VP 09 CHEAT SHEET

Outcome Measures in VRT — Cheat Sheet for Physiotherapists

Pair patient-reported with performance-based, score against MCIDs, plot the curve, drive every decision from the data.

► Why outcome measurement matters

Outcome measurement replaces subjective impression with objective data. Baseline severity, plateau triage, patient buy-in, and referrer/funder confidence all come from numbers — not impressions. Pair patient-reported with performance-based every time; subscale patterns drive treatment focus more reliably than totals.

Indications — when this approach fits

► When to use this pathway

- ► Every VRT patient at session one — set baseline severity, confidence and visual-motion sensitivity, plus one performance-based measure.
- ► Re-test every 4–6 weeks to detect MCID, identify plateaus, redirect emphasis mid-program, and confirm discharge readiness.
- ► Battery selection follows presentation: acute peripheral, PPPD or visual-dependent, and functional dizziness each have a default trio.

Why outcome measurement changes care

Mechanism	Source	Result
Baseline severity	DHI, ABC, VVAS at session 1	Defensible starting point for every re-test
Plateau detection	4–6 weekly re-test vs MCID	Triggers triage, dose change or referral
Patient buy-in	Visible curve with MCID overlay	Engagement and adherence rise
Referrer & funder confidence	Documented numbers vs subjective letter	Numbers travel beyond discharge

► Pearl: pair patient-reported with performance-based

Pair every patient-reported tool with at least one performance-based tool. High DHI with normal FGA points to anxiety-driven handicap; low ABC with low FGA confirms genuine balance deficit. The pairing is the clinical insight — totals alone mislead.

Assessment battery

Domain	Test	Notes
Handicap	Dizziness Handicap Inventory (DHI)	25 items 0–100; 18-pt drop meaningful
Confidence	Activities-specific Balance Confidence (ABC)	16 items 0–100%; under 67% flags falls risk; 10-pt gain
Visual sensitivity	Visual Vertigo Analogue Scale (VVAS)	14 items mean 0–100; 9-pt change meaningful
Cervical contribution	Neck Pain Questionnaire (NPQ)	Cervicogenic / post-concussion screen
Dynamic gait	Functional Gait Assessment (FGA)	10 tasks 0–30; under 22 flags falls risk; 4-pt gain
Balance subsystems	Mini-BESTest	14 items 0–28; 4-pt MCID; exposes deficit subsystem

Prescription / treatment cheat list

Category	Frequency	Duration	Progress when…
Baseline battery	Once at session 1	30–45 min	Goals set; re-test booked at week 4–6
Re-test battery	Every 4–6 weeks	20–30 min	2+ domains meet MCID → progress
Visual curve review	Every re-test	2–3 min in-session	Patient engages with chart and goals
Subscale & sub-domain	Every re-test	5 min	Dominant pattern redirects emphasis
Discharge battery	Once at week 8–12+	30 min	Normative cutoffs across 2+ domains

► Pearl: act on the pattern, not the total

Subscale and sub-domain patterns guide the next program block. High emotional DHI plus low ABC favours psychology referral; physical DHI dominance points to active provocation; high residual VVAS with normalised vestibular tests pushes optokinetic exposure. Totals are signal, patterns are direction.

► Red flags — escalate

Worsening FGA week-to-week. DHI rising despite engagement. Emergent fall events. Sudden ABC collapse — psychological or vestibular crisis. Plateau across all domains by 6–8 weeks → vestibular physician for vHIT, VEMP and MRI. New focal neurology, sudden hearing loss, or vertical/direction-changing nystagmus → urgent neurology or ENT.

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Outcome measures — re-test every 4–6 weeks

Domain	Tool	MCID / threshold
Handicap	Dizziness Handicap Inventory	Drop of 18+ points clinically meaningful
Confidence	ABC scale	Less than 67% = falls risk; 10+ pt gain meaningful
Visual sensitivity	VVAS	Drop of 9+ points clinically meaningful
Dynamic gait	FGA	Up 4 points clinically meaningful
Balance subsystems	Mini-BESTest	Up 4 points clinically meaningful

► Compliance — what helps adherence

Plot the curve at every re-test with MCID overlays — the visual drives engagement more reliably than any single number. Tie goals to patient values. Week-2 telehealth check-in halves drop-off. Re-test exactly every 4–6 weeks — too frequent frustrates, too rare misses plateaus. Frame the questionnaires as 'your data, not the test of you'.

► When to refer onward

- ► Plateau across all domains by 6–8 weeks → vestibular physician for vHIT, VEMP and MRI.
- ► Persistent high VVAS with normalised vestibular tests → consider PPPD pathway and psychology referral.
- ► High emotional DHI subscale with low ABC → clinical psychology or graded exposure work.
- ► Sudden hearing loss, new focal neurology, or vertical / direction-changing nystagmus → urgent ENT or neurology.

► Twelve-second tips

Cover ICF domains. Pair patient-reported with performance-based. MCID, not p-value. Plot the curve. Re-test 4–6 weekly. Subscale patterns drive focus. Numbers travel — impressions do not.

► Common pitfalls — and how to avoid them

- ► Reporting statistical change without MCID context.
- ► Single-tool monitoring — pair patient-reported with performance-based every time.
- ► Ignoring subscale and sub-domain patterns; treating totals.
- ► Re-testing too often (frustrates) or too rarely (misses plateaus).
- ► No written maintenance plan at discharge — patients drift without one.

► Special populations

- ► Older adults — add Berg Balance Scale and Five-Times Sit-to-Stand for falls risk stratification.
- ► Post-concussion — add VOMS and Neck Pain Questionnaire alongside core battery.
- ► PPPD — emphasise VVAS and ABC; document subscale dominance.
- ► Functional dizziness — emphasise ABC + DHI plus brief mood screen (PHQ-9 / GAD-7).

► Patient communication scripts

"These numbers are your baseline — we re-test every six weeks to prove the program is working." | "A meaningful change is at least 18 points on the DHI or 4 points on the FGA." | "The curve, not the number, is the story — we chart your progress so you can see what's improving."

► References / further reading

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