Surveying Facilities That Use Electronic Health Records (EHR)

The Illinois Health Care Association (IHCA) receives a lot of questions concerning the Illinois Department of Public Health’s (IDPH) survey process for long term care (LTC) facilities that use electronic records. In discussions with IDPH, they have stated that they are preparing a policy on how surveyors and LTC facilities are to interact with regard to electronic health records. The basis of this new policy (IHCA will share this new policy with our members as soon as IDPH releases it) is the Centers for Medicare & Medicaid Services’ (CMS) Survey and Certification Letter S&C 09-53 (click here).

The Department of Health and Human Services (HHS) and the CMS are committed to the goal that Americans should have access to health care providers who use EHRs. CMS recognizes the importance of the use of EHRs and their benefits to better patient/resident care and reduced costs to both providers and Medicare/Medicaid. However, there is no mandate for use of EHR and long term care providers have the right to use whatever system of medical records (electronic or paper) they choose as long as that system complies with its Medicare/Medicaid participation requirements.

Surveyors must be able to conduct the survey process in a consistent manner in all facilities regardless of whether the facility uses paper-based records and/or EHRs. During the entrance conference, surveyors will verify with the facility the process they will follow in order to have unrestricted access to the medical records. Impeding the survey process by unnecessarily delaying or restricting access to the medical records may lead to termination from Medicare/Medicaid participation. A LTC provider must grant access to any medical record, including access to EHRs, when requested by the surveyor. If access to an EHR is requested by the surveyor, the facility will (a) provide the surveyor with a tutorial on how to use its particular electronic system and (b) designate an individual who will, when requested by the surveyor, access the system, respond to any questions or assist the surveyor as needed in accessing electronic information in a timely fashion. Each surveyor will determine the EHR access method that best meets the need for that survey. During the entrance conference in a facility using EHRs the survey team must request that the facility provide a terminal(s) where the surveyors may access records. Surveyors will cooperate and work with facilities that use EHR. The number of terminals made available to the surveyor(s) will be discussed between the survey team leader and designated LTC facility manager. Considerations should include, the number of residents in the facility, the number of computers/terminals the facility has, the care needs of the residents and other relevant factors. Any disagreements on this issue should be discussed with the appropriate IDPH Regional Supervisor.

If the facility is unable to provide direct print capability to the surveyor, the provider must make available a printout of any record or part of a record upon request in a timeframe that does not impede the survey process. Undue delays in the production of records are unacceptable. Whenever possible, the facility must provide
surveyors electronic access to records in a read-only format or other secure format to avoid any inadvertent changes to the record. The provider is solely responsible for ensuring that all necessary backup of data and security measures are in place.

During the entrance conference surveyors will establish with the facility the process they will follow in order to have unrestricted access to the medical record. Electronic access to records will not eliminate the need for a surveyor to print a paper copy or to request a paper copy of certain parts of certain records. However, the surveyor shall make reasonable efforts to avoid, where possible, the printing of entire records. The surveyor should print or request a paper copy of only those parts of records that are needed to support findings of noncompliance.

Surveyors are not responsible for assessing compliance with the HIPAA Privacy and Security Rules. The Department of Health and Human Services Office of Civil Rights has the primary responsibility for enforcing the HIPAA Privacy Rule. Surveyors instead are to focus on how the EHR system is being used in the facility, and whether that use is consistent with the Medicare/Medicaid requirements. For example, are computer screens showing clinical record information left unattended and readily observable or accessible by other patients/residents or visitors? Are there documents publicly posting passwords that would be evidence of noncompliance with both confidentiality and medical record authentication requirements? Is there evidence to support a complaint allegation that facility staff shared information obtained from an EHR with unauthorized individuals?

If any questions arise during a survey with regard to EHRs, attempt to address them with the survey team leader or the Regional Supervisor.

**New Guidance on Contact Precautions for Visitors**

*Expert Recommendations for Visitors of Patients with Infectious Diseases*

Leading infectious diseases experts have released new guidance for healthcare facilities looking to establish precautions for visitors of patients with infectious diseases. The guidance looks to reduce the potential for healthcare visitors in spreading dangerous bacteria within the healthcare facility and community. The recommendations are published online in *Infection Control & Hospital Epidemiology*, the journal of the Society for Healthcare Epidemiology of America (SHEA).

“Visitors have initiated or been involved in healthcare-associated infection outbreaks, but it is unknown to what extent this occurs in the transmission of bacteria in healthcare facilities,” said L. Silvia Munoz-Price, MD, PhD, a lead author of the guidance. “The guidance is intended to strike a balance between visitor and patient safety, the potential for pathogen spread in healthcare facilities, the psychosocial implications of isolation and the feasibility of enforcement.”

The SHEA Guidelines Committee, comprised of experts in infection control and prevention, developed the recommendations based on available evidence, theoretical rationale, practical considerations, a survey of SHEA members, author opinion and consideration of potential harm where applicable.

Since not all pathogens present the same risk of transmission to and via visitors, the guidance reflects the protections that should be taken for distinct pathogens. The authors caution that visitor precautions should only be implemented by healthcare facilities if they can be realistically enforced and regularly evaluated for compliance. Healthcare facilities should use the guidance as a framework for developing facility policies. Recommendations include:

- **Hand hygiene** performed prior to entering and immediately after leaving a resident room.
- In areas where they are endemic, methicillin-resistant *Staphylococcus aureus* (MRSA) and Vancomycin-resistant *enterococci* (VRE) do not require contact isolation precautions for visitors given their prevalence
in the community. However, special considerations should be made for immunocompromised visitors or those unable to practice good hand hygiene.

- **Visitors of resident with gram-negative organisms**, such as carbapenem-resistant *Enterobacteriaceae* (CRE) and *Klebsiella pneumoniae carbapenemase* (KPC), should follow contact precautions to help prevent transference of pathogens to guests.
- **Intestinal pathogens**, such as *Clostridium difficile* and norovirus, are potentially harmful to visitors and have low prevalence in the community so contact isolation precautions should be in place.
- **Visitors to rooms with droplet** (i.e., pertussis) or **airborne precautions** (i.e., tuberculosis) should use surgical masks. This is especially the case for household contacts already exposed to the symptomatic resident. N95 respirators are an alternative best used with training and fit testing. Consideration should be given to limit visitation for those visitors requiring high levels of protection (due to lack of documented exposure to the symptomatic resident). In **outbreak situations** or when novel pathogens are suspected, isolation precautions should be enforced for all visitors.
- **For visitors with extended stays**, like parents and guardians, isolation precautions are likely not practical and the benefit of wearing personal protective equipment like gowns and gloves is unclear except if assisting in care delivery. In many cases, these visitors may have had extensive exposure to the patient prior to hospitalization and could be immune to the pathogen or in an incubation period.

A survey of SHEA members showed that the majority of their healthcare facilities have policies for visitation of inpatient isolation rooms and many of these policies mirror healthcare personnel policies. However, most healthcare facilities did not monitor visitors’ compliance with policies.

The authors recommend further research on the role of visitors in the transmission of healthcare-associated infections to better define the risk and preventive measures necessary.


---

**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**McKnight’s Long Term Care News** reports that significant reductions in adverse drug events, infections, wounds and use of restraints in nursing homes are among the key achievements touted [last month] by federal regulators. The good news comes in a [progress report](#) on the Centers for Medicare & Medicaid Services' Quality Improvement Organization Program, a five-year effort designed to enhance the quality of services for Medicare beneficiaries.

CMS redesigned the QIO program in August 2014. More than 5,000 nursing homes were recruited to participate in the national collaborative.

Among the achievements among participating nursing homes:

- 44,640 potential adverse drug events were prevented;
- 3,374 pressure ulcers were prevented or healed in 787 facilities;
- 6,250 Medicare beneficiaries in 981 facilities are now restraint free; and
- 85,149 fewer days with urinary catheters for Medicare beneficiaries.

Two key nursing home goals in the five-year program are a resident-centered care and safety initiative, and an effort to reduce the use of antipsychotics.
Under the quality of resident-centered care and safety initiative, the QIO program hopes to unite nursing homes, key stakeholders and organizations throughout their communities to share tools, knowledge and technology to achieve system-wide improvement. One in five nursing home residents current suffer preventable harm, according to a recent Inspector General report.

The antipsychotics reduction initiative aims to reduce an original 19.8 percent national use of antipsychotics in long-stay nursing home residents while providing education, training and technical assistance to nursing home facilities.

For more information, download the complete report or visit the QIO website.

---

**Important Rules, Regulations & Notices**

1) The following federal Survey and Certification Letters (S&C) were released since the last issue of *Regulatory Beat*:

- **S&C 15-36 – All** - New Instructions for Providers Filing an Appeal with the Departmental Appeals Board (DAB). Effective October 1, 2014, providers that disagree with actions imposed on their facility must file a hearing request electronically using the DAB’s E-Filing System (DAB E-File). DAB E-File Filing Assistance: For assistance in submitting a request through the DAB E-File System, filers may call the Civil Remedies Division main telephone line at 202-565-9462. DAB E-File Technical Assistance: For technical issues regarding the DAB E-File System, filers may contact E-File System Support at OSDABImmediateOffice@hhs.gov.

2) CMS released several notices/announcements since the last issue of *Regulatory Beat*. They include:

- **CMS updates to the wage index and payment rates for the Medicare Hospice Benefit.** On April 30, 2015, CMS issued a proposed rule (CMS-1629-P) that would update fiscal year (FY) 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. The proposed hospice payment rule reflects the ongoing efforts of CMS to support beneficiary access to hospice care. The FY 2016 proposals and other issues discussed in the proposed rule are summarized in the fact sheet (click here).

- **New Medicare prescription drug cost data available.** As part of the Administration’s goals of better, care, smarter spending, and healthier people, the CMS announced the availability of new, privacy-protected data on Medicare Part D prescription drugs prescribed by physicians and other health care professionals in 2013. This data shows which prescription drugs were prescribed to Medicare Part D beneficiaries by which practitioners.

- **Five Facts about ICD-10.** To help dispel some of the myths surrounding ICD-10, CMS recently talked with providers to identify common misperceptions about the transition to ICD-10. The five facts (click here) address some of the common questions and concerns CMS has heard about ICD-10.

- **Money Follows the Person Demonstration: New Report Available.** CMS made available a new report related to the Money Follows the Person (MFP) demonstration, titled “The Right Supports at the Right Time: How Money Follows the Person Programs Are Supporting Diverse Populations in the Community.” MFP supports states’ efforts to help Medicaid beneficiaries living in long term care facilities transition back to the community, where they have more choice about where they live and receive care. This report examines how six MFP grantees are serving populations with diverse needs in the community and the factors that have contributed to their strong performance on key outcome measures. The report is now available on Medicaid.gov under the “MFP Evaluation Information and Reports” section—click here to view.
• **Proposed Fiscal Year 2016 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities.** On April 23, 2015, CMS issued a proposed rule outlining proposed fiscal year (FY) 2016 Medicare payment policies and rates for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the IRF Quality Reporting Program (IRF QRP). The FY 2016 proposals are noted in the fact sheet ([click here](#)).

• **Fiscal Year 2016 proposed Inpatient and Long term Care Hospital policy and payment changes.** On April 17, 2015 CMS issued a proposed rule to update fiscal year (FY) 2016 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long Term Care Hospital (LTCH) Prospective Payment System (PPS). The proposed rule ([click here](#)), which would apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, would affect discharges occurring on or after October 1, 2015.

• **Updated 2015 Spousal Impoverishment Standards.** CMS released an informational bulletin related to the 2015 Supplemental Security Income (SSI) and Spousal Impoverishment Standards. The informational bulletin can be accessed [here](#). The 2015 Supplemental Security Income (SSI) and Spousal Impoverishment Standards can be viewed [here](#).

• **National Partnership to Improve Dementia Care and QAPI - MLN Connects® National Provider Call - Tuesday, June 16th; 1:30-3:00pm ET. To Register: Visit MLN Connects® Upcoming Calls.** Space may be limited, register early. During this MLN Connects National Provider Call, CMS subject matter experts will provide updates for the National Partnership and Quality Assurance and Performance Improvement (QAPI). Additionally, a nursing home will discuss steps taken to achieve antipsychotic medication reduction in their facility, and Indiana University will present information about evidence-based dementia care training. A question and answer session will follow the presentations.

  The [National Partnership to Improve Dementia Care in Nursing Homes](#) and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

  **Agenda:**
  - National Partnership and QAPI updates
  - Antipsychotic reduction success – The Cedars, Maine
  - Evidence-based dementia care training

• **Recent issues of the Medicare Learning Network,** had a couple items of note. They include:
  - New Hospice Reports Available in CASPER. Three new hospice provider reports are now available in the Certification and Survey Provider Enhanced Reports (CASPER) reporting application: (1) HIS Record Error Detail by Provider; (2) HIS Record Error by Field by Provider; and (3) HIS Records With Error Number. Additional information on the reports is available on the [Spotlights & Announcements](#) web page for the Hospice Quality Reporting Program. For questions about access to CASPER or the new provider reports, please contact the QTSO Help Desk at [help@qtsos.com](mailto:help@qtsos.com) or 888-477-7886.
  - “Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Web-Based Training Course — Revised. The “Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Web-Based Training Course (WBT) was revised and is now available. This WBT is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against fraud and abuse, as well as how you can help prevent and report it. Continuing education credits are available to learners who successfully complete this course. See course description for more...
information. To access the WBT, go to MLN Products, scroll to the bottom of the web page and under “Related Links” click on “Web-Based Training Courses.”

- **Affordable Care Act Payment Model Saves More Than $384 Million in Two Years, Meets Criteria for First-Ever Expansion.** Recently, an independent evaluation report released by the Department of Health and Human Services showed that an innovative payment model created as a pilot project by the Affordable Care Act generated substantial savings to Medicare in just two years. Additionally, the independent Office of the Actuary in CMS has certified that this patient care model is the first to meet the stringent criteria for expansion to a larger population of Medicare beneficiaries. Read more about this announcement.

3) The Illinois Department of Public Health (IDPH) recently announced that Ms. Darlene Harney has been hired to be the new Bureau Chief of Long-Term Care, effective Friday, May 1, 2015. She will oversee the Divisions of Long-Term Care Field Operations, Assisted Living and Quality Assurance. Her duties will include serving as a policy-making official for the Bureau, along with interpreting, reviewing, organizing and directing the formulation and implementation of Department policy, rules and regulations. Ms. Harney has been a Registered Nurse for 29 years with experience in clinical nursing and management. Her background includes Medicaid, Long Term Care programs, fraud and abuse. She has previous experience with the Department of Public Health and is very excited to take on her new role.

4) The Illinois Department of Healthcare and Family Services (HFS) issued several notices since the last issue of Regulatory Beat. They include:

- **Reimbursement Rate Reductions Effective May 1, 2015 through June 30, 2015.** This notice informs certain long term care providers that as a result of Public Act 99-0002, the Department is required to reduce reimbursement rates and payments paid to providers of certain services for dates of service on or after May 1, 2015 through June 30, 2015.

  All components of claims reimbursement will be calculated using current reimbursement rates and methodologies and then reduced by 12.6 percent for the following long term care providers:
  - Skilled Nursing Facilities (SNFs) licensed under the Nursing Home Care Act;
  - Supportive Living Program (SLPs); and
  - Specialized Mental Health Rehabilitation Facilities (SMHRFs).

  Please visit the Department website for the most current HFS Medicaid Reimbursement rates.

  These reductions apply to fee-for-service reimbursement. If services are being provided under a Managed Care Organization (MCO) or Managed Care Community Network (MCCN) contract, please refer to those contractual terms.

  If you require a rate letter specific to your facility or if you have other questions, contact the Bureau of Rate Development and Analysis (217) 524-7396.

- **New Provider Enrollment System for the Illinois Medical Assistance Program - Illinois Medicaid Program Advanced Cloud Technology (IMPACT).** The purpose of this informational notice is to inform providers that Illinois is launching a new provider enrollment process and computer system. This will be the first phase in replacing the current Medicaid Management Information Systems (MMIS).

- **HFS Provider Notice: This quarter’s Hospital ACA Access payments.** Per the hospital provider notice posted February 2, 2015, the Department has posted the calculations and payment amounts for the next quarter’s Hospital ACA Access payments. The amounts listed will be paid the months of May, June and July. The new file can be found at the Hospitals ACA Access Payments website (click here).
5) The **American Health Care Association** (AHCA) released two resources for AL providers. They include:

- The AL Emergency Preparedness Guide. This is a members-only document and can be found on the AHCA/NCAL Emergency Preparedness website. In collaboration with the Florida Health Care Association, NCAL has published an updated version of the Emergency Preparedness Guide for Assisted Living Communities. This comprehensive guide supports assisted living communities in developing emergency operations plans and includes templates and numerous additional resources. NCAL members can access this guide on the AHCA/NCAL Emergency Preparedness website.

- A friendly reminder that our members also have access to the Assisted Living Incident Command System (ALICS). The Incident Command System (ICS) is one component of the National Incident Management System or (NIMS). ALICS is a simplified ICS and through its use, long term care providers can become part of this standardized system of efficient response. ICS was modified by two consultants for assisted living and reviewed by AALNA board members and then reviewed by the NCAL Workgroup of the AHCA/NCAL Emergency Preparedness Committee.

6) The **American Association of Retired Persons** (AARP) recently released a report entitled, “Outpatient Observation Status Can Prove Costly for Medicare Patients.” AARP’s Public Policy Institute released a new report showing how observation patients can face unexpected, high out-of-pockets costs under Medicare rules compared with people who have been admitted as inpatients. Nearly two out of three observation patients who needed skilled nursing facility (SNF) care after hospital discharge did not meet Medicare’s 3-day inpatient requirement for coverage, according to the report.

7) The **United States Government Accountability Office’s** (GAO) 2014 annual report identifies 66 new actions that executive branch agencies and Congress could take to improve the efficiency and effectiveness of government in 24 areas. The report includes comments on non-emergency medical transportation, Medicare post-payment claims reviews, programs for serious mental illness and state Medicaid sources of funds.

8) The federal **Department of Health and Human Services - Office of the Inspector General** recently released their annual report, which highlights statistical achievements from the investigations and prosecutions conducted by 50 MFCUs nationwide. In FY 2014, MFCUs reported 1,318 criminal convictions involving the spectrum of providers who provide services to Medicaid beneficiaries. Three-quarters of these criminal convictions were for fraud, consistent with recent years, and recoveries in criminal cases reached nearly $300 million. Additionally, MFCU convictions led to the exclusion of 1,337 providers from federal health care programs.

9) **HealthData Management** recently published two articles of interest. They include:

- **One article** discussed how Medicare beneficiaries as well as providers could be issued electronically readable cards—with magnetic stripes, bar codes and “smart” cards that can process data—as replacements for the current paper-based cards which display Social Security numbers, according to the GAO. Such cards could help reduce certain types of Medicare fraud through the authentication of beneficiary and provider identity at the point of care, electronically exchanging beneficiary medical information, and electronically conveying beneficiary identity and insurance information to providers, argues a new GAO report.

- **The other article** discusses a proposed federal rule setting Medicare FY 2016 payment rates for skilled nursing facilities sets no requirements nor offers substantial help for these critical partners in care coordination to adopt electronic health records and health information exchange technologies. The rule, from CMS, follows a bill awaiting President Obama’s signature changing how physicians are paid under Medicare that also declares interoperable electronic health records across the nation by 2019 to be a national objective. It also follows a draft national Interoperability Roadmap from the Office of the National Coordinator for Health IT, accelerated work by Health Level Seven to complete its FHIR initiative.
creating an open healthcare data standard using the latest web standards, and ramped up operations by industry-backed interoperable organizations CommonWell and Healtheway.

10) **MedPage Today** had several recent articles of interest. They include:

- **Six of 10 Health Data Breaches Due to 'Criminal Activity'** - Most records are compromised by theft, rather than computer system hacking. Theft, illegal hacking, and other breaches of protected health information have compromised 29 million medical records in 949 incidents between 2010 and 2013, spelling out a crying need for better data security, according to a report published in *JAMA* Tuesday.

- **Breast Cancer Trends Predict Rising Numbers, Older Patients** - An increase of as much as 50 percent predicted in next 15 years. An evolving patient population will fuel as much as a 50 percent increase in the number of breast cancer cases over the next 15 years, according to National Cancer Institute (NCI) projections.

- **Novel Shingles Vaccine Effective in Older Adults** - New form of vaccine also effective in persons with immunosuppression. A herpes zoster subunit vaccine (HZ/su) was associated with a high vaccine efficacy for adults over 50 compared with placebo, according to phase III results of an ongoing controlled trial. Overall efficacy for HZ/su was 97.2 percent (95 percent CI: 93.7-99.0, P <0.001) against the shingles virus, reported Himal Lal, MD, of GlaxoSmithKline Vaccines in King of Prussia, Penn., and colleagues. Even when stratified by age group, there was no significant difference in vaccine efficacy (range 96.6-97.9 percent).

11) **MedlinePlus** recently published an article entitled, “**Half of U.S. Hospitals Could Do More to Prevent Serious Infections.**” Too few hospitals in the United States are doing everything they can to protect patients from a potentially deadly intestinal infection, a new study finds. Researchers from the University of Michigan surveyed almost 400 hospitals nationwide to determine what measures they had taken to prevent *Clostridium difficile* infections, which kill nearly 30,000 Americans a year and cause illness in hundreds of thousands more.

12) **Modern Healthcare** recently published an article entitled, “**More Docs Report Quality Data and E-Prescribe, But Many Prefer Penalty.**” The CMS paid out more than $380 million in incentive payments through its physician-quality reporting system and electronic-prescribing incentive programs, but more than 400,000 providers accepted pay cuts rather than participate. The agency issued a new report on the programs late Thursday. The numbers come as the CMS and physicians prepare for the Physician Quality Reporting System, or PQRS, to be rolled into what's intended to be a more cohesive approach to quality reporting and incentives under the recently enacted legislation repealing and replacing Medicare's sustainable growth-rate formula.

13) The **New York Times** had a recent article entitled, “**Nursing Homes Are Starting to Supplant Hospitals as Focus of Basic Health Care.**” The notion that a hospital remains the safest place for old patients dies hard. Many families still believe their aging relatives belong in a hospital when they’re ailing. But 20-plus years of research have documented the risks of hospitalization for older adults, particularly those frail or ill enough to need nursing home care.

14) **McKnight’s** has published several article of interest since the last issue of *Regulatory Beat*. They include:

- **Police blame post-hospital transition issues in mysterious death.** A lack of communication between a discharging hospital and a residential-care facility is being blamed for the death of a 63-year-old man found drowned in a marsh, nine days after leaving the hospital.

- **Top Medicaid fraud convicts are nursing and home health aides, OIG says.** Nearly one-third of Medicaid fraud criminal convictions the federal government obtained last year involved home health aides, the Inspector General for Health & Human Services reports.

- **Better provider policies needed in wake of historic Alzheimer’s sex case, experts say.** A 78-year-old retired lawmaker was found not guilty of sexual abuse of his Alzheimer's-afflicted wife. The Iowa case attracted nationwide attention and has been watched closely by many long-term care professionals. Indeed,
various experts told the Washington Post the case points to the need for nursing homes to have clearer policies on sex and intimacy.

- **Social Security numbers to be removed from Medicare beneficiary cards.** After more than 10 years of warnings by government investigators, CMS now has a mandate to remove Social Security numbers from enrollees' cards — a practice identified as one of the top personal financial threats seniors face today.

- **HIPAA audits to resume soon.** Long term care providers should get ready for the second round of HIPAA compliance audits this year, but the agency in charge of them is keeping mum about the exact date. And while Health & Human Services' Office for Civil Rights (OCR) expects to single out only around 110 providers, long term care facilities are being urged to begin preparations as soon as possible, Kelly McLendon, managing director of CompliancePro Solutions, said during a recent Health Care Compliance Association webinar. That includes performing security and risk analyses, updating privacy and security incident response plans and automating privacy and security investigation, tracking and management protocols, according to published reports. The agency has not announced specifics yet, but the coming round of audits could focus heavily on HIPAA security and privacy risk management, breach notification and Notice of Privacy practices.

- **Nurses, assistants most injury prone in healthcare: CDC.** Health care jobs have long been among the riskiest, most dangerous and injury-prone occupations around. Nurses and nurse assistants are the unluckiest among them, according to a new report from the CDC.

- **Dementia residents among most antibiotic-resistant, study reveals.** Because they are prone to rehospitalization, typically demand intensive hands-on care and are heavy users of antibiotics, advanced dementia residents in nursing homes commonly harbor dangerous strains of drug-resistant bacteria, according to new research published this week.

15) Interesting (and very scary) Fact: The use of electronic cigarettes by high school and middle school students tripled last year, in an extraordinary gain that outstripped teen use of every other tobacco product for the first time in the history of a national student survey, the federal government said. More than one in eight high school students — 13.4 percent — said they had used an e-cigarette at least once in the 30 days before the survey, compared with 4.5 percent in 2013, according to the National Youth Tobacco Survey. For middle school students, the rate climbed in one year from 1.1 percent, to 3.9 percent.