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# BMJ Open

## Systematic Review of the Measurement Properties of Performance-based Functional Tests in Patients with Neck Disorders

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031242
Article Type:	Research
Date Submitted by the Author:	24-Apr-2019
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Keywords:	functional, psychometric properties, neck pain, cervical, outcome measures

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Manuscripts

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2  
3 1 **Title:** Systematic Review of the Measurement Properties of Performance-based Functional  
4 Tests in Patients with Neck Disorders

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50  
51 **Key Words:** functional, psychometric properties, neck, cervical, outcome measures

52  
53 **Word Count:** 4239

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## 61 Abstract

62 **Objective:** The purpose of this systematic review is to identify and synthesize studies evaluating  
63 performance-based outcome measures designed to evaluate the functional abilities of patients  
64 with mechanical neck pain.

65 **Setting:** Not applicable

66 **Participants:** Participants with neck disorders

67 **Methods:** A literature search using PubMed, Scopus, CINAHL, Embase, COCHRANE, Google  
68 Scholar, and a citation mapping strategy was conducted through June 2018. Selected articles  
69 were appraised using the COSMIN risk of bias checklist tool and the Quality Appraisal for  
70 Clinical Measurement Research Reports Evaluation Form (QACMRR). Relevant data were then  
71 extracted from selected articles using an extraction guide.

72 **Results:** The search obtained 12 articles which reported on 4 outcome measures reporting to  
73 assess the functional abilities in patients with mechanical neck pathology. Of the selected papers:  
74 1 reports content validity, 5 construct validity, 4 reliability, 1 sensitivity to change, and 1 both  
75 reliability and construct validity. COSMIN sub-scores ranged from “inadequate” to “very good”  
76 and QACMRR scores ranged from 68% to 95%.

77 **Conclusions:** A limited number of performance-based tests have been developed or validated  
78 for assessing neck function. The pool of research in this area is sparse and insufficient to make  
79 conclusive recommendations.

80 **Prospero registration:** CRD42018112358

81

82

83 **Strengths and limitations of this study**

- 84 • The psychometric properties of performance outcome measures for neck pain were  
85 synthesized and critically appraised
- 86 • This study assessed the risk of bias and the quality of measurements properties
- 87 • The feasibility or usability of these tools was not assessed

## 89 Introduction

90 Neck pain has been associated with high disability and is regarded as a substantial  
91 societal burden. (1,2) Approximately 70% of people experience neck pain within their lifetime  
92 and about 33% of adults experience neck pain every year. (3,4) Further concern is warranted as it  
93 has been suggested that the incidence of neck pain is increasing. (5,6,7) The economic burden  
94 due to neck disorders is high, including lost wages, costs of treatment, and compensation  
95 expenditures to injured people. (8,9) Neck pain is second only to low back pain in annual  
96 workers' compensation costs in the United States.(7)

97 Outcome measures are a crucial component in monitoring patients with neck pain to  
98 determine the effects of treatment, evaluation of interventions, guiding return to work, and  
99 justifying treatment. Several self-reported outcome measures currently exist to assess disability  
100 and function in those with neck pain (e.g. the Neck Disability Index (NDI) or the numeric pain  
101 rating scale (NPRS). (10) Evidence-based clinical practice guidelines suggest that measures  
102 assessing physical performance should also be used for people with neck pain. (11)  
103 Performance-based testing is where the assessment is based on actual performance of a task or  
104 activity. Physical performance can be assessed by testing a person's ability to execute a  
105 standardized activity in a standardized environment (i.e. clinical setting). (12) Time to complete  
106 the activity, number of repetitions performed, and weight lifted are frequently used to quantify

1  
2  
3 107 the physical performance. (13) Conversely, self-report measures examine patients' perception  
4  
5 108 and experience of their ability to perform functional tasks. (12) Previous research has  
6  
7  
8 109 demonstrated poor to fair relationships between physical performance and self-report measures  
9  
10 110 of ability in patients with various musculoskeletal disorders suggesting that these measures  
11  
12 111 assess different constructs of function. (13,14) Consequently, physical performance tests and  
13  
14 112 self-report measures complement each other and may each contribute unique information about a  
15  
16  
17 113 patient's function. (15)

18  
19 114 A fundamental component of monitoring outcomes is having reliable and valid tools  
20  
21 115 with known measurement properties. (16,17) While recent research has investigated the  
22  
23 116 psychometric properties of patient-reported outcomes in people with neck pain (1,10, 18,19,20)  
24  
25  
26 117 there is a gap in knowledge with respect to performance-based functional outcomes. The purpose  
27  
28 118 of this systematic review was to identify and synthesize clinical measurement studies that  
29  
30 119 evaluate psychometric properties of performance-based functional tests in patients with neck  
31  
32  
33 120 disorders.

34  
35 121

## 36 122 **METHODS**

### 37 123 **Patient and Public Involvement**

38 124 No patient involved  
39  
40  
41  
42  
43 125

### 44 126 **Study Design and Protocol Registration**

45  
46 127 We conducted a systematic review to evaluate the psychometric properties of  
47  
48 128 performance-based functional tests for people with mechanical neck disorders. The protocol was  
49  
50  
51 129 registered in PROSPERO register with registration number CRD42018112358.  
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## 131 **Search Strategy**

132 A database search using CINAHL, PubMed, Scopus and Google Scholar was performed  
133 to identify articles published before July 2018. The following search strategy was used to search  
134 all databases for eligible studies: (Reliability OR validity OR responsiveness OR calibration OR  
135 validation OR (minimal detectable change) OR (clinically important difference) OR  
136 (psychometric properties) AND cervical OR neck OR c-spine AND (performance measure) OR  
137 (functional test) OR (functional outcome) OR (performance outcome)). A citation map of articles  
138 and systematic reviews selected for the full-text review was performed. This strategy was  
139 included to minimize the risk of publication bias. The Preferred Reporting Items for Systematic  
140 Reviews and Meta-Analyses (PRISMA) process (21) was followed to ensure all appropriate  
141 steps were taken in the selection process (**FIGURE 1**).

142

## 143 **Inclusion and Exclusion Criteria**

144 Articles were included in the final review if all of the following criteria were met: 1)  
145 >50% of the study's patient population had neck pain or a musculoskeletal neck disorder 2)  
146 Patients in the study completed a functional-based test 3) Clinometric properties of at least one  
147 performance-based test were reported. Definitions for the properties can be found in

## 148 **APPENDIX A.**

149

## 150 **Article Selection**

151 Titles and abstracts generated by the search strategy were screened by two authors  
152 independently. Articles that met the inclusion criteria and selected for a full text review were also



1  
2  
3 153 reviewed in pairs of authors. Disagreements were resolved by the most experienced author  
4  
5 154 (JCM)  
6  
7  
8 155

## 9 10 156 **Data Extraction**

11  
12 157 Data extraction and critical appraisal was performed in pairs of two raters among the  
13  
14 158 authors, after the completion of a calibration session. When reviewers disagreed during data  
15  
16 159 extraction and/or critical appraisal, and consensus could not be met, a third author arbitrated. A  
17  
18 160 data extraction form (17) (**APPENDIX A and APPENDIX B**), developed by one of the authors  
19  
20 161 (JCM.), was used to ensure systematicity. Authors extracted sample size, patient population  
21  
22 162 characteristics, functional tests performed and reported psychometric properties.  
23  
24  
25  
26 163

## 27 28 164 **Risk of Bias and Quality Assessment**

29  
30 165 Two authors used the Consensus-based Standards for the selection of health  
31  
32 166 Measurement Instruments (COSMIN) (22) checklist to assess risk of bias in the articles selected  
33  
34 167 for publication. The COSMIN checklist was recently adapted to evaluate risk of bias in studies  
35  
36 168 on measurement properties of patient reported outcome measures (PROMs). (22) After  
37  
38 169 completing a calibration session, each article was scored on the 4-point scale as “very good”,  
39  
40 170 “adequate”, “doubtful” or “inadequate” for each of the checklist criteria for relevant  
41  
42 171 measurement properties (e.g. reliability, responsiveness, etc.). To determine the overall score for  
43  
44 172 each measurement property, the worst score counts method was used wherein the lowest score  
45  
46 173 for the checklist criteria of the relevant property was taken as the overall score. (23) Pairs of  
47  
48 174 authors critically appraised the quality of each study using a standardized 12-item evaluation tool  
49  
50 175 (QACMRR) designed to assess the quality of studies determining measurement properties in  
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3 176 outcome measures (**APPENDIX C**). (24) Total scores on the tool can range from 0 to 24, with a  
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5 177 higher score indicating higher quality. Scores can be normalized to range between 0-100%. This  
6  
7  
8 178 tool has been found to have good to excellent pre-consensus inter-rater reliability (ICC: 0.69-  
9  
10 179 0.91) across a number of systematic reviews. (17,24-28) Raw scores were converted to  
11  
12 180 standardized percentage scores and ranked based on percentage values. There were no formal  
13  
14  
15 181 mechanisms developed to weight the studies based on quality scores.  
16  
17 182

## 183 **RESULTS**

184 The search strategy resulted in 840 published articles. After duplications were removed,  
185 31 articles were deemed relevant and were screened at full text. Overall, 12 articles met our  
186 inclusion criteria (**FIGURE 1**). The characteristics of the included studies and the summary of  
187 psychometric properties are presented in **TABLE 1**. The risk of bias and the quality assessment  
188 is summarized and presented in **TABLE 2-3**. The 12 articles that were included for review  
189 provided properties on the following performance based tests: Functional Capacity Evaluations  
190 (FCE) (29,30,31,32,33,34), The Baltimore Therapeutic Equipment Work Simulator II (BTEWS  
191 II) (35), Functional Impairment Test- Hand and Neck/Shoulder/Arm (FIT-HaNSA) (36), as well  
192 as items off of a physiotherapy test package including a cervical and lumbar Progressive  
193 Isoinertial Lifting Evaluation (PILE-C, PILE-L) test (37,38,39,40) and 2 x 20 m with burden  
194 walking test (2x20M-WWB) (37,38,39,40). Descriptions of all performance-based tests and their  
195 relevant subtasks are provided in **APPENDIX D**.

196

### 197 **FCE**

1  
2  
3 198 Six articles reported measurement properties for a FCE battery. We identified multiple  
4  
5 199 versions of the FCE in the literature with one article reporting properties on the Workwell FCE  
6  
7  
8 200 (30), two reporting on the Whiplash Associated Disorder (WAD) FCE (29,31) and three  
9  
10 201 reporting on the neck-FCE. (32,33,34) These test batteries include various combinations of  
11  
12 202 muscular strength, endurance and functional based tests. The measurement properties of the  
13  
14 203 functional based tests used by the FCE are outlined in **TABLE 4**.

15  
16  
17 204 An article evaluating the Workwell FCE (30) reported convergent validity and predictive  
18  
19 205 criterion validity of future work capacity in workers diagnosed with WAD I or II. Correlations  
20  
21 206 between FCE sub scores and baseline work capacity ranged between  $r=0.06$  and  $r=0.39$ . FCE  
22  
23 207 subscores did not predict future work capacity at 1, 3, 6 and 12 months.

24  
25  
26 208 An article evaluating the WAD FCE (29) evaluated test-retest reliability and  
27  
28 209 measurement error in sick listed workers diagnosed with WAD grade 1 or 2. Interclass  
29  
30 210 Correlation Coefficients (ICC) ranged from 0.66 to 0.96 (moderate to excellent). Limits of  
31  
32 211 agreement relative to mean performance ranged from 21 to 57% for functional based sub-tests.  
33  
34 212 Another WAD FCE article (31) evaluated convergent validity and known-groups validity. FCE  
35  
36 213 subscales showed small to moderate correlations with each of: pain, self-reported functional  
37  
38 214 ability, self-reported disability, anxiety and depression. It was found that the FCE had known-  
39  
40 215 group sex validity (males vs females) for 1 of 3 functional subtests (lifting waist-overhead) and  
41  
42 216 reported significant performance differences between culture groups (german vs non-german  
43  
44 217 language groups).

45  
46  
47 218 Reesink et al. developed an independent FCE for patients with musculoskeletal neck  
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49 219 disorders (neck FCE). (34) They performed a review of epidemiological literature and identified  
50  
51 220 four physical risk factors for work-related neck disorders and used that information to develop an  
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221 FCE consisting of eight performance-based tests. Content validity was established by following  
222 operational definitions of the risk factors when searching the literature and using current  
223 literature to provide a rationale to guide their development of the tasks comprising the FCE.  
224 Because of the unconventional methods used by this study to establish content validity, the  
225 authors of this review determined that the tools used to critically appraise other articles would be  
226 inappropriate and were given scores of N/A for the COSMIN and QACMRR. An additional  
227 article measured test-retest reliability of the subscales of the neck FCE in patients with  
228 multifactorial neck pain. (32) Test retest ICC's ranged from poor to excellent. Limits of  
229 agreement relative to mean performance range from 32.0% to 56.5% for functional based sub  
230 tests. Convergent validity was performed against the Neck Disability Index (NDI) items and total  
231 score. (33) The authors found weak to moderate Pearson correlations for the FCE sub scores to  
232 both NDI individual items and the NDI total score.

## 234 BTEWS II

235 Lomond and Cote reported on the reliability, measurement error, minimum detectable change  
236 (MDC) and validity of the power output (PO) task during the BTEWS II test in patients with  
237 chronic neck and shoulder pain (TABLE 5). (35) Test-retest reliability, measured with Spearman  
238 Rank correlations and ICC's was measured at  $\rho=0.37$  and  $ICC_{2,1} = 0.54$ , respectively. The  
239 standard error of measurement (SEM) and the minimal detectable change at 90% confidence  
240 (MDC<sub>90</sub>) for the PO task were measured as 30.25 and 70.59, respectively.

241 Weak Spearman Rank correlations between the PO task and the NDI, Shoulder Pain and  
242 Disability Index (SPADI) and Numeric Rating Scale (NRS) for pain tests were recorded. There  
243 were no significant performance differences between control and pain groups for the PO task.

244

**Fit-HaNSA**

246 Pierrynowski and colleagues reported on the reliability, measurement error, MDC and  
247 validity of the Fit-HaNSA test in a sample of people with WAD II following motor vehicle  
248 collision (MVC) (**TABLE 6**). (36) Intra-rater reliability ICC's for patient subtask and total  
249 scores ranged between 0.70-0.78. (36) Inter-rater reliability ICC's for patient subtask and total  
250 scores ranged between 0.54-0.84. (36) The Bland and Altman plot for the patient group showed a  
251 26 s bias in terms of improved performance on the second test (possible learning effect). The  
252 standard deviation of difference was 124 s and 95% Limits of Agreement (LoA<sub>95</sub>) was 248 s.  
253 (36) The SEM for people with WAD II was reported to be 76 s. (36) The MDC<sub>90</sub> was measured  
254 as 176 s. (36)

255 Spearman rank correlations were also calculated between the Fit-HANSA, Numeric Pain  
256 Rating Scale (NPRS), NDI, the disabilities of arm, hand and shoulder (DASH) and 6 cervical  
257 range of motion measures. Most (59 of 78) of the correlations between performance and  
258 comparator measures were poor ( $r < 0.4$ ). (36) All correlations between total Fit-HaNSA scores  
259 and subtask scores had good correlations ( $r < 0.75$ ), except for Task 1-Task 3. (36) Significant  
260 performance differences between WAD II and control groups (known group validity) were  
261 recorded for the total Fit-HaNSA score and all 3 subtask scores. (36)

262

**Physiotherapy Test Package Subtests**

264 Ljungquist et al published a series of articles which evaluated the clinometric properties  
265 of a physiotherapy test package for patients with spinal pain (**TABLE 7**). (37,38,39,40) This  
266 package included muscular strength & endurance tests, submaximal endurance tests, and three

1  
2  
3 267 functional tests. These functional tests included the PILE-C, PILE-L, and 2x20M-WWB test.

4  
5 268 Ljungquist's series of articles reported on convergent validity, known-groups validity, reliability,  
6  
7  
8 269 measurement error and sensitivity to change for these tests. (37,38,39,40)  
9

10 270 In a 1999 article (38), correlations between the tests of the package and pain (CR-10) and  
11  
12 271 perceived exertion (Borg RPE) were determined. All correlations were weak, except for a  
13  
14 272 moderate correlation between the PILE-C test and pain intensity and a moderate correlation  
15  
16 273 between 2x20M-WWB test and pain intensity.  
17  
18

19 274 In a paper from 1999, the PILE-C, PILE-L and 2x20M-WWB tests were found to have  
20  
21 275 significant discriminative abilities in distinguishing healthy subjects from patients with spinal  
22  
23 276 pain. (37) The sensitivity and specificity for this known group discrimination for the PILE-C test,  
24  
25 277 were reported to be 0.93 and 0.69, respectively. (37) The sensitivity and specificity for the PILE-  
26  
27 278 L test were reported to be 0.85 and 0.65, respectively. In a 2003 article, the PILE-C, PILE-L and  
28  
29 279 2x20M-WWB tests were tested to determine their ability to discriminate between known-groups  
30  
31 280 (neck pain vs back pain). (40) Subjects with spinal pain completed the CR-10, the University of  
32  
33 281 Alabama Pain Behavior scale (UAB) and the Borg RPE test. Specific cut points were used to  
34  
35 282 distinguish patients with high vs. low pain intensity, high vs. low pain behavior, and high vs. low  
36  
37 283 perceived exertion in patients, respectively. Participants then completed the test package and it  
38  
39 284 was determined if each subtest could discriminate between participants with high vs. low pain  
40  
41 285 intensity. The functional tests were able to discriminate between all 3 subgroups with the  
42  
43 286 exception of the PILE-C being unable to discriminate between participants with high vs. low  
44  
45 287 perceived exertion.  
46  
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50  
51 288 The inter and intra rater reliability were tested on participants with spinal pain. (38)  
52  
53 289 Limits of agreement were used to measure inter rater reliability and repeatability, defined as 2x  
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3 290 the within-subject standard deviation of each variable. Interrater agreement for 2 tests was  
4  
5 291 deemed “acceptable”, while all 3 functional tests had “clinically acceptable” intrarater reliability.  
6  
7  
8 292 (38) Sensitivity-to-change was evaluated in the test package following 6 months of a  
9  
10 293 physiotherapy intervention. Using ROC curves, Wilcoxon sign ranked tests and spearman  
11  
12 294 correlation coefficients, only the 2x20m-WWB test and the PILE-C (women only) were deemed  
13  
14  
15 295 to be sensitive to change. (39) Additionally, moderate to high effect sizes were found for all test  
16  
17 296 components.  
18

19 297

## 20 21 298 **DISCUSSION**

22  
23  
24 299 This study synthesized 12 studies assessing clinometric properties of 4 different  
25  
26 300 performance-based functional assessments. Given the limited number of studies, the substantial  
27  
28 301 variation in the types of tests examined, the methods used to assess the clinical measurement  
29  
30 302 properties, and the study populations, the current state of knowledge does not allow firm  
31  
32 303 conclusions regarding recommendations for an optimal performance-based test at this time.  
33  
34  
35 304 Overall, there is weak to strong evidence for a range of properties of the 4 different assessments  
36  
37 305 in patients with acute or chronic neck pain that is musculoskeletal in origin.  
38

## 39 40 306 **FCE**

41  
42 307 The breadth of a performance-based test is variable and defined by the developers. An  
43  
44 308 advantage of the functional assessment designed by Reesink et al. (34) is that they mapped the  
45  
46 309 eight subtests to risk factors identified in the literature for work-related neck disorders. The eight  
47  
48 310 subtests consist of: material handling tasks, lifting floor to waist, overhead lift test, one-handed  
49  
50 311 and two-handed carrying, overhead working, repetitive reaching, overhead lifting, and repetitive  
51  
52 312 bending and overhead reaching. Given the systematic approach and rationale these authors used  
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3 313 in developing the FCE and this approach being used in previous research (41), we suggest that  
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5 314 this test has strong content validity. However, the nature of the reporting of content validity  
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8 315 made it difficult to formally assess this paper using the COSMIN tool.  
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10 316 Six articles address the clinical measurement properties of this FCE. There is adequate  
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12 317 evidence that the FCE is stable over test-retest time of 7-14 days. (29,32) These measures  
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14 318 demonstrate longer stability over time compared to self-report measures such as the Neck  
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16 319 Disability Index (NDI) which has demonstrated test-retest reliability within only a short period  
17  
18 320 of 0-3 days. (17) Whether this longer-term stability is a characteristic of performance-based tests  
19  
20 321 or reflects differences in study populations in context requires further testing. Although test-  
21  
22 322 retest reliability has been assessed, inter-rater and intra-rater reliability has yet to be researched.  
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24 323 Unlike self-report measures, we expect measurement error due to the evaluator and performance-  
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26 324 based tests. Thus, future research should explore these aspects of reliability.  
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31 325 Convergent validity is often examined in clinical measurement studies. We suggest that  
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33 326 this may be because these comparisons are easily performed by correlating different tests rather  
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35 327 than providing strong confidence in the validity of the measurement. Often convenient  
36  
37 328 comparisons are performed rather than those most relevant. Across many domains and measures  
38  
39 329 it has become clear that the relationship between self-reported function and performance-based  
40  
41 330 function or physical impairment is often low to moderate. Therefore the value of assessment of  
42  
43 331 these relationships as a form of validation has limited value. Several studies of varying quality  
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45 332 have reported on the convergent validity of the FCE. (30,31,33) One article of adequate quality  
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47 333 found the relationship between the FCE and work capacity to be poorly associated with one  
48  
49 334 another. (30) The same study found that the ability of the FCE to predict future work capacity  
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52 335 was poor. This may be considered a more important comparison since ideally performance-based  
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3 336 tests would relate to important outcomes like return to work. No studies to our knowledge report  
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5 337 the responsiveness or sensitivity to change of the FCE. This is an important gap since the focus  
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8 338 of rehabilitation is often to remediate limitations in goal impairments or work capacity, and  
9  
10 339 assessment of these changes is critical to clinical decision-making and reporting outcomes. Thus,  
11  
12 340 future research should evaluate the responsiveness of the FCE to provide insight in the measure's  
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15 341 ability to detect change after an intervention.

### 16 17 342 **FIT-HaNSA**

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19 343 One very good quality study assessed the FIT-HaNSA, a test consisting of two reaching tasks  
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21 344 (waist and eye-level) and sustained overhead task performance. (36) Overall, the FIT-HaNSA  
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23  
24 345 demonstrates excellent inter-rater reliability and strong intra-rater reliability. The specific  
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26 346 subtests included within the FIT-HaNSA similarly demonstrate moderate to strong inter-rater  
27  
28 347 and intra-rater reliability. The FIT-HaNSA also demonstrated a clear ability to distinguish  
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30  
31 348 between people with WAD 2 and healthy controls. Correlations between the FIT-HaNSA and  
32  
33 349 other patient self-report disability and functional outcome measures (NPRS, NDI, DASH,  
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35 350 CROM and FIT-HaNSA) were generally poor ( $\rho < 0.4$ ), consistent with other studies comparing  
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37  
38 351 performance and self-report. (13,14) The largest limitation in critically synthesizing information  
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40 352 for this test is that only a single study was found that reported the measurement properties for  
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42 353 people with neck disorders. It should be noted however that it has been validated in other MSK  
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44 354 disorders. (1–6) Although others have noted the lag in development of performance-based  
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46  
47 355 measures in comparison to self-report measures, FIT-HaNSA was recommended as a  
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49 356 performance-based measure for people with shoulder disorders. (2)

### 50 51 357 **BTEWS II**

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3 358 One study of doubtful to adequate quality according to the COSMIN risk of bias tool  
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5 359 assessed the efficacy of the BTEWS II where the participants performed a dynamic pushing and  
6  
7 360 pulling task in which power output was recorded over a 10 second sample. (35) While the  
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9 361 convergent validity aspect of this paper was assessed as adequate through the critical appraisal  
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11 362 process, the relationship between the power output on the BTEWS and measures of pain and  
12  
13 363 disability (NDI, SPADI, NRS) were poorly associated with each other. In addition, the power  
14  
15 364 output component was not found to be significantly different between people with neck pain and  
16  
17 365 healthy controls which suggests it might not be discriminative. Discrimination between patients  
18  
19 366 and those without any symptoms is a low benchmark, and tests that cannot fulfil this benchmark  
20  
21 367 should be viewed with caution. Because of the weak measurement properties demonstrated by  
22  
23 368 the power output component of the BTEWS II, it does not appear to be a desirable performance-  
24  
25 369 based measure to assess function in people with neck pain. However, we acknowledge for all of  
26  
27 370 the performance-based tests the evidence pool is so shallow that there is high potential that future  
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29 371 studies might lead to different conclusions.  
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### 35 372 **Physiotherapy Test Package Subtests**

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37 373 Four studies assessing relevant items from a physiotherapy test package, including a lift  
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39 374 from floor-to-waist and a waist-to-shoulder task and a two-handed carrying task, ranged in  
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41 375 quality from “inadequate” to “very good”. The properties of these assessment items include weak  
42  
43 376 to moderate correlations to pain, perceived exertion, and had “adequate” reliability. The 2x20m-  
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45 377 WWB and PILE-C tests were found to be sensitive-to-change which is valuable information as  
46  
47 378 no other study has assessed this property in performance-based measures in patients with neck  
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49 379 disorders. Thus, this measure may be of value in clinical settings when assessing functional  
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51 380 capacity before and after a treatment intervention. All tests had discriminative ability for  
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3 381 detecting participants with spinal pain vs healthy controls. Most of the three tests demonstrated  
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5 382 poor construct validity in that they were poorly related to pain and perceived exertion, although  
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8 383 this was observed in a study of “doubtful” quality. Thus, further research of better quality is  
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10 384 necessary to investigate these constructs.

### 11 385 **Limitations**

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14 386 A challenge in synthesizing clinical measurement evidence is the wide range of  
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16 387 properties and indicators that need to be considered. Unlike effectiveness studies where one can  
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18 388 focus on the effect size of treatment there are many considerations that would affect the  
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20 389 recommendations made about outcome measures. This is further complicated when the pool of  
21  
22 390 evidence is shallow. Although the COSMIN and the quality assessment tool (QACMRR)  
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24 391 developed by one of the authors of this review which assess risk of bias and the quality of design  
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26 392 of individual studies respectively, were useful for interpreting the evidentiary pool, there is no  
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28 393 clear method to synthesize the extracted clinical measurement evidence. While some systematic  
29  
30 394 reviews on treatment might only report findings from high-quality studies, it is important to see  
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32 395 how outcome measures perform in different contexts. Further, the assessment of risk of bias and  
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34 396 quality are complicated given that clinical measurement studies have so many dimensions.  
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36 397 Therefore, exclusion of lower quality studies has questionable value. Thus, a more practical  
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38 398 approach is to consider quality when interpreting the findings, rather than excluding studies.

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40 399 The COSMIN and the QACMRR provide different perspectives since one focuses on the  
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42 400 risk of bias and the other the quality of the research design. For example, the article by Van de  
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44 401 Meer et al. was determined to be doubtful according to the COSMIN which is the lowest score  
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46 402 attainable on the tool whereas the QACMRR yielded a score of 86%. Additionally, the COSMIN  
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48 403 score for the Reneman 2017 paper in this review was found to be adequate, a much better result  
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3 404 than many other articles in this review but yielded the lowest score on the QACMRR of 67%.  
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5 405 This difference is likely attributed to the QACMRRs focus on different design issues. For  
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7 406 example, it provides lower scores where there are problems with small sample size or poor  
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9 407 subject retention, whereas the COSMIN did not ask any specific questions that captured these  
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11 408 qualities. The QACMRR focuses on whether the authors made appropriate decisions in selecting  
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13 409 the scope and methods of their clinical measurement evaluations within a given study and  
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15 410 provides descriptors of poor fair or good design options. Quality focuses on issues that might  
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17 411 affect risk of bias or imprecision in estimates; whereas risk of bias assessments focusses on items  
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19 412 that might result in a biased estimate. For example, insufficient power is a precision (quality)  
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21 413 issue, not a risk of bias. Although it is difficult to interpret the meaning of the percentage of the  
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23 414 QACMRR as there are no established cut-offs for distinguishing good and poor-quality studies, it  
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25 415 provides one way of ranking the articles in order of quality. Since the COSMIN rates bias  
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27 416 according to specific measurement properties whereas the the QACMRR evaluates the overall  
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29 417 study design, we found that these tools provide complementary perspectives on the studies.  
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31 418 Therefore, agreement on the scores was not expected.  
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38 419 Another limitation in this review was that the feasibility or usability of these tools was  
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40 420 not assessed. While feasibility was not the focus of this review, information on the practical  
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42 421 application of these performance-based measures provides valuable information to clinicians for  
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44 422 determining whether these tests are appropriate to use in their given setting. Thus, future research  
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46 423 should not only investigate further the psychometric properties of these tools, but also report the  
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48 424 feasibility of using these tests so that they may be used in clinical settings and to identify  
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50 425 limitations that restrict their application in practice.  
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## 427 CONCLUSION

428 This study confirms that performance-based tests have had far less development and  
429 evaluation than self-report measures. Limitations include the number of tests and insufficient  
430 body of evidence to make confident recommendations with respect to performance-based testing.  
431 It is clear that self-report and performance-based measures provide different perspectives.  
432 Theoretically, performance-based tests are important to inform our understanding about the  
433 mechanisms of intervention and how interventions increase capacity. Overall more work is  
434 required to further establish the psychometric properties of performance-based tests in persons  
435 with neck disorders, including sensitivity-to-change, responsiveness, and predictive validity. The  
436 data presented suggest that the FIT-HaNSA has the strongest clinometric properties though this  
437 is based on a single high-quality paper specific to neck disorder. (36, 5) Importantly, normative  
438 data have been published (6), it has been validated in multiple studies in patients with shoulder  
439 conditions (1,3,4) and has been recommended when compared to other measures (2). The FCE  
440 has a limited evidence base from which to draw, though it was developed with strong content  
441 validity and further evaluation may demonstrate its usefulness. Performance-based evaluation in  
442 people with neck disorders is an area needing much research attention both to establish the  
443 measurement properties of existing measures, potentially to develop innovative new measures  
444 and to perform head-to-head comparisons of measures before an optimal performance-based  
445 tests can be identified.

## 447 Authors' contributions

448 SM contributed significantly to conception and design of the study, data extraction, critical  
449 appraisal, interpretation of data and drafting of the manuscript. TS, TA, PB, and CC were involved  
450 in literature search, critical appraisal and interpretation of data and drafting. AG was involved in

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2  
3 451 critical appraisal and drafting. JM was also involved in the conception and design of the study,  
4 452 drafting, and revised the manuscript for important intellectual content. PB and CATWAD were  
5 453 involved in the drafting and review of the manuscript. All authors have given their final approval  
6 454 on the manuscript to be published  
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10 455

## 11 456 **Declarations**

### 12 457 **Ethics approval and consent to participate**

13 458 Not applicable  
14  
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16  
17 459

### 18 460 **Consent for publication**

19 461 Not applicable  
20  
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22 462

### 23 463 **Availability of data and material**

24 464 Data sharing is not applicable to this article as no datasets were generated or analyzed during the  
25 465 current study  
26  
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28 466

### 29 467 **Funding Statement**

30 468 This work was supported by the Canadian Institutes of Health Research (CIHR) with funding  
31 469 reference number (FRN: SCA-145102).  
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### 36 471 **Competing Interest Statement**

37 472 None to report.  
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**TABLE 1.** Summary of Studies Reporting Psychometric Properties of Functional-based Tests in Neck Disorder Patients

Study	Population	Sample Size (n)	Functional Tests	Intervention/Test Interval
Ljungquist et al. 1999	Neck pain, back pain, multiple pain sites, chronic pain	53	PILE-C, PILE-L	N/A
Ljungquist et al. 1999	Neck pain, lumbar pain, thoracic pain, shoulder pain, multiple pain sites, chronic pain	68	PILE-C, PILE-L, 2 WWB	20m 8 days
Ljungquist et al. 2003	Neck pain, lumbar pain, thoracic pain, shoulder pain, lower extremity pain, multiple pain sites, chronic pain	235	PILE-C, PILE-L, 2 WWB	20m N/A
Ljungquist et al. 2003	cervical pain, lumbar pain, cervical and lumbar pain, multiple pain sites, chronic pain	186	PILE-C, PILE-L, 2 WWB	20m 6 months
Lomond and Cote. 2011	Chronic neck and shoulder pain	32	BTEWS II	9.5 days
Pierrynowski et al. 2016	Sub-acute and chronic WAD II	66	FIT-HaNSA	2-7 days
Reesink et al. 2007	N/A	N/A	Neck-FCE	N/A
Reneman et al. 2017	Chronic multifactorial neck pain	18	Neck-FCE	2 weeks
Trippolini et al. 2013	Sub acute and chronic WAD I and II	32	WAD FCE	7 days
Trippolini et al. 2014	Sub acute and chronic WAD I and II	267	Workwell FCE	N/A
Trippolini et al. 2015	Sub acute and chronic WAD I and II	314	WAD FCE	N/A
Van der Meer et al. 2013	Chronic WAD I and II	40	Neck FCE	N/A

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PILE-C, Progressive Isoinertial Lifting Evaluation-Cervical; PILE-L, Progressive Isoinertial Lifting Evaluation; CBT, Cognitive-Behavioural Therapy; PT, Physical Therapy; NRPS, Numeric Pain Rating Scale; BTEWS II, Baltimore Therapeutic Equipment Work Simulator II; WAD, Whiplash Associated Disorder; MVA, Motor Vehicle Accident; FIT-HaNSA, Functional Impairment Test-Hand and Neck/Shoulder/Arm; FCE, Functional Capacity Evaluation; EXP, Experimental; M, Male; F, Female

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**TABLE 2.** Summary of Psychometric Properties Reported in Studies and COSMIN risk of bias checklist scores

Study	Psychometric Properties Reported	COSMIN Score
Ljungquist et al. 1999	Known-groups Validity	Adequate
	Convergent Validity	Very Good
Ljungquist et al. 1999	Reliability	Inadequate
	Measurement Error	Adequate
Ljungquist et al. 2003	Known-groups Validity	Very Good
Ljungquist et al. 2003	Sensitivity to Change	Doubtful
Lomond and Cote. 2011	Reliability	Doubtful
	Measurement Error	Doubtful
	Known-groups Validity	Doubtful
	Convergent Validity	Adequate
Pierrynowski et al. 2016	Reliability	Very Good
	Measurement Error	Adequate
	Known-groups Validity	Very Good
	Convergent Validity	Very Good
Reesink et al. 2007	Content Validity	N/A*
Reneman et al. 2017	Reliability	Adequate
	Measurement Error	Adequate
Trippolini et al. 2013	Reliability	Adequate
	Measurement Error	Adequate
Trippolini et al. 2014	Convergent Validity	Very Good
	Predictive Criterion Validity	Very Good
Trippolini et al. 2015	Known-groups Validity	Very Good
	Convergent Validity	Inadequate
Van der Meer et al. 2013	Convergent Validity	Doubtful

COSMIN, Consensus-based Standards for the Selection of health Measurement Instruments

\*Paper is not applicable for completion of COSMIN checklist



**TABLE 3.** Quality of Studies on Psychometric Properties of Functional-based Tests Evaluated in Neck Disorder Patients

Study	Item Evaluation Criteria												Total (%)
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	
Trippolini et al, 2014	2	2	2	2	1	2	2	2	2	2	1	2	92%
Lomond and Cote, 2011	2	2	1	2	0	2	2	2	2	2	2	2	88%
Pierrynowski et al, 2016	2	2	1	2	0	2	2	2	2	2	2	2	88%
Trippolini et al, 2015	2	2	2	0	1	N/A	2	2	2	2	2	2	86%
Van der Meer et al, 2013	2	1	2	1	2	N/A	2	1	2	2	1	2	86%
Ljungquist et al 2003 KGV	2	2	2	0	0	N/A	2	2	2	2	2	2	82%
Ljungquist et al 1999 Rel	2	1	1	2	0	2	2	2	2	2	1	2	79%
Ljungquist et al 2003 STC	1	1	1	2	1	1	2	2	2	2	2	2	79%
Trippolini et al, 2013	2	2	1	1	0	0	2	2	2	2	2	2	75%
Ljungquist et al 1999 KGV	2	1	1	2	0	N/A	2	1	2	2	1	2	68%
Reneman et al, 2017	1	2	1	1	1	0	1	2	2	2	2	1	67%
Reesink, 2007*	-	-	-	-	-	-	-	-	-	-	-	-	N/A

\*Paper is not applicable for completion of study quality tool

**TABLE 4.** Psychometric Properties of the Functional Capacity Evaluation

FCE Battery	Type of Properties	Statistical Test	Value	Quality
Neck FCE	Test-retest	ICC	0.39-0.96	Poor-excellent
	Measurement Error	Ratio of LoA	32.0-56.5%	
	Convergent Validity	Pearson or Spearman correlation	NDI total: 0.39-0.62 NDI items: 0.03-0.63	Weak to moderate Negligible to moderate
WAD FCE	Test-retest Reliability	ICC	0.66-0.96	Moderate-excellent
	Convergent Validity	Pearson Correlation	Pain* 0.31-0.39 SFS: 0.42-0.61 NDI: 0.34-0.45 HADS-A: 0.27-0.36 HADS-D: 0.30-0.41	Weak Moderate Weak Negligible-weak Weak
	Known-groups Validity (German vs Non-German)	Linear Regression Analysis	p<0.001	Significant for All tasks
	Known-groups Validity (sex)	t-test	p<0.001	Significant for Two tasks
Workwell FCE	Convergent Validity	Pearson or Spearman Correlation	Work Capacity: 0.1-0.3	Weak
	Predictive Validity	Pearson or Spearman Correlation	0.06-0.39	Weak
		Linear Mixed Model Regression of All Predictors	$\beta=-0.04$ , 95% CI: -0.15 – 0.06 p=0.428 (task 6)	Not Significant

FCE, Functional Capacity Evaluation; ICC, Intraclass correlation coefficient; LoA, Limits of Agreement; NDI, Neck Disability Index; Mod., Moderate; Neg., Negligible; SFS, Spinal Function Sort; HADS-A, Hospital Anxiety and Depression Scale – Anxiety; HADS-D, Hospital Anxiety and Depression Scale – Depression; CI, Confidence Interval Sig., Significant

\*Pain measured via Numeric Rating Scale

**TABLE 5.** Summary of Fit-HaNSA's psychometric properties in neck disorder patients

Test	Type of Property	Statistical Test	Value	Quality
Fit-HaNSA	Intra-rater Reliability	ICC	0.78	Strong
Fit-HaNSA	Inter-rater Reliability	ICC	0.84	Strong
Fit-HaNSA	Measurement Error	SEM	76 s	
		LOA <sub>95</sub>	248 s	
		MDC <sub>90</sub>	176 s	
Fit-HaNSA	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Moderate - Strong
Fit-HaNSA	Known-groups Validity WAD II vs Control	F-test	62.6, <p,0.001	Significant
Fit-HaNSA Functional Sub-tasks	Intra-rater reliability	ICC	0.70-0.72	Strong
	Inter-reliability	ICC	0.54-0.80	Moderate
	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Moderate - Strong
	Known-groups Validity WAD II vs Control	F-test	42.0-53.3, p<0.001	Significant

Fit-HaNSA, Functional Impairment Test, Hand and Neck/Shoulder/Arm; ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; LOA<sub>95</sub>, 95% Limits of Agreement; MDC<sub>90</sub>, 90% Minimal Detectable Change; WAD, Whiplash Associated Disorder; Mod, Moderate

\*Correlations completed with Numeric Pain Rating Scale, Neck Disability Index, Disabilities of Arm, Shoulder, Hand and 6 cervical range of motion tests

**TABLE 6.** Psychometric Properties of Baltimore Therapeutic Equipment Work Simulator II – Power Output Task

Test	Type of Property	Statistical Test	Value	Quality
BTEWS II	Test-retest reliability	ICC	0.53	Moderate
		Spearman	0.37	Poor
BTEWS II	Measurement Error	SEM	30.25	
		MDC <sub>90</sub>	70.59	
BTEWS II	Convergent Validity*	Spearman	Not Reported	Weak
BTEWS II	Known-groups Validity (Pain vs Control)	Two-way Repeated Measures ANOVA	Not Reported	Non-significant

ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; MDC<sub>90</sub>, 90% Minimal Detectable Change; ANOVA, Analysis of Variance

\*Spearman correlations completed with Numeric Rating Scale, Neck Disability Index and Shoulder Pain and Disability Index

**TABLE 7.** Psychometric Properties of performance-based tests included in physiotherapy test package

Test	Type of Property	Statistical Test	Value	Quality
PILE-C	Inter-rater Reliability	Mean Difference LoA	-0.24 -2.46 and 1.82	
PILE-C	Inter-rater Reliability	Repeatability (2X SD) % of Range	M=3.93; F=1.19 M=10.5%; F=6.1%	
PILE-C	Convergent Validity	Spearman Correlation	CR-10: Unreported* Borg RPE: Unreported	Moderate Low
PILE-C	KGV: spinal pain vs. control	Sensitivity and Specificity	0.93, 0.69	
PILE-C	KGV: spinal pain vs. control	Wilcoxon Sign Ranked Test	p=0.008	Significant
PILE-C	KGV: High vs. low pain intensity	Mann-Whitney U	p=0.003	Significant
PILE-C	KGV: High vs. low Pain behavior	Mann-Whitney U	p=0.005	Significant
PILE-C	KGV: High vs. low perceived exertion	Mann-Whitney U	p=0.154	Non-significant
PILE-C	Sensitivity to Change	Effect Size	Subjects improving: 0.39 - 0.73 Subjects deteriorating: 0 - 0.4	Low – Moderate Negligible – Low
PILE-L	Inter-rater Reliability	Mean Difference LoA	-0.11 -2.33 and 2.11	
PILE-L	Intra-rater Reliability	Repeatability % of Range	M=4.0; F=3.59 M=10.7%; F=18.5%	
PILE-L	Convergent Validity	Spearman Correlation	CR-10: Unreported Borg RPE: Unreported	Low Low
PILE-L	KGV: spinal pain vs no spinal pain	Sensitivity and Specificity	0.85, 0.65	
PILE-L	KGV: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.002	Significant

PILE-L	KGV: High vs. low pain intensity	Mann-Whitney U	p=0.001	Significant
PILE-L	KGV: High vs. low pain behaviour	Mann-Whitney U	p<0.001	Significant
PILE-L	KGV: High vs. low perceived exertion	Mann-Whitney U	p<0.001	Significant
PILE-L	Sensitivity to change	Effect Size	Subjects improving: 0.02 – 1.08 Subjects deteriorating: 0.42-0.81	Negligible – Strong Weak – Strong
2 x 20m WWB	Inter-rater Reliability	Mean Difference LoA	0.05 -1.33 and 1.43	
2 x 20m WWB	Intra-rater Reliability	Repeatability % of Range	3.2 10.7%	
2 x 20m WWB	Convergent Validity	Spearman Correlation	CR-10: Unreported Borg RPE: Unreported	Moderate Low
2 x 20m WWB	KGV: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.014	Significant
2 x 20m WWB	KGV: High vs. low pain intensity	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	KGV: High vs. low pain behaviour	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	KGV: High vs. low perceived exertion	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	Sensitivity to change	Effect Size	Subjects improving: 0.38-0.78 Subjects deteriorating: 0.13-0.62	Weak – Moderate Negligible – Moderate

PILE-C, Progressive Iso-inertial Lifting Evaluation – Cervical; PILE-L, Progressive Iso-inertial Lifting Evaluation – Lumbar; LoA, Limits of Agreement; SD, Standard Deviation; M, Male; F, Female; RPE, Rating of perceived exertion; KGV, Known-groups Validity; Neg., Negligible; Mod., Moderate, \*CR-10: Measurement of pain construct

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**Figure 1.** Selection of the studies for inclusion in the systematic review

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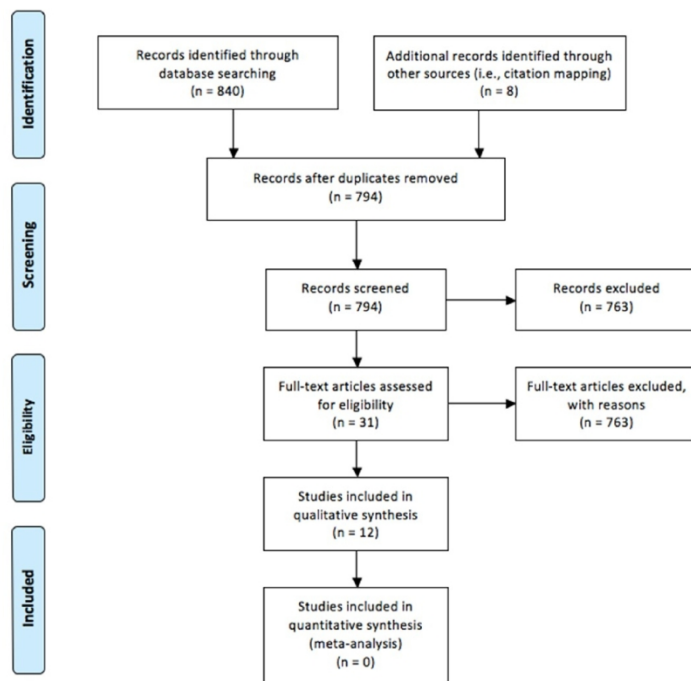


Figure 1. Selection of the studies for inclusion in the systematic review

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## APPENDICES

### APPENDIX A. Data extraction guide for studies evaluating the quality of studies evaluating the clinical measurement properties of outcome measures

#### Instructions

Clinical measurement studies may evaluate a wide spectrum of measurement properties; or evaluate aspects that relate to the implementability or interpretation of outcome measures. Individual clinical measurement studies cannot address every aspect of the measurement properties of an instrument. Ideally systematic reviews will synthesize the quality and content of research evidence addressing the clinical measurement properties of individual outcome measures. The summative knowledge about the measurement properties, cultural transferability, and utility across different contexts provides the scope of information needed to select an outcome measure for a specific patient (population), purpose and context.

This guide should facilitate extraction of data from individual clinical measurement studies. An explanation of the measurement property addressed in each item and how it might be measured within a given study is listed to facilitate finding and extracting that information. The accompanying extraction form can then be used to collect the specific information on these measurements or utility properties from specific studies.

The purpose of data extraction is to extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. Evaluation of the quality of the published version of the clinical measurement study (also called critical appraisal) is performed in a separate step. See the accompanying critical appraisal tool and guide. It is advisable to extract detailed specific information from the study; recognizing that this information may later be synthesized or subject to meta-analysis.

There is no standardized process for synthesizing clinical measurement information. Based on the findings of extraction you may elect to present the synthesize data in a descriptive way by creating a summary table of the data extracted in each category. If you find some studies with similar designs, you may be able to conduct a meta-analysis of some properties like clinically important difference (CID) or minimal detectable change (MDC); if appropriate given the sample and technique - this can be valuable as it may provide more stable estimates of these important properties.

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<b><u>Population studied</u></b>		
Population	A description of the study population	Sample size, pathology/disorder, demographics, setting, acute vs. chronic, where subjects were chosen from. Report meaningful demographics and indicators of the population studied.
Intervention	Interventions (if applicable) applied during longitudinal studies	Description of the nature, frequency, intensity of the intervention and the follow-up interval.
<b><u>Reliability</u></b>		
Reliability Description	The extent to which the same results are obtained on repeated administrations of the same measure when no change in status has occurred (reliability) or the precision of the scores on repeated measurements (agreement).	Test procedures or measures are typically reapplied on repeated occasions in individuals considered to have a stable condition during that time frame which repeated testing occurs. Repeated testing may be performed on different occasions (test-retest) for self-report measures, OR by the same rater (intra-rater) or different raters (inter-rater) if it is an observer-based scale. In some cases different test instruments (inter-instrument) are evaluated. The most common statistic used is the intraclass correlation coefficient for quantitative data (Shrout & Fleiss, 1979) and kappa (Landis & Koch, 1977) for nominal data. Standard error of measurement is used to present a quantitative estimate of the reliability—in the original units of measure. Report the type of reliability evaluated and coefficients obtained.
Reliability (relative)	The relationship (ratio) between variability in test scores when repeating the test on the same person in comparison to the overall variability (including variation between people)—typically indicated by a reliability coefficient	ICCs (Shrout & Fleiss, 1979) or another reliability coefficient and their associated confidence intervals are extracted.
Reliability (absolute)	Absolute reliability is portrayed as the quantity of error that could be anticipated upon repeated testing - reported in the original units of measure.	This may be reported as 1. Standard error of measurement (in older articles you may see coefficient of variation),

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		2. Altman and Bland graphical technique (Bland & Altman, 1990; Bland & Altman, 1987; Bland & Altman, 1986) where the difference on repeated tests for each individual (limits of agreement) is plotted versus their mean score. The mean difference and the boundaries of 2SD are shown to define the limits of agreement.
Minimum Detectable Change	Calculated from the reliability coefficient and the level of confidence specified for error margins. This indicator reflects the amount of change required before you can be confident that change exceeds the random error that occurs in stable patients.	Extract the number and level of confidence.
<b><u>Content/structural validity</u></b>		
Internal consistency	The extent to which items on a test or subscale are related (an indication of the consistency of the concept measured).	Cronbach's alpha is the inter-item correlation usually reported. Report alpha and whether it relates to the entire instrument or specific subscales.
Content Validity	The extent to which the conceptual domain or construct that a test is designed to measure is adequately reflected by the items in the measure. In assessing content validity, it is important to consider the population to whom the measure applies, the completeness of the content, the relevancy and emphasis of the content assessed.	<p>A variety of techniques can be used to assess the extent to which items on a given measure reflected the necessary content to capture the concept of interest. Some of the techniques you will find are listed. Extract what was done to determine content validity and what was found.</p> <ol style="list-style-type: none"> <li>1) Patients and experts were involved during item selection/reduction - report how they were used and key decisions</li> <li>2) Patients were consulted for reading and comprehension - report key findings</li> <li>3) Cognitive interviews (Cibelli, 1994; Ojanen &amp; Gogates, 2006) were done with patients to determine how items were interpreted by respondents, their perceptions of the items - report key findings</li> <li>4) Expert panels or Delphi procedures were used to select items or evaluate the validity of the instrument - report key findings and decisions</li> </ol>

		<p>5) During translation specific study, the meaning of the questions to another cultural or language group was studied - report key findings and decisions</p> <p>6) ICF linking (Cieza et al., 2002) or other coding of content was performed - report the results which may include the distribution of content across ICF domains, or the distribution of specific codes</p>
Floor-Ceiling Effects	The measure is unable to indicate a worsening score in patients who have clinically deteriorated and/or an improved score in patients who have clinically improved	There are a variety of potential methods; so the method and conclusion should be reported. Descriptive statistics of the distribution of scores that may be presented graphically or numerically may be used to indicate this. Other studies report the percentage of patients sustained a floor or ceiling effect defined by the number of people who fall in the extremes ranges. Note different studies may define the extreme ranges for floor/ceiling differently, so extract how it was defined and % of patients who obtained floor or ceiling category scores.
Factorial validity	The extent to which factor analysis supports assumptions surrounding constructs measured as defined by the measure or as indicated by subscale structure	Factor analysis may be reported as raw results; or compared to the inherent structure of the instrument or factor analysis upon which its construction was based. Report the type of factor analysis performed (exploratory or confirmatory), rotations used and the number of factors derived; specify whether this confirms the expected instrument structure or original factor structure.
Item response /Rasch Analyses	The extent to which items cross a range of difficulty, or a spectrum of the concept measured. The measurement scaling of the items.	Using item response theory or Rasch analysis, items are fit to a model to demonstrate interval scaling and determine item difficulty (Pallant & Tennant, 2007). Analyses might address item difficulty, person's ability curves, and comparison of ability estimation. Most commonly, the item difficulty and the composition of the test that fulfills interval scaling are defined. Data to be extracted include information on the scaling of the items, whether the interval scaling has been established; and the presence or absence of differential item functioning

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		(DIF), where items perform differently on different types of respondents.
<b>Construct Validity</b>		
<b>Construct Validity - correlational</b>	<p>Constructs are artificial frameworks that are not directly observable. Construct validity assesses the extent to which measures perform according to a priori defined constructs. Construct validity can be cross-sectional or longitudinal (predictive).</p> <p>Constructed hypotheses can assess convergent validity where measures are thought to represent similar constructs or divergent validity where it is assumed they measure different constructs.</p> <p>For cross-cultural validation, the expected relationships are those that have been reported in validation of the instrument in its original language/format.</p>	<p>When extracting data about correlational validity, the pre-constructed hypothesis and whether it is supported should be documented. For correlational construct validity, this will be the nature and strength of the prespecified relationship and the correlations that support that. Relation to other indices/constructs that are similar (convergent) or different (divergent) can be reported. Ideally, hypotheses are formulated/reported and supported by correlations that are in accordance with the hypotheses. Note that there is no consistent agreement on what subjective term should be applied to validity correlations.</p> <p>Note that there is no consistent agreement on what subjective term should be applied to validity correlations. Some authors use subjective terminology defined for reliability such as: strong (&gt;0.70) and moderate (0.40-0.70) correlations; others use the correlations like effect size benchmarks that 0.4 indicates a moderate effect and 0.6 a large effect. For validity assessment is more important than correlations prespecified constructed hypotheses, although not all papers are written clearly with respect to this.</p>
<b>Convergent</b>	The Relationship between similar scales/tests. Correlations are generally expected to be moderate to strong if the relationship is one where there is confidence that they measure a similar construct.	Extract test names, prespecified expected relationship and correlations observed.
<b>Divergent</b>	Divergent validity assesses the extent to which different scales/tests that are designed to	Extract test names, prespecified expected relationship and correlations observed.

	measure different constructs demonstrate that they are different by a lack of correlation between them.	
Construct validity - known groups	Known groups analysis supports the validity of a measure by demonstrating that the measurement is able to differentiate between groups that are prespecified and <u>known</u> to be different on the construct being assessed.	Data extraction should include the nature of the subgroups and the size of the difference observed between them (and its statistical significance). Typically, statistical tests of difference are performed.  Since known groups analysis can provide data that is useful in clinical practice as benchmarks for comparing these known groups, it is a more practical form of construct validity than correlational. Data extraction/presentation should reflect this by presenting the group central tendency, their margins and statistical significance in an accessible manner.
Longitudinal Validity	This form of validity supports the validity of a measure by demonstrating that the change that occurs over time onto similar instruments is correlated in a manner consistent with the nature of the relationship between the scales. It is measured over a retest interval when clinically relevant change could be expected.	Extract test names and correlations  Note: since longitudinal validity is based on four measures (pre-and post-test on two different measures), and since error tends to mitigate the strength of correlations, strong longitudinal correlations can be difficult to obtain.
Criterion validity Description	Criterion validation is determined by comparing a given outcome measure to an accepted standard of measure. For subjective constructs like pain and disability, it can be argued that there is no criterion since there is no external gold standard. Therefore, for self-report measures, validation focuses on construct validity.  For performance measures, it is common to have a criterion measure that is considered to be highly precise and rigorous as the criterion comparator.	Authors will state that their measure is being compared against a specific instrument and report the correlation or agreement between the measures. Extract the test names and results: correlations if other as reported.
Concurrent criterion	Concurrent validity is assessed by comparing a scale and its criterion at a single point in time	Extract the test names and correlations.

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Predictive criterion	Predictive validity is evaluated by determining the extent to which the results of administering an outcome measure at one point in time can accurately predict a future status or outcome.	Extract the test names and correlations and time interval. (and important cutoffs if those were established/reported), if diagnostic test methodology was used to examine prediction, and sensitivity specificity and other diagnostic criteria were reported, they should be extracted.
<b><u>Responsiveness/Clinical Change</u></b>		
Responsiveness	Does the instrument detect changes over time that matters to patients?	Extract indicators of responsiveness include: effect size, standard response mean and the method for assessing whether patients were improved, stable or worse. (Beaton, 2000)
Clinically Important Difference (CID)	CID is the difference in scores that patients find to be observable and clinically important. It is assessed by comparing scores to an external benchmark of clinical relevance such as a global rating of change or some other method. The terminology used to rate the nature of this difference will affect the estimation process. Differences in methods include how clinically importance is framed and the metrics/process by which that is determined.	Extract the MID or CID and note the method/cut-off used to define importance. Extract how the clinically important differences were framed to respondents; or determined. For example, minimal, moderate, extreme improvement or better/not better, etc.

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**APPENDIX B.** Data extraction form for studies evaluating the clinical measurement properties of outcome measures

Authors: \_\_\_\_\_ Year: \_\_\_\_\_ Rater: \_\_\_\_\_

Instructions

When using the data extraction form, it is important to realize that the purpose of data extraction is to remove or extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. To make data extraction as useful as possible, and to avoid the need for repeated data extractions, it is advisable to read the accompanying guide and then be as specific as possible when extracting information.

<b>DATA EXTRACTED</b>	
Population studied	
Population	
Intervention	
Reliability	
Reliability (relative)	
Reliability (absolute)	
Minimum Detectable Change	
Content/structural validity	

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Internal consistency	
Content Validity	
Floor-Ceiling Effects	
Factorial validity	
Item response /Rasch Analyses	
Construct/Criterion Validity	
Known groups	
Convergent	
Divergent	
Longitudinal Validity	
Concurrent criterion	
Predictive criterion	
Responsiveness/Clinical Change	

Responsiveness	
Minimally Clinical Important Difference	

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**APPENDIX C. Quality Appraisal for Clinical Measurement Research Reports Evaluation Form**

Rater (Group) \_\_\_\_\_

Author(s) (Study Author(s)) \_\_\_\_\_

Year (Year of publication) \_\_\_\_\_

1. Was the relevant background work cited to define what is currently known about the measurement properties of measures under study, and the potential contributions of the current research question to informing that knowledge base?

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2. Were appropriate inclusion/exclusion criteria defined? \*

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3. Were specific clinical measurement questions/hypotheses identified?

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4. Was an appropriate scope of measurement properties considered?

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5. Was an appropriate sample size used?

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6. Was appropriate retention/follow-up obtained? (for studies involving retesting; otherwise n/a)

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3 2  
4 1  
5 0  
6  
7 7. Were specific descriptions provided of the measure under study and the method(s) used to administer  
8 it?  
9 2  
10 1  
11 0  
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13 8. Were standardized procedures used to administer all study measures in a manner that minimized  
14 potential sources of error/bias (including the study measure and its comparators)?  
15 2  
16 1  
17 0  
18  
19 9. Were analyses conducted for each specific hypothesis or purpose?  
20 2  
21 1  
22 0  
23  
24 10. Were appropriate statistical tests performed to obtain point estimates of the measurement  
25 properties?  
26 2  
27 1  
28 0  
29  
30 11. Were appropriate ancillary analyses done to quantify the confidence in the estimates of the clinical  
31 measurement property (Precision/Confidence intervals; benchmark comparisons/ROC curves, alternate forms of  
32 analysis like SEM/MID, etc.)?  
33 2  
34 1  
35 0  
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37 12. Were clear, specific and accurate conclusions made about the clinical measurement properties; that  
38 were associated with appropriate clinical measurement recommendations and supported by the study objectives,  
39 analysis and results?  
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Subtotals (of column 1 and 2)

Total Score (sum of subtotals/24\*100)

**APPENDIX D. Description of each performance battery from selected articles**

Battery	Description of Tasks
<b>Relevant FCE Subtasks</b> <sup>25,26,27,28,29,30</sup>	<p>Material Handling Tasks: All lifting tests were executed with a wooden crate (40 × 30 × 26 cm) of 2.5 kg, and four to five weight increments of 2.5 kg or 5 kg each were used until the maximum amount of weight was reached. Maximum performance was recorded in kg.</p> <p>Lifting floor to waist: Measured after five lifts of crate from floor to table and vice versa (time limit &lt; 90 s): hands remained on the crate during the test. Increase weight in 4-5 steps until maximum is reached</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p> <p>Two-handed carrying: Carrying of a crate for a short distance measured after five carries of 1.5 m distance at waist height. Hands remain on the crate during the test.</p> <p>One-handed carrying: Carrying wooden crate for 15 m within 90 s beginning with the right hand and thereafter the left hand.</p> <p>Overhead working: Standing with hands at crown height for manipulation of nuts and bolts. The time that the position was held is recorded (sec).</p> <p>Repetitive reaching: fast horizontal movements of the upper extremity in a sitting position. Marbles are removed from bowls at arm length distance at table height from left to right and vice versa, with right and then left arm. The time taken to remove 30 marbles is recorded (sec).</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p>

	<p>Repetitive bending and overhead reaching: 20 marbles in 2 bowls at table height and crown height. Standing in front of bowl of marbles and moving the marbles as fast as possible from table height to crown height.</p>
<p><b>A Physiotherapy Test Package</b><sup>33,34,35,36</sup></p>	<p><b>PILE Tests:</b> “The lifting tests were performed standing in front of bookshelves with shelves at 0.76m and 1.37 m from the floor. Subjects were asked to lift weights in a plastic box from floor to waist level (0–0.76 m) for the lumbar PILE test, or from waist to shoulder height (0.76–1.37 m) for the cervical PILE test. The initial weight was 3.6 kg for women and 6.9 kg for men. A ‘lifting movement’ involved a single transfer from one level to the next and back again. After every four such lifting movements (= 20 s), the weight was increased by 2.5 kg for women and 4.5 kg for men. The weight managed during the last lifting movement was recorded and used as a test result, as well as this maximum weight divided by the ‘adjusted weight’”.</p> <p><b>2x20m WWB:</b> “Subjects were asked to walk 20 m at a comfortable speed along a corridor, to turn around where 20 m was marked and then to walk 20 m back to the starting point. In the first walking test they carried no extra weight, but in the second they carried one carrier bag in each hand, containing 4 kg each for the women, 8 kg each for the men. The time taken was recorded to get the walking speed. The tests were discontinued after 50 s”.</p>
<p><b>BTEWS II</b><sup>31</sup></p>	<p>“The protocol consisted of performing a series of shoulder functional tasks before and after a fatiguing activity. Functional tasks consisted of active shoulder range of motion (ROM) in both flexion and abduction and cumulative power output (PO) accumulated over 10s during a repetitive pushing/pulling task in a horizontal plane at shoulder level”.</p>
<p><b>FIT - HaNSA</b><sup>32</sup></p>	<p>“The FIT-HaNSA protocol consists of three timed tasks and each task is performed for a maximum of 300 seconds (s) with approximately 30 s pause between them (set-up time for next task). Task 1 (waist-up) requires the patient to alternately “grab, lift, move and place” three 1000 g containers located on waist level and 25 cm above waist level shelves, using their affected arm, at a metronome pace of 60 beats per minute for 300 s or until they felt unable to continue. The time to complete Task 1 is measured using a stopwatch. Task 2 (eye down) is identical to Task 1 except that the two shelves are placed at eye-level and 25 cm below. Task 3 (overhead work) requires a patient to repeatedly screw and unscrew bolts in a sagittal plane oriented plate</p>

positioned at eye-level using both arms". More complete description at [https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol\\_April2007.pdf](https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol_April2007.pdf)

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# PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	1
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
<b>METHODS</b>			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	3
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	4
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	3-4
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3-4
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	4
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	4
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	5
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	NA
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., $I^2$ ) for each meta-analysis.	NA





# PRISMA 2009 Checklist

Page 1 of 2

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	NA
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	NA
<b>RESULTS</b>			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	6-7
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICCO, follow-up period) and provide the citations.	6-7
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	6-10
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	6-10
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	6-10
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6-10
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	NA
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	11-13
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	14-16
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	16
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	18

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).

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# BMJ Open

## Systematic Review of the Measurement Properties of Performance-based Functional Tests in Patients with Neck Disorders

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031242.R1
Article Type:	Original research
Date Submitted by the Author:	22-Aug-2019
Complete List of Authors:	McGee, Steven; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Sipos, Taylor; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Allin, Thomas; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Chen, Celia; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Greco, Alexandra; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Bobos, Pavlos; Western University, Health and Rehabilitation Sciences; University of Toronto, Dalla Lana School of Public Health, Institute of Health Policy Management and Evaluation MacDermid, Joy ; Western University, School of Physical Therapy, Health and Rehabilitation Sciences Group, CATWAD; Michele Sterling, Anne Söderlund, Michele Curatolo, Jim Elliott, David M Walton, Helge Kasch, Linda Carroll, Hans Westergren, Samuel McLean, Gwendolen Jull, Genevieve Grant Luke Connelly, Joy C MacDermid, Mandy Nielsen, Pierre Côté, Tonny Elmoose Andersen, Trudy Rebbeck Annick Maujean, Sarah Robins, Kenneth Chen, Julia Treleaven
<b>Primary Subject Heading</b>:	Rehabilitation medicine
Secondary Subject Heading:	Rehabilitation medicine
Keywords:	functional, psychometric properties, neck pain, cervical, outcome measures

SCHOLARONE™  
Manuscripts

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3 1 **Title:** Systematic Review of the Measurement Properties of Performance-based Functional  
4 Tests in Patients with Neck Disorders

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50  
51 **Key Words:** functional, psychometric properties, neck, cervical, outcome measures

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53 **Word Count:** 4509

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3 **61 Abstract**

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5 **62 Objectives:** The purpose of this systematic review is to identify and synthesize studies evaluating  
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8 **63** performance-based outcome measures designed to evaluate the functional abilities of patients with  
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10 **64** neck pain.

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12 **65 Design:** Systematic review

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14 **66 Data Sources:** A literature search using PubMed, Scopus, CINAHL, EMBASE, COCHRANE,  
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17 **67** Google Scholar, and a citation mapping strategy was conducted till July 2019

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19 **68 Eligibility criteria:** More than half of the study's patient population had neck pain or a  
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22 **69** musculoskeletal neck disorder and completed a functional-based test. Clinimetric properties of at  
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24 **70** least one performance-based functional tests were reported. Both traumatic and non-traumatic  
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26 **71** origins of neck pain were considered.

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28 **72 Data extraction and synthesis:** Relevant data were then extracted from selected articles using an  
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31 **73** extraction guide. Selected articles were appraised the Quality Appraisal for Clinical Measurement  
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33 **74** Research Reports Evaluation Form (QACMRR).

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35 **75 Results:** The search obtained 12 articles which reported on 4 outcome measures (Functional  
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38 **76** Capacity Evaluations (FCE), Baltimore Therapeutic Equipment Work Simulator II (BTEWS II),  
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40 **77** Functional Impairment Test- Hand and Neck/Shoulder/Arm (FIT-HaNSA)) reporting to assess the  
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42 **78** functional abilities in patients with mechanical neck pathology. Of the selected papers: 1 reports  
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44 **79** content validity, 5 construct validity, 4 reliability, 1 sensitivity to change, and 1 both reliability  
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46 **80** and construct validity. QACMRR scores ranged from 68% to 95%.

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49 **81 Conclusions:** This review found very good quality evidence that the FIT-HaNSA has  
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51 **82** excellent inter and intra-rater reliability and very weak to weak convergent validity. Excellent  
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54 **83** quality evidence of fair test-retest reliability, weak convergent validity, and very weak known

84 groups validity for the BTEWS II test was found. Good to excellent quality evidence exists that an  
85 FCE battery has poor to excellent reliability and very weak to strong validity. Good to excellent  
86 quality of weak to strong validity and trivial to strong effect sizes were found for a physiotherapy  
87 test package.

88 **Prospero registration:** CRD42018112358

### 91 **Strengths and limitations of this study**

- 92 • The psychometric properties of performance outcome measures for neck pain were  
93 synthesized and critically appraised
- 94 • This study assessed the risk of bias and the quality of measurements properties
- 95 • The feasibility or usability of these tools was not assessed

### 97 **Introduction**

98 Neck pain has been associated with high disability and is regarded as a substantial societal  
99 burden.[1] Approximately 70% of people experience neck pain within their lifetime and about 33%  
100 of adults experience neck pain every year.[2,3] Further concern is warranted as it has been  
101 suggested that the incidence of neck pain is increasing.[4–6] The economic burden due to neck  
102 disorders is high, including lost wages, costs of treatment, and compensation expenditures to  
103 injured people.[7,8] Neck pain is second only to low back pain in annual workers' compensation  
104 costs in the United States and has been associated with many other comorbidities such as  
105 headaches, anxiety, depression, back pain and arthralgias.[6,9,10]

1  
2  
3 106 Outcome measures are a crucial component in monitoring patients with neck pain to  
4  
5 107 determine the effects of treatment[11,12], evaluation of interventions, guiding return to work, and  
6  
7  
8 108 justifying treatment.[13,14] Several self-reported outcome measures currently exist to assess  
9  
10 109 disability and function in those with neck pain (e.g. the Neck Disability Index - NDI). [13]  
11  
12 110 Evidence-based clinical practice guidelines suggest that measures assessing physical performance  
13  
14 111 should also be used for people with neck pain.[15] Performance-based testing is where the  
15  
16 112 assessment is based on actual performance of a task or activity. Physical performance can be  
17  
18 113 assessed by testing a person's ability to execute a standardized activity in a standardized  
19  
20 114 environment (i.e. clinical setting).[16] Time to complete the activity, number of repetitions  
21  
22 115 performed, and weight lifted are frequently used to quantify the physical performance.[17]  
23  
24 116 Conversely, self-report measures examine patients' perception and experience of their ability to  
25  
26 117 perform functional tasks. [16] Previous research has demonstrated poor to fair relationships  
27  
28 118 between physical performance and self-report measures of ability in patients with various  
29  
30 119 musculoskeletal disorders suggesting that these measures assess different constructs of function.  
31  
32 120 [17,18] Consequently, physical performance tests and self-report measures complement each other  
33  
34 121 and may each contribute unique information about a patient's function. [19]  
35  
36  
37  
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39

40 122 A fundamental component of monitoring outcomes is having reliable and valid tools with  
41  
42 123 known measurement properties.[20,21] While recent research has investigated the psychometric  
43  
44 124 properties of patient-reported outcomes in people with neck pain [21,22] there is a gap in  
45  
46 125 knowledge with respect to performance-based functional outcomes. The purpose of this systematic  
47  
48 126 review was to identify and synthesize clinical measurement studies that evaluate measurement  
49  
50 127 properties of performance-based functional tests in patients with neck disorders.  
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## 129 **METHODS**

### 130 **Patient and Public Involvement**

131 There was no patient or public involvement in the design or planning of this study.

132

### 133 **Study Design and Protocol Registration**

134 We conducted a systematic review to evaluate the psychometric properties of performance-  
135 based functional tests for people with mechanical neck disorders. The protocol was registered in  
136 PROSPERO register with registration number CRD42018112358.

137

### 138 **Search Strategy**

139 A database search using CINAHL, PubMed, Scopus and Google Scholar was performed  
140 to identify articles published till July 2019. The following search strategy was used to search all  
141 databases for eligible studies: (Reliability OR validity OR responsiveness OR calibration OR  
142 validation) OR (minimal detectable change) OR (clinically important difference) OR  
143 (psychometric properties) AND cervical OR neck OR c-spine AND (performance measure) OR  
144 (functional test) OR (functional outcome) OR (performance outcome). MeSH terms were searched  
145 in PubMed. A citation map of articles and systematic reviews selected for the full-text review was  
146 performed. This strategy was included to minimize the risk of publication bias. The full search  
147 strategy is summarized in **APPENDIX 1**. The Preferred Reporting Items for Systematic Reviews  
148 and Meta-Analyses (PRISMA) process[23] was followed to ensure all appropriate steps were taken  
149 in the selection process (**FIGURE 1**).

150

### 151 **Inclusion Criteria**



1  
2  
3 152 Articles were included in the final review if all of the following criteria were met:

- 4  
5 153
- 6 • >50% of the study's patient population had neck pain or a musculoskeletal neck disorder
  - 7 (e.g. whiplash associated disorder (WAD II))
  - 8 154
  - 9 155 • Patients in the study completed a functional-based test
  - 10 156 • Clinometric properties of at least one performance-based test were reported.

11  
12  
13  
14  
15 157 A test was considered functional-based if it met the following criteria:

- 16  
17 158
- 18 • assessment of a patient's ability to execute a standardized activity in a standardized
  - 19 159 environment
  - 20 160 • tests assessing muscular endurance (e.g. cervical flexion test) or proprioception were not
  - 21 161 deemed functional-based as they are often not reflective of physical working conditions.

22  
23  
24 162 Both traumatic and non-traumatic origins of neck pain were considered. Definitions for the  
25 163 properties can be found in **APPENDIX A**.

26  
27  
28  
29 164

### 30 165 **Article Selection**

31  
32  
33 166 Titles and abstracts generated by the search strategy were screened by two authors (SM  
34 167 and PB) independently. Articles that met the inclusion criteria and selected for a full text review  
35 168 were also reviewed in pairs of authors. Disagreements were resolved by the most experienced  
36 169 author (JCM)

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### 43 171 **Data Extraction**

44  
45 172 Data extraction and critical appraisal was performed in pairs of two raters among the authors, after  
46 173 the completion of a calibration session in which the most experienced author (JCM) reviewed the  
47 174 data extraction tools with the authors that performed the data extraction. When reviewers disagreed

1  
2  
3 175 during data extraction and/or critical appraisal, and consensus could not be met, a third author  
4  
5 176 arbitrated. A data extraction form [24] (**APPENDIX A and APPENDIX B**), developed by one of  
6  
7  
8 177 the authors (JCM.), was used to ensure systematicity. Authors extracted sample size, patient  
9  
10 178 population characteristics, functional tests performed and reported psychometric properties. The  
11  
12 179 ICC interpretation of  $ICC < 0.40$  indicating poor,  $0.40 \leq ICC < 0.75$  indicating fair-to-good and  
13  
14 180  $ICC \geq 0.75$  indicating excellent reliability were used as a common benchmark. For validity  
15  
16 181 estimates, correlation coefficient (Pearson's/Spearman) and the 95% confidence intervals were  
17  
18 182 extracted if were available. [24,25] Evan's guidelines to interpret the strength of the correlation  
19  
20 183 was used which included: 0.00–0.19 “very weak”, 0.20–0.39 “weak”, 0.40–0.59 “moderate”,  
21  
22 184 0.60–0.79 “strong”, and 0.80–1.00 “very strong”. To assist clinical decision making, standard  
23  
24 185 benchmark scores of trivial ( $< 0.20$ ), small ( $\geq 0.20$  to  $< 0.50$ ), moderate ( $\geq 0.50$  to  $< 0.80$ ) or large  
25  
26 186 ( $\geq 0.80$ ), as proposed by Cohen, were used. [26]  
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### 189 **Quality Appraisal for Clinical Measurement Research Reports Evaluation Form**

34  
35  
36 190 Pairs of authors critically appraised the quality of each study using a standardized 12-item  
37  
38 191 evaluation tool (QACMRR) designed to assess the quality of studies determining measurement  
39  
40 192 properties in outcome measures (**APPENDIX C**). If disagreement was present a third person (JM)  
41  
42 193 assist in resolving the discrepancy. [24] This tool has been found to have good to excellent pre-  
43  
44 194 consensus inter-rater reliability (ICC: 0.69-0.91) across a number of systematic reviews.[24,25,27]  
45  
46 195 The evaluation criteria of this tool included twelve items: 1) Thorough literature review to define  
47  
48 196 the research question; 2) Specific inclusion/exclusion criteria; 3) Specific hypotheses; 4)  
49  
50 197 Appropriate scope of psychometric properties; 5) Sample size; 6) Follow-up; 7) The authors  
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2  
3 198 referenced specific procedures for administration, scoring, and interpretation of procedures; 8)  
4  
5 199 Measurement techniques were standardized; 9) Data were presented for each hypothesis; 10)  
6  
7  
8 200 Appropriate statistics-point estimates; 11) Appropriate statistical error estimates; and 12) Valid  
9  
10 201 conclusions and recommendations. [24,25] Each item is scored from 0 to 2 with (score=2) is the  
11  
12 202 best; (score=1) is acceptable but suboptimal; (score=0) is not done/documentated, substantially  
13  
14 203 inadequate or inappropriate. An article's total score – quality - was calculated by the sum of scores  
15  
16 204 for each item, divided by the numbers of items and multiplied by 100%. [24,25] Overall, the quality  
17  
18 205 summary of appraised articles ranges from (0%-30%) Poor, (31%-50%) Fair, (51%-70%) Good,  
19  
20 206 (71%-90%) Very Good, and (>90%) Excellent  
21  
22  
23  
24 207  
25  
26 208  
27

## 28 209 **RESULTS**

30  
31 210 The search strategy resulted in 840 published articles. After duplications were removed, 31  
32  
33 211 articles were deemed relevant and were screened at full text. Overall, 12 articles met our inclusion  
34  
35 212 criteria (**FIGURE 1**). The excluded articles were removed due to inappropriate patient  
36  
37 213 populations, investigations into self-report measures or tests assessing proprioception/muscular  
38  
39 214 endurance rather than functional-based measures, or because the articles were found to be  
40  
41 215 systematic reviews. The characteristics of the included studies and the summary of psychometric  
42  
43 216 properties are presented in **TABLE 1**. The quality assessment is summarized and presented in  
44  
45 217 **TABLE 2**. Percent agreement was calculated for quality scores between the 2 raters and it was  
46  
47 218 90%.  
48  
49  
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52 219

## 54 220 **Participants**

221 Participants in the selected articles had various types of neck pain including subacute,  
222 chronic, and whiplash-associated disorder. The mean/median age of the samples of each study  
223 ranged from 30-48 years of age. The proportion of females in each article ranged from 34-78% of  
224 the study population. Two studies that had a mixed sample of subjects with various spinal pain did  
225 not report the demographics of the neck pain portion of their sample. One study did not contain  
226 any subjects and performed a review of epidemiological literature to establish content validity for  
227 work-related neck disorders **TABLE 1**.

228

### 229 **Functional-Based Tests**

230 The 12 articles that were included for review provided properties on the following  
231 functional based tests: Functional Capacity Evaluations (FCE)[28–33], The Baltimore Therapeutic  
232 Equipment Work Simulator II (BTEWS II) [34], Functional Impairment Test- Hand and  
233 Neck/Shoulder/Arm (FIT-HaNSA) [35], as well as items off of a physiotherapy test package  
234 including a cervical and lumbar Progressive Isoinertial Lifting Evaluation (PILE-C, PILE-L) test  
235 [36–39] and 2 x 20 m with burden walking test (2x20M-WWB) [36–39]. Descriptions of all  
236 functional-based tests and their relevant subtasks are provided in **APPENDIX D**.

237

### 238 **Functional Capacity Evaluations (FCE)**

239 Six articles reported measurement properties for an FCE battery. We identified multiple  
240 versions of the FCE in the literature with one article reporting properties on the Workwell FCE  
241 [29], two reporting on the Whiplash Associated Disorder (WAD) FCE [28,30] and three reporting  
242 on the neck-FCE.[31–33] These test batteries include various combinations of muscular strength,

243 endurance and functional based tests. The measurement properties of the functional based tests  
244 used by the FCE are outlined in **TABLE 3**.

245

### 246 *Individuals with Sub-acute to chronic WAD*

247 Trippolini et al. (2014)[29] evaluated the Workwell FCE test-retest reliability,  
248 measurement error, convergent validity and predictive criterion validity of future work capacity in  
249 workers diagnosed with WAD I or II. Interclass Correlation Coefficients (ICC) ranged from 0.66  
250 to 0.96 (good to excellent). Limits of agreement relative to mean performance ranged from 21 to  
251 57% for functional based sub-tests. Correlations between FCE sub scores and baseline work  
252 capacity were very weak to weak ranging between  $r=0.06$  and  $r=0.39$ . FCE sub scores did not  
253 predict future work capacity at 1, 3, 6 and 12 months.

254 Trippolini et al. (2015)[28] assessed the WAD FCE (31) and evaluated convergent validity  
255 and known-groups validity. FCE subscales showed very weak to strong correlations (0.15-0.68)  
256 with each of: pain, self-reported functional ability, self-reported disability, anxiety and depression.  
257 It was found that the FCE had known-group sex validity (males vs females) for 1 of 3 functional  
258 subtests (lifting waist-overhead) and reported significant performance differences between culture  
259 groups (German vs non-German language groups).

260

### 261 *Work-Related Neck Disorders*

262 Reesink et al. (2007)[33] developed an independent FCE for patients with musculoskeletal  
263 neck disorders (neck FCE). They performed a review of epidemiological literature and identified  
264 four physical risk factors for work-related neck disorders and used that information to develop an  
265 FCE consisting of eight functional-based tests. Content validity was established by following

operational definitions of the risk factors when searching the literature and using current literature to provide a rationale to guide their development of the tasks comprising the FCE.

### ***Chronic Neck Pain***

Reneman et al. (2017)[31] measured test-retest reliability of the subscales of the neck FCE in patients with multifactorial neck pain. Test-retest ICC's ranged from poor to excellent (0.39-0.96). Limits of agreement relative to mean performance range from 32.0% to 56.5% for functional based sub tests. Convergent validity was performed against the Neck Disability Index (NDI) items and total score.[32] The authors found weak to strong Pearson correlations (0.39-0.70) for the FCE sub scores to both NDI individual items and the NDI total score.

### **The Baltimore Therapeutic Equipment Work Simulator II (BTEWS II)**

#### ***Chronic Neck Pain***

Lomond and Côté, (2011)[34] reported on the reliability, measurement error, minimum detectable change (MDC) and validity of the power output (PO) task during the BTEWS II test in patients with chronic neck and shoulder pain (TABLE 4). Test-retest reliability, measured with Spearman Rank correlations and ICC's was of fair and measured at  $\rho=0.37$  and  $ICC_{2,1} = 0.54$ , respectively. The standard error of measurement (SEM) and the minimal detectable change at 90% confidence (MDC<sub>90</sub>) for the PO task were measured as 30.25 and 70.59, respectively. Weak Spearman Rank correlations between the PO task and the NDI, Shoulder Pain and Disability Index (SPADI) and Numeric Rating Scale (NRS) for pain tests were recorded. There were no significant performance differences between control and pain groups for the PO task.

## 289 **Functional Impairment Test- Hand and Neck/Shoulder/Arm (Fit-HaNSA)**

### 290 *Sub-acute to chronic WAD*

291 Pierrynowski et al. (2016)[35] reported on the reliability, measurement error, MDC and  
292 validity of the Fit-HaNSA test in a sample of people with WAD II following motor vehicle  
293 collision (MVC) (**TABLE 5**). Intra-rater reliability ICC's for patient subtask and total scores were  
294 good to excellent ranging between 0.70-0.78. [35] Inter-rater reliability ICC's for patient subtask  
295 and total scores were fair to excellent and ranged between 0.54-0.84. [35] The Bland and Altman  
296 plot for the patient group showed a 26 seconds (s) bias in terms of improved performance on the  
297 second test (possible learning effect). The standard deviation of difference was 124 s and 95%  
298 Limits of Agreement (LoA<sub>95</sub>) was 248 seconds. [35] The SEM for people with WAD II was  
299 reported to be 76 s. The MDC<sub>90</sub> was measured as 176 s. [35]

300 Spearman rank correlations were also calculated between the Fit-HANSA, Numeric Pain  
301 Rating Scale (NPRS), NDI, the disabilities of arm, hand and shoulder (DASH) and 6 cervical range  
302 of motion measures. Most (59 of 78) of the correlations between performance and comparator  
303 measures were very weak to weak ( $r < 0.4$ ). [35] All correlations between total Fit-HaNSA scores  
304 and subtask scores had good correlations ( $r < 0.75$ ), except for Task 1-Task 3. [35] Significant  
305 performance differences between WAD II and control groups (known group validity) were  
306 recorded for the total Fit-HaNSA score and all 3 subtask scores. [35]

### 307

## 308 **Physiotherapy Test Package Subtests**

309 Ljungquist et al. published a series of articles[36–39] which evaluated the clinimetric  
310 properties of a physiotherapy test package for patients with spinal pain (**TABLE 6**). This  
311 package included muscular strength & endurance tests, submaximal endurance tests, and three

1  
2  
3 312 functional tests. These functional tests included the PILE-C, PILE-L, and 2x20M-WWB test.

4  
5 313 Ljungquist's series of articles reported on convergent validity, known-groups validity, reliability,

6  
7 314 measurement error and sensitivity to change for these tests. [36–39]

8  
9 315

### 10 316 *Undetermined duration of neck pain*

11  
12 317 In a 1999 article [38], correlations between the tests of the package and pain (CR-10) and  
13  
14 318 perceived exertion (Borg RPE) were determined. All correlations were very weak to moderate  
15  
16 319 (0.10-0.48) except for moderate to strong correlations (0.55-0.65) between the PILE-C test and  
17  
18 320 pain intensity and between 2x20M-WWB test and pain intensity.

19  
20 321 In a 2003 article[36], the PILE-C, PILE-L and 2x20M-WWB tests were tested to determine  
21  
22 322 their ability to discriminate between known-groups (neck pain vs back pain). Subjects with spinal  
23  
24 323 pain completed the CR-10, the University of Alabama Pain Behavior scale (UAB) and the Borg  
25  
26 324 RPE test. Specific cut points were used to distinguish patients with high vs. low pain intensity,  
27  
28 325 high vs. low pain behavior, and high vs. low perceived exertion in patients, respectively.  
29  
30 326 Participants then completed the test package and it was determined if each subtest could  
31  
32 327 discriminate between participants with high vs. low pain intensity. The functional tests were able  
33  
34 328 to discriminate between all 3 subgroups with the exception of the PILE-C being unable to  
35  
36 329 discriminate between participants with high vs. low perceived exertion.

37  
38 330 In a paper from 1999[38], the PILE-C, PILE-L and 2x20M-WWB tests were found to have  
39  
40 331 significant discriminative abilities in distinguishing healthy subjects from patients with spinal pain.  
41  
42 332 The sensitivity and specificity for this known group discrimination for the PILE-C test, were  
43  
44 333 reported to be 0.93 (very strong) and 0.69 (strong), respectively. The sensitivity and specificity for  
45  
46 334 the PILE-L test were reported to be 0.85 (very strong) and 0.65 (strong), respectively.



1  
2  
3 335 The inter and intra rater reliability were tested on participants with spinal pain.[37] Limits  
4  
5 336 of agreement were used to measure inter rater reliability and repeatability, defined as 2x the within-  
6  
7  
8 337 subject standard deviation of each variable. Interrater agreement for 2 tests was deemed  
9  
10 338 “acceptable”, while all 3 functional tests had “clinically acceptable” intra-rater reliability.

11  
12 339 Sensitivity-to-change was evaluated in the test package following 6 months of a  
13  
14 340 physiotherapy intervention. Using ROC curves, Wilcoxon sign ranked tests and spearman  
15  
16 341 correlation coefficients, only the 2x20m-WWB test and the PILE-C (women only) were deemed  
17  
18 342 to be sensitive to change. [39] Additionally, moderate to large effect sizes were found for all test  
19  
20  
21 343 components.

22 344

## 23 24 25 26 345 **DISCUSSION**

27  
28 346 This study synthesized 12 studies assessing clinometric properties of 4 different functional-  
29  
30 347 based assessments. Given the limited number of studies, the substantial variation in the types of  
31  
32 348 tests examined, the methods used to assess the clinical measurement properties, and the study  
33  
34 349 populations, the current state of knowledge does not allow firm conclusions regarding  
35  
36 350 recommendations for an optimal functional-based test at this time. Overall, the quality ranging  
37  
38 351 from good to excellent (67-92%,) as determined by the QACMRR, for a range of properties of the  
39  
40 352 4 different assessments in patients with acute or chronic neck pain that is musculoskeletal in origin.  
41  
42 353 Studies obtaining higher percentages indicate research that has been consistent with best practice  
43  
44 354 where studies with lower percentages are more likely to be inadequate or inappropriate

## 45 46 47 355 **FCE**

48  
49 356 The breadth of a functional-based test is variable and defined by the developers. An  
50  
51 357 advantage of the functional assessment designed by Reesink et al.[33] is that they mapped the  
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3 358 eight subtests to risk factors identified in the literature for work-related neck disorders. The eight  
4  
5 359 subtests consist of: material handling tasks, lifting floor to waist, overhead lift test, one-handed  
6  
7  
8 360 and two-handed carrying, overhead working, repetitive reaching, overhead lifting, and repetitive  
9  
10 361 bending and overhead reaching. Given the systematic approach and rationale these authors used  
11  
12 362 in developing the FCE and this approach being used in previous research [40], we suggest that  
13  
14  
15 363 this test has strong content validity.

16  
17 364 Six articles address the clinical measurement properties of this FCE ranging from good to  
18  
19 365 excellent quality (67-92%). There was evidence that the FCE was stable over test-retest time of  
20  
21 366 7-14 days. [30,31] These measures demonstrate longer stability over time compared to self-report  
22  
23 367 measures such as the Neck Disability Index (NDI) which has demonstrated test-retest reliability  
24  
25 368 within only a short period of 0-3 days. [27] Whether this longer-term stability is a characteristic of  
26  
27 369 functional-based tests or reflects differences in study populations in context requires further  
28  
29  
30 370 testing. These two studies had relatively lower quality scores on the QACMRR (67-75%)  
31  
32 371 compared to other studies in this review putting into question test-retest time. Although test-retest  
33  
34 372 reliability has been assessed, inter-rater and intra-rater reliability has yet to be researched. Unlike  
35  
36 373 self-report measures, we expect measurement error due to the evaluator and functional-based tests.  
37  
38 374 Thus, future research should explore these aspects of reliability.

39  
40 375 Convergent validity is often examined in clinical measurement studies. We suggest that  
41  
42 376 this may be because these comparisons are easily performed by correlating different tests rather  
43  
44 377 than providing strong confidence in the validity of the measurement. Often convenient  
45  
46 378 comparisons are performed rather than those most relevant. Across many domains and measures  
47  
48 379 it has become clear that the relationship between self-reported function and performance-based  
49  
50 380 function or physical impairment is often very weak to moderate. Therefore, the value of assessment  
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3 381 of these relationships as a form of validation has limited value. Several studies of very good to  
4  
5 382 excellent quality have reported on the convergent validity of the FCE. [28,29,32] The highest  
6  
7  
8 383 quality article determined by the QACMRR (92%) found the relationship between the FCE and  
9  
10 384 work capacity to be poorly associated with one another. [29] The same study found that the ability  
11  
12 385 of the FCE to predict future work capacity was poor. This may be considered a more important  
13  
14 386 comparison since ideally functional-based tests would relate to important outcomes like return to  
15  
16 387 work. No studies to our knowledge report the responsiveness or sensitivity to change of the FCE.  
17  
18  
19 388 This is an important gap since the focus of rehabilitation is often to remediate limitations in goal  
20  
21 389 impairments or work capacity, and assessment of these changes is critical to clinical decision-  
22  
23 390 making and reporting outcomes. Thus, future research should evaluate the responsiveness of the  
24  
25  
26 391 FCE to provide insight in the measure's ability to detect change after an intervention.  
27

## 28 392 **FIT-HaNSA**

29  
30  
31 393 One study of very good quality (88%) assessed the FIT-HaNSA, a test consisting of two  
32  
33 394 reaching tasks (waist and eye-level) and sustained overhead task performance. [35] Overall, the  
34  
35 395 FIT-HaNSA demonstrated excellent inter-rater reliability (0.84) and intra-rater reliability (0.78).  
36  
37 396 The specific subtests included within the FIT-HaNSA similarly demonstrate fair to excellent (0.54-  
38  
39 397 0.80) and good (0.70-0.72) inter-rater and intra-rater reliability respectively. The FIT-HaNSA also  
40  
41 398 demonstrated a clear ability to distinguish between people with WAD 2 and healthy controls.  
42  
43 399 Correlations between the FIT-HaNSA and other patient self-report disability and functional  
44  
45 400 outcome measures (NPRS, NDI, DASH, CROM and FIT-HaNSA) were generally very weak to  
46  
47 401 weak ( $p < 0.4$ ), consistent with other studies comparing performance and self-report. [17,18] The  
48  
49 402 largest limitation in critically synthesizing information for this test is that only a single study was  
50  
51  
52 403 found that reported the measurement properties for people with neck disorders. It should be noted  
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1  
2  
3 404 however that it has been validated in other MSK disorders. [34,40] Although others have noted  
4  
5 405 the lag in development of functional-based measures in comparison to self-report measures, FIT-  
6  
7  
8 406 HaNSA was recommended as a functional-based measure for people with shoulder disorders. [41]  
9

## 10 407 **BTEWS II**

11  
12 408 Another study of very good quality (88%) assessed the efficacy of the BTEWS II where  
13  
14 409 the participants performed a dynamic pushing and pulling task in which power output was recorded  
15  
16  
17 410 over a 10 second sample.[34] While the convergent validity aspect of this paper was assessed as  
18  
19 411 consistent with best practice through the critical appraisal process, the relationship between the  
20  
21 412 power output on the BTEWS and measures of pain and disability (NDI, SPADI, NRS) were poorly  
22  
23 413 associated with each other. In addition, the power output component was not found to be  
24  
25 414 significantly different between people with neck pain and healthy controls which suggests it might  
26  
27 415 not be discriminative. Discrimination between patients and those without any symptoms is a low  
28  
29 416 benchmark, and tests that cannot fulfil this benchmark should be viewed with caution. Because of  
30  
31 417 the weak measurement properties demonstrated by the power output component of the BTEWS II,  
32  
33 418 it does not appear to be a desirable functional-based measure to assess function in people with  
34  
35 419 neck pain. However, we acknowledge for all of the functional-based tests the evidence pool is so  
36  
37 420 shallow that there is high potential that future studies might lead to different conclusions.  
38  
39  
40

## 41 421 **Physiotherapy Test Package Subtests**

42  
43 422 Four studies ranging from good to very good quality (68-82%) assessed relevant items  
44  
45 423 from a physiotherapy test package, including a lift from floor-to-waist and a waist-to-shoulder task  
46  
47 424 and a two-handed carrying task. The properties of these assessment items include weak to  
48  
49 425 moderate correlations to pain, perceived exertion, and had “fair to good” reliability. The 2x20m-  
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51 426 WWB and PILE-C tests were found to be sensitive-to-change which is valuable information as no  
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3 427 other study has assessed this property in functional-based measures in patients with neck disorders.  
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5 428 Thus, this measure may be of value in clinical settings when assessing functional capacity before  
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8 429 and after a treatment intervention. All tests had discriminative ability for detecting participants  
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10 430 with spinal pain vs healthy controls. Most of the three tests demonstrated poor construct validity  
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12 431 in that they were poorly related to pain and perceived exertion. Thus, further research is necessary  
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15 432 to investigate these constructs.

### 16 17 433 **Clinical Implications**

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19 434 This study confirms that functional-based tests have had far less development and  
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21 435 evaluation than self-report measures. Limitations include the number of tests and insufficient body  
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23 436 of evidence to make confident recommendations with respect to functional-based testing. It is clear  
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26 437 that self-report and functional-based measures provide different perspectives. Theoretically,  
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28 438 functional-based tests are important to inform our understanding about the mechanisms of  
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30 439 intervention and how interventions increase capacity. Overall more work is required to further  
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33 440 establish the psychometric properties of functional-based tests in persons with neck disorders,  
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35 441 including sensitivity-to-change, responsiveness, and predictive validity.

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38 442 The data presented suggest that the FIT-HaNSA has the strongest clinometric properties  
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40 443 though this is based on a single higher quality paper specific to neck disorder. [35] Importantly,  
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42 444 normative data have been published [42], it has been validated in multiple studies in patients with  
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44 445 shoulder conditions [43–45] and has been recommended when compared to other measures [41].  
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47 446 The FCE has a limited evidence base from which to draw, though it was developed with strong  
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49 447 content validity and further evaluation may demonstrate its usefulness.

### 50 51 448 **Limitations**

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3 449 A challenge in synthesizing clinical measurement evidence is the wide range of properties  
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5 450 and indicators that need to be considered. Unlike effectiveness studies where one can focus on the  
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7 451 effect size of treatment there are many considerations that would affect the recommendations made  
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9 452 about outcome measures. This is further complicated when the pool of evidence is shallow.  
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11 453 Although the quality assessment tool (QACMRR) developed by one of the authors of this review  
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13 454 which assess the quality of design of individual studies were useful for interpreting the evidentiary  
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15 455 pool, there is no clear method to synthesize the extracted clinical measurement evidence. While  
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17 456 some systematic reviews on treatment might only report findings from high-quality studies, it is  
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19 457 important to see how outcome measures perform in different contexts. Further, the assessment of  
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21 458 quality is complicated given that clinical measurement studies have so many dimensions.  
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23 459 Therefore, exclusion of lower quality studies has questionable value. Thus, a more practical  
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25 460 approach is to consider quality when interpreting the findings, rather than excluding studies.

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27 461 The QACMRR focuses on whether the authors made appropriate decisions in selecting the  
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29 462 scope and methods of their clinical measurement evaluations within a given study and provides  
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31 463 descriptors of poor fair or good design options. Quality focuses on issues that might affect risk of  
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33 464 bias or imprecision in estimates; whereas risk of bias assessments focusses on items that might  
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35 465 result in a biased estimate. For example, insufficient power is a precision (quality) issue, not a risk  
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37 466 of bias. Although it is difficult to interpret the meaning of the percentage of the QACMRR as there  
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39 467 are no established cut-offs for distinguishing good and poor-quality studies, it provides one way  
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41 468 of ranking the articles in order of quality. We did not use COSMIN checklist since it was developed  
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43 469 for PROMS and some of the components/steps that involved are not applicable to performance-  
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45 470 based tests.

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3 471 Another limitation in this review was that the feasibility or usability of these tools was not  
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5 472 assessed. While feasibility was not the focus of this review, information on the practical  
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8 473 application of these functional-based measures provides valuable information to clinicians for  
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10 474 determining whether these tests are appropriate to use in their given setting. Thus, future research  
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12 475 should not only investigate further the psychometric properties of these tools, but also report the  
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14 476 feasibility of using these tests so that they may be used in clinical settings and to identify  
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17 477 limitations that restrict their application in practice.  
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## 21 479 **CONCLUSION**

24 480 This review found very good quality evidence that the FIT-HaNSA has excellent inter and  
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26 481 intra-rater reliability and very weak to weak convergent validity. Excellent quality evidence of fair  
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28 482 test-retest reliability, weak convergent validity, and very weak known groups validity for the  
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30 483 BTEWS II test was found. Good to excellent quality evidence exists that an FCE battery has poor  
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33 484 to excellent reliability and very weak to strong validity. Good to excellent quality of weak to strong  
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35 485 validity and trivial to strong effect sizes were found for a physiotherapy test package. Functional-  
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38 486 based evaluation in people with neck disorders is an area needing much research attention both to  
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40 487 establish the measurement properties of existing measures, potentially to develop innovative new  
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42 488 measures and to perform head-to-head comparisons of measures before an optimal functional-  
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45 489 based test can be identified.

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### 49 491 **Authors' contributions**

51 492 SM contributed significantly to conception and design of the study, data extraction, critical  
52  
53 493 appraisal, interpretation of data and drafting of the manuscript. TS, TA, PB, and CC were involved  
54  
55 494 in literature search, critical appraisal and interpretation of data and drafting. AG was involved in

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3 495 critical appraisal and drafting. JM was also involved in the conception and design of the study,  
4 496 drafting, and revised the manuscript for important intellectual content. PB and CATWAD were  
5 497 involved in the drafting and review of the manuscript. All authors have given their final approval  
6 498 on the manuscript to be published  
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## 11 500 **Declarations**

### 12 501 **Ethics approval and consent to participate**

13 502 Not applicable  
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### 18 504 **Consent for publication**

19 505 Not applicable  
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### 23 507 **Availability of data and material**

24 508 Data sharing is not applicable to this article as no datasets were generated or analyzed during the  
25 509 current study  
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### 30 511 **Funding Statement**

31 512 This work was supported by the Canadian Institutes of Health Research (CIHR) with funding  
32 513 reference number (FRN: SCA-145102).  
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### 37 515 **Competing Interest Statement**

38 516 None to report.  
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**TABLE 1.** Summary of Studies Reporting Psychometric Properties of Functional-based Tests in Neck Disorder Patients

Study	Population	Sample Size (n)	Functional Tests	Intervention/Test Interval	Quality
Ljungquist et al. 1999	Neck pain (55%), back pain, multiple pain sites,	53	PILE-C, PILE-L	N/A	Good (68%)
Ljungquist et al. 1999	Neck pain (50%), lumbar pain, thoracic pain, shoulder pain, multiple pain sites,	68	PILE-C, PILE-L, 2 x 20m WWB	8 days	Very Good (79%)
Ljungquist et al. 2003	Neck pain, lumbar pain, thoracic pain, shoulder pain, lower extremity pain, multiple pain sites,	235	PILE-C, PILE-L, 2 x 20m WWB	N/A	Very Good (82%)
Ljungquist et al. 2003	cervical pain (25%), lumbar pain, cervical (25%) and lumbar pain, multiple pain sites,	186	PILE-C, PILE-L, 2 x 20m WWB	6 months	Very Good (79%)
Lomond and Cote. 2011	Chronic neck and shoulder pain (100%)	32	BTEWS II	9.5 days	Very Good (88%)
Pierrynowski et al. 2016	Sub-acute and chronic WAD II	66	FIT-HaNSA	2-7 days	Very Good (88%)
Reesink et al. 2007	N/A	N/A	Neck-FCE	N/A	N/A
Reneman et al. 2017	Chronic multifactorial neck pain	18	Neck-FCE	2 weeks	Good (67%)
Trippolini et al. 2013	Sub acute and chronic WAD I and II	32	WAD FCE	7 days	Very Good (75%)
Trippolini et al. 2014	Sub acute and chronic WAD I and II	267	Workwell FCE	N/A	Excellent (92%)



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Trippolini et al. 2015	Sub acute and chronic WAD I and II	314	WAD FCE	N/A	Very Good (86%)
Van der Meer et al. 2013	Chronic WAD I and II	40	Neck FCE	N/A	Very Good (86%)

PILE-C, Progressive Isoinertial Lifting Evaluation-Cervical; PILE-L, Progressive Isoinertial Lifting Evaluation; CBT, Cognitive-Behavioural Therapy; PT, Physical Therapy; NRPS, Numeric Pain Rating Scale; BTEWS II, Baltimore Therapeutic Equipment Work Simulator II; WAD, Whiplash Associated Disorder; MVA, Motor Vehicle Accident; FIT-HANSA, Functional Impairment Test-Hand and Neck/Shoulder/Arm; FCE, Functional Capacity Evaluation; EXP, Experimental; M, Male; F, Female

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**TABLE 2.** Quality of Studies on Psychometric Properties of Functional-based Tests Evaluated in Neck Disorder Patients

Study	Item Evaluation Criteria												Total (%)
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	
Trippolini et al, 2014	2	2	2	2	1	2	2	2	2	2	1	2	92%
Lomond and Cote, 2011	2	2	1	2	0	2	2	2	2	2	2	2	88%
Pierrynowski et al, 2016	2	2	1	2	0	2	2	2	2	2	2	2	88%
Trippolini et al, 2015	2	2	2	0	1	N/A	2	2	2	2	2	2	86%
Van der Meer et al, 2013	2	1	2	1	2	N/A	2	1	2	2	1	2	86%
Ljungquist et al 2003 KGV	2	2	2	0	0	N/A	2	2	2	2	2	2	82%
Ljungquist et al 1999 Rel	2	1	1	2	0	2	2	2	2	2	1	2	79%
Ljungquist et al 2003 STC	1	1	1	2	1	1	2	2	2	2	2	2	79%
Trippolini et al, 2013	2	2	1	1	0	0	2	2	2	2	2	2	75%
Ljungquist et al 1999 KGV	2	1	1	2	0	N/A	2	1	2	2	1	2	68%
Reneman et al, 2017	1	2	1	1	1	0	1	2	2	2	2	1	67%

Reesink, 2007*	-	-	-	-	-	-	-	-	-	-	-	-	N/A
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\*Paper is not applicable for completion of study quality tool

**TABLE 3.** Psychometric Properties of the Functional Capacity Evaluation

FCE Battery	Type of Properties	Statistical Test	Value	Interpretation
Neck FCE	Test-retest	ICC	0.39-0.96	Poor-excellent
	Measurement Error	Ratio of LoA	32.0-56.5%	
	Convergent Validity	Pearson or Spearman correlation	NDI total: 0.39-0.62 NDI items: 0.03-0.63	Weak to moderate Very weak to strong
WAD FCE	Test-retest Reliability	ICC	0.66-0.96	Good-excellent
	Convergent Validity	Pearson Correlation	Pain* 0.31-0.39	Weak
			SFS: 0.42-0.61	Moderate-strong
			NDI: 0.34-0.45	Weak-moderate
			HADS-A: 0.27-0.36 HADS-D: 0.30-0.41	Weak Weak-moderate
Known-groups Validity (German vs Non-German)	Linear Regression Analysis	p<0.001	Significant for All Tasks	
Known-groups Validity (sex)	t-test	p<0.001	Significant for Two tasks	
Workwell FCE	Convergent Validity	Pearson or Spearman Correlation	Work Capacity: 0.1-0.3	Very Weak – weak
	Predictive Validity	Pearson or Spearman Correlation	0.06-0.39	Very weak - Weak
		Linear Mixed Model Regression of All Predictors	$\beta$ =-0.04, 95% CI: -0.15 – 0.06 p=0.428 (task 6)	Not Significant

FCE, Functional Capacity Evaluation; ICC, Intraclass correlation coefficient; LoA, Limits of Agreement; NDI, Neck Disability Index; Mod., Moderate; Neg., Negligible; SFS, Spinal Function Sort; HADS-A, Hospital Anxiety and Depression Scale – Anxiety; HADS-D, Hospital Anxiety and Depression Scale – Depression; CI, Confidence Interval Sig., Significant

\*Pain measured via Numeric Rating Scale

**TABLE 4.** Summary of Fit-HaNSA's psychometric properties in neck disorder patients

Test	Type of Property	Statistical Test	Value	Interpretation
Fit-HaNSA	Intra-rater Reliability	ICC	0.78	Excellent
Fit-HaNSA	Inter-rater Reliability	ICC	0.84	Excellent
Fit-HaNSA	Measurement Error	SEM	76 s	
		LOA <sub>95</sub>	248 s	
		MDC <sub>90</sub>	176 s	
Fit-HaNSA	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Weak – Strong
Fit-HaNSA	Known-groups Validity WAD II vs Control	F-test	62.6, <p,0.001	Significant
Fit-HaNSA Functional Sub-tasks	Intra-rater reliability	ICC	0.70-0.72	Good
	Inter-reliability	ICC	0.54-0.80	Fair - Excellent
	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Weak - Strong
	Known-groups Validity WAD II vs Control	F-test	42.0-53.3, p<0.001	Significant

Fit-HaNSA, Functional Impairment Test, Hand and Neck/Shoulder/Arm; ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; LOA<sub>95</sub>, 95% Limits of Agreement; MDC<sub>90</sub>, 90% Minimal Detectable Change; WAD, Whiplash Associated Disorder; Mod, Moderate

\*Correlations completed with Numeric Pain Rating Scale, Neck Disability Index, Disabilities of Arm, Shoulder, Hand and 6 cervical range of motion tests

**TABLE 5.** Psychometric Properties of Baltimore Therapeutic Equipment Work Simulator II – Power Output Task

Test	Type of Property	Statistical Test	Value	Interpretation
BTEWS II	Test-retest reliability	ICC	0.53	Fair
		Spearman	0.37	Poor
BTEWS II	Measurement Error	SEM	30.25	
		MDC <sub>90</sub>	70.59	
BTEWS II	Convergent Validity*	Spearman	Not Reported	Weak
BTEWS II	Known-groups Validity (Pain vs Control)	Two-way Repeated Measures ANOVA	Not Reported	Non-significant

ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; MDC<sub>90</sub>, 90% Minimal Detectable Change; ANOVA, Analysis of Variance

\*Spearman correlations completed with Numeric Rating Scale, Neck Disability Index and Shoulder Pain and Disability Index

**TABLE 6.** Psychometric Properties of performance-based tests included in physiotherapy test package

Test	Type of Property	Statistical Test	Value	Interpretation
PILE-C	Inter-rater Reliability	Mean Difference LoA	-0.24 -2.46 and 1.82	
PILE-C	Inter-rater Reliability	Repeatability (2X SD) % of Range	M=3.93; F=1.19 M=10.5%; F=6.1%	
PILE-C	Convergent Validity	Spearman Correlation	CR-10: 0.55-0.65* Borg RPE: 0.10 - 0.48	Moderate - Strong Very weak - moderate
PILE-C	KGV: spinal pain vs. control	Sensitivity and Specificity	0.93, 0.69	Strong – Very Strong
PILE-C	KGV: spinal pain vs. control	Wilcoxon Sign Ranked Test	p=0.008	Significant
PILE-C	KGV: High vs. low pain intensity	Mann-Whitney U	p=0.003	Significant
PILE-C	KGV: High vs. low Pain behavior	Mann-Whitney U	p=0.005	Significant
PILE-C	KGV: High vs. low perceived exertion	Mann-Whitney U	p=0.154	Non-significant
PILE-C	Sensitivity to Change	Effect Size	Subjects improving: 0.39 - 0.73 Subjects deteriorating: 0 - 0.4	Small – Moderate Trivial – Small
PILE-L	Inter-rater Reliability	Mean Difference LoA	-0.11 -2.33 and 2.11	
PILE-L	Intra-rater Reliability	Repeatability % of Range	M=4.0; F=3.59 M=10.7%; F=18.5%	
PILE-L	Convergent Validity	Spearman Correlation	CR-10: 0.11 – 0.45	Very weak – moderate Very weak – moderate

				Borg RPE: 0.10 - 0.48	
PILE-L	KGV: spinal pain vs no spinal pain	Sensitivity and Specificity	0.85, 0.65		Strong – Very Strong
PILE-L	KGV: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.002		Significant
PILE-L	KGV: High vs. low pain intensity	Mann-Whitney U	p=0.001		Significant
PILE-L	KGV: High vs. low pain behaviour	Mann-Whitney U	p<0.001		Significant
PILE-L	KGV: High vs. low perceived exertion	Mann-Whitney U	p<0.001		Significant
PILE-L	Sensitivity to change	Effect Size	Subjects improving: 0.02 – 1.08 Subjects deteriorating 0.42-0.81		Trivial – Large Small – Large
2 x 20m WWB	Inter-rater Reliability	Mean Difference LoA	0.05 -1.33 and 1.43		
2 x 20m WWB	Intra-rater Reliability	Repeatability % of Range	3.2 10.7%		
2 x 20m WWB	Convergent Validity	Spearman Correlation	CR-10: 0.55 - 0.65 Borg RPE: 0.10 - 0.48		Moderate - Strong very weak – moderate
2 x 20m WWB	KGV: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.014		Significant
2 x 20m WWB	KGV: High vs. low pain intensity	Mann Whitney U	p<0.001		Significant
2 x 20m WWB	KGV: High vs. low pain behaviour	Mann Whitney U	p<0.001		Significant
2 x 20m WWB	KGV: High vs. low perceived exertion	Mann Whitney U	p<0.001		Significant
2 x 20m WWB	Sensitivity to change	Effect Size	Subjects improving: 0.38-0.78		Small – Moderate Trivial – Moderate

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Subjects deteriorating:  
0.13-0.62

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PILE-C, Progressive Iso-inertial Lifting Evaluation – Cervical; PILE-L, Progressive Iso-inertial Lifting Evaluation – Lumbar; LoA, Limits of Agreement; SD, Standard Deviation; M, Male; F, Female; RPE, Rating of perceived exertion; KGV, Known-groups Validity; Neg., Negligible; Mod., Moderate, \*CR-10: Measurement of pain construct

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**Figure 1.** Selection of the studies for inclusion in the systematic review

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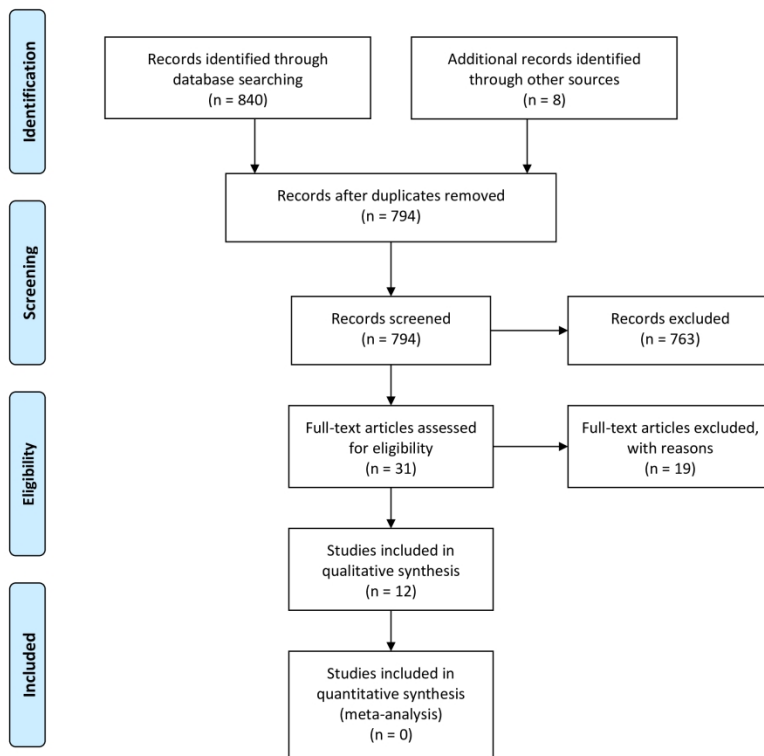


Figure 1

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## Appendix 1: Search terms

### EMBASE-OVID

1. exp "outcome and process assessment (health care)"/ or "outcome assessment (health care)"/ or treatment outcome/
2. outcome?.ti.
3. exp "Range of Motion, Articular"/
4. Pain Measurement/
5. exp disability evaluation/
6. "Recovery of Function"/
7. Questionnaires/
8. self-report.tw.
9. ((impairment or disability or function) adj2 (measure? or scale? or evaluation?)).tw.
10. range of motion.tw.
11. (strength adj2 (measure? or scale? or evaluation?)).tw.
12. (outcome? adj2 (measure\* or scale? or indicator?)).tw.
13. or/1-12
14. "reproducibility of results"/
15. exp "Sensitivity and Specificity"/
16. reliability.mp.
17. validity.mp.
18. responsiveness.mp.
19. Psychometrics/
20. rasch.mp.
21. factor analysis, statistical/
22. factor analysis.tw.
23. differential functioning.mp.
24. (validity or validation).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
25. (validity or validation).mp.
26. item difficulty.mp.
27. translation.tw.
28. or/14-27
29. 13 and 28
30. Neck Pain/
31. exp Brachial Plexus Neuropathies/
32. exp neck injuries/ or exp whiplash injuries/
33. cervical pain.mp.
34. neckache.mp.
35. whiplash.mp.
36. cervicodynia.mp.
37. cervicgia.mp.
38. brachialgia.mp.
39. brachial neuritis.mp.
40. brachial neuralgia.mp.
41. neck pain.mp.

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- 2
- 3 42. neck injur\*.mp.
- 4 43. brachial plexus neuropath\*.mp.
- 5 44. brachial plexus neuritis.mp.
- 6 45. thoracic outlet syndrome/ or cervical rib syndrome/
- 7 46. Torticollis/
- 8 47. exp brachial plexus neuropathies/ or exp brachial plexus neuritis/
- 9 48. cervico brachial neuralgia.ti,ab.
- 10 49. cervicobrachial neuralgia.ti,ab.
- 11 50. (monoradicul\* or monoradickl\*).tw.
- 12 51. or/30-50
- 13 52. exp headache/ and cervic\*.tw.
- 14 53. exp genital diseases, female/
- 15 54. genital disease\*.mp.
- 16 55. or/53-54
- 17 56. 52 not 55
- 18 57. 51 or 56
- 19 58. neck/
- 20 59. neck muscles/
- 21 60. exp cervical plexus/
- 22 61. exp cervical vertebrae/
- 23 62. atlanto-axial joint/
- 24 63. atlanto-occipital joint/
- 25 64. Cervical Atlas/
- 26 65. spinal nerve roots/
- 27 66. exp brachial plexus/
- 28 67. (odontoid\* or cervical or occip\* or atlant\*).tw.
- 29 68. axis/ or odontoid process/
- 30 69. Thoracic Vertebrae/
- 31 70. cervical vertebrae.mp.
- 32 71. cervical plexus.mp.
- 33 72. cervical spine.mp.
- 34 73. (neck adj3 muscles).mp.
- 35 74. (brachial adj3 plexus).mp.
- 36 75. (thoracic adj3 vertebrae).mp.
- 37 76. neck.mp.
- 38 77. (thoracic adj3 spine).mp.
- 39 78. (thoracic adj3 outlet).mp.
- 40 79. trapezius.mp.
- 41 80. cervical.mp.
- 42 81. cervico\*.mp.
- 43 82. 80 or 81
- 44 83. exp genital diseases, female/
- 45 84. genital disease\*.mp.
- 46 85. exp \*Uterus/
- 47 86. 83 or 84 or 85
- 48 87. 82 not 86
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- 4 88. 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or
- 5 74 or 75 or 76 or 77 or 78 or 79 or 87
- 6 89. exp pain/
- 7 90. exp injuries/
- 8 91. pain.mp.
- 9 92. ache.mp.
- 10 93. sore.mp.
- 11 94. stiff.mp.
- 12 95. discomfort.mp.
- 13 96. injur\*.mp.
- 14 97. neuropath\*.mp.
- 15 98. or/89-97
- 16 99. 88 and 98
- 17 100. Radiculopathy/
- 18 101. exp temporomandibular joint disorders/ or exp temporomandibular joint dysfunction
- 19 syndrome/
- 20 102. myofascial pain syndromes/
- 21 103. exp "Sprains and Strains"/
- 22 104. exp Spinal Osteophytosis/
- 23 105. exp Neuritis/
- 24 106. Polyradiculopathy/
- 25 107. exp Arthritis/
- 26 108. Fibromyalgia/
- 27 109. spondylitis/ or discitis/
- 28 110. spondylosis/ or spondylolysis/ or spondylolisthesis/
- 29 111. radiculopathy.mp.
- 30 112. radiculitis.mp.
- 31 113. temporomandibular.mp.
- 32 114. myofascial pain syndrome\*.mp.
- 33 115. thoracic outlet syndrome\*.mp.
- 34 116. spinal osteophytosis.mp.
- 35 117. neuritis.mp.
- 36 118. spondylosis.mp.
- 37 119. spondylitis.mp.
- 38 120. spondylolisthesis.mp.
- 39 121. or/100-120
- 40 122. 88 and 121
- 41 123. exp neck/
- 42 124. exp cervical vertebrae/
- 43 125. Thoracic Vertebrae/
- 44 126. neck.mp.
- 45 127. (thoracic adj3 vertebrae).mp.
- 46 128. cervical.mp.
- 47 129. cervico\*.mp.
- 48 130. 128 or 129
- 49 131. exp genital diseases, female/
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132. genital disease\*.mp.
133. exp \*Uterus/
134. or/131-133
135. 130 not 134
136. (thoracic adj3 spine).mp.
137. cervical spine.mp.
138. 123 or 124 or 125 or 126 or 127 or 135 or 136 or 137
139. Intervertebral Disk/
140. (disc or discs).mp.
141. (disk or disks).mp.
142. 139 or 140 or 141
143. 138 and 142
144. herniat\*.mp.
145. slipped.mp.
146. prolapse\*.mp.
147. displace\*.mp.
148. degenerat\*.mp.
149. (bulge or bulged or bulging).mp.
150. 144 or 145 or 146 or 147 or 148 or 149
151. 143 and 150
152. intervertebral disk degeneration/ or intervertebral disk displacement/
153. intervertebral disk displacement.mp.
154. intervertebral disc displacement.mp.
155. intervertebral disk degeneration.mp.
156. intervertebral disc degeneration.mp.
157. 152 or 153 or 154 or 155 or 156
158. 138 and 157
159. 57 or 99 or 122 or 151 or 158
160. animals/ not (animals/ and humans/)
161. 159 not 160
162. exp \*neoplasms/
163. exp \*wounds, penetrating/
164. 162 or 163
165. 161 not 164
166. 29 and 165
167. guidelines as topic/
168. practice guidelines as topic/
169. guideline.pt.
170. practice guideline.pt.
171. (guideline? or guidance or recommendations).ti.
172. consensus.ti.
173. or/167-172
174. meta-analysis/
175. exp meta-analysis as topic/
176. (meta analy\* or metaanaly\* or met analy\* or metanaly\*).tw.
177. review literature as topic/

178. (collaborative research or collaborative review\* or collaborative overview\*).tw.
179. (integrative research or integrative review\* or intergrative overview\*).tw.
180. (quantitative adj3 (research or review\* or overview\*)).tw.
181. (research integration or research overview\*).tw.
182. (systematic\* adj3 (review\* or overview\*)).tw.
183. (methodologic\* adj3 (review\* or overview\*)).tw.
184. exp technology assessment biomedical/
185. (hta or thas or technology assessment\*).tw.
186. ((hand adj2 search\*) or (manual\* adj search\*)).tw.
187. ((electronic adj database\*) or (bibliographic\* adj database\*)).tw.
188. ((data adj2 abstract\*) or (data adj2 extract\*)).tw.
189. (analys\* adj3 (pool or pooled or pooling)).tw.
190. mantel haenszel.tw.
191. (cochrane or pubmed or pub med or medline or embase or psycinfo or psychlit or psychinfo or psychlit or cinahl or science citation indes).ab.
192. or/174-191
193. 173 or 192
194. 166 and 193

## APPENDICES

### APPENDIX A. Data extraction guide for studies evaluating the quality of studies evaluating the clinical measurement properties of outcome measures

#### Instructions

Clinical measurement studies may evaluate a wide spectrum of measurement properties; or evaluate aspects that relate to the implementability or interpretation of outcome measures. Individual clinical measurement studies cannot address every aspect of the measurement properties of an instrument. Ideally systematic reviews will synthesize the quality and content of research evidence addressing the clinical measurement properties of individual outcome measures. The summative knowledge about the measurement properties, cultural transferability, and utility across different contexts provides the scope of information needed to select an outcome measure for a specific patient (population), purpose and context.

This guide should facilitate extraction of data from individual clinical measurement studies. An explanation of the measurement property addressed in each item and how it might be measured within a given study is listed to facilitate finding and extracting that information. The accompanying extraction form can then be used to collect the specific information on these measurements or utility properties from specific studies.

The purpose of data extraction is to extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. Evaluation of the quality of the published version of the clinical measurement study (also called critical appraisal) is performed in a separate step. See the accompanying critical appraisal tool and guide. It is advisable to extract detailed specific information from the study; recognizing that this information may later be synthesized or subject to meta-analysis.

There is no standardized process for synthesizing clinical measurement information. Based on the findings of extraction you may elect to present the synthesize data in a descriptive way by creating a summary table of the data extracted in each category. If you find some studies with similar designs, you may be able to conduct a meta-analysis of some properties like clinically important difference (CID) or minimal detectable change (MDC); if appropriate given the sample and technique - this can be valuable as it may provide more stable estimates of these important properties.



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<b><u>Population studied</u></b>		
Population	A description of the study population	Sample size, pathology/disorder, demographics, setting, acute vs. chronic, where subjects were chosen from. Report meaningful demographics and indicators of the population studied.
Intervention	Interventions (if applicable) applied during longitudinal studies	Description of the nature, frequency, intensity of the intervention and the follow-up interval.
<b><u>Reliability</u></b>		
Reliability Description	The extent to which the same results are obtained on repeated administrations of the same measure when no change in status has occurred (reliability) or the precision of the scores on repeated measurements (agreement).	Test procedures or measures are typically reapplied on repeated occasions in individuals considered to have a stable condition during that time frame which repeated testing occurs. Repeated testing may be performed on different occasions (test-retest) for self-report measures, OR by the same rater (intra-rater) or different raters (inter-rater) if it is an observer-based scale. In some cases different test instruments (inter-instrument) are evaluated. The most common statistic used is the intraclass correlation coefficient for quantitative data (Shrout & Fleiss, 1979) and kappa (Landis & Koch, 1977) for nominal data. Standard error of measurement is used to present a quantitative estimate of the reliability—in the original units of measure. Report the type of reliability evaluated and coefficients obtained.
Reliability (relative)	The relationship (ratio) between variability in test scores when repeating the test on the same person in comparison to the overall variability (including variation between people)—typically indicated by a reliability coefficient	ICCs (Shrout & Fleiss, 1979) or another reliability coefficient and their associated confidence intervals are extracted.
Reliability (absolute)	Absolute reliability is portrayed as the quantity of error that could be anticipated upon repeated testing - reported in the original units of measure.	This may be reported as 1. Standard error of measurement (in older articles you may see coefficient of variation),

		2. Altman and Bland graphical technique (Bland & Altman, 1990; Bland & Altman, 1987; Bland & Altman, 1986) where the difference on repeated tests for each individual (limits of agreement) is plotted versus their mean score. The mean difference and the boundaries of 2SD are shown to define the limits of agreement.
Minimum Detectable Change	Calculated from the reliability coefficient and the level of confidence specified for error margins. This indicator reflects the amount of change required before you can be confident that change exceeds the random error that occurs in stable patients.	Extract the number and level of confidence.
<b><u>Content/structural validity</u></b>		
Internal consistency	The extent to which items on a test or subscale are related (an indication of the consistency of the concept measured).	Cronbach's alpha is the inter-item correlation usually reported. Report alpha and whether it relates to the entire instrument or specific subscales.
Content Validity	The extent to which the conceptual domain or construct that a test is designed to measure is adequately reflected by the items in the measure. In assessing content validity, it is important to consider the population to whom the measure applies, the completeness of the content, the relevancy and emphasis of the content assessed.	<p>A variety of techniques can be used to assess the extent to which items on a given measure reflected the necessary content to capture the concept of interest. Some of the techniques you will find are listed. Extract what was done to determine content validity and what was found.</p> <ol style="list-style-type: none"> <li>1) Patients and experts were involved during item selection/reduction - report how they were used and key decisions</li> <li>2) Patients were consulted for reading and comprehension - report key findings</li> <li>3) Cognitive interviews (Cibelli, 1994; Ojanen &amp; Gogates, 2006) were done with patients to determine how items were interpreted by respondents, their perceptions of the items - report key findings</li> <li>4) Expert panels or Delphi procedures were used to select items or evaluate the validity of the instrument - report key findings and decisions</li> </ol>

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		<p>5) During translation specific study, the meaning of the questions to another cultural or language group was studied - report key findings and decisions</p> <p>6) ICF linking (Cieza et al., 2002) or other coding of content was performed - report the results which may include the distribution of content across ICF domains, or the distribution of specific codes</p>
Floor-Ceiling Effects	The measure is unable to indicate a worsening score in patients who have clinically deteriorated and/or an improved score in patients who have clinically improved	There are a variety of potential methods; so the method and conclusion should be reported. Descriptive statistics of the distribution of scores that may be presented graphically or numerically may be used to indicate this. Other studies report the percentage of patients sustained a floor or ceiling effect defined by the number of people who fall in the extremes ranges. Note different studies may define the extreme ranges for floor/ceiling differently, so extract how it was defined and % of patients who obtained floor or ceiling category scores.
Factorial validity	The extent to which factor analysis supports assumptions surrounding constructs measured as defined by the measure or as indicated by subscale structure	Factor analysis may be reported as raw results; or compared to the inherent structure of the instrument or factor analysis upon which its construction was based. Report the type of factor analysis performed (exploratory or confirmatory), rotations used and the number of factors derived; specify whether this confirms the expected instrument structure or original factor structure.
Item response /Rasch Analyses	The extent to which items cross a range of difficulty, or a spectrum of the concept measured. The measurement scaling of the items.	Using item response theory or Rasch analysis, items are fit to a model to demonstrate interval scaling and determine item difficulty (Pallant & Tennant, 2007). Analyses might address item difficulty, person's ability curves, and comparison of ability estimation. Most commonly, the item difficulty and the composition of the test that fulfills interval scaling are defined. Data to be extracted include information on the scaling of the items, whether the interval scaling has been established; and the presence or absence of differential item functioning

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		(DIF), where items perform differently on different types of respondents.
<b>Construct Validity</b>		
<b>Construct Validity - correlational</b>	<p>Constructs are artificial frameworks that are not directly observable. Construct validity assesses the extent to which measures perform according to a priori defined constructs. Construct validity can be cross-sectional or longitudinal (predictive).</p> <p>Constructed hypotheses can assess convergent validity where measures are thought to represent similar constructs or divergent validity where it is assumed they measure different constructs.</p> <p>For cross-cultural validation, the expected relationships are those that have been reported in validation of the instrument in its original language/format.</p>	<p>When extracting data about correlational validity, the pre-constructed hypothesis and whether it is supported should be documented. For correlational construct validity, this will be the nature and strength of the prespecified relationship and the correlations that support that. Relation to other indices/constructs that are similar (convergent) or different (divergent) can be reported. Ideally, hypotheses are formulated/reported and supported by correlations that are in accordance with the hypotheses. Note that there is no consistent agreement on what subjective term should be applied to validity correlations.</p> <p>Note that there is no consistent agreement on what subjective term should be applied to validity correlations. Some authors use subjective terminology defined for reliability such as: strong (&gt;0.70) and moderate (0.40-0.70) correlations; others use the correlations like effect size benchmarks that 0.4 indicates a moderate effect and 0.6 a large effect. For validity assessment is more important than correlations prespecified constructed hypotheses, although not all papers are written clearly with respect to this.</p>
<b>Convergent</b>	The Relationship between similar scales/tests. Correlations are generally expected to be moderate to strong if the relationship is one where there is confidence that they measure a similar construct.	Extract test names, prespecified expected relationship and correlations observed.
<b>Divergent</b>	Divergent validity assesses the extent to which different scales/tests that are designed to	Extract test names, prespecified expected relationship and correlations observed.

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	measure different constructs demonstrate that they are different by a lack of correlation between them.	
Construct validity - known groups	Known groups analysis supports the validity of a measure by demonstrating that the measurement is able to differentiate between groups that are prespecified and <u>known</u> to be different on the construct being assessed.	Data extraction should include the nature of the subgroups and the size of the difference observed between them (and its statistical significance). Typically, statistical tests of difference are performed.  Since known groups analysis can provide data that is useful in clinical practice as benchmarks for comparing these known groups, it is a more practical form of construct validity than correlational. Data extraction/presentation should reflect this by presenting the group central tendency, their margins and statistical significance in an accessible manner.
Longitudinal Validity	This form of validity supports the validity of a measure by demonstrating that the change that occurs over time onto similar instruments is correlated in a manner consistent with the nature of the relationship between the scales. It is measured over a retest interval when clinically relevant change could be expected.	Extract test names and correlations  Note: since longitudinal validity is based on four measures (pre-and post-test on two different measures), and since error tends to mitigate the strength of correlations, strong longitudinal correlations can be difficult to obtain.
Criterion validity Description	Criterion validation is determined by comparing a given outcome measure to an accepted standard of measure. For subjective constructs like pain and disability, it can be argued that there is no criterion since there is no external gold standard. Therefore, for self-report measures, validation focuses on construct validity.  For performance measures, it is common to have a criterion measure that is considered to be highly precise and rigorous as the criterion comparator.	Authors will state that their measure is being compared against a specific instrument and report the correlation or agreement between the measures. Extract the test names and results: correlations or other as reported.
Concurrent criterion	Concurrent validity is assessed by comparing a scale and its criterion at a single point in time	Extract the test names and correlations.

<p>Predictive criterion</p>	<p>Predictive validity is evaluated by determining the extent to which the results of administering an outcome measure at one point in time can accurately predict a future status or outcome.</p>	<p>Extract the test names and correlations and time interval. (and important cutoffs if those were established/reported), if diagnostic test methodology was used to examine prediction, and sensitivity specificity and other diagnostic criteria were reported, they should be extracted.</p>
<p><b><u>Responsiveness/Clinical Change</u></b></p>		
<p>Responsiveness</p>	<p>Does the instrument detect changes over time that matters to patients?</p>	<p>Extract indicators of responsiveness include: effect size, standard response mean and the method for assessing whether patients were improved, stable or worse. (Beaton, 2000)</p>
<p>Clinically Important Difference (CID)</p>	<p>CID is the difference in scores that patients find to be observable and clinically important. It is assessed by comparing scores to an external benchmark of clinical relevance such as a global rating of change or some other method. The terminology used to rate the nature of this difference will affect the estimation process. Differences in methods include how clinically importance is framed and the metrics/process by which that is determined.</p>	<p>Extract the MID or CID and note the method/cut-off used to define importance. Extract how the clinically important differences were framed to respondents; or determined. For example, minimal, moderate, extreme improvement or better/not better, etc.</p>

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**APPENDIX B.** Data extraction form for studies evaluating the clinical measurement properties of outcome measures

Authors: \_\_\_\_\_ Year: \_\_\_\_\_ Rater: \_\_\_\_\_

Instructions

When using the data extraction form, it is important to realize that the purpose of data extraction is to remove or extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. To make data extraction as useful as possible, and to avoid the need for repeated data extractions, it is advisable to read the accompanying guide and then be as specific as possible when extracting information.

	<b>DATA EXTRACTED</b>
	Population studied
Population	
Intervention	
	Reliability
Reliability (relative)	
Reliability (absolute)	
Minimum Detectable Change	
	Content/structural validity

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Internal consistency	
Content Validity	
Floor-Ceiling Effects	
Factorial validity	
Item response /Rasch Analyses	
Construct/Criterion Validity	
Known groups	
Convergent	
Divergent	
Longitudinal Validity	
Concurrent criterion	
Predictive criterion	
Responsiveness/Clinical Change	

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Responsiveness	
Minimally Clinical Important Difference	

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**APPENDIX C. Quality Appraisal for Clinical Measurement Research Reports Evaluation Form**

Rater (Group) \_\_\_\_\_

Author(s) (Study Author(s)) \_\_\_\_\_

Year (Year of publication) \_\_\_\_\_

1. Was the relevant background work cited to define what is currently known about the measurement properties of measures under study, and the potential contributions of the current research question to informing that knowledge base?

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2. Were appropriate inclusion/exclusion criteria defined? \*

2

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3. Were specific clinical measurement questions/hypotheses identified?

2

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0

4. Was an appropriate scope of measurement properties considered?

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0

5. Was an appropriate sample size used?

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6. Was appropriate retention/follow-up obtained? (for studies involving retesting; otherwise n/a)

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3 2  
4 1  
5 0  
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7 7. Were specific descriptions provided of the measure under study and the method(s) used to administer  
8 it?  
9 2  
10 1  
11 0  
12  
13 8. Were standardized procedures used to administer all study measures in a manner that minimized  
14 potential sources of error/bias (including the study measure and its comparators)?  
15 2  
16 1  
17 0  
18  
19 9. Were analyses conducted for each specific hypothesis or purpose?  
20 2  
21 1  
22 0  
23  
24 10. Were appropriate statistical tests performed to obtain point estimates of the measurement  
25 properties?  
26 2  
27 1  
28 0  
29  
30 11. Were appropriate ancillary analyses done to quantify the confidence in the estimates of the clinical  
31 measurement property (Precision/Confidence intervals; benchmark comparisons/ROC curves, alternate forms of  
32 analysis like SEM/MID, etc.)?  
33 2  
34 1  
35 0  
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37 12. Were clear, specific and accurate conclusions made about the clinical measurement properties; that  
38 were associated with appropriate clinical measurement recommendations and supported by the study objectives,  
39 analysis and results?  
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Subtotals (of column 1 and 2)      Total Score (sum of subtotals/24\*100)

**APPENDIX D. Description of each performance battery from selected articles**

Battery	Description of Tasks
<p><b>Relevant FCE Subtasks</b><sup>25,26,27,28,29,30</sup></p>	<p>Material Handling Tasks: All lifting tests were executed with a wooden crate (40 × 30 × 26 cm) of 2.5 kg, and four to five weight increments of 2.5 kg or 5 kg each were used until the maximum amount of weight was reached. Maximum performance was recorded in kg.</p> <p>Lifting floor to waist: Measured after five lifts of crate from floor to table and vice versa (time limit &lt; 90 s): hands remained on the crate during the test. Increase weight in 4-5 steps until maximum is reached</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p> <p>Two-handed carrying: Carrying of a crate for a short distance measured after five carries of 1.5 m distance at waist height. Hands remain on the crate during the test.</p> <p>One-handed carrying: Carrying wooden crate for 15 m within 90 s beginning with the right hand and thereafter the left hand.</p> <p>Overhead working: Standing with hands at crown height for manipulation of nuts and bolts. The time that the position was held is recorded (sec).</p> <p>Repetitive reaching: fast horizontal movements of the upper extremity in a sitting position. Marbles are removed from bowls at arm length distance at table height from left to right and vice versa, with right and then left arm. The time taken to remove 30 marbles is recorded (sec).</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p>

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	<p>Repetitive bending and overhead reaching: 20 marbles in 2 bowls at table height and crown height. Standing in front of bowl of marbles and moving the marbles as fast as possible from table height to crown height.</p>
<p><b>A Physiotherapy Test Package</b><sup>33,34,35,36</sup></p>	<p><b>PILE Tests:</b> “The lifting tests were performed standing in front of bookshelves with shelves at 0.76m and 1.37 m from the floor. Subjects were asked to lift weights in a plastic box from floor to waist level (0–0.76 m) for the lumbar PILE test, or from waist to shoulder height (0.76–1.37 m) for the cervical PILE test. The initial weight was 3.6 kg for women and 6.9 kg for men. A ‘lifting movement’ involved a single transfer from one level to the next and back again. After every four such lifting movements (= 20 s), the weight was increased by 2.5 kg for women and 4.5 kg for men. The weight managed during the last lifting movement was recorded and used as a test result, as well as this maximum weight divided by the ‘adjusted weight’”.</p> <p><b>2x20m WWB:</b> “Subjects were asked to walk 20 m at a comfortable speed along a corridor, to turn around where 20 m was marked and then to walk 20 m back to the starting point. In the first walking test they carried no extra weight, but in the second they carried one carrier bag in each hand, containing 4 kg each for the women, 8 kg each for the men. The time taken was recorded to get the walking speed. The tests were discontinued after 50 s”.</p>
<p><b>BTEWS II</b><sup>31</sup></p>	<p>“The protocol consisted of performing a series of shoulder functional tasks before and after a fatiguing activity. Functional tasks consisted of active shoulder range of motion (ROM) in both flexion and abduction and cumulative power output (PO) accumulated over 10s during a repetitive pushing/pulling task in a horizontal plane at shoulder level”.</p>
<p><b>FIT - HaNSA</b><sup>32</sup></p>	<p>“The FIT-HaNSA protocol consists of three timed tasks and each task is performed for a maximum of 300 seconds (s) with approximately 30 s pause between them (set-up time for next task). Task 1 (waist-up) requires the patient to alternately “grab, lift, move and place” three 1000 g containers located on waist level and 25 cm above waist level shelves, using their affected arm, at a metronome pace of 60 beats per minute for 300 s or until they felt unable to continue. The time to complete Task 1 is measured using a stopwatch. Task 2 (eye down) is identical to Task 1 except that the two shelves are placed at eye-level and 25 cm below. Task 3 (overhead work) requires a patient to repeatedly screw and unscrew bolts in a sagittal plane oriented plate</p>

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	positioned at eye-level using both arms". More complete description at <a href="https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol_April2007.pdf">https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol_April2007.pdf</a>
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# PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	1
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
<b>METHODS</b>			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	3
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	4
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	3-4
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3-4
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	4
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	4
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	5
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	NA
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., $I^2$ ) for each meta-analysis.	NA



# PRISMA 2009 Checklist

Page 1 of 2

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	NA
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	NA
<b>RESULTS</b>			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	6-7
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICCO, follow-up period) and provide the citations.	6-7
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	6-10
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	6-10
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	6-10
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6-10
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	NA
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	11-13
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	14-16
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	16
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	18

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From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

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# BMJ Open

## Systematic Review of the Measurement Properties of Performance-based Functional Tests in Patients with Neck Disorders

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031242.R2
Article Type:	Original research
Date Submitted by the Author:	08-Oct-2019
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<b>Primary Subject Heading</b>:	Rehabilitation medicine
Secondary Subject Heading:	Rehabilitation medicine
Keywords:	functional, psychometric properties, neck pain, cervical, outcome measures

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3 1 **Title:** Systematic Review of the Measurement Properties of Performance-based Functional  
4 Tests in Patients with Neck Disorders

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50  
51 **Key Words:** functional, psychometric properties, neck, cervical, outcome measures

52  
53 **Word Count:** 4509

## 61 Abstract

62 **Objectives:** The purpose of this systematic review is to identify and synthesize studies evaluating  
63 performance-based functional outcome measures designed to evaluate the functional abilities of  
64 patients with neck pain.

65 **Design:** Systematic review

66 **Data Sources:** A literature search using PubMed, Scopus, CINAHL, EMBASE, COCHRANE,  
67 Google Scholar, and a citation mapping strategy was conducted till July 2019

68 **Eligibility criteria:** More than half of the study's patient population had neck pain or a  
69 musculoskeletal neck disorder and completed a functional-based test. Clinimetric properties of at  
70 least one performance-based functional tests were reported. Both traumatic and non-traumatic  
71 origins of neck pain were considered.

72 **Data extraction and synthesis:** Relevant data were then extracted from selected articles using an  
73 extraction guide. Selected articles were appraised using the Quality Appraisal for Clinical  
74 Measurement Research Reports Evaluation Form (QACMRR).

75 **Results:** The search obtained 12 articles which reported on 4 outcome measures (Functional  
76 Capacity Evaluations (FCE), Baltimore Therapeutic Equipment Work Simulator II (BTEWS II),  
77 Functional Impairment Test- Hand and Neck/Shoulder/Arm (FIT-HaNSA)) and a physiotherapy  
78 test package, to assess the functional abilities in patients with mechanical neck pain. Of the selected  
79 papers: 1 reports content validity, 5 construct validity, 4 reliability, 1 sensitivity to change, and 1  
80 both reliability and construct validity. QACMRR scores ranged from 68% to 95%.

81 **Conclusions:** This review found very good quality evidence that the FIT-HaNSA has  
82 excellent inter and intra-rater reliability and very weak to weak convergent validity. Excellent  
83 quality evidence of fair test-retest reliability, weak convergent validity, and very weak known

84 groups validity for the BTEWS II test was found. Good to excellent quality evidence exists that an  
85 FCE battery has poor to excellent reliability and very weak to strong validity. Good to excellent  
86 quality of weak to strong validity and trivial to strong effect sizes were found for a physiotherapy  
87 test package.

88 **Prospero registration:** CRD42018112358

### 91 **Strengths and limitations of this study**

- 92 • The psychometric properties of performance outcome measures for neck pain were  
93 synthesized and critically appraised
- 94 • This study assessed the risk of bias and the quality of measurements properties
- 95 • The feasibility or usability of these tools was not assessed

### 97 **Introduction**

98 Neck pain has been associated with high disability and is regarded as a substantial societal  
99 burden.[1] Approximately 70% of people experience neck pain within their lifetime and about 33%  
100 of adults experience neck pain every year.[2,3] Further concern is warranted as it has been  
101 suggested that the incidence of neck pain is increasing.[4–6] The economic burden due to neck  
102 disorders is high, including lost wages, costs of treatment, and compensation expenditures to  
103 injured people.[7,8] Neck pain is second only to low back pain in annual workers' compensation  
104 costs in the United States and has been associated with many other comorbidities such as  
105 headaches, anxiety, depression, back pain and arthralgias.[6,9,10]

1  
2  
3 106 Outcome measures are a crucial component in monitoring patients with neck pain to  
4  
5 107 determine the effects of treatment[11,12], evaluation of interventions, guiding return to work, and  
6  
7  
8 108 justifying treatment.[13,14] Several self-reported outcome measures currently exist to assess  
9  
10 109 disability and function in those with neck pain (e.g. the Neck Disability Index - NDI). [13]  
11  
12 110 Evidence-based clinical practice guidelines suggest that measures assessing physical performance  
13  
14 111 should also be used for people with neck pain.[15] Performance-based testing is where the  
15  
16 112 assessment is based on actual performance of a task or activity. Physical performance can be  
17  
18 113 assessed by testing a person's ability to execute a standardized activity in a standardized  
19  
20 114 environment (i.e. clinical setting).[16] Time to complete the activity, number of repetitions  
21  
22 115 performed, and weight lifted are frequently used to quantify the physical performance.[17]  
23  
24 116 Conversely, self-report measures examine patients' perception and experience of their ability to  
25  
26 117 perform functional tasks. [16] Previous research has demonstrated poor to fair relationships  
27  
28 118 between physical performance and self-report measures of ability in patients with various  
29  
30 119 musculoskeletal disorders suggesting that these measures assess different constructs of function.  
31  
32 120 [17,18] Consequently, physical performance tests and self-report measures complement each other  
33  
34 121 and may each contribute unique information about a patient's function. [19]  
35  
36  
37  
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39

40 122 A fundamental component of monitoring outcomes is having reliable and valid tools with  
41  
42 123 known measurement properties.[13,20] While recent research has investigated the psychometric  
43  
44 124 properties of patient-reported outcomes in people with neck pain [13,21] there is a gap in  
45  
46 125 knowledge with respect to performance-based functional outcomes. The purpose of this systematic  
47  
48 126 review was to identify and synthesize clinical measurement studies that evaluate measurement  
49  
50 127 properties of performance-based functional tests in patients with neck disorders.  
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## 129 **METHODS**

### 130 **Patient and Public Involvement**

131 There was no patient or public involvement in the design or planning of this study.

132

### 133 **Study Design and Protocol Registration**

134 We conducted a systematic review to evaluate the psychometric properties of performance-  
135 based functional tests for people with mechanical neck disorders. The protocol was registered in  
136 PROSPERO register with registration number CRD42018112358.

137

### 138 **Search Strategy**

139 A database search using CINAHL, PubMed, Scopus and Google Scholar was performed  
140 to identify articles published till July 2019. The following search strategy was used to search all  
141 databases for eligible studies: (Reliability OR validity OR responsiveness OR calibration OR  
142 validation) OR (minimal detectable change) OR (clinically important difference) OR  
143 (psychometric properties) AND cervical OR neck OR c-spine AND (performance measure) OR  
144 (functional test) OR (functional outcome) OR (performance outcome). MeSH terms were searched  
145 in PubMed. A citation map of articles and systematic reviews selected for the full-text review was  
146 performed. This strategy was included to minimize the risk of publication bias. The full search  
147 strategy is summarized in **APPENDIX 1**. The Preferred Reporting Items for Systematic Reviews  
148 and Meta-Analyses (PRISMA) process[22] was followed to ensure all appropriate steps were taken  
149 in the selection process (**FIGURE 1**).

150

### 151 **Inclusion Criteria**

1  
2  
3 152 Articles were included in the final review if all of the following criteria were met:

- 4  
5 153
- 6 • >50% of the study's patient population had neck pain or a musculoskeletal neck disorder
  - 7 (e.g. whiplash associated disorder (WAD II))
  - 8 154
  - 9 155 • Patients in the study completed a functional-based test
  - 10 156 • Clinometric properties of at least one performance-based test were reported.

11  
12  
13  
14  
15 157 A test was considered functional-based if it met the following criteria:

- 16  
17 158
- 18 • assessment of a patient's ability to execute a standardized activity in a standardized
  - 19 159 environment
  - 20 160 • tests assessing muscular endurance (e.g. cervical flexion test) or proprioception were not
  - 21 161 deemed functional-based as they are often not reflective of physical working conditions.

22  
23  
24 162 Both traumatic and non-traumatic origins of neck pain were considered. Definitions for the  
25 163 properties can be found in **APPENDIX A**.

26  
27  
28  
29  
30  
31 164

### 32 33 165 **Article Selection**

34  
35 166 Titles and abstracts generated by the search strategy were screened by two authors (SM  
36 167 and PB) independently. Articles that met the inclusion criteria and selected for a full text review  
37 168 were also reviewed in pairs of authors. Disagreements were resolved by the most experienced  
38 169 author (JCM)

39  
40  
41  
42  
43  
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45 170

### 46 47 171 **Data Extraction**

48  
49 172 Data extraction and critical appraisal was performed in pairs of two raters among the authors, after  
50 173 the completion of a calibration session in which the most experienced author (JCM) reviewed the  
51 174 data extraction tools with the authors that performed the data extraction. When reviewers disagreed



1  
2  
3 175 during data extraction and/or critical appraisal, and consensus could not be met, a third author  
4  
5 176 arbitrated. A data extraction form [23] (**APPENDIX A and APPENDIX B**), developed by one of  
6  
7  
8 177 the authors (JCM.), was used to ensure systematicity. Authors extracted sample size, patient  
9  
10 178 population characteristics, functional tests performed and reported psychometric properties. The  
11  
12 179 interpretation of ICC was as follows:  $ICC < 0.50$  indicating poor,  $0.50 \leq ICC < 0.75$  indicating  
13  
14 180 moderate,  $0.75 \leq ICC < 0.9$  indicating good, and  $ICC \geq 0.9$  indicating excellent reliability were used  
15  
16 181 as a common benchmark. [24] For validity estimates, correlation coefficient (Pearson's/Spearman)  
17  
18 182 and the 95% confidence intervals were extracted if were available. [23,25] Evan's guidelines to  
19  
20 183 interpret the strength of the correlation was used which included: 0.00–0.19 “very weak”, 0.20–  
21  
22 184 0.39 “weak”, 0.40–0.59 “moderate”, 0.60–0.79 “strong”, and 0.80–1.00 “very strong”. [26] To  
23  
24 185 assist clinical decision making, standard benchmark scores of trivial ( $< 0.20$ ), small ( $\geq 0.20$  to  $<$   
25  
26 186 0.50), moderate ( $\geq 0.50$  to  $< 0.80$ ) or large ( $\geq 0.80$ ), as proposed by Cohen, were used. [27] For  
27  
28 187 studies assessing construct validity specifically, results in accordance with pre-defined hypotheses  
29  
30  
31 188 were evaluated to interpret the findings.  
32  
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### 191 **Quality Appraisal for Clinical Measurement Research Reports Evaluation Form**

192 Pairs of authors critically appraised the quality of each study using a standardized 12-item  
193 evaluation tool (QACMRR) designed to assess the quality of studies determining measurement  
194 properties in outcome measures (**APPENDIX C**). If disagreement was present a third person (JM)  
195 assist in resolving the discrepancy. [23] This tool has been found to have moderate to excellent  
196 pre-consensus inter-rater reliability ( $ICC: 0.69-0.91$ ,  $\kappa = 0.62-1.00$ ) across a number of systematic  
197 reviews.[23,25,28] The evaluation criteria of this tool included twelve items: 1) Thorough

1  
2  
3 198 literature review to define the research question; 2) Specific inclusion/exclusion criteria; 3)  
4  
5 199 Specific hypotheses; 4) Appropriate scope of psychometric properties; 5) Sample size; 6) Follow-  
6  
7  
8 200 up; 7) The authors referenced specific procedures for administration, scoring, and interpretation of  
9  
10 201 procedures; 8) Measurement techniques were standardized; 9) Data were presented for each  
11  
12 202 hypothesis; 10) Appropriate statistics-point estimates; 11) Appropriate statistical error estimates;  
13  
14 203 and 12) Valid conclusions and recommendations. [23,25] Each item is scored from 0 to 2 with  
15  
16 204 (score=2) is the best; (score=1) is acceptable but suboptimal; (score=0) is not done/documentated,  
17  
18 205 substantially inadequate or inappropriate. An article's total score – quality - was calculated by the  
19  
20 206 sum of scores for each item, divided by the numbers of items and multiplied by 100%. [23,25]  
21  
22 207 Overall, the quality summary of appraised articles ranges from (0%-30%) Poor, (31%-50%) Fair,  
23  
24 208 (51%-70%) Good, (71%-90%) Very Good, and (>90%) Excellent  
25  
26  
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32

## 33 211 RESULTS

34  
35 212 The search strategy resulted in 840 published articles. After duplications were removed, 31  
36  
37 213 articles were deemed relevant and were screened at full text. Overall, 12 articles met our inclusion  
38  
39 214 criteria (**FIGURE 1**). The excluded articles were removed due to inappropriate patient  
40  
41 215 populations, investigations into self-report measures or tests assessing proprioception/muscular  
42  
43 216 endurance rather than functional-based measures, or because the articles were found to be  
44  
45 217 systematic reviews. The characteristics of the included studies and the summary of psychometric  
46  
47 218 properties are presented in **TABLE 1**. The quality assessment is summarized and presented in  
48  
49 219 **TABLE 2**. Percent agreement was calculated for quality scores between the 2 raters and it was  
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51  
52 220 90%.  
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221

## 222 **Participants**

223 Participants in the selected articles had various types of neck pain including subacute,  
224 chronic, and whiplash-associated disorder. The mean/median age of the samples of each study  
225 ranged from 30 to 48 years of age. The proportion of females in each article ranged from 34-78%  
226 of the study population. Two studies that had a mixed sample of subjects with various spinal pain  
227 did not report the demographics of the neck pain portion of their sample. One study did not contain  
228 any subjects and performed a review of epidemiological literature to establish content validity for  
229 work-related neck disorders **TABLE 1**.

230

## 231 **Functional-Based Tests**

232 The 12 articles that were included for review provided properties on the following  
233 functional based tests: Functional Capacity Evaluations (FCE)[29–34], The Baltimore Therapeutic  
234 Equipment Work Simulator II (BTEWS II) [35], Functional Impairment Test- Hand and  
235 Neck/Shoulder/Arm (FIT-HaNSA) [36], as well as items off of a physiotherapy test package  
236 including a cervical and lumbar Progressive Isoinertial Lifting Evaluation (PILE-C, PILE-L) test  
237 [37–40] and 2 x 20 m with burden walking test (2x20M-WWB) [37–40]. Descriptions of all  
238 functional-based tests and their relevant subtasks are provided in **APPENDIX D**.

239

## 240 **Functional Capacity Evaluations (FCE)**

241 Six articles reported measurement properties for an FCE battery. We identified multiple  
242 versions of the FCE in the literature with one article reporting properties on the Workwell FCE  
243 [30], two reporting on the Whiplash Associated Disorder (WAD) FCE [29,31] and three reporting

244 on the neck-FCE.[32–34] These test batteries include various combinations of muscular strength,  
245 endurance and functional based tests. The measurement properties of the functional based tests  
246 used by the FCE are outlined in **TABLE 3**.

247

### 248 *Individuals with Sub-acute to chronic WAD*

249 Trippolini et al. (2014)[30] evaluated the Workwell FCE test-retest reliability,  
250 measurement error, convergent validity and predictive criterion validity of future work capacity in  
251 workers diagnosed with WAD I or II. Interclass Correlation Coefficients (ICC) ranged from 0.66  
252 to 0.96 (moderate to excellent). Limits of agreement relative to mean performance ranged from 21  
253 to 57% for functional based sub-tests. Correlations between FCE sub scores and baseline work  
254 capacity were very weak to weak ranging between  $r=0.06$  and  $r=0.39$ . FCE sub scores did not  
255 predict future work capacity at 1, 3, 6 and 12 months.

256 Trippolini et al. (2015)[29] assessed the WAD FCE (31) and evaluated convergent validity  
257 and known-groups validity. FCE subscales showed very weak to strong correlations (0.15-0.68)  
258 with each of: pain, self-reported functional ability, self-reported disability, anxiety and depression.  
259 It was found that the FCE had known-group sex validity (males vs females) for 1 of 3 functional  
260 subtests (lifting waist-overhead) and reported significant performance differences between culture  
261 groups (German vs non-German language groups). To test construct validity, 29 a priori  
262 formulated hypotheses were tested, 4 related to gender differences, 20 related associations with  
263 other constructs, 5 related to cultural differences. In total 23 out of 29 hypotheses were confirmed  
264 (79 %).

265

### 266 *Work-Related Neck Disorders*

1  
2  
3 267 Reesink et al. (2007)[34] developed an independent FCE for patients with musculoskeletal  
4  
5 268 neck disorders (neck FCE). They performed a review of epidemiological literature and identified  
6  
7  
8 269 four physical risk factors for work-related neck disorders and used that information to develop an  
9  
10 270 FCE consisting of eight functional-based tests. Content validity was established by following  
11  
12 271 operational definitions of the risk factors when searching the literature and using current literature  
13  
14  
15 272 to provide a rationale to guide their development of the tasks comprising the FCE.  
16  
17 273

### 19 274 *Chronic Neck Pain*

21 275 Reneman et al. (2017)[32] measured test-retest reliability of the subscales of the neck FCE  
22  
23 276 in patients with multifactorial neck pain. Test-retest ICC's ranged from poor to excellent (0.39-  
24  
25 277 0.96). Limits of agreement relative to mean performance range from 32.0% to 56.5% for functional  
26  
27 278 based sub tests. Convergent validity was performed against the Neck Disability Index (NDI) items  
28  
29 279 and total score.[33] The authors found weak to strong Pearson correlations (0.39-0.70) for the FCE  
30  
31 280 sub scores to both NDI individual items and the NDI total score.  
32  
33 281

### 37 282 **The Baltimore Therapeutic Equipment Work Simulator II (BTEWS II)**

#### 39 283 *Chronic Neck Pain*

41 284 Lomond and Côté, (2011)[35] reported on the reliability, measurement error, minimum  
42  
43 285 detectable change (MDC) and validity of the power output (PO) task during the BTEWS II test in  
44  
45 286 patients with chronic neck and shoulder pain (**TABLE 4**). Test-retest reliability, measured with  
46  
47 287 Spearman Rank correlations and ICC's was moderate and measured at  $\rho=0.37$  and  $ICC_{2,1} = 0.54$ ,  
48  
49 288 respectively. The standard error of measurement (SEM) and the minimal detectable change at 90%  
50  
51 289 confidence ( $MDC_{90}$ ) for the PO task were measured as 30.25 and 70.59, respectively. Weak  
52  
53  
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1  
2  
3 290 Spearman Rank correlations between the PO task and the NDI, Shoulder Pain and Disability Index  
4  
5 291 (SPADI) and Numeric Rating Scale (NRS) for pain tests were recorded. There were no significant  
6  
7  
8 292 performance differences between control and pain groups for the PO task.  
9

293

## 294 **Functional Impairment Test- Hand and Neck/Shoulder/Arm (Fit-HaNSA)**

### 295 *Sub-acute to chronic WAD*

16  
17 296 Pierrynowski et al. (2016)[36] reported on the reliability, measurement error, MDC and  
18  
19 297 validity of the Fit-HaNSA test in a sample of people with WAD II following motor vehicle  
20  
21 298 collision (MVC) (**TABLE 5**). Intra-rater reliability ICC's for patient subtask and total scores were  
22  
23 299 moderate to good ranging between 0.70-0.78. [36] Inter-rater reliability ICC's for patient subtask  
24  
25 300 and total scores were moderate to good and ranged between 0.54-0.84. [36] The Bland and Altman  
26  
27 301 plot for the patient group showed a 26 seconds (s) bias in terms of improved performance on the  
28  
29 302 second test (possible learning effect). The standard deviation of difference was 124 s and 95%  
30  
31 303 Limits of Agreement (LoA<sub>95</sub>) was 248 seconds. [36] The SEM for people with WAD II was  
32  
33 304 reported to be 76 s. The MDC<sub>90</sub> was measured as 176 s. [36]

34  
35 305 Spearman rank correlations were also calculated between the Fit-HANSA, Numeric Pain  
36  
37 306 Rating Scale (NPRS), NDI, the disabilities of arm, hand and shoulder (DASH) and 6 cervical range  
38  
39 307 of motion measures. Most (59 of 78) of the correlations between performance and comparator  
40  
41 308 measures were very weak to weak ( $r < 0.4$ ). [36] All correlations between total Fit-HaNSA scores  
42  
43 309 and subtask scores had good correlations ( $r < 0.75$ ), except for Task 1-Task 3. [36] Significant  
44  
45 310 performance differences between WAD II and control groups (known group validity) were  
46  
47 311 recorded for the total Fit-HaNSA score and all 3 subtask scores. [36]  
48  
49  
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312

### 313 **Physiotherapy Test Package Subtests**

314 Ljungquist et al. published a series of articles[37–40] which evaluated the clinimetric  
315 properties of a physiotherapy test package for patients with spinal pain (**TABLE 6**). This  
316 package included muscular strength & endurance tests, submaximal endurance tests, and three  
317 functional tests. These functional tests included the PILE-C, PILE-L, and 2x20M-WWB test.  
318 Ljungquist’s series of articles reported on convergent validity, known-groups validity, reliability,  
319 measurement error and sensitivity to change for these tests. [37–40]

320

### 321 *Undetermined duration of neck pain*

322 In a 1999 article [39], correlations between the tests of the package and pain (CR-10) and  
323 perceived exertion (Borg RPE) were determined. All correlations were very weak to moderate  
324 (0.10-0.48) except for moderate to strong correlations (0.55-0.65) between the PILE-C test and  
325 pain intensity and between 2x20M-WWB test and pain intensity.

326 In a 2003 article[37], the PILE-C, PILE-L and 2x20M-WWB tests were tested to determine their  
327 ability to discriminate between known-groups (neck pain vs back pain). Subjects with spinal pain  
328 completed the CR-10, the University of Alabama Pain Behavior scale (UAB) and the Borg RPE  
329 test. Specific cut points were used to distinguish patients with high vs. low pain intensity, high  
330 vs. low pain behavior, and high vs. low perceived exertion in patients, respectively. Participants  
331 then completed the test package and it was determined if each subtest could discriminate  
332 between participants with high vs. low pain intensity. The PILE-C and the 2x20M-WWB tests  
333 were hypothesized to be more difficult for persons with neck pain and the PILE-L was  
334 hypothesized to be more difficult for persons with back pain. Subjects with neck pain performed  
335 worse on the PILE-C test compared to those with back pain. Subjects with back pain did not

336 perform worse than those with neck pain on the PILE-L test and subjects with back pain  
337 performed worse on the 2x20M-WWB test.

338 The functional tests were able to discriminate between all 3 subgroups with the exception of the  
339 PILE-C being unable to discriminate between participants with high vs. low perceived exertion.

340 In a paper from 1999[39], the PILE-C, PILE-L and 2x20M-WWB tests were found to have  
341 significant discriminative abilities in distinguishing healthy subjects from patients with spinal pain.  
342 The sensitivity and specificity for this known group discrimination for the PILE-C test, were  
343 reported to be 0.93 (very strong) and 0.69 (strong), respectively. The sensitivity and specificity for  
344 the PILE-L test were reported to be 0.85 (very strong) and 0.65 (strong), respectively.

345 The inter and intra rater reliability were tested on participants with spinal pain.[38] Limits  
346 of agreement were used to measure inter rater reliability and repeatability, defined as 2x the within-  
347 subject standard deviation of each variable. Interrater agreement for 2 tests was deemed  
348 “acceptable”, while all 3 functional tests had “clinically acceptable” intra-rater reliability.

349 Sensitivity-to-change was evaluated in the test package following 6 months of a  
350 physiotherapy intervention. Using ROC curves, Wilcoxon sign ranked tests and spearman  
351 correlation coefficients, only the 2x20m-WWB test and the PILE-C (women only) were deemed  
352 to be sensitive to change. [40] Additionally, moderate to large effect sizes were found for all test  
353 components.

354

## 355 **DISCUSSION**

356 This study synthesized 12 studies assessing clinometric properties of 4 different functional-  
357 based assessments. Given the limited number of studies, the substantial variation in the types of  
358 tests examined, the methods used to assess the clinical measurement properties, and the study



1  
2  
3 359 populations, the current state of knowledge does not allow firm conclusions regarding  
4  
5 360 recommendations for an optimal functional-based test at this time. Overall, the quality ranging  
6  
7  
8 361 from good to excellent (67-92%) as determined by the QACMRR, for a range of properties of the  
9  
10 362 4 different assessments in patients with acute or chronic neck pain that is musculoskeletal in origin.  
11  
12 363 Studies obtaining higher percentages indicate research that has been consistent with best practice  
13  
14 364 where studies with lower percentages are more likely to be inadequate or inappropriate

### 17 365 **FCE**

19 366 The breadth of a functional-based test is variable and defined by the developers. An  
20  
21 367 advantage of the functional assessment designed by Reesink et al.[34] is that they mapped the  
22  
23 368 eight subtests to risk factors identified in the literature for work-related neck disorders. The eight  
24  
25 369 subtests consist of: material handling tasks, lifting floor to waist, overhead lift test, one-handed  
26  
27 370 and two-handed carrying, overhead working, repetitive reaching, overhead lifting, and repetitive  
28  
29 371 bending and overhead reaching. Given the systematic approach and rationale these authors used  
30  
31 372 in developing the FCE and this approach being used in previous research [41], we suggest that  
32  
33 373 this test has strong content validity.

37 374 Six articles address the clinical measurement properties of this FCE ranging from good to  
38  
39 375 excellent quality (67-92%). There was evidence that the FCE was stable over test-retest time of  
40  
41 376 7-14 days. [31,32] These measures demonstrate longer stability over time compared to self-report  
42  
43 377 measures such as the Neck Disability Index (NDI) which has demonstrated test-retest reliability  
44  
45 378 within only a short period of 0-3 days. [28] Whether this longer-term stability is a characteristic of  
46  
47 379 functional-based tests or reflects differences in study populations in context requires further  
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49 380 testing. These two studies had relatively lower quality scores on the QACMRR (67-75%)  
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51 381 compared to other studies in this review putting into question test-retest time. Although test-retest  
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3 382 reliability has been assessed, inter-rater and intra-rater reliability has yet to be researched. Unlike  
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5 383 self-report measures, we expect measurement error due to the evaluator and functional-based tests.  
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8 384 Thus, future research should explore these aspects of reliability.  
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10 385 Convergent validity is often examined in clinical measurement studies. We suggest that  
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12 386 this may be because these comparisons are easily performed by correlating different tests rather  
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14 387 than providing strong confidence in the validity of the measurement. Often convenient  
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16 388 comparisons are performed rather than those most relevant. Across many domains and measures  
17  
18 389 it has become clear that the relationship between self-reported function and performance-based  
19  
20 390 function or physical impairment is often very weak to moderate. Therefore, the value of assessment  
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22 391 of these relationships as a form of validation has limited value. Several studies of very good to  
23  
24 392 excellent quality have reported on the convergent validity of the FCE. [29,30,33] The highest  
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26 393 quality article determined by the QACMRR (92%) found the relationship between the FCE and  
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28 394 work capacity to be poorly associated with one another. [30] The same study found that the ability  
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30 395 of the FCE to predict future work capacity was poor. This may be considered a more important  
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32 396 comparison since ideally functional-based tests would relate to important outcomes like return to  
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34 397 work. No studies to our knowledge report the responsiveness or sensitivity to change of the FCE.  
35  
36 398 This is an important gap since the focus of rehabilitation is often to remediate limitations in goal  
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38 399 impairments or work capacity, and assessment of these changes is critical to clinical decision-  
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40 400 making and reporting outcomes. Thus, future research should evaluate the responsiveness of the  
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42 401 FCE to provide insight in the measure's ability to detect change after an intervention.  
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#### 49 402 **FIT-HaNSA**

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51 403 One study of very good quality (88%) assessed the FIT-HaNSA, a test consisting of two  
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53 404 reaching tasks (waist and eye-level) and sustained overhead task performance. [36] Overall, the  
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3 405 FIT-HaNSA demonstrated excellent inter-rater reliability (0.84) and intra-rater reliability (0.78).  
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5 406 The specific subtests included within the FIT-HaNSA similarly demonstrate fair to excellent (0.54-  
6  
7 407 0.80) and good (0.70-0.72) inter-rater and intra-rater reliability respectively. The FIT-HaNSA also  
8  
9 408 demonstrated a clear ability to distinguish between people with WAD 2 and healthy controls.  
10  
11 409 Correlations between the FIT-HaNSA and other patient self-report disability and functional  
12  
13 410 outcome measures (NPRS, NDI, DASH, CROM and FIT-HaNSA) were generally very weak to  
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15 411 weak ( $\rho < 0.4$ ), consistent with other studies comparing performance and self-report. [17,18] The  
16  
17 412 largest limitation in critically synthesizing information for this test is that only a single study was  
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19 413 found that reported the measurement properties for people with neck disorders. It should be noted  
20  
21 414 however that it has been validated in other MSK disorders. [35,41] Although others have noted  
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23 415 the lag in development of functional-based measures in comparison to self-report measures, FIT-  
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25 416 HaNSA was recommended as a functional-based measure for people with shoulder disorders. [42]  
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27 417 Further research is necessary to investigate the responsiveness of the FIT-HaNSA.  
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## 33 418 **BTEWS II**

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35 419 Another study of very good quality (88%) assessed the efficacy of the BTEWS II where  
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37 420 the participants performed a dynamic pushing and pulling task in which power output was recorded  
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39 421 over a 10 second sample.[35] While the convergent validity aspect of this paper was assessed as  
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41 422 consistent with best practice through the critical appraisal process, the relationship between the  
42  
43 423 power output on the BTEWS and measures of pain and disability (NDI, SPADI, NRS) were poorly  
44  
45 424 associated with each other. In addition, the power output component was not found to be  
46  
47 425 significantly different between people with neck pain and healthy controls which suggests it might  
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49 426 not be discriminative. Discrimination between patients and healthy controls is a low standard for  
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51 427 an outcome measure, and tests that cannot fulfil this benchmark should be viewed with caution.  
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3 428 Because of the weak measurement properties demonstrated by the power output component of the  
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5 429 BTEWS II, it does not appear to be a desirable functional-based measure to assess function in  
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8 430 people with neck pain. However, we acknowledge for all of the functional-based tests the evidence  
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10 431 pool is so shallow that there is high potential that future studies might lead to different conclusions.  
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12 432 Future research should also investigate the reliability and responsiveness of the BTEWS II.

### 14 433 **Physiotherapy Test Package Subtests**

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17 434 Four studies ranging from good to very good quality (68-82%) assessed relevant items  
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19 435 from a physiotherapy test package, including a lift from floor-to-waist and a waist-to-shoulder task  
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21 436 and a two-handed carrying task. The properties of these assessment items include weak to  
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23 437 moderate correlations to pain, perceived exertion, and had “fair to good” reliability. The 2x20m-  
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25 438 WWB and PILE-C tests were found to be sensitive-to-change which is valuable information as no  
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28 439 other study has assessed this property in functional-based measures in patients with neck disorders.  
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30 440 Thus, this measure may be of value in clinical settings when assessing functional capacity before  
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32 441 and after a treatment intervention. All tests had discriminative ability for detecting participants  
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34 442 with spinal pain vs healthy controls. Most of the three tests demonstrated poor construct validity  
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36  
37 443 in that they were poorly related to pain and perceived exertion and the results were not in  
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39 444 accordance with pre-defined hypotheses. Thus, further research is necessary to investigate these  
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41 445 constructs. Three of the four results from the studies assessing the physiotherapy test package had  
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43 446 a mixed sample of patients with various pain sites including back pain. While the majority of each  
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45 447 cohort in these studies had neck pain, careful consideration should be taken to apply these tests to  
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47 448 a neck pain specific population.

### 51 449 **Clinical Implications**

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3 450 This study confirms that functional-based tests have had far less development and  
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5 451 evaluation than self-report measures. Limitations include the number of tests and insufficient body  
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7 452 of evidence to make confident recommendations with respect to functional-based testing. It is clear  
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9 453 that self-report and functional-based measures provide different perspectives. Theoretically,  
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11 454 functional-based tests are important to inform our understanding about the mechanisms of  
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13 455 intervention and how interventions increase capacity. Future research may benefit by also  
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15 456 comparing results from a functional-based measure to work capacity to when assessing construct  
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17 457 validity. Overall more work is required to further establish the psychometric properties of  
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19 458 functional-based tests in persons with neck disorders, including sensitivity-to-change,  
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21 459 responsiveness, and predictive validity.  
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26 460 The FCE evaluated patients with neck pain of varying origin including WAD, work-related  
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28 461 neck disorders, and chronic idiopathic neck pain. The BTEWs II evaluated functional capacity in  
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30 462 patients with chronic neck pain, the FIT-HaNSA evaluated patients with WAD, and the  
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32 463 physiotherapy test package did not specify the origin of musculoskeletal neck pain in their cohort.  
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34 464 Thus, specific functional-based measures may be more applicable depending on the origin of the  
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36 465 musculoskeletal neck pain being assessed.  
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40 466 The data presented suggest that the FIT-HaNSA has the strongest clinometric properties  
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42 467 though this is based on a single higher quality paper specific to neck disorder. [36] Importantly,  
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44 468 normative data have been published [43], it has been validated in multiple studies in patients with  
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46 469 shoulder conditions [44–46] and has been recommended when compared to other measures [42].  
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48 470 The FCE has a limited evidence base from which to draw, though it was developed with strong  
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50 471 content validity and further evaluation may demonstrate its usefulness.  
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## 54 472 **Limitations**

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3 473 A challenge in synthesizing clinical measurement evidence is the wide range of properties  
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5 474 and indicators that need to be considered. Unlike effectiveness studies where one can focus on the  
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8 475 effect size of treatment there are many considerations that would affect the recommendations made  
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10 476 about outcome measures. This is further complicated when the pool of evidence is shallow.  
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12 477 Although the quality assessment tool (QACMRR) developed by one of the authors of this review  
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14 478 which assess the quality of design of individual studies were useful for interpreting the evidentiary  
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17 479 pool, there is no clear method to synthesize the extracted clinical measurement evidence. While  
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19 480 some systematic reviews on treatment might only report findings from high-quality studies, it is  
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21 481 important to see how outcome measures perform in different contexts. Further, the assessment of  
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23 482 quality is complicated given that clinical measurement studies have so many dimensions.  
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26 483 Therefore, exclusion of lower quality studies has questionable value. Thus, a more practical  
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28 484 approach is to consider quality when interpreting the findings, rather than excluding studies.

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31 485 The QACMRR focuses on whether the authors made appropriate decisions in selecting the  
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33 486 scope and methods of their clinical measurement evaluations within a given study and provides  
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35 487 descriptors of poor fair or good design options. Quality focuses on issues that might affect risk of  
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38 488 bias or imprecision in estimates; whereas risk of bias assessments focusses on items that might  
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40 489 result in a biased estimate. For example, insufficient power is a precision (quality) issue, not a risk  
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42 490 of bias. Although it is difficult to interpret the meaning of the percentage of the QACMRR as there  
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44 491 are no established cut-offs for distinguishing good and poor-quality studies, it provides one way  
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47 492 of ranking the articles in order of quality. We did not use COSMIN checklist since it was developed  
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49 493 for PROMS and some of the components/steps that involved are not applicable to performance-  
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51 494 based tests.

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3 495 Another limitation in this review was that the feasibility or usability of these tools was not  
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5 496 assessed. While feasibility was not the focus of this review, information on the practical  
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7 497 application of these functional-based measures provides valuable information to clinicians for  
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9 498 determining whether these tests are appropriate to use in their given setting. Thus, future research  
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11 499 should not only investigate further the psychometric properties of these tools, but also report the  
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13 500 feasibility of using these tests so that they may be used in clinical settings and to identify  
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15 501 limitations that restrict their application in practice.  
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## 21 503 **CONCLUSION**

24 504 This review found very good quality evidence that the FIT-HaNSA has excellent inter and  
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26 505 intra-rater reliability and very weak to weak convergent validity. Excellent quality evidence of fair  
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28 506 test-retest reliability, weak convergent validity, and very weak known groups validity for the  
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30 507 BTEWS II test was found. Good to excellent quality evidence exists that an FCE battery has poor  
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32 508 to excellent reliability and very weak to strong validity. Good to excellent quality of weak to strong  
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34 509 validity and trivial to strong effect sizes were found for a physiotherapy test package. Functional-  
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36 510 based evaluation in people with neck disorders is an area needing much research attention both to  
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38 511 establish the measurement properties of existing measures, potentially to develop innovative new  
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40 512 measures and to perform head-to-head comparisons of measures before an optimal functional-  
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42 513 based test can be identified.  
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## 49 515 **Authors' contributions**

51 516 SM contributed significantly to conception and design of the study, data extraction, critical  
52  
53 517 appraisal, interpretation of data and drafting of the manuscript. TS, TA, PB, and CC were involved  
54  
55 518 in literature search, critical appraisal and interpretation of data and drafting. AG was involved in  
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3 519 critical appraisal and drafting. JM was also involved in the conception and design of the study,  
4 520 drafting, and revised the manuscript for important intellectual content. PB and CATWAD were  
5 521 involved in the drafting and review of the manuscript. All authors have given their final approval  
6 522 on the manuscript to be published  
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## 11 524 **Declarations**

### 12 525 **Ethics approval and consent to participate**

13 526 Not applicable

14 527

### 15 528 **Consent for publication**

16 529 Not applicable

17 530

### 18 531 **Availability of data and material**

19 532 Data sharing is not applicable to this article as no datasets were generated or analyzed during the  
20 533 current study

21 534

### 22 535 **Funding Statement**

23 536 This work was supported by the Canadian Institutes of Health Research (CIHR) with funding  
24 537 reference number (FRN: SCA-145102).

25 538

### 26 539 **Competing Interest Statement**

27 540 None to report.

28 541

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**TABLE 1.** Summary of Studies Reporting Psychometric Properties of Functional-based Tests in Neck Disorder Patients

Study	Population	Sample Size (n)	Functional Tests	Intervention/Test Interval	Quality
Ljungquist et al. 1999	Neck pain (55%), back pain, multiple pain sites,	53	PILE-C, PILE-L	N/A	Good (68%)
Ljungquist et al. 1999	Neck pain (50%), lumbar pain, thoracic pain, shoulder pain, multiple pain sites,	68	PILE-C, PILE-L, 2 x 20m WWB	8 days	Very Good (79%)
Ljungquist et al. 2003	Neck pain, lumbar pain, thoracic pain, shoulder pain, lower extremity pain, multiple pain sites,	235	PILE-C, PILE-L, 2 x 20m WWB	N/A	Very Good (82%)
Ljungquist et al. 2003	cervical pain (25%), lumbar pain, cervical (25%) and lumbar pain, multiple pain sites,	186	PILE-C, PILE-L, 2 x 20m WWB	6 months	Very Good (79%)
Lomond and Cote. 2011	Chronic neck and shoulder pain (100%)	32	BTEWS II	9.5 days	Very Good (88%)
Pierrynowski et al. 2016	Sub-acute and chronic WAD II	66	FIT-HaNSA	2-7 days	Very Good (88%)
Reesink et al. 2007	N/A	N/A	Neck-FCE	N/A	N/A
Reneman et al. 2017	Chronic multifactorial neck pain	18	Neck-FCE	2 weeks	Good (67%)
Trippolini et al. 2013	Sub acute and chronic WAD I and II	32	WAD FCE	7 days	Very Good (75%)
Trippolini et al. 2014	Sub acute and chronic WAD I and II	267	Workwell FCE	N/A	Excellent (92%)



Trippolini et al. 2015	Sub acute and chronic WAD I and II	314	WAD FCE	N/A	Very Good (86%)
Van der Meer et al. 2013	Chronic WAD I and II	40	Neck FCE	N/A	Very Good (86%)

PILE-C, Progressive Isoinertial Lifting Evaluation-Cervical; PILE-L, Progressive Isoinertial Lifting Evaluation; CBT, Cognitive-Behavioural Therapy; PT, Physical Therapy; NRPS, Numeric Pain Rating Scale; BTEWS II, Baltimore Therapeutic Equipment Work Simulator II; WAD, Whiplash Associated Disorder; MVA, Motor Vehicle Accident; FIT-HANSA, Functional Impairment Test-Hand and Neck/Shoulder/Arm; FCE, Functional Capacity Evaluation; EXP, Experimental; M, Male; F, Female; N/A, not applicable

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**TABLE 2.** Quality of Studies on Psychometric Properties of Functional-based Tests Evaluated in Neck Disorder Patients

Study	Item Evaluation Criteria												Total (%)
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	
Trippolini et al, 2014	2	2	2	2	1	2	2	2	2		1	2	92%
Lomond and Cote, 2011	2	2	1	2	0	2	2	2	2		2	2	88%
Pierrynowski et al, 2016	2	2	1	2	0	2	2	2	2		2	2	88%
Trippolini et al, 2015	2	2	2	0	1	N/A	2	2	2		2	2	86%
Van der Meer et al, 2013	2	1	2	1	2	N/A	2	1	2		1	2	86%
Ljungquist et al 2003 KGV**	2	2	2	0	0	N/A	2	2	2		2	2	82%
Ljungquist et al 1999 Rel****	2	1	1	2	0	2	2	2	2		1	2	79%
Ljungquist et al 2003 STC***	1	1	1	2	1	1	2	2	2		2	2	79%
Trippolini et al, 2013	2	2	1	1	0	0	2	2	2		2	2	75%
Ljungquist et al 1999 KGV**	2	1	1	2	0	N/A	2	1	2		1	2	68%
Reneman et al, 2017	1	2	1	1	1	0	1	2	2		2	1	67%
Reesink, 2007*	-	-	-	-	-	-	-	-	-		-	-	N/A

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3 12-item evaluation tool (QACMRR) designed to assess the quality of studies determining measurement properties in outcome  
4 measures. Questions 1-12 in the tool evaluate aspects of study question, study design, measurements, analyses, and study  
5 recommendations.

6 KGV, known-groups validity; rel, reliability; STC, sensitivity-to-change

7 \*Paper is not applicable for completion of study quality tool  
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**TABLE 3.** Psychometric Properties of the Functional Capacity Evaluation

FCE Battery	Type of Properties	Statistical Test	Value	Interpretation
Neck FCE	Test-retest	ICC	0.39-0.96	Poor-excellent
	Measurement Error	Ratio of LoA	32.0-56.5%	
	Convergent Validity	Pearson or Spearman correlation	NDI total: 0.39-0.62 NDI items: 0.03-0.63	Weak to moderate Very weak to strong
WAD FCE	Test-retest Reliability	ICC	0.66-0.96	moderate-excellent
	Convergent Validity	Pearson Correlation	Pain* 0.31-0.39	Weak
			SFS: 0.42-0.61	Moderate-strong
			NDI: 0.34-0.45	Weak-moderate
			HADS-A: 0.27-0.36	Weak
		HADS-D: 0.30-0.41	Weak-moderate	
	Discriminative Validity (German vs Non-German)	Linear Regression Analysis	p<0.001	Significant for All Tasks
	Discriminative Validity (sex)	t-test	p<0.001	Significant for Two tasks
Workwell FCE	Convergent Validity	Pearson or Spearman Correlation	Work Capacity: 0.1-0.3	Very Weak – weak
	Predictive Validity	Pearson or Spearman Correlation	0.06-0.39	Very weak - Weak
		Linear Mixed Model Regression of All Predictors	$\beta=-0.04$ , 95% CI: -0.15 – 0.06 p=0.428 (task 6)	Not Significant

FCE, Functional Capacity Evaluation; ICC, Intraclass correlation coefficient; LoA, Limits of Agreement; NDI, Neck Disability Index; Mod., Moderate; Neg., Negligible; SFS, Spinal Function Sort; HADS-A, Hospital Anxiety and Depression Scale – Anxiety; HADS-D, Hospital Anxiety and Depression Scale – Depression; CI, Confidence Interval Sig., Significant

\*Pain measured via Numeric Rating Scale

**TABLE 4.** Summary of Fit-HaNSA's psychometric properties in neck disorder patients

Test	Type of Property	Statistical Test	Value	Interpretation
Fit-HaNSA	Intra-rater Reliability	ICC	0.78	Good
Fit-HaNSA	Inter-rater Reliability	ICC	0.84	Good
Fit-HaNSA	Measurement Error	SEM	76 s	
		LOA <sub>95</sub>	248 s	
		MDC <sub>90</sub>	176 s	
Fit-HaNSA	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Weak – Strong
Fit-HaNSA	Discriminative WAD II vs Control	F-test	62.6, <p,0.001	Significant
Fit-HaNSA Functional Sub-tasks	Intra-rater reliability	ICC	0.70-0.72	Moderate
	Inter-reliability	ICC	0.54-0.80	Moderate – good
	Convergent Validity	Spearman Rank Correlation	<0.4 - >0.75	Weak - Strong
	Discriminative Validity WAD II vs Control	F-test	42.0-53.3, p<0.001	Significant

Fit-HaNSA, Functional Impairment Test, Hand and Neck/Shoulder/Arm; ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; LOA<sub>95</sub>, 95% Limits of Agreement; MDC<sub>90</sub>, 90% Minimal Detectable Change; WAD, Whipash Associated Disorder; Mod, Moderate

\*Correlations completed with Numeric Pain Rating Scale, Neck Disability Index, Disabilities of Arm, Shoulder, Hand and 6 cervical range of motion tests

**TABLE 5.** Psychometric Properties of Baltimore Therapeutic Equipment Work Simulator II – Power Output Task

Test	Type of Property	Statistical Test	Value	Interpretation
BTEWS II	Test-retest reliability	ICC	0.53	Moderate
		Spearman	0.37	Poor
BTEWS II	Measurement Error	SEM	30.25	
		MDC <sub>90</sub>	70.59	
BTEWS II	Convergent Validity*	Spearman	Not Reported	Weak
BTEWS II	Discriminative Validity (Pain vs Control)	Two-way Repeated Measures ANOVA	Not Reported	Non-significant

ICC, Intraclass correlation coefficient; SEM, Standard Error of Measurement; MDC<sub>90</sub>, 90% Minimal Detectable Change; ANOVA, Analysis of Variance

\*Spearman correlations completed with Numeric Rating Scale, Neck Disability Index and Shoulder Pain and Disability Index

**TABLE 6.** Psychometric Properties of performance-based tests included in physiotherapy test package

Test	Type of Property	Statistical Test	Value	Interpretation
PILE-C	Inter-rater Reliability	Mean Difference LoA	-0.24 -2.46 and 1.82	
PILE-C	Inter-rater Reliability	Repeatability (2X SD) % of Range	M=3.93; F=1.19 M=10.5%; F=6.1%	
PILE-C	Convergent Validity	Spearman Correlation	CR-10: 0.55-0.65* Borg RPE: 0.10 - 0.48	Moderate - Strong Very weak - moderate
PILE-C	Discriminative: spinal pain vs. control	Sensitivity and Specificity	0.93, 0.69	Strong – Very Strong
PILE-C	Discriminative: spinal pain vs. control	Wilcoxon Sign Ranked Test	p=0.008	Significant
PILE-C	Discriminative: High vs. low pain intensity	Mann-Whitney U	p=0.003	Significant
PILE-C	Discriminative: High vs. low Pain behavior	Mann-Whitney U	p=0.005	Significant
PILE-C	Discriminative: High vs. low perceived exertion	Mann-Whitney U	p=0.154	Non-significant
PILE-C	Sensitivity to Change	Effect Size	Subjects improving: 0.39 - 0.73 Subjects deteriorating: 0 - 0.4	Small – Moderate Trivial – Small
PILE-L	Inter-rater Reliability	Mean Difference LoA	-0.11 -2.33 and 2.11	
PILE-L	Intra-rater Reliability	Repeatability % of Range	M=4.0; F=3.59 M=10.7%; F=18.5%	
PILE-L	Convergent Validity	Spearman Correlation	CR-10: 0.11 – 0.45 Borg RPE: 0.10 - 0.48	Very weak – moderate Very weak – moderate
PILE-L	Discriminative: spinal pain vs no spinal pain	Sensitivity and Specificity	0.85, 0.65	Strong – Very Strong

PILE-L	Discriminative: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.002	Significant
PILE-L	Discriminative: High vs. low pain intensity	Mann-Whitney U	p=0.001	Significant
PILE-L	Discriminative: High vs. low pain behaviour	Mann-Whitney U	p<0.001	Significant
PILE-L	Discriminative: High vs. low perceived exertion	Mann-Whitney U	p<0.001	Significant
PILE-L	Sensitivity to change	Effect Size	Subjects improving: 0.02 – 1.08 Subjects deteriorating: 0.42-0.81	Trivial – Large Small – Large
2 x 20m WWB	Inter-rater Reliability	Mean Difference LoA	0.05 -1.33 and 1.43	
2 x 20m WWB	Intra-rater Reliability	Repeatability % of Range	3.2 10.7%	
2 x 20m WWB	Convergent Validity	Spearman Correlation	CR-10: 0.55 - 0.65 RPE: 0.10 - 0.48	Moderate - Strong very weak – moderate
2 x 20m WWB	Discriminative: spinal pain vs control	Wilcoxon Sign Ranked Test	p=0.014	Significant
2 x 20m WWB	Discriminative: High vs. low pain intensity	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	Discriminative: High vs. low pain behaviour	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	Discriminative: High vs. low perceived exertion	Mann Whitney U	p<0.001	Significant
2 x 20m WWB	Sensitivity to change	Effect Size	Subjects improving: 0.38-0.78 Subjects deteriorating: 0.13-0.62	Small – Moderate Trivial – Moderate



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3 PILE-C, Progressive Iso-inertial Lifting Evaluation – Cervical; PILE-L, Progressive Iso-inertial Lifting Evaluation – Lumbar; LoA,  
4 Limits of Agreement; SD, Standard Deviation; M, Male; F, Female; RPE, Rating of perceived exertion; KGV, Known-groups  
5 Validity; Neg., Negligible; Mod., Moderate, \*CR-10: Measurement of pain construct  
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**Figure 1.** Selection of the studies for inclusion in the systematic review

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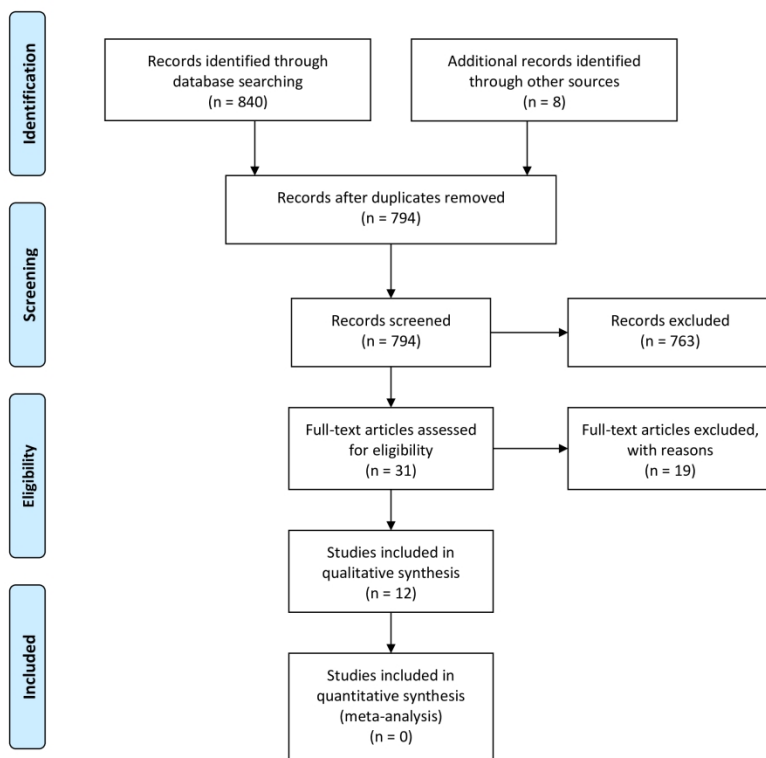


Figure 1

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## Appendix 1: Search terms

### EMBASE-OVID

1. exp "outcome and process assessment (health care)"/ or "outcome assessment (health care)"/ or treatment outcome/
2. outcome?.ti.
3. exp "Range of Motion, Articular"/
4. Pain Measurement/
5. exp disability evaluation/
6. "Recovery of Function"/
7. Questionnaires/
8. self-report.tw.
9. ((impairment or disability or function) adj2 (measure? or scale? or evaluation?)).tw.
10. range of motion.tw.
11. (strength adj2 (measure? or scale? or evaluation?)).tw.
12. (outcome? adj2 (measure\* or scale? or indicator?)).tw.
13. or/1-12
14. "reproducibility of results"/
15. exp "Sensitivity and Specificity"/
16. reliability.mp.
17. validity.mp.
18. responsiveness.mp.
19. Psychometrics/
20. rasch.mp.
21. factor analysis, statistical/
22. factor analysis.tw.
23. differential functioning.mp.
24. (validity or validation).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
25. (validity or validation).mp.
26. item difficulty.mp.
27. translation.tw.
28. or/14-27
29. 13 and 28
30. Neck Pain/
31. exp Brachial Plexus Neuropathies/
32. exp neck injuries/ or exp whiplash injuries/
33. cervical pain.mp.
34. neckache.mp.
35. whiplash.mp.
36. cervicodynia.mp.
37. cervicgia.mp.
38. brachialgia.mp.
39. brachial neuritis.mp.
40. brachial neuralgia.mp.
41. neck pain.mp.

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- 4 42. neck injur\*.mp.
- 5 43. brachial plexus neuropath\*.mp.
- 6 44. brachial plexus neuritis.mp.
- 7 45. thoracic outlet syndrome/ or cervical rib syndrome/
- 8 46. Torticollis/
- 9 47. exp brachial plexus neuropathies/ or exp brachial plexus neuritis/
- 10 48. cervico brachial neuralgia.ti,ab.
- 11 49. cervicobrachial neuralgia.ti,ab.
- 12 50. (monoradicul\* or monoradicl\*).tw.
- 13 51. or/30-50
- 14 52. exp headache/ and cervic\*.tw.
- 15 53. exp genital diseases, female/
- 16 54. genital disease\*.mp.
- 17 55. or/53-54
- 18 56. 52 not 55
- 19 57. 51 or 56
- 20 58. neck/
- 21 59. neck muscles/
- 22 60. exp cervical plexus/
- 23 61. exp cervical vertebrae/
- 24 62. atlanto-axial joint/
- 25 63. atlanto-occipital joint/
- 26 64. Cervical Atlas/
- 27 65. spinal nerve roots/
- 28 66. exp brachial plexus/
- 29 67. (odontoid\* or cervical or occip\* or atlant\*).tw.
- 30 68. axis/ or odontoid process/
- 31 69. Thoracic Vertebrae/
- 32 70. cervical vertebrae.mp.
- 33 71. cervical plexus.mp.
- 34 72. cervical spine.mp.
- 35 73. (neck adj3 muscles).mp.
- 36 74. (brachial adj3 plexus).mp.
- 37 75. (thoracic adj3 vertebrae).mp.
- 38 76. neck.mp.
- 39 77. (thoracic adj3 spine).mp.
- 40 78. (thoracic adj3 outlet).mp.
- 41 79. trapezius.mp.
- 42 80. cervical.mp.
- 43 81. cervico\*.mp.
- 44 82. 80 or 81
- 45 83. exp genital diseases, female/
- 46 84. genital disease\*.mp.
- 47 85. exp \*Uterus/
- 48 86. 83 or 84 or 85
- 49 87. 82 not 86
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- 5 74 or 75 or 76 or 77 or 78 or 79 or 87
- 6 89. exp pain/
- 7 90. exp injuries/
- 8 91. pain.mp.
- 9 92. ache.mp.
- 10 93. sore.mp.
- 11 94. stiff.mp.
- 12 95. discomfort.mp.
- 13 96. injur\*.mp.
- 14 97. neuropath\*.mp.
- 15 98. or/89-97
- 16 99. 88 and 98
- 17 100. Radiculopathy/
- 18 101. exp temporomandibular joint disorders/ or exp temporomandibular joint dysfunction
- 19 syndrome/
- 20 102. myofascial pain syndromes/
- 21 103. exp "Sprains and Strains"/
- 22 104. exp Spinal Osteophytosis/
- 23 105. exp Neuritis/
- 24 106. Polyradiculopathy/
- 25 107. exp Arthritis/
- 26 108. Fibromyalgia/
- 27 109. spondylitis/ or discitis/
- 28 110. spondylosis/ or spondylolysis/ or spondylolisthesis/
- 29 111. radiculopathy.mp.
- 30 112. radiculitis.mp.
- 31 113. temporomandibular.mp.
- 32 114. myofascial pain syndrome\*.mp.
- 33 115. thoracic outlet syndrome\*.mp.
- 34 116. spinal osteophytosis.mp.
- 35 117. neuritis.mp.
- 36 118. spondylosis.mp.
- 37 119. spondylitis.mp.
- 38 120. spondylolisthesis.mp.
- 39 121. or/100-120
- 40 122. 88 and 121
- 41 123. exp neck/
- 42 124. exp cervical vertebrae/
- 43 125. Thoracic Vertebrae/
- 44 126. neck.mp.
- 45 127. (thoracic adj3 vertebrae).mp.
- 46 128. cervical.mp.
- 47 129. cervico\*.mp.
- 48 130. 128 or 129
- 49 131. exp genital diseases, female/
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132. genital disease\*.mp.
133. exp \*Uterus/
134. or/131-133
135. 130 not 134
136. (thoracic adj3 spine).mp.
137. cervical spine.mp.
138. 123 or 124 or 125 or 126 or 127 or 135 or 136 or 137
139. Intervertebral Disk/
140. (disc or discs).mp.
141. (disk or disks).mp.
142. 139 or 140 or 141
143. 138 and 142
144. herniat\*.mp.
145. slipped.mp.
146. prolapse\*.mp.
147. displace\*.mp.
148. degenerat\*.mp.
149. (bulge or bulged or bulging).mp.
150. 144 or 145 or 146 or 147 or 148 or 149
151. 143 and 150
152. intervertebral disk degeneration/ or intervertebral disk displacement/
153. intervertebral disk displacement.mp.
154. intervertebral disc displacement.mp.
155. intervertebral disk degeneration.mp.
156. intervertebral disc degeneration.mp.
157. 152 or 153 or 154 or 155 or 156
158. 138 and 157
159. 57 or 99 or 122 or 151 or 158
160. animals/ not (animals/ and humans/)
161. 159 not 160
162. exp \*neoplasms/
163. exp \*wounds, penetrating/
164. 162 or 163
165. 161 not 164
166. 29 and 165
167. guidelines as topic/
168. practice guidelines as topic/
169. guideline.pt.
170. practice guideline.pt.
171. (guideline? or guidance or recommendations).ti.
172. consensus.ti.
173. or/167-172
174. meta-analysis/
175. exp meta-analysis as topic/
176. (meta analy\* or metaanaly\* or met analy\* or metanaly\*).tw.
177. review literature as topic/

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3 178. (collaborative research or collaborative review\* or collaborative overview\*).tw.  
4 179. (integrative research or integrative review\* or intergrative overview\*).tw.  
5 180. (quantitative adj3 (research or review\* or overview\*)).tw.  
6 181. (research integration or research overview\*).tw.  
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## APPENDICES

### APPENDIX A. Data extraction guide for studies evaluating the quality of studies evaluating the clinical measurement properties of outcome measures

#### Instructions

Clinical measurement studies may evaluate a wide spectrum of measurement properties; or evaluate aspects that relate to the implementability or interpretation of outcome measures. Individual clinical measurement studies cannot address every aspect of the measurement properties of an instrument. Ideally systematic reviews will synthesize the quality and content of research evidence addressing the clinical measurement properties of individual outcome measures. The summative knowledge about the measurement properties, cultural transferability, and utility across different contexts provides the scope of information needed to select an outcome measure for a specific patient (population), purpose and context.

This guide should facilitate extraction of data from individual clinical measurement studies. An explanation of the measurement property addressed in each item and how it might be measured within a given study is listed to facilitate finding and extracting that information. The accompanying extraction form can then be used to collect the specific information on these measurements or utility properties from specific studies.

The purpose of data extraction is to extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. Evaluation of the quality of the published version of the clinical measurement study (also called critical appraisal) is performed in a separate step. See the accompanying critical appraisal tool and guide. It is advisable to extract detailed specific information from the study; recognizing that this information may later be synthesized or subject to meta-analysis.

There is no standardized process for synthesizing clinical measurement information. Based on the findings of extraction you may elect to present the synthesized data in a descriptive way by creating a summary table of the data extracted in each category. If you find some studies with similar designs, you may be able to conduct a meta-analysis of some properties like clinically important difference (CID) or minimal detectable change (MDC); if appropriate given the sample and technique - this can be valuable as it may provide more stable estimates of these important properties.

<b><u>Population studied</u></b>		
Population	A description of the study population	Sample size, pathology/disorder, demographics, setting, acute vs. chronic, where subjects were chosen from. Report meaningful demographics and indicators of the population studied.
Intervention	Interventions (if applicable) applied during longitudinal studies	Description of the nature, frequency, intensity of the intervention and the follow-up interval.
<b><u>Reliability</u></b>		
Reliability Description	The extent to which scores for patients who have not changed are the same for repeated measurement under several conditions: for example, using different sets of items from the same health-related instrument (internal consistency), over time (test retest) by different persons on the same occasion (interrater) or by the same persons (i.e., raters or responders) on different occasions (intra-rater)	Test procedures or measures are typically reapplied on repeated occasions in individuals considered to have a stable condition during that time frame which repeated testing occurs. Repeated testing may be performed on different occasions (test-retest) for self-report measures, OR by the same rater (intra-rater) or different raters (inter-rater) if it is an observer-based scale. In some cases different test instruments (inter-instrument) are evaluated. The most common statistic used is the intraclass correlation coefficient for quantitative data (Shrout & Fleiss, 1979) and kappa (Landis & Koch, 1977) for nominal data. Standard error of measurement is used to present a quantitative estimate of the reliability—in the original units of measure. Report the type of reliability evaluated and coefficients obtained.
Measurement Error	The systematic and random error of a patient's score that is not attributed to true changes in the construct to be measured	This may be reported as 1. Standard error of measurement (in older articles you may see coefficient of variation) 2. Altman and Bland graphical technique (Bland & Altman, 1990; Bland & Altman, 1987; Bland & Altman, 1986) where the difference on repeated tests for each individual (limits of agreement) is plotted versus their

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		mean score. The mean difference and the boundaries of 2SD are shown to define the limits of agreement.
Internal consistency	The extent to which items on a test or subscale are related (an indication of the consistency of the concept measured).	Cronbach's alpha is the inter-item correlation usually reported. Report alpha and whether it relates to the entire instrument or specific subscales.
<b><u>Validity</u></b>		
Content Validity	The degree to which the content of a health-related instrument is an adequate reflection of the construct to be measured	<p>A variety of techniques can be used to assess the extent to which items on a given measure reflected the necessary content to capture the concept of interest. Some of the techniques you will find are listed. Extract what was done to determine content validity and what was found.</p> <ol style="list-style-type: none"> <li>1) Patients and experts were involved during item selection/reduction - report how they were used and key decisions</li> <li>2) Patients were consulted for reading and comprehension - report key findings</li> <li>3) Cognitive interviews (Cibelli, 1994; Ojanen &amp; Gogates, 2006) were done with patients to determine how items were interpreted by respondents; their perceptions of the items - report key findings</li> <li>4) Expert panels or Delphi procedures were used to select items or evaluate the validity of the instrument - report key findings and decisions</li> <li>5) During translation specific study, the meaning of the questions to another cultural or language group was studied - report key findings and decisions</li> <li>6) ICF linking (Cieza et al., 2002) or other coding of content was performed - report the results which may include the distribution of content across ICF domains, or the distribution of specific codes</li> </ol>
Construct Validity	The degree to which the scores of a health-related instrument are consistent with hypotheses (for instance with regard to internal	When extracting data about correlational validity, the pre-constructed hypothesis and whether it is supported should be documented. For correlational construct

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	relationships, relationships to scores of other instruments, or differences between relevant groups) based on the assumption that the health-related instrument validly measures the construct to be measured	validity, this will be the nature and strength of the prespecified relationship and the correlations that support that. Relation to other indices/constructs that are similar (convergent) or different (divergent) can be reported. Ideally, hypotheses are formulated/reported and supported by correlations that are in accordance with the hypotheses. Note that there is no consistent agreement on what subjective term should be applied to validity correlations. Note that there is no consistent agreement on what subjective term should be applied to validity correlations. Some authors use subjective terminology defined for reliability such as: strong (>0.70) and moderate (0.40-0.70) correlations; others use the correlations like effect size benchmarks that 0.4 indicates a moderate effect and 0.6 a large effect. For validity assessment is more important than correlations prespecified constructed hypotheses, although not all papers are written clearly with respect to this.
Structural Validity/Hypothesis Testing	The degree to which the scores of a health-related instrument are an adequate reflection of the dimensionality of the construct to be measured	Extract test names, prespecified expected relationship and correlations observed.
Structural validity - discriminative	discriminative analysis supports the validity of a measure by demonstrating that the measurement is able to differentiate between groups that are prespecified and <u>known</u> to be different on the construct being assessed.	Data extraction should include the nature of the subgroups and the size of the difference observed between them (and its statistical significance). Typically, statistical tests of difference are performed.  Since known groups analysis can provide data that is useful in clinical practice as benchmarks for comparing these known groups, it is a more practical form of construct validity than correlational. Data extraction/presentation should reflect this by presenting the group central tendency, their margins and statistical significance in an accessible manner.

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<p>Criterion validity</p>	<p>Criterion validation is determined by comparing a given outcome measure to an accepted standard of measure. For subjective constructs like pain and disability, it can be argued that there is no criterion since there is no external gold standard. Therefore, for self-report measures, validation focuses on construct validity.</p> <p>For performance measures, it is common to have a criterion measure that is considered to be highly precise and rigorous as the criterion comparator.</p>	<p>Authors will state that their measure is being compared against a specific instrument and report the correlation or agreement between the measures. Extract the test names and results: correlations or other as reported.</p>
<p><b>Responsiveness/Clinical Change</b></p>		
<p>Responsiveness</p>	<p>The ability of a health-related instrument to detect change over time in the construct to be measured</p>	<p>Extract indicators of responsiveness include: effect size, standard response mean and the method for assessing whether patients were improved, stable or worse. (Beaton, 2000)</p>
<p><b>Interpretability</b></p>		
<p>Interpretability</p>	<p>The degree to which one can assign qualitative meaning that is, clinical or commonly understood connotations to an instrument's quantitative scores or change in scores.</p>	

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**APPENDIX B.** Data extraction form for studies evaluating the clinical measurement properties of outcome measures

Authors: \_\_\_\_\_ Year: \_\_\_\_\_ Rater: \_\_\_\_\_

Instructions

When using the data extraction form, it is important to realize that the purpose of data extraction is to remove or extract the specific information reported by authors within a study, not to evaluate the validity or value of that piece of information. To make data extraction as useful as possible, and to avoid the need for repeated data extractions, it is advisable to read the accompanying guide and then be as specific as possible when extracting information.

<b>DATA EXTRACTED</b>	
Population studied	
Population	
Intervention	
Reliability	
Reliability (relative)	
Reliability (absolute)	
Minimum Detectable Change	
Content/structural validity	
Internal consistency	
Content Validity	

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Floor-Ceiling Effects	
Factorial validity	
Item response /Rasch Analyses	
Construct/Criterion Validity	
Known groups	
Convergent	
Divergent	
Longitudinal Validity	
Concurrent criterion	
Predictive criterion	
Responsiveness/Clinical Change	
Responsiveness	

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**APPENDIX C. Quality Appraisal for Clinical Measurement Research Reports Evaluation Form**

Rater (Group) \_\_\_\_\_

Author(s) (Study Author(s)) \_\_\_\_\_

Year (Year of publication) \_\_\_\_\_

1. Was the relevant background work cited to define what is currently known about the measurement properties of measures under study, and the potential contributions of the current research question to informing that knowledge base?

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2. Were appropriate inclusion/exclusion criteria defined? \*

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3. Were specific clinical measurement questions/hypotheses identified?

2

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4. Was an appropriate scope of measurement properties considered?

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5. Was an appropriate sample size used?

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6. Was appropriate retention/follow-up obtained? (for studies involving retesting; otherwise n/a)

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7. Were specific descriptions provided of the measure under study and the method(s) used to administer it?
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8. Were standardized procedures used to administer all study measures in a manner that minimized potential sources of error/bias (including the study measure and its comparators)?
- 2  
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9. Were analyses conducted for each specific hypothesis or purpose?
- 2  
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10. Were appropriate statistical tests performed to obtain point estimates of the measurement properties?
- 2  
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11. Were appropriate ancillary analyses done to quantify the confidence in the estimates of the clinical measurement property (Precision/Confidence intervals; benchmark comparisons/ROC curves, alternate forms of analysis like SEM/MID, etc.)?
- 2  
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12. Were clear, specific and accurate conclusions made about the clinical measurement properties; that were associated with appropriate clinical measurement recommendations and supported by the study objectives, analysis and results?
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- Subtotals (of column 1 and 2)      Total Score (sum of subtotals/24\*100)

## APPENDIX D. Description of each performance battery from selected articles

Battery	Description of Tasks
<b>Relevant FCE Subtasks</b> <sup>25,26,27,28,29,30</sup>	<p>Material Handling Tasks: All lifting tests were executed with a wooden crate (40 × 30 × 26 cm) of 2.5 kg, and four to five weight increments of 2.5 kg or 5 kg each were used until the maximum amount of weight was reached. Maximum performance was recorded in kg.</p> <p>Lifting floor to waist: Measured after five lifts of crate from floor to table and vice versa (time limit &lt; 90 s): hands remained on the crate during the test. Increase weight in 4-5 steps until maximum is reached</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p> <p>Two-handed carrying: Carrying of a crate for a short distance measured after five carries of 1.5 m distance at waist height. Hands remain on the crate during the test.</p> <p>One-handed carrying: Carrying wooden crate for 15 m within 90 s beginning with the right hand and thereafter the left hand.</p> <p>Overhead working: Standing with hands at crown height for manipulation of nuts and bolts. The time that the position was held is recorded (sec).</p> <p>Repetitive reaching: fast horizontal movements of the upper extremity in a sitting position. Marbles are removed from bowls at arm length distance at table height from left to right and vice versa, with right and then left arm. The time taken to remove 30 marbles is recorded (sec).</p> <p>Overhead lift test: Five lifts from waist to crown height and vice versa within 90 s in standing position. Increase weight in 4–5 steps until maximum is reached</p> <p>Repetitive bending and overhead reaching: 20 marbles in 2 bowls at table height and crown height. Standing in front of bowl of marbles and moving the marbles as fast as possible from table height to crown height.</p>

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<p><b>A Physiotherapy Test Package</b><sup>33,34,35,36</sup></p>	<p><b>PILE Tests:</b> “The lifting tests were performed standing in front of bookshelves with shelves at 0.76m and 1.37 m from the floor. Subjects were asked to lift weights in a plastic box from floor to waist level (0–0.76 m) for the lumbar PILE test, or from waist to shoulder height (0.76–1.37 m) for the cervical PILE test. The initial weight was 3.6 kg for women and 4.9 kg for men. A ‘lifting movement’ involved a single transfer from one level to the next and back again. After every four such lifting movements (= 20 s), the weight was increased by 2.25 kg for women and 4.5 kg for men. The weight managed during the last lifting movement was recorded and used as a test result, as well as this maximum weight divided by the ‘adjusted weight’”.</p> <p><b>2x20m WWB:</b> “Subjects were asked to walk 20 m at a comfortable speed along a corridor, to turn around where 20 m was marked and then to walk 20 m back to the starting point. In the first walking test they carried no extra weight, but in the second they carried one carrier bag in each hand, containing 4 kg each for the women, 8 kg each for the men. The time taken was recorded to get the walking speed. The tests were discontinued after 50 s”.</p>
<p><b>BTEWS II</b><sup>31</sup></p>	<p>“The protocol consisted of performing a series of shoulder functional tasks before and after a fatiguing activity. Functional tasks consisted of active shoulder range of motion (ROM) in both flexion and abduction and cumulative power output (PO) accumulated over 10s during a repetitive pushing/pulling task in a horizontal plane at shoulder level”.</p>
<p><b>FIT - HaNSA</b><sup>32</sup></p>	<p>“The FIT-HaNSA protocol consists of three timed tasks and each task is performed for a maximum of 300 seconds (s) with approximately 30 s pause between them (set-up time for next task). Task 1 (waist-up) requires the patient to alternately “grab, lift, move and place” three 1000 g containers located on waist level and 25 cm above waist level shelves, using their affected arm, at a metronome pace of 60 beats per minute for 300 s or until they felt unable to continue. The time to complete Task 1 is measured using a stopwatch. Task 2 (eye-down) is identical to Task 1 except that the two shelves are placed at eye-level and 25 cm below. Task 3 (overhead work) requires a patient to repeatedly screw and unscrew bolts in a sagittal plane oriented plate positioned at eye-level using both arms”. More complete description at <a href="https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol_April2007.pdf">https://srs-mcmaster.ca/wp-content/uploads/2015/04/FIT-HaNSAProtocol_April2007.pdf</a></p>



# PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	1
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
<b>METHODS</b>			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	3
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	4
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	3-4
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3-4
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	4
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	4
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	5
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	NA
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I <sup>2</sup> ) for each meta-analysis.	NA



# PRISMA 2009 Checklist

Page 1 of 2

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	NA
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	NA
<b>RESULTS</b>			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	6-7
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICCO, follow-up period) and provide the citations.	6-7
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	6-10
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	6-10
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	6-10
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6-10
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	NA
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	11-13
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	14-16
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	16
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	18

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

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