UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
Eighteenth Region

CHILDREN'S HEALTH CARE, d/b/a CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA[1] Employer and SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) HEALTHCARE MINNESOTA Petitioner	Case 18-RC-073160

DECISION AND DIRECTION OF ELECTION

The Petitioner seeks to represent a unit limited to technical employees employed by the Employer at its Minneapolis, Minnesota acute-care hospital. The Employer maintains that the unit sought by the Petitioner is not appropriate and that the only appropriate unit would also include technical employees employed at its St. Paul, Minnesota acute-care hospital.[2] The parties also disagree concerning the placement of technical employees variously denominated as "casual," "on call" and "per diem." The Employer, contrary to the Petitioner, contends that these employees are regular part-time employees and therefore should be included in the unit. The hearing officer ruled

[1] The name of the Employer appears as amended at the hearing.

[2] The Employer offered in evidence a letter dated October 31, 2001, from the Petitioner's counsel, taking the position that a bargaining unit of technical employees had to include employees at both hospitals. The Petitioner (acting as an Intervenor) also took this position at the hearing in Case 18-RC-16888. The Petitioner offered in evidence a copy of the Decision and Direction of Election in that case issued on December 28, 2001, by then-Regional Director Ronald M. Sharp, in which he concluded that a unit limited to the technical employees at the Employer's Minneapolis facility was an appropriate unit. My decision in this case is based on the Employer's operations as they exist today—and not on the position taken by a party more than a decade ago or a decision of comparable vintage by a former Regional Director.

that this issue should be resolved, if need be, through the challenged-ballot procedure and did not allow testimony concerning this issue. Finally, the parties disagree about the unit status of Emergency Medical Technicians (EMTs). The Petitioner, contrary to the Employer, contends that the EMTs are technical employees and should be included in the unit. For the reasons set forth below, I conclude that the petitioned-for unit limited to the Employer's full-time and regular part-time technical employees employed at its Minneapolis facility is not appropriate. I also conclude that the EMTs are not technical employees and therefore should be excluded from the unit.

Under Section 3(b) of the Act, I have the authority to hear and decide this matter on behalf of the National Labor Relations Board. Upon the entire record in this proceeding, I find:

1. The hearing officer's rulings made at the hearing, including in particular her refusal to permit testimony concerning the regular part-time status of casual, on call and per diem employees,[3] are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.[4]

3. The labor organization involved claims to represent certain employees of the Employer.

[3] The hearing officer properly received evidence concerning casual, on call and per diem employees insofar as it was relevant to the issue of employee interchange and contact (as opposed to their status as regular part-time employees).

[4] The Employer, Children's Health Care d/b/a Children's Hospitals and Clinics of Minnesota, a non-profit Minnesota corporation, is engaged in the operation of acute-care hospitals in Minneapolis and St. Paul, Minnesota. The Employer annually derives gross revenue in excess of $1,000,000 and purchases goods or supplies valued in excess of $50,000 directly from suppliers located outside the State of Minnesota.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. I will begin the Facts section of this decision with a general overview of the Employer's operations. I will then turn to the question of the scope of the unit. The Board applies the general rule that a single-facility unit is presumptively appropriate to employers in the health care industry. *Manor Healthcare Corp.*, 285 NLRB 224 (1987). In determining whether the presumption has been rebutted, the Board considers such factors as geographic proximity, centralized control of management and supervision, functional integration, employee interchange and transfer, and bargaining history. *Alamo Rent-A-Car*, 330 NLRB 897 (2000); *West Jersey Health System*, 293 NLRB 749, 751 (1989). The Board also permits a party in the health care industry who opposes a single-facility unit to establish that there is a substantial, increased risk of work stoppages or other adverse consequences of labor disputes that Congress sought to minimize in this industry. *Manor Healthcare Corp.*, 285 NLRB at 226, recently cited with approval in *Specialty Healthcare & Rehabilitation Center of Mobile*, 357 NLRB No. 83, slip op. at 14 (2011). I will describe the record evidence concerning each of the foregoing factors in turn. I will also describe the record evidence concerning the EMTs in order to determine whether they are properly classified as technical employees (as the Petitioner contends) or as service and maintenance employees (as the Employer contends). Next, in the Analysis section of this decision, I will apply Board law to the facts of this case to explain why the single-facility presumption has been rebutted. Finally, I will explain why the EMTs are not technical employees and are therefore appropriately excluded from the unit.

I. FACTS

A. The Employer's Operations

The Employer operates two acute-care hospitals serving newborns and children in Minneapolis and St. Paul, Minnesota. It also operates an ambulatory surgery center in Minnetonka, Minnesota, a western suburb of Minneapolis. Finally, the Employer operates clinics throughout the Twin Cities metropolitan area. Only the two hospitals are at issue in this case. The two hospitals were separate organizations prior to 1994 and merged in that year. The Employer currently employs approximately 4,280 employees. The hospitals have a combined total of approximately 345 beds, with slightly more beds at the Minneapolis facility. The average length of stay is slightly higher in Minneapolis than in St. Paul (6.9 versus 5.8 days). The Employer has a single tax I.D. number and accreditation for both facilities. A section of the Employer's web site ("About Us") provides aggregate information concerning the Employer, its services and service providers.

B. Geographic Proximity

The Minneapolis and St. Paul hospitals are located approximately 10 miles from each other.

C. Centralized Control of Management and Supervision

The Employer has one Board of Directors that is composed of volunteers. There is one President and CEO. There is an Executive Leadership Team, which is composed of high-level staff. Most of the leadership team works out of the Minneapolis facility. One member, the Senior Administrator, St. Paul Site, was assigned to the St. Paul facility in order to better represent the leadership team there. The Employer's

organizational chart does not differentiate between the two hospitals (or the hospitals and the clinics for that matter). Rather, the chart is organized along functional or departmental lines. For example, the radiology and imaging department, the surgical services department, the laboratory department, and the respiratory therapy department are the same for both hospitals. The Employer has a single general counsel. Philanthropic, marketing, communications, public relations, finance, and employee compensation and benefits are centrally controlled.

The Chief of Pediatrics, the Chief of Surgery, the Chief of Critical Care and the Chief of Staff all report to the President and CEO. The Chief Operating Officer (COO) also reports to the President and CEO. Occupying the next level are the Senior Administrator, St. Paul Site, and the Clinical Services Chiefs and Directors. These individuals report to the COO. The Senior Director of Diagnostic and Therapeutic Services reports to the Senior Administrator, St. Paul Site. This individual has oversight responsibility for pharmacy, radiology and laboratory. Clinical Services includes surgical services, pediatric intensive care, respiratory services and the short-stay unit. The Senior Director of Critical Care Services has oversight responsibility for surgical services. The Senior Director of Clinical Services has oversight responsibility, among other things, for respiratory therapy. This individual reports to the Chief Nursing Officer. All of the foregoing individuals have responsibilities that extend to both the Minneapolis and the St. Paul facilities.

The Employer's human resources department is headed by the Vice President of Human Resources. Five Human Resources Business Partners report to this individual. Responsibility among the five is apportioned along departmental lines that do not differentiate between the two hospitals. The HR Business Partners work out of a facility

referred to in the record as the Westgate location but more frequently perform their duties in the field. Three HR Consultants report to the HR Business Partners. They also work out of the Westgate location but spend more of their time at the hospitals. The HR Consultants perform human resources and labor relations functions, including recruiting and more serious forms of discipline such as suspension or discharge, for the entire organization along the same department lines as the HR Business Partners. The Employer maintains a single set of approximately 75 HR policies that apply to both hospitals.

Supervision and management at the department level vary somewhat. For example, there are separate emergency department and pathology managers for the two facilities. The record is unclear with respect to the pulmonary medicine departments at each facility. The same individual manages the radiology department and the respiratory care services department at both facilities. The surgery departments are separately managed. There are separate day and evening/night operations supervisors for each facility. Department managers have overall responsibility for the management of their respective departments.

Some services are performed at only one of the hospitals. For example, the Employer has a Cardiovascular Care Center at its Minneapolis hospital. All cardiac surgeries are performed at that facility. Similarly, all in-patient and out-patient hematology and oncology services are provided at the Minneapolis hospital. “ECMO” heart and lung services are performed only in Minneapolis. Other services are uniquely provided at the St. Paul hospital. These include a sleep lab, and neurology, neurosciences, diabetes, endocrine and epilepsy services. The Minneapolis emergency department is becoming a Level 1 trauma center. There are no similar plans for the

St. Paul emergency department. The two departments provide "essentially the same" services except for Level 1 trauma services.

D. Functional Integration

1. In General

Job openings for both hospitals are posted and applications accepted on the Employer's web site. Current employees can also apply for positions on the web site. Applicant screening is performed by and job offer letters are sent by human resources staff. Orientation for new employees is held twice each month. Attendance is based on where the orientation is held rather than where the new employee will work. Fringe benefits, including eligibility requirements and Employer contribution, for unrepresented employees are the same at both of the Employer's hospitals. Pay grades vary depending on the job classification but are the same at both hospitals. Personnel files for all hospital employees are kept at the Westgate location. All technical employees employed at the hospitals are required to wear name badges that are used to swipe in and out of work. The same payroll system is used to track hours of employees at both hospitals. Employee benefits are administered at a service center at the Westgate location for employees of both hospitals. Employees of both hospitals can use the Internet to access their payroll and other personal information. The Employer maintains an intranet that is accessible to employees of both hospitals. Paid-time-off accrual is based on seniority. Employees who transfer from a position at one hospital to the same or a different position at the other hospital maintain their prior accrual rate. Service awards and seniority are based on longevity with the Employer regardless of which hospital an employee works at.

2. Respiratory Care Services Department

The System Manager of Respiratory Care Services has an office in Minneapolis and shares an office with the Systems Supervisor for Respiratory Care Services in St. Paul. The latter reports to and shares supervisory responsibility with the former. The System Supervisor for Respiratory Care Services has an office at both hospitals. She estimated that she and the System Manager of Respiratory Care Services both spend approximately 70 percent of their time in Minneapolis and 30 percent in St. Paul. The System Manager of Respiratory Care Services and the System Supervisor for Respiratory Care Services supervise approximately 97 respiratory care employees who fall within technical employee categories. These employees are divided between the Minneapolis and St. Paul facilities (65 and 32 employees, respectively) for accounting (cost center) purposes. However, this allocation does not determine supervision; where the employees can work; or what their pay, benefits or work flow are. Respiratory care therapists typically work in hospital locations outside their own department.

The minimum requirements for respiratory therapists are the same at both hospitals and are the same for casual, on call and per diem respiratory therapists as for other respiratory therapists. Casual and on call employees, unlike per diem employees, are not required to work a minimum number of hours. Respiratory therapists perform the same duties regardless of whether they are full-time or less than full-time. All respiratory therapists use the same equipment and supplies and work in the same areas of the hospitals. Full-time and less-than-full-time respiratory therapists work on the same shifts and interact on a daily basis. They all need to satisfy the same competency training and standards and are evaluated on the same basis. The same policies and procedures also apply to all of them and the reporting lines are the same.

All of the respiratory department casual, on call and per diem employees are long-term employees (at least five to almost 20 years). Casual, on call and per diem employees do not accrue paid time off and do not have Employer-provided medical or dental insurance. The same is true of other employees if they fall below .5 FTE.

The Respiratory Equipment Supervisor supervises five respiratory technicians or assistants. He works at both hospitals. These individuals are not part of the petitioned-for unit. Their job is to clean and assemble equipment. Two of the five work at both hospitals.

The Support Services Coordinator schedules respiratory care employees for both hospitals. Employees other than casual, on call and per diem employees work regular schedules.

There are 17 respiratory therapists who are specially trained to work on a "transport team" (together with a neonatal nurse practitioner) to transport neonates by ambulance or helicopter. A minimum of two transport team respiratory therapists are on duty every shift and the goal is three. Since June 2011, these individuals have worked out of the Minneapolis hospital facility. From June 2011 through January 29, 2012, the transport team transported 111 neonates to the Minneapolis facility and 118 to the St. Paul facility. Upon arrival at the hospital, the transport team respiratory therapist "hands off" the neonate to the respiratory therapist and nurse who will be caring for the patient.

Vacancies are filled in the same way at both hospitals. The System Manager of Respiratory Care Services submits a request to the human resources department to fill a vacancy. The request needs to be approved by the Chief Nursing Officer and the Director of Critical Care Services. Applicants are interviewed by the System Manager of

Respiratory Care Services and possibly by the System Supervisor of Respiratory Care Services.

Either the System Manager of Respiratory Care Services or the System Supervisor of Respiratory Care Services, or both, investigates misconduct issues. Human resources personnel may be involved depending on the seriousness of the potential discipline. Either the System Manager of Respiratory Care Services or the System Supervisor of Respiratory Care Services performs annual performance evaluations for employees in their department. Requests for time off, including for funeral leave, are submitted to and approved by the Support Services Coordinator. Requests for leaves of absence are submitted to the human resources department and have to be approved by the System Manager of Respiratory Care Services. The Support Services Coordinator monitors employee absenteeism and approves time cards for respiratory care employees at both hospitals. The System Manager of Respiratory Care Services, the System Supervisor of Respiratory Services and the Support Services Coordinator all have the authority to correct employee time cards. The System Manager of Respiratory Care Services is responsible for ensuring that employees are undergoing required training. Either the System Manager of Respiratory Care Services or the System Supervisor of Respiratory Care Services would follow up with an employee if there is a deficiency. The same disciplinary, performance evaluation, leave of absence, time card modification and training follow-up procedures are followed at both hospitals.

The Unit Educators serve on the practice and equipment committee (together with supervisory personnel and others). The committee deals with issues such as procedures, new equipment, policy updates and safety concerns. Committee meetings

alternate between the two hospitals. The System Supervisor of Respiratory Care Services and respiratory therapists from both the Minneapolis and St. Paul cost centers participate in the clinical ladder committee, a volunteer committee that deals with issues such as merit pay, departmental needs, community needs and professional development. The System Manager of Respiratory Care Services, the System Supervisor of Respiratory Care Services and the Unit Educators participate in leadership and educators meetings, which are held to discuss issues such as orientation, educational needs and competency standards for both hospitals. The meetings are held monthly and alternate between the two hospitals. A Unit Educator who is based in St. Paul spent 24 hours providing training at a mandatory "competency fair" held at the Minneapolis facility for all respiratory care department employees. An NCIU educator from St. Paul spent an unspecified number of hours providing training at the same event. Approximately 19 individuals serve on the asthma team, a voluntary group devoted to learning more about asthma and providing training to others. The team is composed of respiratory care department employees from both facilities. Asthma team meetings are held monthly and alternate between the two hospitals. There are also "staff meetings," the subjects and frequency of which are not developed in the record. Employees who work at the Minneapolis facility would typically not attend staff meetings at the St. Paul facility, or vice versa, although employees who work at both facilities could attend staff meetings at either facility.

The Employer maintains a so-called "G drive" that is accessible by computer to respiratory therapists at both facilities and that contains a variety of reference and educational material. Respiratory department policies and procedures common to both hospitals are contained on the Employer's intranet. Equipment and supplies are shared

between the hospitals depending upon availability and need. The System Supervisor of Respiratory Care Services testified that transfers of supplies and equipment between the two hospitals, and conversations between respiratory therapists at the two facilities concerning these transfers, occur "almost daily." The Employer also rents equipment from outside vendors to cover shortages.

3. Radiology Department

The System Radiology Manager and System Radiology Supervisor have overall responsibility for the radiology department employees at both hospitals and at the Minnetonka clinic. Technical employee job classifications are divided by specialty (also referred to in the record as "modalities") and include General Radiology Techs, CTs, MRI Technologists, Ultrasound Technologists, and Nuclear Medicine Technologists. The radiology department also has scheduling staff. An additional supervisor supervises the Health Unit Coordinators (front desk and film room staff) at both facilities. The System Manager of Radiology and the System Supervisor of Radiology attempt to be at different hospitals on any given day. They typically speak by phone during the day. They divide their time approximately equally between the two hospitals.

The System Manager of Radiology and the System Supervisor of Radiology interview applicants together. The decision-making process is the same at both hospitals. Job postings have a "home base" for accounting purposes. Applicants for casual positions (but not full-time positions) are advised that the job entails working in both Minneapolis and St. Paul. The System Manager of Radiology and the System Supervisor of Radiology divide up performance evaluations equally. Which of the two meets with the employee to discuss the evaluation depends on who happens to be at the hospital where the employee works. The System Manager of Radiology and the

System Supervisor of Radiology handle discipline at both hospitals. Human resources personnel participate depending on the severity of the potential discipline. The human resources contact persons are the same regardless of which hospital the employee works at. The application procedure and job descriptions are the same for radiology department employees at both hospitals. The radiology department policies and procedures are the same at both facilities with one exception (based on an incident that occurred at the Minneapolis facility). Radiology department employees have access to the same "G drive," which includes policy and procedure information, protocols, contact information, information concerning employee recognition events, standards and guidelines, and orientation and training information. Orientation and training of radiology department employees is the same at both hospitals.

The radiology department includes both "full time equivalent" (FTE) and "casual" employees. Both sets of employees receive the same training, have the same credentials and duties, and use the same equipment. There is no restriction on which category of employee is permitted to staff any particular shift. Casual employees are required to work four 8-hour shifts per month and are subject to discipline if they fail to meet that requirement. One casual employee resigned due to inability to meet the requirement, but none has been terminated. A CT Technologist from a temporary agency was used during the past year.

4. Surgery Department

The Manager of Surgery supervises the Minneapolis surgery department, including performing such functions as conducting performance evaluations and administering discipline. There are 18 surgical technologists employed at the Employer's Minneapolis facility. None is classified as an on call, casual or per diem

employee. The record does not disclose how many surgical technologists are employed in St. Paul.

The Manager of Surgery has an office next to the surgical suite. A Surgical Technologist testified that the Manager of Surgery works exclusively at the Minneapolis facility and only goes to the St. Paul facility to attend meetings. The frequency of the meetings is unclear (the witness indicated that they occurred "[n]ot very often"). The same witness also testified that she received her orientation at the Minneapolis facility but could not recall whether any St. Paul employees also attended this orientation; that she does not initiate or receive telephone calls or emails to or from surgical counterparts in St. Paul; that brain tumor surgery and cardiovascular surgery are performed exclusively at the Minneapolis facility; that babies from Hennepin County Medical Center in Minneapolis are sometimes transported to the Employer's Minneapolis facility for surgery and then transported back; that babies on occasion are transported from St. Paul to Minneapolis for surgery; that she is aware that the Employer maintains a "G drive" but had not used it; that she was aware of an instance in which a human resources representative was involved in disciplining a Surgical Technologist; that the individual who orders supplies for the Minneapolis facility does not do so for the St. Paul facility; and that she did not know whether personnel policies were the same for the two facilities.

5. Laboratory Department

The Employer provides laboratory services at both its Minneapolis and St. Paul facilities. Each facility has an on-site Laboratory Manager. The Minneapolis and St. Paul Laboratory Managers provide operational oversight in their respective laboratories. They lack the technical expertise to supervise much of the highly technical work done

by employees in their departments. As a consequence, technical oversight is instead provided by Technical Supervisors as described below. There are two Day Supervisors and Evening/Night Supervisors (Operations Supervisors) at each facility who report to their respective facility managers. The Minneapolis and St. Paul Laboratory Managers in turn report to the Lab Director and Chief Pathologist (one person). The Lab Director and Chief Pathologist in turn reports to individuals who have responsibility for departments in addition to the laboratory and at both facilities.

The Minneapolis and St. Paul Laboratory Managers have daily contact with each other. They also have a weekly meeting together with their superiors. Topics include staffing, discipline, consistency between the two facilities and training.

There is a supervisors meeting on the second Wednesday of each month. The Lab Director and Chief Pathologist, the Minneapolis and St. Paul Laboratory Managers, the Evening/Night Supervisors, the Technical Supervisors (described below) and the AP Scientists (also described below) attend this meeting. The attendees share any concerns they have, including any performance issues. The same individuals attend another meeting on the fourth Wednesday of the month. The focus of this meeting is quality. The meetings alternate between the two facilities.

Laboratory department employees in the unit sought by the Petitioner are Clinical Lab Technicians II (CLTs) and Anatomic Pathology Scientists (AP Scientists). Ten CLTs are allocated to each facility for cost accounting purposes. There are “several” CLTs who work the day shift and do not rotate between the two facilities; there are at least three CLTs who work evening and night shifts and who rotate (one only does so once per month). Three AP Scientists are allocated to the Minneapolis facility and two to St. Paul for cost accounting purposes. None of the CLTs or AP Scientists is a casual,

on call or per diem employee. The allocations do not dictate where laboratory employees work or what they do. The duties performed by CLTs and the AP Scientists are identical at the two facilities. Some tests are uniquely performed at each facility, and specimens are sent by courier "constantly" throughout the day. AP Scientists assist the Employer's pathologists. They perform the same duties at both facilities.

The Employer has a "quality manual" that touches on quality issues throughout its operations. Each section within the laboratory department maintains "quality metrics" that measure quality within the section. The metrics are the same for both facilities. They are discussed at the fourth Wednesday meeting described above.

The laboratory department is divided into seven sections. A Technical Supervisor has technical oversight responsibility with respect to each section. The Technical Supervisors have either bachelor or masters degrees and supervise the technical work of the CLTs. CLTs are cross-trained to work in several sections. AP Scientists report to the Pathology Assistant. There is an additional department (blood bank) that is located elsewhere on the laboratory department organizational chart but that functions similarly to the other seven sections. Technical Supervisors have offices and work at both the Minneapolis and the St. Paul facilities. They have oversight responsibilities for their respective sections at both facilities. Section supervisors are responsible for determining the training regimen for their respective sections. They are also responsible for performing a six-month review of employees following the completion of their training and an annual competency evaluation. Section supervisors develop policies and procedures unique to their sections but that apply to both facilities, unless the specific procedure is uniquely performed at one facility. These policies and

procedures are maintained in hard copy and, incrementally, are being placed on the Employer's intranet.

The Minneapolis and St. Paul Laboratory Managers are responsible for performance evaluations of CLTs and AP Scientists. The evaluations include input from the Technical Supervisors. The process is the same regardless of which facility the employee works at. Since CLTs generally work in more than one section, a CLT's evaluation may include input from more than one Technical Supervisor. The Employer maintains a merit-pay system, and the performance evaluation has "a huge implication" for pay increases. The Minneapolis and St. Paul Laboratory Managers collaborate to ensure that there is consistency in rating and pay between the two facilities. The Minneapolis and St. Paul Laboratory Managers utilize the services of the same human resources department personnel in dealing with disciplinary issues at both facilities.

Prior to the summer of 2011, the Minneapolis and St. Paul laboratories maintained separate schedules. The Employer's Minneapolis Laboratory Manager testified that at that time the two schedules were combined into one because laboratory employees were frequently rotating between the two facilities and there were inconsistencies in approving paid time off and scheduling. The Employer established a committee to deal with this issue. The Minneapolis and St. Paul Laboratory Managers and four CLTs (one from Minneapolis and three from St. Paul) participate in the committee. The committee devised a master schedule for both facilities. It also devised a standardized procedure for scheduling to account for holidays, paid time off and weekend staffing (the two facilities previously had different procedures for each of these).

The laboratory department has a suggestion procedure referred to as the Act Team. There are separate teams at each facility. The Minneapolis and St. Paul Laboratory Managers are members of the teams. The Act Teams meet weekly for 30 minutes at each facility, and the two teams hold a combined meeting (apparently by teleconference) to share ideas.

The laboratory department has an Education Coordinator, who reports to both the Minneapolis and St. Paul Laboratory Managers. As her title suggests, the Education Coordinator plays a role in training and continuing education and does so for both facilities.

The computer system used by the two facilities is the same. A sample or specimen might be taken at one facility and tests performed at the other facility. In this situation, information concerning the sample or specimen is entered into the computer system when it is taken. The sample is then transferred by courier to the other facility for testing. Next, the test results are entered into the computer system at the testing facility. At that point information concerning the entire testing process can be accessed at either facility. The Minneapolis Laboratory Manager testified that this process happens “multiple times a day.” She also testified that supplies are shared between the facilities “weekly.”

AP Scientists at both facilities participate by phone in a “daily huddle” to discuss such things as the types of cases they are dealing with, equipment problems, and scheduling and specimen transfer issues. CLTs at both facilities interact by phone on a daily basis concerning such things as testing, scheduling and equipment problems. The Employer uses an internal email system to notify employees of shifts that need to be filled. The notices are sent to employees at both facilities.

E. Employee Interchange and Transfers

1. In General

An Employer witness who works in the human resources department testified that he recalled two employees who transferred from one facility to the other during the past year. The Employer's System Supervisor of Respiratory Care Services testified that at least two employees transferred between the Minneapolis and St. Paul hospitals during the past year. She also testified that at least two employees transferred from "per diem" positions that involved working at both hospitals to full-time or regular part-time positions at one of the hospitals during the same time period. An employee need not resign his or her old position in order to transfer to the new position; i.e., the employee does not "start over" as a new employee when transferring into a new position.

2. Respiratory Care Services Department

The Employer's Support Services Coordinator sends out an email weekly to all "open schedule cross campus" respiratory department employees at both hospitals, specifying the shifts that are available at each hospital. Respiratory therapists also email the Support Services Coordinator as to their availability to fill these positions. They are then slotted into the schedule. If the respiratory department at one hospital is working short, the lead therapist at that hospital typically contacts the lead therapist at the other hospital to determine whether someone who is "cross-campus trained" is available to fill that spot. If one of the hospitals is overstaffed, there is a set procedure to "cancel" the excess employee(s).

Respiratory therapy employees work at both hospitals, except for two CV Tech Respiratory Therapists who work "mainly" in Minneapolis. The Employer introduced in

evidence a summary (Employer Exhibit 43)[5] indicating that between January 8, 2011 and January 20, 2012, a total of 22 respiratory department employees worked at both the Minneapolis and St. Paul hospitals. Of these, five are classified as "per diem" respiratory therapists (four in Minneapolis and one in St. Paul for cost center purposes). These therapists are required to work a minimum of six shifts during a four-week scheduling period. A minimum of two of those shifts have to be worked at the other hospital.

There are five per diem employees. Based on the Employer's summary, Employee A worked a total of 887.25 hours, of which 72 percent was in Minneapolis and 28 percent was in St. Paul; Employee B worked a total of 1297.75 hours, of which 94 percent was in Minneapolis and 6 percent was in St. Paul; Employee C is a new employee who had not yet worked any hours; Employee D worked a total of 329.25 hours, of which 30 percent was in Minneapolis and 70 percent was in St. Paul; and Employee E worked a total of 700.75 hours, of which 58 percent was in Minneapolis and 42 percent was in St. Paul.

There are four "open schedule" respiratory employees who are free to pick and choose open shifts at either hospital. Employee F worked a total of 1965.5 hours, of

[5] The hearing officer received in evidence an earlier version of this summary, Employer Exhibit 10. The hearing officer overruled the Petitioner's objections that the witness who provided the foundation for this exhibit did not prepare it and could not testify that it was accurate; and that the Employer had not provided the Petitioner with the underlying documents. See Federal Rule of Evidence 1006. Later in the hearing, the hearing officer reconsidered her ruling and ordered that the Employer furnish the Petitioner the underlying documents. The Employer did so. During the production process, the Employer discovered that some of the data on Employer Exhibit 10 was incorrect. In fact, testimony by the individual who compiled the underlying data demonstrates that Employer Exhibit 10 is riddled with errors. There is no evidence that the errors were other than inadvertent.

In its post-hearing brief, the Petitioner argues that the Employer failed to establish that the summary, which is Employer Exhibit 43, is accurate, and points to an alleged discrepancy between the summary and the underlying payroll records for a particular employee. However, the Employer's witness testified concerning this and other alleged discrepancies and explained why the summary is accurate.

which 46 percent was in Minneapolis and 54 percent was in St. Paul; Employee G worked a total of 1437.5 hours, of which 67 percent was in Minneapolis and 33 percent was in St. Paul; Employee H worked a total of 1436.25 hours, of which 58 percent was in Minneapolis and 42 percent was in St. Paul; and Employee I worked a total of 1808 hours, of which 47 percent was in Minneapolis and 53 percent was in St. Paul.

There are four “blocked/planned” employees who are assigned to work specific days at a specific hospital. Employee J worked a total of 1448 hours, of which 34 percent was in Minneapolis and 66 percent was in St. Paul; Employee K worked a total of 1743 hours, of which 18 percent was in Minneapolis and 82 percent was in St. Paul; Employee L worked a total of 1550.5 hours, of which 66 percent was in Minneapolis and 34 percent was in St. Paul; and Employee M worked a total of 1788.75 hours, of which 63 percent was in Minneapolis and 37 percent was in St. Paul.

There are nine “cross campus” employees who worked at the opposite hospital from their “home” hospital. This is done on a voluntary basis. Employee N worked a total of 1731 hours, of which 14 percent was in Minneapolis and 86 percent was in St. Paul; Employee O worked a total of 1752.25 hours, of which 99 percent was in Minneapolis and 1 percent was in St. Paul; Employee P worked a total of 1690.25 hours, of which 92 percent was in Minneapolis and 8 percent was in St. Paul; Employee Q worked a total of 1289.25 hours, of which 71 percent was in Minneapolis and 29 percent was in St. Paul; Employee R worked a total of 148.75, of which 39 percent was in Minneapolis and 61 percent was in St. Paul; Employee S worked a total of 2365.75 hours, of which 86 percent was in Minneapolis and 14 percent was in St. Paul; Employee T worked a total of 2131.5 hours, of which 93 percent was in Minneapolis and 7 percent was in St. Paul; Employee U worked a total of 2323.25 hours, of which 65

percent was in Minneapolis and 35 percent was in St. Paul; Employee V worked a total of 1707.75 hours, of which 27 percent was in Minneapolis and 73 percent was in St. Paul.

Three of the employees listed on Employer Exhibit 43 are transport team members.

The Employer also employs six Respiratory Care Unit Educators (three at each facility for cost center purposes). They perform the same services at both hospitals.

There is one Respiratory Care Cystic Fibrosis/Chronic Care lead employee. This individual works in Minneapolis because that is where the Employer's cystic fibrosis clinic is located.

3. Radiology Department

There are 34 radiology technical employees, including 16 employees classified as "casual" employees, whose "home base" for accounting purposes is located at each of the two hospitals. Except as noted below, none of the regularly scheduled employees who are based in Minneapolis also works in St. Paul, or vice versa.

The 16 casual employees, three full-time Nuclear Medicine Technologists and three Ultrasound Technologists "float" between the two hospitals. Two Nuclear Medicine Technologists generally work at the Minneapolis hospital and one at the St. Paul hospital. These three employees rotate among the two hospitals and in the past have done so on both a two-week and a monthly basis. The Employer intends to continue the rotation through 2012. Consequently, each Nuclear Medicine Technologist works 50 percent at each hospital. A casual Nuclear Medicine Technologist picks up unstaffed shifts at both hospitals. One Radiology Technologist who is based at the Minnetonka clinic "floats" to both hospitals. During the period from January 1, 2011

through January 30, 2012, this individual worked 374 hours at the Minneapolis hospital and 181 hours at the St. Paul hospital. The Employer employs approximately eight casual Radiology Technologists who are required to work a minimum of four, 8-hour shifts per month. Those shifts can be fulfilled at either hospital.

The Employer sends an email to casual radiology department employees, advising them of available shifts. Casual employees respond by email, indicating their preferences. The Employer's Supervisor of Radiology testified that approximately 12 percent of all radiology department shifts are covered by casual employees.

During the period from January 1, 2011 through January 30, 2012, casual radiology technologists worked the following hours: Employee W worked a total of 324.75 hours in Minneapolis and 674 in St. Paul; Employee X worked a total of 597.50 hours in Minneapolis and 64.50 hours in St. Paul; Employee Y worked a total of 560 hours in Minneapolis and 56 hours in St. Paul; Employee Z worked a total of 385.25 hours in Minneapolis and 48 hours in St. Paul; Employee AA worked a total of 36 hours in Minneapolis and 436.75 hours in St. Paul; Employee BB worked a total of 40 hours in Minneapolis and 1951.25 hours in St. Paul; Employee CC worked a total of 4.50 hours in Minneapolis and 1911.50 hours in St. Paul; Employee DD worked a total of 1152 hours in Minneapolis and a total of 312.75 hours in St. Paul.

The Employer employs five full-time Ultrasound Technologists and three casual Ultrasound Technologists. The usual staffing pattern is for three Ultrasound Technologists to work at the Minneapolis hospital and two at the St. Paul hospital. If the St. Paul facility is short an Ultrasound Technologist, the Employer requests that one of the Minneapolis employees "float" to St. Paul. One Ultrasound Technologist worked in

St. Paul for 11 years and approximately a year ago transferred to Minneapolis. However, the employee continues to work “on call” in St. Paul.

Ultrasound Technologists are on call during the evening and night hours during the week and all weekend. Both regular and casual Ultrasound Technologists take calls. During the period from January 1, 2011 through January 30, 2012, Employee EE worked a total of 2667.5 hours in Minneapolis and 2695.65 hours in St. Paul, including approximately 170 hours of regular, non-call staffing.[6] Two additional Ultrasound Technologists are trained to work at both hospitals. One of them, Employee FF, during the same time period, worked 4950 hours (including call hours) in Minneapolis and 47 hours in St. Paul. A casual Ultrasound Technologist, Employee GG, works at both hospitals as well. During the period from January 1, 2011 through January 30, 2012, this employee worked a total of 421.5 hours in Minneapolis and 454.75 in St. Paul. The Manager of Radiology and the Supervisor of Radiology also take calls at both hospitals.

The Employer also employs MRI and CT Techs. Some of these employees are cross-trained as both. No MRI techs currently work in both Minneapolis and St. Paul, except for one Minneapolis tech who, during the same time period specified above, worked 2878 hours in Minneapolis and 13.5 hours in St. Paul. Employees whose schedules were reduced below an FTE were given the option to pick up shifts at either of the hospitals. The record does not disclose how many employees did so or to what extent.

[6] Employees receive a minimum of four paid hours when called to work. Thus, the actual number of hours worked may be less than the hours paid.

The Employer's Supervisor of Radiology identified six radiology department employees, including one casual employee, who transferred between Minneapolis and St. Paul in the last six or seven years.

4. Surgery Department

Two Surgical Technologists permanently transferred from Minneapolis to St. Paul during 2011 and did so voluntarily. One employee transferred because of scheduling difficulties. There have been no temporary transfers between the two facilities in the past five years. The Minneapolis surgery department has Surgical Technologists who fill unstaffed shifts ("float"). These floaters work exclusively in Minneapolis. St. Paul Surgical Technologists do not float to the Minneapolis facility.

5. Laboratory Department

Employees GG and HH, both FTE AP Scientists, are assigned to the St. Paul and Minneapolis cost centers, respectively. They rotate with each other and divide their work equally between the Minneapolis and St. Paul facilities. (A third employee participated in this rotation until she left in the summer of 2011. The position has not been filled.) Four of the five AP Scientists (two assigned to each cost center) share a weekly on-call rotation for evening shifts at the St. Paul facility. The one AP Scientist who does not share in the rotation works the evening shift at the Minneapolis facility. An AP Scientist is paid a minimum of four hours for responding to a call. The same on-call procedure is followed on weekends. Employees are called in "a couple of times a month" in the evenings and on weekends. The Employer expects that future AP Scientists will also be part of the on-call rotation.

Certain blood bank procedures are performed only at the Minneapolis facility. In order to ensure that St. Paul blood bank employees maintain their competencies, the

Employer rotates those employees to the Minneapolis facility. St. Paul blood bank Employees II and JJ work four days per six-week period in Minneapolis; and Employee KK works five days every six-week period in Minneapolis. Minneapolis blood bank Employee LL recently completed unspecified training and will be assigned "as needed" to the St. Paul facility. The Employer's Minneapolis Laboratory Department Supervisor testified that this "could end up [being] far more than four days per six weeks, because she might be covering, backfilling for multiple – for different people." One of the Operations Supervisors at the St. Paul facility also works four days every six weeks at the Minneapolis facility for competency reasons.

Employee MM, a CLT, has worked for the Employer since November 2010. The Minneapolis Laboratory Supervisor testified that she told this employee that he would be working at both facilities; that the employee was trained at both facilities; and that the employee works 12 shifts every six weeks at the St. Paul facility and the remaining 18 shifts at the Minneapolis facility; and that since the hiring of Employee MM, all laboratory department applicants are advised that it is a "system position."

The Minneapolis Laboratory Supervisor also testified concerning the training and work location of laboratory department employees hired since November 2010. Employee NN, a full-time CLT who worked for the Employer from May until October 2011, received training primarily at the St. Paul facility and has subsequently divided her work approximately equally between the two facilities. Employee OO, a full-time CLT, received his training at both facilities and has subsequently worked primarily at the St. Paul facility to cover leaves taken by employees. The plan is to have him work at both facilities in the future. Employee PP, a recently hired, full-time CLT, is currently

receiving training at both facilities and is projected to work at both facilities when his training is completed.

Employee QQ, a CLT who is a .8 FTE, works primarily at the St. Paul facility. Beginning January 2012, she started working the first Monday of each month in Minneapolis.

The Minneapolis Laboratory Manager testified that during her tenure of 12 years there had been 10 permanent, voluntary transfers from the St. Paul facility to the Minneapolis facility, of which one was a CLT and one an AP Scientist. She further testified that no CLTs or AP Scientists transferred from Minneapolis to St. Paul but that an unspecified number of other laboratory department employees had done so.

F. Bargaining History

The Petitioner currently represents service and maintenance employees at both of the Employer's hospitals. Both hospitals participate in multi-employer bargaining with six unrelated hospitals with respect to service and maintenance employees. There is no history of collective bargaining with respect to the technical employees at issue in this case.

G. Work Stoppages or Other Adverse Consequences of Labor Disputes

The Employer offered evidence concerning the integrated nature of its operations in order to establish that a technical unit limited to its Minneapolis facility created an increased risk of work stoppages or other adverse consequences of labor disputes.

H. The Status of EMTs

The Employer's Senior Director of Emergency Services has oversight responsibility for the emergency departments at both the Minneapolis and St. Paul

facilities. The two facilities have separate on-site supervisors. The Minneapolis Patient Care Manager, a registered nurse (RN), supervises the emergency department at the Employer's Minneapolis facility. She is responsible for discipline and performance evaluations. RNs working in that department and the EMTs report to her. The Minneapolis Patient Care Manager testified that the EMTs provide patient-care services under the direct supervision of the department's RNs. There are no EMTs in the St. Paul emergency department. Instead, the St. Paul emergency department is staffed by RNs and Clinical Support Associates (CSAs). The CSAs, as their title suggests, perform support services for other providers. These employees are represented (apparently in a service and maintenance unit, although the record is not entirely clear in this regard).

Two witnesses testified concerning the operation of the emergency department at the Minneapolis facility and the training and duties of EMTs: The Employer called the Minneapolis Patient Care Manager, and the Petitioner called an EMT.

There are 14 Minneapolis EMTs—12 part-time and two casual (who are required to work 16 hours per month). The Minneapolis Patient Care Manager testified that one of those works "frequently" and the other, a paramedic, works "infrequently." The EMT testified that it is his understanding that casual employees are supposed to work at least 24 hours per month but that one of the casual EMTs did not work that number of hours. The EMT testified that he works at least 36 hours per week (three 12-hour shifts) and sometimes picks up additional hours. Most of the other EMTs work similar schedules. The casual employees can decline shifts. Neither the EMT nor to his knowledge other Minneapolis EMTs have ever worked at the St. Paul facility. He testified that he was

unaware of any St. Paul emergency department employees ever working at the Minneapolis facility.

The EMT who testified has an associate degree in automotive technology. He worked as an auto mechanic for "a few years." He is also a certified nursing assistant (CNA) and a certified EMT-B (described below). In order to become a CNA, he took a semester-long class at Minneapolis Community and Technical College and then passed the Nursing Assistant Test Out (NATO) exam. The EMT also took some course work in medical terminology, the details of which are not disclosed in the record. No course work is required for certification as a CNA by the State of Minnesota. The applicant just has to be able to pass the NATO test. The EMT testified that he decided not to work as a CNA because he did not regard the work as sufficiently challenging.

There are three levels of EMTs: EMT-B (basic), EMT-I (intermediate) and EMT-P (paramedic). The Employer requires that its EMTs have at least an EMT-B license. Unlike EMTs in other work settings, the Employer's EMTs perform their services exclusively within the confines of the hospital. They do not, for example, ride in ambulances. The Minneapolis Patient Care Manager testified that since the Employer's EMTs work under the direct supervision of RNs, they generally provide a lesser range of services than in some other work settings. She further testified that the EMTs perform the same support role at the Minneapolis facility that the CSAs perform at the St. Paul facility. She also identified several duties that EMTs now perform that had not been the case at an earlier point in time. These duties include sitting with a patient who is a danger to self or others and operating a piece of equipment that determines whether a patient has a strep infection.

EMTs and CSAs are required to have a high school degree (or GED). The EMT job description indicates that post-secondary education and prior experience are preferred. Postings for CSA job postings at both the Minneapolis and St. Paul facilities indicate that one year of experience as a nursing assistant is required (a requirement that can be otherwise satisfied by nursing students). EMTs, CSAs and all of the Employer's other employees who have patient-care responsibilities are required to have a BLS (Basic Life Support) Certification, training that is similar to CPR training.

In Minnesota, the Emergency Medical Services Regulatory Board licenses the three levels of EMTs. In order to qualify for an EMT-B license, an applicant has to complete a 110-hour certification class. The written material for this class is the U.S. Department of Transportation National Standard Curriculum (Union Exhibit 6). This material is approximately one and three-quarters inches thick, copied double-sided. Among the topics covered are introduction to emergency medical care; airway; patient assessment; medical/behavioral emergencies and obstetrics/gynecology; trauma; infants and children; operations; and advanced airway (a topic that the materials indicate is "elective"). The EMT testified that this was "just the base" of what his course actually covered and that these materials were supplemented by the course instructors. CSAs are also required to take this class. The Employer's Minneapolis Patient Care Manager testified that there is "no comparison" between the EMT curriculum and the curriculum required to become a paramedic or an RN. She further testified that a broad swath of the curriculum, including ambulance operation, child delivery, and obstetrics and gynecology, is inapplicable to the role of EMTs in the Employer's Minneapolis emergency department.

In addition to the 110-hour course, an applicant for the EMT-B must pass the National Registry for EMT Exam. Part of the exam is written and part is "observational" in nature; i.e., the examiner observes the applicant perform certain skills in the context of a variety of medical emergencies. Each exam takes "several hours" and is conducted on separate days. In order to qualify for the EMT-I license, the applicant has to take an additional 52-hour course, and then pass the National Registry for EMT Exam. In order to qualify for an EMT-P license, an applicant has to complete a nine-month to year-long program or complete a two-year associate degree program. The Employer's EMTs are required to have only the EMT-B license. Initial certification and renewal are regulated by the Minnesota Emergency Services Regulatory Board.

EMTs are required to undergo continued education or training, which is also based on the National Standard Curriculum. In order to retain certification, an EMT has to pass a CPR test. In addition, an EMT has to take the U.S. Department of Transportation refresher course and successfully pass the skills test. Alternatively, the EMT can take 48 hours of classroom instruction, some of which is related to patient assessment and medical emergencies; injuries involving musculoskeletal, nervous/digestive and genital/urinary systems; environmental emergencies and rescue techniques; emergency childbirth and other special situations. The Employer's Minneapolis Patient Care Manager is responsible for ensuring EMT licenses are current. An EMT would have to be removed from duty if his or her certification expired. As set forth in Union Exhibit 5, the Employer applies the same procedures for ensuring proper licensure to RNs, Licensed Practical Nurses (there may no longer be any employed by the Employer) and EMTs. Unlike EMTs and RNs, who are required to

renew their certifications every two years, CSAs are not subject to continuing education requirements.

The EMT job description indicates that EMTs provide direct patient care to patients in the emergency room setting and logistical support under the direction of an RN; and that EMTs are required to have strong computer skills and the ability to coach others. The Employer's Minneapolis Patient Care Manager testified that she did not know whether CSAs perform similar duties in the St. Paul emergency department.

The EMT job description also indicates that among the duties these employees perform are holding patients and assisting with procedures; assisting with critical care patients as directed by a doctor or RN; transporting patients from the emergency department to other areas of the facility; tracking rooms to be cleaned when vacated by a patient and then doing the cleaning; ensuring adequate supplies are available; performing daily room checks; reporting defective equipment to an RN; assessing and recording certain vital signs data and notifying an RN or doctor if a patient requires immediate intervention (for example, if the patient stopped breathing or suffered a seizure); and preparing rooms with the appropriate equipment. CSAs generally perform similar duties at the St. Paul facility.

According to the Minneapolis Patient Care Manager, EMTs do not perform diagnoses, develop treatment plans, provide medication, draw blood, start IVs, swab throats, administer a nebulizer, or otherwise perform invasive procedures. EMTs—but not CSAs—can immobilize an extremity with a splint. Although the EMT job description indicates that EMTs transcribe patient-care orders, the Employer's Minneapolis Patient Care Manager testified that they do not perform this function. She further testified that EMTs assist with IV starts, do chest compressions, assist nurses with back-boarding

(immobilizing a patient in order to prevent spinal damage), and infrequently assisted patients with breathing; that CSAs are qualified to do chest compressions; that "assist" in this context often consists of "holding" or "providing an extra pair of hands"; and that EMTs—but not CSAs—assist with certain other procedures.

According to the EMT, his main daily responsibilities include attending to trauma patients (for example, procedures involving airway management that are part of basic life support training); doing chest compressions; back-boarding a patient ; placing cardiac three-leads; assisting with pulse oximetry; applying blood pressure cuffs; stripping the patient when necessary; assisting with tests (for example, i-STAT test, point-of-care glucose test, strep test); operating machinery (for example, Bear Hugger air heating pad and Belmont Rapid Infuser fluid warming); assisting RNs and doctors with specimen collection and ensuring that the specimen is put in an appropriate container; delivering specimens to the lab; performing triage duties for at least four hours per day; taking vital signs; transporting patients to other areas of the hospital or a separate, adjacent hospital; hanging IV bags and attaching the tubes and identification tags; stocking supplies; turning over and cleaning rooms (along with RNs); taking phone calls; and determining from the computer system and tracking icons what tests are going to be performed on a patient and begin preparing for those tests. According to the EMT, the entire process is complicated by the fact that different patients have different needs, and different doctors and nurses have individual preferences as to how they like to perform different procedures.

The EMT provided detailed testimony concerning the roles played by an EMT and an RN with respect to beginning an IV. The decision whether to begin an IV is made by a doctor or physician's assistant—and not the EMT. The EMT performs the

set-up functions. He testified that this can be complicated because different nurses prefer different setups and different equipment such as chevrons (sections of tape) and Tagaderms (clear pieces of tape-like material). When the RN enters the room to start the IV, the EMT's role at that point is "primarily to hold the patient, depending on the need for it." For an older child, the EMT might explain what is going on and why the procedure is necessary. The EMT ensures that the arm is in a proper anatomical position for the IV. The RN actually starts the IV. After the IV has been started, "80 to 90 percent of the time the rest is me." This includes drawing blood through the IV, switching out the syringe for another, collecting blood samples, flushing the IV line, and ensuring that the blood sample is handled properly. All of these functions are performed under the supervision and in the presence of an RN or doctor. The doctor decides what tests to perform on blood samples. The EMT decides what containers to place the sample in and how to transport them. The EMT also tapes the IV down and does so in a way to minimize the possibility of the patient pulling it out.

Vital Signs. The EMT testified that he is responsible for taking and recording vital sign information. He also testified that he knows some but not all indicators concerning vital sign information; and that it is not his responsibility to interpret that information but to notify a nurse or doctor if a patient's vital signs pose a concern. He gave as an example the situation where a patient's blood pressure was rapidly declining.

Tests. The EMT testified concerning his role in performing certain tests. For example, with respect to the i-STAT test, the doctor chooses one of four available cartridges. The EMT inserts blood drawn from the patient into the cartridge and then places the cartridge into a machine. Approximately two minutes later the machine generates data that the EMT then relays to the care provider. With respect to the point-

of-care glucose test, the EMT testified that one of the first things he does each day is perform a quality control test on the point-of-care glucose machines. The doctor or other care provider decides whether to administer the test. Doing so involves placing a sample of blood on a test strip, entering patient and EMT information, and inserting the strip into the machine. The machine generates results in a matter of seconds. Again, the EMT reports the information to the doctor or other care provider. The EMT is not required to interpret the data with respect to either the i-STAT or the glucose machine. With respect to the Belmont Infuser, the EMT's role is to prepare the machine for use, including turning on the heater and setting up IV supplies. An RN inserts the IV into the patient. With respect to the Bear Hugger, this is a machine that functions as a highly sophisticated blanket that is used to warm a patient. With respect to strep tests, the EMT inserts the specimen into a machine but does not swab the patient's throat to obtain the specimen.

Specimen Collection. The EMT testified that different specimens need to be put into different containers depending on the type of specimen and the type of test. The EMT is responsible for putting the specimen into the proper container and then taking it to the lab. The EMT does not decide what specimens to collect.

Triage. EMTs perform triage duties during the evening and night shifts. The Employer's Minneapolis Patient Care Manager testified that they infrequently performed those duties during the day shift. The EMT testified that he has performed triage functions on the day shift when a nurse has left to use the restroom or for other temporary absences. The triage area at the Minneapolis facility is separate from the emergency room itself. During the overnight shift, the EMT is the first person to deal with a patient. The EMT takes their vital signs, measurements, enters patient

information into the computer, and finds out if the patient has any food or medication allergies. The EMT also assesses whether the patient needs immediate treatment. Infants in particular require prompt assessment because their condition can deteriorate rapidly. The only other person in the triage area on the overnight shift is a security guard who plays no role in the actual triage process. If the EMT determines that the patient is in danger, he either calls a nurse or takes the patient to a "crash room." At that point treatment decisions are made by a doctor or a nurse.

Transporting Patients. The EMT testified that the manner of transportation depends on the patient's condition and needs. All beds in the emergency room are supposed to have oxygen tanks. The EMT makes sure there is a tank and that it is full. The EMT connects the patient to the oxygen tank and a portable pulse oximeter where appropriate. The EMT then gets a status report from the nurse concerning the patient's condition and what he should be looking out for. The EMT may stay with the patient during testing and assist in the testing where appropriate. If the patient is being taken to a room, the EMT is responsible for "handing off" the patient to a nurse and is not supposed to leave until having done so. An EMT-B can only provide "basic life support" transportation. Anything involving "advanced life support" transportation would require a paramedic.

Holding Patients. The EMT testified that he draws upon his training and on-the-job experience in deciding what does and does not work in holding a patient. He also takes direction in this regard from a doctor or nurse. Other factors in determining how to hold a patient include whether a specimen is being collected and what kind, and the size and demeanor of the patient.

Other Miscellaneous Duties. With respect to lumbar-puncture procedures, the EMT testified that he sets up a sterile field and secures the appropriate tray and equipment, makes sure oxygen is ready to be administered, and, in the case of an infant, positions the patient. With respect to suturing, the EMT testified that he sets up the appropriate tray and equipment, and holds the patient or extremity during the procedure. He does not decide whether a suture is necessary. With respect to splinting, the EMT testified that EMTs do almost all of the splinting in the emergency room. In some instances, the EMT is instructed to apply a specific splint. At one point the EMT testified that "on occasion" a doctor or physician's assistant asks for a recommendation concerning the type of splint. At another point he testified that this occurs 50 percent of the time. In any event, he acknowledged that "he did not make the end decision on that." The EMT secures the appropriate materials and applies the splint. Typically, there are no other medical personnel present during the splinting process. With respect to wounds, the EMT testified that he cleans wounds, applies an antibiotic and then bandages the wound. The EMT testified that on one occasion he assisted a nurse with a deceased child by tying and positioning the body, placing it in a shroud and tagging it, and securing the deceased's belongings.

EMTs are on duty at all times throughout the day and on weekends. They work regular shifts that are eight or 12 hours long. EMTs and CSAs attend the Employer's annual competency fair and participate in activities appropriate to their duties, including clinical competencies (most recently 100 versus 65 minutes, respectively).

The Employer has an orientation process for EMTs. The EMT testified that he participated in that orientation as a new employee and has oriented other new employees. The formal orientation process lasts four days.

Technical employees in the petitioned-for unit (excluding the EMTs) fall within Grades 11 through 15. Wage rates for Grade 11 range from $16.25 to $27.05 per hour. Wage rates for Grade 15 range from $24.80 to $42.20 per hour. The average wage rate for service and maintenance employees at the Minneapolis hospital is $17.75 per hour. Unit Operations Coordinators work in the emergency department performing clerical duties such as answering phones, registering patients and paging. These employees fall within Grade 9. EMTs fall within Grade 8 of the Employer pay system. Wage rates in Grade 8 range from $12.65 to $20.95 per hour. The average wage rate for EMTs at the Minneapolis facility is $15.68 per hour.

II. ANALYSIS

A. Scope of Unit

The party who contends that a single-facility unit is inappropriate bears a heavy burden. *California Pacific Medical Center*, 357 NLRB No. 21, slip op. at 1 (2011). To meet its burden here, the Employer must demonstrate that the integration between the Minneapolis and St. Paul facilities is so substantial as to negate the separate identity of the Minneapolis facility. *Id*. For the reasons set forth below, and on the basis of the entire record in this case, I conclude that the Employer has satisfied its burden.

The Employer has a single tax identification number and one accreditation. It holds itself out to the public as an integrated operation. The Minneapolis and St. Paul hospitals are both located within the Twin Cities metropolitan area and are approximately 10 miles apart. The upper echelons of the Employer's management are responsible for both facilities. Similarly, lower echelons of the Employer's management are organized along functional or departmental lines and are not hospital-specific. At the departmental level, some departments that include technical employees have

separate on-site supervision (surgery and laboratory). Others do not (radiology and respiratory care services).[7] Human resources policies apply system-wide. Individuals who perform human resources functions are assigned based on department—and not by hospital.

There is overall functional integration among employees in the departments at the Minneapolis and St. Paul facilities that employ the technical employees in the petitioned-for unit. Employment application procedures, new employee orientation, job classifications, pay and fringe benefits, and computer systems are all common to both hospitals.

As shown below, there is functional integration within at least three of the four departments that employ technical employees in the petitioned-for unit.

Respiratory Care Services. The Manager of Respiratory Care Services and Supervisor of Respiratory Care Services share supervisory responsibility for employees at both hospitals. Both individuals work at both hospitals (albeit more at the Minneapolis facility than the St. Paul facility). The Support Services Coordinator also works at both hospitals. The minimum requirements for respiratory therapists are the same regardless of hospital, and are the same for therapists who work full-time and those who work less than full-time.

Seventeen respiratory care therapists from both hospitals participate on the transport team and transport children to and interact with respiratory therapists at both hospitals. Unit Educators perform the same education and training functions at both hospitals. Respiratory care therapists from both facilities serve on committees that deal

[7] Since I have found below that the EMTs at the Employer's Minneapolis facility are not technical employees, I regard the fact that the emergency departments at the Minneapolis and St. Paul facilities are separately supervised to be irrelevant.

with issues of common concern among technical employees at both facilities. Transfers of equipment and supplies and conversations concerning these transfers occur on a daily basis.

Radiology Department. The System Manager of Radiology and the System Supervisor of Radiology share supervisory responsibility for radiology services at both the Minneapolis and St. Paul hospitals. They alternate working at the two hospitals. Policies and procedures are uniform throughout the department (with one insignificant exception). Employee orientation and training is the same at both.

Surgery Department. The record evidence concerning the surgery department is somewhat sparse. There is little evidence of functional, department-specific integration between the Minneapolis and St. Paul hospitals.

Laboratory Department. Although there is separate on-site supervision at the laboratories located at the Minneapolis and St. Paul hospitals, this supervision is limited to operational matters. The on-site supervisors have daily contact with each other and meet weekly. These meetings include a higher level supervisor (Lab Director and Chief Pathologist), who has oversight responsibility for both facilities, and the Technical Supervisors, who have technical oversight responsibility for both facilities. Operational and technical policies are consistent throughout the entire department. At least some testing procedures are uniquely performed at each facility, and there is an integrated procedure for dealing with the circumstance where a specimen or sample is taken at one facility and tested at the other.

The record evidence concerning employee interchange and transfers also supports the conclusion that the Minneapolis facility lacks a separate identity. Much of the evidence in this regard relates to casual, on call and per diem employees. The

Petitioner contends that because casual, on call and per diem employees are compensated differently than other employees, and because they are free to turn down available shifts, they lack a community of interest with other employees and should not be considered in evaluating employee interchange and transfers. The Petitioner cites no case law in support of its position. If the record evidence concerning these employees could be ignored, there might be a more compelling argument for concluding that the Minneapolis facility retains a separate identity. However, the record in this case demonstrates that casual, on call and per diem employees have the same job classifications, perform the same duties and work in the same locations as employees in the petitioned-for unit. The Board routinely includes employees who work less than full-time but who have a substantial work history and a substantial probability of future employment in bargaining units with other, similarly situated employees provided that they work a sufficient number of hours to be considered regular part-time employees, an issue that was deferred to the challenged ballot procedure and not litigated in this proceeding. There are two additional problems with limiting the analysis in the way the Petitioner suggests. First, I am unaware of any Board decision, and the Petitioner cites none, that supports the conclusion that employees who otherwise qualify as regular part-time employees "don't count" when it comes to determining whether a facility lacks or retains a separate identity. And second, as shown below, there are a significant number of full-time (or nearly so) employees who regularly work at both facilities.

Respiratory Care Services. The record evidence summarized earlier in this decision demonstrates that 21 casual, on call and per diem employees worked at both the Minneapolis hospital and the St. Paul hospital from the beginning of January 2011 to

mid-January 2012.[8] The 21 employees worked a substantial number of hours—an average of 1501.53 hours each. The percentages of hours worked between the two facilities varied considerably. A few employees worked substantially all of their hours at one of the facilities. An overwhelming number of employees worked substantial hours at both facilities. Thirteen employees worked more hours at the Minneapolis facility than at the St. Paul facility, and eight worked more at St. Paul than at Minneapolis. In addition, the 17 transport team members—only three of whom are casual, on call or per diem employees—also regularly transport children to both hospitals and interact with other respiratory care employees at those hospitals.

Radiology Department. Radiology department employees who work at both hospitals are primarily the 16 casual employees. As summarized earlier in this decision, they work, in total, a substantial number of hours at both facilities. Regular and casual Ultrasound Technologists who work at the Minneapolis facility "float" to the St. Paul facility to cover a shortage. In addition, all of the Ultrasound Technologists are "on call" to cover evening, night and weekend hours at both facilities. Six radiology department employees transferred between the two facilities in the last six years.

Surgery Department. There is little evidence of interchange or other contact in this department. However, there were two transfers between Minneapolis and St. Paul facilities during 2011.

Laboratory Department. There is considerable evidence of interchange and contact in this department. Two full-time AP Scientists rotate with each other between the two facilities. Four of five AP Scientists share an on-call rotation at both facilities. As summarized earlier in this decision, other laboratory employees work at both

[8] An additional, new employee had not worked any hours during that period.

facilities as well. For example, one employee currently works 18 shifts at the Minneapolis facility and 12 shifts at the St. Paul facility. Another employee currently divides her time equally between the two facilities. A third employee works one day per month at the Minneapolis facility and the remainder of her time in St. Paul. The two facilities have a combined schedule. There have been 10 voluntary, permanent transfers between the two facilities in the last 12 years.

Turning to the remaining factors the Board considers in single-facility versus multi-facility cases, there is no history of bargaining in a technical employee unit. The Employer opposes a single-facility unit and contends that because of the integrated operations at its two hospitals, there is a substantial, increased risk of work stoppages or other adverse consequences.

Based on the close proximity of the two hospitals, centralized control of management and supervision, functional integration, employee interchange and transfer, and the absence of bargaining history in a single-facility unit, I conclude that the presumptive appropriateness of a single-facility unit consisting of the Employer's Minneapolis hospital has been rebutted. I therefore conclude that a multi-facility unit consisting of technical employees employed at the Minneapolis and St. Paul facilities is appropriate. *St. Luke's Health System*, Inc., 340 NLRB 1171 (2003); *West Jersey Health System*, 293 NLRB 749 (1989). In these circumstances, I conclude that it is unnecessary to determine whether there is a substantial increased risk of work stoppages or other adverse consequences if a multi-facility unit is found appropriate.

B. The Status of EMTs

The Board has traditionally held that technical employees in the health care industry are those whose jobs involve the use of independent judgment and specialized

training in major occupational health groups. *Virtua Health, Inc.*, 344 NLRB 604, 610 (2005) (citations omitted). See generally *Litton Industries of Maryland, Incorporated*, 127 NLRB 722, 724-725 (1959). The parties have not cited, and my own research has not disclosed, a Board case that definitively resolves whether employees like the EMTs involved in this case are technical employees as that term is used by the Board.[9] The Regional Director for Region 4, in *Virtua Health*, concluded that the paramedics involved in that case were technical employees. The Board reversed the Regional Director on other grounds and, in doing so, specifically noted that no party had requested review of her finding that the paramedics were technical employees. 344 NLRB 604 at fn. 2. I assume, for purposes of this decision, that her conclusion concerning the technical status of paramedics is correct. However, a comparison of the paramedics involved in that case and the EMTs involved in this case, and the entire record in this case, reveals why the former but not the latter are plausibly classified as technical employees. In particular, as more fully explained below, paramedics are more highly trained and skilled than the EMTs. In addition, the paramedics in *Virtua Health*, unlike the EMTs here, spent the vast amount of their time in the field. Finally, and partly as a consequence of working in the field outside the direct supervision of higher-level medical personnel, the paramedics were required to exercise independent judgment concerning what treatments to administer, and whether to apply a standing order or to contact emergency room personnel for further guidance and instruction. The EMTs in the present case, in contrast, never work outside the confines of the hospital and always

[9] The Board found in several cases that it was unnecessary to decide the technical status of EMTs. *Virtua Health*, 344 NLRB at 610, fn. 15 (citing cases). *Lifeline Mobile Medics*, 308 NLRB 1068 (1992), cited by the Petitioner in its post-hearing brief, does not support the Petitioner's position since in that case no party disputed the Regional Director's finding that EMTs were technical employees and the Board therefore simply assumed that they were.

work under the direct supervision of RNs (or higher level medical professionals such as physician assistants and doctors).

At first blush, the curriculum required for certification as an EMT-B is sophisticated and impressive. It is a 110-hour course that covers a wide variety of emergency medical and operational procedures. I am cognizant of the EMT's testimony that the curriculum was "just the base" of what his course covered. I am also cognizant of the facts that EMTs are required to undergo continued training in order to be recertified; and that EMT recertification, like that of RNs (who are regarded as professional employees), takes place every two years. However, the Employer's Minneapolis Patient Care Manager testified without contradiction that there is "no comparison" between the curriculum required to be certified as an EMT-B and a paramedic (EMT-P). She also testified that much of what is included in the EMT-B curriculum is inapplicable to work the EMTs perform in the Minneapolis emergency department. Finally, the record evidence concerning the EMT job description and the actual duties they perform on a daily basis do not support a finding that the EMTs are technical employees.

The job description sets forth essentially routine duties that are performed under the direct and immediate supervision of RNs or other higher-level medical personnel. Duties such as holding, assisting, cleaning, transporting, and assessing and recording vital signs, as described earlier in this decision, do not require the use of independent judgment and specialized training. The EMT role with respect to testing is similarly routine—the EMT does not decide what test is to be performed or perform invasive procedures to secure the sample or specimen to be tested. Rather, the EMT's role is simply to place a sample or specimen into a machine or a container. Reporting the

results determined by a machine similarly does not require independent judgment or specialized training. I have given careful consideration to the role EMTs play with regard to splinting, starting an IV and triage. As described by the EMT, splinting undoubtedly requires skill. However, there is insufficient evidence to conclude that splinting requires independent judgment or specialized training. As described by the EMT, the decision whether to start an IV is made by others. Starting the IV is performed by others. The EMT does play a role before and after the IV is started, but it is a role that is performed under the direct supervision of other medical personnel. As described by the EMT, the EMTs play an important role in the initial assessment of an emergency department patient's needs. However, this assessment is not in the nature of diagnosis. It is instead a common-sense observation of readily observable conditions, such as trauma, seizure and pupil dilation. The only judgment exercised by the EMT is how quickly and where to move the patient for medical treatment by others. Finally, I note that the EMTs are paid considerably less than other undisputed technical employees. Indeed, the average wage rate of EMTs is less than the average wage rate of service and maintenance employees. *Southern Maryland Hospital*, 270 NLRB 1470, 1470 (1975) (noting that technical employees generally receive far greater pay than non-technical employees), enfd. in pertinent part, 801 F.2d 666 (4th Cir. 1986). In these circumstances, I conclude that the EMTs are not technical employees as the Board uses that term. *Id.* (concluding that emergency room technicians are not technical employees).

The Petitioner indicated at the hearing that it would proceed to an election in any unit found to be appropriate. Accordingly, I will direct an election in the multi-facility unit, excluding the EMTs, as set forth below.

The following employees of Children's Health Care d/b/a Children's Hospitals and Clinics of Minnesota constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:[10]

> All full-time and regular part-time technical employees, including Clinical Lab Technician II, Anatomic Pathology Specialist, CV Tech Respiratory Therapist, Surgical Technologist, Radiology Technologist I, Radiology Technologist II, Radiology Technologist III, Ultrasound Technologist, MRI Tech, CT Tech, CT/MRI Technologists, Nuclear Medicine Technologist, Respiratory Therapist, Respiratory Therapist I, Respiratory Therapist II, Respiratory Therapist III, Respiratory Therapist IV, Senior Respiratory Therapist, Respiratory Care Unit Educator, and Respiratory Care CF/Chronic Care Lead employed by the Employer at its Minneapolis and St. Paul acute-care hospitals; excluding registered nurses, professional employees, all other non-professional employees, skilled maintenance employees, business office clerical employees, managerial employees, and guards and supervisors, as defined in the Act.

DIRECTION OF ELECTION

An election by secret ballot will be conducted by the undersigned among the employees in the unit found appropriate at the time and place set forth in the Notice of Election to be issued subsequently, subject to the Board's Rules and Regulations.

A. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending immediately preceding the date below, and who meet the eligibility formula set forth above. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike which commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as

[10] The parties stipulated at the hearing to the job classifications that are included in and excluded from the unit, with the exception of the Emergency Medical Technicians (EMTs).

strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are persons who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced.[11]

Those eligible shall vote whether or not they desire to be represented for collective-bargaining purposes by **Service Employees International Union (SEIU) Healthcare Minnesota.**

B. Employer to Submit List of Eligible Voters

To file the eligibility list electronically, go to the Agency's website at www.nlrb.gov, select ***File Case Documents***, enter the NLRB Case Number, and follow the detailed instructions.

[11] To ensure that all eligible voters have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. *Excelsior Underwear Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969). Accordingly, it is directed that two copies of an election eligibility list containing the full names and addresses of all the eligible voters must be filed by the Employer with the Regional Director within seven (7) days of the date of this Decision and Direction of Election. *North Macon Health Care Facility*, 315 NLRB 359 (1994). The Regional Director shall make the list available to all parties to the election. In order to be timely filed, this list must be received in the Minneapolis Regional Office, 330 South Second Avenue, Suite 790, Minneapolis, MN 55401-2221, on or before close of business **March 2, 2012**. No extension of time to file this list may be granted by the Regional Director except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the filing of such list. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570-0001. This request must be received by the Board in Washington by **March 9, 2012**. *The request may be filed electronically through the Agency's website, www.nlrb.gov,*[12] *but may not be filed by facsimile.*

Signed at Minneapolis, Minnesota, this 24th day of February, 2012.

/s/ Marlin O. Osthus

Marlin O. Osthus, Regional Director
National Labor Relations Board – Region 18
330 South Second Avenue, Suite 790
Minneapolis, MN 55401-2221

[12] To file the request for review electronically, go to www.nlrb.gov, select ***File Case Documents***, enter the NLRB Case Number, and follow the detailed instructions.