AGENDA

COURTS & PUBLIC SAFETY COMMITTEE

111 S. Michigan Ave., Room 200, Saginaw MI 48602

Tuesday, June 3, 2025 – 4:00 p.m.

Members: Christopher Boyd - Chair, Sheldon Matthews – Vice-Chair, Mark Piotrowski, Rich Spitzer, Jack Tany

Others: Administrator, Finance Director, Civil Counsel, Board Staff, *Media*

I. Call to order

II. Welcome/Roll-call

III. Correction/Approval of Minutes *(**April 1, 2025 –** Attached) [May meeting cancelled]*

IV. Public comment

- *Speakers limited to 3 minutes*

V. Agenda

1. **Mary McLaughlin, Manager/Coordinator, Community Corrections,** re:
   - **6-17-4** Submitting for approval a Resolution authorizing the Office of Community Corrections to accept the MDOC-Saginaw OCC grant and budget if awarded *(Resolution 2025-_)*

2. **Christopher Manriquez, Operations Manager, Mobile Medical Response,** re:
   - **6-17-5** Submitting its Tri-Annual Report on response times and other related information pursuant to the Ambulance Service Agreement *(Receive & File)*

3. Any other matters to come before the committee

VI. Miscellaneous

VII. Adjournment

5-30-25/rls,sek

DRAFT

MINUTES

COURTS & PUBLIC SAFETY COMMITTEE

111 S. Michigan Ave., Room 200, Saginaw MI 48602

Tuesday, April 1, 2025 – 4:00 p.m.

Present: Christopher Boyd - Chair, Sheldon Matthews – Vice-Chair, Rich Spitzer, Jack Tany
Absent: Mark Piotrowski
Others: Mary Catherine Hannah, Koren Thurston, Dave Gilbert, Jaime Ceja, Steve Fenner, Darcie Totten, Suzy Koepplinger, Renee Sharkey and Catherine Hicks

I. Call to order---***Chair Boyd at 4:04 p.m.***
II. Welcome/Roll-call
III. Correction/Approval of Minutes *(**February 4, 2025**) [March meeting cancelled]*
- ***Moved by Matthews, seconded by Tany, to approve. Motion carried.***

IV. Public comment---**None**
V. Agenda

1. **Mary Catherine Hannah, County Administrator, re:**
   - **4-15-2** Submitted a recommendation to approve a new County Policy titled "Animal Care & Control Volunteer Policy, Code of Conduct and Training"
   - **Discussion was held. This policy has come back as a separate item. The Board at its March 18, 2025 session approved Communication No. 3-18-16 granting "authority to the Director of Saginaw County Animal Care & Control to complete and enact a Volunteer Handbook that includes a Code of Conduct, which along with appropriate training will be mandatory for all volunteers of Saginaw County Animal Care & Control." The policy codifies the authority into a policy which can be managed by the Administrator and the Board of Commissioners. Having a policy in place will help to organize the steadily increasing number of volunteers at the shelter. The Animal Control Advisory Council supports the Animal Control Director and the new handbook and policy. In addition, other departments who operate with volunteers, such as the Commission on Aging, use a volunteer handbook.**
   - ***Moved by Tany, seconded by Matthews, to approve. Motion carried. (Board Report)***

2. **INFORMATIONAL COMMUNICATIONS**: ***(To be Received & Filed in Committee)***
   - **4-15-3** **POLICE CHIEFS' ASSOCIATION OF SAGINAW COUNTY** submitted a letter of support to establish a regional morgue facility to serve Saginaw, Bay, Tuscola, Midland, Alcona and Arenac counties
   - **Committee members discussed the advantages of having a regional morgue facility, one advantage being a reduction in the cost of transport. Saginaw County has the greatest need for autopsies in our region. Administrator Hannah, Chairman Tany, and Chair Boyd all acknowledged the quality work the Medical Examiner's Office Manager, Randy Pfau, has done since he has been in this position agreeing, "We are lucky to have him." (Informational-no action)**

3. Any other matters to come before the committee---**None**

VI. Miscellaneous**---None**

VII. Adjournment**---*Moved by Tany, seconded by Matthews, to adjourn. Motion carried; time being 4:22 p.m.***

Respectfully submitted,
Christopher Boyd, Committee Chair
Suzy Koepplinger, Committee Clerk

County of Saginaw

OFFICE OF COMMUNITY CORRECTIONS

111 S. Michigan Avenue
Saginaw, Michigan 48602
989-790-5584

COURTS & PUBLIC SAFETY

Mary M. McLaughlin
Manager/Coordinator

6-17-4

May 29, 2025

Commissioner Jack Tany, Chairman
Board of Commissioners
City of Saginaw
111 S. Michigan Avenue
Saginaw, MI 48602

RE: FY 2025 COMMUNITY CORRECTIONS GRANT

Dear Chairman Tany:

Community Corrections, otherwise known as Public Act 511, establishes statewide policy and funding process for locally designed corrections programs. The Act requires the county to develop alternatives to incarceration that protect the public, provide needed rehabilitative services, and utilize valuable jail beds to house serious, violent criminals.

Saginaw County Community Corrections programs have utilized legal and evidence-based practices designed to increase jail bed utilization and increase public safety while addressing the needs and risks of moderate to high risk pretrial and sentenced felony populations. Our Pretrial Services programs provide vital information to the court to assist with bail determination to reduce unnecessary incarceration at the county jail and to reduce harm to the citizens that could be associated with arrest and incarceration. Our Pretrial Services also provide individualized supervision services that support and promote appearance in court and public safety. Our Opiate Methamphetamine Specific Program (OMSP) and H.E.A.T. program, which offers intensive, holistic, (re)habilitative options to incarceration and effectively address past, present, and future challenges related to substance use and trauma.

Each year we complete no less than 2000 assessments and enroll approximately 800 new participants to our pretrial supervision program each year. By the end of fiscal year 2025, the Community Corrections office will have met and provided services to almost 3,000 criminal justice involved clients.

FINANCIAL INFORMATION SECTION: The FY 2026 budget request to the Michigan Department of Corrections-Office of Community Corrections is in the amount of $707,569.45.

- Administration Wages: $158,519.05
- Equipment/Training/Supplies: $16,000
- Pretrial Assessments: $117,015.12
- Pretrial Supervision: $214,240
- Pretrial Case Mgt.: $88,795.28
- H.E.A.T. Program: $50,000
- OMSP: $63,000

County of Saginaw
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989-790-5584

Mary M. McLaughlin
Manager/Coordinator

There is no match funds required for this grant application; however, there have been grant funding deficits in years prior, which have been subsidized using an MEDC grant, general fund dollars and mid-year funding allocations from the State of Michigan.

If the requested amount of the grant is not awarded to Saginaw County there are options to revise our budget document and, with the approval of the CCAB members, allocate funding to specific programs and services, which best fit with identified priorities and needs of the County.

The Saginaw Community Corrections Advisory Board met on May 27, 2025 and reviewed and approved the MDOC-Saginaw OCC grant for submission. The grant is due to the State of Michigan by June 1, 2025 and therefore, I would respectfully request the Courts and Public Safety Committee and Board of Commissioners approve, and accept if awarded, the FY 2026 Community Corrections grant and budget application.

Sincerely,

Mary M. McLaughlin

Mary M. McLaughlin
Community Corrections Manager

c: Mary Catherine Hannah
Koren Thurston
CCAB Members

SAGINAW COUNTY
RESOLUTION 2025 - _

AUTHORIZING RESOLUTION

Christopher S. Boyd, Jack B. Tany, Lisa R. Coney, Denny M. Harris, John L. Kaczynski, Gerald D. Little, Sheldon Matthews, Mark S. Piotrowski, Tracey L. Slodowski, Richard A. Spitzer and Michael A. Webster

At a regular meeting of the Board of Commissioners of the County of Saginaw, Michigan, held on June 17, 2025.

PRESENT:

ABSENT:

The following resolution was offered by Commissioner _____ and seconded by Commissioner _____:

WHEREAS, the Michigan Department of Corrections (MDOC) has invited Units of General Local Government to apply for its Office of Community Corrections (OCC) Grant; and

WHEREAS, the Saginaw County Community Corrections Office (SCOCC) has applied for $707, 569.45 in MDOC-OCC funds to support a comprehensive approach to early intervention and effective diversion within the criminal justice system and rehabilitative services to address psycho-social drivers of unlawful behavior and support positive change and successful reintegration into society; and

WHEREAS, the application has been approved by the Saginaw County Community Corrections Advisory Board on May 27, 2025; and

WHEREAS, the SCOCC is not required to commit local funds from the general fund; and

WHEREAS, the proposed project is consistent with the local Community Corrections Plan as described in the Application; and

WHEREAS, the proposed project will benefit all individuals involved with the criminal justice arena; and

NOW, THEREFORE, BE IT RESOLVED that the Saginaw County Board of Commissioners hereby designates the Saginaw Count Community Corrections Manager as the person authorized to certify the MDOC-Saginaw OCC Application, the person authorized to sign the Grant Agreement and payment requests, and the person authorized to execute any additional documents required to carry out and complete the grant.

Yeas:
Nays:
Absent:

STATE OF MICHIGAN)
) SS
COUNTY OF SAGINAW)

I, the undersigned, the duly qualified County Clerk of the Board of Commissioners of the County of Saginaw, State of Michigan, do hereby certify that the foregoing is a true and complete copy of proceedings taken at a regular meeting of the Board of Commissioners of said County, held on the 17th day of June, 2025. Public notice of said meeting was given pursuant to and in compliance with Act No. 267, Public Acts of 1976, as amended.

IN WITNESS WHEREOF, I have hereunto affixed my official signature on this 17th day of June, 2025.

_____
Vanessa Guerra, County Clerk
County of Saginaw

MMR
MOBILE MEDICAL RESPONSE
A non-profit community service

COURTS & PUBLIC SAFETY

6-17-5

Saginaw County Board of Commissioners

Courts and Public Safety February 4th, 2025

The information contained in this report covers the Dates January1st until April 30th, 2025

- Response Times for Saginaw County

- Pre-Hospital Blood Products
  - The first Pre-Hospital Blood product protocol submitted to the State of Michigan.
  - Currently on track to be the first county in the state of Michigan to carry blood products for not only Traumatic injuries but for medical hemorrhage like gastrointestinal bleeds.
  - Deployed on supervisor units with a specialized blood refrigerator.
  - Approximately 24 cases last year where the use of pre-hospital blood could have improved patient outcome in Saginaw County.

- Community benefit
  - During January we provided training and continuing education credits to Fire Rescue, Law enforcement and EMS during the County wide Active Shooter Exercise.
  - Multiple events around the county

- MMR education
  - The EMT academy started in January and completed with a 100% pass rate.
  - 170 applicants for the July Saginaw EMT academy, interviews starting June 9th.

- Community Paramedic
  - April 1st focusing on falls
  - Partnered with Covenant Healthcare for follow up on chronic disease conditions.
    - Congestive Heart Failure
    - Sepsis
    - COPD
    - Diabetes
  - Considerations to expand into partnering with Primary care
  - Plans to expand into SUD

CAAS ACCREDITED
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Community Benefit

- Saginaw County Active Shooter training
- Frankenmuth SnowFest
- Carrollton High School Narcan Training
- Birch Run Career Fair
- Michigan Youth Soccer
- SVSU NCAA Softball playoffs
- Special Olympics
- Federal Wildlife refuge annual training
- YMCA Healthy Kids day
- Heritage Career Exploration and Job Fair

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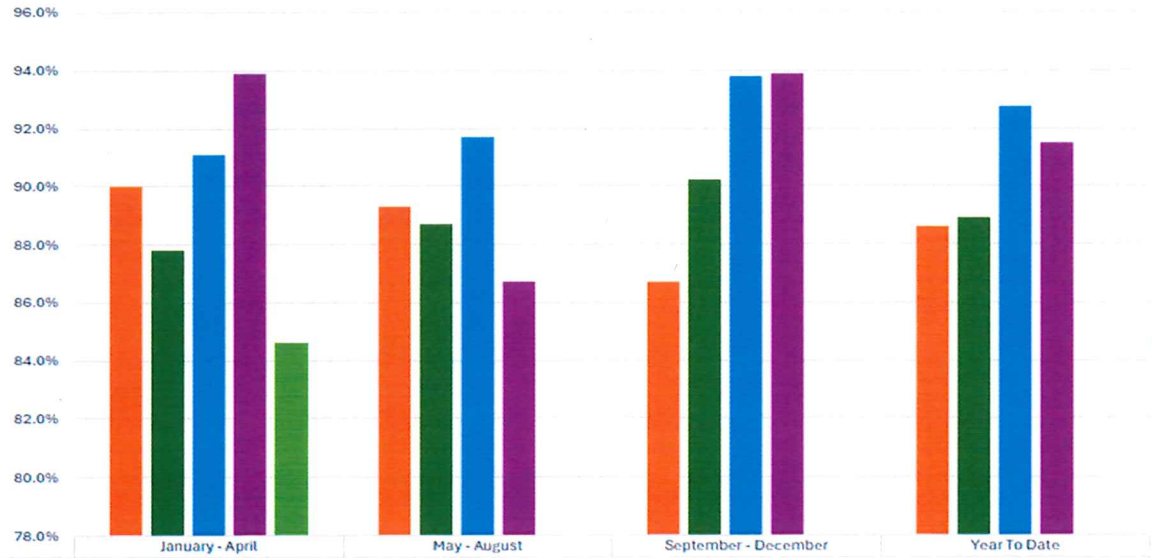
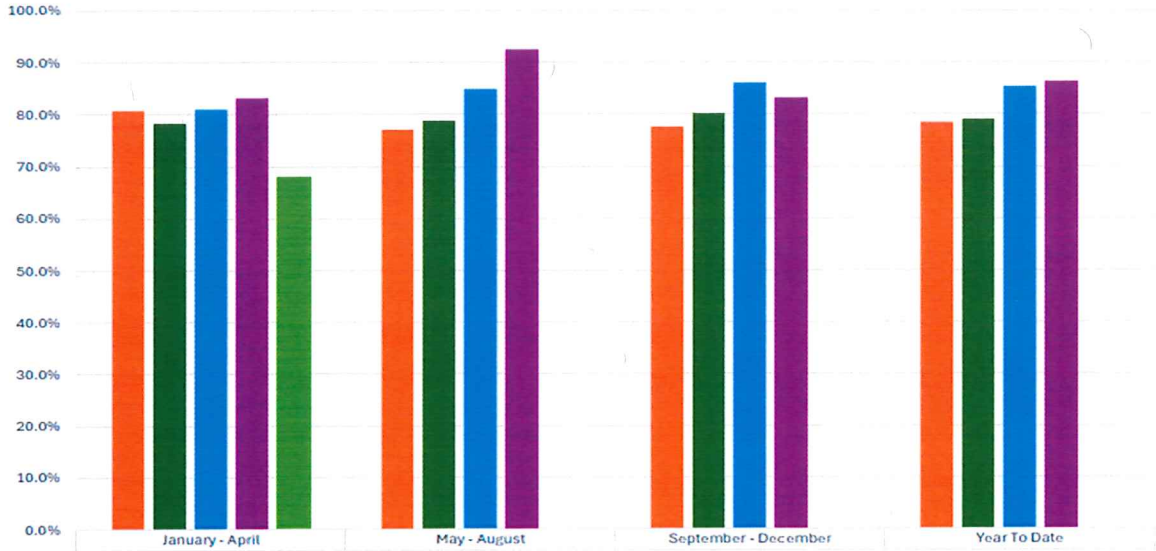
Mobile Medical Response, Inc. Area "A" Compliance Rate (8 Minutes 59 Seconds - 90%)



	January - April	May - August	September - December	Year To Date
2021 Year To Date: 15409	90.0%	89.3%	86.7%	88.6%
2022 Year To Date: 14625	87.8%	88.7%	90.2%	88.9%
2023 Year To Date: 24619	91.1%	91.7%	93.8%	92.8%
2024 Year To Date: 15957	93.9%	86.7%	93.9%	91.5%
2025 Year To Date: 710	84.6%			

Mobile Medical Response, Inc. Area "B" Compliance Rate (12 Minutes 59 Seconds - 80%)



	January - April	May - August	September - December	Year To Date
2021 Year To Date: 4092	80.8%	77.0%	77.6%	78.4%
2022 Year To Date: 3932	78.3%	78.7%	80.1%	79.0%
2023 Year To Date: 5750	81.1%	84.9%	86.1%	85.4%
2024 Year To Date: 5022	83.2%	92.5%	83.2%	86.3%
2025 Year To Date: 244	68.0%			

ACCREDITED

ACE

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MOBILE MEDICAL RESPONSE
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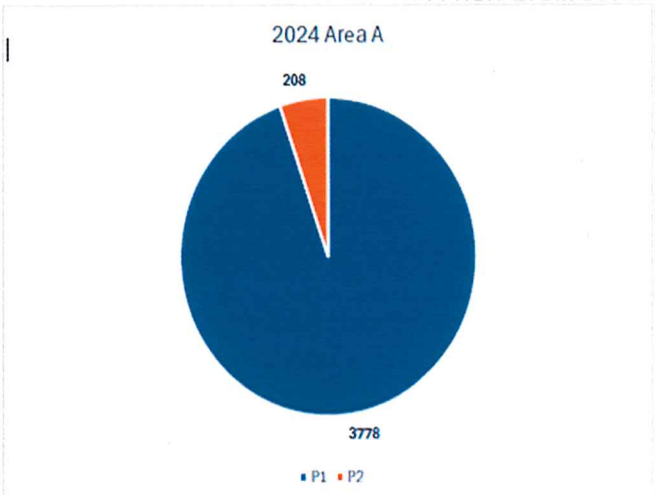

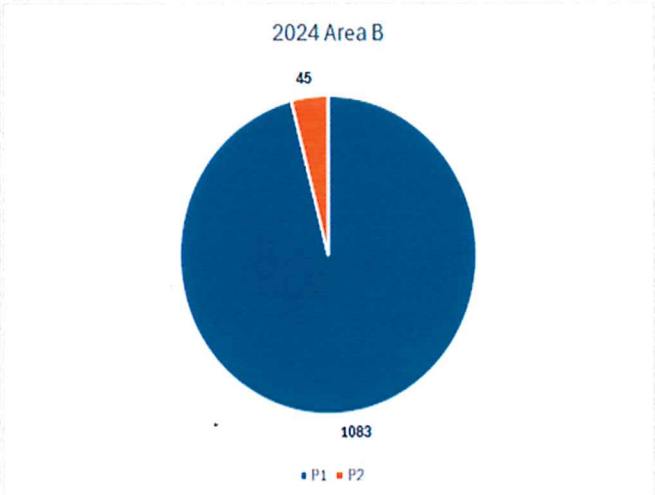

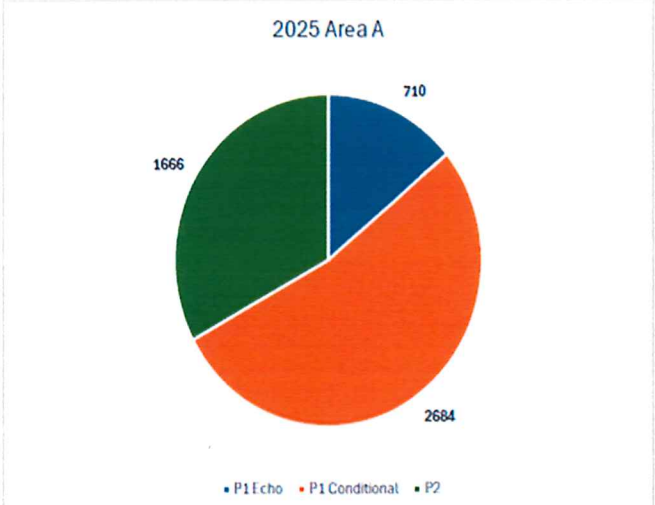

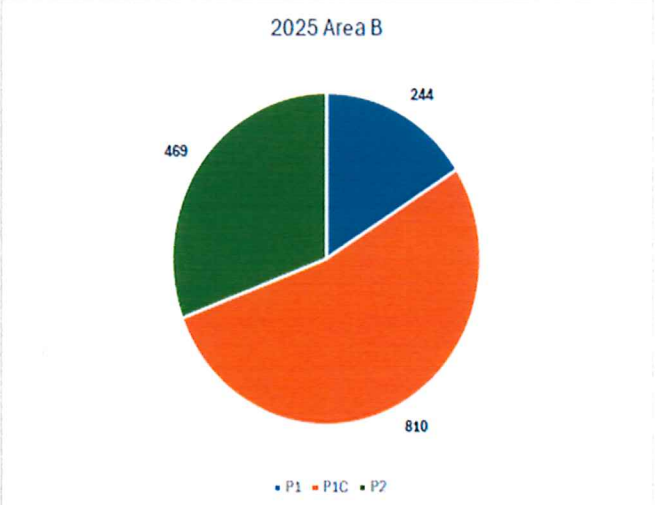

Joint Position Statement on EMS Performance Measures Beyond Response Times

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Chip Decker, Robert Dunne, Peter Dworsky, Richard Ferron, Joseph Grover, Daniel Gerard, Joseph House, Jeff Jarvis, Sheree Murphy, Jerry Overton, Michael Redlener, George Solomon, Andrew Stephen, Randy Strozyk, Marv Trimble, Thomas Wieczorek, Kathryn Wise

Emergency Medical Services (EMS) exist to provide safe and effective out-of-hospital medical care to communities. Historically, response time has been the primary measure used to assess the performance of an emergency medical services (EMS) system/agency. Public policymakers have adopted response time because it is objective, quantifiable, and easily understood, however, this standard is derived from the need to respond quickly to cardiac arrest and time-sensitive conditions. While it is essential to continue to monitor and promote effective response, the majority of 911 EMS responses do not require a response time under ten minutes[i]. Reliance solely on response time performance increases the cost of EMS and the risk of EMS vehicle crashes. It also prevents communities from evaluating other EMS system quality measures that demonstrate system effectiveness for patient care, experience, and outcomes.

This joint statement encourages EMS systems and community leaders to implement an approach to EMS system performance that prioritizes patient-centered care and uses a broad, balanced set of clinical, safety, experiential, equity, operational, and financial measures to evaluate the effectiveness of EMS systems.

This statement is endorsed by the Academy of International Mobile Healthcare Integration, American Ambulance Association, American College of Emergency Physicians, American Paramedic Association, Center for Patient Safety, International Academies of Emergency Dispatch, International Association of EMS Chiefs, International City/County Management Association, National Association of EMS Physicians, National Association of Emergency Medical Technicians, National Association of State EMS Officials, National EMS Management Association, National EMS Quality Alliance, National Volunteer Fire Council and Paramedic Chiefs of Canada. These associations recommend that local communities and governments modernize the assessment of the performance of their EMS systems/agencies by evaluating a broad array of domains with key performance indicators (KPIs) that can be measured and trended over time, and whenever possible, benchmarked with comparable EMS systems, or other national data, and published to local community stakeholders on a regular basis. The domains that communities should consider when evaluating an EMS system/agency are:

- **Effective**: Is the health care provided clinically appropriate and high quality?
- **Safe**: Are services being provided in a way that is clinically and operationally safe for patients, responders, and the community?
- **Satisfying**: How do patients and EMS clinicians feel about the service being provided?
- **Equitable**: Is the system providing care that is equitable based on patient demographics and service area geography?
- **Efficient**: Is this service being provided in a way that maximizes the use of economic and operational resources?

Whenever feasible, evidence-based performance measures should be used that are associated with improved patient outcomes and system performance. Resources are cited in the attached table that can help to guide selection.

It is also essential for government and community leaders and decision-makers to consider all elements of the EMS system from the moment a 9-1-1 call is made to the conclusion of care by the EMS system/agency.

Innovative programs such as mobile integrated healthcare/community paramedicine, alternative response models and response dispositions to enable a broader array of services to patients and communities should be considered.

By considering these additional performance measures, local communities can gain a more comprehensive understanding of the effectiveness of their EMS system/agency, identify areas for improvement in patient care, system efficiency, and overall emergency response capabilities.

FINAL approved by Named Associations 4/9/24

Examples of EMS System Performance Domains and Potential Measures for Consideration

Domain	Potential Type of Measure for Consideration	Source/Benchmark
Clinical	• Out-of-Hospital Cardiac Arrest • STEMI • Stroke • Trauma • Hypoglycemia • Asthma/COPD • Seizures/Status Epilepticus • Invasive Airway Management • Special Mental Health Crisis Management	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSIS Public Dashboards. Cardiac Arrest Registry to Enhance Survival (CARES) AHA Mission Lifeline Other state, regional, provincial, or other community clinical indicators
Safety	• % of responses and transports using lights and siren (L&S). • Crash rate/100,000 miles. • Job-related injuries/100,000 hours worked. • Job-related illness/100,000 hours worked. • Reviews of all dispatch priority assignments. • EMS recall rate after a non-transport response.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSIS Public Dashboards.
Operational	• The number of produced unit hours compared to scheduled unit hours. • Mission failure rate/100,000 miles. • Response time, for high acuity clinical responses, measured from the time the call is placed to a communication center, to the time of patient contact. • QA assessments to insure reliability of prioritization of responses.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies.
Experiential	• Patient experience surveys • Hospital experience surveys • First Response Organization (FRO) experience surveys • Personnel engagement surveys • Employee turnover/retention • Emergency dispatcher engagement surveys	Validated, externally conducted patient and provider experience surveys, such as: • EMS Survey Team • Malcolm Baldrige • Press Ganey Alternatively, internal surveys could be conducted by the agency or local jurisdiction.
Financial	EMS system costs and revenues, reported per: • Staffed Unit Hour • Response • Patient Contact • Transport • Dispatch staffing deficits vs. fully staffed periods.	Internal agency data trended over time. Benchmarked to the Academy of International Mobile Healthcare Integration (AIMHI) survey of EMS systems, or other national data sources.

**These examples are not meant to be all-inclusive; communities should establish patient-centric and evidence-based performance measures based on value to their local stakeholders.*

[i] MurrayB, KueR. The Use of Emergency Lights and Sirens by Ambulances and Their Effect on Patient Outcomes and Public Safety: A Comprehensive Review of the Literature. Prehosp Disaster Med. 2017;32(2):209–216.

Dr. Shaun Ramsey, MMR
Medical Director

"The MMR Community Paramedicine program aims to provide the highest quality care in the comfort of your own surroundings. You are our main priority as we assist in improving your health and well-being while preventing hospitalizations. Thank you for giving us the opportunity to care for you!"

Dr. Ramsey serves as our Medical Director, providing expert oversight for our Community Paramedicine program.

MMR
MOBILE MEDICAL RESPONSE

An MMR Customer Care Representative may reach out to you soon to see how you are doing, and if you are interested in scheduling your first appointment.

Customer Care Representative
989.907.2042

Program Coordinator
989.907.2028

834 South Washington Ave.
Saginaw, MI 48601

www.mobilemedical.org

MMR
MOBILE MEDICAL RESPONSE

COMMUNITY
PARAMEDICINE

WHAT IS COMMUNITY PARAMEDICINE?

Community Paramedicine is a modern approach where Community Paramedics provide in-home care alongside your medical team to help manage chronic conditions, prevent hospital visits, and support independent living. These personalized visits offer check-ups, post-hospital care, and health guidance. Trained beyond emergency response, Community Paramedics assist with mental health, medication management, and connect people to doctors, social workers, and community resources.

Health

Wellness

Community

HOW CAN WE HELP YOU?

CHRONIC DISEASE SUPPORT

MMR Community Paramedics are specially trained to help people living with long-term health conditions like diabetes, heart disease, and breathing problems. They focus on improving your overall health and quality of life by working with you and your doctors to manage symptoms, stay safe at home, and avoid unnecessary hospital visits.

FALL REDUCTION

One main goal of our Community Paramedics is to assist in preventing future falls by identifying both medical and environmental risk factors.

LOCAL RESOURCES

Deeply connected to the community and equipped with local resources, our Community Paramedics are here to support your unique physical, mental, and social health needs. Their goal is to be a trusted partner in your health and well-being.

HEALTHCARE COORDINATION

Our Community Paramedics will work alongside your established healthcare team - including home nursing, primary care, physical therapy, and more - to ensure their care plan aligns with your team's goals.

MISSION STATEMENT:

We innovate community healthcare by providing accessible, patient-centered care that improves outcomes, reduces costs, and minimizes emergency department visits. Through collaboration and a focus on social determinants of health, we build trust and promote wellness.

VALUES:

Patient-Centered Care
Accessibility
Collaboration
Prevention & Wellness
Trust & Relationship-Building

Patient Prioritization and Use of Lights and Siren

This protocol is designed to provide a safe and orderly response to all requests for emergency medical care in the State of Michigan.

A. **Michigan Motor Vehicle Code** *(§257.603 and 257.653)*
The Michigan Motor Vehicle Code governs the driving of emergency vehicles. All licensed life support vehicles will abide by the Michigan Motor Vehicle Code.

1. This protocol does not supersede the Michigan Motor Vehicle Code.

B. **Authority to Require Lights and Siren Use**
Neither the patient's sending nor receiving physician has the authority to require the use of lights and siren during transport; this policy shall be followed at all times. Only the EMS transport crew can determine transport mode, based on patient priority.

C. **Prudent Use of Lights and Siren During Response and Transport**
Per criteria in this protocol, Lights and sirens may be used to clear traffic and then shut down, if appropriate , when the obstruction or delay is cleared. Preferably, both lights and siren should be activated at least 500 feet before any intersection or obstruction to be cleared. When lights and siren are not in use, the vehicle must be operated as a typical non-emergency vehicle, per the Motor Vehicle Code.

1. Use of lights and sirens during response will be dictated based on criteria set forth in this protocol.
2. Use of lights and sirens during transport will be dictated by parameters listed in this protocol and provider clinical judgement

D. **Returning from the transport, returning to a service area**

1. EMS units may ONLY utilize lights and sirens to return to their area IF THEY ARE RESPONDING TO AN EMERGENCY CALL.
2. Lights and sirens will **NOT** be used to return to an area when the unit is not responding to another emergency call.

E. **Education**
Life Support Agencies shall ensure MCA approved annual training surrounding the Michigan Motor Vehicle Code, safe use of lights and siren, this protocol and related agency polices.

F. **Agency and Medical Control Authority Specific Policies**
This protocol does not preclude MCAs from developing protocols and/or individual agencies from developing internal policies on this subject, as long as it includes the contents of this protocol as a minimum.

1. LSAs may have policies that govern the use of lights and sirens in situations such as, but not limited to, inclement weather, road hazards, and highways. These policies must be approved by the STMCA

G. When in doubt, contact medical control to determine if there is an urgent need to transport with lights and siren.

H. **Response**
Response to the scene will be based on the criteria below as identified by protocol 8-30 "MPDS":

	P1 "ECHO"	L & S Mandatory
	P1 (Conditional)	L & S only as conditions warrant
Initial Call P2 "In Process" =>	P2 Emergency, no lights	Emergency, No L&S
	P3 Non-emergency	Non-emergency

i. P1 "Echo" – Crews must use lights and sirens. This priority is limited to MPDS "Echo" level calls, and other severely time critical situations
ii. P1 (Conditional) – Emergency calls where normal driving is expected to be an appropriate response. Crews may utilize lights and sirens as indicated in this protocol to circumvent traffic as needed.
iii. P2 Emergency, No lights – Emergency response, but no lights and sirens. This will also serve as the initial call priority during the call intake process.
iv. P3 Non-emergency – Non-emergency. No lights or sirens

I. **Transport**

1. Transport to the hospital is determined by patient priority.
2. If the patient priority changes during transport follow the appropriate use of lights and sirens for the new patient priority.

1. Unstable Patients

Priority	Description	Example(s) include, but not limited to	

Unstable/ Priority 1	**Unstable** patients with a critical and immediate life-threatening illness or injury, or require time sensitive interventions	A patient that has an acutely life-threatening illness or injury and is unstable.
		• Unstable or deteriorating vital signs
		• Compromised airway that cannot be secured by EMS.
		• Severe respiratory distress/failure
		• Cardiac arrest or post cardiac arrest
		• STEMI
		• Tonic Clonic seizures unresponsive to treatment
		• Significant blunt or penetrating trauma including but not limited to:
		  ○ Airway compromised
		  ○ Respiratory distress
		  ○ Signs of inadequate perfusion	

a) Lights and sirens **<u>may</u>** be utilized for this category.

2. Potentially Unstable Patients:

Priority	Description	Example(s) include, but not limited to
Potentially Unstable/ Priority 2	**Potentially unstable** patients that are ill or injured *<u>without immediate</u>* life-threatening condition and do not require time sensitive interventions	A patient that is currently stable but is felt to have a condition that may become unstable or life-threatening if not evaluated and treated rapidly. • Hemodynamically stable chest pain without signs of STEMI • Altered mental status – not acutely deteriorating • Seizure - Post-ictal not actively seizing • Hemodynamically stable abdominal pain • Hemodynamically stable >65 y/o fall with confirmed or suspicion of head injury and currently taking blood thinner medications

a. Do not transport using lights and sirens unless the patient's category changes.

3. Stable Patients:

Priority	Description	Example(s) include, but not limited to
Stable/ Priority 3	**Stable** patients are Ill or injured patients not fitting the above two categories who require medical attention but do not have a life-threatening condition.	A patient that does need to receive medical evaluation but does NOT have a potentially life-threatening illness or injury at the time of assessment or transport by EMS.

a. Respond and transport using normal traffic patterns to the incident and to the hospital

4. Dead Patients:

Priority	Description	Example(s) include, but not limited to
Dead	**Dead** patients are absent of all vital signs and do not require further medical attention, per protocol.	**See Patient Death, Termination of Resuscitation and Pronouncement Protocol**

a. Do not transport using lights and sirens.

Special Considerations

1. Within the STMCA, there are certain scenarios that will have a no lights or sirens response regardless of the dispatch priority. Examples are, but not limited to, urgent care centers or physicians' offices, unless a P1 "ECHO" priority is obtained.
2. The call taker, dispatcher, road supervisor, or medical director can:
    a. Upgrade a call in rare or unusual circumstances.
    b. Upgrade a call if the patient's condition changes from the initial determinant.
    c. Downgrade a call if the patient's condition changes from the original determinant.
    d. Assign second and subsequent units to a call with a priority based on conditions and situation.
        i. The STMCA will develop guidelines to assist in these scenarios.
3. Response priorities can be modified by public safety personnel once they have arrived on scene and made patient contact.
4. Terms used in this protocol may change based on operational conditions, but the meaning of the category will remain in effect.

Protocol Source/Reference: Michigan 8.2 Prioritization/Use of Lights and Sirens; Version 12/27/22.