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# Rapid Interdisciplinary Senior Engagement (RISE)

Initiative Type

Model of Care

Status

Deliver

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## Summary

The Rapid Interdisciplinary Senior Engagement (RISE) model of care enhances access to allied health, nursing, and geriatrician services to rapidly support older residents in the community. RISE helps older community members return home sooner and or keep them home whilst keeping them safe through rapid access to community-based services including allied health and nursing. In

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addition, the RISE service provides improved rapid access to services within a non-acute care setting whilst bridging and coordinating the gap between acute care presentation and engagement with other community care providers for ongoing care. It also provides the ability to be a point of contact out of the acute setting for partner organisations who may have a client at risk of presentation to Fraser Coast Acute hospitals.

### Key dates

Mar 2022

### Implementation sites

Fraser Coast, Wide Bay Hospital and Health Service

### Partnerships

Healthy Ageing Collaborative, Urangan Community Wellbeing Centre, Allied Health Fraser Coast

## Key Contacts

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## **Aim**

To improve access to community-based services for non-complex older persons to safely reduce acute service demand.

## **Benefits**

- community based management and optimisation of preventable admission conditions
- reduced utilisation of acute/hospital services including short stay services
- safe earliest discharge for older community

## **Background**

Fraser Coast, within Wide Bay Hospital and Health Service (WBHHS), faces the challenges of an ageing population with increased levels of potentially preventable admissions and demand for acute care services for our older community members.

The initiative was the result of extensive work undertaken by the Fraser Coast Healthy Ageing collaborative. The collaborative was a group of public and private health services, community organisations, general practitioners, consumers, residential aged care facilities and supportive living arrangement providers with a common goal of assisting Fraser Coast older persons to access the right care in the right place at the right time. Further guidance was obtained from opportunities identified by peer review processes and gap identification with key stakeholders within the acute areas and allied health.

## **Solutions Implemented**

A model of care was developed that rapidly connects with patients, consisting of an intradisciplinary shared skill approach inclusive of allied health and nursing. Services are delivered within the community setting, depending on needs of the patient and their goals. Establishing and building connections through delivery of services and advice within a non-acute setting at rooms within the Urangan Community Wellness Centre. Establishing improved access to evidence-based information and services to the community through connections with community social groups and events run out of the wellness centre. Developing activities to establish connections with community service providers inclusive of General Practice to provide a referral pathway that helps avoid presentation to Fraser Coast Acute Services.

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## Evaluation and Results

From March 2022 to 30 September 2022:

- 181 total referrals
- 646 occasions of service
- an average of 30 referrals received each month
- maximum of 40 referrals received each month
- 84% of referrals actioned in 48 hours or less
- 87% of patient on program for 14 days or less

## Lessons Learnt

- implementation during peak of COVID experienced by Queensland
- staffing shortages meant need to work collaboratively and flexibly
- exceptionally valuable to have patient focused clinicians and discipline leads who share the vision
- beneficial to have a 'how can we' approach and to focus on the initial reasons for the service at times of challenges

## References

[Fraser Coast, Wide Bay Hospital and Health Service Calderdale Framework](#)

PDF saved 02/04/2025