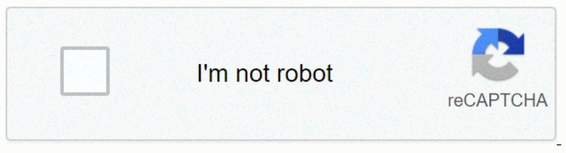

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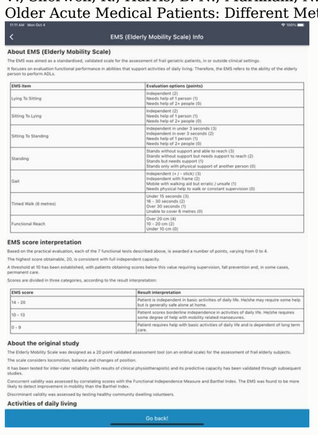
Elderly mobility scale pdf printable

Apply Today The Elderly Mobility Scale (EMS) is a 7-item objective measure designed to assess mobility and function in elderly adults. Number of items in the instrument: 7 (lying to sitting, sitting to lying, sitting to standing, standing, gait, timed walk, functional reach) ● Minimum score = 0, maximum score = 20 Description of item scoring: determined by the ability to perform the assessed activity and level of assistance needed Administration instructions: static and dynamic activities are completed by the patient with the appropriate level of assistance and a score is given based off of performance. Item scores are summed. Meter stick Stopwatch Bed Chair Walking aid (if typically needed by patient) Wall Space for 6m walk Form to record scores No training required but familiarization with tool beforehand is recommended Older Adult & Geriatric Care: (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) MDC90 = 4.3 (95% CI 2.8-6.7) Older Adult & Geriatric Care: (De Morton Et Al, 2008; N=15, 19, 28; Age= 78-93, 71-91, Not Provided) Estimated MCID = 2 Points MCID % of scale width = 10.0% Older Adult & Geriatric Care: (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) Using distribution-based method MCID = 2.73 MCID % OF SCALE WIDTH = 13.7% Using criterion based approach MCID = 6.97 MCID % OF SCALE WIDTH = 34.85% Discharge outcomes and EMS scores Score 14-20 = home (independent in basic ADLs) Score 11-13 = part iii accommodation (discharged home with high levels of care - community care package or relative) Score 0-6 = nursing home Score 5-13 = home with caretaker Score 1 = died Level of independence and EMSscores Score > 14 = independent in basic ADLs Score 10-13 = borderline in terms of safe mobility and independence in ADLs (require some help with some mobility maneuvers) Score < 10 = dependent (require help with mobility and ADLs) Older Adult & Geriatric Care: (Chiu et al, 2009, n=78, age= 65+) Fall risk and EMS scores Non-fallers: score = 19 - 20 Single-fallers: score = 19 - 20 Multiple fallers: score < 15 Older Adult & Geriatric Care: (Spilg Et Al, 2001, N=76, Median Age = 80, Median Followup Time = 108 Days Post-Discharge) Fall Risk And EMS Scores (If Barthel Index >=17 On Discharge) Score <20 On Discharge = Moderate Risk Score >= 20 On Discharge = Low Risk Inter-Rater Reliability Excellent Inter-Rater Reliability (R = 0.88, P < 0.0001) (Prosser And Canby, 1997; N = 66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study) Excellent Inter-Rater Reliability (Mann Whitney Test = 196, P = 0.75) (Smith, 1994; N=36; Age= 70-93) Excellent Inter-Rater Reliability (R2 = 0.0051, P = 1.00) Based On The Influence Of Particular Therapists (Nolan Et Al, 2008; N =32; Mean Age = 76.6 (9.1)) Excellent Inter-Rater Reliability (R2 = 0.0058, P = 1.00) Based On Years Of Clinical Experience (Nolan Et Al, 2008; N=32; Mean Age = 76.6 (9.1)) Excellent Inter-Rater Reliability (R2 = 0.0048, P = 1.00) Based On Number Of EMS Assessments Previously Completed In Clinical Practice (Nolan Et Al, 2008; N=32; Mean Age = 76.6 (9.1)) Excellent Inter-Rater Reliability Showed By The EMS Score Of An Individual Being The Variable That Placed Them In A Cluster (R2 = 0.8263, P = 0.000) (Nolan Et Al, 2008; N=32; Mean Age = 76.6 (9.1)) Intra-Rater Reliability Good Intra-Rater Reliability (R2 = 0.0035, P= 0.72) (Nolan Et Al, 2008; N=32; Mean Age = 76.6 (9.1)) Predictive Validity Poor Predictive Validity Of A Person Being Classified As A Single Faller Based On Performance In The EMS (P = 0.197) (Chiu Et Al, 2009, N=78, Age= 65+) Multiple Fallers Were Significantly Worse Than The Controls And The Single Fallers In Their Performance Even After Adjusting For Age, Gender And BMI (All With P < 0.001) (Chiu Et Al, 2009, N=78, Age= 65+) Group Differences In Discharge Destination Data And Significant Between Group Differences (P = 0.0005) Were Confirmed With A Chi Squared Test (Chi-Squared = 20.164) (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Community Dwelling Older Persons With Multiple Falls In The Six Months Prior To The Study Scored Significantly Lower On The EMS Compared To Older Persons Who Had Experienced No Falls Or Only A Single Fall In The Six Months Prior To The Study (P < 0.001) (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) The Scale As A Whole Cannot Be Used To Predict Those At Risk Of Falling, As Those Who Fell During The Study Were Of A Wide Range Of EMS Scores; However, The Functional Reach Component May Be Of Value (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Statistically Significant Relationship Between EMS Scores At Hospital Discharge And Risk Of >/= 2 Falls During 4 Month Follow-Up Period (Logistic Regression, P= 0.008) (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) Statistically Significant Association Shown Betwee EMS On Discharge And Patient Having 2 Or More Falls Over Follow-Up Period (Spilg Et Al, 2001, N=76, Median Age = 80, Median Follow-up Time = 108 Days Post-Discharge) Concurrent Validity Modified Rivermead Mobility Index (MRMI) Excellent Correlation With MRMI Scores (R = 0.887, P < 0.05, 95% CI:779 To 0.944) (Nolan Et Al, 2008; N=32; Mean Age = 76.6 (9.1)) Barthel Index (BI) Excellent Correlation With BI Scores (R = 0.962) (Smith, 1994; N=36; Age= 70-93) BI And EMS Scores Rendered A Lower Though Still Acceptable Level Of Correlation Than In The Original Study By Smith; However, The EMS And Barthel Are Not Measuring Exactly The Same Abilities (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Functional Independence Measure (FIM) Excellent Correlation With FIM Scores (R = 0.948) (Smith, 1994; N=36; Age= 70-93) Convergent Validity Barthel Index (BI) Excellent Correlation Of BI And EMS Scores (R = 0.96) (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) Excellent Correlation Of BI And EMS Scores (R = 0.787, P < 0.001) (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Functional Independence Measure (FIM) Excellent Correlation Of FIM And EMS Scores (R = 0.95) (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) De Morton Mobility Index (DEMMI) Excellent Correlation Of DEMMI And EMS Scores (R = 0.93 - 0.96, 95% CI, P = 0.00) (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) The EMS Items And Response Options Are Worded Clearly And Simply And The Seven Items Can Be Classified As Measuring The Domain Of Mobility (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) The Qualitative Methods Employed To Develop The EMS Items Were Not Clearly Reported By The Test Developer, But The Item Generation And Development Based On Expert Opinion And The Existing Literature Provides Evidence Of Content Validity (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) EMS Is Appropriate And Has Content Validity In That Mobility Is Broken Down Into Comprehensive And Relevant Components As Perceived By Physiotherapists (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Older Adult & Geriatric Care: The Qualitative Methods Employed To Develop The EMS Items Were Not Clearly Reported By The Test Developer, But The Item Generation And Development Based On Expert Opinion And The Existing Literature Provides Evidence Of Face Validity (De Morton Et Al, 2008; N=15, 19, 28; Mean Age= 78-93, 71-91, Not Provided) EMS Has Face Validity For Application In The Acute Hospital Setting (Smith, 1994; N=36; Age= 70-93) EMS Is Appropriate And Has Face Validity In That Mobility Is Broken Down Into Comprehensive And Relevant Components As Perceived By Physiotherapists (Prosser And Canby, 1997; N=66, 19 (Inter-Rater Reliability Study); Age = 66-69, 71-95 (Inter-Rater Reliability Study)) Ceiling Effects Poor ceiling effect of 50% identified for community-dwelling older adults who had experienced a single fall in the previous 6 months (7.5); Within 48 Hours Of Hospital Admission And Discharge) Adequate Ceiling Effect Of 15% Found For Persons At Hospital Discharge (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) Poor Ceiling Effect Of 35.3% Found Within The MDC Of The Highest Scale Score (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) 20 Healthy 81-90-Year-Old Women All Scored The Maximum 20 Points On The Scale (Smith, 1994; N=36; Age= 70-93) Floor effects Adequate floor effect of 20% found for persons at hospital admission (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) 83% of patients expected to improve after falls rehabilitation program showed improved ems scores and A significant improvement in EMS scores was identified between assessments (p < 0.001) (de Morton et al, 2008; n=15, 19, 28; Mean Age= 78-93, 71-91, not provided) Effect Size Index (ESI) Point Estimate = 0.76 (0.60-0.93) (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) Guyatt's Responsiveness Index Point Estimate = 1.68 (1.24 - 2.12) (De Morton Et Al, 2015; N=120; Mean Age (SD)= 82.2 (7.5); Within 48 Hours Of Hospital Discharge) Chiu, A. Y. Y., Au-Yeung, S. S. Y., Lo, S. K. (2009). "A Comparison Of Four Functional Tests In Discriminating Fallers From Non-Fallers In Older People." Disabil Rehabil 25(1): 45-50. Find It On Pubmed De Morton, N. A., Berlowitz, D. J., Keating, J. L. (2008). "A Systematic Review Of Mobility Instruments And Their Measurement Properties For Older Acute Medical Patients." Health Qual Life Outcomes 6(44). Find It On Pubmed De Morton, N. A., Nolan, J. S., O'Brien M. J., Thomas, S. K., Govier, A.
V., Sherwell, K., Harris, B. N., Markham, N. O. (2015). "A Head-To-Head Comparison Of The De Morton Mobility Index (DEMMI) And Elderly Mobility Scale (EMS) In An Older Acute Medical Population." Disabil Rehabil 37(20): 1881-1887. Find It On Pubmed De Morton, N. A., Nolan, J. S. (2011). "Unidimensionality Of The Elderly Mobility Scale In Older Acute Medical Patients: Different Methods, Different Answers." J Clin Epidemiol 64(6): 667-674. Find It On Pubmed Nolan, J. S., Remilton, L. E., Green, M. M. (2008). "The Reliability And Validity Of The Elderly Mobility Scale In The Acute Hospital Setting." The Internet Journal Of Allied Health Sciences And Practice 6(4).


EMS (Elderly Mobility Scale) Info

About EMS (Elderly Mobility Scale)

The EMS was aimed as a standardised, validated scale for the assessment of frail geriatric patients, in or outside clinical settings.

It focuses on evaluation functional performance in abilities that support activities of daily living. Therefore, the EMS refers to the ability of the elderly person to perform ADLs.

EMS item	Evaluation options (points)
Lying To Sitting	Independent (2) Needs help of 1 person (1) Needs help of 2+ people (0)
Sitting To Lying	Independent (2) Needs help of 1 person (1) Needs help of 2+ people (0)
Sitting To Standing	Independent in under 3 seconds (3) Independent in over 3 seconds (2) Needs help of 1 person (1) Needs help of 2+ people (0)
Standing	Stands without support and able to reach (3) Stands without support but needs support to reach (2) Stands but needs support (1) Stands only with physical support of another person (0)
Gait	Independent without frame (3) Independent with frame (2) Mobile with walking aid but erratic / unsafe (1) Needs physical help to walk or constant supervision (0)
Timed Walk (6 metres)	Under 15 seconds (3) 15 - 30 seconds (2) Over 30 seconds (1) Unable to cover 6 metres (0)
Functional Reach	Over 25 cm (4) 10 - 25 cm (2) Under 10 cm (0)

EMS score interpretation

Based on the practical evaluation, each of the 7 functional tests described above, is awarded a number of points, varying from 0 to 4.

The highest score obtainable, 20, is consistent with full independent capacity.

A threshold at 10 has been established, with patients obtaining scores below this value requiring supervision, fall prevention and, in some cases, permanent care.

Scores are divided in three categories, according to the result interpretation:

EMS score	Result interpretation
14 – 20	Patient is independent in basic activities of daily life. He/she may require some help but is generally safe alone at home.
10 – 13	Patient scores borderline independence in activities of daily life. He/she requires some degree of help with mobility related manoeuvres.
0 – 9	Patient requires help with basic activities of daily life and is dependent of long term care.

About the original study

The Elderly Mobility Scale was designed as a 20-point validated assessment tool (on an ordinal scale) for the assessment of frail elderly subjects.

The scale considers locomotion, balance and changes of position.

It has been tested for inter-rater reliability (with results of clinical physiotherapists) and its predictive capacity has been validated through subsequent studies.

Concurrent validity was assessed by correlating scores with the Functional Independence Measure and Barthel Index. The EMS was found to be more likely to detect improvement in mobility than the Barthel Index.

Discriminant validity was assessed by testing healthy community dwelling volunteers.

Activities of daily living

Go back!

Find It On Nsuworks Prosser, L.


MODIFYING AND ADJUSTING
CHILD SUPPORT
FACT SHEET

You must determine whether a change in circumstances has occurred in order to ***request a modification***, whether it is job-related or there has been a change in the situation of children. Gather any evidence that shows a change of circumstances has taken place. For example, if you lost your job, get a statement from your previous employer. If your child is sick and now requires expensive medical care, save copies of all of the medical bills.

Some courts use standardized forms for the modification of child support orders. Contact your local court or an attorney for more information. If you request modification pro se (without an attorney), you may want to consider having an attorney review the modification prior to filing.

The courts will only consider "the best interest of the child." If your motivation to apply for a ***modification*** of a child support order is to reduce the amount you pay or increase the amount you receive for personal gain, think twice before moving forward.

When you divorce in Georgia, the court determines whether either parent owes child support, and, if so, how much. Once the court orders child support, that order can be changed only if one of the parents asks the court to modify the original order.

How often can I file to reduce or increase a child support obligation?

You can file any time after the original child support order is entered as long as there has been a substantial change in the financial status and/or income of either parent or in the financial needs of the child. Once you file a motion to modify child support, however, you cannot file for modification again until two years have passed, unless an exception applies.

Can either parent request a modification?

Yes. Either the payor or the recipient of child support can request the court to modify an existing order for child support. A modification can only be made of a periodic payment, such as a weekly, biweekly or monthly payment schedule. A request for a modification of child support cannot be made if the requestor had asked the court to change a child support order within the last two years, unless there was an involuntary loss of income by the parent who is paying child support.

A., Canby, A. (1997). "Further Validation Of The Elderly Mobility Scale For Measurement Of Mobility Of Hospitalized Elderly People." Clin Rehabil 11(4): 338-343. Find It On Pubmed Smith, R. (1994). "Validation And Reliability Of The Elderly Mobility Scale." Physiotherapy 80(11): 744-747. Find It On Sciencedirect Spilg, E. G., Martin, B. J., Mitchell, S. L., & Aitchison, T. C. (2003). Falls Risk Following Discharge From A Geriatric Day Hospital. Clinical Rehabilitation, 17(3), 334–340. Find it on PubMed.