Paralyzed Veterans of America

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STATEMENT OF

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NATIONAL PRESIDENT PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

"STRENGTHENING SERVICES FOR VETERANS WITH SPINAL CORD INJURY AND DISORDER"

SEPTEMBER 17, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, I appreciate the opportunity to speak with you today on behalf of Paralyzed Veterans of America (PVA) about the strengths and weaknesses of Department of Veterans Affairs' (VA) care for veterans with spinal cord injuries and disorders (SCI/D). For nearly 80 years, PVA has been the leading voice on issues that affect catastrophically disabled veterans. Throughout the decades, we have championed critical changes within the VA SCI/D system by partnering with VA and working with members of Congress as they develop important processes and procedures that affect the lives of paralyzed veterans.

When I testified in March before a Joint Session of the House and Senate Veterans' Affairs Committees, I expressed our frustration with the existing state of the SCI/D system and a fair degree of trepidation about its future. We have relayed some of our biggest concerns to Secretary Collins and he has signaled to us on more than one occasion that VA's specialized services and the care of catastrophically disabled veterans will be a priority in this administration. But he can't do it alone. We need Congress's leadership and support to make the necessary changes to address long-standing systemic needs that will strengthen the system for veterans with SCI/D.

VA's SCI/D system of care uses a hub and spoke model. The 25 SCI/D centers are the hubs and each center has highly trained and experienced providers, including doctors, nurses, social workers, therapists, psychologists, and other professionals who can address the unique problems that affect veterans with SCI/D. VA's SCI/D system of care is the crown jewel of the VA's health care system. It is unequaled in the care it provides for the tens of thousands of veterans with SCI/D. This system is the difference between life and death for our members. It's because of this system of care that veterans can live in their own homes, travel, work, volunteer, and otherwise contribute to society.

PVA firmly believes VA is the best health care provider for disabled veterans, particularly those with catastrophic disabilities. More importantly, our members consistently choose VA's SCI/D system of care, because it provides a coordinated life-long continuum of services that has increased the lifespan of these veterans by decades. Beyond the loss of use of arms and legs, an SCI/D can affect other bodily systems, including skin, bowel, bladder, and breathing. Because of the profound and lasting effects of an SCI/D, which disrupts both physical and neurological functions, seeing a provider who understands the impact on each body system is a vital necessity.

Recently, a PVA member expressed this sentiment when he relayed that while he has had surgery in the community, the VA doctors he sees at the SCI/D spoke site at the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas, understand the full nature of his trauma and they provided the tailored support with post-surgery rehab and long-term support that increase his quality of life. Other PVA members in Iowa and Nebraska relayed that while they regularly use the VA SCI/D clinic at the VA Nebraska-Western Iowa Health Care System, most, if not all, of them also travel to an SCI/D center (Minneapolis or Milwaukee) once a year for their annual exams. They choose VA over the community because of the comprehensive level of care they receive.

Most community care providers lack the knowledge, expertise, and time to properly understand the impact of SCI/D on body systems, which is the number one reason why most of our members choose VA direct care verses community care, even when it means traveling beyond the nearest medical facility. A PVA member in Colorado recently shared his contrasting experiences between VA and community emergency room visits following a severe flare-up of multiple sclerosis (MS). VA News published the story, and I strongly encourage you to read it.[1]

We know that transportation to care can often be a significant barrier for catastrophically disabled veterans, especially for those living in rural areas. The absence of robust transportation infrastructure limits their options. The VA has implemented various programs to address these challenges, such as the Beneficiary Travel Program, Veterans Health Administration (VHA)-Uber Health Connect, and the Veterans Transportation Service, but each of these programs has problems or limitations that need to be addressed. That's why we support increasing access to beneficiary travel for these veterans and improving access to adapted vehicles.

Although VA's SCI/D system of care provides the best healthcare for paralyzed veterans, PVA has three primary concerns about the ability of the VA's SCI/D system of care to continue serving catastrophically disabled veterans both now and in the future. These concerns are ongoing staffing vacancies, delayed infrastructure improvements, and the continued shortage of specialty long-term care beds.

Staffing Vacancies—In March, I spoke about how the lack of proper staffing was undermining not just VA's SCI/D system of care, but VA's specialized services in general. Blinded veterans and those with traumatic brain injuries also benefit from VA's specialized systems focusing on specific conditions or diseases that require advanced knowledge, technology, and treatment approaches. This distinction is vital for ensuring veterans receive appropriate and effective care for their distinct health challenges.

[1] An Army Veteran's contrasting ER experiences - VA News.

Staffing levels for the SCI/D system of care are detailed in VHA Directive 1176. PVA strongly believes in each of the requirements outlined in this directive because they are based on the level of care needed to maintain the health and well-being of veterans with SCI/D. Unfortunately, some VA leaders have treated them as a guide rather than requirements based on best care standards. For example, at the end of July, using 1176 as our guide and focusing on nursing levels alone, we estimate that VHA's SCI/D system of care lacked 36 percent of its acute care nurses (896 of the 2475 recommended) and 7 percent of its long-term care nurses (short 23 out of 311 recommended).

In recent years, critically needed positions at SCI/D centers have gone unfilled. As a result, essential positions across VHA have been "lost" due to an inability to recruit for them. In some cases, they were even being "abolished." Specifically, many vacant positions in social work, nursing, and several therapy disciplines have been eliminated. We understand VHA inactivated nearly 500 SCI/D positions in fiscal year 2004 alone, and it is not surprising to us that some of the facilities that had the greatest number of reductions are the same ones that are unable to fully staff their full complement of recommended operational beds today. When medical staff leave, their vacated positions are often not backfilled, causing strain on the system and ultimately denying veterans access to health care services.

During PVA's annual visits to each SCI/D center, we identify critical vacancies at the facilities and provide that information to VA leaders. Totaling in the hundreds, VA typically agrees with roughly 80 percent of our recommendations, but only a small number of the positions are eventually filled. Too often at VA, we see "staffing on a wire," an unstable practice of maintaining just enough staff to handle a limited number of beds. Again, using 1176 as our guide, VA should have about 990 operational beds, but persistent staffing vacancies have shrunk that number to 639 (64 percent). The impact of such practice is profound, causing severe delays in critically needed routine care, including annual exams, colonoscopy preparation, and respite; and acute care, including admitting new injuries and addressing pressure wounds. Such delays have real consequences for veterans who need care now.

Additionally, these figures are based on nursing shortages alone. If we factored in provider shortages, the number of vacancies would be much worse. A good example of this is the Albuquerque SCI/D center. Of its 30 mandated beds, only 20 are operational due to nursing shortages, and of those 20 only 10 can be filled due to provider shortages. Shortages like these impair a facility's ability to adapt to changing life events like staff illnesses and injuries. Without proper staffing, veterans may be forced to accept care in the community, even when it is not the quality or type of care they would receive at a VA facility, and most importantly, when it is not their choice to do so.

Depending on the function level of an acute SCI/D patient, a nurse may spend an hour or more each time they enter a veteran's room doing physical transfers, repositioning, wound care, feeding assistance, bowel and bladder care, and other tasks. Nurses in other areas of work may be in and out of a patient's room in a matter of minutes. Despite the increased care that veterans with SCI/D require, not all SCI/D nursing staff, including Licensed Practical Nurses and Certified Nursing Assistants, receive specialty pay, which often elevates turnover rates. Due to nursing shortages in the SCI/D system of care, innovative and creative new approaches need to be reviewed, investigated, and implemented to attract, recruit, and retain nurses. This includes making specialty pay (5-10 percent above base)

mandatory, across the board throughout VHA), for all SCI/D nurses; along with the Education Debt Reduction Program, relocation assistance, bonuses, and all other current authorized incentives.

The PACT Act (P.L. 117-168) and the RAISE Act (P.L. 117-103) gave the VA new pay and bonus authorities to recruit in-demand health care workers, but we know that more needs to be done. Consistently relying on overtime to fill needs often leads to burnout. Giving VA additional tools, including additional financial resources so it can better compete for the highly qualified medical personnel it needs to care for catastrophically disabled veterans, is a must. New approaches are particularly needed in hard to recruit locations, such as Puerto Rico, Albuquerque, and Memphis. It is not only difficult to find and hire nursing staff in these areas, but also nearly impossible to find and hire medical providers, such as doctors, plastic surgeons, and specialists to fill the vacancies at these SCI/D centers.

PVA also supports efforts to streamline VA's hiring processes to allow clinicians to be identified and onboarded as quickly as possible. For too long, VA's processes have caused hiring delays and resulted in desperately needed clinicians taking positions in the community, which is able to bring nurses and other health care clinicians on board faster. While VA must ensure that medical professionals meet all necessary requirements, the process is overly bureaucratic and stands in the way of ensuring veterans have timely access to VA direct care.

Infrastructure—VA's SCI/D system of care is comprised of 25 acute care centers and six long-term care centers ranging in age from four to 70 years with an average age of nearly 40 years old. Many of the older SCI/D centers have only had minor cosmetic interior finish renovations. Consequently, we saw traumatic and disruptive incidents at several SCI/D centers last year. For example, a piping system failure at one facility flooded half of the SCI/D center. This caused the immediate evacuation of the acute and long-term care units and ultimate relocation of veterans with SCI/D into the unaffected patient care units and an adjacent community living center. Fortunately, the medical center was able to repair the plumbing system, restore the impacted areas, and move patients back into the SCI/D center in about a month. Meanwhile, a faulty HVAC design at another facility allowed condensation from the cooling system to form and drip onto patients while they were in bed. The problem, which PVA identified many years ago, was finally corrected when a construction project at the facility was completed late last year.

Many SCI/D centers (14 of 25) continue to use four-bed patient rooms, accounting for 61 percent of the mandated available in-patient beds. These rooms do not meet VA requirements and represent an antiquated and outdated patient-care philosophy in modern health care environments due to infection control concerns. When patients need to be isolated, the other beds in the room must be closed.

Current construction projects in the SCI/D system of care will add a new SCI/D acute and long-term care center at the Jennifer Moreno VA Medical Center in San Diego and a long-term care center at the Dallas Campus of VA's North Texas Health Care System. Due to the diligent and collaborative efforts of the VA medical center, VA's Office of Construction and Facilities Management, US Army Corps of Engineers, and the construction team, the state-of-the art project in San Diego, which began in April 2021, is expected to be open to veterans by early 2026. Unanticipated delays prolonged the initial construction of the new SCI/D long-term care center in Dallas, so it is now expected to be completed in the spring of 2027.

The SCI/D system of care is not immune to the design and construction delays inherent in the VA project funding and delivery system. There are currently two super-major, 10 major, and 16 minor SCI/D center projects either awaiting funding, in design, or pending approvals to proceed. VA has spent a significant amount of money and resources on these projects, most of which have languished within the department's Strategic Capital Investment Planning process. Also, replacement SCI/D center projects designed for the Bronx, New York, (acute and long-term care) and the Brockton, Massachusetts, (long-term care) VA medical centers intended to modernize and expand capacity were shovel-ready but abandoned by the VA.

In reviewing VA's infrastructure, decision-makers must remember that VA's SCI/D system of care is unique and not replicated outside of VA. PVA believes that VA should return to the past practice of placing greater emphasis on funding facilities that support the types of services, like SCI/D care, which the department uniquely provides. Greater investment in these areas would greatly strengthen VA's specialty care services and ensure their future availability.

Even with a comprehensive strategy and adequate infrastructure funding, VA's capacity to manage a growing portfolio of construction projects is constrained by the number and capability of its construction management staff. To manage a larger, more complex capital asset portfolio, VA must have sufficient personnel with appropriate expertise—both within VA's Central Office and onsite throughout the VA system. Thus, PVA strongly supports legislation that would improve staffing to manage construction of VA assets and ensure that there are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

PVA also supports efforts to remove disability-related barriers throughout the health care system. Our members routinely face such barriers when accessing care at the VA and within the community. For example, we have heard of VA women's clinics that have examination rooms that are too small for veterans who use wheelchairs or lack overhead patient ceiling lifts. Although VA has worked to address access barriers for disabled veterans, establishing a Veterans Accessibility Advisory Committee would help ensure the VA is meeting the needs of veterans. We strongly support S. 1383, the Veterans Accessibility Advisory Committee Act of 2025, and urge swift passage of this legislation.

Long-Term Care Beds for Veterans with SCI/D—Our nation's lack of adequate long-term care options is an enormous problem for people with catastrophic disabilities. There are very few long-term care facilities that are capable of appropriately serving veterans with SCI/D. The VA is required to maintain 198 authorized (181 operating) SCI/D long-term care beds. Due to construction/renovation, only 167 are currently available. This is a critical deficit, as there are over 20,000 veterans with SCI/D receiving care and treatment within the VA system. This number fluctuates depending on several variables like staffing, women residents, and isolation precautions. When averaged across the country, that equates to about 3.4 beds available per state.

Currently, only one of VA's six specialized SCI/D long-term care facilities lies west of the Mississippi River. Even after the construction project in San Diego is completed, only 32 long-term care beds will be available for the thousands of veterans with SCI/D that reside in this area of the country. Many aging veterans with SCI/D need VA long-term care services, but because of the department's extremely

limited capacity, veterans sometimes remain in the acute setting for months or years at a significant cost because other placements are simply not available. Others must reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. As a result, veterans staying in community nursing facilities often develop severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center.

The North Texas project I previously mentioned includes shell space for an additional 30 long-term care beds (60 total) and would provide shared resident dining, kitchen, and living areas to support them, as well as common resident gathering areas and space to support staff on that level. There is currently no funding to support building out the shell space. The need for long-term care beds is particularly severe in the south-central region as there is not a VA SCI/D long-term care center within 1,000 miles of Dallas despite a significant regional population of veterans with SCI/D. Not funding this project postpones the opportunity to further address the shortage of VA long-term care beds for the aging population of veterans with SCI/D. We strongly recommend that Congress provide the additional funds to construct this part of the project.

Veterans with SCI/D also depend on a wide range of services and support available to veterans throughout VA. Many PVA members depend on VA home and community-based services (HCBS) throughout their lives. We are very appreciative of Congress's passage last year of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210). This bill made critically needed improvements to help veterans access VA HCBS. One of the most important provisions in the new law raised the cap on how much the VA can pay for the cost of home care from 65 percent of the cost of nursing home care to 100 percent, and even more if it's in the veteran's best interest. Intended to bring veterans with ALS and other catastrophic disabilities immediate relief, we are greatly disappointed that this provision has not been implemented. We urge the committee to intervene and correct this as quickly as possible.

Another section of the new law requires the VA to administer its Veteran Directed Care (VDC), Homemaker and Home Health Aide, Home-Based Primary Care, and Purchased Skilled Home Care programs at all medical centers within two years of the date of enactment of this legislation. Our members are very interested in VDC because it allows them to prioritize their own care needs and select their own care providers from their local communities. VDC is particularly effective in rural areas that have limited or no access to home health agency care.

According to the VA, VDC programs were established at all major VA facilities last year, but the feedback we have received from the field suggests some of them exist in name only. Some locations lack dedicated staff to manage the program, and insufficient funding often constrains the number of veterans who can participate in it at many others. We understand VA wants to expand VDC and enroll more veterans, but the department is having a difficult time finding agencies willing to participate in it. Unfortunately, this is a pretty common problem as many VA facilities do not have the appropriate Aging and Disability Network Agencies within their catchment areas to support veterans as they plan for and direct their long-term services and supports. VA is currently examining ways to execute Veteran Care Agreements (VCA) with alternative VDC providers. We encourage Congress to support these efforts and make sure VA has proper funding for the expansion of this important program.

Veterans with SCI/D also depend on VA's Bowel and Bladder program. SCI/D can significantly impact a person's quality of life, and neurogenic bladder and bowel dysfunction are crucial aspects of their care. These conditions affect many veterans with SCI/D and can lead to complications, re-hospitalizations, and mortality. Managing neurogenic bladder and bowel requires specialized attention, can be costly, often demands significant caregiver support, and is essential to veterans' health and well-being.

VA's Bowel and Bladder program is administered by VHA's SCI/D National Program office. Veterans with SCI/D who qualify for bowel and bladder care may receive that care through a home health agency, a family member, or an individually employed caregiver. The clinic of jurisdiction, or VA medical facility, authorizes bowel and bladder care under the Office for Integrated Veteran Care (IVC), to enrolled veterans with SCI/D who are dependent upon others for bowel and bladder care while residing in the community. Once designated caregivers successfully complete training from the VA, all necessary forms are forwarded to IVC for approval. Additionally, the caregiver must obtain a National Provider Identifier, complete a VCA, track the amount of time needed to perform the veteran's bowel and bladder care daily, and submit it along with a VA Form 10-314, Request for Payment of Bowel and Bladder Services, to be reimbursed.

The current program is fraught with challenges for caregivers and is unevenly applied across the VA. Timely reimbursement and the tax treatment of payments are the chief complaints of PVA members. Unlike virtually all other VA payments, including those provided through the Program of Comprehensive Assistance for Family Caregivers, Bowel and Bladder program reimbursements are taxable. Even family caregivers are considered federal contractors and must pay self-employment tax.

Another reason to make the Bowel and Bladder program a statutory requirement is that it fails to offer veterans due process. There is no formal notification to the veteran, caregiver, or the provider that a VCA agreement must be renewed. Hence, due to the lack of notification, veterans and caregivers continue to file monthly claims, but payments stop, and they don't know why. Getting the program reinstated is difficult and may result in the veteran losing their caregiver due to lack of payment. The whole process starts all over again, with the veteran having to find, train, and formally designate a caregiver which can take weeks or months to complete, putting the veteran with SCI/D at risk of not receiving timely care. Also, neither the veteran nor the caregiver is notified if they file a monthly claim that has errors or missing information. They simply don't get paid and it is up to them to find out why.

The Bowel and Bladder program is a life-sustaining program providing support to veterans with SCI/D. Codifying the program would allow Congress to finally resolve the tax burden and delayed payments for family members who perform bowel and bladder care. And because our members are the principal users of the program, we will seek ample opportunities to "shape" the program's language.

Most veterans with SCI/D also depend heavily on access to high quality wheelchairs and other assistive devices for their health and independence. Aside from lingering supply chain issues, most prosthetics-related concerns, with a few exceptions, have returned to normal following the pandemic. We now see minor delays in processing and receiving parts, equipment, and/or durable medical equipment.

The most significant delays we have seen recently involve VHA's national contract with Scootaround for the repair of VA-issued wheelchairs, powerchairs, and scooters. Because it has been challenging for the company to find enough dedicated vendors in certain parts of the country, veterans were waiting for sometimes a week or two to receive needed assistance. Veterans often end up returning to their VA medical center's Prosthetics Department to bypass the contractor and obtain the necessary parts and repairs directly.

Scootaround appears to be gradually resolving operational issues and improving service delivery. That said, in certain regions where Scootaround has consistently underperformed due to vendor shortages, many affected VA medical centers bypass the contractor and place orders themselves, resulting in more timely and effective service for veterans. We urge the committee to provide rigorous oversight of this rollout to ensure veterans' access to prosthetics, including needed repairs, is not delayed.

When considering the unique needs of veterans with SCI/D, it is important to note that not all such veterans receive their care through the SCI/D system. Specifically, some SCI/D centers do not provide treatment for veterans with amyotrophic lateral sclerosis (ALS) or MS. Veterans at these locations and elsewhere are likely to receive care through their medical center's neurology department.

Every VA medical center has an ALS Coordinator and about a dozen of VHA's clinics have been designated as Certified Treatment Centers of Excellence and Recognized Treatment Centers. To be certified as a center of excellence, an ALS clinic must meet rigorous clinical care and treatment standards, participate in ALS-related research and successfully complete a comprehensive site review. Providers at these locations possess a high degree of expertise in treating the disease because it is their sole focus. While VA is a leader in the delivery of care for ALS, a 2024 study by the National Academies discussed the importance of establishing an integrated, nationwide system of care and research for individuals living with ALS, as well as at-risk genetic carriers.[2] The study also recommended that, "Congress should allocate specific funding to create a VA network for ALS clinical care, research, education, and innovation to align with the new system of care outlined in this report."[3] We urge consideration of this recommendation.

Likewise, VA's MS Centers of Excellence (MSCoE), East and West, are gold standards of interdisciplinary MS care, research, education, and informatics. MSCoE East is at the Baltimore and Washington, D.C. VA medical centers. MSCoE West is jointly based at VA Puget Sound Health Care System in Seattle and the VA Portland Health Care System. Together, they coordinate the delivery of MS care via a national hub and spoke network. Each VISN has at least one MS Regional Specialty Program (RSP) that serves as a hub for MS specialty consultation, clinical care, and education within that region. RSPs provide MS specialized care, coordinate services across facilities, and support surrounding VA sites through consultations and telehealth. This network ensures nationwide access to care for veterans with MS. VA providers at each of these locations have specialized knowledge of service-related health concerns such as exposure to military hazards, PTSD, and other challenges that are unique to veterans. VA health care professionals are attuned to the cultural and psychological factors affecting veterans, providing a more

[2] National Academies of Sciences, Engineering, and Medicine. 2024. Living with ALS. Washington, DC: The National Academies Press. https://doi.org/10.17226/27739.
[3] *Id*. at 129.

supportive and understanding environment. MS healthcare in the VA is superior to the private sector due to its specialized focus, coordinated care, cost efficiency, and veteran satisfaction and veterans with MS should be made aware of its availability.

Finally, PVA is concerned about our members' access to inpatient mental health and substance use disorder (SUD) treatment, specifically, residential rehabilitation treatment programs (RRTP). While research is limited on the impacts of SUD for veterans with SCI/D, data suggests that individuals with SCI/D are disproportionately at-risk of SUD. Because of the risk factors associated with SCI/D veterans, it is critical that VA ensure they can engage in residential SUD programs tailored to at-risk veterans.

Significant medical comorbidities are also expected because of injury or trauma, which is especially true when discussing the lifecycle years beyond acute injury. These complexities make the holistic treatment of veterans with SCI/D critical for their independence and well-being. However, if a veteran needs help from a caregiver with an activity of daily living, they are unable to access RRTP, even within the VA.

Recently, VA provided a list of seven locations that would accept PVA members. However, after speaking with a social worker for one of the programs, it was brought to our attention that per VHA Directive 1162.02, the Mental Health Residential Rehabilitation Program,[4] no veteran with an additional nursing need is authorized for admission into an RRTP. In Section 3(d), the admission criteria for the program, clearly states that, a veteran must be "capable of self-preservation (ability to protect oneself from harm) and basic self-care (able to independently complete activities of daily living such as bathing, dressing without assistance, take medications, etc.)."[5]

Many of the most vulnerable and at-risk veterans are barred from accessing this critical program. One PVA member shared his experience of trying to access such treatment. During an intake call, a few days before his check-in date, he mentioned using a wheelchair. The nurse informed him that because he needed to use a wheelchair he wouldn't be able to participate in the program. This veteran struggled with an addiction to pain medication after sustaining an injury and he was ready to receive treatment. To be told that he was unable to receive the care he needed was devastating. Thanks to the love and tireless support of his wife this veteran finally freed himself from the addiction he struggled with but not without a cost. It strained his relationship with his wife, who was also his caregiver, and he lacked the mental health support to help him with his darkest thoughts, but he remains with us today and he hopes his story can help prevent another veteran from experiencing the same awful situation. We appreciate this committee's recent support of a pilot program to provide this type of care to veterans with SCI/D through VA's direct care system and urge its swift passage.

Chairman Moran, Ranking Member Blumenthal, and members of the committee, I would like to thank you once again for the opportunity to present our views on some of the most critical needs of PVA members. We look forward to continuing our work with you to ensure that veterans get timely access to high quality healthcare and all the benefits that they have earned and deserve. I would be happy to answer any questions.

[4] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program.
[5] *Id*.

ROBERT L. THOMAS JR.
PVA NATIONAL PRESIDENT & CHAIRMAN OF THE BOARD

"PVA has changed my life by introducing me to things that I believed to be over when I became injured, such as the National Veterans Wheelchair Games, and showing me that you can still live a fulfilling life although you have sustained a catastrophic injury."

Robert Thomas grew up in Cleveland, Ohio and played football and basketball. He enlisted in the U.S. Army shortly after graduating high school in 1987. Thomas served as a power generation equipment specialist at Fort Sill, Oklahoma; Camp Humphreys, South Korea; and Fort Bragg, NC. While on active duty, in 1991, Thomas had a diving accident that severed his fifth and sixth vertebrae. He was introduced to PVA through the Cleveland VA. PVA helped him navigate his new life by working to obtain his earned benefits through the VA and reintegrating him back into society through social outings with the recreational therapist.

Thomas joined PVA in 1993 as a member of the Buckeye Chapter of PVA in Ohio, and a little while later, began volunteering with the chapter. He took some time off to earn his associate degree in information technology and returned to the Buckeye Chapter of PVA board in 2010. He served as the chapter's vice president from 2012-2015, and as the chapter's representative on the national Field Advisory Committee and the Resolution Committee.

Thomas was reelected in May 2024 during the organization's 78th Annual Convention and began serving his second one-year term as President and Chairman of the Board on July 1, 2024. He initially joined PVA leadership at the national level in 2015 as the parliamentarian and was elected to serve on the Executive Committee in 2017.

Thomas continues to serve PVA because he wants to help lead the organization well into the future. "My inspiration to serve stems from PVA's past and present leadership," Thomas says. "Being a member for 30 years and seeing how unselfishly each leader, member, employee, and volunteer gives of themselves makes me want to continue to serve an organization that does so much for veterans and the disabled community."

In addition to serving as the President and Chairman of the Board for PVA, Thomas currently serves as the chair of PVA's Education Foundation. He was also appointed to the VA's Family Caregiver and Survivors Advisory Committee. Thomas and his wife, LaShon, live in Macedonia, Ohio. Thomas enjoys reading, watching sports, and playing adaptive sports like power soccer, bowling, air guns, and scuba diving.