



Newly Updated Workplace FAQs For Healthcare Providers And 8-Point COVID-19 Action Plan

Insights

4.06.20

The healthcare industry is truly on the front lines of the nation's and the world's response to COVID-19. As a result, healthcare providers, their employees, and affiliates are likely already well-versed on the virus and how to handle it in a clinical setting. But healthcare providers may need help understanding and managing the impact that COVID-19 is likely to have on their workforce.

To assist healthcare employers, Fisher Phillips' Healthcare Industry Practice Group has created an eight-point action plan and updated our answers to frequently asked questions (FAQs). Just like the outbreak itself, this situation is extremely dynamic. We will continue to update these FAQs and action plan, but we also recommended staying abreast of the CDC's guidelines and updates. **NOTE: These FAQs were updated on April 6 as a response to the recent questions and answers released by the Department of Labor, directly impacting the healthcare industry. They have also been updated to include a specific section for unionized workplaces.**

PAID LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

UPDATED ANSWER (April 6, 2020)

Who is a healthcare provider?

This is an important question with respect to complying with the newly-passed Families First Coronavirus Response Act (FFCRA), which is explained in detail at this link. Among other things, the FFCRA establishes and requires Emergency Paid Sick Leave and expands the Family and Medical Leave Act (FMLA) for certain employees. But "health care providers" and "emergency first responders" *can be* excluded from these benefits – although this exemption is not automatic. Therefore, a threshold compliance issue for healthcare employers is: who – or what – is a healthcare provider?

On April 1, the DOL issued a Temporary Rule that defined who is a health care provider and who is an emergency responder. *Employers must be cautious in interpreting and applying this definition, however, taking into account:* (1) the DOL's more limiting commentary, which is contained in the preamble; and (2) an April 1 letter from Senator Patty Murray and Congresswoman Rosa L. DeLauro to Secretary of Labor Eugene Scalia, challenging the Department's interpretations of the FFCRA.

Before addressing those caveats, employers should consider the language of the DOL's Temporary Rule issued on April 2, 2020, which explains that a "Health Care Provider" is

Rule, issued on April 2, 2020, which explains that a **Health Care Provider** is:

Anyone employed at any doctor's office, hospital, health care center, clinic, postsecondary educational institution offering health care instruction, medical school, local health department or agency, nursing facility, retirement facility, nursing home, home health care provider, any facility that performs laboratory or medical testing, pharmacy, or any similar institution, Employer, or entity. This includes any permanent or temporary institution, facility, location, or site where medical services are provided that are similar to such institutions.

This includes any individual employed by an entity that contracts with any of these institutions described above to provide services or to maintain the operation of the facility where that individual's services support the operation of the facility. This also includes anyone employed by any entity that provides medical services, produces medical products, or is otherwise involved in the making of COVID-19 related medical equipment, tests, drugs, vaccines, diagnostic vehicles, or treatments. This also includes any individual that the highest official of a State or territory, including the District of Columbia, determines is a health care provider necessary for that State's or territory's or the District of Columbia's response to COVID-19.

This definition applies *only* for the purpose of determining whether an employer may elect to exclude an employee from taking leave under EPSL or EFMLA. For all other purposes, including identifying health care providers who may advise an employee to self-quarantine for COVID-19 related reasons, the much more limited FMLA definition of health care provider should be used.

An **"Emergency Responder"** is:

Anyone necessary for the provision of transport, care, healthcare, comfort and nutrition of such patients, or others needed for the response to COVID-19. This includes but is not limited to military or national guard, law enforcement officers, correctional institution personnel, fire fighters, emergency medical services personnel, physicians, nurses, public health personnel, emergency medical technicians, paramedics, emergency management personnel, 911 operators, child welfare workers and service providers, public works personnel, and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency, as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility. Again, this includes any individual whom the highest official of a State or territory, including the District of Columbia, determines is an emergency responder necessary for that State's or territory's or the District of Columbia's response to COVID-19.

To minimize the spread of COVID-19, the Department of Labor encourages employers to be judicious when using these definitions to exclude health care providers and emergency responders from taking EPSL or EFMLA. If an employer does not elect to exclude an otherwise-eligible health care provider or emergency responder from EPSL or EFMLA, the employer will be eligible to claim the tax credit available under the FFCRA as it would as to any other eligible employee who takes such leave.

Employers should proceed prudently before exempting employees from EPSL or EFMLA benefits. Not only is the entire COVID-19 landscape, including legal requirements, continuing to evolve quickly, but the two concerns mentioned above merit some special consideration.

- In the preamble to the Rule, the Department explains that the term “health care provider” includes individuals capable of providing health care services necessary *to combat the COVID-19 public health emergency*. This includes workers involved in research, development, and production of equipment, drugs, vaccines and other necessary items. Similarly, the authority to exempt first responders reflects a balance struck by the FFCRA, which seeks to keep employees from having to choose between their paychecks and the individual and public health measures necessary to combat COVID-19. At the same time, the EPSL and EFMLA are not intended to come at the expense of fully staffing necessary functions of society, including emergency responders. Thus, the FFCRA should be interpreted to further the work being done on the front lines to treat and prevent the spread of COVID-19, while simultaneously keeping Americans safe and with access to essential services. While these definitions and comments still appear to permit a wide swath of employees to be exempted from EPSL and EFMLA benefits, employers should recognize that the exemption is not automatic or all-encompassing. Instead, employers’ decisions regarding exemption of some or all employees warrants consideration of the Department’s commentary. And such decisions could be later challenged.
- It is almost impossible to accurately predict whether the letter from Senator Murray and Congresswoman DeLauro will result in further changes to the DOL’s guidance or the law. Both lawmakers clearly contend that the Rule potentially exempts too many employees from the benefits established under the FFCRA. Additional DOL guidance or Congressional action would obviously alter the landscape and employers’ analysis once again.

UPDATED QUESTION AND ANSWER (April 6, 2020)

Who is an emergency responder?

In addition to “healthcare providers,” the Act also permits employers to exclude “emergency responders” from the paid leave provisions of the Act. There was no reliable definition for this term until the DOL provided one, again through the Q&A forum and then in the temporary rule. According to the DOL, several patient-facing employees are included, such as “emergency medical services personnel, physicians, nurses, public health personnel, emergency medical technicians, paramedics, emergency management personnel.” For healthcare employers, however, this exemption is likely superfluous because of the broadly defined “healthcare provider” exemption.

UPDATED ANSWER (April 6, 2020)

Who constitutes a “healthcare provider” that may advise individuals to self-quarantine due to concerns related to COVID-19 for purposes paid sick leave under the Act?

This answer is found in the regulations for the FMLA. Section 825.125(a) of the FMLA regulations defines a healthcare provider as:

1. A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or
2. Any other person determined by the Secretary to be capable of providing healthcare services.

Subsection (b) of the same regulation includes others capable of providing healthcare services such as:

1. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;
2. Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;
3. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. When an employee or family member is receiving treatment from a Christian Science practitioner, an employee may not object to any requirements from an employer that the employee or family member submit to examination (through not treatment) to obtain a second or third certification from a health care provider other than a Christian Science practitioner except as otherwise provided under applicable State or local law or collective bargaining agreement;
4. Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and
5. A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.

UPDATED QUESTION AND ANSWER (April 6, 2020)

We are short staffed. Several patient-care staff called out due to “self-quarantine” and have not shown up for their scheduled shifts for days. None of them have provided a doctor’s certification nor any documentation making such a quarantine necessary. Under our time and attendance policy, a doctor’s certification is required for absences or illness that exceed three days. May we require a doctor’s certification from the employees?

The CDC’s guidance recommends that employers “ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of and understand these policies.” The CDC’s guidance also provides that “employers should not require a positive COVID-19 test result or a healthcare provider’s note for employees who are sick to validate their illness, qualify for sick leave, or to return to work. Healthcare provider offices and medical facilities may be extremely busy and not able to provide such documentation in a timely manner.”

In this case, the employer's human resources department may consider reaching out to the employees to ensure that they are safe and exploring leave options that are consistent with the employer's policies and maintain workplace safety standards. As explained above, an employer of healthcare providers may exempt those employees from EPSL and EFMLA benefits.

For eligible employees seeking paid leave under the EPSL and EFMLA from covered employers, the DOL has explained that employees must provide their employer documentation in support of their paid sick leave as specified in applicable IRS forms, instructions, and information. The employer will need such documentation in support of their claims for corresponding tax credits.

Documentation requirements are limited, however, and do not require disclosure of medical diagnoses. Employers should also require employees to provide documentation in support of their EFMLA leave taken to care for the employee's child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19-related reasons. Appropriate documentation may include: a notice of closure or unavailability from the child's school, place of care, or child care provider, including a notice that may have been posted on a government, school, or day care website, published in a newspaper, or emailed to the requesting employee by another employee, school official, place of care, or child care provider.

DOL guidance states that employers must retain the notices or documentation submitted in support of their requests for expanded family and medical leave, including leave that runs concurrently with paid sick leave, if taken for the same reason.

The DOL also notes "all existing certification requirements under the FMLA remain in effect" if the employee is taking leave for one of the existing qualifying reasons under the FMLA." For example, if an employee is taking leave beyond the two weeks of emergency paid sick leave because their "medical condition for COVID-19-related reasons rises to the level of a serious health condition," the employee must provide corresponding medical certification to the employer, consistent with the employer's existing FMLA policies and practices.

WORKPLACE SAFETY ISSUES

What if an employee appears sick?

If any employee presents at work with a fever or difficulty in breathing, this indicates that they should seek medical evaluation (regardless of the COVID-19 crisis). While these symptoms are not always associated with coronavirus and the likelihood of an employee having coronavirus may be low (depending on the healthcare services you provide), it pays to err on the side of caution, particularly because healthcare workers are collectively at greater risk. Ensure that all members of the management team understand how to address this situation in order to prevent panic among the workforce and patient population and reduce further spread.

Can healthcare providers ask an employee to stay home or require them to leave work if they exhibit symptoms of the COVID-19?

Yes, you are permitted to ask employees to seek medical attention and get tested for COVID-19. You are also permitted to require employees to leave work – even if they refuse. The CDC states that employees who exhibit symptoms of influenza-like illness at work during a pandemic should leave the workplace.

During the H1N1 pandemic, the Equal Employment Opportunity Commission (EEOC) stated that advising workers to go home is not disability-related if the symptoms present are akin to the seasonal influenza or the H1N1 virus. The EEOC has confirmed that this same guidance applies to the COVID-19 crisis.

Can healthcare employers require employees over the age of 65 who are without symptoms to stay home without pay?

Generally speaking, the answer is no. But employers may be able to encourage established high-risk employee populations to consider reassignment, staying home or working remotely.

UPDATED ANSWER (April 6, 2020)

When can employees return to work if sent home because of suspected COVID-19 infection?

If an employee contracted COVID-19, they can return to work after their fever has resolved; respiratory symptoms have improved; and they obtained negative testing results from two consecutive nasopharyngeal swab specimens collected more than 24 hours apart. Or they may return if for at least 72 hours they have been without fever (without fever-reducing medications) and respiratory symptoms (cough, shortness of breath) have improved **and** at least 7 days have passed since the symptoms first appeared.

UPDATED ANSWER (April 6, 2020)

How should an employer respond if an employee who would not be exposed to COVID-19 patients asks to wear a facemask while working?

Obviously, employees involved in direct patient care should use all necessary personal protective equipment (PPE), which will typically include masks, gloves, gowns and/or other protections.

Employers should monitor CDC guidance. If an employee requests to wear a facemask, employers should at least evaluate the employee's specific circumstances. An employee with an underlying disability may need to wear a mask as an accommodation. Employers may also consider permitting other employees to wear a facemask, even if there is no CDC recommendation or legal requirement to do so, particularly where the employee is concerned about exposing a vulnerable family member.

UPDATED ANSWER (April 6, 2020)

Can employers mandate temperature testing of their employees?

Under the current circumstances, yes. Taking an employee's temperature will be considered a medical examination under the Americans with Disabilities Act, which normally restricts an

employer's ability to conduct temperature testing. But, because COVID-19 has reached pandemic status, employers may measure body temperature employers may exercise this option, especially where the testing is job-related and consistent with business necessity. Again, employers should monitor CDC guidance.

If taking temperatures, employers must take reasonable steps to ensure the confidentiality of this information and should use a qualified, trained person to conduct this testing in a private room. Temperature readings should not be retained in employees' personnel files (because they represent medical information). Also, keep in mind that some people with COVID-19 will not have a fever.

Although temperature can be tested in a variety of ways, a forehead scan - the method that involves the least risk to the tester - should be used where possible. In all cases, the tester should follow Standard Precautions and use appropriate PPE, as further explained below.

Please remember that state-specific requirements may also apply. For instance, if your organization is subject to the California Consumer Privacy Act, it will require you to provide the employee a compliant Notice prior to taking his temperature.

UPDATED ANSWER (April 6, 2020)

What about visitors?

You may be able to test temperatures of visitors. Generally, medical inquiries to visitors would have to be necessary. Under the current circumstances, workplace and patient safety is necessary, though the requirement may depend on the nature of care that your organization provides. State law may also apply to either prohibit this testing or impose additional requirements (e.g., a Notice pursuant to the California Consumer Privacy Act).

UPDATED ANSWER (April 6, 2020)

If an employer does take temperatures, what precautions should be exercised to protect the individuals who performs that function?

The protection should match the protective measures used when taking patient temperatures. In other words, employers must conduct an evaluation of reasonably anticipated hazards and what precautions can be taken, including PPE such as gloves, masks and/or gowns, as explained below.

Employers must assess the risk to which the individual may be exposed. The safest thing to do would be to assume the testers are going to potentially be exposed to someone who is infected. Based on that exposure, employers must determine what mitigation efforts can be taken to protect the employee by eliminating or minimizing the hazard, including PPE.

Different types of devices can take temperatures without exposure to bodily fluids. For instance, the tester could wear a face shield or N95 respirator in case someone sneezes or coughs. The CDC and OSHA recommend that healthcare workers exposed to COVID-19 patients wear gowns, gloves,

National Institute for Occupational Safety and Health (NIOSH)-certified, disposable N95 or better respirators, and eye/face protection (e.g., goggles, face shield). Because testers could be exposed to COVID-19 patients, we suggest healthcare employers take these precautions for them and any other employee who might be exposed.

A comprehensive respiratory protection program that meets applicable requirements of OSHA's Respiratory Protection standard (29 CFR 1910.134) will generally include medical exams, fit testing, and training.

UPDATED QUESTION AND ANSWER (April 6, 2020)

A patient-care staff member refused to assist a symptomatic patient who arrived in the ER despite being assigned to do so. When asked about her refusal, the staff member stated that she has diabetes and an autoimmune disorder.

Given the preexisting conditions of the staff member, it would be most prudent for the employer to consider reassigning the staff member to a function where the risk of exposure is significantly or completely reduced. Guidance from the CDC states that healthcare employers should ensure healthcare professionals are “educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.”

Both the CDC and OSHA have issued guidance on precautions and protections for healthcare workers. The CDC publishes updated infection prevention and control recommendations for healthcare workers managing suspected or confirmed cases of COVID-19 and stresses that infection control procedures – including the appropriate use of PPE – should be followed to assist with protecting healthcare professionals who come into close contact with patients with COVID-19. The CDC also published guidance on Risk Assessment and Public Health Management of Healthcare Personnel in a Healthcare Setting with Potential Exposure to COVID-19 to assist healthcare employers with assigning risks and taking appropriate actions to minimize exposure.

UPDATED QUESTION AND ANSWER (April 6, 2020)

A patient-care staff member was exposed to a patient with a confirmed diagnosis of COVID-19. Do we have to notify her co-workers or patients with whom she had contact?

No. There is currently no CDC or other guidance which recommends informing patients and co-workers where the staff member was merely exposed to a patient with a positive diagnosis. However, the CDC's guidance on Risk Assessment and Public Health Management of Healthcare Personnel in a Healthcare Setting with Potential Exposure to COVID-19 provides additional steps that are recommended depending on the level of the staff member's exposure.

UPDATED QUESTION AND ANSWER (April 6, 2020)

A group of Environmental Services employees have voiced concerns about exposure to COVID-19 in cleaning patient rooms. They have demanded that we purchase additional protective

17 in cleaning patient rooms. They have demanded that we purchase additional protective clothing and equipment as well as a list of cleaning supplies that they prefer. Do we have an obligation to provide the clothing, equipment, and supplies?

Generally, there is no requirement to purchase the employees' preferred cleaning supplies or new additional cleaning equipment that is unnecessary. The CDC's Healthcare Infection Prevention and Control FAQs for COVID-19 states: "If the responsibility of cleaning patient rooms is assigned to EVS personnel, they should wear all recommended PPE when in the room. The CDC's website states that recommended PPE includes gloves, a gown, respiratory protection (at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator or facemask — if a respirator is not available), and eye protection (e.g. goggles or disposable face shield that covers the front and sides of the face) ... PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene."

The CDC's guidance states that after discharge, terminal cleaning may be performed by EVS personnel. However, they should delay entry into the room until a sufficient time has elapsed for enough air changes to remove potentially infectious particles. According to the CDC's guidance, "after this time has elapsed, EVS personnel may enter the room and should wear a gown and gloves when performing terminal cleaning. A facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated or otherwise required based on the selected cleaning products."

Additionally, the CDC's Interim Prevention and Control Recommendations for Patients with suspected or confirmed COVID-19 in Healthcare Setting contains guidance on implementing environmental infection control. That guidance includes specific recommendations for handling equipment.

MISCELLANEOUS CONCERNS

UPDATED QUESTION AND ANSWER (April 6, 2020)

Several of our patient-care employees have voiced concern about reporting to work due to a shelter in place order issued by the government. What can we do to allay their concerns and ensure that they are protected from enforcement measures that the government may take?

You should consider drafting a letter to present to law enforcement officials should your employee be stopped or pulled over on their commute to work. The letter should indicate that you are an essential business, the name and job title of the employee, and that the employee is expected to travel to and from work for their shift, and a summary of the employee's shift.

UPDATED QUESTION AND ANSWER (April 6, 2020)

Two of our caregivers appeared on the news and made comments about our shortage of PPE. They claimed that our patient-care staff have been instructed to reuse masks, gloves, and other protective coverings. They claimed that they are concerned about the "unsafe working conditions." The employees' conduct violates our Media Relations policy and is embarrassing to the organization. What should we do?

the organization. What should we do :

Generally, employees who appeal to the media or members of the public concerning their wages, hours, or terms and conditions of employment are engaged in protected activity. In this case, the employees were acting together when they spoke to the media about working conditions – being instructed to reuse certain PPE and their concern about unsafe working conditions. Thus, their conduct would be protected under the NLRA, as long as the employees do not purport to speak on behalf of the organization or make maliciously false statements about the organization.

Employers should consider communicating with their employees concerning operations and efforts to keep them safe during the COVID-19 crises. Employers should also consider having a strategy in place to respond to media inquiries or stories that may appear in the media. This includes identifying a designated spokesperson to whom members of the press will be directed for questions and/or comments.

UPDATED QUESTION AND ANSWER (April 6, 2020)

Several of our employees take public transportation to work. They have voiced concerns about traveling to work due to concerns about exposure to COVID-19, and are demanding to work remotely. Do we have an obligation to permit and make provisions for remote work? What are our options?

Generally, there is no obligation to create a telework program if you do not already have one in place. The Department of Labor's Wage and Hour Division states that an employee may telework when the employer permits or allows the employee to perform work while the employee is at home or at a location other than your normal workplace.

If you have a telework program in place and wish to permit some, but not all, employees to telework, you should seek appropriate legal counsel to ensure that your application of the telework policy does not run afoul of anti-discrimination laws such as Title VII and local human rights laws. Under the circumstances here, other options that the employer may consider is offering flexible scheduling to permit employees to commute to work during less busy times or offering reimbursement to employees who use other means to get to work. For example, the employer may consider reimbursing employees for parking if they drive their personal vehicles to work.

If you do not have a telework policy, and you have employees who work in close proximity to each other (such as Coders, Accounts Payable, or Medical Records personnel), you may want to consider developing a telework policy if social distancing standards cannot be adhered to in their usual work setting. Note that, in some instances, telework may be a reasonable accommodation under the ADA.

UNIONIZED WORK SETTINGS

UPDATED QUESTION AND ANSWER (April 6, 2020)

We required certain employees to submit to temperature tests to ensure patient safety. The union is now requesting the following for each tested employee: the grounds for testing, the results of the test, and a plan of action if the test revealed an elevated temperature. We believe this information is confidential. Do we have to provide this information to the union?

this information is confidential. Do we have to provide this information to the union?

Yes, but likely not without some limitation. Factors to consider include: (a) whether the information sought is for employees that the union represents, employees that the union does not represent, or both; and (b) whether the information meets the standard to be deemed “confidential” under the NLRA.

A union has a right to information relevant to its role as collective-bargaining representative. Information concerning wages, hours, and other terms and conditions of employment for bargaining-unit employees is presumptively relevant to the union’s role. Here, the information sought by the union would be within the scope of information that the union generally has a right to because it concerns temperature tests administered to employees at work and the employer’s planned course of action which impact the working conditions of those employees.

Generally, an employer’s failure to provide a union with requested relevant information violates the National Labor Relations Act (NLRA). However, when it comes to certain confidential information, the union’s right to the information is subject to the confidentiality interest at stake. The National Labor Relations Board (NLRB) recognizes only certain categories of information as “confidential.” One category is individual medical records and psychological test results. Additionally, the NLRB recognizes other federal and state laws that may deem this type of information as confidential.

However, even if the information sought falls within a category of information that the NLRB considers “confidential,” an employer is not at liberty to flatly refuse to provide the information. Instead, the employer must negotiate with the union concerning an accommodation to providing the information that protects the employer’s interest in confidentiality and meets the union’s need for the information. In the scenario here, some accommodations may include redacting the names of the employees and any personally identifying information (employee ID, medical ID, social security numbers) from the information or asking the union to submit written authorizations from each employee about whom the union is seeking the information.

When it comes to requested information concerning employees that the union does not represent, the union would need to demonstrate how that information is related to its role as representative for the bargaining-unit employees before an employer’s obligation to furnish the information is triggered. Even if the union can establish that the information is related to its role as representative of the bargaining unit employees, the same steps above should be followed in terms of protecting confidentiality.

UPDATED QUESTION AND ANSWER (April 6, 2020)

The union is requesting a list of the all patients who have tested positive for COVID-19. Do we have an obligation to provide this information to the union?

As stated above, the union will need to demonstrate how the requested information is relevant to its role as the representative for the bargaining unit, to the extent that the scope of the request covers both bargaining-unit and non-bargaining unit members. The union could satisfy this requirement by

simply stating that it wants the information to determine the impact of the COVID-19 patient population on the employees that the union represents.

Since the employer would still have an obligation to comply with certain privacy laws like HIPAA, the employer should inform the union that the information is confidential per applicable laws and then negotiate concerning an accommodation to providing the information. In this case, the employer may offer the number of patients and employees in the facility who have tested positive for COVID-19 and the units on which those patients are located.

UPDATED QUESTION AND ANSWER (April 6, 2020)

The union filed a grievance regarding nurse assignments. It alleges that we assigned a nurse to a COVID-19 care area despite knowledge of the nurse's preexisting conditions that make her more vulnerable to contracting the COVID-19 virus. We are very busy. Do we have an obligation to still process grievance meetings at this time? If so, how should we conduct grievance meetings with social distancing measures in place?

Yes, you would still need to adhere to the terms of your collective-bargaining agreements concerning grievances. At this time, the NLRB has not issued guidance stating that employers may suspend processing grievances pursuant to a grievance and arbitration clause in a collective-bargaining agreement due to the circumstances created by COVID-19.

However, you should reach out to your union to discuss grievance processing procedures (including applicable deadlines) and alternatives to conducting in-person grievance meetings. One option that you may consider is conducting grievance meetings via video conference applications. It would also be prudent to proactively meet with your union representatives to decide in advance how grievances will be processed during this critical time.

UPDATED QUESTION AND ANSWER (April 6, 2020)

The union is demanding to bargain about staffing assignments, namely which employees are assigned to work on units reserved for COVID-19 patients. Our Management's Rights provision in our collective-bargaining agreement reserves to management the right to determine staffing levels and to make staffing assignments. Do we have to meet with the union over these mid-term modifications to our collective-bargaining agreement?

While it is acceptable for either party to propose mid-term modifications, the other side is not required to agree (or even bargain over it). You should stress to the union the importance of staffing and assignment flexibility at this time. However, while you may have no legal obligation to bargain over your decisions concerning staffing and assignments generally, you may have a legal obligation to bargain with the union concerning the effects of your decision.

For example, subjects of effects bargaining may include types of PPE to be given to the employees assigned to COVID-19 units, health-related considerations of the employees selected to work on the COVID-19 units, or the rotation of shifts for selected employees working on the COVID-19 units.

Planning for Success:

8 Steps Healthcare Providers Should Consider Taking Now

1. Thoroughly familiarize yourself and remain current with OSHA guidance for workers with potential occupational exposure to COVID-19.

To comply with OSHA, healthcare employers that are actively treating patients with suspected or confirmed cases of COVID-19 should ensure their workforces are using controls to prevent exposure. The control measures can include, but are not limited to, implementing safe work practices, requiring PPE for employees at risk of exposure, and isolating potentially infectious individuals. While these are clearly not new requirements for healthcare providers, the present circumstances are. Thus, it is especially important to continue following these developments. Healthcare employers should also determine whether there are any state-specific requirements that must be followed to protect healthcare workers, such as CAL/OSHA.

2. Also familiarize yourself and stay current with CDC guidance related to healthcare employees who are caring for patients with possible or confirmed COVID-19.

Healthcare employers in the current global crisis bear significant responsibilities – not only to patients, but also to employees. To minimize disruption to your operation and protect your workforce, you should immediately ensure implementation of current CDC guidance related to healthcare personnel who are caring for patients with confirmed or possible COVID-19. This includes the use of PPE, using Standard Precautions, and exercising consistent and thorough hygienic measures.

3. Communicate with all of your employees.

Most healthcare employers have probably already done this – at least for hands-on providers. But healthcare employers should ensure that each member of its workforce (not just providers), including volunteers, has received adequate information about the employer's response to and all relevant precautions concerning COVID-19. This information should of course describe mandatory hygiene practices and advise what employees should do if they have been exposed to a confirmed case of COVID-19 or if they are experiencing symptoms consistent with COVID-19. Do not assume that all employees know best practices simply because they work in healthcare. Now, perhaps more than ever, it is vital to strike a calm, clear and confident posture in communicating with the entire workforce, emphasizing that everyone is dealing with this crisis together.

4. Take additional, particularized precautions with food service and nutrition, to the extent that your organization provides such services.

Hospitals, and certain other healthcare providers, provide nutrition or food services to patients, employees, and others. Many healthcare providers rely on third parties to operate food services, while others do not. Regardless of your model, healthcare providers that serve food to patients, employees, and/or others, should ensure that appropriate measures are taken to reduce the

possibility of contamination.

For instance, you should consider temporarily discontinuing the use of any self-service bars (salad, potato, burger, etc.). You should ensure the workers providing food services (whether yours or a third party's) are trained on heightened sanitary measures. While COVID-19 has not been proven to be transmitted through food, the virus can survive on solid surfaces such as silverware and serving pieces for several hours, if not several days.

5. Certain providers should prepare for an upsurge in work and a worker shortage.

As the outbreak grows, healthcare employers offering primary and emergency care should expect a significant increase in demand. While everyone hopes that the preventative measures being implemented by the government and private business owners will #flattenthecurve, it is likely that at least some parts of the healthcare infrastructure will become severely taxed for a period of time.

These healthcare employers should anticipate and prepare for a worker shortage. Not only are employees of primary and emergency care providers more likely to be exposed to COVID-19, making it more likely that they will contract the virus, they share the general concerns that workers across all industries are having. They may be extremely worried that patient interaction poses too great a risk to them or their families, especially family members who are at higher risk. Or, they may simply be overwhelmed by family obligations due to school closures. Whatever the reason, you may start to see the pool of available workers shrink.

To combat this, healthcare employers may, if feasible, consider increasing pay for certain work during critical times, add new workers (perhaps borrowing from healthcare providers not providing coronavirus-related care and have temporarily reduced or ceased operations), and cross-train workers to perform multiple positions (where possible). The most promising strategy in the near term is likely for providers to focus exclusively on immediately necessary services, cancelling elective or routine procedures and then reassigning employees who have been freed up as a result. This could be especially helpful if recovery-room nurses and other respiratory care professionals can be temporarily reassigned to deal with COVID-19 issues.

During this time, it is especially vital for leaders to recognize that everyone is dealing with additional stress. Thus, it is paramount for leaders to be as visible and accessible as possible and more importantly, to convey a sense of calm assurances, recognizing that the workforce will get through this situation together.

6. Offer telework options where possible.

While many healthcare jobs require the employees' physical presence at the facility, not all do. Healthcare employers would be wise to evaluate whether certain positions can shift to telework. Not only will this subject fewer employees to COVID-19 exposure, but it provides at least a layer

of protection if a “shelter in place” order that impacts your operations (e.g., because you are not an essential business or the employee doesn’t provide a service that is integral to your operations) is imposed or members of your workforce are required to quarantine.

To clearly communicate expectations regarding telework, employers should review their remote work policy (or implement one, if there is none), in collaboration with their employment attorney. Among other things, this policy should prohibit off-the-clock work by non-exempt employees and address workplace safety and ergonomics considerations, as well as instructions for business expense reimbursement.

7. Healthcare employers who are temporarily reducing operations may consider short-term modifications of “benefits eligibility” policies and standards.

Many healthcare employers use “hours worked” measurements to determine whether employees maintain full time status for purposes of benefit eligibility. In the event your operations are being temporarily reduced, either to comply with CDC guidance or out of an abundance of caution, you may want to consider relaxing (or suspending) your benefits standards for this period of slow down so that normally classified full-time employees do not suffer a loss. Before implementing such steps, employers must confer with the applicable benefit plan insurer or administrator or their ERISA attorney.

8. Ensure compliance with any existing collective bargaining agreement.

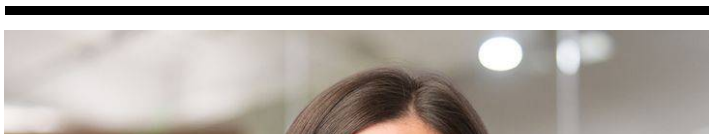
Many healthcare employers are parties to collective bargaining agreements. Therefore, before you take any steps to tailor your workforce-related response to COVID-19, you should ensure your response does not violate the agreement and first notify the union, if required.

Conclusion

We will continue to monitor this rapidly developing situation and provide updates as appropriate. Make sure you are subscribed to Fisher Phillips’ alert system to gather the most up-to-date information. If you have any questions about this situation or how it may affect your school, please contact any member of our Healthcare Industry Practice Group or your Fisher Phillips attorney. You can also review our nationwide Comprehensive and Updated FAQs for Employers on the COVID-19 Coronavirus and our FP Resource Center For Employers, maintained by our Taskforce.

This Legal Alert provides an overview of a specific developing situation. It is not intended to be, and should not be construed as, legal advice for any particular fact situation.

Related People





Laurel K. Cornell
Regional Managing Partner
502.561.3987
[Email](#)



A. Kevin Troutman
Senior Counsel
713.292.5602
[Email](#)

Service Focus

Workplace Safety and Catastrophe Management

Industry Focus

Healthcare

Trending

COVID-19/Vaccine Resource Center