EMPLOYMENT LAW IN THE HEALTH CARE INDUSTRY: 2018 YEAR IN REVIEW

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U.S. Health Care and Labor, Employment & Workplace Safety Alert

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2018 brought developments in employment law issues that have particular relevance to the health care industry. These include continuing developments regarding employee resistance to vaccination mandates, increased requirements regarding workplace violence prevention, wage and hour guidance at the federal level, marijuana legalization, the ever-shifting definition of "joint employer" under federal labor laws, expanded efforts to prevent sexual harassment, and more. The following Alert -- prepared by K&L Gates' collaborative team of employment lawyers dedicated to tracking and serving health care industry participants -- summarizes these key developments in 2018 and provides recommendations for action in 2019.

EMPLOYEES GO ON THE OFFENSIVE OVER REQUIRED VACCINATIONS

Employees continued to file cases seeking exemptions, on religious grounds, from vaccination requirements. These cases typically involve employers who either categorically deny vaccine exemption requests or refuse to offer alternatives.

To state a claim under federal law, [1] an employee merely needs to show that he or she has a sincerely held religious belief that conflicts with a work policy (such as a vaccination requirement), shared that belief with the employer, and was disciplined for failing to comply with the policy. The definition of "religion," according to the Equal Employment Opportunity Commission ("EEOC"), includes new or uncommon religions, as well as ones that may seem "illogical," "unreasonable," or lack belief in divine beings. Applying these standards, one federal district court found that an objection rooted in an employee's vegan lifestyle could plausibly constitute a religious belief, so long as the employee's commitment was sincerely held in a manner similar to traditional religious views.

An employer may potentially defeat a discrimination claim by showing that the requested accommodation presents an "undue hardship." This might seem to be a relatively easy burden to meet in cases involving nonvaccinated health care workers. However, each case must be evaluated on its on facts, as several cases from 2018 illustrate.

For example, in *EEOC v. St. Vincent Hospital and Health Center, Inc.*, a hospital asked a records clerk, sonographer, and four registered nurses who refused vaccinations to provide clergy attestation of the validity of their religious beliefs with their exemption requests. When they failed to do so, they were fired. The employees sued, alleging failure to accommodate their religious beliefs. The hospital settled for $300,000, offered reinstatement, and promised to end its policy of automatically rejecting vaccination requests not accompanied by clergy attestation.

In *EEOC v. Mission Hospital Inc.*, a federal district court denied a hospital's motion for summary judgment. The hospital had a policy of giving employees a grace period to get flu shots but not for employees seeking a religious exemption from the shots. The parties ultimately settled for $89,000, with the hospital agreeing to revise its accommodation policies, hold annual management training on religious accommodations, and provide periodic reporting to the EEOC regarding its religious exemptions.

In the pending case of *EEOC v. Baystate Medical Center*, the employer, a medical center, allegedly gave a Christian human resources employee the option of wearing a mask after she refused to get a vaccination. The medical center suspended her without pay when a superior saw her without a mask. The EEOC has alleged that the mask policy is unreasonable because others had a hard time understanding her when she spoke. The EEOC claims that allowing her to remove the mask while speaking would pose no undue hardship to the hospital, given her lack of patient contact.

Vaccination issues also generated a disability accommodation decision in 2018. In *Hustvet v. Allina Health System*, the employee refused to take steps to develop immunity to rubella. Granting summary judgment to the employer, the Eighth Circuit Court of Appeals found that the employee was not "disabled" because her alleged "chemical sensitivities and allergies" did not substantially limit any of her major life activities. In addition, even assuming the plaintiff had a disability, her claim failed as a matter of law. The rubella requirement was mandated to ensure that patient-care providers would not spread disease. Thus, it was job related, consistent with business necessity, and did not violate the Americans with Disabilities Act or the Missouri Human Rights Act.

HEALTH CARE WORKPLACE VIOLENCE PREVENTION EFFORTS CONTINUE

The Joint Commission Outlines Steps to Prevent Workplace Violence

Tragically, violence in the health care workplace remained a prevalent topic in 2018. In November, a shooting at Mercy Hospital in Chicago left four people dead. Other hospitals encountered incidents of gun violence, including the University of Kansas Medical Hospital, Westchester Medical Center in New York, Mount Sinai Hospital in Chicago, and the University of Alabama at Birmingham Highlands Hospital.

As a result of incidents such as these, the Joint Commission, an independent, nonprofit organization that sets standards for and certifies thousands of health care organizations and programs in the United States, has increased its focus on workplace violence. It found that health care workers are four times more likely to experience workplace violence than workers in private industry, and 75 percent of nearly 25,000 workplace assaults reported annually occur in health care and social services settings. Many violent incidents involve patients who have a mental illness, use controlled substances, are in police custody, have received bad news about a diagnosis, or have engaged in criminal activity. Other factors include the presence of weapons and domestic disputes among patients or visitors.

In 2018, the Joint Commission advised health care organizations to implement measures to address workplace violence. Failure to do so could jeopardize an organization's accreditation status with the Joint Commission. [2] To provide guidance in this area, the Joint Commission released a Sentinel Event Alert that outlines seven steps health care organizations should take to prevent workplace violence:

1. Clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence incidents, including verbal abuse;

2. Recognize that data comes from several sources; capture, track, and trend all reports of workplace violence, including verbal abuse and attempted assaults when no harm occurred;
3. Provide appropriate follow-up and support to victims, witnesses, and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary;
4. Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence and worksite conditions to determine priority situations for intervention;
5. Develop quality improvement initiatives to reduce incidents of workplace violence, including changes to the physical work environment, changes to work practices, and administrative procedures;
6. Train all staff, including security, in de-escalation, self-defense, and response to emergency codes; and
7. Evaluate workplace violence reduction initiatives.

For further guidance, the Joint Commission reiterated several of its previous standards that relate directly or indirectly to workplace violence, including: Leadership, Rights and Responsibilities of the Individual; Provision of Care, Treatment and Services; Environment for Care, and Emergency Management.

The Workplace Violence Prevention for Health Care and Social Service Workers Act is Introduced

The federal Occupational Safety and Health Act ("OSHA") only addresses workplace violence hazards under the "General Duty Clause." This clause requires employers to furnish a place of employment free from recognized hazards that are causing or are likely to cause death or serious physical harm.

Health care employers may face steep penalties from OSHA if they fail to adequately protect employees from workplace violence. As a result of what is arguably a regulatory gap in OSHA on health care-specific workplace violence, in November 2018, Rep. Joe Courtney (D-CT) introduced, the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (House Resolution 7141). The bill would have forced OSHA to issue an interim final rule on workplace violence requiring certain employers in health care, social services, and similar sectors to develop and implement a comprehensive workplace violence prevention plan.

It would also have required, among other things, workplace violence prevention plans to include risk assessments; hazard prevention and engineering controls; reporting, incident response, and post-incident investigation procedures; procedures for emergency response (including procedures for threats of mass casualties and for incidents involving a firearm or dangerous weapon); procedures for communicating with and training of employees; annual evaluation procedures; and anti-retaliation provisions.

The bill died at the close of 2018, but we will continue to monitor whether similar legislation is introduced at the state or federal level in 2019.

California Becomes the First State to Require Acute Care Hospitals and Skilled Nursing Facilities to Implement Workplace Violence Prevention Plans

Effective April 1, 2018, California became the first state to require all acute care hospitals and skilled nursing facilities to develop and implement comprehensive workplace violence prevention plans. The new law requires acute care hospitals, skilled nursing facilities, and other specified medical providers to develop, review, and train employees regarding workplace violence prevention programs.

The statute establishes three key responsibilities for employers: developing a plan, reviewing the plan, and conducting training. The plan must include procedures enabling employees to, among other things, report incidents of workplace violence without retaliation, obtain assistance from law enforcement personnel during all shifts, and assess safety risks posed by patients, visitors, and the facility's environment.

The regulations also direct employers to review the plan and ensure it is adequate to keep employees safe, taking into account the facility's personnel, security systems, and security risks. In addition, covered employers must train all employees and new hires on the plan and provide additional training sessions whenever they implement new procedures, utilize new equipment, or identify new safety risks.

Illinois Adopts the Health Care Violence Prevention Act

The Illinois Health Care Violence Prevention Act, effective January 1, 2019, requires hospitals and other health care facilities to develop and implement a workplace violence prevention program that complies with OSHA guidelines for preventing workplace violence. The act was passed in response to two incidents in which inmates receiving treatment at Illinois hospitals assaulted nurses.

The law requires workplace violence prevention programs to also include (i) classifications of workplace violence (as provided under OSHA), (ii) worksite analysis and identification of hazards, (iii) management commitment and worker participation, (iv) safety and health training, and (v) hazard prevention and control.

The law also requires covered facilities to offer immediate post-accident medical treatment and access to a psychological evaluation to any health care worker involved in an incident and requires specific safety procedures for treatment of incarcerated individuals.

Additionally, the law provides whistleblower protection to health care workers who report acts of workplace violence to law enforcement.

THE DEPARTMENT OF LABOR ISSUES GUIDANCE ON CAREGIVER REGISTRIES AND HOME HEALTH CARE AID COMPENSATION

Bulletin Regarding Employer Status of Caregiver Registries Under the FLSA

In July 2018, the U.S. Department of Labor's ("DOL") Wage and Hour Division ("WHD") published Field Assistance Bulletin No. 2018-4, "*Determining Whether Nurse or Caregiver Registries are Employers of the Caregiver*." The Bulletin provides guidance to WHD field staffers to help them determine whether home care, nurse, or caregiver registries are employers under the Fair Labor Standards Act ("FLSA").

A caregiver registry matches people who need caregiver services with caregivers who provide those services (e.g., nurses, home health aides, or personal care attendants). The bulletin underscores the WHD's longstanding position that a caregiver registry that simply facilitates matches between clients and caregivers — even if it provides certain other services — is *not* an employer under the FLSA.

On the other hand, a caregiver registry that controls the terms and conditions of the caregiver's employment activities *may* be an employer subject to the FLSA. The determination must be performed on a case-by-case basis. The bulletin provides multiple examples and insights about how this analysis should be performed. It also notes that simply calling a caregiver an "independent contractor" will not, by itself, preclude the finding of an employment relationship.

Home Health Care Aide Compensation

In December 2018, the DOL published Opinion Letter FLSA 2018-28, addressing compensation plans for home health aides who travel between client locations during the workday. To calculate weekly pay, the employer multiplied the employees' time with clients by their hourly pay rate, and divided the result by total hours worked, which included both client time and travel time. The employer guaranteed that the quotient met both federal and state minimum wage requirements. If an employee worked over 40 hours in a week, the employee was paid time and one-half for all time over 40 hours based on the typical $10 regular hourly rate.

The DOL concluded that the employer's compensation plan complied with the FLSA's minimum wage requirements because, although the average hourly pay rate varied from workweek to workweek, the employer always ensured that the average hourly pay rate exceeded minimum wage for all hours worked.

In contrast, the DOL cautioned that the compensation plan would not comply with the FLSA's overtime requirements if the employer assumed a regular rate of pay of $10 per hour when an employee's actual rate of pay exceeded that rate. The plan would comply, however, for all employees whose actual regular rates of pay were less than $10 per hour, because an employer may choose to pay an overtime premium in excess of the statutorily required amount.

CONTINUING CONFLICT BETWEEN FEDERAL AND STATE MARIJUANA LAWS

In 2018, states continued the trend of legalizing marijuana use. Michigan legalized recreational cannabis, while Utah and Missouri legalized medical marijuana. Thirty-three states have now legalized medical marijuana; while 10 have legalized recreational use. In addition, 10 states prohibit employers from discriminating against employees who use medical marijuana away from work.

This legal patchwork conflicts with the federal Controlled Substances Act ("CSA"), which prohibits marijuana use, possession, or distribution, including medicinal use. Moreover, the Drug Free Workplace Act ("DFWA") requires all federal grantees, and federal contractors with contracts valued at $100,000 or more, to have a drug-free workplace. Some states that have legalized marijuana, however, allow employers to refuse employment to marijuana users if they would otherwise lose federal grants, contracts, or benefits.

Before 2017, most state and federal courts held that employers were not required to accommodate employees' lawful use of medical marijuana under state law, given its illegality under federal law. In 2018, however, signs of a trend in the opposite direction continued.

For example, in *Noffsinger v. SSC Niantic Operating Co., LLC*, a job applicant claimed that a nursing facility discriminated against her in violation of the Connecticut Palliative Use of Marijuana Act ("PUMA"). The defendant, a federal contractor, revoked the plaintiff's job offer after she failed a drug test. The applicant used medical marijuana, as allowed under PUMA, to treat her night terrors. The district court rejected the nursing facility's argument that hiring the plaintiff violated the DFWA, finding that the statute does not require drug testing and does not regulate illegal off-duty drug use.

Similarly, in December 2018, a Delaware state court in *Chance v. Kraft Heinz Food Co.* decided a case involving an equipment operator, a medical marijuana user, who operated a shuttle wagon when it derailed, which prompted the employer to request a drug test. The employee was terminated for failing the test. The court held

that a private cause of action exists under Delaware's medical marijuana law, which was not preempted by the CSA, and permitted the employee to proceed with his lawsuit.

Noffsinger and *Chance* are consistent with recent rulings in favor of employees in Rhode Island and Massachusetts, states where medical marijuana has been legalized. In the Rhode Island case, a state superior court held that the CSA does not preempt the state's medical marijuana law because the CSA, which focused on anti-drug trafficking, had no applicability to employment or anti-discrimination law. The Massachusetts Supreme Court ruled in another case that an employer's refusal to accommodate an employee's use of medical marijuana off work can constitute disability discrimination under state law.

THE DEFINITION OF "JOINT EMPLOYER" UNDER FEDERAL LABOR LAW REMAINS UNRESOLVED

2018 continued to bring significant developments regarding the standard for holding an entity to be a joint employer under federal labor law. The issue has heightened significance for health care employers, given the prevalence of staffing, temporary, and locum tenens work arrangements in the industry.

The National Labor Relations Board's ("NLRB") 2015 decision in *Browning-Ferris Industries of California, Inc.* ("*BFI*") dramatically expanded the definition of "joint employer" under the National Labor Relations Act. Under the pre-*BFI* standard, which had been in place for decades, joint employer status required a showing that the entity actually, substantially, directly, and immediately controlled the terms and conditions of employment. Potential but unexercised authority was insufficient.

Yet in *BFI*, the NLRB held that control could exist even where it was contractually reserved but *never exercised*. BFI was appealed to the U.S. Court of Appeals for the District of Columbia Circuit. While the appeal was pending, a new, Republican-appointed majority NLRB overturned the *BFI* standard in *Hy-Brand Industrial Contractors, Ltd. et al.* However, the NLRB's inspector general deemed *Hy-Brand* invalid due to a conflict of interest, and as a result, in February 2018, the NLRB, ruling without the conflicted member, restored the *BFI* standard.

In May 2018, the NLRB proposed a new standard that would require demonstration of control over essential elements of employment by an entity in order to find joint employment. In December, the circuit court validated the *BFI* standard, ruling that reserved control could be a factor in findings of joint employment and remanding the matter to the district court for further proceedings.

In January 2019, NLRB Chairman John Ring indicated in an NLRB responsive letter that the circuit court's decision is limited to the *BFI* case only and does not foreclose the NLRB's joint employer rulemaking, despite language in the circuit court's ruling indicating that it is generally binding on the NLRB, beyond *BFI*.

Litigation and agency action will likely continue over this issue, as the NLRB proceeds with its rulemaking in 2019 and the *BFI* case continues to proceed in federal court. We will continue to monitor further developments.

#METOO-INSPIRED ANTI-HARASSMENT LAWS ENACTED IN CALIFORNIA AND NEW YORK

With the advent of the #MeToo movement, public awareness of sexual harassment in the workplace has increased substantially. While health care has not had as much media attention regarding sexual harassment as

other industries, such as technology, media, or entertainment, employers in the industry regularly experience sexual harassment claims.

According to Medscape's 2018 Sexual Harassment of Physicians Report, 10 percent of the 6,200 physicians and clinicians surveyed had experienced sexual harassment from a colleague in the past three years. Of those experiencing sexual harassment, 79 percent had experienced harassment from one to three perpetrators, with 12 percent of medical residents experiencing harassment from over seven perpetrators.

A separate 2018 Medscape poll found that 71 percent of nurses and 47 percent of physicians had been sexually harassed by a patient in the workplace. And sexual harassment in the industry is hardly a recent trend. A study published in 1995 found that 52 percent of women in academic medicine had experienced a form of sexual harassment and in 2012, a physician's assistant in California was awarded close to $168 million from a jury in her sexual harassment lawsuit against a hospital and its parent company.

Motivated by heightened cultural awareness of these issues, in 2018, California, New York State, and New York City enacted significant new laws aimed at preventing sexual harassment.

California Substantially Redefines Hostile Work Environment Harassment and Requires Increased Training

Effective January 1, 2019, California implemented new laws expanding liability for workplace harassment, as well as requirements for anti-harassment training.

One new law significantly expands the circumstances in which hostile work environment harassment may be found to exist by rejecting the "severe or pervasive" standard developed and refined over several decades by California courts. "Harassment" is now redefined to encompass a broad spectrum of conduct, specifically:

> Harassment creates a hostile, offensive, oppressive, or intimidating work environment and deprives victims of their statutory right to work in a place free of discrimination when the harassing conduct sufficiently offends, humiliates, distresses, or intrudes upon its victim, so as to disrupt the victim's emotional tranquility in the workplace, affect the victim's ability to perform the job as usual, or otherwise interfere with and undermine the victim's personal sense of well-being.

In addition, employees are no longer required to prove that their productivity has declined as a result of harassment. Rather, they only need to show that the harassment made it more difficult for them to do their job. A single incident of harassing conduct potentially may support a claim. Furthermore, a single remark made by someone unconnected to a termination decision may be circumstantial evidence of discrimination.

New training requirements were also enacted. Under prior law, California employers with 50 or more employees were required to provide two hours of anti-harassment training to supervisory employees every two years. Now, any employer with five or more employees, including temporary and seasonal workers, must provide two hours of anti-harassment training to supervisors and one hour of training to nonsupervisors by January 1, 2020, and then once every two years thereafter. The law also requires the California Department of Fair Employment and Housing to develop anti-harassment courses and post them online.

New York State and New York City Expand Anti-Harassment Protections

2018 ushered in two new laws governing workplace harassment for employers operating in New York State and New York City. First, in April, Governor Andrew Cuomo signed into law the 2019 New York State Budget, which updated the State's sexual harassment laws. A month later, Mayor Bill de Blasio signed into law the Stop Sexual Harassment in NYC Act, a comprehensive legislative package aimed at addressing and preventing sexual harassment in the workplace. This included an expansion of the City Human Rights Law in cases of gender-based harassment to extend protections to all employees, regardless of the size of their employer. Specific to both laws is a mandated harassment training requirement for employees of covered employers.

In addition to the training requirement, under the state statute, all employers were required to adopt a sexual harassment prevention policy as of October 2018 and provide all employees with a copy of the policy. A complaint form must also be made available to employees and referenced in the policy.

Mandated training for all employees must be conducted by October 9, 2019, and annually thereafter. The New York State Human Rights Law protects not only employees but contractors, subcontractors, vendors, consultants, and others providing services in the workplace. However, anti-harassment training is only required for employees, including part-time, temporary, and seasonal workers, who work any portion of time in the state.

Effective April 2019, city employers with 15 or more employees are required to conduct annual anti-sexual harassment training for all employees, including interns and, in some cases, independent contractors.

Prior to April 1, 2019, the City Human Rights Commission will develop and publish an online training that will satisfy both the state and city training requirement.

Employers covered under the state and city regulations are free to provide their own annual anti-sexual harassment training for required personnel, provided that it includes certain required elements:

- An explanation of sexual harassment as a form of unlawful discrimination under state and local law;
- A description of what sexual harassment and retaliation are, using examples;
- Any internal complaint process available to employees through their employer to address sexual harassment claims;
- The complaint process available through the City Human Rights Commission, the State Division of Human Rights, and the EEOC, including contact information; and
- The specific responsibilities of supervisory and managerial employees in the prevention of sexual harassment and retaliation, as well as measures that such employees may take to appropriately address sexual harassment complaints.

Under the city statute, training must include information concerning bystander intervention. Under both laws, the training must be interactive. Both live and Web-based training are permitted, but under the state law, the training must include a Q&A session or allow participants to provide feedback.

City employers must maintain a record of all trainings, including a signed employee acknowledgement, while the state law only encourages this practice. Furthermore, all city employers must conspicuously display anti-sexual harassment rights and responsibilities notices in English and Spanish and distribute a factsheet in English and Spanish to employees at the time of hire (this may be included in an employee handbook).

New York State also enacted a prohibition on mandatory arbitration to resolve sexual harassment claims, except where inconsistent with federal law. Additionally, nondisclosure provisions in sexual harassment settlement agreements are now prohibited unless included at the employee's request, and they must be memorialized in a settlement agreement that includes a 21-day consideration period and a seven-day revocation period.

COLORADO ISSUES A NEW LAW RESTRICTING PHYSICIAN NONCOMPETITION AGREEMENTS AS TO PATIENTS WITH RARE DISORDERS

Colorado Senate Bill 18-082, effective April 2, 2018, amended the Colorado Non-Compete Statute. [3] Prior to this amendment, an agreement among Colorado physicians could contain a covenant not to compete under which a physician who left a group practice could be compelled to pay damages if he or she solicited patients who were former or prospective patients of the practice.

The new law excludes from this general rule patients with rare disorders (as determined in accordance with nationally recognized criteria by the National Organization for Rare Disorders, Inc.) who were previously receiving treatment from the departing physician and who therefore would otherwise likely not have ready access to a physician with the necessary expertise to treat the disorder. The law specifically states that notwithstanding a covenant not to compete, a departing physician may disclose his or her continuing practice and new contact information to any qualifying patient, and neither the departing physician nor his or her new employer may be liable to any party to the prior noncompete agreement for damages alleged to have resulted from the physician's disclosure of the information or treatment of the patient.

RECOMMENDED ACTIONS FOR HEALTH CARE EMPLOYERS

In light of these changes, health care industry employers should consider taking the following actions:

- Carefully craft vaccination policies to ensure that they take into account potential objections based on religious, disability, or other objections related to protected status. Ensure that all similarly situated employees are treated equally with respect to vaccination requests, such as notice requirements, grace periods, and verification requirements. Avoid requiring certain verification formats, such as letters from clergy. Allow for discussion and an interactive process regarding potential accommodations. Consider infection-control alternatives, such as transfers to nonpatient contact positions.
- Review workplace violence prevention standards in light of the new Joint Commission recommendations and make changes as necessary. Conduct training on how to handle workplace violence incidents.
- Conduct a wage and hour audit at least annually to evaluate compliance under the FLSA and applicable state and local regulations.
- Develop or refine policies on medical marijuana, taking care to ensure that they are drafted in a manner that balances competing state and federal considerations. Consider avoiding policies that indicate employees will be automatically terminated for off-duty use and provide nuanced language to allow management to use discretion in discipline, depending on the circumstances.
- Evaluate contracts with staffing agencies, temporary employees, providers of locum tenens physicians and nurses, and other third parties regarding joint employment issues. Evaluate which party is responsible for supervising daily tasks, whether control is direct or reserved; which entity is responsible

for wage and hour, anti-discrimination, leaves of absence, and workers' compensation; and whether indemnification and related responsibilities are appropriately addressed.

- Educate all employees about laws prohibiting harassment, including how to appropriately make and respond to complaints of harassment. Distribute copies of updated anti-harassment policies. Consider issuing a statement from executive leadership regarding the organization's commitment to preventing harassment, discrimination, and retaliation.
- Update training policies, procedures, and materials to comply with applicable anti-harassment training requirements, and train employees at least annually or as otherwise required by law.
- Review noncompete agreements to ensure that any restrictions comply with applicable law.

The K&L Gates Health Care Employment group comprises a distinctive set of lawyers from our Health Care; Labor, Employment and Workplace Safety; Immigration; and Employee Benefits practice groups who work in concert to advise clients in the health care industry. Through building unique industry knowledge, this collaborative K&L Gates team has a proven track record of successful representations of health care industry players in all facets of employer-employee relations.

NOTES

[1] State and local law anti-discrimination laws have different standards and protections than those provided under federal law.

[2] Joint Commission accreditation can be earned by many types of health care organizations, including hospitals, doctor's offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services.

[3] C.R.S. § 8-2-113.

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