

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

GROUP HEALTH PLAN, INC., d/b/a
GROUP HEALTH, INC.

Employer

and

MINNESOTA'S HEALTH CARE UNION,
SEIU, LOCAL NO. 113

Union/Petitioner

Cases 18-UC-377 and
18-UC-378

DECISION AND ORDER

The Union filed these petitions and asks me to find that five classifications of employees—customer service intake specialists, staffing coordinators, research nurses, care coordination specialists (telephonic) and care coordination specialist (telephonic) assistants—should be included in one of the four units currently represented by the Union. The Employer contends that both the customer service intake specialist and staffing coordinator classifications have been historically excluded from the bargaining unit, and that their inclusion now would be inappropriate. Regarding the remaining classifications, the Employer claims that these employees should be excluded from any and all of the four units currently represented by the Union. I conclude that both the customer service intake specialists and staffing coordinator classifications have historically been excluded from the bargaining unit and I therefore dismiss those

classifications from the petition in Case 18-UC-377. I further conclude that the research nurses, care coordination specialists (telephonic) and care coordination specialist (telephonic) assistants should be excluded from any unit represented by the Union.

Under Section 3(b) of the Act, I have the authority to 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 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.¹

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

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. To explain my conclusions as set forth in the introductory paragraph, I will summarize the record evidence from both the instant case and from a previous hearing held in Cases 18-UC-365 and 18-UC-366. In so doing, I rely on the fact that the hearing officer took official notice of the transcript, exhibits and Decision and Order in Cases 18-UC-365 and 18-UC-366.

The Employer's Operation

¹ The Employer, Group Health Plan, Inc., d/b/a Group Health, Inc., is a Minnesota corporation engaged in providing medical health services and insurance and HMO coverage at various locations within the greater Minneapolis and St. Paul area. During the past 12 months, a representative period, the Employer received at its Minnesota facilities goods and services valued in excess of \$50,000 directly from suppliers located outside the State of Minnesota. During that same period, the Employer earned gross revenues in excess of \$500,000.

The Employer is one part of an organization known as Health Partners. The Employer owns and operates about 20 medical and dental clinics in the Minneapolis/St. Paul, Minnesota metropolitan area, and through those sites the Employer provides medical health care services. The Employer also operates a health insurance plan, which provides claims, membership accounting, case management and member services. The Employer's insurance operation services not only its own clinics but also 700 other clinics not owned or operated by it. In 1980 (at the time the four units described below were certified), a major part of the Employer's business was health care delivery at its clinics. Now about half of the Employer's operation is health care delivery and half is as an insurance provider.

In addition to its medical and dental clinics, the Employer has a 14-story corporate headquarters, referred to as the 8100 Building, which is located in Bloomington, Minnesota. Across a parking lot from the 8100 Building is a two-story structure known as the Mod C Building. The 8100 Building has the only cafeteria used by all employees, including employees in Mod C. All employees use facilities in both buildings.

The Employer employs about 5,000 employees. Approximately 1,500 of the Employer's employees are represented by the Union, and another 1,500 office and clerical employees are represented by Office and Professional Employees International Union, Local 12. The Employer further maintains that all of the job classifications currently represented by the Union provide direct care to patients, with the limited exception of the custodians, building engineers, and maintenance assistants.

The Collective Bargaining Relationship between the Employer and Union

The Employer and Union are parties to two collective bargaining agreements covering employees in four separate units. Both agreements are effective from February 20, 2002 through January 31, 2005. The first agreement covers three units of employees. Each unit is specifically delineated in the agreement. The first unit is a service and maintenance unit (Unit I). The second unit is technical employees (Unit II). The third unit is office staff and answering service registered nurses (also called CareLine nurses) (Unit III). The second of the two agreements includes all professional employees, excluding physicians, dentists and registered nurses included in the third unit described above. In all of these units, employees within the classifications covered by the unit descriptions are included in the units when employed at all building locations and clinics in the Minneapolis/St. Paul seven-county metropolitan area.

Procedural History

In its petitions as originally filed, the Union sought to include the behavioral health care manager, manager-behavioral care (these are different classifications), senior customer service intake specialist, and utilization management specialist in one of the units it currently represents. At the hearing the Union sought to amend its petitions to no longer seek these positions. The Union's motion to amend its petitions was not opposed by the Employer, and therefore, the Hearing Officer granted the motion. The Union also further amended its petition in Case 18-UC-377 to seek to clarify in the unit the job classification of customer service intake specialist. As this amendment was not opposed by the Employer, the Hearing Officer granted it. Also at the hearing, the

Employer moved to sever Cases 18-UC-380 and 18-UC-381, which were originally consolidated for hearing with the instant cases. The Union did not oppose the Employer's motion to sever, and the Hearing Officer granted it. Thus, Cases 18-UC-380 and 18-UC-381 are no longer a part of these proceedings and remain pending for investigation or hearing. Finally, by letter dated January 6, 2003, the Union moved to amend petition 18-UC-378 and no longer seeks the job classification pharmacy managed care resident. I hereby grant the Union's motion. In view of these various amendments/withdrawals by the Union, all of the positions it originally sought to include in one of its units in Case 18-UC-378 (behavioral health care manager, manager-behavioral health, pharmacy managed care resident, and utilization management specialist) are no longer in issue. Therefore, the petition in 18-UC-378 is moot, and it is hereby dismissed.

Thus, the classifications that the Union seeks in Case 18-UC-377, as amended at the hearing, are customer service intake specialists, staffing coordinators, research nurses, care coordination specialists (telephonic) and care coordination specialist (telephonic) assistants.

Customer Service Intake Specialists

The Union seeks to include the customer service intake specialists with the office staff and answering service registered nurses unit through clarification of the unit. The Employer contends that while there has been a recent title change, this classification has been historically excluded from any units. With respect to both the customer service intake specialist and staffing coordinator classifications, the parties specifically

agreed during bargaining for the current contract that the Union did not waive its right to challenge the unit placement of this and the other classifications in dispute in this matter.

The customer service intake specialists and the staffing coordinators work closely together, and share office space on 6 north in the 8100 building. Both classifications relate to the hospice program run by the Employer. Generally, the intake specialists receive referrals from providers, (i.e. hospitals, physicians, etc.) initiating a home care or hospice referral. The intake specialists then gather information regarding the patient and what type of insurance plan will be covering the service. They also must determine whether or not the patient meets the eligibility criteria set out by the insurance plans and secure prior authorization for an initial visit, if authorization is required by the insurer. Next, the customer service intake specialists identify what kind of service is needed. If the Employer is unable to staff the request, intake specialists may refer the patient to a contracted vendor. Customer service intake specialists then enter the information into the computer, generate the referral and convey the information to the staffing coordinators.

There are currently three employees who work as customer service intake specialists, each of whom is an LPN.

In March 2001, the customer service intake specialist's job description was revised. Prior to March 2001, the classification was titled customer service specialist, and that title had been used since at least August of 1996. Thus, the change in March 2001 was to add the word "intake". The job code did not change, however, in March 2001. A comparison of the job duties contained in the two job descriptions reveals that

there has been very little (if any) change in the actual functions of the job. While a new computer system is used now, the customer service intake specialists perform basically the same duties that the customer service specialists have been performing since 1996. At the hearing, Linda Hasselman who is currently employed as a customer service intake specialist, and who was hired in 1996, compared her job before and after March 2001. In so doing, she testified that her job functions are essentially the same now, as they were when she was hired in 1996. For example, in 1996 she initiated and completed home care referrals by screening referrals for appropriateness and confirming eligibility, gathering information and passing it on to the staffing department. She does the same today. Since 1996, she has answered questions from internal customers regarding Medicare policies.

The Union highlighted some changes in the customer service intake specialist job while questioning Hasselman. For example, the intake specialists may work with more or different departments than in 1996 when they only accepted referrals for Health Partners patients, and did not deal with other providers. Because they only dealt with Health Partners then, they did not need to get prior authorizations, whereas sometimes now they do. Some days, according to Hasselman, she may make 3-4 calls a day regarding prior authorizations, others she may make none. In addition, since 2000, the customer service intake specialists have acted as a liaison for contracted vendors. Prior to 2000, this function was not performed by intake specialists. During the hearing, the Union also pointed to the new computer system as evidence of significant change. Hasselman testified, however, that the information that she compiles now is the same, it is just conveyed via computer rather than via paper.

In 1996, Hasselman reported to Office Systems Supervisor Mary Karnes. Now she reports to Tori Sahnaw, who is the Senior Customer Service Intake Specialist.

Staffing Coordinators

The primary function of the staffing coordinator is to receive a hospice or home care referral from the intake specialists and then assign the referral to a registered nurse, social worker and/or home health aide on the appropriate geographic team. Prior to July 2001, this classification was referred to as case management assistant. During the hearing there was some confusion over which job description applied to the position as it existed prior to July 2001. I conclude, however, that Employer Exhibit #37 accurately reflects the job description of the case management assistant classification, which was the classification that preceded the staffing coordinator classification. Moreover, it is apparent, that the job descriptions for the case management assistant and staffing coordinator classifications are nearly the same. For example, #1 under "Accountabilities" (which was described as the primary function) on both documents states: "Staffs all [continuing care] cases by either assigning to team, or finding appropriate vendor agency to assume care of the case in an efficient, accurate and timely manner. Uses current technologies to communicate caseload assignments and schedules when appropriate."

Staffing Coordinator Kimberly Hansen further supported the lack of change in duties at the time that the title of the job changed. She testified that when she was hired in 1998 her title was case management assistant. With respect to most of her current job functions, Hansen testified that she performed them in 1998 and continues to

perform them today. Specifically, Hansen testified that she receives hospice referrals from the intake specialists, contacts the patient and verifies the address and sets up a date and time for the initial assessment. She then assigns a nurse to do the assessment along with a social worker and case manager and voice mails everyone to inform them of their involvement with the case. These are the same duties that she performed when she started, although she says she is much busier now. She further testified that she sets up services for patients with contracted home care providers when necessary and provides those agencies with the relevant information regarding the patient. She has done this since she started.

According to Hansen, a primary difference from when she started is the advent of the new computer system that enables the staffing coordinators to do electronically, what used to be done on paper. Additionally, she acknowledged that she now calls the client or family member directly to set up the initial assessment much more frequently now than in 1998. In 1998, the only time she would make these initial calls was if the nurse was unable to get a hold of the client or called her to ask for help.

Currently there are two staffing coordinators, neither of whom holds an LPN or RN license. At the time of the job title change, the employees' supervisor remained the same, as did their compensation and benefits.

Applicable Legal Standard – Historical Exclusion

The Employer urges that both the customer service intake specialist classification and the staffing coordinator classification have been historically excluded from the unit, and the unit cannot be clarified now to include these classifications, unless the Union

establishes recent and substantial changes in the duties and responsibilities of the positions. Contrary to the Employer, the Union's argument for inclusion is based strictly on community of interest factors. The Union does not address in its brief the Employer's claim that these classifications have been historically excluded from the bargaining unit.

Board law is clear that where a classification has been historically excluded from a unit, it cannot be added by means of accretion. Ziegler, Inc., 333 NLRB No. 114, slip op. at 2-3 (2001) (and cases cited therein). I find that since the two classifications at issue here clearly have been historically excluded from the unit, that a community of interest analysis is not appropriate. Moreover, there is no evidence to establish that these classifications have undergone recent, substantial changes in the duties and responsibilities of the employees so as to create real doubt as to whether the employees in the classification continue to come within the exclusion. Robert Wood Johnson University Hospital, 328 NLRB 912, 915 (1999). Whatever changes exist are minor in nature and a result of improvements in technology and expansion of the customer base, and are not the kind of changes which would justify clarifying the unit to include these employees whose job functions have remained essentially the same since at least 1996. Bethlehem Steel Corporation, 329 NLRB 243,244 (1999) (where job functions remain the same, with separate supervision and little temporary interchange with unit employees, clarification not appropriate where classification has been historically excluded); Hill-Rom Co., 297 NLRB 351 (1989) (technological changes do not warrant removal of positions from unit, where job functions are unchanged), enf. den. 957 F.2d 454, 139 LRRM 2673 (7th Cir. 1992).

The Union presented some testimony by an employee that in 1995 for a year or possibly two, an employee named Cindy Lord, whose title was home care nurse, performed intake functions. The employee also testified that Lord was in the bargaining unit at the time. I find that the testimony regarding this one employee, who may have performed intake functions for a limited period of time, does not establish that unit employees have performed the same functions as customer service intake specialists. The Union has not offered any evidence that bargaining unit employees performed this function consistently, or at any time after sometime in 1996 or 1997. Cf. Premcor, Inc., 333 NLRB No. 164 (2001).

As with the customer service intake specialist classification, the evidence establishes that the staffing coordinator, although now operating under a different title, has been historically excluded from the bargaining unit. The Union did not produce evidence of recent significant change. Any changes that did occur, such as being busier now or using a new computer system, do not constitute significant changes in duties and responsibilities. Although it appears that the staffing coordinators may now have more contact with some unit employees, this is not the kind of substantial change which would compel their inclusion in the unit, particularly when the nature of the job has not changed. See Bethlehem Steel, 329 NLRB at 244.

In conclusion, the petition will be dismissed insofar as it seeks to include in the unit staffing coordinators and customer service intake specialists. There is no evidence that the Union has filed any grievances contending that these positions are or should be included in the existing contract. Absent such evidence, where the evidence is that positions have been historically excluded from the unit, a petition is to be dismissed.

The practical effect of such a dismissal is to continue the exclusion of the staffing coordinators and the customer service intake specialists. See Robert Wood Johnson University Hospital, 328 NLRB at 915, fn. 8.

Research Nurses

Unlike the customer service intake specialists and staffing coordinators, no party contends that the research nurses, or the remaining classifications discussed hereafter, have been historically excluded from any of the units.

According to its post-hearing brief, the Union seeks to include the research nurse classification in bargaining unit III with the other staff nurses. The Employer seeks to exclude this classification from any and all existing units.

The four research nurses were hired specifically to staff a study called the Otitis Media/Maternal Immunization study. This study is being conducted under the auspices of the Health Partners Research Foundation. The purpose of the study is to determine whether giving a certain vaccination to a pregnant woman will then protect her baby from ear infections from 0-6 months. It is a three year study which involves 180 women and their infants, with each research nurse being assigned about 45 patients. Mothers receive the vaccine at some point late in their pregnancy, and the babies receive four subsequent vaccinations after birth. Both the mother and the baby are monitored for any negative effects from the vaccine. The first research nurse was hired in August of 2000. The position requires RN licensure with one year of clinical experience.

As described by Andrew Nelson, Executive Director of Health Partners Research Foundation and Vice President of Research, the mission of the Research Foundation is

to provide leadership and development of research to help Health Partners find new ways to improve health. The Foundation is organized as a 501(c)(3) non-profit organization, and is its own corporate entity. Its funding comes from a variety of sources including government agencies, private foundations, and pharmaceutical companies. It is subject to both state and federal regulations which require it to keep information separate from Health Partners non-research departments. A certain protocol must be followed to ensure privacy and confidentiality of the research subjects. The Foundation has an office suite in Mod C and a separate computer and security system. Approximately 120 employees work for the Foundation, which currently runs about 250 studies.

The research nurses' job entails receiving a list of patients who may be eligible for the study. After reviewing the information (which they access through the computer) on the patients and analyzing for inclusion or exclusion criteria, research nurses contact health care providers to ensure they have no objections to their patients participating in the study. Then the research nurses contact the patients directly, usually by phone. The research nurses then go through a highly rehearsed and regulated process of explaining the study, and answering questions. They may even meet with patients. If patients consent to participate in the study, the nurses then review the enrollment process, which includes extensive information gathering and comprehensive data collection about their health histories.

During the course of the study, the research nurse administers the vaccination to the mother and gives the infant four separate vaccinations after birth. These vaccinations take place at the clinic where the patient is seen. Over the course of the

study each research nurse will give approximately 225 injections. Although it is not clear from the record, the research nurse may also take several blood draws from the mother and infant. However, this function may also be performed by unit nurses or laboratory technicians, who are represented by the Union. Additionally, a sample of the mother's milk, if she's breastfeeding, is taken a couple months after birth. It is unclear who collects this sample. The research nurses may have contact with the bargaining unit staff to coordinate visits and vaccinations, and have some contact with bargaining unit employees when they go to the clinics to give the vaccinations. As the Union correctly noted at hearing, these are the same patients that bargaining unit nurses otherwise care for.

Nelson testified that the research nurses would primarily work with project coordinators at the Research Foundation, with the FDA, with the University of Minnesota, and with drug companies that are involved in the study. He estimated that a very small percentage of the research nurses time, less than one percent, is spent administering the vaccinations. He further stated that no Union employees have ever substituted for research nurses or administered the vaccine, and that either event would be a violation of protocol. Additionally, no research nurses have ever substituted for bargaining unit nurses. The vaccine for the study is kept on-site at individual clinics. Thus, the vaccine is stored in the clinic pharmacies which are staffed by bargaining unit pharmacists.

The research nurses are supervised by Julie Toth, who is the research coordinator. She also supervises research specialists, who are not represented by the Union. According to Nelson, no employees in the Foundation are represented by the

Union. It is unclear from the record whether, at the end of the study, the research nurses will be retained or laid off.

Care Coordination Specialists (telephonic) and Care Coordination Specialist (telephonic) Assistant

The job functions of these two classifications are closely related, and the two classifications of employees work in the same department. In the attachment to its petition, the Union contends that the care coordination specialist (CCS) should be included in Unit III and the Care Coordination Specialist Assistant (CCSA) should be included in Unit II. However, in its brief the Union claims that both groups share a community of interest with the nurses in Unit III.

The CCS and the CCSA both work in the case management department, under the inpatient case management section. They work at the 8100 Building, sixth floor. Both classifications are supervised by Barbara Bailey, who is the supervisor for inpatient case management. Bailey also supervises a group of clerical support staff, and some CCSs who work in hospitals. Bailey does not supervise any employees represented by the Union.

Bailey described the inpatient case management function as a coordination of the care and discharge planning for patients who are hospitalized. Thus, the department is responsible for discharge planning, which is then turned over to the outpatient case management team. The team then follows patients after they are released, ensures that patients have the appropriate referrals, and are otherwise getting the appropriate care after their discharge. The employees who perform the actual outpatient case management are all registered nurses, and they are called outpatient

case managers. Catherine Sherman, who is the outpatient case management supervisor, supervises those employees. The Union does not represent the outpatient case managers.

The CCSs at corporate headquarters provide utilization management, care coordination and discharge planning services for Health Partners members who are patients in hospitals where there is no CCS on-site, including out-of-state facilities. According to the job description, this position requires current Minnesota nursing licensure and a minimum of three years experience as an RN. The job functions of the CCS include calling the utilization review department at the hospital, and asking for clinical information regarding the patient's status, the orders, the plan of care, and discharge needs. Then the CCS would compare the information with the Employer's guidelines and then enter the information into the computer. The CCSs work with the social workers (employed by the hospital) and the discharge planners to help with providing care upon discharge. They have interaction with nurses in the quality utilization improvement (QUI) department when notifying them that they are sending a patient out to a skilled nursing facility or to home care. The Union does not represent the QUI nurses. The CCS also interacts with the on-site case managers when dealing with a complex patient. Bailey testified that the work performed by the CCSs and the CCSs on-site is almost exactly the same, the only difference being physical location of the employees. The primary function of the CCS on-site is to review the medical records of Health Partners Medical Group patients on a daily basis and compare it to the inpatient guidelines that the Employer has to see if the patient is progressing according to the guidelines, and identify and work out potential delays. They are also responsible

for care coordination and discharge planning. The CCSs working at corporate headquarters get the information regarding the patient over the phone rather than by looking at a chart. The CCSs on-site are not represented by the Union.

No employee represented by the Union has ever substituted for a CCS, and no CCS has ever filled in for someone represented by the Union. However, two CCSs are former bargaining unit nurses.

Frances Tufvander is the only employee who currently holds the position CCSA. According to the job description, this position requires a LPN degree and current license, with three years clinical experience. Tufvander's job is to assist the CCSs. Every day she goes through the active case report which indicates every Health Partners patient that is hospitalized. She then determines whether a patient needs to be added to the list of patients serviced by the CCSs. She will then call the utilization review department and ask for a clinical review to be called in to the appropriate nurse. Then she will notify the CCS that she has been assigned a patient. She also follows unwell newborns until they get their own identification number and then assigns them to a CCS. Tufvander has daily interaction with the CCSs, with member services, and with employees in the admissions department. She may have occasional interactions with the on-site case managers, but never with employees represented by the Union. When Tufvander is absent, one of the CCSs fills in for her.

Applicable Legal Standard - Accretion

The Union contends that the legal standard for determining unit placement is whether or not the new employees "share common interests" with the unit employees.

John B. Scripps Newspaper Corp., 329 NLRB No. 74 slip op. at 4 (1999). It urges that I look at a variety of factors including compensation, work hours, supervision, qualifications, skills, training, job functions, location, work contact, integration, interchange and bargaining history. However, in the Scripps case, the unit was defined by the work performed, and as such the unit description was accorded special significance. Two other cases cited by the Union, Phoenix Resort Corporation, d/b/a the Phoenician, 308 NLRB 826 (1992) and J.C. Penny Company, Inc., 328 NLRB 766 (1999) in support of its position, involve community of interest analysis in a pre-election proceedings.

The Employer asserts that the legal standard for determining unit placement for newly created positions is restrictive and that a valid accretion will occur “only when the additional employees have little or no separate group identity...and when the additional employees share an overwhelming community of interest with the preexisting unit to which they are accreted.” The Employer cites three cases, Super Valu Stores, 283 NLRB 134, 136 (1987); Towne Ford Sales, 270 NLRB 311 (1984); and Union Electric Co., 217 NLRB 666, 667 (1975). In these cases, the Board applied a restrictive policy because to do otherwise would compel a group of employees to be included in an overall unit without allowing the employees the opportunity of expressing their preference in a secret election. Thus, I conclude that the Employer is correct when it argues that I should apply restrictive accretion standards.

Applying accretion principles, it is clear that none of the three classifications should be included in any unit represented by the Union.

With regard to the research nurses, the only evidence supporting the Union's position is that they are required to be licensed as are nurses in the unit, that they give injections to patients as do nurses in the unit, and that there is some interaction with unit employees when the research nurses go to the clinics to retrieve vaccine and administer the injections. However, the testimony establishes that the research nurses spend a very small amount of time actually giving injections. Moreover, it is clear that the Employer employs other licensed registered nurses who are not represented by the Union.

Important to my conclusion regarding research nurses is that the focus and operation of the Research Foundation is completely different from the health care clinics. The Foundation is focused on developing and improving medical science through research. Unlike the unit RNs, whose focus is on providing direct patient care, the research nurses primary function is to aid in a specific research project by recruiting and screening subjects for eligibility and obtaining informed consent, collecting data, administering the vaccine, and monitoring the electronic record for adverse reactions. Particularly compelling are the undisputed facts that research nurses are separately supervised, and have no interchange and little interaction with unit employees. Research nurses are officed in separate facilities and work for a separate corporation which has different funding sources than the Employer. For all these reasons, I find that the research nurse classification should be excluded from any unit represented by the Union.

With respect to the CCSs and CCSA, the Union claims that they have functions similar to the bargaining unit CareLine nurses. With respect to CareLine nurses, there

are distinct differences between their job functions and those of the CCSs. As the Union acknowledges, the CareLine nurses use their expertise to make diagnoses and recommend treatment over the phone. On the other hand, the CCSs review the appropriateness of outpatient care, not through contact with the patient, but through contact with hospital staff. They make no recommendations regarding treatment, but only review the appropriateness of the care the patient is receiving. With respect to both positions, the Union points to the fact that they must have licenses, as must unit nurses. While it is true that both the CCS and CCSA positions require RN or LPN licenses, this itself is not enough to compel the inclusion of these two groups of employees into an existing unit, particularly as not all RNs and LPNs employed by the Employer are otherwise represented by the Union.

Most important to my conclusion that CCSs and the CCSA should be excluded from Unit III are the undisputed facts that the CCSs and CCSA are separately supervised from unit employees; that the Union represents no employees in the inpatient care management area, which employs the CCSs and CCSA; that there is no evidence of day to day interchange; and that there is little evidence of interaction between these two classifications and employees represented by Union. Never explained by the Union is its justification for seeking the CCSs employed at corporate headquarters, but not the CCSs employed by the Employer in hospitals.

ORDER

IT IS HEREBY ORDERED that the petition in Case 18-UC-378 is dismissed.

IT IS FURTHER ORDERED that the petition in Case 18-UC-377 is dismissed insofar as the Union seeks to include customer service intake specialists and staffing coordinators, as I conclude that they have been historically excluded from any units represented by the Union.

Finally, **IT IS HEREBY ORDERED** that both the technical unit (Unit II) and the office, staff and Careline registered nurse unit (Unit III), both exclusively represented by Minnesota' Health Care Union, SEIU, Local 113, be, and they hereby are, clarified to specifically exclude care coordination specialists (telephone), care coordination specialist (telephone) assistants, and research nurses.²

Dated at Minneapolis, Minnesota, this 23rd day of January, 2003.

Ronald M. Sharp, Regional Director
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² 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, D.C. 20570. This request must be received by the Board in Washington by **February 6, 2003**.