US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of VHA's Screening and Evaluation of Traumatic Brain Injury in Post-9/11 Veterans

National Review | 24-03541-173 | August 5, 2026

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) initiated a national review in December 2024 to evaluate components of the Veterans Health Administration's (VHA's) screening and evaluation processes for traumatic brain injury (TBI) in veterans who separated from active duty after the attacks of September 11, 2001, (9/11), and received VA medical care. Beginning in January and concluding in September 2025, the OIG interviewed VHA national program office leaders, Veterans Integrated Service Network and polytrauma network site representatives, and facility-level TBI program staff. The OIG continued data collection and analysis through March 2026.

Since 9/11, TBI became *the signature injury* of the Iraq and Afghanistan conflict era, causing casualties and disabilities in military service members and veterans.[1] VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury,* requires that all veterans separating from active duty after 9/11 and "receiving VA medical care must be screened for possible deployment-related TBI," and that veterans with positive screens must be offered a comprehensive TBI evaluation and treatment by providers with expertise in TBI.[2] The screening is also required to be performed following redeployment.[3]

The OIG found that VHA screened 2.7 million post-9/11 veterans for possible deployment-related TBI from September 11, 2001, through March 31, 2025. Among those who screened positive, 331,089 were offered a comprehensive TBI evaluation, and most accepted; however, only about half (158,907) of those who accepted ultimately received the evaluation.

To assess more recent performance, the OIG analyzed VHA's recent comprehensive TBI evaluation completion rate beginning with positive TBI screens conducted in fiscal year 2024. The OIG found that VHA completed 61.1 percent of comprehensive TBI evaluations, and of those completed, fewer than 50 percent of veterans received the evaluation within 28 days. Although the percentage of comprehensive TBI evaluations completed reflects an 8-percentage-point improvement over the historical average, veterans remain at risk of not receiving necessary treatment.

Additionally, the OIG found the comprehensive TBI evaluation template used by providers in the electronic health record is restricted to one-time use after a positive TBI screen, which leads to inaccurate data collection of completed comprehensive TBI evaluations, which could result in veterans not receiving a comprehensive TBI evaluation or delaying care.

---

[1] National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Disability Determination Process for Traumatic Brain Injury in Veterans* (Washington, DC: The National Academies Press, 2019), https://www.nationalacademies.org/read/25317.

[2] VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury*, January 3, 2022.

[3] VHA Directive 1184.

The OIG made three recommendations to the Under Secretary for Health related to ensuring veterans interested in further evaluation are referred for a comprehensive TBI evaluation, considering a uniform referral method for Polytrauma System of Care resources, and reviewing the comprehensive TBI evaluation template.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Under Secretary for Health concurred with recommendations 1 and 2 and concurred in principle with recommendation 3. The Under Secretary for Health provided an acceptable action plan that included collaborating with VHA national program offices, enhancing resource sharing, and ensuring documentation of evaluations. The OIG will follow up on the planned actions until they are completed.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

OIG	Office of Inspector General
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a national review in December 2024 to evaluate components of the Veterans Health Administration's (VHA's) screening and evaluation processes for traumatic brain injury (TBI) in veterans who separated from active duty after the attacks of September 11, 2001, (9/11), and received VA medical care. Beginning in January and concluding in September 2025, the OIG interviewed VHA national program office leaders, Veterans Integrated Service Network (VISN) and polytrauma network site representatives, and facility-level TBI program staff. The OIG analyzed data through March 2026.

Background

Since 9/11, TBI became *the signature injury* of the Iraq and Afghanistan conflict era, causing casualties and disabilities in military service members and veterans. TBI is a disruption of brain function from an external force such as a blow, bump, jolt to the head, or a penetrating head injury that affects how the brain works and may lead to temporary or permanent health problems.[1]

According to the Department of Defense, 515,885 service members were diagnosed with TBI between 2000 and 2024.[2] Research indicates a higher prevalence of TBI among veterans compared to their civilian male counterparts.[3] The increased prevalence is attributed to various causes, such as blast exposures, motor vehicle accidents, falls, and other combat-related incidents. TBI is commonly associated with polytrauma, which involves injuries to multiple body parts and organ systems, such as amputation, burns, musculoskeletal injuries, auditory and visual damage, and post-traumatic stress disorder or other mental health problems.[4] Due to the severity and complexity of polytrauma, veterans diagnosed with TBI often require integrated and coordinated clinical care and supportive services.

---

[1] National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Disability Determination Process for Traumatic Brain Injury in Veterans* (Washington, DC: The National Academies Press, 2019), https://www.nationalacademies.org/read/25317; "Traumatic Brain Injury & Concussion, Facts About TBI," Center for Disease Control, accessed September 25, 2025, https://www.cdc.gov/traumatic-brain-injury/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/traumaticbraininjury/get_the_facts.html.

[2] "DOD Numbers for Traumatic Brain Injury Worldwide, 2000-2024 Q4," Military Health System, accessed June 23, 2025, https://web.archive.org/web/20250625224207/https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers.

[3] Kornblith, Erica S et al. "Prevalence of Lifetime History of Traumatic Brain Injury among Older Male Veterans Compared with Civilians: A Nationally Representative Study." *Journal of Neurotrauma* vol. 37, issue 24 (2020): 2680-2685. https://journals.sagepub.com/doi/10.1089/neu.2020.7062.

[4] VHA Directive 1172.01, *Polytrauma System of Care*, January 24, 2019, rescinded and replaced by VHA Directive 1172.01, *Polytrauma System of Care*, April 18, 2024.

Polytrauma System of Care

The VHA Polytrauma System of Care provides comprehensive, coordinated care for veterans with multiple complex injuries, including TBI, to restore maximum function and independence through individualized treatment plans.[5] The Polytrauma System of Care integrates specialized polytrauma rehabilitation centers, network sites, and support clinic teams, offering an interdisciplinary approach to rehabilitation.[6] Through support from the Physical Medicine and Rehabilitation Services national program office, Polytrauma System of Care leaders and program staff are responsible for oversight of the screening and evaluation processes of veterans with possible TBI.[7]

Overview of the TBI Screening and Evaluation Process

VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury,* requires that all veterans separating from active duty after 9/11, and "receiving VA medical care must be screened for possible deployment-related TBI." Additionally, veterans with positive screens must be offered a comprehensive TBI evaluation and treatment by providers with expertise in TBI.[8]

The TBI screen is completed by a VHA healthcare team member through a clinical reminder in the electronic health record. The screening includes asking the veteran to confirm post-9/11 deployment and having no previous diagnosis of TBI.[9] Four sequential questions are then asked regarding the veteran's deployment-related traumatic events, immediate disturbance of consciousness after the traumatic event(s), new or worsening symptoms after the event(s), and current "within the past week" symptoms.[10] If the veteran answers negatively to any of the questions, "the screen is negative and the TBI screen is complete."[11] Four affirmative responses result in a positive TBI screen. The provider and veteran discuss the results of the positive screen, and if interested in a further assessment, veterans are referred for a comprehensive TBI evaluation. See Appendix A for an overview of the TBI screening process with embedded screening questions.[12]

---

[5] VHA, *Polytrauma System of Care Case Management Orientation Manual*, July 2024.

[6] VHA, *Polytrauma System of Care Case Management Orientation Manual*.

[7] VHA Directive 1172.01;VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury*, January 3, 2022.

[8] VHA Directive 1184.

[9] VHA Directive 1184; VHA, *Polytrauma System of Care Case Management Orientation Manual*. The TBI screen can be completed by a licensed vocational nurse/licensed practical nurse, licensed social worker, clinical pharmacist, or a licensed independent provider.

[10] VHA Directive 1184.

[11] VHA Directive 1184.

[12] Underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

TBI specialists, specifically, physiatrists, neurologists, neurosurgeons, and neuropsychiatrists, are licensed independent medical providers who complete the comprehensive TBI evaluation to confirm or rule out a TBI diagnosis and create an appropriate treatment plan based on the outcome of the evaluation.[13] The templated evaluation is accessible from the electronic health record and includes establishing the origin of the veteran's injury, symptoms, pain, medication, physical examination, diagnosis, and plan.[14] See Appendix B for the components of a comprehensive TBI evaluation.

Prior OIG Reports

From September 26, 2024, through January 8, 2026, the OIG published two healthcare inspection reports with recommendations related to TBI.[15] The September 2024 report resulted from allegations that the VA Tuscaloosa Healthcare System in Alabama failed to provide follow-up care to a patient's positive TBI screen. The OIG substantiated that facility staff did not submit a consult, which is "a request for service on behalf of a veteran," for TBI evaluation following the veteran's positive TBI screen, as required.[16] The OIG made 14 recommendations with one related to TBI screening, consult requirements, and compliance. The recommendation related to TBI screening has since been closed. In the January 8, 2026, report, the OIG substantiated that a provider at the VA Marion Healthcare System failed to provide appropriate treatment to a veteran with TBI. The OIG made 13 recommendations to the Facility Director with one related to training on generating referrals to the TBI clinic. The recommendation related to TBI has since been closed.

OIG Concern

After discussion between Office of Healthcare Inspections leaders and the medical director of Walter Reed National Military Medical Center's inpatient TBI program in June 2024, the OIG opened a national review in December 2024 to determine whether veterans who separated from active duty after 9/11 and received VA medical care were screened for possible deployment-related TBI, and whether those with positive screens were offered a comprehensive TBI evaluation.

[13] VHA Directive 1184. TBI specialists are providers that have TBI expertise and training to complete the evaluation.

[14] VHA Directive 1184. VHA utilizes standardized evaluation templates, titled TBI instruments, accessible through a specialized menu in the electronic health record, which assist with polytrauma and TBI data collection.

[15] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*, Report No. 23-02393-250, September 26, 2024; VA OIG, *Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois*, Report No. 24-02987-27, January 8, 2026.

[16] VHA Directive 1232, *Consult Management*, November 22, 2024.

Scope and Methodology

The OIG initiated this national review on December 4, 2024. The OIG team reviewed applicable VHA policies related to TBI, the Polytrauma System of Care, and other relevant documents and literature.

The scope of the review included veterans with initial TBI screening through completed comprehensive TBI evaluation, and excluded veterans with diagnoses other than TBI, such as acquired brain injuries (for example, strokes or aneurysms), and those requiring follow-up services.

The OIG identified a study population of 2.9 million (2,884,582) veterans who separated from active duty after 9/11, through March 31, 2025, a span of approximately 23.5 years, and engaged in VA medical care. To assess overall compliance with VHA Directive 1184, the OIG analyzed TBI screening and evaluation data for the approximately 23.5-year period.[17] To ascertain a snapshot of current practices, the OIG also narrowed this review to a subset of the study population, specifically veterans who had TBI screening during fiscal year 2024 (October 1, 2023, through September 30, 2024).[18]

The OIG interviewed Physical Medicine and Rehabilitation Services program leaders, and Polytrauma System of Care staff: four polytrauma network site representatives, and 49 randomly selected facility-level TBI program staff representing all 18 VISNs.[19]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

[17] The OIG obtained patient care information, such as appointment data, through the Corporate Data Warehouse, which collects real-time health care data from VHA's electronic health record system. "Corporate Data Warehouse (CDW)," VA Health Systems Research, accessed November 19, 2025, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm. (Site no longer accessible.); VHA Directive 1184.

[18] The OIG utilized fiscal year 2024 screening data, rather than fiscal year 2025, to allow time for comprehensive TBI evaluation completion.

[19] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

The OIG determined that VHA screened a high percentage of veterans for possible deployment-related traumatic brain injury (TBI); however, approximately half of the veterans who agreed to a comprehensive TBI evaluation did not receive the required assessment. Of the completed comprehensive TBI evaluations, over half were not performed within the required time frame. The OIG identified factors that impede comprehensive TBI evaluation completion and further noted the lack of operational capacity to conduct evaluations.

TBI Screenings

VHA Directive 1184 requires screening for possible deployment-related TBI in all veterans who separated from active duty after 9/11 and present at a VA medical facility for care, regardless of the reason for the visit.[20]

The OIG found that over the approximate 23.5-year period, VHA initiated the screening process for 2.7 million veterans (94.4 percent) of the study population (2.9 million veterans) for possible deployment-related TBI. After 1 million veterans were excluded from further TBI screening for reasons including being in progress with, stopped, or declined the screening; or those who self-reported a prior TBI diagnosis, a previous screening since their most recent deployment, or no previous deployments—the remaining 1.7 million veterans completed the TBI screen. Of the 1.7 million veterans screened, 347,650 veterans (20.6 percent) screened positive for a possible deployment-related TBI.

Comprehensive TBI Evaluations

VHA Directive 1184 states that veterans who screen positive for TBI are offered a comprehensive TBI evaluation by TBI specialists to receive diagnostic and treatment recommendations.[21]

The OIG found that of the 347,650 veterans who screened positive, 331,089 (95.2 percent) were offered a comprehensive TBI evaluation. Among those offered, 301,177 veterans

[20] VHA Directive 1184.

[21] VHA Directive 1184.

(91 percent) agreed to a comprehensive TBI evaluation; however, only 158,907 veterans (52.8 percent) received an evaluation (see figure 1).[22]

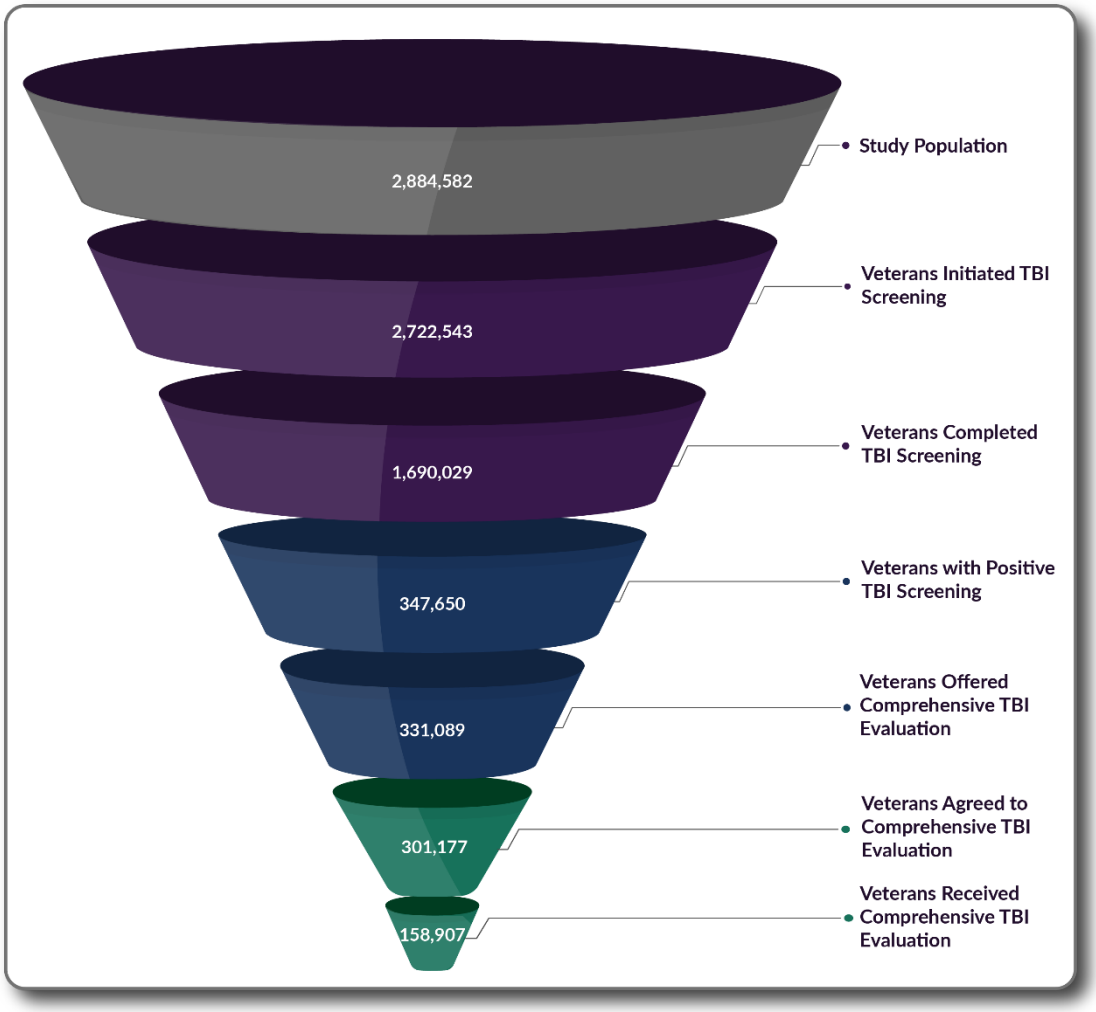

Figure 1. *Initial TBI screening and comprehensive TBI evaluation completion rates, from September 11, 2001, through March 31, 2025.*
Source: VHA Corporate Data Warehouse.

The OIG recognized that VHA screened 94.4 percent of veterans and offered comprehensive TBI evaluation to 95.2 percent of those who screened positive; however, 47 percent of veterans who screened positive (142,270) did not receive a comprehensive TBI evaluation.

[22] According to VHA officials, VHA considered a comprehensive TBI evaluation as complete if a comprehensive TBI evaluation was recorded at any point in time, regardless of the patient's separation date. The OIG considers a comprehensive TBI evaluation completed after the first positive screen following the patient's most recent deployment.

Recent Comprehensive TBI Evaluation Completion Trends: October 2023 through September 2025

To assess more recent performance, the OIG identified screenings that occurred from October 1, 2023, through September 30, 2024 (fiscal year 2024); and reviewed subsequent comprehensive TBI evaluations through September 30, 2025.[23]

The OIG found that VHA initiated the screening process for 373,967 veterans during fiscal year 2024. Of the 136,781 veterans that completed TBI-specific screening sections, 23,682 (17.3 percent) screened positive for deployment-related TBI.

The OIG found that 23,654 veterans (99.9 percent) were offered a comprehensive TBI evaluation. Among those offered, 19,989 veterans (84.5 percent) agreed to a comprehensive TBI evaluation, however, only 12,212 veterans (61.1 percent) received an evaluation (see figure 2).[24]

[23] The OIG did not review completed comprehensive TBI evaluations that were a result of a TBI screening completed in fiscal year 2025.

[24] The OIG noted that for purposes of data calculation, the data capture system incorrectly considers completion of a comprehensive TBI evaluation as completed although the patient may have subsequent separation dates and TBI screenings.

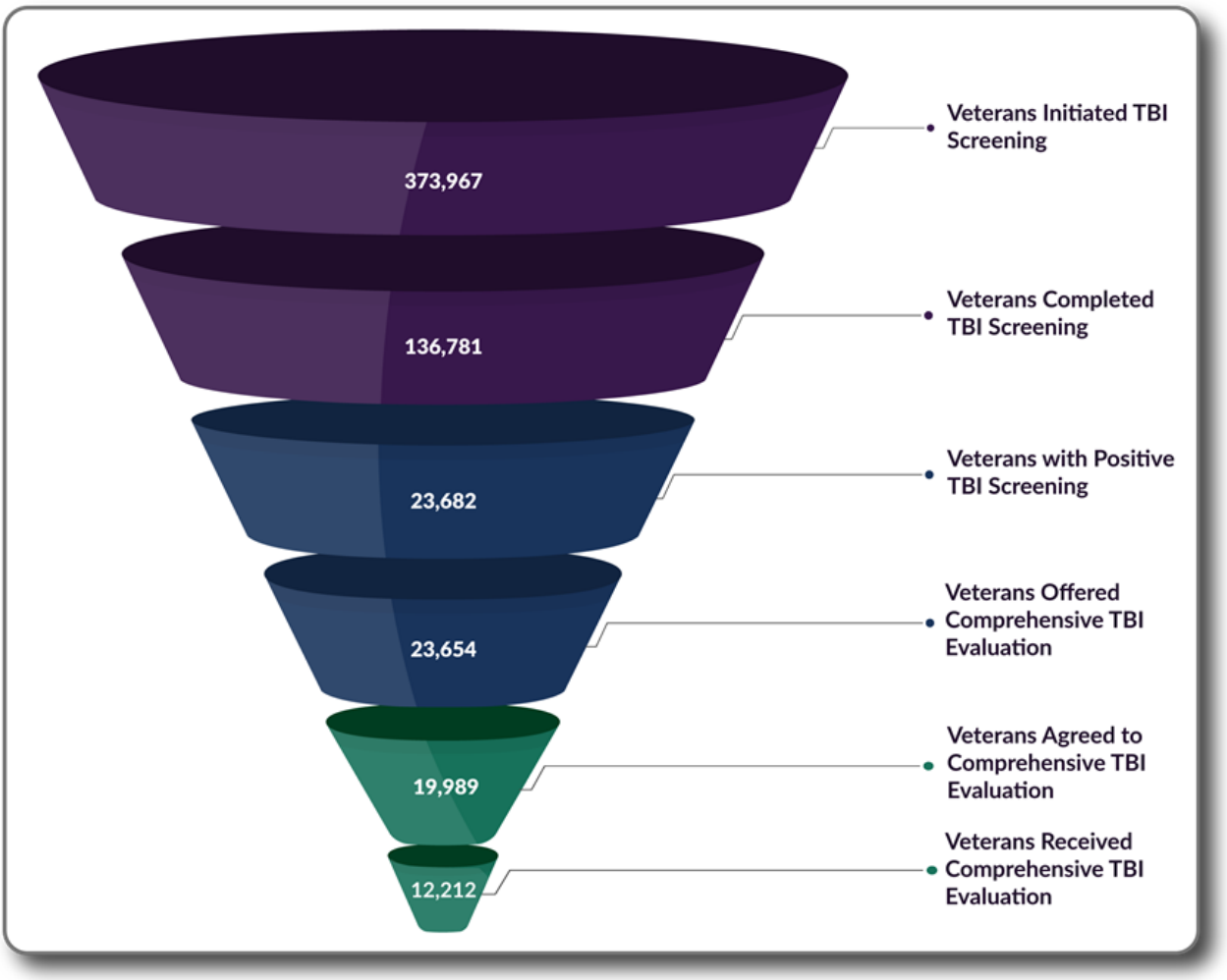

Figure 2. *Comprehensive TBI evaluation completion rates through fiscal year 2025, based on initial TBI screens completed in fiscal year 2024.*
Source: VHA Corporate Data Warehouse

To understand why veterans who agreed, but did not receive a comprehensive TBI evaluation, the OIG reviewed electronic health records of a statistical sample of 100 veterans in the fiscal year 2024 subset of the study population and found

- veterans either canceled the appointment or did not respond to VHA's efforts to schedule an appointment (65 percent),
- VHA staff did not place a consult for a comprehensive TBI evaluation (15 percent),
- comprehensive TBI evaluation was not completed for reasons other than those previously mentioned (6 percent).

Additionally, the OIG found that in 14 percent of the electronic health records reviewed, VHA staff completed the comprehensive TBI evaluation without using the comprehensive TBI

evaluation template. Per VHA Directive 1184, comprehensive TBI evaluations are completed using the required comprehensive TBI evaluation template.[25] Comprehensive TBI evaluation performance metrics rely on staff's utilization of the template for data capture, which may explain the discrepancy in the data.[26]

To understand the lack of consults placed for comprehensive TBI evaluations, the OIG asked 49 facility points of contact for potential causes. When asked, more than one-third of facility points of contact reported that the staff responsible for conducting the initial TBI screen, such as registered nurses, licensed practical nurses, and licensed vocational nurses, did not have the ability to directly enter consults into the electronic health record, and therefore relied on notification of a licensed independent provider to place the consult.

Although VHA's recent comprehensive TBI evaluation completion rate of 61.1 percent is an 8-point improvement over the historical 23.5-year average of 52.8 percent, the OIG concluded that significant risk still exists that veterans will not receive the treatment they need.

Comprehensive TBI Evaluation Scheduling

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 requires VHA to offer veterans community care if their request for specialty care, such as a comprehensive TBI evaluation, cannot be met within 28 days.[27]

The OIG reviewed VHA's completed comprehensive TBI evaluation appointment data for veterans (12,212) who completed a comprehensive TBI evaluation during fiscal year 2024. The OIG found that fewer than 50 percent of these veterans received a comprehensive TBI evaluation within 28 days from the date of the positive TBI screen.[28] During interviews with facility points of contact, the OIG learned 22 percent reported a lack of VHA providers with TBI expertise as a challenge for completion of the comprehensive TBI evaluation within the required 28 days.

Facility points of contact shared several actions taken to support completion of comprehensive TBI evaluations within 28 days:

---

[25] VHA Directive 1184.

[26] VHA Support Service Center (VSSC), "Data Definition Documentation For Comprehensive Traumatic Brain Injury Evaluation (CTBIE) Reports And Traumatic Brain Injury (TBI) Screening Reports," August 10, 2021. Comprehensive TBI evaluation template-based reports are updated daily and tracked monthly to monitor the use of the comprehensive TBI evaluation template.

[27] "Understanding Community Care," U.S. Department of Veterans Affairs, accessed on June 25, 2025, https://www.va.gov/files/2023-01/community-care-qsg.pdf; VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 1393 (2018).; 38 C.F.R. § 17.4040 (2026).

[28] "Pending Appointments," VHA Support Service Center, https://pyramid.cdw.va.gov/direct?id=f34c65f5-6998-4d2a-b850-d35f84b4cdbc&slideNumber=1. (This website is not publicly accessible.) The OIG used new patient appointments within the Polytrauma/Traumatic Brain Injury (TBI) – Individual clinic for this data element.

- Adjustments to providers' schedules were made to improve access (33 percent).
- Additional outreach was made to veterans to confirm appointment dates (31 percent).
- Telehealth agreements were established with other facilities to complete comprehensive TBI evaluations (29 percent).[29]

When asked if veterans were referred to community care when a facility is unable to meet the 28-day requirement, all facility points of contact responded that community care was not utilized.

The National Director of Physical Medicine and Rehabilitation Services was aware of facilities' reluctance to utilize community care due to the nature of the specialized comprehensive TBI evaluation template and the lack of specialized expertise for TBI in the community, as well as documentation challenges upon a veteran's return to the VA facility. However, the National Director also told the OIG that guidance from national Physical Medicine and Rehabilitation Services program leaders has been for facilities to follow VHA policy and seek community care when VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 requirements cannot be met.

Polytrauma System of Care Resource Sharing

VHA Directive 1172.01, *Polytrauma System of Care*, notes the system's balance of "access and expertise to provide specialized polytrauma and TBI care at locations across VA medical facilities."[30] Polytrauma Network sites provide resources to medical centers that do not have TBI specialists to assist with comprehensive TBI evaluation completion and provide treatment through in-person and real-time interactive telehealth video visits.[31]

The OIG found that 94 percent of facility points of contact interviewed reported reliance upon telehealth services to ensure comprehensive TBI evaluations were completed. Further, 29 percent reported having telehealth agreements with other facilities that assisted with TBI services. Several facility points of contact told the OIG that these agreements were set up with other facilities. Three of the four polytrauma network site representatives interviewed reported facilitating assistance to facilities that are struggling with completing comprehensive TBI evaluations by connecting them with other sites that have capacity to assist through telehealth.

In interviews with national Physical Medicine and Rehabilitation Services program leaders and facility points of contact, the OIG learned that the VA Hudson Valley Healthcare System

[29] "What is Telehealth?" VA Telehealth, accessed June 30, 2025, https://telehealth.va.gov/what-telehealth. "Telehealth uses technology and data to improve the way VA provides patient-centered care to Veterans."

[30] VHA Directive 1172.01

[31] VHA Directive 1184; "What is Telehealth?" VA Telehealth; VHA Directive 1172.01.

(Hudson Valley) provided assistance to several facilities across the country by completing comprehensive TBI evaluations through telehealth. The National Director of Physical Medicine and Rehabilitation Services told the OIG that national Physical Medicine and Rehabilitation Services program office leaders have referred struggling facilities directly to Hudson Valley and also noted that a representative from Hudson Valley reports availability during national program calls. Additionally, the National Director of Physical Medicine and Rehabilitation Services encouraged polytrauma network sites to create interfacility consults within their own system of care to assist with the completion of comprehensive TBI evaluations, but reinforced that the use of interfacility consults is not a long-term solution.

In an interview, a Hudson Valley point of contact reported having no formal system for facilities to request assistance with comprehensive TBI evaluations. The point of contact noted challenges with establishing a telehealth agreement with new facilities and stated that when the requesting facility has not previously established a telehealth service agreement or obtained executive leadership concurrence, the process is delayed. The OIG reviewed data provided by Hudson Valley that showed the site assisted 17 facilities across the country with comprehensive TBI evaluation completion through telehealth in fiscal year 2024.

As fewer than 50 percent of veterans completed the comprehensive TBI evaluation within 28 days from their positive TBI screen during fiscal year 2024, the OIG concluded the Polytrauma System of Care does not maximize the use of telehealth resources.

Management of Comprehensive TBI Evaluation Completion Rates

VHA Directive 1232, *Consult Management*, requires providers to submit consult requests through the electronic health record for tracking purposes and prohibits cancellation of consults to manage capacity issues.[32] According to VHA's Case Management Orientation Manual, July 2024, the target rate for comprehensive TBI evaluation completion is 70 percent.[33]

The OIG reviewed the comprehensive TBI evaluation completion rates nationally and identified nine VA facilities with completion rates below 50 percent. According to VHA Support Service Center data, nine facilities had comprehensive TBI evaluation completion rates ranging from 20.2 percent to 49.2 percent, with a median of 33.6 percent, as of March 21, 2025.

Interviews with facility points of contact revealed that eight of the nine facilities implemented actions, such as increasing provider availability, leveraging telehealth, and consulting VISN and national resources. However, one facility point of contact reported canceling 135 consults after unsuccessful attempts to secure assistance, citing a one-year vacancy for a provider responsible for completing comprehensive TBI evaluations. This facility point of contact was no longer employed by VHA as of May 2025. According to a VISN official, another VA facility began

[32] VHA Directive 1232.

[33] VHA, *Polytrauma System of Care Case Management Orientation Manual*.

assisting the facility with completing comprehensive TBI evaluations in June 2025, and as of December 2025, 93 of 135 consults had been completed.

On May 13, 2026, VHA Support Service Center data for the period January 2026 through March 2026, the most recently completed quarter, showed the facility's comprehensive TBI evaluation completion rate as 80 percent. Quarterly comprehensive TBI evaluation completion data for the same period demonstrated improvement across most of the nine facilities: two facilities remained below 50 percent, three facilities had increased their comprehensive TBI evaluation completion rates above 50 percent, and four facilities exceeded the 70 percent target. This data reinforces the opportunity for VHA to leverage telehealth, VISN, and Polytrauma System of Care resources to continue improving comprehensive TBI evaluation completion rates.

Use of Comprehensive TBI Evaluation Template

The OIG identified that the comprehensive TBI evaluation template, which was designed to improve data collection and accuracy of TBI diagnosis, is restricted to one-time use following a positive TBI screen. This limitation prevents providers from using the template to document subsequent evaluations should a veteran return from a redeployment, receive a positive TBI screen, and accept the offer for a new comprehensive TBI evaluation. The restriction of the one-time use template leads to inaccurate data collection of completed comprehensive TBI evaluations; moreover, it could result in veterans not receiving a comprehensive TBI evaluation or delayed care.

VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury*, requires that the TBI screen is repeated for veterans if the date of separation changes due to a repeat deployment.[34] Further, VHA mandates that comprehensive TBI evaluations are documented in the electronic health record using the comprehensive TBI evaluation template.[35]

The OIG analysis of fiscal year 2024 comprehensive TBI evaluation completion data revealed a sub-population of 41 post-9/11 veterans who had a comprehensive TBI evaluation, were redeployed, had a subsequent positive TBI screen, and agreed to further evaluation. The OIG found that 9 veterans did not receive an evaluation due to a consult not being placed. Additionally, providers were unable to document the evaluation using the template for 13 veterans due to the one-time use restriction, and instead used alternative documentation

[34] VHA Directive 1184.

[35] VHA Directive 1184.

methods such as a consult note, which could result in veterans not receiving all components of the comprehensive TBI evaluation.[36]

During an OIG interview, a Physical Medicine and Rehabilitation Services leader, confirmed the comprehensive TBI evaluation template is designed to be completed only once per veteran and then "locks down." In response to the restriction of the comprehensive TBI evaluation template, the Physical Medicine and Rehabilitation Services leader stated that providers "use a local consult note" and recognized that this evaluation would probably not be captured in the data.

Conclusion

The OIG conducted this national review to evaluate components of VHA's screening and evaluation processes for TBI in post-9/11 veterans who received VA medical care.

VHA completed a high percentage of TBI screening for the post-9/11 veteran population but did not ensure that veterans who screened positive received timely follow-up comprehensive TBI evaluations. VHA did not complete the required comprehensive TBI evaluation for approximately 53 percent of the veterans who agreed to an evaluation between September 11, 2001, through March 31, 2025. Fewer than 50 percent of veterans who completed a comprehensive TBI evaluation in fiscal year 2024 were done within 28 days of the positive TBI screen. TBI program points of contact reported veterans' cancellation or nonresponse to VHA's efforts to schedule appointments, limited number of providers with TBI expertise, veteran cancellations, and community care challenges as factors affecting the completion of the comprehensive TBI evaluations.

Facility points of contact reported relying upon other Polytrauma System of Care services, such as telehealth, rather than community care to complete comprehensive TBI evaluations. The Polytrauma System of Care does not maximize the use of telehealth resources.

Nine VA facilities had comprehensive TBI evaluation completion rates below 50 percent and at one facility, a Polytrauma System of Care point of contact canceled 135 consults for comprehensive TBI evaluations after unsuccessful attempts at requesting assistance. Notably, seven of the nine facilities increased comprehensive TBI evaluation completion rates during the inspection time frame, including the one facility who previously canceled consults.

The comprehensive TBI evaluation template is restricted to one-time use following a positive TBI screen regardless of subsequent separations with positive TBI screens. This limitation prevents providers from using the template to document subsequent evaluations should a veteran return from a redeployment, receive a positive TBI screen, and accept the offer for a new

[36] Eighteen veterans did not have the evaluation completed due to the veteran either canceling the appointment or not responding to VHA's efforts to schedule an appointment.

comprehensive TBI evaluation, thus resulting in the possibility of veterans not receiving a comprehensive TBI evaluation or the evaluation being delayed.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–3

1. The Under Secretary for Health reviews the comprehensive traumatic brain injury evaluation referral process for veterans with positive traumatic brain injury screens and ensures veterans interested in further evaluation are referred for a comprehensive traumatic brain injury evaluation.

2. The Under Secretary for Health considers the development of a uniform referral method for the utilization of Polytrauma System of Care resources.

3. The Under Secretary for Health reviews the one-time use limitation of the comprehensive traumatic brain injury evaluation template to allow documentation of additional evaluations whenever a veteran screens positive for deployment-related traumatic brain injury after a subsequent separation.

Appendix A: TBI Screening Process

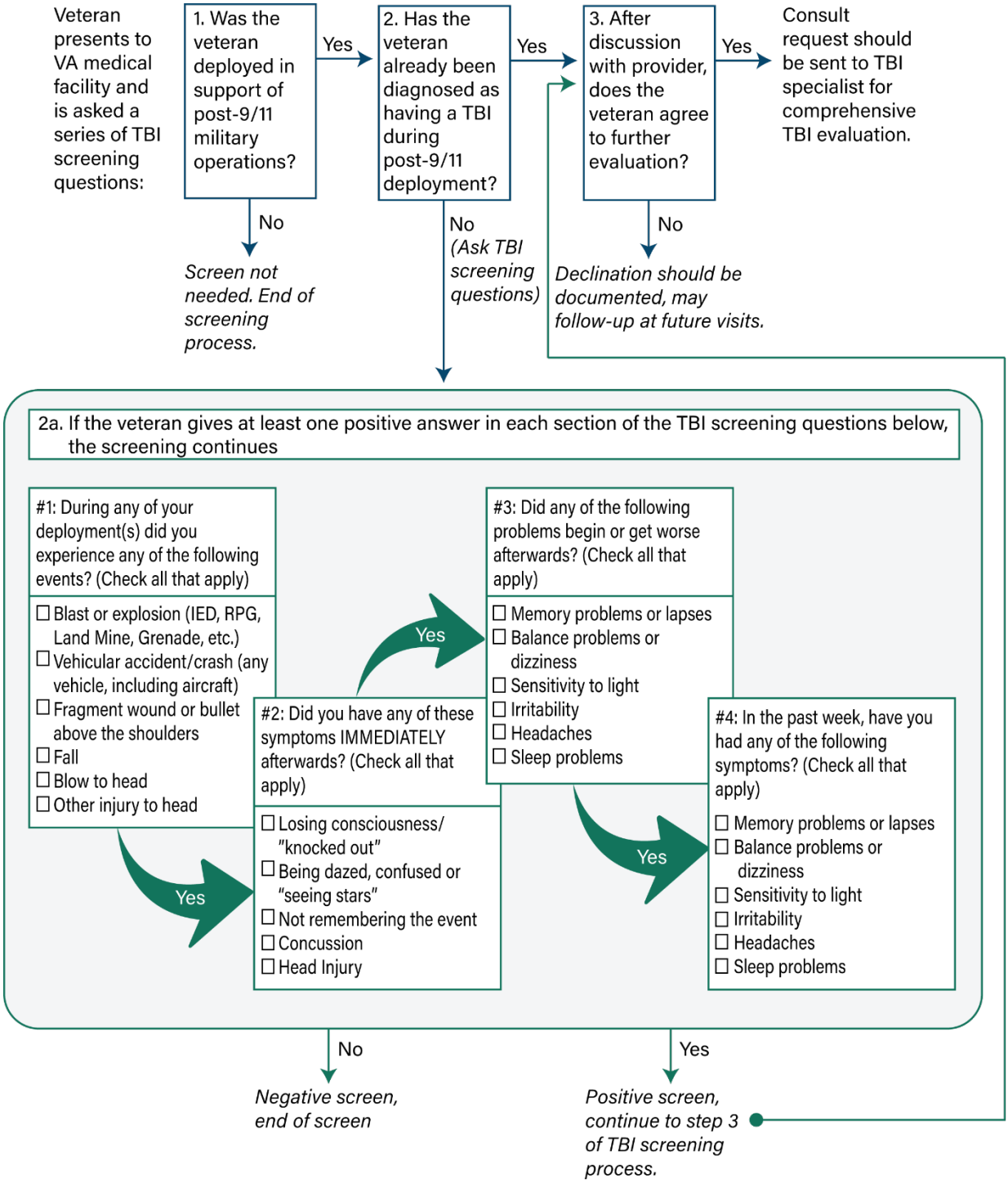

Figure A.1. *TBI screening process.*
Source: VHA Directive 1184 and OIG graphic summarization of TBI screening.

Appendix B: Comprehensive TBI Evaluation Components

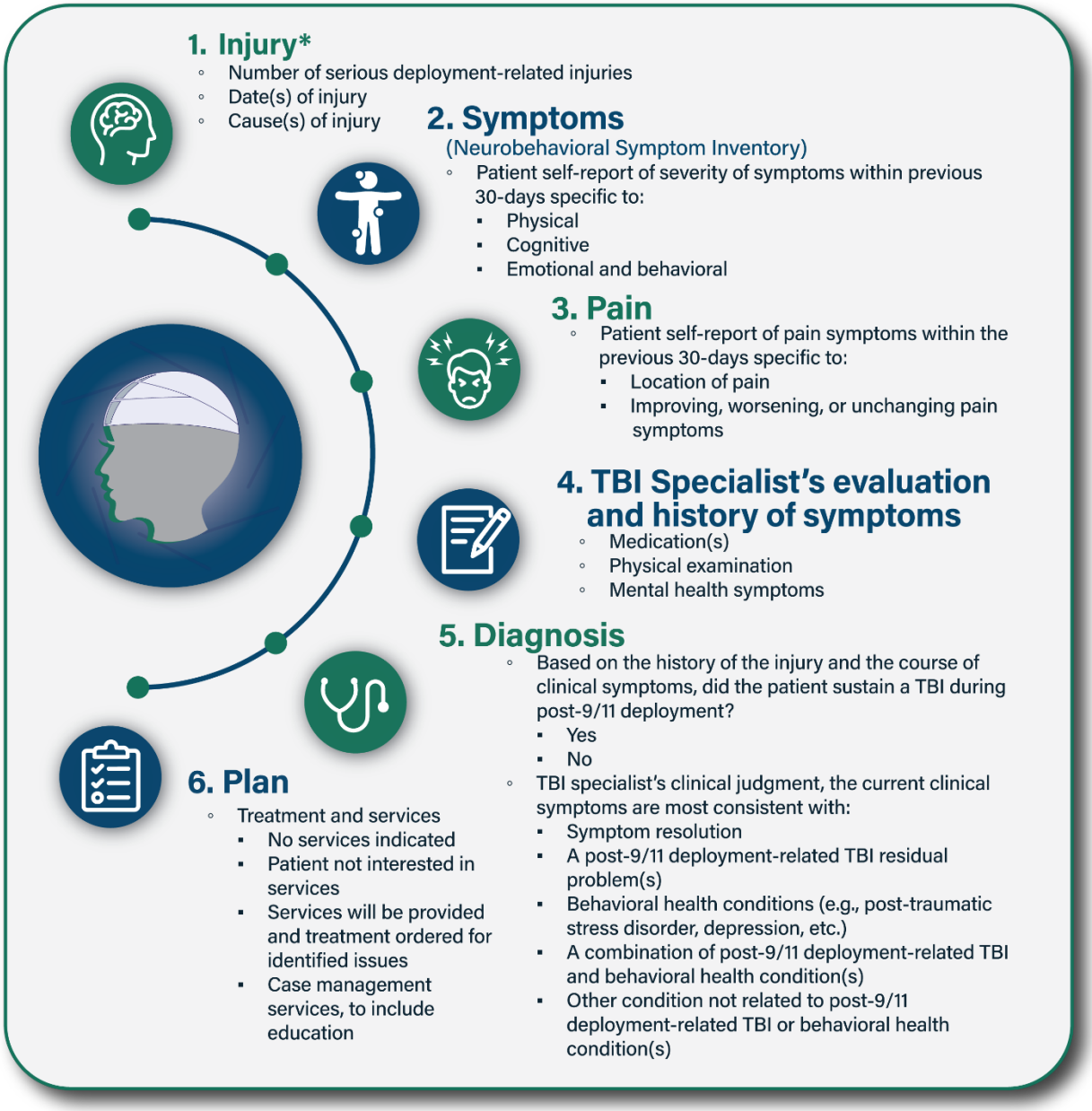

Figure B.1. *Components of the comprehensive TBI evaluation.*
Source: Comprehensive TBI Evaluation (CTBIE) Template, May 18, 2022.
OIG graphic summarization of the comprehensive TBI evaluation.
**Note: For purposes of this graphic, the OIG is using injury in the singular; however, multiple injuries may be captured in the comprehensive TBI evaluation.*

Appendix C: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: June 25, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report—Review of VHA's Screening and Evaluation of Traumatic Brain Injury in Post-9/11 Veterans

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of VHA's Screening and Evaluation of Traumatic Brain Injury in Post-9/11 Veterans. Attached is the Veterans Health Administration's (VHA) action plan.
2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

John J. Bartrum, JD, MBA

[OIG comment: The OIG received the above memorandum from VHA on June 25, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health reviews the comprehensive traumatic brain injury evaluation referral process for veterans with positive traumatic brain injury screens and ensures veterans interested in further evaluation are referred for a comprehensive traumatic brain injury evaluation.

_X _Concur

____Nonconcur

Target date for completion: June 2027

Under Secretary for Health Comments

The national Physical Medicine & Rehabilitation Service (PM&RS) Program will review solutions for three different areas to address dependencies between positive traumatic brain injury (TBI) screens and further evaluation. PM&RS will collaborate with the Office of Primary Care to review TBI screening and referral processes across the enterprise to identify best practices for potential dissemination across system of care. PM&RS will collaborate with information technology (IT) leads to review possible technical solutions to enhance order processing following a positive TBI screen. Finally, PM&RS will standardize Veteran outreach scripts to address no-response/cancellations.

Recommendation 2

The Under Secretary for Health considers the development of a uniform referral method for the utilization of Polytrauma System of Care resources.

_X _Concur

____Nonconcur

Target date for completion: March 2027

Under Secretary for Health Comments

PM&RS will collaborate with each lead Veterans Integrated Service Networks (VISN) polytrauma site to review evaluation completion rates, review existing Clinical Video Telehealth agreements and workflows, and analyze polytrauma funding PM&RS will utilize the information gained to consider a uniform referral method and/or develop an action plan to enhance resource sharing and national Tele-TBI hub support.

Recommendation 3

The Under Secretary for Health reviews the one-time use limitation of the comprehensive traumatic brain injury evaluation template to allow documentation of additional evaluations whenever a veteran screens positive for deployment-related traumatic brain injury after a subsequent separation.

_X _Concur in Principle

____Nonconcur

Target date for completion: September 2026

Under Secretary for Health Comments

While there is a one-time limitation on the use of the comprehensive TBI evaluation (CTBIE), clinicians may use the TBI Follow Up Assessment in either legacy EHR or the TBI Comprehensive evaluation power form in the Federal EHR an unlimited amount of times.

The TBI Follow Up Assessment allows clinicians to document their evaluation using the same standardized content as the CTBIE template when individuals have been redeployed or when a previously evaluated Veteran is referred for an assessment. PM&R will socialize standard workflow using national email groups and existing Polytrauma calls to educate clinicians on the use of TBI Follow Up Assessment template in TBI Instruments when the CTBIE template was previously completed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Clarissa Reynolds, MBA, NHA, Director Limin Clegg, PhD Jonathan Ginsberg, JD Ping Luo, PhD James McMahon, MPT, AT Carrie Mitchell, MSW, LCSW Nancy Short, LCSW Robert Yang, MD
Other Contributors	Karen Berthiaume, RPh, BS Sheyla Desir, MSN, RN Christopher Hoffman, LCSW, MBA Barbara Mallory-Sampat, RN, JD Larry Ross Jr., MS Natalie Sadow, MBA April Terenzi, BA, BS

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Assistant Secretaries

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.vaoig.gov.