

Emergency Medical Services System in Washington State

A Guide for Community Midwives

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While most community births attended by community midwives are free of complications, about 16.2% of birthing patients and 1.8% of neonates require transport to a higher level of care.¹ When these situations occur, Emergency Medical Services (EMS) is often called to transport the patient(s) to a local hospital. While EMS personnel are trained to recognize and treat obstetric and neonatal emergencies, these scenarios are low frequency and high acuity, and co-management of these situations with an attending community midwife are beneficial to the patient.

Through survey data and provider interviews, Smooth Transitions has found that broadly, EMS/community midwife working relationships have room for improvement. Our goal is to refine mutual expectations in part by expanding community midwife knowledge of the EMS system, provider capabilities and limitations, EMS scope of practice, and educational base. In addition, local community midwives can meet with their primary 911 response agency to establish relationships through “Meet and Greets” and collaborative training sessions. By establishing a baseline of understanding, our working relationships and team cohesion can improve for the benefit of our mutual patients.

Due to the regional variability of EMS systems, it is important that community midwives know which resources may be available during an emergency. EMS can be provided by city fire departments, regional fire service authorities, fire districts, public hospital districts, and private ambulance services, or a combination of these agencies. EMS providers can be paid or volunteer. Agencies may have only Basic Life Support (BLS) providers and rely on mutual aid for Advanced Life Support (ALS) level of care, or they may have an ALS provider on every fire engine. Fire engines may co-respond with private, for-profit ambulances, or there may be fire department-staffed transport units.

To find out which agency provides 911 coverage for your local area in Washington State, visit [EMS & Trauma \(wa.gov\)](https://www.wa.gov/ems) and select the “Primary Agency Response Area” layer of the map.

In general, the following system components are consistent across all EMS systems:

911 Dispatch

Every 911 call starts at the Emergency Communication Center. In larger systems, 911 calls are typically answered by a Call Receiver, who works in tandem with a Dispatcher. Call Receivers ask certain questions in a methodical manner, prompted by Emergency Medical Dispatch (EMD) Protocols, which are created and reviewed by a Medical Program Director. While the Call Receiver is speaking to the 911 caller, messages are being entered into a Computer Aided Dispatch program, which are read and reviewed by the Dispatcher, who in turn dispatches the appropriate units and communicates over the radio to first responders.

Responses are triaged into different categories based on previously determined criteria. Calls that may require a higher level of medical care will have an Advanced Life Support (ALS) paramedic unit dispatched. Medical calls that do not meet ALS criteria will have a Basic Life Support (BLS) unit response. 911 dispatch protocols vary geographically. It is important to explain to your patients the possibility of a

bill for transport service, and to accurately modify expectations of 911 response. Questions regarding bills for transport can be answered by your local EMS agency.

Protocols

EMS protocols vary regionally (usually by county) due to preferences of the overseeing Medical Program Director (MPD). Every EMS provider is able to practice medicine by an extension of their MPD's license. The MPD is responsible for continually evaluating the protocols, updating them based on evidence-based medicine, and overseeing quality assurance programs within their jurisdiction.

EMS providers are authorized to practice medicine through an extension of their Medical Program Director MD's license. They must abide by written protocols (standing orders) or by direction of an MD through base station contact. To better understand Washington State EMS Protocols, review the EMS protocols of the primary response agencies in your area for shared expectations.

Basic Life Support (BLS)

In Washington State, most firefighters are trained as EMT-Basic (EMT-B) providers. EMT-Bs have a limited scope of practice which includes oxygenation, basic airway control, some oral medications like aspirin and glucose, and are generally trained to provide supportive care. Most private ambulances are staffed by two BLS providers, but this staffing model varies regionally. Examples of perinatal transports that would usually be BLS are failure to progress, request for pain relief, or maternal exhaustion.

Advanced Life Support (ALS)

Paramedics (EMT-P) are providers who are trained to provide Advanced Life Support (ALS) care. They have gone through more training than EMT-Bs and have a wider scope of practice. They are able to administer medications and perform invasive procedures such as IV/IO, endotracheal intubation, and ECG interpretation. Some agencies can use point of care ultrasound and central lines. No EMS provider can perform intravaginal procedures without first contacting "on-line medical control" (MD base station contact) for permission.

Resource Allocation

There are generally many more BLS providers than ALS within an EMS system due to the higher cost of staffing and equipment for ALS units. Some counties like King and Thurston use a "tiered system response" strategy, which sends BLS providers to every medical call and attaches ALS providers based on criteria as determined by EMD protocol. BLS providers may also upgrade response level to ALS based on assessment in the field. This type of system is designed for maximum resource efficiency, as most 911 calls do not require the services of an ALS provider.

It is important to note that it is the EMS team which makes the decision for appropriate level of care based on system design, not the community midwives. ALS units may be limited based on availability. If a higher level of care is needed, BLS transport units may "rendezvous" with an ALS provider enroute to the hospital, or it may be in the patient's best interest to expedite transport to definitive hospital-based care using the closest available BLS transport unit.

Contacting Your Local EMS Agency

EMS and community midwives usually only interact if there is a need to transport a patient from the community setting to a hospital based higher level of care. These highly emotional situations are easier to navigate together if a relationship between the two disciplines has been previously established. An easy way to start building group familiarity is by scheduling a “Meet and Greet” presentation with your local EMS agency, or by participating in planned training events.

Contact your local EMS agency and ask to speak to the Medical Safety Officer (MSO) or the officer in charge of training. Review your local responding agency’s EMS Protocols to establish a base of understanding of which procedures and directions are included in the agency’s scope of practice for obstetrics, gynecology, and childbirth. A downloadable “Meet and Greet” presentation is available on the Smooth Transitions resource page for anyone to use and adapt for their practice and local EMS agencies.

Above all, remember that all parties are equally interested in the best outcome for birthing patients and babies, and that everyone is operating as directed by their training, protocols, and system limitations. Together, EMS and community midwives can collaborate to provide excellent quality of care to their shared patients.

Hays K, Denmark M, Levine A, de Regt RH, Andersen HF, Weiss K. Smooth Transitions: Enhancing Interprofessional Collaboration when Planned Community Births Transfer to Hospital Care. *J Midwifery Womens Health*. 2022 Nov;67(6):701-706. doi: 10.1111/jmwh.13441. Epub 2022 Nov 26. PMID: 36433815; PMCID: PMC10099526.