

## SPECIAL NOTES ON EMPLOYEE HEALTH & SCREENING FOR HEALTHCARE CLIENTS – 1/2001

### Drug & Alcohol Testing

***Employer Liability*** – A well designed and implemented drug and alcohol testing program serves as a good supplemental tool in the hiring and maintenance of desirable and healthy staff. To this end, drug and alcohol testing is commonly used along with in-depth background checks, evolved interviewing skills, clear job descriptions, meaningful physical examinations, competency testing and the active utilization of the probation period. There is a strong correlation between drug abuse and absenteeism, poor work performance, workplace violence episodes, and other related problems stemming from the same issue surrounding a pattern of destructive behavior. Extension of drug and alcohol testing to volunteers and attending physicians could yield similar benefits.

The drawback exists that individuals may retaliate or protest that it is an unnecessary invasion of privacy. It is important that the drug and alcohol testing policy is clear and consistently implemented. It needs to define the ***sound business reasons*** for the substances it tests for, the population it monitors, and the method in which it is conducted (randomly). In that sense, the employer shows good cause and that it is not acting capriciously. The employer establishes the necessity of such a program to ensure optimal productivity and to limit different types of risks to patients, staff and visitors.

***Workers' Compensation Insurance*** – Drug and alcohol testing does not play a significant role in diminishing workers' compensation liability on a case-by-case basis. In New York State, the rules are such that the employer must prove that an employee's influence under drugs or alcohol was the ***sole cause*** of the accident in order to gain relief. This is nearly impossible to prove. Therefore, though many employers have tried to seek relief, rarely have any received such relief from a workers' compensation claim that arose at work while the employee was under the influence.

This provides another good reason to screen new hirers and employees in a regular screening program. But there is little point in testing immediately after an incident to try to determine if substance use was a contributing cause, unless a positive finding allows the employer to discharge the employee based on its own internal employment policy. The policy should clearly define parameters whereupon drug use would be suspected, including after certain accidents and incidents and that a test would be conducted immediately and confirmed positive findings can lead to immediate discharge. Again, all this should pass the ***'sound business reason'*** muster. Despite the termination, the employee can still continue to establish a workers' compensation case and receive medical coverage and compensation from the employer's workers' compensation

insurance policy. The employee will then likely collect unemployment insurance concomitantly.

***General Insurance (GL) & Professional Insurance (PL)*** – A good drug and alcohol testing program could limit the liability of other insurance coverages, in the same sense that it enables you to better ensure the quality of the staff, volunteers and people working on your site with your patients and staff. We have some insurance statistics readily available at our office for nursing homes, but not hospitals. They are as follows:

- GL claims outnumber PL claims 4 to 1
- The most common GL claims allegations are falls by visitors on the grounds (70%)
- The most common PL claims allegations are related to negligence, including medication errors, burns, and lack or improper care (39%), falls (37%), abuse (10%), wrongful death (10%) (I would imagine that there are less abuse allegations and more negligence and wrongful death allegations for hospitals)
- PL claims cost seven times higher than for GL claims
- The average PL claim is \$49,000
- The average GL claim is \$6,000
- Most costly PL allegation is wrongful death, averaging \$65,000

### **Hepatitis B Vaccine**

***OSHA Requirement to Cover “Employees”*** – OSHA requires that the HBV vaccine be offered to all “employees” that are covered under the Bloodborne Pathogens Standard. It applies to those who have a reasonable risk of potential exposure to blood and other potentially infectious materials. They were careful not to include “volunteers” as such. They explicitly said it covers “. . . employees with occupational exposure, regardless of how often the exposure may occur. Part-time and temporary employees are included in this coverage . . . Federal OSHA has not previously extended coverage to volunteers because they were not considered to be employees.”

In other explanatory letters, OSHA clarifies that the OSHA Act itself extends only to employees of an organization. “*Students volunteering and/or learning in a state or regional hospital or other healthcare institution are not covered by OSHA regulations. High school, college, or professional nursing students are also not considered employees of the hospital . . . ‘job-shadowing’ involves no payment of wage or salary to the student.*” They do advise to check with local, municipal and state authorities to see if other provisions exist that may cover students or volunteers in healthcare settings. In addition, the HBV vaccination availability requirement “. . . does not encompass wholly voluntary ambulance organizations where members receive ‘no compensation, remuneration, payment, or other quid pro quo. . . . for the service they provide . . . (OSHA’s) legal department determined that this ‘altruistic’ service therefore defines them as non-employees.” Thus, it appears that the exclusion of volunteers as such is based on the fact that there are no wages, forms of compensation or other benefits exchanged.

That said, OSHA reiterates that their jurisdiction extends to the employer-employer relationship only. *“While a number of factors may be considered in establishing such a relationship (such as compensation), true volunteers are not currently covered under the OSHA Act.”* It is arguable, then that certain institution-volunteer/attending physician arrangements in healthcare settings, could possibly be seen as deriving some mutual benefits. Can one safely say that these are *“true volunteers”*? This begs the question about the simplicity and purity of the *‘true volunteer’* definition which speaks to employer responsibility towards such individuals for training and other requirements, i.e. HBV vaccine, best available technology in needlestick prevention, etc.

As a historic and general rule, (regardless of this particular HBV availability requirement or the application of the Bloodborne Standard), OSHA makes references to an *entity’s impact on the work environment*. The employer is responsible to the degree that it is involved in *“creating the hazard”* and its ability to *“controlling the hazard”*. It is responsible to its employees, volunteers, per diem staff, agency staff, contractors, etc. in this work environment. Historically, this rule was applied to construction sites. Employees of various different contractors, sub-contractors, and landowners worked everywhere and amongst each other. It is difficult or impossible to discern where lines of responsibilities began and ended in covering your own employees’ health and safety versus another employer’s. In healthcare, the metrics of indirect responsibility towards non-employees have extended to include a measure of whether, and to what degree, the employer *“supervises”* and *“directs”* their activities.

In reality, the test for employer responsibility extends beyond wages, compensation, quid pro quo and deriving a benefit. Employer control over the work environment and the work performed, regardless of the employee status of the individual, is another active measure of employer obligation. Of course, worker’s compensation definition differs in this regard, employing different rules for coverage of claims and employer protection under exclusive remedy. Non-employees, like volunteers, usually cannot successfully file a workers’ compensation claims against you. However, unlike your own employees, non-employees can sue you directly. Thus, the degree of responsibility an employer has to those *“non-employees”* in the work environment, is directly related to the degree of impact it has in creating hazards and controlling them in this work environment, and to the degree it supervises and directs their activities. In light of this, volunteers and attending physicians in a healthcare setting can begin to take on a different pallor.

It is rather clear now, that employers are obligated to provide training on Bloodborne Pathogens to non-employees, like agency staff and volunteers. In the same vein, employers are required to provide a safe and healthy work environment to such individuals to the degree that they can control the environment and dictate the method of operations and how work is conducted. Many healthcare institutions do offer HBV vaccines to volunteers & attending physicians as a measure of good occupational health practices and decidedly more conservative and proactive interpretation of these requirements and definitions. An economic-feasibility/employer-obligation showdown between healthcare operator concerns and OSHA would result in any pointed dispute

over the HBV vaccine coverage of such non-employees. Ultimately, I would suspect that OSHA would win this argument.

***HBV as a prophylaxis after an “exposure incident”*** – The HBV vaccine may be recommended as part of the post-exposure evaluation after an individual experience an “exposure incident”. In such cases, the treatment of the needlestick or the physical trauma wound to the site of entry is considered “treatment” for a workplace injury, and thus covered by workers’ compensation (for employees). However, the HBV vaccine is not considered “treatment” of an injury per se in the classic sense of treating a broken bone, a rash or the wound. It is a prophylaxis and preventative medical service. Therefore, HBV vaccines provided after an “exposure incident” are not covered by worker’s compensation. If the exposure incident leads to actual development of a disease requiring medical treatment, then the case will be continued, and such medical costs would be covered if a “*causal relation*” is found and established. More likely, such cases are not filed with the carrier but paid out of pocket by employers as a “First Aid Claim” as most cases do not have any further action. The only “exposure incident” case our office is handling involves a psychological disability due to anxiety as a result of the incident, but no physical medical findings.

### **Hepatitis C Screening**

***HCV treated like HBV & HIV*** - Screening for HCV is an understandably progressive measure to help identify individuals with this infection, and to establish a baseline to limit the potential liability to the hospital from an individual developing an active or fulminant state of the disease from a pre-existing infection. OSHA has specifically added HCV as a mandatory disease to be included in training, exposure assessment and control, post-exposure evaluation, etc. exactly as HIV and HBV are covered. There are no screening requirements for HCV, as is the case with HBV and HIV. There is cause to believe, however, that HCV may become the more persistent and difficult infection of the three to manage as it seems to be more infectious, virulent, and becoming more prevalent.

***HCV Risk Factors & Future Developments*** - Less is known about the long-term consequences of infection and other epidemiological aspects of this infection than of HBV and HIV. It appears that sexual and household transmission is rare. The highest correlation to HCV infection is intravenous drug use and medical use of blood products. HCV infection was found in 1.7% of the study population conducted by CDC. The highest prevalence was found in males and persons aged 30 to 49 years. African Americans, Hispanics and individuals at lower socioeconomic status are also at increased risk. The majority of individuals infected with HCV, do not develop acute jaundice but remain asymptomatic. 75-85% of acute infections become chronic. Chronic HCV infection is again, asymptomatic in most cases, and does not lead to clinically apparent liver disease or premature mortality. Nearly all patients with chronic HCV infection have indications of chronic hepatitis on liver biopsy. After one or more decades, possibly 10-20% of chronic infections progress to cirrhosis, associated with the development of hepatocellular carcinoma in 1% to 5% of chronic HCV infections. Factors linked to progressive liver fibrosis include age greater than 40 years at the time of HCV infection,

male sex, and alcohol consumption. Currently, HCV is the major infectious cause of chronic hepatitis, cirrhosis, and hepatocellular carcinoma. It is the leading cause of liver disease requiring organ transplants among adults. About 8-10 thousand deaths each year in the U.S. result from HCV infection.

***HCV Screening Tests*** - As I understand it, testing for anti-HCV had required two different types of assays because screening tests were prone to false positive results. This multi-step procedure detected anti-HCV in  $\geq 97\%$  of infected patients. But it may not be detected by this approach for several weeks or months after initial infection and among immunocompromised people. Diagnosis for such cases were made by the identification of HCV RNA using a gene amplification technique, (reverse transcription polymerase chain reaction, RT-PCR), which was more difficult and expensive. Now, I believe there are FDA approved HCV test kits that are relatively inexpensive (approximately \$55 a test). I am not familiar with the various tests, their costs, advantages and disadvantages that are available to an institution such as yours

***Cost Effectiveness*** – We have no information at this time on the cost-benefits of an HCV screening program, especially since the future costs of infection proliferation, and thus, employer liability, is unknown. The new and different issues this infection brings to the formula include: not having a vaccine for HCV; its higher infectivity; the greater likelihood that it would be contracted via needlesticks and such exposures; the lesser likelihood it was sexually transmitted; the likelihood of increased rates of infection; the unknown proliferation and cost of these cases; how such cases would be interpreted at the Workers' Compensation Board (most likely, rather liberally on the side of labor if a reasonable "causal relation" can be determined); and who will ultimately bear the cost of the treatment (health insurance, Medicaid/Medicare, disability, workers' compensation?).

*This is not a conclusive discussion by all means, but touch on a few pressing issues relevant to our clients in regard to worker's compensation and OSHA compliance. Any comments and discussion would be greatly appreciated to help us provide better insights to other clients with the same concerns.*