7

Start-Ups and Replication

STEVEN L. DAWSON

Originating in 1985 in a gritty South Bronx office—one that looked unnervingly like it belonged to a private detective on the skids—the Cooperative Health Care Network now links three profitable home health care cooperatives in the inner cities of the South Bronx, Philadelphia, and Boston (Nye and Schramm 1994). This federation of employee-owned businesses stands as a rather rare exception to a long and frustrating history of community-based enterprise creation (Lehmann 1994; Vidal 1992). Together, these three cooperatives now employ more than 500 paraprofessional home care aides, nearly all of whom are African American and Latina women. Of these, more than 400 were formerly dependent upon public assistance.

The various actors within our story will be difficult to follow, however, without a scorecard. Figure 7.1 illustrates the relationships among the entities described below. Cooperative Home Care Associates (CHCA) is the initial cooperative, started in the South Bronx in 1985, which now employs 390 home health aides. CHCA and the other two enterprises are structured as worker-owned cooperatives, in which each employee—from the president to every home health aide—has the option of owning one voting share of stock.

Home Care Associates (HCA) is the first replication site, started in Philadelphia in 1993, which now employs 70 aides. Cooperative Home Care of Boston (CHCB) is the second replication site, started in Boston in 1994, which now employs 60 aides.

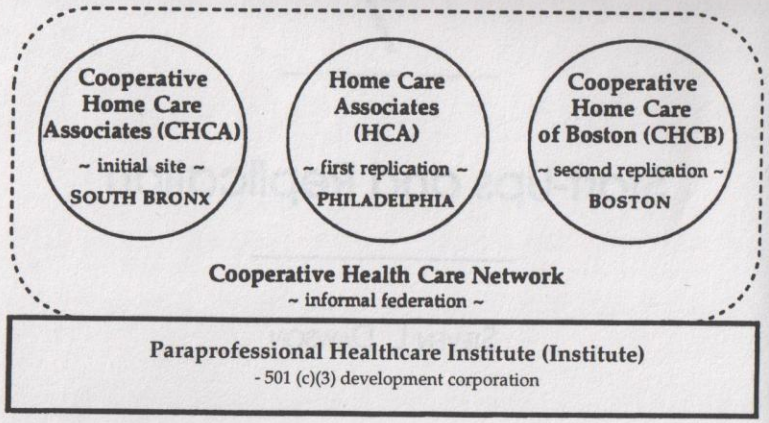

Figure 7.1. The Relationships Among the Elements of the Cooperative Health Care Network

Finally, the Paraprofessional Healthcare Institute (the Institute), of which I serve as president, is the 6-year-old 501(c)(3) nonprofit agency based in the South Bronx that undertook the replication program. The Cooperative Health Care Network is the informal federation that links together the three for-profit cooperatives.

In the remainder of this chapter, I provide a description of the people the Cooperative Health Care Network trains and employs, the types of jobs they perform, and the three cooperatives that employ them. I also provide a brief chronology, lessons learned about the process of enterprise replication, and the key "design elements" of our community/labor-based enterprise model.

Context

Participants

The Cooperative Network's typical entry-level trainee is a woman of color between the ages of 22 and 55. She is single, the mother or guardian of young children, and was dependent on public assistance before participating in the training and employment program. Although she may have done poorly in school—math and reading skills typically range between the fourth- and eighth-grade levels—she is nonetheless an extremely resourceful and caring individual.

Home Care Jobs

Home health care provides one of the few types of jobs available to women who have little formal schooling and limited job experience; in fact, in recent years home care has become one of the first stops off public assistance for literally hundreds of thousands of inner-city, low-income women.

Home health care aides provide paraprofessional care—hands-on assistance with health care needs, bathing, toileting, grooming, and meal preparation for their ill and elderly homebound clients. These and other closely related frontline health care jobs—home attendant and personal care positions, as well as certified nurse's aide positions in hospitals and nursing homes—employ more than 2.2 million people in the United States, of whom 85% are women and 30% are women of color (Himmelstein, Lewontin, and Woolhandler 1996).

Unfortunately, these jobs are of such poor quality that nearly 600,000 medical care workers have family incomes below the federally defined poverty line (Himmelstein, Lewontin, and Woolhandler 1996). Current federal Medicare regulations require no more than 2 weeks of training for these positions, and they make no attempt to ensure that these workers are provided a livable income and adequate benefits—average wages typically range near $6.00 per hour or less (Dow 1991, 1993), and many positions, particularly in the home care industry, are part-time, averaging 25 hours per week (Bayer, Stone, and Friedland 1993). In a bitter irony, 42% of all health care workers in 1993 had no employer contribution toward health insurance at all, up from 37% in 1989 (Himmelstein, Lewontin, and Woolhandler 1996).

In particular, the job of a home care aide is extraordinarily demanding—requiring that she care for her client alone, in the client's home, with almost no on-site supervision. She must also be prepared to resolve a range of unpredictable problems—from calming an irate family member to responding to a sudden health crisis. And most important, she must each day be a warm, caring companion to an elderly man or woman who may be insecure, lonely, or disoriented.

Given that such a difficult job is rewarded with poor wages and benefits, it is not surprising that annual turnover of home care paraprofessionals is extremely high—estimated nationwide at between 40% and 60% (Surpin, Haslanger, and Dawson 1994). The result is that many low-income women "cycle" between

home care and welfare, entering low-barrier, low-quality employment as a home health aide and then—whenever the next family crisis necessitates—falling back to public assistance.

The Cooperative Enterprises

All three home care cooperatives discussed in this chapter act as subcontractors within their local health care markets. In many urban areas, a Medicare-certified home health agency—a visiting nurse association or a major hospital—will provide skilled nursing care and subcontract for paraprofessional services from an agency such as ours. In these cases, the homebound client will receive nursing services from the "professional" agency and aide services from the "paraprofessional" agency.

Remaining a subcontractor has obvious business limitations, yet creating a company that employs home health aides almost exclusively has allowed each enterprise to establish an extremely supportive "corporate culture" defined by and built around the frontline worker. The one-person, one-vote cooperative legal structure—with the vast majority of worker-owners being low-income women of color—in turn reinforces that culture.

Finally, the paraprofessional wages and benefits provided by the three cooperatives, although not as high as we would like, range from 10% to 20% higher than the norm within each local subcontractor home care market: Average wages range from $7.50 to $8.00 per hour, with hours per worker averaging between 31 and 34 per week. Individual health care insurance is offered to all workers who pass their probationary period.

Chronology

Cooperative Home Care Associates

In the early years, the survival of Cooperative Home Care Associates was by no means assured. CHCA was initially conceived by Rick Surpin and Peggy Powell from within the relatively safe Manhattan walls of the Community Service Society (CSS), one of New York City's largest nonprofit social service organizations. In the beginning, neither Surpin nor Powell expected to manage CHCA—they were economic developers who intended to use the nonprofit CSS as a staging area from which to launch a variety of worker-owned enterprises. However, after more than a year of chaos under an "industry-experienced" manager—during which the fledgling enterprise nearly went bankrupt—the two nonprofit developers soon found themselves managing day-to-day operations at the helm of their faltering for-profit venture.

The detailed story of CHCA's near-death experience has been eloquently recounted elsewhere (Dawson and Kreiner 1993). What is critical to note here is the entrepreneurial role played by the nonprofit CSS in starting and then nurturing CHCA through its early, troubled years—contributing not only Surpin's and Powell's time, but also investing grant support that substituted for equity. In this way, CSS's developmental capacity foreshadowed the creation of the nonprofit Paraprofessional Healthcare Institute and the Institute's entrepreneurial role in replicating CHCA in Philadelphia and Boston.

The Training Institute

In 1991, the nonprofit Institute was formed from the rib of CHCA, initially to run CHCA's entry-level training program, but soon to undertake the CSS-like entrepreneurial role of spawning new start-ups within other inner-city markets—providing professional expertise in the initial feasibility assessment, writing the business plan, hiring and orienting top management, and then sheltering the new enterprise with substantial equity and training funds.

The Replication Sites

In 1992, the Institute identified Philadelphia as the first replication site and hired Scott Gordon to be the CEO of Home Care Associates of Philadelphia.

With lead national support from the Charles Stewart Mott Foundation and the Ford Foundation, federal support from the Administration on Aging of the Department of Health and Human Services, and local support from the Pew Charitable Trusts, the Institute provided HCA substantial technical assistance for business planning and initial market development, invested $300,000 in equity, and arranged for $250,000 in long-term debt through a variety of program-related investments.

Viewed from a distance, the start-up of HCA appears to have been remarkably smooth. Under Gordon's leadership, the company broke even, on schedule, within 18 months of opening its doors. Within 3 years, HCA became the largest Medicare home care subcontractor in inner-city Philadelphia—based on its reputation of providing the highest-quality paraprofessional services in the city.

Furthermore, HCA has continued to build its workforce to more than 70 paraprofessionals—more than 85% of whom had formerly been on public assistance. HCA has also succeeded in upgrading the employment status of an additional 9 women who began with the company as home health aides and now work in administrative positions at HCA headquarters. Finally, more than 50 women have chosen to become worker-owners and have enjoyed dividends for the past 3 years averaging from $200 to $650 per worker.

Up close, however, the story of HCA is more complex, for the local home care market in Philadelphia proved far less fertile than that in New York: The average home care visit in Philadelphia is only 75 minutes, compared with New York's average of nearly 3 hours. Aides in Philadelphia must travel among several cases each day, with the result that hours per worker hover just above 30 hours per week—far above the local market's typical home care hours of 22 to 25 per week, but still significantly less than CHCA's average in New York of 34 hours per week.

Given this grudging environment, HCA has struggled since start-up to diversify its business services to provide more full-time work. In recent years this has led to a "temporary-to-permanent placement" strategy in which HCA trains and employs entry-level workers not only for its own home care business, but also for 3-month "temporary" placements within institutional settings, such as mental health facilities. Temporary employees who perform well are then hired by these new agencies, ensuring them full-time jobs.

On the one hand, this strategy promises a significant number of new, decent jobs—hopefully more than 50 per year by 1998. On the other hand, it challenges the cooperative culture of HCA, because successful employees will not stay as worker-owners of HCA but instead will become full-time employees elsewhere.

In Boston, in 1993, the Institute hired Seth Evans as CEO of Cooperative Home Care of Boston. Again, the Institute provided personnel, equity, finance, and training support identical to that provided to HCA in Philadelphia—this time assisted by the Mott and Ford Foundations, by the federal Job Opportunities for Low-income Individuals program of the Department of Health and Human Services, and by local support from, among others, the Boston, Hyams, and Riley Foundations.

Again, from a distance the start-up of CHCB appears nearly flawless: Under Evans's leadership the company broke even, on schedule, within 18 months and has remained profitable ever since. The Boston home care market's case configuration lies midway between those of the Philadelphia and New York markets—the typical visit averages slightly more than 2 hours—and with tremendous effort and ingenuity CHCB has been able to provide its workforce between 33 and 34 hours per week.

Furthermore, CHCB's contractors now consistently name the cooperative's services as among the highest quality in the city, and specifically ask for CHCB aides by name. Therefore, the workforce has grown now to more than 60 workers, and in early 1997 CHCB home health aides began purchasing their membership shares.

Yet viewed up close, the story is again more complex: In Massachusetts, welfare has been reformed with a vengeance, in particular disrupting the recruitment networks for new trainees that CHCB so carefully constructed during its first 2 years. Furthermore, CHCB has began to saturate its inner-city market: Additional growth of any significance will be obtained only if CHCB expands beyond Boston to cover surrounding cities. Although the resulting growth should provide the cooperative greater economic stability, clearly such regional expansion will, among other things, challenge the sense of community among the inner-city workforce that the cooperative forged during its start-up years.

Finally, in New York, Cooperative Home Care Associates is itself being forced to change: Hospital consolidation and changes in Medicaid regulations have combined in the past 2 years to cut the New York City home care market by 10%—but fortunately, close cooperation with the Visiting Nurse Service, CHCA's largest contractor, has recently placed the cooperative on a renewed track of job growth.

In addition, CHCA has embarked on an ambitious plan to create a specialized chronic care management organization for severely disabled children and adults. From an employment perspective, this initiative is designed to gain greater control over both reimbursement and service-provision mechanisms—allowing CHCA to strengthen the role of the paraprofessional and in turn create a better-trained, more highly valued, and better-paid career track for CHCA's home health aides.

Lessons of Replication

As the above chronology suggests, the replication of CHCA has little to do with transporting a static model into static sites. Instead, the replication of CHCA quickly became the introduction of a multifaceted, dynamic model into differing and very dynamic sites. Furthermore, the process is far from over: CHCA, HCA, and CHCB all continue to grow and, more important, all are substantially

adjusting their initial strategies in response to the turbulence now churning throughout the nation's health care industry.

Organizational Characteristics

What remains constant within this complexity, however, are four essential characteristics shared by all of the three enterprises. First, they all possess an overriding *mission* to provide both high-quality paraprofessional jobs for inner-city women and high-quality care for clients who are elderly or disabled. Second, they all employ a set of organizational *core competencies* in the selection, training, supervision, and support of paraprofessional health care workers. Third, all cultivate an organizational *culture* that engenders openness, mutual respect, fairness, and a sense of community. Finally, all three possess an *organizational structure* that encourages workers' career development, participation in decision making, and ownership in their own cooperative.

Underlying Premises

In reflecting on this experience, we have confirmed some of our original premises. First, our ability to create better jobs for low-income people has been in direct proportion to how deeply we have been able to engage within local markets. As industry participants, we have access to information, opportunities, and, most important, relationships that are unavailable to even the most sophisticated researchers and analysts.

We have also confirmed that opportunities are created, not discovered. Our insider position has allowed us to identify and solve the problems of other industry actors in ways that meet simultaneously their business interests and our social goals. As a result, our intervention has constructed a pragmatic and compelling "business logic" for creating quality jobs for low-income people; we have forged an industry argument, not a charitable plea, for addressing a societal need.

Our replication program has also generated many new lessons that we had not originally foreseen. Three lessons have been key. The first involves CEO training and support. We miscalculated the relevance of CHCA's current experience to the reality of the start-ups: CHCA is a 13-year-old, 390-worker agency in a large and very established market, and the new managers were faced with the very different task of starting new agencies with very small staffs. On the one hand, this miscalculation generated a significant degree of frustration on the

part of the new managers, who perceived that "New York" did not fully understand local realities. At the same time, the replication staff members were forced to provide far more on-site support—even to this day—than we had anticipated or were initially staffed to provide.

However, at least two initiatives undertaken to train and orient senior management were highly valued by the local managers. The first was a several-months-long "immersion" in CHCA's day-to-day operations—we invited prospective managers to work alongside various staff people in New York to see firsthand how various operations were handled, from training to case scheduling. The second initiative involved the selection of a replication staff person to work closely with each manager as a "mentor"—someone with whom the new manager could talk through problems on a regular basis and who could act as an advocate for the replication sites among the other New York staff.

The third lesson learned concerns the dynamics of replication. Replicating a successful program is far more complex, both substantively and psychologically, than traditional technical assistance. Emotional dynamics—of the founders wishing to protect the integrity of the original model, of new leaders wishing to create something new of their own—create a tension that appears to be endemic to the process. So far, the replication program has managed this tension—though not without considerable friction at times—through constant attention to communication and continuing attempts to restructure staffing and other resources to meet the changing demands of all three sites.

One structural change that has enhanced communication and created a greater sense of shared ownership within the Cooperative Network has been the placing of representatives from all three sites on the Institute's Board of Directors, which oversees the replication program. This formal representation has created a federationlike structure to our governance, which helps keep the Institute more accountable to the local sites.

Another structural issue is the composition of the management team. We initially envisioned a simple staffing model, with each replication site having a fully trained CEO who would in turn train other senior staff. We have since learned that we must attend directly to the training of middle managers as well—particularly the lead operations director and senior trainer.

In addition, we have found identifying women of color for the senior management position to be exceptionally difficult—of the three senior managers, two are white men and the third is a white woman—though all three sites have filled all other senior positions exclusively with women, most of whom are women of color.

Key Strategic Design Elements

Finally, each of the Cooperative Network's three enterprises has succeeded in conventional terms—as a profitable, for-profit business—but each has also succeeded in "social" terms—having benefited not only their low-income workers with higher-quality jobs, but also their clients with higher-quality care.

We believe our conventional *business* success is attributable to a set of "production elements"—including strong management, a demonstrated market demand, and adequate equity—that is now widely accepted as essential to any community-based enterprise initiative (Emerson and Twersky 1996). However, we strongly believe the Cooperative Network's *social* success is attributable to four strategic "design elements."

The Dual Model: For-Profit Business and Training Program

The Cooperative Network represents a dual model that integrates two distinct components: Each of the enterprises includes both a profitable business and an on-site, employer-based training program. The short-term classroom training program (ranging from 4 to 7 weeks, depending on the site) leads to immediate placement in a permanent, unsubsidized job within the cooperative. Then, once the new employee is on the job, the respectful style of management, in-service training, personal and vocational counseling, careful supervision, and (later) career upgrading programs together all weave for her a supportive work community and learning environment.

For the successful training participant, this dual model guarantees the availability of a decent job—secured through a series of small, structured steps throughout the often difficult transition from welfare to work. The process is nearly seamless as the participant moves from the training program into the enterprise, for the training program and the enterprise share the same mission, style of management, performance expectations, and even physical space.

For the cooperative, this dual model guarantees maximum control over recruitment, selection, and training, thereby ensuring the best employee performance possible—which the cooperative in turn uses to secure a high-end market niche.

A Sectoral Employment Strategy

The Cooperative Network model is a tested example of a *sectoral employment strategy,* that is, one that "targets a particular occupation within an industry, and then intervenes by becoming a valued actor within that industry—for the primary purpose of assisting low-income people to obtain decent employment—eventually creating systemic change within that occupation's regional labor market" (Clark and Dawson 1995).

Most industries currently accessible to inner-city, low-income women offer poor-quality jobs, with low pay, few benefits, and no chance of upward mobility. These entry-level jobs no longer act—as some once did for low-income people—as the "first rung on a ladder" leading to increased skills, responsibility, and compensation. This reality presents two strategic paths. The first is to identify industries that offer high-quality jobs currently inaccessible to low-income women, and then assist low-income women in securing those positions by eliminating barriers to employment. The second is to identify industries that already employ large numbers of low-income women, and then work to mold those poor-quality jobs into "decent employment." The Cooperative Network chose the second path: reshaping an industry that currently keeps large numbers of low-income women working, but poor.

Sectoral influence on an occupation can be achieved in two ways: by changing the public regulatory framework (e.g., through a "living wage" law that creates a wage floor for any occupation under public contract) or by changing private industry practice (e.g., through a labor innovation on the part of one competitor that is so compelling it forces other businesses within that market to respond in kind).

By intervening inside the home care industry as an employer, the Cooperative Network model uses both tactics: Within the regulatory framework, CHCA co-led a coalition of unions, consumer advocates, and service providers in securing labor reimbursement rate increases from the New York State Legislature. And within industry practice, the superior quality of the cooperatives has convinced contractors in each of the three local markets to place higher expectations on the labor standards of their other subcontractors.

A Labor-Based Design

The design of the Cooperative Network is intentionally labor based rather than neighborhood based. From an enterprise perspective this is essential, because a

labor-based strategy recognizes that most businesses do not respect neighborhood boundaries—for customers, suppliers, or workers. Except for retail stores, businesses are not typically neighborhood phenomena, but regional phenomena.

From the community perspective, a labor-based strategy recognizes that, like everyone else, inner-city residents live within several overlapping yet distinct "communities"—neighbors, friends, family, church members, coworkers. Some of these communities are geographically based, some are not. Therefore, given modern-day transportation and communication, the Cooperative Network model assumes that community should not be perceived solely in neighborhood terms.

In low-income communities, neighborhood strategies and labor strategies can be mutually reinforcing—which is why all three cooperatives work in partnership with local community development corporations. As those geographically based organizations work to strengthen the bonds of community among groups of neighbors, the cooperatives work to strengthen the bonds of community among groups of coworkers. Clearly, helping Latina women who live in one low-income neighborhood to develop mutually supportive work relationships with African American women who live in another is one effective way among many to "build community."

However, although all three cooperatives work in partnership with local neighborhood groups, the Network has intentionally avoided creating an ownership structure that blends worker and neighborhood control, believing that the political complexity of such a dual ownership structure would entangle what must remain an agile, market-oriented enterprise.

Perhaps most important, the experience of the Cooperative Network enterprises has now provided incontrovertible proof that this type of service business can be managed to "maximize the value of labor," and yet still succeed within a market economy.

Any successful business within a market economy must manage several factors simultaneously—return on capital, cash flow, labor, technology, and market position, to name a few. However, closer inspection reveals that businesses are often managed not from a logic of equalizing all factors, but from a logic of maximizing from among them one key factor, with the others managed to ensure the primacy of that key factor. The choice of which factor to maximize is to some extent dictated by the structure of the particular industry, but also—and this is critically important—it is determined in large part by the values of the decision makers in a particular business. For example, corporate investment firms often manage their holdings to maximize short-term return on investment, and in the process are accused of ignoring the harm their corporate decisions place on other "factors," such as consumers, workers, and communities. McDonald's manages for market share, pouring hundreds of millions of dollars into advertising. The local auto repair shop manages for cash flow, basing almost all business decisions on how cash can best be conserved. Apple Computer was maximized for technology—to the eventual detriment of its market share.

All of the businesses in these examples—with the apparent exception of Apple—are able to thrive in the marketplace while maximizing different variables. What the Cooperative Network has proven is that business can also be managed to maximize *labor* and nonetheless remain profitable within the marketplace. Should all of us who are working to create community/labor-based businesses ever demonstrate this same phenomenon in a wider range of companies within a greater variety of market settings, the implications would be profound for the building of a more humane, labor-based market economy.

One example of maximizing labor from within our cooperatives may prove helpful: As I noted earlier, turnover in paraprofessional positions in the home care industry is extremely high—ranging between 40% and 60%. The cost of replacing a worker—including recruitment, training, on-the-job orientation, and increased supervision—is approximately $3,500 per new employee. Therefore, a 100-worker agency spends nearly $175,000 every year ($3,500 times an average of 50 new workers annually) simply to maintain its workforce.

Clearly, a home care agency that invests in its frontline workforce will save substantial money if the result is lower turnover. Yet, realistically, investment in the frontline workforce *costs* money as well (in higher wages and benefits, for example). Therefore, both high-turnover and low-turnover agencies might in the end achieve the same profitability, but the low-turnover (high-investment) agency will have created a higher-quality service and a far more humane company. Furthermore, as has been true for all three of our cooperatives, the resulting high-quality reputation may in turn be rewarded in the marketplace through the generation of increased demand for services.

The Cooperative Network invests in its frontline workforce because the frontline worker is at the core of the Network's mission—a mission reinforced by the fact that the owners of the companies are the frontline workforce. Thus we are managing the companies primarily to maximize labor, yet when such management has been undertaken thoughtfully, it has proven in addition to be a successful, profitable business strategy.

Conclusion

Today, the Cooperative Health Care Network includes three home care cooperatives. For all their differences of size, market, and leadership personalities, they are remarkably similar—both in their day-to-day functions and in their core

mission. However, 3 years from now, the Network will appear increasingly different: The sites will continue to evolve in directions that meet the varying demands of their local markets and the visions of their local leadership teams. In addition, the sheer number of entities associated with the Network will grow: CHCA in New York will initiate a separate chronic care management organization, HCA in Philadelphia will create its own distinct training and enterprise development corporation, and CHCB in Boston will likely open branch offices in surrounding towns. The Institute will also add entirely new enterprise sites as well—each of which will no doubt, in this chaotic health care industry, be uniquely configured to meet local market conditions.

At that time, we will judge our success by how well we have maintained throughout the Cooperative Network our core mission: maximizing the value of the frontline worker to provide high-quality care—in turn creating entrepreneurial, dynamic enterprises.

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