Wounded Warrior Project
4899 Belfort Road, Suite 300
Jacksonville, Florida 32256
O 904.296.7350
F 904.296.7347

WOUNDED WARRIOR PROJECT®

WOUNDED WARRIOR PROJECT
STATEMENT FOR THE RECORD

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

AGING IN PLACE:
EXAMINING VETERANS' ACCESS TO HOME AND COMMUNITY BASED SERVICES

July 27, 2021

Chairwoman Brownley, Ranking Member Bergman, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement. We are grateful for the opportunity to highlight WWP's views on the care provided to aging veterans through the Veterans Health Administration (VHA).

Wounded Warrior Project was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing more than 20 life-changing programs and services to over 190,000 registered post-9/11 warriors and their families, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. Through these programs, experiences, and our collaboration with other organizations, WWP is part of an ecosystem that creates a sense of community and identity for warriors around the country. We are pleased to share this perspective for today's hearing on home and community-based services. Over the next several months, we are hopeful that we can assist your work to improve the lives of veterans and their families during the 117th Congress.

Geriatric and Extended Care, Aging Veterans, and the Needs of Wounded Warriors

All veterans enrolled in VA's health care system are potentially eligible for long-term services and supports (LTSS), a suite of VHA programs that includes facility-based services, end-of-life services, and – most critically for purposes of this hearing – geriatric outpatient programs and home and community-based services. Factors including clinical needs, disability ratings, geography, and preferences drive eligibility determinations rooted in whether services are needed to promote, preserve, or restore a veteran's health. This statement is intended to highlight the impact of one factor that is not expressly considered: age.

Providing necessary LTSS, to include sufficient amounts of those services, to veterans who are relying on them earlier in life is a WWP priority. While WWP is meeting that priority through services like our Independence Program, the Subcommittee can drive critical improvements to VA LTSS by considering two key facts. First, veterans under the age of 65 are using VHA's Geriatrics and Extended Care (GEC) programs at a high and increasing rate. In 2020, 27 percent of GEC program users were veterans under the age of 65.[1] That figure represents a 10 percent increase over 2019, when veterans under age 65 accounted for 16.7 percent of GEC program users.[2] Across all VA long term programs from fiscal year 2014 through 2018, the number of veterans who served on or after 9/11 and received long-term care has increased at a faster rate than the overall number of veterans who received this care.[3]

Second, veterans under the age of 65 are more likely to have been the beneficiaries of modern life-saving military medicine and technology during their time in service. Improvements in combat casualty care including better use of tourniquets, quicker blood transfusions, and faster prehospital transport times have saved the lives of many who would have been lost in previous wars, including those most critically injured, who experienced a three-fold increase in survival rates from 2001 to 2017.[4] Many of those who survived due to these advances in medical technology and battlefield care were very seriously wounded and will be challenged by lifelong physical disabilities or mental health conditions. Thus, this increased survival rate will continue to contribute to the need for LTSS services that are responsive to a community of younger veterans who will require more intensive care and case coordination over a longer period.[5]

Taken together, the factors above provide compelling evidence for the Subcommittee to consider the perspective of how younger veterans are relying on LTSS and how that reliance will grow and shift over time. While VA and Congressional action can and should appropriately consider how elderly veterans rely on these programs, WWP is pleased to help provide a perspective and suggestions on how VA LTSS – particularly those offered in a non-institutional setting – can be responsive to the needs of a non-elderly cohort of veterans.

Expand Veteran Directed Care

Through years of service to severely wounded warriors, WWP has learned that the provision of care at home and support in the local community can be critical to maintaining better quality of life. Our Independence Program provides long-term support to catastrophically wounded veterans living with moderate to severe brain injury, spinal cord injury, or neurological

[1] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2022 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-187, https://www.va.gov/budget/docs/summary/fy2022VAbudgetVolumeIsupplementalInformationAndAppendices.pdf (last visited July 12, 2021).
[2] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2021 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-92, https://www.va.gov/budget/docs/summary/archive/FY-2021-VA-BudgetSubmission.zip (last visited July 12, 2021).
[3] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-84, VA HEALTH CARE: VETERANS' USE OF LONG-TERM CARE IS INCREASING, AND VA FACES CHALLENGES IN MEETING THE DEMAND (2020).
[4] Howard JT, Kotwal RS, Stern CA, et al. *Use of Combat Casualty Care Data to Assess the US Military Trauma System During the Afghanistan and Iraq Conflicts, 2001-2017*. Surgery. Published online 2019, *available at* https://jamanetwork.com/journals/jamasurgery/article-abstract/2729451.
[5] Ben Barry, *Battlefield Medicine: Improving Survival Rates and 'The Golden Hour,'* INT'L INST. FOR STRATEGIC STUDIES, Apr. 16, 2019, www.iiss.org/blogs/military-balance/2019/04/battlefield-medicine.

conditions that impact independence.[6] Working alongside the warrior, the warrior's family and caregivers, and a network of case managers familiar with local resources, WWP can provide services that are highly individualized and supplemental to VA care, including: case management, in-home care, transportation, life skills coaching, traditional therapies (physical, occupational, speech, etc.), alternative therapies (art, music, equine, etc.), and community volunteer opportunities. For many, this is a chance to participate in the types of daily tasks and meaningful activities that others take for granted.

The Independence Program has created an indispensable service to many warriors who are often among those younger veterans who also rely on VA LTSS. Fortunately, an analogous program has taken shape within VA to provide similar support. In 2008, VA developed a self-directed Home and Community Based Service (HCBS) program in collaboration with the Department of Health and Human Services' Administration on Community Living (ACL) – the Veteran Directed Care (VDC) program. With a goal of helping veterans at risk of institutionalization to continue to live at home and remain a part of their communities, VDC creates an attractive option for younger veterans who prefer not to live at nursing home facilities that may not feel age appropriate.

Veterans participating in VDC invariably have complex needs; each is eligible for VA nursing home services. Through VDC, veterans hire their own workers to deliver care, set wages and hours, and enjoy greater control over the services they receive. The local Aging and Disability Agency provides an options counselor to assist the veteran in planning his or her care and a financial management service to ensure the integrity of a veteran's budget. By putting the veteran in charge of his or her own care, the veteran can receive higher quality care, which is customized for their needs, and enjoy greater flexibility, control, and satisfaction from the care they receive. Not coincidentally, VDC has been popular with younger veterans but its reach remains limited.

There are currently 69 VA Medical Centers (VAMCs) with VDC programs. Over 3,400 veterans have been served through VDCs thus far, but more would benefit from program expansion – both within participating VAMC catchment areas and at new VAMCs. As the program is discretionary and left to local VAMC leaders, more than half of VAMCs across the country do not offer the service. And among those facilities that do offer the program, it is not guaranteed that the local VDC program is staffed to meet demand in the area. VDC staff duties include reviewing patient applications, supervising patient counselors, and collaborating with medical teams to ensure appropriate referrals. Efforts to expand VDC must therefore consider that significant time and attention is needed to appropriately administer this program for eligible veterans.

Fortunately, VDC can be a cost-saving mechanism without reducing care and support to the veteran. By allowing veterans to receive care in their own homes, VDC has reduced hospital admissions, emergency department visits, and the need for nursing home care. In addition to higher rates of veteran satisfaction[7], VDC has proven mutually advantageous by simultaneously

[6] For more information about WWP's Independence Program, see Appendix at page 9.

[7] To review examples at three VAMCs, see *San Diego Veterans Independence Services at Any Age*. SD-VISA. Veteran-Directed Home and Community-Based Services Program. No Wrong Door. October 2015, available at nwd.acl.gov/pdf/SD%20Visa%20Flyer_100215_508.pdf; *Veteran Independence Plus: Cost Benefit Analysis,* VA Boston Healthcare System. No Wrong Door. June 24, 2013,

lowering costs for VA. The cost of supporting a veteran through VDC is far less than supporting a veteran in a nursing home; on average, the cost of providing veterans with home-based care is $144 less per day per veteran, for a total of $52,800 savings per year.[8] While nursing homes will continue to be a better option for some, VDC still provides great potential for VA to continue providing veterans with personalized access to care while concurrently enjoying significant cost savings. Furthermore, the Program of Comprehensive Assistance for Family Caregivers has heightened eligibility standards to require designated caregivers to provide near constant support, sending thousands of veterans and their caregivers on a path to being dropped from the program.[9] For these veterans, the opportunity to pay family members and friends through VDC to provide personal assistance services on a more periodic basis can preserve home-based caregiving and reduce reliance on VA care and services.

Continue to Leverage Medical Foster Homes

An additional alternative to traditional nursing homes for younger veterans has been VA's Medical Foster Home (MFH) program. While this program ultimately combines the provision of nursing-home level care and supervision in a homelike setting, the cost of participating can be a limiting factor for many veterans. Conventional nursing homes are covered under VA benefits for eligible veterans, but veterans in MFHs need to pay out of pocket for housing and parts of their care, often totaling between $2,500 and $3,000 per month[10]. Many veterans can apply various benefits to help cover the cost, but federal legislation to lower that burden would make this a more attractive option.

Wounded Warrior Project supports VA's FY 22 budget request to provide legislative authority that will allow the agency to defray the cost of MHHs for eligible veterans. Specifically, WWP supports the proposal to amend 38 U.S.C. § 1720C(d) to remove the 65 percent (of nursing home care costs) cap on what VA can spend on non-institutional care costs for a veteran. The proposal would authorize a 100 percent cap to take its place. Under this proposal, VA could spend up to $446,421 per Veteran per year (an increase of $156,247) with the goal of keeping the veteran at home if that is his or her preference[11]. With this authority, VA would have flexibility to better meet veterans' needs in a clinically appropriate and veteran-centric setting.

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nwd.acl.gov/pdf/VDHCBS_Boston.pdf; *Comparison of a Veterans Directed Health Care Program vs. Community Nursing Home Placement*, Medical College of Wisconsin Department of Psychiatry. No Wrong Door, nwd.acl.gov/pdf/VDHC-Poster.pdf.

[8] Mary Lazare*, A Better Way to Care for Our Veterans?*, ADMIN. FOR CMTY. LIVING. Feb. 6, 2020, acl.gov/news-and-events/acl-blog/better-way-care-our-veterans.

[9] *See* Economic Regulatory Impact Analysis for RIN 2900-AQ48(P), Attachment 1: Agency's Regulatory Impact Analysis at 11-12, U.S. DEP'T OF VET. AFFAIRS (Mar. 4, 2020).

[10] Mitch Mirkin, *No Place Like Home: Studies on VA Medical Foster Homes Show Good Outcomes for Vets*, VA RESEARCH COMMUNICATIONS, Oct. 3, 2019, www.research.va.gov/currents/1019-Studies-on-VA-medical-foster-homes-show-good-outcomes-for-Vets.cfm

[11] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2021 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-86, https://www.va.gov/budget/docs/summary/archive/FY-2021-VA-BudgetSubmission.zip (last visited July 12, 2021).

Improve Training and Case Coordination at VA

The clinical diagnoses and symptomatology of veterans relying on VA LTSS is diverse, but for younger veterans with serious, persistent combat injuries, certain presentations may be more common illustrative. For the post-9/11 generation, traumatic brain injury (TBI) provides a helpful benchmark of how VA programs are currently meeting the need of wounded warriors who are relying on LTSS earlier in life. Recent research indicates that 1 in 4 veterans who have been hospitalized with TBI will develop long-term disability[12], and from 2000 to the fourth quarter of 2020, the DoD reports 434,618 TBIs among Active Duty Service members.[13] Other 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.[14]

In a recent study of the service needs and barriers faced by veterans years after sustaining moderate to severe TBI, the most frequently cited barrier to care was not knowing where to get help.[15] This finding underscores the fact that, while the number of Service members catastrophically injured in service has decreased in recent years, the needs of severely injured Service members and veterans with TBIs have not diminished over time and will, in many cases, grow. In the experience of WWP's Independence Program and Complex Case Coordination team, this lack of awareness is not limited to those with brain injury and is often an issue across the spectrum of injury and illness.

Wounded Warrior Project has found that establishing treatment and support programs may simply not be enough. Overlapping resources and nonuniform availability of federal, state, and local resources require a broad community effort to connect those in need with the services created for them. For this younger generation, VA's nomenclature has an impact. The word "Geriatric" – in reference to VA's Geriatric and Extended Care program office – can be a source of confusion or deterrence for both the veteran and their case manager or social worker to seek services. To overcome even this most basic barrier as well as others, a menu of available program options tailored to the veteran/family and based on his or her needs and eligibility would maximize the use and impact of those services. In addition, younger veterans with long term care needs and their caregivers are often overlooked for programs like VDC and Home-Based Primary Care because they are a small – but vulnerable – portion of the eligible population. In many cases, they are in desperate need of these services but simply are not aware they exist. Because this population is relatively small and geographically diverse, increased training to identify younger veterans in need of LTSS may be needed.

Although contextually limited to the TBI landscape of care, the need for more coordinated care and outreach has been previously acknowledged. In a June 2013 report to

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[12] Yll Agimi et al, *Estimates of Long-Term Disability Among US Service Members With Traumatic Brain Injuries*, J. HEAD TRAUMA REHAB, Jan.-Feb., 2021, available at https://pubmed.ncbi.nlm.nih.gov/32472830/.

[13] DEF. HEALTH AGENCY, U.S. DEP'T OF DEF., https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/Research-and-Development/Traumatic-Brain-Injury-Center-of-Excellence/DoD-TBI-Worldwide-Numbers (last visited Jul. 23, 2021).

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

[15] R. Jay Schulz-Heik et al, *Service Needs and Barriers to Care Five or More Years After Moderate to Severe TBI Among Veterans*, BRAIN INJURY, vol. 31, 2017, at 1219, *available at* https://www.tandfonline.com/doi/full/10.1080/02699052.2017.1307449.

Congress, the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) outlined three broad goals for TBI care in the military and veteran community: (1) increased awareness, (2) improved surveillance, and (3) stronger collaboration across the federal government.[16] Several recommendations – which were composed in collaboration with the Department of Defense and VA – have been implemented, but guiding factors can still serve to improve the landscape of care today.

In order to improve continuity of quality care and service delivery along with inter-service, interagency, intergovernmental, and public and private collaboration for care, CDC and NIH called on VA to establish multiple reforms including implementing uniform training for recovery coordinators and medical and non-medical care/case managers, establishing a single tracking system, and providing a comprehensive plan for the seriously injured. The Federal Recovery Coordination Program was cited as a main driver of these reforms, but that office has since transformed 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.

In consideration of recent research revealing the barriers created by poor awareness of programs and anecdotal evidence from warriors that supports the same conclusion, WWP has and will continue to explore ways to improve the ability of veterans with moderate and severe TBI symptomatology – and other veterans requiring close attention for severe disabilities – to navigate the systems of care available to them. We invite the Subcommittee to join those efforts to explore ways to improve the ability of veterans to take advantage of the long-term care programs available to them.

Prepare for Long-Term Care Needs of Patients with a History of TBI While Offering More Care Options Today

Traditionally, VA has provided 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 that can create or maintain increased independence. This kind of rehabilitation is a key part of a continuum of services that should be provided to support continuous rehabilitation throughout a veteran's lifetime. Because these 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. A notable VA pilot program, the Assisted Living for Veterans with Traumatic Brain Injury (AL-TBI) Program, demonstrated a demand for these types of facilities before sunsetting in 2018.[17]

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[16] CTRS. FOR DISEASE CONTROL AND PREVENTION & NAT'L INSTS. OF HEALTH, *Report to Congress on Traumatic Brain Injury in the United States: Understanding the Public Health Problem Among Current and Former Military Personnel* (June 2013).
[17] *See generally*, *Polytrauma/TBI System of Care*, U.S. DEP'T OF VET. AFFAIRS (June 3, 2015), https://www.polytrauma.va.gov/about/Rehabilitation_Team.asp.

Eligible candidates typically suffered from moderate or severe TBI and benefitted from caregivers, family or otherwise, in home settings in order to escape institutionalization. Others lived in nursing homes provided by VA where those around them were much older and required different services and care, or where a majority of residents were civilians that could not create the bond of military service found in other VA institutional settings. Most courses of rehabilitative treatment took place over the course of 6 to 12 months and were effective even when conducted several years after the injury occurred (although studies suggest that more immediate rehabilitative care may be favorable).[18]

Although this pilot lasted for nearly a decade, its utility in providing step-down therapies and rehabilitation has not been replicated despite ongoing need. Modest participation numbers are not reflective of the need for this type of programming and may be a false representation of actual need in consideration of the progressive nature of the TBI process. While VA's five Polytrauma Transitional Rehabilitative Care facilities provide support for some veterans, these facilities are limited in scope, accessibility, and availability. Additionally, though directed to produce a report following the AL-TBI program, the information VA provided was limited and quantitative while also lacking feedback that could help shape future programs and care within the VA system.

The AL-TBI Program was written in response to a need for "specialized residential care and rehabilitation" with the purpose of enhancing "rehabilitation, quality of life, and community integration."[19] Nothing suggests that this need for care has expired despite the program being allowed to sunset. Furthermore, DVBIC's *7-Year Progress Update to a 15-Year Longitudinal Study* affirms the need for this type of care by recommending that "TBI patients needing supervised environments for years beyond injury should have access to residential brain injury treatment in an age-appropriate setting and community-based extended services."[20]

The need for residential support and services remains while access to appropriate rehabilitative facilities covered by the VA is limited mostly to nursing homes where aging populations often are a poor fit for a younger person with TBI. For this reason, TBI-affected veterans and their caregivers are best served when they have the option to seek care in community-integrated rehabilitative centers where they are more likely to receive care most appropriate for TBI and also participate in therapy with similarly injured persons whose objectives may include returning home or to participation in the community.

[18] Irwin M. Altman, et al., *Effectiveness of Community-Based Rehabilitation After TBI for 489 Completers Compared with those Precipitously Discharged*, PHYSICAL MED. & REHABILITATION (Nov. 2010) available at https://www.archives-pmr.org/article/S0003-9993(10)00649-0/fulltext#sec4.
[19] *Polytrauma/ TBI System of Care,* U.S. DEP'T OF VET. AFFAIRS (June 3, 2015) https://www.polytrauma.va.gov/about/AL-TBI.asp.
[20] *Report to Congress, Section 721 of the NDAA for Fiscal Year 2007 (P.L. 109-364), 7-Year Update. Longitudinal Study on Traumatic Brain Injury Incurred by Members of the Armed Forces in Operation Iraqi Freedom and Operation Enduring Freedom*, DEP'T OF DEF. (June 2017).

CONCLUSION

Wounded Warrior Project thanks the Subcommittee on Health and its distinguished members for inviting our organization to submit this statement. We are grateful for and inspired by this Subcommittee's proven dedication to our shared purpose to honor and empower our nation's warriors. Your efforts to provide interventions to meet the growing needs of a diverse veteran population and support quality physical and mental health care will certainly have a strong impact on the post-9/11 generation. We are proud of all the work that has been done and look forward to continuing to partner on these issues and any others that may arise.

APPENDIX

"AGING IN PLACE" SUPPLEMENTAL DATA

Annual Warrior Survey (AWS)

In 2020, WWP completed the 11th year of the Annual Warrior Survey. The survey represents the wounded, injured, and ill post-9/11 veterans registered with WWP.

In the general population, mild cognitive impairment is common among the aging population, adults 65 years and older, and increases with age (Lin et al., 2013). Veterans more frequently manage traumatic brain injury (TBI) and experience cognitive decline and/or complete physical and mental disability much earlier in life due to combat-related trauma, which can lead to early onset aging, and have a symptomatic display of dementia, comparable to older adults with Alzheimer's, Parkinson's, or stroke. While there are relatively few studies, evidence suggests individuals who cope with TBI are estimated to be around 5 years older than their chronological age (Cole, Leech, & Sharp, 2015).

The 2020 AWS results show that, for injuries incurred as a result of post-9/11 military service, 37% of warriors reported having traumatic brain injury (TBI); while 10% reported having spinal cord injury (SCI). Due to physical injuries or problems, 11% of our warrior population reported a need of aid or attendance of another person, while 27% of warriors with TBI and 41% of warriors with SCI reported the same need.

Why Warriors Need Aid & Attendance:

- 31% of all warriors indicated some level of need due physical or mental health injuries
- 40% of all warriors self-reported TBI, SCI or both[21].

43% of Warriors who self-report TBI, SCI or both reported a need for aid or assistance due to mental or physical problems compared to 24% all other warriors[22].

Warriors in Need of Aid or Attendance of Another Person – 2020 Annual Warrior Survey*		
	All Warriors***	Warriors with TBI or SCI**
Yes, because of physical or mental injuries or problems	24%	43%
No	76%	57%
Warriors may have selected one or more options* * Self-reported injury* ****All warriors exclude warriors with TBI and/or SCI*		

[21] Collapsed variable of warriors who indicated one or both injuries (SCI & TBI) were present.
[22] Warriors excluding those with TBI and/or SCI.

How much Aid & Attendance Warriors Need:

Warriors who self-report TBI, SCI or both report needing more hours (≥31 hours) of assistance at a greater rate (35%) compared to warriors who do not report TBI or SCI (26%).

Average Hours per Week of Aid and Attendance Needed Among those Needing Assistance – 2020 Annual Warrior Survey		
	All Warriors**	Warriors with TBI or SCI**
10 hours or less	34%	25%
11-20 hours	25%	23%
21-30 hours	15%	17%
31-40 hours	8%	10%
More than 40 hours	18%	25%
**Self-reported injury* ***All warriors exclude warriors with TBI and/or SCI*		

Independence & Aging:

Activities of daily living (ADL) represent basic activities[23] necessary for independent living, greater need in assistance for performing these activities directly relates to overall level of independence ("Activities of Daily Living Checklist & Assessments," 2021). Greater dependency or need in ADLs is present in up to 10% of persons aged 75 years or older and typically requires need of a caregiver or placement in nursing home (Edemekong, Bomgaars, Sukumaran, & Levy, 2021). The presence of ADLs has a negative or diminished affect on life expectancy and quality of life, that is the impact of disability leading to lower functional independence approximates 10 years older, spending much more of remaining life years being disabled (Population & Gilford, 1988). WWP's Independence program specifically assists warriors requiring a caregiver or regular assistance due to service-connected injury.

[23] ADLs look at 5 basic categories: personal hygiene, dressing, eating, maintaining continence, and transferring/mobility.

Independence Program Warriors

Wounded Warrior Project's Independence Program (IP) helps warriors cope with moderate to severe brain injury, spinal cord injury, or neurological conditions and take positive steps toward independent living.

WWP has a total of 725 warriors registered with IP:

- 45% indicate Traumatic Brain Injury (TBI)
- 35% with other brain injury
- 10% with spinal cord injury (SCI) and
- <1% with neurological or neurodegenerative condition

Wounded Warrior Project, Registered IP Warriors (N=725)		
Qualifying Diagnosis	**N**	**%**
Brain Injury	252	35%
Spinal Cord Injury (SCI)	72	10%
Traumatic Brain Injury (TBI)	323	45%
Rank		
E1-E4	256	36%
E5-E6	277	39%
E7-E9	89	13%
W1-W5	7	1%
O1-O3	49	6%
O4-O10	35	5%
Age (mean years)	725	43
Time in IP Program[24]		
0 – 2 years	34	5%
2 – 4 years	115	18%
4 – 6 years	281	43%
6 – 8 years	216	33%
Gender		
Male	620	86%
Female	99	14%

[24] Among those who are registered with WWP's IP program and have completed a program survey (N=431)

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