THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Ransomware Defense 101

by Jeff Mongelli

When a ransomware attack turns your most important files into encrypted gibberish and paying to get those files back is your only option, you're in big trouble.

Ransomware is a type of malware that threatens to publish the victim's data or perpetually block access to it unless a ransom is paid. While some simple ransomware may lock the system in a way that is not difficult for a knowledgeable person to reverse, more advanced malware uses a technique that encrypts the victim's files, making them inaccessible, and demands a ransom payment to decrypt them. In a properly implemented crypto viral extortion attack, recovering the files without the decryption key is an intractable problem, and an untraceable digital currency such as Bitcoin is demanded as the means for paying the ransoms, making it practically impossible to locate and prosecute the perpetrators.

Unfortunately, when it comes to ransomware, once your files are encrypted, there's not much you can do — besides cut your losses or pay up. And even if you do pay up, there's a chance you won't get your files back, so you're out access to the files and your cash.

That's why it's so important to prevent ransomware attacks from happening in the first place.

Ransomware Prevention Tips

1. **Establish a real backup solution.** I don't mean an external hard drive in your office, or a remote backup service like Carbonite or digital tape. We advocate implementing a Business Disaster Recovery (BDR) device. A good BDR, properly configured and deployed, will create near real-time backups, take copies off the network, make them inaccessible to an attacker, synchronize with offsite data centers, and step in to replace a compromised server to keep your operations running. It's time to stop considering these devices as optional. The only way to survive

a ransomware attack and not pay the fine is to restore from backup. Newer variants are proving to be "unhackable," meaning once the ransomware encryption takes root, you have three options: pay the ransom, restore from backup, or lose your data. That's it.

Please stop thinking you won't get hit. It's just a matter of time.

2. **Make images of key workstations.** If your network is properly configured, all your critical and sensitive data is stored on your server(s), and those are being backed up by your BDR. However, in many cases, certain workstations on your network have applications installed or are configured in such a way that would be troublesome to recreate. Those workstations should have periodic images created of their hard drives. Those images, along with a generic image to use on your typical workstations, greatly simplify the task of rebuilding a compromised network. Those images need to be stored offline.

3. **Institute a practice of continual workforce training.** If you think meeting the HIPAA requirement of annual training is adequate, you are mistaken.

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Today's cyber climate is changing so rapidly, you need to prod your user base on a daily or weekly basis to keep security at the forefront of their minds. Of course, your team will make mistakes, but keeping them trained and alert will reduce the chances of getting hit with a successful ransomware attack.

Of course, there's more you can do, but even if you only follow the advice offered in Prevention Tip #1, you will have dramatically increased the likelihood of surviving a ransomware attack. In fact, not only surviving the attack but reducing your actual downtime to mere minutes. BDRs aren't cheap, but they're cheaper than being down for days, paying the HIPAA fines for the breach, paying a ransom, or losing all your data. If you need help selecting or implementing a BDR, we can work with you or your IT team.

Finally, stay informed. One of the most common ways that computers are infected with ransomware is through social engineering. Educate yourself on how to detect phishing campaigns, suspicious websites, and other scams. And above all else, exercise common sense. If it seems suspect, it probably is.

Jeff Mongelli is CEO of Acentec, Inc., a nationwide provider of HIPAA compliance and medical IT management services. If you have any questions about this article or would like recommendations, please contact him for a free consultation at 800-970-0402 or at jeffm@acentec.com.

Update Your Membership Information to Help with Your Year-End Planning

If you are contemplating a change in your practice, please notify CAP as soon as possible so our Membership Services Department can review your options with you and make your coverage transition a smooth one. Changes include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice
- Reduction or change in the scope of your practice
- Employment with a government agency or non-private practice setting
- Employment with an HMO or other self-insured organization
- Joining a practice insured by another carrier
- Moving out of state
- Termination of membership

The Board of Trustees of the Mutual Protection Trust will levy an assessment in November 2019. To allow ample processing time, we recommend that members advise us in writing no later than October 31, 2019, of any of the above changes to be considered eligible for waiver or proration of the next assessment.

To make an update, please log in to the Member's Area of the CAP website. Upon logging in, you will be prompted to **Update/Verify Your Information Now**. Our online Membership Information Update Form takes less than five minutes to complete.

If you have not yet registered for the Member's Area, please register for an account at https://member.CAPphysicians.com/register. You will need your member number and the last four digits of your Social Security Number.

Risk Management and Patient Safety News

Tracking and Recall Systems Can Save a Life

Physicians and their staff often mistakenly believe they have systems in place to protect their patients to ensure that care is coordinated and timely. The reality is that many of these office systems are insufficient and allow patients and/or their test results to fall through the cracks. Effective tracking and recall systems are lifesaving processes engineered to ensure timely followup on patients, referrals, laboratory results, and imaging studies.

Diagnostic error is the most common reason for a paid malpractice claim in the ambulatory setting.[1] Although diagnostic errors frequently involve errors in cognition and clinical judgment, they can also result from wholly preventable deficiencies in office systems — specifically, in the management, transfer, and communication of clinical data.

According to Dr. Peter Birnstein, who chairs CAP's Risk Assessment Peer Review Committee, "In Risk Assessment Peer Review, we see the same scenarios playing out over and over, resulting in diagnostic delays, devastating patient injury and lawsuits. These scenarios involve failures in tracking and recall systems in which patients themselves and/or important clinical data — just fall through the cracks. These failures cut across all specialties!

"When we ask the member if he or she has a tracking system in their office, invariably they'll answer, "Yes!" After further discussion, we realize that their tracking systems are insufficient because they are not designed to detect or safeguard against failure.

"Whether it's a patient, a laboratory result, or an imaging study, there needs to be a way to timely identify if the test result is delayed or missing, or if the patient has failed to return to the office for follow-up. This allows the practice to intervene. The ability to timely detect failure and take action is essential to a robust tracking system."

The following examples illustrate how the absence of tracking systems can cause delay in diagnosis:

1. Laboratory tests or diagnostic imaging are ordered, but there is no mechanism in place to compare ordered tests with those received by the office. Therefore, the missing test results go unnoticed. Additionally, there is no protocol for physician review of results and/or communication to the patient.

2. The plan includes referral to a specialist. There is no process for tracking referrals and no way of knowing if this consultation occurred.

3. There is no process for recalling patients with high-risk conditions requiring regular follow-up. Examples may include patients with a history of cancer, diabetes, hypertension, or those who require reminders of screening tests such as mammograms and colonoscopies.

Tracking and recall systems are essential to preventing patients and clinical data from being lost to follow-up. Like any critical alarm system, a tracking or recall system should detect missing data and disruptions in care early enough to enable the practice to intervene.

There is no singular, optimal tracking system. For a tracking system to be effective, it must work for your office and be implemented consistently!

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Tracking Laboratory Tests, Diagnostic Studies and Referrals.

- Develop an office policy to track tests and referrals. The policy can include the expected time frames for results, the frequency for reviewing tracking logs, documentation standards, and the protocols for managing missing reports.

- An important aspect of any tracking system is that it is maintained outside of the medical record. In other words, to detect that a patient's results have failed to return to the office, one should never have to access information within the patient's medical record.

- Tracking systems need not be fancy. They can be log books, lists in laboratory interfaced systems, or alert lists within the electronic medical record. At a minimum, they should include the test or referral ordered, the date ordered, and the patient's name. Once received, results should be reviewed, signed, and dated by the ordering physician with any action noted and filed or scanned into the patient's medical record. Patients should be notified of all test results — even those that are normal.

- As a secondary safeguard, educate patients that the office contacts patients about all their laboratory results. Patients should be instructed to call the office if they don't hear the results of tests in a timely fashion to prevent the assumption that "no news is good news."

The Missed Appointments Safety Net

An important aspect of ensuring patient safety and reducing liability exposure is ensuring patients follow up as recommended. Consider the following measures to keep patients from "slipping through the cracks":

- Schedule high-risk patients and time-sensitive follow ups *before* they leave the office. This simple practice ensures the patient is "in the books." If patients refuse to schedule a follow-up appointment before they leave your office, enter their names on a call-back list to contact them later.

- Use appointment reminders to improve follow-up and decrease "no-shows." Every missed appointment is a missed opportunity to reevaluate the patient.

- When patients don't show, activate the missed appointment protocol: staff should attempt to contact patients who miss their appointment, document the reason for the missed appointment, and reschedule the visit. Additionally, staff should inform the physician or provider of any patient who misses an appointment. The physician should decide what action to take depending on the patient's reason for the visit and medical history. Some patients may require more aggressive follow up, such as a physician call or a certified letter explaining the risks of failing to follow up.

Communicate and Document!

Compliance and outcomes greatly improve when physicians educate their patients and discuss the rationale for their treatment recommendations. Documenting one's efforts to educate demonstrates professionalism and your respect for the patient's right to information. Further, when patient education and attempts to reach the patient are not documented, the defense is greatly compromised, and the physician is vulnerable to allegations that these activities never occurred.

Patients-turned-plaintiffs commonly allege that they were noncompliant because they were never properly educated about the treatment plan or the consequences of deviating from it. *"I didn't know. I wasn't told. Had I known, I would have followed the physician's treatment recommendation"* are statements that resonate with lay jurors, who are patients themselves. Therefore, resistance on the part of the patient may require communication from the physician in the form of a well-documented phone call or a certified letter, whereby associated risks of not following the plan are clearly explained.

Countless incidents of diagnostic delays and severe patient injury occur because of preventable failures in tracking and recall systems. Understanding the essential elements of a robust tracking and recall system can save a life and prevent a lawsuit. To assist you in assessing your office systems and keeping your patients safe, contact CAP's Risk Management and Patient Safety Department at 800-252-0555.

[1] Bishop TF, Ryan AK, Casalino LP. Paid malpractice claims for adverse events in inpatient and outpatient settings. JAMA 2011;305:2427-2431.

New Requirements for Vaccination Exemptions on the Horizon

by Gabriela Villanueva

California state Senator and pediatrician Dr. Richard Pan (D-Sacramento) has introduced multiple vaccination-related legislation during his tenure as Chair of the Senate Health Committee. Starting in 2015, SB 277, was passed to eliminate all non-medical (i.e., religious and personal belief) exemptions for immunizations required for school entry. According to the California Department of Public Health (CDPH), while SB 277 was successful in raising immunization rates across the state, there has also been an increase in the number of medical exemptions issued. The CDHP notes the percentage of kindergarteners with medical exemptions rose from 0.2 percent of students in the 2014-2015 school year to 0.9 percent of students in 2018-19.

At a time when there has been both a rise of medical exemptions in the state and in a year that has seen the worst measles epidemic in 27 years, vaccination-related legislation was back front and center at the state Capitol in 2019, making it one of the year's most contentious issues.

According to the Centers for Disease Control website, from January 1 to September 12, 2019, 1,241 individual cases of measles have been confirmed in 31 states, including California.

Back in February, Dr. Pan introduced SB 276 to address what he considered the dramatic increase in medical exemptions from vaccinations required for school entry. The bill went through several iterations, as discussions prompted multiple amendments throughout the committee hearing process and discussions with the Governor's Office, which was closely following the developments.

In its final version signed by Governor Newsom, SB 276 will require:

- By January 1, 2021, the CDPH shall develop and make available for use by licensed physicians and surgeons an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department's California Immunization Registry (CAIR). The form shall be printed, signed, and submitted directly to the school or institution at which the child will attend, submitted directly to the governing authority of the school or institution, or submitted to that governing authority through the CAIR, where applicable.
- CDPH will annually review exemption forms that meet any of the following criteria: 1) submitted to schools with overall immunizations rates less than 95 percent; 2) submitted by physicians who have granted more than five medical exemptions in one year; or 3) submitted to schools that have failed to report their immunization records to CDPH.
- The State Public Health Officer or a physician designee may deny or revoke medical exemptions that do not align with CDC/ACIP or AAP guidelines if the exemption is determined to be inconsistent with standard of care.
- The Department will notify the Medical Board of California of any physician who submits an exemption that is denied or revoked, and of any physician from whom the Department is not accepting exemptions.
- The Department will not accept medical exemptions from physicians who pose a risk to the public's health, or from physicians with pending accusations with the Medical Board of California until the accusation is resolved in favor of the physician.
- The bill would authorize a parent or guardian to appeal a medical exemption denial or revocation to the Secretary of California Health and Human Services. The appeal would be conducted by an independent expert review panel of licensed physicians and surgeons established by the secretary. The bill would require the independent expert review panel to evaluate appeals consistent with specified guidelines and to submit its decision to the secretary.

In signing SB 276, Governor Newsom also signed a companion bill, SB 714, which allows a child who has a medical exemption issued before January 1, 2020, to be allowed to continue enrollment until the child enrolls in the next grade span.

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Public Policy

Case of the Month

by Gordon Ownby

The Active Role of the Referring Physician

The word "passive" derives from the Latin *passivus*, capable of suffering. From *passivus* came *pati*, to suffer, endure, from which we get "patient" (both the adjective and the noun). An opposing attorney will leap at an opportunity to paint a picture of a passive physician.

A 38-year-old trained teacher and foreign mission worker visited a primary care physician, Dr. FP, for a physical, examination of moles on his calf and scalp, and vasectomy referral. Dr. FP's physical exam revealed a melanocytic nevus on the patient's right calf and a mass on his head. The plan was for routine blood work, a urology referral for the vasectomy, referral to a general surgeon for the head mass, and a two-week return for removal of the nevus.

At the return visit, the patient signed a consent for "excision biopsy of highly suspicious nevus R/O melanoma." Dr. FP noted that he excised a "good margin of normal skin tissue." The diagnosis on the specimen was melanoma, 1.4 mm thick, extending to within 1 mm of the peripheral edge of the specimen, stage 2a. Dr. FP later said he informed the patient of the melanoma and referred him to a dermatologist for a decision on further treatment, including a possible wider excision. Dr. FP gave the patient a copy of the pathology report to give directly to the dermatologist and also gave him a handout on melanoma. Dr. FP's chart that day described the patient's melanoma as "post excision."

The patient went to the clinic of the referred dermatologist but instead of seeing that physician, the patient participated in a teledermatology consult. Dr. FP's office received word that the telehealth consult was to take place and a note by Dr. FP's staff said that the patient "will hand carry melanoma report to Derm." The actual telehealth consult did not involve direct interaction between the patient and the remote dermatologist. Instead, a clinic PA took photos of various moles and nevi of the patient and transmitted the images to the remote MD for consideration. As it turned out, the PA did not take a photo of the excision area and the remote MD was not advised of the melanoma diagnosis. The remote MD did not receive or review Dr. FP's referral, which included the melanoma diagnosis, even though it was within the clinic's records.

The remote dermatologist assessed a neoplasm on the abdomen and recommended a shave biopsy; other areas looked like benign melanocytic nevi. The remote dermatologist's plan was for the PA to educate the patient on what to look for with suspicious skin growths. He recommended to the PA a six-month follow-up for the patient.

When the patient was a no-show at Dr. FP's office two months later, the office contacted the patient and charted that he had "already seen the dermatologist and will just follow up with them."

Nearly six months later, the patient applied for benefits with a faith-based organization for sharing medical expenses. In the application, the patient noted that he had a melanoma skin mole removed and that he had a complete recovery.

When the patient next returned to Dr. FP (approximately one year following the no-show), the record shows the patient requested a dermatologist referral because his previous dermatologist told him to follow up in one year. Dr. FP had not received a report from the telehealth dermatologist but noted "per patient everything was fine." Dr. FP completed a referral request form to a dermatologist

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for melanoma history and multiple nevi. Two weeks later, Dr. FP's office sent a one-page referral by fax to a new dermatologist that listed "cyst melanoma history." Though that dermatologist initially consulted with the patient without apparent knowledge of the melanoma history, he made an addendum a week later noting the patient's history of "melanoma 1.4 mm to right shin."

After another no-show, the patient returned to Dr. FP five months after the second dermatology consult with a complaint of a torn muscle in his right thigh. Dr. FP discussed with the patient the possibility of lymph node involvement from the melanoma, to which the patient responded that neither dermatologist mentioned lymph pathologies. Dr. FP ordered an ultrasound of the groin, which revealed a solid mass. After an MRI, Dr. FP sent the patient to a surgeon, whose excision biopsy revealed metastatic carcinoma with extensive necrosis and BRAF mutations.

In the course of his cancer treatment (during which he told his doctors that the original lesion had been removed), the patient declined BRAF and MEK inhibitors in favor of a naturopathy course. The patient died several months later — two years after his first consultation with Dr. FP. His family sued Dr. FP and other providers. Dr. FP and the family resolved the legal matter informally.

In situations of life-threatening illnesses, jurors will expect to see detailed documentation of the patient education process and a referring physician's hands-on coordination with patient's other physicians. A record showing less than a physician who is actively involved in the at-risk patient's follow-up will suffer under litigation's withering review.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

End-of-Year Savings on Medical Practice Loans

CAP members should act quickly to take advantage of limited-time savings now available on practice loans.

Bank of America's Practice Solutions program is offering CAP members access to a fixed, 3.89% interest rate on practice loans for up to 15 years![1] Whether you are building a new practice, expanding your current practice, or acquiring an existing practice, a loan can help you fulfill your year-end professional goals.

Set yourself up for success in 2020. Let a dedicated project manager help you reach your goals and get things done on time and on budget.

Offer valid through November 30, 2019. To get started immediately, please contact your practice solutions specialist, **Ali Karjoo**, at **ali.karjoo@bofa.com** or call **949-613-4711**.

[1]For the limited time beginning with applications submitted on July 1st, 2019, and ending with applications submitted on or before November 30, 2019, take advantage of a 3.89% interest rate on terms no less than 10 years and no greater than 15 years on qualifying approved Practice Solutions secured term Practice Sales and Acquisitions, Debt Consolidation, Remodels, Relocation, Expansions and Additional Locations and Equipment loans closed by or booked by December 31, 2019. Loan approval amounts must total a minimum of $250,000 on eligible product types in order to qualify. Payoff prohibited in the first year of the loan, and a prepayment fee will apply for each of the following four years of the loan term. Excludes Practice Solutions startup loans, lines of credit, and commercial real estate loans, and any product that contains a variable rate. To be eligible for the interest rate offer of 3.89% the borrower before loan closing must have a demand deposit account with Bank of America that is the primary business operating account of the borrower. Promotional rate is not applicable during the project phase of the loan. Subject to credit approval. Other restrictions may apply.

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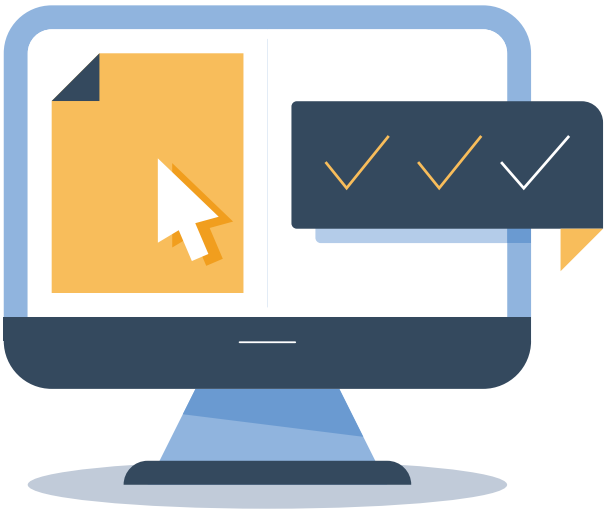

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2 If you have never created a log in, you will need to click on the "Register" button.
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3 Enter your first initial, last name and CAP member ID in the "Provided ID" field (i.e., John Smith 12345 will be jsmith12345).

4 Enter CAPBENEFITS18 in the "Provided Password" field.

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