

Factors in Forming a Homecare Worker's Cooperative

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January 9, 2008 (revised)

Initiating agents in organizing homecare worker co-ops:

- 1) **Caregiver initiated** – Distribute press releases to the media with the hope that local newspapers will run stories about existing home care co-ops (in Wisconsin and the east coast). This may spark caregivers to contact listed representatives with the desire to form their own cooperative. (*grass roots approach*)
- 2) **Community organization initiated** – A local organization (community action agency, faith based organization, co-op development center) would support a local project coordinator to contact regional caregivers and start the development process. (*fertilizer approach to the grassroots*)
- 3) **State initiated** – The Department of Workforce Development, the Department of Health and Family Services, or another statewide organization would identify receptive regions to co-op model replication, would identify regional champions, and would help finance the development process. A state agency could create a request for proposal to identify regional groups willing to support co-op formation. (*top down approach*)

Market –

Assumption: Cooperatives have a competitive workforce advantage. Nearly all agencies face high caregiver turnover rates due to low wages and lack of benefits. Cooperatives eliminate external agency owners and shareholders. Given current industry constraints, worker co-op ownership maximizes what is available for higher wages, health insurance, benefits, and patronage refunds to caregivers. Caregivers appreciate having a voice in policy and decision making.

Assumption: Diversify your income stream. Don't be overly concerned with the percentage of elders in a population. Demand for homecare is growing everywhere. Focus on the funding stream (private pay, public pay, long term care insurance) and what populations to serve (elderly, developmentally disabled, adults with disabilities, respite for families with special needs children, etc.).

- *Competition* – How many existing agencies serve the region (both homecare and home health)? How long have they been in existence? What is their structure (locally owned, nonprofit, franchise)? How many employees?
- *Rates* - Market rate to clients? Minimum number of hours? Mileage rates?
- *Wages* - What are market wages and benefits to caregivers?
- *Demographics* –
 - *Urban settings* - Homecare co-ops can start-up in the private pay market in urban areas (sufficient diversity of income). Even though franchises and other agencies may already exist in the market, a homecare workers co-op has the labor force competitive advantage (ownership, higher wages, benefits, patronage refunds, real voice in policies).

- *Poor rural settings* - Co-ops forming in rural areas with high poverty may need to rely more heavily on public pay contracts. Low income elders and people with disabilities cannot afford to pay out of pocket for homecare.
- *Rural areas with high savings* - Elders with substantial life savings, in theory, should be able to pay out of pocket for homecare. However survivors of the depression may be reluctant to pay an outsider \$20 to do the laundry. A co-op may need to market to adult children or to create bundles of services (rather than charge by the hour).
- *Market niches* - Are there market niches in which quality of care and labor force stability is paid a premium? In the public sector, is there more funding for disability care than for elder care? Respite care for families with disabled children tends to offer very low reimbursement rates (babysitting wages).
- *Marketing strategy* – Bundle the services and compare co-op rates to assisted living facility/nursing home costs (i.e. quote monthly rates rather than per hour rates). Don't compare a co-op to other agencies; compare the co-op to other living arrangements.
- *Benevolent agencies* – Wages tend to be flat and benefits nonexistent statewide. Most agencies operate with a “temporary help” mentality (in constant recruitment since high turnover rates are expected) Are there some agencies that have been relatively supportive of caregivers? If so, how do we interact with them?

Caregiver demographics –

Assumption: Start a co-op with experienced caregivers.

- *Employment status* – Are caregivers independent or self-employed? Do they work for agencies? Are caregivers engaged in patchwork employment (work for an agency and assisted living facility while doing independent cares on the side)?
- *Availability of Certified Nursing Assistant (CNA) training* – Where do caregivers gain the CNA training and who pays for it? (Paid for out of pocket at a technical college? Work for a nursing home to get free training and then leave to do homecare? Trained by RN to care for a family member?)
- *Outreach strategies* – Acquire an independent caregiver list through Senior and Disability Resource Center? Area social workers? CNA registry? Place an ad?

Organizational support –

Assumption: Need a local project coordinator as well as project champions within local organizations.

- *Strategic alliances* – Only licensed home health agencies can directly bill Medicare/Medicaid. Partner with a home health care agency struggling to retain CNAs and homemakers. The home health agency can bill Medicare/Medicaid (10%-15% cut of rate), allowing the co-op to care for public pay clients (stretching county funds). For elders with long term care insurance, most policies require care through a home health agency. Alliances would be a mutual source of referrals. Rates will be raised to cover cut.

- *Workforce focused groups* – Seek the support of local groups serving low income women in business/economic development. Examples include Community Action Agencies (focused on poverty elimination), Workforce Development Boards (focused on skills enhancement), Small Business Development Centers and Economic Development Corporations (focused on business development), and Family Living Agents of University Extension (holistic community focus).
- *Social service providers* – Develop solid relationships to foster future client referrals. Examples include Senior and Disability Resource Centers, county human services, Lutheran Social Services, Catholic Charities, First Call for Help, Meals on Wheels, Centers of Aging, clergy, hospital discharge coordinators, etc.)
- *Advocacy groups* – Create awareness with senior citizen and disability advocates (AARP, ARC, Alzheimer’s family support groups, etc.)
- *Mentoring* - Established co-ops and credit unions can help with specific tasks (developing a co-op culture and culture of ownership, management, scheduling, setting up co-op accounting, networking, marketing our cooperative advantage)
- *Loan financing* – Availability through Northcountry Cooperative Development Fund, revolving loan funds (USDA, WI Commerce, local), credit unions.
- *Grants for co-op development* – Need funds to pay for a project coordinator for 18-24 months, sponsoring organization, visits from worker co-op members.

External wildcards

- Established homecare agencies – Be aware of non-compete clauses
- Labor union activity –
 - The “public authority” model of the west coast
 - Professional Employer Organizations (employee leasing) – co-op membership in a PEO runs counter to co-op principle #4

Beware of the hierarchical medical model!

The organizers of the Wisconsin co-ops inadvertently fell into the trap of assuming a medical model – in which a high salaried, external director and office staff had to be hired to “take care of business” on behalf of the member-owners. Why can’t a caregiver co-op be not only member owned, but member operated?

- ***Caregiver coordinators rather than an externally hired executive director*** - Why not divide up administrative tasks instead of hiring an executive director? (Coordinator of client services, coordinator of finances and business operation, coordinator of caregiver and owner services) - Stay tuned...
- ***Multi-tasking caregivers*** - Why can’t caregivers spend part time caring for clients and be paid part time to handle administrative tasks?
- ***Paid committees*** - Why not pay small committees of caregivers to perform human resource or other duties (recruitment, hiring, mentoring, disciplinary actions)? Union Cab Co-op of Madison has “jury duty” within its cooperative. Members who face disciplinary action may take their concerns to a grievance committee. That committee consists of randomly chosen peers who serve a one year term.