TRUE NORTH READINESS
Continuous Readiness for Safer Care

EXECUTIVE READINESS TOOL

JULY 2026

EMTALA READINESS CHECKLIST

A focused screen for leaders who need to know where risk lives - before a complaint does.

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HOW TO USE THIS CHECKLIST

Complete with emergency services, nursing, medical staff, compliance, and transfer-center leaders. Use policy review, observation, staff interview, and targeted records. Score the weakest evidence you can validate. Add all 24 scores (maximum 48), then apply the critical-risk override.

- **2 RELIABLE** — Implemented and sustained
- **1 PARTIAL** — Inconsistent or weak evidence
- **0 ABSENT** — Not implemented or unsafe

CRITICAL-RISK OVERRIDE
Any critical item scored 0 requires immediate action. A critical item scored 1 caps the overall rating at Elevated Risk until validated.

1 SCOPE AND GOVERNANCE		EVIDENCE / ACTION	SCORE
1.1	A current EMTALA policy is approved and applied across the dedicated emergency department(s), hospital campus, labor and delivery, behavioral health, and relevant off-campus locations.		
1.2 !	Qualified medical personnel (QMP) roles are defined in medical staff bylaws or rules, consistent with State scope of practice, and supported by current privileges or competency evidence.		
1.3	Executive, medical staff, nursing, compliance, and transfer-center accountabilities are clear, with a 24/7 escalation path for suspected EMTALA risk.		
1.4	The hospital reviews refusals, left-without-being-seen cases, transfers, on-call failures, and complaints; a workflow addresses suspected improper inbound transfers, including reporting to CMS or the State agency within 72 hours.		

2 ACCESS, SIGNAGE AND CENTRAL LOG		EVIDENCE / ACTION	SCORE
2.1	CMS-specified EMTALA signs are conspicuous at entrances, admitting, waiting, and treatment areas; Medicaid participation is stated and language access needs are addressed.		
2.2	All dedicated emergency departments are identified, including departments licensed or held out as emergency care locations and departments meeting the one-third urgent-visit test.		
2.3 !	Staff understand when a request or prudent-layperson observation triggers action on hospital property, including parking areas and ambulances; patients are not improperly redirected.		
2.4 !	The central log captures every individual who comes seeking emergency assistance and records the required disposition; related department logs are linked and promptly available.		
2.5	A six-month validation finds no unexplained gaps when the central log is reconciled with triage, EMS, labor and delivery, behavioral health, refusal, and transfer records.		

CLINICAL AND TRANSFER READINESS

3 MEDICAL SCREENING AND STABILIZATION		EVIDENCE / ACTION	SCORE
3.1 !	An appropriate medical screening examination (MSE) is provided when requested or indicated by appearance or behavior, without delay for registration, insurance, payment, or authorization.		
3.2	The MSE is tailored to presenting signs and symptoms, uses routinely available ancillary services when indicated, and is applied consistently to similarly situated individuals.		
3.3 !	Triage is not treated as the MSE unless the clinician is an authorized QMP and the examination meets the hospital's approved MSE process.		
3.4	Policies and practice address minors, pregnancy and labor, behavioral health, substance use, disability, language access, and high-risk walkouts or refusals.		
3.5 !	When an emergency medical condition (EMC) exists, the hospital provides monitoring and stabilizing treatment within its capability and capacity, with reassessment documented through disposition.		
3.6	If examination or treatment is refused, staff explain risks and benefits, take reasonable steps to obtain written informed refusal, and document the offer, discussion, and refusal.		

4 ON-CALL RESPONSE, CAPABILITY AND CAPACITY		EVIDENCE / ACTION	SCORE
4.1	The on-call list names individual physicians, contains accurate contact information, reflects current privileges, and is readily available to emergency and transfer staff.		
4.2 !	Written policy defines response and in-person appearance expectations, backup coverage, and escalation; staff can describe and execute the process when the on-call physician cannot respond.		
4.3	On-call failures or refusals are time-stamped, escalated, reviewed, and included in transfer records when applicable; patterns lead to medical staff and leadership action.		
4.4 !	As a potential recipient, the hospital reliably assesses and documents specialized capability and actual capacity, and does not refuse an appropriate transfer when both are available.		

5 APPROPRIATE TRANSFERS		EVIDENCE / ACTION	SCORE
5.1 !	An individual with an unstabilized EMC is transferred only after a written patient request or a signed physician/QMP certification with case-specific benefits and risks.		
5.2 !	Before transfer, treatment minimizes risk; the receiving facility has space and qualified personnel and has agreed to accept the individual, with acceptance documented.		
5.3 !	Available records accompany the individual, including history, findings, diagnosis, tests, treatment, consent/certification, and applicable on-call failure details; late results follow promptly.		
5.4 !	Qualified transport personnel, equipment, and life-support measures match the individual's condition; clinical status and transport needs are reassessed near departure.		
5.5	Transfer records are retained for at least five years, and routine audits cover outbound and inbound transfers, including recipient-hospital obligations and transfer-center decisions.		

SCORE, PRIORITIZE, ACT

HOSPITAL / FACILITY	REVIEW TEAM	DATE

READINESS DASHBOARD

TOTAL SCORE	CRITICAL 0s	CRITICAL 1s
0-48	Immediate action	Validation needed

INTERPRET THE RESULT

42-48 — **READY WITH VALIDATION**

Maintain controls and target any partial evidence.

34-41 — **ELEVATED RISK**

Assign owners and complete corrective validation within 30 days.

0-33 — **IMMEDIATE ACTION**

Escalate, protect current patients, and complete a focused lookback.

TOP THREE PRIORITIES

RISK / FINDING	CORRECTIVE ACTION	OWNER	DUE

A PRACTICAL VALIDATION SAMPLE

- Walk every emergency entrance and presentation route; interview registration, triage, a QMP, and the transfer center.
- Review a six-month log reconciliation plus at least 10 targeted records: refusals, walkouts, transfers, labor, behavioral health, and on-call events.
- If an active concern or recent potentially improper transfer is identified, escalate through clinical, compliance/legal, and executive pathways immediately.

PRIMARY SOURCES

CMS EMTALA overview and resources
CMS State Operations Manual, Appendix V
42 CFR 489.20 and 42 CFR 489.24

Use note: This screening tool summarizes selected federal readiness expectations; it is not exhaustive, legal advice, or a substitute for current law, CMS guidance, State requirements, or case-specific counsel. Verify requirements before use.