STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

REGENTS OF THE UNIVERSITY OF CALIFORNIA, Employer, and UPTE, CWA LOCAL 9119, Exclusive Representative.	Case No. SF-UM-626-H PERB Decision No. 2107-H May 10, 2010

Appearances: Littler Mendelson by Robert G. Hulteng, Joshua J. Cliffe, and Joshua D. Kienitz, Attorneys, for Regents of the University of California; Leonard Carder by Katherine Hallward, Attorney, for UPTE, CWA Local 9119.

Before Dowdin Calvillo, Chair; McKeag and Wesley, Members.

DECISION

DOWDIN CALVILLO, Chair: This case is before the Public Employment Relations Board (PERB or Board) on exceptions filed by the Regents of the University of California (UC) to the proposed decision of an administrative law judge (ALJ). The unit modification petition filed by UPTE, CWA Local 9119 (UPTE), sought to place all case manager classifications for which registered nurse status is not a job qualification in the bargaining unit represented by UPTE and place those case manager classifications for which registered nurse status is a job qualification in the bargaining unit represented by the California Nurses Association (CNA).[1] The ALJ found that the case manager classification shares a community of interest with classifications in the unit represented by UPTE and ordered that unit modified to include all case manager positions, except for certain supervisory positions.

[1] CNA joined in UPTE's second amended petition but is not a party to this appeal.

The Board has reviewed the proposed decision and the record in light of UC's exceptions, UPTE's response to the exceptions, and the relevant law. Based on this review, the Board affirms the unit modification as ordered for the reasons discussed below.[2]

FACTUAL BACKGROUND

When PERB established the systemwide bargaining units for UC in 1982, it divided non-physician health care professional classifications into two units. Registered nurse (RN) classifications received their own unit (NX unit) while all other non-physician health care professional classifications were placed in a residual unit (HX unit). (*Unit Determination for Professional Patient Care Employees of the University of California* (1982) PERB Decision No. 248-H.) The HX unit currently includes approximately 4,000 employees in such classifications as physician assistant, pharmacist, dietician, clinical laboratory scientist, physicist, nuclear medicine technician, cytotechnologist, clinical social worker, social work associate, child development associate, child life specialist, occupational therapist, recreation therapist, music therapist, psychologist, audiologist, speech pathologist, orthopedist, genetic counselor and psychometrist.

[2] UC requested oral argument in this matter. Historically, the Board has denied requests for oral argument when an adequate record has been prepared, the parties had ample opportunity to present briefs and have availed themselves of that opportunity, and the issues before the Board are sufficiently clear to make oral argument unnecessary. (*United Teachers of Los Angeles (Valadez, et al.)* (2001) PERB Decision No. 1453; *Monterey County Office of Education* (1991) PERB Decision No. 913.) Based on our review of the record, all of the above criteria are met in this case. Therefore, UC's request for oral argument is denied.

Case Manager Job Duties and Functions

The principal duties of employees in the Case Manager group[3] at issue in this case are utilization review, discharge planning and overall care coordination. Some case managers perform more specialized roles, such as assessing the need for patients to transfer to a UC medical center from another facility or analyzing treatment data to maximize reimbursement rates from third-party payors.

Utilization Review

Third-party payors (i.e., the government, through Medicare and Medicaid, and private insurers) require documentation of conditions presented and treatments administered. This documentation must be entered in the patient's chart with adequate detail and accuracy for reimbursement purposes. Case managers retrospectively review the recorded conditions and treatment interventions to ensure that they justify the length of stay in the hospital, particularly in its high-cost units. Medicare reimbursement is governed by a published guidance for utilization review ("Interqual") which many case managers are required to understand and apply. Interqual methodology, which has also been adopted by many private insurers, determines the level of services for reimbursement purposes based on severity of illness and intensity of service. Reimbursement criteria for patients admitted for observation without a confirmed diagnosis are strict and require close monitoring.

Case managers also monitor patients' movement through the hospital as their conditions and diagnoses change. The goal is to ensure not only that the severity of illness and

[3] The parties stipulated that the Case Manager group consists of "those currently unrepresented health care professional employees (both RN and non-RN) working as 'Case Managers' (and related variations on that title), including but not limited to all employees systemwide in the 9170 payroll code and those 'AN IIIs' [Administrative Nurse III] working as Case Managers at the UCSD Medical Center. The duties assigned to this group of employees include but are not limited to discharge planning and/or utilization review or some combination of the two."

intensity of service are fully documented, but that the in-patient status level is appropriate to those indicators. Communication with the insurer regarding the patient's condition may occur on a daily basis and usually occurs when authorization to transfer to another facility is required.

Discharge Planning

In theory, discharge planning for the case manager begins as early as admission to the hospital. The case manager begins by investigating post-discharge placement options, the patient's insurance status, and the patient's family support system. Medical equipment needs for in-home use will be investigated and arranged, as will in-home procedures like wound dressing. Discharge planning activities include arranging for ambulance transportation, and securing admission to skilled nursing care facilities, acute rehabilitation centers, and hospice care. Coordination of the services of therapists of various types may also be involved.

A psychosocial patient assessment is a critical part of the process, including assessment of the patient's functional independence, family dynamics, relevant behavioral observations, and coping mechanisms. Discharge becomes problematic when the patient is uninsured, homeless, mentally ill, has exhausted Medicare skilled-nursing-care benefits, or has no suitable placement options. Identification of abuse in the home may require referrals to social workers for professional assessment. Discussion and completion of advance directive forms often fall to case managers. In this regard, case managers function like clinical social workers, with whom they work closely, in addressing such issues as income and health insurance maintenance (e.g., identifying the need for, and assisting in securing, Family Medical Leave Act and COBRA benefits).

Care Coordination

Care coordination is the overarching concept of case manager work. Case managers monitor the patient's stay and serve as the primary point of contact for the patient and the patient's family. The utilization review phase focuses on dynamic review of the patient's diagnosis and course of treatment, while discharge planning focuses on coordinating hospital care with post-discharge care. This coordinative function emphasizes monitoring the various phases of treatment, particularly where more than one hospital department is involved or complex discharge plans are required. In these cases, physicians in different departments are assisted by communication regarding progress through different treatment specialties. A case manager may be responsible for coordinating the transfer of a patient within the hospital from a higher level of service to a lower one. Also, in teaching hospitals especially, where residents rotate through hospital floors irrespective of the patient's particular course of care and bedside nurses rotate through their eight-hour shifts, seamless health care delivery benefits significantly from the enhancement of this function. One case manager described the care coordination component of her work as focusing on the needs of the patient and patient's family to ensure that all services required have been arranged by the time of discharge (i.e., "pulling the plan together" or "bringing the plan to life").

At medical centers like UCLA and UC Irvine, the coordination component embodies a greater emphasis on facilitating or "managing" the work. At these medical centers, case managers oversee discharge planning, delegating many of the necessary tasks to support staff. These positions typically serve more as a "hub" or "quarterback" of the patient care process and in theory allow (and expect) the case manager to operate more as a peer with the providers.

Division of Tasks

In the blended positions, case managers divide their time between discharge planning, utilization review and care coordination, with the proportion allocated to each varying based on the type of patient, hospital service, and course of treatment. Thus, in departments where an initial admission is authorized for a minimum number of days, utilization review is lighter because the admission review is completed on the first day and not subject to continual review thereafter. In offering an across-the-board estimate, one case manager estimated that case managers spend about 40 to 50 percent of their time on discharge planning. The record suggests that utilization review time is somewhat less overall. Care coordination constitutes the balance of the work.[4] A typical case manager splits his/her time equally between interacting with patients and their families, desk- and paper-work, and communication with the interdisciplinary team.

UC Davis is unique among the medical centers in having moved toward a further division of labor, separating utilization review from discharge planning. Within the utilization review side of the Department of Patient Care Services, government coverage is further differentiated from private insurance. Yet another group of case managers in the Department of Managed Care conducts medical necessity reviews of the population of capitated patients (25 percent of all patients at the medical center) falling under the umbrella of the UC Davis medical group's managed care network. They determine if a service is authorized under the patient's plan, and if not, issue a denial of the referring physician's request for services (e.g.,

[4] Witnesses offered estimates ranging from 20 to 85 percent for discharge planning and from 15 to 50 percent for utilization review. UCLA's Santa Monica facility represents the 85-discharge-planning/15-utilization-review split. UCSF case managers described their work as a 50/50 split. Utilization review is higher for pediatrics because of the need to verify a qualifying diagnosis, and is very high for bone marrow transplant patients for whom daily review is required. The low of 20 percent for discharge planning is associated with UCLA case managers who delegate the implementation of discharge tasks to support staff.

elective surgery not qualifying for admission on an in-patient basis). This function is primarily a reimbursement function, and as distinguished from most case managers, places them more in an adversarial role as representative for the payors.

UC Davis also employs transfer center case managers, positions specializing in communication between other medical facilities to screen and act on requests to transfer into the hospital. The center is a central point for identifying patients qualifying for emergent care, presenting conditions appropriate for teaching purposes, and needing the higher level of care which UC Davis provides as a Level I trauma center. This screening includes obtaining information on medical conditions as well as discharge planning needs. For example, the transfer center case manager may direct a patient needing intravenous-line (IV) therapy to a skilled-nursing facility rather than allow admission to the hospital because the underlying condition does not qualify for reimbursement. Case managers consult closely with physicians on these cases and refer to detailed written guidelines. These case managers are also responsible for monitoring hospital patient anti-dumping obligations under the federal Emergency Medical Treatment and Active Labor Act. The position involves a lot of "customer service" in terms of dealing with outside parties.

Specialization of another kind is found in the diagnostic related group (DRG) case managers, employed at UC Irvine and UC San Diego, and soon to be employed at UC Davis. These case managers, like transfer center case managers, are not assigned caseloads. This form of utilization review focuses on chart review but is more analytical in nature. DRG case manager chart review focuses on patients grouped by severity of illness because group patient acuity is a predictor of hospital mortality rates. Accurate and prompt determination of patient acuity at admission as well as secondary diagnoses are expected to result in improved mortality rates and thereby improve cost-effective delivery of care. The low mortality rates in relation to

patient acuity permit the medical center to be rated competitively with other hospitals in terms of quality assurance aspects of care. DRG case managers are responsible for identifying and communicating chart documentation recommendations directly to the providers, often going out on the floors to correct identified problems. The position is limited to individuals with an RN license. At one medical center, interchangeability between utilization review case managers and DRG case managers is being achieved through cross-training.

Qualifications, Training and Skills

Case management is an acquired discipline that involves a unique blending of nursing and social work skills. There is no academic degree or professional schooling for such work but some case managers hold a certificate from the American Case Management Association in the discipline. The membership of the American Case Management Association is a mix of those with nursing degrees and those with social work degrees. The presidency of the organization alternates between disciplines. One case manager testified that she looks to this type of organization to advance her understanding of the field.

Each of the medical centers has developed qualifications for the case manager position incorporated in its job descriptions and job postings. At UCSF and UC Davis, most of the positions require either a nursing degree (either bachelors or masters) or a masters of social work degree; they do not require RN licensure. At UC Davis, transfer center case managers must have an RN license. For utilization review positions, an RN license is preferred.[5] At UCLA, which, like UCSF, has only the blended positions, the job descriptions have been written to require active RN licensure. At UC Irvine and UC San Diego, all of the positions

[5] The job description states that graduation from a nursing school is required, as is experience in an acute care setting, though discharge planning or case management experience may substitute for the experience requirement. All utilization review case managers in the UC Davis Patient Care Services Department are currently RNs.

are limited to RNs with active licensure. Despite the RN requirement at UC San Diego and UCLA, each employs a case manager (in UCLA's case, two) performing the full range of duties who is classified as a social worker.[6]

Both the UC San Diego and UCLA managers conceded that the RN license requirement could be dispensed with based on industry practice. UCLA had a practical reason for the limitation: the decision to avoid a jurisdictional dispute with UPTE over unit placement. Even if RN licensure were never to become a requirement systemwide, it would likely be a preferred background at the majority of medical centers because of the ease of new employee orientation, particularly in regard to utilization review. Still, much of utilization review is administrative in character in that the case manager is not interpreting medical information or symptoms. Rather the case manager is checking the chart for specific benchmarks for severity of illness and intensity of service, such as frequency of taking vital or neurological signs in physician orders to nurses, types of medication prescribed, and symptoms recorded.

In hiring, UC medical center managers look primarily for prior case manager work experience, preferably in an acute care setting. Though such experience often consists of case management work itself, the critical components are the ability to work in a fast-paced environment with understanding of UC's complex institutional requirements, think critically, exercise independent judgment, problem-solve, respond to multiple demands and crisis situations, and communicate effectively with health care professionals, third-party financial representatives, patients, and family members. At facilities where the position conforms to the blended-discipline model, care coordination managers do not distinguish between those with RN backgrounds and those with social work backgrounds. In-patient social workers at UCSF

[6] In UC San Diego's case, a social work background was preferred due to the nature of the position - in a dialysis unit - and necessity for specific relevant experience.

also perform discharge planning, and the manager there believes that social workers have many of the same skills as case managers, such as crisis management, communication, and problem-solving.

Due to the specialized nature of case manager work, the medical centers have established extensive training and orientation regimens lasting up to six months. UC Irvine described its training for hires without prior case manager experience as an apprenticeship. This training typically consists of "shadowing" an experienced case manager. Such training is necessary regardless of the employee's prior experience as an RN or social worker. Because of the highly technical nature of their work, DRG case managers undergo an additional 120 hours of training beyond what other case managers receive. Indeed, only current case managers are eligible to move into a DRG case manager position.

There is a significant degree of similarity in terms of skills and technical knowledge between case managers and both NX and HX unit members. There was considerable testimony that RNs, social workers, and case managers view themselves as patient advocates, and indeed those who are licensed RNs are obligated by the nursing practice statute to conduct themselves professionally as such. Case managers, RNs and social workers have similar skill sets in terms of psychosocial assessment ability. To the extent case managers advocate and arrange for care and assist patients and their families to navigate through the hospital stay, they do closely resemble clinical social workers in the more general sense.

Employee Interchange and Interaction

Due to the specialized nature of the case manager position and because the medical centers look for candidates with prior case management experience, there is limited movement into the position by employees in the HX and NX units. Although many case managers may have previously worked as RNs or clinical social workers, voluntary movement out of the case

manager position to RN or social work positions was not indicated in the record, perhaps owing to the higher compensation levels.[7]

Generally, clinical social workers, or other similar HX unit employees, do not substitute for case managers in cases of absence or staff shortage, or vice versa. However, to the extent that several of the medical centers have recruited case managers from the ranks of clinical social workers, there is potential for substitution. Two medical centers acknowledged limited use of social workers to substitute or fill-in on weekends for case managers but generally not for the utilization review aspects. UCLA contracts with a case manager registry for additional staffing needs.

Due to the specialization of function of the health care professionals on the treatment team, contact and interaction between case managers and other health care professionals varies depending on the course of treatment and department. But it can be said that there is regular interaction between the case manager as the hub (or at least shared hub - with bedside nurses) and other HX unit professionals, because of the need to coordinate the array of services provided as the patient moves toward discharge. In discharge planning, the case manager takes the lead of a team that typically includes a social worker, therapists, attending nurses, physicians, and patient service representatives from the financial department. For example, a case manager will consult with the bedside nurse for the purpose of confirming that, prior to discharge, the patient has been educated about medications and how to self-administer them. At UC San Diego, each bedside nurse presents her/his patients daily to a team consisting of the case manager, a social worker and a financial representative. At UCLA, the case manager

[7] From the backgrounds of case managers who testified, it appears that case manager is a career typically undertaken after work as a clinical nurse or social worker, and not vice versa. A number of social workers who previously handled discharge planning transitioned into case manager positions.

"rounds" with the physicians, checking with each patient on the floor. As a general rule, case managers have most frequent interaction with the treating physicians, who direct the patient care.[8] To the extent that staff meetings occur within the care coordination departments, case managers are more likely to have extended interaction with clinical social workers than bedside RNs. Transfer center case managers have regular (telephone) contact with physicians inside and outside of the hospital, discharge planners, nursing staff, and staff who monitor bed space. By virtue of their focus on diagnosis documentation and corrective action, DRG case managers have frequent interaction with physicians and other case managers.

Working Conditions

Case managers spend a significant amount of time on the hospital floor interacting with patients, their families and the attending health care providers, including nursing staff and other health care professionals (social workers, physical therapists, pharmacists, etc.). Case managers also spend a considerable amount of time away from patients. They are typically assigned an office or cubicle in a location separate from the hospital floor but generally close to where their patients receive care. Their office desk is where they make telephone calls and complete the paperwork associated with the position. They use computers. Not having a caseload, transfer center case managers work in offices devoted solely to this function away from the patient floors.

Case managers work professional hours, meaning they are held accountable for completing all of the tasks associated with the caseload or the position. They generally work a 40-45 hour work week, five days per week, with flex-schedule alternatives available at some medical centers. Demands for weekend case manager coverage are not high, and medical

[8] A UC San Diego case manager testified she interacted 50 percent of the time with physicians, 15 to 20 percent with other case managers, and the same amount with bedside nurses.

centers have varying methods of arranging adequate staffing, such as voluntary rotations and compensated time-off. Transfer center case managers at UC Davis and UC Irvine work on a round-the-clock basis.

With the exception of UC Davis, case managers are salaried. Systemwide they have a wide range of compensation, from a low of approximately $55,000 to a high of $105,000, annually. Compensation depends to some degree on geographic region, with higher top ranges at UCLA and UCSF. There is consistency at the bottom end of the scale. The manner in which compensation is calculated varies, with some medical centers employing an hourly, and others a yearly rate. Case managers as a group are comparable to the more highly compensated classifications in the HX and NX bargaining units (e.g., pharmacists, physician assistants, physicists, nurse practitioners, and nurse anesthetists).

HX and NX unit members, by contract, are entitled to layoff protections, including the protection of seniority. Such provisions do not apply to case managers. But nothing suggests the absence of these protections is driven by operational necessity.

Permanent status employees systemwide are eligible for the same set of retirement benefits (e.g., UC's retirement plan, defined contribution accounts, etc.). The same holds true for access to UC's plans for health and welfare benefits, including medical, dental, vision care, disability insurance, and life insurance.

Departmental Organization and Supervision of Case Managers

The medical centers are organized by service department (intensive care, medical/surgery, cardiology, neurology, etc.). Most case managers are assigned to a specific department or service and a caseload of patients in that department. At the UCLA Santa Monica Orthopedic Hospital, case managers are cross-trained to cover all specialties.

Unlike nursing assignments, which rotate on a shift-basis, there is one case manager for each patient.

Case managers at UCSF, UCLA, UC Irvine and UC San Diego are assigned to a care coordination department.[9] Clinical social workers are also assigned to care coordination departments at UCSF, UCLA, UC San Diego, and UC Davis. Where case managers work in care coordination departments with social workers, they share upper level supervision. Case managers at UC Irvine and a portion of those at UC Davis are assigned to departments consisting solely of case managers. At UC Davis, as distinguished from the other medical centers, case managers handling only utilization review and transfer center case managers are assigned to the division of patient care services, sharing upper level supervision with clinical nurses.

Except for UC San Diego, all care coordination departments ultimately report to the chief medical officer. Chief medical officers are typically responsible for hospital functions such as risk management, licensing, quality assurance, and administrative supervision of the physician staff. At UC San Diego, the department reports to the chief nursing officer. At UC Davis, an organization separate from the medical center, known as the UC Davis Health System (a managed care network), houses utilization review case managers reporting to a nurse manager and ultimately the Managed Care chief medical officer.

[9] UC San Diego's department was named the Clinical Resource Management Department before being renamed Care Coordination. Care Coordination are also the words used in the name for the departments at UCLA and UCSF. UC Irvine's department is the Department of Outcomes, Case Management. UC Davis assigns case managers to two departments, Department of Clinical Social Services and Patient Care Services Department, with only the former department handling discharge planning. Case managers are also assigned to the Department of Managed Care and engage strictly in a form of utilization review.

Establishment and Expansion of the 9170 Case Manager Classification

Because the Case Manager classification did not exist in 1982, it was not considered in PERB's unit determination proceedings for the UC system. In 1994, employees at UC Irvine began performing case management work under the working title of "case manager." This position soon spread to UC San Diego, UCLA, UC Davis and UCSF. UC did not create a new classification for case managers at this time. Rather, it placed these positions in existing non-represented classifications such as Administrative Nurse and Administrative Analyst. UPTE witnesses testified without contradiction that it is the classification, not the position title, that determines bargaining unit placement.

Prior to 1997, the HX unit was unrepresented. In that year, UPTE was certified as the exclusive representative of the HX unit after it prevailed in a consent election. Prior to the election, UPTE and UC negotiated to agreement on the classifications that would be allowed to vote in the election. Case managers were not discussed. Following certification, UPTE and UC began negotiations for a memorandum of understanding (MOU).

In September 1998, UC Irvine submitted a draft proposal to the University of California Office of the President (UCOP) for a systemwide case manager title. UCOP approved the new Case Manager title code of 9170 in September 1999. The classification was not placed in an existing bargaining unit.

UC Irvine reclassified its case managers from Administrative Nurse II to the 9170 Case Manager classification in 2002. The 9170 classification was implemented at UCLA in 2003. UPTE filed a grievance that year asserting that HX unit social workers were being improperly reclassified to the 9170 classification. UPTE agreed to settle the grievance based on UC's representation that the 9170 classification would be limited to employees with RN licensure.

UCSF adopted the 9170 classification in 2004. That same year, UPTE filed a grievance similar to the one at UCLA, alleging that UCSF was improperly reclassifying HX unit social workers to the 9170 classification. Following unsuccessful efforts to resolve the grievance, UPTE filed the instant unit modification petition on May 25, 2005.[10]

UC Davis began to use the 9170 classification in March 2006. On September 27, 2006, UPTE filed an amended petition to include UC Davis case managers and also to allege that UC San Diego was employing a case manager outside of the HX unit. Meanwhile, sometime in mid-2006, UC San Diego reclassified its case managers to Administrative Nurse III (AN III), a classification outside of the HX unit. UPTE filed a second amended petition on January 5, 2007, to include these UC San Diego case managers.

At the time of hearing there were approximately 163 case managers covered by the petition, including approximately 144 classified under the 9170 Case Manager title and the remainder (at UC San Diego) classified as AN IIIs.[11]

DISCUSSION

Neither party has excepted to the ALJ's ruling that the UC Irvine transfer center case manager/supervisor and the three UCLA lead case managers (classified as Clinical Nurse Specialist, Supervisor) are subject to exclusion from the HX unit because they meet the criteria for "supervisory employee" under section 3580.3 of the Higher Education Employer-Employee

[10] UPTE simultaneously filed an unfair practice charge (Case No. SF-CE-757-H) alleging that UC unilaterally transferred work out of the bargaining unit by reclassifying HX unit social workers to the unrepresented 9170 classification. UPTE withdrew the charge when it filed its second amended petition.

[11] Ten of these positions, all at UC Irvine, are listed as per diem employees. The parties' MOUs indicate that per diem employees are not excluded from the unit. However, both acknowledge that maintenance of such status is determined by UC policy, which may vary by campus. No determination is made as to whether the per diem employees at issue here actually meet those requirements.

Relations Act (HEERA)[12]. Nor has either party excepted to the ALJ's conclusion that the remainder of the positions in the stipulated Case Manager group are not supervisory. Accordingly, the ALJ's ruling regarding the supervisory status of the various positions in the Case Manager group remains binding upon the parties, but shall have no precedential effect with respect to other cases. (PERB Regs. 32215 and 32300(c);[13] *City of Porterville* (2007) PERB Decision No. 1905-M; *Palos Verdes Peninsula Unified School District* (1979) PERB Decision No. 96.)

Additionally, it appears that CNA does not wish to participate in this appeal. Although it joined in UPTE's second amended petition and participated in the hearing, CNA did not file exceptions to the proposed decision, nor did it join in UPTE's response to the exceptions or file its own response. Further, UPTE states in its response to UC's exceptions that "CNA and UPTE agreed to support any decision that would place the entire Case Manager group in one bargaining unit if that was how PERB determined the appropriate community of interest." Viewing CNA's inaction in tandem with its purported agreement with UPTE, we conclude that CNA has withdrawn as a party to this matter.

In light of the above, the issue before the Board is whether the positions in the stipulated Case Manager group should be added to the HX unit or remain in non-represented classifications. Before turning to that issue, however, it is necessary to address UC's

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[12] HEERA is codified at Government Code section 3560 et seq. Unless otherwise indicated, all statutory references are to the Government Code.

[13] PERB regulations are codified at California Code of Regulations, title 8, section 31001 et seq. PERB Regulation 32215 provides, in relevant part: "Unless expressly adopted by the Board itself, a proposed or final Board agent decision, including supporting rationale, shall be without precedent for future cases." PERB Regulation 32300(c) provides in full: "An exception not specifically urged shall be waived."

contention that PERB should deny UPTE's petition even if the Case Manager group meets the statutory criteria for inclusion in the HX unit.

1. UC's Contentions Regarding the Unit Modification Petition

UC contends that PERB should deny UPTE's petition because: (1) UPTE waived its right to file a unit modification petition because it did not file the petition immediately upon learning of the creation of the case manager position; and (2) UPTE failed to show proof of majority support among the employees it seeks to add to the HX unit.

a. Waiver

UC claims that UPTE was aware of the 9170 Case Manager classification at least as early as 1999, and certainly no later than 2003, yet did not file a unit modification petition until May 2005. UC also points out that UPTE failed at the bargaining table in 2003 to have case managers included in the HX unit. According to UC, both the filing delay and the inability to obtain the unit modification through bargaining constituted a waiver of UPTE's right to file the instant petition.

HEERA section 3563, subdivision (a) grants PERB the authority "[t]o determine in disputed cases, or otherwise approve, appropriate units." PERB's unit modification procedure is the proper mechanism by which to resolve disputes over unit placement. (*The Regents of the University of California* (1989) PERB Decision No. 722-H.) Parties cannot divest PERB of its jurisdiction to resolve such disputes. (*Trustees of the California State University* (2005) PERB Order No. Ad-347-H; *Hemet Unified School District* (1990) PERB Decision No. 820.)

In *Hemet Unified School District*, *supra*, the classified employee organization and the school district agreed in writing to exclude certain classifications from the bargaining unit. The employee organization then filed a unit modification petition with PERB to add those classifications to its unit. The Board held that "PERB is empowered to resolve any unit

placement 'disputes' and the parties cannot, by agreement or otherwise, divest the Board of such jurisdiction." Thus, a party's right to file a unit modification petition seeking to add unrepresented classifications to an established bargaining unit, and PERB's authority to resolve the underlying placement dispute, cannot be waived either expressly or by implication. Moreover, neither HEERA nor PERB Regulations establish a specific time period in which such a unit modification petition must be filed. (Cf. HEERA § 3577, subd. (b) [listing time periods for filing initial representation petition]; PERB Reg. 32776(c)-(g) [listing time periods for filing decertification petition]; PERB Reg. 51680(b) & (c) [listing time periods for filing severance petition under HEERA].) Accordingly, UC's claim that UPTE waived its right file the instant petition is without merit.

b. Proof of Majority Support

UC also asserts that UPTE's petition must be denied because it was not accompanied by proof of majority support among the employees sought to be added to the unit. UC argues that proof of majority support is required by PERB regulations, National Labor Relations Board (NLRB) case law and the doctrine of employee free choice.

i. PERB Regulation 32781

PERB Regulation 32781 governs petitions for unit modification. UPTE's petition was filed under subsections (b)(2), which authorizes PERB "[t]o make technical changes to clarify or update the unit description," and (b)(3), which authorizes PERB "[t]o resolve a dispute as to unit placement or designation of a new classification or position." Though not cited in UPTE's petition, subsection (a)(1) authorizes PERB to "add to the unit unrepresented classifications or positions."

UC argues that subsection (e)(1) of the regulation gives PERB discretion to require proof of majority support for UPTE among the Case Manager group. However, PERB case law and the regulation's history do not support UC's interpretation of subsection (e)(1).

In *State of California, Department of Personnel Administration* (1989) PERB Decision No. 776-S, an employee organization filed a unit modification petition to add approximately 2,000 unrepresented employees to a unit of approximately 9,000 employees, an increase of slightly more than 22 percent. At that time, PERB Regulation 32781(f) allowed PERB discretion to require proof of majority support on a case-by-case basis. Noting that PERB had consistently required proof of majority support when a petition "seeks to add a substantial number of employees to an established bargaining unit," the Board upheld the regional director's determination that proof of majority support among employees in the classifications to be added to the unit was required because the addition of so many employees "would constitute a substantial change in the structure of that unit," thereby creating a question concerning representation.[14]

In 2006, PERB amended the regulation to incorporate the "ten percent rule" from *State of California, Department of Personnel Administration, supra.* The amendment was intended

> to eliminate ambiguity and add clarity regarding when majority proof of support is required for a petition that seeks to add unrepresented positions to a unit. Section 32781(e) . . . states that PERB "may require" such support, but the regulations do not provide criteria for when PERB "should" require support. Use of a standard whereby support was required if the positions to be added equal 10 percent or more of the number of employees in

[14] A "question concerning representation" arises when there is a legitimate doubt about whether the union has majority support in the bargaining unit. (See *International Union of Operating Engineers, State of California Locals 3, 12, 39 and 501, AFL-CIO (California State Employees' Association, SEIU, AFL-CIO)* (1984) PERB Decision No. 390-S [decertification petition raises question concerning representation]; *Pittsburg Unified School District* (1983) PERB Decision No. 318 [representation petitions filed by competing employee organizations created question concerning representation].)

> the established unit was approved in a Board decision (*State of California, Department of Personnel Administration* (1989) PERB Decision No. 776-S) but never adopted as "the standard" by the Board. The proposed amendments to section 32781 . . . would incorporate the 10 percent standard and make it mandatory.

(Cal. Reg. Notice Register 2005, No. 51-Z, p. 1773.)

Subsection (e)(1) currently provides in full:

> If the petition requests the addition of classifications or positions to an established unit, and the proposed addition would increase the size of the established unit by ten percent or more, the Board shall require proof of majority support of persons employed in the classifications or positions to be added.

UC argues that the 2006 amendment left untouched PERB's discretion to require proof of majority support when the number of positions to be added is less than ten percent of the established unit. We find no such "residual" discretion in the amended regulation.

"[A]dding a large group [of employees] to a preexisting unit calls into question the majority status of the representative in the acquiring unit." (*Salinas Union High School District* (2002) PERB Order No. Ad-315.) In *State of California, Department of Personnel Administration*, *supra*, and subsequent cases, the Board determined that increasing the size of a bargaining unit by ten percent or more through addition of unrepresented positions necessarily creates a question concerning representation. PERB Regulation 32781(e)(1) codifies this determination. The necessary implication from the amended regulation, in light of PERB case law, is that increasing the unit by less than ten percent does not call into question the incumbent union's majority support. Therefore, PERB may not require proof of majority support when a unit modification petition seeks to add unrepresented positions that total less than ten percent of the established unit.

ii. NLRB Accretion Cases

UC argues that proof of majority support among the Case Manager group is required because those positions have been historically excluded from the HX unit. In support of this argument, UC cites NLRB case law that requires a showing of majority support among the positions to be added when the positions have been "excluded for a significant period of time" from the established unit. (*Laconia Shoe Co.* (1974) 215 NLRB 573, 576; *Union Electric Co.* (1975) 217 NLRB 666, 667.)

Contrary to the NLRB, PERB has never considered the length of time the classification was excluded from the established unit in determining whether a showing of majority support is required. Instead, PERB has always looked to the number of classifications or positions to be added to the established unit. (*State of California, Department of Personnel Administration*, *supra*.) Indeed, PERB Regulation 32781(e)(1) makes no mention of requiring proof of support based upon any time period of exclusion from the unit. Therefore, because it appears to be contrary to PERB case law and regulations, we decline to incorporate the rule from *Laconia Shoe*, *supra*, and its progeny into PERB's unit modification procedures.[15]

As UC points out, the Board in *Trustees of the California State University* (2004) PERB Order No. Ad-342-H, quoted the following passage from *Union Electric Co.*, *supra*:

> Unit clarification, as the term itself implies, is appropriate for resolving ambiguities concerning the unit placement of individuals who, for example, come within a newly established classification of disputed unit placement or, within an existing classification which has undergone recent, substantial changes in the duties and responsibilities of the employees in it so as to create a real doubt as to whether the individuals in such classification continue to fall

[15] *Hemet Unified School District*, *supra*, further supports this position. While that case involved PERB's jurisdiction over a unit modification petition, not whether proof of majority support is required, the decision suggests that the parties' conduct with regard to exclusion of particular classifications from a bargaining unit can have no effect on PERB's unit modification procedures.

> within the category-excluded or included-that they occupied in the past. Clarification is not appropriate, however, for upsetting an agreement of a union and employer or an established practice of such parties concerning the unit placement of various individuals, even if the agreement was entered into by one of the parties for what it claims to be mistaken reasons or the practice has become established by acquiescence and not express consent.

Following this quotation, the Board noted that the union could not use a unit clarification petition to bring into the bargaining unit a substantial number of employees who had been excluded from the unit by stipulation of the parties. Later in the decision, however, the Board stated that such a stipulation has no bearing on whether excluded classifications should be added to an established unit pursuant to a unit modification petition, citing *State of California, Department of Personnel Administration* (1989) PERB Decision No. 727-S. In light of the decision's ambiguity on this issue, we cannot conclude that the Board adopted the *Union Electric/Laconia Shoe* rule. However, to the extent *Trustees of the California State University, supra*, can be read to adopt that rule, it is hereby overruled.

For the above reasons, we conclude that the length of time a particular classification has been excluded from the bargaining unit is irrelevant to whether proof of support is required among the positions to be added to the unit pursuant to a unit modification petition. Consequently, we need not decide whether there was an established practice of excluding the Case Manager group from the HX unit.

iii. Employee Free Choice

Finally, UC argues that proof of majority support is required by the doctrine of employee free choice. HEERA sections 3560, subdivision (e), and 3565 grant higher education employees the right to choose which employee organization, if any, will represent them in their employment relations with the employer. However, the Legislature has subordinated this right of employee free choice to the overriding policy of avoiding

proliferation of bargaining units. (*Los Angeles Unified School District* (1998) PERB Decision No. 1267, citing Assem. Advisory Council on Public Employee Relations, Final Report (March 15, 1973) p. 86.) Thus, while employees have the right to choose which employee organization, if any, they want to represent them, they have no right to choose the bargaining unit in which their classification or position is placed. (*Elk Grove Unified School District* (2004) PERB Decision No. 1688; *Salinas Union High School District, supra.*) Accordingly, the doctrine of employee free choice does not compel PERB to require proof of majority support when a unit modification petition seeks to add unrepresented positions that total less than ten percent of the unit to which they would be added.

2. Proper Unit Placement of the Case Manager Group

In determining the appropriate unit placement of a classification, it is necessary to utilize the unit determination criteria from the applicable statute. (*Trustees of the California State University* (2007) PERB Decision No. 1881-H.) HEERA's unit determination criteria are set forth in section 3579, subdivision (a):

> In each case where the appropriateness of a unit is an issue, in determining an appropriate unit, the board shall take into consideration all of the following criteria:
>
> (1) The internal and occupational community of interest among the employees, including, but not limited to, the extent to which they perform functionally related services or work toward established common goals, the history of employee representation with the employer, the extent to which the employees belong to the same employee organization, the extent to which the employees have common skills, working conditions, job duties, or similar educational or training requirements, and the extent to which the employees have common supervision.
>
> (2) The effect that the projected unit will have on the meet and confer relationships, emphasizing the availability and authority of employer representatives to deal effectively with employee organizations representing the unit, and taking into account factors such as work location, the numerical size of the unit, the relationship of the unit to organizational patterns of the higher

> education employer, and the effect on the existing classification structure or existing classification schematic of dividing a single class or single classification schematic among two or more units.
>
> (3) The effect of the proposed unit on efficient operations of the employer and the compatibility of the unit with the responsibility of the higher education employer and its employees to serve students and the public.
>
> (4) The number of employees and classifications in a proposed unit, and its effect on the operations of the employer, on the objectives of providing the employees the right to effective representation, and on the meet and confer relationship.
>
> (5) The impact on the meet and confer relationship created by fragmentation of employee groups or any proliferation of units among the employees of the employer.

In its original UC unit determination proceedings, the Board found the following about the HX unit:

> We find that the employees in this requested unit share a common goal and perform functionally related patient care services. All possess advanced training and experience and/or education which enables them to provide specialized patient care. All work in medical settings, some performing 'hands-on' patient care and others performing vital laboratory functions in furtherance of the common health care goal.
>
> Having granted the requested unit of registered nurses, it is deemed appropriate to grant the requested residual unit. This unit, containing as it does the bulk of the remaining patient care professionals, will serve the statutory goal of avoiding impairment of the University's operational efficiency and avoid potential undue unit proliferation. It will further provide employees with their right to units in which they may be effectively represented.

(*Unit Determination for Professional Patient Care Employees of the University of California, supra.*)

Applying the statutory criteria in light of the Board's earlier findings, we conclude that the Case Manager group is properly placed within the HX unit for the following reasons.

a. Community of Interest Factors

Like members of the HX unit, case managers are involved in patient care in a specialized capacity. Most case managers have patients assigned to them, as do many of the residual health care professionals. Case managers' interaction with patients is more episodic than continuous, another characteristic of HX unit classifications. Case managers do not provide "hands on" patient care like the various therapists in the HX unit. However, they do much of their work in acute care settings alongside physicians, nurses and other HX unit members as part of an interdisciplinary team. Thus, to the extent they work in an adjunct capacity to the direct patient care process by assisting the providers, case managers share much in common with residual health care professional classifications working in a similar capacity.

Case managers also share common skills and duties with HX unit classifications. For example, discharge planning involves psychosocial assessment similar to that performed by clinical social workers in the HX unit. Indeed, UC admitted that it shifted discharge planning duties from HX unit social workers to case managers without any change in those duties. Moreover, at some medical centers HX unit social workers perform discharge planning duties when case managers are absent. To the extent case managers advocate and arrange for care and assist patients and their families navigate through the hospital stay, they closely resemble clinical social workers in the more general sense.

The utilization review and case coordination functions appear unique to case managers. However, in the context of a residual professionals unit, this uniqueness does not preclude finding a community of interest. Many of the classifications in the HX unit share little, if any, duties. For example, audiologists and dieticians have largely different duties and functions yet are both members of the HX unit. Thus, the fact that some but not all of the case manager

duties overlap with those of HX unit classifications weighs in favor of placing case managers in the HX unit.

Case managers also possess advanced educational qualifications and skills like HX unit classifications. Unlike many HX classifications, case managers do not hold a license in their particular field, though some do hold a certificate in the discipline. Most of the case manager positions require either a nursing degree or a masters of social work degree. In hiring case managers, the critical components are the ability to work in a fast-paced environment with understanding of UC's complex institutional requirements, think critically, exercise independent judgment, problem-solve, respond to multiple demands and crisis situations, and communicate effectively with health care professionals, third-party financial representatives, patients, and family members. These qualifications and skills are similar to those required for HX unit classifications.

Case managers share similar working conditions with HX unit classifications. Case managers spend a significant amount of time on the hospital floor interacting with patients, their families and the attending health care providers, including nursing staff and other health care professionals. Case managers generally work a 40-45 hour work week, five days per week, with flex-schedule alternatives available at some medical centers. Case managers do not regularly work weekends but some participate in voluntary rotations to ensure adequate weekend staffing. Only transfer center case managers at UC Davis and UC Irvine work on a round-the-clock basis. With the exception of UC Davis, case managers are salaried. Their compensation is comparable to the more highly compensated classifications in the HX unit (e.g., pharmacists, physician assistants, and physicists). Permanent status case mangers receive the same health and retirement benefits as other UC employees of the same status.

The affinity with the HX unit is also demonstrated by the fact that case managers for the most part have been placed in care coordination departments that are not supervised together with the nursing staff. More often they share supervision with social workers represented by UPTE. For example, at UCSF case managers and social workers are assigned work and evaluated by the same individual. The same holds true for non-RN case managers at UC Davis.

The fact that the Case Manager group is currently unrepresented does not weigh against finding a community of interest. The parties have never agreed, explicitly or implicitly, that case managers do not belong in the HX unit. On the contrary, UPTE has consistently disputed UC's determination that the 9170 Case Manager classification falls outside of the HX bargaining unit. Thus, "the history of employee representation with the employer" is of little relevance in this case.

b. Other Statutory Criteria

Adding the Case Manager group to the HX unit would not have a negative effect on UC's efficient operations. While UC would be required to meet and confer concerning an additional 163 employees, we find this additional obligation minimal in light of the thousands of currently represented employees at UC.

Further, adding the Case Manager group to the HX unit would further the statutory objective of "providing the employees the right to effective representation." UPTE, as representative of a diverse set of occupational groupings, is well suited to managing the dynamics of a pluralistic bargaining unit, and so placement of case managers in the HX unit is likely to ensure responsive yet even-handed representation.

UC contends that application of the statutory unit determination criteria leads to the conclusion that case managers "share a distinct community of interest with each other" rather

than with HX unit classifications. It goes without saying that every occupational group has some internal community of interest. However, in the health care field, only two occupational groups, physicians and nurses, have been found to have such a separate and distinct community of interest that they require placement in their own bargaining unit. (*Unit Determination for Professional Patient Care Employees of the University of California, supra*; *Mercy Hospitals of Sacramento* (1975) 217 NLRB 765.) Following UC's argument to its logical end would result in either the abolition of the HX unit or creation of a separate bargaining unit for each classification within the existing unit. Neither result is consistent with the criteria set forth in HEERA section 3579, subdivision (a) or the overall purposes of HEERA. (*Unit Determination for Professional Patient Care Employees of the University of California, supra* [creation of residual health care professionals unit avoids "potential undue unit proliferation" and provides "employees with their right to units in which they may be effectively represented"]; see *Mercy Hospitals of Sacramento, supra* [noting Congressional intent to avoid undue proliferation of bargaining units in the health care industry].)

Based on the community of interest factors and pertinent statutory criteria, we conclude that the stipulated Case Manager group should be added to the HX unit, an occupationally diverse unit of health care professionals involved in adjunct forms of patient care.

ORDER

For the above reasons and based upon the entire record in this case, it is hereby ORDERED that the unit modification petition of UPTE, CWA Local 9119, to add the positions named in the stipulated Case Manager group to the residual health care professionals unit is GRANTED, with the exception of the UC Irvine transfer center case manager/supervisor and the three UCLA lead case managers classified as Clinical Nurse Specialist, Supervisor.

Member Wesley joined in this Decision.

Member McKeag's dissent begins on page 31.

McKEAG, Member, dissenting: I respectfully disagree with the majority's ruling that the case managers should be put in the HX bargaining unit represented by UPTE, CWA Local 9119 (UPTE). For the reasons set forth below, I believe the unit modification petition filed by UPTE should be dismissed.

HEERA section 3565 provides:

> Higher education employees shall have the right to form, join and participate in the activities of employee organizations of their own choosing for the purpose of representation on all matters of employer-employee relations and for the purpose of meeting and conferring. Higher education employees shall also have the right to refuse to join employee organizations or to participate in the activities of these organizations subject to the organizational security provision permissible under this chapter.

In the instant case, the record shows that the case managers were satisfied with their unrepresented status and had no interest in being represented by UPTE. However, notwithstanding Section 3565, the majority ruling granted UPTE's unit modification petition and ordered the case managers into the HX bargaining unit.

In reaching this decision, the majority concludes that PERB Regulation 32781(e)(1) prohibits the Board from ordering proof of support. I respectfully disagree. PERB Regulation 32781(e)(1), by its express terms, applies only to situations in which a unit modification petition seeks to increase the size of an existing unit by ten percent or more. This regulation, however, is silent regarding situations in which a unit modification petition seeks to increase the size of an existing unit by less than ten percent. In order to preserve the rights afforded by HEERA section 3565, I would find that that the Board possesses the discretion to order proof of support in such cases when there is a legitimate question concerning the representation of the employees who are the subject of the petition.

In the instant case, the record supports the conclusion that the case managers are satisfied with their unrepresented status but, if compelled to join a union, would prefer to be represented by the California Nurses Association. Based on the foregoing, I believe there is a legitimate question concerning the representation of the case managers. Accordingly, the Board should order UPTE to provide proof of support by the case managers.