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National Labor Relations Board Sets New Standard That Will Make It Easier for Unions to Organize Nursing Homes and Other Non-Acute Health Care Facilities



By KARA M. MACIEL AND MARK M. TRAPP

On Aug. 23, 2011, the Washington, D.C., area experienced a 5.9 magnitude earthquake. A week later, a “labor law earthquake” of far greater magnitude had its epicenter in a federal agency in the District of Columbia. In the coming weeks and months, its after-

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shocks will be felt by unprepared employers, particularly those operating non-acute health care facilities.

In an opinion that America's largest private sector labor union called a “monumental victor[y] . . . for unions,”¹ the National Labor Relations Board (NLRB or Board) upended decades of precedent and placed virtually all non-acute health care providers at risk of organizing by so-called “micro unions.” The decision, *Specialty Healthcare and Rehabilitation Center*, 357 NLRB No. 83 (Aug. 26, 2011) (20 HLR 1344, 9/15/11), was made public on Aug. 30. *The New York Times* reported that day that the NLRB had “released a decision that would make it easier to unionize nursing home workers,”² but the decision's ramifications are much broader.

Historical Treatment of Non-Acute Health Care Employers

To properly understand the significance of the decision and its ramifications for employers, it is necessary to understand the history of how the NLRB has treated non-acute health care employers.

In 1974, Congress amended the National Labor Relations Act to extend coverage to nonprofit hospitals, which had previously been excluded. During the Congressional hearings over the amendment, some members of Congress noted their concern that numerous small units in health care institutions might increase labor disputes and adversely affect patient care. Nevertheless, while noting with approval the trend toward broader units, Congress ultimately decided against lim-

¹ “USW Remakes NLRB Law in Two Landmark Cases,” United Steelworkers Aug. 30 press release, available at http://www.usw.org/media_center/releases_advisories?id=0420.

² See Steven Greenhouse, N.Y. TIMES, Aug. 30, 2011).

iting the Board's jurisdiction to determine appropriate bargaining units.

After several of its adjudicatory approaches were subjected to severe criticism, in 1989, the NLRB issued regulations that set certain parameters for the number and composition of bargaining units at "acute care hospitals." The Board defined "acute care hospitals" as "either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days."³ The definition of "acute care hospitals" specifically excluded "facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals" and provided that the NLRB would "determine appropriate units in other health care facilities . . . by adjudication."⁴

Thus, the contours of an "appropriate bargaining unit" in "non-acute health care" facilities, such as nursing homes, remained subject to adjudication by the Board. Accordingly, two years after its 1989 rulemaking, the Board decided the case of *Park Manor Care Center, Inc.*,⁵ which involved the question of appropriate bargaining units in nursing homes. In *Park Manor*, the Board stated that "comparing and contrasting individual nursing home workforces with those in acute care hospitals would aid in determining appropriate units."⁶ While the Board cited a number of factors to consider, as a general matter, the *Park Manor* decision has been viewed as siding with the proposition that appropriate units at non-acute health care facilities should not differ largely from those at acute care facilities.

For the past 20 years, following the pattern established by its 1989 rulemaking and the *Park Manor* decision, the Board consistently approved facility-wide "service and maintenance units" consisting of nonprofessional service and maintenance employees at nursing homes, and its decisions generally reflected the concern that Congress had expressed. Indeed, as noted by dissenting Member Brian Hayes, in its history, the Board has directed elections in just four cases involving CNA-only units, and each of those elections was pursuant to a stipulated election agreement, rather than a direction of election. In other words, the Board had consistently avoided an unnecessary multiplicity of units at such facilities, and had *never* previously directed an election in the type of unit it approved in *Specialty Healthcare*.

The Specialty Healthcare Decision

At issue in the case was the appropriate standard to be applied in determining the scope of a bargaining unit that the United Steelworkers sought to represent. The union had petitioned the NLRB to represent a unit consisting solely of 53 certified nursing assistants (CNAs) employed by a skilled nursing facility. The employer, on the other hand, consistent with *Park Manor* and 20 years of Board precedent, asserted that the unit should include not only the CNAs, but all other nonprofessional service and maintenance employees at its skilled nursing facility.

³ 29 C.F.R. § 103.30(f)(2).

⁴ 29 C.F.R. § 103.30(g).

⁵ See *Park Manor Care Center, Inc.*, 305 NLRB 871 (1991), is available at <http://op.bna.com/hl.nsf/r?Open=byul-8lvsfp>.

⁶ *Park Manor*, 305 NLRB at 875.

Nevertheless, casting aside its own 20-year-old precedent, in *Specialty Healthcare*, the Board majority overruled *Park Manor*, and, in the process, laid out a radical new standard that will allow unions to organize employees in groups as little as two individuals, even when those individuals share a community of interest with other (excluded) employees. Obviously, this will make it much easier for unions to organize employees, as they can selectively choose which groups, and, perhaps even which employees, they wish to represent.

Under the new standard, organized employees need only be "readily identifiable as a group (based on job classifications, departments, functions, work locations, skills, or similar factors)" and share a community of interest. Previously, a union bore the burden of showing that the unit it sought to represent had interests "sufficiently distinct from other employees to warrant the establishment of a separate unit."⁷ In sharp contrast, under the new standard established by the *Specialty Healthcare* decision, an employer bears the burden of showing that the excluded employees share an "overwhelming community of interest" with the employees in the petitioned-for unit—a burden which Member Hayes described as "virtually impossible."

It is a truism that a union normally will not petition to represent employees it has been unsuccessful in organizing but will instead "propose the unit it has organized."⁸ In direct contrast to the command of the National Labor Relations Act that "the extent to which employees have organized shall not be controlling" in determining whether a unit is appropriate, *Specialty Healthcare* will allow a union to pick and choose the employees it wishes to represent (*i.e.*, those it can persuade) and to organize them in small groups based only on negligible differences with other employees. Demonstrating the breadth of its holding, the Board majority left open the possibility of organizing among classifications of employees by shift or even by floor, stating only that such proposed units "might be" inappropriate.

Anticipated Effects of Specialty Healthcare Decision

While the effects of this landmark NLRB decision are likely to be felt by all businesses over time, the immediate impact will be realized by non-acute health care facilities, such as nursing homes. Under *Specialty Healthcare*, a union could potentially organize employees of non-acute health care facilities by classification, department, shift, or even location within the facility by floor or otherwise.

Not only has *Specialty Healthcare* made the process of union organizing easier, but several factors make the health care industry a prime target of unions. For example, union density in the healthcare industry has risen as it has become an increasing target of labor unions over the past decade. In the most recent government statistics, whereas only 6.9 percent of private sector employees are union members, in 2010, 15 percent of workers in health care practitioner and technical occupations were represented by unions. Unions also represented 9.2 percent of health care support occupa-

⁷ See *Wheeling Island Gaming*, 355 NLRB No. 127, Slip. Op. at *1 (Aug. 27, 2010).

⁸ *Laidlaw Waste Systems, Inc. v. NLRB*, 934 F.2d 898, 900 (7th Cir. 1991).

tions.⁹ In addition, the health care industry has survived the ongoing recession remarkably well, and with increased life expectancies and the retirement of the “baby boomers,” it is likely to see increased growth.¹⁰ The passage of the Affordable Care Act, set to be fully implemented over the next several years will also surely increase employment in the health care industry.

As manufacturing and blue-collar jobs have declined in America, unions have increasingly targeted the health care industry. For example, labor organizations “such as the AFL-CIO and Teamsters, which previously represented mostly manufacturing and factory workers, are now organizing nurses and other health professions in hospital settings.”¹¹

This is likely to expand into non-acute care settings. As recently stated by the *Kansas City Star*: “A blue-collar pipe fitter isn’t the classic illustration of union organizing anymore. It’s a health care professional in comfortable white shoes.”¹² The newspaper further noted that “the health care sector has the fastest growth rate in the organized labor movement.”¹³ The American Medical News has also reported that reported that “[i]nterest in unions specific to the health care setting also is increasing.”¹⁴

The impact of *Specialty Healthcare* will serve as further inducement for unions to target employees at non-acute health care facilities. Even before the opinion made it procedurally easier, it had been noted that “the growth trend [of unions] is expected to continue in healthcare,” as the “mostly nonunionized workforce is a prime target for union organizers.”¹⁵

Clearly, as a result of the *Specialty Healthcare* decision, non-acute health care facility employers face

greater risk that unions will target small groups of employees, since, as noted by the dissent, under the announced standard, the NLRB’s regional directors “will have little option but to find almost any petitioned-for unit appropriate.”

Conclusion

As dissenting Member Hayes recognized, this case had nothing to do with employees’ free choice, and everything to do with “reversing the decades-old decline in union density in the private American work force.” Combined with the NLRB’s recent mandate that employers post a notice informing their employees of the right to organize, and its proposed rule shortening the time frame in which employers may respond to union organizing, the intended result is clear. As Member Hayes noted, “the majority seeks to make it virtually impossible for an employer to oppose the organizing effort either by campaign persuasion or through Board litigation.”

In its press release commenting on the decision,¹⁶ the union that sought to represent the CNAs at issue in the case makes plain the anticipated impact of *Specialty Healthcare*, asserting that the ruling “remakes NLRB law.” The union also asserted that it had “successfully prevailed upon the Board to permit unions to more freely choose the types of bargaining units they wish to organize.”¹⁷ These claims indicate how far the Board has shifted its policy towards unions, and away from employees. Instead of employees choosing as a group whether and how to be represented, the decision in *Specialty Healthcare* places the decision largely in the hands of unions, which may select only those employees who support the union in order to ensure victory.

Once a union successfully gets its foot in the door, it will next seek to organize further small groups of sympathetic employees, while ignoring those employees who disagree with its message. Non-acute health care facility employers would be well served to carefully analyze their operations and take immediate steps to address any potential vulnerabilities. Specifically, such employers should ensure that their supervisors, managers and executives recognize and are prepared to effectively respond to organizing activity that is sure to come.

¹⁶ “USW Remakes NLRB Law in Two Landmark Cases,” United Steelworkers press release, dated Aug. 30, 2011, available at http://www.usw.org/media_center/releases_advisories?id=0420.

¹⁷ *Id.*

⁹ See Bureau of Labor Statistics, 2010 “Economic News Release: Table 3. Union Affiliation of Employed Wage and Salary Workers by Occupation and Industry,” available at <http://www.bls.gov/news.release/union2.t03.htm>.

¹⁰ See Catherine A. Wood, *Employment in health care: a crutch for the ailing economy during the 2007-2009 recession*, MONTHLY LABOR REVIEW, April 2011, 13 at 16-17, available at <http://www.bls.gov/opub/mlr/2011/04/art2full.pdf>.

¹¹ See Donna Malvey, *Unionization in Healthcare Background and Trends*, JOURNAL OF HEALTHCARE MANAGEMENT, May/ Jun 2010.

¹² See Diane Stafford, *Union organizing shifts to white-collar jobs, especially in hospitals*, KANSAS CITY STAR, Sept. 4, 2011.

¹³ *Id.*

¹⁴ See Victoria Stagg Elliott, *Unions for health care workers are growing*, Feb 22, 2010, available at <http://www.ama-assn.org/amednews/2010/02/22/bisb0222.htm>.

¹⁵ Malvey, *supra* n. 11.