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Patient and provider perspectives regarding criteria for patient prioritization in two specialized rehabilitation programs

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Patient and provider perspectives regarding criteria for patient prioritization in two specialized rehabilitation programs

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Abstract

To increase fairness and equity in access to rehabilitation services, a strategy emerging from the literature is patient prioritization. Selecting explicit prioritization criteria is a complex task because it is important to simultaneously consider the objectives of all stakeholders. The of this study was to compare service users' and service providers' perspectives regarding patient prioritization criteria in two rehabilitation programs. We conducted a multiple case study in two rehabilitation programs, i.e., a driving evaluation program and a compression garment manufacturing program. We sent a web-based survey asking two groups (patients and providers) to individually produce a set of criteria, then individual answers were coded and combined in a single set of criteria. Stakeholders identified a total of 32 criteria to prioritize patients. Some criteria, such as age, occupation, functional level, pain, absence of caregiver, and time since referral, were considered important by both stakeholders in both programs. Patients and providers tended to have similar opinions about criteria to prioritize patients in waitlists. Taking into consideration the opinions of all stakeholders concerning prioritization criteria is an important part of the decision-making process.

Keywords

Prioritization, patient, provider, perspectives, healthcare, rehabilitation, waiting lists, criteria

Introduction

Waiting lists are commonly used to manage access to healthcare services when demand outstrips capacity.^{1,2} Waiting lists exist in a wide variety of healthcare services, such as routine care (e.g., diagnostic or therapeutic technologies),³ acute care (e.g., elective surgery)⁴ and specialized care (e.g., rehabilitation programs).^{5,6} However, wait times for rehabilitation services have increased in the past years,^{3,6-8} suggesting that waiting lists alone may not be an optimal strategy to improve access to healthcare. Patients who experience excessive wait times can suffer significant consequences, such as increased pain and impact on function, and deterioration in quality of life.^{7,9}

There is an urgent need to find solutions to improve how waiting lists are managed and to reduce negative impacts of long wait times for rehabilitation services. In addition, waiting lists should be managed as fairly as possible to ensure that patients with greater or more urgent needs receive services ahead of those with less need, and that patients with approximately the same degree of need wait about the same length of time.^{1,10} A strategy emerging from the literature to ensure more fairness and equity in managing waiting lists is patient prioritization.

Prioritization is the process of ranking all referrals in a certain order based on various criteria.^{2,11} Patient prioritization means the ranking of patients due to receive

a specified service in a certain order of priority, in contrast to a triage system which is used to sort patients into groups within programs.² Patient prioritization has been a strategy commonly used to manage waiting list among a variety of healthcare services, such as cataract surgery,^{12,13} arthroplasty^{14,15} and children mental health services.¹⁶ Patient prioritization has been used in rehabilitation programs, mostly for occupational therapy¹⁷⁻²⁰ and physiotherapy^{17,21} services. However, despite its apparent homogeneity and simplicity, this practice can take different forms from one rehabilitation program to the next¹⁹ and vary widely, creating important differences in prioritization outcomes. Effects of prioritization on waiting times are still to be clearly demonstrated in the literature, such as effects on transparency and equity for patients and acceptability for stakeholders.²²

Patients' relative priority can be based on various types of criteria such as severity, urgency, need and expected benefit of the intervention.¹⁰ The aim of patient prioritization is for patients with the greatest needs to be treated first and for patients' relative priority to be determined objectively on the basis of a common set of criteria.^{4,10} Prioritization criteria, either specific or subjective, are usually determined by consultation between clinicians in a given program.^{19,21} Selecting criteria is a complex task, because it is not always based solely on individual needs, but may also be influenced by funding arrangements or specific aspects of the health service and/or be subject to consumer (patient) pressures and special interest groups or pressure.² Consequently, different sets of criteria can be proposed to prioritize patients depending on the service offered, which may include general criteria that encompass personal factors (e.g., age), social factors (e.g., ability to work),⁴ or any other factor deemed relevant (e.g., patient's quality of life).^{10,23} Some specific criteria are objective and measurable and are often related to disease-specific outcomes (e.g., visual acuity for cataract surgery)²³ despite the fact that many criteria are subjective (e.g., pain). Subjective criteria may be difficult to evaluate and opinions about their relative importance may vary.

Allocating limited resources to a group of patients, which is related to patient prioritization, is an ethical decision and should therefore take into account a range of viewpoints, including those of various individuals and professions.²⁴ Many studies have explored patient perspectives or experiences related to healthcare decisions.^{21,25-30} McKie and colleagues demonstrated that general public consultation can be incorporated in all decision-making, at the individual patient level, program level and health system level.²⁴ Methods to probe patients or citizens can be used to increase citizen participation in the political discussion by improving communications between policy-making bodies and the population.²⁵ Patients' involvement and engagement in improving or redesigning healthcare

services have progressively become more important in recent years.³² This involvement can result in new directions that change and improve healthcare delivery systems.^{28,29}

Thus, patient perspective is an important component in evaluating the quality of healthcare services, as a change in patient prioritization can make a difference in their experiences.²⁶ However, little is known about the level of agreement between diverse groups of individuals involved in explicitly prioritizing waiting lists.^{27,31} Edwards et al.³¹ conducted several surveys of specific groups with the aim of eliciting preferences regarding which factors should and should not determine waiting time. They found that the majority in each group surveyed (general practitioners, consultants, health authority commissioners and members of the general public) believed that some criteria, such as pain severity, rate of deterioration of disease, distress level, and disability level, should play the most influential role in determining waiting times. However, different groups might have differing opinions about the relative importance of the key criteria used to prioritize patients on waiting lists.^{18,27} For example, patients and relatives tended to give less weight to difficulty in doing daily activities and scored pain much higher than the other groups. This may be attributable to their previous disease experience, such as suffering from pain, adaptation to everyday activities, and ability to cope with impairments.²⁷ The fact that priority decisions are influenced by certain personal characteristics or experiences within each group of respondents suggests that designing prioritization tools that apply to a heterogeneous population remains a challenge.¹⁸ Having an objective, explicit scoring system derived from everyone concerned would be expected to produce needs-based patient prioritization and improve equity, and may increase the acceptability and credibility of the system.^{22,27} However, in order to develop such a prioritization tool, it is important to understand these stakeholders' similar and differing opinions regarding healthcare decisions and their preferences concerning prioritization criteria.

The aim of this study was to compare and discuss service users' and service providers' perspectives regarding patient prioritization criteria in two rehabilitation programs.

Methods

Study design and setting

We conducted a multiple case study³³ in two specialized rehabilitation programs of the Centre intégré universitaire de santé et de services Sociaux de la Capitale-Nationale (CIUSSSCN) in Quebec City (Canada) between January and December 2018. We chose this design because it helps to understand the dynamic present in particular settings, and because those involved in two rehabilitation programs agreed to collaborate in the study, i.e., a driving evaluation program and a compression garment manufacturing

program for burn victims. These programs are publicly funded and wait list management is one of their main concerns with respect to accessing rehabilitation services in a timely manner.

The driving evaluation program offers a range of specialized rehabilitation services related to driving abilities, mostly to outpatients with physical and intellectual disabilities. The program is delivered by a multidisciplinary team that includes occupational therapists, driving instructors, a neuropsychologist, a social worker, a clinical coordinator and a manager. Referrals come from other rehabilitation professionals who encounter driving-related problems with their patients.

The compression garment manufacturing program customizes compression garments for burn victims during their inpatient or outpatient rehabilitation. It is mainly occupational therapists and tailors who work together to adapt garments to patients' needs. Plastic surgeons refer patients to the compression garment manufacturing program after their skin graft if they think it is necessary for the healing process. Other professionals are in contact with the burn victim and participate in the general rehabilitation process, such as physiotherapists, nurses, clinical coordinator and managers.

Ethical

Centre intégré universitaire de santé et de services Sociaux de la Capitale-Nationale Ethic Committee granted full ethic approval (reference EMP-2017-587) and Centre Hospitalier Universitaire de Québec-Université Laval Ethic Committee approved the project as well to probe service providers from their institution. All participants answered an electronic question asking for consent and describing potential consequences of the study, prior to participating. They were free to decline the invitation to answer the questionnaire or to drop out of the study at any time.

Participants

We recruited participants from the two rehabilitation programs and created two groups in each program: 1) service users group, and 2) service providers group, including clinicians, coordinators, and managers. We aimed to have between 6 and 10 participants in each group. Clinical coordinators facilitated recruitment by targeting potential participants in their program (patients, clinicians and managers). They first contacted patients to obtain their consent to participate in the study. Then we called participants to provide more details about the study and explain their contribution to the project. We contacted clinicians and managers directly by email to explain the project and obtain their consent to participate. Inclusion criteria for patient participants were to be 18 years of age or older, have physical disabilities, be on the waiting list or have received services from the program within the past

year, and speak French. Inclusion criteria for service provider participants were to have been working in the program for at least 6 months and work for a minimum of 3 days/week. These were to make sure that participants have the required experience about the context and the population in order to identify criteria that reflected the clinical reality of the program.

Procedure

With the aim of selecting prioritization criteria, we sent a web-based survey asking a group of informed stakeholders to individually produce a set of options (called "criteria" in this study). The objective was to elicit a list of criteria from various stakeholders that would help answer the research question and provide a broad representation of views and more comprehensive set of ideas. To operationalize data production, we sent a web-based questionnaire using an online survey platform (LimeSurvey). The platform uses email addresses to send the link to the web-based questionnaire. To access the questionnaire, participants must enter an invitation code provided in the email. Up to three invitation emails were sent if necessary, at one-week intervals. A research team member (master's student) designed the questionnaire, activated the sending of the initial and reminder emails, and collected the answers for analysis.

Data Collection Tool

The questionnaire aimed to document individual perspectives regarding patient prioritization criteria in each program. It included only one open-ended question asking the participant to suggest multiple criteria that he/she considered most important for patient prioritization. To help participants conceptualize the notion of prioritization criteria, some examples were given, such as criteria related to the person (e.g., age, sex), person's condition (e.g., degree of impairment, pain, severity of depression), functioning (e.g., disability level, ability to walk), or any other criterion the participant deemed relevant. Sociodemographic questions about age and sex of the participants were included at the end of the electronic questionnaire. Occupational questions about their profession and their experience were included for the providers. Research team members tested a draft version of the questionnaire for clarity and relevance with a clinician from each program.

Analysis

We extracted data from LimeSurvey into analysis software (Dedoose). We conducted an inductive thematic analysis to group answers concerning criteria from all participants. We identified themes or patterns in the criteria elicited and organized them into coherent categories.³⁴ These categories allow similar criteria to be combined under the same label in order to create a manageable list of criteria in the group phase. Thus, individual answers from each group (patients and providers) were coded and combined

in a single set of criteria. The principal investigator reviewed and validated the grouping of the criteria included in the set.

Results

We sent email requests to 24 rehabilitation service providers and 20 patients. A total of 20 providers and 11 patients answered the electronic questionnaire, which represents a mean participation rate of 83% and 55%, respectively. Table 1 shows sociodemographic and occupational characteristics of the provider groups. We had a broad range of providers, including clinicians, managers, coordinators, and others such as tailors (who

prepare compression garments) and driving instructors (who educate patients about driving techniques). All the main service providers working with patients in the programs are represented in each group. Table 2 presents the characteristics of patients participating in the study. We asked age of the participants with categorical variable to facilitate the completion of the questionnaire and in order to respect the privacy of the respondents.

Following a thematic analysis and after combining similar criteria, driving evaluation program participants proposed a total of 22 criteria to prioritize patients in a driving evaluation program setting. Table 3 lists the criteria with number of occurrences of each criterion mentioned by

Table 1. Sociodemographic and occupational characteristics of providers in each program

		Compression garment manufacturing program providers (n=12)	Driving evaluation program providers (n=8)
Age (years)	Mean	42.8	44.8
	SD	8.6	9.2
Sex	Men	-	1
	Women	12	7
Workplace	Rehabilitation centre	8	8
	Hospital	4	-
Program	Acute care	4	-
	Rehabilitation	4	8
	Technical aids	4	-
Occupation	Tailor	3	-
	Manager	1	1
	Driving instructor	-	1
	Coordinator	1	1
	Clinician	7	5
Years of experience in occupation	Mean	18	19.8
	SD	7.1	10.3
Years of experience in program	Mean	11.8	4.6
	SD	8.3	4.0
Education/Area of expertise	Administration	-	1
	Education and road safety	-	1
	Fashion design	3	-
	Neuropsychology	-	1
	Nursing	2	-
	Occupational therapy	5	4
	Physiotherapy	2	-

Table 2. Sociodemographic characteristics of patients in each program

		Compression garment manufacturing program patients (n=5)	Driving evaluation program patients (n=6)
Age (years)	30-39	1	2
	40-49	3	1
	50-59	-	1
	60-69	1	-
	70-79	-	2
Sex	Men	1	4
	Women	4	2
Waiting situation	On the waitlist	-	2
	Receiving services	4	1
	Already received services	1	3

providers and patients. Of these criteria, both stakeholders mentioned 10 (45%), providers only 9 (41%) and patients only 3 (14%) of them. Compression garment manufacturing program participants listed 27 criteria to prioritize patients in a compression garment manufacturing program setting. Similar to the first group, stakeholders agreed on 9 criteria (33%), providers added 14 (52%) of their own, and patients mentioned 4 more (15%). Overall, a total of 41 criteria were elicited by all stakeholders, and from these criteria, 16/41 (39%) were shared between patient and provider. However, we can state that 81% (17/21) of patients' criteria were mentioned by providers as well. It should be noted that some criteria were only mentioned by the patients in one program group and by both stakeholders in the other program group (pain, absence of caregiver and time since referral), that is why we duplicated them in the table.

We also compared criteria shared by both rehabilitation programs. Stakeholders in both programs mentioned a total of 8 criteria (2 only by the provider group and 6 by both groups of stakeholders). Table 3 shows that criteria such as age, occupation, functional level, pain, absence of caregiver, and time since referral were considered important in patient prioritization by both stakeholders and in both programs.

Patients in both groups mentioned a common set of criteria related to personal factors: diagnosis, pain, absence of caregiver and everyday consequences. Providers also mentioned some organizational elements, such as reasons for referral, origin of referral/inpatients, imminent appointment and organizational constraints.

Discussion

Our study compared patients' and providers' perspectives regarding prioritization criteria in two rehabilitation programs. Stakeholders pointed to a wide variety of criteria, based on both individual (e.g., diagnosis, age, pain) and organizational (e.g., reasons for referral, origin of referral, time since referral) factors. Our results show that patients and providers tended to have similar opinions about the criteria to prioritize patients on waitlists, with agreement on almost half of the criteria. Although from two different rehabilitation programs, stakeholders shared opinions concerning some generic prioritization criteria such as age, occupation, functional level, pain, absence of caregiver, and time since referral. Other criteria such as degree of burn, driving responsibilities for a relative, and many others might be labelled as specific to each rehabilitation program since they are linked to the type of healthcare service provided.

Relevance of patients' perspectives

Recent trends in healthcare system policies and organization tend to be patient-centered^{35,36} and consider the patient as an expert who can provide relevant information about a given problem.^{31,37,38} According to this paradigm, all stakeholders, including patients, must be taken into account in healthcare decision-making^{37,39} and consequently in selecting which criteria to use to prioritize access to healthcare services. One argument for considering patients' preferences is that patients are affected by the consequences of a disease and could experience impacts on their quality of life.^{37,40} It could be linked to Patient Reported Outcome measures that aim to obtain valuable information directly from the

Table 3. Criteria reported by patients and providers in each rehabilitation program by number of occurrences

	Driving evaluation program (n_{patient}=6, n_{provider}=8)	Shared by both programs (n_{total}=31)	Compression garment manufacturing program (n_{patient}=5, n_{provider}=12)
Patient (n _{total} =11)	<ul style="list-style-type: none"> • Buying a car (2) • Diagnosis (1) • Pain^a (1) 		<ul style="list-style-type: none"> • Everyday consequences (1) • Flowing wound (1) • Absence of caregiver^b (1) • Time since referral^b (1)
Shared (n _{total} =31)	<ul style="list-style-type: none"> • Having children (8) • Degenerative aspect (5) • Transportation alternatives (4) • Need for driving adaptations (3) • Payor agency conditions (2) 	<ul style="list-style-type: none"> • Age (16) • Occupation (work, studies) (15) • Functional / disability level (13) • Pain^a (5) • Absence of caregiver^b (4) • Time since referral^b (3) 	<ul style="list-style-type: none"> • Severity of burns (7) • Location of burns (7) • Hypertrophic scars (7) • Motor impairment (3) • Pruritus (2)
Provider (n _{total} =20)	<ul style="list-style-type: none"> • Reasons for referral (6) • Driving responsibilities for a relative (2) • Stability of health condition (2) • Condition of car (1) • Motivation (1) • Distress level (1) • Security (1) 	<ul style="list-style-type: none"> • Geographical area (8) • Origin of referral / inpatients (7) 	<ul style="list-style-type: none"> • Location of burns (6) • First garment (5) • Imminent appointment (3) • Self-esteem (3) • Skin tone (3) • Psychosocial impact (3) • Esthetic aspects (2) • Garment compliance (2) • Modification/repair (2) • Healing problems (1) • Organizational constraints (1) • Time since burn (1)

^a Criterion reported by one patient only in driving evaluation program group and by both stakeholders in compression garment manufacturing program group.

^b Criterion reported by one patient only in compression garment manufacturing program group and by both stakeholders in driving evaluation program group.

patient on their health status, quality of life, symptoms and functional status.⁴¹ Such tool could play a role in successful shared decision making and to enhance delivery of care by providing insights into patient’s experiences ⁴². In our view, considering patients’ opinions about prioritization criteria is an important part of the decision-making process. Diederich and colleagues²⁴ asked a large sample of patients and citizens who should be served first, second, etc. They found that citizens agreed on what can and cannot be used as prioritization criteria for health services, and that the results can be used to indicate patient acceptance of priority setting in medical treatment decisions.²⁴ A large majority of the general public want their preferences to influence priority-setting decisions in healthcare, particularly with respect to how to prioritize across healthcare programs, as well as criteria used to

allocate funds across different population groups.⁴³ These results demonstrate that patients and the general public see a legitimate role for their preferences as they can contribute to guiding health care priorities.^{43,44} Although we found that patients and providers tended to have similar perspectives regarding prioritization criteria, we agree with the authors cited above who pointed to the importance of considering patients’ opinions despite their similarity with other stakeholders’ views.^{24,43,44} It may be tempting to assume what patients’ opinions are, based solely on the fact that there is some similarity with providers’ opinions. Public participation in healthcare decisions, such as selecting prioritization criteria, contributes to advocating for patient legitimacy and acceptance with respect to healthcare policies and organization. Thus, it is important to prompt patients to

participate in healthcare decisions because their opinions are a vital part of the decision-making process. This collaboration has a relevant role to play in facilitating public acceptance of those decisions.

Relevance of provider's perspectives

Our results show that providers tended to select criteria encompassing patients' personal needs as well as criteria based on their clinical experience of patients as service providers. In our study, criteria such as condition of the car, skin tone and esthetic aspects supported this finding. They may also consider criteria linked to organizational aspects related to their daily practice, such as reasons for and origin of the referral. The larger vision of service providers is also confirmed by the fact that they identified substantially more ideas about prioritization criteria than patients.

The combination of these two aspects (personal and organizational) in their viewpoint makes their opinion relevant in decisions about healthcare since they are one of the main actors, like patients, in the healthcare system. Clinicians are more likely to use criteria chosen in a tool or system to prioritize their patients when they participated in creating those criteria because it seems more acceptable to them. Raymond and colleagues¹⁹ found that clinicians expressed dissatisfaction with their current prioritization tool and hoped to develop a more objective and precise tool in the future. Successful implementation of and clinical adherence to such tools can be eased when clinicians contributed to their development process.^{25,45} The application of criteria in clinical practice provided more equitable services and had a positive impact on managing therapists' caseloads, resulting in less employee stress.^{22,45} It appears that service providers are the cornerstone of the implementation of prioritization criteria, as they are the main users of prioritization tools applicable in clinical practice.

Decisions regarding prioritization criteria

As mentioned previously, stakeholders from two very different rehabilitation programs cited criteria that can be used to prioritize patients in both programs. Edwards and colleagues³⁰ found a high degree of consistency across four groups of stakeholders (general practitioners, consultants, health authority commissioners and members of the general public) concerning prioritization criteria to access elective healthcare services. The majority of each of the groups surveyed believed that some criteria, such as pain severity, rate of deterioration of disease, distress level and disability level, should play the most influential role in determining wait times.³⁰ Our results show that pain severity, disability level and rate of deterioration (close enough to degenerative aspect in our view) are criteria which could be applicable in a wide variety of prioritization situations to access healthcare services. MacCormick and colleagues suggested this concept of generic and specific criteria when they reviewed criteria

used for patient prioritization for elective surgery.²³ They maintained that generic criteria can be less evidence-based but more generalizable than specific criteria²³. In our case, we found that specific prioritization criteria were related to the type of rehabilitation service offered by the program, which could not be generalized from one program to another (e.g., degree of burn and transportation alternatives). We understand that the two programs that participated in this study are very different from each other, which makes it difficult to find a link between their rehabilitation services that can support the similarity in their prioritization criteria. However, we can hypothesize that potentially there are prioritization criteria that can be generalized from one rehabilitation program to another, and even from one type of healthcare service to another. Further studies comparing prioritization criteria used across all healthcare services are required to confirm this hypothesis.

A growing number of studies reveals the importance of including patients in healthcare decision-making, such as setting priorities.^{43,46} However, there is limited information on stakeholders' perceptions regarding prioritization criteria, especially in rehabilitation settings. Sampietro-Colom and colleagues²⁶ performed a large conjoint analysis (technique used to rate the relative importance of different attributes, or criteria, in the provision of a good or service) of multiple stakeholders' perceptions in order to develop a priority scoring system for patients waiting for joint replacement. They asked the participants (consultants, allied-health professionals, patients and their relatives, and the general population of Catalonia) to select criteria and rate their relative importance. They found no substantial differences between groups in the number and type of criteria. However, although the scoring criteria pattern was the same, the estimated weights for each criterion were not. This would lead to variations in patients' positions on the list, and to different wait times, depending on which group scores were considered.²⁶ These findings show that even if no difference is noted in the selection of prioritization criteria, as displayed in our study, the relative importance attributed to each criterion can make a major difference in the application of those criteria in practice.

A recent study was performed in a rehabilitation home care setting with occupational therapists and their patients.¹⁸ The main finding was that home-based occupational therapists and their target population had differing opinions on the relative importance of the key criteria used to prioritize waiting lists. According to the authors, patients and providers can base their choices on different types of knowledge and values, where patients incorporate knowledge on the basis of personal experiences and therapists are likely use knowledge based on clinical implications of the problems, institutional pressures or system priorities.¹⁸ There is little likelihood that patients are aware of these organizational elements

that could be considered in the prioritization process, as their choices are likely to be more related to their personal experience.

Another study by Raymond and colleagues presented criteria contained in prioritization tools used in home care occupational therapy services across all Health and Social Services Centres in the province of Quebec.¹⁹ They listed a wide variety of criteria pertaining to clients or clients' situations, and criteria pertaining to the type of service requested. They found that, in general, criteria were not based on scientific evidence and differed greatly across all 55 respondents in their studies. This illustrates the need for consensus between stakeholders concerning prioritization criteria and how to apply them concretely in clinical practice. Priority-setting decisions, like determining criteria to prioritize patients on healthcare waiting lists, is a complex task involving various stakeholders. A healthcare organization encompasses a wide variety of constituencies that need to be informed to ensure organizational effectiveness.⁴⁷ There are statements from all stakeholders, managers, employees, and clients, who espouse differing views of what the organization's goals should be.⁴⁷ Our study demonstrated the importance and richness of an approach in which all actors have differing views that can be taken into account in an organization or system. There is no urgency to force stakeholders to reach a consensus concerning priority-setting decisions as we have similar or differing opinions concerning patient prioritization criteria. This could be an argument for probing every potential actor linked to the organization regarding decisions concerning priority setting. Giving a voice to multiple stakeholders, such as patients, in healthcare decisions could contribute to broaden point of views and then fuel the debate on equity in care. We argue that patients' perspective can add a different vision that was not often taken into consideration in healthcare decisions, even less for selection of prioritization criteria. Our results represent a start in bridging gaps between patients' and service providers' perspectives, leading to standardized and shared decision-making prioritization criteria aimed at improving equity in access to rehabilitation services.

Study Limitations

First, the small number of participating patients from both programs (despite extensive recruitment efforts) led to small samples that could limit the variety of answers and criteria mentioned by these groups. We are also aware that our results portray only one local organization, and more research is needed to expand our findings to another level. However, our results showed that there was a strong tendency for the criteria identified to be consistent across patients and service provider groups. Thus, proportionally to all providers working in the program, our sample was representative of the stakeholders. As we did not

distinguish criteria elicited by managers – we had only three in our sample – from those elicited by clinicians, this limited our analysis of differences between stakeholders. Second, the data collection method may have limited the participation rate, especially in patient groups, because they were first contacted by phone, then invited by email to participate in answering the electronic questionnaire. This method may have included too many steps, which could have dissuaded some potential respondents from participating. We used this method in order to have a consistent data collection procedure between stakeholders and to have the same outputs from questionnaires. Third, the question on perceptions regarding criteria was open-ended, not allowing for much detail on each of the criteria mentioned. A face-to-face or phone consultation would have contributed to richer answers and explanations of choices of criteria. Fourth, it would have been beneficial that a patient and a clinician test a draft version of the questionnaire for clarity and relevance. It could have had a potential impact on stakeholders' comprehension and on the answers they gave. Finally, to obtain a broader perspective, we could have added the general public as another participant group, which would have provided another interesting view of the prioritization process, as they have different experiences of specialized rehabilitation services. We acknowledge that more studies are needed with a much larger sample and even other populations in order to confirm the exploratory findings presented in our study.

Conclusion

By highlighting the comparison between patients' and providers' perspectives regarding prioritization criteria, the results of this study show the importance of considering a wide variety of stakeholders in the healthcare decision-making process. We clearly need further research to formulate additional recommendations about concordance between prioritization criteria in rehabilitation settings. This study can serve as a starting point for more investigations of similar and differing stakeholders' opinions concerning waitlist prioritization criteria. More studies in the same field could help clinicians and decision-makers question their practices in terms of patient prioritization in their own healthcare settings. A next logical step would be to bring the service users and service providers together to co-design a patient prioritization tool and then test its effectiveness in clinical settings.

Conflicts of Interest

The authors report no conflicts of interest.

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