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Understanding frictions in patient-reported outcome-based community healthcare – An institutional logics perspective

Caroline Trillingsgaard Mejdahl[1], Berit Kjærside Nielsen[1], Camilla Palmhøj Nielsen[1,2], Lise Arnth Nielsen[1] and Morten Deleuran Terkildsen[1,3,4]

Abstract

Objective: Patient-reported outcome (PRO) measures in community-based healthcare play a significant role in the emerging field of digital health. This qualitative study explored healthcare professionals' (HCPs') experiences of integrating 'MyPROfile' as a dialogue tool in consultations in community healthcare.

Methods: Adopting a qualitative approach with a social constructivist perspective, the study utilised qualitative interviews, participant observations, and focus group interviews. Data were analysed using reflective thematic analysis, guided by theories on institutional logics.

Results: In the analysis, we identified two distinct institutional logics related to HCPs' experiences integrating PRO measures into their existing practice. Frictions emerged as HCPs integrated the PRO-based dialogue tool, highlighting frictions between an existing Care logic rooted in a holistic health promotion paradigm and the introduced PRO logic. According to the HCPs, the PRO-based practice was perceived as divergent from holistic, narrative-based care, emphasising a shift towards a more reductionist and evaluative model of care.

Conclusions: The study underscores the importance of understanding institutional logics in integrating technologies like PRO measures in healthcare settings. The identified frictions necessitate reflexive venues and collaborative relationships to align differing logics for successful integration. Additionally, incorporating citizens' perspectives is vital for developing effective rehabilitation and prevention programmes. Moving forward, stakeholder engagement in reflective discussions and workshops is crucial to bridge the gap between the introduced technology and the existing health promotion paradigm, ensuring a seamless and meaningful integration of PRO measures in community healthcare settings.

Keywords

Patient-reported outcome measures, institutional logics, community healthcare, qualitative study, barriers

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Introduction

Over recent decades, healthcare has increasingly prioritised person-centred care, placing greater emphasis on self-reported health measures. This transition has led to the widespread adoption of patient-reported outcome (PRO) measures.[1,2] PRO is defined as: 'any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response

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[1]DEFACTUM – Public Health Research, Central Denmark Region, Aarhus, Denmark
[2]Department of Public Health, Aarhus University, Aarhus, Denmark
[3]Department of Forensic Psychiatry, Aarhus University Hospital Psychiatry, Aarhus, Denmark
[4]Department of Clinical Medicine, Aarhus University, Aarhus, Denmark

Corresponding author:
Caroline Trillingsgaard Mejdahl, DEFACTUM – Public Health Research, Central Denmark Region, Olof Palmes Alle 15, 8200 Aarhus N, Denmark.
Email: carmej@rm.dk

by a clinician or anyone else'.[3] PRO is designed to capture measurements of any aspect of health status directly from patients[4] and was initially developed for research purposes. Still, the application of PRO measures has expanded across healthcare settings worldwide.[2,5] In Danish contexts, the initial application of PRO measures primarily occurred within the hospital sector.[6,7] Still, in recent years, there has been a notable expansion towards their utilisation in community healthcare settings.[8,9]

PRO measures are utilised across healthcare settings with a broad range of purposes and ambitions.[6,10–12] PRO measures can inform clinical practice, support health service programming, direct performance measurement and improve quality.[13] Several reviews, including randomised controlled trials, have demonstrated that PRO measures in clinical settings support patient–clinician communication, increase patient satisfaction and enhance the detection of functional and mental health issues among patients.[14–17] Moreover, PRO measures can inform clinical decision-making, facilitate self-management and increase involvement experiences.[7,17–21]

Despite the potential benefits of applying PRO measures, evidence indicates that consistent and standardised use of PRO measures in rehabilitative community healthcare settings has not been extensively adopted.[22,23] Empirical evidence underscores that the predominant impediments to integrating PRO measures in chronic care are deficiencies in knowledge, misconceptions, healthcare professionals' (HCPs) attitudes, organisational dynamics and technological infrastructure.[17] A comprehensive systematic review investigating the facilitators and barriers to implementing PRO measures within outpatient rehabilitation settings revealed a prevalence of barriers over facilitators, aligning with an observed underutilisation of PRO measures.[22] Significantly, impediments to PRO implementation were identified at the individual level, primarily manifesting as a lack of recognised value and knowledge in HCPs.[22,24] Such identified impediments to PRO implementation align with the existing scholarly literature in social science implementation, accentuating the intricate nature of the processes involved in implementing and adopting organisational innovations such as PRO measures. Moreover, scholarly contributions, such as those by Supper[25] and Bureau,[26] underscore the pivotal role played by HCPs as catalysts in effecting transformative changes. Consequently, a critical imperative emerges to explore HCPs' perspectives on and utilisation of PRO measures, aiming to discern the latent potentials and challenges inherent when PRO measures are introduced in a new setting, namely community healthcare. This understanding is crucial as it can guide future applications of PRO measures in community healthcare settings, ensuring effective integration and optimal outcomes.

Aim

This qualitative study aimed to explore how HCPs experience and integrate the PRO-based dialogue tool 'MyPROfile' in health consultations in community healthcare, focusing on their experiences of frictions.

Methods

The study uses a qualitative approach with a social constructivist perspective, which underscores the contextual nature of knowledge and knowledge production, as well as the importance of reflexivity.[27] We view PRO-based practice as a social practice in which participants negotiate meanings within their local contexts. This approach emphasises that our understanding of the findings is shaped not only by the data collected but also by the interactions and relationships that inform the research process. As researchers, we are aware of our role as co-creators of knowledge, recognising how our perspectives influence the interpretation of results. The consolidated criteria for reporting qualitative research were used to guide the study's reporting. The study was conducted by a multidisciplinary team comprising a public health scientist (female, PhD), a psychologist (female, PhD), a political scientist (female, PhD) a nurse (female, MD) and an anthropologist (male, PhD).

Study setting: 'MyPROfile'

Danish healthcare is politically and organisationally managed on a state, regional and municipal level. The state is responsible for the overall regulation of health and elderly care. Five administrative regions are primarily responsible for organising and managing hospitals (somatic and psychiatric) and primary practitioners. Additionally, 98 municipalities handle diverse primary health services, including disease prevention, health promotion and rehabilitation outside hospitals.[28] In 2019, the initiative 'MyPROfile' was implemented in eight municipalities in Denmark, aiming to enhance patient activation in people with chronic conditions. 'MyPROfile' is a PRO-based dialogue tool with a twofold purpose:

1. Increasing citizens' sense of involvement in health consultations through the systematic and active use of PRO measures and
2. Strengthening citizens' engagement and knowledge about their health and health competencies is expected to lead to a higher level of self-management.

'MyPROfile' is managed by HCPs in community-based prevention and rehabilitation programmes. The 'MyPROfile' builds upon a core of two internationally validated questionnaires measuring health-related quality of life (SF-12) and patient activation (PAM-13).[29–31]

The PRO questionnaires are sent to citizens via e-Boks, a trusted Nordic provider of secure platforms and digital postboxes. They are electronically filled out before their first health consultation in prevention and rehabilitation programmes, upon completion of the programme and during a follow-up consultation approximately 12 months later. PRO data are transferred to the community health centre in real-time, and 'MyPROfile' is available to the HCPs before the health consultations. During health consultations, a printout of 'MyPROfile' serves as a dialogue tool between citizens and HCPs. In line with the importance of training and skill-building for HCPs concerning integrating PRO measures in clinical practice, HCPs underwent a training programme in person-centred communication and coaching focusing on self-management.[32,33] This programme included 'hands-on' courses that equipped HCPs with the skills to systematically incorporate PRO data. The training emphasised interpreting PRO responses and facilitating PRO-based discussions, enabling HCPs to engage meaningfully with citizens. Follow-up webinars featuring real-life cases reinforced learning and encouraged knowledge sharing, further enhancing their capacity to utilise MyPROfile in daily practice.

Data collection

The first and last authors, both of whom have substantial experience in qualitative data collection and analysis, conducted data collection at three community health centres in three singled-out municipalities in Central Denmark. These three municipalities were selected based on different socio-geographical profiles. We generated data through individual semi-structured interviews with 15 HCPs, participant observation during 11 health consultations and three focus group interviews with 16 HCPs. Given the relatively limited number of HCPs experienced with using 'MyPROfile', we opted for convenience sampling,[33] inviting all eligible individuals who had worked with 'MyPROfile' for a minimum of 6 months via email, telephone or face-to-face to participate in individual and focus group interviews. Upon being invited, participants were provided with details about the purpose of the research as well as information about the researchers. The participants and researchers had no prior acquaintance before the study began, and recruitment proceeded until the researchers determined that enough data had been collected to allow for a thorough and robust analysis.

The individual semi-structured interviews lasted 28–67 minutes (mean 45 minutes) and were conducted from May to June 2021. We developed an interview guide based on a review of relevant literature and clinical experiences. The themes of the interviews were broad and focused on the HCP's personal experiences of 'MyPROfile'. Subsequently, five main themes were raised during the interviews: 'MyPROfile's' influence on (a) community health education practice, (b) interactions, relations and communication with citizens, (c) organisational issues such as workflows and structuring of rehabilitation programmes, (d) professional competencies and (e) job satisfaction.

The participant observations were performed from September to December 2021, and the focus group interviews were conducted from December 2021 to January 2022 and lasted 72–78 minutes. All interviews were recorded and transcribed verbatim. The participant observations were conducted during health consultations in two community health centres. We observed both initial and concluding consultations across various prevention and rehabilitation programmes. Field notes were taken, either during observations or immediately afterwards. The participant observations formed the basis for understanding the context in which 'MyPROfile' were integrated and were actively incorporated into subsequent focus group interviews. During these interviews, HCPs were asked to discuss selected observations regarding integrating PRO measures. Prior to these interviews, we developed an interview guide based on a review of relevant literature and preliminary analysis from earlier individual interviews and participant observations. The following key themes were discussed during the focus groups: (a) Benefits of using PRO measures in health consultations, (b) Barriers to using PRO measures in health consultations, (c) Citizen engagement in using PRO measures, (d) PRO measures as a dialogue support tool and (e) Competing activities, context and values.

The magnitude of the three data sources was as follows: Field notes from participant observations totalled 25 A4 pages, focus group interviews amounted to 54 pages, and individual interviews comprised 253 pages, all in Word with 1.5 line spacing.

Analysis process

We facilitated data management using the qualitative software programme NVivoTM.[34]

The first and last authors conducted the data analysis in collaboration with the research team. We utilised a reflexive thematic analysis approach, drawing inspiration from the method outlined by Braun and Clarke.[35,36] Initially, we read through the transcribed interview data and field notes multiple times to become familiarised with the data and wrote down initial concepts. We then systematically coded interesting features throughout the dataset and gathered data relevant to each initial code. After grouping our data into meaningful categories, we began identifying themes. At this stage, we observed consistent resistance among the HCPs towards PRO-based health consultations. We found a strong resonance between the resistance identified in the codes and a possible theoretical framework.[37,38]

The nature of the resistance, strongly resonated with elements from an institutional logics perspective.[39] At this point in the analysis, we therefore decided to draw on elements from an institutional logics perspective. Thus, inspired by an institutional logics perspective, we identified two overarching themes: *Care logic* and *PRO logic*. We then re-coded all the material, identifying key assumptions that the HCPs ascribed to the two logics. We sorted the different initial codes into potential sub-themes and collated all the relevant coded data extracted within the identified themes. Next, we reviewed, refined and named our proposed themes and sub-themes. Finally, we selected compelling extract examples that captured the essence of themes and subthemes.[35] To ensure a robust integration of data across sources, we triangulated between interviews, field notes and theoretical frameworks. We used an iterative process, continuously comparing findings from the different data sources to refine our themes. In terms of investigator triangulation, each step of the analysis was revisited by multiple researchers, who engaged in critical discussions to ensure consistency in coding and theme development.[40] Additionally, preliminary interpretations of the results were presented to a steering group comprising representatives from community healthcare services to ensure that our findings resonated with practice.

Theoretical framework

This study employs the conceptual framework of institutional logics to examine the process of creating meaning among stakeholders engaged in implementing PRO measures within consultations between HCPs and care-seeking citizens in community healthcare settings.[39,41,42] Thornton and Ocasio[41] define institutional logics as representing historical sociocultural patterns comprised of symbolic representations and material practices.[41] These sociocultural patterns are embedded within fundamental assumptions and values, shaping how significance is attributed to everyday actions and personal and collective institutional experiences.[41] For individuals in institutions, institutional logics establish a foundational symbolic framework, furnishing both comprehension and structure to the social environment, thereby delineating the appropriateness of institutional practices and their objectives.[43] In introducing new practices like PRO-based consultations, institutional logics provides a symbolic framework that equips stakeholders with a vocabulary to define the suitable form and role of PRO measures in community healthcare. In complex organisational settings, multiple institutional logics may co-exist and sometimes these may give rise to frictions, as meanings and practices collide.[42,43] Investigating the characteristics, functions and frictions of institutional logics involves scrutinising the process of meaning-making and pinpointing the core assumptions that stakeholders draw upon when delineating PRO's appropriate form and utility (or absence thereof) within healthcare consultations.

Findings

We interviewed 20 HCPs, 11 of whom participated in both individual interviews and focus group sessions. We also observed 11 health consultations by 5 HCPs (Table 1). In our analysis, we found no meaningful differences in the experience of using PRO measures among the various professional groups. For instance, it did not appear that nurses had different perspectives on PROs compared to dietitians. Instead, the participants seemed to form a relatively unified group in their views, with no significant divergence based on profession. Therefore, in reporting our findings, we do not distinguish between the different professions.

Our analysis showed that the HCPs were ambivalent towards PRO-based health consultations. Thus, most participants could point to some positive aspects of using PRO measures, such as 'the citizens being more prepared for the consultation' and 'a better overview of the citizen's health status'. Nevertheless, a distinct resistance to PRO-based health consultations was most prominent across the empirical material. Our analysis shows that the HCPs describe PRO-based practice as fundamentally different from their existing practice. As one of the HCPs said:

> It is two completely different worlds. You have this data-world and then you have a world close to the citizen's everyday life.

In the analysis, we identified two main themes: *Care logic* and *PRO logic* (Table 2). In the following, key assumptions ascribed to *Care logic* and *PRO logic* respectively are described along with associated subthemes and illustrated by participant quotes. To comprehend how the two practices function as competing logics, we will outline the key assumptions that HCPs attribute to their current practice (*Care logic*) and the new practice (*PRO logic*). This will help us to understand the meaning HCPs ascribe to PRO-based health consultations.

Care logic

Striving for holism through narratives

Across the empirical material, our analysis displayed that the HCPs, to a great extent, lend themselves to a holistic care tradition. They all emphasised the importance of focusing on the wholeness of a citizen within a social and cultural context. As seen in the following quote, the HCPs stressed the importance of considering the uniqueness of the individual citizen's needs in community healthcare.

> With the PROfile, one quickly becomes biased, and then you don't approach the citizen openly. And I think our

Table 1. Participant characteristics.

Characteristics	Participant observations (*N* = 11)	Individual interviews (*N* = 15)	Focus group interviews (*N* = 16)
HCP profession			
Nurse	3	6	6
Physiotherapist	4	3	3
Dietitian	2	4	4
Other	2	2	3
HCP gender			
Male	4	1	2
Female	7	14	14
HCP age (years)			
<30		2	3
30–40		3	6
41–50		4	3
51–60		6	4
>60		0	0
Rehabilitation/ prevention programme			
Cancer	2		
Diabetes	1		
COPD	2		
Heart disease	2		
Lifestyle changes	4		

Note. A total of 20 HCPs participated in both individual interviews and focus group discussions. However, some participants took part in both types of interviews, which may result in overlapping counts. Therefore, the numbers presented in each column do not represent distinct individuals and may slightly overestimate the total number of participants. HCPs, healthcare professionals; COPD, chronic obstructive pulmonary disease.

> primary task is simply to take off those glasses and meet them with respect, trying to see them openly and just listen to what they have to say.

Table 2. Findings.

Care logic	PRO logic
• Striving for holism through narratives • Path to health: empowerment and professional-citizen relationship	• PRO – a misplaced and unwanted practice • Balancing the PROs in healthcare and addressing concerns of reductionism • PRO measures as a fastidious evaluative practice challenging holistic healthcare ideals

Note. PRO, patient-reported outcome.

Another HCP explained:

> The most important thing to me is acknowledging the human before me. I need to show that I'm interested in them as a person, the whole person.

More HCPs focus on restoring power and responsibility to citizens and encouraging them to take an active role in their care, which was perceived as a key aspect of the holistic care tradition.

Thus, they refrained from treating citizens as passive recipients of care. They saw it as their task to provide citizens with the tools and resources to manage their health and encourage them to take an active role in making decisions about their health and care. The HCPs highlighted the importance of encouraging citizens to be the leading driver of changes in their health.

Accordingly, our analysis showed that focusing on the citizens' everyday lives was an essential part of this holistic approach because it helped ensure that care was tailored to their needs and priorities. Thus, the HCPs emphasised the importance of considering the dynamics of the citizen's everyday life. In the health consultations, they highlighted 'life narrative' as the most distinguished form of conversation. According to HCPs, citizens' life narratives allow them access to their everyday lives. This is because narratives provide a rich and detailed insight into a person's experiences, preferences and challenges, which, according to the HCPs, could be difficult to capture through standardised PRO questionnaires. A HCP said:

> We might need to discuss something more significant for the citizens. And something that can be more significant is, in fact, everyday life. It's about how their everyday lives are and how they can make them work and cope with their chronic illness. It's all those life stories that don't appear in the PROfile.

Path to health: empowerment and professional-citizen relationship

In the journey toward holistic health, empowerment and mastery emerged as essential pillars of care, deeply connected to the nature of professional-citizen relationships. Among HCPs, there was broad agreement that reasonable care revolved around empowering citizens, recognising them as the primary experts in their lives and, thus, key actors in defining and achieving a healthy life. As one HCP expressed it:

> They are the bosses of their own lives.

To support citizens in creating a positive care trajectory, HCPs agreed that the focus should be on health initiatives that help citizens flourish within the context of their everyday lives. As another professional noted:

> Because, you could say, our primary task, as I see it, is that we are well-being facilitators here. It's about ensuring that the citizens who engage with us have the best possible well-being according to their resources.

Mastery was seen as a necessary precondition for flourishing. It was understood as the ability to harness and manage one's hidden, yet powerful, life capacities. HCPs frequently emphasised that it was not their role to dictate what citizens should do, but rather to help them discover their capacities for change. As one HCP explained:

> It's they themselves who hold the key to making changes; it's not us who should tell them what to do.

Care, in this logic, was understood as a social practice where HCPs explored citizens' lives, helping them articulate their hidden capacities and, in doing so, laying the groundwork for mastery. A HCP described this process:

> And then we need to figure out what they need our help with. We should help them try to put things into words. That's also what can help them move forward, making it easier for them to manage the situation.

Equally important in promoting mastery was the nature of the professional-citizen relationship and the distribution of power within it. HCPs highlighted that meaningful meetings and dialogues, built on strong professional-citizen relationships, were critical for fostering mastery. As one HCP put it:

> There has to be a relationship. Because otherwise, we can't change anything

However, not all relationships were viewed as equally productive. Productive relationships were often explicitly framed as being based on equality, where different forms of knowledge were recognised and valued. HCPs emphasised that effective care required acknowledging both their medical expertise and the citizen's unique lived experience. As one HCP stated:

> And the relationship is the most important thing, and for a good relationship, it needs to be equal.

Such relationships were not merely about mutual recognition but about ensuring that the citizen's unique knowledge position as the expert of their life was fully acknowledged. This meant giving citizens the power to define what mattered and what interventions could be beneficial. As one HCP emphasised:

> I firmly believe that citizens decide what their needs are. I'm not here to dictate whether we talk about one thing or another. My job is to make space for them to talk about what they want, ensure they are heard, and allow them to ask about what they need. Then, we need to find a program that suits them if that's what they need.

When this kind of power distribution was achieved, citizens left the meetings empowered, taking the first steps toward mastering their lives on their terms. As one professional metaphorically described:

> We really want the citizens to leave here feeling like they were the king or queen of the conversation, that what they brought mattered.

However, the path toward empowerment and mastery was seen as potentially fraught with challenges. HCPs viewed their role as one of protective companionship, offering ongoing support while avoiding an over-focus on failures. Instead, they focused on the citizens' resources and successes to ensure that setbacks did not derail their progress. One HCP expressed this approach:

> When we talk and delve into problems, I think it's essential to remember that it's just as important to talk about resources. If we only talk about problems and forget the rest, it doesn't help the citizens much; they might leave with more significant problems than when they arrived.

PRO measures were explicitly mentioned in achieving health via mastery and empowerment as providing a saliently different and crucially counterproductive arrangement of knowledge and practices.

PRO logic

PRO – a misplaced and unwanted practice

In the interviews with the HCPs, it was saliently agreed that PRO-questionnaires and the data they could produce constituted products meant for a different scenario, such as a hospital. A HCP uttered:

> What has struck me is that my feeling is that it's all based on the hospital world hospital environment, with a focus on problems and diagnoses, and that it leans more towards collaboration between doctors and other hospital staff.

Embedded within such perceptions of PRO measures as a tool for hospitals were ideas of health being something clearly defined as a problem, usually understood in terms of specific disease causalities, in which an isolated somatic problem could be defined and remedied via medicine or training. In such perceptions, the HCPs emphasised a distinction between more soft values and more hard values, the former being framed as the kind of information providing insights into the citizens' lives as 'wholes', and seeking such information could provide an understanding of the resources and capacities that could allow them to flourish and master their lives (as seen in the prior section). Contrastingly, PRO measures were seen as producing more hard values understood as numbers, stripping away what was seen as the complex but also potentially resourceful lives of citizens, focusing instead on the specificities of a particular problem in need of fixing via defined generic interventions and continuous monitoring. A HCP explained in a focus group interview:

> It was different before when we didn't have MyPROfile; more citizens left here cheering with their hands in the air. It was our job to ensure they felt boosted. I think no one was left dissatisfied when we finished with them. Now, numbers are being put on things. When numbers are assigned, it becomes something else. It becomes quantitative instead of qualitative; there was a different softness in the qualitative

Our analysis further displays that according to HCPs, PRO measures appear to contradict the values and practices that are deeply embedded in a community healthcare setting. Our analysis demonstrated, how PRO measures may be at odds with existing values in such settings.

Balancing the PROs in healthcare and addressing concerns of reductionism

During our analysis, it was evident that HCPs had reservations about the potential for PRO measures to hold an overly dominant position in their interactions with citizens. As seen in the following quote, this reluctance emanates from their perception of PRO measures as possessing reductionist qualities, where collected data oversimplifies individuals, subjecting them to predetermined categories.

> And sometimes, I can feel that particularly the patient activation measures make it a bit artificial. It quickly becomes like I'm putting them in a specific box.

HCPs emphasise that PRO measures only provide 'facts' or 'fragments' of information and do not offer the rich 'explanations' or 'stories' that are crucial for understanding the individual's overall health and well-being. They believe that a narrow focus on PRO measures alone can result in a reductionist practice, which oversimplifies complex needs and experiences and may lead to a limited understanding of the citizen's health concerns. A HCP said:

> I'm having a hard time recognizing the citizen in MyPROfile. The citizen is so much more than a questionnaire; you simply can't reduce a person to a piece of paper. I believe that it goes against our values because the citizen is being reduced to a number and put into a box.

Our analysis revealed a consensus among HCPs that the use of PRO data could lead to a narrowing of their practice and limit their ability to demonstrate professionalism when interacting with citizens. A HCP uttered:

> I think some of the resistance comes from the fact that we have many years of experience with these conversations. We've developed questioning and listening techniques that we've found effective over a long time. So we believe we have a very broad approach to meeting the citizens, and then this PRO form comes along, which we feel narrows down the interaction with the citizens. And that's what we find limiting.

Thus, the HCPs, to a great extend, opposed the standardized PRO practice because they perceived it as not allowing flexibility in the meeting with the citizen. Another HCP stated:

> I think it becomes a bit too rigid. It affects the flexibility that should be there when meeting with the citizens. I don't necessarily need to go through all these areas because there might be other challenges that need to take priority. The other stuff shouldn't 'pollute the conversation'. It can take us off track from what we're really there to discuss.

Furthermore, the HCPs experienced health consultations based on PRO measures as fixed and limiting because 'MyPROfile' was seen as prescriptive and did not consider each citizen's unique needs and circumstances. Additionally, they found that 'MyPROfile' set an unnatural agenda, as they felt that the focus on these measures restricted the scope of the conversation and prevented them from exploring other essential issues that may be relevant to the citizen's everyday life and overall well-being.

> It's hard if you're used to moving freely in a conversation, just sensing and listening to where the citizen wants to go. Then MyPROfile comes in and sets an unnatural agenda, so there is no room for the citizen's agenda.

PRO measures as a fastidious evaluative practice challenging holistic healthcare ideals

The material further revealed that PRO measures were perceived as a fastidious evaluative practice, which, by focusing on specific local bodily conditions either remaining stable, progressing or deteriorating, in turn also opened possibilities for citizens to fail, which stood in radical contrast to the ideals of working holistically as advocated by the HCPs. A HCP explained it like this:

> As a professional, you start with the belief that whatever the citizen does or can do is okay, alright, good, and we can work from there. But with this PROfile, where citizens are placed high or low if they end up at the bottom of the scale, it makes the citizen seem wrong in some way.

Another HCP framed PRO measures and the data it could produce as a 'stamp' or 'label':

> I think the PROfile assesses the citizens. It's like labelling them, a sort of sticker we put on them.

In such utterances, labels or stamps were seen as fixed and reductive. As a label maker, PRO measures would force citizens and professionals to orient their work towards narrow health categories. According to the HCPs, by following the narrow confines of PRO measures, citizens' multiple capacities and resources would have to fit with the streamlined goals of PRO and its demand for progress for them to be deemed resources. This potentially results in resources not fitting with PRO becoming overlooked and disowned. According to the HCPs, this could lead to disempowerment and feelings of meeting a schema rather than the citizen or feeling of 'working for the system rather than the citizen'. PRO measures were seen as promoting asymmetrical power relations in which the normative power to define and evaluate the citizen's health was vested with the professional rather than the citizen as intended. A HCP said:

> What I need as a professional is to meet the person and for the person to meet me, not a form. I don't want to signal to the citizen that I've already decided who they are because I've read it from their PROfile. That's why I put the PROfile in the background.

Moreover, the interface and built-in algorithm in 'MyPROfile' in which health state, progress or deterioration was presented with numbers further exacerbated such feelings of evaluative normativity by making problems measurable. A HCP explained:

> So, the citizen gets a number in the PROfile, and of course, it's better to be at 68 than at 29, for example. In that way, the citizen gets an assessment of where they stand, and I think that goes a bit against what we are actually trying to work on

Numbers within 'MyPROfile' were seen as opening the door to potential individual stigmatisation because their generic numbers permitted comparisons between health course participants. One HCP said:

> And it's about how, as a citizen, you're ranked, you're ranked to others, you're ranked according to recommendations. So, in that way, I also think it's an evaluation and kind of a 'fault-finding' approach.

According to some HCPs, the nature of PRO measures has led to discrepancies between how the citizens experienced their lives, their health problems, their engagement in health programmes and ultimately, their outcomes and the numbers produced by PRO measures. To avoid disempowering the citizen, one HCP remarked how she sometimes chose to leave 'MyPROfile' out of the health consultation. These discrepancies occurred when PRO measures showed little numerical progress, but the citizen expressed having experienced progression by participating in the intervention:

> Sometimes, I've actually chosen not to bring up the PROfile. Suppose a citizen feels like they've made significant progress or are really on the right track, and I see the citizen's score is just scraping the bottom of the scale. In that case, I'm afraid it could demotivate them and blow their confidence, so I don't bring it up.

Some HCPs remarked that the normative and evaluative numbers also served a goal far from what they saw as the interests of the individual citizen. Here, numbers were seen as ways to monitor health programmes in general and ensure that organisational goals were met.

> But I know we have some higher-ups in the system who like to see numbers, and sometimes, that's what we're struggling with.

Discussion

This paper specifically investigated where frictions emerge when HCPs situated in community healthcare settings integrate and use a PRO-based dialogue tool in health consultations. We raised this question because, as inferred in this paper, the HCPs in our study predominantly found such integration and use to be a salient challenge. Drawing inspiration from theories of institutional logics, we have conceptualised this challenge as resulting from a clash between two opposing approaches: a Care logic and a PRO logic. This can be understood through two key themes identified in our research: Care logic, which includes 'striving for holism through narratives' and 'path to health: empowerment and professional-citizen relations'; and PRO logic, which includes 'PRO – a misplaced and unwanted practice', 'balancing the PROs in healthcare and addressing concerns of reductionism' and 'PRO measures as a fastidious evaluative practice challenging holistic healthcare ideals'.

Our study underlines the crucial role of institutional logics in shaping the meaningfulness of instruments like PROs when implemented in community settings. As noted by Akmal et al.,[43] Reay & Hinnings,[44] Terkildsen et al.,[39] and Vickers et al.,[41] organisational settings often hold diverse institutional logics due to multiple stakeholders with different professional backgrounds. Therefore, integrating new tools may lead to frictions stemming from the symbolic values and assumptions underlying the concept or tool, particularly when various professional stakeholders (e.g. innovation, administrative staff and clinical professionals) need to collaborate in the integration process.[42,43] We agree, but our study adds that frictions may also emerge when tools are simply transferred from their original context to a new setting where they are intended to be used. As we have demonstrated, even though the professional background of the stakeholders in our study is clinical, resembling those in other studies where PRO measures have been successfully implemented, a shift in setting constitutes a shift in institutional logics. As shown, this results in very different perceptions of the meaningfulness of the tool.[43] When examining the largely negative and constrained perceptions of PRO measures among HCPs in our study, we note a contrast with the more positive views held by health professionals especially nurses working in hospital settings.[45–47] We argue that the limited capabilities attributed to PRO measures should not be seen as an inherent quality of the tool. Instead, they reflect differences in institutional logic. In this context, a tool like a PRO measure is inscribed with specific meanings that are perceived as alien or even negative within the community setting. Additionally, the generic nature of tools like SF-12 and PAM may not fully align with the needs of HCPs for facilitating person-centred interventions if not further tailored to the needs of patients. While these tools provide a broad overview of health status and patient activation, they may lack the specificity and direct actionability required for more individualized, value-creating care pathways, further contributing to the constrained perceptions of their utility.

In our study, we show that HCPs perceive PRO measures as 'alien instruments' that introduce problematic evaluative reasoning in health consultations, contradicting their goals. Instead of supporting a holistic approach to citizens' psychosocial issues, HCPs view PROs as reductionist tools that oversimplify complex needs to fit within healthcare system constraints. The literature review reveals that the friction points identified in our study are generally viewed more positively in settings like hospitals, where PROs have been implemented more widely and for longer periods.[48,49] The differences between hospital care and municipal care for health promotion and rehabilitation are significant and must be considered when drawing conclusions. While context certainly matters for the logics surrounding PRO measures, it is important to recognise that the context can also influence outcomes. Factors beyond institutional logics, such as available resources, staff training and patient/citizen engagement, may further impact the effectiveness of PRO measures in different care settings. The perception of PROs as inherently reductionist contrasts sharply with existing research from hospital settings. Many studies indicate that HCPs recognise PROs as tools that support a holistic approach and enhance focus on patients' psychosocial issues.[50–54] A systematic review of HCPs' attitudes toward PRO measures found that they help identify health problems, including psychosocial issues and facilitate open discussions on sensitive topics.[55] Moreover, numerous studies demonstrate that PRO measures aid HCPs in addressing sensitive issues with patients,[56–58] ultimately supporting patient-centred communication in hospitals.[14,16,59] In contrast, our study found that PROs were viewed as evaluative practices that assign normative power to HCPs, leading to a problem-oriented focus rather than a resource-oriented one. This finding differs from studies suggesting that PROs can positively influence the patient–clinician power balance.[53,56,57,60,61]

These contrasts underscore the need to recognise how context significantly affects the integration of PRO measures across different settings.

This discrepancy should not be seen as inherent qualities of PRO measures but as a product of the *Care logic* identified in our study, including its grounding assumptions and values, which resonate with health promotion ideals. This logic aligns with Antonovsky's holistic approach to health.[62] HCPs' resistance to PRO measures can be examined through Antonovsky's salutogenic model, emphasising holistic health factors rather than specific disease causes. The friction between PRO's quantifiable metrics and the *Care logic* of HCPs, rooted in a health promotion paradigm, may explain their resistance. Antonovsky's focus on the sense of coherence further elucidates how PRO challenges the meaningfulness and predictability these professionals associate with their existing health promotion practices.[62]

Implication for future practices

Although diverse institutional logics can create frictions, as evidenced in our study of PRO measures, they do not have to hinder integration efforts. Collaborative relationships can help mitigate these frictions.[44] Terkildsen et al.[42] emphasise the need for institutions to provide reflexive venues where stakeholders can discuss and align differing logics. When institutional logics are illustrated, differences may become the subject of collaborative reflection and stakeholders can negotiate and align, ultimately promoting the management of identified frictions.

We agree and, as a way forward, propose that integrating PRO measures in a community healthcare setting requires the establishment of reflexive venues. It is crucial to hold stakeholder workshops that focus on critically assessing both the logic of the tool being integrated and the logics that HCPs draw upon. These workshops should be provided early in the implementation phase to effectively address the integration barriers described in this paper. Additionally, citizen participation is essential in this process; engaging citizens ensures that their perspectives are considered, ultimately enhancing the relevance and effectiveness of PRO measures within a health promotion framework. Given the importance of a participatory approach highlighted by Foster et al.,[63] it is equally vital to involve frontline staff in the development of PRO measures, ensuring that their insights and experiences contribute to the creation of effective interventions.

Strengths and limitations

Our analytical inspiration from an institutional logics perspective allowed us to view the challenges in applying PRO measures in community healthcare settings in terms of the sense that HCPs make of PROs rather than a lack of understanding of or training in using PRO measures.

While our study provides valuable insights, it has certain limitations. Data were collected during the initial year of health professionals' use of the PRO system, possibly not fully capturing the evolving attitudes over a more extended period. Resistance patterns and health professionals' perspectives may change as they gain more experience with the PRO tool. Another limitation of our study is that the logics underpinning the PRO tool are solely viewed from the perspective of the HCPs. Consequently, this paper does not assess how citizens participating in the prevention and rehabilitation programmes perceive the PRO framework. While convenience sampling facilitated efficient participant recruitment, it may limit the generalisability of our findings and introduce bias, as the sample may not represent the broader population of HCPs or citizens. Future research should utilise more diverse sampling methods to capture a wider range of perspectives.

Conclusion

This study examined the experiences of HCPs in integrating ‘MyPROfile’ as a dialogue tool within community healthcare consultations. Our empirical findings reveal significant frictions arising from the clash between the existing Care logic – rooted in a holistic health promotion paradigm – and the introduced PRO logic associated with PRO measures. HCPs reported that this transition fundamentally altered their practice, shifting from a holistic, narrative-based approach to a more reductionist and evaluative model.

Furthermore, our findings highlight the necessity of considering citizens' perspectives on PRO use, as these insights are vital for developing effective rehabilitation and prevention programmes. The identified frictions underscore the importance of understanding how institutional logics impact the integration of PRO measures in healthcare settings. To address these challenges, we recommend establishing reflexive venues and fostering collaborative relationships among stakeholders. Engaging in reflective discussions and workshops may help bridge the gap between the introduced tool and the existing health promotion paradigm, enhancing the integration of PRO in community healthcare settings.

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Data availability: Participants only consented to external data-sharing in an anonymised form for this study. Since full transcripts cannot be fully anonymised due to the highly individual context, the transcripts cannot be shared in a public repository.

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Guarantor: CTM

ORCID iDs: Caroline Trillingsgaard Mejdahl https://orcid.org/0000-0001-7361-6082
Morten Deleuran Terkildsen https://orcid.org/0000-0002-0974-3164

References

1. Devlin AJ. *Using patient reported outcomes to improve health care*. Chichester, West Sussex: John Wiley & Sons Inc, 2016, p. 1009.
2. Greenhalgh J, Dalkin S, Gooding K, et al. Functionality and feedback: a realist synthesis of the collation, interpretation and utilisation of patient-reported outcome measures data to improve patient care. *Health Serv Deliv Res* 2017; 5: 1–280.
3. Health USDo, Human Services FDA. Guidance for industry: patient-reported outcome measures: use in medical product development to support labeling claims: draft guidance. *Health Qual Life Outcomes* 2006; 4: 79.
4. Valderas JM and Alonso J. Patient reported outcome measures: a model-based classification system for research and clinical practice. *Qual Life Res* 2008; 17: 1125–1135.
5. Garratt A, Schmidt L, Mackintosh A, et al. Quality of life measurement: bibliographic study of patient assessed health outcome measures. *BMJ (Clinical Research ed)* 2002; 324: 1417.
6. Hjollund NHI. Fifteen years' use of patient-reported outcome measures at the group and patient levels: trend analysis. *J Med Internet Res* 2019; 21: e15856.
7. Schougaard L, Larsen LP, Jessen A, et al. Ambuflex: tele-patient-reported outcomes (telePRO) as the basis for follow-up in chronic and malignant diseases. *Qual Life Res* 2016; 25: 525–534.
8. Sekretariat P. Organisering af PRO i Danmark. 2023. https://pro-danmark.dk/da/information-og-udvikling/organisering (accessed 10 December 2024).
9. MoEva 2.0. Monitorering og evaluering af kommunale og regionale sundhedstilbud: DEFACTUM (accessed 10 December 2024).
10. Gon PI. Framework and guidance for implementing patient-reported outcomes in clinical practice: evidence, challenges and opportunities. *J Comp Eff Res* 2016; 5: 507–519.
11. Snyder CF, Aaronson NK, Choucair AK, et al. Implementing patient-reported outcomes assessment in clinical practice: a review of the options and considerations. *Qual Life Res* 2012; 21: 1305–1314.
12. Howard JS, Toonstra JL, Meade AR, et al. Feasibility of conducting a web-based survey of patient-reported outcomes and rehabilitation progress. *Digital Health* 2016; 2: 2055207616644844.
13. Porter I, Davey A, Gangannagaripalli J, et al. Integrating patient reported outcome measures (PROMs) into routine nurse-led primary care for patients with multimorbidity: a feasibility and acceptability study. *Health Qual Life Outcomes* 2021; 19: 133.
14. Valderas JM, Kotzeva A and Espallargues M. The impact of measuring patient-reported outcomes in clinical practice: a systematic review of the literature. *Qual Life Res* 2008; 17: 179–193.
15. Marshall S, Haywood K and Fitzpatrick R. Impact of patient-reported outcome measures on routine practice: a structured review. *J Eval Clin Pract* 2006; 12: 559–568.
16. Chen J, Ou L and Hollis SJ. A systematic review of the impact of routine collection of patient reported outcome measures on patients, providers and health organisations in an oncologic setting. *BMC Health Serv Res* 2013; 13: 211.
17. Eriksen J, Bygholm A and Bertelsen P. The association between patient-reported outcomes (PROs) and patient participation in chronic care: a scoping review. *Patient Educ Couns* 2022; 105: 1852–1864.
18. Johansen MA, Berntsen GKR, Schuster T, et al. Electronic symptom reporting between patient and provider for improved health care service quality: a systematic review of randomized controlled trials. Part 2: methodological quality and effects. *J Med Internet Res* 2012; 14: e126.
19. Mejdahl C, Schougaard LMV, Hjøllund NHI, et al. PRO-based follow-up as a means of self-management support: an interpretive description of the patient perspective. *Journal of Patient Reported Outcomes* 2018; 2: 38.
20. Grove BE, Schougaard LMV, Ivarsen P, et al. Remote follow-up based on patient-reported outcomes in patients with chronic kidney disease: a qualitative study of patient perspectives. *PloS one* 2023; 18: e0281393.
21. Skovlund PC, Vind Thaysen H, Schmidt H, et al. Effect of patient-reported outcomes as a dialogue-based tool in cancer consultations on patient self-management and health-related quality of life: a clinical, controlled trial. *Acta Oncol (Madr)* 2021; 60: 1668–1677.
22. Briggs MS, Rethman KK, Crookes J, et al. Implementing patient-reported outcome measures in outpatient rehabilitation settings: a systematic review of facilitators and barriers using the consolidated framework for implementation research. *Arch Phys Med Rehabil* 2020; 101: 1796–1812.
23. Churchill K, Warner L, Keogh E, et al. Implementation of EQ-5D-5L as a routine outcome measure in community outpatient and specialized rehabilitation services. *J Patient Rep Outcomes* 2021; 5: 103.
24. Nielsen BK, Terkildsen MD, Jensen AL, et al. Endocrinologists' use of patient-reported outcome measures in the care of people with diabetes: a qualitative study. *Diabet Epidemiol Manag* 2023; 12: 100159.
25. Supper I, Catala O, Lustman M, et al. Interprofessional collaboration in primary health care: a review of facilitators and

barriers perceived by involved actors. *J Public Health (Oxf)* 2015; 37: 716–727.

26. Burau V, Carstensen K, Lou S, et al. Professional groups driving change toward patient-centred care: interprofessional working in stroke rehabilitation in Denmark. *BMC Health Serv Res* 2017; 17: 662.
27. Hammersley M and Atkinson P. *Ethnography: principles in practice*. 4 ed. Milton: Routledge, 2019.
28. Healthcare in Denmark – an overview 2017.
29. Nielsen BK, Nielsen PB, Mejdahl CT, et al. Mental well-being and patient activation during the first eight months of the COVID-19 pandemic in Denmark – a cohort study among 710 Danish adults with chronic conditions. *BMC Public Health* 2023; 23: 1472.
30. John EW, Mark K and Susan DK. A 12-item short-form health survey: construction of scales and preliminary tests of reliability and validity. *Med Care* 1996; 34: 220–233.
31. Hibbard JH, Mahoney ER, Stockard J, et al. Development and testing of a short form of the patient activation measure. *Health Serv Res* 2005; 40: 1918–1930.
32. Skovlund PC, Ravn S, Seibaek L, et al. The development of PROmunication: a training-tool for clinicians using patient-reported outcomes to promote patient-centred communication in clinical cancer settings. *J Patient Rep Outcomes* 2020; 4: 10.
33. Santana MJ, Haverman L, Absolom K, et al. Training clinicians in how to use patient-reported outcome measures in routine clinical practice. *Qual Life Res* 2015; 24: 1707–1718.
34. Qsr International PL. NVivo qualitative data analysis Software. Version 11. https://www.qsrinternational.com/nvivo/home ed2016 (accessed 10 December 2024).
35. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
36. Braun V and Clarke V. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res* 2021; 21: 37–47.
37. Mejdahl CT, Nielsen BK, Mehlsen MY, et al. COVID-19 as moral breakdown: entangled ethical demands experienced by hospital-based nurses in the early onset of the pandemic. *Nurs Inq* 2022; 30: e12508.
38. Terkildsen MD, Kennedy HG, Jentz C, et al. Online video games and patient–staff power relations. A qualitative study of care and custody in forensic psychiatry. *J Psychiatr Ment Health Nurs* 2022; 29: 493–503.
39. Thornton PH, Ocasio W and Lounsbury M. *The institutional logics perspective: a new approach to culture, structure and process*. Oxford: Oxford University Press, 2012.
40. Thorne S. *Interpretive description: qualitative research for applied practice*. Second edition ed. New York, NY: Routledge, 2016.
41. Thornton PH, Ocasio W. Institutional Logics. In: Greenwood R, Oliver C, Suddaby R, et al. (eds) *The SAGE handbook of organisational institutionalism*. London: Sage Publications Ltd, 2008, pp.99–128.
42. Terkildsen MD, Bollerup S, Palmhøj C, et al. How institutional logics shape the adoption of virtual reality in mental health care: a qualitative study. *Digit Health* 2024; 10: 20552076241248914.
43. Akmal A, Foote J, Podgorodnichenko N, et al. Understanding resistance in lean implementation in healthcare environments: an institutional logics perspective. *Prod Plan Control* 2022; 33: 356–370.
44. Reay T and Hinings CR. Managing the rivalry of competing institutional logics. *Organ Stud* 2009; 30: 629–652.
45. Mejdahl CT, Schougaard LMV, Hjollund NH, et al. Exploring organisational mechanisms in PRO-based follow-up in routine outpatient care – an interpretive description of the clinician perspective. *BMC Health Serv Res* 2018; 18: 546.
46. Mejdahl CT, Schougaard LMV, Hjollund NH, et al. Patient-reported outcome measures in the interaction between patient and clinician – a multi-perspective qualitative study. *J Patient Rep Outcomes* 2020; 4: 3.
47. Schougaard LMV, Friis RB, Grytnes R, et al. Exploring the Nurses' perspective on using remote electronic symptom monitoring in clinical decision-making among patients with metastatic lung cancer. *Semin Oncol Nurs* 2023; 39: 151517.
48. Hughes S, Aiyegbusi OL, Lasserson D, et al. Patient-reported outcome measurement: a bridge between health and social care? *J R Soc Med* 2021; 114: 381–388.
49. Black N. Patient reported outcome measures could help transform healthcare. *BMJ* 2013; 346: f167.
50. Absolom K, Holch P, Pini S, et al. The detection and management of emotional distress in cancer patients: the views of health-care professionals. *Psychooncology* 2011; 20: 601–608.
51. Snyder CF, Blackford AL, Wolff AC, et al. Feasibility and value of PatientViewpoint: a web system for patient-reported outcomes assessment in clinical practice. *Psychooncology* 2013; 22: 895–901.
52. Korzeniowski M, Kalyvas M, Mahmud A, et al. Piloting prostate cancer patient-reported outcomesin clinical practice. *Support Care Cancer* 2016; 24: 1983–1990.
53. Semple CJ, Lannon D, Qudairat E, et al. Development and evaluation of a holistic surgical head and neck cancer post-treatment follow-up clinic using touchscreen technology – feasibility study. *Eur J Cancer Care* 2018; 27: e12809–e12n/a.
54. Maguire R, Ream E, Richardson A, et al. Development of a novel remote patient monitoring system: the advanced symptom management system for radiotherapy to improve the symptom experience of patients with lung cancer receiving radiotherapy. *Cancer Nurs* 2015; 38: E37–E47.
55. Nic Giolla Easpaig B, Tran Y, Bierbaum M, et al. What are the attitudes of health professionals regarding patient reported outcome measures (PROMs) in oncology practice? A mixed-method synthesis of the qualitative evidence. *BMC Health Serv Res* 2020; 20: 102.
56. Brundage MD, Barbera L, McCallum F, et al. A pilot evaluation of the expanded prostate cancer index composite for clinical practice (EPIC-CP) tool in Ontario. *Qual Life Res* 2019; 28: 771–782.
57. Noble-Jones R, Thomas MJ and Bose P. The lymphoedema genitourinary cancer questionnaire in urology follow-up clinics. *Int J Urol Nurs* 2019; 13: 5–12.
58. Mejdahl C. *Patient-reported outcome measures in outpatient follow-up – a multiperspective interpretive description*. Aarhus: Aarhus University, 2018.

59. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *JAMA* 2013; 310: 2191–2194.
60. Groff S, Holroyd-Leduc J, White D, et al. Examining the sustainability of screening for distress, the sixth vital sign, in two outpatient oncology clinics: a mixed-methods study. *Psychooncology* 2018; 27: 141–147.
61. Jagsi R, Chiang A, Polite BN, et al. Qualitative analysis of practicing oncologists' attitudes and experiences regarding collection of patient-reported outcomes. *J Oncol Pract* 2013; 9: e290–e2e7.
62. Antonovsky A. The salutogenic model as a theory to guide health promotion. *Health Promot Int* 1996; 11: 11–18.
63. Foster A, O'Cathain A, Harris J, et al. Using co-production to implement patient reported outcome measures in third sector organisations: a mixed methods study. *J Patient Rep Outcomes* 2022; 6: 78–10.