

TABLE 5.6.1. TIMED UP AND GO REFERENCE VALUES FOR COMMUNITY-DWELLING, OLDER ADULTS⁵

AGE (YEARS)	MEAN (SECONDS)	95% CI
60 to 69	8.1	7.1 to 9.0
70 to 79	9.2	8.2 to 10.2
80 to 89	11.3	10.0 to 12.7

CI: confidence interval

Minimal Detectable Change

TABLE 5.6.2. TIMED UP AND GO MINIMAL DETECTABLE CHANGE VALUES

DIAGNOSTIC GROUP	MINIMAL DETECTABLE CHANGES (SECONDS)	REFERENCES
<i>Alzheimer's disease</i>	4.09	Ries et al ⁸
<i>Chronic stroke</i>	2.9	Flansbjerg et al ⁹
<i>Parkinson's disease</i>	11.3	Dal Bello-Haas et al ¹⁰

Minimal Clinically Important Difference

Write et al¹¹ measured the TUG scores at baseline, and then after 9 weeks of physical therapy in a group of patients with hip osteoarthritis. Using 3 different statistical calculation methods they reported that a reduction in the TUG time greater than or equal to 0.8, 1.4, and 1.2 seconds are the MCID.¹¹

Cut-Off Scores

Cut-off scores are commonly used to identify individuals at risk for falls. The cut-off score is different in different populations and across different diagnostic groups (Table 5.6.3). For example, using a cut-off score of 20 seconds, the TUG was 87% sensitive and specific in distinguishing older community-dwelling fallers from nonfallers.¹² Clinicians, however, should not rely solely on the TUG to identify fall risk because of the variability reported between studies and populations in cut-off scores as reported in systematic reviews and meta-analyses.¹³⁻¹⁶ Furthermore, the TUG is not suitable to identify fallers in high-functioning, older adult populations because it is not challenging enough (ceiling effect).¹⁶ In addition to timing the TUG, clinicians should observe how the individual performs the TUG to gain important clinical insight into the quality of the sit-to-stand, stepping, arm swing, steadiness, ability to turn, etc.