Arkansas Department of Health
Office of Preparedness and Emergency Response, Section of EMS
Arkansas EMS Advisory Committee
Advisory and Recommendations

ALS to BLS Release Statewide Clinical Practice Guideline

As prepared by the Clinical Practice Subcommittee

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A. Executive Summary

The Arkansas EMS Advisory Committee is recommending the development and publication of this statewide Clinical Practice Guideline, along with a rules revision, authorizing and permitting Advanced Life Support (ALS) providers to transfer care of a stabilized patient to a Basic Life Support (BLS) crew for transport, when specific clinical criteria are met, after any indicated ALS interventions have been completed, the patient no longer requires ALS level of care, and the patient is safe to be transported by BLS providers. This practice is intended primarily for tiered-response systems and agencies with limited paramedic availability, where an ALS unit is otherwise obligated to complete a low-acuity transport it did not need to perform, at the expense of its availability for the next ALS-level 911 call.

Adoption would remain optional and would rest with each agency's medical director and service director, consistent with existing Arkansas medical direction requirements.

B. Problem Statement

Arkansas EMS systems that operate in a tiered response model, or that have limited ALS (paramedic) availability, frequently dispatch ALS units to calls that, upon evaluation, either do not require ALS-level of care, or after care is provided, do not require ALS-level of transport. Under current Arkansas EMS Rules, once an ALS provider makes patient contact, that unit is typically obligated to complete the transport regardless of the patient's clinical status at the time of assessment. The relevant provisions are:

- Section III.D.5.i – Licensed advanced response services shall only transfer care to a licensed paramedic transporting service or maintain an advanced level of care throughout transport if care is rendered to a basic life support transporting ambulance service.

- Section IV.C.4.b – Advanced Response permitted vehicles: patient care must be transferred to a licensed transporting service, and paramedic level of care must be maintained throughout transport if paramedic level of care is initiated.

Both provisions govern non-transporting Advanced Response Services rather than transporting paramedic ambulances, and neither contains an explicit, blanket prohibition on a transporting ALS ambulance releasing a stabilized patient to a BLS crew. The Arkansas EMS Rules are effectively silent on this specific scenario for transporting services. That silence has created an unaddressed gap: agencies that informally practice ALS-to-BLS release, or that would like to, do so (or would do so) without a consistent, state-vetted set of clinical criteria, documentation standards, or medical-legal protections.

The operational consequence is a significant inefficiency. ALS units are tied up transporting lower-acuity patients who could safely be transported by a BLS crew, leaving the ALS unit unavailable for higher-acuity 911 calls. In communities with limited paramedic staffing, this can directly impact response times and patient outcomes for true ALS-level emergencies.

C. Guiding Principles

- ALS retains full clinical authority. Only an ALS provider may determine that a patient is stable enough for release; BLS providers do not initiate release.
- Release is a hand-off, not an obligation. The accepting BLS lead must be comfortable continuing care and may decline, returning the patient to ALS.
- The guideline is additive, not restrictive. It is intended to authorize a practice that is clinically reasonable, not to compel any agency to change its current operations.
- Local flexibility is preserved. Individual agency medical directors may adopt or decline the guideline based on local system needs, consistent with their existing authority over agency protocols.

D. Proposed Release Criteria Framework

The EMSAC recommends that the statewide sample guideline be built in two layers: (1) general release criteria that apply to every ALS-to-BLS release regardless of presenting complaint, and (2) illustrative clinical scenarios and associated medications, provided as a starting point for local adoption rather than an exhaustive list.

Table 1. General Release Criteria (Applies to All Releases)

Requirement	Standard
Initial contact	An ALS provider performs a full patient assessment and determines that ongoing ALS-level care is not required.
Physiologic stability	Vital signs stable for the patient's baseline, GCS 15 (or patient's documented baseline), no evidence of clinical deterioration.
Access / infusions	Saline lock only permitted (no fluids or medications actively infusing) at the time of hand-off.
Observation period	Minimum of 10 minutes of ALS monitoring following any medication administration (permitted list below in Table 3), with no adverse effects or clinical deterioration, before release is considered.

Requirement	Standard
BLS acceptance	The accepting BLS lead must be comfortable continuing care for the patient and may decline the hand-off and return the patient to ALS at any time before transport begins.
Documentation	The releasing ALS provider must document the assessment findings, any treatment rendered, and the clinical basis for release; both ALS and BLS crews document the transfer of care. The BLS provider will document their own assessment at the time of hand-off and all care provided during BLS transport.
Refusal of ALS care	A patient who is requiring, but refuses ALS-indicated care (e.g., a needed IV or medication) should be transported by ALS rather than released to BLS, unless the patient is refusing transport entirely, in which case the agency's non-transport / refusal protocol applies.
Multi-casualty incidents	This guideline is not intended to apply during an active MCI; triage and resource allocation decisions during an MCI are governed by the agency's MCI protocol.
Post-release deterioration	BLS may request ALS intercept at any point after hand-off if the patient's condition changes or deteriorates en route.

Table 2. Sample Clinical Scenarios and Release Criteria

The following sample criteria represent clinical situations in which ALS-to-BLS release may be appropriate, subject to medical director approval and agency adoption.

Clinical Presentation	ALS Required Intervention(s)	BLS Release Criteria	Contraindications
Minor trauma (isolated extremity injury, laceration)	IV access if needed, pain assessment, 12-lead if indicated	Vitals stable, GCS 15, pain controlled	Obvious or potential life- or limb-threatening injuries; severe uncontrolled pain
Allergic reaction (mild, no anaphylaxis)	Diphenhydramine and/or steroid administration, IV access, epinephrine assessment	Vitals normal, no respiratory distress, no urticaria progression, minimum 10-minute post-treatment observation with documented improvement of symptoms	Ongoing respiratory distress, development of hypotension, or other diagnostic criteria for anaphylaxis
Low blood glucose / hypoglycemia	Dextrose or glucagon administration, IV access	Blood glucose ≥80 mg/dL post-treatment, patient alert and oriented, able to tolerate oral intake	Altered beyond their baseline, glucose < 80 mg/dL, unable to tolerate oral glucose
Asthma / mild bronchospasm	Albuterol nebulization, IV access if indicated, SpO2 monitoring	SpO2 ≥94% (with or without oxygen), no accessory muscle use, able to speak in full sentences	Respiratory distress, or requiring steroids, magnesium, terbutaline, epinephrine, or CPAP
Nausea/vomiting (non-cardiac, non-surgical)	IV antiemetic, fluid bolus if dehydrated	Vomiting resolved, vitals stable, no abdominal rigidity or surgical concern	Ongoing emesis, abnormal vitals, requiring additional medications or fluids

Table 3. Sample Medication Disposition

This sample guideline distinguishes medications that may be released to BLS immediately after administration because they fall within the BLS scope of practice, from medications that require a minimum 10-minute ALS observation period, with no adverse effects or clinical deterioration, before release is appropriate.

Releasable Immediately After Administration (BLS scope of practice)	Releasable After a 10-Minute Observation Period with No Adverse Effects
Albuterol / Atrovent Oral glucose Epinephrine IM Aspirin Naloxone (intranasal) Nitroglycerin (sublingual) Ondansetron (oral)	Diphenhydramine IV Fentanyl IV/IM Acetaminophen IV Naloxone IV/IM/IN (must document improved respiratory rate and GCS) Ondansetron IV/IM Dextrose IV Crystalloid bolus

E. Documentation and Quality Assurance

The releasing ALS provider must document the patient assessment, any treatment rendered, a reassessment, and the specific clinical basis supporting release to BLS. The accepting BLS crew must document its own assessment and acceptance of care, as well as any additional treatment rendered

Agencies adopting this guideline should incorporate ALS-to-BLS releases into their existing quality improvement process, including:

- Clinical quality review of ALS-to-BLS releases
- Review of any release followed by a BLS request for ALS intercept, or by a subsequent adverse outcome
- Tracking of release frequency by presenting complaint, to refine local criteria over time
- Structured feedback to ALS and BLS providers as part of ongoing credentialing

F. End Goal and Recommendations

The end goal of this advisory is to make a vetted, medically-directed ALS-to-BLS release framework available statewide as an optional tool, primarily benefiting tiered systems and agencies with limited ALS resources. Specifically, the Committee recommends the following:

- The Section of EMS will publish this advisory on ALS-to-BLS Release guidelines, incorporating the general release criteria, sample clinical scenarios, and documentation standards described in Section E.

- The Section of EMS will modify or revise the relevant rules outlined in Section B (Section III.D.5.i and Section IV.C.4.b), and explicitly allow both Advanced Response (Paramedic non-transport apparatus) and Paramedic-level EMS Providers to handoff to BLS providers after ALS assessment and care rendered, in accordance with approved agency protocols or clinical practice guidelines.

- Each participating EMS agency, through the medical director, will establish their own protocol or guidelines for ALS-to-BLS release and any necessary training requirements for ALS and BLS providers using the protocol or guidelines, including initial orientation and periodic competency review.

- Each participating agency, in coordination with the medical director, will establish a framework for clinical quality review of ALS-to-BLS releases, consistent with Section E, that agencies can incorporate into their existing QI programs.

G. Implementation Considerations

- Optional adoption: This guideline is intended to be available statewide but adopted only at the discretion of the individual agency medical director, consistent with existing Arkansas medical direction requirements.

- Training: Agencies adopting this guideline should perform and document the training and orientation to both ALS and BLS providers on the general release criteria, the agency's protocol or guideline, and the agency's specific documentation expectations before the guideline goes into effect. Proof of individual provider training should be made available upon request of the Section of EMS.

- Scope of clinical scenarios: The sample scenarios in Table 2 are illustrative and not exhaustive. Agencies and their medical directors retain the authority to add, remove, or modify scenarios and criteria to reflect local patient population, provider scope of practice, and transport times.

- Liability protection: The Section of EMS and the EMS Advisory Committee assumes no liability for the agency's release of a patient from ALS care to a BLS transporting unit. The interest and safety of the patient should always take priority and preference over the operations and logistics of the participating EMS agency.

H. Conclusion

Arkansas currently has restrictions on the ability for ALS providers to hand off to BLS providers, and no existing framework to safely allow this practice. There are many tiered-response agencies within the state who would benefit from a standardized, medically-directed framework to allow the practice. This advisory proposes a two-layer framework of general release criteria and illustrative clinical scenarios, paired with documentation and quality improvement standards, and suggested changes to the regulatory language in the state EMS rules. The Arkansas EMS Advisory Committee respectfully requests that the Arkansas Department of Health, Section of EMS, evaluate and act upon the recommendations set forth in this advisory.

I. References

1. Arkansas Department of Health, State Board of Health, Section of EMS. Arkansas EMS Rules, https://healthy.arkansas.gov/wp-content/uploads/EMS-Rules_.pdf
2. Ark. Code Ann. § 20-13-201 et seq. – Arkansas Emergency Medical Services Act.