S
troke remains one of the major public health problems in
the United States today, with approximately 500 000 new
or recurrent cases occurring each year.1 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 classi-
fication 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
Symposium2 determined that the complex nature of stroke
recovery demands clarification of its natural history and classi-
fication 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.3 Building on the work and recommen-
dations 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 impair-
ments, 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.4–6 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 determi-
nation of functional outcome.7–9 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 survivors10 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 pa-

tients with diseases of the heart framework.11 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 recom-


mends 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 impair-
ment.2 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

AHA Scientific Statement

The American Heart Association
Stroke Outcome Classification

Panel
Margaret Kelly-Hayes, EdD, RN, Cochair; James T. Robertson, MD, Cochair;
Joseph P. Broderick, MD; Pamela W. Duncan, PhD, PT; Linda A. Hershey, MD, PhD;
Elliot J. Roth, MD; William H. Thies, PhD; Catherine A. Trombly, ScD, OT
# 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 domains impaired</td>
<td></td>
<td></td>
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<tr>
<td>1 domain impaired</td>
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<tr>
<td>2 domains impaired</td>
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<tr>
<td>&gt;2 domains impaired</td>
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**Number of Neurological Domains Impaired**

<table>
<thead>
<tr>
<th>Score</th>
<th>Neurological Domains</th>
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<tbody>
<tr>
<td>0</td>
<td>Motor, sensory, vision, affect, cognition, language</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
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**Severity of Impairment**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>No/minimal neurological deficit due to stroke in any domain</td>
</tr>
<tr>
<td>B</td>
<td>Mild/moderate deficit due to stroke in ≥1 domain(s)</td>
</tr>
<tr>
<td>C</td>
<td>Severe deficit due to stroke in ≥1 domain(s)</td>
</tr>
</tbody>
</table>

**Function**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td><strong>Independent</strong> 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.</td>
</tr>
<tr>
<td>II</td>
<td><strong>Independent</strong> 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.</td>
</tr>
<tr>
<td>III</td>
<td><strong>Partially dependent</strong> in BADL (&lt;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.</td>
</tr>
<tr>
<td>IV</td>
<td><strong>Partially dependent</strong> 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.</td>
</tr>
<tr>
<td>V</td>
<td><strong>Completely dependent</strong> in BADL (≥5 areas) and IADL. Patient is unable to live alone safely and requires full-time care.</td>
</tr>
</tbody>
</table>

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American Heart Association Stroke Outcome Classification (AHA.SOC). BADL indicates Basic Activities of Daily Living: feeding and swallowing, grooming, dressing, bathing, continence, toileting, and mobility; and IADL, Instrumental Activities of Daily Living: using the telephone, handling money, shopping, using transportation, maintaining a household, working, participating in leisure activities, etc.
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, agraphesthesia, 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.  

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) and the Canadian Neurological Scale 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). 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. To screen for the presence of cognitive changes, the task force recommends the Mini-Mental State Examination (MMSE). 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. The Neurobehavioral Cognitive Status Examination (NCSE) 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. 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. 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.

**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. Depression can result either from the direct biological effect of brain infarction, such as that associated with left anterior cortex and basal ganglia lesions, 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
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 scale and the Geriatric Depression Scale. 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. 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. The Functional Independence Measure (FIM) is another widely used disability measure. 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 FIM and its sensitivity to change.

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. Two assessments are recommended in Post-Stroke Rehabilitation: Clinical Practice Guideline. The Philadelphia Geriatric Center (PGC) Instrumental Activities of Daily Living Scale measures IADL at home and in the community. Using self-reports by the patient and his or her family, 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, the Barthel Index, the Lawton IADL score, the Geriatric Depression Scale, and the MMSE. 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
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 = B; functional classification level = III. 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, toilet- ing, 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

<table>
<thead>
<tr>
<th>Stroke Deficit Scales</th>
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<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>NIH Stroke Scale</td>
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<tr>
<td>Canadian Neurological Scale</td>
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<tr>
<th>Mental Status Screening Test</th>
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<tbody>
<tr>
<td>Scale</td>
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<tr>
<td>Mini-Mental State Exam</td>
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<tr>
<th>Language Scales</th>
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<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>Boston Diagnostic Aphasia Examination</td>
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<td>ASHA FACS</td>
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Depression Scales

<table>
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<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Depression Scale (GDS)28</td>
<td>Self-rating scale with 30 items in “yes/no” format. No items refer to disability.</td>
<td>Uses: screening and monitoring</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>
</tbody>
</table>

BADL Scales

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<th>Scale</th>
<th>Description and Type of Scale</th>
<th>Time and Administration</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Barthel Index29</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 &lt;40 min</td>
<td>Widely established measure for disability; strong reliability and validity.</td>
</tr>
<tr>
<td>FIM36</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 &lt;40 min</td>
<td>Widely accepted in rehabilitation; proven measure of ADL and social cognition; standardized interobserver reliability by certification of clinicians.</td>
</tr>
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</table>

IADL 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>PGC Instrumental Activities of Daily Living41</td>
<td>Guttman scale Questions on telephone use, shopping, food preparation, walking, public transportation, and medicines</td>
<td>Interviewer &lt;30 min</td>
<td>Simple measure design with general functioning questions on information necessary for independent living.</td>
</tr>
<tr>
<td>Frenchay Activities Index46</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>Uses: monitoring Time: 10–15 min</td>
<td>Developed specifically for stroke patients. Assesses broad array of activities of daily living.</td>
</tr>
</tbody>
</table>

Acknowledgment

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

References

AHA Stroke Outcome Classification


Key Words: AHA Medical/Scientific Statements stroke  prognosis  stroke outcome  disability  evaluation