lin K-c, Horng Y-s. Responsiveness and validity of two outcome measures of instrumental activities of daily living in stroke survivors receiving rehabilitative therapies.Clinical Rehabilitation 2011; 26:176-183 <u>Find it on</u> <u>PubMed</u> 			and 135-	
				nd 's of <u>in</u>	



Year published	
	2013
Instrument in PDF Format	
	Yes
Approval Status	American
	Approved



19: REHAB MEASURES DATABASE: MOTRICITY INDEX

Link to Instrument	http://depts.washington.edu/yqol/IQOL
Title of Assessment	Motricity Index
Acronym	MI
Instrument Reviewer(s)	Initial review completed by Maggie Bland, PT, DPT, NCS and Nancy Byl, PT, MPH, PhD, FAPTA and the StrokEdge II Task Force of the Academy of Neurologic Physical Therapy - a component of APTA 2016
Summary Date(s)	4/2016
Purpose	The Motricity Index (MI) is an ordinal method of measuring limb strength developed by Demeurisse et al in 1980.
Description	In the original study, numerous arm and leg movements were analyzed in the first six months post stroke. One movement at the proximal, middle and distal joints from the arm and leg was selected to represent strength at each joint. Based on an analysis of early stroke recovery in the first 6 months post stroke, weighted scores were developed to represent the difficulty of progressing from one muscle grade to the next. Maximum total arm score is 99+ (range 0- 99) and the same for the leg score. Guidelines for administering the MI were developed by Collin and Wade 1990.
Area of Assessment	Upper and Lower limbs
	 UE tests: shoulder abduction, elbow flexion, pinch grip LE tests: hip flexion, knee extension, dorsiflexion (Tests administered in the sitting position) Scoring for all movements except grip: 0 - No movement 9 - Palpable contraction in muscle, but no movement 14 - Visible movement, but not full range and not against gravity 19 - Full range of movement against gravity, but not resistance 25 - Full movement against gravity but weaker than the other side 33 - Normal power Grip scoring 0 - No movement 11 - Beginnings of prehension 19 - Able to grip cube, but not hold it against gravity 22 - Able to grip and hold the cube against gravity 26 - Able to grip and hold the cube against a weak pull, but weaker than the other side 33 - Normal power



Body Part	Shoulder, elbow and wrist in the arm and hip, knee and ankle of the leg.	
ICF Domain	Body function and structure	
Domain	Strength as measured on a weighted, ordinal scale.	
Assessment Type	Examiner assessment (including observation and palpation following instructions to move the limb in the desired directions)	
Length of Test	20 minutes or less	
Time to Administer	5 minutes for experienced examiners working with patients who are cognitively intact	
Number of Items	6 items on each side (3 for the arm; 3 for the leg)	
Equipment Required	2.5 cm x 2.5 cm cube	
Training Required	No	
Type of Training Required	None; fast and easy to learn	
Cost	None	
Actual Cost	None	
Age Range	20-80 years	
Administration Mode	Patient asked to voluntarily perform a movement task	
Diagnosis	Acute, subacute and chronic stroke (Moderate and Severe)	
Populations Tested	Adults post stroke (inpatients and outpatients)	
Standard Error of Measurements (SEM)	n/a	
Minimal Detectable Change (MCD)	n/a	
Minimally Clinically Important Difference MCID)	n/a	
Cut-Off Scores	n/a	
Normative Data		
Test-Retest Reliability	n/a unknown	
Interrater/Intrarater Reliability	 (Collin and Wade; 1990) 40 subjects sub acute post stroke measured at 6, 12 and 18 weeks with two raters. Eexcellent inter-rater reliability (r=0.88) 	



MI arm	0.88
MI leg	0.87
MI Total	0.88

	 (Fayazi, et al, 2012) Twenty participant (± 13.45) years old and an average of months post-stroke were administered extremity on two occasions, one week lintra-rater reliability was excel Cl = 0.84-0.97, p = 0.000) 	ts, average of 55.58 19.41 (± 17.37) the MI for the lower apart. lent (ICC = 0.93, 95%
Internal Consistency	(Cameron and Bohannon, 2000) Fiftee • Eexcellent ; Cronbach alpha=0	n patients with stroke 0.77
Criterion Validity (Predictive/Concurrent)	 Criterion Validity Collin and Wade, 1990 Eexcellent predictive correlation weeks and walking ability at 18 Eexcellent criterion validity with dynamometer measurements a leg MI scores (r=0.78 and 0.91 Congruent Validity (Arwert HJ et al, 2016) The purpose of establish the validity of the Michigan Ha Questionnaire in 51 patients up to 5 ye (average 8 months post stroke) who has stroke rehabilitation. A significant, excellent correlate between the MHQ and the Arm (0.78) A significant moderate correlate between the MHQ and the Arm less than 100 on the Arm MI (a) Tthe Arm MI had moderate to a with the functional sub scales Subscales of the MHQ Overall Hand Function ADL Pain Work Performance Aesthetics Satisfaction MHQ total 	n of MI score at 6 8 weeks n correlation between and the arm and the respectively f the study was to and Outcomes ars post stroke ad participated in ion was documented n MI for all patients ion was documented n MI for patients with 0.65) excellent correlations of the MHQ <u>MI correlation</u> 0.797 0.669 0.431 0.590 0.674 0.715 0.780
	(Sunderland et al 1989) Patients acute	post stroke.

When comparing the 9 Hole Peg Test, Motor Club Impairment, Frenchay Arm Test and Mtricity Index Arm Score:



• Tthe Motricity Index Arm test was the most sensitive measure in detecting early change

(Bohannon et al, 1999)

• Tthere was an excellent correlation between dynamometry measurements of the upper extremity and the Motricity Index Arm Score (r=0.89;p<0.00l)

(Cameron and Bohannon, 2000)

 Tthere was an excellent correlation between dynamometry measurements and the Leg Motricity Index (r=-.77; p<0.001)

(Collin and Wade, 1980)

•

 Tthere was a good correlation between the Rivermead Motor Assessment and the Motricity Index

Time	RMA/MI-	RMA/MI-		
	arm	leg		
6 wks	0.76*	0.81*		
12 wks	0.73*	0.81*		
18 wks	0.74**	0.75**		

* p<0.001; ** p<0.010

(Lu et al, 2015) Establish concurrent validity of the Wisconsin Gait Scale (WGS) and Gait Abnormality Rating Scale (GARS) for Chinese subjects with hemiplegia post first stroke (n=22; mean age 54.8 [8.5 years]) who could walk independently.

- Mmean lower extremity MI score was 70.4 (21.5)
 - Aadequate correlation of the WGS with the MI (0.687;p<0.01)
- Eexcellent correlation of the GARS with the MI (-0.742;p<0.01)

(Meyer et al , 2015) 122 subjects (77 males), within 6 months post stroke (mean of 82 days) averaging 67 years of age, with 82% in acute rehabilitation centers were evaluated for the presence of sensory and motor deficits .

- Uupper limb somatosensory impairments were common, with prevalence rates 21%- 54%
- Ppoor to adequate correlations were found between somatosensory and motor deficits (r=0.22-0.61)
- Vvisual spatial neglect was present in 27 patients (22%)
- Tthere were consistently stronger correlations between motor and somatosensory deficits in patients with visuospatial neglect (r=0.44-0.78) compared to patients without neglect (r=0.08-0.59)
- Tthe MI median (interquartile range) was 67.5 for patients overall and 23 (0-83) for those with Neglect and 76 for patients without neglect (p<0.016)



Tthe correlations of somatosensory deficits and MI scores for the UE were adequate (ranging from - 0.564 to 0.348)

Somatosensation	Association with
	MI
Exteroceptive	
Em-NSA light touch	0.318
Em-NSA pressure	0.337
Em NSA pinprick	0.348
PTT light touch	-0.564
Proprioceptive	
Em-NSA movement sense	0.394
TFT position sense	-0.354
Higher Cortical	
Em-NSA sharp/dull	0.220
NSA stereognosis	0.535
Two point discrimination	-0.316

Em-NSA (Erasmus MC modification of the revised Nottingham Sensory Assessment, TFT (Thumb finding test)

* Statistically significant adequate correlations

(Bertrand et al, 2015; n = 34) Participants were recruited from an acute neurology ward after their first stroke, and were administered the MI Arm, Chedoke Arm and Hand Activity Inventory (CAHAI), and the ABILHAND questionnaire.

• Eexcellent correlations were found between the MI Arm and the CAHAI at weeks 2, 4, 8, and 12 (0.87-0.94) and between the MI Arm at weeks 1, 2, 4, 8, and 12 and the ABILHAND at week 12 (0.69-0.82)

Predictive Validity

(Sunderland et al, 1989)

Patients acute post stroke were measured at admission, 1,3,and 6 months post stroke with multiple measures of hand structure and function (grip strength, the 9-Hole Peg Test, MI arm ,Motor Club Impairment and Frenchay Arm Test)

 Tthe Motricity Index for the arm was able to best predict outcomes

(Collin and Wade, 1980)

• Aat 6 weeks post stroke, lower scores on the MI-Leg combined with the Trunk Control Test predicted failure to walk by 18 weeks.

(Kong K-H et al, 2011) Motor outcomes measures (Motor Assessment Scale (MAS), Upper Extremity Motricity Index (UEMI), Lower Extremity Motricity Index (LEMI) and the Modified Barthel Index (MBI) were administered to 140



patients (61.0 years [13.3 years]) more than one year post stroke (41.7 months [35.1 months]).

- Oonly 28.3% gained upper limb dexterity post stroke
- Ssensory impairment, severe spasticity and low scores on MAS, UEMI and LEMI were significantly correlated to poor dexterous function
- Ssevere spasticity was correlated with low UEMI score and poor dexterity
- Ppoor dexterous function was predicted by a severe stroke, neglect, sensory impairment, total/partial anterior circulation stroke and low MBI, UEMI and LEMI scores on rehabilitation admission
- Tthe most important predictor of dexterity was the UEMI score on admission to rehabilitation
- Tthe ability to do a pin grip at admission to acute rehabilitation was a predictor of recovering UE dexterity (e.g. the probability of regaining dexterity was 3.4% in patients with absent pinch group but 80% in those with MI scores of 22 or higher)

Factors correlating MI scores to Upper Limb Dexterity

Factors	Upper Limb		P Value
	Dexterity		
	Yes	No	
Upper Extremity	82.5	44.9	<0.0001
MI	(10.8)	(24.6).	
Lower Extremity	81.7	55.4	<0.0001
MI	(12.6)	(17.6)	

MI Scores Predicting Upper Limb Dexterity

Variable	Upper Limb Dexterity		P Value
	Yes	No	
Upper Extremity	48.7	11.2	<0.001
MI score (Rehab)	(20.7)	(19.1)	
Lower Extremity	55.0	19.8	<0.001
MI score (Rehab)	(17.6)	(23.7)	

(Bland et al, 2012) Two samples of patients in an inpatient rehabilitation facility unit (n=110 and 159; mean age 62 (± 14) and 63 (± 15) respectively) were evaluated at admission and discharge to determine which clinical assessments at admission most simply predicted discharge walking ability and what differentiated household versus community ambulators.

 Aadmission Lower extremity MI was 65 (26) and 59 (30) respectively in patients subacute post stroke



	 Tthe Lower extremity MI at admission was adequately (0.47) correlated with the speed of the 10 meter walk at discharge Tthe lower extremity MI did not explain a significant amount of the variance in walking speed at discharge nor differentiate household versus community. (Aufman et al, 2013) N = 143 participants, mean age broken down by group: non-drivers = 64.1 (± 14.0), non-returners = 59.9 (±13), and returners = 61.5 (± 13.7) years old admitted to an IRF were assessed at admission (additional measures were taken from their acute care stay). A logistic regression was run and the final model selected used the LEMI and the Functional Independence Measure, Cognition (FIM-C). LEMI and FIM-C explained 30% of the variance in patients who returned to driving at six months post-stroke.
Construct Validity (Convergent/Discrimina nt)	 Construct Validity (Bohannon et al 1999) Ffound excellent construct validity of the MI arm as measured with Cronbach alpha (0.968) (Collin and Wade ,1990) Eexcellent Congruent validity of the MI arm score and the MI leg score with the Rivermead Motor Assessment (r=0.71 and 0.81 respectively)
Content Validity	na
Face Validity	na
Floor/Ceiling Effects	 (Sunderland et al, 1989) Group strength was compared to four established UE measures. Tthe Frenchay and 9-hole peg test showed floor effects on admission Tthe Motricity Index showed that 57% of patients had measureable pinch grip within the first 3 weeks of a stroke. Oonly 2% had normal grip. (Arwert, 2016) Wwhen all patients were examined 0% showed a floor effect and 28% showed a ceiling effect with respect to the MI Arm. lin the subgroup with MI Arm score <100, 0% of patients had a floor or ceiling effect.
Responsiveness	 (Collin and Wade, 1990) Rreported the MI for the arm and leg improved in patients post stroke when measured 6 weeks apart. Tthe standard response mean ranged from 0.51-1.20. (Vos-Vroman et al 2005) Responsiveness was measured with the 10 M Walk, BBS and MI in 19 patients acute post stroke:



• Tthe effect size was poor and the SRM adequate for the MI -Leg

	Effect Size	SRM
10 M Walk	1.17	1.68
BBS	0.59	0.99
MI	0.27	0.96

Professional Association Recommendations

Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Stroke Taskforce (StrokEDGE II are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcareprofessionals/neurology-section-outcome-measuresrecommendations

Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
StrokEDGE II	HR	HR	HR



Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatie	Skilled	Out	Home
		t	Nursing	natient	Health
		Rehabi	Facility	putient	
		ta-		Rehabilita	1
		tion		n	
StrokEDGE	R	R	R	R	R
					-

Recommendations for entry-level physical therapy education and use in research:

	Students	Students	Appropriate	ls
	should	should	for use in	additional
	learn to	be	intervention	research
	administe	exposed	research	warranted
	r this	to tool?	studies?	for this
	tool?	(Y/N)	(Y/N)	tool (Y/N)
	(Y/N)			
StrokEDGE	No	Yes	Yes	No

Considerations

This test is fast and easy to learn and administer, but as with other measures attempting to grade strength in the stroke population, it is only one piece of the puzzle. The ability to generate force and power in a muscle is necessary for movement, but in the presence of increased tone or without the ability to coordinate and grade the movement, full function is not restored.

Although test procedures are vague on patient position for testing,, the test is usually administered with the patient sitting. Shoulder abduction begins with the arm at the side and elbow flexed to 90 o.

The test has excellent reliability and excellent reported construct, concurrent validity particularly relative to and predictive validity correlating admission levels of limb strength and recovery of upper limb function and walking ability.

(Gor-Garcia-Fogeda et al,2014) In this systematic review of 2b level studies, six measurement scales for gross motor function were included: (Motor Assessment Scale, Fugl-Meyes Assessment,, Sodring Motor Evaluation for Stroke Patients, Stroke Rehabilitation Assessment of Movement, Motricity Index and Rivermead Motor Assessment. All six scales (including the MI) were found to be useful for



clinical research and clinical practice, but the scales for which the most psychometric properties have been established in clinical trials were the Fugl Meyer Assessment (FMA) and the Stroke Rehabilitation Assessment of Movement (STREAM)

(Geroin et al, 2013) performed a systematic review of outcome measures used following motor training using electromechanical and robotic devices in patients post stroke. A total of 45 scales were identified from 27 studies involving 966 subjects. The most commonly used outcome measures were: Functional Ambulation Category (18 studies) , 10- Meter Walking Test (13 studies), Motricity Index (12 studies), 6- Minute Walking Test (11 studies), Rivermead Mobility Index (8 studies) and the Berg Balance Scale (8 studies). All of the outcome measures belonged to the activity domain of the ICF except the MI which was classified as a measurement of body function and structure. No scales belonged to the participation category. For the MI, Inter-rater reliability and Construct validity were excellent.

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Vos-Vromans et al (2005) Responsiveness of the ten meter walking test and other measures in patients with hemiparesis in the acute phase. Phys Ther Prac. 21:173 (abstract only)



Year Published	1980
Instrument in PDF Format	No
Approval Status	



20.	REHAB	MEASURES	DATABASE:	NIH STROKE SCALE
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Link to instrument	Measure available at Strokecenter.org (external link)			
Title of Assessment	National Institutes of Health Stroke Scale			
Acronym	NIHSS			
Instrument Reviewer(s)	_Updated by Carmen Capo-Lugo, PT, PhD and Dorian Rose PT, PhD and the Stroke Edge II task force in 2016.			
Summary Date	3/9/16			
Purpose	 Measures the severity of symptoms associated with cerebral infarcts; used as a quantitative measure of neurological deficit post stroke. A retrospective scoring algorithm has been found to be reliable for research purposes (Williams et al, 2000). 			
Description	 A composite scale derived from the Toronto Stroke Scale, the Oxbury Initial Severity Scale, the Cincinnati Stroke Scale and the Edinburgh-2 Coma Scale 15 items assessing severity of impairment in LOC, ability to respond to questions and obey simple commands, papillary response, deviation of gaze, extent of hemianopsia, facial palsy, resistance to gravity in the weaker limb, plantar reflexes, limb ataxia, sensory loss, visual neglect, dysarthria and aphasia severity Items are graded on a 3 or 4 point ordinal scale; 0 equates no impairment Scores range from 0 – 42. Higher scores indicate greater severity. Stroke severity may be stratified on the basis of NIHSS scores as follows (Brott et al, 1989): Very Severe: >25 Severe: 15 – 24 			



• Mild to Moderately Severe: 5 –	14
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 \circ Mild: 1 – 5

Area of Assessment	Aphasia; Behavior; Cognition; Dysarthria; Vision & Perception		
Body Part	Not Applicable		
ICF Domain	Body Function		
Domain	Cognition; Motor		
Assessment Type	Observer		
Length of Test	05 Minutes or Less		
Time to Administer	6 minutes		
Number of Items	15		
Equipment Required	None		
Training Required	Yes: Training and Certification DVD available through the American Academy of Neurology, the American Heart Association and the National Stroke Association.		
Type of training required	Training Course		
Cost	Free		
Actual Cost	None		
Age Range	Adult: 18-64 years		
Administration Mode	Paper/Pencil		
Diagnosis	Stroke		
Populations Tested	Stroke		



Standard Error of Measurement (SEM)	Not Established						
Minimal Detectable Change (MDC)	Not Est	Not Established					
Minimally Clinically Important Difference (MCID)	Not Established						
Cut-Off Scores	Stroke as follo	severity i ows (Brot	may be stra t et al, 1989	itified o)):	n the bas	sis of NIHSS	scores
		0	Very Seve	'e : >25			
		0	Severe : 15	-24			
		0	Mild to Mo	oderate	ly Severe	e: 5 – 14	
		0	Mild : 1 – 5				
	Acute :	Stroke: (S	chlegel et a	al, 2003	; Rundek	et al, 2000)
	Outcomes related to NIHSS scores at admission:						
	 Scores of <5; 80% of stroke survivors will be discharged to home 						
	• Score between 6 and 13 typically require acute inpatient rehabilitation						
	•	Scores of care	o f >14 frequ	uently r	equire lo	ng-term ski	lled
Normative Data	Acute : patient	<u>Stroke</u> : (\ ts assesse	Villiams et d 1 and 3 r	al, 1999 nonths); n = 34, (+/- 1 we	first stroke ek) after st	, roke)
	Health-Related Quality of Life (NIHSS mean scores)						
		1 Month			3 Month	ıs	
		A Lot Worse	A Little Worse	Same	A Lot Worse	A Little Worse	Same
	NIHSS	3.4	3.2	1.5	2.4	1.1	1.1



Test-retest Reliability	 <u>Acute Stroke</u>: (Goldstein & Samsa, 1997; 4 patients assessed by 30 physicians and 29 study coordinators; 3 months between assessments) Excellent test-retest reliability; ICC = 0.93 		
Interrater/Intrarater Reliability	Acute Stroke: (Goldstein & Samsa, 1997)		
	• Excellent interrater reliability; ICC = 0.95		
	Acute Stroke: Interrater Agreement (Goldstein et al, 1989; <i>n</i> = 20 with 2 independent observers)		
	• Adequate to Excellent agreement was found for 9 of the 13 items on the NIHSS (Kappa = 0.32 to 0.79); lowest levels of agreement were found for the Facial palsy (Kappa = 0.22) and limb ataxia (Kappa = -0.16) items.		
Internal Consistency	Not established		
Criterion Validity (Predictive/Concurrent)	 Acute Stroke: Predictive validity (Adams et al, 1999; n = 1268) NIHSS scores at baseline predicted outcome at 7 and 90 days An excellent outcome was achieved by nearly two-thirds of the survivors who scored 3 or less at day 7 Only a few patients who scored more than 15 at baseline achieved excellent outcomes after 90 days Acute Stroke: Predictive validity (Baird et al, 2001; n = 66; <48 hours post-stroke) NIHSS combined with Magnetic Resonance Diffusion-Weighted imaging (MR DWI) and volume of ischaemic brain tissue on MR DWI significantly predicted stroke recovery 		
	 <u>Acute Stroke</u>: (Bohannon et al, 2002; n = 92, mean age = 70.0 (12.4) years; NIHSS was administered while patients were still in the emergency department, prior to admission) Poor* (but significant) correlation with length of stay (r = 0.276) 		



	 Adequate* correlation with hospital charges (r = 0.320) 				
	 Adequate* correlation with discharge destination (home or elsewhere) (r= - 0.355) 				
	*Significant at p < 0.05				
	Acute Stroke: Concurrent Validity (Fink et al, 2002)				
	 Adequate to Excellent correlations with diffusion weighted MRI lesion volumes (r = 0.48 right, r = 0.58 left); and perfusion-weight hypoperfusion volumes (r = 0.62 right, r = 0.60 left) 				
	Chronic Stroke: Concurrent Validity (Peters, et al., 2015)				
	Examined the concurrent validity of the NHISS with the Stroke Impact Scale. No association between NIHSS and SIS-physical dimension (Spearman's rho =036; p =.666). SIS-overall perception of recovery (Spearman's rho =039; p =.640) nor SIS ADL/IADL score (Spearman's rho =054; p =.520).				
Construct Validity	Acute Stroke: (Schlegel et al, 2003; Rundek et al, 2000)				
(Convergent/Discriminant)	Outcomes related to NIHSS scores at admission:				
	 Scores of <5; 80% of stroke survivors will be discharged to home 				
	• Score between 6 and 13 typically require acute inpatient rehabilitation				
	 Scores of >14 frequently require long-term skilled care 				
Content Validity	Items are based on components of a standard neurological examination (Kasner, 2006)				
Face Validity	Not statistically established				
Floor/Ceiling Effects	Acute Stroke:				
	• Floor effects are less commonly reported in the literature to date				



	• Ce wi 20	eiling effects (Pickard et al, 2005) A ceiling effect as observed at 6 months with the NIHSS effecting 0% of patients who completed the measure
Responsiveness	Acute Stro NIHSS sco computed 10 items of days. How	bke : (Brott et al, 1989) res were compared to infarction size (measured by tomography) on 65 patients at 1 week post stroke. demonstrated an average of 25% change over 7 rever, changes in limb ataxia and best gaze may
Professional Association Recommendations	 have been overstated. Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare- professionals/neurology-section-outcome-measures- 	
	Abbrevia	ations:
	HR	Highly Recommend
	R	Recommend
	LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
	NR	Not Recommended
	Recomme	ndations for use based on acuity level of the

patient:



	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	R	NR	NR

Recommendations based on level of care in which the assessment is taken:

	Acu te Care	Inpatient Rehabilitat ion	Skille d Nursi ng Facilit Y	Outpatient Rehabilitat ion	Hom e Heal th
StrokED GE II	R	NR	NR	NR	NR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administ er this tool? (Y/N)	Student s should be expose d to tool? (Y/N)	Appropriat e for use in interventio n research studies? (Y/N)	Is additiona I research warrante d for this tool (Y/N)
StrokEDG E II	No	Yes	Yes	Not reported

• The NIHSS may be most useful for early prognostication assessment, whereas the Barthel

Considerations



Index may be more useful for planning rehabilitation interventions (Kasner, 2006)

- The NIHSS was originally designed to assess differences among clinical trial interventions.
 However, the NIHSS is increasingly used as an initial assessment tool and for planning post-acute care (Kasner, 2006).
- 4 items have poorly reliability or are redundant (level of consciousness, facial weakness, ataxia, and dysarthria (Kasner, 2006)
- The following information is provided on the Korean NIHSS and the Hindi NIHSS:

Content Validity

• Korean Version of the NIHSS (K-NIHSS) (Oh et al., 2012)

Used the Content Validity Index (CVI) which is the proportion of expert raters (n=11) rating an item higher than 3 points on a 4-point ordinal rating scale; a rating of 1 denotes an irrelevant item, and a rating of 4 denotes an extremely relevant item. Ten of the NIHSS items received a 1.0 meaning that all of the expert raters, rated that item higher than a 3. The visual fields item received a CVI of 0.91 as one rater, rated that item a "2" in terms of relevancy. Items with a CVI of at least 0.78 are accepted as valid (Lynn; 1986). The means scores of the CVI for each item ranged from 3.46-3.73.

Construct Validity

• Korean Version of the NIHSS (K-NIHSS) (Oh et al., 2012).

Construct Validity determined by comparison with the Glasgow Coma Scale (Spearman rho=-6.71; p<0.001)

Predictive Validity

 K-NIHSS at baseline (within 7 days of stroke onset) and modified Rankin Scale at 90-days post-onset was significantly positively correlated (Spearman's rho=0.600; p<0.001).



- K-NIHSS significantly negatively correlated with the Barthel Index for the same time period (Spearman's rho=-0.647; p<0.001).
- Hindi version (HV_NIHSS; Prassad et al., 2012) and

Glasgow Coma Scale at 3 months (Spearman's rho: -0.863, p<0.001)

- HV_NIHSS and Barthel Index at 3 months (Spearman's rho: -0.829, p<0.001)
- HV_NIHSS and Modified Rankin Scale at 3 months (Spearman's rho: 0.851, p<0.001)

Inter-rater/Intra-rater Reliability

Korean version of the NIHSS (K-NIHSS) (Oh et al., 2012; n=19 with 21 raters).

- Excellent interrater reliability; ICC=0.998. Lowest levels of agreement were found for Facial paresis (Kappa = 0.439) and dysarthria (Kappa = 0.465).
- Excellent intrarater reliability; ICC=0.969

Hindi version of NIHSS (Prassad et al, 2012; n=107 with 2 raters)

• Excellent interrater reliability; ICC=0.995

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Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u>!

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Year published	1989
Instrument in PDF Format	Yes
Approval Status	Approved
21	

21.



22. REHAB MEASURES DATABASE: NOTTINGHAM ASSESSMENT OF SOMATOSENSATION



Link to instrument	
Title of Assessment	Nottingham Assessment of Somato-Sensation
Acronym	NSA
Instrument Reviewer(s)	Initially reviewed by Jane Sullivan, MPT, DHS and the Stroke EDGE task force in 2011. Updated by Dorian Rose, PhD, PT and the StrokEdge II task force in 2017.
Summary Date	1/21/2017
Purpose	This tool has been used in clinical trials following stroke to test interventions such as electrical stimulation and task specific training.
Description	Multi-modal sensory examination includes tests of: 1) Tactile sensation (light, touch, touch localization, temperature discrimination, pinprick sensation, bilateral simultaneous stimulation) 2) Kinesthesia 3) Stereognosis.
	Scoring of instrument:
	Tactile sensation:
	0 – Absent – fails to identify the test sensations on 3 trials
	1 – Impaired – identifies the test sensation, but not on all 3 trials in each region of the body of feels duller
	2 - Normal - correctly identifies the test sensation on 3 trials
	For Stereognosis:
	2 – Normal – item is correctly named or matched
	1 – Impaired – some features of object identified or attempts descriptions of objects
	0 – Absent – unable to identify the object in any manner
	For Kinesthesia:



	0 - Absent - no appreciation of movement taking place
	1 – Appreciation of movement taking place – indicates on each movement that a movement takes place but the movement direction is incorrect
	2 – Direction of movement sense – able to appreciate and mirror the direction of the test movement, but is inaccurate in its new position
	3 – Joint Position Sense – accurately mirrors the test movement to within 10 degrees of the new test position
Area of Assessment	Sensation
Body Part	Upper Extremity and Lower Extremity
ICF Domain	Body Structure; Body Function
Domain	Sensory
Assessment Type	Performance Measure
Length of Test	60 Minutes or More
Time to Administer	Entire test can take up to 60 minutes, depending on client's sensory impairment. Kenesthesia and Sterognosis tests tkae approximately 15 minutes each
Number of Items	3
Equipment Required	For tactile sensation: blindfold, cotton ball, Neurotip, 2 test tubes for hot and cold water, talcum powder.
	For sterognosis assessment: blindfold, 2 different coins, pen, pencil, comb, scissors, sponge, piece of flannel cloth, cup, glass.
Training Required	Methods of sensory examination taught in most entry-level curricula are not as rigorous as this one. The NSA might be included in an examination courses as an example of a standardized sensory examination.
Type of training required	training course; Reading an Article/Manual
Cost	Not Free



Actual Cost	< £100
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Stroke
Populations Tested	Stroke
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established
Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Not Established
Normative Data	Not Established
	 One physical therapist tested patients on two occasions between 2-52 days apart. Kappa coefficients = -0.13-0.92; k >0.7 for 17/54 items
Interrater/Intrarater Reliability	 Stroke: (Lincoln NB et al, 1991; n = 20 acute stroke patients) Assessed by two physical therapists within 2-52 days of each other. Kappa coefficients = 0.01-0.89; only 1 item k > 0.7 (Lincoln NB et al, 1998; n = 27 stroke patients) Kappa coefficients showed acceptable agreement on 12 out of the 86 items for inter rater reliability. Light touch and pressure scales were most reliable and pinprick and temperature scales were least reliable For inter rater reliability of the stereognosis subtest reported kappa coefficients 0.38 to 1.0. Coefficients were higher on the unaffected side and for certain items (scissors, sponge, cup) Intracranial Disorders:


(Stolk-Hornsveld F et al, 2006; n = 18 inpatients; mean age = 57.7 years; diagnosed with intracranial disorder)

Intra rater and inter rater reliability of the Erasmus MC modifications to the Nottingham Sensory Assessment (EmNSA), kappa coefficients 0.58 to 1.00. Two-point discrimination was less reliable 0.11 to 0.63. Inter rater reliability of EmNSA, kappa coefficients of 0.46 to 1.00. Two-point discrimination was less reliable of 0.10 to 0.66

(Oauhart CO and Maalatt CD, 0000 m. 00 stacks notion

Stroke: Stereognosis Assessment

	 (Gaubert CS and Mockett SP, 2000, <i>N</i> = 20 stroke patients (3.85±2.78 weeks post-stroke) The stereognostic ability of the subjects was assessed using the NSA procedures by 2 of 3 examiners within a 24-hour period. Kappa values ranged from 0.42 (moderate) to 0.85 (almost perfect) between Examiners 1 and 2 Kappa values ranged from 0.38 (fair) to 0.84 (almost perfect) between Examiners 1 and 3 Kappa values ranged from 0.40 (fair) to 0.80 (substantial) between Examiners 1 with Examiners 2 and 3. For all 3 levels of comparison, the lowest Kappa value was for the pencil item.
Internal Consistency	Not Established
Criterion Validity (Predictive/Concurrent)	 Stroke: (Connell LA et al, 2008; n = 70 stroke patients) Upper limb tactile sensation at rehab admission (within 6 wks of stroke onset) predictive of upper limb tactile sensation at 6-months post-stroke (R² =0.56; p < 0.001) Lower limb tactile sensation at rehab admission (within 6 wks of stroke onset) predictive of lower limb



	 tactile sensation at 6-months post-stroke (R² =0.46; p < 0.001) Stereognosis and proprioception at rehab admission (within 6 wks of stroke onset) predictive of stereognosis at 6-months post-stroke (R² =0.71; p < 0.001) Proprioception and upper limb tactile sensation at rehab admission (within 6 wks of stroke onset) predictive of proprioception at 6-months post-stroke (R² =0.51; p < 0.001) (Meyer et al, 2016; n = 32 acute stroke patients) Proprioception (movement sense) as measured by the Erasmsus MC (revised) NSA at one week post-stroke, moderately predicted motor ability at 6-months post-stroke as measured by the UE Fugl-Meyer (Spearman p = 0.27), the Motricity Index (Spearman p = 0.27) and the Action Research Arm Test (Spearman p = 0.26). Stereognosis measured by the UE Fugl-Meyer (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.37) and the Action Research Arm Test (Spearman p = 0.56).
Construct Validity (Convergent/Discriminant)	 Stroke: (Scalha et al, 2011; n = 20 stroke patients (> 2 yrs post-stroke) Total Fugl-Meyer (FM) UE Sensation (proprioception and light touch) correlated with UE Nottingham Stroke Assessment (NSA) score; Spearman's r=0.69; p<0.001) UE FM arm light touch correlated with NSA tactile sensation subscale (p< 0.005) UE FM palm light touch correlated with NSA tactile sensation subscale (p<0.005)



- UE FM shoulder/elbow proprioception correlated with NSA proprioception subscale (r=0.59; p=0.007)
- UE FM wrist/hand proprioception correlated with NSA proprioception subscale (r=0.75;p < 0.001).

Content Validity	Not Establi	ished		
Face Validity	Not Establi	ished		
Floor/Ceiling Effects	Not Establi	ished		
Responsiveness	Not Establi	ished		
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the Americ Physical Therapy Association's Multiple Sclerosis Task (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Injury Taskforce (PD EDGE), Stroke Taskforce (Stroke II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of resea clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthca professionals/neurology-section-outcome-measures- recommendations		n the American is Taskforce Spinal Cord StrokEDGE), and These research and ations were ealthcare- ures-	
	Abbrevia	tions:		
	HR	Highly Recommend		
	R	Recommend		
	IS/UR	Reasonable to use,	but limited study	
	207 01	group / Unable to R	ecommend	in target
	NR	group / Unable to R Not Recommended	ecommend	r in target



StrokEDGE II	UR	UR	UR
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Recommendations based on level of care in which the assessment is taken:

	Acu te Car e	Inpatient Rehabilita tion	Skille d Nursi ng Facili ty	Outpatien t Rehabilita tion	Hom e Heal th
MS EDGE	NR	NR	NR	NR	NR
StrokED GE II	NR	UR	UR	UR	UR

Recommendations based on EDSS Classification:

	EDSS	EDSS 4.0	EDSS 6.0	EDSS 8.0
	0.0 – 3.5	- 5.5	- 7.5	- 9.5
MS EDGE	NR	NR	NR	NR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administ er this tool? (Y/N)	Student s should be expose d to tool? (Y/N)	Appropria te for use in interventi on research studies? (Y/N)	Is addition al research warrante d for this tool (Y/N)
MS EDGE	No	No	No	Yes
StrokEDG E II	No	Yes	Yes	Yes

Considerations

It is unlikely that the entire test will be performed in any of these practice settings, however components of the test may be appropriate if the systems review/screening exam indicates sensory loss and/or if sensory loss is hypothesized to underlie the patient's movement dysfunction.

Clinical utility is poor due to the time to complete the entire test and the need for specific equipment that may not be available in the clinic (e.g. neurotip). The stereognosis and kinesthesia subscales have better clinical utility (equipment and time). Those two tests may be more appropriate for use in the clinic



	that they use standardized equipment procedures and have some acceptable psychometric data available.
	The inclusion of sensory outcome measure in clinical trials could advance knowledge by identifying those intervention that are associated with sensory improvement as well as helping to determine those client characteristics (beyond motor and functional status) that are associated with improvement following selected interventions. This information would assist clinicians to target appropriate interventions based on client baseline characteristics.
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Year published	2011
Instrument in PDF Format	Yes
Approval Status	Approved



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Link to instrument	Can be found on the Stroke Center Website (external link)	
Title of Assessment	Orpington Prognostic Scale	
Acronym	OPS	
Instrument Reviewer(s)	Updated by Carmen Capo-Lugo, F Rose PT, PhD of the Stroke Edge I	PT, PhD and Dorian I Task Force in 2016.
Summary Date	3/7/16	
Purpose	Assessment of stroke severity (e., proprioception, balance and cogr	g., motor deficits, hition)
Description	The OPS assessment includes mer (arm), proprioception, balance ar The OPS is based on an earlier pro Edinburgh Prognostic Score (Pres an assessment of cognitive dysfur 1993). OPS scores range from 1.6 to 6.8 indicate greater deficit (Kalra & C 1994; Lai et al, 1998). Deficits can be categorized as (Ka et al, 1998): Mild to moderate: Moderate to moderately severe: Severe or major:	asures of motor deficit ad cognition. Ognostic tool, the cott et al, 1982) but adds nction (Kalra & Crome, such that higher scores rome, 1993; Kalra et al, lra and Crome, 1993; Lai (scores <3.2) (scores 3.2 – 5.2) (scores >5.2)
Area of Assessment	Activities of Daily Living	
Body Part	Not Applicable	
ICF Domain	Body Function	
Domain	Motor	



Assessment Type	Observer		
Length of Test	05 Minutes or Less		
Time to Administer	5 minutes		
Number of Items	Not applicable		
Equipment Required	None Necessary		
Training Required	None Necessary		
Type of training required	No Training		
Cost	Free		
Actual Cost	Free		
Age Range	Adult: 18-64 years		
Administration Mode	Paper/Pencil		
Diagnosis	Stroke		
Populations Tested	Stroke		
Standard Error of Measurement (SEM)	Not Established		
Minimal Detectable Change (MDC)	Not Established		
Minimally Clinically Important Difference (MCID)	• Not Established		
Cut-Off Scores	Acute Stoke: (Kalra & Crome, 1993; <i>n</i> = 96; assessed 1, 2, and 4 and 16 weeks post stroke; Kalra & Eade, 1995; <i>n</i> = 71)		
	 Scores < 3.2 indicate a high likelihood of returning home. 		
	 Scores that fall between 3.2 and 5.2 generally respond better to rehabilitation. 		



	 Patients with scores > with an increased risk 	5.2 are typof institut	pica iona	lly depend alization.	lent
Normative Data	Chronic & Acute Stroke: (Riec mean age = 77 (9.0) years; 419	k & Morela % had a pro	and, evio	, 2005; n = ous stroke)	65;
	OPS total scores by discharge	location*			
		Day 7 O total	PS	Day 14 (total	OPS
	Home:	3.2 (1.6 - 6.4)	n = 45	3.2 (1.6 - 5.2)	n = 34
	Family's Home:	3.6 (2.4 - 4.4)	n = 4	.6 (2.4 - 4.0)	n = 3
	Retirement Home:	3.0 (2.0 - 4.4	n = 8	2.8 (2.0 - 5.2)	n = 6
	Nursing Home:	4.8 (3.2 - 6.4)	n = 14	5.0 (2.8 - 6.8)	n = 16
	Expired:	6.0 (4.8 - 6.4)	n = 5	6.4 (6.0 - 6.8)	n = 3
	Transferred out of hospital to other rehabilitation unit:	4.0 (2.8 - 6.8)	n = 5	4.4 (3.2 - 6.4)	n = 6
	*median (minimum–maximur	n)			
	Comparison of findings at da	y 14:			
		Rieck (200)5) k	Kalra (1993	3)
	Discharge home	< 4.8	1	1.6 – 5.2	
	Discharge to Long Term Care	5.4 – 6.8	2	2.8 – 6.8	
Test-retest Reliability	Chronic & Acute Stroke: (Riec	k & Morela	and,	, 2005; n =	27;

mean age 76 (12.2) years; sample included patients with prior stroke)



	• Excellent test-retested reliability (ICC = 0.95)			
Interrater/Intrarater Reliability	<u>Chronic & Acute Stroke</u> : (Rieck & Moreland, 2005; $n = 65$; mean age 77 (9) years; assessed 7 and 14 days post stroke by two physiotherapists; sample included patients with prior stroke)			
	• Excellent inter-rater reliability (ICC = 0.99)			
	 Excellent inter-rater reliability (weighted kappa = 0.84 - balance) 			
	Acute Stroke: (Weir et al, 2003; prospectively $n = 2$ clinicians and 92 patients / retrospectively $n = 2$ auditors & 200 patients)			
	 Adequate inter-rater reliability (weighted kappa = 0.53-proprioception; 0.64-cognition; 0.72 motor deficit 			
Internal Consistency	Not Established			
Criterion Validity (Predictive/Concurrent)	<u>Acute Stroke</u> : (Brott et al, 1989; Wright, Swinton & Green, 2004; Celik, Aksel & Karaoglan, 2006)			
	 Excellent concurrent validity with NIHSS (see below for specific values by study): 			
	Study 1: NIHSS (rho = 0.83)			
	Study 2: NIHSS (rho = 0.60) Study 3: NIHSS (rho = 0.76)			
	<u>Acute Stroke</u> : (Kalra & Crome, 1993; Studenski et al, 2001; <i>n</i> = 413; 3 to 14 days post stroke)			
	• Excellent predictive validity:			
	Predicts Barthel Index ADL scores at discharge.			
	A better predictor of Barthel Index scores (R-sqr = 0.89) when compared to Edinburgh Prognostic Score (R-sqr = 0.57)			
	Predicts Barthel Index ADL and Sf-36 Physical Function scores at 1, 3, and 6 months post-stroke			
	• Adequate predictive validity with:			



Functional Recovery Rate (OPS cut-offs <2.4 and >4.4 at 3 months)

<u>Chronic Stroke</u> (Alghwiri, 2015; n=61; mean 3.3 months post-stroke. All assessments were conducted in Arabic.)

OPS Level	BDI Score	DGI Score	SIS-16 Score
Mild	22.7	35.2	35.6
Moderate	37.3	22.2	23.1
Severe	38.7	7.2	25.6

The non-parametric Kruskal-Wallis H test was used to assess any differences between participant's depression, balance, and self-reported physical performance measurements among OPS levels of stroke severity. Beck Depression Scores (BDI) revealed higher depressive symptoms with increasing severity of stroke as measured by the OPS. Similarly more severe stroke levels showed lower balance ability (DGI Score) and lower self-reported physical functioning (Stroke Impact Scale -16).

Construct Validity (Convergent/Discriminant)

Convergent validity:

Acute Stroke: (Meldrum et al, 2004; OPS performed within 48 hours of admission; Pittock et al. 2003; *n* = 117; assessed 48 hours post stroke and again 6 and 24 months later)

- OPS administered 2 days post-stroke demonstrated adequate predictive validity of upper limb function at 6 and 24 months post stroke
- OPS administered within 2 days of stroke predicted Rivermead Motor Assessment, Oxford Handicap Scale, Barthel Index and length of stay at 6 and 24 months. Results suggest significant convergence in predicted motor performance, disability level, ADL and length of stay (particularly at month 6).



Content Validity	Not Established			
Face Validity	Not Established			
Floor/Ceiling Effects	Not Established			
Responsiveness	<u>Comparison of Results across stu</u> 2005)	dies: (Riec	k & Moreland,	
	Predictive statistics comparing r	esults:		
		Kalra (1994)	Rieck (2005)	
	Sensitivity	96%	82% (0.68 – 0.93)	
	Specificity	36%	42% (0.25 – 0.61)	
	Accuracy	75%	65% (0.52 – 0.76)	
	Positive Predictive Value (going home) OPS < 3.0	100%	81% (0.58 – 0.95)	
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.		t from the the American rosis Taskforce , Spinal Cord e (StrokEDGE GE), and w. These el of research process.	
	For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-</u> professionals/neurology-section-outcome-measures- recommendations			



Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	HR	NR	NR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	HR	HR*	NR	NR	NR

*If within 2 weeks post-stroke

Recommendations for entry-level physical therapy education and use in research:

Students should	Studen ts	Appropria te for use	ls addition
learn to	should	in	al
administ	be	interventi	research



		er this tool? (Y/N)	expose d to tool? (Y/N)	on research studies? (Y/N)	warrant ed for this tool (Y/N)
	StrokED GE II	No	Yes	Yes	Not reported
Considerations	 Sho al, 1 Scal neu Opt adn 199 Do you see instrument 	uld not be u 1994). le should on rological co imal predict ninistered 2 4) an error or h summary? F	ly be used ndition ha ive power weeks pos nave a sug Please <u>e-ma</u>	ute prognosis when the pa s stabilized was observe st stroke (Kaln gestion for th <u>ail us</u> !	s (Kalra et tient's d when ra et al, is
Bibliography	Alghwiri AA and physica Cerebrovase Brott, T., Ac acute cereb Stroke 20(7 Celik, C., Ak Orpington P Institutes of of the funct Rehabil 28: Kalra, L. and scores in tai	. The correlated I functioning cular Diseased lams, H. P., J ral infarction): 864-870. <u>F</u> sel, J., et al. Prognostic So Health Stro ional status 609-612. <u>Fir</u> I Crome, P. (rgeting strok	ation betw g post stro es. 2015. <u>F</u> (r., et al. (1 n: a clinica find it on F (2006). "C cale (OPS) ke Scale (I of patient <u>ad it on Pu</u> (1993). "The ce rehabilit	een depressi ke. Journal o ind it on Pub .989). "Measu l examination PubMed omparison of and the Natio NIHSS) for the s with stroke bMed he role of pro tation in elde	on, balance, f Stroke and <u>Med</u> urements of n scale." The onal e prediction " Disabil gnostic rly
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Year published	1993
Instrument in PDF Format	Yes
Approval Status	Approved



Title of Assessment	Postural Assessment Scale for Stroke
Acronym	PASS
Instrument Reviewer(s)	Reviewed by the StrokEDGE Task Force, Neurology Section, APTA , 2011
	Reviewed by Shweta Subramani on 12/04/2014
	Updated by Heather Anderson and Rie Yoshida from the StrokEdge II Task Force, Neurology Section, APTA on 4/11/16.
Summary Date	4/11/16
Purpose	It is a 12 item performance-based scale used for assessing and monitoring postural control following stroke.
Description	It is specially designed for individuals with stroke regardless of their postural competence.
	It is especially sensitive for assessment of postural control in the first 3 months and can discriminate between right and left brain damage in individuals with stroke.
	It measures the ability of an individual with stroke to maintain stable postures and equilibrium during positional changes
	The scale comprises of 12 items with increasing difficulty which measure balance and functional ability. Each item is scored on a 4 point scale where the items are scored from 0 to 3 and the total scoring ranges from 0 to 36. Test activities include:
	1. Sitting without support (sitting on the edge of an 50-cm-high
	examination with the feet touching the floor)
	2. Standing with support (feet position free, no other constraints)
	3. Standing without support (feet position free, no other constraints)
	4. Standing on non-paretic leg (no other constraints)

23. REHAB MEASURES DATABASE: POSTURAL ASSESSMENT SCALE FOR STROKE



	5. Standing on paretic leg (no other constraints)
	6. Supine to affected side lateral
	7. Supine to non-affected side lateral
	8. Supine to sitting up on the edge of the table
	9. Sitting on the edge of the table to supine
	10. Sitting to standing up
	11. Standing up to sitting down
	12. Standing, picking up a pencil from the floor
	Modified versions of the PASS include the PASS trunk control items (PASS- TC) and the Short-Form PASS (SFPASS). Both have 5 items instead of the original 12 included with the PASS.
Area of Assessment	Functional balance in supine, sitting and standing
Body Part	Trunk and Lower extremity
ICF Domain	Activity
ICF Domain Domain	Activity Motor
ICF Domain Domain Assessment Type	Activity Motor Performance measure
ICF Domain Domain Assessment Type Length of Test	Activity Motor Performance measure 06 to 30 Minutes
ICF Domain Domain Assessment Type Length of Test Time to Administer	Activity Motor Performance measure 06 to 30 Minutes 10 minutes
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items	Activity Motor Performance measure 06 to 30 Minutes 10 minutes 12 items
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items Equipment Required	Activity Motor Performance measure 06 to 30 Minutes 10 minutes 12 items 50cm-high examination table (e.g. Bobath plane)
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items Equipment Required	Activity Motor Performance measure 06 to 30 Minutes 10 minutes 12 items 50cm-high examination table (e.g. Bobath plane)
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items Equipment Required	ActivityMotorPerformance measure06 to 30 Minutes10 minutes12 items50cm-high examination table (e.g. Bobath plane)Stop watch
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items Equipment Required	ActivityMotorPerformance measure06 to 30 Minutes10 minutes12 items50cm-high examination table (e.g. Bobath plane)Stop watchPen
ICF Domain Domain Assessment Type Length of Test Time to Administer Number of Items Equipment Required Training Required	ActivityMotorPerformance measure06 to 30 Minutes10 minutes12 items50cm-high examination table (e.g. Bobath plane)Stop watchPenNo specific manual or training required, but it is essential that the clinician using the scale must be aware of balance impairments and safety issues following stroke



Cost	Free			
Actual Cost	Cost of equipment			
Age Range	Adults			
Administration Mode	Paper/pencil			
Diagnosis	Stroke			
Populations Tested	Stroke patients			
Standard Error of Measurement (SEM)	Chronic Stroke: (Liaw et al, 2008; n=52; mean age= 60.4(13.4);time since stroke onset = 6 to 292 months; Liaw et al, 2012; n = 52; mean age = 60.4 (13.4) years; time since stroke onset = 13.3-53.5 months) 1.14 points for PASS (Liaw et al, 2008) 0.78 point for SFPASS (Liaw et al, 2012) Acute Stroke: (Chien et al, 2007b; n=287; mean age= 65.5(11.3); 14 days post stroke)			
	• 2.4 points (<u>+</u> 4.7 points, 95% CI)			
Minimal Detectable Change (MDC)	 Sub-acute Stroke: (Chien et al, 2007a; n=40; mean age=58.6+/-12.0) MDC at an individual score level: 2.22 points (95% Cl) MDC at a group score level: 0.50 points (95% Cl) Chronic Stroke: MDC of PASS: 3.2 points (Liaw et al, 2008) MDC of SFPASS: 2.2 points (Liaw et al, 2012) Acute Stroke: (Hsuen et al, 2013; n = 251; mean age 67.3 + 10.9; 14 and 30 days post stroke) MDC mean individual ratio of PASS 1.8; SD= 1.7 (95% Cl) 			
Minimally Clinically Important Difference (MCID)	Not Established			
Cut-Off Scores	 Acute Stroke: (Huang et al, 2016; n = 341; mean age = 63 (13.28) for ambulatory group and 69 (13.83) for non-ambulatory group; mean time since stroke = 26.22 (30.30) day s for ambulatory group and 31.05 (39.42) days for non-ambulatory group; Taiwanese study) 3.5 points for static PASS (sensitivity 77.9%, specificity 82.1%) 			



	 8.5 points for dynamic PASS (sensitivity 77.9%, specificity 82.5%) 12.5 points for total PASS (sensitivity 78.9%, specificity 83.7%)
Normative Data	<u>Healthy older adults: (</u> Benaim et al, 1999; n=30; mean age= 63.3+/- 1.5 years)
	 Mean PASS score =35.7 points, range= 32 to 36 points
Test-retest Reliability	 Excellent test-retest reliability (Intra Class Coefficient (ICC)=0.84) (Chien et al, 2007a) Excellent relative test-retest reliability (ICC=0.97) over 7 days (Liaw et al, 2008) Excellent test-retest reliability in SFPASS (ICC = 0.93) (Liaw et al, 2012)
Interrater/Intrarater Reliability	Interrater reliability: Acute/Subacute Stroke: (Benaim et al, 1999; n=12; 30 and 90 days post stroke) • Adequate to excellent inter-rater reliability for individual items (average alpha=0.88, range 0.64-1) • Excellent inter-rater reliability for total score (r=0.99, p<0.001) Acute Stroke: (Mao et al, 2002; n=112;mean age=69.3+/-11.2; 14 days post stroke) • Adequate to excellent inter-rater reliability for individual items(median alpha=0.88, range 0.61-0.96) • Excellent inter-rater reliability (ICC=0.97, 95% confidence interval (CI 0.95-0.98)) for total score. Acute Stroke: (Hsieh et al, 2002; n=169; mean age= 66.8(11.3)) • Excellent inter-rater reliability of the trunk control items (PASS-TC: items 1,6,7,8,9 ICC =0.97) Intrarater reliability: Acute/Subacute Stroke: (Benaim et al, 1999) • Good intrarater reliability for individual items (average k=0.72)
	 Good intrarater reliability for individual items (average k=0.72, range 0.45-1)



	• Excellent intrarater reliability for total score (r=0.98, p<0.001)
Internal Consistency	 Stroke: Excellent internal consistency Cronbach's alpha= 0.95 (Benaim et al, 1999-acute/subacute) Cronbach's alpha= 0.94-0.96 at 14, 30, 90 and 180 days post stroke (Mao et al, 2002) Cronbach's alpha= 0.93-0.94 (Hseih et al, 2002-acute)
Criterion Validity (Predictive/Concurrent)	Concurrent validity: <u>Acute Stroke: (</u> Mao et al, 2002)
	 Excellent relationship with Fugl-Meyer Assessment modified balance scale (FMA-B) (<i>p</i>=0.95-0.97) and Berg Balance Scale (BBS) (<i>p</i>=0.92-0.95) Acute/Subacute Stroke: (Wang et al,2004; n=77; mean age= 59.8(11.9);14, 30 and 90 days post stroke) Excellent relationship between all measures (PASS, PASS-3P, BBS)
	and BBS-3P) (rho>/=0.91, P<0.0001) • Excellent relationship with BBS (<i>p</i> =0.94,P<0.0001) and with PASS- 3P (<i>p</i> =0.94,P<0.0001; ICC=0.97, 95%CI 0.96-0.98) <u>Acute Stroke:</u> (Chien et al, 2007b)
	 Excellent relationship with the SFPASS (ICC=0.98;96% variance) in 287 individuals at 14 days post stroke Excellent relationship with the SFPASS (ICC=0.98) in 179 individuals with stroke Acute Stroke: (Di Monaco et al, 2010; n=60; mean age= 68.0(12.2); mean time post stroke= 21.4 (13.3)days)
	 Excellent relationship with the Trunk Impairment Scale (TIS) (p=0.849, P<0.001) Predictive validity: <u>Acute/Subacute Stroke:</u> (Benaim et al, 1999)



 Good predictive validity of PASS total score (r=0.75,p<0.001), transfer items (r=0.74,p<0.006) and locomotion items (r=0.71,p<0.001) at 30 days post stroke when compared with Functional Independence measure (FIM) scores at 90 days post stroke

Acute Stroke: (Mao et al, 2002)

• **Excellent** predictive validity of PASS (*p*=0.86-0.90) at 14, 30 and 90 days post stroke when compared with the walking subscale of the Motor Assessment Scale at 180 days post stroke

Acute Stroke: (Hsieh et al, 2002)

• Excellent predictive validity of the trunk control items of PASS (PASS-TC: items 1,6,7,8,9) (r=0.68,p<0.001) at 14 days post stroke when compared with Barthel Index (BI) and Frenchay Activities Index (FAI) at 6 months post stroke

Stroke: (Wang et al, 2004;n=226 and n=202;14 and 30 days post stroke)

 Excellent predictive validity of PASS and modified PASS that used 3-level scale (12-item PASS-3P) at 14 days (p=0.78) and 30 days (p=0.82) post-stroke when compared with BI scores at 90 days post-stroke

Acute Stroke: (Chien et al, 2007b)

- Adequate predictive validity of PASS (r=0.49) and SFPASS (r=0.48) at 14 days post-stroke when compared with BI scores at 90 days post-stroke
- Excellent predictive validity of PASS (r=0.83) and SFPASS (0.82) on replication of the process in 179 individuals following stroke on admission to rehabilitation with BI scores on discharge from hospital

Acute Stroke: (Di Monaco et al, 2010)

 Excellent predictive validity of PASS (*p*=0.687,p<0.001)on admission to inpatient rehabilitation when compared with FIM discharge scores

<u>Acute Stroke:</u> (Yu et al, 2012; n=85; mean age = 65 (11.6) years, mean time since stroke onset = 19 (5-79) days)

• **Sufficient** predictive validity of PASS, when compared with BI (r2=0.39,p<0.001) and Stroke Rehabilitation Assessment of



	 Movement mobility subscale (MO-STREAM) (r2=0.63,p<0.001) discharge scores Acute Stroke (Yu et al., 2013); n=66; mean age: 63.1 yrs (12.2); 18 days (6-64) post stroke Predictive validity of PASS at rehab admission compared to Barthel Index at Discharge (mean = 31 days (6-76); r=0.69 (p<0.001) Predictive validity of PASS at rehab admission compared to MO-STREAM at Discharge (mean = 31 days (6-76); r=0.80 (p<0.001)
Construct Validity (Convergent/Discriminan t)	 Acute/Subacute Stroke: (Benaim et al, 1999) Excellent correlations between PASS and FIM total score (r=0.73), transfer tasks (r=0.82) and locomotor tasks (r=0.73); and motricity scores of lower limb (r=0.78) and upper limb (r=0.63) Adequate negative correlations with the star cancellation test of spatial inattention (r=0.53) and lower limb pressure sensitivity (r=0.45) as well as upper limb pressure sensitivity (r=0.42) Adequate negative correlations with measurement of postural stabilization (r=0.48) and postural orientation with respect to gravity (r=0.36) (Benaim et al, 1999; n=31; 90 days post stroke) Acute Stroke: (Mao et al, 2002)
	 Excellent convergent validity between PASS and BI (<i>p</i>= 0.88-0.92) Acute Stroke: (Hsieh et al, 2002) Excellent convergent validity of PASS-TC with BI (r=0.89) and with the Fugl-Meyer balance test (FM-B) (r=0.73) Stroke: (Wang et al, 2004) Excellent convergent validity of the PASS and PASS 3P with BI (<i>p</i>=0.84, <i>p</i>= 0.82 respectively) Acute Stroke: (Chien et al, 2007b) Excellent correlations between the PASS, SF PASS and BI, (PASS R=0.87; SFPASS r=0.86) and between the PASS, SFPASS and FIM (PASS r=0.75; SFPASS r=0.75)



<u>Acute stroke</u>: (Chinsongkram et al, 2014; *n* =70, mean age = 57 (12.24) years; mean time since stroke = 1.11 (2.00) month; Thai study)

• **Excellent** convergent validity with BESTest (*r* = 0.96)

<u>Chronic stroke</u>: (Lin et al, 2010; n = 45, mean age = 60 ± 12.6 years; mean time since stroke = 9 (3-22) months; tested after 1 week, 2 months and 5 months of outpatient therapy; Taiwanese study)

· Modelate						
Time point of	PASS vs DGI	PASS vs DGI-4	PASS vs FGA			
assesement						
1 st wk of	0.85	0.75	0.83			
therapy						
2 mos after	0.76	0.74	0.75			
therapy						
5 mos after	0.83	0.78	0.83			
therapy						

• **Moderate to high** convergent validity (ρ) with DGI, DGI-4, and FGA

<u>Subacute Stroke</u>: Huang et al., 2016; n=341; mean days post stroke = 34.40; retrospective study completed in Taiwan

PASS cut-off scores predictiv	ve of patient	ambulation at	t discharge:
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Scale	Cut-off points	Non- Ambu- latory	Ambu -latory	Sensitivity/ Specificity	ROC curve AUC	PPV
		n, %	n, %			
Static	< 3.5	202; 59.2%	21; 6.2%	77.9%/	0.860	0.627
PASS	<u>></u> 3.5	44; 12.9%	74; 21.7%	82.1%		
Dynamic	< 8.5	203; 59.5%	21; 6.2%	77.9%/	0.876	0.632
PASS	> 8.5	43; 12.6%	74; 21.7%	82.5%		
Total	< 12.5	206; 60.4%	20; 5.9%	78.9%/	0.884	0.652
PASS	> 12.5	40; 11.7%	75; 22%	83.7%		
p-value fo	or all < 0.	.001	1	1		1
AUC = Are	ea Unde	r Curve				
		بالمبر منتخما الم	0			

Content Validity

Not established



Face Validity	Not established
Floor/Ceiling Effects	 <u>Acute/Subacute Stroke:</u> (Benaim et al, 1999; n=58; 30 and 90 days post stroke) Large ceiling effects at 90 days post stroke (38%)
	Acute Stroke: (Mao et al, 2002;14, 30, 90 and 180 days post stroke)
	• Adequate floor and ceiling effects at all time points (floor effect range 2.2-3.8%; ceiling effect range 3.3-17.5%)
	 Acute stroke: (Chinsongkram et al, 2014) Significant ceiling effect (37.1% of patients received a score within the top 10% of the PASS)
	 Acute Stroke: (Hsueh et al, 2013; n = 251; mean age = 68.4 (10.4) years; assessed at 14 and 30 days after stroke onset on PASS and SFPASS; Taiwanese study) No floor/ceiling effects for PASS (0-7.2%) Notable floor effect (21.9%) for SFPASS at 14 days after stroke onset (but not at 30 days after stroke onset-12.7%) No ceiling effect (0-14.3%) for SFPASS
	 Acute Stroke (Yu et al., 2013); n=66; mean age: 63.1 yrs (12.2); 18 days (6-64) post stroke Negligible to small ceiling effect at rehabilitation admission (1.5%) and at rehabilitation discharge (6.1%)
	 <u>No floor effect at rehabilitation admission (0%) or discharge (0%)</u>
	 Acute Stroke: (Yu et al, 2012) No notable floor or ceiling effect at admission (< 15%)
Responsiveness	 Acute Stroke: (Mao et al, 2002) Large responsiveness of PASS from 14-30 days (Effect Size (ES)=0.89) Moderate responsiveness from 30-90 days (ES=0.64) Low responsiveness from 90-180 days (ES=0.31)



• Large overall responsiveness from 14-180 days (ES=1.12)

• Large responsiveness from 14-180 days (ES=1.54) in severe stroke Acute Stroke (Yu et al., 2013); n=66; mean age: 63.1 yrs (12.2); 18 days (6-64) post stroke

• Large responsiveness between rehab admission and discharge (mean = 31 days (6-76); ES=0.86; SRM=1.23

Stroke: (Wang et al, 2004; n=202 and n=167; 14,30and 90 days post stroke)

- Large responsiveness of the PASS and PASS-3P from 14-30 days post stroke (Standard Response Mean (SRM) =0.84 and 0.86 respectively) and from 14-90 days post stroke (SRM=1.02 and 1.04 respectively)
- **Moderate** responsiveness from 30-90 days post stroke (SRM=0.65 and 0.67 respectively)
- **Moderate** responsiveness of PASS and PASS-3P (PASS SRM range 0.43-0.78; PASS-3P SRM range 0.46-0.78) in individuals with mild stroke (Fugl Meyer motor assessment (FM) score of 80 or greater)
- Moderate to large responsiveness (PASS SRM range 0.52-1.12; PASS -3P SRM range 0.56-1.19) in individuals with moderate stroke (FM score 36 to 79)
- Large responsiveness (PASS SRM range 0.92-1.35; PASS-3P SRM range 0.92-1.34) in individuals with severe stroke (FM score 0 to 35)
- Large responsiveness of both measures in the period of 14-30 days and 14-90 days post stroke as compared to 30-90 days post stroke.

Sub-acute Stroke: (Chien et al, 2007a)

• Small responsiveness of the PASS (d=0.41) over an interval of 2 weeks

Acute Stroke: (Chien et al, 2007b)

- Small responsiveness of the PASS (ES=0.42)
- Small responsiveness of the PASS (ES=0.43) (Chien et al, 2007b; n=179; admission to rehabilitation to discharge from hospital)
 Acute Stroke: (Yu et al, 2012)
 - Adequate internal responsiveness of PASS(d=0.87)



	Suffici	ent exter	nal responsi	veness (ic=0	.44, r2=	0.20, p	o<0.001),
	(ic=0.7	7, r2=0.5	9, p<0.001) t	o changes in	functio	on (Bl c	hanges
	scores) and cha	nges in mobi	lity (MO-STR	ean cr	ange s	scores)
	Acute Stroke:	(Hsueh et	: al, 2013)				
	• Group	level resp	oonsiveness:	moderate to	o large	respon	siveness
	(0.46-0	0.91) for b	ooth PASS an	d SFPASS			
	Individ	lual patie	nt-level resp	onsiveness: I	PASS m	ore res	sponsive
	than S	FPASS in	that PASS de	tected signif	icantly	greate	r proportion
	of par	a a contraction of the second s	nowing signi	ificant impro	vemen	than :	SFPASS (53%
	Versus		(cetively)				
Recommendations	American Phys Taskforce (Stro	okEDGE II)	apy Associati) recomment	on (APTA) No dations on a	eurolog 4 point	y secti scale-	on's Stroke
	4= highly reco	mmendec	l; the outcon	ne has excell	ent psy	chome	etric
	properties and	l clinical u	tility				
	3= recommen	ded: the o	outcome mea	sure has goo	od psvc	homet	ric
	properties and	l good clir	nical utility		50 6090	lonice	
	2= unable to r	ecommen	d at this time	e; there is in:	sufficie	nt info	rmation to
	support a reco	mmendai	tion of this o	utcome mea	sure		
	1= not recomr	nended; t	he outcome	measure has	s poor p	sychoi	metric
	properties and/or poor clinical utility						
	Bractico cottin	a					
	Fractice Settin	Б					
		Acute	IP Rehab	Home	SNF		OP
	StrokEDGE II	4	4	4	4		4
	Patient Acuity						
		Acut	е	Sub-acute		Chro	nic
	StrokEDGE II	4		1-3 (most		1	
				appropriat	e devia)		
				within 90 (uays)		
	Education						



	StrokEDGE II	Stude learn admir	nts should to nister tool	Students sho be exposed t x	ould to tool	Do not recommend
	Research Use StrokEDGE II		Appropriat research p X (acute st	e for urposes roke only)	Not a resea	appropriate for arch purposes
Considerations	This scale is easy to administer with no special requirement. Any clinician can easily, rapidly and confidently administer th However, the clinician must have the understanding of balan impairments and safety issues that are seen following stroke It is more sensitive for assessment of stroke in the first 3 more			ent. er the scale. alance oke. months.		
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24.REHAB MEASURES: RPE



Link to instrument	
Title of Assessment	Borg Rating Scale of Perceived Exertion
Acronym	RPE
Instrument Reviewer(s)	Developed by: Gayatri Mathur, PT; Updated by: Jill Smiley, MPH Reviewed by Patricia Kluding, PhD, PT of the StrokEdge task force, Neurology Section, APTA in 2010; Updated by Dorian Rose, PhD, PT of the StrokEdge II task force, Neurology Section, APTA in 2017
Summary Date	7/13/2012; 1/28/17
Purpose	Used as a means to determine intensity of exercise
Description	 A 15-point category scale with verbal descriptors to standardize perceived exertion across tasks and individuals. Instructions for use: scale used to rate how hard person is working, explain 6=rest, 20=absolute maximum, grade effort using numbers and/or words. Used as a measure for training intensity and outcomes for exercise - parallels physiological variables. Many authors suggest carrying afferent input to RPE but as yet there is no consensus in the literature as to what they are/what their effects may be (Hampson et al '01) For any individual capable of exercising
Area of Assessment	Aerobic Capacity; Gait
Body Part	Not Applicable
ICF Domain	Body Function
Domain	
Assessment Type	Physiological
Length of Test	06 to 30 Minutes



Time to Administer	Time for initial explanation, instant feedback from patient			
Number of Items	15-point category scale			
Equipment Required	Printed copy of 6-20 scale with numbers and words for descriptors			
Training Required	Read American College or Sports Medicine guidelines, textbook or article.			
Type of training required	Read American College or Sports Medicine guidelines, textbook or article.			
Cost	Free			
Actual Cost	Free			
Age Range	Preschool Child: 2-5 years; Child: 6-12 years; Adolescent: 13-17 years; Adult: 18-64 years; Elderly adult: 65+			
Administration Mode	Verbal Response by looking at available numerical range with corresponding definition of "how hard are you working" scorecard			
Diagnosis	Cardiac Conditions; Geriatrics; Multiple Sclerosis; Spinal Cord Injury; Stroke			
Populations Tested	 Healthy Blind Active and sedentary Adolescents Cardiac Neurological Elderly 			
Standard Error of Measurement (SEM)	Well-trained Males: (Doherty, 2001; n=15; 30s of the subpraximal run for each test) • 30 seconds: SEM = 0.79 (0.49-1.16) • 60 seconds: SEM = 0.78 (0.50-1.12) • 90 seconds: SEM = 0.80 (0.51-0.99) • 120 seconds: SEM = 0.76 (0.47-0.93)			



Minimal Detectable Change (MDC)	Not reported		
Minimally Clinically Important Difference (MCID)	Not reported		
Cut-Off Scores	Not reported		
Normative Data	Not reported		
Test-retest Reliability	Frail older adults:		
	• (Mendelssohn et al, 2008)		
	• HR & METs ICC=0.85-0.91		
	Healthy adults:		
	• (Lamb et al., 1999) Test-retest reliability is variable in studies of		
	healthy subjects, with ICC values of 0.75-0.82		
	Not reported in stroke, however, one study (Eng et al, 2002; n=25; 4.4±3.0 yrs) assessed RPE in people with stroke at minute 6 during a 6-minute walk test and a 12-minute walk test in the same subjects, with almost identical mean values (11.6 and 11.7) for the 2 assessments, as would be expected if test-retest reliability was high		
Interrater/Intrarater Reliability	Interrater Reliability:		
	In Braille:		
	• (Buckley et al, 2000)		
	 interrater reliability: good 		
	Adolescent females:		
	• (Pfeiffer, 2002)		
	o ICC=0.78		
	Intrarater Reliability:		



Healthy subjects:

- (Eston et al, 2006)
 - Predicted VO2 max from RPE ICC 0.66-0.95
 - o No gender differences
- (Lamb et al, 1999)
 - o ICC = 0.75-0.82
- (Eston and Williams, 1988)
 - o Between trials ICC=0.83 or higher

Internal Consistency				
Criterion Validity (Predictive/Concurrent)	Concurrent Validity: (Eng et al., 2002; n=25; 4.4±3.0 yrs)			
	 RPE poorly correlated with 6 MWT and 12 MWT distance in people with stroke. (Tseng et al., 2010; n=21; 4.1±3.5 yrs) 			
	• Strong correlation between RPE and ratings of exertion fatigue on a visual analog scale following exercise (r=0.8, p=0.00) in people with stroke.			
	<u>RPE accross the Lifespan:</u>			
	(Groslambert and Mahon, 2006)			
	Children 3-7 years; poor			
	• 8-12 years; variable			
	• 13+ years similar to adults - good to excellent			
	• 50-65, >65 no significant age effect on validity			
	Criterion Validity:			



• Chen, et al 2002)

A meta-analysis of criterion-related validity between RPE and physiological measures in healthy individuals (mean age of subjects in studies was 32.7; range 9 to 75 years).

Heart	Blood	VO_{2max}	Ventilat	Resp
rate	lactate	or VO_2	ion	rate
0.47- 0.61	0.42- 0.69	0.31- 0.76	0.53	

Range of mean validity coefficients with RPE:

Strongest relationships were noted in highly fit male participants at high (maximal) exertion.

Predictive Validity

The RPE scale (with rating of 6 to 20) was developed so heart rate could be predicted by multiplying the RPE by 10 (Borg, 1982).

(Eng et al., 2002; n=25; 4.4±3.0 yrs)

In stroke, predicted HR based on RPE was significantly higher than the actual HR during 6 minute and 12 minute walk tests, and predicted and actual HR were not correlated

Construct Validity (Convergent/Discriminan t)	Not reported
Content Validity	Sage et al., 2013. 37 patients post-stroke (14.5 \pm 10.2 days post-stroke). Respiratory gas exchange was monitored for analysis of VO ₂ while completing a graded maximal exercise test, while HR and RPE (Borg CR10 Scale) were measured at the end of each minute. 76.2%, 69.0%, and 38.9% of participants fell into the expected RPE range at each intensity. RPE appears to be a reasonable indicator of exercise intensity after stroke at moderate (60%-70% VO _{2peak}) but not high intensity exercise (80% VO _{2peak}).
Face Validity	Not reported



Floor/Ceiling Effects	Not reported			
Responsiveness	Not reported			
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Stroke Taskforce (StrokEDGE II), are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-</u> section-outcome-measures-recommendations			
	Abbr	eviations:		
	HR	Highly Recommend		
	R	Recommend		
	LS / UR	Reasonable to use, but limited study in target group / Unable to Rec		
	NR	Not Recommended		

Recommendations for use based on acuity level of the patient:

	Acute (CVA < 2 months post)	Subacute (CVA 2 to 6 months)	Chronic (> 6 months)
StrokEDGE II	NR	R	R

See considerations below.

Recommendations based on level of care in which the assessment is taken:

Acute Care	Inpatient Rehabilitat ion	Skilled Nursing Facility	Outpatient Rehabilitat ion	Home Health
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StrokED GE II	R	R	R	R	R
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See considerations below.

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administ er this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokED GE II	No	Yes	No	Yes

See considerations below.

Considerations	This test of perceived exertion may give useful information about fatigue during an activity, but lack of established research on test-retest reliability and low validity to physiologic measures are significant concerns. The research indicates that this scale may not be appropriate as an outcome measure, may not be useful as a substitute for other measures of endurance, and may not be appropriate to guide exercise prescription in people with stroke. Not recommended except as a measure of perceived fatigue during an activity Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u> !
Bibliography	 Eng JJ, Chu KS, Dawson AS, Kim CM, Hepburn KE. Functional walk tests in individuals with stroke: Relation to perceived exertion and myocardial exertion. <i>Stroke.</i> 2002;33:756-761. Find it on PubMed Lamb K, Eston R, Corns D. Reliability of ratings of perceived exertion during progressive treadmill exercise. <i>Br J Sports Med.</i> 1999;33(5):336- 339. Find it on PubMed Tseng BY, Gajewski BJ, Kluding P. Reliability, responsiveness, and validity of the Visual Analog Fatigue Scale to measure exertion fatigue in



	people with chronic stroke: A preliminary study. <i>Stroke Res Treat.</i> 2010;2010:7 pages. Find it on PubMed
	Chen M, Fan X, Moe S. Criterion-related validity of the Borg rateings of perceived exertion scale in healthy individuals: a meta-analysis. <i>J Sports Sci.</i> 2002;20:873-899. Find it on PubMed
	Borg G. Pyschophysical bases of perceived exertion. <i>Med Sci Sports Exerc.</i> 1982;14(5):377-381. Find it on PubMed
	Sage et al., 2013. Validity of Rating of Perceived Exertion Ranges in Individuals in the Subacute Stage of Stroke Recovery. Top Stroke Rehabil 20(6): 519-527. Find it on PubMed
Year published	1982
Instrument in PDF Format	Yes
Approval Status	Pending



25. REHAB MEASURES: RIVERMEAD Somatosensory Performance Assessment

Instrumen t	
Title of Assessme nt	Rivermead Assessment of Somatosensory Performance
Acronym	RASP
Instrumen t Reviewer(s)	Initial review completed by Jane Sullivan, Co-Chair of the Neurology Section's StrokEdge Task Force; Updated by Dorian Rose, Co-Chair of the Neurology Section's StrokEdge II Task Force
Summary Date(s)	9/29/2015; 1/21/17
Purpose	The RASP is a multi-modal sensory tool that tests 6 sensations (sharp/dull discrimination, surface pressure, tactile localization, temperature discrimination, joint movement and joint movement direction discrimination), and 2 secondary sensations (sensory extinction and two-point discrimination).
Descriptio	 Sharp/dull discrimination: each Neurometer (one with sharp; one with dull Neurotip end showing) is applied to the test area in a pseudo-randomized order. A total of 60 trials are administered to 10 test regions. Twenty sham trials are given, two for each area. (The sham consists of the examiner moving the Neurometer to within 6 in of the patients' skin surface and making the same audible sound with the instrument by applying it to his/her own hand. Surface pressure touch: One Neurometer is set to Level 1 (15.5 g pressure) and is applied to designated testing areas for a total of 60 trials. Twenty sham trials are also included. Surface localization: Using one Neurometer (Level 1; 15.5 g), the subject is requested to identify designated areas on their body where they have been touched. Temperature discrimination: The Neurotemps are prepared prior to testing to ensure that the temperature settings are at the warmest of coolest end of the designated temperature window for each instrument. The patient indicates "warm" or "cold" when touched. Joint movement: Examiner moves the following joints up and down in a random sequence: elbow thumb or finger, ankle, toe. Each joint 1 is moved six times. The examiner first evaluates subject's appreciation of limb position movement by asking the patient to indicate if a passive movement to Joint movement discrimination: Then the patient is asked to indicate "up" or "down." Bilateral touch discrimination (sensory extinction): Two Neurometers (Setting 2; 67.5 g) are applied simultaneously and then separately to homologous testing areas on the hand or face. The patient is told they may feel either both areas touched together or a touch on the left or a touch on the right. They are requested to indicate what they feel. Two-point discrimination: The Neurodisc is applied to the apds of the fingertips, perpendicular to the skin surface and depressed by approximately 1 mm briefly, bef
Area of Assessme nt	Sensation
Body Part	Sensation is tested on the face, hand and foot (10 test regions, 5 of left; 5 on right side of body).
ICF Domain	Body Structure/Function
Domain	Sensation
Assessme nt Type	Performance Measure



Length of Test	20-45 minutes depending on the client's level on sensory deficit
Time to Administer	20-45 minutes depending on the client's level on sensory deficit
Number of Items	Eight items
Equipment Required	 In an effort to improve reliability of sensory testing, custom equipment were developed for the test: "Neurometer" – a pen shaped device that allows consistent amount of pressure to be applied to an area, "Neurotemp" which has temperature displays standardization of temperature stimuli, and the
	 "Two-point neurodiscriminator" - a 4-pointed fixed distance discriminator used to test 2- point discrimination on the finger pads
Training Required	No training
Type of Training Required	No training
Cost	£199.75 (Thames Valley Test Company)
Actual Cost	£199.75
Age Range	Adult
Administra tion Mode	Paper & Pencil
Diagnosis	Stroke
Population s Tested	Stroke
Standard Error of Measurem ents (SEM)	Not reported
Minimal Detectable Change (MCD)	Not reported
Minimally Clinically Important Difference MCID)	Not reported
Cut-Off Scores	 Winward et al 2002: Suggested impairment cut-off determined from testing 50 control participants. Sharp/dull discrimination: less than 22 Surface touch: less than 29 Surface localization: less than 28 Two-point discrimination: N/A Temperature discrimination: less than 25 Proprioceptive Movement discrimination: less than 28 Proprioceptive direction discrimination: less than 28
Normative Data	Winward et al 2002: Data from 50 control participants



	 Mean±SD (Range) provided Sharp/dull discrimination: Left Side (26.6±2.6;18-30) Right Side (26.5±2.5; 21-30) Surface touch: Left Side (29.9±0.3;28-30) Right Side (29.9±0.7; 25-30) Surface localization: Left Side (29.9±0.4;18-30) Right Side (29.8±1.1; 22-30) Two-point discrimination: Right Hand – 3mm: n=16, 4mm: n=18, 5mm: n=14; Left Hand – 3mm: n=16, 4mm: n=15, 5mm: n=16 Temperature discrimination: Left Side (28.4±1.7;24-30) Right Side (28.6±1.8; 23-30) Proprioceptive Movement discrimination: Left Side (29.9±0.8;24-30) Right Side (30±0.1; 29-30) Proprioceptive direction discrimination: Left Side (29.8±0.9;24-30) Right Side (29.8±0.9; 24-30)
Test- Retest Reliability	 Sub-Acute Stroke: (Winward et al 2002; n=100; 4-6 weeks post-stroke) Total RASP score: Pearson correlation, r=0.92 Sharp/dull subtest: Pearson correlation, r=0.84 Surface pressure touch subtest: Pearson correlation, r=0.90 Surface localization subtest: Pearson correlation, r=0.96 Temperature subtest: Pearson correlation, r=0.84 Proprioceptive movement subtest: Pearson correlation, r=0.83 Proprioceptive direction subtest: Pearson correlation, r=0.50
Interrater /Intrarate r Deliability	 Sub-Acute Stroke: (Winward et al 2002; n=100; 4-6 weeks post-stroke) Total RASP score: Pearson correlation, r=0.92
Internal Consistenc y	Not reported
Criterion Validity (Predictive /Concurre nt)	Sub-Acute Stroke : (Winward et al 2002; n=100; 4-6 weeks post-stroke) Motricity Index and proprioception movement: Spearman r=0.31; (p<0.01) Motricity Index and proprioception direction detection: Spearman r=0.36; (p<0.01) Barthel Index and proprioception movement: Spearman r=0.35; (p<0.01) Barthel Index and proprioception direction detection: Spearman r=0.41; (p<0.01)
Construct Validity (Converge nt/Discrim inant)	Sub-Acute Stroke : Winward et al 2002 Discriminated significantly between people with (n=100; 4-6 weeks post-stroke) and without (n=50) brain damage (p < 0.001).
Content Validity	Not statistically established; all sub-tests are drawn from traditional clinical tests.
Face Validity	Not statistically established; all sub-tests are drawn from traditional clinical tests.
Floor/Ceili ng Effects	Not reported
Responsiv eness	Not reported
Profession al Associatio n	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Stroke Taskforce (StrokEDGE, StrokEDGE II), These



Recommendations were developed by a panel of research and clinical experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-</u> recommendations

Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCl < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	NR	NR	NR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Healtl
StrokEDGE II	NR	NR	NR	NR	NR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warrante for this tool (Y/N)
StrokEDGE II	No	No	Yes	Yes



Considerat ions	The need for customized equipment and its length limits the clinical utility of this test.
Bibliograp hy	 Winward CE, Halligan PW, Wade DT. The Rivermead Assessment of Somatosensory Performance (RASP): standardization and reliability data. <i>Clinical Rehabilitation</i>. 2002;16(5):523-533. "Find it on PubMed" Winward CE, Halligan PW, Wade DT. Rivermead Assessment of Somatosensory Performance. Suffolk, England: Thames Valley Test Company Limited; 2000.
Year Published	2002
Instrumen t in PDF Format	No
Approval Status	



26. REHAB MEASURES: RIVERMEAD Motor Assessment

Link to instrument	
Title of Assessment	Rivermead Motor Assessment
Acronym	RMA
Instrument Reviewer(s)	Originally reviewed by the StrokEDGE Task Force Updated by Heather Anderson and Rie Yoshida of the StrokEdge II Task Force.
Summary Date	4/11/16
Purpose	Assesses functional mobility following stroke (e.g., gait, balance, and transfers).
Description	 RMA is a performance-based measure developed specifically for the stroke population with the intent to be used for both the clinic and research purposes. Consists of 3 sections: gross function (RMA-gf), leg and trunk (RMA-lt), and the arm (RMA-a). Each item is scored either yes '1' or no'0'. It is based on Guttman scaling, which presumes that each subsequent item is of a more difficult nature. To advance to the next question, one must score "1" on an item, otherwise the test is stopped.
Area of Assessment	Gross function, leg and trunk, arm
Body Part	Upper extremity, trunk, lower extremity
ICF Domain	Activity
Domain	Motor



Assessment Type	Observer
Length of Test	
Time to Administer	45 minutes, less with more involved patients
Number of Items	RMA-gf consists of 13 items, RMA-lt 10 items, and RMA-a 15 items.
Equipment Required	 Block of 20 cm height Pencil Volleyball Tennis ball Piece of paper Fork and knife Plate and container (use box of putty as container) Beanbag Cord Putty Watch with chronometer Non-slip mat
Training Required	None Necessary
Type of training required	No Training
Cost	
Actual Cost	Cost of equipment
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Stroke



Populations Tested	Stroke
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established
Minimally Clinically Important Difference (MCID)	Collen et al. (1990) found that a 3 point change in the total RMA score represented a clinically meaningful change.
Cut-Off Scores	Not Established
Normative Data	Not Established
Test-retest Reliability	 Stroke: (Lincoln and Leadbitter 1979) Adequate test-retest reliability RMA-gf r=0.66 RMA-lt r=0.93 RMA-a r=0.88
Interrater/Intra rater Reliability	Not Established
Internal Consistency	 Subacute Stroke: (Kurtais et al. 2009; n = 107; mean age = 62.4 (12.8) years; mean time since onset = 5.6 (SD = 11.2, range = 0.5-78) months; patients in inpatient rehabilitation unit) Good internal consistency RMA-gf - Cronbach's a= 0.93, ICC=0.88 RMA-lt - Cronbach's a= 0.88, ICC=0.84 RMA-a - Cronbach a= 0.95, ICC=0.93



Criterion	Concurren	Concurrent Validity						
Validity (Predictive/ Concurrent)	Brain Injur	Brain Injury: (Endres, et al. 1990)						
	•	 RMA has excellent correlation with BI across each assessment period initial (r=0.84), one month (0.78), and one year (0.63). 						
	Chronic St	r <u>oke</u> : (Rous	seaux et al, 2	012; <i>n</i> = 46;	; 14.1 <u>+</u> 25.	9 mo after st	roke)	
	Excelle correla Gross I	e nt validity ation of Glol Motor Asse	with Upper L bal Question ssment (RMA	imb Assessr naire (Q) an Ascore) (r =	ment in Dai d Test scor 0.80 and 0.	ly Living (ULA es (T) with Ri 88, respectiv	ADL): vermead vely; p < 10 ⁻⁴)	
	Predictive	Validity						
	Collin and prognosis t	Wade (1990 to ambulate)): low RMA s e.	scores at 6 v	veeks post	stroke predio	cted poor	
Construct Validity (Convergent/ Discriminant)	Acute to So High conver- • Subacute So time since rehabilitati Moderate	ubacute Str ergent validi 7-10 days 3 months Stroke: (Kur onset = 5.6 ion unit) to high ext Admissio	oke: (Soyuer ity between t post stroke: post stroke: tais et al. 200 (SD = 11.2, r ernal constr	and Soyue otal RMA and r = 0.87 for r = 0.88 for 09; <i>n</i> = 107; ange = 0.5-7 uct validity	r 2005) nd FIM total FIM, r total FIM, r mean age = 78) months, when comp	= 0.90 for m = 0.89 for m = 62.4 (12.8) ; patients in i pared to FIM	otor FIM otor FIM years; mean npatient score	
		Admissio			Discharge			
		Motor	Care	Mobility	Motor	Care	Mobility	
	RMA-of	0.865	0.815	0.844	0.820	0.757	0.817	
	RMA-lt	0.784	0.726	0.782	0.747	0.702	0.764	
	RMA-a	0.386	0.390	0.386	0.467	0.480	0.483	
	Spearman	r, <i>p</i> <0.001						

<u>Acute-Subacute Stroke</u>: (Houwink et al. 2011; n = 21; mean age = 61.7 ± 7.9 years; time since stroke onset = within 4 months; only used RMA-a)



	 Strong cross-sectional correlation of RMA-a with SULCS (Stroke Upper Limb Capacity Scale) with ρ = 0.85 Moderate longitudinal correlation of RMA-a with SULCS (ρ = 0.48) 				
Content Validity	Not Established				
Face Validity	Not Established				
Floor/Ceiling Effects	TBI: Williams et al. 2006 A large ceiling effect was noted on the Gross Motor Function Subscale of the RMA when compared to HIMAT				
Responsiveness	 Subacute Stroke: (Kurtais et al. 2009; n = 107; mean age = 62.4 (12.8) years; mean time since onset = 5.6 (SD = 11.2, range = 0.5-78) months; patients in inpatient rehabilitation unit) Good sensitivity RMA-gf ES = 0.51, SRM = 0.83 RMA-lt ES = 0.45, SRM = 0.86 RMA-a ES = 0.61, SRM = 1.20 				
Professional Association Recommendati ons	Recomme Physical TH (StrokEDG of research For detaile visit: <u>http</u> outcome-r	ndations for use of the instrument from the Academy of Neurologic herapy of the American Physical Therapy Association's Stroke Taskforce E II) are listed below. These recommendations were developed by a panel h and clinical experts using a modified Delphi process. ed information about how recommendations were made, please ://www.neuropt.org/go/healthcare-professionals/neurology-section- measures-recommendations			
	Abbreviations:				
	HR	Highly Recommend			
	R	Recommend			
	LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend			
	NR	Not Recommended			



Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
StrokEDGE II	R	R	R

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilita tion	Skilled Nursing Facility	Outpatient Rehabilitat ion	Home Health
StrokEDGE II	NR	R	R	R	NR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
Strok EDGE II	No	Yes	Yes	Yes

Considerations

•

Used extensively in research and clinic, primarily in Europe.



	 Designed for the stroke population and used primarily with that population. Gross motor section has been used with TBI and the elderly to a lesser extent. Several studies have noted that their results show the actual hierarchy of the test items to be different from the original test. Therefore, when administering the test, it is recommended that all items be tested rather than stopping the arm or gross functions test when 3 consecutive items are scored a "0", as originally instructed. 				
	Do you see an error or have a suggestion for this instrument summary? Please <u>e-</u> <u>mail us</u> !				
Bibliography	Collen FM, Wade DT, Bradshaw CM. Mobility after stroke: reliability of measures of impairment and disability. Int Disabil Stud. 1990; 12:6-9.				
	Collin, C., Wade, D. (1990). Assessing motor impairment after stroke: A pilot reliability study. Journal of Neurology, Neurosurgery, and Psychiatry, 53, 576-579.				
	Endres, M., Nyary, I., Banhidi, M., Deak, G. (1990). Stroke rehabilitation: A method and evaluation. International Journal of Rehabilitation Research, 13, 225-236.				
	Houwink A, Roorda LD, Smits W, Molenaar IW, Geurts AC. Measuring upper limb capacity in patients after stroke: reliability and validity of the stroke upper limb capacity scale. Archives of physical medicine and rehabilitation. 2011 Sep;92(9):1418-22.				
	Kurtais Y, Kucukdeveci A, elhan A, et al. Psychometric properties of the Rivermead Motor Assessment: its utility in stroke. J Rehabil Med 2009; 41: 1055-61.				
	Lincoln N, Leadbitter D. Assessment of moto function in stroke patients. Physiotherapy 1979; 65: 48-51.				
	Rousseaux M, Bonnin-Koang HY, Darne B, et al. Construction and pilot assessment of the Upper Limb Assessment in Daily Living Scale. Journal of neurology, neurosurgery, and psychiatry. 2012 Jun;83(6):594-600.				
	Soyuer F,Souyuer A. Ischemic stroke: Motor impairment and disability with relation to age and lesion location (Turkish). Journal of Neurological Sciences, 22(1), 43-49. (source: StrokEngine)				
	Van de Winckel Ann; Feys Hilde; Lincoln Nadina; De Weerdt Willy. Assessment of arm function in stroke patients: Rivermead Motor Assessment arm section revised with Rasch analysis. Clin Rehabil 2007; 21: 471-9.				
	Williams, G., Robertson, V., Greenwood, K., Goldie, P., Morris, M. E. The concurrent validity and responsiveness of the high-level mobility assessment tool for measuring				



	the mobility limitations of people with traumatic brain injury. Archives of Physical Medicine and Rehabilitation 2006; 87(3), 437-442.
Year published	1991
Instrument in PDF Format	Yes
Approval Status	Approved



27. REHAB MEASURES DATABASE—SATISFACTION WITH LIFE SCALE

Link to instrument	SWLS is available on Dr. Ed Diener's webiste				
Title of Assessment	Satisfaction With Life Scale				
Acronym	SWLS				
Instrument Reviewer(s)	Initially reviewed by Susan Deems-Dluhy, PT, NCS in 7/2011; Updated by Anna de Joya, PT, MS, NCS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 5/2012; reviewed by Rie Yoshida and Heather D Anderson 4/11/16 and the Stroke Edge II Task Force				
Summary Date	4/11/16				
Purpose	A subjective quality of life measure designed to measure global life satisfaction, a subjective cognitive assessment, in contrast to an objective quality of life survey (e.g. Sickness Impact Profile, Short Form-36).				
Description	 The SWLS contains five statements about life satisfaction: three set in the present, one in the past, and one in the future Can be self-administered or completed by interview 7-point Likert scale from "strongly disagree" to "strongly agree", 5 items: In most ways my life is close to my ideal The conditions of my life are excellent I am satisfied with my life So far I am getting the important things I want in life If I could live my life over, I would change almost nothing Translated in a number of languages. Scoring: Global score is computed Higher scores indicate better health Scores range from 5 to 35 A score of 20 represents a neutral point at which the respondent is equally satisfied and dissatisfied 				
Area of Assessment	Life Participation; Quality of Life				
Body Part	Not Applicable				
ICF Domain	Participation				



Domain	
Assessment Type	Performance Measure
Length of Test	05 Minutes or Less
Time to Administer	Less than 5 minutes
Number of Items	5
Equipment Required	Survey form
Training Required	No training
Type of training required	no training
Cost	Free
Actual Cost	Free
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Geriatrics; Spinal Cord Injury; Traumatic Brain Injury
Populations Tested	 General and student populations Patients with: spinal cord injury, traumatic brain injury
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established
Minimally Clinically Important Difference (MCID)	Not Established
Cut-Off Scores	Not Established
Normative Data	 Traumatic Brain Injury: (Corrigan et al, 1998; n = 95 adults with traumatic brain injuries, 6 months to 5 years after inpatient rehabilitation; mean age = 32.4 years) Mean score of 19.0 (7.6) Time post-injury was significantly associated with higher SWLS total score



<u>Undergraduate students</u>: (Diener et al, 1985; n = 176 undergraduates at University of Illinois who were enrolled in psychology classes)

• Mean score of 23.5 (6.43)

<u>Cross-sectional assessment of the SWLS</u>: (Durak et al, 2010; study assessed difference in life satisfaction between three groups; n = 547 university students, n = 166 correctional officers, n = 123 elderly persons; mean age = 68.18 (5.10) years; for the elderly population 2 reported their health as "very poor", 10 as "poor", 51 as "average", 46 as "well" and 14 as "very well"; Turkish sample)

	SWLS Item Level Norms								
			Item #	Mean	SD	ITC*			
			1	4.77	1.80	0.68			
			2	4.82	1.72	0.78			
			3	5.18	1.58	0.70			
			4	4.91	1.70	0.78			
			5	4.14	2.11	0.72			
			All Items	23.8	7.44				
			* ITC item	total	corre	lation			
		SWLS and	Other Maj	jor Lif	e Ou	tcome	es:		
		Scale			R	ange	Mean	SD	
		SWLS			5	to 35	23.82	7.44	
		Self esteem	1		10) to 50	36.94	6.84	
		Perceived c	urrent heal	th stat	us 1	l to 5	3.49	0.86	
		Late-life de	pression		0	to 30	11.13	5.70	
Test-retest Reliability	Unde •	Adequate Stuc	<u>lents</u> :(Diener e ro month test-re	et al, 1985 etest relia	5) bility (I	CC = 0.8	32) n 20 o	Idor	
	mem male stude	bers of the Char s, 23 females; S ents; sex = 51 m	npaign-Urbana tudy 2: $n = 125$ ales, 85 female	commur 5 Univers s)	nity; me ity of II	ean age =	n = 39 0 = 74 (8.97 Champaiç); sex = jn-Urba	= 16 ana
	•	Excellent ov Study 2: Exc	erall test-retest :ellent test-rete	reliability est reliabi	/ (ICC lity (IC	= 0.83) C = 0.84))		
	<u>Spin</u> meas	<u>al Cord Injury</u> : (sures)	(Hill et al, 2010	; <i>n</i> = 14 a	articles	reporting	g on 13 Q	OL	



	Poor two week test-rete	est reliability (ICC = 0.39	- 0.65)		
Interrater/Intrarat er Reliability	General population: (Pavot et al, 1993; A review of the SWLS)				
	Adequate to Excellent	item total correlations (0	.51 - 0.8)		
Internal Consistency	Undergraduate students: (Die	ner et al, 1985)			
	Adequate to Excellent 0.89)	internal consistency (Ch	ronbach's alpha = 0.61 -		
	 <u>Cross-sectional assessment of the SWLS</u>: (Durak et al, 2010; only assessing internal consistency for elderly respondents) <u>Adequate internal consistency</u> (Chronbach's alpha = 0.72) 				
Criterion Validity	Traumatic Brain Injury: (Hanks	s et al, 2008; <i>n</i> =174 who	o met criteria for		
(Predictive/Concur rent)	admission to inpatient brain injury rehabilitation; mean age = 38.15 (18.07) years)				
	• Poor predictive validity for quality of life 1 year post-injury				
Construct Validity (Convergent/Discri minant)	 <u>Undergraduate students</u>: (Dientified of the students) Adequate correlation with the students of the student	ner et al, 1985) rith Life Satisfaction Inde: rith interviewer (<i>r</i> = 0.43)	x (<i>r</i> = 0.46)		
	Correlations between the SW	LS and other measures	s of subject well-being:		
		Sample 1 (<i>n</i> = 176)	Sample 2 (<i>n</i> = 163)		
	Fordyce 1	0.58 (Adequate)	0.57 (Adequate)		
	Fordyce (%)	0.58 (Adequate)	0.62 (Excellent)		
	DPQ	0.68 (Excellent)			
	Cantril	0.62 (Excellent)	0.66 (Excellent)		
	Gurin	0.59 (Adequate)	0.47 (Adequate)		
	Andrews and Withey	0.68 (Excellent)	0.62 (Excellent)		
	Campbell	0.75 (Excellent)	0.59 (Adequate)		
	Bradburn-PAS	0.50 (Adequate)	0.51 (Adequate)		
	Bradburn-NAS	0.37 (Adequate)	-0.32 (Adequate)		
	Summed Domain Satisfaction		0.57 (Adequate)		
	AIM	0.09 (Poor)			



	DPQ= Differ = Negative A administered satisfaction i	ential Personality Questionnaire. PAS = Positive Affect Scale. NAS Affect Scale. AIM = Affect Intensity Measure. Sample 2 was not d to the the DPQ or AIM, and Sample1 did not complete the domain tems
	Elderly: (Par • Ade	vot et al, 1991) quate convergent validity with Life Satisfaction Index (<i>r</i> = 0.81)
Content Validity	Not Establish	ned
Face Validity	Spinal Cord	Injury: (Hill et al, 2010)
	Leve relate	I of injury, number of hospitalizations and number of pressure ulcers ed to life satisfaction ($p < 0.05$), but completeness of injury did not
Floor/Ceiling Effects	Traumatic B	a rain Injury: (Corrigan et al, 1998)
	Mean incre	n score declines at year 1 post injury with a subsequent gradual ease over five years post injury
Responsiveness	Not Establish	ned
Professional Association Recommendations	Recommend Physical The Sclerosis Tas Injury Taskfo Injury Taskfo below. These clinical exper	ations for use of the instrument from the Academy of Neurologic arapy of the American Physical Therapy Association's Multiple skforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord arce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain arce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed are recommendations were developed by a panel of research and ts using a modified Delphi process.
	For detailed visit: http://w outcome-me	information about how recommendations were made, please www.neuropt.org/go/healthcare-professionals/neurology-section- asures-recommendations
	Abbreviati	ons:
	HR	Highly Recommend
	R	Recommend
	LS/UR	Reasonable to use, but limited study in target group / Unable to Recommend



INK	

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Not Recommended
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Recommendations for use based on acuity level of the patient:

	Acute (CVA < 2 months post) (SCI < 1 month post) (Vestibular < 6 weeks post)	Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	Chronic (> 6 months)
SCI EDGE	LS	LS	R
StrokEDGE II	UR	UR	UR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
StrokEDGE II	UR	UR	UR	UR	UR
TBI EDGE	NR	NR	NR	LS	LS

Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	R	R

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant
TBI EDGE	N/A	N/A	N/A

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
SCI EDGE	No	Yes	Yes	Not reported
StrokEDGE II	No	No	No	Not reported
TBI EDGE	No	Yes	Yes	Not reported

Considerations

• Not recommended for use as a physical therapy outcome measure at this time; may be useful as a team screening tool

- Studied mainly in general population
- Some questions may be inappropriate in rehab population

Do you see an error or have a suggestion for this instrument summary? Please e-mail us!



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	Pavot, W. and Diener, E. (1993). "Review of the satisfaction with life scale." Psychological Assessment 5(2): 164.
	Pavot, W., Diener, E., et al. (1991). "Further validation of the Satisfaction with Life Scale: evidence for the cross-method convergence of well-being measures." J Pers Assess 57(1): 149-161. Find it on PubMed
Year published	1985
Instrument in PDF Format	Yes
Approval Status	Approved



28. REHAB MEASURES DATABASE—SHORT FORM 36

Link to instrument	Available for purchase at SF-36.org (external link)
Title of Assessment	Medical Outcomes Study Short Form 36
Acronym	SF-36; SF-36v2
Instrument Reviewer(s)	Initially reviewed by the Rehabilitation Measures Team; Updated by Wendy Romney, PT, DPT, NCS, Cara Weisbach, PT, DPT, and the SCI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012; Updated by Sue Saliga PT, DHSc, CEEAA and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012. Updated by Erin Hussey, PT, DPT, MS, NCS and Cathy Harro PT, PhD and the PD EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2013. Updated by Melissa Eden, PT, DPT, OCS in 2014. Updated by Carmen Capo-Lugo, PT, PhD and Dorian Rose PT, PhD of the STROKEdge II task force in 2016.
Summary Date	9/20/2015; 10/2/2016
Purpose	The SF-36 is a generic patient-reported outcome measure aimed at quantifying health status, and is often used as a measure of health-related quality of life.
Description	36 item measure divided into 8 subscales and 2 composite domains The 8 subscales are:
	(1) Physical Functioning
	(2) Role Limitations due to Physical Problems
	(3) General Health Perceptions
	(4) Vitality
	(5) Social Functioning
	(6) Role Limitations due to Emotional Problems
	(7) General Mental Health
	(8) Health Transition
	Respondents are asked to answer items referring to the past 4 weeks



	Recommended scoring system for the SF-36 is a weighted Likert system for each item
	Items within subscales are totaled to provide a summed score for each subscale or dimension.
	Each of the 8 summed scores is linearly transformed onto a scale from 0 (negative health) to 100 (positive health) to provide a score for each subscale. Each subscale can be used independently.
	For each domain (physical and mental composite) mean score = 50 and standard deviation = 10
	Version 2 norms are based on the 1998 National Survey of Functional Health Status (NSFHS); more information on version 2 can be found on the SF-36 website: http://www.sf-36.org/tools/sf36html
Area of Assessment	Activities of Daily Living; Quality of Life
Body Part	Not Applicable
ICF Domain	Body Function; Activity; Participation
Domain	ADL; General Health
Assessment Type	Patient Reported Outcomes
Length of Test	06 to 30 Minutes
Time to Administer	10 minutes; 41 and 47 minutes, respectively, for individuals with paraplegia & tetraplegia (Anderson, et al 1999)
Number of Items	36
Equipment Required	Suggests enlarged copy of item response options (Steffen & Seney 2008)
Training Required	Acquire and reading manual needed for item administration and scoring.
Type of training required	No Training



Cost	Not Free
Actual Cost	Contact QualityMetric Incorporated for information regarding licensing fees for your institution.
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Arthritis; Cardiac Conditions; Geriatrics; Multiple Sclerosis; Pain; Spinal Cord Injury; Stroke; Traumatic Brain Injury
Populations Tested	The following conditions each have 50 or more publications (Turner-Bowker et al, 2002):
	Arthritis
	Back pain
	Cancer of the Head & Neck
	Low back pain
	Multiple sclerosis
	Musculoskeletal conditions
	Neuromuscular conditions
	Osteoarthritis
	Parkinson Disease
	Rheumatoid arthritis
	Spinal injuries
	Stroke
	Trauma
	Traumatic Brain Injury (Nichol et al, 2011)
Standard Error of Measurement (SEM)	Not Established



Minimal	Parkinsonism (included Parkinson Disease and Parkinson-plus syndromes):				
Detectable Change (MDC)	(Steffen & Seney, 2008; n (12); mean disease duration = 2 (range = 1 to 4); Stage test-retest by same rater a interview.	= 37 (PD n = 35, Pa on = 14 (6) years; F 1: n = 3, Stage 2: r at 1-week interval;	arkinson-Plus n = 2); mean age = 71 Ioehn and Yahr stages median score n = 7, Stage 3: n = 9, Stage 4: n = 8; Administered SF-36 by direct		
	MDC-95 for each subscale	e of SF-36 (V1)	1		
	SF-36 Subscale	MDC95			
	Physical Functioning	28	-		
	Role limits - Physical	45	-		
	Bodily pain	25	-		
	General health	28			
	Vitality	19			
	Social functioning	29			
	Role limits - emotional	45			
	Mental health	19			
Minimally Clinically Important Difference (MCID)	Not Established				
Cut-Off Scores	Not Applicable				
Normative Data	Parkinson Disease:				
	(Banks and Martin, 2009; n = 339 with PD (164 male; 179 female); mean age = 54.6 (range 27-75); Version 2 of SF-36; tested multiple configurations to determine recommended model for use and if this scale useful for PD. Identified 8 subscales and 6 models: physical functioning [1], role-physical [2], bodily pain [3], general health [4], vitality [5], social functioning [6], role-emotional [7] and mental health [8]. Compared various models of subscale combinations and assessments and compared against typical recommendation that summary measures of physical health (scales 1–4) and mental health (scales 5–8) can also be calculated and used independently.)				



SF-36 subscale scores	Mean	SD
Physical functioning	44.03	26.44
Role–physical	25.41	34.24
Bodily pain	50.22	34.24
General health	44.08	20.89
Vitality	36.08	20.12
Social functioning	57.05	25.81
Role–emotional	47.81	44.03
Mental health	61.10	19.57

(Leonardi et al, 2012. N = 96 (64 male); mean age = 64.1 (11.3; range 24-90); 74% were married; 79.2% were not employed; Hoehn & Yahr stages: 1 = 13, 2 = 55, 3 = 22, 4 = 6. Compared to normative data from general Italian population.)

	Mean score (SD)	Normative data	t-test	P-value
SF-36 (v2)				
Physical Functioning	72.0 (22.6)	84.46	-5.04	P < 0.001
Role Physical	46.9 (38.9)	78.21	-7.88	P < 0.001
Bodily Pain	58.9 (29.9)	73.67	-4.83	P < 0.001
General Health	41.2 (20.5)	65.22	-11.44	P < 0.001
Vitality	56.7 (20.1)	61.89	-2.52	P = 0.013
Social Functioning	69.2 (27.6)	77.43	-2.93	P = 0.004
Role Emotional	68.4 (40.3)	76.16	-1.88	P = 0.063
Mental Health	64.6 (19.6)	66.50	-0.94	P = 0.350
PCS	40.0 (8.8)	50	-11.09	P < 0.001



MCS	46.7 (11.0)	50	-2.90	P = 0.005

Chronic Stroke:

(Anderson et al, 1996; n = 90; mean age = 72 (12) years; assessed 1 year post stroke; Australian version)

SF-36 Domain	Mean	SD
Physical functioning	48	33
Role limits–physical	76	34
Bodily pain	76	28
General health	64	22
Vitality	56	20
Social functioning	86	23
Role limits-emotional	83	31
Mental health	77	22

Chronic Spinal Cord Injury:

(Forchheimer et al, 2004; n = 215, mean age = 38.8 years; assessed > 1 year post traumatic SCI)

SF-36 Domain	Mean	SD
Physical functioning	26.6	11.5
Role Physical	40.7	10.9
Bodily pain	42.2	12.4
General Health	44.4	11.8
Vitalitiy	46.8	9.6
Social Functioning	43.0	13.3
Role Emotional	49.0	10.6



Mental Health	48.3	11.0
Physical Component Summary	33.5	10.1
Mental Component Summary	53.5	11.6
TBI:		

(Colantonio et al., 1998; n = 51; mean age = 18.28 (2.04) years; assessed 5 years post TBI)

	Mild (n :	= 24)	Moderate / Severe (n = 27)	
	Mean	SD	Mean	SD
Physical Functioning	84.91	22.02	75.43	35.43
Role Limits– physical	79.17	36.94	75.32	37.01
Bodily Pain	77.40	19.29	81.44	17.89
General Health	63.98	26.74	68.33	22.74
Vitality	53.54	9.83	52.90	13.79
Social Functioning	72.92	27.25	73.15	27.23
Mental Health	46.50	16.42	46.67	17.40
Role Limits– mental health	81.94	32.57	75.64	38.36

Mild Traumatic Brain Injury:

(Emanuelson et al, 2003; n = 117, patients assessed at 3 months post injury and n = 101, patients assessed 1 year post injury; age = 16-60)

Domain	Patients 3	Patients 1 Year	Mean	SD	Median	Minimum	Maximu
in SF-36	Months (n =	(n = 101)					
	117) Mean,	Mean, SEM,					
	SEM, median	median					
PF	85.4 (1.9), 95	87.5 (2.1), 95	0.85	12.93	0.00	-35.00	60.00



RF	72.5 (3.5), 100	74.7 (3.8), 100	-0.42	30.07	0.00	-100.00	100.00
BP	66.7 (3.0), 72	72.2 (3.1), 74	1.31	25.52	0.00	-69.00	69.00
GH	68.3 (2.4), 72	70.9 (2.5), 72	0.78	17.67	0.00	-52.00	48.00
VT	59.3 (2.4), 60	62.3 (2.6), 65	1.86	19.97	0.00	-70.00	60.00
SF	81.6 (2.5), 100	83.2 (2.4), 100	-0.12	20.35	0.00	-62.50	50.00
RE	72.7 (2.4), 80	77.2 (3.7), 100	3.00	33.87	0.00	-100.00	100.00
MH	71.2 (2.4), 80	74.9 (2.2), 84	1.74	17.87	0.00	-48.00	56.00
PCS	48.4 (1.2), 52	49.1 (1.1), 52	-0.02	6.80	-0.06	-23.16	18.94
MCS	44.8 (1.2), 48	46.5 (1.3), 51	1.09	10.43	0.47	-36.97	36.67

PF =physical functioning, RF =role physical, BP =bodily pain, GH =general health, VT =vitality, SF = social functioning, RE =role emotional, MH =mental health, PCS =physical composite score, MCS =mental composite score.

Mild Traumatic Brain Injury:

(Emanuelson et al, 2003; n = 117, patients assessed at 3 months post injury and n = 101, patients assessed 1 year post-injury; age = 16-60)

Domain in SF-36	Patients 3 Months (n = 117) Mean, SEM, median	Patients 1 Year (n = 101) Mean, SEM, median
Physical Function	85.4 (1.9), 95	87.5 (2.1), 95
Role Functioning:Physical	72.5 (3.5), 100	74.7 (3.8), 100
Bodily Pain	66.7 (3.0), 72	72.2 (3.1), 74
General Health	68.3 (2.4), 72	70.9 (2.5), 72
Vitality	59.3 (2.4), 60	62.3 (2.6), 65
Social Functioning	81.6 (2.5), 100	83.2 (2.4), 100
Role Functioning: Emotional	72.7 (2.4), 80	77.2 (3.7), 100
Mental Health	71.2 (2.4), 80	74.9 (2.2), 84



Physical Composite	48.4 (1.2), 52	49.1 (1.1), 52
Mental Composite	44.8 (1.2), 48	46.5 (1.3), 51

Previously untreated, primary HNC:

(Funk G.F., Karnell L.H., Dawson C.J., et al, 1997; n = 180, mean age 58.9 (range, 20-85))

	US Norms	95% CI	HNC Pre-Surgery	95% CI
45-64 years				
(n = 39)				
PCS	49.64	49.58-49.70	42.64	39.00-46.28
MCS	50.53	50.47-50.59	41.97	38.25-45.69
55-64 years				
(n = 51)				
PCS	45.90	45.82-45.98	43.82	40.94-46.70
MCS	51.05	50.98-51.12	44.68	41.52-47.84
65-74 years				
(n = 48)				
PCS	43.33	43.28-43.38	42.33	39.05-45.61
MCS	52.68	52.54-52.72	49.87	46.88-52.86

	HND pre- surgery(n=180)	SC	HNC, 6 months post-surgery (n=109)	SD	P-value
PCS	43.61	11.49	42.88	10.61	0.0470
MCS	45.05	11.97	47.19	11.82	0.1463



General Population:

Reliability

(Ware J.E., Kosinski M., Keller S.D., 1994)

General population mean for SF-36 component scores (not specific to head and neck cancer) = 50 (SD, 10)

Test-retest Parkinsonism (included Parkinson Disease and Parkinson-plus syndromes):

(Steffen & Seney, 2008; n = 37 (PD n = 35, Parkinson-Plus n = 2); mean age = 71 (12); mean disease duration = 14 (6) years; Hoehn and Yahr stages median score = 2 (range = 1 to 4); Stage 1: n = 3, Stage 2: n = 7, Stage 3: n = 9, Stage 4: n = 8; test-retest by same rater at 1-week interval; mean number of falls in the past 6 months = 7; Administered SF-36 (v1) by direct interview.)

SF-36 Domain	Test-Retest reliability (ICC)
Physical Functioning	0.80 Adequate
Role Physical	0.85 Excellent
Bodily Pain	0.89 Excellent
General Health	0.85 Excellent
Vitality	0.89 Excellent
Social Functioning	0.71 Adequate
Role Emotional	0.84 Excellent
Mental Health	0.83 Excellent

Chronic Stroke:

(Dorman et al, 1998; n = 209; 3 weeks between assessments; mean time since stroke onset 64(30) weeks)

Domain	Patient ICC's	Proxy ICC's	Combined ICC's
Physical Functioning	0.80	0.59	0.74



Role Limits–physical	0.77	0.45	0.67
Bodily Pain	0.81	0.65	0.75
General Health	0.81	0.71	0.79
Vitality	0.77	0.55	0.70
Social Functioning	0.79	0.76	0.80
Role Limits–emotional	0.60	0.50	0.57
Mental Health	0.30	0.24	0.28

Chronic Traumatic Spinal Cord Injury:

(Lin et al, 2007; n = 187; 4 weeks between assessments; mean time since injury was 7.8 years)

20 random participants were selected to assess their original responses within 2 weeks; n = 10 by same interviewer (intra interviewer), n = 10 with a second interviewer (inter interviewer)

SF-36 Domain	Intra interviewer	Inter interviewer	
	(ICC)	(ICC)	
Physical Functioning	0.71	0.67	
Role Physical	0.89	0.90	
Bodily Pain	0.87	0.70	
General Health	0.85	0.41	
Vitality	0.93	0.86	
Social Functioning	0.93	0.52	
Role Emotional	0.99	0.98	
Mental Health	0.77	0.57	
Excellent Intra ICC > 0.9 in BOLD; Excellent Inter ICC > 0.7 in BOLD			

Interrater/Intrarat er Reliability



Internal Consistency

(Steffen & Seney, 2008; n = 37; mean age = 71; mean disease duration = 14 (6) years); Hoehn and Yahr Stages range from 1-to-4. ; Stage 1: n = 3, Stage 2: n = 7, Stage 3: n = 9, Stage 4: n = 8; Test-retest by same rater at 1-week interval; mean number of falls in the past 6 months = 7)

Parkinsonism (included Parkinson Disease and Parkinson-plus syndromes):

Internal Consistency for SF-36 v1 (Cronbach's alpha): [No source for this linked to SF-36v2]

SF-36 Domain	Internal Consistency Cronbach's alpha Strength
Physical Functioning	0.87 Excellent
Role Physical	0.74 Adequate
Bodily Pain	0.91 Excellent
General Health	0.80 Adequate
Vitality	0.91 Excellent
Social Functioning	0.84 Excellent
Role Emotional	0.89 Excellent
Mental Health	0.93 Excellent

(Brown et al, n = 96 total (n = 58 with follow-up data and 38 without); mean age = 72 (88% white, 84% male); years of school = 15.7 (2.4); via standardized telephone interview at baseline and ~18 months (mean = 17.9 (4.2) months In PD subjects, Hoehn & Yahr stages not reported.)

Subscale (item #)	Cronbach's alpha (strength)
Physical Functioning (10)	0.94 (Excellent)
Role Limitations–Physical (4)	0.81 (Excellent)
Role Limitations–Emotional (3)	0.98 (Excellent)
Pain (2)	0.85 (Excellent)



Emotional Well-Being (5)	0.86 (Excellent)
Energy (4)	0.92 (Excellent)
General Health (5)	0.76 (Adequate)
Social Function (2)	0.98 (Excellent)
Physical Health (PCS)	0.93 (Excellent)
Mental Health (MCS)	0.97 (Excellent)

Acute Stroke:

(Hagen et al, 2003; n = 136; mean age = 70 (11) years; assessed 1, 3 and 6 months post-stroke)

Adequate to Excellent internal consistency across domains (alpha > 0.70) over multiple administrations (1, 3 and 6 months) except Vitality at 1 month post stroke (a = 0.6824) and General Health at 3 months post-stroke (a = 0.6650)

Chronic Stroke:

(Anderson et al, 1996)

Excellent internal consistency (Cronbach's alpha > 0.7, except Vitality section):

SF-36 Domain	Strength	alpha
Physical Functioning	Excellent	0.9
Role Limits–physical	Adequate	0.8
Bodily Pain	Excellent	0.9
General Health	Adequate	0.7
Vitality	Adequate	0.6
Social Functioning	Adequate	0.7
Role Limits–emotional	Excellent	0.9
Mental Health	Adequate	0.7



Spinal Cord Injury:

(Forchheimer, et al 2004)

Adequate to Excellent internal consistency across all domains (Chronbach's α = 0.76 to 0.90, mean = 0.82)

SF-36 Domain	Internal Consistency (Cronbach's alpha)
Physical Functioning	0.98
Role Physical	0.94
Bodily Pain	0.79
General Health	0.82
Vitality	0.76
Social Functioning	0.72
Role Emotional	0.89
Mental Health	0.78
Excellent internal consistency > 0	.80 in BOLD; Adequate internal

consistency 0.70-0.80

Chronic SCI:

(van Leeuwen et al 2012, n = 145, AIS A-D, 5 years post injury)

Adequate internal consistency of the Mental Health subscale of SF-36 (MHI-5), Cronbach's α = 0.79

Traumatic Brain Injury: (Mackenzie, et al 2002, n =1230 (1197 without proxy, 33 by 18-54 years, gender=male 66%)

The α coefficient for the SF-36 health survey with the cognitive function scale

SF-36 Domain	α coefficient	Strength
Physical Functioning	0.93	Excellent
Role Limits–physical	0.88	Excellent
Bodily Pain	0.89	Excellent


General Health	0.77	Adequate
Vitality	0.84	Excellent
Social Functioning	0.82	Excellent
Role Limits–emotional	0.87	Excellent
Mental Health	0.88	Excellent

Traumatic Brain Injury: (Findler et al; n=597 (without disability, n=271; mild TBI, n=98; moderate-se TBI, n=228); Mean age at interview=no disability, 38.5(12.7); mild TBI, 41.7(10.8), moderate-severe 35.7(9.8)

Cronbach's alpha ranged from 0.68-0.87 (adequate to excellent) for the comparison group , from 0. 0.91 (excellent) for the mild TBI group, and from 0.79-0.92 (adequate to excellent) for the moderate severe TBI group

Traumatic Brain Injury: (Guilfoyle et al, 2011; n=514; mean age=36.6 (16.1) years; gender=male 76.3

SF-36 domain	Alpha coefficient	Strength
Physical Function	0.95	Excellent
Role Physical	0.89	Excellent
Bodily Pain	0.90	Excellent
General Health	0.83	Excellent
Vitality	0.83	Excellent
Social function	0.82	Excellent
Role Emotional	0.90	Excellent
Mental Health	0.86	Excellent

Patients undergoing surgery for oral or oropharyngeal SCCA:

(Rogers S., Humphris G., Lowe D., Brown J., Vaughan E., 1998; n = 48, mean age (SD), 61 (12))

Subscale	Cronbach's alpha		
Physical functioning	0.95		



Role limitation, physical	0.92
Role limitation, mental	0.86
Social functioning	0.77
Mental health	0.78
Energy/Vitality	0.72
Pain	0.81
General health perception	0.79

Laryngeal cancer (Italian version):

(Mosconi P., Cifani S., Crispino S., Fossati R., Apolone G., 2000; n = 165, 64 (9.2), patients 0-262 months post-treatment)

	Subscale	Cronbach's alpha
	Physical functioning	0.88
	Role limitation, physical	0.83
	Role limitation, mental	0.84
	Social functioning	0.91
	Mental health	0.81
	Energy/Vitality	0.81
	Pain	0.85
	General health perception	0.69
v	Parkinson Disease:	

Criterion ValidityParkinson Disease:(Predictive/Concur
rent)(Leonardi et al, 2012; n = 86 all scales)Pearson correlations all significant at p < 0.0001</td>



N=86 all scales	SF-36 PCS /	SF-36 MCS /	NMS Questionnaire	
	Correlation Strength	Correlation	/	
		Strength	Correlation Strength	
WHO-DAS II summary score	-0.70 / Excellent	-0.52 / Adequate	0.65 / Excellent	
NMS questionnaire	-0.54 / Adequate	-0.40 / Adequate		

NMS = non motor symptoms questionnaire

WHO-DAS II = World Health Organization Disability Assessment Schedule

(Nilsson et al, 2010; n = 79 with diagnosis of idiopathic PD, 37 outpatient and 42 via survey; mean age 64 years (7.2) correlation study; 8.8 (2.3) days between testing sessions; duration of diagnosis = 15.9 (7.3) years; Hoehn & Yahr ratings not specified. Focus of study on FES (Swedish-13) & SAFFE (modified Survey of Activities and Fear of Falling in the Elderly))

Adequate correlation SF-36v1 PF subscale and FES(s): rs = 0.66; p < 0.001

Excellent SF-36v1 PF subscale and SAFFE: rs = -0.76; p < 0.001

Chronic Stroke:

(Dorman et al, 1999; n = 688)

Adequate concurrent validity between the EuroQol health-related quality of life and the SF-36's general health domain r = 0.66

Poor concurrent validity between SF-36 mental health domain and the EuroQol psychological functioning subtest

Excellent to Poor correlations between individual Barthel Index scores at five years and dimensions of the SF36. (Wilkinson et al, 1997; UK sample, n = 97, mean age at stroke = 61, mean follow-up 4.9 years)

SF36	r =
Physical functioning	0.810
Social functioning	0.481
Role: physical	0.415
Role: emotional	0.217
Mental health	0.332



Vitality	0.500
Bodily pain	0.356
General health	0.438

Chronic SCI:

(Van Leeuwen et al, 2012)

Concurrent Validity	Spearman Correlation
LiSat 9	0.531°
Neuroticism	-0.546ª
SF- Vitality	0.528ª
SF- general health	0.367ª
Divergent Validity	
FIM	0.094
SIP-mobility range	-0.283
Type of injury	-0.009
Completeness of injury	-0.008
Cause of injury	0.192
Demographics	
Age	-0.020
Gender	-0.067
Education	0.028
^a =Adequate validity 0.31-0.59; I anticipated poor correlations w	Poor validity ≤ 0.30; VanLeeuwen ith Demographics and injury

Patients within 2 years of diagnosis for head and neck cancer:

(Karvonen-Gutierrez C.A., Ronis D.L., Fowler K.E., Terrell J.E., Gruber S.B., Duffy S.A., 2008; n = 495)

Predictive Validity:



	When controlling for demographic, health behavior and clinical variables, QOL as measured by the SF-36, the PCS score is significantly associated with survival (hazard ratio 0.86, 95% CI 0.80-0.93).							
	For every 5-point increase in the PCS score, the risk of death decreased 0.14 times.							
Construct Validity	Parkinson Dise	ease: (Lec	onardi et a	l, 2012)				
(Convergent/Discri minant)	Distinguish severity: SF-36v2 composite scores were significantly different between patients rated Hoehn & Yahr < 3 (n = 68) and those rated HY \ge 3 (n = 28), with the more advanced group reporting lower composite scores on PCS (reduced by 16.8%) and MCS (reduced by 18.1%)							
	Chronic Spinal	Cord Inju	ury:					
	(Forchheimer,	et al 200	4)					
	Excellent discriminant validity established between Physical capacity score (PCS) and Mental capacity score (MCS) constructs (-0.075)							
	Excellent convergent validity between impairment severity and PCS (F = 5.62, df = 3, P = 0.001)							
	Excellent Divergent validity between impairment severity and MCS scores (F = 0.175, df = 3, P = NS)							
	Chronic Spinal Cord Injury:							
	(Lin et al, 2007)							
			WHOQO	L-BREF				1
	SF-36	Rating Scale	Overall	Physical Capacity	Psych	Social	Environ	-
	Rating Scale		0.68	0.73	0.64	0.54	0.57	-
	Physical Functioning	0.71	0.57	0.78	0.57	0.50	0.54	-
	Role physical	0.47	0.35	0.51	0.40	0.33	0.48	-
	Bodily pain	0.64	0.52	0.68	0.56	0.48	0.55	-
	General Health	0.72	0.65	0.69	0.62	0.45	0.59	-
	Vitality	0.59	0.59	0.67	0.65	0.48	0.62	-



Social Functioning	0.50	0.52	0.62	0.63	0.43	0.58
Role Emotional	0.32	0.30	0.41	0.37	0.24	0.39
Mental Health	0.36	0.51	0.52	0.59	0.40	0.56

Excellent correlation > 0.60 in BOLD; Adequate correlation 0.31-0.59; Excellent to Adequate convergent validity between SF-36 and WHOQOL-BREF subscales

Chronic Spinal Cord Injury:

(Anderson et al, 1999 n = 181 veterans with SCI who were hospitalized within 6 months of assessment)

Excellent to adequate correlations between SF-36 and Behavioral Risk Factor Surveillance System (BRFSS) subscales

Mental Capacity Summary to all BRFSS subscales (r = -0.427-0.761)

Mental Health subscale to all BRFSS subscales (r= -0.446 - -0.795)

Vitality subscale to all BRFSS subscales (r = -0.450 - -0.789)

Social Functioning subscale to all BRFSS (r = -0.293 - -0.622)

Role Emotional subscale to all BRFSS (r = -0.290- -0.610)

Poor to adequate correlations between SF-36 subscales Physical Functioning, Role Physical, Bodily Pain, General Health and Physical Summary and all BRFSS subscales (r = 0.065- 0.597)

Poor to adequate correlations between SF-36 and Quality of Well Being (r = 0.044 to 0.417) (poor ≤ 0.03 ; adequate 0.31-0.59)

Adequate to Poor correlation between SF-36 and IADLs (r = -0.159- to -0.454)

Traumatic Brain Injury: (Findler et al; n=597 (without disability, n=271; mild TBI, n= TBI, n=228); Mean age at interview=no disability, 38.5(12.7); mild TBI, 41.7(10.8), m 35.7(9.8)

Mild TBI:

Adequate to excellent correlations (-0.50 to -0.63) were found between SF-36 scale to physical functioning (General Health, Physical Functioning, Physical Role, Bodily I the Physical symptoms scale of the Symptoms Checklist (SCL)



Excellent correlations between SF-36 scales and participants' Health Problems List (HPL) responses 0.60 to -0.75)

Emotional Role and Mental Health scores were more strongly related to psychological factors (Cognitive and Affective/Behavioral) than to physical factors on the Symptom Checklist (SCL)

Adequate to excellent correlations (-0.52 to -0.77) were found between Beck Depression Inventory second edition (BDI-II) scores and the SF-36 subscales

Moderate to Severe TBI:

Correlations were lower and more uniform, strongest correlations found between the SF-36 Emotic Role scale and the SCL Affective/Behavioral scale (-0.53).

Correlations between the Physical Functioning scale of the SF-36 and the Cognitive and Affective/Behavioural scales of the SCL were lower than other correlations between scales within th group (-0.11 and -0.19, respectively).

Multiple Neurologic Diagnosis (polio, acute stroke, and TBI): McNaughton et al., 2005; n=308, Polio n=38, Stroke n=181, TBI n=89; mean age=polio 62.5 (11.3), stroke=74.4 (12.0), TBI=34.0 (17.8); gene female=polio 27%, stroke 96%, TBI 32%)

examined validity of the mental component score (MCS) and physical component score (PCS)

Principal component analysis (PCA) on the 12-month measures for subjects with stroke and TBI: 2 dimensions might account for a large proportion of the variability in the data set

Varimax rotation shows that the 2-factor model has 85% of the variance of the underlying variables with 1 factor loading mainly onto the Barthel Index, Functional Independence Meausre (FIM), PCS,Community Integration Questionnaire (CIQ), and London Handicap Scale (LHS) and the other fa mainly onto the MCS

Traumatic Brain Injury: (Guilfoyle et al; n=514; mean age=36.6 (16.1) years; gender=male 76.3%)

Principal component analysis (PCA) of the correlation matrix of the eight SF-36 domains extracted a single PC with an eigenvalue exceeding unity, which explained 59.2% of the variance in the data

The second PC extracted had an associated eigenvalue of 0.75, and accounted for only 9.4% of the variance

Known Groups

Traumatic Brain Injury: (Findler et al; n=597 (without disability, n=271; mild TBI, n=98; moderate-se TBI, n=228); Mean age at interview=no disability, 38.5(12.7); mild TBI, 41.7(10.8), moderate-severe 35.7(9.8)

mild TBI and moderate to severe TBI groups reported significantly lower health status across all sca compared to the comparison group



mild TBI group reported significantly lower scores (poorer health)on all scales compared to the moderate± severe TBI group, with the exception of Physical Function, where there were no differer between the two groups

Traumatic Brain Injury: (Jacobsson et al., 2010 n=67, mild TBI n=32, moderate to severe TBI n=35; m age at time of injury=mild TBI:13 (13) years, moderate to severe TBI: 30 (12) years); gender=mild TE male75%, moderate to severe TBI: male 77%; Swedish version of the SF-36)

	SF- 36PCS	MCS	SWLS	Sex	Age at Injury	Injury Severity	Time since injury	Marital status	Vocational situation
SF-36: MCS	-0.00								
SWLS	0.41**	0.48**		-			-		
Sex	-0.19	0.01	-0.02						
Age at injury	-0.14	0.29*	0.05	0.23					
lnjury severity	0.20	-0.10	-0.06	-0.03	0.32**				
Time since injury	0.13	0.06	0.30*	-0.05	-0.15	0.10			
Marital status	0.11	0.06	0.36**	-0.01	18	-0.11	0.08		
Vocational situation	0.48**	-0.02	0.32**	-0.11	- 0.37**	0.13	0.11	0.21	
Self appraisal of the TBI	- 0.54**	-0.12	-0.46**	0.09	-0.05	-0.31**	-0.04	-0.27*	-0.35**

Correlation (Spearman's rho) is significant (two-tailed) on *0.05, and **0.01 levels

SWLS-Satisfaction With Life Scale

Patients with cancer of the upper aero digestive tract:

(Chen A.Y., Frankowski R., Bishop-Leone J., et al., 2001)



Construct validity of the MD Anderson Dysphagia Index (MDADI) was determined through correlati the subscales of the SF-36 and MDADI. (Spearman correlation coefficient, greater than 0.60 - strong correlation, 0.40-0.60 - moderate to substantial, less than 0.40 - weak)

	MDADI Subscales			
SF-36 Subscales	Global	Emotional	Functional	Physical
Physical functioning	0.29	0.36	0.31	0.40
Role - physical	0.31	0.33	0.37	0.38
Bodily Pain	0.21	0.23	0.24	0.26
General Health	0.21	0.33	0.28	0.32
Vitality/Energy	0.34	0.50	0.45	0.52
Social Functioning	0.44	0.50	0.45	0.51
Role - Emotional	0.34	0.40	0.42	0.43
Mental Health	0.27	0.30	0.29	0.34
PCS	0.25	0.30	0.29	0.34
MCS	0.44	0.54	0.51	0.54

Patients with head and neck cancer who underwent selective or modified radical neck dissection:

(Taylor R.J., Chepeha J.C., Teknos T.N., Bradford C.R., Sharma P.K., Terrell J.E., Hogikyan N.D., Wolf (Chepeha D.B., 2002; n = 54, patients had a minimum postoperative convalescence of 11 months)

Convergent validity of the Neck Dissection Impairment Index (NDII):

(Spearmen or Pearson not specified)

Subscale	Correlation to NDII	P-value	
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Physical functioning	0.50	<0.001
Role limitation, physical	0.60	0.001
Role limitation, mental	0.59	0.001
Social functioning	0.62	0.001
Mental health	0.56	0.001
Energy/Vitality	0.44	0.001
Pain	0.32	0.001
General health perception	0.55	0.001

Patients undergoing surgery for oral or oropharyngeal SCCA:

(Rogers S., Humphris G., Lowe D., Brown J., Vaughan E., 1998)

Correlation between SF-36 and University of Washington Hand and Neck Questionnaire:

Subscale	Pearson's Correlation
Physical functioning	0.61, P<0.001
Role limitation, physical	0.66, P<0.001
Role limitation, mental	0.47, P<0.01
Social functioning	0.54, P<0.001
Mental health	-0.08
Energy/Vitality	0.43, P<0.01
Pain	0.61, P<0.001
General health perception	0.42, P<0.01

(Rogers S.N., Lowe D., Brown J.S., Vaughan E.D., 1998)



Spearman correlation coefficients:

SF-36 with European Organization for Research and Treatment of Cancer (EORTC): r = 0.83

SF-36 with University of Washington Head and Neck Disease-Specific Measure (UW-QOL): r = 0.80

Laryngeal cancer (Italian version):

(Mosconi P., Cifani S., Crispino S., Fossati R., Apolone G., 2000)

Convergent Validity - within subscale coefficients all higher than 0.40

Discriminant Validity - higher item-scale correlations found within the subscale than between the subscales

Acute Stroke: convergent validity(Ojo Owolabi, 2010; n=100;

> 1-month post-stroke)

All SF-36 subscales were significantly correlated with Stroke Levity Scale and modified Rankin Scale (($0.31 < \rho$ magnitude < 0.67, 0.0000001).

SF-36 and Health-related Quality of Life in Stroke Patients (HRQOLISP)

- Physical domain: highly correlated (p=0.79)
- Psychological domain: highly correlated (ρ=0.69)
- Social domain: moderately correlated (ρ=0.47)
- Physical domain of HRQOLISP: moderate to high correlation with all SF-36 domains (0.30<p<0.78).
- Spiritual domains of HRQOLISP: not correlated with SF 36 domains

Acute stroke (57 days of inpatient rehabilitation (SD=28 days); Katona 2015; Authors did not designate version or language used.) Convergent validity

- EQ-5D Index and SF-36 physical domain: moderate correlation
 - Admission: r (Pearson) = 0.60; p < 0.001
 - Discharge: r (Pearson) = 0.68; p < 0.001
- EQ-5D Index and SF-36 mental health domain: weak correlation
 - Admission: r (Pearson) = 0.35; p < 0.05
 - Discharge: r (Pearson) = 0.43; p < 0.05

Sub-acute Stroke: Known Groups (Ojo Owolabi, 2010; n=100;

> 1-month post-stroke)

All SF-36 domains sub-domains differed significantly among mRS strata (0.000001).



Content Validity	Items that compose the SF-36 were drawn from a number of prior measures including:						
	The General Psychological We	The General Psychological Well-Being Inventory (GPWBI) (Dupuy, 1984)					
	Physical and role functioning Cassel, 1973; Reynolds, Rushi	measures (Patri ing, & Miles, 197	ck, Bush, & '4; Stewart	Chen, 1973; Hulka & , Ware, & Brook, 1981)			
	The Health Perceptions Ques	tionnaire (HPQ)	(Ware, 197	76)			
	The Functioning and Well-Bei	ing Profile (FWB	P) (Stewart	& Ware, 1992)			
Face Validity	Not statistically assessed						
Floor/Ceiling	Parkinson Disease:						
Effects	(Brown et al, 2009) regarding	SF-36v1 {not lo	cated for Sl	-36v2}			
	Floor effects:SF-36v1 subscales: Role limitations – physical (51% scored min possible); Role limits – emotional (21.9% scored min possible).						
	Ceiling effects: SF-36v1 subsc possible); Pain (15.6% scored possible).	ale: Role limitat max possible); \$	ions – Emo Social funct	tional (75% scored max ion (29.2% scored max			
	Subscale	% score min (0)	max (100)				
	Physical Functioning	4.2	3.1				
	Role Limitations—Physical	51.0	10.4				
	Role Limitations—Emotional	21.9	75.0				
	Pain	0.0	15.6				
	Emotional Well-Being	1.0	0.0				
	Energy	3.1	0.0				
	General Health	2.1	1.0				
	Social Function	6.3	29.2				



Acute Stroke:

(Hagen et al, 2003; n = 153; 1 month post stroke)

SF-36 Domain	% Floor	% Ceiling
Physical Functioning	23	1
Role Physical	70	4
(Lack of) Bodily Pain	6	35
General Health	0	3
Vitality	4	0
Social Functioning	27	16
Role Emotional	37	26
Mental Health	0	2

Acute Stroke

(Ojo Owolabi, 2010; n=100; > 1-month post-stroke))

SF-36 Domain	% Floor	% Ceiling
Physical Functioning	18	19
Role Physical	74	7
Role-emotional	58	30
Vitality	0	7
Mental Health	0	34
Social Functioning	6	19
Bodily Pain	2	35



General health	0	3
Health Transition	11	32

Chronic Stroke:

(Anderson et al, 1996)

The SF-36 avoids the "ceiling effect" of most disability scales:

SF-36 Domain	% floor	% ceiling
Physical Functioning	4	6
Role Physical	7	53
(Lack of) Bodily Pain	2	43
General Health	2	2
Vitality	1	1
Social Functioning	3	67
Role Emotional	7	72
Mental Health	1	4

Traumatic Brain Injury:

(Guilfoyle et al, 2011; n = 514; mean age = 36.6 (16.1) years; gender = male 76.3%)

Floor effects were observed in two domains—Role Physical and Role Emotional and ceiling effects were observed in four domains—Physical Function, Role Physical, Bodily Pain, and Role Emotional

SF-36 domain	Floor %	Ceiling %
Physical	4.7%	16.7
Function		



	Role Physical	56.8	19.1		
	Bodily Pain	2.0	21.4		
	General Health	0.2	5.1		
	Vitality	2.2	2.8		
	Social function	7.3	0.0		
	Role Emotional	43.9	37.5		
	Mental Health	0.6	4.0		
	Patients unde	rgoing su	irgery for oral or ord	opharyngeal SCCA:	
	(Rogers S., Hu No floor or ce	mphris G iling effe	5., Lowe D., Brown J. cts	, Vaughan E., 1998)	
Responsiveness	Chronic spina	l cord inj	ury:		
	(Lin et al, 200	7)			
	Highly sensitiv Physical Funct	ve (ES = 0 tioning ai	0.60 & 0.92) with res nd Role Physical don	pect to employment status v nains.	vith
	Moderately se Social Functio	ensitive (ning, Rol	ES = 0.21-0.44) with e Emotional and Me	respect to employment state ental Health domains	us with
	Small respons Bodily Pain, G	iveness (eneral He	ES = 0.00-0.16) with ealth, and Vitality do	respect to employment stat omains.	us in
	Mild Traumat age=mTBI 32.	ic Brain I 7 (11.9),	njury (mTBI): (Panial control 30.4 (11.6))	k et al.,1999; n=120 with mild	d TBI, 120 co
	SF 36 variable	2	Effect Size		
	Physical Func	tioning	3.5	Moderate change	
	Social		1.98	Small change	



Role Functioning Physical	2.72	Moderate change
Bodily Pain	2.04	Moderate change
Mental Health	0.90	Small change
Role Functioning Emotional	0.96	Small change
Vitality	1.78	Small change
General Health	0.18	Small change
Mental	0.93	Small chage
Physical	2.48	Moderate change

Traumatic Brain Injury: (Hawthorne et al, 2009; n=66; mean age at time of injury=36 (15); mean time since injury=32 months; utilized SF-36 version 2)

SF 36 variable	Effect Size
Physical Functioning	-0.56
Role Functioning Physical	-0.77
Bodily Pain	-0.38
General Health	-0.44
Vitality	-0.43
Social Function	-0.81
Role Functioning Emotional	-0.86
Mental Health	-0.70
Physical	-0.47
Mental	-0.76

The largest effect sizes were for sub-scales assessing social, emotional, and mental health, but there were moderate to large effects across all of the eight sub-scales, suggesting that TBI may have very broad effects across many different life parts.

Laryngeal cancer (Italian version):



	Subscale	Effect Size			
	Physical functioning	0.45	_		
	Role limitation, physical	0.78	_		
	Role limitation, mental	0.40	_		
	Social functioning	0.66	_		
	Mental health	0.29	-		
	Energy/Vitality	0.04	_		
	Pain	0.88	_		
	General health perception	0.74	_		
	Component Summary Scores		-		
	Physical	1.1	_		
Professional Association Recommendations	Mental	0.09	-		
	(reference: first level of treatment extent, 0.60 indicates an important magnitude of change)				
	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE, StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.				
	For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations				

(Mosconi P., Cifani S., Crispino S., Fossati R., Apolone G., 2000)



Abbreviations:			
HR	Highly Recommend		
R	Recommend		
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend		
NR	Not Recommended		

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(Vestibular < 6 weeks post)	(SCI 3 to 6 months)	
SCI EDGE	NR	LS	R
StrokEDGE II	NR	R	R

Recommendations Based on Parkinson Disease Hoehn and Yahr stage:

	1	II	111	IV	V
PD EDGE	LS/UR	LS/UR	LS/UR	LS/UR	LS/UR

Recommendations based on level of care in which the assessment is taken:

	Acute	Inpatient	Skilled	Outpatient	Home
	Care	Rehabilitation	Nursing Facility	Rehabilitation	Health
MS EDGE	NR	NR	NR	R	R
StrokEDGE II	NR	R	R	R	R



TBI EDGE	NR	NR	NR	LS	LS
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Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	R	R

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderately Dependant
TBI EDGE	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5
MS EDGE	R	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students	Students	Appropriate for	Is additional
	should learn	should be	use in	research
	to administer	exposed to	intervention	warranted for
	this tool?	tool? (Y/N)	research	this tool (Y/N)
	(Y/N)		studies? (Y/N)	
MS EDGE	No	Yes	Yes	No
PD EDGE	No	No	Yes	Not reported
SCI EDGE	No	Yes	Yes	Not reported



	StrokEDGE II	No	Yes	Yes	Not reported			
	TBI EDGE	No	Yes	Yes	Not reported			
Considerations	Physical function disabilities due to Recommend the with spinal cord	Physical function domain: significant floor effects for patients with SCI and other disabilities due to inability to perform some of the physical tasks described. Recommend the SF-36 state "walkwheel" to improve responsiveness for patients with spinal cord injury. (Lee et al., 2009)						
	Not recommend	led for:						
	Patients who ca	nnot unders	stand written	or spoken langu	age			
	Severely affecte assessment	d stroke sur	rvivors who re	equire a proxy to	complete the			
	To document pa	itient chang	e (Dorman et	al., 1999)				
	Some disadvantaged populations, slight declines in reliability may result (Turner- Bowker et al., 2002)							
	Postal administration of the SF-36 is not recommended (O'Mahony et al, 1998)							
	The Mental Hea the future to de persons with SC	The Mental Health Subscale of SF-36 (MHI-5) VanLeeuwen, 2012 may be used in the future to determine mental health and severe mental health problems in persons with SCI. Cut off score \leq 72 and \leq 60 respectively.						
	The Brazilian version was evaluated by Cabral et al., 2012 (n=120; chronic stroke > 6 months after stroke)							
	Internal consistency: Reasonable internal consistency across domains (Cronbach's α =0.79)							
	Convergent validity of SF-36-Brazilian Version & Nottingham Health Profile							
	Convergent Va	lidity Spe	arman p					
	Vitality	0.47	7					
	Pain	0.63	3					
	Mental health	0.70	5					
	Social function	ing 0.4:	3					
	Total		2					
		0.80	5					
	Intra- & inter-rater reliability (n=74)							

1	Reliability	ICC (95% CI)	p-value
		· · ·	



Test-retest	0.89 (0.83-0.93)	<0.01
(1 rater)		
Inter-rater	0.89 (0.83-0.93)	<0.01
(2-raters)		

Floor & ceiling effects Chronic Stroke

SF-36 Domain	% floor	% ceiling
Vitality	6.7	5.8
Pain	9.2	13.3
Mental health	4.2	7.5
Social functioning	4.2	44.2
Functional capacity	8.3	3.3

The SF-12 is a shorter version of the SF-36 containing 12 items; covers the summary physical health and mental health scales, but no information about each of the eight dimensions of the SF-36

The SF-12 is beginning to be more commonly used in the TBI population however its psychometric properties in this population have not been specifically assessed (Nichol et al, 2011)

Do you see an error or have a suggestion for this instrument summary? Please email us!

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Year published	1992
Instrument in PDF Format	Yes



Approval Status Approved



REHAB 29. MEASURES DATABASE: STROKE IMPACT SCALE



Title of Assessment	Stroke Impact Scale		
Link to instrument	Available for free at the Landon Center on Aging SIS Homepage (external link)		
Purpose	Assesses health status following stroke		
Acronym	SIS		
Instrument Reviewer(s)	iewer(s) Initially reviewed by Jason Raad, MS and Jennifer Moore, PT, DHS, NCS and the Rehabilitation Measures Team; Updated by Jane Sullivan, PT, DH and the Stroke EDGE taskforce of the Academy of Neurologic Physical Therapy - a component of APTA; Updated by Jill Smiley, MPH and the Rehabilitation Measures Team in June 2013. Updated by Maggie Bland and Nancy Byl and the Stroke EDGE II taskforce Academy of Neurologic Physical Therapy - a component of APTA in 2016.		
Summary Date	07 06 2013		
Description	A 59 item measure		
	• 8 domains assessed:		
	 Strength (4 items) 		
	 Hand function (5 items) 		
	 ADL/IADL (10 items) 		
	 Mobility (9 items) 		
	 Communication (7 items) 		
	 Emotion (9 items) 		
	 Memory and thinking (7 items) 		
	 Participation/Role function (8 items) 		
	• Each item is rated in a 5-point Likert scale in terms of the difficulty the patient has experienced in completing each item		
	 Summative scores are generated for each domain, scores range from 0-100 		



- An extra question on stroke recovery asks that the client rate on a scale from 0-100 how much the client feels that he/she has recovered from his/her stroke
- Formula for scoring domains: Transformed Scale = [(Actual raw score - lowest possible raw score) / Possible raw score] * 100 (free scoring software available)
- 3 items change polarity in the "emotion" domain: 3f, 3h, and 3i; when manually scoring items must be reverse-scored
- A proxy version is available if patients are unable to answer (Duncan et al, 2002)
- Designed for repeated administration to track changes over time (refer to manual)
- Can be used in both in clinical and research applications (Refer to manual)
- Factor analysis of the SIS 2.0 revealed that the 4 domains (strength, hand function, mobility, and ADL/IADL) could be summed together to create a physical dimension score (the SIS-16)
- The SIS-16 consists of 16 items capturing daily activities
- For each item, the individual is asked to rate the level of difficulty of the item in the past 2 weeks using the following scale:
 - 1 = could not do it at all
 - 2 = very difficult
 - 3 = somewhat difficult
 - 4 = a little difficult
 - o 5 = not difficult at all

ICF Domain	Activity, Participation
Time to Administer	15-20 minutes
Number of Items	59



Equipment Required	Score sheet; Computer scoring requires Microsoft Access, find it free at the instruments website	
Training Required	• Yes, refer to the <u>measures website</u> for more information:	
	• The <u>SIS Manual</u> is also available	
Actual Cost	Free to non-profit users via link above.	
	Contact information and permission to use:	
	MAPI Research Trust, Lyon, France:	
	Email: PROinformation@mapi-trust.org	
	Internet: <u>www.mapi-trust.org</u>	
	Scale: <u>http://www.mapi-</u>	
	trust.org/services/questionnairelicensing/catalog-questionnaires/298-sis	

Populations Tested	Stroke	
Standard Error of	<u>Stroke</u> :	
Measurement (SEM)	(Lin et al, 2010; <i>n</i> = 74; mean age = 54.1 (11.4); mean time post-stroke = 17.5 (17.7) months, Chronic Stroke)	
	• Strength = 8.7	
	• ADL/IADL = 6.3	
	• Mobility = 5.5	
	• Hand function = 9.4	
Minimal Detectable	<u>Stroke</u> :	
Change (MDC)	Minimal Detectable Change (Lin et al, 2010, Chronic Stroke)	
	• Strength = 24.0	
	• ADL/IADL = 17.3	
	• Mobility = 15.1	
	• Hand function = 25.9	



Minimally Clinically	<u>Stroke</u> : Clinically Important Differences (Lin et al, 2010, Chronic Stroke)		
Important Difference (MCID)			
	• Strength = 9.2		
	• ADL/IADL = 5.9		
	• Mobility = 4.5		
	• Hand function = 17.8		
Cut-Off Scores	Not Applicable		
Normative Data	<u>Stroke</u> :		
	(Duncan et al, 2002; <i>n</i> = 287; mean age = 72.6 (10.0) years; < 28 days post- stroke; SIS Version 3.0, Acute Stroke)		

SIS Domain	Mean (SD)
Strength	61.9 (22.0)
Memory	77.8 (19.1)
Emotion	74.3 (18.1)
Communication	81.0 (19.1)
ADL/IADL	66.5 (23.2)
Mobility	60.2 (23.1)
Hand function	55.9 (34.5)
Social participation	58.9 (25.7)
SIS-16 physical	67.5 (21.2)

(Huang et al, 2010; *n* = 58; mean age = 56.42 (11.67) years; 17.85 months post stroke, range 7-88, Chronic Stroke)



SIS Domain	Mean (SD)
Strength	40.73 (20.05)
Memory	81.54 (19.17)
Emotion	59.63 (17.25)
Communication	89.71 (16.87)
ADL/IADL	67.41 (20.10)
Mobility	79.25 (18.08)
Hand function	29.63 (25.39
Social participation	47.92 (25.13)
SIS-16 physical	61.98 (12.27)

Test-retest Reliability <u>Stroke</u>:

(Duncan et al, 1999; n = 33 minor severity; n = 58 moderate severity; mean age minor severity = 69.3 (10.1); mean age moderate severity 71.9 (10.1); enrolled < 14 days post-stroke, Acute Stroke)

SIS version 2.0 (current version = 3.0) at 1, 3 and 6 months post-stroke:

• Adequate to Excellent test-retest reliability ICC = 0.70 to 0.92 (except for the emotion domain, ICC = 0.57)

(Edwards and O'connell, 2003; n = 74 individuals who suffered from a stroke; mean age = 58.35(14.80) years; mean time since stroke = 56.8 months; Anglo-Saxon Australian sample, Chronic Stroke)

- Adequate to Excellent test-retest reliability in all domains except for the emotion domain
- Poor test-retest reliability in the emotion domain



Interrater/Intrarater	<u>Stroke:</u>				
Reliability	(Carod-Artal et al, 2009); N = 180 proxy-stroke patient pairs; mean age = 57.9 (13.5) years; Gender = 100 males and 80 females; mean time since stroke = 20.3 (23.6) months post stroke (chronic),				
	 Excellent interrater reliability for hand function (ICC = 0.82) and mobility (ICC = 0.80) domains 				
	• Adequ (ICC =	 Adequate interrater reliability for strength (ICC = 0.61), ADL/IADL (ICC = 0.74), and memory and thinking (ICC = 0.43) domains 			51), ADL/IADL Iomains
	 Poor interrater reliability for communication (ICC = 0.39), emotion (ICC = 0.17), and social participation (ICC = 0.29) domains 				D.39), = 0.29)
	(Chou et al, 2015) In Taiwan, patients post stroke (N=121) we and retested while in acute hospital, acute rehabilitation or o clinic in Taiwan with baseline test and retested 2 weeks late			were tested or outpatient iter.	
	SIS 3.0	Cronbach's Alpha	ICC	SEM	SRD
	Total Score	0.96	0.94	4.3	12.0
	Composite Physical0.970.924.312.0				12.0
	SIS-16	0.94	0.95	4.8	13.2

Internal Consistency	Stroke:				
	(Duncan et al,	(Duncan et al, 1999; SIS version 2.0, Acute Stroke)			
	• Excelle domai	• Excellent: Cronbach's alpha ranged from 0.83 to 0.90 across the 8 domains			
	(Carod-Artal et al, 2009, Chronic Stroke)				
	Excelle	 Excellent internal consistency for 7 of the domains: Strength (ICC = 0.82) 			
	0				
	0	Hand function (ICC = 0.95)			
	0	 Mobility (ICC = 0.94) 			
	0	ADL/IADL (ICC = 0.87)			



- Memory (ICC = 0.92)
- Communcation (ICC = 0.84)
- Social participation (ICC = 0.85)
- Adequate interrater reliability for emotion domain (ICC = 0.49)

Criterion Validity	
--------------------	--

(Predictive/Concurrent)

(Dun	can et	al, 200	2, Acute	Stroke)

Stroke:

Measures Assessed	Patient r	Proxy r
Folstein MMSE and SIS memory	0.42	0.37
Barthel Index and SIS ADL/IADL	0.72*	0.78*
Barthel Index and SIS mobility	0.69	0.7*
Lawton IADL and SIS ADL/IADL	0.77*	0.78*
Motricity and SIS strength	0.67	0.69
*indicates excellent correlation		

Predictive Validity

(Kwon et al, 2006, Acute Stroke)

- Excellent correlation between FIM-motor correlation and SIS-ADL (r = 0.86*)
- Excellent correlation between SF-36V (Physical Component) and SIS-PHYSICAL (r = 0.77*)

*SIS at 12 weeks; FIM and SF-36v at 16 weeks

(Duncan et al, 1999; SIS version 2.0, Acute Stroke)

SIS Domain	Comparative Measure	Correlation	Rating
Hand function	FMA-Upper Extremity Motor	<i>r</i> = 0.81	Excellent
Mobility	FIM Motor	<i>r</i> = 0.83	Excellent
	Barthel Index	<i>r</i> = 0.82	Excellent
	Duke Mobility Scale	<i>r</i> = 0.83	Excellent



	SF-36 Physical Functioning	<i>r</i> = 0.84	Excellent
Strength	NIHSS Motor	r = -0.59	Adequate
	FMA Total	<i>r</i> = 0.72	Excellent
ADL/IADL	Barthel Index	<i>r</i> = 0.84	Excellent
	FIM Motor	<i>r</i> = 0.84	Excellent
	Lawton IADL	<i>r</i> = 0.82	Excellent
Memory	MMSE	r = 0.58	Adequate
Communication	FIM Social/Cognition	<i>r</i> = 0.53	Adequate
	NIHSS Language	<i>r</i> = -0.44	Adequate
Emotion	Geriatric Depression Scale	r = -0.77	Excellent
	SF-36 Mental Health	<i>r</i> = 0.74	Excellent
Participation	SF-36 Emotional Role	<i>r</i> = 0.28	Poor
	SF-36 Physical Role	<i>r</i> = 0.45	Adequate
	SF-36 Social Functioning	<i>r</i> = 0.70	Excellent
Physical	Barthel Index	<i>r</i> = 0.76	Excellent
	FIM Motor	r = 0.79	Excellent
	SF-36 Physical Functioning	<i>r</i> = 0.75	Excellent
	Lawton IADL	<i>r</i> = 0.73	Excellent

(Lin, Fu, et al, 2010, Chronic Stroke)

 Adequate to Excellent criterion validity for the hand function subscale (rho = 0.51-0.68; p < 0.01)

(Huang et al, 2010) Patients (N=58), mean age 56.42 (± 11.67) years old, (an average of 17.85[range 7-88] monthschronic post-stroke h were treated with CIT for 2 hours daily for 3 weeks)

• The initial FIM score predicted the overall and ADL/IADL subscale scores.



	 Participants between 63.5 and 67.9 years had the greatest improvement in overall SIS. 		
	(Lin, Chuang, et al, 2010) Fifty-nine participants, mean age 55.50 (± 11.66) years old, seen an average of 16.14 ± 13.95 months post-stroke.		
	 Adequate concurrent validity between the SIS Hand Function Domain (version 3.0) and the Berg Balance Test (0.52 - 0.59, p < 0.01) and the Action Research Arm Test (0.36 - 0.45, p < 0.01). Adequate to Excellent concurrent validity between the SIS Hand Function Domain (version 3.0) and the Nine Hole Peg Test (-0.58 - -0.66, p < 0.01). 		
	 Chen et al, 2012) Predictive validity examined for the ARAT and the SIS in 191 patients post stroke, mean age 55.17 (±11.14) years old, an average of 17.19 (± 15.29) months post-stroke. The correlation of the ARAT and the SIS hand function and SIS-Physical was 0.58 (95% CI = 0.49-0.67) and 0.45 (95% CI = 0.33to 0.56) respectively, significant at P<0.001. 		
Construct Validity	<u>Stroke</u> :		
	Convergent validity		
(Convergent/Discriminant)	Convergent validity		
(Convergent/Discriminant)	 Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) 		
(Convergent/Discriminant)	 Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) 		
(Convergent/Discriminant)	Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity 		
(Convergent/Discriminant)	Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity (Carod-Artal et al, 2009, Chronic Stroke) 		
(Convergent/Discriminant)	Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity (Carod-Artal et al, 2009, Chronic Stroke) Correlation between proxy ratings and stroke functional measures tended to be slightly lower than for patient-based self assessment 		
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(Convergent/Discriminant)	 Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity (Carod-Artal et al, 2009, Chronic Stroke) Correlation between proxy ratings and stroke functional measures tended to be slightly lower than for patient-based self assessment Correlations were observed between functional status and the following SIS proxy-version domains: Mobilty (r = -0.73) Excellent 		
(Convergent/Discriminant)	 Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity (Carod-Artal et al, 2009, Chronic Stroke) Correlation between proxy ratings and stroke functional measures tended to be slightly lower than for patient-based self assessment Correlations were observed between functional status and the following SIS proxy-version domains: Mobilty (r = -0.73) Excellent ADL/IADL (r = -0.69) Excellent 		
(Convergent/Discriminant)	 Convergent validity Excellent correlation between Burden of Stroke Scale (BOSS) and SIS total scores (r = -0.83) (Duncan et al, 1999, Acute Stroke) Most domains of the SIS can differentiate between patients with varying degrees of stroke severity (Carod-Artal et al, 2009, Chronic Stroke) Correlation between proxy ratings and stroke functional measures tended to be slightly lower than for patient-based self assessment Correlations were observed between functional status and the following SIS proxy-version domains: Mobility (r = -0.73) Excellent ADL/IADL (r = -0.69) Excellent Strength (r = -0.44) Adequate 		



	 Correlations were observed between the Barthel Index and the following SIS proxy-domains:
	• Mobility (<i>r</i> = 0.80) Excellent
	• ADL/IADL ($r = 0.74$) Excellent
	 Strength (r = 0.52) Adequate
	• Hand function ($r = 0.52$) Adequate
	 Poor correlation between the HADS-Depression subscale and the SIS emotion domain were observed (r = -0.20)
	(O'Dell, 2013) Thirty-two community dwelling participants an average of 4.1 ± 4.5 years post-stroke participated in upper extremity robotics training.
	 Adequate correlation between the SIS Hand Function Domain and the Arm Motor Ability Test-9 (0.40, p = 0.025). Poor correlation between the SIS Communication Domain and the Arm Motor Ability Test-9 (-0.16, p = 0.39).
Content Validity	Development of the SIS was based on a study at the Landon Center on Aging, University of Kansas Medical Center (Duncan, Wallace, Studenski, Lai, & Johnson, 2001) using feedback from individual interviews with patients and focus group interviews with patients, caregivers, and health care professionals
Face Validity	Not Established
Floor/Ceiling Effects	Acute Stroke:
	(Duncan et al, 1999; SIS version 2.0)

% of sample who	o encounte	ered Floor or (Ceiling effe	ects
	Minor Stroke (n = 96)		Moderate Stroke (n = 144)	
SIS	%Floor	%Ceiling	%Floor	%Ceiling
Strength	0	13.5	1.4	2.1
Hand Function	2	14.6	40.2	4.9
Mobility	0	6	0.6	2.1



ADL/IADL	0	2.1	2.8	1.4
Memory	0	12.5	0.6	10.4
Communication	0	35.4	1.4	25.7
Emotion	0	4.1	0	4.2
Participation	0	15.6	3.5	1.49
Physical	0	1	0.6	0
Barthel	0	64.6	0	24.8

Chou et al, 2015 (N=121 patients acute and subacute post stroke)

Percent of sample who encountered Floor or Ceiling effects				
	Stroke (n =121)		ltem Domain)	
			Correlation corrected	
SIS	%Floor	%Ceiling	Range	
Strength	10	11	0.79-0.83	
Hand Function	26	24	0.90-0.96	
Mobility	1	19	0.52-0.90	
ADL/IADL	1	22	0.34-0.87	
Memory	1	37	0.55-0.78	
Communication	1	60	0.63-0.77	
Emotion	1	6	0.29-0.62	
Participation	2	16	0.52-0.75	
Physical	1	8	0.28-0.85	
Total			0.17-0.79	
SIS-16 Total	1	14	0.33-0.86	

Responsiveness

Stroke:



	(Duncan et al, 1999; SIS version 2.0, Acute Stroke)	
	For patients with minor and moderate strokes, the SIS is sensitive to change from 1 to 3 and 1 to 6 months post-stroke. However the SIS is not sensitive between 3 to 6 months for minor stroke, but does demonstrate sensitivity for this period with moderate stroke patients.	
	(Lin, Fu, et al, 2010, Chronic Stroke)	
	• The hand function subscale showed medium responsiveness (SRM = 0.52; Wilcoxon Z = 4.24; <i>p</i> < 0.05)	
	 Responsiveness of the SIS total score was significantly larger than that of the Stroke Specific Quality of Life Scale total (SRM difference = 0.36; 95% CI, 0.02-0.71) 	
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.	
	For detailed information about how recommendations were reade related	

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>

Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

Acute	Subacute	Chronic


	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)		
	(SCI < 1 month post)	(SCI 3 to 6 months)			
	(Vestibular < 6 weeks post)				
StrokEDGE	NR	HR	HR		

Recommendations based on level of care in which the assessment is taken:

	Acut e Care	Inpatient Rehabilita- tion	Skilled Nursing Facility	Outpatient Rehabilita- tion	Home Health
StrokEDGE	NR	UR	HR	HR	HR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/	Is additional research warranted for this tool (Y/N)
StrokEDGE	Yes	Yes	Yes	Not reported

Considerations

• The respondent must be able to follow a 3-step command

- The author recommends that patients score at least 16 on the Mini-Mental Exam
- The SIS can be mail administered, completed by proxy, completed by proxy by mailed administration, or be administered by telephone
- Proxies (if used) are more likely to rate a patient as impaired (Duncan et al, 2002)



	 The SIS should be used with caution in individuals with mild impairment as the items in the communication, memory, and emotion domains are considered easy and only capture limitations in most impaired individuals
	• Would be appropriate in these settings provided the client has spent time living in the community since stroke diagnosis as many items relate to living at home
	 Alternately, the tool could be used and a percentage score calculated omitting "home-based" items
	Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u> !
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	O'Dell, M.W., Kim, G., Rivera, L., et al. (2013) "A psychometric evaluation of the arm motor ability test." J Rehabil Med 45(6): 519-527.
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Link to instrument	Available for free at the Landon Center on Aging SIS Homepage (external link)



Link to instrument	STREAM
Title of Assessment	Stroke Rehabilitation Assessment of Movement Measure
Acronym	STREAM
Instrument Reviewer(s)	Reviewed by Heather Anderson and Rie Yoshida of the StrokEdge II task force, Neurology Section, APTA.
Summary Date	3/24/16
Purpose	• The STREAM was designed for use by physical therapists to provide a quantitative evaluation of motor functioning for stroke patients. The STREAM was specifically designed to be easy to administer in a clinical setting.
Description	The STREAM is composed of 30 items distributed across 3 domains:
	Upper-limb (UL) movements (scored on a 3-point ordinal scale
	Lower-limb (LL) movements (scored on a 3-point ordinal scale)
	Basic mobility (MO) items (scored on a 4-point ordinal scale)
	Scoring the STREAM:
	• Total of 20 points for each of the limb sub-scales (40 points total)
	Total of 30 points for the mobility subscale
	Scores can be transformed, allowing for items that can't be scored
	• Subscales are converted to a percentage, even though the scores are not interval based. This is done to allow for occasional items that cannot be scored. Total scores are calculated using the average of the 3 subscale scores
	Instructions for score transformation can be found in the instruments manual
	Three versions of STREAM exists: the original 30 item STREAM-30, revised STREAM-27, and simplified STREAM-15
	 STREAM-27 omitted 2 UL subscale items: scapular elevation and opposition; 1 LL subscale item: hip abduction from STREAM-30 STREAM-15 comprises of 5 items in each of the subscales from original STREAM-30

30. REHAB MEASURES DATABASE: STROKE REHABILITATION ASSESSMENT OF MOVEMENT MEASURE



Area of Assessment	Coordination; Functional Mobility; Range of Motion
Body Part	Upper Extremity; Lower Extremity
ICF Domain	Body Function; Activity
Domain	Motor
Assessment Type	Performance Measure
Length of Test	06 to 30 Minutes
Time to Administer	15 minutes
Number of Items	30
Equipment Required	None
Training Required	None
Type of training required	No Training
Cost	Free
Actual Cost	Free
Age Range	Adult: 18-64 years; Elderly adult: 65+
Administration Mode	Paper/Pencil
Diagnosis	Stroke



Populations Tested	• Stroke
Standard Error of Measurement (SEM)	 <u>Chronic Stroke</u>: (Chen et al, 2007; n = 50; mean age = 60.9 (12.8) years; median time between stroke and assessment = 24 months, mean Barthel Index (BI) scores = 15.9 (5.3) points) Standard Error of Measurement (SEM) = 1.5 points
Minimal Detectable Change (MDC)	 Chronic Stroke: (Chen et al, 2007) Smallest Real Difference (SRD) = 4.2 points Acute Stroke: (Hsueh et al, 2008; n = 50 mean age = 61.9 (11.7) years; onset to admission 18.6 (11.7) days; stay in rehab = 22.3 (5.7) days)

•

STREAM Smallest Real Difference:						
Measure	ICC	95% CI	SRD (SRD%)			
STREAM						
UE-STREAM	.97	0.96-0.98	2.8 (14.0)			
LE-STREAM	.98	0.96-0.99	2.5 (12.6)			
Motor-STREAM	.98	0.97-0.99	3.9 (9.9)			
S-STREAM						
UE-S-STREAM	.95	0.92-0.97	11.6 (11.6)			
LE-S-STREAM	.97	0.95-0.98	9.1 (9.1)			
Motor-S-STREAM	.97	0.95-0.98	17.4 (8.7)			
FM						
UE-FM	.98	0.96-0.99	7.2 (10.9)			
LE-FM	.95	0.91-0.97	3.8 (11.3)			
Motor-FM	.98	0.97-0.99	8.4 (8.4)			
S-FM						



	U	E-S-FM	.93	0.89-0	.96	12.2 (12.)	2)			
	LE	E-S-FM	.96	0.93-0	.97	8.6 (8.6)				
	Ν	lotor-S-FM	.96	0.94-0	.98	16.0 (8.0)			
	ST SF FT S- U LE	STREAM = Motor Scale of Stroke Rehabilitation Assessment of Movement S-STREAM = Simplified Motor Scale of STREAM SRD = smallest real difference FM = Fugl-Meyer Motor Scale S-FM = Simplified Fugl-Meyer Motor Scale UE = Upper Extremity LE = Lower Extremity								
Minimally Clinically Important Difference (MCID)	 Stroke: (Hsieh et al, 2008; n = 81 stroke patients who were recruited from Departments of Physical Medicine and Rehabilitation of three hospital in Taiwan; mean age = 55.9 (13.3) years; mean MMS score = 25.8 (2.8) years; mean STREAM baseline score = 10.27 (7.6) for upper extremity, 9.6 (6.7) for lower extremity, and 16.1 (7.6) for mobility) MCID for upper-extremity subscale (n = 42) = 2.2 MCID for lower-extremity subscale (n = 38) = 1.9 MCID for mobility subscale (n = 43) = 4.8 							Physical an MMSE 6 (6.7) for		
Cut-Off Scores	Not Established									
Normative Data	<u>Acute Stroke</u> : (Ahmed et al, 2003; <i>n</i> = 63; mean age = 67 (14) years; assessed within a week of stroke, then again at 4 weeks and 3 months)									
	STREAM Norms Over Time with Comparisons:									
	Instrume	nt	Initial	nitial		5 week				
	Name	Domain	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median		
	STREAM	Total Score	75 (26.7)	86	86 (19.1)	94	89 (18.0)	97		
		UE subscale	73 (33.3)	90	85 (26.2)	100	88 (24.0)	100		
		LE subscale	75 (28.9)	85	86 (22.3)	95	90 (19.0)	100		
		Mobility subscale	74 (25.9)	83	88 (16.4)	97	91 (15.0)	97		



	Barthel Index	Total	72 (27.9)	85	86 (20.4)	100	92 (14.0)	100
	Gait speed (m/s)	Total	0.55 (0.38)	0.58	0.82 (0.43)	0.90	0.85 (0.36)	0.93
	STREAM = Stro UE = Upper Ext LE = Lower Extr	ovement	1		1			
Test-retest Reliability	Chronic Stroke	(Chen et al, 2	2007, <i>n</i> = 50, 7	days b	etween asse	ssmen	ts)	
	Test re-test dat	a for the Mot	oility subscale	of the S	STREAM			
	First Session M	First Session Mean (SD)						
	Second Session	Second Session Mean (SD)						
	Mean <i>d</i> (SD)	Mean <i>d</i> (SD)						
	ICC (95% CI)	ICC (95% CI)			8)*			
	SEM	SEM						
	SRD	SRD						
	*Excellent	*Excellent						
	d = difference of ICC = intraclass CI = confidence SEM = standard SRD = smallest	d = difference of score between the 2 test sessions ICC = intraclass correlation coefficient CI = confidence interval SEM = standard error of measurement SRD = smallest real difference						

Interrater/	<u>Chronic Stroke</u> : (Daley et al, 1999; <i>n</i> = 20; mean age = 66.7 (10.7) years; mean time between stroke
Intrarater	onset and assessment = 104.5 (42.7) days)
Reliability	

Interrater and Intrarater Reliability:



	Sub scale	2	Direct Observ Agreement)	vation (Interrate	r Video (Intra	Videotaped Assessments (Intrarater Agreement)			
	Upper-ex subscale	xtremity	.994		.963	.963			
	Lower-ex subscale	xtremity	.993		.999				
	Basic mo subscale	bility	.982		.999	.999			
	Total sco STREAM	ores on	.995		.999				
GCC = generalizability correlation coefficient Reliability coefficients of .95 or better are recommended									
Internal Consistency	 Chronic Stroke: (Daley et al, 1999) Internal Consistency (Cronbach's alpha): Excellent: Mobility subscale = .965 Excellent: Limb subscales = .979 Excellent: overall STREAM scores = .984 								
Criterion Validity (Predictive/	Acute Stroke: (Ahmed et al, 2003)								
Concurrent)	STREAM	Predictive	and Concurre	nt Validity Corre	lations:				
	Stream	Time	Box and Block	Box and Block	Barthel	Balance	TUG	Gait	
			(Affected UE)	(Unaffected UE)					
	Total	Initial	.73	.36	.78	.75	.80	.74	
		5 weeks	.77	.37	.71	.68	.64	.62	
		3 months	.78	.44	.75	.65	.57	.73	
	UE	Initial	.78	.31	.67	.57	.69	.56	
		5 weeks	.79	.36	.66	.61	.49	.53	



	3 months	.76	.31	.67	.53	.60	.64
LE	Initial	.53	.40	.71	.73	.75	.74
	5 weeks	.64	.29	.59	.55	.59	.55
	3 months	.70	.30	.63	.55	.51	.65
Mobility	Initial	.66	.55	.84	.88	.85	.83
	5 weeks	.69	.40	.75	.71	.57	.65
	3 months	.66	.40	.82	.78	.62	.76

<u>Acute Stroke</u>: Ward et al, 2011; n = 30; mean age 66.5 (SD 13.7) years; mean time assessed following stroke 7.8 days (SD 3.5; range 3-15); assessed at admission and discharge; mean time in rehabilitation = 23.3 (range 7-53) days)

Spearman correlations and corresponding p-values								
STREAM		Adı	mission	Disc	narge	Change		
		FIM	SIS-16	FIM	SIS-16	FIM	SIS-16	
Total STREAM	rho: p-value:	0.7766 <.0001	0.7073 <.0001	0.7802 <.001	0.7153 <.0001	0.2535 .1765	0.4456 .0136	
Mobility STREAM	rho: p-value:	0.6501 .0001	0.6451 .0001	0.8292 <.0001	0.7985 <.0001	0.3055 .1007	0.2655 .1561	
UE STREAM	rho: p-value:	0.7489 <.0001	0.6088 .0004	0.7012 <.0001	0.5499 .0016	0.1277 .5011	0.2461 .1898	
LE STREAM	rho: p-value:	0.7905 <.001	0.5992 .0005	0.6954 <.0001	0.6371 .0002	0.2811 .1324	0.1955 .3006	
STREAM = Stroke Rehabilitation Assessment of Movement FIM = Functional Independence Measure SIS-16 = 16 item Stroke Impact Scale								

SRM = Standardized response mean



Acute Stroke: Ward et al, 2011

Spearman correlations (values are Spearman rho coefficients) between admission FIM, SIS-16 and STREAM scores and predicted vs actual length of stay

Measure	Predicted length of stay	Actual length of stay				
Motor FIM	-0.9438	-0.6846				
SIS-16	-0.6743	-0.7953				
Total STREAM	-0.8011	-0.7972				
Mobility STREAM	-0.6361	-0.7423				
UE STREAM	-0.7717	-0.7469				
LE STREAM	-0.8446	-0.7364				
P-values are <.0001 for all correlations except for STREAM mobility and predicted length of stay where P = .0002						
STREAM = Stroke Rehabilitation Assessment of Movement FIM = Functional Independence Measure						

SIS-16 = 16 item Stroke Impact Scale

Construct Validity (Convergent/Dis criminant)	Acute S stroke Conve	Acute Stroke: (Hsueh et al, 2003, n = 59; mean age 64.2 (11.5) years; assessed within 14 days of stroke onset, Taiwanese sample) Convergent Validity and Predictive Validity of the STREAM at 4 Time Points						
	Days n Co		Convergent Validity* (p)	Predictive Validity† (p)				
	14	57	0.80	0.54				
	30	54	0.87	0.67				
	90	44	0.82	0.81				
	180	43	0.76					



*Relationships between the STREAM and the BI at 4 time points.
⁺ Relationships between the STREAM and the BI at 3 time points (14, 30, and 90 days)
after stroke.

Content Validity Items from the initial STREAM were reviewed by two panels of experts made up to 20 physical therapists. Feedback from these experts were used to refine the measure.

Face Validity Not statistically assessed

Floor/CeilingAcute Stroke: (Hsueh et al, 2008)Effects

STREAM Floor and Ceiling Effects at Admission and Discharge						
	At Admissi	on, n (%)	t Discha	rge, n (%)		
	Floor	Ceiling	Floor	Ceiling		
UE-STREAM	13 (26.0)	10 (20.0)	4 (8.0)	20 (40.0)		
LE-STREAM	10 (20.0)	2 (4.0)	1 (2.0)	12 (24.0)		
Motor-STREAM	9 (18.0)	1 (2.0)	1 (2.0)	10 (20.0)		
S-STREAM	2 (4.0)	0 (0.0)	0 (0.0)	6 (12.0)		
UE = Upper Extremity LE = Lower Extremity STREAM = Motor Scale of Stroke Rehabilitation Assessment of Movement S-STREAM = Simplified Motor Scale of STREAM						

Acute Stroke: (Hsueh et al, 2003)

STREAM Floor and Ceiling Effects at 4 Time Points					
Days after Stroke	Floor	Ceiling			



	n (%)	n (%)
14 (n = 57)	0 (0)	0 (0)
30 (n = 54)	0 (0)	2 (3.7)
90 (n = 44)	0 (0)	6 (13.6)
180 (n = 43	0 (0)	7 (16.3)

Subacute Stroke: (Huang et al, 2015, *n* = 195; mean age = 63.4 (13.7) years, Taiwanese sample, compared original 30-item STREAM with STREAM-27 and simplified STREAM-15)

- Significant floor and ceiling effects in STREAM-30
 - UL subscale: both significant floor effects (21.0%-31.3%) and ceiling effects (19.0%-26.2%) found for both admission and discharge
 - LL subscale: significant floor effect (20.5%) at admission and significant ceiling effect (19.5%) at discharge
 - o MO subscale: no significant floor or ceiling effects

Neither floor nor ceiling effects found in 3 subscales of STREAM-27 and STREAM-15

Responsiveness Acute Stroke: (Higgins et al, 2005; *n* = 55; mean age = 66 (15), assessed at 5 weeks after onset)

Standard Response Means (SRM) for STREAM:					
Sub-scale	SRM	95% Confidence Interval			
STREAM Total	0.98	0.74 - 1.17			
STREAM (upper limb)	0.75	0.56 – 0.93			
STREAM (lower limb)	0.63	0.36 - 0.86			

<u>Acute Stroke</u>: (Hsueh et al, 2008; assessed at admission and within 48 hours of discharge; mean time in rehabilitation = 22.3 (5.7) days)

• S-STREAM found to be the most responsive

STREAM Responsiveness:



Scale	Change score (SD)	Strength	Effect Size <i>d</i>	SRM
STREAM				
UE-STREAM	3.3 (4.2)	small	0.38	0.78
LE-STREAM	3.3 (3.9)	small	0.44	0.84
Motor-STREAM	6.5 (6.9)	small	0.45	0.95
S-STREAM				
UE-S-STREAM	14.5 (12.2)	small	0.49	1.19
LE-S-STREAM	14.7 (12.9)	medium	0.54	1.14
Motor-S-STREAM	29.1 (23.2)	medium	0.53	1.26
FM				
UE-FM	8.4 (8.5)	small	0.34	1.00
LE-FM	4.3 (5.2)	small	0.41	0.83
Motor-FM	12.7 (11.0)	small	0.38	1.16
S-FM				
UE-S-FM	14.6 (14.4)	small	0.47	1.00
LE-S-FM	14.9 (17.9)	medium	0.51	0.83
Motor-S-FM	29.4 (29.7)	medium	0.51	0.99

STREAM = Motor Scale of Stroke Rehabilitation Assessment of Movement S-STREAM = Simplified Motor Scale of STREAM

- FM = Fugl-Meyer Motor Scale
- UE = Upper Extremity
- LE = Lower Extremity
- S-FM = Simplified Fugl-Meyer Motor Scale
- SRM = Standardized Response Mean

Acute Stroke: Ward et al, 2011



Scale	Change score (SD)	Strength	SRM			
Total STREAM	12.3 (8.8)	Large	1.40			
UE-STREAM	12.4 (12.9)	Large	0.97			
LE-STREAM	10.2 (9.9)	Large	1.03			
Mobility-STREAM	11.9 (14.4)	Large	0.83			
FIM (motor)	23.7 (10.1)	Large	2.34			
SIS-16	23.1 (14.0)	Large	1.65			
STREAM = Stroke Rehabilitation Assessment of Movement FIM = Functional Independence Measure SIS-16 = 16 item Stroke Impact Scale SRM = Standardized response mean						

Change score = difference in score between admission and discharge Strength = Small (0.20 - <u><</u>0.50); Medium (0.50 - <u><</u>0.80); Large_> 0.80

Acute Stroke: (Hsueh et al, 2003)

Responsiveness of the STREAM at Different Stages of Recovery					
Days	n	SRM	Wilcoxon z		
14–30	51	1.17	6.02*		
30–90	43	0.95	4.95*		
90–180	43	0.40	2.23†		
14–90	43	1.61	5.72*		
14–180	43	1.65	5.57*		
*P < 0.001; †P	P < 0.05		I		

<u>Acute Stroke</u>: (Yu et al, 2013; n = 66; mean age 63.1 (SD 12.1) years; mean time assessed following stroke 18 days (range 6-64)



 A moderate to good association (0.80; p < 0.001) between changes in scores on the Mobility STREAM and the Hierarchical Balance Short Form (HBSF); Difference 0.00; 95% CI: (-0.10 – 0.10)

<u>Acute Stroke</u>: (Yu et al, 2012; n = 85; mean age 65.5 (SD 11.6) years; mean time assessed following stroke 19 days (range 5-79)

- **Moderate** external responsiveness (p<0.001) for changes in Mobility STREAM compared to Balance Computerized Adaptive Test (CAT): ($\beta = 0.67$; r² = 0.44); compared to Postural Assessment Scale for Stroke patients (PASS): ($\beta = 0.77$; r² = 0.59)
- **Sufficient** explanatory power of predictive validity (p<0.001) for changes in Mobility STREAM at discharge compared to Balance CAT: ($\beta = 0.76$; r2 = 0.57); compared to PASS: ($\beta = 0.80$; r = 0.63)

Subacute Stroke: (Huang et al, 2015)

- Group level responsiveness:
 - Internal responsiveness: similar among 3 STREAM versions (STREAM-30, STREAM-27, STREAM-15)
 - External responsiveness: similar among the 3 STREAM measures. The UL and LL subscales demonstrated moderate external responsiveness and the MO subscale showed high external responsiveness
 - The results demonstrate that all versions of stream are equally able to identify changes in movement status and mobility when used in a group
- Individual level responsiveness:
 - Internal responsiveness: mean SCs for STREAM-27 significantly higher than those of STREAM-15 in all subscales (UL, LL, and MO)
 - External responsiveness: significantly more participants found to have important improvement by STREAM-27 or BI than by STREAM-15 and BI in MO subscale

The results demonstrate that STREAM-27 can detect more participants with significant movement and mobility improvement than STREAM-15

ProfessionalRecommendations for use of the instrument from the Academy of Neurologic Physical Therapy of
the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's
Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II),
Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below.
These recommendations were developed by a panel of research and clinical experts using a
modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>



Abbreviations:	
HR	Highly Recommend
R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCl < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	HR	HR	HR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Heal
StrokEDGE II	HR	HR	HR	HR	HR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
StrokEDGE II	No	Yes	Yes	Ν

Considerations

Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u>!



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Year published	1986
Instrument in PDF Format	Yes
Approval Status	Approved



31. REHAB MEASURES DATABASE: STROKE SPECIFIC QUALITY OF LIFE SCALE

Link to instrument	http://www.strokengine.ca/wp- content/uploads/2015/01/Stroke-Specific-Quality-of-Life- Scale.pdf		
Title of Assessment	Stroke Specific Quality of Life Scale		
Acronym	SS-QOL		
Instrument Reviewer(s)	Initially reviewed by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto-Zipp, PT, EdD, of the StrokEDGE II, Neurology Section, APTA, in 3/2016		
Summary Date			
Purpose	Assessment of health-related quality of life specific to stroke survivors		
Description	 49 items Items are assessed on 5-point Likert Scale Each item is answered using 1 of 3 different response sets (1) amount of help required to do specific tasks, ranging from no help to total help (2) amount of trouble experienced when attempting tasks, ranging from unable to do it to no trouble at all (3) degree of agreement with statements regarding their functioning, ranging from strongly agree to strongly disagree Provides both summary and domain specific scores Domain scores are composed of unweighted averages Summary scores are composed of an unweighted average of the 12 domain average scores Scores range from 49-245 Higher scores indicate better functioning 		



	The twelve domains include		
	 Mobility 		
	o Energy		
	 Upper Extremity Function 		
	 Work and Productivity 		
	o Mood		
	o Self-care		
	 Social Roles 		
	o Family Roles		
	o Vision		
	o Language		
	o Thinking		
	o Personality		
	• May be used with proxies, however research suggests agreement between patient and proxy was best for observable physical domains (Duncan et al, 2002)		
Area of Assessment	Behavior; Cognition; Functional Mobility; Language; Negative Affect; Personality; Quality of Life; Social Relationships; Upper Extremity Function		
Body Part	Not Applicable		
ICF Domain	Participation		
Domain	Cognition; Emotion; General Health; Motor		
Assessment Type	Patient Reported Outcomes		
Length of Test	06 to 30 Minutes		
Time to Administer	10-15 minutes		
Number of Items	49		



Equipment Required	None			
Training Required	None			
Type of training required	No Training			
Cost	Free			
Actual Cost	Scale can be found in: Williams, L. S., M. Weinberger, et al. (1999). "Development of a stroke-specific quality of life scale." Stroke 30(7): 1362- 1369.			
Age Range	Adult: 18-64 years; El	lderly adult: 65+		
Administration Mode	Paper/Pencil			
Diagnosis	Stroke			
Populations Tested	Stroke			
Standard Error of Measurement (SEM)	Not Established			
Minimal Detectable Change (MDC)	Chronic Stroke: (Lin et al 2011);n=25 patients >6 months post stroke.			
		MDC ₉₅	% of patients exceeding MDC ₉₅	
	Mobility Subscale	5.9 points	9.5% - 28.4%	
	Self-Care Subscale	4.0 points	6.8% - 28.4%	
	UE Function 5.3 points 12.2% - 33.8% Subscale			
Minimally Clinically Important Difference (MCID)	<u>Chronic Stroke:</u> (Lin e post stroke	et al 2011); n=74; pa	tients >6 months	
		MDC ₉₅	% of patients exceeding MDC ₉₅	
	Mobility Subscale	1.5 – 2.4 points	9.5% - 28.4%	



	Self-Car	e Subsca	le 1.2 –	1.9 poi	nts	6.8% - 28	.4%
	UE Func Subscale	tion 2	1.2 –	1.8 poi	nts	12.2% - 33	3.8%
Cut-Off Scores	Not Estab	lished					
Normative Data	Acute Str years; par week); m Canadian	Acute Stroke: (Williams et al, 1999; <i>n</i> = 34; mean age = 61 years; patients assessed 1 & 3 months post stroke (+/- 1 week); mean Canadian Neurologic Scale at admission = 9.2)				: 61 1	
	1 Month** 3 Months**				hs**		
	Measure	A Lot Worse	A Little Worse	Same	A Lot Worse	A Little Worse	Same
	SS-QOL	3.23	3.61	4.19	3.10	3.89	4.35
	SF-3	41	52	63	33	49	68
	BI	93	91	97	92	98	99
	NIHSS	3.4	3.2	1.5	2.4	1.1	1.1
	*Overall	HRQOL v	was rated b	oy patie	nts at bo	th time po	oints
	** mean	scores					
Test-retest Reliability	Not Estab	Not Established					
Interrater/Intrarater Reliability	Not Estab	olished					



Internal Consistency

Acute Stroke: (Williams et al, 1999):

• Excellent Internal Consistency

Domain	Items	Mean (SD)	Alpha		
Energy	3	2.9 (1.44)	0.88		
Family Roles	3	3.74 (1.28)	0.79		
Language	5	4.41 (0.68)	0.85		
Mobility	6	4.11 (0.84)	0.86		
Mood	5	3.91 (1.03)	0.80		
Personality	3	3.57 (1.21)	0.77		
Self-care	5	4.51 (0.85)	0.89		
Social Roles	5	3.07 (1.33)	0.85		
Thinking	3	3.39 (1.21)	0.73		
Upper Extremity Function	5	4.21 (0.94)	0.83		
Vision	3	4.61 (0.72)	0.81		
Work/Productivity	3	3.67 (1.11)	0.75		
Excellent; Cronbach's alpha (\geq 0.73 across each of the 12 domains)					

<u>Subarachnoid Haemorrhage</u>: Boosman et al, 2009; n=141; 36.1±7.9 (23-52) months post-SAE

- **Good** internal consistency for all 12 domains Cronbach's alpha 0.80.
- **Excellent** reliability of the Physical and Psychosocial Subscores and total score.



Criterion Validity (Predictive/Concurrent)

<u>Chronic Stroke</u>: (Lin et al 2010; *n* = 74; mean age = 54.11 (11.44) years; pre and post 3-week intervention; mean time since stroke 17.46 (17.67) months)

- Excellent correlation only between the SS-QOL Self-Care and FIM
- Adequate to poor correlations between the domains of the SS-QOL and the Fugl-Meyer Assessment, FIM, and Frenchay Activities Index

SS-QOL Domain	FMA	FIM	FAI
UE Function	0.30*	0.39**	0.21
Self-care	0.27	0.65**	0.52**
Work/Productivity	0.27*	0.40**	0.44**
Family Roles	0.28*	0.38**	0.32**
Social Roles	0.34**	0.21	0.12
Mobility	0.03	0.38**	0.2
Energy	0.16	0.13	0.12
Language	0.08	0.15	0.22
Mood	0.01	0.23	0.16
Personality	0.1	0.19	0.06
Thinking	0.02	0.21	-0.04
Vision	0.02	0.21	-0.04
* P<.05, ** P<.01			

FMA: Fugl-Meyer Assessment FIM: Functional Independence Measure FAI: Frenchay Activities Index



Subarachnoid Haemorrhage: (Bosman et al, 2009; n=141, mean age=51.4 (12.3) years; mean time since SAH s/p aneurysm occlusion via clipping or coiling 36.1 (7.9) months

- Moderate to Strong correlation between all SS-QOL domains and Physical Subtotal scores with CFQ, LiSat-9, and HADS
- Weak to Moderate correlations between Physical SS-QOL subtotal and GOS

SS-QOL Domain	GOS	CFQ	LiSat-9	HADS
Self-Care	0.42	-0.30	0.56	-0.42
Mobility	0.26	-0.39	0.55	-0.50
UE Function	0.33	-0.44	0.56	-0.48
Language	0.10	-0.53	0.42	-0.44
Vision	0.08	-0.38	0.41	-0.48
Work	0.14	-0.49	0.60	-0.61
Thinking	0.03	-0.65	0.40	-0.45
Family Roles	0.08	-0.40	0.57	-0.61
Social Roles	0.10	-0.40	0.62	-0.63
Personality	0.05	-0.43	0.51	-0.65
Mood	0.09	-0.43	0.57	-0.71
Energy	0.03	-0.42	0.44	-0.64
Physical Subscore	0.25	-0.52	0.64	-0.59
Psychological Subscore	0.07	-0.53	0.61	-0.73
Correlations above 0.24 were significant <i>p</i> <0.0033; two tailed, using Bonferroni correction				
GOS – Glasgow Outcome Scale				

CFQ – Cognitive Failure Questionnaire

LiSat-9 – Life Satisfaction Checklist

HADS – Hospital Anxiety and Depression Scale



Construct Validity (Convergent/Discriminant)

Acute Stroke: (Williams et al, 1999)

Construct Validity of SS-QOL Domains				
SS-QOL Domain*	Established Measure	Strength	r2	p
Energy	SF-36 vitality	Adequate	0.51	< 0.001
Family Roles	SF-36 emotional and physical role limitations	Poor	0.29	< 0.001
Mobility	SF-36 physical function	Adequate	0.41	< 0.001
Mood	BDI	Adequate	0.43	< 0.001
Personality	BDI	Adequate	0.33	< 0.001
Self-care	BI	Adequate	0.45	< 0.001
Work/Productivity	SF-36 physical role limitations	Adequate	0.31	< 0.001
Overall SS-QOL score	Overall SF-36 score	Excellent	0.65	< 0.001

• Items in the language and thinking domains were not associated with items on the NIHSS.

 These results may have occurred because patients with cognitive and language deficits were excluded from the study.

Content Validity

Acute Stroke: (Williams et al, 1999)

 Items and domains were developed through interviews conducted with stroke patients (n = 32 poststroke patients)



SS-QOL and International Classification of
Functioning, Disability, and Health (ICF) categories
were independently assessed by two healthcare
professionals.

 Agreement across all but three concepts was acceptable; kappa ranged from 0.75 to 1.00 (Teixeira-Salmela et al, 2009)

Not Established

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Floor/Ceiling Effects

Face Validity

Acute Stroke: (Williams et al, 1999)

Domain	Items	% Floor	% Ceiling
Energy	3	17	18
Family Roles	3	4	35
Language	5	1	37
Mobility	6	1	23
Mood	5	1	30
Personality	3	4	23
Self-care	5	3	51
Social Role	5	9	14
Thinking	3	4	13
Upper Extremity Function	5	1	31
Vision	3	1	63
Work/Productivity	3	3	21

Subarachnoid Haemorrhage: Boosman et al, 2009



 Ceiling effect present for 10/12 domains and for physical component. Most strongly self-care & vision domains.

Responsiveness

Acute Stroke: (Williams et al, 1999)

Domain	Responsiveness	SES*
Energy	mildly responsive	0.36
Family Roles	mildly responsive	0.41
Language	moderately responsive	0.63
Mobility	moderately responsive	0.53
Mood	mildly responsive	0.41
Personality	mildly responsive	0.20
Self-care	moderately responsive	0.55
Social Role	markedly responsive	0.83
Thinking	mildly responsive	0.36
Upper Extremity Function	mildly responsive	0.44
Vision	moderately responsive	0.59
Work/Productivity	moderately responsive	0.54
*Standardized Effect Sizes		

Acute Stroke: (Lin et al 2010)

Responsiveness of the Stroke Impact Scale 3.0 (SIS) was found to be significantly larger than the SS-QOL total (Standard Response Mean difference = .36; 95% CI = .02 to .71)

Professional AssociationRecommendations for use of the instrument from the
Academy of Neurologic Physical Therapy of the American
Physical Therapy Association's Multiple Sclerosis Taskforce



(MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.

For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-</u> professionals/neurology-section-outcome-measuresrecommendations

Abbreviations:	
HR	Highly Recommend
R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	UR	UR	UR



Recommendations based on level of care in which the assessment is taken:

	Acu te Care	Inpatient Rehabilitat ion	Skille d Nursi ng Facilit y	Outpatient Rehabilitat ion	Hom e Heal th
StrokED GE II	NR	NR	NR	UR	UR

Recommendations for entry-level physical therapy education and use in research:

		Students should learn to administ er this tool? (Y/N)	Student s should be expose d to tool? (Y/N)	Appropriat e for use in interventio n research studies? (Y/N)	Is additiona I research warrante d for this tool (Y/N)
	StrokEDG E II	No	No	Yes	Yes
Considerations	 Due appr disal SS-C 95% diffe their scale Do you see a summary? P 	to linguistic ropriate for p bilities (Hilar QOL-12 has g of the varia erences betw r 95% CI wer e. (Post et al an error or h lease <u>e-mail</u>	complexity patients wi ri and Byng good criterio nce of the veen the SS re generally , 2011) ave a sugge us!	r, the SS-QOL r th communica , 2001). on validity, pre original SS-QO -QOL-12 and S within 0.1 po estion for this i	nay not be tion dicting 88- L. Mean S-QOL and ints on a 1-5 instrument
Bibliography	Boosman, H. Stroke Speci	., Passier, P., fic Quality o	, et al. (201 f Life scale	0). "Validation in patients wit	of the :h



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Williams, L. S., Weinberger, M., et al. (1999). "Measuring quality of life in a way that is meaningful to stroke patients." Neurology 53: 1839-1843. <u>Find it on PubMed</u>



	Williams, L. S., Weinberger, M., et al. (1999). "Development of a stroke-specific quality of life scale." Stroke 30(7): 1362- 1369. <u>Find it on PubMed</u>
Year published	1999
Instrument in PDF Format	Yes
Approval Status	Approved

32. REHAB MEASURES DATABASE—TARDIEU SPASTICITY SCALE

Link to instrument	
Title of Assessment	Tardieu Scale/Modified Tardieu Scale
Acronym	MTS
Instrument Reviewer(s)	Initially reviewed by Christopher Newman, PT, MPT, NCS, Jennifer H. Kahn, PT, DPT, NCS, and the SCI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 8/2012. Updated by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto-Zipp, PT, EdD, of the StrokEDGE II, Neurology Section, APTA, 3/2016
Summary Date	12/23/2013; March 2016
Purpose	To assess the muscle's response to stretch at various given velocities.
Description	 Tardieu is a scale for measuring spasticity that takes into account resistance to passive movement at both slow and fast speed. The scale originally began development in the 1950s and has gone through multiple revisions (reviewed in Haugh 2006). The most recent versions of the Modified Tardieu Scale use the following criteria: Individuals are positioned in sitting to test the UEs and supine to test the LEs 2 Measurements: Quality of muscle reaction Angle of muscle reaction Speed definitions: V1 is slow as possible V2 speed of limb falling under gravity V3 moving as fast as possible Quality of Muscle Reaction (scored 0-5); 0 is no resistance to passive ROM to 5 indicating joint is immobile. (Some versions scored 0-4)
	0 No resistance throughout the course of the passive movement



	1 Slight resistance throughout the course of the passive movement, with no clear catch at precise angle
	2 Clear catch at precise angle, interrupting the passive movement, followed by release
	3 Fatigable clonus (<10 seconds when maintaining pressure)
	4 Infatigable clonus (>10 seconds when maintaining pressure)
	occurring at precise angle
	 Joint Angle: Modified Tardieu describes R1 and R2; R1 is the angle of muscle reaction, R2 is the full PROM The angle of full ROM (R2) is taken at a very slow speed (V1). The angle of muscle reaction (R1) is defined as the angle in which a catch or clonus is found during a quick stretch (V3). R1 is then subtracted from R2 and this represents the dynamic tone component of the muscle. (Boyd 1999)
Area of Assessment	Functional Mobility
Body Part	Not Applicable
ICF Domain	Body Structure; Body Function
Domain	Motor
Assessment Type	Performance Measure
Length of Test	
Time to Administer	Dependent on number of joints being tested.
Number of Items	Dependent on number of joints being tested.
Equipment Required	Goniometer
Training Required	No formal training required. Recommend training from an experienced tester for better understanding of how to correctly administer test.
Type of training required	No Training
Cost	Free
Actual Cost	Free
Age Range	
Administration Mode	
Diagnosis	Cerebral Palsy; Geriatrics; Stroke; Traumatic Brain Injury
Populations Tested	Cerebral Palsy
	Adults with severe brain injury
	Stroke



	Adults with profound intellectual and multiple of the second	tiple disabilit	ies (PIMD)
Standard Error of Measurement (SEM)	 <u>Stroke:</u> (Paulis et al, 2011; n = 13 subjects living in a num 70.2(12.30) years; compared test-retest and inter elbow flexors measured with goniometry vs. inert Tardieu (R2-R1) SEM Goni = 6.19, IS = 8.8 Passive ROM (R2) SEM Goni = 5.04, IS = 6. Angle of Catch (R1) SEM Goni = 4.47, IS = 5 <u>Severe Brain Injury:</u> (Mehrholz et al, 2005; n = 30, patients with impai severe cerebral damage of various etiologies; measured 	sing home; r rrater reliabil ial sensors (1 80 5.72 red consciou ean age = 63	nean age = ity of Tardieu of IS)) ISness due to 3.9(12.9) years)
			1
	SEM for Intra-rater Reliability	0.000	
	Domain	SEM	
	Shoulder flexion	0.05	
	Shoulder external rotation	0.05	•
	Elbow flexion	0.04	
	Elbow extension	0.04	
	Wrist flexion	0.02	
	Wrist extension	0.04	
	Hip flexion	0.02	
	Hip extension	0.04	-
	Knee flexion	0.05	
	Knee extension	0.03	
	Ankle extension (knee joint flexed)	0.02	
	Ankle extension (knee joint fully extended)	0.04	J
	SEM for Inter-rater Reliability		1
	Domain	SEM	
	Shoulder flexion	0.05	
	Shoulder external rotation	0.05	
	Elbow flexion	0.03	
	Elbow extension	0.03	
	Wrist flexion	0.07	
	Wrist extension	0.03	
	Hip flexion	0.04	
	Hip extension	0.03	
	Knee flexion	0.04	
	Knee extension	0.03	
	Ankle extension (knee joint flexed)	0.03	
	Ankle extension (knee joint fully extended)	0.04	
Minimal Detectable Change (MDC)	<u>Stroke:</u> (Paulis et al, 2011)		
	Smallest Detectable Difference (SDD) calculated data and test retest data:	from above	referenced SEM



	 Tardieu (R2-R1) SEM Goni = 17.16, IS = 24.41 Passive ROM (R2) SEM Goni= 13.98, IS= 18.85 Angle of Catch(R1) SEM Goni = 12.39, IS= 15.85 			
Minimally Clinically Important Difference (MCID)	Not Established			
Cut-Off Scores	Not Established			
Normative Data	<u>Severe brain injury:</u> (Mehrholz et al, 2005) Patient Characteristics			
	Characteristic	Patients,		
		<i>n</i> = 30		
	Age (years) ^a	63.9		
		(±12.9)		
	Sex (female/male)	9/21		
	Diagnosis			
	Ischemic Stroke	7		
	Intracerebral Hemorrhage	11		
	Traumatic brain injury	5		
	Cerebral hypoxia	7		
	Duration of illness (days) ^a	78 (±93)		
	Antispastic therapy			
	Local (botulinum toxin)	0		
	Systemic (baclofen or tizanidine)	2		
	Implanted intrathecal baclofen pump system	0		
	Glasgow Coma Scale score ^a	6.9 (±2.3)		
	Coma Remission Scale score ^a	8.0 (±4.5)		
	Body mass index (kg/m^2) ^a	24.1		
		(±3.8)		
	^a Mean ± standard deviation.			
Test-retest Reliability	Severe Brain Injury: (Mehrholz et al, 2005)		roupo tootodu	
	 Adequate initial telefability k = 0.05-0.07 for hidscle gloups tested, except shoulder ER k = 0.53 Angle of muscle reaction: joint (ICC = elbow flexors, 0.73 (Adequate); knee flexors, 0.72 (Adequate); ankle PF with knee flexed, 0.70 (Adequate); ankle PF with knee extended, 0.65 (Adequate)) 			
	<u>Children with CP:</u> (Fosang et al, 2003; $n = 18$, ages 2-10 yrs old, determine reliability and magnitude of error for MAS, PROM, and Tardieu Scale)			
	 Adequate to Excellent Correlation for MTS at Hamstrings (ICC = 0.68-0.90) Poor to Excellent Coorelation of MTS at Gastroc (ICC = 0.38-0.90) Adequate to High Correlation MTS at Hip Add (ICC = 0.61-0.93) 			
		,	,	



Stroke:

(Paulis et al, 2011)

Test-retest reliability of Tardieu performed with goniometer and with inertial sensors (IS) of elbow flexors

<u>R2-R1</u>	<u>ICC</u>
Goniometric	Excellent 0.86
IS	Excellent 0.76
PROM, R2	ICC
Goniometric	Excellent 0.87
IS	Excellent 0.86

AoC (R1)*	ICC
Goniometric	Excellent 0.91
IS	Excellent 0.82

*AoC: Area of Catch

Interrater/Intrarat er Reliability <u>Severe Brain Injury:</u> (Mehrholz et al, 2005)

Intrarater reliability

Domain	Cohen's	Standards
	kappa	for use
Shoulder flexion	0.65	Poor
Shoulder external rotation	0.53	Poor
Elbow flexion	0.78	Adequate
Elbow extension	0.75	Adequate
Wrist flexion	0.87	Excellent
Wrist extension	0.71	Adequate
Hip flexion	0.76	Adequate
Hip extension	0.72	Adequate
Knee flexion	0.67	Poor
Knee extension	0.81	Excellent
Ankle extension (knee joint flexed)	0.82	Excellent
Ankle extension (knee joint fully extended)	0.72	Adequate

Interrater reliability

Domain	Cohen's	Standards
	kappa	for use
Shoulder flexion	0.44	Poor
Shoulder external rotation	0.39	Poor
Elbow flexion	0.48	Poor
Elbow extension	0.51	Poor
Wrist flexion	0.33	Poor
Wrist extension	0.38	Poor
Hip flexion	0.42	Poor
Hip extension	0.37	Poor
Knee flexion	0.53	Poor
Knee extension	0.44	Poor
Ankle extension (knee joint flexed)	0.47	Poor


Ankle extension	(knee	ioint fully	v extended))	0.29	Poor	
					00		

Stroke:

(Ansari et al, 2008; n = 30 individuals with hemiplegia > 1 month post stroke)

Interrater reliability for MTS used to assess elbow flexor spasticity:

- Adequate interrater reliability for R2-R1 (ICC = 0.72)
- Adequate interater reliability for MTS quality (ICC = 0.74) and R1 (ICC = 0.74) and R2 (ICC = 0.56)

Stroke:

(Paulis et al, 2011)

<u>R2-R1</u>	ICC
Goniometric	Adequate 0.66
IS	Excellent 0.84
PROM, R2	ICC
Goniometric	Excellent 0.89
IS	Excellent 0.89

AoC* (R1)	ICC
Goniometric	Adequate 0.60
IS	Excellent 0.87

*AoC: Angle of Catch

Stroke:

(Singh et al, 2011; n = 91 people with acute stroke; mean age = 64 (SD = 11.1) years)

ICCs	elbow flexors	ankle plantar flexors	
R1	Excellent 0.998	Excellent 0.990	
R2	Excellent 0.978	Excellent 0.995	
R2-R1	Excellent 0.991	Excellent 0.907	
MTS scores	Excellent 0.847	Excellent 0.863	
p < 0.0001 for all of the above			

Children with CP:

(Yam and Leung, 2006; n = 17 children with CP; mean age = 7yr 9mo) Interrater reliability between MAS and MTS, 4 joints in LE tested:

- **Poor to Adequate**: Modified Tardieu (ICC = 0.22-0.71)
- Poor to Adequate: R1 (ICC = 0.37-0.71); R2 (ICC = 0.17-0.74; R2-R1 (ICC = 0.4-0.69)

Children with CP:

(Fosang et al, 2003)

• Adequate interrater reliability (ICC = 0.58-0.72)

Internal Consistency

Not Established



Criterion Validity (Predictive/Concur rent)	Not Establishe	ed		
Construct Validity (Convergent/Discri minant)	Stroke: (Patrick and Ada, 2006; $n = 16$, chronic stroke living in the community, compared MAS, MTS, and clinical measure of spasticity in laboratory - EMG)		mmunity, comparing EMG)	
	 PEA (Period of spatial of spati	ercentage of exact agreement asticity, 100% for elbow flex at Convergent Validity ($r =$ of Tardieu and laboratory r flexors and plantar flexors at Convergent Validity ($r =$ s)	ent) of Tardieu and la kors and plantar flexo 0.86 elbow flexors; 0 neasures of contractu 6 0.89 for elbow flexors	boratory measure ors .62 ankle) ure was 94% for s; 0.84 for plantar
Content Validity	Not Establishe	ed		
Face Validity	Not Establishe	ed		
Floor/Ceiling Effects	Not Establishe	ed		
Responsiveness	Not Established			
Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Co Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Bra Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit: http://www.neuropt.org/go/healthcare-professionals/neurology-section- outcome-measures-recommendations		ny of Neurologic ion's Multiple EDGE), Spinal Cord I), Traumatic Brain GE) are listed of research and nade, please prology-section-	
	Abbreviatio	ns:		
	HR	Highly Recommend		
	R	Recommend	<u> </u>	
	LS/UR	Reasonable to use, but lin Recommend	nited study in target g	group / Unable to
	NR	Not Recommended		
	Recommenda	tions for use based on acu	ity level of the patien	t:
		Acute	Subacute	Chronic
		(CVA < 2 months	(CVA 2 to 6	(> 6 months)
		(SCI < 1 month post)	(SCI 3 to 6 months)	



	(Vestibular < 6 weeks post)		
SCI EDGE	LS	LS	LS
StrokEDGE II	UR	UR	UR

Recommendations based on level of care in which the assessment is taken:

	Acute Care	Inpatient Rehabilitation	Skilled Nursing Facility	Outpatient Rehabilitation	Home Health
MS EDGE	UR	UR	UR	UR	UR
StrokEDGE II	UR	UR	UR	UR	UR

Recommendations based on SCI AIS Classification:

	AIS A/B	AIS C/D
SCI EDGE	LS	LS

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 – 7.5
MS EDGE	UR	UR	UR

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	Is additional research warranted for this tool (Y/N)
MS EDGE	No	No	No	Yes
SCI EDGE	No	No	No	Not reported
StrokEDGE II	No	Yes	Yes	Yes

Considerations Do you see an error or have a suggestion for this instrument summary? Please e-mail us!

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Boyd, R. N. and Graham, H. K. (1999). "Objective measurement of clinical findings in the use of botulinum toxin type A for the management of children with cerebral palsy." European Journal of Neurology 6(S4): s23-s35.



	 Fosang, A. L., Galea, M. P., et al. (2003). "Measures of muscle and joint performance in the lower limb of children with cerebral palsy." Developmental Medicine and Child Neurology 45(10): 664-670. Find it on PubMed Haugh, A. B., Pandyan, A. D., et al. (2006). "A systematic review of the Tardieu Scale for the measurement of spasticity." Disability and Rehabilitation 28(15): 899-907. Find it on PubMed Mehrholz, J., Wagner, K., et al. (2005). "Reliability of the Modified Tardieu Scale and the Modified Ashworth Scale in adult patients with severe brain injury: a comparison study." Clinical Rehabilitation 19(7): 751-759. Find it on PubMed Patrick, E. and Ada, L. (2006). "The Tardieu Scale differentiates contracture from spasticity whereas the Ashworth Scale is confounded by it." Clinical Rehabilitation 20(2): 173-182. Find it on PubMed Paulis, W. D., Horemans, H. L., et al. (2011). "Excellent test-retest and inter-rater reliability for Tardieu Scale measurements with inertial sensors in elbow flexors of stroke patients." Gait and Posture 33(2): 185-189. Find it on PubMed Singh, P., Joshua, A. M., et al. (2011). "Intra-rater reliability of the modified Tardieu scale to quantify spasticity in elbow flexors and ankle plantar flexors in adult stroke subjects." Ann Indian Acad Neurol 14(1): 23-26. Find it on PubMed
	Yam, W. K. and Leung, M. S. (2006). "Interrater reliability of Modified Ashworth Scale and Modified Tardieu Scale in children with spastic cerebral palsy." Journal of Child Neurology 21(12): 1031-1035. Find it on PubMed
Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



33. REHAB MEASURES DATABASE: TRUNK CONTROL TEST

Link to instrument	Available on the Government of Western Australia's Website		
Title of Assessment	Trunk Control Test		
Acronym	тст		
Instrument Reviewer(s)	Initially reviewed by Irene Ward, PT, DPT, NCS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 6/2012; Update by Rie Yoshida and Heather Anderson of the StrokEdge II Task Force, Neurology Section, APTA		
Summary Date	11/16/2012; updated March 2016		
Purpose	To measures four simple aspects of trunk movement		
Description	 4 items (rolling to weak side, rolling to strong side, balance in sitting position, sit up from lying down). Total score range: 0 (minimum) to 100 (maximum, indicating better performance). Score of each item: (0, 12 or 25) 0= unable to perform movement without assistance; 12= able to perform movement, but in an abnormal style, for example, pulls on bed 		
	clothes, rope or monkey pole, or uses arms to steady self when sitting; 25=able to complete movement normally. For the sitting balance item, a patient scores 12 if they need to touch anything with their hands to stay upright, and 0 if they are unable to stay up (by any means) for 30 seconds.		
	 Total score of TCT= Sum points (rolling to weak side + rolling to strong side + balance in sitting + sit up from lying down). Collin C., Wade D. (1990) Assessing motor impairment after stroke: a pilot reliability study. <i>Journal of Neurology, Neurosurgery, and</i> <i>Psychiatry</i>. 53:576-579. 		
Area of Assessment	Bed Mobility and Sitting Balance		
Body Part	Trunk		



ICF Domain	Body Structure; Body Function
Domain	Motor
Assessment Type	Performance
Length of Test	05 Minutes or Less
Time to Administer	Less than 5 minutes
Number of Items	4 items
Equipment Required	Bed or treatment table
Training Required	Description of measure can be found in the following reference: Collin C., Wade D. (1990) Assessing motor impairment after stroke: a pilot reliability study. <i>Journal of Neurology,</i> <i>Neurosurgery, and Psychiatry</i> . 53:576-579.
Type of training required	None specified
Cost	None
Actual Cost	Not specified
Age Range	Adult
Administration Mode	Paper/pencil
Diagnosis	Geriatrics; Stroke
Populations Tested	StrokeElderly (recovering from acute illness)
Standard Error of Measurement (SEM)	Not Established
Minimal Detectable Change (MDC)	Not Established



Minimally Clinically Important Difference (MCID)	Not Established		
Cut-Off Scores	 Stroke: (Collin and Wade, 1990; 12 female and 24 male patients, age range of male patients = 15-77 years, age range of women = 45-69 years; tested 6, 12 and 18 weeks post stroke) At 18 weeks, scores of 50 or more were associated with recovery of walking Patients scoring under 40 were non-ambulatory 		
Normative Data	 Chronic stroke: (Verheyden et al, 2006, n = 51,16 females, 35 males, mean age= 65 (11) years, range 39-84 years; median days post stroke= 129 days; 29 patients walked without assistance, 22 patients could not walk without assistance or were non-ambulatory) The median score on TCT was 61 points (61%) Subjects unable to walk without physical assistance had a median score on the TCT of 43 points (24-49) Subjects who were able to walk without physical assistance had a median score on the TCT of 61 points (61-100) 		
Test-retest Reliability	Not Established		
Interrater/Intrarater Reliability	 Stroke: (Collin and Wade, 1990) Excellent interrater reliability (r = 0.76, p<0.001) 		
Internal Consistency	 Stroke: (Franchignoni et al,1997; n = 49, mean age=68 (13) years; average interval from onset of stroke to admission to rehab was 46 days (median, 40; range 31-78 days)) Cronbach's index suggests that the items of the TCT describe a homogeneous variable: the values for the TCT at admission and at discharge were alpha=0.86 and alpha=0.83, respectively. 		
Criterion Validity (Predictive/Concurrent)	Predictive Validity: <u>Stroke:</u> (Duarte et al, 2002, <i>n</i> = 28, mean time after stroke onset= 15.3 (6) days; mean initial disability measured with the FIM and motFIM was 84 (22.4) and 52.7 (19.2); mean TCT= 76.4 (24))		



•	The better the initial trunk control patients have, the longer
	walking distance and the faster speed they achieve at hospital
	discharge.

0	TCT showed a statistically significant difference
	(p=0.003) between patients whose walking distance at
	discharge was longer than 50 m (mean TCT 88.9 (SD
	14.3)) and patients whose walking distance was
	shorter than 50 m (mean TCT 61.9(25.2)).

- Excellent correlations were also statistically significant between the TCT and the time required to walk a 10 m straight walkway at a comfortable (*r* = -0.644) and at maximal (*r* =-0.654) safe pace: the better initial TCT was, the higher gait velocities at discharge were.
- **Excellent** inverse correlation between TCT and length of stay: hemiparetic patients with worse trunk control at admission stay longer in a rehabilitation ward. (r=-0.722).
- **Excellent** correlation between admission TCT scores and FIM at discharge. Total FIM *r* = 0.738, motFIM =0.723.

Elderly: (Farriols et al, 2009, n = 21 patients, mean age 78.5(6.7) years, who had developed walking disability after prolonged bed rest for an acute condition)

 Contrary to earlier studies involving younger individuals with stroke, this study failed to show a good correlation between TCT and ability to walk in elderly patients after prolonged bed rest for an acute illness.

<u>Acquired Brain Injury:</u> (Montecchi, 2013, n = 59 patients, mean age 48.9(14.01) years, who had developed ABI following stroke, head trauma or anoxia)

 Excellent correlation between TCT and TRS (Trunk Recovery Scale). Spearman's rank correlation coefficient r_s = 0.943; 95% CI: 0.904 – 0.967)

Construct Validity	Stroke: (Collin and Wade, 1990)
(Convergent/Discriminant)	• Excellent construct validity between the TCT and the gross
	motor function subscale of the Rivermead Motor Assessment
	at 6, 12 and 18 weeks post stroke. (r = 0.70 to 0.79)



Content Validity	Not Established		
Face Validity	Not Established		
Floor/Ceiling Effects	 Chronic stroke: (Verheyden et al, 2006) Twelve participants (24%) reached the maximum score of 100 points on the TCT. This indicates a ceiling effect on the TCT in non-acute and chronic stroke patients. 		
Responsiveness	 Stroke: (Franchignoni et al, 1997) 36 patients (72%) changed the overall TCT score at discharge The TCT test showed a good sensitivity to change 		
Professional Association Recommendations	Recomment Neurologic Association Taskforce (Taskforce (and Vestibu recomment experts usi For detailed please visit professiona recomment	dations for use of the instrument from the Academy of Physical Therapy of the American Physical Therapy a's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), ular Taskforce (VEDGE) are listed below. These dations were developed by a panel of research and clinical ng a modified Delphi process. d information about how recommendations were made, : <u>http://www.neuropt.org/go/healthcare-</u> als/neurology-section-outcome-measures- dations	
	Abbreviations:		
	HR Highly Recommend		
	R	Recommend	
	LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
	NR	Not Recommended	



	Acute (CVA < 2 months post) (SCI < 1 month post) (Vestibular < 6 weeks post)	Subacute (CVA 2 to 6 months) (SCI 3 to 6 months)	Chronic (> 6 months)
StrokEDGE II	NR	NR	NR

Recommendations for use based on acuity level of the patient:

Recommendations based on level of care in which the assessment is taken:

	Acut e Care	Inpatient Rehabilitatio n	Skilled Nursin g Facility	Outpatient Rehabilitatio n	Home Healt h
MS EDGE	UR	UR	UR	NR	UR
StrokEDG E II	LS	LS	NR	NR	NR
TBI EDGE	LS	LS	LS	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderate Dependar
TBI EDGE	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 -
MS EDGE	NR	NR	NR



Recommendations for entry-level physical therapy education and use in research:

		Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	ls additional research warranted for this tool (Y/N)
	MS EDGE	No	No	No	Yes
	StrokEDGE II	No	No	No	Yes
	TBI EDGE	Νο	Yes	No	Not reported
Considerations	 Farriols et al did not find this tool effective in predicting recovery of ambulation in the elderly population following acute illness. Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u>! 				
Bibliography	Collin, C. and V stroke: a pilot and Psychiatry Duarte, E., Ma predictor in st <u>PubMed</u>	Wade, D. (1990 reliability stuc y 53(7): 576-57 arco, E., et al. (rroke patients.'	0). "Assessin _i ly." Journal c '9. <u>Find it on</u> 2002). "Trun ' J Rehabil M	g motor impairm of Neurology, Ner <u>PubMed</u> k control test as led 34(6): 267-27	eent after urosurgery a functional 72. <u>Find it on</u>
	Farriols, C., Bajo, L., et al. (2009). "Functional decline after prolonged bed rest following acute illness in elderly patients: is trunk control test (TCT) a predictor of recovering ambulation?" Archives of Gerontology and Geriatrics 49(3): 409-412. <u>Find it on PubMed</u>				
	Franchignoni, F. P., Tesio, L., et al. (1997). "Trunk control test as an early predictor of stroke rehabilitation outcome." Stroke (00392499) 28(7): 1382-1385. <u>Find it on PubMed</u>				
	Montecchi MO Recovery Scale with severe ad	G, Muratori A, e: A new tool t cquired brain i	Lombardi K, o measure p njury. A stud	Morrone E, Briar ostural control ir y of the psychom	nti R. Trunk n patients netric



	properties. <i>European Journal of Physical Medicine and Rehabilitation</i> . 2013; 49(3):341-351. Find it on PubMed
	Verheyden, G., Nieuwboer, A., et al. (2007). "Clinical tools to measure trunk performance after stroke: a systematic review of the literature." Clinical Rehabilitation 21(5): 387-394. <u>Find it on PubMed</u>
	Verheyden, G., Vereeck, L., et al. (2006). "Trunk performance after stroke and the relationship with balance, gait and functional ability." Clinical Rehabilitation 20(5): 451-458. <u>Find it on PubMed</u>
Year published	
Instrument in PDF Format	Yes
Approval Status	Approved



34. REHAB MEASURES DATABASE: TRUNK IMPAIRMENT SCALE

Link to instrument	Available on the Government of Western Australia's Website			
Title of Assessment	Trunk Impairment Scale			
Acronym	TIS			
Instrument Reviewer(s)	Initially reviewed by Irene Ward, PT, DPT, NCS and the TBI task force of the Academy of Neurologic Physical Therapy - a component of APTA in 6/2012; Updated by Onkar J. Rajadhyaksha, PT in 10/2012; Updated with references from the PD population by Rosemary Gallagher, PT, DPT, GCS and the PDEdge Taskforce of the Academy of Neurologic Physical Therapy - a component of APTA in 2/2013; Updated by Michele Sulwer, PT, DPT, NCS and Genevieve Pinto-Zipp, PT, of the StrokEdge II, Neurology Section, APTA in 3/2016			
Summary Date	1/29/2014			
Purpose	To measure the motor impairment of the trunk after a stroke through the evaluation of static and dynamic sitting balance as well as co- ordination of trunk movement (Verheyden et al, 2004)			
Description	 Scores range from a minimum of 0 to a maximum of 23. If patient scores 0 on the first item, the total score on the TIS is 0. Each item can be performed three times. The highest score counts. Otherwise, no practice session allowed. The patient can be corrected between attempts. The tests are verbally explained to the patient and can be demonstrated if needed. Three subscales: static sitting, balance, dynamic sitting balance and coordination. Each subscale has between three and 10 items. Starting position: patient is sitting at the edge of a bed or treatment table without back and arm support. Thighs are supported, knees at 90*, feet flat on the floor, arms resting on the legs, head and trunk in midline position. If hypertonia is present, the position of the arm is taken as the starting position. 			



•	The TIS can be found in the Appendix of the following article:
	Verheyden G. and Nieuwboer A. (2004). The trunk impairment
	scale: a new tool to measure motor impairment of the trunk
	after stroke. Clinical Rehabilitation. 18:326-334.

Area of Assessment	
Body Part	
ICF Domain	Body Structure; Body Function; Activity
Domain	
Assessment Type	Performance Measure
Length of Test	06 to 30 Minutes
Time to Administer	< 20 minutes
Number of Items	17 items
Equipment Required	 Treatment table or bed without back and arm support Score sheet Stop watch
Training Required	None necessary
Type of training required	No Training
Cost	Not Free
Actual Cost	Cost of equipment
Age Range	
Administration Mode	
Diagnosis	Cerebral Palsy; Multiple Sclerosis; Parkinson's Disease; Stroke; Traumatic Brain Injury



Populations Tested	• Stroke				
	Cerebral Palsy				
	Multiple Sclerosis				
	Parkinson's Disease				
	Traumatic Brain Injury				
Standard Error of Measurement (SEM)	Not Established				
Minimal Detectable Change (MDC)	Not Established				
Minimally Clinically Important Difference (MCID)	Not Established				
Cut-Off Scores	Not Established				
Normative Data	Sub-Acute Stroke:				
	(Verheyden & Nieuwboer, 2004; <i>n</i> = 28, median age = 63 years, median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery)				
	• Time needed to complete the TIS ranged between 2 to 18 minutes				
	• Scores ranged between 0 and 21, median score was 14				
	Chronic stroke				
	(Verheyden et al. 2006, <i>n</i> = 51 (16 females, 35 males), mean age = 65 (11) years (range 39-84), median days post stroke= 129, 29 patients walked without assistance, 22 patients could not walk without assistance or were non-ambulatory)				
	walked without assistance, 22 patients could not walk without assistance or were non-ambulatory)				
	 walked without assistance, 22 patients could not walk without assistance or were non-ambulatory) Median total score = 11 points (48%) 				
	 walked without assistance, 22 patients could not walk without assistance or were non-ambulatory) Median total score = 11 points (48%) Median score for the static sitting balance subscale = 6 (86%) 				
	 (11) years (range 55 64), median days post stroke 125, 25 patients walked without assistance, 22 patients could not walk without assistance or were non-ambulatory) Median total score = 11 points (48%) Median score for the static sitting balance subscale = 6 (86%) Median score for the dynamic sitting balance subscale = 3 (30%) 				



- Non-ambulatory patients had a median TIS score of 8 (3-9)
- Ambulatory patients had a median TIS score of 14 (11-18)

Healthy individuals:

(Verheyden et al, 2005; n = 80, 40 patients with stroke and 40 age- and sex- matched healthy individuals; Mean age of patients with stroke = 64(14) years and that of healthy individuals = 65(14) years; Median number of days since stroke onset = 46 (range = 9-2341))

TIS (Subscale)	Median	IQR	Range
Static Sitting Balance (range 0-7)	7	7	7
Dynamic Sitting Balance (range 0-10)	10	9-10	6-10
Coordination (range 0-6)	6	5-6	4-6
Total TIS (range 0-23)	23	22-23	17-23

Test-retest Reliability Sub-Acute Stroke:

(Verheyden & Nieuwboer, 2004; n = 28, median age = 63 years, median days since stroke = 61 days, majority of patients had moderate ADL function and limited motor recovery)

- **Excellent** reliability for clinical care and research in the static sitting balance subscale, 0.91 (0.83)
- **Excellent** reliability for clinical care and research in the dynamic sitting balance subscale, 0.94 (0.89)
- **Good** reliability for research in the coordination subscale, 0.87 (0.76)
- Overall, **excellent** reliability for clinical care and research in the TIS, 0.96 (0.93)

Sub-acute to chronic Stroke:



	 (Verheyden et al, 2003; n = 28; Median age = 63 (Range = 32-87); days since stroke = 21-2341) Excellent test-retest reliability (ICC = 0.96) 				
Interrater/Intrarater Reliability	Interrater Reliability: Sub-Acute Stroke:				
	(Verheyden & Nieuwboer, 2004; <i>n</i> = 28, median age = 63 years, median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery)				
	• Excellent reliability in the static sitting balance subscale, 0.99 (0.99)				
	 Excellent reliability in the dynamic sitting balance subscale, 0.98 (0.96) 				
	• Excellent reliability in the coordination subscale, 0.85 (0.74)				
	• Overall, excellent reliability for in the TIS, 0.99 (0.97)				
	Sub-acute to chronic Stroke:				
	(Verheyden et al, 2003)				
	• Excellent inter-observer reliability when the patients were observed on the same day separated by 1 or 2 hours of recovery time (ICC = 0.99)				
Internal Consistency	Sub-Acute Stroke:				
	(Verheyden & Nieuwboer, 2004; n = 28, median age = 63 years, median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery)				
	 Adequate for static sitting balance subscale(Cronbach's alpha 0.79) 				
	• Excellent for dynamic sitting balance subscale (Cronbach's alpha 0.86)				
	• Not adequate for the coordination subscale (Cronbach's alpha 0.65)				
	• Excellent for the total TIS (Cronbah's alpha 0.89)				



Criterion Validity (Predictive/Concurrent)

Concurrent validity:

Parkinson's Disease:

(Verheyden et al, 2007; n = 52; 26 PD(17M) mean age 65(9) years, mean disease duration 9(4)years, 26 Controls)

 Significant Spearman Rank correlation with a combination of part III score of the UPDRS (partial R2 = 0.54, P < 0.000) and age (partial R2 = 0.09, P = 0.030)

Sub-Acute Stroke:

(Verheyden & Nieuwboer, 2004; n = 28, median age = 63 years, median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery)

• Excellent concurrent validity between TIS and Trunk Control Test, 0.83

Acute Stroke:

(Di Monaco et al, 2010; n = 60, mean age = 68.0(12.2), interval between stroke and admission to rehab = 21.4(13.3) days)

 Excellent concurrent validity between TIS and Postural Assessment Scale, (0.849, P < 0.001)

Sub-acute to chronic Stroke:

(Verheyden et al, 2003)

Excellent correlation between the TIS and Trunk Control Test
 (ρ = 0.83) in patients with acute to sub-acute stroke

Predictive validity:

Acute Stroke:

(Verheyden et al, 2007, n = 102, mean age = 70(10) years, 47 female and 55 men, tested upon admission to acute rehab and again 6 months after stroke)

 Total TIS (partial R2 = 0.52, p < 0.0001) and static sitting balance subscale score (partial R2 = 0.50, p < 0.0001) were the most important factors when predicting Barthel Index score at 6 months after stroke.

Acute Stroke:



	(Di Monaco et al, 2010; $n = 60$, mean age = 68.0(12.2), interval between stroke and admission to rehab = 21.4(13.3) days)
	• Excellent validity between TIS at admission and FIM scores at discharge (0.695, P < 0.001)
	 TIS scores assessed at admission to rehabilitation were significantly lower in the patients who were transferred to an institution than those discharged home at the end of inpatient rehabilitation (P = 0.002)
	 Odds ratio analysis of TIS and discharge destination (0.620, 95% CI 0.393 to 0.979, P = 0.040)
	Sub-acute to Chronic Stroke
	(Kim et al, 2015) n = 135, mean age = 62.14 (12.9), tested at 4 weeks post stroke and again at 6 months after stroke.
	 Initial total TIS scores (and subscales including Sitting, Dynamic TIS) in non-ambulatory patients were positively correlated with all sub-items in the Korean version of Modified Barthel Index (K-MBI) at 4 weeks after stroke (p<0.05). Particularly the TIS – Dynamic subscale was shown to be the only significant factor for K-MBI 6 months after stroke (R² = 0.653, p < 0.001) Initial total TIS scores (and subscales including Sitting, Dynamic TIS) in non-ambulatory patients were significantly correlated with Functional Ambulation Categories at 4 weeks and 6 months after stroke
Construct Validity	Convergent:
(convergency Discriminancy	Parkinson's Disease:
	(Verheyden et al 2007)
	 The authors state that results of the study demonstrate Construct validity of the TIS in people with PD because they had significantly lower scores than controls on the total TIS and static sitting balance and coordination subscale of the TIS. Scores on the dynamic sitting balance subscale were lower for people with PD but were not significant.
	Sub-Acute Stroke:



Floor/Ceiling Effects	Chronic stroke:
Face Validity	Not Established
Content Validity	 Sub-Acute Stroke: (Verheyden & Nieuwboer, 2004; n = 28, median age = 63 years, median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery) Content validity of the TIS was achieved through literature review, observation of stroke patients, clinical experience of the authors and discussing the content of the scale with stroke rehabilitation specialists.
	 Significant differences between stroke patients and healthy individuals (P < 0.0001)
	(Verheyden et al 2005, 40 stroke patients and 40 age and sex-matched healthy individuals, mean age = 65)
	Discriminant: Stroke:
	 Construct validity of dynamic sitting balance and coordination subscale confirmed using Rasch analysis. (chi-square = 42.65;p-value = 0.0052 for dynamic sitting balance, chi-square = 7.87, p-value = 0.446 for coordination subscale)
	(Verheyden & Kersten, 2010; n = 162; Mean age = 67(11) years; all stages of stroke)
	Acute to Sub-acute Stroke:
	 Excellent spearman rank correlation between the TIS and the Barthel Index (ρ = 0.86)
	(Verheyden et al, 2003)
	Sub-acute to chronic stroke:
	• Adequate construct validity between the TIS and Barthel Index, 0.86
	median days since stroke 61 days, majority of patients had moderate ADL function and limited motor recovery)

(Verheyden & Nieuwboer, 2004; n = 28, median age = 63 years,



(Verheyden et al, 2006, n = 51 (16 females, 35 males), mean age = 65 (11) years (range 39-84), median days post stroke = 129, 29 patients walked without assistance, 22 patients could not walk without assistance or were non-ambulatory)

• No patient was able to score the maximum of 23 points on the TIS as opposed to 12 (24%) participants reached the maximum score of 100 points on the Trunk Control Test.

Acute to Sub-acute Stroke:

(Verheyden & Kersten, 2010; n = 162 from acute unit, in-patient and out-patient rehabilitation setting ; Mean age = 67(11) years; days since stroke = 6-94 days)

• **Poor** ceiling effects (90%)(ceiling effect for static sitting balance subscale was large and hence, it was excluded from the TIS version 2.0)

Parkinson's Disease:

(Verheyden et al 2007)

 Poor ceiling effects: 73% reached max score on static sitting balance subscale; 38% reached max score on dynamic sitting balance subscale; (8%) reached max score on coordination subscale; and (4%) reached max score of total TIS

Responsiveness	Not Established	
Professional Association Recommendations	Recommendations for use of the instrument from the Academy of Neurologic Physical Therapy of the American Physical Therapy Association's Multiple Sclerosis Taskforce (MSEDGE), Parkinson's Taskforce (PD EDGE), Spinal Cord Injury Taskforce (PD EDGE), Stroke Taskforce (StrokEDGE II), Traumatic Brain Injury Taskforce (TBI EDGE), and Vestibular Taskforce (VEDGE) are listed below. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process.	
	For detailed information about how recommendations were made, please visit: <u>http://www.neuropt.org/go/healthcare-professionals/neurology-section-outcome-measures-recommendations</u>	



Abbreviations:		
HR	Highly Recommend	
R	Recommend	
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend	
NR	Not Recommended	

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	R	R	R

Recommendations Based on Parkinson Disease Hoehn and Yahr stage:

	I	II	111	IV	V
PD EDGE	LS/UR	LS/UR	LS/UR	LS/UR	NR

Recommendations based on level of care in which the assessment is taken:

Acut Inpatient e Rehabilitatio Care n	Skilled Nursin g Facility	Outpatient Rehabilitatio n	Home Healt h
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MS EDGE	R	R	R	NR	R
StrokEDG E II	R	R	R	R	R
TBI EDGE	LS	LS	LS	LS	LS

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependant	Moderate Dependar
TBI EDGE	N/A	N/A	N/A

Recommendations based on EDSS Classification:

	EDSS 0.0 – 3.5	EDSS 4.0 – 5.5	EDSS 6.0 -
MS EDGE	NR	R	R

Recommendations for entry-level physical therapy education and use in research:

	Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	ls additional research warranted for this tool (Y/N)
MS EDGE	Yes	Yes	Yes	Yes
PD EDGE	No	No	No	Not reported
StrokEDGE II	Yes	Yes	Yes	Yes
TBI EDGE	No	Yes	No	Not reported

Considerations

There are two different scales both named the Trunk Impairment Scale and both intended for the stroke population.

•



	One scale was originally published in 2004 by Verheyden et al and is the focus of this review. The other scale was published by Fujiwara in 2004 and is not the focus of this review.
	• The patient will need to be permitted to sit-up for the test and be able to follow basic commands.
	 The TIS has sufficient reliability, internal consistency and validity for use in clinical practice and stroke research (Verheyden et al, 2004).
	• Younger individuals, females and individuals who are more active in their daily life are found to score higher on TIS. Older individuals, males and less physically active individuals score lower on TIS. (Verheyden et al, 2005)
	• TIS 2.0 consists of dynamic balance subscale and coordination subscale. The sitting balance subscale was not included due to ceiling effects. (Verheyden and Kersten, 2010)
	 TIS-modNV is the Norwegian version with modifications of combining items from the dynamic sitting balance and coordination subscales. Six ordinal superitems (called testlets) were constructed. It demonstrated good construct validity, excellent internal consistency, and high intertester and test- retest reliability for the total score. (Gjelsvik et al, 2012)
	• The TIS has been found to have large ceiling effects in two out of the three subscales of the test in this population. Further research is needed regarding: reliability, measurement error, predictive validity, and responsiveness before this measure can be recommended for clinical or use in research.
	Do you see an error or have a suggestion for this instrument summary? Please <u>e-mail us</u> !
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Year published	
Instrument in PDF Format	Yes



Approval Status

Approved



35. REHAB MEASURES DATABASE: WOLF MOTOR FUNCTION TEST

Link to instrument	WMFT info can be found on Stroke (external link)
Title of Assessment	Wolf Motor Function Test
	Originally called the Emory Motor Test (Woodbury et al, 2010)
Acronym	WMFT
Instrument Reviewer(s)	Initially reviewed by Jason Raad MS and the Rehabilitation Measures Team; Updated by Irene Ward, PT, DPT, NCS and the TBI EDGE task force of the Academy of Neurologic Physical Therapy - a component of APTA in 2012.; Updated by Heather Anderson and Rie Yoshida of the StrokEdge II task force in 2016.
Summary Date	3/19/2016
Purpose	Quantitative measure of upper extremity motor ability through timed and functional tasks
Description	 The original version consisted of 21 item; the widely used version of the WMFT consists of 17 items Composed of 3 parts: Time Functional ability Strength Includes 15 function-based tasks and 2 strength based tasks Performance time is referred to as WMFT-TIME Functional ability is referred to as WMFT-FAS Items 1-6 involve timed functional tasks, items 7-14 are measures of strength, and the remaining 9 items consist of analyzing movement quality when completing various tasks Examiner should test the less affected upper extremity followed by the most affected side. Uses a 6-point ordinal scale "0" = "does not attempt with the involved arm" to



	 "5" = "arm does participate; movement appears to be normal."
	Maximum score is 75
	Lower scores are indicative of lower functioning levels
	WMFT-TIME allows 120 seconds per task
Area of Assessment	Dexterity; Strength; Upper Extremity Function
Body Part	Upper Extremity
ICF Domain	Activity
Domain	Motor
Assessment Type	Performance Measure
Length of Test	06 to 30 Minutes
Time to Administer	35 minutes
Number of Items	The original version consisted of 21 items (Wolf et al., 2005)
Equipment Required	 Standardized table (54 inches long, 30 inches wide, and 29 inches high) and chair
	Standardized test item template
	Height-adjustable bedside table
	 Box (one that does not require patient to flex or abduct shoulder more than 90 degrees)
	Individual wrist weights, 1-20 pounds
	• 12-oz beverage can, unopened
	• 7" pencil with 6 flat sides
	• 2" paper clip
	• 3 checkers
	• Three 3" x5" note cards
	• Standardized lock and key board at 45 degree angle



	• :	Standardized face tow	el	
	•	Standardized basket		
	•	Dynamometer		
	•	Talcum powder to red	uce friction	as needed
	•	Stopwatch		
	• `	Video camera (optiona	al)	
Training Required	None ne	cessary		
Type of training required	No Train	ing		
Cost	Free			
Actual Cost	Free			
Age Range	Adult: 18	3-64 years; Elderly adu	lt: 65+	
Administration Mode	Compute	er		
Diagnosis	Stroke; 1	Fraumatic Brain Injury		
Populations Tested	Stroke Traumat	ic Brain Injury		
Standard Error of Measurement (SEM)	Chronic 90) year	<u>Stroke</u> : (Fritz et al. 200 s)	09; <i>n</i> = 96; r	nean age = 62.3 (range, 19–
	• :	Standard error of mea	surement (S	SEM) in stroke: 0.2 seconds
	Reliabili	ity Indices for WMFT:		
	Item No	. Item Description	SEM	
	Average	WMFT time score	0.2	
	1	Forearm to table	0.8	
	2	Forearm to box	0.6	
	3	Extend elbow	0.6	



4	Extend elbow with weight	0.8
5	Hand to table (front)	0.5
6	Hand to box (front)	0.7
7	Weight to box (lbs)	1.9
8	Reach and retrieve	1.2
9	Lift can	1.2
10	Lift pencil	1.1
11	Lift paper clip	0.8
12	Stack checkers	1.1
13	Flip cards	0.4
14	Grip strength (lbs)	0.0
15	Turn key in lock	0.4
16	Fold towel	0.4
17	Lift basket	0.7
Avorago	NMET FAS	0.1

Minimal Detectable Change

(MDC)

• Average for WMFT Functional Ability Scale: 0.1 points

Reliability Indices for WMFT:			
ltem No.	Item Description	95% MDC	
Average	WMFT time score	0.7	
1	Forearm to table	2.1	
2	Forearm to box	1.6	
3	Extend elbow	1.7	



4	Extend elbow with weight	2.4
5	Hand to table (front)	1.5
6	Hand to box (front)	1.9
7	Weight to box (lbs)	5.2
8	Reach and retrieve	3.4
9	Lift can	2.0
10	Lift pencil	3.0
11	Lift paper clip	2.2
12	Stack checkers	3.2
13	Flip cards	1.2
14	Grip strength (lbs)	0.1
15	Turn key in lock	1.0
16	Fold towel	1.2
17	Lift basket	2.0
Average	WMFT FAS	0.1

<u>Chronic Stroke</u>: (Lin et al., 2009; n = 57; mean age = 54.6(11.5) years> 6 mo post-stroke)

- MCD at 90% confidence:
 - WMFT Time = 4.36 (SD = 5.91, r = 0.90, SEM = 1.87)
 - WMFT FAS = 0.37 (SD = 0.73, r = 0.90, SEM = 0.16)

Minimally Clinically Important Difference (MCID)	Acute Stroke: (Lang et al, 2008; <i>n</i> = 52; mean age = 64 (14) years; < 28 days post-stroke)		
	MCID (Functional Ability):		



	 1.0 points (Dominant Side Affected) 			
	 1.2 points (Non-dominant Side Affected) 			
	 17% change (Dominant Side Affected) 			
	 20% change (Non-dominant Side Affected) 			
	• MCID (time):			
	 -19.0 seconds (Dominant Side Affected) 			
	 16% change (Dominant Side Affected) 			
	Chronic Stroke: (Lin et al., 2009)			
	• MCID (time):			
	 1.5 - 2 seconds (Anchor based = 1.64; 0.2 SD = 1.37) 			
	• MCID (FAS):			
	 0.2 - 0.4 points (Anchor based = 0.33; 0.2 SD = 0.14) 			
Cut-Off Scores	Not established			
Normative Data	<pre>Chronic Stroke: (Wing et al, 2006; n = 35; mean age = 60.2 (14.1) years; rehab = 3–6 hours/day, 4–5 days/week, ≥2 weeks; mean time since stroke = 40.9 (29.1) months)</pre> Outcome measure:			
	Measure <i>n</i> Pretest mean Posttest mean			
	Wolf Motor Function Test (mean)2955.6 s45.2 s			
	TUG 30 31.0 s 20.2 s			
	Berg Balance3246.547.2			
	Fugl-Meyer (m) 34 31.8 37.0			
	Box and Block 11 11.2 18.0			
	s = seconds; all means were significant			



	TUG = Timed Up & Go Test Fugl-Meyer (m) = 66-point Fugl-Meyer motor assessment		
Test-retest Reliability	 <u>Chronic Traumatic Brain Injury</u>: (Shaw et al., 2005; n = 22; Mean age = 39.3 (14.4) years, onset at least 1 year prior to assessment; relative hemiparesis) Excellent ICC = 0.97 (range = 0.89 - 0.97); agreement between the self-report and objective measures <u>Chronic Stroke</u>: (Morris et al, 2001; n = 24; mean age 61; mean time since one set = 6 years; Whithall et al, 2006; n = 66; mean age = 58 (14) years; >6 months post-stroke) 		
	 Excellent test-retest reliability, Functional ability and performance tests (r = 0.95; 0.90, respectively) 		
	• Excellent overall total score (<i>n</i> = 66; ICC = 0.97)		
Interrater/Intrarater Reliability	<u>Chronic Stroke</u> : (Morris et al, 2001; Whithall, 2006; Wolf et al, 2001; $n = 19$, mean age = 61.4 (9.5) years; mean time since stroke = 4.9 (6.4) years)		
	• Excellent inter-rater reliability:		
	 Study1: n = 24: ICC = 0.93; 0.99, functional ability and performance test respectively. 		
	• Study 2: <i>n</i> = 10; ICC = 0.99		
	 Study 3: n = 19; ICC = 0.97 		
	Subacute Stroke: (Nijland et al, 2010; $n = 40$; mean age = 60.0 (13.6) years; mean time since stroke = 0.41 (0.25-0.77) years)		
	 Excellent inter-rater reliability (ICC=0.94) Excellent intra-rater reliability (ICC=0.95) 		
Internal Consistency	Chronic Stroke: (Morris et al, 2001, Nijland et al, 2010)		
	Excellent Internal Consistency		
	Study 1: n=24; Cronbach's alpha = 0.92		
	Subacute Stroke: (Nijland et al, 2010)		
	• Excellent Internal Consistency (Cronbach's alpha = 0.98)		



	Acute Stroke: (Edwards et al, 2012; $n = 51$; mean age = 63.7 ± 13.6 years; mean time since stroke = 9.5 ± 4.5 days and tested at day 0, 1 and 90)			n age = 63.7 ± 13.6 nd tested at day 0, 14	
	• Exceller (day 0)	 Excellent internal consistency (Cronbach's alpha = 0.96 (day 0); 0.97 (day 14); 0.98 (day 90). 			
Criterion Validity (Predictive/Concurrent)	 Chronic Stroke: (Wolf et al., 2001; Whithall et al., 2006; Chen et al., 2012; n = 191; mean age = 55.17 ± 11.14 years; mean time since stroke = 17.19 ± 15.29 months) Adequate concurrent validity with: Upper Extremity Fugl-Meyer Assessment Study 1: n = 19 (r = - 0.57) Study 2: n = 66 (r = - 0.88) Strong correlation with the 9-item version Arm Motor Ability Test (AMAT-9) n=32 (r=.78; p=0.001) (O'Dell et al., 2013) Moderate to good predictive validity between the ARAT and the WMFT-TIME: Spearman p=66; (95% Cl: -0.57- 0.73) Good to excellent predictive validity between the ARAT and the WMFT-FAS (p= 0.76) Acute Stroke: (Edwards et al, 2012) High concurrent validity with APAT total score				
	Variable	Day 0	Day 14	Day 90	
	WMFT FA score	0.745	0.827	0.863	
	WMFT time score	-0.641	-0.825	-0.772	
	WMFT grip score	0.702	0.631	0.553	
Construct Validity (Convergent/Discriminant)	 Wolf et distingu stroke (Known showed domina 	al (2001) evalu iish between in n = 19) from th group's validitu that the WMF nt hand of ind	uated whether the ndividuals with imp nose without impa y, as calculated usi T scores for the do ividuals without im	WMFT was able to pairment secondary to irment (<i>n</i> = 19). ng Wilcoxon test, pminant and the non- pairment were	



	significant higher when compared to the most and to the least affected upper extremities of clients with stroke.			
	 Edwards et al. (2012) compared WMFT scores to measures of sensorimotor status, kinematic assessments of reach and grasp, and disability as measured by the FIM. 			
	UE stren function pain. UI modera	ngth and spasticity w nal ability (FA) and tir E strength and the kir ate correlation at 0, 1	ere more highly correlated with ne scores than with light touch or nematics of reach and grasp had a 4 and 90 days.	1
	Correlation scores v	tions among WMFT s were higher for FA an	cores and the FIM motor and UE d strength scores than for time.	
	• FIM_cor high (.7	relation coefficients i 0) and increased in m	ranged from moderate (.40) to agnitude from day 0 to day 90.	
Content Validity	Not Established	Not Established		
Face Validity	Not Established			
Floor/Ceiling Effects	 <u>Subacute Stroke</u>: (Nijland et al., 2010; n=40; mean age 60 (13.6) years; Netherlands sample) None found with floor established < 4 points (5% of sample) and ceiling >71 points (17% of sample). Presence of floor/ceiling effect if >20% of sample scored above and/or below cut-offs. 			
Responsiveness	Acute Stroke: (Hsieh et al, 2009; $n = 57$; mean age = 54.56 (11.52) years; Taiwanese sample)			
	Responsiveness of 3 Outcome Measures:			
	Scale Name	SRM (95% CI)	Wilcoxon Test Z-Value	
	WMFT-TIME	0.38 (0.22, 0.59)	5.97*	
	WMFT-FAS	1.30 (1.03, 1.67)	5.59*	
	FIM-total	0.36 (0.17, 0.59)	3.39*	
	FIM-motor	0.37 (0.17, 0.58)	3.18*	
	FMA	1.42 (1.19, 1.80)	6.33*	



	ARAT	0.95 (0.75, 1.20)	4.64*	
	*P<0.001			
	WMFT-TIME = performance time of the Wolf Motor Function Test WMFT-FAS = functional ability scale of the Wolf Motor Function Test FIM = Functional Independence Measure FMA = Fugl-Meyer Assessment ARAT = Action Research Arm Test SRM = standardized response mean CI = confidence interval			
	 Acute Stroke: (Edwards et al., 2012; n=51; mean age=63.7 (13. days post stroke) Moderate to large responsiveness (using Cohen criteria coefficients ≥.80 large; .5080 moderate; <.50 small) Functional Ability scores (day 0-14=1.09; day 0-90=1.6 responsive than time (day 0-14=0.61; day 0-90=0.85) a strength (day 0-14=0.69; day 0-90=0.84) 			
Professional Association Recommendations	Recommence Neurologic F Association' Taskforce (P Taskforce (S and Vestibul recommend experts usin	lations for use of the instr Physical Therapy of the An s Multiple Sclerosis Taskfo D EDGE), Spinal Cord Injur trokEDGE II), Traumatic Br lar Taskforce (VEDGE) are ations were developed by g a modified Delphi proce	ument from the Academy of herican Physical Therapy rrce (MSEDGE), Parkinson's ry Taskforce (PD EDGE), Stroke rain Injury Taskforce (TBI EDGE), listed below. These a panel of research and clinical ss.	
	For detailed information about how r please visit: <u>http://www.neuropt.org</u> , <u>professionals/neurology-section-outc</u> <u>recommendations</u>			
	Abbreviati	ons:		
	HR	Highly Recommend		


R	Recommend
LS / UR	Reasonable to use, but limited study in target group / Unable to Recommend
NR	Not Recommended

Recommendations for use based on acuity level of the patient:

	Acute	Subacute	Chronic
	(CVA < 2 months post)	(CVA 2 to 6 months)	(> 6 months)
	(SCI < 1 month post)	(SCI 3 to 6 months)	
	(Vestibular < 6 weeks post)		
StrokEDGE II	HR	HR	HR

Recommendations based on level of care in which the assessment is taken:

	Acut e Care	Inpatient Rehabilitatio n	Skilled Nursin g Facility	Outpatient Rehabilitatio n	Home Healt h
StrokEDG E II	NR	R	UR	R	UR
TBI EDGE	NR	LS	LS	LS	NR

Recommendations for use based on ambulatory status after brain injury:

	Completely Independent	Mildly dependent	Moderately Dependent
TBI EDGE	N/A	N/A	N/A



Recommendations for entry-level physical therapy education and use in research:

		Students should learn to administer this tool? (Y/N)	Students should be exposed to tool? (Y/N)	Appropriate for use in intervention research studies? (Y/N)	ls additional research warranted for this tool (Y/N)
	StrokEDGE	No	No	Yes	Not reported
	TBI EDGE	No	No	Yes	Not reported
Considerations	Observer plots were a less stable method of scoring the WMFT, suggesting relatively higher measurement error for the WMFT than the ARAT. (Nijland, 2010)				
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Year published	1989
Instrument in PDF Format	No
Approval Status	Approved