UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 27

CLINICA CAMPESINA FAMILY HEALTH SERVICES D/B/A CLINICA FAMILY HEALTH & WELLNESS

Employer/Petitioner

and **Case 27-RM-369131**

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 105, AFL-CIO

Union

DECISION AND DIRECTION OF ELECTION

I. INTRODUCTION

Based on a demand for recognition submitted by the Union, the Employer/Petitioner (or Employer) filed the instant petition. The primary issue presented in this case is whether the unit sought by the Union limited to employees employed at the Employer's Westminster Medical Clinic (also referred to herein as the Westminster Clinic), is an appropriate unit for collective bargaining (hereinafter called the demanded unit); or whether, as the Employer/Petitioner contends, the unit must also include employees at four (4) of the Employer's 14 other facilities known as the Pecos Clinic, Thornton Clinic, Boulder - People's Clinic, and the Lafayette Clinic. There are approximately 30 employees in the demanded unit. There are approximately 240 employees in the unit proposed by the Employer/Petitioner.

A hearing officer of the Board held a hearing in this matter, and the parties orally argued their respective positions prior to the closing of the hearing. As explained below, based on the record and relevant Board law, I find that the demanded unit consisting of employees employed at the Westminster Medical Clinic is an appropriate unit and shall direct an election in that unit. The parties agree that employees employed at the Westminster Clinic in the classifications of case manager, clinic operations specialist, enrollment specialist, medical assistant, medical records, referral case manager, behavioral health professional, nurse, nurse practitioner, physician assistant, and physician (MD and DO)[1] constitute an appropriate single-facility unit.[2]

[1] The parties stipulated that registered nurses, nurse practitioner, physician assistant, and physician (MD and DO) are professional employees as defined in Section 2(12) of the Act.

[2] The parties stipulated that two classifications should vote subject to challenge regardless of the scope of unit: Office Technician and Assistant Medical Director of Employee Health. Accordingly, their eligibility was not litigated. Having found the demanded unit to be appropriate, approximately four individuals in these two classifications are permitted to vote subject to challenge.

The Board has delegated its authority in this proceeding to me under Section 3(b) of the Act. I find that the hearing officer's rulings are free from prejudicial error and hereby affirm them. I further find that the Employer is engaged in commerce within the meaning of the Act; it will effectuate the purposes of the Act to assert jurisdiction; the Union is a labor organization within the meaning of the Act; and a question affecting commerce exists concerning the representation of certain of the Employer's employees.

II. FACTS

A. The Employer's Overall Operations

The Employer is a federally qualified community health center that provides low-cost primary care to uninsured or underinsured patients. Some of the clinics also provide dental care, mental health, and substance use care. The Employer/Petitioner's operations include 14 facilities in Adams, Boulder, Broomfield and Gilpin counties in Colorado.

Three (3) of the Employer's 14 facilities are located in Adams County. One of these three clinics, the Westminster Clinic, is where the employees in the demanded unit are employed and it provides physical health care. The Employer seeks to add employees employed at the remaining two Adams County clinics to a unit with employees employed at the Westminster clinic: 1) the Pecos Clinic that provides physical health care and a pharmacy and is located 2.4 miles from the Westminster Clinic[3], and 2) the Thornton Clinic, that provides physical health, pharmacy and dental services, and is located 3.3 miles from the Westminster Clinic.

Nine (9) of the Employer's 14 facilities are located in Boulder County, specifically in the cities of Boulder, Nederland, and Longmont. The Employer seeks to include employees employed at two (2) of these clinics in a unit with those employees employed at the Westminster Clinic: The Lafayette Clinic on Public Road (located 12.8 miles from the Westminster Clinic), which provides physical health and dental care, and the People's Clinic (located 21.8 miles from the Westminster Clinic), which provides physical health and pharmacy services.

The remaining seven (7) facilities in Boulder County are *not* sought by the Employer to be included in a unit with the employees employed at the Westminster Clinic: 1) The Lafayette Clinic on Dixson Avenue, which provides mental health care; 2) the Nederland Clinic, which provides physical health and mental health care; 3) the Norton Center for Behavioral Health, which provides mental health and pharmacy services; 4) the Ryan Wellness Center (also known as the Alpine Clinic), which provides physical and mental health care; 5) the St. Vrain Community Hub, which provides mental health services; 6) the Walk-in Crisis & Addiction Services Center, which provides crisis services. Employees at the Walk-in Crisis & Addiction Center are currently

[3] The only record evidence regarding distances between clinics are for those between the Westminster facility and the other four clinics the Employer seeks to include in the unit.

represented by the Union[4]; and 7) the Wellness Education Center,[5] which provides mental health care.

The two (2) remaining clinics are the Broomfield Clinic, located in Broomfield County, which provides mental health care, and the Gilpin Clinic, located in Gilpin County, which provides physical health care. As noted, the Employer does not seek to add employees employed at either of these clinics in a unit with Westminster Clinic employees.

The Employer's model uses integrated care teams to deliver care to patients. On a typical care team there would be a primary care provider (PCP), a medical assistant, a behavioral health professional, a case manager, a nurse, a registered dietician, and an "OT," which is front-desk staff, medical records employee, and a referral case manager. The Employer describes its clinic layout as a "pod" model. Clinics are made up of one to four pods where the care team staff members sit together, with the patient exam rooms situated around the pod. The pods have color names. There are typically three exam rooms for every one PCP. All pods have a lab and procedure room. They may also have an ultrasound room or NST room (also for pregnant patients). Patients are assigned home clinics and pods within that clinic, and providers within that pod. Patients generally do not transfer between clinics or have appointments outside their home clinic.

B. Daily Operations and Labor Relations

Heather Blatchley is the Employer's Vice President of Operations. She is responsible for overseeing the operation of the Pecos Clinic, Thornton Clinic, Westminster Clinic, Lafayette Clinic (Public Road), Nederland Clinic, People's Clinic, and the Gilpin Clinic. The Nederland and Gilpin Clinics share a care team of five employees, and four employees are at the Gilpin Clinic. The total number of employees who work for the Employer is about 900, and Blatchley oversees approximately 200 of them. There is no record evidence regarding who oversees the other clinics.

Supervision/Management

Each clinic has a Clinic Director that is responsible for the day-to-day operations at the site, such as making sure staffing is sufficient and handling patient flow. The Clinic Director at the Westminster Clinic does not oversee any other facilities. Clinic Directors have a weekly clinic director meeting they all attend with Blatchley where they discuss topics such as patient access, staffing and patient volume, and organization level quality metrics.

Supervisors within each clinic report to the Clinic Director. These positions are Clinic Operations Manager (who is the Office Technician's supervisor), Clinic Medical Assistant Manager (CMAN) (who supervises medical assistants), an Office Manager, and in some cases, an Assistant Nursing Director. Within the proposed multi-facility unit, there are two Assistant Nursing Directors, one for the clinics at Westminster, Lafayette, and People's, and one for Pecos

[4] The record does not reflect when this location became organized.

[5] In October 2024, the Employer merged with Mental Health Partners to close care gaps at each of the entities' facilities. Prior to the merger, the Employer/Petitioner did not provide specialized mental health services and instead referred those services to outside entities.

and Thornton clinics. They supervise nurses at those clinics. The Assistant Nursing Director who covers the Westminster Clinic reports to the Clinic Director at the People's Clinic. The record is silent as to which Clinic Director the Assistant Nursing Director who covers Pecos and Thornton reports.

Primary care providers (Physicians, Physician Assistants, Nurse Practitioners) in the clinics report to the Clinic Medical Director. The Clinic Medical Director reports to Zach Wachtel, VP of Medical Services, who reports to the Chief Medical Officer (CMO). Medical records and referral case managers within the clinics, including the Westminster Clinic, report to local RCM/Medical Records supervisors and Referral Case Manager/Medical Records Supervisors. The behavioral health providers report to the Behavioral Health Team Manager, who reports to the Director of Behavioral Health, who reports to the Chief Population Health Officer. Registered Dieticians report to the ECS Director. The medical assistants report to the local Clinic Medical Assistant Manager (CMAN). Enrollment Specialists report to an Enrollment Manager, who reports to an Enrollment Director, who reports to the Chief Population Health Officer. The Enrollment Director oversees the Enrollment Managers at each site. The Chief Population Health Officer oversees all the facilities. Case Managers at the clinics report to a local Case Manager/Team Manager, who reports to the Enhanced Care Service Director. OB-GYNs report to Director of OB-GYN Services. Psychiatrists report to the Chief Medical Officer.

The Employer also employs triage nurses, who are part of a centralized team that works across all sites. They work remotely from home. They can be accessed through the call center. When a patient calls with symptoms, the call center will forward the call to the triage nurse team. Patients can also access them directly through the call center phone tree from any site for medical advice. There are approximately eight nurses on the triage team. They manage incoming calls and do task box entries for all sites.[6] The triage team works for the Employer's primary care medical services. They could potentially cover as a Registered Nurse at a clinic, but there is no evidence in the record that they have done so. The record fails to indicate who they report to. The parties stipulated that the triage nurses would be included in the proposed multi-facility unit.

Hiring

Clinic Directors identify a need and initiate hiring for a vacant position but need approval from the executive team to post it. The Clinic Directors then work with the centralized recruiting department to post the position, and candidates are received through the Employer's recruiting platform. The recruiter screens the candidates and passes them through to the "hiring managers," who are in most cases Clinic Directors.[7] Interviews happen at the local level and the Clinic Director makes a recommendation for hire. The hiring manager then partners with the Human Resources (HR) department to complete the hiring process, which includes background checks and salary assignment and orientation scheduling. Job postings are for specific clinics.

[6] The task box function is discussed in detail in the similarity of skills and functional integration section below.
[7] The "hiring manager" could also be the Clinic Operations Director or the Assistant Nursing Director, both of which are local to the hiring clinic.

Discipline/Discharges

Clinic Directors issue verbal warnings, coaching, and lower-level discipline. In cases of more serious discipline, such as performance improvement plans or termination, the Clinic Directors recommend such action but are required to "partner with HR to follow a standard and org-level plan." The record lacks evidence describing what occurs when the Clinic Directors "partner with" HR, and whether their recommendations are generally followed, as well as what type of review HR conducts.

B. Interchange

Employees and supervisors can permanently transfer from one clinic to another on a voluntary basis. An Employer exhibit indicates that at least four of the twenty transfers occurring between September 2024 and July 2025 were made to non-unit positions. The record revealed that no permanent transfer in that time period was mandatory.

Some employees have prescheduled shifts outside of their home clinics. These employees split their full-time equivalent between clinics. An exhibit submitted by the Employer indicates that there are 26 employees who allegedly split their time.[8] However, eight (8) of these employees are triage nurses, who work remotely and cover all sites. There are five (5) OBMAs from the clinics in Pecos, Thornton and Westminster who, from their home sites, work one shift per week remotely supporting tasks across the organization. The same exhibit contains numbers that refer to "shifts." A shift is four hours, so a full eight-hour day would be two shifts. For example, one shift/four hours would be represented by .1 on the exhibit, and .2 would be two shifts, and so-on. There is a Case Manager who works .5 shifts at the Westminster Clinic and .5 at Pecos. There is a behavioral health case manager who works .5 at Pecos and .5 at Lafayette. There is a Psychiatry employee who works .2 at Peoples and .4 at Thornton, and one who works .3 at Westminster, .475 at Pecos, .225 at Lafayette and once a month at Nederland and Gilpin. There are two nurse practitioners who work some of their time at Alpine and some at Peoples, and one who works at Nederland, Lafayette and Gilpin. There are also MDs who work at Alpine .2 of the time and more time at Peoples. There are two Enrollment Specialist Leads who work four days at their home site and one day at Lafayette or Westminster. There are a couple of OBs who work at Peoples and Thornton and who are on call the rest of the time. The exhibit also contains a reference to "multiple," which is meant to refer to unnamed staff who cover tasks for non-home sites as needed, with no quantities of time included.[9]

Employees occasionally cover at other clinics that are short-staffed. This usually occurs when employees are on leave or there are call-offs. An Employer exhibit illustrates dates employees covered shifts at sites other than their home clinics and includes hours worked at the non-home site each day. The exhibit shows one employee working 32 hours a day. It does not provide a denominator of the total number of hours worked at that facility or the others at issue (the total number of shifts by week at *each* location). Another Employer exhibit shows the total

[8] I note that the exhibit used to show this was created for the hearing and not by the witness who testified about its contents.

[9] The dates covered by this exhibit appear to be April 7, 2025 to July 7, 2025. There are no specifics in the record regarding whether this is an average of shifts between those dates or what the parameters are.

number of hours worked by unit employees at clinics other than their own. The Employer represented on the record that the way to determine the percentage of time employees worked at a clinic other than their home clinic would be to compare the two aforementioned exhibits. The comparison is covered in the Analysis portion of my decision. In addition, all short-term coverage is initiated by site-level leadership. An employee would learn the Employer is seeking coverage at another clinic from their supervisor. Employees are asked, but are not mandated, to cover patient needs at another clinic. This coverage is voluntary and does not lead to disciplinary action if rejected. There are staff who have never covered at another clinic. There is no evidence of interchange between the Gilpin and Nederland clinics and those the Employer seeks to include in the multi-facility unit, nor at the Alpine clinic, which is focused on severe mental healthcare. The Employer covers mileage if employees work somewhere other than their home clinic.

Once a year all the providers from all the clinics attend a "team time" meeting. Other than that, all meetings at the Westminster Clinic are with staff from that clinic. For example, once a week the Westminster Clinic employees meet with their clinic's operations manager and their medical director. There are provider team meetings once a month for the behavioral health providers at the Westminster Clinic led by the clinic's medical director, and behavioral health team meetings that include the Westminster Clinic behavioral health supervisor, and the two behavioral health providers.

C. Similarity of Skills, Working Conditions and Functional Integration

Employees in the same role at various clinics generally perform the same functions. Clinics are set up in a similar fashion. Patient visits in the clinics are generally the same. Office and patient care supplies are roughly the same. There are different patient populations served at different clinics, depending on location. In addition, management styles at different clinics differ. For example, a behavioral health provider who has worked at two locations noted differences between how her supervisors wanted things done at the People's Clinic versus the Westminster Clinic, and the amount of oversight they provided.

Benefits/hours

The executive team sets clinic hours. Each of the Employer's 14 clinics are open from 8:00 a.m. to 12:00 (noon), with a closure for lunch between 12:00 (noon) and 1:00 p.m., and open again from 1:00 p.m. to 5:00 p.m. Most clinics have evening hours one night a week from 5:00 p.m. to 8:00 p.m. The employee handbook applies at all sites. Benefits are the same across all clinics. Pay structures are the same. Standard operating procedures manuals (things like medical records, vaccines, HIPAA, referrals, language interpretation, etc.,), medical provider and administrative manuals apply at all clinics. The same care resources are available to all clinics on the Employer's intranet, with folders containing guidelines for specific patient care and referrals.

Training

Newly hired employees receive training depending on their roles. Training programs for each role are very similar across sites. New employees are assigned required training, and the training materials are on the Employer's public and role-specific SharePoint drives. Some clinics may also conduct their own separate training.

Task box

Task box is a tool used by the Employer that exists inside the patient's electronic health record. Each role at each clinic has a task box, which looks like an email inbox. The tasks in the task box are typically handled by employees at that particular clinic. However, if there is a patient surge or staffing shortage at the patient's home clinic, different staff members at other clinics can be added to the task box to avoid delays in care. Blatchley testified that she "suspects" this happens daily but provided no evidence to support this assertion. A "task" could be communicating with a patient about labs, calling patients to do a cholesterol teaching, or reaching out to a patient with whom a provider wants to do a follow-up. Some examples of how it is used are as follows: Referral Case Managers (RCM) use the task box when a provider requests a referral to a specialist; medical records staff use it when a patient calls the call center to ask for their records; and PCPs can task the nurses team to have them follow up with patients about labs and education relating to their results. Triage nurses take calls through the call center, and "manage task box work for all sites." Other than what is outlined above, there is a lack of specificity in the record as to what exactly is being entered into the task boxes.

Task box volume is observed by local clinic staff and leadership. If the tasks from one clinic are not being done in a timely manner, local management at the originating clinic collaborates with local management at other sites to get the work covered. Work is not assigned from one clinic to other sites. Rather, employees can add themselves to the task box and handle those tasks. The record fails to disclose whether it is voluntary or mandatory that providers at one clinic take on tasks from other clinics. There was also no evidence introduced to show the frequency with which tasks are being completed for other clinics. Blatchley merely stated "it is part of our operational workflows and clinical protocols that tasks are addressed in a specific timely manner." Blatchley went on to say it is "functionally integrated" in that it manages labor and to avoid delays in treatment.

A Behavioral Health Provider at the Westminster Clinic testified that she performs a task for another clinic less than once a week. Most of her tasks come from providers at her clinic asking her to follow up with a patient they saw when she was not available. A Registered Nurse at the Westminster Clinic testified that her task box is for Westminster Clinic patients and tasks are assigned by Westminster Clinic employees. A Referral Case Manager employed at the Westminster clinic testified that 95% of her tasks come from employees in the Westminster Clinic. They are typically providers sending her referrals for Westminster Clinic patients. The only time she gets them from outside would be from patients who called the call center and needed a referral. Her assigned tasks are only for Westminster Clinic patients.

III. BOARD LAW AND ANALYSIS

The Board has long held that a petitioned-for single-facility unit is presumptively appropriate, unless it has been so effectively merged or is so functionally integrated that it has lost its separate identity. *Heritage Park Health Care,* 324 NLRB 447, 451 (1997). This presumption applies equally in healthcare settings. *Manor Healthcare*, 285 NLRB 224, 225 (1987). The party opposing the single-facility unit has the heavy burden of rebutting its presumptive appropriateness. To determine whether the single-facility presumption has been rebutted, the Board examines (1) centralized control over daily operations and labor relations, including the extent of local autonomy; (2) the degree of employee interchange, transfer, and contact; (3) functional integration; (4) similarity of employee skills, functions, and working conditions; (5) geographic proximity; and (6) bargaining history, if any exists. *Mercy Sacramento Hospital*, 344 NLRB 790 (2005) (citing *Passavant Retirement & Health Center,* 313 NLRB 1216,1218 (1994); *Heritage Park Health Care,* 324 NLRB 447, 451 (1997)). Moreover, the Board considers the degree of interchange and separate supervision to be of particular importance in determining whether the single-facility presumption has been rebutted. *Passavant Retirement & Health Center*, 313 NLRB 1216, 1218 (1994). In the health care industry, the Board also examines whether a single-facility unit creates an increased risk of work disruption or other adverse impact upon patient care should a labor dispute arise. *Manor Healthcare Corp.*, 285 NLRB at 226. The Board has frequently found single-facility units in hospitals and other health care settings to be appropriate. *Mercy Sacramento Hospital*, 344 NLRB 790 (2005).

In finding that the Employer/Petitioner has not met its heavy burden of rebutting the single facility presumption, I rely on the following analysis of the above factors and record evidence as described below. I further find that a single-facility unit demanded by the Union would not create an increased risk of work disruption or other adverse impact on patient care should a labor dispute arise. In reaching the conclusion that the single-facility unit demanded by the Union is appropriate, I rely on the following analysis and record evidence.

1. Centralized control over daily operations and labor relations, including the extent of local autonomy

The Board has made clear that "the existence of even substantial centralized control over some labor relations policies and procedures is not inconsistent with a conclusion that sufficient local autonomy exists to support a single local presumption." *California Pacific Medical Center*, 357 NLRB 197, 198 (2011). Instead, "the Board puts emphasis on whether the employees perform their day-to-day work under the supervision of one who is involved in rating their performance and in affecting their job status and who is personally involved with the daily matters which make up their grievances and routine problems." Id. Therefore, the primary focus of this factor is the control that facility-level management exerts over employees' day-to-day working lives. See also *Mercy Sacramento*, 344 NLRB at 792.

While the facilities in dispute here are subject to the same personnel policies, employee handbook, wage and benefit programs, and some training, these facilities have distinct supervision and significant local-level autonomy. The record is replete with evidence indicating that the Clinic Directors are responsible for the day-to-day operations of their respective facilities. They have

local management that reports to them, including the Clinic Operations Manager and Office Manager. Most employees at each clinic are supervised directly by supervisors in their own clinic. While there are two Assistant Nursing Directors who cover the five clinics in the multi-facility unit proposed by the Employer/Petitioner, there was little evidence presented regarding their roles.

Clinic Directors play a significant role in hiring at their respective clinics. They identify a need to hire and work with HR to get the job posted. The jobs posted are specific to a particular clinic, and not companywide. Candidate interviews are done locally by the Clinic Director, who is the one to recommend them for hire. The Clinic Director then works with HR to complete the hiring process.

While they have to consult with HR regarding performance improvement plans or terminations, Clinic Directors also have authority to handle other disciplinary matters on a local level. The record evidence is insufficient to imply the Clinic Directors lack authority when it comes to discipline.

As a final note on this topic, Heather Blatchley, the Employer's Vice President of Operations and the Employer's only witness, testified that she oversees seven clinics, but only five of the seven clinics she oversees are in the proposed multi-facility unit. The fact that the Employer/Petitioner is proposing to include employees at only 5 of 14 clinics in any multi-facility unit, rather than a system-wide unit, is contrary to any argument that labor relations are so centralized as to be a significant factor here.

While there is some degree of control exercised centrally, most of the employees' day-to-day work life is guided by local management. The Employer/Petitioner has not presented sufficient evidence to support overriding the single-facility unit presumption on this factor.

2. Degree of employee interchange, transfer, and contact

Employee contact is considered interchange where a portion of the workforce of one facility is involved in the work of the other facilities through temporary transfer or assignment of work. However, a significant portion of the workforce must be involved, and the workforce must be actually supervised by the local branch to which they are not normally assigned in order to meet the burden of proof on the party opposing the single-facility unit. *New Britain Transportation Co*., 330 NLRB 397, 398 (1999). For example, the Board found that interchange was established and significant where, during a 1-year period, there were approximately 400 to 425 temporary employee interchanges among three terminals in a workforce of 87 and the temporary employees were directly supervised by the terminal manager from the terminal where the work was being performed. *Dayton Transport Corp*., 270 NLRB 1114 (1984). On the other hand, where the amount of interchange is unclear both as to scope and frequency because it is unclear how the total amount of interchange compares to the total amount of work performed, the burden of proof is not met, including where a party fails to support a claim of interchange with either documentation or specific testimony providing context. *Cargill, Inc*., 336 NLRB 1114 (2001); *Courier Dispatch Group*, 311 NLRB 728, 731 (1993). Lack of significant interchange between groups of employees is a "strong indicator" that employees enjoy a separate community of interest. *Executive Resources Associates*, 301 NLRB 400, 401 (1991). Also important in considering interchange is

whether the temporary employee transfers are voluntary or required, the number of permanent employee transfers, and whether the permanent employee transfers are voluntary. *New Britain Transportation Co*., supra.

The record evidence fails to establish that there is significant employee interchange to support the Employer/Petitioner's claim that only a multi-facility unit is appropriate. Of 20 permanent transfers in the past year or so, seven were due to promotions and at least four were transfers to non-unit positions. All were voluntary. Permanent transfers are a less significant indication of interchange than temporary transfers. *Walt Disney World Co.,* 367 NLRB No. 80, slip op at 7 (2019) (citing *Frontier Telephone of Rochester, Inc.*, 344 NLRB 1270, 1272 (2005). Voluntary, permanent transfers are given less weight in unit determinations. *Overnite Transportation Company,* 331 NLRB 662, 663 (2000) (citing *Red Lobster,* 300 NLRB 908, 911 (1990).

While there are some employees who split their shifts between clinics, given that there are approximately 240 employees in the multi-facility unit sought by the Employer/Petitioner, the numbers are insignificant. Moreover, interchange is relevant to whether employees in a petitioned-for unit (or in this case, the demanded unit) have a separate community of interest from employees at other facilities, meaning the only relevant evidence of interchange involves unit employees at the petitioned-for facility. (*See D&L Transportation, Inc.,* 324 NLRB 160, 161 (1997) ("That the locations other than Shelton may have a higher or significant level of interchange with each other to accommodate the Employer's daily operations does not negate the separate community of interest shared by the Shelton drivers, who rarely interchange for this purpose."). Further, in its attempt to show interchange by shift splitting at the facilities the Employer/Petitioner seeks to include in the five-facility unit it proposes, it also shows interchange between employees at the Westminster Clinic and the other facilities the Employer/Petitioner is *not* proposing to include. Such evidence contradicts a claim that the Westminster Clinic must be included with the four other facilities to constitute an appropriate unit.

The record also fails to show that there is significant interchange that occurs from employees covering clinics other than their home clinic. The evidence introduced by the Employer to show this interchange provides hours worked by certain employees at sites other than their own, including some remote assistance.[10] There was no testimony about the percentage of this type of interchange. There is likewise no record evidence indicating who supervises employees working at other locations than their home clinics. Analyzing the Employer's exhibits shows that a total of 1.678.5 hours were worked outside employees' home clinics in the 13-week period preceding the filing of the petition from April 7, 2025 and July 7, 2025.[11] The exhibits show the total number of hours worked by unit employees at the five clinics for the same time period as 105,012.75. Accordingly, the record evidence indicates that the percentage of interchange is approximately 1.6%. Moreover, such coverage at other clinics is completely voluntary. As stated above, the Board

[10] The Exhibit in question was shown to have errors at hearing. For example, it shows one enrollment specialist from the Westminster Clinic worked 32 hours on June 5, 2025, at the Thornton Clinic and 16 hours at the Thornton Clinic on June 3, 2025. Accordingly, I do not rely on its accuracy.

[11] As previously noted, one of the Employer's exhibits contains errors, so the actual number of hours worked by employees out of their home clinics is even less.

has noted that voluntary interchange should be afforded less weight in rebutting the single-facility presumption.[12]

Finally, it has not been established that there is substantial contact between employees of the Westminster Clinic and other clinics that would mandate their inclusion in a multi-facility unit. The only contact between them, unless they are voluntarily covering a shift at another clinic, is one meeting that occurs once a year for all providers. Otherwise, their contact is with employees within their own clinic. In sum, I find that this factor weighs in favor of finding the demanded single-facility unit to be appropriate.

3. Functional Integration

Evidence of functional integration is also relevant to the issue whether a single-facility unit is appropriate. Functional integration refers to when employees at two or more facilities are closely integrated with one another functionally notwithstanding their physical separation. *Budget Rent A Car Systems*, 337 NLRB 884 (2002). This functional integration involves employees at the various facilities participating equally and fully at various stages in the employer's operation, such that the employees constitute integral and indispensable parts of a single work process. *Id*. However, an important element of functional integration is that the employees from the various facilities have frequent contact with one another. *Id* at 885.

The record in the instant case reveals limited evidence of functional integration. As a primary matter, patients have home clinics and do not visit others in the Employer's network. The Employer's evidence for this factor mainly relies on its use of "task boxes." While it is true that sometimes providers at other clinics assist with "tasks" stemming from another clinic due to patient surges or staffing shortages, the record fails to indicate the frequency with which this occurs, or that employees are required to assist with tasks from another clinic. In fact, the record evidence indicates that nearly all tasks assigned to employees at the Westminster Clinic come from within their own clinic. Importantly, nothing in the record indicates that employees at the Westminster Clinic have frequent contact with employees at any other clinics. Accordingly, I find that this factor weighs in favor of a single-facility unit.

4. Similarity of employee skills, functions, and working conditions;

The similarity or dissimilarity of work, qualifications, working conditions, wages, and benefits between employees at the facilities the Employer/Petitioner contends should be in the unit has some bearing on determining the appropriateness of the single-facility unit. However, this factor is less important than whether individual facility management has autonomy and whether there is substantial interchange. *See Dattco, Inc*., 338 NLRB 49, 51 (2002) ("This level of interdependence and interchange is significant and, with the centralization of operations and uniformity of skills, functions and working conditions is sufficient to rebut the presumptive appropriateness of the single-facility unit").

[12] *New Britain Transp. Co.*, 330 NLRB 397, 398 (1999) ("[V]oluntary interchange is given less weight in determining if employees from different locations share a common identity."); *Red Lobster*, 300 NLRB at 911 (noting that "the significance of that interchange is diminished because the interchange occurs largely as a matter of employee convenience, *i.e., it is voluntary*") (emphasis added).

The record indicates that each clinic has similar hours, uses similar equipment and supplies, and training for employees in the same job classification is similar. They are subject to the same handbook and policy and procedure manual. They also share the same pay scales and benefits, and employees in the same roles at different clinics perform the same type of work. Importantly, these items apply at *all* clinics, not just those in the proposed multi-facility unit. This undercuts the Employer/Petitioner's argument that only 5 of its 14 facilities constitute an appropriate unit. Moreover, the Employer seeks to include triage nurses, who do not perform the same work as clinic nurses, and who work remotely, in the multi-facility unit. In any event, while there are commonalities, this factor is at best neutral and does not rebut the single-facility presumption when weighed with the other factors, particularly individual autonomy of locations and lack of interchange.

5. Geographic Proximity

The record evidence indicates that the Westminster Clinic is located between 2.4 and 21.8 miles from the other clinics sought to be included by the Employer/Petitioner. The Board has found that distances of 6-20 miles between locations favor a single-facility unit. See *New Britain Transportation Co.*, 330 NLRB 397, 398 (1999); *Hilander Foods*, 348 NLRB 1200, 1204 (2006). Importantly, there is no geographic overlap of patients between these facilities, and no significant interchange of employees between these locations. Accordingly, I find that this factor weighs in favor of a single-facility unit.

6. Bargaining history

The absence of bargaining history is a neutral factor in the analysis of whether a single-unit facility is appropriate. *Trane,* 339 NLRB 866, 868 (2003). Thus, the fact that there is no bargaining history in this matter neither supports nor negate the appropriateness of the demanded unit. There is no bargaining history in the multi-facility unit proposed by the Employer/Petitioner. The record indicates that employees at one of the Employer's clinics, the Walk-in Crisis and Addiction Center in Boulder, are currently represented by the Union. Where there is evidence of a lengthy history of single-facility bargaining, the Board is reluctant to find a multi-facility unit to be the only appropriate unit. *California Pacific Medical Center*, 357 NLRB at 197; *Children's Hospital of San Francisco*, 312 NLRB 920 (1993). There is very little record evidence regarding the length or history of bargaining at the one represented clinic. However, the fact that the only bargaining relationship between these parties exists at a single facility weighs in favor of finding another single facility would also be appropriate. Accordingly, this factor weighs in favor of a single-facility unit as demanded by the Union.

IV. CONCLUSION AND FINDINGS

Based upon the entire record and in accordance with the discussion above, I find that the demanded single facility unit consisting of employees employed at the Employer's Westminster Medical Clinic is appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act. The Employer/Petitioner has failed to sustain its burden of demonstrating

that the Westminster Medical Clinic has been so effectively merged or is so functionally integrated that it with the Employer's other clinics that it has lost its separate identity. The factors discussed above weigh in favor of a single-facility unit as demanded by the Union.

Therefore, based upon the entire record in this matter and in accordance with the discussion above, I find and conclude as follows:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer/Petitioner is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.[13]

3. The Union is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer/Petitioner.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer/Petitioner within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:

Professional Unit: Voting Group A

Included: All full-time and regular part-time registered nurses, nurse practitioners, physician assistants, and physicians (all MDs, DOs) employed by the Employer at its Westminster Medical Clinic located in Westminster, Colorado.

Excluded: Case Manager Team Manager, Medical Assistant Team Manager, office clerical employees, confidential employees, managerial employees, temporary employees, locum tenens employees, independent contractors, per diem employees, non-professional employees, guards, and supervisors as defined in the Act, and all other employees.

Others Permitted to Vote in Group A: At this time, no decision has been made regarding whether the individual(s) in the classification of Assistant Clinic Medical Director of Employee Health are included in, or excluded from, the Professional Unit, and individual(s) in that classification may vote in Voting Group A, but their ballots will be challenged since their eligibility has not been resolved. The eligibility or inclusion of these individual(s) will be resolved, if necessary, following the election.

[13] The Employer, Clinica Campesina Family Health Services d/b/a Clinica Family Health & Wellness, is a Colorado non-profit corporation, with a principal location in Lafayette, Colorado, and branch locations in Denver, Thornton, Westminster, Lafayette, and Boulder Colorado, is a medical services provider. During the last calendar year, a representative period of its operations, the Employer had gross revenues in excess of $250,000 and purchased and received at its Colorado facilities goods valued in excess of $5,000, which goods were shipped to the Employer's facilities from points located outside the State of Colorado.

Non-Professional Unit: Voting Group B

Included: All full-time and regular part-time employees employed by the Employer at its Westminster Medical Clinic located in Westminster, Colorado including employees in the classifications of case manager, clinic operations specialist, enrollment specialist, medical assistant, medical records, referral case manager, and behavioral health professional.

Excluded: Case Manager Team Manager, Medical Assistant Team Manager, office clerical employees, confidential employees, managerial employees, temporary employees, locum tenens employees, independent contractors, per diem employees, professional employees, guards, and supervisors as defined in the Act, and all other employees.

Others Permitted to Vote in Group B: At this time, no decision has been made regarding whether the individual(s) in the classification of Office Technician are included in, or excluded from, the Non-Professional Unit, and individual(s) in that classification may vote in Voting Group B, but their ballots will be challenged since their eligibility has not been resolved. The eligibility or inclusion of these individual(s) will be resolved, if necessary, following the election.

Or

In the event the majority of Professional employees (Voting Group A) vote to be included in a unit with non-Professional Employees (Voting Group B), the following combined unit is appropriate:

Combined Unit

Included: All full-time and regular part-time employees employed by the Employer at its Westminster Medical Clinic located in Westminster, Colorado including employees in the classifications of case manager, clinic operations specialist, enrollment specialist, medical assistant, medical records, referral case manager, behavioral health professional, nurse, nurse practitioner, physician assistant, and physician (all MDs, DOs).

Excluded: Case Manager Team Manager, Medical Assistant Team Manager, office clerical employees, confidential employees, managerial employees, temporary employees, locum tenens employees, independent contractors, per diem employees, guards, and supervisors as defined in the Act, and all other employees.

Others Permitted to Vote: At this time, no decision has been made regarding whether the individuals in the classifications of Office Technician and Assistant Clinic Medical Director of Employee Health are included in or excluded from the Unit. Individual(s) in the Assistant Clinic Medical Director of Employee Health classification may vote in Voting Group A, and individual(s) in the Office Technician classification may vote in Voting Group B, but their ballots will be challenged since their eligibility has not been resolved.

The eligibility or inclusion of these individuals will be resolved, if necessary, following the election. [14]

Voting Procedure

Since the Combined Unit includes professionals and non-professional employees who cannot be joined in a single unit without the desires of the professional employees being determined in a separate vote, elections will be conducted in the Voting Groups identified above with Professional employees voting in Voting Group A and the Non-Professional employees voting in Voting Group B.

The employees in the professional Voting Group A will be asked the following two questions on their ballots:

1) Do you wish to be included in the same unit with nonprofessional employees of the Employer for the purpose of collective bargaining?

2) Do you wish to be represented for purposes of collective bargaining by the Service Employees International Union, Local 105, AFL-CIO?

To which the choices for an answer will be "YES" or "NO".

The employees in the non-professional Voting Group B will be asked the following question on their ballot:

Do you wish to be represented for purposes of collective bargaining by the Service Employees International Union, Local 105, AFL-CIO?

To which the choice for an answer will be "YES" or "NO".

As indicated, professional employees will vote separately as to whether or not they wish to be included in the same bargaining unit with non-professional employees. If a majority of the professional employees in Voting Group A vote "Yes" to the first question, indicating their wish to be included in a unit with non-professional employees, they will be so included, in the overall Combined Unit, as described above. Their votes on the second question will then be counted together with the votes of the non-professional employees in Voting Group B to decide whether the Petitioner has been selected to represent the Combined Unit.

If a majority of the professional employees in Voting Group A do not vote for inclusion in the same bargaining unit with non-professional employees, they will not be included with the non-professional employees. Their votes on the second question will be counted to decide whether they wish to be represented by the Petitioner in a separate professional unit and the votes in Voting Group B will be counted separately.

In the event that the professionals vote for separate representation, the separate appropriate units will be described as set forth in voting Group A and voting Group B above.

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[14] The details concerning the voting groups in which individuals in the Office Technician and Assistant Clinic Medical Director of Employee Health classifications would cast challenged ballots was discussed with both parties after the hearing closed.

V. 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 be represented for purposes of collective bargaining by **Service Employees International Union, Local 105, AFL-CIO.**

A. Election Details

The election will be held on **Wednesday, January 14, 2026** from 11:30 a.m. to 1:30 p.m. in the Walk-in Room/Purple Group Visit Room at the Westminster Medical Clinic located at 8510 North Bryant Street, Westminster, Colorado 80026.[15]

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **Friday, December 12, 2025**, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible to vote are employees in the unit who have worked an average of four (4) or more hours per week in the 13 weeks immediately preceding the eligibility date for the election.

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, and, in a mail ballot election, before they mail in their ballots to the Board's designated office; (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/Petitioner must provide the Regional Director and parties named in this decision a list of the full names (that employees use at work), 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.

[15] The election details were discussed with both parties after the record closed.

To be timely filed and served, the list must be *received* by the regional director and the parties by **Tuesday, December 30, 2025**. The list must be accompanied by a certificate of service showing service on all parties. ***The Employer must provide separate voter lists for Voting Group A and Voting Group B, with a separate section on each list for the individuals who are voting subject to challenge in each voting group, and a master list comprised of both Voting Groups A and B.*** **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 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. **In this case, the Notice of Election must be posted and distributed by 12:01 a.m. on Friday, January 9, 2026.** 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. **The English/Spanish Notice of Election will issue under separate cover.**

VI. 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.

Dated, in Denver, Colorado, on this 23rd day of December 2025.

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