TO: CHA Members  
FROM: Gail M. Blanchard-Saiger, Vice President, Labor and Employment  
SUBJECT: Frequently Asked Questions Regarding H1N1

As health care providers prepare for the expected surge of patients as a result of the H1N1 flu, many human resources-related questions arise. Finding answers to these questions is particularly challenging because there are various state and federal agencies providing guidance to health care employers in a dynamic environment. Moreover, many of the issues implicate leave of absence, as well as anti-discrimination, harassment and retaliation laws. Additionally, if employees are represented by a union, there are collective bargaining agreement and other labor relations issues to consider.

CHA has developed the attached *Frequently Asked Questions Regarding H1N1* to address pressing issues based on currently available information. As noted above, however, as guidance from federal and state agencies develops, the answers to some of the questions may change. Therefore, it is important to stay abreast of recent developments. CHA will periodically update this document to reflect new developments. Important websites containing such information are included in the FAQ. In addition, CHA has a website — www.calhospitalprepare.org — dedicated to disaster preparedness. The website includes a checklist that incorporates several human resources functions at www.calhospitalprepare.org/h1n1Checklist. Given the many uncertain labor and employment issues involved, we recommend consulting with counsel before taking action.

CHA will offer a member conference call to review the FAQs and provide members with the opportunity to ask questions of representatives from state administrative agencies. The call will be held October 26 from 10 a.m. to 11:30 a.m. In addition, a panel presentation on the legal issues of H1N1 and workforce management will be presented at CHA’s Labor and Employment Law Seminar on November 12 in Sacramento and November 19 in Pasadena. More information on the conference call and seminar is posted on the CHA website at www.calhospital.org/Education.

I would like to thank Jeffrey Tanenbaum, partner at Nixon Peabody, and Jeffrey Berman, partner at Sidley Austin, for their contributions to the FAQ document. If you have any questions, please contact me at (916) 552-7621 or gblanchard@calhospital.org.

GBS:kb  
Attachment
FREQUENTLY ASKED QUESTIONS REGARDING H1N1
October 16, 2009

Q1: Can an employer require an employee to be vaccinated for H1N1?
A: Cal. Health & Safety Code 1288.7 requires hospitals to annually offer onsite influenza vaccinations, if available, to all hospital employees at no cost to the employee. Section 1288.7 also provides that “each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination.” While this suggests that an employee has the right to decline the vaccine, CHA is seeking clarification from the California Department of Public Health (CDPH) on this issue.

In an All Facilities Letter (AFL) dated October 1, 2009, CDPH did confirm its position that H1N1 is an influenza covered by section 1288.7. Therefore, the H1N1 vaccine should be offered to employees, if available, at no cost, and employees can be required to sign the declination statement if they decline the vaccine. A copy of the AFL is available on the CHA website at www.calhospital.org/H1N1Requirements.

Although the new Aerosol Transmissible Disease (ATD) Standard (discussed in more detail below) does not require hospitals to offer various vaccines until September 1, 2010, it does provide a model declination form that hospitals may use. The form is posted on the Department of Industrial Relations (DIR) website at www.dir.ca.gov/Title8/5199-c1.html.

Q2: What are the current public health guidelines on when a health care worker who has exhibited H1N1 flu symptoms can return to work?
A: Current Centers for Disease Control and Prevention (CDC) guidance, available on the CDC website at www.cdc.gov/h1n1flu/guidelines_infection_control.htm, provides:

“Healthcare personnel who develop a fever and respiratory symptoms should be:
- Instructed not to report to work, or if at work, to promptly notify their supervisor and infection control personnel/occupational health.
- Excluded from work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines.
- If returning to work in areas where severely immunocompromised patients are provided care, considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer. Clinical judgment should be used for personnel with only cough as a symptom, since cough after influenza infection may be prolonged and may not be an indicator of viral shedding. Healthcare personnel recovering from a respiratory illness may return to work with immunocompromised patients sooner if absence of 2009 H1N1 viral RNA in respiratory secretions is documented by real-time reverse transcriptase-polymerase chain reaction (rRT-
PCR). Additional information on diagnostic testing for 2009 H1N1 influenza infection can be found at http://www.cdc.gov/h1n1flu.

- Reminded of the importance of practicing frequent hand hygiene (especially before and after each patient contact) and respiratory hygiene and cough etiquette after returning to work following an acute respiratory illness.”

Current CDPH guidelines indicate that health care workers should remain off work for seven days from symptom onset or 24 hours after resolution of symptoms, whichever is longer. The CDPH guidance on H1N1 in the health care setting is available at www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1UpdatedRecforHealthCareSettings.pdf. CDPH has informed CHA that it is reviewing its guidance in light of the recent change in CDC guidance.

It is also important to note that the definition of “healthcare personnel” for purposes of the CDC guidance differs from the definition of “healthcare worker” as used in the CDPH guidance. According to the most recent CDC guidance, “healthcare personnel” includes:

“All persons whose occupational activities involve contact with patients or contaminated material in a healthcare, home healthcare, or clinical laboratory setting. Healthcare personnel are engaged in a range of occupations, many of which include patient contact even though they do not involve direct provision of patient care, such as dietary and housekeeping services. This guidance applies to healthcare personnel working in the following settings: acute care hospitals, nursing homes, skilled nursing facilities, physician’s offices, urgent care centers, outpatient clinics, and home healthcare agencies. It also includes those working in clinical settings within non-healthcare institutions, such as school nurses or personnel staffing clinics in correctional facilities. The term “healthcare personnel” includes not only employees of the organization or agency, but also contractors, clinicians, volunteers, students, trainees, clergy, and others who may come in contact with patients.”

CDPH has advised CHA that the definition of “healthcare worker” in its H1N1 guidance for healthcare facilities covers all workers in an acute-care hospital or other covered health care facility.

Q3: Can an employer require an employee to use a respirator or follow precautionary controls?
A: Yes, although employers need to consider their obligations under federal and state law prohibiting discrimination on the basis of disability and religion, etc.

Q4: Can an employer take an employee off the schedule and/or discipline an employee who declines a vaccination and refuses to wear a respirator or follow precautionary controls?
A: Yes, if an employer reasonably determines that this is needed to protect employee health and/or patient health, although employers need to consider their obligations under federal and state law prohibiting discrimination on the basis of disability and religion, etc. Hospitals should consult with counsel.
Q5: Can an employer discipline an employee who refuses to re-don a mask per CDC guidelines?
A: The answer depends on the specific facts and circumstances. Assuming the employee has been fully trained on re-donning protocol, and the mask is appropriate to re-don, has not been damaged or otherwise compromised, Cal/OSHA has verbally advised CHA that a health care employer would have a business justification for discipline.

Q6: Does California law provide protection to employees who refuse to perform work due to safety concerns?
A: Yes. California Labor Code 6311 provides:

“No employee shall be laid off or discharged for refusing to perform work in the performance of which this code, including Section 6400, any occupational safety or health standard or any safety order of the division or standards board will be violated, where the violation would create a real and apparent hazard to the employee or his or her fellow employees. Any employee who is laid off or discharged in violation of this section or is otherwise not paid because he or she refused to perform work in the performance of which this code, any occupational safety or health standard or any safety order of the division or standards board will be violated and where the violation would create a real and apparent hazard to the employee or his or her fellow employees shall have a right of action for wages for the time the employee is without work as a result of the layoff or discharge.”

Q7: Can an employer ask an employee why he/she is absent from work to determine if it is related to H1N1 exposure?
A: Hospitals should first consider whether they need this information. If not, it is advisable not to ask because California law generally limits medical inquiries of current employees. Two primary exceptions are inquiries made as part of 1) the interactive accommodation process to determine if an employee has a disability (or a medical condition that qualifies as a disability) that may require reasonable accommodation or 2) as part of a medical examination that is job related and consistent with business necessity. In the latter case, the employer is required to ask the question of all employees in the job classification. While there is an argument that the question is job related and consistent with business necessity, employers should evaluate the need for the information before adopting this practice.

Q8: Current guidance from the CDC and county public health officials recommends that individuals do not see their doctor for regular H1N1 symptoms, but employer policies may require a doctor’s note for California Family Rights Act/Family Medical Leave Act (CFRA/FMLA) certification. How should this be resolved?
A: If an employee does not obtain a medical certification, the hospital is not required to designate the time off as a CFRA/FMLA leave. However, the employee still may be entitled to the time off under the hospital’s policies.

It is important to note that regular flu symptoms generally would not qualify as a serious health condition. Under CFRA, a “serious health condition” means an illness, injury (in-
Including on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent or spouse of the employee which involves either:

1. inpatient care (i.e., an overnight stay) in a hospital, hospice or residential health care facility; or
2. continuing treatment or continuing supervision by a health care provider, as detailed in FMLA and its implementing regulations, 29 CFR 825.113-.115.

As a result of the public health guidance advising against seeing a doctor for regular flu symptoms, you may consider revising your policy during the period of the H1N1 outbreak. Hospitals should consult with counsel before making any changes.

Q9: How should employers handle employees who do not report to work during an H1N1 flu alert period?
A: The employer can apply its general policies regarding unexcused absences. Some employers have adopted modified policies anticipating school closures, etc. It is important to remember that workers’ compensation, kin care, FMLA or CFRA may entitle the employee to protected leave.

Q10: Can a hospital (public or private) screen employees each morning with a non-invasive instrument for an elevated temperature?
A: The answer to this question is not clear. CDPH is not recommending individual screening. Additionally, federal and state law limits the circumstances under which an employer can conduct medical examinations. An employer can conduct a medical examination if it is job related and consistent with business necessity. Equal Employment Opportunity Commission (EEOC) guidance on this issue is available at www.eeoc.gov/policy/docs/guidance-inquiries.html. This document also provides guidance on what qualifies as a “medical examination.” EEOC has also published guidance titled Pandemic Preparedness in the Workplace and the Americans With Disabilities Act, which is available at the EEOC website at www.eeoc.gov/facts/pandemic_flu.html. CDPH materials related to H1N1 are available at www.cdph.ca.gov/HealthInfo/discond/Pages/SwineInfluenza.aspx.

Q11: Can a hospital require employees to take the swine flu test if they have symptoms?
A: See answer to Q10. An employer may ask an employee if he/she is feeling okay and may have the employee take a fitness-for-duty exam if there is a reasonable belief the employee is unfit to work due to illness.

Q12: Should a hospital reassign pregnant employees to positions that do not involve patient contact?
A: Federal and state law prohibit an employer from denying pregnant women the opportunity to work in hazardous jobs and/or determining what course of action is best for the individual employee. A hospital should not have a mandatory reassignment policy, but should consider requests for accommodation from pregnant employees, which may include reassignment.

Q13: Should a hospital inquire as to whether employees are in a high-risk group?
A: No. Federal and state anti-discrimination laws prohibit such inquiries. However, if an employee in a high-risk group asks for reasonable accommodation, you have an obligation to engage in the interactive process.

Q14: What is the Cal/OSHA standard regarding ATDs?
A: On August 5, 2009, Cal/OSHA’s ATD Standard went into effect. The standard is available on the DIR website at www.dir.ca.gov/Title8/5199.html. The standard applies to any ATD or aerosol transmissible pathogen (ATP), including H1N1, seasonal influenza, avian influenza, tuberculosis, chickenpox, smallpox, SARS and meningitis. A list of covered diseases is contained in Appendix A of the ATD Standard at www.dir.ca.gov/Title8/5199-a.html.

In addition to the ATD Standard, Cal/OSHA has posted general guidance for employers on its website www.dir.ca.gov/dosh/SwineFlu/Cal-oshaguidanceswineflu.pdf.

Q15: Does the Cal/OSHA ATD Standard apply to H1N1 influenza?
A: Yes. Because H1N1 is an ATD, some portions of the ATD Standard apply.

Q16: Which sections of the ATD Standard apply to H1N1?
A: It depends on how H1N1 is classified. The ATD Standard incorporates the CDPH definition of “reportable aerosol transmissible disease” (RATD) and “novel” disease. According to a recent communication to CHA from CDPH, “Pandemic H1N1 (2009) influenza (aka novel H1N1 influenza) is reportable in California; specifically, individual cases of pandemic H1N1 influenza in intensive care unit (ICU) patients and in fatal cases are reportable, as are aggregated hospitalized cases.” Therefore, sections applicable to RATDs would apply.

CDC currently classifies H1N1 as a “novel” disease, and CDPH has adopted this CDC classification. Therefore, sections applicable to “novel” viruses would also currently apply. It is important to read each section carefully to determine whether it applies to any ATD or only to RATDs and/or novel diseases. It is also important to keep up to date on how CDPH is classifying the virus.

Cal/OSHA interim guidance on the ATD Standard as it relates to H1N1, and particularly the use of respirators, is available on the DIR website at www.dir.ca.gov/dosh/SwineFlu/Interim_enforcement_H1N1.pdf.

Q17: Does section (h) of the ATD Standard addressing medical services apply to H1N1 exposure?
A: Yes. Section (h) applies to an “occupational exposure.” Section (a) defines “occupational exposure” as “exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs (aerosol transmissible pathogen)....” The ATD Standard specifically addresses whether “occupational exposure” encompasses employees who work in an office environment: “For example, occupational exposure typically does not exists where a hospital employee works only in an office environment separated from patient care facilities, or works only in other areas sepa-
rate from those where the risk of ATD transmission, whether from patients or contami-
nated items, would be elevated without protective measures.”

It is important to remember that section (h) of the ATD Standard only applies to “occupa-
tional exposure.” If an employee exhibits H1N1 symptoms, but there is no evidence relat-
ing his/her illness to an occupational exposure, then the provisions of section (h) would not
apply.

Q18: What medical services are required in the event of an occupational exposure?
A: Section (h) of the ATD Standard sets forth the required protocol. In the event of an “occu-
pational exposure,” the employee should be referred to a physician or other licensed health
care professional (PLHCP). For most of CHA members, this referral is to the hospital em-
ployee health department. If the employee refuses to consent to post-exposure evaluation
by the employer acting as the evaluating health professional, the employer must make an-
other PLHCP available at the employer’s expense. Nothing in the standard appears to pre-
clude an employer from choosing another PLHCP.

The PLHCP shall conduct the evaluation, provide medical services and make determina-
tions based on applicable public health guidelines.

Q19: Section (h)(8) of the ATD Standard refers to “precautionary removal.” What is “precau-
tionary removal?”
A: The ATD Standard does not define “precautionary removal.” The Initial Statement of Rea-
sons, page 35, provides this guidance:

“Subsection (h)(8) is intended to address situations where employees covered by this
standard, who have experienced an exposure incident at work or a TB conversion
must be removed from their normal duties for infection control purposes. Some
RATDs have incubation periods, which may be delayed, during which a person may
be infectious but asymptomatic.”

An internal Cal/OSHA memo dated June 27, 2006, provides this definition:

“The proposed [ATD Standard] defines the period of precautionary removal to be
only that period of time that is after the exposure to the ATD but before the em-
ployee has been either determined to be noninfectious (in which case he or she can
return to his or her regular job), or the employee is determined to be ill with the ATD
(in which case he or she would be entitled to workers’ compensation based upon
having acquired an occupational illness. Thus, the precautionary removal require-
ment of the proposed ATDS only applies during the incubation period between the
time that an employee has been exposed to an ATD and when he or she has been de-
termined to be capable to transmitting the ATD to others or not.”

8 Cal. Code Reg. 5199(h)(8)(B) states that “Precautionary removal provisions do not ex-
tend to any period of time during which the employee is unable to work for reasons other
than precautionary removal.”
Q20: Does the “precautionary removal” provision in section (h)(8) of the ATD Standard apply to H1N1?
A: The answer is not entirely clear. The Initial Statement of Reasons to the Standard at page 36 states that the precautionary removal provisions set forth in 8 Cal. Code Reg. 5199(h)(8)(B) are limited to RATD, and Cal/OSHA has verbally taken that position. CHA is attempting to clarify that issue as the ATD Standard itself is not clear on that point.

At this time, it appears that the precautionary removal provisions could apply to H1N1 because it is an RATD. However, Cal/OSHA has verbally stated that current public health guidelines do not contain any recommendation that an employee be placed on precautionary removal after an “occupational exposure.” Therefore, according to Cal/OSHA, the precautionary removal provisions should not apply to the H1N1 incubation period.

According to the most recent CDC guidance for H1N1 in the health care setting, “… in general, the incubation period for influenza is estimated to range from 1 to 4 days with an average of 2 days. Influenza virus shedding (the time during which a person might be infectious to another person) begins the day before illness onset and can persist for 5 to 7 days, although some persons may shed virus for longer periods, particularly young children and severely immunocompromised persons. The amount of virus shed is greatest in the first 2-3 days of illness and appears to correlate with fever, with higher amounts of virus shed when temperatures are highest.”

However, Cal/OSHA has informally opined that there may be a very limited circumstance under which the precautionary removal provisions could apply to an occupational exposure to H1N1, during the period after the symptoms have resolved but public health guidelines indicate the employee should not return to work.

As noted above in the answer to Q2, public health guidelines provide limited circumstances under which employees who have exhibited flu-like symptoms should remain off work even though they are now symptom free. According to Cal/OSHA’s preliminary analysis, the period of time that the employee is symptom free, but unable to return to work, could qualify under the “precautionary removal” provisions. Hospitals should consult with counsel to determine when the ATD Standard requires “precautionary removal.”

Q21: Is an employer required to pay an employee during the precautionary removal period?
A: The ATD Standard states that an employer shall maintain the employee’s earnings, seniority and all other rights and benefits during the period of precautionary removal (8 Cal.Code Reg. 5199(h)(8)(B)). However, hospitals should discuss this with legal counsel because there is a question as to whether this section of the ATD Standard is enforceable. Please also note that Cal/OSHA has verbally taken the position that an employer may not use PTO or other accrued leave to maintain earnings.

Q22: How do you pay a per-diem employee who is placed on precautionary removal under the ATD Standard, but who does not have a regular schedule?
A: The ATD Standard does not address this issue. Hospitals should consult with counsel. Cal/OSHA has verbally informed CHA that it will accept any reasonable approach to estimating an average of earnings for the period.

Q23: How can an employer determine whether an exposure resulted from work such that a workers’ compensation claim should be filed?
A: General workers’ compensation principles apply, and hospitals should discuss this with their workers’ compensation carrier.

Self-insured employers would conduct a typical investigation. If an employee reports that he/she has had an occupational exposure, the ATD Standard requires that the employee be referred to employee health or a PLHCP. Hospitals may consider completing a workers’ compensation incident report at that time. If the employee later develops H1N1, hospitals would conduct an investigation to determine whether the illness arose out of the occupational exposure or if there is other evidence to support a causal connection to the workplace. If an employee comes down with H1N1, but has not earlier reported an occupational exposure, hospitals should follow general workers’ compensation protocol with regard to conducting an investigation and make a determination based on that investigation.

For example, if an employee reports an occupational exposure on November 1, he/she would be sent for evaluation by employee health or a PLHCP. If, at that time he/she does not have any symptoms, he/she would return to work. If, on November 3, he/she has a 101 fever, the hospital would conduct a further investigation to determine if the illness arose out of the occupational exposure. If the conclusion is that there was a causal connection to the workplace, the hospital would take the employee off work and file a workers’ compensation claim. The three-day waiting period would apply, during which the employee would use accrued time off according to the hospital’s policy. This period does not qualify as “precautionary removal” because the employee is “otherwise unable to work” due to illness.

If the hospital’s conclusion, after an investigation, is that the illness did not result from a workplace exposure, the employee would still be off work and regular sick leave policies would apply.

Q24: Can an employee apply for Short-Term Disability (SDI) when out of work due to H1N1?
A: Yes, if the illness did not result from workplace exposure and other eligibility requirements were met. If the illness resulted from the workplace, it would be covered by workers’ compensation.

Q25: Are any special rules applicable to the handling of bargaining unit employees?
A: Yes. Before changing existing work rules or working conditions involving union-represented employees, a hospital should review its collective bargaining agreement(s) to determine if it contains any prohibitions to the contemplated action. The hospital also should consult with its labor counsel to determine if it must bargain with the union about either the contemplated change or the effects of the change.
Q26: Will staffing ratios apply if there is widespread exposure?
A: It depends. In the event of a declared state of emergency, the Governor has authority to suspend the staffing ratios.

Q27: May hospitals limit visitor/vendor access or require use of personal protective equipment?
A: As long as the restrictions are not discriminatorily enforced, a hospital may limit third-party access or require use of personal protective equipment to reduce the spread of H1N1 or any other disease.

Q28: Who will get priority for receiving the H1N1 vaccine once it is available?
A: Information regarding priority for H1N1 vaccine distribution is available on the CDPH website at www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH2009H1N1MassVaxGuidance.pdf. CDPH is currently working on defining terms such as “medical conditions that put them at higher risk for influenza-related complications” and “health care personnel.”

Because information regarding H1N1 continues to develop, members should regularly visit www.calhospitalprepare.org. CHA will periodically update this document to reflect these changes. For more information, contact Gail Blanchard-Saiger, CHA vice president, labor and employment, at (916) 552-7620 or gblanchard@calhospital.org.