COURSE #91240 — 1 CONTACT HOUR/CREDIT Release Date: 03/01/25 Expiration Date: 02/29/28

The Role of Healthcare and Social Service Providers in Ensuring Access to Leave

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Beth Ribet, PhD, JD, is the co-founder and co-director of Repair, a health and disability justice organization. Dr. Ribet obtained her doctorate in Social Relations (Sociology & Anthropology) from the University of California-Irvine, and her law degree at UCLA, with a specialization in Critical Race Studies. Her areas of expertise include disability and employment, disability civil rights, medical sociology, healthcare advocacy, and social psychology. (A complete biography appears at the end of this course.)

Leslie Bunnage, PhD, is an associate professor of sociology and director of the Lewinson Center for the Study of Labor, Inequality & Social Justice at Seton Hall University. Her research falls within the two main areas of social movement mobilization and strategic formation and labor and inequalities. Her recent projects include an analysis of Internet communication technology as a basis for cohering social movement organization (SMO) messaging and strengthening collective identity (with Deana Rohlinger), and a qualitative study of dehistoricization and rhetoric in the U.S. Tea Party movement. (A complete biography appears at the end of this course.)

Lisa Concoff Kronbeck, JD, graduated from UCLA School of Law in June 2010 and was admitted to the California State Bar later that year. She also holds a master's degree in public policy from the UCLA School of Public Affairs, with a concentration in health and social policy. Following law school, Ms. Concoff Kronbeck worked for two years as a staff attorney in the public benefits unit at Disability Rights California, assisting clients primarily with benefits linked to disability, including Medi-Cal, Supplemental Security Income, Social Security Disability Insurance, and In-Home Supportive Services. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Beth Ribet, PhD, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Leslie Bunnage, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Lisa Concoff Kronbeck, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all physicians, physician assistants, nurses, social workers, counselors, and allied healthcare professionals with patients who require or would benefit from protected leaves of absence.

A complete Works Cited list begins on page 10.

Mention of commercial products does not indicate endorsement.

Accreditations & Approvals

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

Designations of Credit

NetCE designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 1 MOC point in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

This activity has been approved for the American Board of Anesthesiology's® (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program® (MOCA®), known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program® and MOCA® are registered certification marks of the American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 1 MOC point in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 1 Lifelong Learning (Part II) credit for the American Board of Pathology Continuing Certification Program.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

Social workers completing this intermediate-to-advanced course receive 1 Non-Clinical continuing education credit.

NetCE designates this continuing education activity for 0.5 NBCC clock hour.

NetCE designates this continuing education activity for 1 CE credit.

NetCE designates this continuing education activity for 1 ANCC contact hour.

This activity was planned by and for the healthcare team, and learners will receive 1 Interprofessional Continuing Education (IPCE) credit for learning and change.

NetCE designates this continuing education activity for 1.2 hours for Alabama nurses.

AACN Synergy CERP Category C.

Individual State Nursing Approvals

In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2025); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Individual State Behavioral Health Approvals
In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals
This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective
The purpose of this course is to provide healthcare and social service professionals with the information necessary to guide patients and make clinical decisions regarding the needs for an extended leave from work.

Learning Objectives
Upon completion of this course, you should be able to:

1. Identify best practices when counseling clients/patients about leave-taking.
2. Compare and contrast temporary disability leave and permanent disability retirement.
3. Discuss the impact of employer retaliation for leave-taking.
4. Describe the role of healthcare and social services providers in preparing clients/patients for returning from leave.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Family and medical leave in the United States has a substantial legal and social history, with certain states providing leave-taking rights as early as the 19th century [1]. In contemporary parlance, family and medical leave, also known as FML or "leave-taking," is the practice of taking a temporary leave of absence from employment for a set of legally protected and/or employer-sponsored reasons [1]. Leave-taking is generally recognized as a vital resource for worker and family health [2]. Millions of workers have exercised rights provided since 1993 under the federal Family and Medical Leave Act (FMLA), and existing analyses indicate that access to appropriate leave-taking is substantial factor in worker and family health. It also affects gender equity in employment and the ability of parents and children to bond during infancy or subsequent to an adoption [2; 3]. In order to meet the needs of patients and maximize family, community, and public health, healthcare practitioners and institutions should be able to fully understand their prospective role in helping to ensure appropriate leave-taking access.

COUNSELING AND EDUCATING CLIENTS AND PATIENTS ABOUT LEAVE-TAKING

WORKERS' MISGIVINGS ABOUT LEAVE-TAKING

Workers' own misgivings about their needs or entitlement may pose a barrier to leave-taking. Health and social welfare practitioners are uniquely situated to counsel workers about the need for leave-taking, as they are best equipped to convey the health impacts of working while injured or of having inadequate care for a loved one who is ill. While practitioners should avoid pressuring workers to take leave when they are financially unable to take time away from work, they should provide encouragement and counseling to workers who are hesitant to take leave out of discomfort about asking for help, denial about the seriousness of their situation, belief that leave-taking is only warranted in dire emergencies, fear of how they will be perceived if they take leave, or guilt about creating extra work for coworkers in their absence. Practitioners should emphasize the legitimacy of leave-taking needs and may wish to provide patients with language they can use to help mitigate any misunderstandings or misconceptions held by others, including employers, coworkers, and family members.

LACK OF AWARENESS OF AVAILABLE BENEFITS

A 2018 survey by the U.S. Department of Labor revealed that about 6.9% of workers needed to take leave in the prior 12 months but were not able to do so; a 50% increase compared with the 2012 rate. The workers' reasons for not taking leave were largely related to economic security and job protection. Roughly two-thirds of "leave-needers" said they could not afford to take leave, a more than 40% increase compared with 2012 [4].

DIFFERENTIATING TEMPORARY DISABILITY LEAVE AND PERMANENT DISABILITY RETIREMENT

In evaluating patients seeking medical certification for a personal disability, it is important to distinguish between disability leave, in which a worker leaves the workplace temporarily due to illness or injury but intends to return upon recovery, and disability retirement, in which a worker becomes permanently unable to participate in the workforce due to disability. In short, the distinction is that under FMLA leave, a worker departs from the workplace temporarily, whereas in a disability retirement, a worker departs from the workforce permanently. This distinction is particularly relevant when patients request medical certification in order to apply for state-funded disability benefits.

It is critical that healthcare and social welfare providers are aware of the availability of benefits for both temporary and permanent leave. Healthcare and social welfare providers function as gatekeepers to the extent that public benefits require medical certification. While healthcare practitioners are typically asked to certify the patient's specific condition and limitations, as opposed to certifying the patient's eligibility for a particular benefit, a misunderstanding of the eligibility requirements can make practitioners reluctant to certify an otherwise eligible worker for leave.

CLIENTS/PATIENTS EXPERIENCING WORKPLACE RETALIATION

RECOGNIZING EMPLOYER RETALIATION

As discussed, the consequences of employer retaliation are far-reaching and may involve harm to the worker's health and well-being. Failure to take leave for a major illness can have an obvious and immediate health impact on an employee who needs to recover from an illness, or on a family member who needs the employee at home to provide care. In the U.S. Department of Labor's 2012 survey, 17% of workers who failed to take needed disability or caregiving leave did so because they feared losing their job [4]. In addition, 6% reported that their employer denied their request for leave, a significant decrease from 20.8% in 2000 [4].

However, a violation of FMLA rights is not always as simple as an outright refusal to allow leave-taking or to reinstate a position after leave. Employers also penalize workers for exercising FMLA rights in the form of ongoing retaliation, and this can create additional physical and emotional stress and further aggravate the worker's condition. In some cases, a worker may not even realize that the employer is retaliating or that the added stress may be harmful to his or her health.

Leave-taking retaliation can come in many forms, but the following are some examples of behaviors that may constitute retaliation, particularly if the actions are catalyzed or motivated in response to leave-taking:

- An employer imposes an unusually excessive workload or unreasonable deadlines on an employee taking intermittent leave or on an employee who has just returned to work.
- An employee is passed over for a promotion or otherwise excluded from advancement opportunities as punishment for taking leave previously.
- The employer delivers an ultimatum ("If you don't come to work on Monday, you are fired.").
- The employer reassigns the employee to a different work site that entails a burdensome commute.
- The employer assigns predominately undesirable work hours.
- The employer cuts benefits and imposes a gag order so workers cannot discuss benefits with one another and learn that benefits were cut unevenly.
- The employer fails to provide a customary annual raise only to those employees who took leave recently.

Note that this list of scenarios is not intended to be all inclusive, but rather is meant to illustrate the variety of tactics employers may use to penalize workers who exercise their rights under the FMLA.

Providers should know that a worker's need for leave-taking may also be an escalating factor in existing racial or gender harassment of vulnerable workers. FMLA retaliation can be further complicated by the existence of racism, homophobia, ableism, anti-immigration bias, and other detrimental social factors present in the workplace and may therefore violate civil and human rights laws in addition to the FMLA. For example, people of color often report feeling that they need to over-perform to compensate for or live down racial stereotypes, and women often repeat this sentiment, particularly in positions and fields traditionally dominated by men [6]. Anything short of flawlessness may appear to fulfill stereotypes for already-biased employers, so people of color and women might be hesitant to "rock the boat" by requesting leave or even disability accommodations, and employers may penalize people of color and women more harshly than other employees for taking leave or may require more of them upon return to work in order to be "forgiven" for accessing their rights [7].

The need for leave itself may be used as a tool of discrimination or exploitation. For example, an employer might refuse to allow a male employee to take FMLA leave to care for his sick husband even though state and federal law protect leave-taking for legally married couples regardless of gender. A worker who relies on her employer for an immigration visa may find her immigration status in jeopardy if the employer chooses not to cooperate with her request for leave. Because retaliation is not always obvious, health and social welfare providers can assist vulnerable workers in accessing their FMLA rights by recognizing the more subtle forms of retaliation when patients discuss details of their work environment in connection with their effort to seek leave, and by documenting these acts to the extent that they interfere with patient health.

DOCUMENTING MEDICAL AND SOCIAL CONSEQUENCES ASSOCIATED WITH RETALIATION

Health and social welfare providers play a key role in documenting the physical and mental health consequences of working while ill and working in a hostile environment. Providers who have been asked to document the health consequences of retaliation should consider, among other things, the retaliation's impact on the health condition for which the worker took leave; the retaliation's impact on the worker's stress level and overall well-being; and whether the increase in stress has generated, escalated, or contributed to any ongoing or new health challenges.

Documentation should focus on the patient's history and avoid drawing legal conclusions. For example, a provider might report that the patient was injured or became ill on a given date; that the provider advised the patient not to return to work for a certain period of time; that the patient told the provider the employer had refused to grant time off (or otherwise acted to prevent leave-taking); that the patient returned to work before it was medically advisable to do so; and that as a result of his or her premature return to work, the injury or illness was further exacerbated. It would also be appropriate to report any additional health problems that arose after the patient returned to work too soon, including physical harms, mental health stressors, and any other detrimental impacts that may be correlated to working while injured or ill. While it would be reasonable for the provider to conclude that the worker incurred damage to health as a result of returning to work while injured or ill, it would be inappropriate for the provider to state that the worker's health damage was the result of an FMLA violation, as this is a legal argument and should be made either by the employee or his or her legal representative.

REFERRALS FOR LEGAL ADVOCACY OR INVESTIGATION

Healthcare professionals should avoid offering legal advice and should ensure that patients do not interpret recommendations or suggestions as such. To avoid confusion, it may be useful to state outright that only attorneys are allowed to offer legal advice and to recommend that patients consult with an attorney if they have specific questions about their leave-taking rights. Patients should also be advised that seeking legal advice does not mean they have to file a lawsuit. Many patients will not need legal representation but may benefit from legal counseling about their rights based on their particular circumstance, recommendations to help them self-advocate, or some minimal assistance in enforcing leave-taking rights.

For many patients, consulting with a private attorney is not a feasible option. Providers should be prepared to refer patients to nonprofit legal organizations for advice and recommendations. Nonprofit agencies may provide representation at their discretion, but if legal action is necessary, they may also have referral lists of attorneys who will work on contingency or on a sliding scale.

COUNSELING AND EDUCATING CLIENTS AND PATIENTS ABOUT THE PROCESS OF RETURNING TO WORK

Under the FMLA, employers may require certification that workers on temporary disability leave are able to return to work safely. In some cases, workers may be dealing with long-term health ramifications following an illness or injury, and a return to work may require some job modifications. It may be useful to refer patients for legal advice regarding how to request reasonable accommodations, particularly if a previous request has been denied. However, health and social welfare providers should also have a basic understanding of the process, as workers will need providers to document the need for accommodations necessitated by ongoing disability.

The federal Americans with Disabilities Act (ADA) requires an employer to "provide reasonable accommodation to qualified individuals with disabilities who are employees or applicants for employment, except when such accommodation would cause an undue hardship" [8]. Under the ADA, employers are required to enter into a good-faith "interactive process" (the legal term for a negotiation of prospective disability accommodations) to determine if there is a reasonable accommodation that would allow the worker to continue to perform his or her essential job functions [9]. The worker must be able to perform the essential job functions, with or without accommodations, in order to be protected against termination. Therefore, it is important for providers to avoid being overbroad in their recommendations, as negative language regarding an employee's limitations may be used against the employee if legal action is taken. For example, if a provider writes, "The patient is able to perform her essential job functions with the following accommodations," the possibility is still open that other accommodations might also allow the patient to keep working. On the other hand, if the provider states, "The patient cannot perform her job functions without the following accommodations," this restricts the interactive process. Specifically, the employer has the opportunity to first argue that the requested accommodations pose an undue hardship on business operations [5]. The employer may then argue that the employee must be terminated because he or she has admitted being unable to perform essential job functions without those specific accommodations. Providers, therefore, should avoid creating documentation that forecloses further discussion about potential accommodations, particularly those that could allow the worker to remain employed.

RESOURCES

Equal Rights Advocates
https://www.equalrights.org

AAUW Legal Advocacy Fund
Know Your Rights: Family and Medical Leave Act
https://www.aauw.org/resources/legal/laf/fmla

National Partnership for Women and Families
https://www.nationalpartnership.org

National Advocates for Pregnant Women
https://www.nationaladvocatesforpregnantwomen.org

Family Values at Work
https://familyvaluesatwork.org

Patient Advocate Foundation
https://www.patientadvocate.org

International Labour Organization
https://www.ilo.org

Institute for Women's Policy Research
https://iwpr.org

Family Caregiver Alliance
https://www.caregiver.org

National Organization for Women
https://now.org

National Conference of State Legislatures
State Family and Medical Leave Laws
https://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx

U.S. Department of Labor Wage and Hour Division Family and Medical Leave Act
https://www.dol.gov/agencies/whd/fmla

Office of Personnel Management
Fact Sheet: Family and Medical Leave
https://www.opm.gov/policy-data-oversight/pay-leave/leave-administration/fact-sheets/family-and-medical-leave

CONCLUSION

Family and medical leave law remains a dense and at times contested area of U.S. law and policy, while simultaneously delivering or enabling leave-taking rights for millions of U.S. workers. Despite the salience of family and medical leave law as one of the most utilized and high-impact areas of labor and health law, many professionals concerned with community health remain uncertain about its applications and content. For many workers and families, however, healthcare and social service providers (rather than legal service providers or employers) are a primary resource when attempting to learn about and pursue access to leave. Confusion, lack of information, or misinformation in health and social service spheres can therefore be particularly detrimental to worker and family health, to the extent that it contributes to the under-utilization of leave resources. While medical and social service providers should not be expected to become thoroughly fluent in this area of law, basic "legal literacy," involving awareness of applicable law and policy and its core meanings in health spheres, is a critical element in ensuring that health and family needs are more effectively reconciled with employment and economic imperatives.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

FACULTY BIOGRAPHY

Beth Ribet, PhD, JD, is the co-founder and co-director of Repair, a health and disability justice organization. Dr. Ribet obtained her doctorate in Social Relations (Sociology & Anthropology) from the University of California-Irvine, and her law degree at UCLA, with a specialization in Critical Race Studies. Her areas of expertise include disability and employment, disability civil rights, medical sociology, healthcare advocacy, and social psychology. Her particular research and teaching interests focus on the production of new disabilities and illnesses as a result of violence, exploitation, and inequity and strategies for using law and policy to address the concerns of people disabled or injured by inequity. Dr. Ribet speaks publicly and trains healthcare, legal, and social service practitioners regarding work with vulnerable populations, including but not limited to trafficked and exploited persons, refugees, incarcerated persons, and children and youth with disabilities.

Leslie Bunnage, PhD, is an associate professor of sociology and director of the Lewinson Center for the Study of Labor, Inequality & Social Justice at Seton Hall University. Her research falls within the two main areas of social movement mobilization and strategic formation and labor and inequalities. Her recent projects include an analysis of Internet communication technology as a basis for cohering social movement organization (SMO) messaging and strengthening collective identity (with Deana Rohlinger), and a qualitative study of dehistoricization and rhetoric in the U.S. Tea Party movement. Dr. Bunnage also examines labor movement revitalization and intersectional racial, gender, and socioeconomic barriers to leadership development in the AFL-CIO "Union Summer" youth training program. She is currently developing a socio-legal research agenda examining the impact of family and medical leave law and policy on the materialization of workers' rights.

Lisa Concoff Kronbeck, JD, graduated from UCLA School of Law in June 2010 and was admitted to the California State Bar later that year. She also holds a master's degree in public policy from the UCLA School of Public Affairs, with a concentration in health and social policy. Following law school, Ms. Concoff Kronbeck worked for two years as a staff attorney in the public benefits unit at Disability Rights California, assisting clients primarily with benefits linked to disability, including Medi-Cal, Supplemental Security Income, Social Security Disability Insurance, and In-Home Supportive Services. At present, she is caring for her tiniest client thus far: her young daughter who has Down syndrome.

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