Stroke remains one of the major public health problems in the United States today, with approximately 500,000 new or recurrent cases occurring each year. About 4,000,000 persons alive today have survived a stroke and have some neurological deficits. Although the magnitude of healthcare resources used to treat and rehabilitate stroke survivors is considerable, to date a standardized, comprehensive classification system to document the resultant impairments and disability has not been developed.

Successful management of any disabling disease, including stroke, should benefit from the use of a classification system to judge the impact of treatment, particularly emerging therapies. Participants in the Methodologic Issues in Stroke Outcome Symposium determined that the complex nature of stroke recovery demands clarification of its natural history and classification of the variable patterns of functional recovery. For stroke survivors to receive the best care, a comprehensive stroke outcome classification system is needed to direct appropriate therapeutic interventions. Building on the work and recommendations of the Stroke Outcome Symposium, the American Heart Association Classification of Stroke Outcome Task Force has worked to develop a valid and reliable global classification system that accurately summarizes the neurological impairments, disabilities, and handicaps that occur after stroke.

The development of a stroke outcome classification system is predicated on the belief that neurological deficits often lead to permanent impairments, disabilities, and compromised quality of life. Although a person's ability to complete daily functional tasks is thought to be largely dependent on and often limited by the type and degree of impairment, additional factors are often relevant in the ultimate determination of functional outcome. Thus, a classification of stroke outcome should include the broad range of disabilities and impairments as well as the relationship of disability and impairment to independent function.

It is important to underscore that impairment alone does not define level of disability. In a study of stroke survivors it was determined that although a disability is most directly influenced by impairments, current stroke scales that measure impairments only partially explained the level of disability, handicap, or quality of life for those surviving at least 6 months. Some persons adapt well to many and/or severe impairments caused by stroke. Others with only minimal neurological impairments can be severely disabled. Many factors determine function, including the influence of poststroke rehabilitation training and the physical and social environments.

Approach to Stroke Assessment

The schema for the stroke outcome classification score presented here is conceptually similar to the New York Heart Association functional and therapeutic classification of patients with diseases of the heart framework. However, unlike heart disease, in which the primary limitation is impairment of physical activity due to chest pain, shortness of breath, and fatigue, stroke impairs many critical neurological functions, resulting in a greater number and broader range of physical and social disabilities. The AHA Stroke Outcome Classification (AHA.SOC) score (Figure) classifies the severity and extent of neurological impairments that are the basis for disability. The classification also identifies the level of independence of stroke patients according to basic and more complex activities of daily living both at home and in the community. The classification score is meant to describe the limitations resulting from the current stroke. It is not an evaluation of disabilities caused by other neurological events. Furthermore, it is a summary score. The task force recommends that clinicians support their rating decisions with standardized assessment instruments whenever possible.

Components of the AHA Stroke Outcome Classification Score

Classification of Neurological Impairments

The first area of assessment in the AHA.SOC score is the evaluation of neurological impairment. A complete clinical examination is the basis for documenting the major domains of neurological impairment. In this classification schema the number of affected domains is recorded as well as severity of impairments.

Potentially affected neurological domains are

- **Motor**: Motor impairments are the most prevalent of all deficits seen after stroke, usually with involvement of the face, arm, and leg, alone or in various combinations. Motor functions assessed in the AHA.SOC include cranial nerve...
Stroke Outcome Classification

AHA.SOC Score

<table>
<thead>
<tr>
<th>Number of Domains</th>
<th>Severity</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>1</td>
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<td>2</td>
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<td>&gt;2</td>
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Number of Neurological Domains Impaired

<table>
<thead>
<tr>
<th>Score</th>
<th>Neurological Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Motor, sensory, vision, affect, cognition, language</td>
</tr>
<tr>
<td>1</td>
<td>No/minimal neurological deficit due to stroke in any domain</td>
</tr>
<tr>
<td>2</td>
<td>Mild/moderate deficit due to stroke in ≥1 domain(s)</td>
</tr>
<tr>
<td>&gt;2</td>
<td>Severe deficit due to stroke in ≥1 domain(s)</td>
</tr>
</tbody>
</table>

Severity of Impairment

Level

A  No/minimal neurological deficit due to stroke in any domain
B  Mild/moderate deficit due to stroke in ≥1 domain(s)
C  Severe deficit due to stroke in ≥1 domain(s)

Function

Level

I  Independent in BADL and IADL activities and tasks required of roles patient had before the stroke. Patient is able to live alone, maintain a household, and access the community for leisure and/or productive activities such as shopping, employment, or volunteer work.

II  Independent in BADL but partially dependent in routine IADL. Patient is able to live alone but requires assistance/supervision to access the community for shopping and leisure activities. Patient may require occasional assistance with meal preparation, household tasks, and taking medications.

III  Partially dependent in BADL (<3 areas) and IADL. Patient is able to live alone with substantial daily help from family or community resources for more difficult BADL tasks such as dressing lower extremities, bathing, or climbing stairs. Patient requires assistance with such IADL tasks as meal preparation, home maintenance, community access, shopping, handling finances, and/or taking medications.

IV  Partially dependent in BADL (≥3 areas). Patient is unable to live alone safely and requires assistance with IADL except for simple tasks such as answering the telephone.

V  Completely dependent in BADL (≥5 areas) and IADL. Patient is unable to live alone safely and requires full-time care.
function (including speech and swallowing), muscle power and tone, reflexes, balance, gait, coordination, and apraxia.

- **Sensory:** Sensory deficits range from loss of primary sensations to more complex loss of perception. Patients may describe numbness, tingling, or altered sensitivity. The more complex sensory losses include astereognosis, agraphia, and extinction to double simultaneous stimuli.

- **Vision:** Stroke can cause monocular visual loss, homonymous hemianopia, or cortical blindness.

- **Language:** Dysphasia may be exhibited by disturbances in comprehension, naming, repetition, fluency, reading, or writing.

- **Cognition:** Stroke can cause impairments in memory, attention, orientation, calculation abilities, and construction. It is important to assess ability to learn and retain new information in the cognitive evaluation.

- **Affect:** Depression is the most common affective disturbance seen after stroke. It tends to be observed more often in the months after stroke than during the acute event. Symptoms include loss of energy, lack of interests, loss of appetite, and insomnia.\(^1\)

The domains of stroke impairments are documented both in the number and severity of the neurological deficits observed. When >1 domain is affected, severity is defined by the most impaired domain. The categories for the number of domains involved after stroke are Level 0, no domains impaired; Level 1, 1 domain impaired; Level 2, 2 domains impaired; and Level 3, >2 domains impaired. For stroke severity, impairment is classified as being either Level A, minimal or no neurological deficit due to stroke in the above domains; Level B, mild/moderate deficit due to stroke; or Level C, severe deficit due to stroke.

The neurological examination is the basis for determining neurological impairments in the AHA.SOC score. However, the task force recommends that clinicians support their rating decisions by using standardized assessment measures whenever possible. The Appendix describes several available, well-documented assessment instruments that have been tested in stroke populations. This listing is suggestive and not all-inclusive of other available measures.

**Neurological Impairment Scales**

The National Institutes of Health Stroke Scale (NIHSS)\(^4\) and the Canadian Neurological Scale\(^5\) evaluate many of the domains of neurological deficits, including motor, sensory, and visual impairments. In a study comparing the usefulness of the baseline NIHSS, the Canadian Neurological Scale, the Middle Cerebral Artery Neurological Score, and Guy’s Prognostic Score, the NIHSS was the best predictor of outcome at 3 months (alive at home, alive in care, or deceased).\(^6\) The NIHSS is reproducible, easy, and quick to perform (10 minutes) and correlates with infarct volume and functional outcome 3 months after stroke.

Following is an example of the use of a standardized assessment, such as the NIHSS, to determine the neurological impairment-severity part of the score. To translate the NIHSS scores into the AHA.SOC, it is necessary to collapse the NIHSS scores. For example, patients with a motor deficit and an NIHSS score of 4 in 1 limb would receive an impairment rating of C = severe. Patients with any detectable weakness in an arm or a leg (NIHSS score 1 to 3) would receive an impairment rating of B = mild/moderate. Patients with no detectable weakness (NIHSS score 0) would receive a rating of A = no impairment. Patients with a sensory deficit and an NIHSS score of 2 would receive an impairment rating of C = severe. Patients with any detectable sensory loss (NIHSS score 1) would receive an impairment rating of B = mild/moderate. Patients without sensory loss would receive a rating of A = no impairment. Patients with severe aphasia or who are mute (NIHSS aphasia score 3) would receive an impairment rating of C = severe. Patients with mild or moderate aphasia (NIHSS aphasia score 1 or 2) would receive an impairment rating of B = mild/moderate. Patients without aphasia would receive a rating of A = no impairment. Visual deficit can be collapsed similarly (NIHSS visual score 2 = C, severe impairment; NIHSS visual score 1 = B, mild/moderate impairment; NIHSS visual score 0 = A, no impairment). If the patient’s NIHSS scores are motor = 2 (B), sensory = 2 (C), aphasia = 0 (A), and visual = 1 (B), the AHA.SOC severity score is C.

**Cognitive Scales**

About 15% to 25% of stroke patients develop significant cognitive impairment after the acute ischemic event.\(^7\)\(^8\) To screen for the presence of cognitive changes, the task force recommends the Mini-Mental State Examination (MMSE).\(^9\) The MMSE has been widely used to screen for cognitive dysfunction in the stroke population. It is an easily administered 30-item questionnaire that assesses orientation, memory, attention, language, and construction functions. Like other cognitive measures that include tests of arithmetic and language, MMSE scores are highly correlated with educational level.\(^20\)\(^21\) The Neurobehavioral Cognitive Status Examination (NCSE)\(^22\) is another method for assessing severity of dementia. The NCSE measures severity of impairment in multiple domains, including consciousness, orientation, memory, language, and reasoning.

**Language Scales**

Approximately 30% of stroke survivors have some language dysfunction.\(^12\) Speech and language disorders may interfere with a person’s ability to return to a functional independent life. Accurate assessment of the underlying deficits is essential for treatment. Language impairments can best be documented by the use of the American Speech-Language-Hearing Association Functional Assessment of Communication Skills for Adults.\(^23\) This instrument measures adequacy, appropriateness, and promptness of verbal responses. Some measures of language function, such as fluency, naming ability, and comprehension, are also assessed in the NIHSS. Other reliable language-assessment instruments are available, including the Boston Diagnostic Aphasia Examination.\(^24\)

**Depression Scales**

Depression, although common, is perhaps the least-treated sequela of stroke. The prevalence of depression after stroke has been estimated to range from 11% to 68%, a third of which is classified as major depression.\(^13\)\(^15\)\(^26\) Depression can result either from the direct biological effect of brain infarction, such as that associated with left anterior cortex and basal ganglia lesions,\(^13\) or a reaction to the significant losses associated with the stroke. Symptoms of depression can be manifested in cognitive deficits, including difficulty with orientation, memory, language, and distractibility. It is...
Classification of Functional Disabilities and Handicap

The second major area of assessment in determining the stroke outcome classification score is the evaluation of function in terms of resultant disability. Disability is defined as “any restriction or lack of ability to perform an activity in a manner or within the range considered normal for a human being.” The basic self-care tasks are feeding; grooming; dressing; bathing; toileting, including sphincter control; and mobility, including transferring from place to place. These are called basic activities of daily living (BADL). Independence in BADL could enable the stroke patient to live at home with help from family or community providers for meals and other household tasks as needed. More complex activities of daily living are called instrumental activities of daily living (IADL). These tasks are performed to maintain independence in the home and community and include shopping, using transportation, telephoning, preparing meals, handling finances, and maintaining a household. Independence in these activities enables the stroke patient to be discharged to home without being dependent on others. Other instrumental activities of daily living that affect quality of life are work skills, religious activities, and leisure-time and recreational activities (see Appendix).

Basic Activities of Daily Living Scales

To determine the extent of disability after stroke, self-care activities and ability to live independently are assessed. The Barthel Index is a measure of severity of disability and the most frequently used stroke outcome measure. It has been repeatedly shown to be a reliable and valid measure of BADL.29-34 A limitation is that it does not capture significant losses in higher levels of physical functions or activities that are necessary for independence in the home and community. It is responsive to change but has definite ceiling effects in persons with mild stroke.34,35

The Functional Independence Measure (FIM™) is another widely used disability measure.36 The FIM contains 13 items related to self-care, bowel and bladder continence, mobility, and ambulation, and 5 items related to communication, social functioning, and cognition. The first 13 items are summed to develop a motor score, and the last 5 items are summed to develop a social/cognition score. Many studies have evaluated the reliability and validity of the FIM37,38 and its sensitivity to change.39,40

Instrumental Activities of Daily Living Scales

Although several assessments measure BADL adequately, no single assessment measures IADL or leisure-time and recreational activities that a stroke patient may be asked to do or may want to do. Therefore, it is incumbent on the rehabilitation professional to learn what those tasks and activities are by interviewing and selecting the most appropriate assessment(s) for that particular patient. Assessment should be based on performance, not capacity.2 Two assessments are recommended in Post-Stroke Rehabilitation: Clinical Practice Guideline.12 The Philadelphia Geriatric Center (PGC) Instrumental Activities of Daily Living Scale measures IADL at home and in the community.41-43 Using self-reports by the patient and his or her family,44,45 the Frenchay Activities Index measures leisure, work, and outdoor activities as well as IADL at home.

Psychometric Properties of the AHA Stroke Outcome Classification

To test the psychometric properties of the AHA.SOC, cases were selected from the Kansas City Stroke Study. This community-based study follows acute hospitalized stroke cases in the Kansas City area to determine measurable stroke outcomes and track recovery over time using standardized assessment measures. For this project, 3-month poststroke survivors were evaluated with the NIHSS,14 the Barthel Index,29 the Lawton IADL score,41 the Geriatric Depression Scale,20 and the MMSE.19 The task force identified 10 raters with experience in stroke trials, including physicians, nurses, and allied health professionals. Each rater used the AHA.SOC to evaluate the severity and impact of stroke on 10 patients for a total of 100 assessments. Interrater reliability was calculated with weighted kappas, a composite measure of agreement across all categories and raters. A weighted average of the individual kappa values was used to calculate an overall kappa value. Kappa values ≥0.75 are considered an excellent agreement beyond chance; values <0.40 are considered poor agreement beyond chance; values between 0.40 and 0.75 represent fair to good agreement beyond chance. The overall kappa value for the stroke severity classification was 0.76. The overall kappa value for the number of domains impaired was 0.56. The kappa values for the various levels of the functional classification ranged from 0.71 to 0.88. The overall kappa value for the functional disability classification was 0.77. On the basis of the data analysis, it was concluded that the AHA.SOC scores were reproducible and that the AHA.SOC accurately classified neurological impairments and stroke-related disability.

Application of the AHA Stroke Outcome Classification Score to Sample Cases

The following cases illustrate the decision-making process and use of the AHA.SOC in assessments of 3 stroke patients.

Case 1: A 62-year-old man has an ischemic infarct in the left hemisphere. Neurologically he is cognitively intact, not depressed, and able to communicate. He has no residual weakness or sensory loss. Three months after the stroke he is living independently at home without healthcare assistance for basic daily activities. He manages routine household maintenance and needs assistance only with community activities such as shopping and banking. The stroke classification score for this patient is number of domains impaired=0; stroke severity=A; functional classification=Level II. AHA.SOC score=0.A.II.

Case 2 is a 74-year-old woman with a large-vessel infarct in the right hemisphere. Neurologically she has the following residual impairments: partial hemianopia, facial palsy, and sensory loss and weakness in the upper and lower left extremities. She is not depressed and is cognitively intact. She lives at home with professional home healthcare assistance. She requires the assistance of another person to access

sometimes difficult to distinguish depression from dementia because they share similar symptoms, including disorientation, memory loss, and distractibility. Two assessment scales that reliably screen for symptoms of depression in stroke populations are the CES-D scale27 and the Geriatric Depression Scale.28
the community. She is unable to do housekeeping tasks or prepare meals. She can take her own medications and use a telephone; however, she cannot bathe independently or climb stairs. The stroke classification score for this patient is number of domains impaired=3; stroke severity score=B; functional classification level=Ill. AHA.SOC score=3.B.III.

Case 3 is an 85-year-old woman with a right-hemisphere infarct who lives in a skilled-nursing facility. She has paralysis of the left upper and lower extremities, partial hemianopia, cognitive impairment, and depression. She eats independently but is incontinent and needs help with dressing, bathing, toileting, and mobility-related activities. She cannot manage her medications, prepare her meals, use the telephone, or access the community without special transportation arrangements. The stroke classification score for this patient is number of domains impaired=3; stroke severity score=C; functional classification level=V. AHA.SOC score=3.C.V.

Conclusion

New therapies and improved survival after stroke provide an opportune time to develop a stroke outcome classification system that measures the full range of domains affected by stroke. The AHA.SOC score provides a mechanism to comprehensively document stroke impairments and disabilities in a single summary stroke score. The system can be used by healthcare providers to reliably assess recovery, measure responses to treatment, and describe the long-term impact of stroke on survivors.

Appendix

Stroke Deficit Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIH Stroke Scale</td>
<td>15 items scored on 3- or 4-point interval scales</td>
<td>Uses: acute care, screening, formal assessment, and monitoring Time: 10 min</td>
<td>Brief. Can be administered by non-neurologists. Interval scale good reliability to change. Omits dysphagia.</td>
</tr>
<tr>
<td>Canadian Neurological Scale</td>
<td>8 items scored on 3-point interval scale</td>
<td>Uses: acute care, screening, formal assessment, and monitoring Time: 5 min</td>
<td>Brief. Omits ataxia, visual fields, and eye movements. Interval scale relatively insensitive to change.</td>
</tr>
</tbody>
</table>

Mental Status Screening Test

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Mini-Mental State Exam</td>
<td>7 domains, including orientation to time and place, registration of words, attention, calculation, recall, language, and visual construction</td>
<td>Uses: screening, assessment, and monitoring Time: &lt;10 min</td>
<td>Widely used for screening. May misclassify patients with aphasia. Education and normal aging must be considered in interpreting overall score.</td>
</tr>
</tbody>
</table>

Language Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Diagnostic Aphasia Examination</td>
<td>Assesses sample speech and language behavior on a 6-point ordinal scale Modalities assessed: fluency, naming, word finding, repetition, serial speech, auditory comprehension, reading, and writing. Examiner judges grammar, syntax, frequency of paraphrases, and articulation.</td>
<td>Uses: formal assessment and monitoring Time: 1–4 h</td>
<td>Widely used, comprehensive, good standardization data, and sound theoretical rationale.</td>
</tr>
<tr>
<td>ASHA FACS</td>
<td>43-item rating scale of functional communication skills Modalities assessed: social communication, communication of daily needs, reading, writing, number concepts, and daily planning</td>
<td>Uses: formal assessment and monitoring Time: 15 min</td>
<td>Relies on observations of communicative behavior by rater, although input from professionals and families is also permitted.</td>
</tr>
</tbody>
</table>
Depression Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Geriatric Depression Scale (GDS) 14</td>
<td>Self-rating scale with 30 items in “yes/no” format. No items refer to disability.</td>
<td>Uses: screening and monitoring  Time: 10 min</td>
<td>Brief. Less affected by visual impairments, physical illness, difficulty in choosing options, and poor motivation. “Yes/no” format better for the elderly and the cognitively impaired.</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies of Depression (CES-D) 27</td>
<td>Self-rating scale, measures severity of depressive symptoms 20-item questionnaire investigates perceived mood and level of functioning within the past week.</td>
<td>Uses: screening and monitoring  Time: &lt;15 min</td>
<td>Brief self-report, easily administered. Useful in the elderly. Effective for screening stroke population.</td>
</tr>
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</table>

BADL Scales

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<tr>
<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Barthel Index 29</td>
<td>Ordinal scale with scores from 0 (totally dependent) to 100 (independent)  10 weighted items: feeding, bathing, grooming, dressing, bladder control, bowel control, toileting, chair/bed transfer, mobility, and stair climbing</td>
<td>Clinician observation  Time: &lt;40 min  Uses: screening, formal assessment, monitoring, and maintenance</td>
<td>Widely established measure for disability; strong reliability and validity.</td>
</tr>
<tr>
<td>FIM 36</td>
<td>Ordinal scale with 18 items, 7-level scale with scores 18–126. Areas of evaluation: feeding, self-care, sphincter control, mobility, locomotion, communication, and social cognition</td>
<td>Clinician observation  Time: &lt;40 min  Uses: screening, formal assessment, monitoring, maintenance, and program evaluation</td>
<td>Widely accepted in rehabilitation; proven measure of ADL and social cognition; standardized interobserver reliability by certification of clinicians.</td>
</tr>
</tbody>
</table>

IADL Scales

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<tr>
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<th>Time and Administration</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Frenchay Activities Index 46</td>
<td>15 items concerning activities at and outside the home. Summary score (15–60) and subscale scores for domestic, leisure/work, and outdoor activities. Depends on self-reports by patient and family.</td>
<td>Clinician observation  Time: &lt;40 min  Uses: screening, formal assessment, monitoring, and maintenance</td>
<td>Widely accepted in rehabilitation; proven measure of ADL and social cognition; standardized interobserver reliability by certification of clinicians.</td>
</tr>
</tbody>
</table>

Acknowledgment

We thank Sue Min Lai, PhD, for her statistical assistance with this project.

References


**Key Words:** AHA Medical/Scientific Statements ▪ stroke ▪ prognosis ▪ stroke outcome ▪ disability ▪ evaluation
The American Heart Association Stroke Outcome Classification
Panel Margaret Kelly-Hayes, James T. Robertson, Joseph P. Broderick, Pamela W. Duncan, Linda A. Hershey, Elliot J. Roth, William H. Thies and Catherine A. Trombly

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