

125 N. Executive Dr., Suite 102
Borrickfield, WI 53005

voice: 262.821.4444
fax: 262.821.4445

info@wiworkforcealliance.com
www.wiworkforcealliance.com

The Wisconsin Long Term Care Workforce Alliance is a coalition of public and private organizations that recognize the crucial role direct caregivers play in meeting the long term care needs of older persons and persons with disabilities. Providers, worker representatives, consumer advocates, educational institutions and state and local governmental organizations are members.

The Alliance believes in the ability of Wisconsin communities to strengthen their long term care workforce. Our "Community Guides" provide information, gathered from a number of individuals and organizations, that may be useful to local coalitions involved in workforce issues.

This manual examines worker cooperatives as a strategy that has been successfully used by some communities to meet local service needs and develop a more stable long term care workforce. We appreciate the time taken by the authors in writing this guide.

February 2005

Julie Whitaker, Ph.D., University of Wisconsin-Madison, whitaker@ssc.wisc.edu
Stu Schneider, Paraprofessional Healthcare Institute, Stu@paraprofessional.org
Margaret Bau, Wisconsin USDA Rural Development, margaret.bau@wi.usda.gov

Cooperative ownership of home care and home health agencies is a growing trend, positively affecting workers and consumers.¹ Home health aides, personal care assistants, and supportive home care workers are becoming owners of their own businesses, and as such have improved their wages, benefits, training, and level of workplace participation. Within the context of high and growing demand for services, as well as the need to upgrade home care jobs, worker-owned home care cooperatives are a promising model.

We begin with some basic information about cooperatives in general and worker-owned cooperatives in particular. Next, we provide examples of existing and emerging worker-owned home care cooperatives and discuss some of their benefits.

What is a Cooperative?

A cooperative is a business owned and democratically controlled by the people who use its services. A cooperative operates for the benefit of its members

"Worker ownership gives you a voice in the company...when you're a worker-owner you have to understand what it means to be a worker and owner. You share in the good, and you share in the not so good."²

(Joann Poue, board member and worker/owner, CHCA)

rather than to earn profits for external investors. There are several types of cooperatives, differentiated by ownership structure. For example, consumers own a health food or electric co-op; agricultural producers own a dairy co-op; small business owners own a shared services co-op (for joint purchasing, marketing, distribution); and workers own a worker co-op. Although cooperatives permeate the health care industry in other forms (e.g. consumer HMOs such as HealthPartners of Minneapolis, Minnesota and Group Health Cooperative of South Central Wisconsin), our focus in this report is on cooperatives owned in whole or in part by workers.

1 Typically, the term home health care refers to long-term supportive and personal care assistance provided by agencies funded primarily through Medicaid programs. The term health usually refers physician-ordered home based services provided by agencies funded by Medicare. For the sake of simplicity, hereafter we use the term home care exclusively, intending the term to include both home health and home care.

2 Greenhouse, Steven. 2004. "Health aides who get sick days?: Ownership is good for co-op workers, but union complicates mix." New York Times B(1)2, February 14.

Worker Cooperatives: Democracy at Work

In many ways, worker-owned cooperatives are businesses like any other. They produce goods or services in a competitive market. However, in cooperatives, unlike traditional businesses, the members producing the goods or providing the services do so as **owners and managers** of the operation, instead of as **employees**. The inherently local nature of worker-owned enterprises increases the likelihood that the business, along with its revenues, will remain in the community where workers reside.³

Cooperatives are not only inherently local, but also intrinsically democratic. One community economic development scholar referred to worker cooperatives as: "*perhaps the purest form of economic democracy currently operating in the U.S.*"⁴ Democratic decision-making processes related to personnel, finances, and other policies are typically built into the structure of a worker-owned cooperative through a board of directors, elected by and accountable to the members. Managers and other administrative staff handle the day-to-day operations of many cooperatives. Staff are generally hired by and report to the board of directors. Within this general framework, worker cooperatives create mechanisms to fully inform members about up-coming decisions and the ramifications of different choices. The board then solicits member input before formally adopting key policies.

Worker-owned Home Care Cooperatives: A New Breed

Although worker-owned cooperatives have existed in the U.S. for about 150 years, home care cooperatives are a relatively new breed, with the first, Cooperative Home Care Associates (CHCA), emerging in 1985. Of the approximately 300 worker cooperatives in the U.S., four are operating and at least six are emerging in the home care sector. Worker-owned home care cooperatives provide personal and supportive services to people with long-term physical, mental, or developmental disabilities, or with short-term needs for medical or personal assistance. Existing home care cooperatives require one-time refundable membership fees, ranging from \$25 to \$1,000, often deducted from members' paychecks in small installments.

The ten existing and emerging home care cooperatives have unique development processes, operate in different regional home care markets, and are financed by diverse funding mechanisms. Given this variation, we present information about individual home care cooperative models under the following categories: 1) job training 2) independent caregiver 3) conversion and 4) multi-stakeholder/solidarity (see Table 1 for a summary).

- **The Job Training Cooperative Model**

Job training home care cooperatives are designed to upgrade the training and job quality in the home care industry for low-income residents of inner-city neighborhoods. They have positioned themselves as sub-contractors to certified Medicare-home health agencies and other organizations serving people with disabilities consistent with the practices in the densely-populated urban home care markets where they operate.

- 3 Gunn, Christopher, and Hazel Dayton Gunn. 1991. *Reclaiming Capital: Democratic Initiatives and Community Development*. Ithaca, New York: Cornell University Press; Pitegoff, Peter. 2004. Worker Ownership in Enron's Wake – Revisiting a Community Development Tactic. *Journal of Small and Emerging Business Law* 81 (239-260).
- 4 DeFilippis, James. 2004. *Unmaking Goliath: Community Control in the Face of Global Capital*. New York and London: Routledge.

Cooperative Home Care Associates (CHCA) was developed in 1985, as the first job training cooperative model in the U.S. CHCA currently employs approximately 800 home health aides, 70 percent of whom are owner-members. To support its extensive 4- to 5-week clinical training and job skills program, CHCA relies upon Workforce Development funds and foundation support secured with assistance from its non-profit affiliate, Paraprofessional Healthcare Institute. Job training cooperatives characterize themselves as "yardstick corporations," by establishing standards for compensation and other employment practices against which other agencies can measure their performance.⁶

CHCA was developed and initially subsidized by the Community Service Society, a community development organization, and was further developed with substantial support from charitable foundations, especially the Charles Stewart Mott Foundation. The Mott Foundation also funded replication efforts, including the development of Home Care Associates (HCA) in Philadelphia in 1993. HCA, like its affiliate CHCA, employs a large share of women who previously received public assistance. Relative to CHCA, where about 70 percent of home health aides are owners, only about 40 percent (55/138) of HCA's home health aides are worker-owners.⁷

"You own a share of something. It's not a big share, but then you're going to work even harder to try to keep it going...because we own one share, we are going to try to make it the best company out there. When you go into a person's home, you try to do the best work you can."⁵

(Sarah Lee, CHCA, worker/owner, CHCA)

Although some replication efforts have not succeeded,⁸ CHCA and HCA have remained in operation and even expanded despite major cuts to Medicare funding. CHCA has doubled in size since 2000; HCA's business increased by 25 percent in 2004.⁹ These cooperatives have weathered market changes because of their ability to diversify services and maintain positive relationships with their major contractors. A representative from CHCA explained that positive relationships are based on the quality of their services and the financial transparency of their organization. **"Every year we put together a rate proposal that shows what our expenses are, the amount that goes into salaries, health insurance increases, etc... Other agencies don't do that."**¹⁰

5 As quoted in Ruth Glasser and Jeremy Brecher. 2002. *We Are the Roots*, Davis: University of California Center for Cooperatives (see, <http://www.paraprofessional.org/Sections/resources.htm>).

6 Greenhouse 2004; Inserra, Anne, Maureen Conway, and John Rodat. 2002. *Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach*. Washington D.C.: The Aspen Institute.

7 Julie Whitaker's interview with a representative of Home Care Associates, 2004.

8 Two such replications in Boston, Massachusetts and Waterbury, Connecticut closed in the late 1990s. These cooperatives operated as subcontractors for Medicare-certified home health agencies. Both fell victim to the 1997 Balanced Budget Act, where dramatic reductions in Medicare reimbursement rates for home care resulted in slashed operational budgets for many and closure of 14 percent of Medicare-certified home health agencies in the U.S. between 1997 and 1999 (Government Accounting Office. 1999. "Medicare Home Health Agencies: Closures Continue with Little Evidence Beneficiary Access is Impaired.")

9 Inserra et al, 2002; Julie Whitaker's interview with a representative of HCA, 2004.

10 Julie Whitaker's interview with a representative of CHCA, 2004.

- **The Independent Caregiver Cooperative Model**



Picture courtesy of Home Care Associates in Philadelphia

The independent caregiver cooperative model is one whose labor pool was drawn from previously self-employed caregivers. Cooperative Care is, as of this writing, the only such model operating in the U.S. It started in 2001 in rural Waushara County, Wisconsin, with an experienced workforce of 63 independent providers. Cooperative Care was essentially created in a market vacuum, since no other home care agencies in the county provided competition. Prior to the formation of the cooperative, these caregivers were "employed" by their clients, who were participants of publicly funded long-term care programs. Caregivers endured stagnant low wages and no benefits (including worker's compensation).

The newly formed cooperative entered into a 1.5 year, \$850,000 contract with the Waushara County Human Services Department. The contract essentially "bought" the business time to establish itself and expand into other markets (privately financed respite, hospice, and companion care). The transition was relatively seamless, with cooperative members continuing to provide services to the same set of consumers.¹¹

In 2004 the USDA Rural Development funded six "home health" cooperatives in five states. Two of the awards were granted to organizations in Hilo, Hawaii and Outagamie County, Wisconsin to form cooperatives modeled after Cooperative Care. Coordination for the Hawaii project is expected in February, 2005. In Wisconsin the cooperative coordinator, with the non-profit, Community Action Program Services has met with advisory committees, including cooperative specialists. She held meetings in December 2004 with 26 potential cooperative members. Steering committee meetings with caregivers began in January 2005.

- **The Cooperative Conversion Model**

A handful of for-profit and non-profit agencies with a social mission are at various stages of converting their businesses to worker-owned cooperatives. Known examples include Quality Care Partners in New Manchester, New Hampshire (est 1999) and Care at Home in Brooklyn, New York (est 1990), the Andersson Caregiving Group in Mendocino County, California (est. 1996), and I Am Unique Case Management and Special Services in Raleigh, North Carolina (est. 1994). These organizations already use participatory

¹¹ For a more thorough description of Cooperative Care's development see Bau, Margaret, and Diane Harrington. 2003. House Calls: In-home Care Givers Form Cooperative to Provide Vital Services for Elderly, Disabled in Rural Wisconsin. *Rural Cooperatives*, May/June, 9-32.

management practices and/or have invited workers to serve on the board of directors. Some were initiated with a plan to convert to cooperative ownership once the organization was financially stable.

Quality Care Partners and Care at Home, although operating in different home care and labor markets, were inspired by CHCA in the South Bronx. Quality Care Partners was created as a for-profit home care agency with a long-term goal of worker-ownership once the company reached two full quarters of profitability. In the meantime, according to a representative of Quality Care Partners, management is "reaching for ownership mentality and training with our staff." The founder of Care at Home, Thomas O'Brien, explains that affiliation with CHCA is consistent with the inclusive culture they are already trying to foster.

"This industry can be very close to a sweatshop industry and degenerates into it in more instances than people are aware of. We thought it made sense to form an alliance with [CHCA] because we have a similar mission in terms of treating home-care workers with respect and trying to do the right thing for them economically."¹²

Andersson Caregiving Group in rural Mendocino County, California, currently employs predominantly well educated, middle income home care staff. The vast majority of their clients are high income residents whose care is not financed through public programs. The organization started with, what a representative from the organization describes as, **"a network of fairly idealist women who wanted meaningful work with decent pay and wanted to provide the best quality of care."** The owner and board members are currently taking that social mission one step further by drafting legal documents that would transform the organization to a cooperative model.¹⁴ This will ensure the business will maximize wages, benefits, and worker involvement over time. The agency leaders would also like to expand employment to a larger share of low-income workers and serve a broader financial cross-section of the community. Finally, requests to charitable foundations will, if successful, support the development of a substantial three-month apprenticeship program for home care workers.

***"We do not work for a corporation that will manage our funds. At Cooperative Care, all the members are the owners, and any net profit belongs to us."*¹³**

(Donna Tompkins, Board Chair and worker/owner of Cooperative Care in Wisconsin, Speaking at Harvard University, 2004).

Finally, the board members of I Am Unique Case Management and Special Services are planning for the sale of approximately one-third of company shares to employees. Unlike the other home care agencies

12 Greenhouse, 2004.

13 The Harvard presentation was made to a committee voting on the John F. Kennedy Innovations in Government Awards. Cooperative Care was voted 8th of 15 finalists in 2004. This competitive award includes \$100,000 and is given to successful, replicable projects spawned by government agencies.

14 Rather than incorporate formally as a cooperative, the agency will instead convert to a non-profit organization, with bylaws that permit worker control and profit-sharing. Currently the board of directors includes workers and consumers (Julie Whitaker's interview with a representative of Andersson Caregiving Group, 2004).

discussed in this report, who employ paraprofessionals, I Am Unique is a skilled nursing cooperative, whose staff includes RNs and LPNs. Ninety percent of 24 clients served by this organization breath through ventilators, and require intensive (often 24-hour) care. The organization's leaders had intended to also hire paraprofessionals to be trained through a high quality training program modeled after CHCA in the South Bronx. However, they were discouraged by a competitive market for certified nursing assistant training and "integrity problems" among potential personal care providers. However, they were inspired by CHCA and thus intend to convert to employee ownership among skilled nursing staff. They are gearing up for this by increasing employee participation and involvement through leadership conferences and staff focus groups.¹⁵

- **The Solidarity or Multi-stakeholder Cooperative Model**

In 1997 the province of Quebec, Canada pioneered the delivery of home based care through a new type of cooperative called the solidarity or multi-stakeholder cooperative. In this model, care providers, care recipients, and other individuals (e.g., advocacy groups or area hospitals) are joint member-owners. This is in contrast to the conventional co-op structure consisting of a single set of stakeholders (e.g., care providers in a worker co-op, care recipients in a consumer co-op, independent businesses in a shared services co-op).¹⁶

In the U.S., there is one multi-stakeholder model, Partners in Personal Assistance (PPA). This organization, located in Ann Arbor, Michigan, was founded in 1999 by several people with physical disabilities, dissatisfied with the system of care and support they received from existing local agencies. Steve McNutt, one the founders, explains how he felt the traditional agency systems negatively impact consumers and workers.

“The [personal assistant] sent out by an agency is not picked by the consumer. The aides are supervised by the agency and the consumer needs to follow the agency’s schedule. The agencies work on a for-profit basis, necessitating low pay and very poor, if any, benefits to the aides.”¹⁷

Thus, Steve and co-founder Jody Burton-Slowins, with assistance from Inter-Cooperative Council at the University of Michigan and the Association for Community Advocacy, initiated a non-profit cooperative. In this unique cooperative, 32 consumers, 44 personal assistants, and seven volunteers are among the membership. The 2004 board consists of three personal assistants, five consumers, and three "community member" volunteers.¹⁸ Worker members are screened and interviewed by office staff, then interviewed by individual consumer members who select, supervise, and train their personal assistants according to their unique needs. This arrangement allows consumers at PPA to lead self-determined and independent lives, while providing workers with competitive wages and benefits.

15 Julie Whitaker's interview with a representative of I Am Unique, 2004.

16 For more information on Canadian cooperative healthcare models, including the multi-stakeholder model in home care, see http://www.agr.gc.ca/policy/coop/health_e.phtml

17 See http://www.ucp.org/ucp_localdoc.cfm/87/8304/8304/8304-8304/1104

18 Julie Whitaker's interview with PPA representative, 2004.

TABLE 1: HOME CARE COOPERATIVE MODELS IN THE U.S.

JOB TRAINING	INDEPENDENT CAREGIVER	CONVERSION	MULTI-STAKEHOLDER/SOLIDARITY
Cooperative Home Care Associates (South Bronx, NY), est 1985 772 members, 70% of whom are members	Cooperative Care (Wautoma, WI), est 2001, 70 members	I Am Unique Case Management and Special Services (Raleigh, NC), est. 1994, 77 workers	Partners in Personal Assistance (Ann Arbor, MI), est. 1996 76 members, 32 consumers; 44 personal assistants
Home Care Associates (Philadelphia, PA), est 1993 138 workers 40% of whom are members	Yet-to-be Incorporated (Outagamie County, WI)	Quality Care Partners (Manchester, NH) est 1993, 37 workers	
	Yet-to-be Incorporated (Hilo Hawaii)	Care at Home Dioces of Brooklyn (Brooklyn, NY), est 1990, 175 workers ¹⁹	
		Andersson Caregiver Group (Mendocino County, CA), est 1996, 45 workers	

Table 1 summarizes the existing and emerging home care cooperatives (with emerging cooperatives listed in blue).

The Benefits of Home Care Cooperatives

There are a number of benefits of worker ownership in the home care sector:

- **Management Accountability**

The organizational structure of a worker-cooperative ensures accountability between senior leadership and direct care staff. Legally, senior managers must regularly and "officially" discuss key organizational decisions and performance to worker-owners. This structure ensures that members fully participate in the process of establishing organizational goals. The inclusive governing structure of a cooperative fosters member participation, organizational decision-making, and a sense of ownership and belonging.

- **Member Governance and Involvement**

Direct care workers who hold seats on the board make decisions about various issues affecting the operation of their agency. For instance, they evaluate financial statements, personnel policies, business expansion decisions, and training options. Although only a minority of cooperative members can hold elected leadership positions on the board, most home care cooperatives have created a number of committees that integrate non-board members into governance of the organization. Examples include education, personnel, and marketing committees at Cooperative Care; policy action groups at CHCA and HCA; and "sunshine" and "happiness" committees at Cooperative Care and HCA, respectively. Policy action groups write letters and make visits to political representatives; sunshine and happiness committees work on social

¹⁹ Greenhouse, 2004.

events and membership support. Most cooperatives compensate workers for time spent in board-related activities. At CHCA and HCA, members are also paid for the time they spend at committee meetings.

- **Maximization of Income, Hours and Benefits**

Home care agencies operate within slim profit margins, constrained by low and frequently stagnant government reimbursement rates. However, in cooperatives, strong accountability between senior managers, board members, and general members creates a system in which wages and benefits are maximized for members. All home care agencies, including cooperatives, experience pressures to use additional revenue for a myriad of often conflicting organizational goals (e.g., enhanced consumer care, increases to managers' salaries, purchase of extra office equipment, expansion of business operation, and higher stockholder returns). The central place of direct care staff in decision-making tips the balance in favor of those goals that benefit the members. Often choices are made to invest resources that benefit consumer care, managers, business expansion, etc. However, the power balance, combined with adequate and regular revenue sources, increase the likelihood that direct care staff will also have adequate and consistent work hours, competitive wages, and benefits.

At CHCA, for instance, approximately 82 cents of every dollar received as revenue is provided to its home health aides in the form of wages or benefits. Comparably, other home care agencies in New York City typically allocate 60 cents of every dollar as direct wages or benefits to workers.²⁰ Consequently hourly pay rates at CHCA are about 20 percent more than other agencies in New York City.²¹ Moreover, 95 to 97 percent of worker-members are employed full time, 401K retirement plans, and access to affordable health insurance bargained through the cooperative's Service Employees International Union affiliation. Similarly, about one-half of HCA member-owners work full-time and have access to no-cost health insurance, as well as a variety of other employee benefits. Lastly, Wisconsin's Cooperative Care members, formerly "consumer employed" private providers earn about \$2.00 more as co-op members than they had previously. They also have access to health insurance, personal days off, and free training.

Conclusion

The success of worker-owned cooperatives are influenced by a number of factors, including the quality of leadership in the organization, the business environment for home care services, and the availability of charitable foundation support, welfare-to-work funds, and other external forms of support. The cooperatives discussed in this report are fairly distinct. However, they share a commitment to create an alternative home care model: one that combines democratic organizational culture, living wage jobs, and quality caregiving.

For a modified version of this report, including ideas for "future directions" and website resources about home care and cooperative development, as well as cooperative specialist contact information, see <http://www.wisc.edu/uwcc/info/health/homecare.pdf>.

Julie Whitaker would like to thank the Cooperative Foundation for funding the research for this report.

20 Inserra et al, 2002.

21 Ibid; Greenhouse, 2004