LOS ANGELES FIRE DEPARTMENT

JAIME E. MOORE
FIRE CHIEF

October 21, 2026

BOARD OF FIRE COMMISSIONERS
FILE NO. 26-055

TO: Board of Fire Commissioners

FROM: Jaime E. Moore, Fire Chief

SUBJECT: RESPONSE TO EXECUTIVE DIRECTIVE NO. 22 — LOW-ACUITY AND NON-EMERGENCY CALLS FOR SERVICE

FINAL ACTION:	_____ Approved	_____ Approved w/Corrections	_____ Withdrawn
	_____ Denied	_____ Received & Filed	_____ Other

SUMMARY
This report serves as a response to Mayor Karen Bass's Executive Directive No. 22 (ED22), issued September 29, 2026, focused on Los Angeles City Fire Department (LAFD) responses to low-acuity and non-emergency calls for service. ED22 requests that the Board of Fire Commissioners direct the Department to evaluate five areas and develop a communications plan. Each is addressed below in the order presented in the directive.

RECOMMENDATION
That the Board:
Approve and transmit the report to the Mayor.

DISCUSSION
As with most municipal fire departments, requests for emergency medical services (EMS) account for the majority (84%) of LAFD's incidents. The Department provides emergency medical dispatch, on-scene assessment and treatment, and ambulance transportation when appropriate. LAFD's responsibility is to ensure that individuals requesting emergency medical assistance receive an appropriate response while maintaining sufficient resources to respond to other emergencies throughout the City. As ED22 notes, "a structured low-acuity system can reduce avoidable resource utilization without eliminating emergency access for patients whose symptoms warrant it." The LAFD has operated such a system for several years, and this report describes those efforts and the steps needed to expand them.

People call 911 and request EMS resources for conditions that do not, at least on a superficial level, obviously meet the strict definition of a bona fide medical emergency. Consequently, there is considerable discussion about the appropriate use of EMS for seemingly low-severity issues. The LAFD approach to these requests is based on the

following factors:

- Most people requesting EMS do not know the underlying cause of their symptoms and can only report a vague complaint (e.g., "abdominal pain"), which could indicate a wide range of potential causes with varying degrees of severity. Even seemingly minor complaints occasionally turn out to be early indications of serious emergencies. If a person is concerned enough to request EMS, they should normally receive a thorough evaluation by a licensed professional.
- Further complicating the situation are patient-specific factors, including age and preexisting medical conditions, which can significantly influence the severity and consequences of a medical complaint. A condition that poses little risk to one patient may present a substantial threat to another. A patient with a low-acuity condition may still have a legitimate need for assistance if they also face mobility challenges or other individual vulnerabilities.
- In the context of dispatching, the LAFD uses the terms "emergency" and "non-emergency" to distinguish between driving *with* emergency warning devices activated ("lights and sirens") and driving *without* them. Research has consistently demonstrated that the use of lights and sirens increases the risk of traffic collisions. Accordingly, emergency warning devices are reserved for situations where shaving a few minutes of travel time could make a significant difference in patient outcomes. For many patients, the nature of their condition may constitute a medical emergency, but the marginal time saved by using lights and sirens is unlikely to meaningfully affect their outcome. In these cases, the increased risk of a traffic collision while driving "emergency" outweighs the potential benefit of a faster response. In 2025, the LAFD dispatched 4.4% of EMS calls as non-emergency. While "non-emergency" describes a mode of driving without emergency warning devices, it is not a reference to the legitimacy of the patient's medical needs.
- While ED22 questions the use of LAFD resources as a "ride-share," LAFD resources are not used to provide routine transportation to medical appointments. LAFD ambulances operate within the 911 EMS system and follow Los Angeles County EMS Agency patient-destination policies, including Reference No. 502, under local EMS agency authority described in California Health and Safety Code Section 1797.220. LAFD ambulances only transport EMS patients to authorized medical receiving facilities, which consist of hospital Emergency Departments and a small number of alternative destinations (e.g., Psychiatric Urgent Care Centers). While some patients may request EMS transport to an Emergency Department because they lack access to primary care, the LAFD does not transport patients to scheduled appointments.

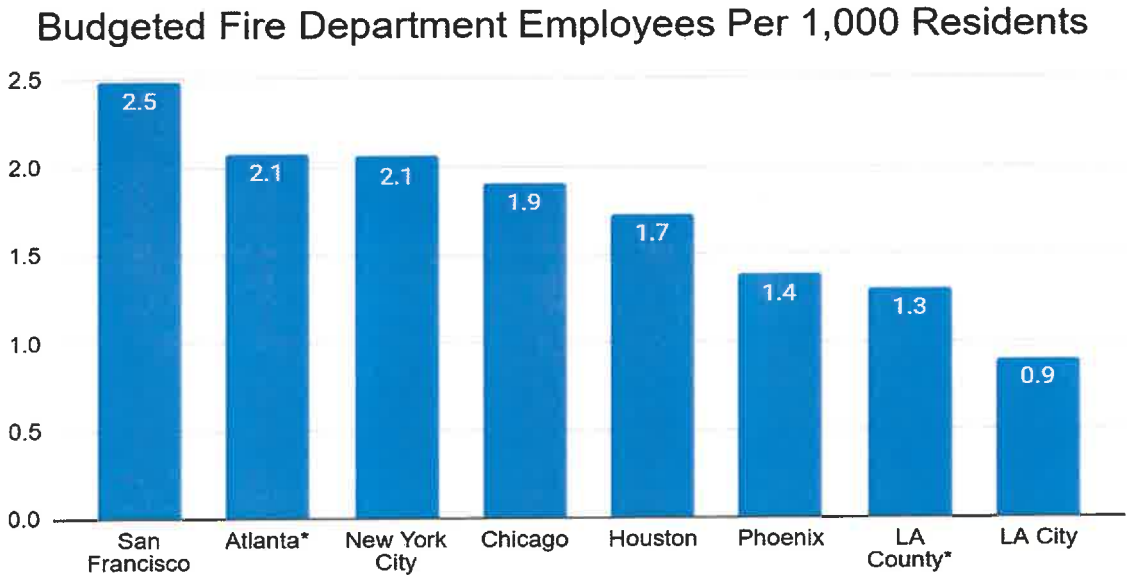
1. Evaluate the LAFD's dispatch protocol, including current policy for responding to non-emergency calls for services by call type, and collections generated from the fee structure

Dispatch Protocol and Call Types

EMS requests do not fall neatly into emergency and non-emergency categories. Like EMS providers across the country, the LAFD receives requests for EMS services that span a broad continuum of severity levels. These EMS requests range from immediately life-threatening emergencies requiring rapid medical intervention to minor complaints and requests for assistance that may not require EMS resources at all.

Historically, most EMS systems have relied on relatively standardized response models, typically dispatching a "first response" fire apparatus and a transport-capable ambulance to address the broad spectrum of medical emergencies. In addition to getting an EMS resource on scene quickly, a standardized EMS response guarantees a sufficient number of responders for any type of patient.

A significant drawback to a standard EMS response model in a busy metropolitan system like the LAFD is that consistently sending two resources (an ambulance and a fire apparatus) to every EMS request quickly depletes the resources available in each neighborhood. Preserving emergency response resources is especially important for the LAFD, which operates with fewer Department employees per capita than other major fire departments, as shown in the following graph. This comparison uses total budgeted staffing to account for differences in how departments classify EMS providers, dispatchers, inspectors, and other specialized personnel. This relatively lean staffing model makes the continuous pursuit of efficiency essential for the LAFD.



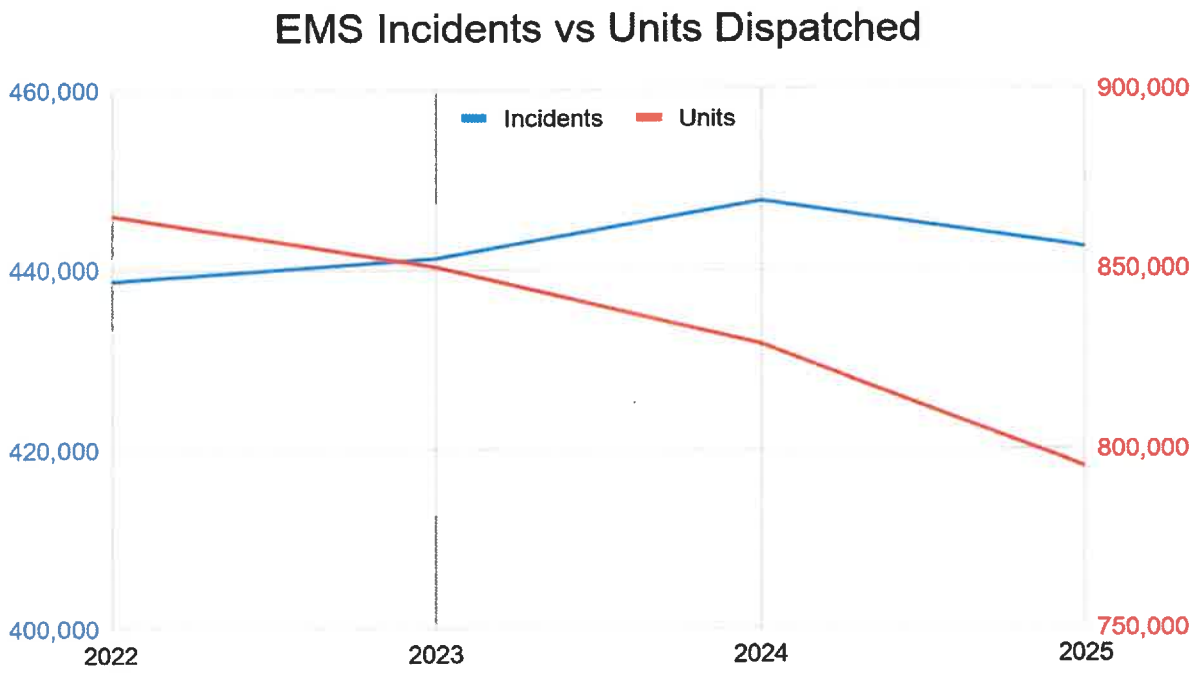
*supplemented with private ambulance employees

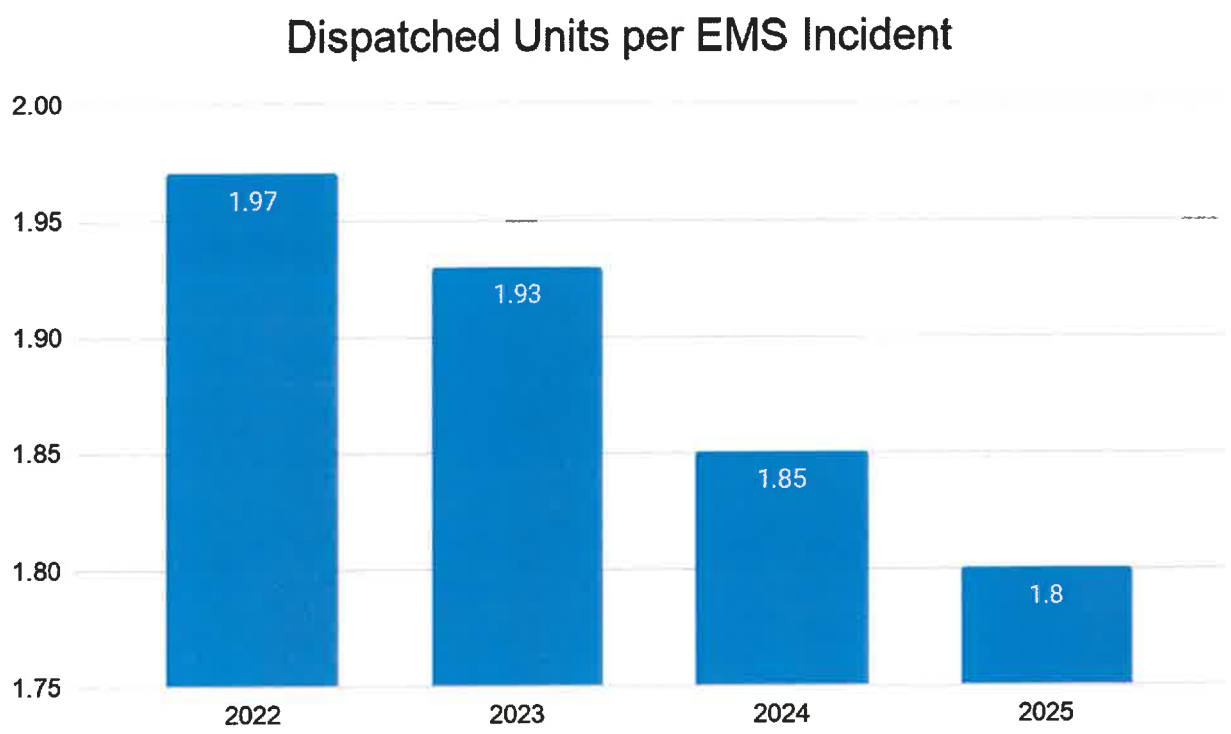
In order to keep EMS resources available for the most severe emergencies, the LAFD

has implemented the Tiered Dispatch System (TDS), in which the level of EMS response is commensurate (i.e., "tiered") with the potential severity of an EMS requestor's complaint. The TDS was specifically developed to address the unique challenges of the LAFD service area, and it is continuously being evaluated, refined, and improved based on local feedback and national trends.

In the TDS model, the Department's Medical Director categorizes EMS call types into hierarchical risk categories based on their potential to present an immediate life threat. Each risk category is linked to a corresponding dispatch algorithm, which determines the appropriate resources to send (i.e., "unit assignment") based on incident location and resource availability. Higher risk algorithms activate an Advanced Life Support (ALS) response and multiple resources, while the lower risk algorithms only require a Basic Life Support (BLS) response by a single resource.

With the support of Captains assigned to the EMS Bureau's Dispatch Support Section, the LAFD Medical Director continually evaluates the categorization of each TDS call type to ensure the appropriate response is sent. Over the past four years, these recurring evaluations have resulted in dispatch modifications that reduced the number of resources being sent to many EMS call types. The number of EMS incidents remained relatively consistent from 2022 to 2025 (increasing by 0.8%), while the number of units dispatched to EMS incidents was reduced by 8.1%. The number of units per EMS incident declined from 1.97 to 1.80. The following graphs demonstrate the reduction in unit dispatches while the number of EMS incidents remained relatively constant. Without the active work to improve the dispatch algorithms over the past four years, more than 70,000 additional units would have been dispatched to EMS incidents in 2025 alone.





Ideally, the dispatch process would result in a unit assignment that perfectly matches each patient's specific needs. However, it is not possible to precisely determine each patient's actual severity during the rapid intake of a 911 call. Any tiered system will send more than is needed to some calls (overtriage) and less than is needed to others (undertriage). Because undertriage and the associated consequences are significantly more dangerous, the TDS is designed to avoid it, which means some overtriage is unavoidable. Without proper context, overtriage can cause LAFD members to lose confidence in the dispatch system. This confidence can be strengthened through education that explains why seemingly excessive responses are sometimes the result of appropriate dispatch decisions. Helping members understand the limitations of information available at dispatch and the importance of balancing efficient resource utilization with patient safety can reinforce trust in the system.

Collections Generated by Call Type

The City of Los Angeles uses a "full cost recovery" model to set the ambulance fees, meaning the fees are set at levels meant to make the service cost-neutral to the City. Based on a cost analysis, the Los Angeles Administrative Code 22.210.2(b) sets the City's ambulance transport fees (Attachment A). These prices are based on the full cost of operating the LAFD EMS system, including ambulance staffing and equipment, a portion of the fire resources, and relevant overhead costs (dispatch, mechanics, training, etc.). Most ambulance transports are not reimbursed at the full Admin Code 22.210.2(b) rates, because the vast majority (~75%) of LAFD's EMS patients use Medicare or Medi-Cal insurance. Regardless of the rates set by the City, Medicare or Medi-Cal rates set their own reimbursement rates. Even with the limited

reimbursements paid by Medicare and Medi-Cal, the LAFD's ambulance transport fees generate over $210 million in gross collections for the City annually.

Fees are currently collected only when patients are transported by LAFD ambulance. The City of Los Angeles does not charge a fee for EMS services if a patient is not transported. While it would be legal for the City to add a non-transport fee, the full cost recovery model would require the City to decrease the transport fees accordingly. According to statute, the City cannot charge fees that exceed the actual cost of providing the service. Repeated analyses of the City's fee structure have determined that the City would actually see an overall *decrease* in ambulance billing collections if the fee structure was shifted to include non-transport fees. One significant reason why non-transport fees would be unproductive is because Medicare does not reimburse EMS providers for responses that do not result in transport, and Medi-Cal reimburses these responses at a significantly lower rate.

2. Evaluate calls identified with Nurse Practitioner designations to review whether facilities with trained staff and access to medical providers can use clearer clinical criteria for emergency 911 activation versus non-emergency medical transportation

NP Designations

The use of "NP" designations in some TDS codes is not a reference to Nurse Practitioners. In this context, "NP" is a two-character abbreviation for "inpatient" and applies to facilities such as convalescent homes and nursing homes, skilled nursing facilities, and inpatient rehabilitation facilities. These codes are not utilized for doctor's offices/clinics, jails, assisted living facilities, or dialysis centers. The purpose of the inpatient TDS card is to accommodate the medical terminology that is often used when inpatient facility staff contact 911.

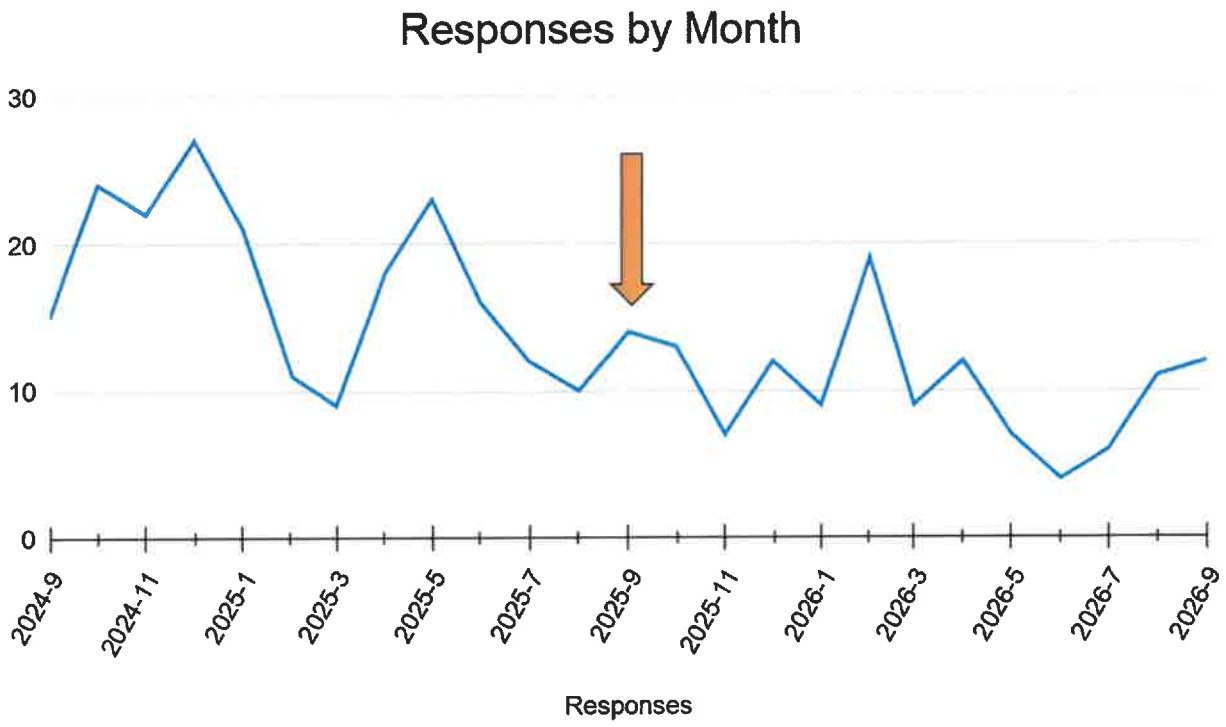
Facility Responses

Every resident at an inpatient facility is there because of a limitation that prevents them from living independently. Consequently, it should be expected that these residents are more likely than the general population to require an EMS response. However, it is also the responsibility of the facilities housing these vulnerable populations to ensure that sufficient staff are available to meet their residents' basic needs. The staff should be adequately trained and equipped to assist residents with routine lift assistance and transfers, without the need for emergency services, as long as the resident is not injured or experiencing health concerns.
Most inpatient facilities provide their residents with appropriate care and take steps to minimize their impact on the EMS system. However, some facilities request EMS at excessive rates and create a disproportionate burden on the system.

Facility Interventions

The LAFD utilizes EMS Battalion Captains as liaisons to healthcare facilities, including hospitals, skilled nursing facilities, and residential care facilities. When LAFD members identify facilities that may be using emergency medical services

inappropriately, EMS Captains intervene to educate facility staff on the appropriate use of 911 and available non-emergency medical transportation options. When education and collaboration fail to resolve ongoing concerns, referral to the appropriate licensing or regulatory agency may be warranted.
The graph below illustrates the effectiveness of this approach at one facility. LAFD members reported concerns regarding excessive 911 utilization and inadequate communication of patient information. In September 2025, the EMS Battalion Captain and LAFD Medical Director met with facility leadership to provide education and establish clear expectations for requesting emergency transportation and communicating patient information.



Following the intervention, the facility's average monthly EMS requests decreased from 17.25 to 10.1 requests per month, a 41% reduction between the 12 months preceding the intervention (orange arrow) and the subsequent 12 months. LAFD members also reported substantial improvements in communication during subsequent responses. Building on this success, LAFD has incorporated the intervention strategies into EMS Captain training and is applying them at other facilities with disproportionately high EMS utilization. While there is currently an EMS Captain assigned to each of the 14 Battalions, only eight of the Battalions have EMS Captains available on a platoon-duty basis. Upgrading the remaining Battalions will improve the level of intervention these officers can provide.

3. Evaluate current dispatch criteria to determine if a "no send" category can be created.

A "No LAFD Send" dispatch category currently exists, and the Department has expanded it significantly over the last two years. Now more than ever, the LAFD is referring calls to other City Departments and civilian response teams.

Existing Dispatch Practices
LAFD continually evaluates its dispatch protocols to identify calls that can be safely managed without sending fire or EMS resources. The Department currently refers certain non-emergency requests, including bees, snakes, minor flooding, leaking hydrants, lockouts, and downed trees, to appropriate City departments or service providers. Certain poison exposure calls may also be resolved through consultation with Poison Control without dispatching an LAFD resource.
These referrals reduce unnecessary responses while ensuring callers receive appropriate assistance. When LAFD identifies a potential medical emergency or life-safety hazard, it continues to dispatch the necessary resources.

Unarmed Model of Crisis Response (UMCR)
Some individuals call 911 for behavioral health or social service needs that do not require an emergency medical response. Through its partnership with the City's Unarmed Model of Crisis Response (UMCR), LAFD can defer eligible calls to trained unarmed crisis response teams rather than dispatching firefighters or paramedics.

Metro Fire Communications (MFC) currently screens for five eligible call codes through the Department's Tiered Dispatch System (TDS). When established medical and safety criteria are met, calls may be deferred to UMCR, providing an existing "No LAFD Send" pathway while ensuring callers receive assistance.

Calls involving potential medical emergencies, unresponsiveness, active self-harm risk, or scene hazards remain with LAFD for an appropriate emergency response.

Current Results
LAFD's partnership with UMCR has been highly effective. Since the partnership began in a single LAPD division in September 2025, more than 2,100 calls have been deferred, connecting callers with crisis services while keeping firefighters and paramedics available for emergencies. UMCR expanded to nine LAPD divisions in May 2026. Increased coverage, dispatcher training, and familiarity with the referral process have also contributed to greater utilization.

Projected Expansion
UMCR is expected to expand into six additional LAPD divisions over the next six months, increasing coverage to 15 of the City's 21 divisions. Based on a sustained 60% deferral rate for eligible call types, the following annual reductions in LAFD responses are projected:

UMCR Coverage	Estimated Annual Deferrals
Current nine divisions	3,830
With six additional divisions (April 2027)	6,390
Future citywide coverage (21 divisions)	8,940

Expansion to 15 divisions could result in approximately 6,400 annual deferrals, nearly doubling the current annualized rate. Full citywide coverage could eventually increase deferrals to approximately 8,900 annually.

These projections assume comparable call volumes across service areas and a sustained deferral rate. Actual results will depend on the timing of expansion, dispatcher utilization, and call eligibility.

Additional Opportunities

The LAFD is evaluating dispatch system enhancements that would allow lower-priority calls to be queued until an appropriate resource becomes available, as well as a re-bidding functionality in the computer-aided dispatch (CAD) system to reassign calls when a closer resource becomes available. Additionally, the Department is exploring the reintroduction of telemedicine to assist with the evaluation and disposition of lower-acuity medical calls. Any expansion of alternative response or No LAFD Send criteria would require appropriate medical oversight, established screening protocols, and safeguards to ensure patient safety.

4. Evaluate the need for an increase or new fees for certain non-emergency calls.

The LAFD proposes evaluating fees for three incident categories: automatic alarms, elevator incidents, and non-emergency lift assists at licensed care facilities.

False Alarm Fees

The Department previously pursued a False Fire Alarm Program intended to recover response costs and generate additional revenue. Although the City adopted Ordinance No. 188013 in 2023, the program was not implemented. An earlier proposal included provisions allowing the fee for an initial false alarm to be waived upon completion of an educational program. Such exemptions could reduce potential revenue while the Department would still incur costs associated with billing, tracking incidents, and administering the program. Additionally, changes to automatic alarm dispatch protocols have substantially reduced LAFD responses, from 33,477 incidents in 2023 to 17,975 in 2025, a 46.3% reduction. Given this decrease, the Department would need to determine whether anticipated revenue would justify the administrative and operational costs of implementing a fee collection program.

Elevator Rescues

Elevator incidents represent another potential opportunity for cost recovery and additional City revenue. LAFD responded to 4,751 elevator incidents in 2023, 5,139 in 2024, and 5,397 in 2025, representing a 13.6% increase over the three-year period. A proposed fee would assess building owners for qualifying LAFD responses to elevator-related incidents. Further analysis would be necessary to establish appropriate billing criteria, determine legal authority, and evaluate anticipated revenue and administrative costs. Consideration would also need to be given to incidents involving emergency rescue or medical assistance to ensure that any proposed fee structure does not discourage requests for necessary emergency services.

Lift Assist Fees

A third category for evaluation is non-emergency "lift assists" at licensed care facilities, including skilled nursing and residential care facilities. LAFD proposes evaluating a fee for requests involving routine patient lifting or transfers that do not require emergency medical care. Such requests place demands on emergency resources for services that should ordinarily be provided through facility staffing and equipment.

The proposed fee would encourage facilities to maintain adequate staffing and appropriate lifting equipment while allowing the Department to recover costs associated with non-emergency assistance. Incidents involving injury, illness, suspected medical emergencies, or the need for emergency evaluation or treatment would be excluded. Emergency responses would continue without delay.

However, the relatively low incident volume may limit the financial viability of a separate billing program. LAFD dispatched 91 nursing home lift-assist incidents in 2023, 128 in 2024, and 118 in 2025. The Department would need to evaluate potential revenue, administrative costs, and impacts on emergency resource availability to determine whether implementing a fee would be operationally and financially justified.

Prior to implementation, LAFD would coordinate with the City Attorney and appropriate City offices to establish legal authority, billing criteria, exemptions, and necessary approvals, supported by a cost-of-service analysis. Affected facilities would receive advance notice explaining the fee, their responsibilities, and options for reducing unnecessary requests. Billing would occur only after the response and review of incident documentation.

If implemented, LAFD would monitor repeat requests, cost recovery, resource availability, and potential impacts on resident safety. The proposal would support the directive's objective of reducing non-emergency demands on LAFD resources while preserving access to emergency medical services. Any fee program would remain subject to legal review and City approval.

5. Make recommendations for additional resources, such as the Advanced Provider Response Unit program and Fast Response Vehicles, as these resources can triage calls and keep engines and trucks available to respond to emergencies.

The LAFD recommends expanding EMS staffing classifications, new Advanced Provider Response Units (APRUs), additional Fast Response Vehicles (FRVs), and restoring the high-utilizer program. These programs improve EMS system efficiency, match resources to patient needs, and preserve engines, trucks, and ambulances for emergencies. The Department has prioritized APRUs and FRVs in its current budget requests to sustain existing services and support expansion.

This approach aligns with the 2023 Standards of Cover, in which Citygate concluded that "the alternative response program needs to scale massively and quickly to lower the workload placed on fire units back down to moderate and serious emergencies." The report identifies a citywide need for 26 alternative-response units.

Expand EMS Staffing Classifications

To address the undersized LAFD workforce and expand EMS capacity, the Department recommends establishing new civil service classifications for Ambulance Operators and Firefighter/Paramedics. Hiring EMTs and paramedics as Ambulance Operators would provide a dedicated workforce for ambulance staffing, allowing the Department to increase the number of ambulances serving the City while preserving firefighter staffing for fire suppression and other emergency responsibilities. The Ambulance Operator classification could also serve as a recruitment pipeline for future firefighters, giving prospective candidates relevant field experience and familiarity with Department operations.

A dedicated Firefighter/Paramedic classification would allow the Department to selectively recruit and hire firefighter candidates who already hold a paramedic license. This would supplement the Department's internal paramedic training pipeline, reduce the time and expense required to develop additional paramedics, and help align hiring with ALS staffing needs. Together, these classifications would provide greater flexibility to expand EMS coverage and deploy personnel according to their qualifications and the needs of the public.

Advanced Provider Response Units

The LAFD has pioneered deploying Advanced Providers in EMS. Beginning in 2015 with a single provider working business hours, the program has grown, based on its success, to five APRUs serving the City seven days a week, 12 hours a day. Each unit pairs a Nurse Practitioner or Physician Assistant with a Firefighter/Paramedic to provide advanced assessment, treatment, and triage in the field.

APRUs treat patients on scene, including those who frequently access the 911 system, and connect them with appropriate follow-up care. These capabilities help reduce unnecessary ambulance transports and emergency department utilization while allowing

engines, trucks, and ambulances to return to service sooner when clinically appropriate. Sustained funding is needed for specialized diagnostic equipment, medical supplies, electronic prescribing, and taxi vouchers that connect eligible patients with clinics and other appropriate care destinations.

The EMS Bureau's expansion proposal recommends fully funding existing operations, including the LAWA-funded AP51 at LAX, and adding 18 community-based units. This would establish a robust AP program supported by permanent staffing, clinical supervision, equipment, vehicles, and recurring operating funds.

Fast Response Vehicles
The LAFD has deployed FRVs to supplement existing resources in the busiest parts of the City. FRVs pair a Firefighter/Paramedic and a Firefighter/EMT to provide rapid EMS assessment, initial treatment, and triage in the field. FRVs have improved resource efficiency by keeping engines and trucks available for emergencies that require heavy fire apparatus. In addition to their critical role at EMS incidents, FRVs have the ability to handle rubbish and encampment fires, which are the LAFD's most common incident type at ~33,000 incidents per year. The LAFD has requested funding to add at least 12 fully staffed (platoon duty) FRVs to alleviate the workload of the City's busiest resources.

High-Utilizer Program
The Department recommends staffing a dedicated high-utilizer program to address the underlying needs of patients who repeatedly access 911. A nine-month pilot version of this program demonstrated a significant reduction in 911 usage by some of the Department's most frequent callers. In this program, a coordinated team identifies eligible patients, conducts individualized assessments, develops care plans, and connects patients with primary care, behavioral health treatment, substance use services, housing support, and other community resources. Candidates for the high-utilizer program are identified through medical records or based on referrals from field resources.

While APRUs and FRVs address immediate needs after a 911 call is made, the high-utilizer program has the ability to provide preventative services, with continuing case management and follow-up intended to reduce avoidable repeat calls. Dedicated staffing and partnerships are necessary to maintain this work without reducing daily emergency response coverage. The Department requests dedicated staffing and funding for this program. The program will measure patient outcomes, repeat EMS use, resource cancellations, unnecessary transports avoided, response times, and engine, truck, and ambulance hours returned to service.

Communications plan about the appropriate use of the 911 system

The LAFD communications plan about the appropriate use of the 911 system and alternative resources can be found in Attachment B.

CONCLUSION

The LAFD has an ethical and moral duty to serve the people who request our help with respect and compassion, as well as a legal responsibility to fulfill our emergency response obligations with professionalism. These responsibilities include requests for assistance that may not involve an immediately life-threatening emergency. A low-acuity complaint can still represent a legitimate need, and patients should receive an appropriate response. At the same time, the Department must maintain sufficient emergency resources to respond promptly to the most urgent incidents throughout the City.

These responsibilities are complementary. Referring eligible calls to other agencies and service providers can connect people with assistance better suited to their needs while keeping fire and EMS resources available for emergencies. Targeted interventions with individuals who frequently access 911 and facilities with disproportionately high EMS utilization can address underlying needs, improve care coordination, and reduce avoidable repeat requests. The goal is to ensure that people receive appropriate help while reducing reliance on emergency resources when other services can safely and effectively meet their needs.

The Department has made measurable progress through refinements to its Tiered Dispatch System, alternative response partnerships, and care facility interventions. Building on this progress will require sustained support for Advanced Provider Response Units, Fast Response Vehicles, and a dedicated high-utilizer program, together with improved dispatch technology and public education. With appropriate staffing, funding, medical oversight, and ongoing evaluation, these efforts can strengthen the Department's service to the public and improve the availability of emergency resources for incidents where rapid intervention matters most.

Board report prepared by Deputy Chief Timothy Wuerfel and Battalion Chief Matthew Conroy, Emergency Medical Services Bureau.

Attachments

Attachment A

Sec. 22.210.2. Reimbursement for Rendering Emergency Ambulance and Helicopter Service.

(a) The Fire Chief is authorized and directed to charge and receive reimbursement for City expenses incurred in rendering emergency ambulance and helicopter service to any patient at the rates set forth in this Article. These rates charged by the City for rendering emergency service represent in each instance only a full or partial recovery of, and do not exceed, the City incurred costs in providing these services.

(b) **Schedule of Charges for Emergency Service.**

Emergency Ambulance Service Rendered By City Personnel	Charges
Basic Life Support Fee, Each Patient	$1,862.00
Advanced Life Support Fee, Each Patient	$2,915.00
Mileage One Way - Per Mile	$29.00

(c) Notwithstanding the above schedule, the Fire Chief shall have authority to set rates for providing ambulance and helicopter transport services to members of pre-paid health plans for the purpose of providing patients transportation directly to a designated hospital.

(d) Any patient receiving emergency ambulance service, the fees for which are not covered by and reimbursable from a policy of insurance, shall be exempt from the payment requirement if that patient qualifies for low-income status. A patient qualifies for low-income status if the combined gross income of all members of the household in which that patient resides is at or below the levels established by or thereafter adjusted by the Board of Water and Power Commissioners of the City of Los Angeles, consistent with standards established by the State Public Utilities Commission for low-income subsidies, in determining eligibility for low-income subsidy credits and reduced rates for electrical and water service to residential households. For purposes of this Article, “gross income” includes all revenues from whatever source, whether taxable or nontaxable.

(e) The Fire Chief in cooperation with the Office of the City Administrative Officer shall at intervals of not more than one year review the schedule of charges and recommend to the City Council any changes or modifications in the charges set forth in this Section, provided that the following patients shall not be charged for emergency ambulance and helicopter services:

i. arrestees and persons incarcerated in the City or County jails; or

ii. City employees suffering illness or injuries in the course and scope of their employment; or

iii. members of the City Police Reserve Corps suffering illness or injuries in the course and scope of their employment.

(f) The charges set forth in this Section shall be due from the patient and from any person or entity responsible or liable for payment of these charges. No more than the total charge shall be paid by any persons responsible or liable for the charge. The Fire Department shall maintain a record of services rendered and charges for those services in a manner approved by the Fire Chief. The charges imposed by this Section shall be waived as to any patient upon a finding by the Fire Chief that the hospital to which the person was transported by City personnel was unable to administer emergency medical care appropriate to the needs of the patient and that as a result the patient was subsequently transported by private ambulance to another hospital where the services were available. The Fire Chief shall require that patients transported by City personnel be advised that the fees for the transportation service may be waived under the conditions set forth in this Section, provided that a written request for waiver is submitted to the Fire Chief within 30 days after the transportation service has been rendered. Upon review of the submitted request for waiver, the Fire Chief shall, after making a determination,

advise the submitter whether the fee has been waived. In the event a fee has been waived, the submitter shall be further advised that a claim for refund may be filed with the City Clerk for any money paid to the City prior to notification of waiver.

(g) The Fire Chief shall, to the extent allowed by State and Federal laws limiting fee recovery, collect all amounts becoming due under the fee schedule established pursuant to this Section and shall deposit same with the City Treasurer. To this end, the Fire Chief shall procure any information as will aid in collection, including the name of the patient's insurance carrier, if any, and the patient's medical coverage under State and Federal law. The Fire Department shall bill patients for the services rendered in conformance with the established fee schedule. If payment is not received within a reasonable time, not to exceed 30 days, follow-up bills shall be mailed to the patient or other person or entity that may be responsible for payment of these charges.

(h) Accounts that have not been paid within 90 days of initial billing shall be deemed delinquent. The Fire Chief shall review the status of unpaid accounts to determine whether the Fire Department is able to collect the debt. In the event that the Fire Department is unable to collect a debt, the Fire Department shall refer that debt for additional collection efforts pursuant to Section 5.181 of this Code.

(i) Any person or entity responsible or liable for payment of uncollected accounts, owed to the City of Los Angeles, that were referred for additional collection efforts pursuant to Section 5.181 of this Code, shall be liable for the underlying obligation and all costs incurred by the City to effectuate collection of those items, including collection agency fees, to the extent allowed by State and Federal laws.

(j) The following emergency ambulance service accounts shall not be referred to collections pursuant to Section 5.181 of this Code.

1. Accounts where the patient has an established payment plan and is making a good faith effort to pay the claim;

2. Accounts that are pending litigation such as car accidents, workers' compensation, or third person liability claims where a lien has been requested on the account;

3. Accounts that are pending review of low- income documentation and/or qualification. Once a decision of ineligibility has been made, the account may be referred at that point;

4. Accounts where a claim or an appeal is currently pending with a health plan, medical group, or hospital responsible for payment of the claim;

5. Accounts that are pending approval or application for victim of crime assistance;

6. Any accounts excluded from collection in accordance with federal and state laws.

(k) Annually or more often, the Fire Chief shall refer those accounts determined to be uncollectible to the Board of Review in accordance with Section 5.182 of this Code.

SECTION HISTORY

Added by Ord. No. 140,506, Eff. 7-1-70.
Amended by: Ord. No. 142,504, Eff. 11-18-71; Ord. No. 143,243, Eff. 5-7-72; Ord. No. 144,182, Eff. 12-29-72; Ord. No. 144,908, Eff. 8-11-73; Ord. No. 147,786. Eff. 11-24-75; Ord. No. 148,107, Eff. 4-5-76; Ord. No. 148,986. Eff. 12-17-76; Schedule of Charges Table. Ord. No. 152,529, Eff. 8-6-79; Schedule of Charges, Ord. No. 153,969, Eff. 7-26-80; Schedule of Charges Table, Ord. No. 156,388, Eff. 3-25-82; Ord. No. 158,565. Eff. 1-19-84; Schedule of Charges Table, Ord. No. 159,648, Eff. 3-15-85. Schedule of Charges Table, Ord. No. 161,002, Eff. 4-25-86; Schedule of Charges Table, Ord. No. 164,882, Eff. 6-26-89; Schedule of Charges Table, Ord. No. 165,770, Eff. 5-20-90; Schedule of Charges Table, Ord. No. 167,098, Eff. 8-17-91; New second para. added, Schedule of Charges Table, Ord. No. 167,427, Eff. 12-28-91; Schedule of Charges and following Paragraph, Ord. No. 171,397, Eff. 12-16-96;

Schedule of Charges Table, Ord. No. 172,025, Eff. 6-26-98; Ord. No. 173,363, Eff. 7-29-00, Oper. 7-1-00; Schedule of Charges Table, Ord. No. 176,074, Eff. 8-10-04; Schedule of Charges Table, Ord. No. 176,961, Eff. 11-2-05; Schedule of Charges Table, Ord. No. 177,718, Eff. 9-4-06; Schedule of Charges Table, Ord. No. 180,565, Eff. 4-4-09; In Entirety, Ord. No. 180,645, Eff. 5-29-09; Schedule of Charges Table, Ord. No. 181,225, Eff. 8-23-10; Schedule of Charges Table, Ord. No. 183,807, Eff. 9-12-15; Schedule of Charges Table, Ord. No. 186,861, Eff. 1-18-21; Schedule of Charges Table, Ord. No. 187,463, Eff. 5-26-22; Schedule of Charges Table, Ord. No. 188,894, Eff. 4-30-26.

Attachment B

Every Call Answered

When to Call 911 Campaign: Strategic Communications Plan

This plan will be reviewed regularly and adjusted as needed, including when the Board acts on the recommendations in this report, when the EMS Bureau or Metro Fire Communications updates its guidance, and when results show a change is needed.

Purpose and background

This campaign is the department's response to Executive Directive No. 22, issued by Mayor Karen Bass on September 29, 2026. It tells the public when to use 911, gives clear notice of any fee schedule changes, and does both without leaving anyone afraid to call during a real emergency.

The department is launching this effort during one of the most difficult periods in its history. Following a catastrophic incident that took civilian lives, our community is watching closely, and so are our own members. Any message about how people should use emergency services will be read through that lens. That reality shapes every decision in this plan.

The campaign has two jobs. The first is practical: connect residents with the care that fits their need, whether that is a 911 response, a nurse advice line, urgent care, or a mental health crisis line. The second is relational: show the public and our members that the department is adding ways to help people, and that we are doing it openly.

What Executive Directive No. 22 requires

The directive asks the Board of Fire Commissioners to direct the department to develop a communications plan that informs the public of when to use 911 and provides notice of fee schedule changes. The department reports the plan back to the Board within 30 days of receiving the directive.

The communications plan cannot get ahead of the operational decisions. Four of the directive's five evaluations will shape what we are allowed to say:

Directive item	What it evaluates	What it means for communications
1. Dispatch protocol and fees	Current response policy by call type and fee collections	Sets the factual baseline for every message about what changes
2. Nurse Practitioner designations	Clearer clinical criteria for facilities with medical staff	Drives a dedicated outreach track for assisted-living and similar facilities
3. "No send" category	Whether some calls receive no unit	The single highest-risk change for public trust. Messaging must be precise and honest
4. New or increased fees	Fees for certain non-emergency calls	Requires formal, plain-language public notice and legal review

Directive item	What it evaluates	What it means for communications
5. Additional resources	Expansion of the Advanced Provider Response Unit program and Fast Response Vehicles	Our strongest proof point that the department is adding capacity, not cutting it

Phase One: No-cost public education

Goal: Lower non-emergency call volume through public education.

This is the first public piece of the campaign, and it runs on what we already have. No new funding and no new personnel. It is built entirely from existing Public Information staff, on-duty members, and the department's own channels.

Why we are doing it this way. Educating the public before anything else changes shows that the department is investing in its communities, not pulling back from them. That is the core purpose of this phase: it makes sure the campaign is seen as education and help, not a cut in service. This is our internal rationale. Publicly, we never say we are doing this so it doesn't look like a cut. We simply lead with help, and the work speaks for itself.

Similarly, "lower call volume" is our internal goal. Public materials talk about getting the right help fast, never about reducing calls.

Objectives

1. Produce an educational PSA for the public.
2. Help residents recognize a life-threatening emergency, and know which other services can help with needs that aren't medical or safety emergencies.
3. Explain what 911 is for, and that if they are unsure, they should call.

Methods (no funding or personnel required)

Method	What it is	Produced by
PSA video	A 60-second video featuring on-duty paramedics and firefighters at their own station, with 15 and 30-second cuts for social and broadcast. Shot on existing department equipment	Public Information with field members
Social media	A series of posts on department channels: the PSA, short "Is it a 911 call?" graphics, and a pinned post with the options list	Public Information
News release	Announces the campaign, leads with the anchor line, and offers the PSA to local TV and radio stations to run at no cost	Public Information
LAFD News article	A longer explainer on the department's own news site covering what 911 is for,	Public Information

Method	What it is	Produced by
	emergency vs. non-emergency, and other options	
Community outreach programs	The PSA, options card, and talking points shared through the community programs and partners we already work with: Neighborhood Councils, CERT programs, community events, senior centers, faith communities, and homeless service providers and street outreach teams. Field members join when on-duty schedules allow. Reaches residents who don't follow department channels	Community Liaison Office with Public Information

Spanish versions can be produced at no cost using bilingual members, and all video should be captioned. Other priority languages can follow as members volunteer.

Accessible by design. The ADA Title II web accessibility rule requires the City to meet WCAG 2.1 Level AA by April 26, 2027, including captions and audio description for prerecorded video. The PSA will be built to meet that standard from the start, at no added cost. Every key point is spoken aloud, and any on-screen text is also read aloud, so no information is only visual. Every version is captioned, with a transcript posted alongside it. The City Attorney or the City's ADA office confirms requirements, including for social media, before production begins.

What 911 is for. 911 is for emergencies: when someone's life, health, or safety is in immediate danger, or when there is a fire or a crime in progress. It connects you to trained dispatchers who send the help you need. If you are not sure, call.

Emergency vs. non-emergency. The final comparison will come from EMS Bureau and Metro. The table below is a placeholder showing the format only. It will be replaced with their guidance, not edited or approved as a starting point.

Call 911	Other options can help faster
Chest pain or pressure	A ride to a scheduled medical appointment
Trouble breathing	Cold, flu, or mild fever symptoms
Signs of a stroke: face drooping, arm weakness, slurred speech	Minor cuts, scrapes, or sprains
Someone who is unconscious or won't wake up	Prescription refills or questions about medication
Severe bleeding or a serious injury	A downed tree or other city service issue (311)
Fire or smoke	Questions about fire safety or smoke alarms
A car crash with injuries	Mental health support when no one is in danger (988)

Call 911	Other options can help faster
A possible overdose	

Every version closes with the anchor line: **If you think it might be an emergency, call 911.**

Timing. Phase One does not start until EMS Bureau and Metro have provided their guidance and confirmed the final message. Because it describes no changes to dispatch or fees, it can then move forward ahead of Board action, with sign-off from the Fire Chief and coordination with the Mayor's Office.

Measuring at no cost. Track video views and shares through built-in social analytics, media pickup of the news release and PSA, and monthly non-emergency call data from the department's existing reports.

Strategic risk and guiding principle

The central risk is simple: the public hears "don't call us." If that happens, the campaign will be seen as a service cut, no matter what we intended.

That perception could come from three directions. Residents may read it as the department pulling back after a tragedy. Media may connect it to budget or staffing conversations. Members may read it as leadership blaming the public for the strain they carry every shift.

Guiding principle: 911 stays open to anyone having an emergency. What changes is how we handle non-emergency use, and we say so plainly.

Every product, statement, and conversation tied to this campaign must pass one test before release: would a resident who reads only this piece come away believing they have more help available than before? If the answer is anything other than yes, it does not go out.

The directive raises the stakes. Its language is already public. Phrases like "curb misuse," "no send," new fees, and taxpayer dollars that "should not be used to subsidize services" are exactly what a service cut story is built from. Some real changes may follow. That means our earlier promise that this campaign removes nothing can no longer be made, and we will not make it.

Our job is to translate the directive for residents without contradicting the Mayor or overpromising. We do that in three ways. We are specific about who the changes are aimed at. We are honest about what is still being decided. And we never say anything that could make a person in a real emergency hesitate to call.

Community Liaison Office Track

The CLO track is how residents see the department showing up in more ways. CLO does not explain call volume or dispatch changes. It brings the people and programs behind "Every Call Answered" into the communities we serve, using existing relationships and no new funding.

Why this track matters. A message about when to call 911 can sound like a door closing. A captain, a paramedic, and a CLO liaison sitting in a community room sounds like a door opening. This track is our most visible proof that the department is adding help, not pulling back.

Tactics

- **Neighborhood council and community meeting tour.** Battalion Chiefs brief neighborhood meetings on every service available to residents, from LAFD programs to community and partner resources.
- **Care network graphic.** One simple visual showing engines, ambulances, Advanced Provider Response Units, Fast Response Vehicles, and crisis response partners working together. Programs that are requested but not yet funded are labeled as requested.
- **Senior, caregiver, and in-language sessions.** Delivered through senior centers, faith communities, community clinics, and partner organizations, by native speakers from our ranks and partner organizations wherever possible.
- **Council office toolkit.** Ready-to-post graphics, newsletter copy, and the approved questions and answers, so elected officials repeat the campaign's framing rather than the directive's language.
- **Community feedback loop.** CLO logs the questions and concerns it hears by district and shares them with Public Information each week, so materials and answers can be adjusted quickly.

Guardrails. CLO uses only bureau-approved guidance and the language guide in this plan. CLO does not discuss proposed fees, call queuing, or dispatch changes beyond the approved answers, and refers those questions to Public Information.

Timing. The CLO track begins alongside the Public Education Track, after members have been briefed and the bureaus have confirmed the message.

Measuring. Meetings held and attendance by district, partner organizations reached, questions logged, and how often community questions reflect the "service cut" concern over time.

Reaching residents experiencing homelessness

Residents experiencing homelessness are among the people most likely to rely on 911 and least likely to see a PSA or a social media post. Reaching them takes trusted messengers and in-person contact, so this outreach runs through the community agencies that already serve them.

- **Partner agencies.** Homeless service providers, street outreach and street medicine teams, the Department of Health Services, shelters and interim housing sites, and the City's crisis response partners share the options card and talking points directly.
- **The right message.** Lead with "If you think it might be an emergency, call 911. We will always answer." Then 988, 211 LA, and the nearest clinic or street medicine team. Never suggest that where someone lives affects whether help comes.
- **Field connection.** Fast Response Vehicles already support people experiencing homelessness. The proposed High Utilizer program would connect people who call often with ongoing care, behavioral health, and housing support, and is described as requested until funded.

Strategic risk and guiding principle

The central risk is simple: the public hears "don't call us." If that happens, the campaign will be seen as a service cut, no matter what we intended.

That perception could come from three directions. Residents may read it as the department pulling back after a tragedy. Media may connect it to budget or staffing conversations. Members may read it as leadership blaming the public for the strain they carry every shift.

Guiding principle: 911 stays open to anyone having an emergency. What changes is how we match each call with the right help, and we say so plainly.

Every product, statement, and conversation tied to this campaign must pass one test before release: would a resident who reads only this piece come away believing they have more help available than before? If the answer is anything other than yes, it does not go out.

The draft response lowers the risk, but doesn't remove it. It proposes no new fee for residents and no new medical "no send" category. Still, the directive's language, including "curb misuse," "no send," and new fees, is already public. Those phrases are exactly what a service cut story is built from, so every message is written as if that story is waiting.

Our job is to translate the directive for residents without contradicting the Mayor or overpromising. We do that in three ways. We are specific about who the changes are aimed at. We are honest about what is still being decided. And we never say anything that could make a person in a real emergency hesitate to call.

Bureaus first: who owns the guidance

Nothing in this campaign moves forward until we have spoken directly with the bureaus most affected and built the message from what they tell us.

Deciding when 911 should and should not be called is an operational and clinical decision. That guidance belongs to the people responsible for EMS operations and dispatch. Communications does not set it, draft it, or approve it.

Who	Role
EMS Bureau and EMS Medical Director	Define what counts as an emergency, the clinical examples, and facility criteria
Metro Fire Communications	Define how dispatch handles calls and what callers should expect
Public Information	Translate the bureaus' guidance into plain-language public messaging, and protect message discipline
Community Liaison Office (CLO)	Share the guidance through existing community relationships and outreach

The sequence is fixed. First, the bureaus provide guidance. Then Public Information builds the message from it. Next, the bureaus confirm the message still says what they meant. Only then do Public Information and CLO take it to the public. Any examples in this plan are placeholders until EMS Bureau and Metro replace them.

This is also how we will report to the Board of Fire Commissioners. The plan is to work with EMS Bureau and Metro first, then decide how Public Information and CLO can best share their guidance with the public.

Goals and objectives

The campaign succeeds when residents feel they have more help available, members feel informed and respected, and the "service cut" narrative never takes hold.

Goal	Objective	How we will know
Meet the directive	Deliver the communications plan to the Board of Fire Commissioners within 30 days of receiving the directive	Plan submitted on time 10/30/26
Protect trust in 911	Reinforce that anyone having an emergency should call 911 and will get help	No measurable rise in public confusion or hesitation about calling
Change institutional behavior	Reduce non-emergency 911 use by facilities with medical staff on site	Call data by facility type, before and after outreach
Give clear fee notice	Make sure everyone affected by fee changes knows what, when, and why before they take effect	Every affected facility notified; public notice published on schedule
Expand awareness of options	Increase resident awareness of alternative care and transport options	Survey data and use of promoted services
Bring members along	Brief every member before public launch	100 percent of companies briefed; members can state the core message
Prevent the service cut narrative	Keep "cutting service" framing out of coverage and public conversation	Media and social sentiment tracking
Reach every community	Deliver the campaign in the languages our residents speak	Materials available in all priority languages at launch

Targets and baselines should be set with the department's data team before launch so we are measuring against real starting points.

Audiences

Our members come first. Everyone else hears it after they do.

Audience	What they need to hear	Primary concern to address
Sworn members and civilian staff	What the directive asks, what it means for their work, and how they will help shape the response	"Leadership is blaming the public" or "this is a cut in disguise"

Audience	What they need to hear	Primary concern to address
Board of Fire Commissioners	A plan that meets the directive and protects public trust	Timing, legal soundness, and alignment with the evaluations
Mayor's Office, City Council, and city partners	What the campaign is, what it is not, and how to talk about it	Being surprised by constituent calls or press questions
Assisted-living and residential care facilities	Clear clinical criteria for when to call 911, the non-emergency transport options available, and any fee changes	Liability if they hesitate, and new costs
Residents, especially high-need communities	Call 911 for emergencies, and there are better options for non-emergency needs	"Will they still come if I call?" and "Will I get a bill?"
Seniors and caregivers	Clear, simple guidance and reassurance	Fear of making the wrong call or being charged
Non-English speaking communities	The same message in their language, from trusted voices	Access and being overlooked
Media	A clear, confident story with facts behind it	Whether this is a service cut or a budget move
Community partners (clinics, faith leaders, schools, neighborhood councils)	Materials they can share and a direct line to us	Being asked to carry a message they do not fully understand

Core message and message architecture

The anchor line appears in every product, in every language, and always comes first: **If you think it might be an emergency, call 911. We will always answer, and we will get you help.**

Campaign theme: **Every Call Answered**

Supporting messages sit underneath the anchor, never in front of it:

1. **Emergencies come first, always.** Chest pain, trouble breathing, a fire, a serious injury, someone who won't wake up. Call 911 right away.
2. **The right help can be the fastest help.** For needs that aren't emergencies, there are services built to help you quickly, often without leaving home.
3. **An ambulance is not a ride to an appointment.** There are transport services for scheduled medical visits, and many are covered by Medi-Cal or insurance.
4. **Facilities with medical staff have a role to play.** We are working with care facilities on clear guidelines so our crews stay ready for emergencies in every neighborhood.
5. **Calling 911 in an emergency will never be the wrong choice.** If you are unsure, call. We would rather answer and help than have you wait.

Language guardrails

The resident is the beneficiary in every sentence. The moment a message sounds like it is about the department's workload, it starts to sound like a service cut.

Avoid	Use instead
"Don't call 911 for..."	"You have more options for..."
"Misuse" or "abuse" of 911	"Getting you the right care"
"Inappropriate calls"	"Needs that other services can help with quickly"
"Freeing up resources"	"Keeping crews ready in your neighborhood"
"Non-emergency calls are straining the system"	"We want to reach every emergency as fast as possible"
"Reducing call volume"	"Connecting people to the best help"
"You should only call if..."	"If you think it might be an emergency, call."

This guide goes to every spokesperson, member, and partner who represents the campaign. Any new wording that does not appear here gets reviewed by Public Information before use.

When asked about the directive's wording. The directive uses words like "misuse" and "burden." Spokespeople should never distance themselves from the Mayor or correct her language. They should bridge to who the changes are aimed at: "The Mayor is focused on non-emergency use of ambulances, especially by facilities that have their own medical staff. For residents, the message is simple. If it might be an emergency, call 911."

Pairing every ask with an offer

We never ask the public to change behavior without giving them something in the same breath. This is our strongest defense against the service cut narrative.

Every campaign product pairs a situation with a real option. Examples, pending confirmation of what is active and staffed:

If you need...	Your options
Help that might be an emergency	Call 911. Always.
A ride to a scheduled medical appointment	Non-emergency medical transportation, often covered by Medi-Cal or insurance
Medical advice for a minor illness or injury	Nurse advice line, telehealth, or your doctor
Care today for something that can't wait but isn't life threatening	Urgent care locator
Help in a mental health or emotional crisis	988 Suicide and Crisis Lifeline

If you need...	Your options
City services like a downed tree or a blocked street	311
Fire safety guidance or a smoke alarm	Department community programs

Before launch, Public Information will confirm with EMS leadership and partner agencies that every option we name is active, funded, and able to handle an increase in demand. Promoting a service that can't keep up would do real damage to the trust we are trying to rebuild.

Where the department has recent investments or expanded programs, we will place them alongside the campaign so the public sees growth, not retreat.

Fee schedule notice

Fee notice is a separate track from the "when to call" campaign. The two are coordinated but never combined in the same creative.

Putting fees inside a public safety message is the fastest way to make someone hesitate during a real emergency. A senior who sees "911" and "fee" on the same flyer may wait too long. So the public campaign stays focused on getting the right help, and fee information lives in its own clearly labeled notice.

Principles for the notice

- **Plain language.** Say what the fee is, who it applies to, how much it is, and when it takes effect. No jargon, no fine print.
- **Lead with who is not affected.** Before anything else, the notice says that anyone having an emergency should still call 911.
- **Notify the most affected first.** Facilities and institutional callers hear about fee changes directly from the department before any public announcement.
- **Explain the reason honestly.** The directive's rationale is that taxpayer dollars should go to emergency response. Say that directly.
- **Give enough lead time.** Affected parties get advance notice before any fee takes effect. The City Attorney sets the minimum notice requirement.
- **Address cost concerns.** If any billing assistance or hardship process exists or is being considered, the notice explains it. If none exists, we should be ready for the question.

Channels. Direct letters and briefings for facilities, a dedicated page on the department website, a formal public notice through the City's required process, and a briefing for the Board of Fire Commissioners and City Council offices.

Facility and institutional outreach

The directive's sharpest focus is on callers who have medical staff on site, so this track needs its own direct approach.

This audience is reached through relationships, not advertising. It is also where the biggest change in call patterns is likely to come from.

1. **Map the callers.** Work with the data team to identify the facilities and institutions that generate the most non-emergency 911 calls.
2. **Develop clear clinical criteria.** Building on directive item 2, work with EMS leadership and the department's Nurse Practitioner program to define when facilities should call 911 and when they should use non-emergency transport.
3. **Meet face to face.** Hold briefings with facility administrators, industry associations, and custody health partners for Men's Central Jail and Twin Towers. Explain the changes, the criteria, and the timeline.
4. **Give them tools.** Provide a simple decision guide for staff, a list of non-emergency transport providers, and a direct contact at the department.
5. **Protect residents and patients.** Make sure facility staff know that if a resident or patient is having a true emergency, they must call 911 without hesitation. No facility should read the new criteria as a reason to delay care.

Liability note. Facilities will worry about liability if they hold off on calling. The clinical criteria and all guidance materials should be reviewed by counsel and framed so facilities never feel they are being told to ignore an emergency.

Internal rollout

The directive is already public, so many members have likely seen it or heard about it secondhand. The first step is a prompt internal message explaining what the directive asks, what is still being evaluated, and that members will help shape the response. After that, no member should learn about a campaign detail from the news.

Our members will be asked about this at the grocery store, on scene, and at family dinners. If they don't understand it or believe in it, their doubts will become the public story. If they helped shape it, they will defend it.

1. **Listen first.** Hold small working sessions with field paramedics, captains, and dispatchers. Ask them which calls could be better served elsewhere and what language would land in their communities. Their input shapes the final materials.
2. **Brief labor leadership early.** Share the purpose, the guardrails, and the timeline. Invite their feedback and address concerns before the plan is final.
3. **Brief the command staff.** Give every chief and captain the talking points and the question and answer guide so they can carry it to their people.
4. **Brief every company.** Deliver a short roll call briefing or video from a respected field voice, not only from headquarters. Explain the why in plain terms.
5. **Give members the tools.** A one page reference card with the anchor line, the options list, and answers to the questions they are most likely to hear.
6. **Keep a feedback channel open.** Give members a direct way to flag confusion, concerns, or what they are hearing in the community, and respond to what comes in.

Members see the final public materials at least one week before launch.

Messengers and partners

The campaign should come mostly from the field and from the community, not from headquarters.

A paramedic explaining how to get faster care for a child's fever at 2 a.m. sounds like help. A chief explaining call volume sounds like an institutional problem. We choose messengers accordingly.

- **Field paramedics and firefighters** are the primary faces of the campaign. They carry the most credibility with residents.
- **Dispatchers** can speak to what happens when someone calls and reassure people that they will always get help.
- **Department leadership** anchors the launch, owns the accountability message, and handles the hard questions from media and officials.
- **Community voices** include neighborhood councils, faith leaders, community clinics, school nurses, senior centers, and trusted local organizations.
- **Healthcare partners** can explain the alternative options directly and confirm they are ready for the people we send their way.

Materials are created in every priority language from the start, not translated afterward. Where possible, native speakers from our own ranks and from partner organizations deliver the message in their communities.

Channels and tactics

We meet people where they already are, with the anchor line visible in every format.

Channel	Tactics	Lead messenger
Internal	Roll call briefings, video message, reference card, intranet page, feedback channel	Field leaders and Public Information
Earned media	Launch event framed around new options, feature stories from the field, op-ed from the Fire Chief	Leadership and field members
Social media	Short videos from paramedics, simple "Where to go" graphics, live Q&A sessions	Field members
Website	A single landing page with the options list, searchable by need and language	Public Information
Community outreach	Neighborhood council presentations, faith community visits, senior center sessions, school newsletters	Local stations and community partners

Channel	Tactics	Lead messenger
Print	Magnets and cards with the options list for homes, clinics, and senior housing	Crews during community visits
Paid media	Targeted placements in multilingual and community outlets, if budget allows	Public Information
Partner channels	Shared content through clinics, hospitals, 988, 311, and city partners, plus the Los Angeles County EMS Agency, the Department of Health Services, and homeless service providers	Partner organizations

Phase One uses only the no-cost channels: department social media, the news release, the LAFD News article, and free PSA placement with local stations.

Phased timeline

The plan runs on two clocks. The first is the directive's 30-day deadline to report the communications plan to the Board. The second is the public launch, which should not happen until the Board has acted on the evaluations, especially the "no send" category and fees.

1. **Phase 1: Internal message and plan development (days 1 to 10).** Internal message to all members on the directive. Field working sessions, labor briefing, and coordination with the teams handling directive items 1 through 5.
    - Gate: members have heard from the department directly about the directive.
2. **Phase 2: Plan completion and legal review (days 11 to 25).** Draft materials with placeholders for fees and dispatch changes. Counsel reviews anchor language, the fee notice approach, and facility guidance.
    - Gate: counsel signs off on the plan.
3. **Phase 3: Report to the Board (by day 30).** Submit the communications plan to the Board of Fire Commissioners with the department's evaluations.
    - Gate: Board action on dispatch changes and fees.
4. **Phase 4: Facility outreach and fee notice (after Board action).** Direct briefings with facilities and custody health partners. Formal fee notice issued on the schedule set by counsel.
    - Gate: affected parties notified before any change takes effect.
5. **Phase 5: Internal rollout of final materials.** Company briefings, reference cards, and final public materials shared with members at least one week before public launch.
6. **Phase 6: Public launch and sustain.** Elected officials and partners briefed 48 hours ahead. Launch leads with the anchor line and the department's added resources, then continues through community outreach and monthly review.

Timing sensitivities. Avoid launching near budget hearings, deployment or staffing announcements, anniversaries or milestones connected to the incident, or the release of any after action or investigative findings. Launching too close to any of these will invite the worst interpretation. When in doubt, wait.

Anticipated questions and approved responses

These answers are drafts for leadership and legal review. Every spokesperson works from the approved version.

Is the department cutting service? No. Anyone having an emergency should call 911 and will get help. The Mayor's directive is focused on non-emergency use, like ambulance rides to scheduled appointments and transports from facilities that have their own medical staff. At the same time, we are expanding programs like the Advanced Provider Response Unit and Fast Response Vehicles.

Is this about money? In part, and we should say so. The directive states that taxpayer dollars should go to emergency response rather than subsidizing non-emergency services. The bigger issue is availability. When an ambulance is on a non-emergency call, it isn't available for the next emergency.

What if I'm not sure it's an emergency? Call 911. That will always be the right answer. Our dispatchers are trained to help you figure out what you need.

Will I get a bill if I call 911? Placeholder until the Board acts on fees. Approved answer will state exactly which calls are affected. Until then: "No one should ever hesitate to call 911 in an emergency. Any fee changes are being evaluated for certain non-emergency calls, and we will give clear notice before anything changes."

Is this connected to the incident? If it is not, say so plainly. If lessons from the incident informed this work, say that openly. It belongs with the accountability the department is already practicing.

Are firefighters and paramedics overworked? Our members carry a heavy load, and we are committed to supporting them. This campaign is about getting residents the right help. It is not about blaming anyone for calling.

Will these other services actually be able to help me? We have confirmed with each partner that they are ready to help. If you ever try another option and it is not working, call 911.

Why should we trust the department right now? Trust is earned through action, not statements. We are being open about what this campaign is and what it is not, and we will report back on how it is working.

What is a "no send" category? Will you refuse to come? Placeholder until the Board acts on directive item 3. The approved answer must explain in plain terms what happens when someone calls with a non-emergency need, and what help they get instead. Until then: "The department is evaluating how dispatch handles calls that are clearly not emergencies. Anyone with an emergency will get help."

Is the Mayor saying residents are misusing 911? The Mayor is focused on non-emergency use of emergency resources, especially by facilities with their own medical staff. Most people who call 911 do so because they need help, and we want them to keep calling when they do.

Why should facilities pay when they are just trying to protect their residents? If a resident is having an emergency, the facility should call 911 immediately. The changes apply to non-emergency transports, where facilities have other options and their own medical staff on site.

Will this slow down response times? The goal is the opposite. When ambulances and engines aren't tied up on non-emergency calls, they are closer and ready when someone has an emergency. We will track response times and report back publicly.

Risk management and legal review

The biggest legal exposure is any message that could be read as discouraging a call during a real emergency. The anchor line and the "when in doubt, call" language are our protection, and they are non-negotiable.

Risk	Mitigation	Owner
A resident delays calling 911 during a real emergency	"When in doubt, call" in every product; counsel reviews all materials	Public Information and City Attorney
Fear of fees keeps someone from calling in an emergency	Fee notice kept separate from public campaign creative; every notice leads with "emergencies, call 911"	Public Information
A "no send" call later turns out to be an emergency	Messaging describes only what the Board approves; rapid response protocol ready before launch	Public Information and EMS leadership
A facility delays a 911 call because of the new criteria	Criteria and guidance stress emergencies first; counsel review	EMS leadership and City Attorney
Campaign is framed as a service cut	Specific audience focus, added resources as proof points, rapid response	Public Information
Members feel blamed or left out	Prompt internal message, field input, open feedback channel	Command staff
Alternative services are overwhelmed or unavailable	Readiness confirmed with every partner before launch	EMS leadership
Missing the 30-day deadline	Phased timeline with gates, placeholders for undecided items	Public Information
Some communities are missed	Multilingual materials from the start and community-based messengers	Community outreach

Legal review checkpoints. Counsel reviews the anchor language and core messages in Phase 1, all final public materials before Phase 3, and any significant new content during Phase 4. Any new program named in campaign materials is verified in writing before it appears.

Rapid response. If "cutting service" coverage or a related incident gains traction, Public Information convenes leadership within hours, confirms facts, and responds directly. We do not wait for a story to pass.

Measurement and evaluation

Call volume alone is not the measure of success. If residents feel they need permission to call, the campaign has failed no matter what the numbers show.

Measure	What we track	Frequency
Public trust in 911	Survey questions on confidence and willingness to call when unsure	Before launch and at 3 and 6 months
Narrative	Share of media and social coverage using "cutting service" framing	Weekly in the first month, then monthly
Facility call patterns	Non-emergency 911 calls from facilities and custody transports	Monthly
Fee notice reach	Share of affected facilities notified before effective date	Before effective date
Response availability	Response times and unit availability	Monthly
Awareness of options	Resident recall of at least one alternative option	Before launch and at 6 months
Member confidence	Pulse survey on understanding and support for the campaign	After rollout and at 3 months
Safety check	Any reported case of delayed calling linked to campaign or fee messaging	Ongoing, reviewed immediately

Results will be shared with members first and then with the public. Reporting back openly, including what isn't working, is part of how we rebuild trust.

Roles, approvals, and next steps

Public Information owns the campaign. Final approval of all public materials rests with the Fire Chief after legal review.

Role	Responsibility
Board of Fire Commissioners	Receives the plan, acts on dispatch and fee recommendations
Mayor's Office	Coordination on messaging and timing
Fire Chief	Final department approval, launch spokesperson, accountability voice

Role	Responsibility
EMS Bureau and EMS Medical Director	Own the guidance on when to call 911, clinical examples, and facility criteria
Metro Fire Communications	Own dispatch guidance and what callers should expect
Director of Public Information	Campaign owner, translates bureau guidance into public messaging, media and rapid response
Community Liaison Office (CLO)	Through Community Track: community meetings with field members, care network materials, the council office toolkit, and a community feedback loop
City Attorney and City ADA office	Legal review, fee notice requirements, and accessibility requirements
Command staff and captains	Internal briefings and member feedback
Labor leadership	Early input and member perspective
Data and analytics	Baselines, facility call mapping, and ongoing measurement

Next steps

- ☐ Meet with EMS Bureau and Metro to get their guidance on when to call 911
- ☐ Confirm the date the directive was received and set the 30-day report deadline
- ☐ Send an internal message to all members on the directive
- ☐ Coordinate with the teams handling directive items 1 through 5
- ☐ Brief labor leadership on purpose and guardrails
- ☐ Align messaging approach with the Mayor's Office
- ☐ Meet with CLO on community distribution through existing relationships
- ☐ Confirm PSA accessibility requirements with the City Attorney or City ADA office
- ☐ Submit anchor language, fee notice approach, and facility guidance for legal review
- ☐ Map top facility and institutional callers with the data team
- ☐ Confirm which alternative care and transport options are active and ready
- ☐ Gather current numbers on the Advanced Provider Response Unit program and Fast Response Vehicles
- ☐ Identify field and community messengers for each priority language
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