UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

ST. JAMES MEDICAL GROUP,

Employer,

and Case 19-RC-233533

MONTANA NURSES ASSOCIATION,

Petitioner.

EMPLOYER'S REQUEST FOR REVIEW

Comes now the Employer, St. James Medical Group (hereinafter "Employer") by and through its attorneys and files the instant Request for Review.

I. STATEMENT OF THE CASE

The Union in this matter, Montana Nurses Association, filed a petition on January 3, 2019, requesting a bargaining unit of all registered nurses for the Employer's Butte campus, a health care clinic.[1] The Employer, in its Statement of Position, explained that such a unit would be inappropriate because: an all-professional unit is mandated by the NLRA; the remaining professionals would result in an inappropriate residual unit; union membership is not an appropriate basis for unit determination and violates Section 9(c)(5);[2] and the Congressional mandate to avoid proliferation of health care bargaining units.[3] Accordingly, the unit should include not only RNs, but also the Advance Practice Practitioners, the Behavior Health Specialist, and the Social Workers.

On January 22, 2019, the Regional Director issued the attached Decision and Direction of Election (the "Decision") in this matter, wherein he found the appropriate unit to be all RNs. This unit consists of twelve employees.[4]

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[1] The petition and all relevant documents are attached hereto.
[2] 29 U.S.C § 159(c)(5).
[3] In 1974, the National Labor Relations Act was amended to extend coverage to health care facilities. In the Joint Senate and House report that accompanied the amendments, Congress mandated that the Board avoid proliferation of bargaining units in health care facilities like the one at issue here. 120 Cong. Rec. 22,575 (1974).
[4] The election has since taken place, and the RNs voted 12-0 in favor of the union. See Tally of Ballots.

The Regional Director's Decision fails to properly apply the recent change in the law set forth by *PCC Structurals*.[5] The "community of interest" standard in *PCC Structurals* requires that the Board determine if "excluded employees have meaningfully distinct interests in the context of collective bargaining that outweigh similarities with unit members."[6] The Employer is now requesting a review of the Regional Director's Decision.

II. GROUNDS FOR REQUEST FOR REVIEW

Pursuant to section 102.67(c) of the Board's Rules and Regulations, a request for review of a Regional Director's Decision in a representation case may be granted, *inter alia*, on the following bases:

> (1) That a substantial question of law or policy is raised because of (i) the absence of, or (ii) a departure from, officially reported Board precedent.
> (2) That the Regional Director's Decision on a substantial factual issue is clearly erroneous on the record and such error prejudicially affects the rights of a party.

The Board should grant review here because the Regional Director has misapplied the standard in *PCC Structurals* and misstated substantial facts throughout the Decision.[7] Stated more simply, while the NLRB has a long history of well-reasoned decisions being issued through this process, for whatever reason the Region missed the mark by a wide margin in the instant Decision, ignoring the clear guidance of *PCC Structurals* as to the legal standard, misstating facts, and relying on conclusory statements rather than facts. Accordingly, based on these factors, and given the importance of this Decision on a national basis in interpreting *PCC Structurals* moving forward, the Request for Review must be granted.

III. FACTS

The Employer operates at four different locations in and around Butte, Montana, with approximately 75 total employees across all locations. (Tr 12-13, 16-17, 123). Among these individuals are a number of professional employees, including Registered Nurses ("RNs"), Advanced Practice Practitioners ("APPs"),[8] and Integrated Behavior Health Professionals,

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[5] 365 NLRB 160 (2017).
[6] *Id*.
[7] *Id*. (stating in footnote 3, "we reinstate the standard established in *Park Manor Care Center*, 305 NLRB 872 (1991), for determining appropriate bargaining units in nonacute healthcare facilities").
[8] The APPs are professional employees who either have a nurse practitioners degree ("NP") or a physician's assistant degree ("PA"). NPs are RNs who have received additional academic

including a Behavior Health Specialist and two Social Workers. The parties have stipulated to the status of these employees as professionals. (Tr 58-60).

The Employer's main facility is located adjacent to the hospital in Butte, Montana, with another facility located approximately two blocks away ("Butte campus"). The other facilities are located in Boulder, Montana, approximately 35 miles away ("Boulder Clinic"), and on the Montana Tech campus, located about 2 miles from the Butte campus.

The Butte campus clinics are broken down into practice groups, or "teams." The main facility on the Butte campus encompasses Pediatrics, Internal Medicine, Family Practice, Neurology, Cardiology, and Integrated Behavioral Health teams, as well as the Summit Lab and CPC. The Urology and OB-GYN teams are located at a separate clinic on the Butte campus. The Boulder Clinic operates in the same fashion as the Butte clinics, while the Montana Tech Student Health Care Facility is distinct, with a single RN working only during the school year and without regular contact with the other clinic operations. (Tr 14, 17).

Most of the teams are small, consisting of a physician, an APP, and a nurse, and perhaps a medical assistant or LPN.[9] The number of APPs and RNs among teams is as follows:

- Pediatrics = 2 RNs and 1APP
- Internal Medicine = 0 RN and 1 APP
- Family Practice = 4 RNs and 1 APP (floats to other locations)
- Neurology = 1 RN and 0 APP
- OB/GYN = 1 RN and 1 APP
- Urology = 1 RN and 1 APP
- Boulder Clinic = 0 RN (float RNs) and 4 APPs

Utilizing this team structure, the RNs and the APPs, in particular, work together on a daily basis to meet patient care needs. (Tr 25-26, 30-32, 43-47). Within the practice group the teams share exam rooms and team members either sit next to each other or across a desk when not performing other duties. (Tr 25-27, 53-54). Two floating RNs are assigned to the practice groups as needed to fill temporary vacancies, both at the Butte campus and Boulder locations, and the APP in family practice also floats to other practice groups (Tr 18-19, 33). Further, a review of the job descriptions for the RNs and the APPs indicates common core functions, common responsibilities in their job functions, and common education and training. (Tr 50-52).

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training, while PAs normally are not RNs prior to receiving their degrees. The Employer treats these individuals under the same job category of APP. (Tr 50-51).

[9] Neither medical assistants nor LPNs are professional team members, and they are not proposed members of any unit. (Tr 10).

It is essential for APPs and RNs to work in an intimate fashion to address patient needs, working collaboratively to see approximately 18 patients each day. (Tr 26, 30). Patients will make appointments for a medical review and interact with various professionals on the care teams to address their health concerns. (Tr 43-47). To address these patient needs, APP's and RN's hours of employment are very similar. (Tr 43-47, 53).

The APPs and RNs also must utilize the same equipment on a regular basis in performing their review and treatment of patients. These employees use the same laptops that are in each exam room to record medical data. Among practice groups, the pediatrics professionals share equipment like scales, blood pressure machines, exam tables, procedure kits, thermometers, and an otoscope. (Tr 53-54). The internal medicine team shares an otoscope, blood pressure machines and a portable oximeter. This same equipment is shared among the family practice and OB-GYN teams in addition to NST machines and Dopplers. (Tr 53-55). Neurology shares an EMG machine, while an EKG machine is shared among these professional employees in cardiology. (Tr 53-55).

The other professional employees, the Behavior Health Specialist and Social Workers, work daily with the RNs and APPs to provide maximum health care coverage. They are located on the Butte campus and come under the same common overall supervision with the APPs and the RNs. (Tr 17, 39, 60). All these employees are subject to the same human resources policies, benefits, training modules, and parking facilities at each given location. (Tr 22-26, 35, 41). The entire Butte campus medical team has daily group "huddles" during which common issues are discussed (Tr 36-37); engages in team building exercises together (Tr 41); participates in "pot lucks" (Tr 42); attends the same holiday parties (Tr 42); and shares break rooms. (Tr 24, 42-43).

The Behavior Health Specialist makes daily rounds on the Butte campus, engaging in direct patient care with the RNs regarding any special behavioral health care needs of their patients. (Tr 101). The Social Workers also interact with RNs on a daily basis, and must work together to achieve the needs of their patients. (Tr 27-28, 89). All these professional employees work similar hours (Tr 53) and are paid in a similar fashion, with the Behavior Health Specialist paid a salary like the APPs (Tr 56, 64-65) and the Social Workers paid on an hourly basis like the RNs (Tr 58).

Additionally of note, four APPs are assigned to the Boulder clinic, and their duties and functions are the same as the APPs on the Butte campus. Integration of operations results from common supervision, HR policies, benefits, and training requirements. Employees are also

integrated among the Butte and Boulder clinics; for example, a Social Worker may be sent to the Boulder clinic when necessary, and one Boulder APP specifically continues to spend significant time on the Butte campus undergoing training. (Tr 34, 40-41).

The Montana Tech Student Health Clinic, on the other hand, employs a single RN who works only during the school year. She worked approximately five hours on December 20, 2018 at the Butte campus, and has otherwise not filled in at the Butte campus since the summer of 2018. (Tr 15-16). She receives no benefits, does not attend huddles or other meetings on the Butte campus, and is otherwise dissimilar from the other RNs and professional employees at issue. (Tr 15-16, 62-63).

IV. LEGAL ANALYSIS

Just months ago, the Board issued *PCC Structurals*, which modified the standard to be applied in this very setting. The Regional Director's Decision failed to follow this new standard, which will impede future application of *PCC Structurals* if upheld. Further, the Decision ignores the Congressional mandate to avoid proliferation of health care bargaining units, violates Section 9(c)(5), creates an improper residual unit, and misstates substantial factual issues. These are all important grounds upon which to reverse the Regional Director's Decision pursuant to Section 102.67(c) of the Board's Rules and Regulations.

A. THE REGIONAL DIRECTOR DEPARTED FROM OFFICIALLY REPORTED BOARD PRECEDENT, RAISING A SUBSTANTIAL QUESTION OF LAW

1. PCC Structurals Not Followed

The Regional Director failed to follow officially reported Board precedent by ignoring the standard for determining an appropriate unit as required by *PCC Structurals*.[10] In *PCC Structurals*, the Board articulated a return to a traditional community of interest test:

> Throughout nearly all of its history, when making this determination, the Board applied a multi-factor test that requires the Board to assess whether the employees are organized into a separate department having distinct skills and training, a distinct job function to perform distinct work, including inquiring into the amount and type of job overlap between classifications; are functionally integrated with the employer's other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised.

[10] 365 NLRB 160 (2017).

As further set forth in *PCC Structurals*:

> The required assessment of whether the sought after employee's interests are sufficiently distinct from those of employees excluded from the petition for a group provides some assurance that extent of organizing will not be determined consistent with Section 9(c)(5); it assures that bargaining units will not be arbitrary, irrational or fractured, that is composed of gerrymandered groupings of employees whose interests are insufficiently distinct from those of other employees to constitute that grouping a separate appropriate unit; and insures Section 7 rights of excluded employees who share a substantial but less than overwhelming community of interests with the sought after group are taken into consideration.

Id. (emphasis added).

Under this precedent, the Union's efforts in this case to create a gerrymandered bargaining unit of only RNs is clearly inappropriate and contrary to what the Board's standard set forth in *PCC Structurals*. The Board clearly stated:

> We merely hold that when it is asserted that the smallest appropriate unit must include employees excluded from the petition for a unit, the Board will no longer be constrained by the extraordinary deference that *Specialty Health Care* affords to the petitioned for unit.

The Regional Director failed to follow the standard as set forth in *PCC Structurals* in determining the appropriate bargaining unit. Namely, the Regional Director fails to determine whether "excluded employees have *meaningfully distinct interests* in the context of collective bargaining that *outweigh* similarities with unit members."[11] The Decision fails to acknowledge that all professional employees utilize the same equipment and interact on a daily basis. (Tr 53-54). The professionals come under similar overall supervision, work in small clinic teams, and treat patients collaboratively. (Tr 17, 39, 43-47). These professional employees engage in daily huddles, share break rooms, and make rounds with one another, essential to the success of this small outpatient clinic. (Tr 24, 27, 42-43). The Regional Director ignores these facts and fails to prove a significant distinction among these professional employees. Indeed the Decision fails to even attempt to establish to establish any meaningfully distinct interests.

[11] *Id*.

Finally, the Decision also blatantly ignores *PCC Structurals* precedent by giving significant deference to the proposed unit.[12] Hence, the Regional Director's legal analysis is a clear departure from, and is inconsistent with, Board precedent.

2. Proliferation Improperly Allowed

Further, the Director's Decision not only provides mere lip service to the community of interest test mandated under *PCC Structurals,* it also ignores the Congressional mandate to avoid proliferation of health care bargaining units. The federal courts of appeals have consistently denied enforcement of NLRB findings that (like the Director's Decision) undermine the mandate by specifically including RNs, but not other professionals: "All the relevant circuit court decisions have criticized the Board for certifying a bargaining unit that is wholly within one broad type but not comprehensive, e.g., RNs but not other professionals." *NLRB v. HMO International*, 678 F2d 806, 9th Cir. (1982); *see also N.L.R.B. v. St. Francis Hosp. of Lynwood*, 601 F.2d 404 (9th Cir. 1979) ("A number of other courts have refused to enforce Board orders concerning hospital unit determinations where the Board failed to make an independent weighing of the factors in the situation but merely relied upon presumptive factors."); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 216 (7th Cir. 1978) (holding the board erred in ignoring that facts of the record suggesting a broader unit and failing to prove how the narrower unit complied with the congressional admonition).

3. Inappropriate Residual Unit

The Regional Director's Decision will force the creation of an inappropriate residual unit at the Employer's facilities. The remaining professionals (3) would be forced into a small unit of "other residual professionals" the Board has consistently tried to avoid. *See Airco, Inc.*, 10-RC-12839 (1984) (addressing residual units that "the Board has normally preferred to avoid creating" when possible); *see also International Building Co.*, 4-RC-21705 (2011) (using a community of interest analysis to approve an appropriate unit that avoided "a small residual unit, which the Board tries to avoid").

[12] The Director included the single RN assigned to the Montana Tech Student Health Care Facility who only works during the school year, does not have any regular contact with the other clinic operations including the Butte campus, receives no benefits like the other employees, and does not attend huddles or other meetings as the other professional employees do. (Tr 14-17). There is a clear lack of a community of interest between this individual and the other RNs, much more so than the APPs and RNs who work together on a daily basis. (Tr 25-27). The Regional Director deciding otherwise is clearly erroneous. (Decision 5).

Smaller health care facility settings like this one are especially prone to residual units when a union attempts to split professional employees into separate bargaining units, and that is precisely what the Regional Director allowed to happen. Even worse, there is a risk these residual employees will be prone to no representation at all. *See Cont'l Web Press, Inc.*, 742 F.2d 1087, 1090 (7th Cir. 1984) (stating "breaking up a work force into many small units creates a danger that some of them will be so small and powerless that it will be worth no one's while to organize them, in which event the members of these units will be left out of the collective bargaining process"). This will produce an undesirable result, one that violates the congressional mandate prohibits, and is prone to reversal. *See St. Francis Hosp. of Lynwood*, 601 F.2d 404 (9th Cir. 1979) (where other professionals were inappropriately relegated to a "residual professionals" unit); *See also Huckleberry Youth Programs*, 326 NLRB 1272, 1274 (1998) ("Their exclusion, as we have found them to be employees, would create a residual unit, which the Board seeks to avoid.").

4. Violation of Section 9(c)(5)

The Regional Director's Decision also violates Section 9(c)(5), which prohibits the authorization of a bargaining unit based solely on the extent of union organizing.[13] Widely recognized by the courts is that "the union will propose the unit it has organized." *NLRB v. Lundy Packing Co.*, 68 F.3d 1577, 1581 (4th Cir. 1995) (citations omitted). This Decision invites unions to petition for the election they are most likely to win, not the appropriate election for those particular employees. Section 9(c)(5) was enacted "to discourage the Board from finding a bargaining unit to be appropriate" simply because it was organized that way.[14]

This Decision ignores the Board recognized position that Section 9(c)(5) was "intended to prevent fragmentation of appropriate units into smaller inappropriate units."[15] In their closing statement the union even admits it can only represent registered nurses pursuant to its bylaws, so it would withdraw the petition if the unit included other professionals. (Tr 131). Clearly, the Director inappropriately authorized this unit based on the extent of union organizing, and the Decision leaves future employees at risk of the same result.

5. Regional Director's Authority is not Persuasive

The string of cases cited by the Regional Director at the end of the Decision are clearly

[13] 29 U.S.C § 159(c)(5).
[14] 93 Cong. Rec. 6601 (1947).
[15] *Overnite Transp. Co.*, 322 NLRB 723, 725 (referencing 29 U.S.C § 159(c)(5)).

distinguishable from the facts of this case. (Decision 6). Most importantly, the facilities in those cases were psychiatric hospitals, not out-patient clinics like the Employer in this case. Those facilities are distinct from the Employer's clinics in terms of size and proximity of the facilities, the functional integration of the professionals, and the similarities of job functions. *See, e.g.*, *Charter Hospital of St. Louis*, 313 NLRB 951, 954 (1994) (involving a psychiatric hospital where RNs had distinct, separated patient care responsibilities from other professionals not involved in patient care); *Holliswood Hospital*, 312 NLRB 1185 (1993) (where the employer sought a wall-to-wall unit of all professional and non-professional employees). The finding that RNs were significantly distinct from other employees in psychiatric hospitals does not support a similar finding in an out-patient clinic here.

The Regional Director also claims there are "important and distinguishing features" among the professional employees, like the difference in mode of payment among APPs and RNs. (Decision 6). However, the Director's claim is supported with no case law, and numerous Board decisions hold just the opposite. *See Huckleberry Youth Programs*, 326 NLRB 1272, 1274 (1998) ("the fact that the wages of PHEs are different from employees in other classifications and that PHEs do not receive certain benefits is not a basis for excluding PHEs from the overall unit of the program employees."); *see also Palmer Manufacturing Corp.*, 105 NLRB 812 (1953) (mode of payment or rate of pay is not determinative).

Further, numerous Board decisions have found appropriate units consisting of RNs and other professional like the Employer proposed unit here. *See Schnurmacher Nursing Home*, 327 NLRB 253 (1998) (unit of Social Workers, NPs, and RNs); *Rockridge Medical Care Center*, 221 NLRB 560 (1975) (NPs and RNs in the same unit); *St. Vincent Healthcare*, 27-RC-8577 (2009) (NPs and RNs in the same unit); *Atlantis Health Care Group, Inc.*, 12-RC-121467 (2014) (unit included Social Workers and RNs).

Again, Board precedent requires that a community of interest analysis be undertaken to determine the appropriate bargaining unit in this case. RNs must be <u>significantly distinct</u> from other professional employees to justify proliferation of a professional bargaining unit in a health care setting. However, The Regional Director failed to engage in a proper community of interest analysis, allowing for proliferation of bargaining units, creating an inappropriate residual unit, in violation Section 9(c)(5), and cited no persuasive authority to do so. These are all valid grounds to grant the Employer's Request for Review of this Decision.

B. THE REGIONAL DIRECTOR'S DECISION ON A NUMBER OF SUBSTANTIAL FACTUAL ISSUES IS CLEARLY ERRONEOUS AND SUCH ERROR PREJUDICIALLY AFFECTS THE RIGHTS OF THE EMPLOYER.

As set forth above, the Regional Director's Decision failed to properly analyze the community of interest among the professional employees. The appropriate unit in this case consists of the RNs, the APPs, the Behavior Health Specialist, and the Social Workers for the Butte campus and the Boulder Clinic. The common elements and interests among these employees is staggering, yet the Regional Director ignored or gave little weight to the clear community of interest among the professional employees and misstates the facts established by the record.

1. Misstatement of Facts

In the "Job Functions" section of the Decision, the Regional Director's factual analysis is replete with gross misstatements of the record in this case. For example, the Director states that the RNs and APPs "may utilize some of the same medical instruments." (Decision 3, emphasis added). In fact, the record shows how virtually all of the equipment is used by both RNs and APPs every single day. (Tr 53-55). These professionals jointly examine the same patients, following the same procedures and use the same tools in doing so. Hence, to state otherwise grossly misstates the record.

The Director also states there is no evidence in the record of job overlap, another blatant fallacy in this Decision. (Decision 3). Not only is there direct overlap in the equipment and tools used, as referenced above, these professionals collaborate on a daily basis in patient care. The written job descriptions and the record demonstrate clearly the great degree of overlap there is among these professionals, working together in small teams at their clinics. (Tr 49-51).

The Regional Director then details extensively the "Functional Integration" of these professionals. (Decision 3). As stated, the employees "work within a system" with clear integration and collaboration necessary to ensure proper patient care. (Decision 3). The Director also emphasizes the centralized recordkeeping, overlap in patient need administration, and consultations among these professionals, which completely contradicts his prior statement that there was "no evidence in the record of job overlap."

The Director so erroneously ignores the clear integration and overlap among these professionals by stating individual employees have "their own discrete and well-defined role." (Decision 4). With no factual support, it is hard to understand the Director's intentions with this

conclusory statement. He seems to suggest this is a meaningful distinction, but every employee in every company has a "discrete and well-defined role." This is anything but a meaningful distinction.

The Regional Director further erroneously summarizes the record in an attempt to belittle the similarities in job functions and duties of these professionals. A reading of the transcript in this case, however, reflects how similar these job functions are; how much overlap they have; and the significance of the employees' professional interactions, on a daily basis. These professionals work on the same team, use the same machinery and equipment, and share almost identical job descriptions and responsibilities. The Regional Director ignored all these similarities, instead issuing a Decision full of factual misstatements and plain inaccuracies that are extremely prejudicial towards the Employer.

What may be the most bizarre and unbelievable factual statement in the Decision is that APPs "undergo specialized training" and licensing. (Decision 4). This is not a meaningful distinction— In fact, specialized training defines a professional employee under the NLRA! (Tr 53). Accordingly, specialized training is evidence of their similarities as professional employees, not a distinction.

The Director also attempts to identify separate supervision as a meaningful distinction, but the overall supervision is the same among all professional employees. (Decision 4). *See Huckleberry Youth Programs*, 326 NLRB 1272, 1274 (1998) (finding they belonged in the same unit because "[w]hile they do not share common immediate supervision, secondary and overall supervision is the same").

The record shows intimate interaction between all the professional employees at these non-acute care outpatient clinics. The Regional Director failed to engage in a true community of interest analysis, as is required by law, and instead relied on minute factual differences falsely labeled as "significant distinguishing features" or gross misstatement of fact. (Decision 6). The factual findings in the Regional Director's Decision show clear error, the proposed unit is not "sufficiently distinct from those of employees excluded from the petition," and it was clearly erroneous for the Regional Director to decide otherwise.

V. CONCLUSION

Simply put, the Regional Director ignored the record evidence and relevant case authority. The standard set forth in *PCC Structurals* must be followed, and under that standard there is a clear community of interest among the Employer's proposed bargaining unit. *PCC Structurals, Inc.* 365 NLRB 160 (2017). The lip-service treatment of this precedent and the congressional mandate against proliferation is grounds for granting the Employer's Request for Review, and the union has failed to prove that a sufficiently distinct bargaining unit of only RNs is appropriate in this non-acute health care setting. The failure to follow Board precedent and the erroneous decisions on substantial factual issues prejudicially affects the rights of the Employer in this case. Accordingly, the Employer's Request for Review should be granted.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing instrument was filed electronically with the Executive Secretary of the NLRB and forwarded via electronic mail this 8th day of March, 2019 to:

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