ISCRR Institute for Safety, Compensation and Recovery Research
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Evaluation of Nurse Navigator (Upper Limb) Pilot Program

Program Evaluation

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ISCRR
Evaluation

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Acknowledgements

The Institute for Safety, Compensation and Recovery Research (ISCRR) would like to acknowledge the Traditional Owners of the land on which we work and live, the Wurundjeri (Woi-wurrung) and Bunurong (Boon Wurrung) Peoples of the Kulin Nation and pay our respects to their Elders past, present, and emerging. We want to extend this acknowledgement to the Traditional Owners of the lands where you work and live.

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Table 1. Glossary

Word	Meaning
Melbourne Shoulder and Upper Limb (MSUL)	A sub-speciality orthopaedic practice based in Melbourne, Australia. The practice focuses on diagnosing and treating acute and chronic conditions, injuries and diseases affecting the shoulder, elbow, wrist and hand.
WorkSafe Victoria (WorkSafe)	Victorian state occupational health and safety regulator and workers' compensation provider.
Nurse Navigator	A multidisciplinary, early intervention approach to the integrated surgical and non-surgical management of upper limb injuries, with the primary aim of improving injured worker recovery and return-to-work outcomes.
Business as usual (BAU)	The normal, day-to-day operations and standard activities of an organisation. Ongoing tasks, systems and processes that maintain a company's function.
Independent Medical Examiner (IME)	A qualified medical professional who evaluates an injured workers injury or illness, usually requested by insurers, legal representatives or tribunals. The primary goal is to provide impartial clinical evidence to help settle compensation claims, assess work capacity and determine future treatment needs.
Patient-Reported Outcome Measures (PROMs)	Standardised questionnaires completed directly by patients to measure their perception of their own health status, quality of life or functional wellbeing following a medical treatment or surgery.

EXECUTIVE SUMMARY

Background

The Nurse Navigator (Upper Limb) Pilot tested a multidisciplinary, early intervention approach to the integrated surgical and non-surgical management of upper limb injuries, with the primary aim of improving injured worker recovery and return-to-work outcomes. Delivered by Melbourne Upper Shoulder and Limb (MSUL) and funded by WorkSafe Victoria, the Pilot aligned with WorkSafe's commitment to high-value care principles, including provider-led approaches and the reduction of low-value care.

The intervention involves a Nurse Navigator who co-ordinates care, including provider-led multidisciplinary clinical case conferences. The Nurse Navigator acts as the injured worker's central point of clinical contact. Agents will receive timely communication, updates and reporting. Employers will receive updates where relevant.

Methods

This program evaluation sought to understand the perspectives of MSUL health providers, WorkSafe project team, agents, and injured workers participating in the Pilot. ISCRR conducted qualitative focus groups and interviews to assess the Pilot's design, strengths, and barriers to delivery, while MSUL collected quantitative data. MSUL's data is not included in this report.

Key Findings

Evaluability limitations: The Pilot was not established with agreed intent; it is not possible to draw evidence-based conclusions about continuation or transition to business as usual.

Multidisciplinary Teams: The clinical care team was considered a significant asset, fostering cross-specialty collaboration and informed decision-making that benefited the injured workers interviewed.

Systemic and workforce barriers: Scheme-wide systemic issues were at the centre of most communication breakdowns between MSUL and WorkSafe. High case manager turnover further disrupted injured workers' recovery and hindered external engagement — to the extent that no case managers were available to participate in this evaluation due to workload constraints.

Recommendations

Theme	Recommendation for future rapid pilot development
Model Reorientation	Trial the model in mental health settings, where multidisciplinary teams and intensive system navigation may offer the greatest benefit.
Scope Expansion	Integrate psychologists, occupational therapists, and return-to-work coordinators directly into the core clinical team. However, this is dependent on the required clinicians being available.
Operational Integration	Organise all treating specialists into a single multidisciplinary team to streamline communication and data sharing.
Governance	Future pilots would benefit from standardised project templates, scoping checklists, and a dedicated WorkSafe internal point of contact to maintain agency-provider alignment. This role's responsibilities should be transferable rather than tied to one individual to decrease the potential impact of staff turnover.

System Simplification	Explore a private insurance or Medicare-style approval structure for accredited pilot clinics, empowering trusted clinicians to deliver timely treatment with compliance managed through retrospective auditing.
Bureaucratic Reform	Develop an accessible AI navigation tool integrated with the WorkSafe platform to provide injured workers with clear, real-time information about claim timelines and obligations. However, this recommendation may require large scale changes to the WorkSafe system, which may not be currently feasible.

BACKGROUND

The Nurse Navigator (Upper Limb) Pilot aims to test a multidisciplinary, early intervention, integrated surgical and non-surgical management approach to upper limb injuries, with the primary outcome to improve recovery and return-to-work outcomes.

Delivered by Melbourne Upper Shoulder and Limb (MSUL) and funded by WorkSafe Victoria (WorkSafe), the Pilot aligns with WorkSafe's commitment to high value care principles including adopting provider-led approaches and reducing low-value care.

The intervention involves a Nurse Navigator who co-ordinates care, including provider-led multidisciplinary clinical case conferences. The Nurse Navigator acts as the injured worker's central point of clinical contact. Agents will receive timely communication, updates and reporting. Employers will receive updates where relevant.

Research Aim

Through a program evaluation, this research aimed to understand the views of MSUL health providers, WorkSafe staff, agents and injured workers participating in the Pilot. Key research questions included:

1. To what extent are the participants satisfied with their experience with the model?
2. What worked well, and what could be improved about the model?
3. Should WorkSafe consider extending the model to be business as usual (BAU)?

METHODOLOGY

This program evaluation was conducted between May 2024 and March 2026 using qualitative methods. MSUL collected quantitative data that is not addressed in this report as it was outside of ISCRR's remit.

Four focus groups were conducted, two with WorkSafe project staff and two with MSUL staff. The first focus group with WorkSafe explored the Pilot's development within the business, areas for improvement, potential barriers to implementation, and considerations for future pilots. Participants included representatives from privacy, data governance, legal counsel, data science, major programs, procurement and research. The first focus group with MSUL took place a few months into the Pilot. It included three out of four treaters and explored their experiences of development and implementation, including what worked well, areas for improvement, confidence in understanding the scheme, and reporting. The concluding two focus groups examined the Pilot's status compared to the original design intent, gaps in implementation, refinement, and recommendations. The focus group with WorkSafe included three staff who were not involved at project inception but inherited the project within their portfolio. The focus group with MSUL included two staff who attended the first focus group. To ensure anonymity, all participant identifiers have been removed from the focus group quotes.

Nine injured workers were invited to participate in the research, and 4 agreed to participate. Semi-structured interviews were conducted with four (n=4). Twenty-four case managers were invited to participate but none elected to participate, stating they had limited capacity due to high workload and low awareness of the Pilot.

Limitations

The small sample size from injured workers limits the breadth of perspectives captured. The absence of case manager participation represents a limitation, as the study omits the frontline operational insights, implementation successes, and challenges of a key stakeholder group.

FINDINGS

The findings address the three primary research questions: first reviewing the Pilot's development; second, evaluating its core strengths and challenges, and finally outlining why the Pilot is not viable to proceed and what considerations should inform future designs.

Pilot Development

This section addresses the development of the Pilot from WorkSafe and MSUL's perspective. Findings in this section are from the first two focus groups.

Strengths

Scheme training

The MSUL team found the training on the compensation scheme helpful, noting it improved their confidence on the topic.

"It's better than what it was." - MSUL FG 1

"Yeah, I definitely have a better understanding of it now." - MSUL FG 1

Monthly and quarterly meetings

MSUL found the monthly meetings valuable for highlighting issues, seeking clarity, gaining some leeway, and addressing broader WorkSafe challenges, including those affecting patients outside the Pilot. WorkSafe felt the communication was open, which helped with understanding data needs and navigating legal and privacy concerns.

"Yeah, they've been good. I feel like I'm always learning something new with that patient experience." - MSUL FG 1

"…the communication was really open I thought, which was great. So there was good back and forth no matter what sort of queries or questions, or possible blockers or seen as blockers we might come up with, it was all really, really great working with everyone." - WorkSafe FG 1

Project Management

Both MSUL and WorkSafe identified early project management as strong.

"I think really a strong positive for this project was [project manager's] leadership and just her way that – I mean it's not easy to coordinate all the stakeholders, so I think that she was really good at following up with everyone, and keeping everyone across all the different aspects that were happening in the project, and probably chasing people up, myself included, if things needed to be followed up on." -- WorkSafe FG 1

Challenges

Slow set up

MSUL stated that it took approximately two years and six months from the ideation of the Pilot to the acceptance of the Pilot.

"It sort of went these circles, and eventually we came back to that original idea again, not from me but they had this innate transition back to the nurse navigator and multidisciplinary, but then had to create the structures around item numbers to do the fee-for-service model." - MSUL FG 1

WorkSafe staffing changes and not getting clear information

There were many staff changes in WorkSafe throughout the life of the Pilot with various levels of engagement.

"I think we're up to the fourth person who's running it" - MSUL FG 1

With these staff changes, MSUL found it difficult to find specific answers.

"And even simple things like do you have cost of a claim, what are metrics that you actually measure that then I can compare to? But it's really hard to get any information." - MSUL FG 1

Internal WorkSafe barriers

WorkSafe staff spoke of existing barriers that could hinder future rapid pilot development. These included siloes, privacy, WorkSafe oversight and lack of understanding between WorkSafe and the provider.

Table 2. Internal WorkSafe barriers

Theme	Quotes from WorkSafe FG 1
Siloes and knowledge not being filtered past managers in WorkSafe	"WorkSafe is this massive, siloed organisation that's crazy. I've been here [number] years now and still haven't broken down barriers really. Part of it is a governance thing or a managerial thing that I see. I think at a higher level we have managers or really that – directors and that sort of stuff are in the room together, but then the information doesn't filter down. So we're talking to each other, but it's just at this really high level and doesn't come down to the boots on the ground people."
Privacy from a legal perspective	"…from a privacy perspective we are going to need a lot more information about how the providers are accessing or storing or using the information, and just making sure that we're confident that we have the right amount of information that we need to feel comfortable proceeding with the pilot as compared to a project that we may be running ourselves."
Reliant on provider to collect and analyse data and WorkSafe oversight on information use	"And it's not just leakage of data, like storage and the privacy issues, it's that you will analyse it correctly, because it's our reputation that comes on the line as well because we are entering into that agreement with them."
Attaining information from provider early in project design	"…having that access information upfront, and having a good way of obtaining it as early as possible…for us to be able to contribute our piece of our advice we need to have good information to rely on to give the best direction as what's the best way to source or contract or manage this pilot."
WorkSafe not understanding providers and providers lacking information on WorkSafe	"…also education for the teams themselves around provider-led training, I think that's something that's new to a lot of teams, so for us to learn about that as well and how we can support in that sort of project." "…understanding for providers around WorkSafe processes and how they can work with us in these types of projects."

Pilot Strengths and Intentions

Participants identified meaningful strengths in the Pilot's design and delivery. These centred on three areas: the intent behind the pilot, the value of multidisciplinary collaboration, and MSUL's role in supporting injured workers through person-centred care and scheme navigation.

The next two subsections draw from all four focus groups and interviews with injured workers. The injured workers represented a range of return-to-work outcomes: one had returned to pre-injury work full-time, two had returned to light duties, and one had not yet returned to work.

Intention

WorkSafe identified that MSUL had great intentions for this Pilot. The intentions were valued as they established mutual trust between the parties that aligned with long-term goals of WorkSafe, such as enhancing high-value care principles for injured workers.

> *"…the intention was right… I felt like [surgeon] truly did want to make a difference… for an orthopaedic surgeon to really want to understand the scheme and help his patients to get better, I think broadly, that intention was in the right spot." – WorkSafe FG 2*

Multi-disciplinary team

Multidisciplinary team meetings were identified as valuable for gathering diverse perspectives and informing decision-making across specialties throughout the life of the Pilot. The MSUL team spoke extensively about the value of this approach, noting that input from various specialists supported learning, more holistic patient care, and the ability to gather critical patient information through specialised questions drawn from their collective expertise and close patient relationships.

> *"We get insights about the mental health or things that they're going through, because they might've opened up to [nurse] but not to me…Or similarly with the pain specialist, we have different sunglasses that we look at the problem from, so they get a different set of history that's been quite useful." – MSUL FG 1*

> *"…the physio, the pain specialist, you know, being able to just reach out to them and ask and get that feedback on. You just get different aspects, or different viewpoints about the patient as well, you know, whereas we have a very one-sided view, I suppose, you know, we're looking at it purely from a surgical perspective…There's a lot of other facets that come into that as well. in terms of holistic care, that was really good." – MSUL FG 2*

MSUL staff also highlighted mutual respect and equal power dynamics within the group, which fostered open discussion around treatment options, clearer communication, and deeper insight into patients' needs, which they identified as leading to better patient engagement.

> *"So then we've brought the surgery forward about three months. The other thing probably has been analgesia around physiotherapy and a lot more aggressive in that aspect to facilitate the rehab, whereas in the past I'd say, 'Just ice it' and things like that, whereas it's been a lot more proactive approach in that regard." – MSUL FG 1*

> *"Able to triage symptomatic change between surgeon and pain specialist early." – MSUL FG 1*

This administrative agility and specialist alignment translated directly into clinical action for the participants. Injured workers highlighted timely and effective treatment and clear communication as standout features of their experience:

> *"The biggest highlight I had was how quick surgery got booked in and where because we were given the choice of a couple of places…So, they bent over backwards to get in, get it done, so yeah, that was a big highlight, which from an approval to having surgery was three days." – Injured Worker 2*

> *"They're very clear on your recovery process and everything like that. They're just very easy to deal with, I guess. And being very clear, they're also direct. They don't overload you with the information so you're going to forget, if that makes sense." – Injured Worker 3*

In addition, the injured workers felt supported by the MSUL team, describing them as "caring", "will stop to listen to you" and "easy to deal with":

"So having that support by them, go home and do them [strength exercises] two or three times a day. And they wanted me to get to the level where I went, and they were very happy with where I was. Because it was a team effort." – Injured Worker 4

Person-centered, holistic care

Numerous examples provide by MSUL highlighted patients in vulnerable situations where the compensation system exacerbated their stress. The team expressed that the person-centered, holistic approach changed their approach to treatment and helped patient recovery.

"I love it because it's a much more holistic approach. So I think with the four of us, in between all of us, we definitely get the whole picture about what's actually going on with this person and their life, and probably what stands out to me is how much those things impact their recovery." - MSUL FG 1

"Fantastic care more to holistically treat patients; Patients feel more supported." - MSUL FG 1

To understand how this holistic approach functioned across the broader system, participants were also asked how well the MSUL team collaborated with the wider treating team — including their GP, case manager, and employer where applicable. Most spoke highly of how the MSUL team integrated care seamlessly across the various treatment disciplines:

"As far as I know, everything was just flowing along." – Injured Worker 2

"[Nurse, surgeon and physiotherapist], they were all on top of it, they knew if I needed new dressings or whatever… I'd say, [physiotherapist], I'm seeing you again on Thursday. I've got a couple more dressings left, can you speak to [nurse] and grab a few more for me? And she'd do that and bring them back to [the location] so I didn't have to drive all the way out to [location]." – Injured Worker 3

"I think I had a really good group of people helping me, supporting me. And there's still pain – well, given that I was doing lighter duties. It was a really good team." – Injured Worker 4

Reflecting the strength of the multidisciplinary hub, any difficulties experienced by workers were almost exclusively attributed to supports external to the core team rather than the Pilot itself:

"I didn't even know that the GP was part of this Pilot program because the GP just referred me to the surgeon… So, I don't think GP had much of an involvement." – Injured Worker 1

"He's [return-to-work specialist] like 'I'm going to put it up to sevens and eights [hours of work]' and I'm like, Mate, that's not how it's meant to work. I'm meant to be gradually getting there… And even [physiotherapist] was like, 'How do you feel about that?' and I'm like, 'Yeah, there's some not nice words about to be let loose about that. He's throwing me in the deep end.' But other than that, everyone's been awesome." – Injured Worker 3

System navigation

MSUL provided many examples demonstrating how they felt they had improved the injured worker's experience of the WorkCover scheme. They viewed this as an important outcome of the Pilot.

"The way it has made a difference is helping patients navigate that process, and that's what we get told that, "we're so lucky that you're here." Like, you know, [nurse] has lots of discussions with them. It's just trying to keep their head above water, because without it, they're navigating this alone. [The nurse], contacts them regularly, just see how they're going." - MSUL FG 2

"The case managers kept changing, [the patient] haven't been paid properly. And [they have] made a remarkable recovery, really good recovery. I saw [them] two or three weeks ago, and [they] said, 'The WorkSafe journey has been terrible.' And this is even with the scrutiny, being in the Pilot, WorkSafe emailing the case manager, et cetera, it's still been really crap. But they said the only good thing that happened was they found us. That's the only positive thing." – MSUL FG 1

Pilot Challenges

While the Pilot produced some positive outcomes as noted above, several challenges impacted its overall success, including: limited WorkSafe engagement, low number of participants, misaligned purpose, poor communication and systemic challenges. The section concludes with information about systemic gaps in worker protections and claims lodgement.

Limited WorkSafe engagement

A foundational challenge was that Pilot expectations were not clearly established from the outset, resulting in misaligned goals. The Pilot was provider-driven, which resulted in limited involvement and engagement from WorkSafe. WorkSafe acknowledged this a weakness on their part.

> *"…it would have been totally fantastic if it was the nurse nav that we were really engaging with. And I think if we'd set up that engagement probably from the start, to say – even if it's low-touch for us to say, "What are you seeing early? We might be able to pick up issues early and redirect things." – WorkSafe FG 2*

Low number of participants

A lower number of injured workers participated in the Pilot than planned, reducing the number of participants available for interviews. Additionally, information sharing from MSUL to ISCRR required additional coordination, including escalation through WorkSafe, which limited the volume of injured workers ISCRR were able to reach in a timely manner.

To secure participants, MSUL expanded the inclusion criteria to include injured workers up to five months post-injury.

> *"One thing we have done is expand our inclusion criteria to five months. It still goes against the initial ethos, but I think it's just trying to fit with reality. I think the design of the Pilot otherwise we're happy with…." - MSUL FG 1*

Misaligned purpose

MSUL and WorkSafe held aligned but distinct views on the original intention of the Pilot. MSUL understood the Pilot's purpose as streamlining decision-making to ensure patients received timely care, while WorkSafe saw it as creating a coordinated approach to improve return-to-work outcomes for injured workers with shoulder injuries.

> *"I thought there was a conflict between what we wanted to convey to the insurer and how they understood it…so we made changes to our systems in terms of trying to cater for what they were looking for but that is not really clear cut." – MSUL FG 2*

Poor communication

The complexity of the relationship between MSUL and WorkSafe staff made the Pilot's goals feel increasingly difficult to achieve. WorkSafe identified themes of accountability, broken communication, and recruitment challenges. MSUL similarly raised concerns about frequent changes to WorkSafe's core project staff.

> *"I think I will hold my hands up and say that I haven't always been quick to set the quarterly meetings. So, that's been a limitation. But I think, as we've said, there's been communication issues. There's been slow reporting. There's been delays to responses. And yeah, a lot of scheme issues identified." – WorkSafe FG 2*

> *"…some [WorkSafe staff] were really driven and really helped build the project, but then it's on and off…." – MSUL FG 2*

Systemic challenges and structural barriers to early intervention

Broader systemic issues within the scheme compounded Pilot challenges. MSUL identified barriers such as case manager turnover and delayed decisions as preventing effective treatment and disrupting patient recovery. Concurrently, WorkSafe noted a tendency for these wider scheme issues to overshadow the Pilot's intended outcomes — emphasising that any shortcomings were not a reflection of the Pilot's effectiveness in isolation.

> *"The challenges we face are still the same, in the sense that case manager turnover…if you ask for surgery, there is a knee-jerk reaction to sending someone to an IME. And IMEs are very variable." – MSUL FG 2*

> *"…the focus has consistently been on these other issues with the scheme, which is not the intention of the Pilot. It is absolutely valid to raise, and the concerns are mostly absolutely legitimate – but it felt like it has deterred from being able to achieve meaningful outcomes, or being able to understand what the outcomes have been based on implementing a nurse navigator in a multidisciplinary team, as part of the pilot. So, I personally don't feel like I've seen what the benefits have been – specifically, what the benefits of the intention of the pilot were." – WorkSafe FG 2*

Although the Pilot was designed for early intervention (originally with a three-month inclusion criterion), MSUL identified several structural features of the broader workers' compensation system actively undermining early intervention efforts.

Case manager turnover

Little continuity existed among the case managers involved, disrupting the coordination and trust that sustained injured worker recovery requires. MSUL noted that constant staffing changes frequently stalled communication:

> *"So I'll be sending reports, like our WorkCover case conferences and it bounces back, 'Oh no, they're not here anymore', and it's like where's the continuity?... huge problem. And even our patients have complained that, 'I don't even know who my case manager is anymore.' So that part has been difficult..." – MSUL FG 1*

Beyond administrative confusion, the lack of case manager continuity directly impacted patient care. MSUL discussed sudden cancellations of 'common sense' assistance by new case managers, damaged patient morale and stalled physical recovery progress:

> *"I get really frustrated with the case managers who go, 'Well we're not approving that', 'Why not?', 'Well they don't need it', and it's like, 'Well do you understand? Do you understand that they can't actually lift their arm up above here and do those things, and they're not allowed to move – you try brushing your hair…Particularly a lot of the women we get who can't do up their bra, can't put their hair up in a ponytail, can't wash their hair, have to get their husband, or if they live by themselves – 'Do you understand how difficult their day-to-day life is? And you're just making it harder by not giving them any support." – MSUL FG1*

Injured workers also discussed challenges with case management turnover, noting it impacted the quality of support they received:

> *"Yeah, look, I had a few case managers. They were varied, their support." – Injured Worker 1*

Delayed approvals and administrative burden

Surgery approvals were frequently delayed by bureaucratic processes, and update requests from MSUL would trigger additional paperwork rather than timely decisions. MSUL explained that protracted wait times created anxiety for injured workers and reduced their time-window for providing effective treatment.

> *"I see people start off normal and usually around that 12 month mark they start to fall in a heap, and then there's nothing I can do to bring them back. Once they're gone, they're gone." – MSUL FG 1*

These delays were further exacerbated when systemic gaps occurred between the initial date of injury and the formal lodgement or approval of a claim, meaning patients were already months into their injury before receiving baseline support:

"– there's other employers who have this thing called injury leave where in construction and construction companies, we have one guy who got injured, he said he got injured, let go for three months, and then he comes back to work, still can't work, then the claim gets put in and it's now – then 28 days later the claim gets approved. It's almost four and a half months since his injury." – MSUL FG 1

Ultimately, these combined administrative deficits left workers feeling adrift within the broader system, separating the clinical care they receive from the wider bureaucracy:

"I've not really had any issues with [MSUL] at all. As I said, it's just all the other people around that it's like you're getting pushed around, if that makes sense?" – Injured Worker 4

Rejection of treatment requests

MSUL identified medical management was compromised when case managers rejected surgery requests or specific treatment methods, leading to predictable re-injuries and long-term harm.

"My first question is like are you a doctor, or a surgeon? So that's something else that we come up against as well, it's like they're questioning our methods or our suggestions for a good rehab and all this sort of stuff…they're like, 'Oh, well she doesn't need it twice a week.' Yes she does." – MSUL FG 1

Independent Medical Examinations (IMEs)

The adversarial use of IMEs emerged as another contentious issue, acknowledged by both MSUL and WorkSafe. MSUL offered numerous examples of how the IME process had derailed recovery by overriding the recommendations of treating specialists.

"[I say] you need surgery, but then they go see an IME for 10 minutes, not even a shoulder specialist will then say, "oh, you don't need it" and then it creates this whole other pathway, then they go to conciliation, they go to medical panel, and by the time they actually end up getting approved for surgery, they've - we had a couple of them who - breached the 52-week mark. They've lost their job because of now beyond the obligation period, and before they get any real treatment, it's already passed that trial period." – MSUL FG 2

This is compounded by the fact that these bureaucratic obstacles often yield no structural benefit, delaying inevitable care:

"…this IME industry has so much inertia that I can't see a way around that and the frustrating thing for me is that a lot of these patients eventually, when they go to conciliation or medical panel, the IME decision is reversed anyway." – MSUL FG 2

Injured workers reported feeling that the IME process was actively hostile toward their recovery teams, operating with a lack of true independence:

"Over the whole thing, the biggest problem I experienced isn't with [MSUL], it's with all the insurance companies and their IMEs where they are not independent. The one I had basically called my physio, my GP, the surgeon, the nurses, all completely incompetent and they don't know what they're talking about." – Injured Worker 2

Employer disengagement

The system challenges extends to the workplace, where employers frequently fail to maintain contact with injured workers, weakening a critical link in the return-to-work recovery chain. MSUL spoke of injured workers who faced distinct challenges navigating relationships with return-to-work coordinators and unengaged employers:

"The employers, it's probably 50-50. For the most party they're pretty positive. I get the odd one that you can actually hear them rolling their eyes when I ring up and start talking about a

WorkCover injury and they're like, 'Oh well', you know. But for the most part they're – they're surprised to hear from someone like, 'Oh.' I say, 'Just ringing to check in', and a lot of them – I say, 'Have you spoken to whoever the patient is?', 'No, we haven't heard from them', and I go, 'You haven't called them and checked in on them?', 'No.'" – MSUL FG 1

Systemic Gaps in Worker Protections and Claims Lodgement

MSUL discussed that workers frequently asked them about how to lodge a claim and the extent of their employer's legal obligations. MSUL documented numerous instances where patients with clear, debilitating injuries had incidents go unreported to WorkSafe, were denied basic care by case managers, or were left in severe financial distress due to uncompensated secondary income.

"I've had quite a few people over the journey going – where their employers have been less than, not honest, but less than forthcoming with any information about how to actually lodge a claim…. I don't know whether that's reluctance on the employer's part, or whether there's genuine not understanding the whole WorkCover thing." – MSUL FG 1

MSUL discussed that this lack of oversight allows for questionable employer practices that actively derail a worker's employment security and recovery trajectory before the treater can even intervene:

"So then when we wanted to enrol her in the Pilot [the employer] said no, and they were just paying the consult bills et cetera. Then we sent another – there was an email on her file saying she's resigned and we're no longer paying. Now I'm not sure what that means, whether she got pushed out, or whether she's actually left because she felt like this is a crap place to work... But nonetheless... she's had a shoulder fracture." – MSUL FG 1

MSUL staff indicated that even when these breaches of worker protection were identified and escalated to regulatory bodies, the system lacked the responsiveness to offer timely intervention:

"But this is after we've recognised the problem, highlighted it, spoken to [case managers or WorkSafe] multiple times, but still nothing's done." – MSUL FG 1

Future Nurse Navigator Pilot Considerations

WorkSafe and MSUL did not endorse continuation of this Pilot. However, they provided learnings to be considered for comparable pilots in the future, including: strengthening governance and frameworks, focusing on mental injury, integrating dedicated return-to-work and workplace allied health roles, centralising the multidisciplinary team structure, creating system navigation enhancements and shifting toward "earned autonomy" and employer education.

Strategic Alignment on BAU Extension

Neither WorkSafe nor MSUL recommended extending the pilot into business as usual, primarily driven by a mutual acknowledgment that the current data is insufficient to justify expansion.

"I don't think we could recommend this service to become BAU at this point. We don't have the insight." – WSV FG 2

A fundamental barrier to a BAU recommendation was a failure to deliver on agreed outcome measures. Key requirements, particularly Patient-Reported Outcome Measures (PROMs) agreed upon between WorkSafe and MSUL, were not fully met due to communication breakdown. Reported outcomes were largely limited to qualitative participant experience measures from injured workers, falling short of the broader, quantifiable commitments made by MSUL at the outset. Without this data, WorkSafe felt unable to isolate the specific value of the pilot:

"I think to be confident recommending it and expanding it, I would need to understand what the outcomes would actually be, based on the nurse navigator being there, which I don't feel like I have a strong understanding of yet... I don't know how specifically the nurse navigator being there to help made a meaningful impact on those navigating these issues that have been identified." – WorkSafe FG 2

Despite these data gaps, WorkSafe explicitly identified that the Pilot's shortcomings were not necessarily a reflection of its effectiveness in isolation. Rather, there was recognition that broader scheme issues actively clouded the data, making it difficult for the Pilot to succeed on paper:

"I would have loved to have seen the outcomes – positive outcomes about that interaction with the nurse nav pilot, so that we could broaden it out. So, this is – it's disappointing. And I hope that the business itself doesn't look at this to say, "This hasn't worked." Because I think it hasn't worked for a number of reasons, and not because the nurse nav was not effective." – WorkSafe FG 2

To reconsider a BAU extension in the future, WorkSafe identified several specific metrics that would need to be rigorously demonstrated. These include improved experience measures, quantitative data on decision timeliness, and tracking how often agents must return to request additional information. While these operational measures may not directly translate to immediate return-to-work outcomes or cost savings, they would provide the meaningful evidence of a better experience required for permanent implementation.

Expanding Scope into Mental Injury and Psychological Care

Both WorkSafe and MSUL discussed the potential benefit of care coordination models for psychological injuries, where care pathways are traditionally fragmented. WorkSafe have previously run care coordination pilots for long-term mental health claims called 'Support Coordination'.

"But again, we know, in mental health, we do know that care coordination does have a positive impact... within treatment and recovery services that we run, I would love to see care coordination trialled in mental health." – WorkSafe FG 2

MSUL noted that academic literature validates care coordination in mental health settings. To proactively address the perceived injustices and psychological distress that stall physical recovery, MSUL recommended embedding a psychologist directly into the core multidisciplinary team.

"Would love to have a psychologist, because there's either a past or there's going to be some problems that come along, and that sense of injustice, all of those sort of things just boil away at patients. So then if we can act proactively in that space I think that would be another really good addition." – MSUL FG 2

Future Rapid Pilot Considerations

Strengthening WorkSafe Governance and Pilot Frameworks

WorkSafe participants highlighted that rapid pilot initiatives require closer operational integration to protect stakeholder relationships and maximise program delivery. Suggestions included appointing an internal WorkSafe "champion" or embedding staff directly on-site with the provider to maintain productive communication channels and assist with recruitment. Furthermore, it was noted that future pilot planning must accord greater weight to the clinical and systemic complexity of the coordinator role.

"...it's probably a very unique person that could do this properly – that they could empathise but wouldn't inflame the situation with the more systemic issues." – WorkSafe FG 2

To maximize recruitment viability, WorkSafe recommended expanding the participant intake windows to realistically capture volume. Both MSUL and WorkSafe agreed that future models must feature more rigorous onboarding to ensure clinical coordinators possess an in-depth understanding of the WorkCover scheme.

> *"…to use nurses or other clinicians and really, really get them to understand the scheme in-depth, and in fact probably co-design or collaborate and work closely under the same umbrella to help them understand the scheme…I think that would be beneficial." – WorkSafe FG 2*

Drawing on their experience with this implementation, WorkSafe staff identified several critical success factors for streamlining the development and execution of future rapid pilot programs:

- **Appoint a dedicated project manager:** Successfully driving a rapid-cycle pilot requires a project manager equipped with exceptional communication, organisational, and stakeholder management skills to keep timelines on track. This role should also serve as the primary liaison with legal teams and oversight bodies to ensure compliance at every stage of the pilot.
- **Engage the 'right' stakeholders early:** Establish connections with key internal and external stakeholders at the inception phase to accelerate project design and secure cross-functional buy-in. This includes early engagement with legal counsel to ensure contracts and pilot processes are developed within appropriate legal frameworks, as well as alignment with Return-to-Work Victoria to ensure the pilot's findings and outcomes can inform and strengthen their programs.
- **Establish context with a project checklist:** Develop a comprehensive pilot checklist and convene early scoping meetings with internal teams to clearly define project context, boundaries, and operational scope. This checklist should explicitly account for provider-specific constraints — such as specialist availability and capacity limitations — to ensure realistic planning and scheduling from the outset.
- **Standardise provider frameworks:** Create clear project templates for external providers that explicitly outline WorkSafe governance, performance expectations, and deliverables. These frameworks should define the level of oversight required throughout the pilot, establish accountability mechanisms, and be developed in close consultation with legal to ensure contractual obligations and compliance requirements are embedded from the start.
- **Define and maintain clear oversight structures:** Establish a governance framework that sets out the level of oversight required at each stage of the pilot, including escalation pathways, reporting cadences, and decision-making authorities. This ensures transparency, manages risk, and supports continuous improvement throughout the pilot lifecycle.

Integrating Dedicated Return-to-Work (RTW)and Workplace Allied Health Roles

MSUL highlighted that injured workers frequently maintain adversarial relationships with external return-to-work and occupational rehabilitation providers, who are often perceived as pressuring patients to return to pre-injury capacity prematurely. Defining the clinical model structure early and embedding specialised return-to-work coordinators or occupational therapists directly within the clinical team would allow for site visits, precise physical duty assessments, and a more gradual, psychologically supportive re-engagement with work.

> *"I think if there's someone within the Pilot that would sit within that sort of structure that's linked to the clinical side, I think that would be to gain a trust... I feel like the end game for a lot of it is return-to-work concerns is more about getting to those pre-injury hours and pre-injury duties... Whereas, in my mind, I think if they can get them back to work soon, but purely for that*

psychological, habitual aspect of it then that is probably good enough to begin with..."
– MSUL FG 2

"The other one probably an occupational therapist... There is that different skillset to then be able to get to a worksite, have a chat to them, understand what the physical duties are to then say, 'Okay, you can't do this, you can't do –', that sort of back and forth." – MSUL FG 1

Centralising the Multidisciplinary Team Structure

Should the model be scaled more broadly, MSUL recommended centralising all treating specialists—including external streams like physiotherapy—under a single clinical banner. Bringing the entire team into one unified structure could facilitate real-time communication, direct therapist-to-surgeon data sharing, and a vastly superior flow of patient care.

"Everything being contained in the one structure that would probably be something that I would be more vocal on... if we're doing a similar model on a broader scale it probably makes sense to centralize the physiotherapy as well... getting a verbal update from therapist to therapist... I think it's more powerful to do that. The physio is a very important part of this journey, because that's who the patient sees once or twice a week." – MSUL FG 2

System Navigation Enhancements: AI Tools and GP Education

To mitigate the confusion caused by scheme complexities, MSUL suggested developing an automated AI navigation tool hosted on the WorkSafe website. This would provide injured workers with clear, immediate answers regarding timelines, claim lodgements, and the 52-week obligation period.

"...it's very hard to understand the WorkCover system... When does the clock start ticking? Because everything matters for that 52 weeks. And it was just really hard to get that sort of information. I think that speaks to then the complexity of the system, if people working in it don't understand it, then what hope does an external, let alone a patient have, in navigating that system?" – MSUL FG 2

Additionally, MSUL emphasised the need for systemic General Practitioner (GP) education. Current GP workflows lean toward sequential, conservative treatments before making specialist referrals, which inadvertently exhausts critical early intervention timelines.

"So usually what will happen is the patient will have already had some physiotherapy, have some investigation, have an injection, then it doesn't work send it to a surgeon, and that's what usually takes about six to nine months... In my GP education session... my messaging is think of this group as a cancer. It's the same as a cancer, just refer earlier, soon as you see them... send them straight away and we'll look after them." – MSUL FG 1

Shifting toward "Earned Autonomy"

Finally, MSUL suggested a structural shift in how approvals are handled and how employers engage with claims. For accredited pilot programs, they advocated for a private-insurance or Medicare-style approval model, allowing clinicians to treat patients immediately and face retroactive audits if necessary, rather than delaying critical care with upfront paperwork.

"Allow us to do what we think is right, treat these patients in a timely fashion, and then if you think we've done something wrong then come after us after." –MSUL FG 1

Employer Education

MSUL suggested educating employers on supporting injured worker, noting proactive, non-adversarial contact between employers and workers is a low-cost, high-impact intervention that significantly improves recovery mindsets.

"...a lot of patients complain and say, 'I've been in the company for 10 years, no one's rung me.'... if someone puts a claim in there's an education package or something that goes into the

employer with some simple things that they can do like… 'Hey Joe, just thinking about how you're going…' Because the interaction's always adversarial at the moment. But I think that paradigm needs to change…" – MSUL FG 1

CONCLUSION

WorkSafe and MSUL agree that the Pilot should not be extended or transitioned into BAU in its current form. The decision not to extend or transition the Pilot into BAU reflects several compounding operational and structural challenges:

- **Misaligned intentions:** WorkSafe and MSUL entered the Pilot with fundamentally different expectations of its purpose. This misalignment disrupted communication throughout the program's life.
- **Insufficient data:** The Pilot's outcomes were largely unquantifiable and did not meet WorkSafe's agreed baseline requirements. MSUL's quantitative data is not included in this report.
- **Systemic and workforce barriers:** Scheme-wide systemic issues were at the centre of most communication breakdowns between MSUL and WorkSafe. High case manager turnover further disrupted injured workers' recovery and hindered external engagement — to the extent that no case managers were available to participate in this evaluation due to workload constraints.

Program Strengths and Value

Despite falling short of its broader goals, the Pilot demonstrated meaningful outcomes in direct patient care and team functioning:

- **Positive patient experiences:** Injured workers reported a positive experience with MSUL, describing feeling heard, respected, and well-supported. Participants specifically noted that their clinical treatment was both timely and effective.
- **System navigation support:** MSUL provided an effective buffer between participants and the broader WorkCover scheme, helping vulnerable workers navigate complex administrative processes with greater confidence.
- **Multidisciplinary team cohesion:** Formal meetings fostered mutual respect, open cross-specialty communication, and a collaborative approach to patient care that built genuine trust with injured workers.

Looking Forward

Although the Pilot did not fulfil its original mandate or produce the quantifiable outcomes required for broader rollout, it demonstrated potential in the value of care coordination as a model. The structures developed during this Pilot — collaborative multidisciplinary teams and dedicated navigational support — offer a useful foundation for future initiatives. One avenue worth exploring is shifting the model's application away from traditional orthopaedic injuries toward mental health settings, where holistic care and intensive system navigation may be better utilised.

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