UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 10, SUBREGION 11

PIEDMONT HEALTH SERVICES, INC.

Employer

and **Case 10-RC-286648**

PIEDMONT HEALTH SERVICES MEDICAL PROVIDERS UNITED

Petitioner

DECISION AND DIRECTION OF ELECTION[1]

Piedmont Health Services, Inc. (the Employer) operates community health centers which provide medical, dental, nutritional, and behavioral health services.[2] On November 23, 2021, Piedmont Health Services Medical Providers United (the Petitioner) filed a petition seeking to represent approximately 50 employees working at ten of the Employer's facilities located throughout North Carolina:

> Included: All community health center medical providers (defined as physicians, nurse practitioners, certified nurse-midwives, and physician assistants) employed by Piedmont Health Services at the Burlington Community Health Center, Carrboro Community Health Center, Chapel Hill Community Health Center, Charles Drew Community Health Center, IFC Health Center, Moncure Community Health Center, Prospect Hill Community Health Center, Scott Community Health Center, Siler City Community Health Center, and Sylvan Community Health Center.
>
> Excluded: All other employees, lead providers, guards, and supervisors as defined by the Act.

The parties stipulated that all petitioned-for employees are professional employees within the meaning of the Act.

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[1] The Petitioner filed this petition under Section 9(c) of the Act. I have the authority to hear and decide this matter on behalf of the Board under Section 3(b) of the Act. I make the following preliminary findings: the hearing officer's rulings are free from prejudicial error and are affirmed; the Employer is an employer engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction; the Petitioner is a labor organization within the meaning of the Act; and a question affecting commerce exists concerning the representation of certain employees of the Employer. Parties were given the opportunity to file briefs, and both parties did so.

[2] The Employer's name appears as amended on the record.

A hearing officer of the National Labor Relations Board conducted the hearing in this matter via videoconference between December 14, 2021, and December 17, 2021.[3]

The Employer asserts that the petition should be dismissed on the ground that all petitioned-for employees are statutory supervisors, primarily based on their authority to responsibly direct other employees. The Employer also argues that the petitioned-for employees effectively recommend hiring, promotion, and discipline of other employees, as well as effectively recommend the adjustment of other employees' grievances and the assignment of work to other employees.[4]

The Employer further asserts that the physicians do not share a sufficient community of interest with the other-petitioned for employees to warrant inclusion in any unit found to be otherwise appropriate.

The final matter before me is the method of election. The Petitioner has requested a mail ballot election, while the Employer prefers a manual election.

I find that the Employer has not met its burden of demonstrating the supervisory status of the petitioned-for employees. I further find that there is a sufficient community of interest between the physicians and the other petitioned-for employees to render the petitioned-for unit appropriate. Finally, based on current Covid-19 data, I am directing a mail-ballot election.

FACTS

The Employer's Structure and Business

The Employer operates ten community health centers that provide medical, dental, nutritional, and behavioral health services. All services are not available at all locations. For example, the Siler, Moncure, Prospect Hill, and Carrboro locations offer dental services. Charles Drew and Chapel Hill do not offer dental services, while IFC offers dental services in a limited capacity. Nutritional services are offered at all sites, but nutritionists cover multiple sites so that nutritional services may not be available at a particular location on a given day. Most sites offer pharmacy services, but some smaller sites use the larger sites' pharmacies. Moncure is the largest site and employs approximately 65 individuals, including at least ten medical providers. By contrast, the Chapel Hill clinic only has two medical providers. Some employees work at multiple sites, and some providers meet with patients virtually.

[3] See *Morrison Healthcare,* 369 NLRB No. 76, slip op. at 2 (2020). The ongoing global Covid-19 pandemic constitutes extraordinary circumstances necessitating the Region to conduct the hearing by videoconference technology.

[4] The Employer asserts in its brief that the petitioned-for employees may also effectively recommend the transfer of other employees, but offers no examples of petitioned-for employees doing so and makes no legal argument in support of its assertion. However, during the course of the hearing, multiple petitioned-for employees testified that they do not have the authority to transfer other employees.

Most clinics are open Monday through Friday, and three clinics are also open on Saturdays. Operating hours vary; a clinic may be open until 1:00 p.m. one day and until 8:00 p.m. the next day.

The Employer's chief executive officer is Brian Toomey, who reports to a Board of Directors. Toomey's direct reports include an executive director, a chief medical officer, a human resources director, a chief financial officer, a director of pharmacy services, a dental director, a community relations specialist, a director of program development, and three site directors. Each site director is responsible for overseeing one or more of the 10 health centers.

Site Director Jason Everson testified that he is responsible for two sites, Moncure and Siler City. He supervises administrative staff and oversees day-to-day operations at his assigned facilities. Referral service managers, center managers, outreach and enrollment staff, and facilities staff report to Everson and the other site directors. The referral service managers coordinate referral services, such as the referral of one of the Employer's patients to a more specialized medical facility. Outreach and enrollment staff handle insurance. Facilities staff include maintenance and housekeeping employees. Center managers supervise patient care coordinators, who register patients and answer telephones. There is one center manager assigned to each of the Employer's facilities, with the exception of IFC Health Center, which is open for clinic only twice per week and shares a center manager with Chapel Hill Community Health Center.

Everson and other site directors do not oversee health care providers. Rather, lead medical providers, who report to Chief Medical Officer Joan East, are responsible for overseeing direct health care providers at the site level. Each health center has a lead medical provider. Lead medical providers may be nurse practitioners, nurse-midwives, physician assistants, or physicians. Dr. East's other reports include an associate medical director for clinical services, an associate medical director for informatics, a behavioral health director, a director of nursing, a director of laboratory services, and a director of corporate compliance and quality. Triage nurses, RN-care managers, and medical assistants report to on-site nurse managers who themselves report to Director of Nursing Crystal Torain.

The Role of the Lead Medical Provider

The parties stipulated that lead medical providers are statutory supervisors who should be excluded from any collective-bargaining unit found appropriate.

Dr. Adrian Mancheno is a lead provider. He testified that he is responsible for supervising the other providers[5] who work in the clinic, including by authorizing time off, authorizing work hours, writing performance evaluations for providers, monitoring workflow, and reviewing providers' work and interactions with staff. He testified that he provides direct patient care three-and-a-half days per week while spending one day doing administrative work as a lead provider or as a physician. He is responsible for ensuring that all providers are performing up-to-date

[5] In this decision, "providers" or "practitioners" refers to the four petitioned-for categories of employees: nurse practitioners, nurse-midwives, physician assistants, and physicians.

medicine, particularly because multiple nurse practitioners work under his license. However, some nurse practitioners and physician assistants have agreements to work under the licenses of physicians who are not lead providers.

Nurse practitioners and physician assistants must have a "supervising physician" listed on their licenses. There is no such requirement for physicians. This regulation is promulgated by the State of North Carolina rather than by the Employer. Under licensing laws, advanced practitioners are required to have a "quality improvement meeting" with their supervising physicians once per month for their first six months of practicing. After that time, they must meet once every six months. Nurse practitioners and physician assistants can treat patients without physicians in the room and prescribe medication without a physician's approval. However, because they are operating under a physician's license, that physician will be held liable for any actions undertaken, such as a misdiagnosis. Physicians are not required to review nurse practitioners' or physician assistants' notes, but may choose to do so. Dr. Mancheno testified that he interacts with his providers' charts at least once a day both in his capacity as a physician and in his capacity as a lead provider.

All physicians, regardless of their status as lead providers, have the potential to be designated as supervising physicians should they reach an arrangement with a nurse practitioner or physician assistant. However, this designation does not necessarily result in the physician interacting with the provider on a regular basis. Indeed, several providers testified that they were most likely to seek advice from colleagues who were close at hand or from colleagues who had a particular area of medical expertise rather than specifically seeking out colleagues who happened to be physicians.

Providers: Physicians, Nurse Practitioners, Nurse-Midwives, and Physician Assistants

A physician has completed a four-year bachelor's degree, a four-year medical degree, and a residency lasting at least three years. After completing a residency, a physician applies for a license from the state board. Additional certifications from the state in which the physician is practicing are also required. A majority of the Employer's physicians completed their residencies in family practice, but some physicians have other specialties. Physicians, unlike nurse practitioners and physician assistants, work under their own licenses. Physicians have continuing education requirements, and the Employer provides funds and time to its physicians to offset these requirements. The petitioned-for unit includes approximately 19 physicians.

A nurse practitioner is licensed as a registered nurse and has received an advanced degree in the form of a master's degree or a doctorate of clinical practice. These programs take approximately two years to complete. The nurse practitioner must then pass a certified exam in the State of North Carolina and annually accrue continuing education units and renewals. The petitioned-for unit includes approximately 15 nurse practitioners.

A nurse midwife is licensed as a registered nurse and has also completed a nurse midwife program. The petitioned-for unit includes approximately two nurse midwives. Nurse-midwives specialize in prenatal care, postpartum care, newborn care, and women's health services.

A physician assistant must complete a physician assistant program, which generally terminates in a master's degree. Physician assistants must then pass a national certifying examination. They are required to take 100 hours of continuing education requirements every two years. The petitioned-for unit includes approximately eight physician assistants.

All providers see patients in a primary care setting. A nurse practitioner or physician assistant sees 16 to 19 patients each day, while a physician sees 18 to 22 patients per day.

Both Dr. Mancheno and Dr. Rupal Yu, a physician at the Carrboro clinic, testified that within a family practice realm, nurse practitioners and physician assistants can perform the same procedures as physicians. Dr. Yu testified that she would consult with a colleague based on that colleague's area of expertise (such as HIV or diabetes) rather than on that colleague's job title (such as nurse practitioner or physician). Dr. Karolyn Forbes, a physician at the Carrboro clinic, testified that she is most likely to consult with a provider who is available regardless of the provider's job title. All petitioned-for employees use the same exam rooms, equipment, and instruments. All petitioned-for employees are required to follow the same dress code.

Dr. Yu testified that on at least one occasion, a physician resigned, and a newly arrived physician assistant took over that physician's entire patient load. Dr. Forbes also testified that providers see one another's patients, as needed, regardless of job title. On-the-job training is not limited by job title, meaning that a nurse practitioner who is a longtime employee may train a newly hired physician.

All providers are subject to the same policies and procedures, including discipline and attendance. Offices are assigned based upon seniority and proximity to workspaces rather than upon job title. Thus, a physician assistant and a physician may share an office. Salaries are based upon job titles and years of experience, but physicians are paid roughly 75% more than other, similarly experienced, providers. An employee who works between 24 and 40 hours per week is considered to be part-time; an employee must work at least 24 hours per week to be eligible for benefits. The majority of the employees work part-time. All providers are eligible for the same health insurance and life insurance.

The Employer classifies nurse practitioners, nurse midwives, and physician assistants as midlevel providers. Hannah Adams, the Employer's human resources director, testified that physicians are expected to provide guidance to midlevel providers, and physicians' ability to act as resources for midlevel providers is noted in their evaluations.

Providers' Interaction with Medical Assistants and Medical Scribes

Lead providers create schedules for other providers and are often responsible for making assignments for medical assistants, although medical assistant assignments may also be handled by a nurse manager.[6] Dr. Mancheno testified that he attempts to assign one medical assistant to

[6] Medical assistants are not members of the petitioned-for unit. It is their job to take vital signs, give vaccinations, make phone calls, and stock exam rooms. They often work pursuant to the Employer's written

each provider, and a provider may request a medical assistant who has experience in that provider's area of work. However, Krishna Kothary, a nurse practitioner, testified that a nurse manager assigns a medical assistant to her without her input. Kothary further testified that she has worked with all medical assistants at her locations in some capacity. Medical assistant Carson Hash testified that some providers communicate with him closely while others expect him to work independently. Hash also testified that on some days he is assigned exclusively to phone work and does not interact with providers at all. On other days, he may work in at a vaccination clinic rather than with a provider.

Dr. Yu, Dr. Forbes, and nurse practitioner Kothary testified that they have not been held accountable for mistakes made by medical assistants.

Each morning, the complete staff of at least one community center has a meeting, called an "extended huddle," at which they discuss, among other topics, which providers are available and which patients may be high risk.[7] After the extended huddle, staff members break into mini-huddles so that providers and their assigned medical assistants can prepare for the day. At this time, providers inform medical assistants if they will have particular or unusual duties that day. Throughout the day, a provider may ask a medical assistant to perform tasks such as retrieving a patient's chart, running a pregnancy test, or telling a patient that his cholesterol is high. Nurse practitioner Kothary testified that medical assistants perform some duties without direction depending upon the circumstances. For example, if a patient states upon arrival that she believes that she has a urinary tract infection, the medical assistant will automatically take a urine sample and run a test. However, if Kothary examines a patient and concludes that the patient may have a urinary tract infection, Kothary will tell the medical assistant to take a urine sample and run a test. Medical assistant Hash likewise testified that when he first checks a newly arrived patient's chart, he will attempt to expedite the patient's visit by independently performing tasks such as an overdue depression screening or urine test. While the provider examines the patient, Hash moves on to prepare the provider's next patient.

Dr. Mancheno testified that providers offer him feedback regarding the performance of medical assistants and that he takes that feedback into consideration. If he determines that a complaint about a medical assistant is legitimate, he will follow protocols to issue discipline. Dr. Mancheno testified that a provider once advised him that a medical assistant was rude to a patient. However, the provider did not recommend discipline, and Dr. Mancheno did not recall whether the medical assistant was ever disciplined. The record reveals no evidence that any provider has ever notified a superior of an employee's infraction and that superior, in turn, disciplined the employee either with or without further investigation. Dr. Forbes testified that she once tried to intervene in a medical assistant's discipline, but a nurse manager told her not to get involved because she was not a supervisor.

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policies which describe, for example, guidelines for administering flu shots. Medical assistants are not required to have official licenses beyond high school diplomas, although the Employer prefers that they have some certification, such as certified medical assistant or emergency medical technician.

[7] Huddle frequency and composition appears to vary by location.

Each location employs a nurse manager who formally evaluates medical assistants; another manager, Jan Lee Santos, formally evaluates medical scribes.[8] No party asserts that Santos or the nurse managers should be a part of the petitioned-for unit.

Nurse managers and lead providers make recommendations to hire medical assistants, though the offer to hire a new medical assistant comes from Human Resources. The nurse manager and Human Resources also terminate, lay off, recall, promote, and reward medical assistants.

However, providers sometimes take part in the interview process and offer feedback to the lead provider and the human resources department. On at least one recent occasion, the human resources department ultimately hired a candidate recommended by providers. Likewise, the record includes several examples of providers suggesting the promotion of employees who were eventually promoted. However, the record does not establish a link between the providers' recommendations and the ultimate promotions. Rather the Employer has a well-established promotion track for medical assistants from level I to level III. Medical assistants must complete a skills checklist and interview with either a nurse manager, assistant director of nursing, or director of nursing in order to receive a promotion.

In February 2021, a group of providers concerned about medical assistant turnover conducted an exit poll of medical assistants and presented the information they gathered to a group of managers. This meeting led to the implementation of an employee satisfaction survey, a wage increase, a change in management structure, and several promotions of medical assistants.

ANALYSIS

Supervisory Status

Pursuant to Section 2(11) of the Act, the term "supervisor" means any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively recommend such action, where the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment. To qualify as a supervisor, it is not necessary that an individual possess all of the powers specified in Section 2(11) of the Act. Rather, possession of any one of them is sufficient to confer supervisory status. *Chicago Metallic Corp,* 273 NLRB 1677, 1689 (1985).

The burden of proving supervisory status rests on the party alleging that such status exists. *NLRB v. Kentucky River Community Care*, 532 U.S. 706, 712, 121 S.Ct. 1861, 167 LRRM 2164 (2001). The Board will refrain from construing supervisory status too broadly, because the

[8] Medical scribes are typically responsible for taking notes. A provider may ask a medical scribe to seek out medical records or to transcribe the discussion which took place during a patient's visit with the provider. Laura Driggers, a physician assistant, testified that she does not tell medical scribes to take notes because medical scribes are present for the express purpose of taking notes and do so automatically. When medical scribes are not present, providers take their own notes.

inevitable consequence of such a construction is to remove individuals from the protection of the Act. *Quadrex Environmental Co.*, 308 NLRB 101, 102 (1992).

The Employer argues that the petitioned-for employees are statutory supervisors because they effectively recommend hiring, promotion, and discipline of other employees, as well as effectively recommend the adjustment of other employees' grievances and the assignment of work to other employees. Finally, the Employer argues that the petitioned-for employees responsibly direct employees.

- The Providers' Role in Assigning Work and Responsible Direction

In *Oakwood Healthcare, Inc.*, 348 NLRB 686 (2006), the Board refined its analysis of the terms "assign," "responsibly direct," and "independent judgment" in assessing supervisory status. The Board announced that it construes the term "assign" to refer to "the act of designating an employee to a place (such as a location, department, or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties, i.e., tasks, to an employee," Id. at 689.

With respect to "responsible direction," the Board explained in *Oakwood* that, if a person has "men under him" and if that person decides what job shall be undertaken next or who shall do it, that person is a supervisor, provided that the direction is both "responsible" and carried out with independent judgment. For direction to be "responsible," the person directing the oversight of the employee must be accountable for the performance of the task by the other. To establish accountability, it must be shown that the employer delegated to the putative supervisors' authority to direct the work and take corrective action, if necessary. It also must be shown that there is a prospect of adverse consequences for the putative supervisors if they do not take these steps, Id. at 689-692.

Finally, the Board held in *Oakwood* that to establish that an individual possesses supervisory authority with respect to any of the statutory functions, the individual must also exercise independent judgment in exercising that authority, which depends on the degree of discretion with which the function is exercised. "[T]o exercise independent judgment, an individual must at a minimum act, or effectively recommend action, free of the control of others and form an opinion or evaluation by discerning and comparing data," Id. at 693. "[A] judgment is not independent if it is dictated or controlled by detailed instructions, whether set forth in company policies or rules, the verbal instructions of a higher authority, or in the provisions of a collective-bargaining agreement," Id. The Board also stated that the degree of discretion exercised must rise above the "routine or clerical," Id.

The providers at issue here do not assign other employees to a time, as schedules are created by lead providers. There is no indication that a provider has ever assigned an employee to work an overtime period. Likewise, the providers do not assign other employees to places; employees are scheduled to work at one or more of the Employer's facilities, and lead providers or other managers assign medical assistants and scribes to work with particular providers (or to perform only phone

work) on a given day.[9] The majority of duties performed by a medical assistant or a scribe who is paired with a provider on a particular day flow naturally from the course of the work without assignment by the provider; for example, a scribe takes notes without being asked to do so because it is the primary responsibility of a scribe to take notes.

Some, but not all, of the petitioned-for physicians are listed on the licenses of other providers as "supervising physicians," as is required by the State of North Carolina for nurse practitioners and physician assistants. The Board has found that a government requirement that nursing staff be supervised by a supervising physician does not establish that the Employer's physicians meet 2(11) supervisory requirements. See *Third Coast Emergency Physicians, P.A.,* 330 NLRB 756, 756 fn. 1 (2000).

Other than the "supervising physician" relationship that I referenced above that I do not deem to be supervisory, there is no evidence to suggest that providers are in any way held accountable for the performance of medical assistants, scribes, or any other employees. Dr. Yu, Dr. Forbes, and Nurse Practitioner Kothary testified that they were not held accountable for mistakes made by medical assistants who were working with their patients. The Employer did not rebut this testimony. Thus, even to the extent that providers communicate patient care needs to medical assistants or other employees, these instructions do not rise to the level of responsible direction.

I find that the Employer has failed to demonstrate that the providers either assign or responsibly direct employees—or effectively recommend such action— within the meaning of *Oakwood Healthcare.*

- <u>The Providers' Role in Hiring, Promotion, Discipline, and Adjustment of Grievances</u>

The Employer has failed to establish that the providers' role in hiring, promotion, discipline, or adjustment of grievances confers supervisory status.

It is undisputed that providers do not possess the authority to hire employees. However, providers sometimes take part in the interview process and offer feedback to the lead provider and the human resources department. On at least one recent occasion, the human resources department ultimately hired a candidate recommended by providers.

[9] The Employer argues that, because lead providers sometimes take providers' preferences into account when determining which medical assistant works with a given provider, providers effectively recommend the assignment of work to medical assistants. The Employer cites no case, and I can find none, in which the Board held that occurrences of this nature are indicative of a statutory authority to assign work. Further, the record does not support the proposition that a provider's preference to work with a particular medical assistant results in automatic assignment without further review by the assigning manager. The Employer also argues that because providers occasionally refer patients to their fellow providers who specialize in those patients' needs, the providers assign work to one another. The record contains insufficient evidence to establish that the work stemming from such referrals constitutes "significant overall duties" or that providers exercise independent judgment when they, for example, transfer a pediatric patient to a pediatric specialist. Rather, such a patient transfer would be routine or clerical.

The Board has consistently applied the principle that effective recommendation generally means that the recommended action is taken without independent investigation by superiors, not simply that the recommendation is ultimately followed. *Children's Farm Home*, 324 NLRB 61, 61 (1997). Where, as here, supervisors like the lead provider also participate in the interview process, it cannot be said that employees whose status is at issue have authority to effectively recommend hiring. *Ryder Truck Rental*, 326 NLRB 1386, 1387 fn. 9 (1998). The Employer's reliance on *Mountaineer Park*, 343 NLRB 1473, 1476 (2004), is inapposite. In that case, even though an employee's superior reviewed a recommendation and added his own judgment, the Board held that the employee was a statutory supervisor because the superior routinely signed off on the subordinate's recommendations. Here, lead providers themselves do not make the final decision to hire new employees, and there is insufficient evidence to establish what weight, if any, the human resources department assigns to providers' recommendations after those recommendations are filtered through a lead provider.

It is undisputed that providers do not possess the independent authority to promote other employees, but the record includes several examples of providers suggesting the promotion of employees who were eventually promoted. However, the record does not establish a link between the providers' recommendations and the ultimate promotions. Indeed, the Employer has a well-established promotion track for medical assistants from level I to level III. Medical assistants must complete a skills checklist and interview with either a nurse manager, assistant director of nursing, or director of nursing in order to receive a promotion. There is no indication that the recommendation of a provider could or would supersede this process.

Likewise, the record lacks evidence that any provider has ever issued discipline to any other employee. There is also no evidence that any provider has ever notified a superior of an employee's infraction and the superior, accordingly, disciplined that employee. Lead provided Dr. Mancheno testified that a provider once informed him that a medical assistant was rude to a patient, but the provider did not recommend discipline and the medical assistant may not have been disciplined.

With respect to the adjustment of grievances, there is no evidence that any provider has ever adjusted an employee's grievance. The Employer notes that in February 2021, a group of providers concerned about medical assistant turnover conducted an exit poll of medical assistants and presented the information they gathered to a group of managers. This meeting led to the implementation of an employee satisfaction survey, a wage increase, a change in management structure, and several promotions of medical assistants. The Employer takes the position that in this manner the providers effectively recommended the adjustment of the medical assistants' grievances. However, the Board has held that relaying grievances to upper management, or simply offering advice or suggestions, does not constitute the authority to adjust grievances. *Avante at Wilson, Inc*., 348 NLRB 1056, 1058 (2006); *Ken-Crest Services*, 335 NLRB 777, 779 (2001)*; California Beverage Co*., 283 NLRB 328, 330 (1987). The Board has also held that even if asserted supervisors have some involvement in a grievance resolution procedure, the evidence must specify with clarity what role they play, and the evidence must show independent judgment is exercised. *Training School at Vineland*, 332 NLRB 1412, 1412 fn. 2 (2000). Finally, the Supreme Court has

held that acts within the scope of employment or on the authorized business of the employer must be in the interest of the employer, *NLRB v. Health Care & Retirement Corp. of America*, 511 U.S. 571, 578 (1994) (citing *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 488–489 (1947). By way of example, the Court stated that the phrase "ensures . . . that union stewards who adjust grievances are not considered supervisory employees." Id. at 579.

Accordingly, the Employer has failed to satisfy its burden of establishing that the providers' involvement in the hiring, promotion, discipline, or grievance adjustment process warrants the conclusion that they are Section 2(11) supervisors.

- Sporadic Supervision

The Employer notes that providers are periodically called upon to fill in as lead providers. For example, during lead provider Dr. Eli Tiller's paternity leave, two other providers acted as lead provider for six to eight weeks, including by approving timecards and PTO requests and leading meetings. It is well-established that an employee who substitutes for a supervisor may be deemed a supervisor only if that individual's exercise of supervisory authority is both regular and substantial. See *Gaines Electric Co*., 309 NLRB 1077, 1078 (1992), and *Canonie Transportation*, 289 NLRB 299, 300 (1988), citing *Aladdin Hotel*, 270 NLRB 838 (1984). The Board considered the issue with respect to physicians in particular in *North Gen Hosp*., 314 NLRB 14, 16 (1994). In that case, the Board held that while a doctor was nominally "in charge" of a department in his superior's absence, the Hospital failed to present any evidence that his duties in this regard encompassed the exercise of Section 2(11) authority or that the substitution for the established supervisor was regular and substantial. The same conclusion is warranted here.

- Secondary Indicia and Conclusion

I conclude that the providers are not statutory supervisors.

In concluding that the Employer has failed to meet its burden of establishing the providers' supervisory status, I acknowledge that the providers possess limited secondary indicia of supervisory status. Most notably, they have assigned offices and are paid at higher rates than the medical assistants. The Board has long held, however, that secondary indicia are insufficient by themselves to establish supervisory status when there is no evidence presented that an individual possesses any one of the several primary Section 2(11) indicia. *Golden Crest Healthcare Center,* 348 NLRB 727, at 730 fn. 10 (2006); *Ken-Crest Services*, supra.

Community of Interest

The Board currently evaluates the community of interest between two or more groups of employees by using the test articulated in, e.g., *United Operations*, 338 NLRB 123, 123 (2002).[10] Under that test, the Board is required in each case to determine:

[10] I note that the Board has invited briefing on whether it should adhere to the current unit appropriateness standard as described in *PCC Structurals, Inc.*, 365 NLRB No. 160, slip op. at 1 (2017), and *The Boeing Company*, 368 NLRB No. 67, slip op. at 3 (2019). However, the precise standard articulated in *PCC*

> Whether the employees are organized into a separate department; have distinct skills and training; have distinct job functions and perform distinct work; including inquiring into the amount and type of job overlap between classifications; are functionally integrated with the Employer's other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised.

Here, the physicians and the other providers are not organized in separate departments. All providers are functionally integrated, share frequent contact with one another, and share common supervision. These factors unequivocally weigh in favor of a finding of a community of interest.

Due to licensing requirements specific to each position, there can be no interchange between the physicians and the other providers. This factor unequivocally weighs against a finding of a community of interest.

The physicians, who must complete a residency as well as a medical degree, undergo more training than the other providers. The other providers have, however, undergone significant training themselves and generally have master's degrees or the equivalent.[11] On-the-job training is not limited by job title: a longtime nurse practitioner may train a newly hired physician. Many of the same skills are used by all providers on a day-to-day basis as they care for patients; all providers, regardless of specific degree or job title, perform the same medical procedures. Despite the more intensive training required of physicians, I find that this factor weighs slightly in favor of finding a community of interest due to the comparable skills utilized by all practitioners in the usual course of their work.

All providers use their similar skills to perform similar or identical work while providing medical care for patients, although physicians are expected to see two to three more patients each day as compared to nurse practitioners. The physicians may occasionally see patients with more complicated health issues, although patients are generally divided amongst all providers, regardless of job title, based upon availability or the providers' unique areas of expertise. For example, one practitioner may disproportionately provide care for pediatric patients while another practitioner disproportionately provides care for HIV-positive patients. On at least one occasion, an entire patient load was transferred from a departing physician to a newly arrived physician assistant. All providers evaluate patients, devise plans for treatment, prescribe medications, and maintain patient charts. I find that the work performed by physicians and the work performed by other providers at Employer's facilities, while not identical, is so similar that this factor must weigh in favor of a community of interest.

Structurals does not apply in cases where, as here, no party asserts that the smallest appropriate unit must include employees excluded from the petitioned-for unit.

[11] Other providers must have a "supervising physician" listed on their licenses while there is no such requirement for physicians. As noted above, this regulation is enforced by the State of North Carolina, not the Employer.

The physicians share some, but not all, terms and conditions of employment with other providers. The physicians are paid roughly 75% more than other, similarly experienced, practitioners. Physicians also receive more professional liability coverage and more funding for continuing education. However, all providers use the equipment and the same workspaces. They report to the same supervisors and are subject to the same evaluations and training. They also receive the same health insurance and life insurance benefits. Thus, this factor weighs in favor of a community of interest.

Accordingly, I find that the petitioned-for employees share a community of interest sufficient to constitute an appropriate voting group.

Method of Election

The Employer proposes that a manual election be held over the course of two days with polling taking place at each of the 10 locations as follows:

Day 1:

Board Agent 1:
Burlington CHC 9:00-10:30
Charles Drew CHC (Burlington) 12:00-1:30
Sylvan CHC (Snow City) 3:00-4:30

Board Agent 2:
Carrboro CHC 9:00-10:30
Chapel Hill CHC 12:00-1:30
IFC Health Center (Chapel Hill) 3:00-4:30

Day 2:

Board Agent 1:
Scott CHC (Burlington) 9:00-10:30
Prospect Hill CHC 12:00-1:30

Board Agent 2:
Moncure 9:00-10:30
Pittsboro 12:00-1:30
Siler City 3:00-4:30

The Employer proposes that the elections take place in the various facilities' break rooms except where breakrooms have only one door. At those locations, voting would take place in an outdoor tent. The Employer is willing to abide by all protocols suggested in Memorandum GC 20-10.

The Petitioner takes the position that the Employer's proposal does not provide sufficient opportunities for the employees to vote due to the employees' varied schedules. The Petitioner further submits that a manual election is not appropriate in light of the recent surge in Covid-19 cases, particularly given that the petitioned-for employees treat patients infected with Covid-19.

In response to the evolving realities of the pandemic, the Office of the General Counsel issued Memorandum GC 20-10 on July 6, 2020. The suggested protocols include: polling times sufficient to accommodate social distancing without unnecessarily elongating exposure among Board Agents and observers; the employer's certification in writing that polling area is consistently cleaned in conformity with CDC standards; a spacious polling area, sufficient to accommodate six-foot distancing; separate entrances and exits for voters; separate tables spaced six feet apart; sufficient disposable pencils without erasers for each voter to mark their ballot; glue sticks or tape to seal challenge ballot envelopes; plexiglass barriers of sufficient size to protect the observers and Board Agent; and provision of masks, hand sanitizer, gloves and disinfecting wipes. The Employer asserts that it is willing to comply with all protocols as necessary.

Memorandum GC 20-10 also requests an employer's written certification of how many individuals have been present in the facility within the preceding 14 days who have tested positive for Covid-19; who have been directed by a medical professional to proceed as if they have tested positive for Covid-19; who are awaiting results of a Covid-19 test; who are exhibiting symptoms of Covid-19; or who have had direct contact with anyone in the previous 14 days who has tested positive for Covid-19.

The Board offered further guidance regarding the direction of manual elections during the Covid-19 pandemic in *Aspirus Keweenaw*, 370 NLRB No. 45 (November 9, 2020). In *Aspirus Keweenaw,* the Board set forth six situations under which a Regional Director should consider directing a mail-ballot election. While *Aspirus Keweenaw* does not require a Regional Director to direct a mail ballot election where one or more of the six factors are present, the Board stated that Regional Directors who direct mail-ballot elections under those circumstances will not be found to have abused their discretion.

The six situations are:

1) The Agency office tasked with conducting the election is operating under "mandatory telework" status;

2) Either the 14-day trend in the number of new confirmed cases of Covid-19 in the county where the facility is located is increasing, or the 14-day testing positivity rate in the county where the facility is located is 5 percent or higher;

3) The proposed manual election site cannot be established in a way that avoids violating mandatory state or local health orders relating to maximum gathering size;

4) The employer fails or refuses to commit to abide by the GC Memo 20-10

protocols;

5) There is a current Covid-19 outbreak at the facility or the employer refuses to disclose and certify its current status; and

6) Other similarly compelling considerations.

As the Board acknowledged, no Regional Office, including Subregional and Resident Offices, has been in a mandatory-telework status since mid-June 2020. The Employer's proposed polling place does not appear to violate any mandatory state or local health orders, and the Employer is willing to comply with GC Memo 20-10. There is no current Covid-19 outbreak at the Employer's facilities.

The Employer's facilities are located in Alamance County, Caswell County, Chatham County, and Orange County.[12] As of January 13, 2022, The Centers for Disease Control listed the positivity rates for these counties as follows: for Alamance County, 32.91%;[13] for Caswell County, 29.84%;[14] for Chatham County, 22.1%;[15] and for Orange County, 20.34%.[16]

Accordingly, because the positivity rates in all four counties remains at least quadruple the 5 percent threshold contemplated by *Aspirus*, I will direct a mail ballot election.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. Employees will vote whether or not they wish to

[12] Specifically, Burlington Community Health Center, Charles Drew Community Health Center, Scott Community Health Center, and Sylvan Community Health Center are located in Alamance County. Prospect Hill Community Health Center is located in Caswell County. Moncure Community Health Center and Siler City Community Health Center are located in Chatham County. Carrboro Community Health Center, Chapel Hill Community Health Center, and IFC Health Center are located in Orange County.

[13] https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=North+Carolina&data-type=Risk&list_select_county=37001 (last visited January 13, 2022).

[14] https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=North+Carolina&data-type=Risk&list_select_county=37033 (last visited January 13, 2022).

[15] https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=North+Carolina&data-type=Risk&list_select_county=37037 (last visited January 13, 2022).

[16] https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=North+Carolina&data-type=Risk&list_select_county=37135 (last visited January 13, 2022).

be represented for purposes of collective bargaining by Piedmont Health Services Medical Providers United.

A. Election Details

The election will be conducted by United States mail. The mail ballots will be mailed to employees employed in the appropriate collective-bargaining unit. The National Labor Relations Board, Region 10, will mail ballots to voters at 2:00pm on **Friday, February 4, 2022**. After receiving their ballots, voters who wish to vote must appropriately mark their ballots and return them in the provided return envelopes. Voters must sign the outside of the envelope in which they return their ballots. Any ballot received in an unsigned envelope will automatically be void.

Voters must return their mail ballots so that they will be received in the National Labor Relations Board, Region 10, Subregion 11, Winston-Salem office by close of business on **Friday, March 4, 2022**. Those employees who believe that they are eligible to vote and did not receive a ballot in the mail by date, should communicate immediately with the National Labor Relations Board by either calling the Subregion 11 Office at (336) 631-5201 or calling our national toll-free line at 1-844-762-NLRB (1-844-762-6572).

Due to the extraordinary circumstances of Covid-19 and the directions of state or local authorities, including but not limited to safer-at-home orders, travel restrictions, social distancing, and limits on the size of gatherings of individuals, I further direct that the ballot count will take place virtually beginning at 1:00pm on **Monday, March 7, 2022**. The count will take place virtually on a platform (such as Skype, Zoom, or WebEx) to be determined by the Regional Director. Each party will be allowed to have one observer attend the virtual ballot count.

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **Saturday, January 15, 2022**, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names, work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the regional director and the parties by Tuesday, **January 25, 2022**. The list must be accompanied by a certificate of service showing service on all parties. **The region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election Tuesday, **February 1, 2022**, in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the election and copies must remain posted until the end of the election.

For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution. Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 10 business days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review must be E-Filed through the Agency's website and may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001, and must be accompanied by a statement explaining the circumstances concerning not having access to the Agency's E-Filing system or why filing electronically would impose an undue burden. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review.

Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board. If a request for review of a pre-election decision and direction of election is filed within 10 business days after issuance of the decision and if the Board has not already ruled on the request and therefore the issue under review remains unresolved, all ballots will be impounded. Nonetheless, parties retain the right to file a request for review at any subsequent time until 10 business days following final disposition of the proceeding, but without automatic impoundment of ballots.

Dated: January 21, 2022

Lisa Y. Henderson
Regional Director
National Labor Relations Board
Region 10
401 W Peachtree St NE Ste 472
Atlanta, GA 30308