Clinical Priority Assessment Criteria
Orthopaedics

On July 1 1998 a new booking system was introduced by the Health Funding Authority. The objective of this was to replace waiting lists for all elective surgery within public hospitals.

The new system has three components: Referral Guidelines (RG), Assessment Criteria for First Assessment (ACA) and Clinical Priority Assessment Criteria (CPAC).

A working group comprising orthopaedic surgeons, general practitioners and HFA representatives was set up early in 1999 to review existing systems and to make recommendations for the future. In attempting to develop a more consistent means of determining Clinical Priority Assessment Criteria, the working group examined a number of systems being used by various medical specialties. It was concluded that a modified version of a proposal, termed the "Integrated Patient Scoring System" (IPSS), developed for Plastic Surgery by Stewart Sinclair appeared promising.

The rationale for IPSS was that a Scoring System cannot be diagnosis independent, prioritisation can only be done by clinicians in that specialty, priority should increase with waiting time and it must be SIMPLE so as to involve the least amount of clinical time. **It was essential that any scoring system provided a ranking of priority, which was consistent with clinical practice.**

Prioritisation:

A. Clinicians

At the first, or any subsequent, consultation a treatment plan is determined. Where surgery is the most appropriate form of treatment, the degree of urgency (i.e. priority) is decided and the patient is given a score between 1 and 5. **The higher the score the higher the priority**.

This is the CLINICAL SCORE, and it should reflect the patient's overall need for surgery relative only to patients with the same condition.

In arriving at the clinical score all factors relevant to the patient should be considered.

eg degree of disability
level of pain
potential for harm through delay etc
social circumstances such as family / community impact, leisure activity
ability to work

In summary, to obtain a Clinical Score the clinician simply identifies the proposed operative procedure by the specific code and records the appropriate score 1-5. (A copy of Orthopaedic Codes should be available in each consulting room.)

B. Secretarial / Administrative

The Clinical Score determines the **PRIORITY RANKING SCORE** from within a permitted range. A Priority Ranking score has been developed for each procedure within a range varying between 5 –100 (this reflects the considered relativity of different procedures).

Eg. A patient requiring an ankle arthrodesis is given a Clinical Score of 3 following assessment. As the score range allocated to “ankle arthrodesis” is 40 - 85, this patient would get a Priority Ranking Score of 62.

This process, and the maintenance of the relative ranking of all patients at any time, can be readily managed by secretarial staff through a computer software programme created specifically for this task. (This is available through the Ministry of Health.)

.