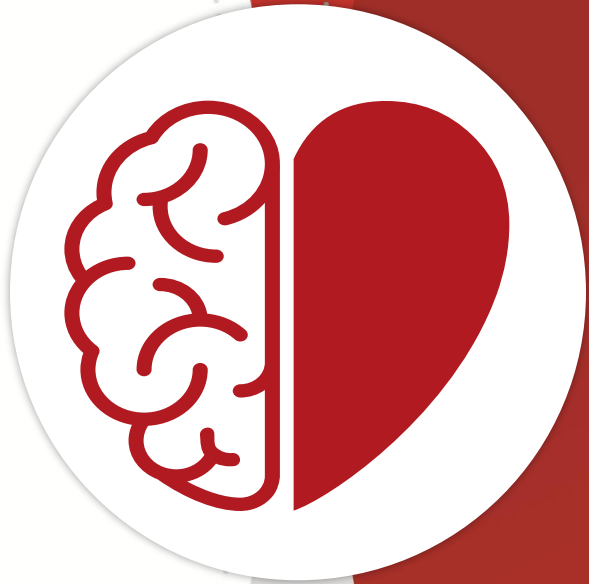


Guideline Essentials:

American Heart Association Clinical Slide Series



ADAPTED FROM:

2026 AHA/ASA Guideline for
Adult Stroke Rehabilitation
and Recovery



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AHA Clinical (PPTX)

Table 1.

Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care

Abbreviations:

SNF indicates skilled nursing facility; IRF, inpatient rehabilitation facility; and LTCH, long-term care hospital.



CLASS (STRENGTH) OF RECOMMENDATION	LEVEL (QUALITY) OF EVIDENCE‡
CLASS 1 (STRONG) Benefit >>> Risk Suggested phrases for writing recommendations: • Is recommended • Is indicated/useful/effective/beneficial • Should be performed/administered/other • Comparative-Effectiveness Phrases†: – Treatment/strategy A is recommended/indicated in preference to treatment B – Treatment A should be chosen over treatment B	LEVEL A • High-quality evidence‡ from more than 1 RCT • Meta-analyses of high-quality RCTs • One or more RCTs corroborated by high-quality registry studies
CLASS 2a (MODERATE) Benefit >> Risk Suggested phrases for writing recommendations: • Is reasonable • Can be useful/effective/beneficial • Comparative-Effectiveness Phrases†: – Treatment/strategy A is probably recommended/indicated in preference to treatment B – It is reasonable to choose treatment A over treatment B	LEVEL B-R (Randomized) • Moderate-quality evidence‡ from 1 or more RCTs • Meta-analyses of moderate-quality RCTs
CLASS 2b (Weak) Benefit ≥ Risk Suggested phrases for writing recommendations: • May/might be reasonable • May/might be considered • Usefulness/effectiveness is unknown/unclear/uncertain or not well-established	LEVEL B-NR (Nonrandomized) • Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies • Meta-analyses of such studies
CLASS 3: No Benefit (MODERATE) Benefit = Risk Suggested phrases for writing recommendations: • Is not recommended • Is not indicated/useful/effective/beneficial • Should not be performed/administered/other	LEVEL C-LD (Limited Data) • Randomized or nonrandomized observational or registry studies with limitations of design or execution • Meta-analyses of such studies • Physiological or mechanistic studies in human subjects
CLASS 3: Harm (STRONG) Risk > Benefit Suggested phrases for writing recommendations: • Potentially harmful • Causes harm • Associated with excess morbidity/mortality • Should not be performed/administered/other	LEVEL C-EO (Expert Opinion) • Consensus of expert opinion based on clinical experience.

COR and LOE are determined independently (any COR may be paired with any LOE).

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guidelines do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

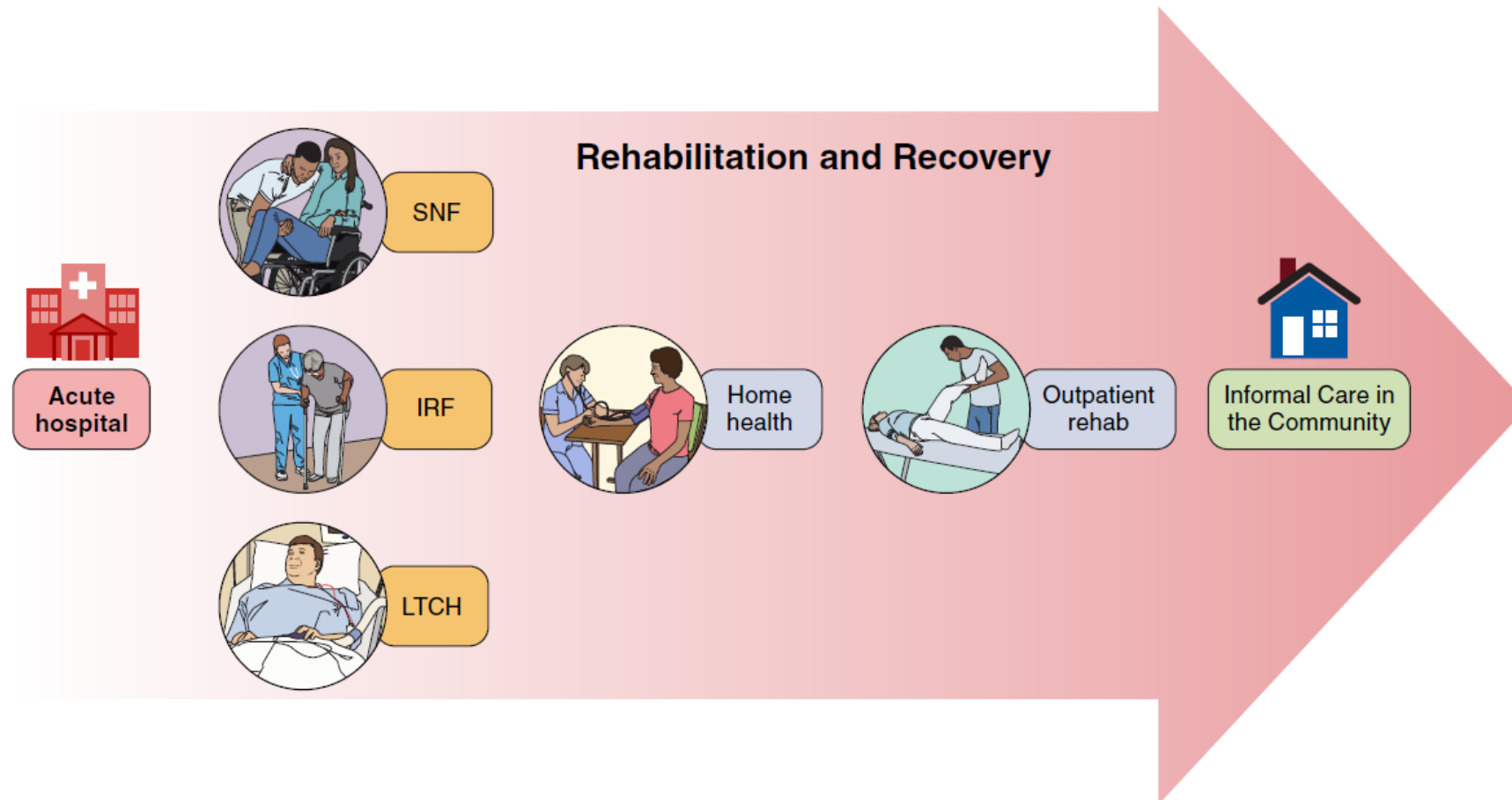
* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).

† For comparative-effectiveness recommendation (COR 1 and 2a; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely-used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

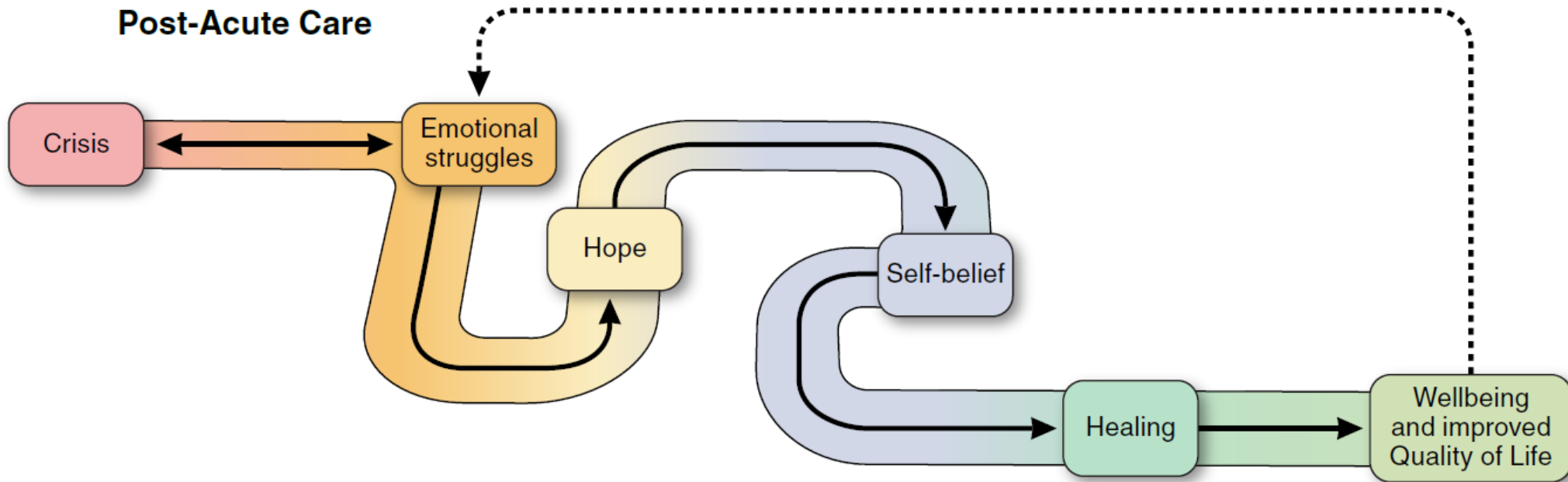
COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; R, randomized; and RCT, randomized controlled trial.

The Path from Acute Stroke through Rehabilitation and Recovery



Abbreviations: SNF indicates skilled nursing facility; IRF, inpatient rehabilitation facility; and LTCH, long-term care hospital.

Emotional Responses and Pathway



Overview: 11 Top Take-Home Messages

2026 AHA/ASA Guideline for Adult Stroke Rehabilitation and Recovery



1. Multidisciplinary Therapeutics



2. Longitudinal Communication for Care Team



3. Acute and Long-Term Rehabilitation



4. Restore Structure and Function with Targeted Therapies



5. Reduce Functional Impairments with Task Practice



6. Rehabilitation Therapy Reassessment and Re-engagement



7. Care Partner Well-Being Requirements



8. Mental Health Post-Stroke



9. Telehealth's Role



10. Clinical Trials of Rehabilitation Interventions are Needed



11. Standardized Outcome Measures for Behavioral Interventions

1. Multidisciplinary Therapeutics



MDT

Multidisciplinary
team approach

Class 1

TAKE-HOME MESSAGE

Goals of rehabilitation:

- Reduce neurological impairment
- Improve function via restorative and compensatory interventions

For successful outcomes, it is critical to:

- Participate in coordinated therapeutics
- Use a multidisciplinary approach

GUIDELINE RECOMMENDATION

In persons with stroke who are candidates for post-acute rehabilitation, organized, coordinated, interprofessional care is recommended to achieve maximal functional independence.



2. Longitudinal Communication for Care Team



COMM

Ongoing
care team
communication

Class 1

TAKE-HOME MESSAGE

Stroke rehabilitation requires:

- Close communication among interprofessional team
- Integration of care among the interprofessional team

Longitudinal communication among providers is critical to delivering:

- Efficient, effective and high-value rehabilitation
- Care across the continuum

GUIDELINE RECOMMENDATION

In persons with stroke seeking outpatient or home-based rehabilitation, organized community-based and coordinated interprofessional rehabilitation care is recommended to achieve more functional improvement.

Recommendation: 2.1.3

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



3. Acute and Long-Term Rehabilitation



REHAB

Acute through
long-term
recovery

TAKE-HOME MESSAGE

Rehabilitation:

- Begins in the acute phase
- Continues long-term
- No expiration date on rehabilitation potential
- Initiation in the acute phase is associated with better outcomes



3. Acute and Long-Term Rehabilitation



Class 1

REHAB

Acute through
long-term
recovery

Class 3: Harm

GUIDELINE RECOMMENDATIONS

In persons with stroke in the acute phase, early mobilization should be undertaken using a graduated mobilization protocol that commences 24-48 hours after stroke onset to improve functional outcomes and quality of life.

In persons with acute stroke, high-dose mobilization within the first 24 hours after stroke onset should not be performed to avoid risk of neurological worsening and worsened functional outcomes.

Recommendation: 2.2.1, 2.2.2

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



4. Restore Structure and Function with Targeted Therapies



TARGET

Targeted
neurological
therapies

TAKE-HOME MESSAGE

Rehabilitation combines interventions for:

- Restitution of body structure and function
- Learning compensatory strategies

Better methods are needed to select:

- Treatment approaches
- Timing of interventions
- Dosing of various interventions



4. Restore Structure and Function with Targeted Therapies



TARGET

Targeted
neurological
therapies

Class 1

GUIDELINE RECOMMENDATIONS

In persons with stroke, an individually tailored exercise program is indicated to optimize physical health, including cardiorespiratory fitness, mobility and to reduce the risk of future vascular events.

For persons with stroke, an evidence-based, goal-oriented, multidisciplinary physical rehabilitation program is recommended to improve gait and mobility.

Recommendation: 5.1.1, 5.5.1

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



4. Restore Structure and Function with Targeted Therapies



TARGET

Targeted
neurological
therapies

Class 1

GUIDELINE RECOMMENDATIONS

In persons with stroke with cognitive impairments, supervised moderate- to high-intensity technology-supported cognitive training programs that are tailored and adaptive to performance are recommended to improve global cognition, attention, and working memory.

In persons with stroke and aphasia, a variety of speech and language treatment approaches should be administered to facilitate restorative or compensatory communication.

Recommendation: 6.1.1, 6.2.2

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



4. Restore Structure and Function with Targeted Therapies



TARGET

Targeted
neurological
therapies

Class 1

GUIDELINE RECOMMENDATIONS

In persons with post-stroke hemiparesis, ADL training tailored to individual needs and eventual discharge setting is useful to achieve an optimal level of independence.

Persons with stroke should receive IADL training tailored to individual needs and eventual discharge setting for optimal function.

Recommendation: 5.6.1, 5.6.2

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



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5. Reduce Upper Limb Functional Impairments with Task Practice



TASK

Task-specific practice improves upper limb function

Class 1

TAKE-HOME MESSAGE

Interventions to reduce upper limb impairments and implementing compensatory strategies depend on a learning process driven by:

- Continuous repetition
- Diverse forms of task practice, including constraint-induced movement therapy

GUIDELINE RECOMMENDATION

In persons with stroke, participation in a program of task-specific upper limb activities commencing in rehabilitation and continuing at home or in the community is recommended to optimize upper limb function and performing activities of daily living.

Recommendations: 5.6.3



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Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



5. Reduce Gait and Mobility Impairments with Task Practice



TASK

Task-specific practice improves gait and mobility

Class 1

TAKE-HOME MESSAGE

Interventions to reduce gait and mobility impairments and implementing compensatory strategies depend on a learning process driven by:

- Task-specific training focused on overground walking, stepping and balance

GUIDELINE RECOMMENDATION

In persons with stroke, participation in a program of task-specific activities commencing in rehabilitation and continuing at home or in the community is recommended to optimize gait and mobility.



5. Improve Cognition through Exercise and Physical Activity



TASK

Exercise and Physical Activity improves cognition

Class 1

TAKE-HOME MESSAGE

Exercise and physical activity have beneficial effects on cognition after stroke.

GUIDELINE RECOMMENDATION

In persons with stroke, participation in a regular program of exercise or physical activity commencing in rehabilitation and continuing at home or in the community is recommended to optimize cognitive health.



5. Using Behavioral Swallowing treatments for Dysphagia



TASK

Behavioral swallowing treatments improves health and quality of life
Class 1

GUIDELINE RECOMMENDATION

For patients with stroke-associated dysphagia, behavioral swallowing treatment is effective for improving swallowing function, increasing tolerance of food textures, reducing the risk of negative health outcomes, and improving quality of life.

Recommendation: 5.10.10

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



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6. Rehabilitation Therapy Reassessment and Re-engagement



RE-ASSESS

Ongoing therapy reassessment

Class 1

TAKE-HOME MESSAGE

Ongoing rehabilitation may require:

- Periodic reassessment
- Re-engagement in therapy at various time points

GUIDELINE RECOMMENDATION

In persons with stroke, a formal assessment of body structures and functions, activity limitations and participation restrictions, and personal and environmental factors is recommended to inform treatment planning, care transitions, and discharge planning.

Recommendation: 4.1.1



7. Care Partner Well-Being Requirements



CARE

Support for care partners

TAKE-HOME MESSAGE

Care partners need comprehensive education and training to effectively support:

- Their own health and well-being
- The stroke survivor's rehabilitation and recovery



7. Care Partner Well-Being Requirements



CARE

Support for care partners

Class 2a

GUIDELINE RECOMMENDATIONS

Active and intentional engagement of caregivers of persons with stroke as early as possible and throughout rehabilitation can be beneficial to improve knowledge about stroke, mental health and caregiver burden.

For persons with stroke, involving caregivers in education and training using teach-back about care and rehabilitation activities can be beneficial to improve patient and caregiver outcomes such as experience of care, activities of daily living and mobility.

Recommendations: 7.2.1 and 7.2.2

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



8. Mental Health Post-Stroke



MH

Mental health
screening &
support

Class 1

TAKE-HOME MESSAGE

Mental health:

- Key component of successful recovery after stroke

Post-stroke depression:

- Common
- Treatable
- Can interfere with successful rehabilitation
- Screening for this condition is advised

GUIDELINE RECOMMENDATION

In persons with stroke, early screening using a valid screening instrument for post-stroke depression (from 3 days to 3 months post-stroke) is recommended to identify individuals in need of further evaluation and treatment.

Abbreviations: MH indicates mental health. **Recommendation:** 3.7.1

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



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9. Telehealth's Role



TELE

Telehealth in
stroke
rehabilitation

Class 2a

TAKE-HOME MESSAGE

Telehealth:

- Growing role in supporting care transitions
- Growing role in rehabilitation across the continuum after stroke
- Provides opportunities to improve access to care
- Provides opportunities to improve the cost-effectiveness of care

GUIDELINE RECOMMENDATION

For persons living at home after mild to moderate stroke, telerehabilitation therapies are reasonable alternatives to in-person therapies when access to these in-person therapies is limited or absent.

Recommendation: 7.4.3

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



10. Clinical Trials of Stroke Rehabilitation Interventions are Needed



RCT

Evidence from
clinical trials
needed

TAKE-HOME MESSAGE

To advance mechanism-based, personalized approaches to stroke rehabilitation, the field requires:

- Larger, well-designed clinical trials: Essential for filling current evidence gaps regarding rehabilitation interventions.
- Continued basic and translational research: Necessary to deepen our understanding of nervous system injury and recovery

Abbreviations: RCT indicates randomized controlled trial.

Richards, L.G., et al. 2026 AHA/ASA Guideline for the Adult Stroke Rehabilitation and Recovery. *Stroke*.



11. Standardized Outcome Measures for Behavioral Interventions



OUTCOMES

Standardized
measurement
frameworks

TAKE-HOME MESSAGE

The successful identification and implementation of future stroke interventions depend on utilizing outcome measures that are both:

- Standardized: Uniformly applied to ensure reliable data.
- Behavior-specific: Directly relevant to behavioral intervention strategies



Overview: 11 Top Take-Home Messages

2026 AHA/ASA Guideline for Adult Stroke Rehabilitation and Recovery



- 1. Multidisciplinary Therapeutics -**
Multidisciplinary team approach for successful rehabilitation outcomes



- 2. Longitudinal Communication for Care Team -**
Critical to delivering effective care across the continuum



- 3. Acute and Long-Term Rehabilitation -**
No expiration date on recovery potential



- 4. Restore Structure and Function with Targeted Therapies -** Better methods are needed to select treatment approaches, timing, and dosing



- 5. Reduce Functional Impairments with Task Practice -** Continuous repetition and diverse forms of task practice support learning processes



- 6. Therapy Reassessment and Re-engagement -**
Required for ongoing rehabilitation



- 7. Care Partner Well-Being Requirements -**
Care giver education and training to support self-care and stroke survivor's recovery



- 8. Mental Health Post-Stroke -** Screening advised for depression, which is common and treatable



- 9. Telehealth's Role -** Supports care transitions and rehabilitation, improves care access and cost-effectiveness



- 10. Clinical Trials of Stroke Rehabilitation Interventions are Needed -** To advance nervous system understanding and personalized strategy development



- 11. Standardized Outcome Measures for Behavioral Interventions are Needed -** For identification and implementation of future strategies.

Reference & Attribution

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