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 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.

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.

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. 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.
EC	EC.02.04.03	34	For 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.

Chapter	Standard	EP	EP Text	comments
EM	EM.02.01.01	16	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated at least every two years; the format of these documents is at the discretion of the hospital.	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.
HR	HR.01.01.01	1	The hospital defines staff qualifications specific to their job responsibilities. (See also HR.01.01.01, EP 32; IC.01.01.01, EP 3; RI.01.01.03, EP 2) 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: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: “Personnel for Nonwaived Testing” §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 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 A for 409.17 requirements. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.	Regarding respiratory treatments: This waiver only applies to who is authorized to administer respiratory care treatments. The waiving of the requirements at 42 CFR §482.57(b)(1) that require hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities may be implemented so long as they are not inconsistent with a state’s emergency preparedness or pandemic plan. Not being required to designate these professionals in writing will allow qualified professionals to operate to the fullest extent of their licensure and training in providing patient care. 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.

Chapter	Standard	EP	EP Text	comments
HR	HR.01.05.03	14	The 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.
HR	HR.01.05.03	25	The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI practices in the MRI environment, including the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) * - MRI safety response procedures for patients who require urgent or emergent medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Footnote *: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).	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.
IM	IM.02.02.03	3	The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation.	Time frames may be extended beyond current hospital requirements to ensure staffing resources are allocated to patient care needs. No maximum time was provided.

Chapter	Standard	EP	EP Text	comments
LD	LD.01.03.01	14	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed	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	1	Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - 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	4	For hospitals that use Joint Commission accreditation for deemed status purposes: The quality assessment and performance improvement program incorporates quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs (for example, data related to hospital readmissions and hospital-acquired conditions).	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
LD	LD.03.05.01	1	The hospital has a systematic approach to change and performance improvement.	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.03.05.01	2	Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support both safety and quality throughout the hospital - Adapt to 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.03.05.01	3	Leaders evaluate the effectiveness of processes for the management of change and performance improvement. (See also PI.02.01.01, EP 13)	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.03.07.01	1	Performance improvement occurs hospital wide.	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.03.07.01	2	As part of performance improvement, leaders do the following: - Set priorities for performance improvement activities and patient health outcomes (See also PI.01.01.01, EPs 1 and 2) - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities, which could include an information technology system designed to improve patient safety and quality of care (See also PI.01.01.01, EPs 3, 5–7, 10, 12, and 13) - Reprioritize performance improvement activities in response to changes in the internal or external 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

Chapter	Standard	EP	EP Text	comments
LD	LD.03.08.01	1	The hospital's design of new or modified services or processes incorporates the following: - The needs of patients, staff, and others - The results of performance improvement activities - Information about potential risks to patients (See also LD.03.09.01, EPs 3, 7, and 8) - Evidence-based information in the decision-making process - Information about sentinel events Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.	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.03.09.01	1	The leaders implement a hospital wide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.	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.03.09.01	8	To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. (See also LD.03.08.01, 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

Chapter	Standard	EP	EP Text	comments
LD	LD.04.01.01	17	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	The entire utilization review (UR) program has been waived by CMS during the time of the declared disaster (pandemic).
LD	LD.04.01.01	18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	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	For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the 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 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 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). (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 requirements 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.
MM	MM.04.01.01	6	The hospital minimizes the use of verbal and telephone medication orders.	The requirement for an order remains. However, an increased frequency of verbal orders may be necessary to meet the needs of patients. The increased frequency will not be considered out of compliance with this standard and element of performance.

Chapter	Standard	EP	EP Text	comments
MM	MM.04.01.01	15	For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines - Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.	**Protocol Development:** Allows for development of protocols and standing orders without having to initiate and obtain approval through full medical staff, nursing leadership and pharmacy review process. **Review of Protocols:** Organizations may utilize an abbreviated process for review and approval of the protocol with a representative from each of the following disiplines: the medical staff, nursing and pharmacy. Additionally, the need for regular review of protocols/standing orders was waived during the pandemic. **Protocol Authentication:** The requirement to authenticate the protocol in the medical record during the time of the declared emergency.
MS	MS.01.01.01	13	The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.01.01.01	14	The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners. (See also EM.02.02.13, EP 2; MS.06.01.13, EP 1)	The Joint Commission published an FAQ which allows for the credentialing and privileging of a provider to be extended until 60 days after the conclusion of the last declared emergency at a regional, state or federal level. Initial privileges should be granted based on requirements at EM.02.02.13.
MS	MS.02.01.01	11	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each practitioner privileged through the medical staff process.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.03.01.01	13	For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.	Applies to surge facilities only: Written policies and procedures for surge facilities are not required.

Chapter	Standard	EP	EP Text	comments
MS	MS.03.01.03	1	Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).	This provision allows for patients to be under the care of practitioners as allowed by the scope of practice other than a licensed independent provider. CMS is waiving requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4), which requires that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. This allows hospitals to use other practitioners to the fullest extent possible.
MS	MS.03.01.03	3	A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	This provision allows for patients to be under the care of practitioners as allowed by the scope of practice other than a licensed independent provider. CMS is waiving requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4), which requires that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. This allows hospitals to use other practitioners to the fullest extent possible.
MS	MS.05.01.03	3	The organized medical staff participates in the following activities: Accurate, timely, and legible completion of patient's medical records. (See also RC.01.04.01, EP 1)	Time frames may be extended beyond current hospital requirements for timely medical records completion. No maximum time was provided. Records completion time frames may be waived to extend beyond the 30 days following discharge.
MS	MS.06.01.03	1	The hospital credentials applicants using a clearly defined process.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.03	2	The credentialing process is based on recommendations by the organized medical staff.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.03	6	The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence	The process for providing privileges in a disaster are outlined in EM.02.02.13.

Chapter	Standard	EP	EP Text	comments
MS	MS.06.01.05	1	All licensed independent practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.	A valid license is still required for all licensed independent practitioners. However, the federal level has relaxed the need to be licensed in the state in which the care is provided. This does not negate any state level restrictions. Organizations will need to determine if their state has relaxed the requirement as well.
MS	MS.06.01.05	2	The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the practitioner's performance within the hospital	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.05	6	An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested. Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the organized medical staff. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.05	7	The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.	The process for providing privileges in a disaster are outlined in EM.02.02.13.

Chapter	Standard	EP	EP Text	comments
MS	MS.06.01.05	8	Peer recommendation includes written information regarding the practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.05	9	Before recommending privileges, the organized medical staff also evaluates the following: - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.05	10	The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.05	12	Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.06.01.07	8	The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.01	1	The organized medical staff develops criteria for medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.01	2	The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.01	3	The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.	The process for providing privileges in a disaster are outlined in EM.02.02.13.

Chapter	Standard	EP	EP Text	comments
MS	MS.07.01.01	5	Membership is recommended by the medical staff and granted by the governing body.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.03	1	Recommendations from peers are obtained and evaluated for all new applicants for privileges.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.03	2	Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.03	3	Peer recommendations include the following information: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.07.01.03	4	Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.	The process for providing privileges in a disaster are outlined in EM.02.02.13.
MS	MS.08.01.01	1	A period of focused professional practice evaluation is implemented for all initially requested privileges.	The process for providing privileges in a disaster are outlined in EM.02.02.13 and required oversite. This oversite does not have to be consistent with FPPE requirements. An FAQ was also published regarding this issue.

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.	**Ongoing Professional Practice Evaluations (OPPE)** • 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.	**Ongoing Professional Practice Evaluations (OPPE)** • 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).	**Ongoing Professional Practice Evaluations (OPPE)** • 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. - For hospitals that use Joint Commission accreditation for deemed status purposes: 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. (See also LD.04.03.09, EPs 4, 9, and 23) - The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.	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.

Chapter	Standard	EP	EP Text	comments
NR	NR.02.03.01	9	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures are as follows: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Approved by the director of nursing - Reviewed at least once every three years	This provision allows for organizations to evaluate their outpatient departments and determine if remaining patient needs require the presence of a registered nurse. This would allow staff to be reallocated to meet the needs of increased patient demands from the pandemic surge.
PC	PC.01.03.01	1	The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also PC.01.02.13, EP 2)	Organizations may wish to develop care plans to assist in delivery of care but are not required at this time.
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 hospitals that use Joint Commission accreditation for deemed status purposes: 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 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 at this time.
PC	PC.01.03.01	23	The 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 at this time.
PC	PC.02.02.03	22	For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.	Waiver only applies to surge treatment sites. Organizations are not required to develop a diet manual for surge sites used for patient care.

Chapter	Standard	EP	EP Text	comments
PC	PC.03.01.01	10	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the 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 482.52(c) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist who is immediately available if needed - A supervised trainee in an approved educational program Note 1: 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. Note 2: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the 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 attests 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 §482.52(a)(5), 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.03.05.09	1	The hospital's policies and procedures regarding restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii):	**Only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19**. Hospitals that are located in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. **The requirements for seclusion for behavioral purposes have not been waived**. Only applies to medical seclusion for infectious purposes.
PC	PC.03.05.19	2	For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	The requirements to have hospitals report to CMS any patient whose death is caused by their disease while in restraints by the end of the next business day has been waived. This only applies to soft restraints in the ICU setting. This does not apply to deaths where restraints were felt to be a causative factor of the death.

Chapter	Standard	EP	EP Text	comments
PC	PC.04.01.01	22	For hospitals that use Joint Commission accreditation for deemed status purposes: The 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 hospital does not limit the qualified providers who are available to the patient.	This requirement is waived by the CMS 1135 waiver
PC	PC.04.01.01	25	For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a 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 requirement is waived by the CMS 1135 waiver.
PC	PC.04.01.01	31	For hospitals that use Joint Commission accreditation for deemed status purposes: The 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 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.	This requirement is waived by the CMS 1135 blanket waiver
PC	PC.04.01.01	33	For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the 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 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.	This requirement is waived by the CMS 1135 blanket waiver
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)	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 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 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	4	The hospital collects data on the following: All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.	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	5	The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. (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	6	The 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

Chapter	Standard	EP	EP Text	comments
PI	PI.01.01.01	7	The 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
PI	PI.01.01.01	10	The hospital collects data on the following: The results of resuscitation. (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 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	13	The hospital collects data on the following: Significant adverse drug reactions. (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 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	3	The hospital uses statistical tools and techniques to analyze and display data.	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.02.01.01	4	The 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.02.01.01	8	The hospital uses the results of data analysis to identify improvement opportunities.	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 hospital takes action on improvement priorities. (See also MM.08.01.01, EP 6; MS.05.01.01, EPs 1–11)	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	4	The hospital takes action when it does not achieve or sustain planned improvements. (See also MS.05.01.01, EPs 1–11)	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
RC	RC.01.01.01	1	The hospital defines the components of a complete medical record.	The organization must define what minimal components of the medical record must be completed during the declared disaster time period. Minimal components must be present to reflect the care, treatment and services the patient received, ensure proper transmission of information for the next care team provider(s) and responses to treatment. Organizations may extend reassessments built into their policy to accommodate patient care needs. All required elements should be captured as part of the emergency operations plan.
RC	RC.01.01.01	5	The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - Information about the patient's care, treatment, and services that promotes continuity of care among providers Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.	The organization must define what minimal components of the medical record must be completed during the declared disaster time period. Minimal components must be present to reflect the care, treatment and services the patient received, ensure proper transmission of information for the next care team provider(s) and responses to treatment. Organizations may extend reassessments built into their policy to accommodate patient care needs. All required elements should be captured as part of the emergency operations plan.
RC	RC.01.03.01	1	The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge.	The 30 day expectation may be extended, if deemed necessary by he organization.
RC	RC.01.03.01	2	The hospital follows its written policy requiring timely entry of information into the patient's medical record. (See also PC.01.02.03, EP 1)	Due to patient care needs, organizations may extend the time listed in their policy to have information entered into the medical record.
RC	RC.01.04.01	1	The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also MS.05.01.03, EP 3)	Organizations are not required to do ongoing assessment of patient care records as part of the QAPI program during this time.

Chapter	Standard	EP	EP Text	comments
RC	RC.02.01.01	2	The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before his or her arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	The organization must define what minimal components of the medical record must be completed during the declared disaster time period. Minimal components must be present to reflect the care, treatment and services the patient received, ensure proper transmission of information for the next care team provider(s) and responses to treatment. Organizations may extend reassessments built into their policy to accommodate patient care needs. All required elements should be captured as part of the emergency operations plan.
RC	RC.02.03.07	4	Verbal orders are authenticated within the time frame specified by law and regulation.	The authentication time frame for verbal orders has been extended beyond 48 hours. No maximum time frame was provided.

Chapter	Standard	EP	EP Text	comments
RC	RC.02.04.01	3	In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	**Psychiatric hospitals only**: Waived under 482.61(e) , organizations are not required to provide a list of follow up post discharge care facilities.
RI	RI.01.01.01	1	The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	**Only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19**. Hospitals that are located in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. The organization should determine how to address patient visitation in light of the COVID-19 pandemic.

Chapter	Standard	EP	EP Text	comments
RI	RI.01.01.01	10	The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.	**Only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19**. Hospitals that are located in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. The requirement has not been waived. The time frame in which the record must be made available has been extended.
RI	RI.01.05.01	1	The 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. - 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. - Whether the hospital will honor advance directives in its outpatient settings. - That the 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.	**<u>Only the bullet points</u> 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.
WT	WT.03.01.01	6	Competence for waived testing is assessed according to 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 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 hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to 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 is instituted, (national, federal, or local level depending upon which allows the most time to address), they have 60 days after the end of the state of emergency to get these items completed.