Review Article | Public Health in Palliative Medicine and Palliative Care

Palliative care in the older adult Veteran

Eva P. Szymanski[1,2], Simon Wallace[3], Deborah Way[3], Erin M. Haley[3]

[1]Division of Geriatrics, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA; [2]Geriatrics and Extended Care Program, Corporal Michael J. Crescenz VA Medical Center, Philadelphia, PA, USA; [3]Palliative Care Service, Corporal Michael J. Crescenz VA Medical Center, Philadelphia, PA, USA

Contributions: (I) Conception and design: All authors; (II) Administrative support: All authors; (III) Provision of study materials or patients: All authors; (IV) Collection and assembly of data: All authors; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Correspondence to: Erin M. Haley, MD, PhD. Palliative Care Service, Corporal Michael J. Crescenz VA Medical Center, 3900 Woodland Avenue, Philadelphia, PA 19104, USA. Email: erin.haley@va.gov.

Abstract: The United States military Veteran population is aging, thus leading to a group of Veterans who have functional disabilities, sensory impairments, and geriatric syndromes such as frailty and dementia. As they age, Veterans are also at risk of being diagnosed with a variety of serious illnesses, such as neurologic conditions and cancers, some of which are a consequence of prior military service or toxic exposures. In addition to frailty and multicomplexity, Veterans have higher rates of mental health disorders than civilians. All of these factors lead to a population of older Veterans who can benefit from palliative care involvement. Major tenets of palliative care focus on enhancing quality of life and provision of goal-concordant care, which are also aims of the services provided by the Veterans Health Administration (VHA) to all enrolled Veterans. Palliative care involvement in the holistic care of Veterans can deliver expert pain and symptom management, promote Veteran-centric plans of care, and provide crucial support of complex medical decision making often required for those Veterans with serious illness. In this review article, we discuss the unique palliative care needs of Veterans as they age, while also sharing information about relevant resources and services provided by the VHA.

Keywords: Palliative care; geriatrics; Veterans

Submitted Jul 26, 2023. Accepted for publication Nov 07, 2023. Published online Dec 13, 2023.
doi: 10.21037/apm-23-492
View this article at: https://dx.doi.org/10.21037/apm-23-492

Introduction

What makes Veterans different from patients who did not serve in the military? Experience in the military can bring many positive benefits to Veterans including comradery and discipline, a sense of self-worth and pride, education and career planning, and life-long connections with other Veterans. Unfortunately, negative consequences of military experience may include physical debility from injuries obtained in the service, post-traumatic stress disorder (PTSD) and other mental health concerns, and toxic exposures and their sequelae, including solid organ failures and malignancy. Caring for Veterans can bring great joy for providers and clinicians, but also comes with challenges in identifying, diagnosing, and managing concerns that are unique to or more prevalent in Veterans. Veterans who receive care at Veterans Affairs (VA) facilities have been found to be sicker than the non-VA Veteran population and the general population, including poorer self-rated health status, more medical conditions, and more outpatient visits and hospitalizations per year (1). This makes their access to care for serious illnesses critical, particularly as the US population ages. Over time, characteristics of the Veteran population are changing, and new laws are being passed to support Veterans whose health was negatively affected by their service (2). Clinicians from all specialties must be adept at handling Veteran needs in this changing landscape.

Throughout this article, we will discuss a wide variety

© Annals of Palliative Medicine. All rights reserved.

of serious illnesses that affect Veterans, often at higher rates than the general population. It is important to note that Veterans can be diagnosed with "service-connected conditions". This relates to "*a monetary benefit paid to Veterans who are determined by the VA to be disabled by an injury or illness that was incurred or aggravated during active military service. These disabilities are considered to be service-connected*" (3). Compensation ranges from hundreds of dollars per month up to over $2,000 per month for Veterans rated at 100%. There are additional compensations made for eligible Veterans with combat-related conditions. Finally, there are some medical diagnoses for which Veterans are automatically considered service-connected, termed "presumptive conditions". Such diagnoses include amyotrophic lateral sclerosis (ALS), certain conditions relating to malnutrition in a Veteran who was a prisoner of war, and diseases attributable to Agent Orange or other herbicide exposures. Formally titled "The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act", the Promise to Address Comprehensive Toxics (PACT) Act is the largest expansion of VA benefits to date (4). The PACT Act adds benefits for Veterans and their families with the following qualifications: service in the Gulf War and Vietnam eras; presence of diseases that had not been previously recognized as related to service (including hypertension and monoclonal gammopathy of undetermined significance); exposures to nuclear weapons, radiation, or contaminated water at Camp Lejeune, North Carolina during certain time periods. There is extensive work being done by the Veterans Health Administration (VHA) to publicize the PACT Act, including the decision to enact it all at once and to require VA clinicians to perform toxic exposure screening on all Veterans when they access VA care (5).

In this publication, we will review the crucial concepts of caring for aging Veterans with a palliative care friendly mindset. We will identify the unique aspects of Veteran care from a disease-state perspective including care for Veterans with geriatric syndromes, mental health disorders, functional disabilities and sensory impairments, and other serious illnesses (including organ failures and malignancy). Finally, we will discuss the importance of social determinants of health (SDOH) as it relates to older Veterans with palliative care needs.

Palliative care considerations for Veterans with geriatric syndromes

Veterans are older than the United States (US) population overall. In 2020, adults 65 years and older made up 46% of all Veterans, compared to 21% of all US adults (6,7). Therefore, geriatric syndromes [multifactorial health conditions prevalent in older adults (8)] and multicomplexity [the presence of multiple health conditions and biopsychosocial factors (9)] are more common in the Veteran population. In a study of Veterans being discharged from the hospital to a skilled nursing facility, 75% of Veterans had at least two geriatric syndromes (10). Geriatric syndromes often cause bothersome symptoms and can affect both quality and quantity of life (11), so palliative care approaches are especially beneficial. Despite this, older adults with a greater burden of geriatric syndromes had worse quality of their ambulatory care on a comprehensive measure incorporating 65 quality indicators (12), and almost one third of Veterans with multimorbidity and high risk of hospitalization reported that their most bothersome symptom was not being treated (11).

Frailty, as defined by the deficit-accumulation model, is a geriatric syndrome that is essentially a measure of multicomplexity since it incorporates physical and psychiatric symptoms, function, cognition, and social vulnerabilities (13). The prevalence of frailty in Veterans has increased over time, from 13% of Veterans who were moderately or severely frail in 2002 to 26.8% in 2012. Additionally, moderate and severe levels of frailty were associated with a 3- to 6-fold increase in mortality in 2012 (14). A study of Veterans who died at VA inpatient facilities noted that Veterans with primary diagnosis of frailty or end-organ failure received lower-quality end-of-life care compared to Veterans with diagnosis of cancer or dementia. Of Veterans with frailty, only 43% received a palliative care consultation in the last 90 days of life, 35% died in intensive care units, and 20% died in inpatient hospice units (15). Palliative and geriatric approaches such as high-quality communication, advance care planning, symptom management, optimization of quality of life, and hospice referral (when applicable) are all appropriate for patients who are frail (16). The VA requires availability of geriatric evaluation services for all Veterans per the 1999 Veterans Millennium Healthcare and Benefits Act (17), and many VA Medical Centers (VAMCs) have multidisciplinary Geriatric Evaluation and Management (GEM) programs both in the inpatient and outpatient settings (18), which are designed to provide comprehensive care to the older adult with geriatric syndromes, multicomplexity, and frailty. While palliative care consultants are not typically an explicit part of these models, the focus is holistic patient-

© Annals of Palliative Medicine. All rights reserved.

centered care that is in line with palliative care principles. Geriatricians are also skilled in these approaches with some geriatricians even having formal palliative care fellowship training.

Dementia is another geriatric syndrome that is common in older Veterans. An estimated 29% of US Veterans 80 years and older had dementia in 2022, with numbers projected to increase over the next decade (19). The number of Veterans with dementia will naturally increase due to the growing number of older Veterans plus the higher incidence of dementia with increasing age, but Veterans also have increased risk of developing dementia due to a higher burden of certain risk factors (20). Veterans have higher rates of traumatic brain injury (TBI), and TBI has been shown to cause an abnormal accumulation of proteins in the brain which are linked to neurodegenerative disease. These proteins include amyloid β and phosphorylated tau (related to Alzheimer's disease), transactive response DNA-binding protein 43 (related to frontotemporal dementia), and alpha-synuclein (related to Parkinson's disease) (20). Risk for developing dementia includes age at which TBI occurred and severity of TBI. One study found that severe TBI experienced in early adulthood increased the risk of developing dementia four times the rate of control (21). Another study found that in a 9-year follow-up period, the risk of developing dementia in the setting of TBI increased by 60% and occurred 2 years earlier in Veterans with TBI (22). Veterans may also have increased risk of developing dementia due to higher burden of other risk factors such as PTSD (though the evidence is still unclear), military deployment (this evidence is also unclear but proposed mechanisms include injury to visual, auditory, and neurologic pathways), sleep disturbance (often exacerbated by factors such as TBI, PTSD, and military deployment), depression, and/or cardiovascular disease (20).

Palliative care approaches are important for all patients with dementia, including high-quality communication both at diagnosis and at inflection points in the disease process, early and ongoing advance care planning, symptom management, caregiver support, and hospice when appropriate (23,24). A 2021 Cochrane Review found that palliative-oriented care delivery for people with advanced dementia may help improve comfort in dying, and advance care planning interventions may help improve goal-concordant care, though the evidence is of low certainty and limited by lack of high-quality studies (25). However, persons living with dementia and their care partners indicate an immense need for improved and integrated palliative care services in dementia (26).

Several initiatives are aimed at Veterans with dementia and their caregivers. For instance, "Partners in Dementia Care", a collaborative partnership between local VAMCs and community service organizations, provides care coordination, telephone and computer-based support, and information to Veterans with dementia and their caregivers. The program has been shown to improve symptoms of depression, embarrassment about memory, and relationships with caregivers (27). VA-funded programs that support Veterans with dementia to remain in the community have focused on supporting caregivers, engaging specialized interdisciplinary care teams, and improving communication/coordination between healthcare providers (28). However, the specific programs available for Veterans with dementia may vary widely based on location.

There are also opportunities to provide palliative care for Veterans with dementia during acute hospitalizations. Studies at non-VA hospital systems have described that inpatient palliative care teams are consulted most often in the context of advanced dementia with downward trajectory and to help with conversations regarding prognosis, goals of care, and/or family conflict which hospitalists either felt less comfortable with or did not have enough time for (29,30). Patients with dementia who received inpatient palliative care consultation were more likely to change their code status and be discharged to hospice (30). Of Veterans with dementia who died in a VA inpatient facility, 61% received a palliative care consult within the last 90 days of life, 94% had a do-not-resuscitate order at time of death, 32% died in an inpatient hospice unit, and 59% of families reported excellent overall quality of end-of-life care. These measures were seen as markers of high-quality end-of-life care, and were more likely to be present for Veterans with dementia compared to Veterans with end-stage organ failures or frailty (15). However, there is still room to improve palliative care for Veterans with dementia. In one study, barriers to inpatient palliative care consultation for patients with dementia included limited family involvement or perception of family resistance to the palliative care, as well as a perceived focus on end-of-life care only or busyness of their palliative care consultants (29). These findings suggest that the decision to consult palliative care for hospitalized patients with dementia is complex, and there is a need for better systems to identify patients who would benefit from palliative care and deliver that care to them. A pilot study at a non-VA hospital showed that a triggered palliative care intervention for hospitalized patients with advanced

© Annals of Palliative Medicine. All rights reserved.

dementia was feasible and led to increased attention to palliative care domains, discussion of prognosis and goals, completion of physician orders for life-sustaining treatment, and hospice referrals (31). Veterans with dementia would also benefit from such a program, and from being connected to palliative and/or geriatric care even earlier in their disease course.

From a practical perspective, health care professionals taking care of older Veterans with dementia, frailty, or other geriatric syndromes should be comfortable providing care using palliative principles and in line with the Geriatric 5Ms (Multicomplexity, Mind, Mobility, Medications, Matters Most) (9). For complex situations or intractable symptoms, one can collaborate with subspeciality-trained palliative care providers, geriatricians, and their teams. There is need for improved communication and coordination of the Veterans' inpatient, outpatient, and home care teams at a systems level to address palliative care needs (32). We should expect to continue seeing new and innovative models of care in this regard, especially as the VA continues to implement age-friendly care (33).

Health care professionals should encourage older Veterans to get enrolled in VA Health Care if eligible. A VA social worker will be able to guide the Veteran and their caregiver(s) regarding available programs and benefits they are eligible for based on health conditions, location, income, etc. Veterans may be eligible for service-connection if their health condition is linked to their military service, or for additional aid and attendance payments if they need assistance with activities of daily living (ADLs) (34). Programs and benefits may include specialized care teams such as the Geriatric Patient Aligned Care Team (GeriPACT) and Home-Based Primary Care (HBPC) (35,36); low- or no-cost medications, personal care items (such as adult incontinence supplies), and mobility devices; services to support remaining in the community such as home health aides, adult day centers, respite care, and caregiver support programs (37); and facility-based care such as VA nursing homes [Community Living Centers (CLCs)] or VA-contracted community nursing homes (38). Appendix 1 includes further details of the locations of care available as resources for Veterans. Of note, palliative and hospice services can be provided at all of the aforementioned sites where Veterans receive their care.

Palliative care considerations for Veterans with mental health disorders

We will focus on the two most prevalent mental health disorders recognized in Veterans, PTSD and depression, and the consequences of aging on these mental health disorders. Note that several other diseases, including but not limited to schizophrenia and chronic adjustment disorders, can provide service-connection and enhanced benefits to Veterans with those diagnoses. Their identification in military Veterans is incredibly crucial in providing robust, holistic care.

An important distinction to make is the difference between PTSD and late-onset stress symptomatology (LOSS). LOSS is considered a normal part of the aging process for combat Veterans as they deal with retirement from careers, changes in health status, and personal losses. It is thought that LOSS occurs in previously non-affected Veterans who engaged in combat in their earlier years and begin to remember and ponder their combat experiences in the context of changes in their day-to-day life with aging (39). This is in contrast to PTSD, which is a pathologic diagnosis under the category of trauma- and stress-related disorders in the DSM-V (39). PTSD diagnostic criteria are (I) exposure to actual or threatened death, serious injury, or sexual violence; (II) presence of one or more intrusion symptoms associated with the traumatic event; (III) persistent avoidance of stimuli associated with the traumatic event; (IV) negative alterations in cognitions and mood associated with the traumatic event; (V) marked alterations in arousal and reactivity associated with the traumatic event; (VI) duration of disturbance >1 month; (VII) disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and (VIII) the disturbance is not attributable to the physiological effects of a substance or another medical condition (40). Veterans have a higher risk for PTSD than civilian counterparts, though rates vary widely depending on the Veteran's specific era of service and combat status. The most recently quoted rates of PTSD are about 6% in the civilian population, *vs.* 7% for all Veterans, and 29% lifetime for those who served in Operations Iraqi Freedom and Enduring Freedom (41). There is increasing research aimed at the connection between Veterans from these specific eras with PTSD and depression having poorer overall health outcomes. For instance, Afghanistan and Iraq War Veterans with PTSD, depression, and substance use disorders have worse disease burden overall, which progresses over time, as well as increased utilization of mental health resources (42). Identification and treatment of PTSD and depression in Veterans is aimed at stemming this trend, in hope of improving outcomes for future generations of Veterans.

© Annals of Palliative Medicine. All rights reserved.

A feared complication of mental illness is suicide. Tragically, the rates of Veteran suicide are over 50% greater than non-Veteran US adults (43). It is suggested that specific forms of combat experience may garner high risk of suicidal ideation and attempts, with Veterans who have seen others killed or mortally wounded having higher risk (44). National efforts to mitigate this public health crisis are evident, and strategies have been implemented across both VA and community agencies with a goal to decrease the rates of Veteran suicide. These strategies are built upon foundational concepts that suicide is preventable, prevention requires a multimodal approach from clinical and community partnership, and everyone can play an important role in suicide prevention (45).

There is a significant role for palliative care engagement for Veterans with serious mental health conditions. Both primary and specialty palliative care can provide pain and symptom management, advance care planning expertise, and support of complex medical decision making. All Veterans with mental health concerns could benefit from assistance in all palliative care domains, remembering that Veterans with PTSD and depression have been found to have worse health burden overall and therefore may have the greatest benefits. The VA has been working diligently on transforming the way that healthcare is viewed for Veterans: from "what's the matter with you" to "what matters to you?" with Whole Health initiatives (46). The Whole Health program is an all-encompassing view of one's health, aimed at identifying what is most important to each Veteran and what provides purpose in life. Many feel that the Whole Health initiatives will become the future of healthcare, with Whole Health interventions aimed at optimizing mental health and resiliency (47).

Palliative care considerations for Veterans with functional disability and sensory impairments

Many Veterans have had injuries or illnesses that resulted in functional or sensory impairments and disabilities because of their service. Impairment is defined as "*the loss or abnormality of psychological*, *physiological*, *or anatomical structure or function resulting from pathology*" (48,49). Disability is defined as "*any restriction or lack of ability to perform an activity in the manner or within the range considered [typical] for a human being*" (48,49). Conditions like spinal cord injury, TBI, limb loss, or sensory impairment require specialty care provided by multidisciplinary teams. Veterans with non-service-related impairments and disabilities, or those who naturally develop debility and sensory impairments over time, also have access to services and resources within the VHA.

The field of Physical Medicine and Rehabilitation (PM&R), also known as Physiatry, historically received early support from the military during World War I and even more so during World War II as injured soldiers returned home. The developing field of rehabilitation medicine promoted physical and mental convalescence through specific activities and programs designed to restore hope, purpose, and quality of life for disabled Veterans (50). According to the field's largest current professional organization, the aim of PM&R is "*to enhance and restore functional ability and quality of life to those with physical impairments or disabilities affecting the brain*, *spinal cord*, *nerves*, *bones*, *joints*, *ligaments*, *muscles*, *and tendons*" (51).

PM&R and palliative care share several core maxims of philosophy and practice. These include a holistic and interdisciplinary approach to care to maximize function and well-being, improve quality of life, and alleviate suffering and burdens experienced by patients, families, and caregivers. At the end of life, often the concerns of functional decline, dependency, and loss of dignity are greater than the fear of death, and rehabilitation may reduce associated distress (52-59).

Rehabilitation goals target improvement in specific skills and abilities. Some goals focus on ADLs, which involve fundamental daily self-care skills. These include things like bathing, dressing, toileting, and transferring. Instrumental ADLs (IADLs) involve more complex tasks that allow individuals to function independently in the home and community. These include managing finances, housekeeping and cooking, medication management, and community interaction and activities.

Skilled therapy and restorative care both serve to improve Veterans' functional status (60). Skilled therapy involves targeting specific functional goals with therapeutic programs designed by qualified rehabilitation therapists [i.e., physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), respiratory therapy (RT)]. Restorative care focuses on treating Veterans who are severely deconditioned and supports their safe transition home or to a lower level of care. This latter service is provided by CLC nursing home staff, often in collaboration with therapy services as consultants.

Veterans with visual or hearing impairments may be eligible for devices and services covered by the VA if they meet certain qualifications (61). Examples include those with service-connected disabilities (conditions directly

© Annals of Palliative Medicine. All rights reserved.

related to military service), those who are former prisoners of war, and those awarded with a Purple Heart. Other examples include visual or auditory sensory impairments caused by an illness or injury (e.g., stroke, diabetes) or its treatment, for which a Veteran is receiving care at the VA. Further, Veterans may qualify if a functional, cognitive, or sensory impairment significantly interferes with functional independence. While support animals are not directly covered by the VA, oftentimes certain organizations will provide dogs and training to eligible Veterans at no cost and the VA may support veterinary and equipment costs (62).

Palliative care considerations for Veterans with other serious illnesses

Veterans are at increased risk of many different diseases and conditions. Use of the Behavioral Risk Factor Surveillance System (BRFSS) data set from the Centers for Disease Control and Prevention revealed that Veterans self-reported the following health issues greater than the general population: obesity, coronary heart disease, stroke, skin cancer, other cancer, chronic obstructive pulmonary disease, arthritis, kidney issues and diabetes. These findings of poor health and multimorbidity suggest the need for further evaluation of Veterans' health conditions, especially as they may relate to their time in the military (63,64). Many of these conditions and diseases can be attributed to their injuries and exposures, their branch of service, and the era in which they served. Some conditions are immediately obvious, such as TBI and physical injury due to combat including burns or traumatic amputations. However, many Veteran experiences manifest after their return from service. Of particular note are the interplay between TBI and dementia (which was discussed above), other progressive neurologic conditions, diabetes, and cancer.

Regarding Veterans and other non-dementia neurologic disorders, in the early 2000s, Department of Defense and VA studies linked ALS to Veterans who served in the Gulf War. Subsequent research linked an increased incidence of ALS to Veterans of any era, exposure, and branch of service. Veterans are at least 60% more likely to develop ALS and more likely to die from the disease. Research continues in this area (65). In 2008, ALS was deemed to be a condition directly related to any service in the military and so Veterans with ALS are entitled to full service-connected benefits. This is different from other presumptive diagnoses, which are generally limited to a certain era or exposure (65). Additionally, the VA has issued a directive for development of an ALS System of Care, which emphasizes "providing optimal quality of life" for Veterans with ALS. The directive calls for comprehensive and multidisciplinary services, including palliative and hospice care (66). Symptoms of ALS that can be addressed with palliative approaches include muscle spasticity, hypersialorrhea, respiratory failure, immobility, pain, and more (67). The VA actively continues research and to expand options for the care of Veterans with ALS (65).

Recognizing liver disease is also of particular importance in caring for the aging Veteran population. In a study of over 4 million hospitalized Veterans, 103,257 Veterans were newly diagnosed with cirrhosis, and the rate of liver cancer diagnoses over the period of follow-up was more than 8 times higher in those Veterans without cirrhosis (68). In this study, liver cancer was more likely to occur in Veterans with cirrhosis of any cause, with cirrhosis due to viral hepatitis cirrhosis having the highest hazard ratio (68). An autopsy-based study found a marked increase in primary liver tumors in male US Veterans compared to the general population, mostly hepatocellular carcinoma (HCC). In this study, significant risk factors for primary liver cancer included cirrhosis and hepatitis C virus (HCV) (69). Of note, the prevalence of HCV in Veterans is more than twice that of the general population (69). The VA began providing unrestricted access to HCV treatment and reportedly achieved cure in 85% of those that they treated. This led to a dramatic decrease in the incidence of HCC/HCV but led to a relative increase in HCC not caused by HCV (70). Unfortunately, cure of HCV that has already caused fibrosis does not reduce the risk of HCC, so we should still expect to take care of Veterans diagnosed with this liver cancer. Recent guidelines from non-VA national organizations have called for integration of palliative care services in all oncologic care (including HCC) and in decompensated cirrhosis (71,72). For decompensated cirrhosis specifically, palliative care is underutilized though studies have shown it is associated with improved symptoms, care coordination, and anticipatory planning (72). Palliative care is widely available for Veterans with cirrhosis and/or HCC, though it appears to be underutilized for Veterans as well, with almost two-thirds of VA sites referring less than 25% of their patients with cirrhosis and/or HCC for palliative services (73).

Diabetes is more prevalent in Veterans compared to the general US adult population. The diagnosis of diabetes is associated with obesity, lower education level and poverty (74). The natural sequelae of this disease therefore occur disproportionately in older Veterans, including

© Annals of Palliative Medicine. All rights reserved.

stroke, cardiovascular disease and conditions that can lead to amputation. For Veterans, the risk for obesity is also increased, thought in part due to several factors including maladaptive eating behaviors learned during their time of service in order to meet weight standards (64). Since the sequelae of diabetes often lead to increased symptom burden, functional impairment, and complex medical decision-making, palliative approaches are beneficial for these Veterans.

Veterans can be highly debilitated from the aforementioned serious illnesses and more, for which they suffer at higher rates than the general population. Given this, it should be highlighted that the VA has certain policies in place to allow for enhanced care for Veterans with serious illness, particularly at the end of life. In 2009, the Department of VA instituted the Comprehensive End of Life Care Initiative, which allows Veterans to pursue both hospice and palliative treatments (75). "Concurrent care" is the term for this concept, which allows Veterans to receive hospice care and support while also pursuing palliative treatments, should they desire to do so. For adult patients who are not Veterans, the conundrum of deciding between receiving excellent end of life care with hospice or continuation of palliative treatments has been termed the "terrible choice", as many who have entered the end stages of their disease processes delay enrollment with hospice because of a desire to maintain important therapeutic connections with their teams who are providing palliative treatments (76). Studies of concurrent care in the Veteran population, particularly those diagnosed with advanced cancer, have found higher rates of pursuing palliative treatments but less intensive interventions, and thus lower healthcare costs, at the end of life (77). While trials or pilots have been attempted in the civilian population, the uptake of "concurrent care" in other adult systems of care has not yet occurred (78). The VA remains the gold standard in providing concurrent hospice and disease-directed palliative treatments for adults with serious illness.

Palliative care considerations for Veterans impacted by SDOH

Along with syndromes, disorders, impairments, and disease states, SDOH are an important aspect to the palliative care of older Veterans. SDOH are "*the non-medical factors that influence health outcomes. They are conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life*" (79). Veterans and non-Veterans can come from the same populations who are at risk of being affected by adverse SDOH, but studies have shown that Veterans are disproportionately more affected (80). Veterans who are of a minority race, not married, and suffer from a service-connected condition are at increased risk of being affected by adverse SDOH (81). It has been noted that significant inequality in access to palliative care is a crisis in healthcare that has yet to be sufficiently tackled, with patients receiving care in hospitals serving primarily minority populations being far less likely to access palliative care (82). Many conditions influence how Veterans and non-Veteran patients and families perceive their serious illness and its treatment, as well as their quality of life and what a "good" end of life entails. As such, it has been posited that excellent patient-centered care requires attention to not just SDOH, but also "social determinants of comfort". Social determinants of comfort have been described as "*structural conditions that influence whether, to what degree, and in what forms comfort measures are offered to and accepted by patients and their families*" (83). The interplay between Veteran status, SDOH, and access to palliative care is complicated, but in order to provide excellent and holistic Veteran-centered care, all of these factors should be taken into account. The VA has a robust and well-integrated Social Work program, whose mission is to "*assist Veterans, their families and caregivers in resolving SDOH challenges to health and well-being*" (84). VA social work services are available in many care settings, and they are often critical members of palliative care and hospice teams.

Conclusions

Whether a Veteran is seeking routine medical care, palliative care, hospice, or care relating to a service-connected condition, engagement with the VA healthcare system is recommended to ensure maximal benefits are obtained and resources are optimized. The VA services mentioned in this article are applicable to Veterans with a variety of palliative care needs; additional information can be found in Appendix 1. Palliative care support for aging Veterans with serious illnesses can be a crucial component in providing holistic, Veteran-centric care plans. All VAMCs are required by policy to have a palliative care team. It is our experience that each individual VAMC operates as able within VA policy to provide palliative care consultative services and collaboration with the community. Veterans and community providers who are interested in learning more should contact the VAMC closest to them and request to speak with a palliative care team member.

© Annals of Palliative Medicine. All rights reserved.

Caring for Veterans who have served to protect our country is an honor and a privilege, and information discussed herein is aimed to provide an overview of how all clinicians can provide the best goal-concordant care for an aging Veteran population.

Acknowledgments

Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned by Guest Editors (Pragnesh Patel, Susan Nathan and Lara Skarf) for the series "Outpatient Palliative Care in Geriatric Clinics" published in *Annals of Palliative Medicine*. The article has undergone external peer review.

Peer Review File: Available at https://apm.amegroups.com/article/view/10.21037/apm-23-492/prf

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at https://apm.amegroups.com/article/view/10.21037/apm-23-492/coif). The series "Outpatient Palliative Care in Geriatric Clinics" was commissioned by the editorial office without any funding or sponsorship. The authors have no other conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to accuracy or integrity of any part of the work are appropriately investigated and resolved.

Open Access Statement: This is an Open Access article distributed in accordance with the Creative Commons Attribution-NonCommercial-NoDerivs 4.0 International License (CC BY-NC-ND 4.0), which permits the non-commercial replication and distribution of the article with the strict proviso that no changes or edits are made and the original work is properly cited (including links to both the formal publication through the relevant DOI and the license). See: https://creativecommons.org/licenses/by-nc-nd/4.0/.

References

1. Agha Z, Lofgren RP, VanRuiswyk JV, et al. Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. Arch Intern Med 2000;160:3252-7.
2. Takano M. H.R.3967 - 117th Congress (2021-2022): Honoring our PACT Act of 2022. 2022. Available online: https://www.congress.gov/bill/117th-congress/house-bill/3967
3. U.S. Department of Veteran's Affairs. Federal Benefits for Veterans, Dependents and Survivors. 2015. [Cited 2023 Jul 24]. Available online: https://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp
4. U.S. Department of Veteran's Affairs. The PACT Act and your VA benefits. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/resources/the-pact-act-and-your-va-benefits/
5. U.S. Department of Veterans Affairs. The VA will begin processing PACT Act benefits claims for all Veterans and survivors on Jan 1. 2022. Available online: https://news.va.gov/press-room/va-will-begin-processing-pact-act-benefits-claims-for-all-veterans-and-survivors-on-jan-1
6. United States Census Bureau. American Community Survey, S0101 AGE AND SEX, 2020: ACS 5-Year Estimates Subject Tables. 2020. [Cited 2023 Jul 24]. Available online: https://data.census.gov/table?q=national+ages+2020&tid=ACSST5Y2020.S0101
7. U.S. Department of Veteran's Affairs. Table 1L_VetPop2020_National_NCVAS. 2022. [Cited 2023 Jul 24]. Available online: https://www.va.gov/vetdata/veteran_population.asp
8. Inouye SK, Studenski S, Tinetti ME, et al. Geriatric syndromes: clinical, research, and policy implications of a core geriatric concept. J Am Geriatr Soc 2007;55:780-91.
9. Molnar F, Frank CC. Optimizing geriatric care with the GERIATRIC 5Ms. Can Fam Physician 2019;65:39.
10. Mixon AS, Yeh VM, Simmons S, et al. Improving Care Transitions for Hospitalized Veterans Discharged to Skilled Nursing Facilities: A Focus on Polypharmacy and Geriatric Syndromes. Geriatrics (Basel) 2019;4:19.
11. Reinke LF, Vig EK, Tartaglione EV, et al. Symptom Burden and Palliative Care Needs Among High-Risk Veterans With Multimorbidity. J Pain Symptom Manage 2019;57:880-9.
12. Min L, Kerr EA, Blaum CS, et al. Contrasting effects of geriatric versus general medical multimorbidity on quality of ambulatory care. J Am Geriatr Soc 2014;62:1714-21.
13. Rockwood K, Mitnitski A. Frailty defined by deficit accumulation and geriatric medicine defined by frailty.

© Annals of Palliative Medicine. All rights reserved.

Clin Geriatr Med 2011;27:17-26.
14. Orkaby AR, Nussbaum L, Ho YL, et al. The Burden of Frailty Among U.S. Veterans and Its Association With Mortality, 2002-2012. J Gerontol A Biol Sci Med Sci 2019;74:1257-64.
15. Wachterman MW, Pilver C, Smith D, et al. Quality of End-of-Life Care Provided to Patients With Different Serious Illnesses. JAMA Intern Med 2016;176:1095-102.
16. Boockvar KS, Meier DE. Palliative care for frail older adults: "there are things I can't do anymore that I wish I could . . .". JAMA 2006;296:2245-53.
17. Stearns C. H.R.2116 - 106th Congress (1999-2000): Veterans Millennium Health Care and Benefits Act. 1999. Available online: https://www.congress.gov/bill/106th-congress/house-bill/2116
18. Powers JS, Eubank KJ. Geriatrics Evaluation and Management in the Veterans Administration-An Historical Perspective. Geriatrics (Basel) 2018;3:84.
19. U.S. Department of Veterans Affairs. Statistical Projections of All Types of Dementia for VA Patients, VA Enrollees, and U.S. Veterans Fiscal Years 2022 and 2033. 2021. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/docs/VHA_ALL_DEMENTIA_Statistical_Projections_FY22_and_FY33_sgc102221.pdf
20. Raza Z, Hussain SF, Ftouni S, et al. Dementia in military and veteran populations: a review of risk factors-traumatic brain injury, post-traumatic stress disorder, deployment, and sleep. Mil Med Res 2021;8:55.
21. Plassman BL, Havlik RJ, Steffens DC, et al. Documented head injury in early adulthood and risk of Alzheimer's disease and other dementias. Neurology 2000;55:1158-66.
22. Yaffe K, Vittinghoff E, Lindquist K, et al. Posttraumatic stress disorder and risk of dementia among US veterans. Arch Gen Psychiatry 2010;67:608-13.
23. Weisbrod N. Primary Palliative Care in Dementia. Neurotherapeutics 2022;19:143-51.
24. Lee EE, Chang B, Huege S, et al. Complex Clinical Intersection: Palliative Care in Patients with Dementia. Am J Geriatr Psychiatry 2018;26:224-34.
25. Walsh SC, Murphy E, Devane D, et al. Palliative care interventions in advanced dementia. Cochrane Database Syst Rev 2021;9:CD011513.
26. Harrison KL, Garrett SB, Halim M, et al. "I Didn't Sign Up for This": Perspectives from Persons Living with Dementia and Care Partners on Challenges, Supports, and Opportunities to Add Geriatric Neuropalliative Care to Dementia Specialty Care. J Alzheimers Dis 2022;90:1301-20.
27. Bass DM, Judge KS, Snow AL, et al. A controlled trial of Partners in Dementia Care: veteran outcomes after six and twelve months. Alzheimers Res Ther 2014;6:9.
28. Davila H, O'Malley KA, Shin MH, et al. Supporting Veterans with dementia to remain in the community: strategies used in 12 Veterans Health Administration programs. Home Health Care Serv Q 2022;41:149-64.
29. Courtright KR, Srinivasan TL, Madden VL, et al. "I Don't Have Time to Sit and Talk with Them": Hospitalists' Perspectives on Palliative Care Consultation for Patients with Dementia. J Am Geriatr Soc 2020;68:2365-72.
30. Sharda N, Zietlow K, Wong S, et al. Characteristics and Outcomes of Dementia Patients Who Receive Inpatient Palliative Care Consultation. J Am Geriatr Soc 2020;68:2027-33.
31. Hanson LC, Kistler CE, Lavin K, et al. Triggered Palliative Care for Late-Stage Dementia: A Pilot Randomized Trial. J Pain Symptom Manage 2019;57:10-9.
32. Tietbohl CK, Dafoe A, Jordan SR, et al. Palliative Care across Settings: Perspectives from Inpatient, Primary Care, and Home Health Care Providers and Staff. Am J Hosp Palliat Care 2023;40:1371-8.
33. Farrell TW, Volden TA, Butler JM, et al. Age-friendly care in the Veterans Health Administration: Past, present, and future. J Am Geriatr Soc 2023;71:18-25.
34. U.S. Department of Veteran's Affairs. VA Financial Benefits. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/pages/VA_Financial_Benefits.asp
35. U.S. Department of Veteran's Affairs. Geriatric Patient Aligned Care Team GeriPACT. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/pages/Geriatric_Patient_Aligned_Care_Team_GeriPACT.asp
36. U.S. Department of Veteran's Affairs. Home Based Primary Care. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/pages/Home_Based_Primary_Care.asp
37. U.S. Department of Veteran's Affairs. Home and Community Based Services. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/pages/Home_and_Community_Based_Services.asp
38. U.S. Department of Veteran's Affairs. Residential Settings and Nursing Homes. 2023. [Cited 2023 Jul 24]. Available online: https://www.va.gov/GERIATRICS/pages/Nursing_Home_and_Residential_Services.asp
39. Potter CM, Kaiser AP, King LA, et al. Distinguishing late-onset stress symptomatology from posttraumatic stress

© Annals of Palliative Medicine. All rights reserved.

disorder in older combat veterans. Aging Ment Health 2013;17:173-9.
40. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.
41. U.S. Department of Veteran's Affairs. Understand PTSD. 2022. [Cited 2023 Jul 24]. Available online: https://www.ptsd.va.gov/understand
42. Possemato K, Wade M, Andersen J, et al. The impact of PTSD, depression, and substance use disorders on disease burden and health care utilization among OEF/OIF veterans. Psychol Trauma 2010;2:218-23.
43. U.S. Department of Veteran's Affairs. National Veteran Suicide Prevention Annual Report. 2022. [Cited 2023 Jul 24]. Available online: https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf
44. Nichter B, Hill M, Norman S, et al. Impact of specific combat experiences on suicidal ideation and suicide attempt in U.S. military veterans: Results from the National Health and Resilience in Veterans Study. J Psychiatr Res 2020;130:231-9.
45. The White House. Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy. 2021. [Cited 2023 Jul 24]. Available online: https://www.whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf
46. Kligler B, Hyde J, Gantt C, et al. The Whole Health Transformation at the Veterans Health Administration: Moving From "What's the Matter With You?" to "What Matters to You?". Med Care 2022;60:387-91.
47. Krist AH, South-Paul JE, Meisnere M. Achieving Whole Health for Veterans and the Nation: A National Academies of Sciences, Engineering, and Medicine Report. JAMA Health Forum 2023;4:e230874.
48. World Health Organization, World Bank. World report on disability 2011. 2011. [Cited 2023 Jul 24]. Available online: https://iris.who.int/handle/10665/44575
49. Montagnini M, Javier N. Physical therapy and other rehabilitation issues in the palliative care setting. UpToDate. 2023. Available online: https://www.uptodate.com/contents/physical-therapy-and-other-rehabilitation-issues-in-the-palliative-care-setting
50. Sandel E. The Early History of Physical Medicine and Rehabilitation in the United States. 2019. [Cited 2023 Jul 24]. Available online: https://now.aapmr.org/the-history-of-the-specialty-of-physical-medicine-and-rehabilitation/
51. American Academy of Physical Medicine and Rehabilitation. About Physical Medicine & Rehabilitation. Available online: https://www.aapmr.org/about-physiatry/about-physical-medicine-rehabilitation
52. Cheville A. Rehabilitation of patients with advanced cancer. Cancer 2001;92:1039-48.
53. Santiago-Palma J, Payne R. Palliative care and rehabilitation. Cancer 2001;92:1049-52.
54. Waterworth S, Jorgensen D. It's not just about heart failure--voices of older people in transition to dependence and death. Health Soc Care Community 2010;18:199-207.
55. Breitbart W, Rosenfeld BD. Physician-Assisted Suicide: The Influence of Psychosocial Issues. Cancer Control 1999;6:146-61.
56. Morita T, Sakaguchi Y, Hirai K, et al. Desire for death and requests to hasten death of Japanese terminally ill cancer patients receiving specialized inpatient palliative care. J Pain Symptom Manage 2004;27:44-52.
57. Yoshioka H. Rehabilitation for the terminal cancer patient. Am J Phys Med Rehabil 1994;73:199-206.
58. Charmaz K. Good days, bad days: The self in chronic illness and time. New Brunswick: Rutgers University Press; 1997.
59. Fischer S, Huber CA, Furter M, et al. Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians. Swiss Med Wkly 2009;139:333-8.
60. U.S. Department of Veteran's Affairs. VHA Directive 1170.03(1): Physical Medicine and Rehabilitation Service. 2022. [Cited 2023 Jul 24]. Available online: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8578
61. U.S. Department of Veteran's Affairs. VA vision care. 2022. [Cited 2023 Jul 24]. Available online: https://www.va.gov/health-care/about-va-health-benefits/vision-care/
62. U.S. Department of Veteran's Affairs. VA blind and low vision rehabilitation services. 2022. [Cited 2023 Jul 24]. Available online: https://www.va.gov/health-care/about-va-health-benefits/vision-care/blind-low-vision-rehab-services/
63. Boersma P, Cohen RA, Zelaya CE, et al. Multiple Chronic Conditions Among Veterans and Nonveterans: United States, 2015-2018. Natl Health Stat Report 2021;(153):1-13.
64. Betancourt JA, Granados PS, Pacheco GJ, et al. Exploring Health Outcomes for U.S. Veterans Compared to Non-Veterans from 2003 to 2019. Healthcare (Basel) 2021;9:604.
65. ALS Association. Defense Health Research Programs:

© Annals of Palliative Medicine. All rights reserved.

Relevance to National Security and Military Families. 2020. [Cited 2023 Jul 24]. Available online: https://www.als.org/sites/default/files/2020-04/navigating-als_military-veterans_als-in-military-white-paper_0.pdf
66. U.S. Department of Veteran's Affairs. VHA Directive 1101.07 Amyotrophic Lateral Sclerosis System of Care. 2021. [Cited 2023 Oct 5]. Available online: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9423
67. Karam CY, Paganoni S, Joyce N, et al. Palliative Care Issues in Amyotrophic Lateral Sclerosis: An Evidenced-Based Review. Am J Hosp Palliat Care 2016;33:84-92.
68. Persson EC, Quraishi SM, Welzel TM, et al. Risk of liver cancer among US male veterans with cirrhosis, 1969-1996. Br J Cancer 2012;107:195-200.
69. Nasir A, Manivel JC, Yousaf H, et al. Markedly Increased Rate of Primary Liver Malignancies at Autopsy in Male US Veterans. Clin Gastroenterol Hepatol 2017;15:316-8.
70. Beste LA, Green P, Berry K, et al. Hepatitis C-Related Hepatocellular Carcinoma Incidence in the Veterans Health Administration After Introduction of Direct-Acting Antivirals. JAMA 2020;324:1003-5.
71. Ferrell BR, Temel JS, Temin S, et al. Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol 2017;35:96-112.
72. Rogal SS, Hansen L, Patel A, et al. AASLD Practice Guidance: Palliative care and symptom-based management in decompensated cirrhosis. Hepatology 2022;76:819-53.
73. Dunn SH, Rogal SS, Maier MM, et al. Access to Comprehensive Services for Advanced Liver Disease in the Veterans Health Administration. Dig Dis Sci 2019;64:3471-9.
74. Liu Y, Sayam S, Shao X, et al. Prevalence of and Trends in Diabetes Among Veterans, United States, 2005-2014. Prev Chronic Dis 2017;14:E135.

Cite this article as: Szymanski EP, Wallace S, Way D, Haley EM. Palliative care in the older adult Veteran. Ann Palliat Med 2023. doi: 10.21037/apm-23-492

75. Mor V, Joyce NR, Coté DL, et al. The rise of concurrent care for veterans with advanced cancer at the end of life. Cancer 2016;122:782-90.
76. Casarett DJ, Fishman JM, Lu HL, et al. The terrible choice: re-evaluating hospice eligibility criteria for cancer. J Clin Oncol 2009;27:953-9.
77. Mor V, Wagner TH, Levy C, et al. Association of Expanded VA Hospice Care With Aggressive Care and Cost for Veterans With Advanced Lung Cancer. JAMA Oncol 2019;5:810-6.
78. ABT Associates. Evaluation of the Medicare Care Choices Model: Annual Report 3. 2020. Available online: https://innovation.cms.gov/data-and-reports/2020/mccm-thirdannrpt
79. Centers for Disease Control and Prevention. NCHHSTP Social Determinants of Health. 2022. [Cited 2023 Oct 19]. Available online: https://www.cdc.gov/nchhstp/socialdeterminants/
80. Muirhead L, Echt KV, Alexis AM, et al. Social Determinants of Health: Considerations for Care of Older Veterans. Nurs Clin North Am 2022;57:329-45.
81. Montgomery AE, Tsai J, Blosnich JR. Demographic Correlates of Veterans' Adverse Social Determinants of Health. Am J Prev Med 2020;59:828-36.
82. Cole AP, Nguyen DD, Meirkhanov A, et al. Association of Care at Minority-Serving vs Non-Minority-Serving Hospitals With Use of Palliative Care Among Racial/Ethnic Minorities With Metastatic Cancer in the United States. JAMA Netw Open 2019;2:e187633.
83. Mendola A, Naumann WC, Mooney-Doyle K, et al. Social Determinants of Comfort: A New Term for End-of-Life Care. J Palliat Med 2021;24:1130-1.
84. U.S. Department of Veterans Affairs. VHA Social Work. 2023. [Cited 2023 Oct 19]. Available online: https://www.socialwork.va.gov/

© Annals of Palliative Medicine. All rights reserved.

Appendix 1

The VHA provides a wide variety of initiatives and services to Veterans and their caregivers. Veterans also receive health care in a variety of settings, including but not limited to inpatient hospital, outpatient clinics, at home, virtually, and in nursing facilities. Aging Veterans with palliative care need often benefit from many initiatives, services, and care settings, many of which were mentioned in this article. Additional details for relevant resources are listed below, though this is not an exhaustive list.

Care settings and associated services

- GeriPACTs are available at many VAMCs and provide geriatric evaluation and ongoing care for Veterans with more than one chronic disease, declining physical abilities, and/or challenges with thinking or memory.
  - https://www.va.gov/GERIATRICS/pages/Geriatric_Patient_Aligned_Care_Team_GeriPACT.asp. Published online Aug 2, 2023. Accessed Oct 19, 2023.
- HBPC involves team-based services designed for Veterans who have difficulty making regular outpatient clinic appointments due to the severity of illness, who are homebound, or whose caregiver is experiencing unmanageable burden. Available services include home by a primary care provider, care management, social work, rehabilitation, psychology, nutrition, and pharmacy.
  - https://www.va.gov/GERIATRICS/pages/Home_Based_Primary_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Telehealth allows mobile access to providers and health information. Visits can be scheduled either by telephone or VA video connect. Veterans can also receive health information via mobile apps.
  - https://www.va.gov/GERIATRICS/pages/Telehealth.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Home health aides are trained in providing personal care services and assistance with ADLs. Home health aides are supervised by registered nurses and work for organizations contracted with the VA.
  - https://www.va.gov/GERIATRICS/pages/Homemaker_and_Home_Health_Aide_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Skilled home health care provides short- or long-term skilled services for Veterans returning home from a hospital or nursing home. Services are provided by a VA-contracted community-based home health agency. Skilled services include skilled nursing, case management, PT, OT, speech therapy, home safety evaluation, wound care, complex medication management, and IV antibiotics.
  - https://www.va.gov/GERIATRICS/pages/Skilled_Home_Health_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Adult day health care is day programming for Veterans to engage in socialization, companionship, and recreational activities. This can take place in VAMCs, state Veterans home, or community settings.
  - https://www.va.gov/GERIATRICS/pages/Adult_Day_Health_Care.asp. Published online June 24, 2023. Accessed July 24, 2023.
- CLCs, which are VA nursing homes, are designed to "restore each Veteran to his or her highest level of well-being". Featuring subacute rehabilitation, long-term care, and hospice units, they serve to "prevent declines in health and to provide comfort at the end of life".
  - https://www.va.gov/geriatrics/pages/va_community_living_centers.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Respite care is program designed to allow caregivers to have time to attend to personal matters or leave town for a short period of time. It can take place in the home or be provided by a nursing home stay.
  - https://www.va.gov/GERIATRICS/pages/Respite_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Palliative care aims to alleviate suffering and maximize quality of life in the setting of serious illness. The palliative care interdisciplinary team supports Veterans and families in treating symptoms, identifying goals, values, and concerns, and aiding in complex medical decision making. Veterans are seen by palliative care providers in both the inpatient and outpatient setting.
  - https://www.va.gov/GERIATRICS/pages/Palliative_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.
- Hospice care is comfort directed care provided to Veterans and their families when a Veteran has been diagnosed with a life-limiting illness, defined as having a prognosis of 6 months or less if the disease takes its natural course, and is no longer seeking curative treatment. Hospice care can be provided in a Veteran's

© Annals of Palliative Medicine. All rights reserved.
https://dx.doi.org/10.21037/apm-23-492

home, in VA-contracted community nursing homes, or in general inpatient hospice unit setting.
  - https://www.va.gov/GERIATRICS/pages/Hospice_Care.asp. Published online June 25, 2023. Accessed July 24, 2023.

Additional VA services and initiatives

- VA social work assists Veterans, plus their families and caregivers, as they navigate SDOH related to their health and well-being. For older Veterans with palliative care needs, this is often an integral part of their care.
  - https://www.socialwork.va.gov/. Published online Sept 13, 2023. Accessed Oct 19, 2023.
- The VA caregiver support program offers services and supports to caregivers of eligible Veterans to help promote health and well-being in their caregiving roles. Caregivers are often a crucial part of the care for older Veterans with palliative care needs.
  - https://www.caregiver.va.gov/. Published online Oct 17, 2023. Accessed Oct 19, 2023.
- "VA's rehabilitation and prosthetic services is responsible for the national policies and programs for medical rehabilitation, prosthetic and sensory aids services that promote the health, independence and quality of life for Veterans with disabilities." Many services are relevant to older Veterans and can be part of a palliative care-focused management plan.
  - https://www.prosthetics.va.gov/index.asp. Published online Oct 19, 2023. Access Oct 19, 2023.
- VHA audiology provides important services to Veterans with hearing impairment and other hearing disorders.
  - https://www.prosthetics.va.gov/audiology/index.asp. Published online March 2, 2022. Accessed Oct 19, 2023.
- Blind rehabilitation services assist Veterans with visual impairment of any degree, including vision assessments, eye examinations, eyeglasses, low vision resources, and more.
  - https://www.prosthetics.va.gov/blindrehab/index.asp. Published online Feb 15, 2023. Accessed Oct 19, 2023.
- Whole health is VA's person-centered approach to health and well-being, centering what matters to you, not what is the matter with you.
  - https://www.va.gov/wholehealth/. Published online Oct 18, 2023. Accessed Oct 19, 2023.

Locations and eligibility

- Veterans can find out if they are eligible for VA health care here:
  - https://www.va.gov/health-care/eligibility/. Published online Sept 30, 2023. Accessed Oct 19, 2023.
- Veterans can find their closest VA health services here:
  - https://www.va.gov/find-locations/. Accessed Oct 19, 2023.

© Annals of Palliative Medicine. All rights reserved.
https://dx.doi.org/10.21037/apm-23-492