Developed by the Stroke Special Interest Group (SIG) of the Academy of Neurologic Physical Therapy
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CLINICAL REASONING · OUTCOME MEASURES · NEUROLOGIC PT

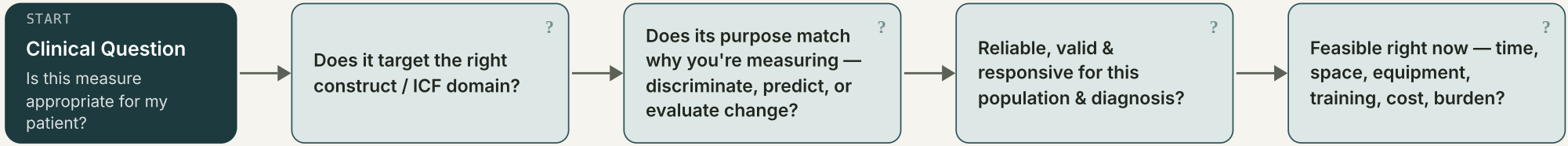
So Many Outcome Measures… So Little Time.

Stage 1: identifying appropriate measures to consider. Stage 2: deciding whether to administer and score each one.

A structured approach to two everyday clinical decisions: whether a standardized outcome measure is the right one to select for this patient, and whether you should administer it at this visit.

1 Choosing the Measure[1]

— before you see your patient, you may already have a measure in mind. The question becomes: is this measure the best choice?



Construct / ICF domain — body structure & function, activity, or participation. The *Guide to Physical Therapist Practice*[2] and the ICF[3] help identify what to measure, but the specific instrument is left to clinical judgment.

Purpose — discriminative measures distinguish between individuals or groups (e.g., the Performance-Oriented Mobility Assessment) but may have limited ability to detect change; predictive measures forecast future status (e.g., the Berg Balance Scale for fall risk); evaluative measures are built to detect change over time (e.g., the 10-Meter Walk Test). Match the measure's validated purpose to your clinical question.

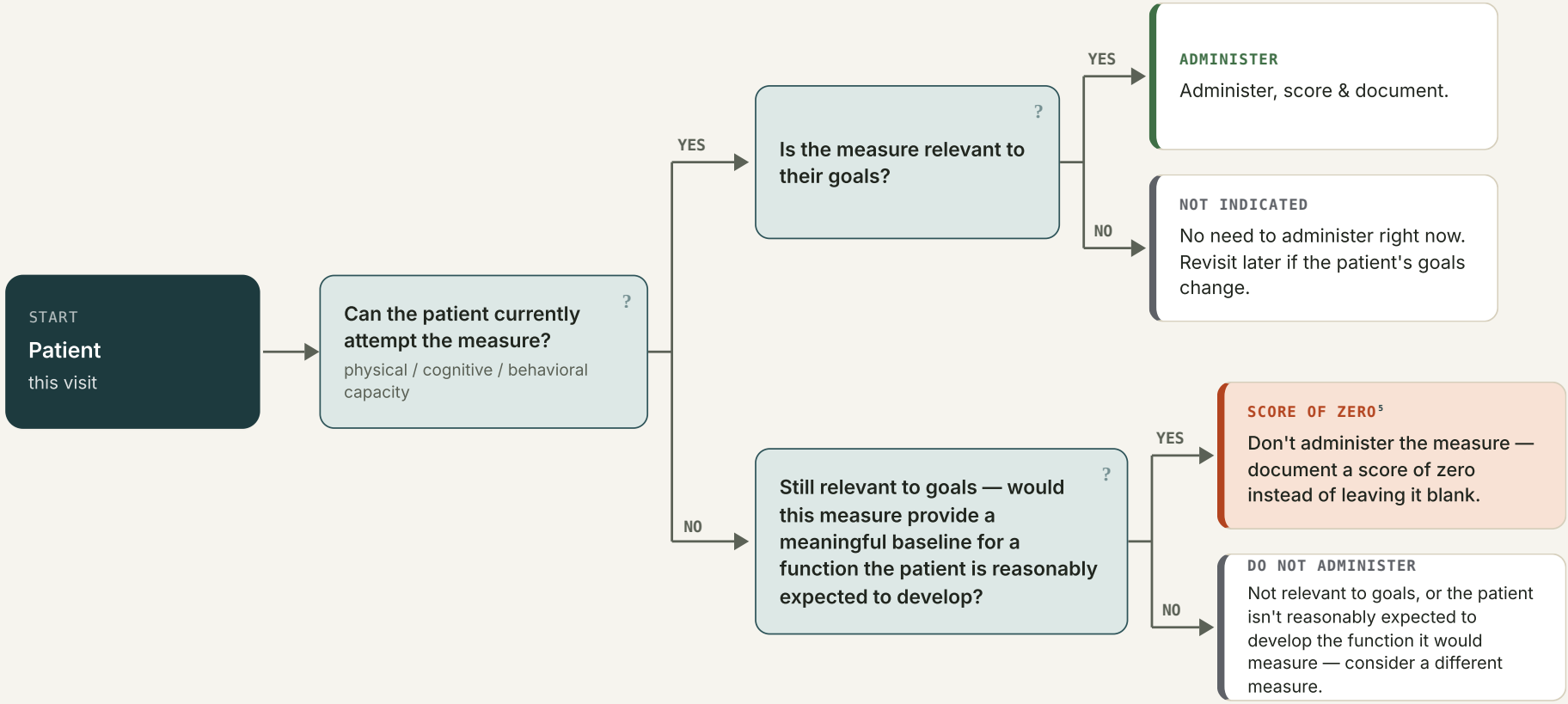
Population fit — reliability, validity, and responsiveness (e.g., minimal detectable change / minimal clinically important difference) established for this diagnosis, age group & setting. Psychometrics vary across patient populations — a reliability or validity statistic established in one neurologic population may not hold for another. Generic measures are beneficial when you want to use the same measure across populations.

Feasibility — time, space, equipment, training or certification, cost, respondent burden, culture & language, proprietary restrictions, and any facility- or payer-mandated reporting requirements.

Measure selected — proceed to Stage 2

2 Deciding to Administer — Today[4]

— with this patient, right now: is it still worth doing today?



Current capacity — even a measure that passed every Stage 1 criterion can still be untestable on a given day. Items pitched too hard or too easy produce floor or ceiling effects — e.g., a patient who needs assistance with sitting balance would be unable to complete the Functional Gait Assessment, but could still attempt the Berg Balance Scale or Postural Assessment Scale for Stroke.

Score of Zero — when the measure is still relevant to the patient's goals and would provide a meaningful baseline for a function they're reasonably expected to develop, don't administer it, but document a score of zero rather than leaving it blank. A blank field reads as missing data; a documented zero is baseline evidence you can later compare a real score against, using the measure's minimal detectable change.

1. Potter K, Fulk GD, Salem Y, Sullivan J. Outcome measures in neurological physical therapy practice: Part I. Making sound decisions. J Neurol Phys Ther. 2011;35(2):57-64. doi:10.1097/NPT.0b013e318219a51a

2. American Physical Therapy Association. APTA Guide to Physical Therapist Practice 4.0. APTA; 2023. Accessed November 10, 2026. https://guide.apta.org

3. World Health Organization. International Classification of Functioning, Disability and Health: ICF. World Health Organization; 2001.

4. Stage 2 algorithm originally developed by Kirsten Potter, PT, DPT, MS; adapted and modified here with permission.

5. Moore JL, Potter K, Blankshain K, Kaplan SL, O'Dwyer LC, Sullivan JE. A core set of outcome measures for adults with neurologic conditions undergoing rehabilitation: a clinical practice guideline. J Neurol Phys Ther. 2018;42(3):174-220. doi:10.1097/NPT.0000000000000229

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