**UNITED STATES OF AMERICA**
**BEFORE THE NATIONAL LABOR RELATIONS BOARD**

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| SPECIALTY HEALTHCARE AND REHABILITATION CENTER OF MOBILE,<br><br>Employer,<br><br>and<br><br>UNITED STEELWORKERS, DISTRICT 9,<br><br>Petitioner. | ) | Case No. 15-RC-8773 |

# BRIEF OF *AMICUS CURIAE* CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA


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## INTRODUCTION

While the issue presented in this case is narrow – whether a unit composed solely of certified nursing assistants ("CNAs") is an appropriate unit – it raises broad concerns for employers in all industries, including the nonacute healthcare industry in particular. The Board's Notice and Invitation to File Briefs portends a sweeping change in the standard for unit determinations in all industries regulated by the National Labor Relations Act.

The standard suggested by the Board majority would hold that a unit composed of employees performing the same job at the same facility is presumptively appropriate. This standard, if adopted, would have serious economic ramifications for the nonacute health care industry, at a time when the nation is attempting to provide affordable universal healthcare. It would lead to the proliferation of smaller, fragmented units, and therefore would increase the likelihood of strikes, jurisdictional disputes, and other disruptions to operations – all of which is contrary to national labor policy in the health care industry. If this standard is applied in the other industries regulated by the Act, it would have the same disruptive and costly impact on those industries, many of which are still struggling to recover and create new jobs after a prolonged recession.

Changing the unit determination standard in this manner might lead to increased union organizing in the short term, but it will not result in meaningful collective bargaining in the long term. Bargaining with a small unit of employees, which excludes many other employees who share a substantial community of interest, will be more costly and less likely to succeed. Ultimately, the Board has a statutory responsibility to approve bargaining units that are not only appropriate for organizing, but also for collective bargaining. The Chamber urges the Board to adhere to its longstanding precedent in unit determination cases, which strikes an appropriate

balance between the statutory goals of allowing employees to exercise their right to organize and bargain collectively, while at the same time promoting industrial peace and minimizing interruptions to commerce through effective collective bargaining.

## INTEREST OF THE AMICUS CURIAE

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest federation of businesses, representing 300,000 direct members and an underlying membership of over 3,000,000 businesses and professional organizations of every size and in every relevant economic sector and geographical region of the country. A principal function of the Chamber is to represent the interests of its members by filing *amicus curiae* briefs in cases involving issues of vital concern to the nation's business community.

## ARGUMENT

### I. The Board Should Adhere to Its Longstanding Precedent Concerning the Scope of Appropriate Bargaining Units.

The Board's Notice and Invitation to File Briefs asks whether a bargaining unit should be presumptively appropriate, in all industries, if it includes only those employees who perform the same job at a single facility. *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 2 (Dec. 22, 2010).[1] The argument for such a standard is set forth in the dissenting opinion of Member Becker in *Wheeling Island Gaming, Inc.*, 355 NLRB No. 127 (Aug. 27, 2010). In that case, dissenting Member Becker argued that a petitioned-for unit consisting only of poker dealers at a casino is an appropriate unit, even though it excludes blackjack dealers and croupiers at the same

[1] This issue is raised in question 7 of the Notice and Invitation to File Briefs. *Id.*, slip op. at 2. In this brief, we first address questions 7 and 8, which concern the standard to be applied in all industries under the Act, and then in part III, *infra*, we address questions 1-6, which are specific to the nonacute healthcare industry. We do not answer these questions in an enumerated question-and-answer format. Instead, we address the issues raised in each question in the context of our broader arguments set forth in this brief.

casino. As the majority opinion noted, however, such a unit would be inconsistent with the Board's longstanding precedent, which holds that the interests of the employees in the unit sought must be "*sufficiently distinct* from those of other employees to warrant the establishment of a separate unit." *Id.*, slip op. at 1 n.2 (quoting *Newton-Wellesley Hosp.*, 250 NLRB 409, 411-12 (1980)). Now, it appears that the Board is reconsidering that longstanding precedent, in favor of a standard that would find a unit appropriate regardless of whether there are other employees who share a substantial community of interest with the employees in that unit.

The Chamber submits that reversing longstanding precedent in this manner would be contrary to the fundamental purposes and polices of the Act. Member Becker has argued that the Board's precedent in unit determination cases "have accumulated into complex and uncertain jurisprudence that threatens to thwart employees' efforts to exercise their right to choose a representative." *Wheeling Island Gaming*, 355 NLRB No. 127, slip op. at 3. This argument ignores that the Act does not exist simply to facilitate and protect organizing in whatever unit a group of employees, or the petitioning labor organization, views to be the most desirable and advantageous. The Act fosters and protects collective bargaining as a means of promoting industrial peace. *See Fibreboard Paper Prods. Corp. v. NLRB*, 379 U.S. 203, 211 (1964) ("One of the primary purposes of the Act is to promote the peaceful settlement of industrial disputes by subjecting labor management controversies to the mediatory influence of negotiation."); *Local 24, Int'l Bhd. of Teamsters v. Oliver*, 358 U.S. 283, 295 (1959) ("The goal of federal labor policy, as expressed in the Wagner and Taft-Hartley Acts, is the promotion of collective bargaining . . . and thereby to minimize industrial strife."); *First Nat'l Maint. Corp. v. NLRB*, 452 U.S. 666, 674 (1981) ("A fundamental aim of the National Labor Relations Act is the

establishment and maintenance of industrial peace to preserve the flow of interstate commerce.") (citing *NLRB v. Jones & Laughlin Steel Corp*., 301 U.S. 1 (1937)).

Section 9(c)(5) of the Act was added to reinforce that the Board should not make unit determinations with a singular focus on the desires of the petitioning employees or labor organization. Thus, Section 9(c)(5) provides that "the extent to which the employees have organized shall *not* be controlling" in the Board's unit determinations. 29 U.S.C. § 159(c)(5) (emphasis added). The Board cannot, as suggested by Member Becker in *Wheeling Island Gaming*, comply with Section 9(c)(5) merely by pointing to some community of interest factors that are consistent with the extent of the union's organizing effort. *Wheeling Island Gaming*, 355 NLRB No. 127, slip op. at 3 n.2. The Board has a statutory responsibility to ensure that its unit determinations will ultimately promote stable and effective collective bargaining relationships. In the rulemaking for acute care hospitals, the Board recognized that its goal "is to find a middle-ground position, to allocate power between labor and management by 'striking the balance' in the appropriate place, with units that are neither too large or too small." 53 Fed. Reg. 33,904 (1988).[2]

The purposes of the Act are not served by making unit determinations that exclude groups of employees who share "a substantial community of interest with employees in the unit sought." *Colo. Nat'l Bank of Denver*, 204 NLRB 243, 243 (1973). For this reason, the Board historically has not approved of "fractured units" – units that "are too narrow in scope or that have no rational basis." *Seaboard Marine, Ltd.*, 327 NLRB 556, 556 (1999). Fragmented

[2] Academic literature describes the economic reasons for striking an appropriate balance between units that are neither too large nor too small. *See* Douglas L. Leslie, *Labor Bargaining Units*, 70 VA. LAW REV. 353, 408-09 (1984).

bargaining units may also effectively disenfranchise certain groups of employees, a result that is also contrary to the policy of the Act.

Member Becker argues that *American Cyanamid Co.*, 131 NLRB 909 (1961), supports a sweeping presumption – one that would apply in all industries – that a unit of "all employees doing the same job and working in the same facility" should be approved absent "compelling evidence that such a unit is inappropriate." *Wheeling Island Gaming*, 355 NLRB No. 127, slip op. at 2.[3] No such presumption can be drawn from *American Cyanamid*. To the contrary, in finding a unit of maintenance employees to be appropriate in that case, the Board specifically disavowed any presumption in favor of a maintenance-only unit in other cases: "collective-bargaining units must be based upon all the relevant evidence *in each individual case*." *American Cyanamid*, 131 NLRB at 911 (emphasis added). Consistent with the statutory mandate to foster industrial peace through effective collective bargaining, "each unit determination must have a direct relevancy to the circumstances within which collective bargaining is to take place." *Id.*

Thus, the Board's unit determinations have long considered, and should continue to consider, whether the scope of a proposed unit makes sense from the standpoint of the collective bargaining that will take place if the union prevails in the election. The Board should not, as Member Becker suggests, simply approve the narrowest unit sought by the petitioning labor organization and then leave it to the parties to reshape the unit if their "experience with collective bargaining suggests to them that bargaining would be more productive in a larger or differently contoured unit…." *Wheeling Island Gaming*, 355 NLRB No. 127, slip op. at 2. The Board has a

[3] The standard applied in *American Cyanamid* is also the subject of question 8 in the Notice and Invitation to File Briefs in this case. *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 2.

statutory responsibility to make that determination in advance, and to withhold approval of bargaining units that are not suitable for effective collective bargaining.

## II. The Board Should Not, in the Context of a Case Arising in the Nonacute Healthcare Industry, Reexamine the Standards Applied in All Other Industries.

Although this case arises in the nonacute health care industry, the Board has expressed that "it will have a duty to at least consider" whether the standard articulated in this case should apply "more generally." *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 3. This is a dangerous proposition. It is contrary to the Board's decision in *American Cyanamid*, which recognized that appropriate unit determinations are individualized determinations that "will vary from industry to industry and from plant to plant." *American Cyanamid*, 131 NLRB at 911. The Board's determination as to the scope of a proposed CNA-only unit in the nonacute healthcare industry should not give rise to a presumption that would apply in the many other industries regulated by the Act.

The Board asserts that "[i]ndustry-specific rules are the exception, not the norm." *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 3. Yet, the healthcare industry clearly is one such exception, given the rulemaking and pattern of decisionmaking that forms the backdrop for this case. Unit determination standards developed in this industry should not be the vehicle for creating a new presumption for all other industries.

Unit determinations in other industries are based on different considerations and patterns of decisionmaking. In the utility industry, for instance, there is a presumption in favor of systemwide bargaining units. *See Alyeska Pipeline Serv. Co.*, 348 NLRB 808, 809 (2006); *Baltimore Gas & Elec. Co.*, 206 NLRB 199, 201 (1973); *Colo. Interstate Gas Co.*, 202 NLRB 847, 848 (1973); *La. Gas Serv. Co.*, 126 NLRB 147, 149 (1960). This presumption rests not only on community of interest factors, but also on the fundamental policy objective of the Act –

minimizing interruptions to commerce resulting from labor disputes. *See Alyeska Pipeline*, 348 NLRB at 812 ("The Board's presumption in favor of a systemwide unit is based, at least in part, on the judgment that an increase in the number of units leads to an increase in the number of potential labor disputes and work stoppages."); *Baltimore Gas*, 206 NLRB at 201 ("That judgment has plainly been impelled by the economic reality that the public utility industry is characterized by a high degree of interdependence of its various segments and that the public has an immediate and direct interest in the uninterrupted maintenance of the essential services that the public utility industry alone can adequately provide.").

There are also unique considerations and patterns of decisionmaking in other industries that play a major role in the national economy, including the trucking industry, the maritime industry, the hotel industry, the retail food industry, the television and radio industry, the newspaper industry, the construction industry, and in higher education. The Board should not, in the context of a case arising in the nonacute healthcare industry, attempt to fashion a new unit determination standard that would apply in all of these industries. The standard to be applied in any industry should be determined only in a case arising in that particular industry, after full development of the unique facts and circumstances and patterns of collective bargaining that exist in that industry.

The Board suggests that changing the unit determination standard may help prevent litigation over the scope of a proposed bargaining unit. *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 3. This is not a sensible reason to upset the unit determination standard in all industries. Under the current standard, litigation concerning the scope of a bargaining unit is rare; over 90% of elections are conducted pursuant to a stipulation. *See* Office of the General Counsel, *Summary of Operations (Fiscal Year 2010)*, Memorandum GC 11-03 (Jan. 10, 2011)

(reporting that 92.1% of representation elections in FY 2010 were conducted pursuant to agreement of the parties, compared to a 91.9% election agreement rate in FY 2009).[4] The Chamber submits that changing the unit determination standard will produce more, not less, litigation because well-established precedent will be called into question and the parties will have an incentive to litigate in an effort to shape the law under the new standard. For this reason as well, the Board should not engage in a sweeping revision of its existing unit determination standards.

## III. The Board Should Not Find That a Unit Composed of Certified Nursing Assistants Only Is an Appropriate Bargaining Unit in the Nonacute Healthcare Industry.

The Board should not find that a bargaining unit consisting only of certified nursing assistants ("CNAs") is appropriate in nonacute healthcare facilities, such as nursing homes and other long-term care facilities. The Board should apply the traditional "community of interest" standard for nonacute healthcare facilities, as set forth in *Park Manor Care Center*, 305 NLRB 872 (1991), in considering whether a broader unit is appropriate. In doing so, the Board must remain consistent with Congressional and Supreme Court admonitions against the proliferation of bargaining units, and fragmented bargaining, in the healthcare industry.

### A. There Is No Reason to Depart from *Park Manor Care Center.*

In this case, the Regional Director failed to properly apply *Park Manor Care Center* in making the unprecedented determination that a bargaining unit consisting of CNAs only is appropriate. The standard for unit determinations in the health care industry has a long and

[4] In *Wheeling Island Gaming*, Member Becker asserted that "litigation, often protracted litigation, over the scope of the unit occurs prior to almost every contested election." 355 NLRB No. 127, slip op. at 3. This is a cleverly worded but misleading statement, given that the overwhelming majority of Board elections are not contested. And, of the small minority of cases that are contested, many do not involve issues of unit scope. They frequently involve issues of unit composition (*e.g.*, exclusion of supervisors) and related issues.

complicated history that sets it apart from unit determinations in other industries. Throughout this history, the Board has taken into account the goal of determining appropriate bargaining units without proliferating small, fractured units in an industry in which continuity of service is critical. When Congress enacted the 1974 health care amendments to the National Labor Relations Act, it admonished that "[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry." S. Rep. 93-766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. 93-1051, 93d Cong., 2d Sess. 7 (1974). In fact, the two Congressional reports issued during debate over the health care amendments specifically cited with approval a health care industry decision in which the Board had found inappropriate a unit consisting solely of maintenance department employees in a nursing home. *Four Seasons Nursing Ctr. of Joliet*, 208 NLRB 403 (1974).

Congress's rationale is easily explained. Congress was concerned that proliferation of bargaining units and fragmented bargaining among small units of employees in health care institutions, including nursing homes, would increase labor disputes and adversely affect patient care. *See* Subcomm. on Labor of the Sen. Comm. on Labor and Public Welfare, 93d Cong., 2d Sess., Legislative History of Nonprofit Hospitals under the National Labor Relations Act (1974). The co-sponsors of the 1974 health care amendments also strongly opposed unit proliferation in the health care industry because it would lead to jurisdictional disputes, work stoppages, wage whipsawing, and higher costs for medical care. *See* 120 Cong. Rec. 12,944-45, 13,559, 22,949 (1974) (remarks of Sen. Taft and Rep. Ashbrook).

Congress left its admonition against proliferation of small health care bargaining units to the Board to enforce through unit determinations. Unions, of course, preferred smaller units they could more easily organize and largely ignored the Congressional admonition against such small

units. Hospitals, in particular, regularly challenged NLRB unit determinations. Several courts of appeal found that the NLRB had not heeded the admonition against bargaining unit proliferation and struck down Board-approved units based on community-of-interest criteria. *See, e.g., Mary Thompson Hosp., Inc. v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB v. Frederick Mem'l Hosp., Inc.*, 691 F.2d 191 (4th Cir. 1982).

In 1984, the Board departed from its traditional "community of interest" standard and briefly flirted with unit determinations based on a "disparity-of-interest" standard that treated three broad units (all professionals, all nonprofessionals, and guards) as presumptively appropriate. *See St. Francis II*, 271 NLRB 948, 950 (1984). This standard was designed to address the unit proliferation issue. The Board began to base unit decisions on a disparity-of-interest standard that treated these three broad units as presumptively appropriate. *Id.* at 952-54. However, a number of courts of appeal rejected the "disparity of interest" standard. *See, e.g., Int'l Bhd. of Elec. Workers, Local Union No. 474 v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987); *NLRB v. Walker Cnty. Med. Ctr., Inc.*, 722 F.2d 1535 (11th Cir. 1984). Soon thereafter, the Board returned to the "community of interest" standard for unit determinations in the health care industry.

In 1987, in an effort to end the conflicting interpretations as to the correct standard for unit determinations in the healthcare industry, the Board engaged in its historic rulemaking. The Board explained that although rulemaking would be time-consuming, it would pay "dividends in the form of predictability, efficiency and ... better judicial and public acceptance." 52 Fed. Reg. 25,142, 25,144 (1987). All the while the Board remained cognizant of the Congressional admonition against small, fragmented bargaining units that would be a disservice to the industry, its patients, its employees, and the public at large. The Board recognized that small, fragmented

units may increase bargaining disputes that are costly for the employer to deal with, and disruptive to patient care, because of "repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength." 53 Fed. Reg. 33,904 (Sept. 1, 1988).

After two years of careful rulemaking, and testimony from thousands of witnesses across the country, the Board announced rules allowing a maximum of eight appropriate units. 54 Fed. Reg. 16,336, 16347-48 (1989). The approved units were the same as those typically resulting from application of the community-of-interest standard. *Id.* These bargaining unit rules were confined to hospital bargaining units. Nonacute healthcare institutions, such as nursing homes, were excluded. Employers and unions viewed these rules as a victory for organized labor, and the hospital industry immediately challenged the Board's rules by arguing that the rules exceeded the Board's powers. The American Hospital Association won an injunction against their implementation. *See Am. Hosp. Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). On appeal, the Supreme Court upheld the rulemaking to define health care bargaining units as an appropriate use of the NLRB's powers. *Am. Hosp. Ass'n v. NLRB*, 499 U.S. 606 (1991). But in that decision, the Court repeated the same admonition against proliferation of bargaining units, warning that its decision was "best understood as a form of notice to the Board that if it did not give appropriate consideration to the problem of proliferation in this [the healthcare] industry, Congress might respond with a legislative remedy." *Id.* at 617.

In its decision in *Park Manor Care Center,* also in 1991, the Board found that the policy against proliferation of small, fragmented bargaining units was "equally applicable to unit determinations in nonacute care facilities." *Park Manor Care Ctr.*, 305 NLRB at 876. Nothing

has changed to reduce the concerns on the part of Congress or the Supreme Court, or for that matter on the part of the public, that the proliferation of small bargaining units in nursing homes and other nonacute care facilities could lead to labor strife that would disrupt patient care and ultimately impede interstate commerce. Nowhere is the danger of fragmented bargaining more obvious than in home care services, retirement homes, or assisted living institutions where disruption of services could have a dramatic impact on elderly patients.

Now, however, the Board appears anxious to create a presumptive CNA-only bargaining unit, which is the first step toward creating fragmented bargaining units in the nursing home industry. This comes dangerously close to allowing unions to gerrymander bargaining units to the extent of their ability to organize, in spite of clear statutory authority to the contrary. *See* 29 U.S.C. 159(c)(5) ("In determining whether a unit is appropriate for the purposes specified in subsection (b) [of this section] the extent to which the employees have organized shall not be controlling.").

The Board majority cites studies concerning the "radical transformation" of the long-term care industry in the last 20 years and the filing of almost 3,000 election petitions in this industry during the last decade. *Specialty Healthcare*, 356 NLRB No. 56, slip op. at 2. But those studies, and the number of petitions in the nursing home industry, do not support a conclusion that CNAs must bargain alone in separate CNA-only bargaining units, or that broader units with other non-professional employees, such as "service and maintenance" units, would not be appropriate. Moreover, changes in the long-term health care industry do not support a practice which, in the face of all of the admonitions from Congress and the courts, would encourage proliferation of smaller, fragmented bargaining units.

The Board majority further asserts that unit determinations are used by employers in the health care industry and elsewhere to delay voting in representation elections. The Board's own statistics belie that general assertion. In the health care industry, as in other industries, the overwhelming majority of elections are conducted by stipulation. For example, in FY 2009, 87 of the 107 elections in the Health Care and Social Assistance industry were conducted by stipulation or consent.[5] The median time for these elections was 40 days from the date of the petition. Thus, the data simply do not support the assertion that unit scope issues are delaying elections in this industry.

B. Bargaining Unit Patterns in the Nursing Home Industry.

When the Board instituted rulemaking for health care industry bargaining units, the Board's rule initially included both acute care hospitals and nursing homes. *See* 52 Fed. Reg. 25,142, 284 NLRB 1516 (1987). It proposed the same bargaining units for small hospitals and nursing homes as for large hospitals. However, the Board decided to eliminate the smaller units in favor of broader ones in small hospitals and nursing homes because it found in those facilities "less division of labor and specialization and thus more functional integration of employees' services than normally is the case in large hospitals." *Park Manor Care Ctr.*, 305 NLRB at 874. The degree of functional integration in nonacute health care institutions is as true today as it was when the Board developed the healthcare bargaining unit rules.

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[5] This figure is based on the NLRB R-Case (elections) Frequently Requested Fields data from CATS (Case Activity Tracking System) for FY 2009, which was downloaded from http://www.data.gov/raw/2148. We then examined closed RC cases with an NAICS Code beginning with 62 (Health Care and Social Assistance) to retrieve the election time data. These cases were cross referenced with the NLRB's monthly election reports, retrieved from http://www.nlrb.gov/election-reports, to obtain the code indicating the type of election.

Thereafter, following extensive hearings throughout the United States, the Board concluded that a rule covering appropriate units in nursing homes was neither feasible nor necessary. The Board determined that to a greater extent than acute care hospitals, nursing homes varied in size and type of service rendered. The Board found that there were basically three types of nursing home facilities: (1) skilled nursing homes, which provide 24-hour inpatient care to chronically ill or stable convalescent patients; (2) intermediate care facilities, which also provide 24-hour inpatient care, but where care is less intensive and more oriented to daily living; and (3) residential care facilities, which meet social needs. These three types of nursing homes ranged in size from 10 – 500 patients. *See* 53 Fed. Reg. 33,927-28 (1988); 284 NLRB at 1567. The Board also found that unlike hospitals, nursing homes are populated primarily by the elderly and provide long-term care rather than medical treatment of a specific illness. *Id.*

Thus, the Board concluded that "there is less diversity in nursing homes among professional, technical, and service employees, and the staff is more functionally integrated …[that] nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities than that provided in acute care hospitals, and thus receive lower salaries." *Park Manor*, 305 NLRB at 874. Also, the Board found that "there appears to be a greater overlap of functions as well as greater work contact between the various nursing home non-professionals." *Id.* (internal citations omitted). For these and other reasons the Board excluded nursing homes from its hospital bargaining unit rules. Instead, the Board chose to rely on its traditional "appropriate unit" determinations for nursing homes through adjudication under a "pragmatic" or "empirical" community of interests test as enunciated in *Park Manor Care Center*.

In its Notice and Invitation to File Briefs in this case, the Board majority fails to make a cogent case for the need to scrap the traditional "pragmatic" or "empirical" community of

interest approach. Yet, the Board majority appears poised to adopt a one-size-fits-all standard as being presumptively appropriate for CNA-only bargaining units, and perhaps, as discussed above, a new standard based on a unit of "all employees performing the same job at a single facility" as presumptively appropriate as a general matter in all industries.

A recent Regional Director decision provides an example of why a CNA-only bargaining unit is inappropriate and inconsistent with the policy against the proliferation of bargaining units in the healthcare industry. In *Delaware Health Corporation d/b/a Harbor Health Care and Rehabilitation Center*, Case No. 5-RC-16610 (Dec. 3, 2010), the Regional Director was called upon to decide whether the petitioned-for unit of approximately 65 CNAs was an appropriate unit for bargaining, or whether the smallest appropriate unit also must include approximately 40 active aides, maintenance assistants, receptionists, and dietary department employees (including porters, dietary aides, cooks, and Meals-on-Wheels aides).[6] The Petitioner, United Food and Commercial Workers International Union, Local 27, claimed that the disputed classifications did not share a close community of interest with the petitioned-for classification of CNAs, which it maintained was an appropriate unit, while the Respondent employer contended that the disputed classifications did constitute an appropriate unit with the CNAs, and that the appropriate unit was a "service and maintenance unit." The parties stipulated that there was no history of collective bargaining between the Employer and the Petitioner at the Employer's facility in Lewes, Delaware.

The Regional Director determined that the petitioned-for bargaining unit must include the disputed classifications. The Regional Director applied the *Park Manor Care Center* standard

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[6] The Regional Director in Region 5 is a long-term career Board professional and a highly respected expert in representation matters, including unit determinations. He formerly was the Director of the Board's Office of Representation Appeals in the Board's Washington headquarters where he was responsible for thousands of such cases across the country.

and the "empirical" community of interest analysis. In particular, he considered the factors of common supervision; similarity in employees' skills and functions; similarity in the scale and manner of determining earnings; similarity in benefits and working conditions; contact among employees; degree of functional integration; interchange; geographical proximity; and the history of any collective bargaining involving the parties. *Harbor Health Care*, Case No. 5-RC-16610 (Feb. 3, 2010), slip op. at 20 (citing *Turner Indus. Grp., LLC*, 349 NLRB 428, 430 (2007); *Kalamazoo Paper Box Co*., 136 NLRB 134, 137 (1962)). After carefully considering all of these factors in a 28-page decision, the Regional Director concluded that the original petitioned-for CNA-only unit was not appropriate, and that a broader "service and maintenance unit" as urged by the Employer was the smallest appropriate unit. He directed an election in a unit that consisted of all full-time and regular part-time certified nursing assistants, activity aides, maintenance assistants, receptionists, porters, dietary aides, cooks, and Meals-on-Wheels aides, for a unit of approximately 105 employees. *Id.*, slip op. at 2.

The Board majority in *Specialty Healthcare* reports that there have been "almost 3,000 petitions under Section 9 of the Act during the last decade." 356 NLRB No. 56, slip op. at 2. However, we are aware of no other case (other than the case at issue here) in which a Regional Director, contrary to the analysis in *Harbor Health Care*, directed an election in a unit composed of CNAs only. Indeed, the Regional Director in *Harbor Health Care* noted that the Petitioner in that case had "failed to cite any case law in which a CNA-only unit was found appropriate." *Harbor Health Care*, Case No. 5-RC-16610, slip op. at 23. He found that such a unit is inappropriate because it would "unnecessarily lead to a proliferation of bargaining units, and would exclude employees who share a close community interest with the CNAs." *Id.*, slip op. at 20.

C. Narrow Certified Nursing Assistant-Only Bargaining Units Would Not Foster Effective Collective Bargaining and Would Impede the Act's Goal of Promoting Industrial Peace.

Ordering an election in a unit consisting exclusively of CNAs would be contrary to the policies of the Act and the interests of the public in the health care industry. Establishing multiple small bargaining units within the workforce of the same employer would create bargaining tensions that do not exist in broader units, and the smaller units would attempt to whipsaw the employer into matching the contractual terms and conditions of employment for each other. Work stoppages, which Congress in the 1974 amendments sought to avoid especially in the health care industry, will be more frequent. Pressures to engage in protests and work stoppages likely will be greater because majority support for a strike is more likely in small, homogeneous units.

Unit determinations are particularly sensitive in the nonacute health care industry because the work force of a nursing home, rehabilitation center, or home care service tends to be at the same time small and heterogeneous. The work force often includes physicians, registered nurses, psychologists, licensed practical nurses, certified nurses' aides or assistants, lab technicians, orderlies, physical therapists, dieticians, cooks, guards, clerical workers, maintenance workers, and others, as in *Harbor Health Care*, but often only a few members of each. If the desirability (from the union standpoint) of homogeneous units is stressed, nursing homes and other nonacute health care institutions might have ten or twenty or even more small, fragmented units, each with just a handful of workers. Multiple small units in the same workplace would make bargaining extremely difficult.

This type of fractious dealing between multiple groups is the type of conflict that section 9(b) and the community-of-interest test are meant to avoid. *See Oakwood Care Ctr.*, 343 NLRB 659, 662-63 (2004). The cost of the institution's labor relations and the probability of work

stoppages would soar. Wage rates also might soar, depending on the amount of whipsawing among the various units, to levels which are unrealistic or potentially unsustainable and noncompetitive. These are matters of serious concern in a period of high and rising costs of health care and national efforts to contain such rising costs even in the face of legislation aimed at achieving universal health care.[7] Such concerns are implicit in the admonition against proliferating small, fractured bargaining units, and are evidenced in cases where the Board has rejected small units of specialized nonprofessional employees.

The adverse consequences of CNA-only bargaining units would not be confined to nursing home employers and their patients. A presumption in favor of CNA-only and other small, individual bargaining units based on performance of the same job at the same facility also could harm the employees in those units. The proliferation of such units would limit employees' ability to advance their careers outside of those units. For example, it could prove to be very difficult in a CNA-only unit for a certified nursing assistant to seek a job transfer or promotion to a higher level position, or to respond to a position posting or job preference outside the bargaining unit. CNA-only bargaining units would ignore the underlying functional reality of the workplace in favor of creating more easily organized presumptive bargaining units. However, the result would be to balkanize the workforce into small, fragmented bargaining units that lock employees into those units limited to a unique job description, such as CNA-only units. This could block the career advancement of the certified nursing assistants to other positions within the workplace that are outside of the CNA-only bargaining unit.

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[7] Indeed, the Supreme Court's warning about Congress interceding to prevent proliferation of bargaining units in the health care industry may be prescient were the Board to consider small, fragmented bargaining units presumptively appropriate, especially given the nearly universal concern with controlling rising health care costs. *See Am. Hosp. Ass'n v. NLRB*, 499 U.S. at 617.

In sum, making "same job" units presumptively appropriate in the nonacute healthcare industry, such as CNA-only units in nursing homes, would result in the proliferation of small, fractured bargaining units and the attendant consequences for employers and employees, which are contrary to the "national policy of promoting labor peace through strengthened collective bargaining." *NLRB v. Truck Drivers Local Union No. 449 ("Buffalo Linen")*, 353 U.S. 87, 95 (1957). The paramount public interest, as expressed by Congress and the Board, is in maintaining uninterrupted access to health care facilities by avoiding disruptions caused by organizing drives, whipsaw bargaining, jurisdictional disputes, primary and sympathy strikes, and slowdowns by small, fragmented bargaining units. Congress concluded that the object of minimizing work stoppages or otherwise disrupting health care services could best be achieved by minimizing the number of units appropriate in the health care industry. Creating a presumption for "same job" bargaining units in the nonacute health care industry would be contrary to well-settled Board law and the national labor policy.

Accordingly, the Board should apply the existing standard established in *Park Manor* and hold that a bargaining unit composed only of CNAs is not an appropriate unit.

## CONCLUSION

For all of the foregoing reasons, the Chamber urges the Board to confine its decision in this case to the nonacute healthcare industry and to hold that the proposed unit composed only of CNAs is inappropriate under the existing *Park Manor Care* standard.

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Respectfully submitted,

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