PRESIDENT'S MESSAGE

Another year is coming to a close as Thanksgiving and Christmas are just around the corner to help me remember how blessed and thankful I am to have such a wonderful family and network of "occupational health" friends!

I would like to provide you with a few key highlights about recent SIG activity before introducing you to one of our key SIG leaders—Jen Klose.

OHSIG UPDATES

The Occupational Health SIG continues to be active in pursuit of excellence in practice and advocacy efforts to be recognized as primary providers under workers' compensation.

The APTA Orthopedics board recently approved our request to expand our Occupational Health Practitioner (OHP) Certificate Program to offer an Occupational Health Practitioner Associate Certificate option that is inclusive to physical therapist assistants, occupational therapist assistants, and athletic trainers.

Since January 2022, we have 186 registrants who have enrolled in ISC 32.4, 110 registrants who have enrolled in ISC 32.5, 40 registrants who have enrolled in 32.W3, and a total of 37 registrants who have completed all program requirements to be awarded the OHP certificate.

We have developed an OHSIG Small Grant Program to assist members in funding research relevant to occupational health practice. The amount of funding available for awards will range from $250 to upwards of $3,000.

At the Combined Sections Meeting (CSM) 2026, we will be offering a 2-part series related to primary care in occupational health:

- Part 1: Primary Care for Working Populations: Lead with Direct-to-Employer Services
- Part 2: Primary Care for Working Populations: Integrating Physical Therapy, Lifestyle Medicine, and Health Coaching

A number of key individuals have made a commitment to revising the clinical practice guideline (CPG) **Clinical Guidance to Optimize Work Participation After Injury or Illness: The Role of Physical Therapists**. Several planning meetings have occurred to recruit members and start planning. We are set to meet in person again at CSM 2026. Our OHP certificate leadership team will be using the results from the updated CPG literature review to determine if any content updates are necessary for the ISCs.

As a reminder, we will transition from being a SIG to Engagement Community at CSM 2026.

OHSIG MEMBER SPOTLIGHT

Jennifer Klose, PT, DPT, MBA is a physical therapist specializing in evaluating and treating workers in occupational health settings. She earned her master's in physical therapy from D'Youville College, followed by her doctorate in physical therapy from Temple University. Jen completed a manual therapy residency through the Manual Therapy Institute, earning an advanced training certificate. She also holds an Occupational Health Practitioner Certificate from the Academy of Orthopaedic Physical Therapy. After multiple business certificate programs, she recently obtained her master's in business administration with a healthcare management concentration from Youngstown State University.

Since joining Concentra in 2001, Jen has contributed to every facet of occupational health, from injury care management to workplace safety and prevention. As Senior Director of Clinical Services for Western Pennsylvania and Eastern Ohio, she drives clinical collaboration across patient care services—promoting best-in-class therapy, specialist referrals, and pharmacy guidance for center teams. Jen serves on Concentra's Therapy Medical Expert Panel, developing evidence-based guidance and resources for therapists treating injured workers. She also supports the internal Occupational Health University Program, offering clinicians and therapists advanced coursework to deepen their expertise in this population.

Active in the Occupational Health Special Interest Group under APTA Orthopedics, Jen collaborates on evidence-based research and best practices to improve therapy outcomes. She currently holds a leadership role as Research Committee Vice Chair and contributed to creating coursework for the Occupational Health Practitioner Certificate program.

Jen lives in Pittsburgh with her husband and two teenagers. The couple recently celebrated their 20th anniversary and are embracing new adventures as empty nesters approach. They own a cabin in northeast Pennsylvania and love outdoor pursuits—you can often find them boating on Pittsburgh's rivers and lakes.

MANAGING DELAYED RECOVERY FROM ACUTE MUSCULOSKELETAL INJURIES IN OCCUPATIONAL HEALTH

Jennifer Klose, PT, DPT, MBA
Courtney Shinost, PT, DPT, MS
Matthew J Klinker, PT, DPT
Shelby Mendez, PT, DPT

In the occupational health setting, musculoskeletal injuries are a leading cause of workers' compensation claims. Current research demonstrates the benefits of timely and effective therapeutic interventions.[1,2] A recent retrospective study of patients with work-related musculoskeletal disorders (WMSDs) found that initiating physical therapy within 0 to 2 days of injury significantly reduced case duration, required fewer therapy visits, and promoted a quicker return to work.[2] This study highlights the essential role of early intervention in optimizing return-to-work (RTW) outcomes. However, not all patients follow this pathway to successful outcomes. WMSDs can evoke a range of emotions and psychosocial factors, including fear, anxiety, and overwhelming worry, which may impede the healing process.[3,4] The heightened focus on the pain, coupled with limited coping strategies, can lead to delayed recovery and increased risk of chronic pain.[5] These psychological barriers, combined with workplace-related concerns, can complicate the

patients' overall RTW. This article reviews predictors of delayed recovery, addresses biopsychosocial concerns, and highlights the role of therapeutic alliance to support injured patients' recovery. By integrating these concepts into our daily practice, physical therapists can appropriately navigate these challenges and improve RTW outcomes.

Predictors of Delayed Recovery

Physical therapists treating injured patients must consider not only the biological impairments that objectively limit functional capabilities, but also the psychosocial factors influencing recovery. These psychosocial factors can positively or negatively affect the patient's rehabilitation, manifesting in their perception of their injury, anticipation of their prognosis, and level of engagement in it.[5] Evidence-based practice emphasizes individualized treatments, and a strong therapeutic alliance is essential for addressing all aspects of RTW following injury.[1] Early identification of psychosocial risk factors allows therapists to recognize patients that have exaggerated pain perception and a higher risk of delayed recovery.

Yellow, orange, blue, and black flags have been utilized to allow physical therapists and clinicians to identify risk factors for poor prognosis and guide appropriate interventions.[6] Yellow flags represent psychosocial risk factors, such as fear-avoidance behaviors, catastrophizing, or low self-efficacy, that can influence pain perception and recovery behaviors.[6] Orange flags are conditions associated with mental health that may impact patient care and recovery. Blue and black flags identify the social and environmental risk factors of the workplace. Blue flags reflect the patients' perception of their work environment and job demands, such as high workload or lack of support, while black flags denote objective workplace conditions, such as inadequate accommodation or delays in claims processing.[6,7]

Patients sustaining a WMSD may experience anxiety or depression postinjury. These emotional responses can interact with pain behaviors, leading to fear-avoidance, pain catastrophizing, or altered beliefs and expectations about their recovery.[6] The presence of yellow flags is associated with predictions for poorer recovery, higher levels of disability, delayed RTW, and increased risk of developing chronic pain.[3,5] Physical therapists should employ screening tools to identify patients likely to benefit from therapeutic interventions aimed at addressing yellow flags. Research demonstrates that addressing fear avoidance, low self-efficacy, and catastrophizing can improve function and RTW outcomes.[3,5]

Social and occupational factors interact with psychosocial factors and amplify delays in recovery. It is essential for physical therapists to identify any work-related factors, depression, and recovery expectations, as they can be predictors of delayed recovery.[4] A case example is a construction worker diagnosed with a shoulder strain who feels anxiety (yellow flag) regarding his injury and objective limitations. The employer is unable to accommodate work modifications due to the high physical job demands (blue flag) and the patient is off work and has feelings of depression and poor coping strategies (yellow flag). There are delays in the adjuster authorizing therapy (black flag) that impede the recovery process and have the potential to lead to chronic pain. This example points out the need for early identification of factors, integrated interventions, and communication between the medical team, employer, and adjuster stakeholders.

Using Outcome Measures Effectively

Patient-reported outcome measures (PROMs) started as a means of determining efficacy of intervention in research but have become commonplace in the healthcare industry.[8] Physical therapists use PROMs to determine a patient's self-reported baseline function following an injury. The more common PROMs for WMSDs are the Oswestry Disability Index (ODI), Fear-Avoidance Beliefs Questionnaire (FABQ), and Tampa Scale of Kinesiophobia (TSK). The STaRT Back Screening Tool (SBST) and the Orebro Musculoskeletal Pain Screening Questionnaire (OMPSQ) have been gaining popularity to determine the risk of chronicity of low back injuries.[9]

With all these tools available for physical therapists to use, it is important to understand when PROMs are valid to predict what they were created to predict. FABQ was designed to identify yellow and orange flags associated with WMSDs.[9,10] However, research suggests the FABQ does not measure fear-avoidance beliefs; rather, it is a measure of expectations.[10]

The TSK, which also measures yellow and orange flags, has 5 versions: TSK-17, TSK-13, TSK-11, TSK-4, and TSK-TMD, with the number indicating how many questions are on the PROMs and TMD being a measure of temporomandibular dysfunction.[11] Research has found that the minimal detectable change varied across the versions of the TSK measures; however, TSK-17 and TSK-13 have been determined to be the most valid, reliable, and responsive.[11]

The SBST and OMPSQ were developed to assess blue and black flags associated with an injury and predict absence and return to function.[9] The SBST divides patients into 2 groups: a "low-risk" and a "high-risk" group. Similarly, the OMPSQ divides patients into either "not at risk" and "at risk."[9] These groups are designed to determine the chronicity of the injury and predict the patient's absence from work. However, the validity of the SBST and OMPSQ is based on 2 weeks postinjury and sixteen days postinjury, respectively.[9] Thus, the use of the SBST and OMPSQ will likely not predict chronicity with acute WMSDs. Similarly, the minimally clinically important difference of the ODI will vary with interpretation of the result.[12] Ideally, physical therapists should understand when to use a PROM and apply its result to determine appropriate treatment strategies that will promote recovery and clinical improvements.

Addressing Increased Biopsychosocial Concerns

A biopsychosocial approach—bolstered by multidisciplinary collaboration and systemic advocacy—is essential for improving recovery outcomes in patients with musculoskeletal injuries. This section will explore strategies that the medical team, employers, and stakeholders can implement to facilitate recovery and reduce the risk of prolonged disability.

A wide array of evidence-based strategies has been explored to address intrinsic factors and include an array of psychological interventions. These include cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), pain neuroscience education (PNE), motivational interviewing (MI), structured interviewing using the ABCDEFW framework, behavioral activation, and general psychoeducation. These interventions aim to target maladaptive beliefs and address underlying psychological barriers and are often used in conjunction with one another. The following **table** summarizes key psychological interventions used to address intrinsic factors.

Extrinsic factor strategies include early and supportive communication, modified duty programs, ergonomic adjustments, education and training, case coordination, fostering

psychological safety, and continuous monitoring of recovery progress in the workplace. These interventions help reduce blue flag barriers and support reintegration.

Systemic approaches include collaborating with case managers and adjusters to streamline claims, advocating for timely access to care, and reducing administrative delays. These strategies address the aforementioned black flag barriers and improve continuity of care.

A truly collaborative approach—engaging physical therapists, physicians, behavioral health specialists, employers, and case managers—ensures coordinated care and shared goals. Shared goals and communication are essential for managing complex cases. Successfully addressing biopsychosocial barriers in work rehabilitation demands a multifaceted strategy rooted in empathy, evidence, and interdisciplinary collaboration. By integrating structured assessments, functional restoration strategies, and therapeutic communication, physical therapists can guide patients through complex recoveries and facilitate successful RTW outcomes.

Facilitating a Therapeutic Alliance and Positive Outcomes

Therapeutic alliance is built on collaboration and trust between physical therapist and patient and is widely recognized as a clinical tool to aid positive outcomes in the workers' compensation population. There is significant evidence demonstrating that psychological factors are more predictive of disability than pathoanatomical factors. The words physical therapists choose shape how patients perceive their condition and help build trust, as highlighted in The Impact of Language in Musculoskeletal Rehabilitation.[26] When patients feel heard and validated, they are more likely to adhere to their treatment plan and communicate their progress and challenges to their physical therapists. Ensuring therapists demonstrate empathy, collaboration, active listening, emotional validation, empowering language, and an alliance over time is vital. It is this communication that allows the collaborative treatment approach to flourish and produce positive outcomes.

When building a therapeutic alliance, it is imperative that the physical therapist demonstrates empathy through their tone, body language, and phrasing of their words throughout their conversation. The therapist's choice of words and their delivery during a stressful situation significantly influence positive patient outcomes. A therapist's words have the possibility of healing or causing long-lasting harm to patients.[26] The interpretation of words by a patient is powerful, and physical therapists should be cognizant of patient's reactions to their choice of words. For example, utilizing "chronic degenerative changes" can be perceived as a positive result on an MRI/disability, while "normal age-related changes" can be perceived as normal.[26] Recognizing a patient's reaction to tone, body language, and the phrasing of words allows a therapist to pivot as needed.

Active listening, emotional validation, and empowering language further strengthen trust and foster the relationship.[27] When a physical therapist takes the time to acknowledge a few key points and emotions from the conversation, utilizing phrases like "It sounds like you are frustrated because …" or "What I heard you say …", the patient feels safe and open to expressing barriers in the future. Additionally, physical therapists can use simple phrases such as "You have improved your … since the last visit" to help highlight progress. The phrases should remain simple, relevant, and framed around potential. [27]

Communication Beyond the Clinic

While the therapeutic alliance between the physical therapist and patient is of the utmost importance, successful patient outcomes in occupational medicine highly depend on communication with key stakeholders. Poor communication and lack of coordination among case managers, employers, insurers, and healthcare providers can create confusion, delay recovery, and undermine the patient's trust in the process.[28] To improve collaboration and patient outcomes, physical therapists should be willing to proactively communicate with key stakeholders.

Identifying opportunities to communicate with the appropriate party can be challenging for clinicians and physical therapists. Establishing communication channels with case

Table. Evidence-Based Psychosocial Interventions

Intervention	Purpose	Applications	Sources
Cognitive behavioral therapy (CBT)	Restructure negative thoughts; reduce fear-avoidance.	Reframe pain experience; develop coping strategies.	Gatchel RJ, Rollings KH. [13] Nicholas MK, et al.[14] Washington State Department of Labor & Industries.[15]
Acceptance and commitment therapy (ACT)	Promote psychological flexibility; accept pain.	Engage in meaningful activities despite discomfort.	McCracken LM, Vowles KE.[16] Washington State Department of Labor & Industries.[15]
Pain neuroscience education (PNE)	Explain neurobiology of pain; reduce fear.	Structured sessions or integrated into physical therapy; often paired with CBT/ACT.	Louw A, et al.[17] Moseley GL.[18] Butler DS, Moseley GL.[19]
Motivational interviewing (MI)	Resolve ambivalence; promote behavior change.	Useful for resistant patients; goal setting and interviews.	Rollnick S, Miller WR.[20] Gross DP, et al.[21]
Structured interviewing and psychosocial screening	Explore psychosocial domains systematically.	ABCDEFW framework; guides referrals and tailored interventions.	Gifford L.[22]
Behavioral activation	Counteract depression and inactivity.	Restore routine and motivation; often used with CBT.	Martell CR, et al.[23] Nicholas MK.[14]
Psychoeducation, graded intervention, and self-management training	Empower patients with recovery knowledge and skills.	Handouts, videos, sessions; includes pacing and goal setting.	Linton SJ, Shaw WS.[24] Workers' Compensation Research Institute.[25]

managers, adjusters, and employers early on in care is key.[28] Communication channels can include documentation systems; scheduled check-ins in person or through phone/email may be appropriate. These communication channels allow physical therapists to advocate for appropriate care in a timely manner.

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