



FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9013
MEMORIAL MEDICAL CENTER

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints within the Medical Center's behavioral health program in Springfield. Allegations were that an adult inpatient's private health information was shared without his authorization and that he was provided an inadequate grievance response, which, if substantiated, would violate rights protected under the Mental Health and Developmental Disabilities Confidentiality Act (405 ILCS 5), the Privacy Rules (45 CFR 164) and Centers for Medicare and Medicaid Services (CMS) Conditions of Participation for Hospitals (42 CFR 482).

An affiliate of the Memorial Health System, the Medical Center's behavioral health program offers inpatient care and partial hospitalization with special treatment for those with dual mental illness and substance abuse diagnoses. Psychiatrists and residents come from the neighboring Southern Illinois University School of Medicine. The matter was discussed with staff involved in this patient's care and their attorneys. Relevant policies were reviewed as were sections of the patient's record with authorization. The patient maintains his legal rights without an appointed guardian.

The complaint states in summary that the patient was having breakfast one morning when his psychiatrist discussed treatment issues in front of others and that he and a medical student called his wife and discussed intimacies of his care without consent. It was also alleged that a related grievance response was "stock" and did not provide thorough answers.

FINDINGS

Two incidents matching the claims are referred to in the patient's record: the first on the day before discharge when a resident noted having called the patient's wife with his permission and listed the phone number to call. The entry reflected a discussion about the impending discharge and whether the wife was comfortable with him coming home. She expressed concerns about his anger but did not feel physically threatened. Nothing else was covered

according to the documentation. The second was on the morning of discharge when another resident wrote that the patient left a day area table to approach him and the psychiatrist about discharge and his wife. They explained the wife's concerns from the previous resident's conversation; the patient denied everything and openly spoke of their relationship. It was further noted that the psychiatrist talked with the wife later about his progress and that she was then fine with discharge. They informed the patient who thanked them and said he wanted to go.

The psychiatrist remembered what occurred and said that in the first instance the resident called the patient's wife after he gave them her number. He and the resident talked with him first, saying they wanted to reach her about discharge in general and get her take on it. He said the patient was quite imperative they call her and that he otherwise had every chance to object if he wanted. In the second instance the patient came up to him and the resident, rebuking how the wife responded. He asked if he could speak with her again and the patient agreed but stormed off. That was his first call to the wife personally and he was intent on knowing if she felt safe, nothing more. The patient had the capacity to make decisions in the psychiatrist's opinion.

On whether there were other patients around who could overhear, he recalled the patient approaching them from a table facing the hallway but not if others were around. He said that in an ideal world they would usher him to a more private space.

Admission records listed the patient's wife as the emergency contact and a visitor sign in sheet showed that she appeared on the unit twice during her husband's stay. The staff said there were no emergency calls to the wife and no one believed she took part in discussions with them whether privately or in family meetings while she was there. There were no authorizations to release information in the records provided, and it was agreed that would typically have been accomplished at admission, which is preferred practice. All staff members are trained under their respective employers in privacy issues including authorization for disclosures.

Documents related to the patient's formal grievances with the hospital were also reviewed. A December 16 email from staff to administration outlined the patient's complaints, including the psychiatrist's open discussion about treatment in front of others and contact with his wife about his condition without releases. In a January 5 written response a privacy director explained that a full investigation was conducted, determining that the psychiatrist's discussion of his personal and medical information was not in keeping with policy. It was also determined that the resident's contact with his wife, thought to be by permission and co-signed by the psychiatrist, also failed to meet policy that requires signed authorization. The letter assured that both incidents were addressed with appropriate actions and education.

Asked to explain further what actions were taken, Memorial said there was a thorough review of information with multiple people whom the patient had contacted. It was decided from there that having written authorization would have been best as policy dictates and the hospital's attorney met with psychiatry staff, physicians and other program agents to reinforce the need for written consents.

CONCLUSION

Memorial's Uses and Disclosures of Protected Health Information policy states that private health information may not be used or disclosed without a valid authorization, which has been completed, dated and signed by the patient. It details the uses and disclosures for when a patient has the opportunity to agree and object pursuant to the HIPAA (Health Insurance Portability and Accountability Act), all of which is spelled out to patients in a Notice of Privacy Practices.

Under the Confidentiality Act, records and communications may only be disclosed to someone other than the patient and any guardian or legal representative with their written consent. (740 ILCS 110/5). Federal regulations (HIPAA) likewise call for disclosures on valid, signed authorization in general but allow for disclosure to family members or others provided the patient is present for or available prior to disclosure, has decisional capacity, is informed in advance and has the opportunity to agree, restrict or prohibit. Oral agreements are acceptable and the disclosure is relevant only to that person's involvement in the patient's healthcare. (45 C.F.R. 164.508; 164.510).

In the first instance the psychiatrist and a resident informed the patient in advance of their intentions for reaching his wife, gained his permission and discussed potentials for his discharge home. In the second instance the patient approached them in the day area and permission was given again for more contact about the impending discharge, which was consistently relayed in the psychiatrist's statements and the documentation. While the claim that other patients were nearby is not discredited, we have no proof to say either way. In any case the HRA agrees with Memorial's response that policy requires valid, written authorization to disclose information and we add the Confidentiality Act's requirement of the same. A violation is substantiated and as reported in the grievance response letter has already been addressed and remedied.

Memorial's Notice of Privacy Practices shared with all patients includes instruction for contacting the Privacy Officer or AlertLine and how to file complaints with them.

Medicare/Medicaid Conditions of Participation for Hospitals require a system for patients to present grievances:

The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care.... At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient

to investigate the grievance, the results of the grievance process, and the date of completion. (42 C.F.R. 482.13).

The hospital's written response was provided timely, about two weeks after the grievance was filed. It contained all required elements under the CMS Rules but perhaps instead of saying there was a full investigation, making clearer how would improve satisfaction for this and any complainant. Still, the requirements seemed to be met at minimum, and a violation is not substantiated.