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Correspondence

'Reply to: Moving forward with value-based healthcare: The need for a scientific approach.'

We thank you for the opportunity to respond to the issues raised in Dr Garvelink's letter and to clarify aspects of our paper in relation to these concerns. We also thank Dr Garvelink and her colleagues for their interest in our paper and for taking the time to express their concerns.

In her letter to the editor, Dr Garvelink notes potential concerns with publishing a paper like this in scientific literature because of the lack of a thorough scientific method. The goal of our paper was to outline the way our value-based strategy was formed and implemented at our institute, as being more of an overview article, instead of a study following or describing a research question.

We described the implementation of a VBHC-strategy (i.e. using a standardized outcome set that encompassed both provider and patient reported outcomes), instead of the full implementation of VBHC since it is not always "one size fits all". The difficulty in assessing the success of implementing VBHC is agreeing on a definition in the first place. The concept of VBHC delivery, as envisioned by Michael Porter, is a structure for rebuilding global healthcare systems with the overarching goal of value for patients [1]. The overarching goal of the implementation of our VBHC-strategy is to improve the quality of our care delivery by measuring and improving outcomes that reflect value; value of the care for patients.

By stating that this strategy was implemented successfully, we meant that measurement of longitudinal PROs and provider reported outcomes was implemented within our standard care, which is the full cycle of breast cancer care. We only evaluated the first two years after the implementation and did not yet include the cost part. Time must tell whether or not this initiative is actually successful in the longer term.

We agree on the brief description of our IPU, that is why we also show our blueprint as a potential guide for other institutes. By calling it a multidisciplinary breast cancer practice unit, we do not think it is incongruent with Porters definition of an IPU. IPUs, as described by Porter, are proposed as an approach of restructuring the organization and work processes of multidisciplinary teams to achieve value in healthcare [1–3]. It is composed of a dedicated team providing the full care for the patient's condition [2]. This first step towards VBHC in breast cancer care already existed at our institute, with a breast cancer-specific multidisciplinary practice unit of oncological (breast)surgeons, oncologists, radiotherapists, radiologists, plastic and reconstructive surgeons, pathologists, clinical geneticists, psychologists, gynecologists and specialized nurses. Within this practice unit professionals of Erasmus MC as well as a general partner hospital participated. Although it is not called an IPU in the method section of our paper, our multidisciplinary team matches with the description of IPUs that was provided by Porters definitions.

The entire IPU was involved in the development of the outcome set and worked together in the different phases of the development. To ensure patients' input in the outcome selection, interviews with breast cancer patients and survivors were conducted and patient surveys carried out.

It is apparent that we share similar goals with Dr Garvelink and her colleagues – to create clarity in the evolving field of VBHC, struggling to defend its basis. By sharing the process of our framework deployed for implementation of an outcome set and the challenges within this implementation process, we tried to serve as a guide for others.

Conflicts of interest statement

No conflicts of interest to declare.

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