They Protected Us. There's No Mechanism to Protect Them Back.

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A Positional White Paper on Mobile Integrated Healthcare – Community Paramedicine for Veterans in Northern Virginia

There is a particular kind of irony in military service: the men and women who spent their careers protecting others often come home to a healthcare system that asks them to do the protecting — navigating referrals, driving across the region for a single appointment, waiting on hold, explaining their history again to someone new. They gave their time, their bodies, and in many cases their peace of mind to defend this country. The least we owe them is a system that doesn't make *them* do the chasing.

This piece exists to say something plainly, because we think plain language matters more than polish on a problem like this: **today, there is no established mechanism — federal, state, or otherwise — to fund Mobile Integrated Healthcare – Community Paramedicine (MIH-CP) for veterans living in Northern Virginia.** The clinical model exists. The licensure exists. The need is well documented. What's missing is the funding architecture to connect the three. This is EMERGILITY®'s attempt to name that gap clearly, and to lay out our position on how it can be closed.

A Region Built Alongside Those Who Served

Northern Virginia is not incidental to military and veteran life — it is woven into it. More than 200,000 residents across our region carry a current or former service record, and roughly 168,000 of them are veterans, living alongside tens of thousands more currently serving on active duty or in the Guard and Reserve. Fairfax County alone is home to an estimated 82,000 veterans. Prince William County counts roughly 43,000. Arlington, Loudoun, the City of Alexandria, and the broader National Capital Region add tens of thousands more — a population shaped by proximity to the Pentagon, Fort Belvoir, Quantico, and the federal government and defense industry that surrounds them.

These are not veterans living in a "health care desert" in the way that term usually gets used. They live near major VA Medical Centers and some of the strongest hospital systems in the country. And that proximity is precisely why the access problem they face is so easy to overlook.

The Problem, Plainly Stated: A Care Model With No Funding Mechanism

The friction Northern Virginia's veterans experience isn't about distance to a state line or a lack of nearby facilities — it's the everyday math of getting to care: a primary care appointment that's technically available, but

weeks out and a 45-minute drive that becomes 90 in regional traffic; a specialty referral that requires a second trip across the Beltway; a scheduling system that assumes flexibility, transportation, and bandwidth a veteran managing chronic pain, mobility limitations, or PTSD-related institutional fatigue may not have. None of that shows up in a wait-time dashboard. It shows up as a missed refill, a skipped follow-up, a problem that was manageable at home and isn't anymore by the time someone finally gets seen.

Recent expansion of VA community care eligibility under the MISSION Act and PACT Act has made it easier, on paper, for veterans to receive care from non-VA providers when wait times or drive times exceed VA's own access standards. That progress is real. But it solves a narrower problem than the one Northern Virginia's veterans actually have. MISSION Act community care is built around *referrals to specific appointments* — a veteran is authorized to see a particular community provider for a particular specialty visit. It is not built around an ongoing, paramedic-led, in-home care relationship of the kind MIH-CP provides — the model isn't designed for proactive, preventive, relationship-based care; it's designed to fill a scheduling gap one visit at a time.

The deeper structural issue sits one layer further back. VA's primary funding engine for exactly this kind of home-based, paramedic-delivered model — the kind that brings a clinician to a veteran's kitchen table instead of routing them through a building — is the VHA Office of Rural Health (ORH). ORH was established by Congress in 2006 under 38 U.S.C. § 7308 with a mandate that is, by statute, scoped to veterans living in rural and highly rural areas. Its Enterprise-Wide Initiatives — Home Based Primary Care expansions, Mobile Prosthetic and Orthotic Care, mobile and tele-enabled chronic disease management — have meaningfully improved access for the roughly five million veterans who call rural America home. That is good and necessary work.

It also means there is no equivalent federal mechanism for the dense, suburban, traffic-bound veteran population of a region like Northern Virginia. A veteran in rural Appalachia and a veteran in Woodbridge can face strikingly similar barriers — distance, time, mobility, institutional fatigue — but only one of them lives in an area Congress has directed VA to build dedicated funding around. The other simply falls outside the architecture, regardless of how real the access gap is.

That is the gap this paper is naming: not a clinical capability gap, and not a population-need gap, but a **funding mechanism gap** — one shaped by a rural/urban statutory line that was never designed to account for a region like ours.

What Mobile Integrated Healthcare – Community Paramedicine Actually Is

Community Paramedicine (CP) is a segment of Mobile Integrated Healthcare (MIH) — a provider-led, patient-centered model that uses advanced-practice EMS-Clinicians to deliver care outside the traditional emergency department or clinic visit. Instead of the patient traveling to the system, the system travels to the patient: in the home, at work, or wherever makes sense for that person's life. At EMERGILITY®, MIH-CP is built around relationship, not transaction — physician-extension support, telemedicine, and direct-access Paramedicine (daP) woven into an ongoing care relationship designed to catch problems early and manage chronic conditions proactively, rather than waiting for a crisis to force a 911 call or an Emergency Department visit.

It is, in other words, almost exactly the kind of model ORH has spent two decades proving out for rural veterans. The clinical logic doesn't change because the ZIP code is suburban instead of rural. The funding logic, as currently constructed, does.

EMERGILITY®'s Position

We are a licensed Virginia OEMS Agency, not a federal funder or a policy body. We can't write Northern Virginia's veterans into ORH's statutory scope, and we won't overstate what we can do on our own. But we believe naming this gap accurately is the necessary first step toward closing it, and we're prepared to act on three fronts simultaneously:

Advocacy. "Underserved" should not be defined by rural geography alone. We intend to make the case — to the Virginia Department of Veterans Services, to our congressional delegation, and to VA stakeholders directly — that a high-density, high-veteran-population region with documented traffic, scheduling, and institutional-access friction deserves its own funding consideration, whether through a state-level grant mechanism, a regional demonstration pilot, or an expansion of how VA defines an underserved population for MIH-style programs.

Partnership. EMERGILITY® already holds the license, the clinical infrastructure, and the regional footprint to deliver MIH-CP today. What's missing is a funder willing to seed it. We are actively open to partnership with veteran service organizations active throughout Northern Virginia, county veteran assistance funds, philanthropic vehicles such as the Community Foundation for Northern Virginia's military and veteran funding programs, and the region's defense-sector employers — many of whom hire the same veterans this gap affects, and have a direct interest in their continued health and readiness.

A Bridge, Now. Structural funding takes time to build, and we don't think veterans should have to wait for policy to catch up before they have any path to this kind of care. While we pursue the advocacy and partnership above, EMERGILITY® can extend its existing direct-access Paramedicine and MIH membership model as a direct-pay or sponsored bridge — available now to individual veterans and families who want this relationship today, and structured so that a future grant, contract, or philanthropic partner could step in to sustain and scale it.

A Northern Virginia Scenario

Imagine a retired service member in his late 60s, living alone in Woodbridge, managing hypertension and a knee that never quite recovered from two decades of service. His nearest VA primary care appointment is weeks out. He doesn't drive well at night anymore, and fighting I-95 traffic for a 20-minute visit isn't worth the day it costs him. So he skips it. The medication refill lapses. Nothing happens — until, eventually, something does.

This is exactly the scenario MIH-CP was built to prevent: a Community Paramedic at the kitchen table instead, vitals and medication reconciliation handled without traffic or a waiting room, same-day telemedicine access to a provider who already knows his history. The clinical model to fix this story already exists. What doesn't yet

exist is the funding mechanism that gets it to him without him — or EMERGILITY® — paying for it entirely out of pocket. That's the gap. That's the work ahead.

Why Now, Why Northern Virginia

Northern Virginia is one of the fastest-growing regions in the country, and its veteran population — concentrated more densely here than almost anywhere else in Virginia — is aging into exactly the chronic-condition, mobility-limited stage of life where Community Paramedicine delivers the most value. At the same time, the region's notorious traffic, sprawling geography, and high cost of time make even "nearby" care feel out of reach for veterans without a flexible schedule. The need is not hypothetical, and it is not small. What's missing is the bridge between a proven care model and the population that needs it.

An Invitation, Not Just a Statement

We're publishing this as a positional paper rather than a service announcement because we don't think this gap gets closed by one EMS agency alone, no matter how ready that agency is. It gets closed by veteran service organizations naming the same problem, by county and state officials willing to look past a rural/urban funding line that was never built with Northern Virginia in mind, by philanthropic partners willing to seed a first pilot, and by employers in this region who understand that the veterans on their payroll deserve a healthcare experience that doesn't ask them to fight for the same thing they spent a career defending.

If you represent a veteran service organization, a county or state office, a philanthropic fund, or an employer in this region and want to talk about what closing this gap could look like, we want that conversation. And if you're a veteran or a family member who doesn't want to wait for that infrastructure to be built before you have access to this kind of care, we want to talk to you too.

EMERGILITY® is a Virginia-licensed Emergency Medical Services Agency (OEMS: 50537) providing Mobile Integrated Healthcare, direct-access Paramedicine, Protective Medicine, and EMS training throughout Northern Virginia.. To start a conversation about veteran-focused MIH-CP — as a partner, a funder, or a veteran seeking care — reach out to our team.