The Joint Commission expects healthcare organizations to comply with all Elements of Performance. In view of the circumstances, The Joint Commission will not cite noncompliance with these Elements of Performance for the period of time during any local, state, or federal declared State of Emergency for COVID-19. The Joint Commission continues to recommend all healthcare organizations use their independent medical judgment on a case by case basis in the best interest of patient safety.

Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	20	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the critical access hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities. Organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.

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Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	21	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity - Scout prescription accuracy - Alignment light accuracy - Table travel accuracy - Radiation beam width - High-contrast resolution - Low-contrast detectability - Geometric or distance accuracy - CT number accuracy and uniformity - Artifact evaluation Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities. Organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.

Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	22	At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity for all radiofrequency (RF) coils used clinically - Signal-to-noise ratio (SNR) for all coils used clinically - Slice thickness accuracy - Slice position accuracy - Alignment light accuracy - High-contrast resolution - Low-contrast resolution (or contrast-to-noise ratio) - Geometric or distance accuracy - Magnetic field homogeneity - Artifact evaluation Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities. Organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.

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Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	23	At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Sensitivity - Energy resolution - Count-rate performance - Artifact evaluation Note 1: The following test is recommended, but not required: Low-contrast resolution or detectability for non-planar acquisitions. Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. He or she may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities.

Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	24	At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Low-contrast resolution or detectability (not applicable for planar acquisitions) - Artifact evaluation Note 1: The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution, and count-rate performance. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities.
EC	EC.02.04.03	25	For computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy. Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities. Organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.

Chapter	Standard	EP	EP Text	comments
EC	EC.02.04.03	34	For critical access hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following: - Beam alignment and collimation - Tube potential/kilovolt peak (kV/kVp) accuracy - Beam filtration (half-value layer) - High-contrast resolution - Low-contrast detectability - Maximum exposure rate in all imaging modes - Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable) Note 1: Medical physicists conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations may defer completing the performance evaluations for diagnostic imaging equipment, such as Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM), Positron Emission Tomography (PET), Fluoroscopy equipment and acquisition monitors for these modalities. Organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.
EM	EM.02.01.01	1	The critical access hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.	This 1135 waiver is only applicable to surge sites developed as a result of influx of COVID-19 patients. Organizations are not required to develop an emergency operations plan for those sites.

Chapter	Standard	EP	EP Text	comments
HR	HR.01.01.01	1	The critical access hospital defines staff qualifications specific to their job responsibilities. (See also HR.01.01.01, EP 32; IC.01.01.01, EP 3) Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix B for 409.17 requirements.	**Regarding CPR, ACLS, BLS:** The Joint Commission released an FAQ supporting the extension of expiration dates for certifications by 60 days, in accordance with published guidance by the American Heart Association.
HR	HR.01.05.03	14	The critical access hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at http://www.imagegently.org and http://www.imagewisely.org, respectively. Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.

Chapter	Standard	EP	EP Text	comments
LD	LD.03.02.01	1	Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - Creating a culture of safety and quality - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
LD	LD.03.02.01	2	Leaders evaluate how effectively data and information are used throughout the critical access hospital.	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
LD	LD.03.03.01	2	Planning is hospitalwide, systematic, and involves designated individuals and information sources.	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
LD	LD.04.01.01	6	Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.	Waived by CMS 1135 Waiver 3/30/20
LD	LD.04.01.01	7	The critical access hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.	Waived by CMS 1135 Waiver 3/30/20
LD	LD.04.01.01	8	The critical access hospital carries out or arranges for, at a minimum, an annual evaluation of its total program which includes a review of the utilization of its services, a representative sample of active and closed records, and health care policies.	The entire utilization review (UR) program has been waived by CMS during the time of the declared disaster (pandemic).

Chapter	Standard	EP	EP Text	comments
LD	LD.04.03.09	23	When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). (See also MS.13.01.01, EP 1) Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site licensed independent practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site.	The requirement listed within this element of performance for a written agreement is being waived to allow for increased access to necessary care for patients. Disaster privileges may be extended under EM.02.02.13.

Chapter	Standard	EP	EP Text	comments
MS	MS.08.01.03	1	The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, Ongoing Professional Practice Evaluations (OPPE) should continue to the extent possible, practitioner performance data collection for OPPE should continue based on the established process. If gaps in data occur as a result of temporary reallocation of resources, the organization should document the contributing factors leading to such gaps. If resources are unavailable to review the data within the defined time frames, the organization may temporarily modify the review process until such time resources can be re-allocated back to resume the process as designed. Any modifications to the review process should allow the medical staff to detect – and address – downward trending performance. Examples may include review of incident reports, staff/patient complaints, post-procedure complications, sentinel or other events resulting in negative patient outcomes, etc. • The organization should periodically reassess the availability of resources to determine when the OPPE data collection and review process can resume as designed.

Chapter	Standard	EP	EP Text	comments
MS	MS.08.01.03	2	The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, Ongoing Professional Practice Evaluations (OPPE) should continue to the extent possible, practitioner performance data collection for OPPE should continue based on the established process. If gaps in data occur as a result of temporary reallocation of resources, the organization should document the contributing factors leading to such gaps. If resources are unavailable to review the data within the defined time frames, the organization may temporarily modify the review process until such time resources can be re-allocated back to resume the process as designed. Any modifications to the review process should allow the medical staff to detect – and address – downward trending performance. Examples may include review of incident reports, staff/patient complaints, post-procedure complications, sentinel or other events resulting in negative patient outcomes, etc. • The organization should periodically reassess the availability of resources to determine when the OPPE data collection and review process can resume as designed.

Chapter	Standard	EP	EP Text	comments
MS	MS.08.01.03	3	The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, Ongoing Professional Practice Evaluations (OPPE) should continue to the extent possible, practitioner performance data collection for OPPE should continue based on the established process. If gaps in data occur as a result of temporary reallocation of resources, the organization should document the contributing factors leading to such gaps. If resources are unavailable to review the data within the defined time frames, the organization may temporarily modify the review process until such time resources can be re-allocated back to resume the process as designed. Any modifications to the review process should allow the medical staff to detect – and address – downward trending performance. Examples may include review of incident reports, staff/patient complaints, post-procedure complications, sentinel or other events resulting in negative patient outcomes, etc. • The organization should periodically reassess the availability of resources to determine when the OPPE data collection and review process can resume as designed.

Chapter	Standard	EP	EP Text	comments
MS	MS.13.01.01	1	All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization. The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited hospital or ambulatory care organization. - The practitioner is privileged at the distant site for those services to be provided at the originating site. - The distant site provides the originating site with a current list of licensed independent practitioners' privileges. - The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - When telemedicine services are provided by a distant-site Medicare-participating hospital,	The process for providing privileges in a disaster are outlined in EM.02.02.13. In addition, a written contract is not required and is waived unless the services will extend beyond the declared disaster timeframe.
PC	PC.01.03.01	4	For swing beds in critical access hospitals: The critical access hospital develops the resident's written plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed.	Organizations may wish to develop care plans to assist in delivery of care, but are not required to do so at this time.

Chapter	Standard	EP	EP Text	comments
PC	PC.01.03.01	5	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals.	Organizations may wish to develop care plans to assist in delivery of care, but are not required to do so at this time.
PC	PC.01.03.01	22	Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.	Organizations may wish to develop care plans to assist in delivery of care, but are not required to do so at this time.
PC	PC.01.03.01	23	The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)	Organizations may wish to develop care plans to assist in delivery of care, but are not required to do so at this time.

Chapter	Standard	EP	EP Text	comments
PC	PC.03.01.01	9	In accordance with the critical access hospital's policy and state scope of practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program (See also PC.03.01.03, EP 1 and PC.03.01.07, EP 4) Note: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that he or she has consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	CMS is waiving requirements under 42 CFR §485.639(c)(2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraphs §482.52(a)(5) and §485.639(c)(2). CRNA supervision will be at the **discretion of the hospital and state law**. This waiver applies to hospitals, CAHs, and Ambulatory Surgical Centers (ASCs). These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

Chapter	Standard	EP	EP Text	comments
PC	PC.04.01.01	22	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient or the patient's representative of his or her freedom to choose among participating Medicare providers and suppliers of post-discharge services and, when possible, respects the patient's or patient representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The critical access hospital does not limit the qualified providers who are available to the patient.	This was waived by CMS 1135 waiver
PC	PC.04.01.01	25	For rehabilitation and psychiatric distinct part units in critical access hospitals: The discharge plan identifies any home health agency or skilled nursing facility in which the critical access hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a critical access hospital. Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act.	This was waived by CMS 1135 waiver

Chapter	Standard	EP	EP Text	comments
PC	PC.04.01.01	31	The critical access hospital assists patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, and long term care hospital data on quality measures and resource-use measures. The critical access hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.	Detailed Information Sharing for Discharge Planning for Hospitals and CAHs. CMS is waiving the requirement 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to provide detailed information regarding discharge planning, described below: • The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. • CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).

Chapter	Standard	EP	EP Text	comments
PC	PC.04.01.01	33	For rehabilitation and psychiatric distinct part units in critical access hospitals: For patients enrolled in managed care organizations, the critical access hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network. If the critical access hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative.	Detailed Information Sharing for Discharge Planning for Hospitals and CAHs. CMS is waiving the requirement 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to provide detailed information regarding discharge planning, described below: • The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. • CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).
PI	PI.01.01.01	1	The leaders (including the governing body) set priorities for and identify the frequency of data collection. (See also LD.03.07.01, EP 2) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders that specify the frequency and detail of data collection is the governing body.	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain

Chapter	Standard	EP	EP Text	comments
PI	PI.01.01.01	2	The critical access hospital collects data on the following: Performance improvement priorities identified by leaders. (See also LD.03.07.01, EP 2)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	3	The critical access hospital collects data on the following: Operative or other procedures that place patients at risk of disability or death. (See also LD.03.07.01, EP 2; MS.05.01.01, EP 6)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	6	The critical access hospital collects data on the following: The use of blood and blood components. (See also LD.03.07.01, EP 2)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	7	The critical access hospital collects data on the following: All reported and confirmed transfusion reactions. (See also LD.03.07.01, EP 2; LD.03.09.01, EP 3)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain

Chapter	Standard	EP	EP Text	comments
PI	PI.01.01.01	8	The critical access hospital collects data on the following: The use of restraints. (See also LD.03.07.01, EP 2)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	9	The critical access hospital collects data on the following: The use of seclusion. (See also LD.03.07.01, EP 2)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	12	The critical access hospital collects data on the following: Significant medication errors. (See also LD.03.07.01, EP 2; MM.08.01.01, EP 1)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.01.01.01	14	The critical access hospital collects data on the following: Patient perception of the safety and quality of care, treatment, or services.	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain

Chapter	Standard	EP	EP Text	comments
PI	PI.02.01.01	4	The critical access hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
PI	PI.03.01.01	2	The critical access hospital takes action on improvement priorities. (See also MM.08.01.01, EP 6; MS.05.01.01, EPs 3–7, 9)	We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain
RC	RC.02.03.07	4	Verbal orders are authenticated within the time frame specified by law and regulation.	The 48 hour time frame for authentication has been extended, no maximum time was provided. The time for authentication is left to the organization to determine.
RI	RI.01.05.01	1	The critical access hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - For outpatient settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Providing the patient upon admission with information on the extent to which the critical access hospital is able, unable, or unwilling to honor advance directives. - Whether the critical access hospital will honor advance directives in its outpatient settings. - That the critical access hospital will honor the patient's right to formulate or review and revise his or her advance directives. - Informing staff and licensed independent practitioners who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive.	**Only the bullet points listed below are waived related to the requirement to give patients advanced directives information:** - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives. - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided.

Chapter	Standard	EP	EP Text	comments
WT	WT.03.01.01	6	Competence for waived testing is assessed according to critical access hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented. Note 1: When a licensed independent practitioner performs waived testing that does not involve an instrument and the test falls within his or her specialty, the critical access hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual practitioner privileges include the specific waived tests appropriate to the scope of practice that he or she is authorized to perform. At the discretion of the person from the critical access hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to critical access hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.	During the COVID-19 pandemic, when a state of emergency has been declared and the organization has activated their emergency operations plan, organizations have 60 days after the end of the state of emergency (national, federal, or local level depending upon which allows the most time to address), to complete these items.