

911 Rescue Care

INSTITUTIONAL BRIEF

Global emergency transport, care delivery and continuity

October 4, 2026 | Draft V2 | For institutional review

Institutional mission

The mission of 911 Rescue Care is to strengthen access to emergency care through coordinated communication, transport and continuity between service providers. Its institutional framework addresses the operational gaps that prevent people from reaching appropriate care, particularly where transport, trained personnel and receiving facilities are limited.

The service vision encompasses ground and air networks, participation by private and nonprofit operators, workforce development, and cooperation with hospitals, public authorities and humanitarian partners. Development begins with documented access barriers and the capacity of existing services. Investment decisions follow evidence of demand, safety, sustainability and clinical value.

This brief establishes the institutional framework for review. Public research, education and partnership information can proceed within that scope. Dispatch, patient transport and clinical services require documented provider capacity, staffing, funding and operational authorization before activation.

Institutional alignment and service scope

911 Rescue Care sits within the Emergency Service Corps framework under United States Service Corps and United States University. Its working domain is 911rescuecare.com. Public information distinguishes the institutional initiative from official emergency dispatch and provides verified, location specific emergency access information.

Responsibilities are coordinated across three initiatives. 911 Physicians addresses professional capacity and education. 911 Rescue Care addresses transport and care delivery. 911 Safe Haven addresses supported passage for personal safety, with qualified providers determining when medical assessment or emergency transport is required.

Emergency Care Innovation at 911care.live and 911rescue.live provides a related preparedness foundation. Reuse of its planning and learning tools should preserve clear ownership, consistent service descriptions and efficient institutional coordination. Governance and legal relationships for the Emergency Service Corps division remain decisions for institutional approval.

Evidence and operational need

WHO’s 2025 prehospital guidance connects dispatch, medical control, protocols and handover within one emergency care system. Transport development therefore requires coordinated attention to communication, clinical decisions and receiving capacity alongside vehicles and aircraft. [1]

WHO’s 2025 Cameroon assessment estimated prehospital coverage at 25% and reported that fewer than one quarter of hospitals met basic functional emergency unit standards. These country specific findings support joint assessment of transport, receiving capacity, records, equipment and workforce readiness. [2]

Regional transport partnership

The pilot framework brings together a receiving hospital, licensed transport operators, an emergency care authority and a community partner within a defined region. Local demand, failed transfers and existing assets inform the operating design. Local leadership and integration with public emergency systems guide implementation.

Operational gap	Pilot responsibility
Unreliable access to existing services	Maintain a verified provider directory covering capabilities, hours, referral criteria, contact routes and review dates.
Incomplete receiving arrangements	Establish provider acceptance and a clinical handover route before planned transfers.
Air service disruption or unsuitable flight conditions	Maintain clinically approved ground alternatives, communications fallback and disruption exercises.
Unfunded readiness capacity	Evaluate transparent readiness payments alongside payment for appropriate completed transfers.
Fragmented operators and duplicated effort	Coordinate shared training, contracted standby coverage and use of existing licensed assets.

ASPR’s September 2026 Trauma Care Readiness and Coordination awards already support regional transfer and capacity coordination. The pilot must identify its specific contribution within the selected region and evaluate the added benefit to participating communities. [3]

Performance and accountability

Core measures include time to receiving acceptance, completed appropriate transfers, cancellations, failed contacts, handover quality, cost per transfer, patient cost burden and performance during disruption. Clinical outcome evaluation requires appropriate governance, consent and analytical methods. Aggregate reporting identifies denominators, limitations and operational lessons.

Ground and air service architecture

The operating model connects ambulance and emergency air services through defined agreements with qualified providers. Initial service delivery relies on licensed partner capacity. Assessment of an owned fleet addresses demand, financial sustainability, safety, maintenance and the availability of appropriate personnel.

Each service area requires documented boundaries, hours, dispatch relationships, medical direction, receiving facilities and escalation procedures. Agreements allocate clinical authority, aircraft control, costs, liability, incident reporting and review responsibilities. Continuity extends through acceptance, transport and handover.

Licensing and payment framework

United States air operations require the relevant FAA certification, aircraft compliance, personnel and insurance arrangements. Florida EMS operations additionally require applicable provider licensure and medical direction; prehospital services may require a county certificate of public convenience and necessity. [4, 5]

International operations require jurisdiction specific aviation, clinical, transport, border and insurance authorization. EASA's helicopter emergency medical service framework, for example, requires competent authority approval within the relevant operating structure. [6] Each participating country therefore requires its own operating assessment.

Medicare ambulance reimbursement depends on eligible services, patient circumstances, provider requirements, medical necessity and documentation. [7] Fleet financing and readiness costs require a separate financial model. Hospital contracts, public procurement, charitable support and patient payment arrangements must identify responsibility for costs and applicable billing protections.

Workforce development

The workforce framework establishes distinct pathways for pilots, communication personnel, physicians, nurses, paramedics, mechanics and logistics staff. Opportunity records identify prerequisites, training costs, service commitments and the responsible employer or regulator. Scholarship and placement announcements follow confirmed funding and administration.

Supervised simulation, observation and research broaden participation for students and early career professionals. Flight and clinical assignments require the relevant licenses, qualifications, supervision and privileges. Transport education and research offer additional routes for medical participation alongside formal flight medicine appointments.

Training cooperation and continuing readiness

The Yellow Ribbon Hospital framework connects transport and communication planning with civilian and military exercises, clinical learning and workforce development. Military participation, equipment support, training authority and liability allocation require formal agreements identifying the duties of each institution.

Exercise priorities include mass casualty arrivals, loss of communications, weather disruption, maternal transfer and continuity after handover. Hospital, transport and public authority partners define competencies, assess performance and maintain corrective action records. Educational attendance and operational qualification are recorded separately.

FEMA learning and provider records

FEMA Independent Study provides free introductory learning. The recommended sequence comprises IS 100.c, IS 700.b, IS 200.c and IS 800.d. At review, FEMA directed IS 800 learners to National Response Framework reading while its interactive course was unavailable. [8, 8a]

The readiness register records course code, version, completion date, certificate and employer or Authority Having Jurisdiction requirements. FEMA does not issue a single NIMS certification. Medical, EMS and aviation credentials, clinical privileges, continuing education and role specific refresher requirements retain their separate authority. [9]

Emergency Medicine Beyond Earth

Research coordination with 911 Physicians addresses emergency care in space travel and microgravity. NASA's existing medical training and emergency procedures provide an established foundation. [10] The institutional contribution focuses on defined problems involving constrained evacuation, supplies, communication and crew capability.

The research agenda includes delayed communication, remote decision support, patient movement and evacuation planning. NASA's exploration communications work identifies the effects of delay and constrained communication on medical operations. [11] Publications, simulation and interdisciplinary education constitute the development scope; operational space rescue requires separate mission capability and authorization.

Public learning

Age appropriate programs explain ambulance systems, emergency communication, aviation and the roles of care teams. Supervised simulations introduce responsible helping and service careers. Clinical procedures, oxygen administration and aircraft operations remain subject to the qualifications and supervision required for those activities.

Funding and implementation readiness

Funding development centers on a defined regional pilot with eligible institutions and measurable outcomes. Coordination staff, training, assessment and partner agreements form a distinct budget from aircraft acquisition and operation. Each funding request requires an approved scope, cost model and accountable lead institution.

Route	Status on October 4 2026
ASPR Hospital Preparedness Program	Continuation funding operates through jurisdictions and coalitions. Seek an approved partnership for exercises and coordination. [12]
CMS Rural Health Transformation	State awards are active for fiscal years 2026 through 2030. Align the pilot with an approved state rural workforce or emergency service plan. [13]
HRSA rural network development and planning	FY2027 opportunities are forecasted. Prepare network governance and needs evidence against the final notices. [14, 14a]
ASPR Trauma Care Readiness and Coordination	The 2026 competition closed; four awards were announced September 30. Assess collaboration with current recipients and subsequently announced competitions. [3]
Hospital and philanthropic support	Develop scoped service contracts and funding requests. Partner commitments, tax treatment and pricing require verification.

Digital delivery and research

The website follows the existing Global Neuroscience interface, using the shared USSC shield and star header after design approval. Content covers mission, transport systems, air care, training, partnerships, country resources, focused PubMed search and an evidence register. External opportunities carry review dates and responsible organizations. Mobile readability, consistent page titles and working links form the publication standard.

Global language access requires documented coverage and qualified review of critical clinical and transport information. Operational systems for dispatch, patient information and capacity coordination require their own staffing, governance and technology approval. Cloudflare infrastructure remains part of the later portfolio technology decision.

Institutional decisions and production sequence

Review establishes the care delivery mission, responsibilities across the three initiatives, initial region, lead institution and priority access gap. The operating decision addresses partner capacity before any owned fleet. Brief approval precedes the executive summary and V1 website review. Parent USSC updates follow approval of the division and shared institutional identity.

Source register

References support the numbered findings in this brief. Research and funding status reflect the October 4, 2026 review. Program frameworks, pilots and operating responsibilities are institutional development recommendations. This revision refines the institutional language while preserving the evidence record.

- [1] **WHO.** [Prehospital emergency care guidance 2025](#)
- [2] **WHO Regional Office for Africa.** [Cameroon emergency medical services assessment 2025](#)
- [3] **ASPR.** [Trauma Care Readiness and Coordination Program](#)
- [4] **Federal Aviation Administration.** [General requirements for Part 135 certification](#)
- [5] **Florida Department of Health.** [EMS service provider licensure](#)
- [6] **European Union Aviation Safety Agency.** [Air Operations rules including SPA HEMS 100](#)
- [7] **Centers for Medicare and Medicaid Services.** [Ambulance service coverage and documentation](#)
- [8] **FEMA.** [IS 800 course status and framework learning](#)
- [8a] **FEMA.** [Get Started and free Independent Study courses](#)
- [9] **FEMA.** [NIMS resources and qualifications](#)
- [10] **NASA.** [Medical training requirements](#)
- [11] **NASA Technical Reports Server.** [Challenges in Communications for Exploration Class Missions](#)
- [12] **ASPR.** [FY2026 Hospital Preparedness continuation guidance](#)
- [13] **CMS.** [Rural Health Transformation](#)
- [14] **HRSA via Grants.gov.** [Rural network development forecast](#)
- [14a] **HRSA via Grants.gov.** [Rural network planning forecast](#)