

When Patient-Centered Care Initiatives Align: Integrating VA Whole Health and Shared Decision-Making for Lung Cancer Screening

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Background: System-wide, patient-centered health care transformations and efforts to enhance shared decision-making (SDM) are often separate initiatives. Multiple initiatives can create competing or inefficient demands on clinicians. This is evident within the US Department of Veterans Affairs (VA) Whole Health System of Care and the aligned but distinct effort to implement SDM for lung cancer screening (LCS).

Observations: This article describes a VA-based research team's efforts to identify alignment between whole health and SDM for LCS and to integrate these initiatives into a single

model to inform future health care practitioner training. The study identified areas of overlap between the 2 initiatives and created a 3-step model for integrating SDM and whole health for LCS.

Conclusions: Integrating 2 programs previously treated as separate initiatives ensured uptake for both SDM for LCS and whole health. This approach of integrating separate initiatives can be applied more broadly to other VA programs or in any health care system seeking to advance SDM within broader patient-centered care initiatives.

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The landmark *Crossing the Quality Chasm* report from the National Academy of Medicine identified patient-centered care as essential to health care quality. The report defines patient-centered care as “respectful of and responsive to individual patient preferences, needs, and values.”¹ Many health care systems, including the Veterans Health Administration, are transforming to a patient-centered model of care.² The US Department of Veterans Affairs (VA) Whole Health System of Care initiative is a system-wide, cultural transformation. Within whole health, *what matters most* to the patient—including their preferences, needs, and values—is foundational to health care and meant to be essential in every clinical encounter. Whole health implementation includes a progressive rollout with health care practitioner (HCP) trainings across the VA.²

Shared decision-making (SDM) is a different but aligned patient-centered care concept. SDM is a process through which a decision or care plan, based on patients' preferences, needs, and values, is made or developed.³⁻⁵ SDM is ideal in situations with equipoise (decisions with equivalent choices), individualized risks, and/or greater uncertainty of the net benefit, such as with lung cancer screening (LCS).³ SDM for LCS is required by the US Centers for Medicare and Medicaid Services and has been adopted

by many US health care systems, including the VA.^{6,7} Early detection of lung cancer can reduce death by 20% at the population level.⁸ However, at the patient level there is wide variation in the risk of developing lung cancer and a range of potential harms.⁸ LCS follow-up procedures may be more invasive than with other cancer screenings. Thus, there is concern about the risk of false-positive results leading to unnecessary care or complications.⁸ Given this balance between benefit and harm and the differing patient value on the trade-offs of LCS, an individualized, patient-centered approach is essential when deciding whether LCS is the right choice for a specific patient.

Despite the importance of LCS SDM, observational studies have shown poor implementation in clinical encounters.^{9,10} HCP barriers include competing demands, limited time, lack of familiarity with and training in SDM, and beliefs biasing screening over no screening.¹¹⁻¹³ Additionally, HCPs may assume that patients want them to make the decision. However, research has shown that patients actually want to be more involved in their health care decisions.¹⁴ One suggested strategy to overcome these barriers is aligning SDM for LCS within an organization's broader patient-centered initiatives.¹⁵

This project sought to align the need for SDM for LCS and the broader VA whole health initiative as part of a multi-

TABLE 1. Alignment of SDM and Whole Health

| Element | SDM | Whole health | SDM in whole health context |
|--|---|---|---|
| Actors | Implicitly dyadic | Team approach | Team approach, different team members involved |
| Patient role | HCP is main actor; patient role is less explicit | Patient has active role as partner in health care team | Patient has explicit, active role as part of health care team |
| HCP role | HCP conceptualized solely in clinical role | HCP's values, preferences, and goals are incorporated; HCP's own whole health and importance of self-care valued; HCP prompted to reflect on own goals and values | HCP's values, preferences, and goals incorporated; HCP's own whole health and importance of self-care valued; HCP prompted to reflect on own goals and values |
| Clinical encounter | Focus on a clinical condition | System perspective, across clinical encounters | Specific clinical encounter and decision understood within system context |
| Patient values, preferences, and goals | Constrained to this conversation; focused values, preferences, and goals related to this decision | All conversations anchored in broader patient values, preferences, and goals; broader life mission, aspiration, and purpose | How do broader patient values, preferences, and goals for their life come into play during this decision? |
| Tools | SDM decision aids | Personal Health Inventory; goals span many health conditions and life context | Use of SDM decision aids along with whole health tools |
| Communication skills training | SDM training | Additional patient-centered communication skills (eg, motivational interviewing) | SDM training along with training in other communication skills |

Abbreviations: HCP, health care practitioner; SDM, shared decision-making.

level strategy to implement SDM for LCS across Veterans Integrated Service Network (VISN) 1.¹⁶ This article addresses HCP-level barriers. HCPs targeted are those typically involved in LCS. The VA utilizes LCS coordinators (LCSCs) in both centralized or consult models (in which LCSCs are involved in all aspects of screening) and hybrid models (in which primary care practitioners and LCSCs are both engaged in LCS tasks). The goal of this program was to generate areas of conceptual alignment between SDM and whole health as a first step in integrating these VA initiatives. This work was conducted as a foundation for an SDM for lung cancer HCP training and consultation initiative.

ALIGNMENT PROCESS

We reviewed relevant literature and resources for SDM and whole health. In reviewing the SDM literature, we included a sample of the most widely cited literature on the topic, and focused primarily on the systematic review by Bomhof-Roordink et al.^{4,5,17,18} This review provided a synthesis of SDM elements across SDM models and identified 53 different elements clustered into 24 components.⁴ The most common components were present in at least half of all SDM published models, including: make the decision, patient preferences, tailor information, deliberate, create

choice awareness, and learn about the patient. Bomhof-Roordink et al provided the guiding framework for this conceptualization of SDM because that study included the available recent published SDM models.⁴

Second, published literature on VA whole health along with supplemental promotional and training materials were reviewed. The whole health materials included 2 sets of training slides developed for VA HCPs (available to VA employees): *Implementing Whole Health in Clinical Care*, which is focused on HCPs' work with patients, and *Whole Health for You and Me*, which is about HCPs' personal well-being.¹⁹ We also reviewed a publication describing the history of whole health and patient-facing online whole health tools.^{2,19}

Each document was reviewed for key elements related to SDM, patient-centered care, and whole health. Using the 53 elements identified by Bomhof-Roordink et al, we reviewed and compared each element to the whole health materials to create the integrated model of SDM and whole health. We iteratively discussed and organized the elements until we reached consensus.

SDM and Whole Health Alignment

We created an integrated model of SDM for LCS within the context of the VA whole health initiative. This integrated model is

directed at HCPs who would likely engage patients in discussions of LCS, including primary care practitioners and nurse coordinators. The model includes 3 steps for HCPs to follow that align SDM within whole health: (1) frame the conversation and partner with the patient; (2) share clinical perspective and elicit patient values; and (3) deliberate and decide together. For each step, the SDM elements, whole health elements, and integration of SDM and whole health are provided. Table 1 provides an overview of the similarities and differences between SDM and whole health. Example phrases that merge SDM and whole health for HCPs to use in patient conversations about LCS are included in Table 2.

STEP 1. FRAME THE CONVERSATION AND PARTNER WITH THE PATIENT

Shared decision-making. Traditional SDM literature includes an initial step of letting patients know that there is a choice to be made between ≥ 2 clinical options.⁴ Ancillary elements of this first step include asking patients their preferences about the degree to which they want to be involved in SDM and about how they like to receive information (eg, verbal, written, video). These steps open the SDM conversation and ensure the patient and HCP are on the same page before moving forward. For example, the US Agency for Healthcare Research and Quality SHARE model's first step is for HCPs to communicate that choices exist and to invite the patient to be involved in decisions.²⁰ Similarly, Elwyn's 3-step SDM model begins with establishing that a choice exists and inviting patient input on making that choice.¹⁷

Whole health. Patients are encouraged to play an active role in their health care. Through whole health programs such as *Taking Charge of My Life and Health*, patients explore their values and set self-care goals.²¹ HCP whole health trainings teach and reinforce communication skills, including SDM, listening skills, and motivational interviewing.¹⁹

Shared decision-making/whole health integration. SDM and whole health both prioritize respect, compassion, and patients' expertise. They focus on the patient-HCP relationship with an emphasis on fostering egalitarian interactions. HCPs frame the SDM conversation and partner with the

patient so they know what to expect and who will be involved. This conversation is framed from the outset as a collaborative discussion. HCPs empower the patient to play an active role in decision-making and help them understand why their engagement is critical.

STEP 2. SHARE CLINICAL PERSPECTIVE AND ELICIT PATIENT VALUES

Shared decision-making. HCPs share clinical perspective on LCS tailored to individual patients while explicitly inviting the patient to share their preferences and values when thinking about whether to undergo LCS. HCPs give a balanced description of LCS, including the benefits and harms, tailored to the patient's unique information needs and questions. Sharing clinical perspective also includes describing treatment options, the most common element across SDM models.⁴ Decision aids, which provide unbiased information and include a values clarification exercise, may be helpful in sharing clinical perspectives and clarifying patient values related to the trade-offs of LCS.²² For example, the VA National Center for Health Promotion and Disease Prevention developed a LCS decision aid to be used for SDM for LCS.

Whole health. The conversation shifts from "What is the matter *with* you?" to "What matters *to* you?" starting with the patient's goals and priorities rather than disease prevention, diagnosis, and treatment.² Several whole health tools exist, including the Personal Health Inventory, used to identify what matters most to patients and understand their current well-being and self-care.²³ Using the inventory, the patient and their health care team develop the patient's personal health plan.²⁴ Additionally, whole health trains HCPs to reflect on their own attitudes and biases when providing clinical care.

Shared decision-making/whole health integration. The LCS conversation can build on other whole health-related conversations with a HCP or other team members. HCPs can reference the patient's personal health plan for documentation of the patient's preferences, values, and goals in the electronic medical record. During this process, HCPs can give space for patients to discuss factors in their life and experiences that impact their perspective and decision-making.

TABLE 2. Steps in a Whole Health, Shared Decision-Making Conversation About Lung Cancer Screening

| Step | Description | Examples of clinician phrases |
|------|--|--|
| 1 | Frame the conversation and partner with patient | We can't make this decision without your input and knowing what is important to you. Let's work together to create a plan that fits your life. |
| 2 | Share clinical perspective and elicit patient values | What about your life should we keep in mind while we are making this decision about lung cancer screening? What matters most to you? |
| 3 | Deliberate and decide together | Does it sound like the right choice for you in your life right now? |

For example, patient concerns could be explored here, including fear of a cancer diagnosis, stigma around smoking, and fears around the screening and/or treatment process. HCPs may ask, “What matters most to you when making this decision?” Finally, by sharing clinical information, HCPs will focus on patient values to help overcome their own biases toward a desire for LCS. HCPs, similar to the rest of the US public, tend to hold highly favorable attitudes toward cancer screening as well as misconceptions about the magnitude of benefits from screening.¹³

STEP 3. DELIBERATE AND DECIDE TOGETHER

Shared decision-making. Decision-making is almost always considered the last SDM step.⁴ In the final step, the patient and HCP discuss the options (ie, to screen or not to screen) considering the patient's values and preferences, and patients decide with their HCP whether they will undergo LCS. Patients may decide they need more time to think about these options. As part of deliberation, HCPs assess what other information patients may need to arrive at a decision. Family members, friends, or peers may be included in making the final decision.

Whole health. In Whole health, decisions also may include the entire health care team and other individuals important to the patient (eg, family, friends). Integration across different health care settings is also considered a key whole health element. Finally, whole health focuses on long-term relationships with patients; thus, the LCS SDM process is situated within longer term relationship building and patient empowerment, both of which will facilitate partnering with the patient in future conversations about other decisions.

Shared decision-making/whole health integration. Both SDM and whole health emphasize partnership with the patient in making a final decision. There is also focus on decision-making as an ongoing process. Deciding whether LCS is the best choice might include naming and addressing emotions, voicing questions not raised, and exploring whether screening fits the patient's goals, values, and life context. HCPs may give guidance, but patients retain the authority to make decisions. The goal is to empower patients to know that the only right decision is the one right for them and they will be supported.

Limitations

This article describes a VA practice program and was not a formal research study. Further work is needed to evaluate the presented strategies. Additionally, we did not conduct a systematic literature review and thus elements of SDM and whole health may not be exhaustive.

CONCLUSIONS

This article describes the alignment of 2 distinct VA initiatives, whole health and SDM for LCS. The goal was to reduce known barriers to SDM, such as competing demands, limited time, and lack of familiarity with and training in SDM.¹¹⁻¹³ These concepts are well aligned. This integrated model is the first step in informing the development of a HCP training program and materials as part of a multilevel strategy that our team is using to implement SDM for LCS in VISN 1.¹⁶ The final training and materials resulting from this work were delivered to LCSCs in 3 ways: (1) a series of 3 interactive group training sessions, including didactic elements, role play, and time for open discussion; (2) 1-on-1

academic detailing; and (3) educational handouts. In academic detailing, a member of the research team trained in academic detailing met virtually with each nurse coordinator, identified that individual's barriers to SDM, and used the training materials to highlight messages to overcome those barriers; follow-up calls provided a forum for discussing progress and overcoming additional challenges. Although this article focused specifically on whole health and SDM, the conceptual alignment process strategy can be applied to other implementations of multiple initiatives.

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Ethics and consent

This study was reviewed and determined to be exempt by the Veterans Affairs Bedford Healthcare System Institutional Review Board.

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References

1. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; 2001. doi:10.17226/10027
2. Bokhour BG, Haun JN, Hyde J, Charns M, Kligler B. Transforming the Veterans Affairs to a whole health system of care: time for action and research. *Med Care*. 2020;58:295-300. doi:10.1097/MLR.0000000000001316
3. Elwyn G, Frosch D, Rollnick S. Dual equipoise shared decision making: definitions for decision and behaviour support interventions. *Implement Sci*. 2009;4:75. doi:10.1186/1748-5908-4-75
4. Bomhof-Roordink H, Gärtner FR, Stiggelbout AM, Pieterse AH. Key components of shared decision making models: a systematic review. *BMJ Open*. 2019;9:e031763. doi:10.1136/bmjopen-2019-031763
5. Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Soc Sci Med*. 1999;49:651-661. doi:10.1016/s0277-9536(99)00145-8

6. Moyer VA; US Preventive Services Task Force. Screening for lung cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2014;160:330-338. doi:10.7326/m13-2771
7. Centers for Medicare & Medicaid Services. Screening for lung cancer with low dose computed tomography (LDCT). February 10, 2022. Accessed February 7, 2025. <https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncid=304>
8. Aberle DR, Adams AM, Berg CD, et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. *N Engl J Med*. 2011;365:395-409. doi:10.1056/NEJMoa1102873
9. Slatore CG, Wiener RS. Pulmonary nodules: a small problem for many, severe distress for some, and how to communicate about it. *Chest*. 2018;153:1004-1015. doi:10.1016/j.chest.2017.10.013
10. Nishi SPE, Lowenstein LM, Mendoza TR, et al. Shared decision-making for lung cancer screening: how well are we "sharing"? *Chest*. 2021;160:330-340. doi:10.1016/j.chest.2021.01.041
11. Wiener RS, Koppelman E, Bolton R, et al. Patient and clinician perspectives on shared decision-making in early adopting lung cancer screening programs: a qualitative study. *J Gen Intern Med*. 2018;33:1035-1042. doi:10.1007/s11606-018-4350-9
12. Melzer AC, Golden SE, Ono SS, Datta S, Triplette M, Slatore CG. "We just never have enough time": clinician views of lung cancer screening processes and implementation. *Ann Am Thorac Soc*. 2020. doi:10.1513/AnnalsATS.202003-262OC
13. Schwartz LM, Woloshin S, Fowler FJ Jr, Welch HG. Enthusiasm for cancer screening in the United States. *JAMA*. 2004;291:71-78. doi:10.1001/jama.291.1.71
14. Lown BA, Rosen J, Marttila J. An agenda for improving compassionate care: a survey shows about half of patients say such care is missing. *Health Aff (Millwood)*. 2011;30:1772-1778. doi:10.1377/hlthaff.2011.0539
15. Scholl I, LaRussa A, Hahlweg P, Kobrin S, Elwyn G. Organizational- and system-level characteristics that influence implementation of shared decision-making and strategies to address them - a scoping review. *Implement Sci*. 2018;13:40. doi:10.1186/s13012-018-0731-z
16. Khanna A, Fix GM, Anderson E, et al. Towards a framework for patient-centred care coordination: a scoping review protocol. *BMJ Open*. 2022;12:e066808. doi:10.1136/bmjopen-2022-066808
17. Elwyn G, Durand MA, Song J, et al. A three-talk model for shared decision making: multistage consultation process. *BMJ*. 2017;359:j4891. doi:10.1136/bmj.j4891
18. Makoul G, Clayman ML. An integrative model of shared decision making in medical encounters. *Patient Educ Couns*. 2006;60:301-312. doi:10.1016/j.pec.2005.06.010
19. Whole Health. US Department of Veterans Affairs. Accessed April 14, 2025. <https://www.va.gov/wholehealth/>
20. Agency for Healthcare Research and Quality. The SHARE approach. Accessed April 14, 2025. <https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html>
21. Abadi MH, Barker AM, Rao SR, Orner M, Rychener D, Bokhour BG. Examining the impact of a peer-led group program for veteran engagement and well-being. *J Altern Complement Med*. 2021;27:S37-S44. doi:10.1089/acm.2020.0124
22. Stacey D, Lewis KB, Smith M, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev*. 2024;1:CD001431. doi:10.1002/14651858.CD001431.pub6
23. US Department of Veterans Affairs, Veterans Health Administration, Office of Patient Centered Care and Cultural Transformation. Personal health inventory. Revised April 2019. Accessed April 14, 2025. https://www.va.gov/wholehealth/docs/10-773_PHI_July2019_508.pdf
24. US Department of Veterans Affairs. Build your personal health plan. Updated July 24, 2024. Accessed April 14, 2025. <https://www.va.gov/wholehealth/phi.asp>