NYSNA, DC37 v. City, Related Public Employers,54 OCB 1 (BOC 1994) [1-94 (Cert.)]

OFFICE OF COLLECTIVE BARGAINING
BOARD OF CERTIFICATION

In the Matter of the Petition of New York State Nurses Association, Petitioner, -and- The City of New York and Related Public Employers, Employer.	Decision No. 1-94 Docket Nos. RU-1118-92 RU-1120-92 RU-1121-92
In the Matter of the Petition of District Council 37, AFSCME, AFL-CIO, Petitioner, -and- The City of New York and Related Public Employers, Employer.	

DECISION AND ORDER

On August 3, 1992, the New York State Nurses Association ("NYSNA") filed a petition docketed as RU-1118-92, requesting that two new titles, Utilization Quality/Management Coordinator, Levels I and II, and Discharge Planning Assessment Specialist, Levels I and II, be added by accretion to Certification No. 30-82 (as amended), covering various nursing titles.

On August 5, 1992, the New York City Health and Hospitals Corporation ("HHC") informed the Office of Collective Bargaining

(the "OCB") that the petitioned for titles had not yet been created, i.e., no personnel order had been issued. Because a personnel order covering the titles seemed imminent, however, the OCB did not ask NYSNA to withdraw its petition. On September 14, 1992, HHC informed the OCB that the personnel order had in fact been issued and that the nomenclature for one of the titles had been changed from Utilization Quality/Management Coordinator to Utilization Review/Management Coordinator. On the same day, the OCB contacted NYSNA regarding this change and an amendment to the petition was effected over the telephone.

Also on September 14, 1992, District Council 37, AFSCME ("DC 37") filed two petitions docketed as RU-1120-92 and RU-1121-92, requesting that the newly created titles be added by accretion to Certification No. 28-78 (as amended), covering various health related titles. The OCB deemed all of the petitions to have been filed on September 14, 1992.

In a letter dated March 2, 1993, addressed to the Director of Representation of the OCB, the City of New York, through its Office of Labor Relations (the "City"), "opposed" NYSNA's petition, taking the position that the DC 37 unit would be the appropriate bargaining unit for these titles. The City stated that its position was "based upon the interchange relationship between the title Medical Utilization Review Analyst ("MURA"), in DC 37's bargaining unit, and the titles at issue."

On notice to the parties the petitions were consolidated,

and hearings were held on April 29, April 30, May 13, July 1 and August 9, 1993, to determine whether the petitioned-for titles would be added to Certification No. 30-82 (as amended) or to Certification No. 28-78 (as amended). Post-hearing briefs were submitted on October 29, 1993 and the record was closed.

Background

To meet the needs of its health care facilities, HHC established the Utilization Review/Management Coordinator ("URMC") and Discharge Planning Assessment Specialist ("DPAS") titles on September 14, 1992. The position description for the URMC title, Levels I and II, provides:

> Purpose of Position:
> Under supervision, determines the appropriateness of admission, quality of care, and medical necessity of a patient's hospitalization. Monitors that the quality of care meets established standards.
> There are two (2) assignment levels to differentiate ascending order of assignment scope with corresponding higher pay levels. All personnel in this title perform related work.
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> MAJOR DUTIES:
> Assignment Level I
> 1. Analyzes patient records to determine that the medical records documentation reflects the appropriateness and medical necessity of hospitalization.
> 2. On a concurrent and/or retrospective basis identifies and reports trends and patterns of care which deviate from established norms.
> 3. Consults with medical, nursing and other staff involved in treatment to clarify issues and secure documentation as required.
> 4. Initiates action and/or works with Social Service Department to monitor timely discharge planning.

5. Excerpts requested medical information from records for Utilization Review Management, Quality Management, and other committees and may otherwise participate as a member of the committee(s).
6. Maintains appropriate files and other clerical records to insure timely review and processing of records.
7. Participates in special studies relating to Utilization Review Management and Quality/Management.
8. Keeps informed of changes in regulations, procedures and treatment standards prescribed by the hospital, regulator and/or reimbursement agencies.
9. Participates in designing valuative measures and procedures by which program efficiency and cost effectiveness can be audited and participates in the evaluation audits.
10. Liaison with third party reimbursers and Utilization Review agents.
11. Prepares special Utilization Management reports, as required.

Assignment Level II

In addition to the duties of Level I, also performs the following:
1. Plans, designs and evaluates quality management programs and systems relating to health care services, the quality of services rendered and implements these activities by appropriate analytical, liaison, consultative and research functions.
2. Analyzes guidelines, policy, protocols and standards of medical practice and delineates the problems relating to their implementation to reflect the appropriateness and medical necessity of hospitalization.
3. Plans and conducts feasibility studies and resources analysis, content and standards for the professional components of health care projects, analysis of socioeconomic and other demographic data.
4. Consults with personnel in other segments of the corporation involved in the financial, operational or professional components of health care program plans.
5. Participates in developing strategies, and alternative approaches for improvement of quality of care.
6. Provides on-going technical assistance to interdisciplinary patient care team.
7. Prepares records for peer review orientation.
8. Provides training and orientation to less experienced staff.
9. Participates in staff meetings and may serve as a member of the Hospital Utilization/Quality Committee, as required.
10. Conducts admission, continued stay, discharge, and other reviews.
11. Assists with development of indicators for evaluation of

Quality Care standards within the service or institution, as they relate to safety, adequate and appropriate health care.
12. Participates in Quality Improvement Projects.

Knowledge and Skills Required:
1. New York State Professional Nursing Licensure (R.N.) and;
2. Two (2) years of experience in a hospital clinical setting in a capacity which provides thorough understanding of medical diagnosis, symptoms and treatment concepts; or one year experience in Utilization/Quality Management.

Direct Line of Promotion:
None. This class of positions is in the non-competitive class.

The position description for the DPAS title, Levels I and II provides:

Purpose of Position:
Under supervision provides identified patients with a plan of post hospital care in collaboration with the health care team, and performs related work.
There are two (2) assignment levels to differentiate ascending order of assignment scope with corresponding higher pay levels.

MAJOR DUTIES:

Assignment Level I

1. Reviews cases to identify patients in need of post hospital care planning.
2. Assesses the clinical needs of the patient in collaboration with the health care team in order to develop the post hospital care plan.
3. Conducts or participates in weekly health care team meetings to develop an appropriate discharge plan for the patient, considering the patients's clinical status/condition and post hospital environment.
4. Participates in designing and implementing alternate strategies to expedite the discharge of long stay and/or difficult to place patients.
5. Documents discharge planning activities in the medical record, including but not limited to, assessments of the patient's clinical status/condition during the hospital stay.
6. Initiates, completes, and updates the hospital community patient review instrument (H/C-PRI) according to New York State Department of Health procedures.
7. Completes and/or reviews, as appropriate, necessary

referral forms to access post hospital services.
8. Provides, in collaboration with the health care team, clinical and post hospital resource information to the patient, family and/or significant other.
9. Performs record keeping as required.

Assignment Level II

In addition to the duties of Level I, also performs the following:
1. Assists in establishing protocols/systems to monitor the quality of the discharge plan and process.
2. Conducts special studies on discharge planning issues.
3. Conducts training and information sessions on post hospital resources.
4. May supervise employees assigned to Level I.
5. Participates in developing in-service training programs.

Knowledge and Skills Required:
1. New York State Professional Nursing Licensure (R.N.) and;
2. Two (2) years of experience in a hospital clinical setting in a capacity which provides thorough understanding of medical diagnosis, symptoms and treatment concepts; or two years public health nursing experience.

Direct Line of Promotion:
None. This class of positions is in the non-competitive class.

The personnel order creating the petitioned for titles contains a reclassification provision which provides:

> All Medical Utilization Review Analysts (MURA) and Senior Medical Review Analysts (Sr. MURA) who hold RN licensure will be reclassified into one of the new titles. The existing MURA title series will be retained and used for individuals who are not licensed RNs. Present MURA incumbents who are certified as Accredited Records Technicians (ART) and who do not possess an RN will also be reclassified into the new titles. However, all future candidates possessing ART certification must be hired into existing MURA titles.

Medical Utilization Review Analysts ("MURA") and Senior Medical Utilization Review Analysts ("Sr. MURA") are titles currently

represented by DC 37 in Certification No. 28-78 (as amended).[1]

In 1976, NYSNA filed a petition seeking certification as exclusive collective bargaining representative of the employees in the MURA title, either as a separate unit or added to its existing unit of nurses established pursuant to Certification No. 73-73 (now set forth in Certification No. 30-82). DC 37 filed an application to intervene on the ground that the petitioned title should be added to its unit of social service and related titles established pursuant to Certification No. 46A-75 (now set forth in Certification No. 28-78). The Board of Certification (the "Board") found neither unit to be appropriate. Instead, the Board, sua sponte, held that the MURA title could be placed appropriately in DC 37's "health services" unit. In so holding, the Board stated that this unit contained "several titles which are closely related to the petitioned title, including three levels of Medical Record Librarians, who, like MURAs, analyze, abstract and evaluate clinical records." Additionally, the Board noted that possession of a nursing degree was one of the alternate requirements for the librarians and that the "health service" unit contained many other titles requiring nursing training, such as various levels of public health nurses and anaesthetist.

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[1] All of the duties set forth in the Sr. MURA job description have been incorporated into the URMC job description. However, an RN license was not required of the MURA position. The duties listed on the DPAS job description were not listed on the Sr. MURA or MURA job descriptions.

The Evidence

URMC title

Amy Terenzio, a registered nurse, testified that she is a URMC employed by HHC in the Utilization Review Department ("UR department") at Bronx Municipal Hospital Center. She has held this position since December of 1992. She reports to Vivian Figueroa, who is the Director of Quality Management, Infection Control and Safety Management. Ms. Figueroa is not a registered nurse. Ms. Terenzio started with the UR department in October of 1989 as a Sr. MURA. Approximately a year later, she was placed in the managerial title of coordinating manager. Susann Tschupp, also a registered nurse, testified that she is a URMC employed by HHC in the UR department at Coney Island Hospital. She has held this position since September of 1992. She reports to Carol Twomey, the director of the UR department, who is not a registered nurse. For the three years prior to being placed in the URMC title, Ms. Tschupp served as a Sr. MURA in the UR department. Both witnesses work Monday through Friday from 8:00 a.m. to 4:00 p.m. Notwithstanding the fact that the witnesses work at different facilities, the job duties and responsibilities described by each are, in all relevant and material aspects, identical.

According to the testimony of the witnesses, and some of the

exhibits entered into evidence, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") is charged with the responsibility of accrediting hospitals. The JCAHO develops standards of health care quality that hospitals must meet in order to become and remain accredited. These standards are published annually in the JCAHO's "Accreditation Manual for Hospitals" (the "AMH"). An independent monitoring organization, known as the Island Peer Review Organization ("IPRO"), which is responsible for enforcing these standards, periodically visits the hospitals and reviews the patient charts. The 1993 AMH includes a section entitled "utilization review" which mandates that hospitals devise a "utilization review plan". This plan, the AMH states, must incorporate "a description of the method(s) for identifying utilization-related problems, including the appropriateness and medical necessity of admissions, continued stays, and supportive service, as well as delays in the provision of supportive services." The utilization review section of the manual also requires hospitals to perform "concurrent" patient review[2] which "focuses on those diagnoses, problems, procedures, and/or practitioners with identified or suspected utilization-related problems." These "utilization-related problems" form the basis of most of the job duties and responsibilities associated with the URMC title, as testified to by the witnesses.

[2] According to the testimony, the term "concurrent patient review" refers to a review that takes place while the patient is still in the hospital.

Each URMC is assigned to one or more services in the hospital. Upon reporting to work in the morning, the URMCs are given computer printouts or "certs" for the patients in their service indicating the patients' "status", i.e., whether the patient is an "admission", meaning that he or she was admitted on the previous day, a "discharge", meaning that he or she is about to be discharged, or a "continued stay", meaning that he or she will remain in the hospital. After receiving the certs, the URMCs proceed to the nursing stations on the wards, and retrieve the charts that correspond to each patient.

Ms. Tschupp testified that in the case of an admission, upon retrieving the patient's chart, she first looks at the propriety of the pre-admission treatment received by the patient. This would include, for example, whether an initial examination by a physician was done, whether the patient's medical history was recorded, whether the patient's body systems, such as the respiratory and digestive systems, were reviewed, whether lab work was completed, and whether a plan of care was devised. She further testified that if she finds that these things were not completed as expected, she contacts the physician or nurse in charge of the patient for an explanation. Next, Ms. Tschupp testified, she must determine whether the patient's admission was justified or that the patient actually requires acute care.[3] She

[3] The terms "acute" and "acute care" were used throughout these proceedings. The skilled nursing care that is provided in (continued...)

stated that this determination is made based upon her training, knowledge and experience as a nurse and illustrated with the following example: Patients are frequently admitted with the diagnoses of "syncope" or, in layman's terms, fainting. Syncope, in and of itself, is not a justification for an admission. Upon finding this diagnosis on a patient's chart, the URMC would begin to ask questions and look to the chart for answers. For example, the URMC would inquire into whether the patient's medical history was recorded, whether the patient is diabetic and was he or she given insulin, whether the patient's blood sugar level was tested and monitored, whether the patient was given food or intravenous fluid, whether the patient has a history of hypertension, et cetera. If answers to these questions cannot be found in the patient's chart, the URMC again looks to the patient's physician or nurse for an explanation. If a satisfactory explanation exists, then the URMC directs the physician or nurse to include the necessary documentation on the patient's chart. If the explanation given is not satisfactory to the URMC, he or she reports the matter either to her supervisor or to the physician's supervisor. The practical result of an unjustified admission is that the hospital will not be reimbursed by Medicare, Medicaid or the private insurer.

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[3](...continued)
a hospital setting is referred to as "acute care". A patient can be considered "acute" when he or she is ill enough to justify the receipt of acute care.

After the URMC has determined that an admission was justified, it is his or her responsibility to allocate to the patient a "length of stay", or specific number of days that the patient is expected to require acute care, based on the diagnosis. This allocation is made in accordance with standards, referred to as "DRGs", established by the federal government.

If the patient's status is "continued stay" then it is the duty of the URMC to assure that the patient is being appropriately cared for. During the patient's stay in the hospital, the URMC reviews his or her chart periodically. In performing these reviews, the URMC is concerned primarily with identifying "quality of care" issues. In the words of Ms. Terenzio, a "quality of care" issue arises when "something in patient management goes awry or needs to be addressed." A determination by IPRO, upon its review of the charts, that the hospital did not appropriately care for a patient puts at risk both the hospital's accreditation and the level of reimbursement received from the various payers.

The record is replete with illustrations of the daily process of identifying quality of care issues. Ms. Tschupp testified, for example, about a recent continued stay review she conducted on a patient with a "Jackson Pratt drain"; a suction device that drains fluids from the patient's abdomen. The chart indicated that the patient had discharge draining from the site where a tube had been inserted. As this is a sign of infection,

the witness brought it to the physician's attention. Upon her next review of the chart, Ms. Tschupp focused on whether the patient had an elevated white blood count or a fever (signs of infection), whether cultures had been ordered so as to identify what types of organisms were growing, whether the patient had been placed on antibiotics, and whether the patient was having any reaction to the antibiotics. She found that an antibiotic was being administered but that the patient still had an elevated white blood count and a fever. At this point, the witness again contacted the physician and suggested an "infectious disease consult".[4] The physician agreed and the consult was ordered. It was Ms. Tschupp's responsibility to make sure that the consult took place and to continue to monitor the situation until the patient was well enough to be discharged. Throughout this process, the URMC is recording her findings, observations and discussions on the patient's cert.

The URMC is also concerned with justifying, on an ongoing basis, the patient's continued receipt of acute care. This justification is closely related to the DRGs and reimbursement. If a patient is well and ready to be discharged in less than the number of days set forth by the DRGs, than it is to the hospital's advantage to do so since the hospital will still

[4] A "consult" is a term used to describe the situation in which a physician from a particular specialty is called in to examine a patient. For example, if a patient is scheduled to undergo surgery, a cardiologist might be called in to examine the patient and certify that his or her heart can withstand surgery.

receive full reimbursement for the DRG number. For this reason, Ms. Tschupp testified, "it is to the hospital's benefit to have the patient's care managed efficiently to get [the patient] well sooner..." On the other hand, if a patient remains in the hospital beyond the number of days prescribed by the DRGs, the hospital must establish, through documentation, that he or she was ill enough to warrant the additional time. If the hospital is unable to do this, it will not get reimbursed by the payor. This type of patient is referred to as an "outlier" and the URMC must oversee the documentation process. Upon finding an outlier, the URMC first looks at the chart for an obvious reason for the prolonged stay such as abnormal lab values. If the reason is not clear, he or she locates the physician assigned to the patient and asks for justification. If justification exists the URMC will direct the physician to record the justification on the patient's chart.

Some patients, usually elderly or homeless, reach a level of wellness where they no longer require acute care, but are not ready to leave the hospital. This is because they require post-hospital care, such as a nursing home or temporary shelter, that is not yet available; the patient is awaiting placement. When the URMC comes across such a patient while reviewing the charts, and believes that the patient's condition does not warrant the receipt of acute care, he or she must locate the appropriate physician and request justification. If the physician cannot

provide adequate justification, the URMC must place the patient on "alternate level of care" ("ALOC") status. This status denotes that the patient is awaiting placement and effects the amount of reimbursement that the hospital receives from the payor. Of course, a patient on ALOC status may become ill again and require acute care. If the URMC reads a chart and finds that a patient developed an infection, for example, it is his or her responsibility to discuss the matter with the physician, make sure that the patient's condition is fully documented on the chart, and reinstate acute care status. On occasion, a physician will inappropriately reinstate acute care. For example, a less experienced physician might note that a patient with an advanced case of AIDS is "spiking" a temperature and reinstate acute care. Since this symptom is the norm with such patients, acute care can not be justified. Under these circumstances, it would be the URMC's duty to speak to the physician and change the patient's status.

A quality of care issue becomes a "risk management" issue when a patient's care has been mismanaged to such an extent that the hospital may incur malpractice liability as a result. It is the responsibility of the URMC to locate risk management issues and report them to the hospital's risk management department for further investigation. According to Ms. Terenzio, this involves reviewing charts and "reading between the lines" since, often times, serious deviations in the management of patient care are

not evident on the face of the chart. Ms. Terenzio gave an example involving renal (kidney) patients. Upon reviewing the charts of several of these patients, she noticed that they were being given a particular antibiotic that is "nephrotoxic" or harmful to the kidneys. Renal specialists had been consulted about the matter and they had indicated that the antibiotic was in fact nephrotoxic. Nevertheless, the infectious disease department continued to prescribe the antibiotic and the physicians continued to administer it. Ms. Terenzio reported the situation to risk management. Ms. Tschupp gave an example involving a hypothetical patient with an abscess. With an abscess, the witness testified, the dressings should be changed daily. Ms. Tschupp testified that if she found in her chart review that the physician failed to order any redressing and did not attend to the patient for several days, she would report this incident to risk management. Other examples of risk management issues include, but are not limited to, premature discharge and return to the hospital, hospital acquired infections, and unplanned returns to the operating room. Along the same lines, it is the responsibility of the URMC to review every mortality and determine whether it was "acceptable" or normal.

In the case of a patient that is about to be discharged, the review done by the URMC is similar to the review done throughout the patient's stay. It is the duty of the URMC to review the

patient's chart in order to assure that the discharge is appropriate or that the patient is well enough to go home. To illustrate, Ms. Terenzio testified about a particular chart that she had reviewed a few days earlier. The physician had indicated that the patient was ready for discharge. In reviewing the chart, Ms. Terenzio found that the patient had a white blood cell count of 25,000, which is abnormal (the normal range is 8,000 to 10,000). She brought this to the physician's attention and suggested that he order a urine culture. As a result of the culture, the doctor determined that the patient had a urinary tract infection and the patient remained in the hospital so that antibiotics could be administered. Ms. Tschupp testified about an elderly woman who was supposedly ready for discharge. Upon reviewing the lab values on the chart, the witness noticed that the patient's thyroid was not functioning properly. She notified the physician and, as a result, he spoke to the patient about her medical history and learned that she had forgotten to mention the fact that she was on thyroid medication when she was admitted.

The URMCs attend weekly meetings or "rounds" for each ward that they cover. Also in attendance at these meetings are staff nurses, physicians, DPASs, social workers, and physical therapists. The purpose of these meetings is to discuss the status and care plan for every patient on the ward. It should be noted that the URMCs also testified to having daily contact, on a less formal basis, with all of the above personnel, except

physical therapists, to discuss patients' physical condition and plan of care.

In accordance with the JCAHO standards, hospitals must assess and monitor the quality of care that they provide with a view towards finding ways to improve it. In order to comply with this mandate, the quality assurance department identifies areas in which they believe quality should be improved. A "screen" is then devised by a physician, occasionally working with a URMC, in order to collect data which will later be evaluated. A screen is a form consisting of a series of questions designed to elicit relevant data. These screens are filled out by the URMC as he or she reviews the charts. As an example, Ms. Tschupp testified about a hip fracture screen. This screen was designed to study blood clots in the hopes of preventing their occurrence. The screen asks a series of questions related to the administration of an anticoagulant called "Coumadin". The URMC is asked to record, among other things, whether the patient's relevant lab values were normal on admission, whether Coumadin was ordered prior to surgery, after surgery, and in what dosages, and how the patient reacted.

Ms. Tschupp testified to having two additional duties, the completion of preauthorization approvals for elective surgery and the processing of IPRO quality issues, that are not shared by other URMCs. However, she stated that they could be reassigned to another URMC at her supervisor's discretion. When a patient

is scheduled for elective surgery, i.e., non-emergency surgery, pre-approval must be obtained from IPRO. It is the responsibility of the URMC to provide IPRO with the information from the patient's chart that it needs in order to justify the surgery. As for the processing of IPRO quality issues, this duty relates to IPRO's periodic reviews of the patient charts at a hospital. If an IPRO reviewer determines, upon reviewing a chart, that a patient was not appropriately cared for, IPRO will issue a citation to which the hospital must respond. It is the responsibility of the URMC to read the citation, decide which department should respond, and assure that a response is provided to IPRO within the specified time period. A citation that is upheld by IPRO effects the accreditation process.

NYSNA entered into evidence approximately 40 forms that are filled out by URMCs. The evidence demonstrated that there is a form that corresponds to almost every aspect of the URMC title. For example, there are forms that are filled out when a patient's status is changed to ALOC or when acute care status is reinstated, there is a form that must be filled out in order to report a risk management issue, and there are forms associated with every study.

When asked about how she allocated her time in a given day, Ms. Terenzio testified that upon arriving at work at about 8:00 a.m. she receives her certs for the day. At about 8:30 a.m., she proceeds to the wards. She remains in the wards until about 3:00

p.m. completing the above described duties and responsibilities. At about 3:00 p.m., she returns to her office, which is across the street from the hospital, and "batches" her work or sorts it so that the data processing department may input it into a computer system. At 4:00 p.m. she leaves for the day. Ms. Tschupp testified to a similar allocation of time except that she completes her work in the wards by 1:00 p.m.. She testified that in the afternoon, she batches her work and then works on the completion of preauthorization approvals for elective surgery and the processing of IPRO quality issues.

Both witnesses were questioned about the various title changes that they have undergone. When asked why she was placed in the coordinating manager title, Ms. Terenzio stated that "the position was offered to me and I took the position because it was an increase in salary." She further stated that after she was made a Coordinating Manager, the remaining MURAs in her department were placed in another managerial title referred to as "HCPPAs" or health care program planning analysts. She testified that this was also done in order to grant a salary increase to the MURAs. Ms. Terenzio explained that she, and the other MURAs, felt that they were underpaid given their educational backgrounds and years of experience. As a result, she stated, the MURAs felt that they "were not being appropriately represented [by] DC 37." She testified that there was "a push from the staff to our boss to get us out of DC 37,

put us in management titles, so that we can make some money and be acknowledged for the professionals that we are." Ms. Terenzio testified that she and her co-workers were taken out of the managerial titles, and placed in the URMC title because "someone from [HHC] told our boss that she had to change us into these titles, and so that was done."

Ms. Tschupp testified that the MURAs at Coney Island hospital were placed in the URMC title for similar reasons. She stated that her director "was very much aware of our dissatisfaction over time with the lack of monies we were getting, the lack of recognition we were getting from the union as nurses." She further stated that because of the salary, the hospital was finding it difficult to hire MURAs and some services, for lack of staff, did not have a MURA assigned to them. To deal with these problems, Ms. Tschupp testified, a committee was formed to "formulate the new titles, along with the job descriptions and functions; to facilitate this whole process that we are in right now."

The witnesses were asked whether their responsibilities had changed each time that their title changed. Although Ms. Terenzio testified that she felt that more was expected of her when she became a manager, she admitted that this was psychological. Otherwise, both witnesses testified to doing the same work whether they were MURAs, managers, or URMCs.

DPAS title

Velma Pryor, a registered nurse, testified that she is employed by HHC as a DPAS in the discharge planning department (the "DP department") at Metropolitan Hospital. She has held this position since approximately October of 1992. She reports to Robert Molk, the director of the DP department. She testified that she was hired by HHC as a MURA in 1984 and was promoted to the Sr. MURA title approximately two years later; she was placed in the Quality Assurance Department for the first four years of that period and in the DP department for the rest of the time. She works from 8:30 a.m. to 4:30 p.m., Monday through Friday. Evelina Freeman, also a registered nurse, testified that she is a DPAS in the DP department at Harlem Hospital. She estimated that she had held that position for approximately a year.[5] She reports to Horace Felix, who is the director of the DP department. Ms. Freeman testified that since being hired by HHC

[5] After Ms. Freeman testified the parties entered into evidence, as joint exhibits, two "personnel action forms" ("PAF") relating to her. One is dated October 16, 1992 and places Ms. Freeman in the DPAS title. The other is dated December 16, 1992 and returns Ms. Freeman to the Assistant Head Nurse title. Ms. Freeman testified that she was aware of the fact that she had been put into the DPAS title, but had no knowledge of the return to the Assistant Head Nurse title. DC 37 moved to have her testimony stricken from the record on the ground that she was an Assistant Head Nurse at the time of her testimony and that she had testified about duties that she was performing in that title. Since the witness testified to having done discharge planning work regardless of what title HHC placed her in, and since the documentary evidence shows that she served in the DPAS title for at least some period of time, the motion to strike was denied.

in 1981, while she has continuously worked in Harlem Hospital's DP department, she has held the following positions consecutively: MURA, Sr. MURA, HCPPA, and Assistant Head Nurse. Ms. Freeman testified to working from 8:30 a.m. to 5:00 p.m, Monday through Friday. As with the URMCs, notwithstanding the fact that the witnesses work at different facilities, the job duties and responsibilities described be each are, in all relevant and material aspects, identical.

The 1993 AMH includes a section entitled "management and administrative services". This section mandates that the hospital's chief executive officer, through the management and administrative staff, provide for hospitalwide policies and procedures on discharge planning. The AMH states that these policies and procedures should include "mechanisms to identify patients who require discharge planning to foster continuity of medical and/or other care to meet their identified needs; and initiate discharge planning on a timely basis." The duties and responsibilities associated with the DPAS title revolve around these mandates.

Each DPAS is assigned to one or more services in the hospital. According to the testimony of the witnesses, upon reporting to work, their supervisors provide them with a list of recently admitted "high risk" patients. On occasion, social workers may refer additional high risk patients to the DPASs. High risk patients are those who are likely to need post hospital

care of some sort. This includes, among others, patients over 65 years of age, homeless patients, AIDS patients, patients who have had strokes, unconscious patients, substance abusers, and patients with diabetes. Post hospital care covers a broad spectrum of services; examples include arranging for the patient to be sent home with equipment or medications, arranging for follow-up visits by a nurse, providing the patient with a home attendant, sending the patient to a drug or alcohol rehabilitation program, and arranging for placement in a nursing home, adult home, or chronic care facility.

After receiving the list of high risk patients, the DPASs go to the wards to perform an "initial assessment" of the patient. The purpose of this assessment is to make a projection about what the patient's post hospital care needs might be. In order to complete the assessment, the DPAS must both review the patient's chart and visually evaluate the patient. From reading the chart, the DPAS learns how, and in what condition, the patient was found, the diagnosis, any tests that have been done, the patient's past medical history, the patient's social/family information, etc. However, the witnesses testified, a visual assessment of the patient is necessary to get a complete picture of the patient's condition for discharge planning purposes. Ms. Freeman testified that, in performing the visual assessment, she evaluates the patient "from head to toe, each system, his mental status, vision, hearing..., the need for dentures..., his

strength in his extremities, whether he is incontinent, whether he has a Foley catheter in...his [ability] to move or turn himself in the bed." If, after reading the chart and observing the patient, the DPAS needs further information or has unanswered questions, he or she will call the physician or nurse in charge of the patient. Throughout this process, the DPAS fills out a standard form that records his or her findings about the patient's condition and projections about the patient's future needs; Ms. Freeman testified to having worked on the creation of this form. This procedure, including the chart review, the observation of the patient, and the completion of the form takes from 15 to 45 minutes per patient depending on the complexity of the patient's condition. In cases where the patient's condition is evolving, the DPAS will perform several of these assessments during the patient's hospital stay in order to arrive at the most appropriate discharge plan.

When a patient requires placement in a nursing home, the DPAS must complete additional standardized New York State Department of Health forms: a "Patient Review Instrument" ("PRI") and a "Screen". These forms, taken together, essentially ask for a detailed evaluation of the patient's ability to care for himself or herself, the patient's mental state and physical condition, and the patient's diagnosis. These forms are sent to various nursing homes in an effort to place the patient. Some nursing homes also request that the patient visit the facility

for screening interviews. According to Ms. Freeman, accompanying the patient to these interviews is one of the duties of the DPASs.

In fact, for almost every type of placement or service that is recommended by the DPAS, there is a corresponding form which must be filled out that summarizes the patient's physical and/or mental/behavioral condition. For example, there is an AIDS Long Term Care Assessment Program form which must be filled out if a patient is to be sent to a chronic care facility for AIDS patients, there is a Physician's Plan of Treatment form that must be completed by the DPAS and signed by the physician if a patient requires visiting nurse services or home care, and there is a New York City Human Resources Administration Housing Placement and Case Management Application which is filled out when a patient is being placed in an adult home or group home.

It is the responsibility of the DPAS, according to Ms. Freeman, to attend "family conferences." These conferences are attended by a social worker, members of the patient's family, a physician, and a DPAS. The purpose is to involve the patient's family in formulating a discharge plan.

The witnesses also testified to attending several "multidisciplinary" meetings per week; Ms. Freeman testified to attending an average of two per day. These meetings are attended by all or some of the following: a DPAS, a physician, a staff nurse, a social worker, a quality assurance representative

and a nutritionist. Each meeting takes between 30 and 45 minutes. Ms. Freeman testified that the purpose of these meetings is to discuss, for each high risk patient, "the patient's care and potential discharge plan and needs." The various attendees at these meetings participate in completing a form that documents the patient's diagnosis, estimated length of stay, and discharge plan. It should be noted that while it is the responsibility of the DPAS to propose a discharge plan, it is not his or her responsibility to actually contact the service providers and make arrangements for placement; this work is done by clerical employees.

Ms. Freeman testified to "orientating" new staff, including interns, residents and nurses, on the subject of discharge planning and to participating in discharge planning seminars and in-services held with other hospital staff. She also stated that, since physicians are primarily focused on the medical aspects of patient care, educating them about a patient's possible post hospital needs from a nursing point of view is an ongoing process.

Ms. Freeman testified to having daily contact with URMCs assigned to her services. She stated that they see each other throughout the day and that they discuss "the level of the patient's care" and the projected discharge plan. More specifically, Ms. Freeman testified that while she and the URMC are concerned with different aspects of the patient's hospital

stay, they work as a team "towards getting the patient out of the hospital [in] a reasonable amount of time at the patient's optimal level of care."

Both witnesses were asked about how their time was allocated in a typical day. Ms. Freeman testified that on the previous day, she had assessed or reevaluated approximately 11 patients and attended a family conference. She stated that the conference took about an hour and the rest of her day was spent on the 11 patients. Ms. Pryor testified to a similar day except that she attended a multidisciplinary meeting that lasted for about an hour and was only responsible for about eight patients.

Ms. Freeman was asked about whether her responsibilities had changed each time that her title changed. She stated that they had changed to a certain extent, but not as a result of the title changes. Rather, the nature of the discharge planning work had changed over the years. She explained that additional new forms had been added to her list of responsibilities and more collaboration with physicians and nurses was required.

MURA title

Julio Sanchez, a foreign doctor, is a MURA in the UR department at Woodhull Hospital. As he is neither an RN nor an ART, he was not placed in either of the two new titles. The job duties and responsibilities associated with the MURA title, as testified to by Mr. Sanchez, are substantially similar to those

described by the URMCs. All of the MURAs in the UR department at Woodhull Hospital who held RN licenses or ART certificates were reclassified into the URMC title and continue to work in the UR department.

Testimony of DC 37 representative

Hector Coto, a Council Representative from DC 37, testified about the circumstances surrounding the various title changes described by the witnesses.

Mr. Coto testified that late in 1991, in his capacity as Council Representative, he began to receive phone calls from individuals in the MURA title. He testified that the callers indicated that HHC was hiring staff nurses, HCPPAs, and coordinating managers to perform the same work that the MURAs were performing. Additionally, the callers represented, the new hires were being paid more than the MURAs.

The witness testified that as a result of these calls, he conducted an investigation and discovered that the claims made by the callers were accurate. He found that HHC had been taking these actions because, as a consequence of the relatively low salary, it was having difficulty hiring and retaining employees in the MURA title. He testified that about 90 percent of the employees who were performing the work of MURAs while serving in the staff nurse, coordinating manager and HCPPA titles, had previously been MURAs. On cross examination, he stated that

these practices had been occurring in the majority of hospitals and for more than three years. When asked about how the salary problem developed, Mr. Coto responded that when the MURA title was created there was little or no disparity between the MURA salary and the staff nurse salary. Therefore, he stated, many RNs were accepting positions as MURA. Later, some time around 1987, NYSNA and the City negotiated a contract with a parity clause. As a result, Mr. Coto testified, the RNs received an increase in salary that the MURAs did not receive and the MURAs began to resign.

According to his testimony, Mr. Coto then contacted Raquel Ayala, the Assistant Vice President of HHC at the time, and scheduled a labor management meeting for February 13, 1992 to discuss the matter. At this meeting the parties agreed that Ms. Ayala would send a memo to HHC's facilities instructing them to refrain from hiring non-MURAs to perform MURA work and that HHC would draft a proposal for dealing with the problem permanently.

As agreed, the memo was issued on February 14, 1992 and HHC produced a proposal on March 12, 1992. The proposal advocated "the development of two separate title series, one to perform the function of discharge planning and the other to perform utilization review." The two titles would have a New York State registered nurse requirement. The proposal also stated that "incumbents in the current MURA title series would be assigned to an appropriate title in the new series based on job duties."

On March 16, 1992, the parties again met to discuss the proposal. Mr. Coto testified that they agreed that the new job descriptions did not constitute an actual change in any job duties. Rather, Mr. Coto stated, they were created as a way to retain the MURAs by granting them a salary increase; an action which could not be taken under the collective bargaining agreement covering the MURAs. After several more meetings, HHC agreed to place incumbent MURAs with ART certifications into one of the new titles as well as RNs. Under the original proposal, neither employees with ART certifications nor foreign doctors would be "grandfathered" into the new titles. According to the witness, it was understood that under the new agreement foreign doctors, who held neither an RN license nor an ART certification, would still remain in the MURA title. Finally, it was agreed that all future hires would hold RN licenses. On cross examination, Mr. Coto was asked why he thought HHC had elected to reserve the two new titles for RNs only. He answered that he was not sure but stated that HHC had been moving towards hiring more RNs into the MURA title in recent years and that most of the incumbent MURAs were in fact RNs.

Mr. Coto testified that DC 37 was not in favor of the creation of two titles during this period of negotiations. He stated that in the past there had been interchange between MURAs in the utilization review departments and MURAs in the discharge planning departments. Under the proposal, he testified, URMCs

and DPASs would be doing completely different work and the interchange would be lost. However, Mr. Coto indicated, HHC would not compromise on this issue.

Positions of the Parties

DC 37's Position

DC 37 maintains that accretion of the URMC and DPAS titles to its health services bargaining unit is appropriate because of the history of collective bargaining in the unit and the similarity and close relationship of the URMC and DPAS titles to the MURA and Sr. MURA titles.

DC 37 points out that it has represented the MURAs and Sr. MURAs since 1977 and argues that the reclassification did not change the job duties of the employees. Moreover, DC 37 argues, the creation of the URMC and DPAS titles was a result of DC 37's effort, through the collective bargaining process, to find a solution to the turnover problems in the MURA and Sr. MURA titles.

DC 37 contends that the URMCs and DPASs have a greater community of interest with the MURAs and Sr. MURAs and other titles within the health services bargaining unit than with the titles in NYSNA's bargaining unit. According to DC 37, "the witnesses who testified in this case have detailed the extensive record keeping duties and functions of the DPAS/URMC titles." In support of this statement, DC 37 asserts that "each witness

provided the Board with a sheaf of documents used by their facility in carrying out their discharge planning and utilization review functions" and that "many, if not all, of these documents are used to secure and insure proper insurance and governmental reimbursement to the hospital for patients' care." Further, DC 37 maintains, "it is clear that DPAS/URMCs spend at least 75% of their time reviewing medical charts, filling out forms and updating the diagnostic information to be entered in their hospital's computer database." Summarizing this point, DC 37 states that the record supports its contention that "the functions of the DPAS/URMC titles are for all practical purposes, identical to those of the MURA/Sr. MURA titles and different from those of other staff nurse titles represented by NYSNA because of the unique and comprehensive record keeping functions associated with their jobs."

DC 37 relies on several other factors to bolster its contention that titles in question should be accreted to the health services unit. DC 37 argues that the job specifications for the new titles and the MURA titles are similar, the MURAs, URMCs and DPASs work in the same departments, they work the same hours, they share the same supervision, they attend the same in-service training, and "they are not considered part of the hospital's nursing staff insofar as they are supervised by non-nurses." Finally, DC 37 contends that, unlike the nurses represented by NYSNA, there is an absence of "any patient care

duties" from the URMC and DPAS titles.

As for the contact between the URMC and DPAS titles and nurses and physicians regarding information on a patient's chart, DC 37 argues that this contact merely "flows from the exercise of their primary function of reviewing patients' medical charts."

Finally, addressing NYSNA's post-hearing brief, DC 37 argues that the RN licence requirement associated with the new titles is not sufficient to establish a community of interest between the new titles and NYSNA's nurses for several reasons. First, DC 37 points out, the URMC and DPAS titles consist of a number of employees with ART certifications rather than RN licenses. Second, DC 37 argues, MURAs and Sr. MURAs continue to work alongside employees in the new titles performing the same functions and serving in the same departments. Third, DC 37 contends, the Health Services unit contains a number of titles which also require an RN license as a qualification.

NYSNA's Position

It is NYSNA's position that the URMC and DPAS titles should be accreted to its unit because the duties and responsibilities associated with these titles are closely related to those of the nurses it represents. NYSNA relies, in part, on the fact that one of the qualifications for the new titles is an RN license and on the fact that the URMCs and DPASs have daily contact with the nurses it represents.

NYSNA cites several private sector cases and asserts that while they are not binding on the Board, they are instructive in this case. These cases are cited for the proposition that the private sector equivalents of the URMCs and DPASs share a sufficient community of interest with the nurses in an RN unit to justify their inclusion in that unit. For example, in Trustees of Noble Hospital and Massachusetts Nurses Association, 218 N.L.R.B 1441, 1974-75 CCH NLRB ¶ 15,980 (1975), a case involving the private sector equivalent of the URMCs, the National Labor Relations Board ("NLRB") found a sufficient community of interest based on the requirement of an RN license, the daily contact with other RNs, and the fact that the duties of the title included the assurance of high quality patient care and appropriate utilization of hospital resources through chart reviews. In Pocono Medical Center and Pennsylvania Nurses Association, 305 NLRB No. 38, 1991-92 CCH NLRB ¶ 16,947 (1991), a case involving the private sector equivalent of the DPASs, the community of interest findings were based on a combination of the RN license requirement, the face-to-face contact with patients, the time spent on a patient care unit and the contact with other staff nurses.

Discussion

Section 12-309b(1) of the New York City Collective Bargaining Law ("NYCCBL") empowers the Board:

> to make final determinations of the units appropriate for purposes of collective bargaining between public employers

> and public employee organizations, which unit shall assure to public employees the fullest freedom of exercising the rights granted hereunder and under executive orders, consistent with the efficient operation of the public service, and sound labor relations...

Title 61, § 1-02(j) of the Rules of the City of New York, formerly §2.10 of the Revised Consolidated Rules of the Office of Collective Bargaining (hereinafter "OCB Rules"), sets forth criteria to be applied by the Board in making determinations of appropriate unit placement of employees. The Rule provides:

> In determining appropriate bargaining units, the Board will consider, among other factors:
>
> 1. Which unit will assure public employees the fullest freedom in the exercise of the rights granted under the statute and the applicable executive order;
>
> 2. The community of interest of the employees;
>
> 3. The history of collective bargaining in the unit, among other employees of the public employer, and in similar public employment;
>
> 4. The effect of the unit on the efficient operation of the public service and sound labor relations;
>
> 5. Whether the officials of government at the level of the unit have the power to agree or make effective recommendations to other administrative authority or the legislative body with respect to the terms and conditions of employment which are the subject of collective bargaining;
>
> 6. Whether the unit is consistent with the decisions and policies of the Board.

In the instant matter, the issue before us is whether, consistent with the criteria quoted above, the newly created job titles of URMC and DPAS should be added, by accretion, to one of two previously certified units. In making such determinations,

we consider whether the new titles, because of their similarity or close relationship to the unit titles, would have been included in the unit at the time of the original certification.[6] Two of the above factors, the history of collective bargaining in the unit and the community of interest with one or the other of the existing units, are of significance here.

We will first consider the history of collective bargaining in the unit which, under the circumstances presented in this case, favors the accretion of the two new titles to DC 37's unit. Pursuant to Decision No. 2-77, DC 37 has represented the MURAs since 1977. The record indicates that most of the employees in the new titles were previously MURAs represented by DC 37. Moreover, the testimony of the witnesses is clear that they continue to perform the same functions in the URMC and DPAS titles that they previously performed in the MURA title.

Turning to the question of whether the new titles share a community of interest with one or the other of the original units, we note that when deciding this issue in the past, the Board has considered a number of factors including:

1. the job duties and responsibilities of the employees;[7]

2. their qualifications, skills and training;[8]

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[6] Decision Nos. 16-93; 15-87; 23-75; 39-69.

[7] See, e.g., Decision Nos. 15-93; 16-86; 13-85; 18-81; 13-81; 34-80.

[8] See, e.g., Decision Nos. 15-93; 13-85; 13-81; 34-80.

3. interchange and contact;[9]

4. wage rates;[10]

5. lines of promotion;[11]

6. organization or supervision of the department, office or other subdivision.[12]

This list is not exclusive; there are a variety of other factors that do not necessarily exist in every case, and that the Board will consider if appropriate. None of the factors necessarily is controlling. We make determinations on a case-by-case basis and balance the various factors to determine where the greater community of interest lies.[13]

There can be no doubt that DC 37 has also demonstrated a significant similarity, if not identity, between the job duties and responsibilities of the contested titles and the MURA title in its unit. The record makes it clear that the witnesses' duties and responsibilities did not change when their titles were changed from MURA to URMC or DPAS. Moreover, Mr. Sanchez, an individual currently serving in the MURA title, testified to duties and responsibilities substantially similar to those

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[9] See, e.g., Decision Nos. 15-93; 29-77; 23-76; 23-75.

[10] See, e.g., Decision Nos. 15-93; 13-85; 41-82; 41-73.

[11] See, e.g., Decision Nos. 15-93; 34-80; 22-75; 42-74; 45-72.

[12] See, e.g., Decision Nos. 15-93; 55-76; 65-73; 61-71.

[13] See, e.g., Decision Nos. 15-93; 9-88; 15-87.

described by the URMCs.

NYSNA has demonstrated some similarity in job duties and responsibilities between the two new titles and the staff nurse title already certified to its existing unit. Staff nurses, like URMCs and DPASs, are concerned with patient care. According to the official HHC job specification for the staff nurse title, staff nurses "develop, implement and evaluate the nursing regimen for assigned patients/clients", they "record and maintain nursing care plans and progress notes on patients/clients to ensure continuity of care", and they "participate with other health team members to plan a comprehensive patient care program." However, there is a difference between the staff nurse title and the two new titles; whereas the staff nurses are involved in planning the initial administration of patient care, the URMCs oversee the quality of patient care and the DPASs attend to the patient's post hospital care. Moreover, while the primary focus of the staff nurse is on the well-being of the patient, the primary purpose of the URMC and DPAS titles, as well as the MURA title, is to insure compliance with the many requirements for the hospital's continued accreditation and reimbursement. Thus, balancing the similarity demonstrated by NYSNA between the new titles and the staff nurse title against the identity demonstrated by DC 37 between the new titles and the MURA title, we find that this factor also favors the accretion of the two new titles to DC 37's unit.

The qualifications, skills and training required for the URMC and DPAS positions do not favor accretion to either unit over the other. The URMC and DPAS positions require an RN license and a certain amount of work experience. The MURA position does not require an RN license. The staff nurse position, on the other hand, does requires an RN license. However, for other titles in DC 37's unit, such as the various public health nurses, possession of an RN license is either a requirement or an alternative requirement.

It is clear that individuals in the URMC and DPAS titles share the greatest number of contacts with the staff nurses, MURAs, and with each other. They have some contact with nutritionists and physical therapists, two titles in DC 37's unit, but this contact is minimal by comparison. As for interchange, a review of the MURA and URMC job descriptions and the testimony of the MURAs, URMCs and DPASs reveals that there is significant interchange of duties among the titles. In fact, almost all of the duties listed on the MURA job description are also listed on the URMC job description. By contrast, there is no interchange between the two new titles and the staff nurse title. Given the contact with DC 37 titles and the high degree of interchange among the titles, we find that the two new titles share a community of interest with the MURAs as to interchange and contact.

The wage rates established for the URMC and DPAS positions

do not favor accretion to either unit over the other. While there is some overlap between the wage rates of the MURA, URMC, DPAS, and staff nurse titles,[14] the ranges associated with the two new titles fall somewhere between ranges associated with the MURA title and the staff nurse title.

The URMCs and DPASs, like the MURAs, are supervised by the directors of either the UR department or the DP department. The staff nurses apparently report to supervisors in the nursing department. Therefore, the two new titles share a community of interest with the MURAs, rather than the staff nurses, as to organization or supervision of the department.

The remaining criterion listed, the lines of promotion, does not favor accretion to either unit. The URMC and DPAS job descriptions indicate that there is no line of promotion to or

[14] We take administrative notice of the fact that the wage rates were as follows at the time that the two new titles were created:

	MIN	MAX
MURA	$29,770	$38,265
Sr. MURA	$32,307	$40,346
URMC		
Level I	$33,950	$42,438
Level II	$36,125	$45,156
DPAS		
Level I	$33,950	$42,438
Level II	$36,125	$45,156
Staff Nurse	$37,833	$52,559

from any other title. While many MURAs have been placed in one of the two new titles, this will not continue in the future since the RN license is a requirement for the two new titles.

In conclusion, four of the factors considered in making a community of interest determination strongly favor accretion to DC 37's unit. These include the history of collective bargaining in the unit, the duties and responsibilities of the employees, the organization and supervision of the department, and the contact and interchange between the new titles and the MURAs. Therefore, based upon the community of interest demonstrated between the MURA title and the URMC and DPAS titles, we find DC 37's unit to be the more appropriate unit for the two new titles.

ORDER

Pursuant to the powers vested in the Board of Certification by the New York City Board of Collective Bargaining, it is hereby

DIRECTED, that the title Utilization Review/Management Coordinator, Levels I and II (Title Code Nos. 005080 and 005090) and Discharge Planning Assessment Specialist, Levels I and II (Title Code Nos. 005100 and 005200) be certified to Certification No. 28-78 (as amended), held by District Council 37, AFSCME.

Dated: March 17, 1994
New York, NY

Malcolm D. MacDonald
CHAIRMAN

Daniel G. Collins
MEMBER

George Nicolau
MEMBER