



WOUNDED WARRIOR PROJECT

Statement for the Record

"Hidden Wounds: Effectively Supporting Veterans with TBI"

**Committee on Veterans' Affairs
Subcommittee on Health
United States House of Representatives**

March 5, 2026

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee – thank you for inviting Wounded Warrior Project to share our perspective on Department of Veterans Affairs (VA) care for veterans with traumatic brain injury (TBI). Supporting veterans and Service members with invisible wounds like TBI and post-traumatic stress disorder (PTSD) has been central to our mission to honor wounded warriors, and our advocacy before Congress has been shaped by our experience delivering life-changing and life-saving care to this community.

Wounded Warrior Project (WWP) is built upon our promise to meet the needs of warriors and family support members no matter what. Since 2003, that promise has included programming designed to assist catastrophically disabled warriors with moderate and severe TBI. In fiscal year 2025, we delivered nearly 285,000 hours of in-home and local care through our Independence Program. This program provides personalized care and ongoing, innovative support to help these warriors remain at home and live more independent lives for as long as possible. Currently serving nearly 1,000 warriors, the Independence Program (IP) is a small but critical part of a larger ecosystem of care and support that spans a wide range of needs veterans have now and will have into the future.

Nearly one in five post-9/11 veterans sustained at least one TBI, and over 500,000 TBIs have been diagnosed in Department of Defense (DoD) personnel since 2000.¹ Research indicates that this figure could be even higher due to undocumented injuries in Iraq and Afghanistan before improvements in documentation implemented in November 2006.² Most of these individuals make a full recovery from their injuries, especially if they only had a single mild TBI, but some require lifelong care and support. At least one report has concluded that 1 in 4 veterans who have been hospitalized with TBI will develop long-term disability.³

¹ DEF. HEALTH AGENCY, U.S. DEP'T OF DEF., <https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers> (last visited Jan. 9, 2026).

² Rachel P. Chase & Remington L. Nevin, *Population Estimates of Undocumented Incident Traumatic Brain Injuries Among Combat-Deployed US Military Personnel*, 30 J. HEAD TRAUMA REHAB. E57 (2015) (available at https://journals.lww.com/headtraumarehab/Abstract/2015/01000/Population_Estimates_of_Undocumented_Incident.14.aspx).

³ Yll Agimi et al., *Estimates of Long-Term Disability Among US Service Members With Traumatic Brain Injuries*, 36 J. HEAD TRAUMA REHAB. 1 (2021) (available at <https://pubmed.ncbi.nlm.nih.gov/32472830/>).

DUTY ★ HONOR ★ COURAGE ★ COMMITMENT ★ INTEGRITY ★ COUNTRY ★ SERVICE



Injury data like the above is underscored by the fact that modern medicine and recent improvements to the delivery of in-theater care have saved more lives than ever before.⁴ Yet while many survived their wounds on the battlefield, recent scholarship has found excess mortality rates among post-9/11 veterans compared with the general U.S. population, particularly among veterans with TBI. Research funded by DoD and the Department of Veterans Affairs (VA) concluded that post-9/11 veterans have higher death rates than expected, and those who had traumatic brain injuries had an even greater risk of dying. More specifically, “[w]hile veterans exposed to moderate/severe TBI accounted for only 3% of the total post-9/11 Veteran population, they accounted for 34% of total excess deaths observed, which was 11-fold higher than would otherwise be expected.”⁵ This study and others draw particularly close attention to the elevated risk of suicide that veterans face after TBI, particularly if those injuries are more severe.⁶

As these figures illustrate, we believe that TBI care must continue to be an area of critical focus for Congress, VA, and other community stakeholders. We are pleased to direct particular attention to several key areas where near-term action will create the long-term support and sustainability that so many need.

Care Journey Overview: The Phases of TBI Care

The continuum of care for TBI spans acute care to long-term support. While TBIs are generally diagnosed along a spectrum of mild, moderate, and severe, this classification based on the severity of the injury does not necessarily correlate to the nature of symptoms or recovery prognosis. Each TBI patient’s journey will have unique combinations of mental, physical, behavioral, and cognitive impacts alongside decisions about when, where, and how frequent health care interventions take place.

In ideal scenarios, veterans will have access to a continuum that integrates clinical treatments with supportive services, but veterans often experience regressions. Issues can arise due to improper diagnoses (perhaps due to a shortage of specialized TBI care providers), inconsistent follow-up care (routinely associated with a multi-disciplinary care approach versus more coordinated interdisciplinary care), delays in intervention, and general lack of knowledge of how and where to access the most appropriate level of care and resources. As observed by the National Academies, “[f]or many people with TBI and their families, a ‘continuum of care’ does not exist. Their journey is more aptly characterized as a fragmented series of silos (prehospital assessment, potential emergency department or hospital-based acute care, perhaps inpatient or outpatient rehabilitation, and possibly additional community or long-term services and supports) [...]”⁷

⁴ Valecia Dunbar, *Trauma Registry Yields Significant Increase in Traumatic Injury Survival Rates*, U.S. ARMY (June 25, 2015), https://www.army.mil/article/150990/trauma_registry_yields_significant_increase_in_traumatic_injury_survival_rates.

⁵ Jeffrey Howard et al., *Association of Traumatic Brain Injury With Mortality Among Military Veterans Serving After September 11, 2001*, 5 JAMA NET. OPEN (2022) (available at <https://doi.org/10.1001/jamanetworkopen.2021.48150>).

⁶ Lisa Brenner et al., *Associations of Military-related Traumatic Brain Injury with New-onset Mental Health Conditions and Suicide Risk*, 6 JAMA Net. Open (2023) (available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807787>); Jeffrey Howard et al., *Suicide Rate Trends for Post-September 11, 2001, US Military Veterans*, 8 JAMA NET. OPEN (2025) (available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2838445>); Kayla McIntire et al., *Factors Increasing Risk of Suicide After Traumatic Brain Injury*, 35 BRAIN INJ, 151–63 (2020) (available at <https://doi.org/10.1080/02699052.2020.1861656>).

⁷ NAT’L ACADS. OF SCIENCES, ENG’G, AND MED., *TRAUMATIC BRAIN INJURY: A ROADMAP FOR ACCELERATING PROGRESS* 167 (2022).

Despite this observation, an overview of stages in the TBI care continuum can help frame areas for congressional action:

- **Acute Phase:** The immediate care provided in trauma centers that focus on stabilization. Interventions like surgery and pain control are most often provided at military treatment facilities and the VA's network of Polytrauma Rehabilitation Centers.
- **Post-Acute Rehabilitation Phase:** After stabilization care, veterans and Service members may receive rehabilitation to restore function, addressing cognitive and behavioral deficits and comorbidities. This stage may last weeks, months, or even years, depending on the severity of the injury and incorporate elements of physical therapy, occupational, therapy, speech and language therapy, cognitive rehabilitation therapy, and psychological support. For veterans using VA, this care can take place in intensive inpatient and/or outpatient settings or Polytrauma Rehabilitation Centers.
- **Long-Term Phase:** During this segment, patients will focus on maintenance of therapies, as well as home and/or institutional support to regain or maintain independence and fulfill behavioral plans. This phase may involve VA home and community-based services including Home Based Primary Care, Adult Day Health Care, and Skilled Home Health Care, as well as VA-purchased care services like Homemaker/Home Health Aide, Veteran Directed Care, and Medical Foster Homes. For complex cases, residential-based care may be provided at VA Community Living Centers, Skilled Nursing Facilities, or at community-based nursing homes.
- **Community Reintegration:** As care becomes more familiar, veterans may move on to focus on independence, addressing isolation and other health issues, while incorporating active and ongoing case management. Aside from health care support, some veterans may benefit from VA services like the Veteran Readiness & Employment program to re-enter the workforce in a new capacity.

While survival and early rehabilitation outcomes have improved, the continuum of care has not evolved to address the lifelong needs of this population. When long-term needs are not addressed, predictable downstream impacts occur including:

- Functional regression and loss of independence resulting from discontinuation of ongoing rehabilitation and long-term supports;
- Higher long-term system costs driven by crisis-based care, emergency department utilization, and avoidable hospitalizations;
- Increased caregiver burden and burnout as veterans' needs increase and caregivers age alongside them, often impacting the entire family unit;
- Premature or inappropriate placement in institutional settings that are not designed to meet the clinical, behavioral, or rehabilitative needs of younger and mid-life veterans with TBI and lack proper government oversight and support personnel; and

- Increased social isolation and elevated suicide risk, with TBI recognized as an independent risk factor for mortality.

Based on these assessments and considerations above, we offer several areas where congressional action can improve the TBI continuum of care.

Improving Case Management

Service members and veterans living with severe injuries or multiple comorbid conditions often navigate some of the most fragmented care systems in the country. Many rely on multiple federal and state programs at the same time, receiving care through Military Treatment Facilities (MTFs), TRICARE, VA, Medicare, Medicaid, private insurance, and local programs – each with its own eligibility requirements, coverage limits, and care-coordination processes. Without consistent, knowledgeable case management, transitions between these systems frequently lead to gaps in services, delayed treatment, and increased strain on caregivers. For veterans with TBI or complex neurological conditions, these disruptions can undermine health, independence, and long-term stability.

In a pair of 2007 memorandums of understanding, DoD and VA launched the Federal Recovery Coordination Program (FRCP) and designated Federal Recovery Coordinators as the “ultimate resource” for monitoring the implementation of services for wounded, ill, and injured Service members. At the time, these actions recognized that because of the dramatic changes in military battlefield medicine and rapid evacuation from the combat theatre, many returning Service members, and subsequently veterans, have multiple complex medical and mental health problems, including TBI, SCI, amputations, burns, and PTSD. Due to the complex nature of their benefits and health care needs, these warriors may receive care from many providers in multiple facilities, including MTFs, VA Medical Centers (VAMCs), private hospitals, rehabilitation facilities, or through home health agencies. Transitions among these facilities and providers, absent coordination, can result in care and benefits gaps.

The challenges that existed then persist to this day, and health systems must remain committed to uniform training for recovery coordinators and medical and non-medical care/case managers, efficient tracking systems, and commitments to comprehensive plans for the seriously injured. As time has passed however, the FRCP was consolidated into the Federal Recovery Consultant Office (FRCO) in February 2018 in response to the Presidential Executive Order, “Comprehensive Plan for Reorganizing the Executive Branch.” While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO is sufficiently resourced to address the reforms that have not been fully realized. Additionally, we believe that similar efforts can be undertaken to support a broader population of veterans with complex needs and should include steps to ensure central oversight of policy implementation.

VA’s Spinal Cord Injury/Disorder (SCI/D) System of Care offers a parallel approach that may be considered and illustrates an established example of how a condition-specific, lifelong care continuum can be structured within the Veterans Health Administration. The SCI/D model works through a hub-and-spokes network of 25 regional centers (“hubs”) supported by local VA facilities (“spokes”), allowing highly specialized, interdisciplinary care to be delivered close to where veterans live while maintaining access to expert clinical teams and necessary services.

These centers provide comprehensive, lifelong care spanning acute medical and surgical treatment, intensive rehabilitation, outpatient follow-up, home care programs, annual evaluations, and tailored long-term support aimed at maximizing independence and quality of life.

Care is coordinated across medical, psychosocial, vocational, and rehabilitation domains, with dedicated providers trained in the unique needs of spinal cord injury and disorder populations. Both primary and specialty care services remain integrated throughout the veteran's lifespan, with interdisciplinary teams actively managing and anticipating evolving needs over time. This structure not only supports continuity of care after initial injury but also promotes community reintegration, functional maintenance, and sustained caregiver support. A similar dedicated program for TBI could help address current fragmentation in care pathways, improve long term outcomes, and ensure that veterans with brain injury have access to care that is both specialized and continuous rather than episodic or plateau-driven within traditional silos.

Expanding Access to Assisted Living

While many veterans and families prefer aging in place, home-based care is not safe or feasible for all individuals due to co-occurring behavioral and cognitive challenges, increasing medical complexity, aging caregivers, and limited natural support networks. When aging in place is no longer appropriate, families are often forced to make care decisions in crisis. In the absence of viable alternatives, families face an unacceptable binary choice: remain at home beyond what is safe or appropriate, or enter traditional geriatric nursing facilities that are ill-equipped to meet the clinical, behavioral, rehabilitative, and social needs of younger and mid-life veterans with TBI.

Wounded Warrior Project's current service to nearly 1,000 severely wounded veterans with moderate or severe TBI has shown us that phases of progressive independent living are missing as care options. Currently, slightly more than 7 percent of our Independence Program participants (average age 45.6) reside in nursing homes/institutions, highlighting the likelihood of an inappropriate placement due to age-generational gap, inability to find an age-suitable facility and/or inability of an institutional or non-institutional caregiving network to provide for the individuals in a safe or effective manner. Traditionally, VA provides clinical services to veterans who suffer the effects of TBI; however, many veterans with TBI may benefit from treatment in an intensive rehabilitation facility to assist with skills allowing for increased independence. Because the facilities are generally residential and the VA does not provide veterans with housing (with some exceptions), accessibility to such programs is limited or requires subsidized payment from other sources to cover the "housing" expense.

The Assisted Living for Veterans with TBI (AL-TBI) pilot program, which ran from 2009 to 2018, provided some of these veterans with placement in private TBI rehabilitation facilities and assumed the living costs that may have otherwise put this treatment beyond their reach. After the program ended, an evaluation by VA concluded that participants had experienced improvements in physical and emotional health, TBI symptoms, and other outcomes. In its place, VA now offers a TBI-Residential Rehabilitation Program, but enrollees must pay for their own room and board, something many veterans cannot afford.

Solutions to remove this financial barrier – and to improve the associated care coordination that can span several systems – are sorely needed. TBI rehabilitation facilities provide a variety of services, primarily therapy in individual and group settings. At the same time, the facilities vary widely in other offerings and lack standardization because individual injuries and the effectiveness of each treatment can vary so significantly.⁸ The tools used to measure progress as well as the methods by which therapy is provided or defined may also contain nuance and disparity between facilities.⁹ These nuances induce “difficulties [with] outcome analysis related to the blurring of program labels, categories, and definitions” while limited uniform populations make randomized trials and studies nearly impossible.¹⁰ Studies indicate that treatment standardization and standard measurements of progress would assist in formalized rehabilitation programs with improved overall treatment.¹¹ Further, anecdotal feedback suggests that veterans are most likely to benefit from particular facilities that can accommodate the difficulties associated with behavioral problems (often rooted in physical injury to the brain) in addition to other TBI symptoms. Such facilities are very limited but are best positioned to support veterans’ needs.

In sum, the AL-TBI pilot program provided a beneficial service to warriors and caregivers during its tenure but has left a gap to be filled by families, private and other non-VA care, often putting the financial burden on the warrior and/or caregiver. Additional urgency is created by the fact that many of these caregivers are aging beyond their ability to provide the necessary support at home. These challenges continue to highlight the need for durable, well-coordinated, and adequately resourced programs capable of supporting veterans with lifelong injuries, not only for months or years, but over a full lifespan.

Increasing Special Monthly Compensation

The Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act represents one of the most meaningful opportunities in decades to strengthen financial security for the nation’s most severely disabled veterans. A key provision of this legislation would increase the amount of Special Monthly Compensation (SMC) by \$10,000 annually for the most severely disabled veterans – those who depend on regular aid and attendance of another, including for residuals of TBI. SMC is arguably the most important ancillary benefit for veterans with severe, service-connected disabilities. SMC-T in particular, which is provided to veterans with TBI, can help offset caregiver burden and the increasing costs of high-quality care – both of which can keep veterans at home and of institutional living.

Wounded Warrior Project supports this legislation because it reflects the core principle that those who sacrificed the most deserve the strongest safety net. Far too many families shoulder around-the-clock caregiving responsibilities with inadequate financial support,

⁸ See, e.g., Tina Trudel, et al., *Brain Injury Treatment Models and Challenges for Civilian, Military and Veteran Populations*, 44 J. REHAB. RESEARCH & DEV. 1007 (2007) (available at <https://www.brainline.org/article/brain-injury-treatment-models-and-challenges-civilian-military-and-veteran-populations>).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

particularly families like the Edmundsons, whose daily lives revolve around complex medical needs following devastating combat injuries.

Coordinating Action on Blast Overpressure

Military service often exposes Service members to blast overpressure, a rapid increase in air pressure generated by explosions or blast waves that exceed normal atmospheric conditions. Both high-intensity and/or repeated exposures are increasingly associated with cumulative neurological effects, including neuroinflammation, cognitive decline, elevated risk of traumatic brain injury, and co-occurring mental health conditions.¹² Those at highest risk include armorers, artillery and gunnery personnel, combat engineers, explosive ordnance disposal specialists, special operations forces, and medical personnel assigned to expeditionary units – as well as individuals working with shoulder-mounted weapons, .50 caliber systems, and indirect fire platforms. While the DoD has taken important steps to reduce blast exposure during training through increased standoff distances, limits on live-fire events, and protective equipment, these measures largely focus on prevention for active-duty personnel, and do not address the long-term health consequences for Service members and veterans already affected.

The *Blast Overpressure Research and Mitigation Task Force Act* (H.R. 6444) would strengthen coordination between the DoD and VA through a Joint Executive Committee (JEC) task force. By mandating annual reports, cross-agency coordination, and integration of mobile, longitudinal diagnostics, the bill would create the infrastructure needed to translate emerging evidence into standardized screening, targeted mitigation strategies, and benefits adjudication for blast-exposed veterans. Further, the inclusion of Task Force recommendations related to VA claims processing and disability evaluations hold the promise of ensuring that veterans affected by blast overpressure injuries are connected to the care and support they have earned through their service.

Increasing Commitment to TBI Research

The Congressionally Directed Medical Research Programs (CDMRP) represent a proven and accountable model for investing federal research dollars to achieve high-impact outcomes. Through its unique, coordinated approach, CDMRP has accelerated advances in patient care, driven breakthrough technologies, and delivered tangible results in areas of critical need – particularly with diseases and conditions that have historically received limited research attention. Congress’ sustained investment of more than \$2.5 billion in the Traumatic Brain Injury and Psychological Health Research Program, led by the Military Health System¹³, has resulted in the award of over 297 research studies for nearly 500,000 Service members diagnosed with traumatic brain injury.¹⁴ These efforts have strengthened DoD’s ability to prevent, detect, treat, and rehabilitate TBI, while improving psychological health outcomes essential to force

¹² See, e.g., Andrea Diociani et al., *Distinct Functional MRI Connectivity Patterns and Cortical Volume Variations Associated with Repetitive Blast Exposure in Special Operations Forces Members*, 315 *Radiology* (2025) (available at <https://pubmed.ncbi.nlm.nih.gov/40167438/>); Kyle Bourassa et al., *Traumatic Brain Injury and Accelerated Epigenetic Aging Among Post-9/11 Members*, *J. HEAD TRAUMA REHAB.* (2025) (available at <https://pubmed.ncbi.nlm.nih.gov/40828005/>).

¹³ Cong. Directed Res. Prog., *Traumatic Brain Injury and Psychological Health Research Program*, U.S. DEP’T OF DEF. (2025), https://cdmrp.health.mil/tbiphrrp/pbks/TBIPHRP%20Summary%20Sheet_22July25.pdf.

¹⁴ Cong. Directed Res. Prog., *Traumatic Brain Injury and Psychological Health*, U.S. DEP’T OF DEF. (2025), <https://cdmrp.health.mil/tbiphrrp/default>.

readiness and long-term veteran well-being. Continued congressional support for CDMRP is essential to maintain momentum, protect prior investments, and ensure that the DoD can meet its obligations to Service members and their families through evidence-based solutions to TBI and psychological health challenges.

Precision Medicine for TBI Care

Despite increased awareness, substantial gaps remain in understanding the long-term effects of repetitive low-level blast exposure and chronic mild TBI. Emerging evidence links these exposures to measurable brain changes, impairments in balance and gait, and increased risk of suicide among veterans. Individuals diagnosed with TBI may continue to suffer from lasting effects that overlap with mental health conditions, substance use disorders, and chronic physical symptoms. These complex and interconnected challenges demand a more precise, data-driven approach to care.

Precision medicine tailors healthcare treatments and interventions to each patient's unique characteristics, including their genetic makeup, lifestyle, and environment. Instead of a one-size-fits-all model, precision medicine uses advanced diagnostic tools – such as genetic testing, biomarker analysis, and imaging techniques – to identify the most effective therapies for individuals. In brain health, this approach takes a specialized form, focusing on neurological and psychiatric conditions. Clinicians analyze a patient's brain structure, function, genetic profile, and cognitive patterns to create targeted treatment plans for conditions like Alzheimer's disease, Parkinson's disease, depression, and TBI. This personalized strategy enhances therapeutic outcomes, reduces side effects, and ensures lasting benefits. Specifically for veterans, this approach can help identify those at higher risk for long-term neurological or psychological effects, such as chronic traumatic encephalopathy (CTE), PTSD, and cognitive decline. The *Precision Brain Health Research Act* (S.800) would advance a more systematic and longitudinal approach by directing VA to implement a coordinated 10-year research strategy and establish a structured data sharing partnership with the DoD. This framework utilizes the promise of precision medicine and would improve tracking of exposure history, support identification of biomarkers associated with brain and mental health conditions, and strengthen VA's ability to deliver earlier, more accurate diagnoses.

Concluding Remarks

Wounded Warrior Project extends our gratitude to the Committee for its sustained focus on TBI research, treatment, and long-term support. A TBI is not an isolated event, it is a chronic condition that requires lifelong management. A journey that requires a coordinated continuum of care, strong case management, appropriate residential and community-based options, meaningful financial support for families, and continued investment in cutting-edge research. From strengthening recovery coordination and restoring viable assisted living pathways, to advancing Special Monthly Compensation and deepening our understanding of blast overpressure and precision brain health, your leadership shapes whether veterans with TBI experience fragmented systems or integrated, life-sustaining care. We are particularly encouraged by congressional efforts to modernize research through precision medicine and cross-agency collaboration,

ensuring that emerging science translates into earlier diagnoses, targeted interventions, and improved long-term outcomes.

The men and women who have sustained these invisible wounds in service to our nation deserve nothing less than a system built for durability, dignity, and lifelong support. We stand ready to work alongside you to ensure that policies enacted today create a sustainable, evidence-based framework of care that honors their sacrifice not only in the immediate aftermath of injury, but across the full span of their lives. Thank you for your continued commitment to these warriors and the families who remain steadfast beside them.