State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

February 18, 2014

N.L. 02-0214
Index: Medical Therapy Program
Supercedes: N.L. 02-0205

TO: ALL CALIFORNIA CHILDREN'S SERVICES COUNTY ADMINISTRATORS, MEDICAL DIRECTORS, SUPERVISING THERAPISTS, MEDICAL THERAPY UNITS, STATE SYSTEMS OF CARE DIVISION STAFF, AND THERAPY CONSULTANTS

SUBJECT: IMPLEMENTATION OF UPDATED TOOLS FOR CLASSIFICATION OF FUNCTION AND MEASUREMENT OF FUNCTIONAL OUTCOMES IN THE MEDICAL THERAPY PROGRAM

PURPOSE

The purpose of this Numbered Letter (N.L.) is to supersede N.L.: 02-0205 and provide guidelines for the California Children's Services (CCS) Medical Therapy Program (MTP) to utilize updated tools and simplify the process used by the MTP to classify levels of function (instead of impairment) and measure client/program functional outcomes. This shift from measuring impairment is in alignment with the World Health Organization's International Classification of Functioning, Disability and Health, which focuses on the individual's body function and structure, activity, participation, environmental and personal factors. The following classification systems replace the use of the *Neuromotor Impairment Severity Scale* (NISS) and will be utilized in conjunction with the *Functional Improvement Scale* (FISC):

1. The Gross Motor Functional Classification System Expanded and Revised (GMFCS E&R) – A five level system of classification for clients with cerebral palsy based on self- initiated movement with emphasis on sitting, transfers, and mobility.

2. The Manual Ability Classification System (MACS) – A five level system of classification for clients with cerebral palsy based on self-initiated ability to handle objects and their need for assistance or adaptation to perform manual activities in everyday life.

3. The Communication Function Classification System (CFCS) – A five level system of classification for clients with cerebral palsy based on their everyday communication performance.

The FISC will continue to be utilized as a standardized outcome measure tool by County CCS MTPs.

BACKGROUND

In January 2005, Systems of Care Division (SCD), formerly the Children's Medical Services (CMS) Branch, introduced the NISS and the FISC, to be utilized in the classification of physical impairment and measurement of functional outcomes for clients receiving physical therapy (PT) and occupational therapy (OT) services in the CCS MTP. They were designed to be used in conjunction with established CCS MTP documentation, policies, and procedures.

NL 02-0205 directed all counties to implement the FISC and include the data in the PT/OT Medical Therapy Unit (MTU) Summary and the Medical Therapy Conference (MTC) Summary for all clients receiving PT and OT services. The FISC was instituted to measure changes in function in key gross motor and activities of daily living (ADL) skills for all clients served in the MTP.

NISS data was to be reported in the same manner and was designed to categorize the severity of impairment for clients with cerebral palsy and similar upper motor neuron conditions (UMN). Independent counties were responsible for the implementation of the NISS following training to assure competence of staff, while Dependent counties would do so based on available staff and training.

Staffing difficulties at both the state and county levels, including lack of qualified trainers, resulted in compliance issues with the implementation and sustainability of the NISS. The FISC continued to be a beneficial tool for measuring a client's progress over time and is easily implemented. A working group consisting of both state and county therapists convened to discuss and recommend a solution to the difficulty in continuing to utilize the NISS as an impairment classification system.

The GMFCS E&R, MACS and CFCS were identified by the workgroup as appropriate replacements for the NISS. At the time the NISS was introduced in January 2005, there was no classification tool(s) available that addressed both gross motor and manual ability function that could be utilized for MTP clients with neuromotor impairments. The GMFCS was originally developed in 1997 by CanChild, Center for Childhood Disability

Research at McMaster University in Canada. It was revised and expanded in 2007, which resulted in it being appropriate for use as a functional level classification for MTP clients. The MACS was developed in 2006 by the Department of Woman and Child Health, Karolinska Institute in Stockholm, Sweden in conjunction with the CanChild, Centre for Childhood Disability Research at McMaster University in Canada. In order to capture the entire spectrum of a client's functional abilities, a communication classification tool has been included. The CFCS began development in 2011 at Michigan State University with ongoing research and development research organized and conducted by Dr. Mary Jo Cooley Hidecker, Ph.D., CCC-A/SLP at the University of Central Arkansas. The GMFCS-E&R, MACS and CFCS are internationally recognized classification systems that can be administered by the therapist without specialized training. While the NISS provided useful information about a client's tone and motor impairment, these classification systems provide a broader view of a client's functional ability.

POLICY

The GMFCS- E&R, MACS, and CFCS are to be used for MTP clients with a diagnosis of cerebral palsy or other upper motor neuron disorders. The combined use of the GMFCS-E&R, MACS, and CFCS for clients with cerebral palsy and other upper motor neuron disorders make it possible to clearly identify the levels of both function and severity of impairment for clients with these diagnoses.

A score for each of the three classifications will be determined by a MTU PT or OT at the initial evaluation, reviewed for accuracy at each subsequent therapy evaluation and will be documented in the MTU OT/PT Summaries. GMFCS- E&R, MACS and CFCS scores are not required for clients who are only receiving MTC services.

Links to the instructions for each classification/measurement tool are available at: http://www.dhcs.ca.gov/formsandpubs/publications/Pages/MedicalTherapyTools.aspx

The FISC v2 is to be used as part of the evaluation for all clients receiving PT and/or OT services. A client's FISC score is to be determined by the therapist at each evaluation. The first FISC score will be considered the Initial FISC score, regardless of the length of time that the client has been enrolled in the MTP. When a client transfers from one county to another the previous FISC score shall be used when calculating units of functional change. A FISC score is not required for clients who are receiving MTC services only. FISC scores are to be documented by each discipline participating in the preparation for the medical review by the client's managing physician. The total FISC score can be graphed to demonstrate the client's functional

change over time. The FISC scores for each functional skill shall be contained in the PT/OT MTU Summaries.

The State training materials for the FISC are attached to this letter**.** See Attachments (1-5) and the list of Additional Materials Available.

IMPLEMENTATION

Effective the date of this NL, use of the NISS as a standardized classification tool is discontinued. The GMFCS- E&R, MACS, and CFCS will be utilized as the standard method of impairment classification in the MTP. Each county MTP should maintain a separate record to document the client's GMFCS E&R, MACS, and CFCS scores for the purpose of future state-wide data collection. County CCS programs will report data collected from the GMFCS, MACS and CFCS (and FISC v2) to the State when requested. The SCD will define the method of collection in a separate correspondence at a future date. The method will be in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA).

Records shall be maintained in the client's chart to document their initial and subsequent FISC scores. The type and number of units of service per discipline provided during FISC intervals should be noted on this record for the purpose of data collection. Units of service should be counted in 15 minute intervals for each discipline; e.g., treatment, evaluation, case conference, and consultation. Documentation shall be counted per minute intervals.

Implementation of the above noted classification systems and outcome measurement tool does not eliminate the current requirements that:

1. Clients receiving PT and OT services shall be evaluated according to MTP policy contained in "Required Testing by Diagnosis."

2. Individual functional goals shall be established based on the results of comprehensive evaluation.

3. Provision of therapy is based on the client's response toward individual functional goals.

The State will continue to identify valid, reliable and internationally recognized assessments of functional abilities. It is anticipated that, in the future, one or more of these tools will augment or replace the FISC as the State approved assessment of functional skills within the MTP.

The links to the approved measurement tools are available at:
http://www.dhcs.ca.gov/formsandpubs/publications/Pages/MedicalTherapyTools.aspx

Questions regarding the implementation, interpretation and use of the subsequent data for these classification/measurement tools should be directed to Jeff Powers, State Therapy Consultant, at (916) 327-3027 or via e-mail at: jeff.powers@dhcs.ca.gov.

Thank you for your assistance in this matter.

Sincerely,

ORIGINAL SIGNED BY ROBERT J. DIMAND, M.D.

Robert J. Dimand, M.D.
Chief Medical Officer
Systems of Care Division

Attachments

FUNCTIONAL IMPROVEMENT SCALE
(FISC v2)
OVERVIEW
MEDICAL THERAPY PROGRAM
CALIFORNIA CHILDREN'S SERVICES

INTRODUCTION

The goal of the California Children's Services (CCS) Medical Therapy Program (MTP) is to assist each eligible child, adolescent, and young adult to reach his or her maximum physical function and independence. Each client is thoroughly evaluated at entry into the program to determine the type of impairment, severity, current functional skills, rehabilitation potential, and medical/surgical needs. Subsequently, individual goals and objectives are established for each client based upon input from the family, therapists and physician. The Medical Therapy Conference (MTC) team or CCS-paneled private managing physician prescribes medically necessary physical therapy (PT), occupational therapy (OT), orthoses and prostheses, durable medical equipment, and makes referrals for specialized medical evaluation, and surgery as needed to meet the client's individual needs.

Therapy goals and objectives are re-evaluated every 6-12 months to determine progress made and appropriateness of the medical therapy plan. Goals will also change over time as the specific needs of the client reflect growth, age, and maturation. The level of services provided by the MTP is commonly prescribed in terms of evaluation, consultation, weekly treatment, and monitoring, and will vary throughout the time the client is enrolled in the program.

DESCRIPTION

The FISC v2 is a tool that identifies the child, adolescent, and young adult's current ability in selected functional tasks and measures change over time in a uniform manner. The FISC v2 has 40 functional tasks that are applicable to children in the MTP. The tasks are clearly defined and are age referenced to unimpaired children who are able to perform the tasks independently. Children who have no impairment usually achieve all of these skills by seven years of age (See Attachment #2). Children with physical impairment usually require training on these skills over a longer period of time.

Each task is scored based on the level of independence demonstrated by the client. The functional tasks are divided in two basic categories: (1) general mobility skills, including transfer skills, and (2) activities of daily living (ADL) skills.

There are 9 levels of independence for each functional skill:

0 – dependent	3 – minimal assist	6 – supervision
1 – maximum assist	4 – contact guard assist	7 – modified independent
2 – moderate assist	5 – standby assist	8 – independent

These levels of independence are an ordinal scale that represents a higher ranking with each upward increment but are not necessarily equal in value. The definitions for each level of independence are clearly defined and are consistent with the prevailing use of the terms in the field of medical rehabilitation. (See Attachment #3)

USE OF THE FISC v2 IN THE MTP

The FISC v2 tool does not replace the requirement that:

- Clients receiving PT and/or OT services shall be evaluated according to MTP policy contained in the "Required Testing by Diagnosis."

- Measurable individual functional goals shall be established based on the results of testing with input from the child, family, and prescribing physician.

- The frequency of therapy services is based on the client's current medical and functional status, response to previous treatment, and level of skilled intervention required to maximize independence.

- MTP services are available to all children enrolled in the program until their 21st birthday, based on medical necessity.

- Improved FISC v2 scores should not be considered a requirement to receive medical therapy services. In some instances, it may not be sensitive enough to measure necessary improvements and/or the client may not be working on a skill(s) that is measured by the FISC v2. The therapy staff is expected to document progress in these areas using another measurement tool or descriptive terms.

The FISC v2 measurement tool has important uses in the MTP:

- Demonstrates the progress of an individual child, adolescent, or young adult in a standardized fashion through periodic scoring of each uniform task. Preliminary data shows that the FISC v2 effectively measures the progress of the majority of clients in the MTP.

- Helps families anticipate the functional outcome of their child based on age, diagnosis, and level of severity.

- Demonstrates that the MTP as a whole improves physical function and independence. Demonstration of effectiveness and outcomes has become the hallmark of current medical treatment. Agencies that fund medical treatment are less likely to support programs that are not "evidence based."

- Identifies excellence of practice that can be shared throughout the MTP. The State has a responsibility to promote the most effective treatment methods for children eligible for the MTP. This is one of several methods that can be used to improve services.

INSTRUCTIONS

Each of the 40 tasks is described in terms of set-up, response, and the developmental age when it is typically achieved. (See Attachment #4)

To complete an evaluation each task must receive a number score. "Not tested" cannot be used. "Not applicable" receives a score of "0" or dependent.

Each task must be performed in an appropriate period of time. A client who can do 100% of the effort of the task at a speed that is too slow to be functional should be scored based on the amount of assistance (minimum, moderate, maximum) that is required to do the job at a reasonable speed.

The term "briefly" means at least 5 seconds when referring to a posture that is attained.

The client is scored based upon the level of independence demonstrated. The scoring can be based on several evaluations or therapy sessions if necessary. A client does not have to be tested in tasks that are developmentally too advanced or unsafe. These are scored as dependent or "0". A client who is independent in most skills does not have to be tested in tasks that would be embarrassing or developmentally too low. These tasks would be scored at their highest level.

The client may use prostheses, braces, splints, durable medical equipment, or adaptive devices during any task at **any** testing level except "Independent." A client that can perform the task in an appropriate amount of time without prosthesis, braces, splints, durable medical equipment, or adaptive devices is given a score of "Independent", even though the client may be instructed to use a device for activities outside of the testing environment. "Modified independent" is used to indicate the client is **unable** to perform the task without a prosthesis, braces, splints, durable medical equipment, or adaptive devices, setup or structured environment.

Three of the tasks (#9 curbs, #15 in and out of bathtub, and #26 bathing) involve significant issues of safety and judgment that go far beyond the physical task and the training offered in the MTP. The developmental age levels in the literature for these tasks are for the motor skill only and do not reflect the older age at which the judgment would be appropriate for full independence. For these three items a client shall only be scored up to the level of "Supervision," but not a level of "Modified Independent" or "Independent." The family has the responsibility to determine whether the child is independent in these tasks. The therapist may wish

to place a comment in the FISC v2 report when the family states that the child is independent in these activities.

Several of the tasks have check boxes to indicate variability in accomplishing the task, such as utensil feeding (□ spoon or □ fork) or moving across the room (□ ambulation, □ manual wheel chair. or □ power wheel chair). For example, a client may begin using a spoon and gain independence showing an increase in the FISC v2 score. Later, switching to a fork, the client could have a lower score because more assistance is needed. A method that allows the FISC v2 to show the functional advancement as a positive score is as follows:

Initial FISC v2	2nd FISC v2	Improvement	3rd FISC v2	4th FISC v2	Improvement
1/1/2012	7/1/2012		7/2/2012	12/31/2012	
Score = 2 with spoon	Score = 8 with spoon	6	Score = 3 with fork	Score = 6 with fork	3

For the period of time between 1/1/2012 and 7/1/2012 the client achieved independence in spoon feeding, demonstrating 6 units of improvement. On 7/2/2012 the goal changed to fork feeding and a new FISC v2 was scored as minimal assist (3) using a fork. Then on 12/31/2012 the independence level with the fork showed a score of supervision (6) reflecting 3 units of improvement.

The above method is to be used at the time of reevaluation, when the therapist is setting the goals/objectives that would be:

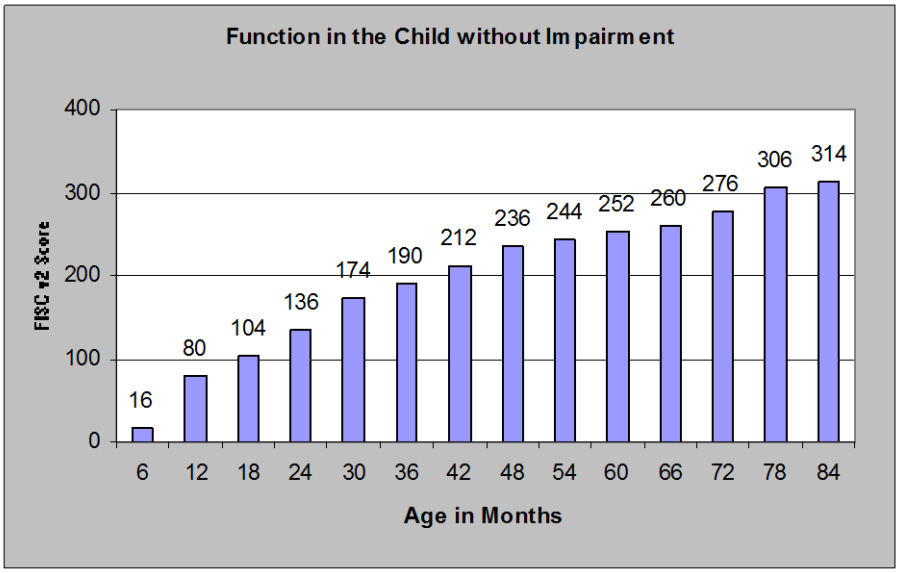
- scored using a different check box, or
- SIGNIFICANTLY more difficult, such as walking with HKAFOs and walker changing to walking with AFO and forearm crutches.

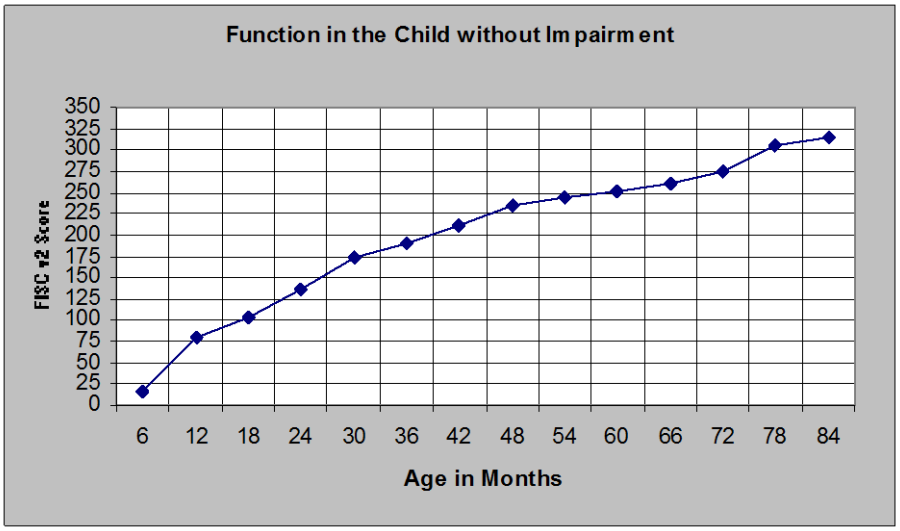
FISC v2 SCORE SHEET

The attached score sheet (See Attachment #5) may be used by the county staff to record each FISC v2 evaluation. The related units of service from the Patient Therapy Record (PTR) are to be recorded on the score sheet or into MTU Online for the interval between the most recent and the prior FISC v2 date.

FISC v2 REFERENCE CHARTS FOR CHILDREN WITHOUT IMPAIRMENT

FISC v2 SCORES FOR THE UNIMPAIRED CHILD			
AGE	**Total**	**GM**	**ADL**
6 m	16	8	8
12 m	80	64	16
18 m	104	80	24
2 y	136	104	32
2.5 y	174	134	40
3 y	190	142	48
3.5 y	212	156	56
4 y	236	156	80
4.5 y	244	156	88
5 y	252	156	96
5.5 y	260	156	104
6y	276	156	120
6.5 y	306	156	150
7 y	314	156	158





INDEPENDENCE LEVELS AND EXAMPLES
FOR
THE FUNCTIONAL IMPROVEMENT SCALE (FISC v2)

Note: the child may use an assistive device (including orthotic or prosthetic device) to accomplish the tasks except for the level "8" independent.

8 = INDEPENDENT (I) = The child performs the entire activity in an appropriate amount of time without a helper, assistive device, structured environment, or set-up.
7 = MODIFIED INDEPENDENT (Mod I) = The child performs the entire activity in an appropriate amount of time without a helper**,** but requires one or more of the following: • assistive device (including orthotic/prosthetic devices) • structured environment (such as modified room or quiet room) • set-up by therapist or helper
6 = SUPERVISION (SUP) = The child performs the entire activity in an appropriate amount of time but requires a therapist or helper in the same room or general area (but **farther away than an arm's reach**) to help stay on task or provide verbal cueing such as sequencing reminders.
5 = STANDBY ASSIST (SBA) = The child performs the entire activity in an appropriate amount of time but requires therapist or helper **standing within arm's reach (but not touching)** for reasons such as safety, verbal cueing or pointing.
4 = CONTACT GUARD ASSIST (CGA) = The child performs **approximately 100%** of the physical effort but **requires tactile cueing or light hands** by the therapist or helper.
3 = MINIMAL ASSIST (MIN) = Child can perform most of the activity (**approximately 75%**), and the therapist or helper is required to carry out only a small portion of the activity.
2 = MODERATE ASSIST (MOD) = The child and the therapist or helper each perform **approximately 50%** of the physical effort.
1 = MAXIMUM ASSIST (MAX) = Child can assist in some part of the activity (**approximately 25%**) and the therapist or helper is required to carry out most of the activity.
0 = DEPENDENT (DEP) = Child does not participate significantly in the activity and requires total assistance. This score is also used when the task is inappropriate.

EXAMPLES
FOR THE
FUNCTIONAL IMPROVEMENT SCALE

The following examples represent a few of the possible ways a child can respond to the tasks and provide additional explanation in the use of independence levels.

On the task of "moves across room"

- A child can move across the room using a walker and braces. Without the assistive devices the time to cross the room is unreasonable. The score would be "Modified Independent".

- A child can cross the room with and without his AFOs. Normally the AFOs are worn for all upright mobility but this is scored "Independent" because the task can be done without the braces if necessary.

On the task of "don a pullover shirt or sweater"

- A child can don a pull-over sweater but the garment must be placed front down and opening toward the child so that the sweater ends up facing front. This is scored as "Modified Independent" due to the set-up requirement.

- A child can perform the task in a quiet environment during a therapy session but does not do the task at home. This is scored "Modified Independent" due to environmental structure requirement.

- A child needs the therapist or helper to stand in arm's range due to risk of falling over backwards. Most of the time the task is done without falling. This is scored as "Stand-by Assist." If light touch is needed most of the time to prevent falling then the task is scored "Contact Guard".

- A child performs the task only if the therapist or helper is very close (within arm's reach) to keep the child from being distracted or provide a lot of verbal cueing. This is scored as "Stand-by Assist."

- A child performs the task if the therapist or helper is in the same room (farther away than arm's reach) but the child cannot stay on task if left alone in the room. Or, the child needs some sequencing instructions that can be given from across the room. This is scored "Supervision."

On the task of “sit to stand”

- A child sits without support in the chair with feet on the ground, stands up, and briefly maintains standing. The therapist or helper assists the child to lean forward to initiate movement, facilitates knee extension, and guides the child to stand. This is scored “Minimal Assist” because approximately 75% of the work is performed by the child.

On the task “utensil feeding”

- A child brings food to mouth but requires therapist to load the spoon. This is scored “Moderate Assist.”

On the task of “curbs”

- A 14-year-old can step up and down from a curb but needs light touch to stop the movement. This is scored “Contact Guard.”

- A 10-year-old child who has poor judgment but can get up and down a curb stopping movement at completion of the task. With the therapist 10 feet away, using a curb in a patio area the child performs the task completely. This is scored as “Supervision.”

- A 12-year-old with severe motor limitation is not tested because the task is beyond his or her motor development. This is scored “Dependent.”

On the task of “bathing”

- An 18-year-old child with good cognitive skills is new to the Medical Therapy Unit. She can demonstrate washing and drying the extremities, chest, and abdomen thoroughly in a “dry setting.” Her family reports that she does this by herself at home on a regular basis. This is scored as “Supervision” because that is the maximum level of independence allowed by the FISC v2. The therapist should state in the notes associated with the FISC v2 that “the family states the child is independent in bathing”.

TASK DESCRIPTIONS
FOR THE
FUNCTIONAL IMPROVEMENT SCALE (FISC v2)

	Task	**Set-up**	**Response**	**Age of independence for unimpaired child**
1.	Assume prone on elbows	Prone	Head moves to vertical position with chest partially raised from mat. Weight is supported on both arms (any arm posture is acceptable). The posture is maintained briefly (at least 5 seconds)	3-5m (Michigan)
2.	Rolling	Supine	Rolls to prone in either direction without trapping arms under the body. (1/2 tries). Log or segmental roll is acceptable	6-7m (Peabody)
3.	Crawling	Prone	Pulls self forward 3 feet using both arms (arms may be in any posture). Legs may assist or be dragged in "combat" style	6-7m (Peabody)
4.	Assume quadruped	Prone	Moves to position bearing weight on hands and knees, with hips over knees, maintains briefly (at least 5 seconds) or begins creeping.	6-8m (Michigan) 8-9m (Peabody)
5.	Sitting	Ring sitting without back support on flat surface (any trunk posture with head upright)	Maintains position for 60 seconds without using arms for support	8-9m (Peabody)
6.	Supine to Sit	Supine	Raises self to any style of sitting position on a flat surface and maintains unsupported sitting briefly (at least 5 seconds)	8m (Bayley)
7.	Sit to stand	Sitting in chair with feet resting flat on the floor	Achieves standing posture briefly (at least 5 seconds). May use arms to push and initiate movement.	12m (Bayley)
8.	Stand on two feet	Standing	Maintains standing in place briefly (at least 5 seconds). May use prescribed assistive devices to reach Mod I level.	13m (Bayley)
9.	Creeping	Prone	Uses reciprocal action on 4 points (any arm posture is acceptable) to move 3 feet forward. Knees do not need to be directly under the hips but stomach must be off the floor.	12-14m (Peabody)

TASK DESCRIPTIONS
FOR THE
FUNCTIONAL IMPROVEMENT SCALE (FISC v2)

	Task	**Set-up**	**Response**	**Age of independence for unimpaired child**
10.	Move across room ❑ Amb., or ❑ MWC, or ❑ PWC	Upright (Standing) or Seated in Wheelchair	Moves 10 feet forward without aid of furniture or walls. May use prescribed assistive devices to reach Mod I level.	15-17m (Peabody) 14m (Brazelton)
11.	Moves backwards ❑ Amb., or ❑ MWC, or ❑ PWC	Upright (Standing) or Seated in Wheelchair	Moves 4 feet backward without aid of furniture or walls. May use prescribed assistive devices to reach Mod I level.	12-15 (Michigan) 24-29m (Peabody)
12.	Manages Curbs	Curb	Steps up and down on curb maintaining upright posture. Child must stop movement once the curb has been ascended and descended.	24-30m (PEDI)
13.	Climb stairs	Standing	Climbs up 3-4 steps using upright posture. May hold rail or wall. Leg movement does not need to be reciprocal.	15-17m (Peabody) 18-24m (PEDI) 24-27m (Michigan)
14.	Descend stairs	Standing	Climbs down 3-4 steps using upright posture. May hold rail or wall. Leg movement does not need to be reciprocal.	24-29m (Peabody)
15.	Moves 150 feet (Short community distance) on concrete ❑ Amb., or ❑ MWC, or ❑ PWC	On flat concrete surface in upright position (Standing) or Seated in Wheelchair	Moves 150 feet forward on a 3 foot wide path of flat concrete IN 5 MINUTES OR LESS	36-42m (PEDI)
16.	Floor ↑↓ Stand	Sitting on floor	Gets up to standing posture briefly (at least 5 seconds) and returns to floor safely. May not use walls or furniture for assistance.	12-15m (Michigan) 17-19m (Bayley)
17. .	Bed ↑↓ ❑Chair or ❑WC	Sitting on edge of bed or raised mat of similar height	Maneuvers to sitting position on chair or WC of similar height.	16-19m (Michigan)
18.	❑Chair or ❑WC ↑↓ Floor	Sitting on a chair or wheelchair that is age/size appropriate	Descends safely to floor from chair or wheelchair and returns to seated position.	16-19m (Michigan)
19.	In and out of bathtub	Standing or sitting beside tub	Climbs or scoots in and out of standard tub.	36-42m (PEDI)
20.	On and off toilet (standard toilet)	Standing or sitting beside toilet	Assumes stable seated position on standard toilet and can resume starting position. May use arms.	36-42m (PEDI)

TASK DESCRIPTIONS
FOR THE
FUNCTIONAL IMPROVEMENT SCALE (FISC v2)

	Task	**Set-up**	**Response**	**Age of independence for unimpaired child**
21.	Lip closure on spoon	Sitting with trunk as upright as possible and head/trunk supported if necessary	Lip closure on spoon that allows removal of food (pureed consistency)	3-5m Michigan
22.	Finger feeding	Sitting at table	Picks up small pieces of food from flat surface and puts it into mouth successfully.	9-11m Michigan
23.	Cup drinking	Sitting at table	Drinks from partly filled cup with one or two hands, with some spilling. (Lid on cup or straw = modified drinking)	12-15m (Michigan) 18m (Brazelton)
24.	Utensil feeding ❑ Spoon ❑ Fork	Sitting at table	Uses spoon or fork to load food and deliver to mouth, with some spilling, but can be expected to complete a meal.	18-24m (PEDI)
25.	Don pullover shirt or sweater	Sitting with garment	Dons a pullover garment (T-shirt or sweater) oriented correctly to the body	24-31m (Michigan)
26.	Wash hands without drying	Sitting or standing	Soap is used on all parts of hands and rubbed as needed. Soap is rinsed off and drops of water are shaken into sink. Drying hands not required.	36m (Brigance)
27.	Don simple pants	Sitting with pants	Dons pants with elastic waist oriented correctly to the body	36-42m (PEDI)
28.	Don socks	Sitting with socks	Dons socks with proper orientation to foot	42-48m (PEDI)
29.	Spread with knife	Sitting or standing. Start with lump of jam or soft topping on corner of bread	Picks up knife and spreads jam or soft topping across bread.	48m (Brigance)
30.	Draw X with pencil	Sitting or standing with of pencil and paper on flat surface	Picks up pencil and draws X after demonstration	48m (Brigance)
31.	Don pants with zipper and top closure ❑ Button ❑ Snap ❑ Hook	Sitting with pants	Dons pants pulling up zipper and closing a button, snap, or hook top closure, correctly aligned to body	48-54m (PEDI)
32.	Don jacket with zipper	Sitting with jacket	Dons jacket correctly aligned to body, joins zipper and pulls up.	48-54m (PEDI)

TASK DESCRIPTIONS
FOR THE
FUNCTIONAL IMPROVEMENT SCALE (FISC v2)

	Task	**Set-up**	**Response**	**Age of independence for unimpaired child**
33.	Don shirt with buttons	Sitting with shirt (buttons are 1/2 to ¾ inch size)	Dons shirt correctly aligned to body and fastens buttons	60-66m (PEDI)
34.	Don shoes	Sitting with shoes	Dons shoes on correct feet without braces (tying laces not required and slip on shoe = ok)	66-72m (PEDI) 72m (Brazelton)
35.	Toileting	Standing or sitting	Manages clothing, and wiping. (Task may be judged by report)	48-60m (Michigan) 72-78m (PEDI)
36.	Wash and dry face	Sitting or standing	Washes and dries face	72-78m (PEDI)
37.	Brush teeth	Sitting or standing	Applies paste, brushes thoroughly, and rinses with water	72-78m (PEDI)
38.	Shampoo hair	Sitting or standing	Applies shampoo, washes and rinses (May do dry simulation)	72-78m plus (PEDI)
39.	Bathing	Sitting in tub or standing in shower stall. Need for seat or rolling shower chair would be a Mod I maximum.	Washes and dries body thoroughly (May do dry simulation)	72-78m (PEDI)
40.	Fastens laced laces	Sitting with shoes with on feet	Ties laces (not necessarily in a bow) Need for elastic laces, lace locks, or other type of adapted lace fasteners would be a Mod I maximum	78-84 (PEDI)