Introduction by Adrienne Eaton & Adria Scharf

JUST HEALTH

Case Studies of Worker Cooperatives in Health and Care Sectors

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Introduction

As a society, we underpay and under-support—under-care-for—the very workers we rely on to provide health and care services to others. The COVID-19 pandemic briefly spotlighted this fact as health workers braved risks to care for the vulnerable. The worst of that crisis has passed—but the extractive business models that structure health and care work under American capitalism endure.

The way we structure work and ownership, in health matters. Healthcare is the largest employer in the country by many estimates.[1] Healthcare workers account for 12% of total employment—not including the self-employed or the millions of workers who perform health-related care work (such as nonmedical home care) but are omitted from many statistics describing the formal health sector.[2]

This volume documents—for the first time—healthcare enterprises that take the form of worker cooperatives. As worker-owned and governed businesses, these cooperatives are breaking with prevalent ownership and organizational models to forge a fundamentally different, more worker-centered approach.

Healthcare Provision

On the one hand, the massive healthcare system in the United States is so complex and sprawling as to defy characterization. On the other hand, it is so distinct that we can make several broad observations. Relative to many other industrial countries, healthcare in the United States is comparatively:

- Highly privatized and commercialized; the U.S. relies on private enterprise to a greater extent than other countries to meet its population's health and care needs.[3]

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[1] Earlene K.P. Dowell, "Health Care Still Largest U.S. Employer." October 14, 2020, https://census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html.

[2] "Total Health Care Employment," Kaiser Family Foundation, May 1, 2021, https://www.kff.org/other/state-indicator/total-health-care-employment; "Health Care Employment as a Percent of Total Employment," Kaiser Family Foundation, May 1, 2021, https://www.kff.org/other/state-indicator/health-care-employment-as-total. Health Care Employment includes these subsectors in the U.S. Bureau of Labor Statistics National Industry-Specific Occupational Employment and Wage Estimates: Ambulatory Health Care Services, Hospitals, and Nursing and Residential Care Facilities. The term "medical industry" encompasses healthcare providers and services, as well as the manufacture of equipment and supplies, healthcare technology, research and development, and pharmaceuticals.

[3] Willem Adema and Maxime Ladaique, "How Expensive is the Welfare State?: Gross and Net Indicators in the OECD Social Expenditure Database (SOCX)," *OECD Social, Employment and Migration Working Papers*, November 13, 2009, https://www.oecd-ilibrary.org/social-issues-migration-health/how-expensive-is-the-welfare-state_220615515052.

- Marked by occupational stratification and extreme disparity.
- Staffed by large numbers of low-paid workers who are disproportionately BIPOC (Black Indigenous and People of Color) and immigrant women.

In addition, many health-providing organizations are managed hierarchically in ways that do not allow meaningful worker control or voice. This is true across for-profit, nonprofit, and public settings (with many exceptions, including in unionized settings). While this is a fact of life across much of the economy, it can have devastating consequences in healthcare if frontline providers, who may have the most knowledge about the patient or client, are not heard.

Ownership

In the United States, healthcare is privately delivered and funded to a degree rarely seen in other countries. According to the American Hospital Association, of the 6,093 hospitals in the country, roughly one-third operate as for-profit investor-owned businesses and about half are private nonprofits; different levels of government run the rest.[4] Outside of hospitals, too, much healthcare is delivered by private for-profit and nonprofit entities. For example, one-third of the 233,350 physical therapists registered in the United States work in private outpatient offices. In addition, nearly 45% of psychologists work in private practice, according to a 2015 survey by the American Psychological Association, with 23.6% working in hospitals or organized social service settings.[5]

Evidence is mixed on the impact of for-profit versus nonprofit status in hospitals. However, multiple studies have found significantly poorer care and more deficiencies in for-profit nursing homes.[6]

For-profit health businesses largely have ownership models that extract and concentrate wealth and profits into the hands of owners, shareholders, and investors.[7] Three major trends are restructuring ownership patterns within large swaths of for-profit private enterprise healthcare:

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[4] "Fast Facts on U.S. Hospitals, 2022," The American Hospital Association, accessed December 1, 2022, https://www.aha.org/statistics/fast-facts-us-hospitals. More than half of community hospitals are now part of a "System."

[5] Auntré Hamp et al., *2015 APA Survey of Psychology Health Service Providers* (Washington, DC: Author, 2016), https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf. About half of respondents reported self employment (48.9%) and 43.6% salaried employment.

[6] "Non-Profit vs. For-Profit Nursing Homes: Is There a Difference in Care?" The Center for Medicare Advocacy, last modified March 15, 2012, https://medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/; Haider J. Warraich, "For-Profit Nursing Homes and Hospices are a Bad Deal for Older Americans," *STAT*, April 19, 2021, https://www.statnews.com/2021/04/19/for-profit-nursing-homes-hospices-bad-deal-older-americans/. Critics argue that for-profit ownership models may undermine care while proponents claim that for-profit models increase efficiency.

[7] These may be large investors, public shareholders, entrepreneurs, or for example with independent private practices and PLLCs, they may themselves be licensed care professionals.

- First, hospitals and hospital systems are consolidating and merging, expanding into ambulatory, clinical, and community-based care and buying up independent practices.[8]
- Second, private equity firms, which pool money from groups of investors, are buying more health companies to restructure and sell the companies at a profit; private equity investments in health more than doubled in 2021 from $66 billion to $151 billion.
- Third, franchise models of ownership (in which an individual or entity provides health services under the brand of an established company) are expanding in certain pockets of the sector, among, for example, home care, physical therapy businesses, primary care, and urgent care clinics.[9]

All three trends raise questions about how profit-imperatives might impact workers and the quality of care. By contrast, while they are also private enterprises, worker cooperatives are designed to balance profit-making with worker needs and other values. By design, they give worker owners mechanisms for genuine voice and a share of profits. Their unique organizational structure may have implications not only for workers but for patients as well.

Disparities

Rigid hierarchies and substantial inequalities among occupational groups characterize this sector.[10] Occupations range from the highly educated and typically highly compensated (such as physicians) to less skilled, or skilled but devalued, jobs like certified nursing assistants and home health aides, receptionists, cleaners, and other administrative roles in health settings.[11]

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[8] Shubham Singhal and Neha Patel, "The Future of U.S. Healthcare: What's Next for the Industry Post-COVID-19," *McKinsey & Company*, July 19, 2022, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-future-of-us-healthcare-whats-next-for-the-industry-post-covid-19. "Hospital systems have been expanding across the care continuum, accumulating assets in ambulatory sites, virtual and digital health, primary care, and post-acute care. A majority of the net patient service revenues of the largest 50 hospital systems are now outside inpatient care."

[9] The COVID pandemic was particularly revealing of the problems facing health care workers including lack of personal protective equipment; by one report, 3,600 U.S. healthcare workers died in the first year of the pandemic. Two-thirds of those who died were people of color. Other healthcare workers experienced moral injury helplessly watching people die. All of this is no doubt a factor in the severe shortages seen in many parts of the sector today. While the pandemic has filled hospitals to bursting points on and off since early 2020, it also, perversely shut down many offices providing more elective or peripheral care in the early months and maintained lower levels of patient volume for additional months.

[10] Ariel C. Avgar et al., "Paying the Price for a Broken Healthcare System: Rethinking Employment, Labor, and Work in a Post-Pandemic World," *Work and Occupations* 47, no.3 (August 2020): 267-436. https://doi.org/10.1177/0730888420923126.

[11] Alethia Jones, "Agents of Change: How Allied Healthcare Workers Transform Inequalities in the Healthcare Industry," in *Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health*, ed. Helena Hansen and Jonathan M. Metzl (Springer, Cham, 2019), 191-209. https://doi.org/10.1007/978-3-030-10525-9_16. Boundaries throughout

While the mean annual wage for "healthcare practitioners and technical occupations" was $91,100 in May 2021, "healthcare support occupations" (such as home health aides, occupational therapy assistants, and medical transcriptionists) earned wages of just $33,330 at the mean.[12] Many healthcare workers and support workers in healthcare settings contend with low wages, unpredictable hours, limited access to benefits, workplace stress and risk, and low job security. Women, Black, Latinx, and immigrant workers disproportionately perform lower-wage jobs with poor job quality.

We know from the existing literature that the terms and conditions of employment for all of these occupations are essential for patient health outcomes. For example, evidence suggests that lower turnover among home-care providers can improve care quality. In addition, it is worth noting that although support workers such as receptionists and cleaners in healthcare organizations do not directly provide healthcare themselves, they nevertheless help to create the environment in which care is provided and do so with substantial potential implications for health outcomes and service quality, an important metric for many healthcare providers.[13]

Home care requires further discussion. The country's 2.6 million home-care workers, who assist older adults and people with disabilities at home, earn a median annual income of $19,100, according to the research group PHI. Eighty-five percent are women. Sixty-three percent are people of color.[14]

Without question, home-care workers provide services that contribute to the health and safety of the client and can provide valuable information to formal healthcare providers and families. We recognize that state laws strictly differentiate "home care" from "home health care": "Home care" agencies provide help with daily living and nonmedical services to people

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the healthcare professions are maintained by law and regulation and can be contentious battlegrounds for scope of practice policies, conflicts in which professional associations often play a major role. For a discussion of these hierarchies and how they intersect with race, see the link above. A larger circle of care work, which some have called the care economy or the social care sector, supports community health but is not reflected in statistics on the formal health sector. Examples of such care work include home care, some doulas, certain mutual aid efforts, health assistance provided within friendship or familial networks, and other health-supporting care work provided outside of formal employment relationships.

[12] "Occupational Employment and Wages, May 2021," Occupational Employment and Wage Statistics, U.S. Bureau of Labor Statistics, accessed November 1, 2022, https://www.bls.gov/oes/current/oes290000.htm; https://www.bls.gov/oes/current/oes310000.htm/.

[13] Adam Seth Litwin, Ariel C. Avgar and Edmund R. Becker, "Superbugs Versus Outsourced Cleaners: Employment Arrangements and the Spread of Health Care-Associated Infections," *ILR Review* 70, no.3 (May 2017): 610-41.

[14] "Direct Care Workers in the United States: Key Facts," *PHI*, September 6, 2022. http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/. Note that these estimates include personal care aides who assist with nonmedical activities and home health aides who can perform certain clinical tasks under supervision, as well as some direct support professionals. The majority of these jobs are funded through public insurance sources such as Medicaid and Medicare; low Medicaid reimbursement rates are one cause of low wages among these occupations. See the link above.

with functional limitations. “Home health” agencies may provide skilled health services such as nursing care which may involve a written order from a physician. Despite the legal distinction, we understand home care to be intertwined with health and a necessary component of health provision in our aging society. Therefore, we have intentionally included home care cooperatives case studies in this volume.[15]

In the United States, health insurance coverage is predominantly employer-based, with 66.5% of the U.S. population covered by employer-provided health insurance, with the rest covered by public schemes.[16] Among other problems, this system, especially before the advent of “Obama-care” left many U.S. residents uninsured, leading to overuse of emergency rooms, institutions burdened by uncompensated care, gross inequalities in access to care, and poor health outcomes. The U.S. remains at the bottom of developed countries in terms of our healthcare outcomes due in part to our patchwork funding system and to the many perverse incentives in the fee-for-service parts of the system, which reward more care but not high-quality or preventive care.

Moreover, employer-provided health is so expensive as to remain out of reach for most very small employers, leaving their workers to stay uncovered or to pursue other options. Insurance companies' rules and requirements, and coverage decisions, impinge on health organizations and their workers, too—including some of the cooperatives documented here. Like other health-service providers and employers, cooperatives have to contend with the complex array of payers and the bureaucratic requirements of those payers in this “system.”

What are the solutions to poor working conditions and disparities? Unionization is undoubtedly one. Unionized healthcare workers are, on average, better paid, more likely to be covered by health insurance and pension benefits, and provided some modicum of voice. But as of 2021, only 7.7% of healthcare (and social assistance) employers and 8.3% of healthcare support occupations were unionized. Those averages across the sector hide variation. In 2018, 14.7% of hospitals and 7.1% of home healthcare services but only 4.2% of physician offices and 1.9% of other health practitioners’ offices were covered by unions. In those cases where

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[15] Different entities categorize home care in various ways—as social assistance work, social care work, direct care work, domestic work, or health-related work.

[16] Katherine Keisler-Starkey and Lisa N. Bunch, “Health Insurance Coverage in the United States: 2020,” *U.S. Census Bureau Current Population Reports*, September 14, 2021, https://www.census.gov/library/publications/2021/demo/p60-274.html. Many employer-based health insurance programs now also require substantial contributions from employees themselves as percentage of the insurance premium, deductibles and/or co-pays. By some measures however, health costs are over two-thirds publicly funded; David U. Himmelstein and Steffie Woolhandler, “The Current and Projected Taxpayer Shares of U.S. Health Costs,” *American Journal of Public Health* 106, no.3 (March 2016): 449-52. https://doi.org/10.2105/AJPH.2015.302997. Many employer-based health insurance programs now also require substantial contributions from employees themselves as percentage of the insurance premium, deductibles and/or co-pays. By some measures however, health costs are over two-thirds publicly funded. See the link above.

management and unions have chosen to formalize partnerships, organized voice in the form of worker and union participation in managerial decision-making is further strengthened.[17] The best known of these partnerships are in hospital systems, including some huge ones and all public or non-profit. Research suggests that unionization and labor-management partnership can be associated with better health outcomes for patients, likely a result of better conditions of work, reduced turnover, and protections for worker voice in these settings.[18]

Many labor scholars have noted the historically explicitly racist exclusion of home-care workers from the legal protections of unionization rights.[19] Nevertheless, over the last three decades, some of the largest and most innovative union organizing campaigns have taken place among home-care workers who are independent contractors employed by low-income clients but reimbursed by the state.[20] Home-care workers have also won some protections under the Domestic Workers Bill of Rights passed thus far by 10 states.[21]

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[17] Adrienne E. Eaton, Rebecca Kolins Givan, and Peter Lazes, "Chapter 6. Labor-Management Partnerships in Health Care: Responding to the Evolving Landscape," in *The Evolving Health Care Landscape: How Employees, Organizations, and Institutions are Adapting and Innovating*, eds. Ariel C. Avgar and Timothy J. Vogus (Labor and Employment Relations Association/Cornell University Press, 2016), 143-70; Thomas A. Kochan et al., *Healing Together: The Labor-Management Partnership at Kaiser Permanente* (Cornell University Press, 2009).

[18] Adam Dean, Atheendar Venkataramani, and Simeon Kimmel, "Mortality Rates from COVID-19 are Lower in Unionized Nursing Homes," *Health Affairs* 39, no.11 (November 2020): 1993-2001. https://doi.org/10.1377/hlthaff.2020.01011; Arindrajit Dube, Ethan Kaplan, and Owen Thompson, "Nurse Unions and Patient Outcomes," *ILR Review* 69, no.4 (August 2016): 803-33. https://doi.org/10.1177/0019793916644251; Michael Ash and Jean Ann Seago, "The Effect of Registered Nurses' Unions on Heart-Attack Mortality," *ILR Review* 57, no.3 (April 2004): 422-42. https://doi.org/10.1177/001979390405700306; Kochan et al., *Healing Together*.

[19] Eileen Boris and Jennifer Klein, "Labor on the Home Front: Unionizing Home-Based Care Workers," *New Labor Forum* 17, no.2 (July 2008): 32-41. https://www.jstor.org/stable/40342996.

[20] Patrice M. Mareschal, "How the West was Won: An Inside View of the SEIU's Strategies and Tactics for Organizing Home Care Workers in Oregon," *International Journal of Organization Theory and Behavior* 10, no.3 (Fall 2007): 386-412. https://doi.org/10.1108/IJOTB-10-03-2007-B006; Patrice M. Mareschal, "Innovation and Adaptation: Contrasting Efforts to Organize Home Care Workers in Four States," *Labor Studies Journal* 31, no.1 (Spring 2006): 25-49. https://doi.org/10.1177/0160449X0603100103; Eileen Boris and Jennifer Klein, "Organizing Home Care: Low-Waged Workers in the Welfare State," *Politics & Society* 34, no.1 (March 2006): 81-107. https://doi.org/10.1177/0032329205284757; Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (Oxford University Press, 2012); This progress is somewhat threatened by the Executive Orders of Republican governors in some states, and also by the Supreme Court's decision in Harris v. Quinn in 2014 which ruled that care workers could not be required to join a union or pay union dues.

[21] "Passed Legislation: States and Cities with a Domestic Workers Bill of Rights," National Domestic Workers Alliance, accessed December 1, 2022, https://www.domesticworkers.org/programs-and-campaigns/developing-policy-solutions/bill-of-rights/passed-legislation/. New York, Illinois, Oregon, California, Nevada, Connecticut, Massachusetts, Hawaii, New Mexico and Virginia. For details, see the link above.

Given the structural limits of the existing experiments in unionization and partnership, it is worth examining additional forms of workplace organization that may lay pathways for something new.

One model that differs from for-profit business models in health, and which also differs from hierarchical nonprofit and government models of organization, is the worker cooperative. Worker cooperatives in the health and care sectors are few in number. Still, this close examination of existing worker cooperatives in health begins to shed light on an emergent organizational form that offers a fundamentally different, more equitable, and worker-centered approach to organizing health work and providing patient or client care. It is a unique model that can give workers of all ranks and occupations in the cooperative an ownership stake, a voice in governance, support, and, unusually, a share of the profits.

This Volume

This volume presents new case studies demonstrating that democratic worker cooperatives have already begun to take root as viable organizational forms, albeit in fairly distinct parts of the health sector. Two of the cases presented are of unionized worker cooperatives. For the most part, though, these organizations are located in settings different from those where major union and labor-management partnerships are being tried.

The nine cases detail, for the first time, at a granular level, how U.S. worker cooperatives in health-related fields are organized, how they govern themselves, and how they prioritize worker well-being while delivering needed services to clients and patients.

By their design as worker-owned and governed businesses, worker cooperatives contrast with predominant business models in which ownership and governing authority are reserved for the few. In cooperatives, worker-owners (who may be called cooperative members) share profits and make significant decisions democratically, either directly or through a system of representation.

The democratic enterprises described in these pages vary in size, structure, workforce demographics, and cultures. They also differ in their membership requirements, wage structures, and the rights and pay they accord to administrative support staff and workers who are not yet owners. Some of the case cooperatives have long track records of demonstrated success. Others are fledgling experiments.

Despite their differences, when we look at these case studies as a whole, several patterns emerge:

- Across the cases, we find pay rates generally equivalent to or above market rate, with profits shares for worker-owners, on top of wages, during profitable periods.[22]

[22] Provision of health and other benefits in the worker cooperatives, however, appears to vary by organization size.

- Nonfinancial benefits are often as salient as financial ones. For immigrants, BIPOC (Black, Indigenous, and people of color), and LGBTQ workers who face discrimination and abuse in conventional settings, the cooperative can mean safety, mutual support, and literal economic survival.
- We see preliminary indications that when workers are owners and are themselves embedded in workplace support systems, they are better able to provide quality care.
- Cooperative governance, founded on the principle of "one person, one vote," means an unusual degree of equality of voice among members across roles and titles.
- We observe, too, that the worker cooperative is a flexible form; a cooperative may be legally structured in a variety of ways, and democratic ownership and governance can be successfully paired with a wide variety of different approaches to day-to-day management and coordination.
- Two examples of unionized cooperatives point to synergies that can result from such partnerships.
- Across cases, we see evidence for the crucial role of ecosystems and partnerships in building cooperative resilience.
- We can also see cooperatives attempting to grapple with the hierarchy and status differentials that plague much of the healthcare system and can create barriers to cross-occupational teams providing care. Of particular interest is the inclusion of clerical and non-provider support staff.
- Cooperatives face institutional and competitive pressures; legal barriers that pose obstacles to democratic ownership; well-financed low-road competitors with large marketing budgets, and the mess that is the U.S. "system," if such a word can be used, for how healthcare is funded here.

The case studies contribute to several broader discussions, from "rethinking the corporation"[23] to envisioning real utopias,[24] alternatives to "racialized capitalism"[25] to "cooperative and participatory forms of organization."[26] We expect these case studies to interest workers, business owners, entrepreneurs, practitioners, advocates, and policymakers. These case studies are also useful teaching resources. (See teaching guide on the Curriculum Library for Employee Ownership website, cleo.rutgers.edu.)

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[23] Renate Meyer, Stephan Leixnering, Jeroen Veldman (editors), *The Corporation: Rethinking the Iconic Form of Business Organization* (Bingley: Emerald Group Publishing, 2022).

[24] Erik Olin Wright, *Envisioning Real Utopias* (London: Verso, 2010).

[25] Sanjay Pinto, "Economic Democracy Against Racial Capitalism: Seeding Freedom" (Forthcoming).

[26] Joyce Rothschild-Whitt, "The Collectivist Organization: An Alternative to Rational-Bureaucratic Models." *American Sociological Review* 44(4):509–27; Katherine K. Chen, *Enabling Creative Chaos: The Organization Behind the Burning Man Event* (Chicago:: University of Chicago Press, 2009).

Research Approach

The research draws primarily from semi-structured interviews with cooperative members and secondarily from documents and data provided by the cooperatives. In some cases, interviews with individuals in adjacent and technical support organizations were also conducted.

To select potential organizations, a list of worker cooperatives in health fields was developed in the fall of 2021, with guidance from staff members of the U.S. Federation of Worker Cooperatives, the Democracy at Work Institute, other sector experts, and database searches.

Confirmatory background research was then conducted to ensure that listed organizations were truly worker cooperatives in health-related fields.

Organizations from the final list were recruited to participate with a recruitment letter. To qualify to participate, at minimum one, and preferably several, company contacts were required to provide signed consent to participate in semi-structured interviews.

Research interviews were conducted, and supplementary documents and information were collected between December 2021 and June 2022. Most interviews were conducted virtually. Interviews were recorded and transcribed. The primary company contact was also asked to complete a brief optional survey.

Company-level pay and employment data are compared to industry or occupational data when feasible. In addition, upon completion of case study drafts, interviewees were allowed to review their quotes and, in some cases, review the entire draft, to check for accuracy and provide feedback.

Book Content

Three of the nine case studies presented here examine home care cooperatives, the most common type of worker cooperative in health. Cooperative Homecare Associates (CHCA), the largest worker cooperative in the country with over 2,000 workers, is a unionized worker cooperative organized around a job quality philosophy. Golden Steps is a cooperative of immigrant women from Central and South America for whom the worker co-op provides one of the few available vehicles for organizing collectively. The five small, loosely networked home care cooperatives in Washington state represent the densest concentration of home care cooperatives in any state in the country.

The next three cases examine professional health practices that chose to structure themselves as worker cooperatives in order to build organizations that better reflect such values as equality, community, support, or liberation. These include the large successful Vermont physical therapy practice PT360, which remains the only worker-owned physical therapy practice in the country; Five Point Holistic Health acupuncture and psychotherapy center in Chicago was boosted when a local insurance carrier began covering acupuncture treatments; and

a nonhierarchical mental health network based in Queens, Alliance Collective, animated by a desire to achieve an organization that is as free as possible from hierarchy and oppression.

The final three case studies describe worker cooperatives positioned strategically in relationship with larger health systems. Allied Up, for example, seeks to provide an alternative to the low-paid contingent worker staffing model as a unionized cooperative staffing organization for allied health professionals. The Evergreen Cooperative Laundry contracts with the Cleveland Clinic to tap into the economic resources of the enormous health system to sustain jobs and benefits for excluded communities. Obran seeks to demonstrate the viability of a worker-centered version of a multinational corporate conglomerate by growing its portfolio of small businesses within a cooperative umbrella.

Close

How we structure ownership and work in the healthcare sector matters.

As the baby boomer generation ages, the health and related care sectors will continue to swell. According to the U.S. Bureau of Labor Statistics, "[e]mployment in healthcare occupations is projected to grow 16% from 2020 to 2030, much faster than the average for all occupations, adding about 2.6 million new jobs. As a result, healthcare occupations are projected to add more jobs than any of the other occupational groups."

With a highly corporatized health sector marked by extreme job stratification and low wages seeing the rapid encroachment of profit-extracting private equity, exploration of more democratic alternative approaches to organizing work in health is overdue.

Overview Table

Worker Cooperative	Service	Location	Members / Workers	Revenue	Governance	Founded
Alliance Collective	Psychotherapy	Queens and Brooklyn, N.Y.	6 members/ 6 workers	$200k	Direct decision-making through consensus	2018
AlliedUP	Health Care Staffing	Ontario, Calif.	40 to 60 members / 1,000 workers placed in jobs	$10m	Worker owners to hold majority of board seats starting Nov. 2023 Labor-Management Committee Collective Bargaining Agreement (SEIU-UHW)	2021
CHCA	Homecare	Bronx, N.Y.	800 members / ~1,800 workers	$56.9m	Managerial team has day to day control. Members elect reps to board. Union representation.	1985
Evergreen Laundry	Laundry Services for Cleveland Clinic	Cleveland, Ohio	~75 members/150 workers	$10.5m expected in 2022	Worker reps on board. Co-op meetings for all co-op members.	2009
Five Point Holistic Health	Acupuncture Bodywork Psychotherapy	Chicago, Ill.	3 members / 15 workers	$605k	Weekly “check-in meetings” Longer strategic owners meetings	2014
Golden Steps	Homecare	Brooklyn, N.Y.	6 members/ 6 workers	Unreported	Elected leadership and Worker committees	2011

Worker Cooperative	Service	Location	Members / Workers	Revenue	Governance	Founded
Obran	Home Health	Multiple Locations	50 workers in “Physicians Choice” home health portfolio company	Unreported	Members may run for board of own workplace and Obran board. Members to vote in future board elections and certain special decisions. May participate in committees. Source: Obran website	2018
PT360	Physical Therapy	Four sites in Chittenden County, Vt.	18 members/ 36 workers	Undisclosed	Members elect board of directors annually. Each member has one equal vote. Five members serve on the board as officers. “Owner Meetings” take place every four to six weeks. Any owner-member can add an item to the agenda. Members discuss and then vote on each agenda item. Decisions are made by majority rule.	2010
Five Washington Home Care Co-ops: Circle of Life Peninsula, Capital, Ridgeline, Heartsong	Home care	Bellingham, Port Townsend, Olympia, Port Angeles, Anacortes in Wash.	74 members/ 96 workers combined across the five cooperatives	$25k -300k	Boards of individual cooperatives elect worker members of that cooperative.	2009, 2016, 2018, 2020, 2021

PART I: Home Care Cooperatives

Golden Steps

Sanjay Pinto, Ph.D.

Overview

Founded in 2012, Golden Steps is a Brooklyn-based worker cooperative of immigrant women of color, all of whom have roots in Central and South America. Providing services to those who do not qualify for Medicare or need more than what Medicare will pay for, Golden Steps operates in a part of the market where home care workers are hired directly by private-pay clients and their families. Workers in this arena continue to labor under racialized legal exclusions dating back to the New Deal Era and face numerous other challenges to building power and voice. In this context, worker co-ops like Golden Steps provide one of the few available vehicles for organizing collectively on a formal basis and building a shared support structure.

Building Power from the Margins

Golden Steps has established a footing on challenging terrain. Despite being essential to the reproduction of family units and foundational to all other economic and social activity,[27] domestic workers providing in-home cleaning and caring services have long labored in isolating conditions, with few rights and protections. Collective organization has consistently been stymied by legal exclusions, structural fragmentation, and the low value accorded to the work.[28]

Long after Emancipation, a majority of Black women employed outside their own homes worked as domestic workers, marking continuities with the roles they played under slavery.[29] Domestic workers continue to work under legal exclusions enshrined during the New Deal era, when white Southern Democrats seeking to preempt the collective power of Black people in the economy blocked the inclusion of domestic workers and farm workers under landmark labor and employment protections.[30]

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[27] Silvia Federici, *Re-enchanting the World: Feminism and the Politics of the Commons* (Binghamton, NY: PM Press).

[28] Laura Dresser, "Cleaning and Caring in the Home: Shared Problems? Shared Possibilities?" in *The Gloves-Off Economy: Workplace Standards at the Bottom of America's Labor Market*, (Labor and Employment Research Association, 2008), 111; Eileen Boris and Premilla Nadasen, "Domestic Workers Organize!" in *WorkingUSA 11(4),* (Leiden, Netherlands: Brill Publishers, 2008), 413-437.

[29] Evelyn Nakano Glenn, "From servitude to service work: Historical continuities in the racial division of paid reproductive labor," in *Signs: Journal of women in culture and society 18(1)* (Chicago: University of Chicago Press), 1-43.

[30] Juan F. Perea, "The Echoes of Slavery: Recognizing the Racist Origins of the Agricultural and Domestic worker Exclusion from the National Labor Relations Act," in *72 OHIO ST. L.J. l 95* (2011).

Generations of new immigrant women have also been employed as domestic workers. Today, new immigrant women from Latin America, the Caribbean, Africa, and Asia comprise a large share of domestic workers in many parts of the country.[31] While shifts in technology, consumption patterns, and social norms have contributed to a relative decline in domestic work as a source of employment since the mid-20th century,[32] growing labor force participation by women and increasing demand for in-home care support among seniors have created significant pockets of demand. Demand for home care specifically has actually increased, driven by longer lifespans, the aging of the baby boom generation, and a growing preference among seniors for aging in place.[33]

New York City has a long history of domestic worker networking and organizing dating back to connections forged among live-in maids in the early 20th century.[34] In recent decades, tens of thousands of the city's home care workers employed by agencies and working in the publicly funded system have unionized with 1199SEIU.[35] And the past 20 years have seen a surge in organizing among immigrant domestic workers employed - often informally - in the private pay market. In 2010, following several years of painstaking organizing, New York became the first state to pass a Domestic Worker Bill of Rights, helping to clarify the legal rights of domestic workers and reverse a number of important legal exclusions. Since then, base building, enforcement, and changing community norms have become focal points for area domestic worker organizing groups.[36]

Drawing energy from broader currents of domestic worker organizing as well as a surge in worker co-op development in New York and other regions since the Great Recession of 2008-2009,[37] numerous domestic worker co-ops have formed across New York City during the past decade.[38] Though still relatively small in their overall footprint, these organizations are modeling important strategies for building bonds among workers and shifting relationships with

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Though some of these exclusions were reversed through legislation enacted in the 1970s, enforcement of legal reforms remains a challenge, and many exclusions remain. For a more precise discussion, see Harmony Goldberg, "13: 'Prepare to Win': Domestic Workers United's Strategic Transition following Passage of the New York Domestic Workers' Bill of Rights," in *New Labor in New York* (Cornell University Press, 2014), 266-288.

[31] Linda Burnham and Nik Theodore, "Home economics: The invisible and unregulated world of domestic work," *National Domestic Workers Alliance*, 2012.

[32] Mignon Duffy, "Doing the Dirty Work: Gender, Race, and Reproductive Labor in Historical Perspective," in *Gender & Society 21(3)*, (Thousand Oaks, CA: SAGE Publications, 2007), 313-336.

[33] Paul Osterman, *Who Will Care For Us?: Long-Term Care and the Long-Term Workforce*, (Russell Sage Foundation, 2017).

[34] Boris and Nadasen, 413-437.

[35] Boris and Nadasen, 413-437.

[36] Goldberg, 266-288.

[37] For some context on recent worker co-op development in New York City, see Lauren Hudson, "New York City: Struggles Over the Narrative of the Solidarity Economy," in *Geoforum 127*, (Amsterdam, Netherlands: Elsevier, 2021), 326-334.

[38] "New York City Domestic Worker Cooperatives," International Labour Organization, https://www.ilo.org/dyn/migpractice/docs/193/NYC.pdf.

employers.

The Evolution of Golden Steps

Founded in 2012, Golden Steps is a Brooklyn-based worker co-op delivering home care services in the private pay part of the market, with members providing in-home support to those who do not qualify for Medicare or need more than what Medicare will cover. The co-op was formed by women with roots in Central and South America, many of whom had experienced language and citizenship as significant barriers to decent employment. When the co-op formally incorporated in 2013, there were 20 - 22 members. Several members were already working in home care, while a number of others joined the cooperative after being displaced by the closure of a local factory.[39]

Like other domestic worker co-ops operating outside of the publicly funded universe, Golden Steps confronted particular challenges in building a client base and arranging training and other forms of support for its members. Training needs for home care workers are particularly high given the kind of in-home support they provide.[40] The Center for Family Life (CFL), a Brooklyn-based social service agency, conducted background research that informed the co-op's business model and provided assistance on all aspects of the co-op's early development, including client referrals, training on running a co-op business, and securing access to job-related training.[41]

Zenayda Bonilla joined Golden Steps in 2013. Having immigrated to the U.S. from El Salvador as a single mother in 2003, Bonilla experienced a decade of struggling financially in different jobs on her own. She heard about the opportunity to work at Golden Steps through a friend who was working at Beyond Care, a childcare co-op developed with support from CFL.

At first, it was hard for Bonilla to imagine herself working as a paid home care provider. She had cared for her father when he became ill with cancer, eventually succumbing to the disease, and the idea of being a caregiver evoked pain. Bonilla decided to attend an open house and go through the co-op's training process, however. Before long, she had become a member of Golden Steps, finding a new calling and sense of belonging.[42]

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[39] Zenayda Bonilla, interview with author, April 28th, 2022.

[40] Emma Yorra, former Co-Director of the CFL Cooperative Development Program, interview with the author, September 15th, 2022.

[41] Maru Bautista, former co-director of CFL's Cooperative Development Program, interview with author, May 20th, 2022. Launched in 2006, CFL's Cooperative Development program helped to incubate 21 cooperatives with more than 450 members in its first 15 years. In addition to technical assistance, CFL provides the co-ops it helps to incubate with start-up grants for brochures, web development, and other business needs. See Eleanor J. Bader, "Co-ops Enable Low-Income Women to Work as Owners and Decision Makers," Truthout, March 30,2015 https://truthout.org/articles/co-ops-enable-women-entrepreneurs-to-work-as-owners-and-decision-makers/

[42] Bonilla, interview.

Shared Ownership and Governance

Golden Steps is legally structured as a marketing co-op. Unlike in a traditional worker co-op, where the enterprise contracts with clients, members of a marketing co-op engage with clients individually.[43] Membership is not based on "shares." Instead, Golden Steps members pay a monthly cooperative membership fee of $100 for access to ongoing training and back-office administrative services. They keep the rest of the hourly wages they earn from clients, earning a substantially larger share of revenues than workers at traditional agencies.[44]

Like many smaller worker co-ops, Golden Steps operates largely by direct democracy, albeit with some delegation of authority to elected leaders. All members are required to attend bi-monthly general meetings where they discuss training needs, job-related challenges, and different aspects of the business. Members also participate in different committees, including a publicity committee, an office committee, and a leadership committee that includes a president, vice president, secretary, and treasurer. Over time, members rotate through different roles, but there is also some degree of specialization based on background and experience - for example, those who are more fluent in English tend to be the ones answering phones as part of their duties on the office committee.[45]

As research on smaller worker co-ops functioning by direct democracy has shown, participating in cooperative governance requires substantial commitments of time, which can be particularly challenging for low-wage workers balancing multiple responsibilities with little support.[46] "We have three jobs: family, the job, and the cooperative," said one Golden Step member in a 2018 interview.[47]

Strength in Community

The co-op also gives something back to members, however, providing a nurturing community that helps to counter the isolation domestic workers providing different kinds of services often experience. "The difference in a cooperative is that you feel like you have a lot of

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[43] Gowri Krishna, "Worker Cooperative Creation as Progressive Lawyering? Moving Beyond the One-Person, One-Vote Floor," in *34 Berkley Journal of Employment & Labor Law 101 (65)* (2013). Krishna (2013:87) explains that marketing co-op "is essentially a modified union hiring hall approach that acts as a referral mechanism," noting that this arrangement "requires less administration and management" than a traditional co-op structure, 101.

[44] Mark Pattison, "Immigrants Seen As Making Their Mark In Their New Homes," *National Catholic Reporter*, February 4, 2019, https://www.ncronline.org/news/justice/immigrants-seen-making-their-mark-their-new-homes.

[45] International Women's Strike NYC, "Elizabeth: Golden Steps – Elder Care Cooperative," *Public Seminar*, March 2, 2018, https://publicseminar.org/2018/03/elizabeth-golden-steps-elder-care-cooperative/.

[46] Krishna, 2013. Krishna notes that retaining member commitment to engaging in the life of the co-op can be particularly challenging once members have realized the most concrete economic benefits, including securing an adequate client base.

[47] Jennifer Bright, Rob Daurio, Armando Moritz-Chapelliquen, Cayce Pack, and Giovania Tiarachristie, "Supporting Worker Cooperatives in Sunset Park," *Urban Design Forum*, April 17, 2018, https://urbandesignforum.org/democratizing-the-workplace/.

support," said another member in a 2018 interview, "...like there are people behind you who have your back."[48] This includes comfort when members lose clients with whom they have been working and established close relationships. It also includes support in navigating issues that are not as directly related to members' jobs at the co-op, such as housing insecurity.[49]

Golden Steps also provides an important community in which members can develop their political analysis and discuss strategies for building relationships with employers. All members receive "anti-oppression" training that provides (or reinforces) a broader framework for understanding why direct care labor provided by women of color is so devalued, helping those who may not have already connected with larger domestic worker movements to situate their own circumstances in the context of broader struggles.[50]

Members also receive training on their rights under the law and strategies for communicating effectively with employers, and have access to a community with whom they can discuss the complexities of building caring relationships while asserting their interests. Membership in the co-op does not solve the structural inequities that undergird members' relations with clients and their families, but it does provide a foundation enabling members to exercise greater agency and voice.

Maintaining community is not easy. In recent years, differences in perspective emerged within Golden Steps that were difficult to reconcile.[51] During the pandemic, a group of members split off and formed a new co-op, Steady Hands. The split was challenging for all involved, but most agree that it was ultimately a healthy outcome. The seven worker-owners who remain at Golden Steps - all of whom joined the co-op shortly after its founding - are now devoting significant energy to recruiting new members, which has included holding their first-ever virtual open houses.[52]

For members of Golden Steps, community building frequently extends beyond the co-op. This has included significant investments of time and energy in a collective formation, Cooperatives United for Sunset Park (CUSP), that provided back-office services for several worker co-ops based in the neighborhood. CUSP was successful in the few years that it was up and running, even incorporating as a nonprofit for a brief period, though it ultimately proved difficult to sustain.[53]

Bonilla, for her part, has engaged in multiple forms of community building and support ranging from promoting English classes to connecting local residents with social services and economic resources. During the pandemic, she helped 50 others apply for support from New

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[48] International Women's Strike NYC, "Alicia: Golden Steps," *Public Seminar*, March 7, 2018, https://publicseminar.org/2018/03/alicia-golden-steps/.

[49] Yorra, interview.

[50] Rebecca A. Matthew and Vanessa Bransburg, "Democratizing Caring Labor: The Promise of Community-Based, Worker-Owned Childcare Cooperatives," in *Affilia 32(1)* (Thousand Oaks, CA: SAGE Publications, 2017), 10-23.

[51] Bonilla, interview.

[52] Yorra, interview.

[53] Yorra, interview.

York State's Excluded Workers Fund - an effort that was noted when she won recognition from the U.S. Federation of Worker Cooperatives as its 2022 "Cooperator of the Year."

Job Quality

In addition to the benefits of shared ownership and a community of support, Golden Steps members earn more than they would working independently or for another agency, according to Bonilla - a rate of $22 - $25 per hour. Members attribute this in part to the collective identity and reputation they have forged through the co-op, which affords them greater respect and value in the eyes of existing and prospective clients. According to one member, being invested in the co-op and wanting to maintain its strong reputation serves as an added motivation for providing high-quality services.[54]

Job-related training also contributes to the co-op's reputation and its ability to charge a premium for its services. Through Golden Steps, members are certified in key skill areas (e.g., adult CPR and first aid, nutrition, and food preparation, preventing falls) that home care providers in the independent, private market must typically find and pay for on their own.[55] This training not only helps members to build skills; it confers legitimacy and professional identity. Golden Steps has also made a commitment to preparing its members to attend to the needs of a diverse client base - e.g., members recently received training in better serving the needs of LGBTQ+ clients.[56]

Bonilla notes the transformative impact that being a member of Golden Steps and receiving professional training on different aspects of caregiving has had on her personally. This training combined with her experience working as a peer and community advocate gave her a different sense of possibility and has led her to start the process of training to be a social worker. "If not for Golden Steps, I would not be where I am today," she says.[57]

Looking Ahead

Golden Steps is currently at an inflection point given the recent organizational split. Bonilla is optimistic about its prospects, helping the co-op to plan for the next stages in its development even as she undertakes her own career transition.

The Golden Steps case raises larger questions about what is needed to support and sustain the development of other co-ops like it. Indeed, the existing footprint of these organizations is far smaller than the workforce that could stand to benefit.[58] Establishing a well-resourced support infrastructure could help to expand this footprint.[59] Access to high-quality training could be part

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[54] International Women's Strike NYC, "Alicia."

[55] Golden Steps has established ongoing relationships with institutions such as Cornell Cooperative Extension, which has provided training to members on nutrition and health. International Women's Strike NYC, "Elizabeth," https://publicseminar.org/2018/03/elizabeth-golden-steps-elder-care-cooperative/.

[56] Bonilla, interview.

[57] Bonilla, interview.

[58] Krishna, 2013.

[59] Bautista, interview.

of this infrastructure,[60] along with back-office services and other forms of ongoing support delivered in a manner accountable to the members of different co-ops - the kind of support that CUSP provided for a brief period in Sunset Park.[61]

In recent years, a growing number of immigrant worker centers have supported the development of worker co-ops in the domestic work arena, often linking enterprise development to larger organizing and power-building strategies. As contemporary domestic worker movements continue to achieve legislative wins and greater cultural visibility, a growing corps of worker co-ops could play an important role in changing community norms and shifting relationships on the ground.

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[60] Bautista, interview.
[61] Yorra, interview.

Five Home Care Cooperatives in Washington State

Adria Scharf, PhD

"Co-ops help other co-ops."

That's a motto often repeated by the administrators of Washington State's five home care cooperatives. An idea grounded in the "cooperative principles," mutual support is something these cooperatives take seriously.[62]

The five worker cooperatives operate in different areas of the Western part of the state, with offices in Bellingham, Port Townsend, Olympia, Port Angeles, and Anacortes. That puts them in close enough proximity to support one another—some have "loaned" caregivers to a sister cooperative in a neighboring county to help cover temporary staffing gaps—but at the same time, the co-ops are located far enough away from one another so as not to directly compete.

They operate in different market conditions—located in more suburban, small-town, or urban settings with larger or smaller senior populations. Some have longer track records and others are newer. They differ somewhat in their sizes, governance practices, cultures, and in the age and gender mix of their members.

For all their particularities though, they share much in common. All have been fostered with the support of the Northwest Cooperative Development Center (NWCDC) a not-for-profit organization based in Olympia whose motto is "Nurturing cooperative growth in the Pacific Northwest."[63] All are seeking, individually and collectively, to forge a fundamentally new business model for home care in the state, one that breaks with dominant, extractive models by sharing ownership, profits, control, and voice with caregivers democratically.

They are surviving, and most are growing, in the face of major challenges: the Covid-19 pandemic, competition from larger, better-capitalized competitors (including national franchises and chains), unpredictable and quickly changing client schedules, and caregiver turnover, a factor of low wages and challenging work that plagues the home care industry broadly. The support of the NWCDC, their support for one another, and federal pandemic business relief funds have been sources of resilience.

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[62] Seven cooperative principles were adopted by the International Co-operative Alliance in 1995. See https://www.ica.coop/en/cooperatives/cooperative-identity. The sixth principle, "Cooperation among Cooperatives," states: "Cooperatives serve their members most effectively and strengthen the cooperative movement by working together through local, national, regional, and international structures."

[63] According to its website, "NWCDC primarily supports cooperatives in Oregon, Washington, and Idaho but has also supported projects as far away as Alaska and Hawai'i. Founded by cooperatives in 1979, the Center has grown into the Northwest's leading provider of services for co-op business development." See: https://nwcdc.coop/about-us/mission.

Although small and limited to serving the private pay market, these cooperatives are beginning to demonstrate that "another way may be possible" for organizing care provision. Their stories suggest that when frontline caregivers share ownership, and authority, and experience genuine respect in their workplace, workers and clients both benefit.

No other state has as many individual home care cooperatives in operation as Washington;[64] this cluster of five small but industrious, mutually supporting cooperatives in Western Washington is unique nationally.

Deborah Craig, Cooperative Development Specialist for the NWCDC, has been involved in the creation or expansion of all five cooperatives. She had worked for Circle of Life Homecare Cooperative before joining the staff of the NWCDC eight years ago. Her job fostering cooperatives in the Pacific Northwest is funded in part through USDA rural development grants. Craig is a lynchpin for the home care cooperatives. Her role as a supporter, connector, and advisor from pre-launch planning onward has been a key factor in the proliferation of the model. She and NWCDC support the co-ops in a wide variety of ways, from holding an annual summer retreat for administrators, to conducting training and strategic planning sessions with co-op board members, and connecting the cooperatives to larger national networks, conferences, and resources.

To Craig, the most important benefit of the worker cooperative model in home care is the simple fact that the structure is expressly designed to serve and benefit worker members, who are predominantly caregivers, rather than outside investors or franchise owners. She says:

> In working with caregivers, I have to remind them of that all the time. Sometimes they want to lower the rates for their clients. No; this first has to work for them. They come first. They are the professionals. They will provide the services. The co-op has oversight of those services, but it's just the structure whose purpose is to help them to accomplish their goals as workers.

About the five home care cooperatives, she observes:

> We have now covered a big chunk of Western Washington with those co-ops. It's significant. We're working to perfect the model. Every time we learn more, and we get a little bit better at it. And we continue to learn.

National and State Context

Nationally, home care work broadly defined is one of the lowest-paid and fastest-growing occupations. Median annual earnings for home care workers nationally are just $18,100, according to PHI, the nonprofit institute.[65] According to PHI, about nine in 10 home care workers are women, more than half are people of color, and over one-quarter were born outside the United States. In addition to poor pay, few benefits, and unpredictable schedules, the work

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[64] See the ICA Group's "2020 Home Care Cooperative Benchmarking Report": https://icagroup.org/wp-content/uploads/2021/09/5465_HC_2020-BenchmarkingReport_9.20.21.pdf.

[65] See "Direct Care Workers in the United States: Key Facts 2021": https://www.phinational.org/wp-content/uploads/2021/09/Direct-Care-Workers-in-the-US-2021-PHI.pdf.

carries significant risks to worker safety and the potential for exploitation by employers and clients.

Demand for home care services is rising rapidly as the population ages. The number of adults 85 and older will nearly quadruple by 2040 over 2000 levels, according to the Urban Institute.[66] The majority of Americans say they want to age at home rather than relocate to a group or institutional setting.[67]

Yet there already exists a shortage of care workers nationally, severe in some regions, and the sector is marked by extremely high turnover. According to the Home Care Pulse Benchmarking Study, caregiver turnover at home care agencies averages around 65% annually, with some years as high as 82%.[68]

The national caregiver shortage represents a growing societal challenge. As Ai-jen Poo, president of the National Domestic Workers Alliance, points out in a recent opinion essay: "The economy doesn't grow or work without care."[69] As a society, we under-pay and under-support—under-care-for—the very people whom we rely on to provide essential care. Arguably policy and systemic solutions will be needed to truly address this societal challenge.

At the enterprise level, meanwhile, important innovation is already underway among home care cooperatives nationwide. With the success of Cooperative Home Care Associates (CHCA) in the Bronx, the country's largest worker cooperative, and the emergence of 15 smaller home care cooperatives operating in eight states (Calif., N.M., N.Y., Ohio, Penn., Texas, Wash., Wis.), cooperative businesses are piloting more humane, democratic, and equitable ways of organizing this work.[70]

Indeed, cooperative home care agencies pay higher wages and experience lower turnover. Home care cooperatives average a turnover rate over twenty percentage points lower than the industry as a whole, according to the ICA Group. Its 2020 Homecare Cooperative Benchmarking Report found that on average cooperatives pay $1.93 more per hour than conventional industry peers.

Washington State parallels national trends. In the state, "Home care is one of the largest and fastest growing occupations," according to the Federal Reserve Bank of San Francisco. There are 62,890 home care workers and personal aides. The occupation has more than doubled over the past 10 years and the state is projected to add 83,410 home care jobs by 2028. The state estimates that seven in 10 Washingtonians over the age of 65 will need long-term services and

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[66] See "The U.S. Population is Aging": https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging#.

[67] "Long-term Care in America: Americans Want to Age at Home," AP-NORC Issue Brief (2021): https://apnorc.org/wp-content/uploads/2021/04/LTC_Report_AgingatHome_final.pdf.

[68] See "Home Care Pulse Benchmarking Study": https://www.homecarepulse.com/benchmarking/.

[69] "How Long Will the U.S. Continue to Disrespect Its Caregivers?" New York Times (August 17, 2022): https://www.nytimes.com/2022/08/17/opinion/home-family-child-care.html

[70] See "2020 Home Care Cooperative Benchmarking Report," ICA Group (2021): https://icagroup.org/wp-content/uploads/2021/09/5465_HC_2020-BenchmarkingReport_9.20.21.pdf.

supports within their lifetimes. Home Health and Personal Care Aides in Washington earn a mean hourly wage of $17.36, according to the BLS, making it the top-paying state of all states for this occupational category based on this measure.[71]

Note that every state strictly differentiates between home care and home health care. The five home care cooperatives are licensed "home care" service providers. As "home care" providers, they provide nonmedical services to people with functional limitations. (By contrast, certified "home health" agencies can provide skilled services such as nursing care and are often covered by Medicare, Medicaid, and/or private health insurance.) Some Washington home care workers are Certified Nursing Assistants (CNAs) or retired LPNs. Having a nursing background can be valuable, but the care they provide to clients is strictly nonmedical.

With respect to governance and decision-making, all five home care cooperatives in Washington State:

- Are governed by boards of directors consisting exclusively of elected worker members, with no external board members.
- Have worker-centric approaches to communication and decision-making.
- Used democratic means to decide how to use PPP funds obtained in 2020 and 2021 and made worker-centric collective choices for how to allocate such funds.
- Are predominantly but not entirely white, predominantly but not entirely female, and employ predominantly low-income people.

With respect to compensation and training, all:

- Raised wages by approximately $2 per hour in either 2021 or 2022.
- Reward membership with a pay rate increase.
- Pay their members the same flat hourly rates regardless of tenure.
- Provide training and skill-building opportunities to members.
- Meet the state requirements for paid sick leave.[72]

When it comes to communication and cooperation, all five:

- Prioritize giving caregivers control over their schedules and communicating respectfully with caregivers around questions of scheduling.
- Encourage cooperation and communication among workers.

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[71] The Washington State Legislature innovated when it became the first state in the country to pass legislation in 2019 creating a public long-term care insurance program known as the "WA Cares Fund"; a new payroll tax will expand access to care services including home care in the future. Benefits will first become available to some Washingtonians starting in 2026. See the WA Cares Fund website: https://wacaresfund.wa.gov/.

[72] See "Paid Sick Leave," Washington State Department of Labor and Industries: https://www.lni.wa.gov/workers-rights/leave/paid-sick-leave/.

All five home care cooperatives in Washington State:

- Use "private pay" arrangements, meaning clients or their families use savings or assets to cover the cost of home care services; a minority of clients do have long-term care insurance.[73]

The cooperatives are similar to one another in that they:

- Pay their members $19.50 per hour (at Circle of Life) to $20 per hour (at the other four cooperatives) as of 2022.
- Charge client rates for services that range from $35 per hour to $45 per hour, with some minor variations in fee structure among the cooperatives.
- Have probationary periods for employees ranging from three months to six months as one precondition to membership.
- Require member equity fees, ranging from $25 to $300, from new members to become co-owners.
- Share profits with members (used interchangeably with "owners"); patronage varies among co-ops in frequency and amounts.

None of the cooperatives:

- Provide personal care or home health care aide certification training.[74]
- Provide health care or retirement benefits.
- Serve Medicaid clients yet, because the bureaucratic, administrative, and cash-flow hurdles to the Medicaid reimbursement system remain significant for all five cooperatives.[75]

See profiles of the five cooperatives, conclusion, and summary table below.

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[73] With long-term care insurance, the company either reimburses the individual for out-of-pocket payments or pays the cooperative directly.

[74] Free home care aide certification training is a significant benefit offered by Cooperative Home Care Associates and Home Care Associates of Philadelphia, the two largest home care cooperatives nationally, but is not yet offered by any of the smaller cooperatives.

[75] Planning will begin next year to consider the feasibility of a Medicaid pilot program in one or more of the cooperatives in the future. Among the challenges are these: 1) Medicaid reimburses at levels lower than these cooperatives' current private pay rate and 2) Medicaid reimburses more infrequently than private pay billing cycles. Therefore, a cooperative taking Medicaid clients must be able to carry its payroll, paying its caregivers for their hours for a period, possibly for months, before receiving reimbursement from Medicaid.

Circle of Life: "Cooperative Values Infused into the Business"

www.circleoflife.coop

The first cooperative home care business in the state, Circle of Life Homecare Cooperative, is both the oldest and largest of the five worker cooperatives, and the fourth largest nationally. It began operations in 2009. The cooperative serves elders and people with disabilities throughout Whatcom County including Bellingham, where its offices are housed, as well as parts of Skagit County to the south. As the first, Circle of Life has served as a model for the newer cooperatives.

Kris Buettner, Circle of Life administrator since 2019, oversees all operations including the hiring of office staff and caregivers. She is the cooperative's third administrator since its founding.

In early 2022, it employed 34 people, of whom 30 were members. The company has been profitable in each of the past three years—2019, 2020, and 2021. Total annual revenue was $about $700,000 in 2021. Circle of Life includes Black, Latino, Native American, and Pacific Islander members, although more than 70% of its staff is white.

Patronage dividends, or profit shares based on hours worked, were distributed for 2019 and 2020, but after it raised wages in 2021 the board decided against patronage dividends that year out of fiscal prudence.

The 2020 dividend was paid out at the beginning of February 2021, having been decided upon at the January meeting of the board. The total amount, divided among the members, was almost $57,000—far larger than any previous dividend. Circle of Life had received a PPP loan earlier in 2020. When that loan was forgiven, it became income on the books, enabling the cooperative to show a large surplus for the year.

Buettner shared:

> It was my happiest day yet at the co-op because of what these caregivers had endured at the start of this pandemic ... Because caregivers had to quarantine if they were exposed to the virus, other caregivers were often working overtime covering their clients. We were constantly asking people to change their schedule and do more and stretch and bend. I handed a check for over $6,000 to a couple of caregivers. It was the most money that they'd ever gotten, I think. They were just completely beside themselves. They couldn't believe it.

To Kris Buettner, a worker-owned home care cooperative is fundamentally "different from capitalistic businesses I've seen." She worked in leadership roles in different social service agencies before. "I left because my values were not reflected in terms of how direct care workers were treated, and what that meant for patients or clients," she says.

By contrast, the worker cooperative model is about "building strong relationships and an equitable workplace. Cooperative values are infused into the very structure of the business."

That starts with treating caregivers as "participants in the quality of care." The caregivers

know what their clients need. “They are the ones doing the work.” Secondly, ownership is key. “If people are owners of the business, they’re going to be a lot more invested,” she says.

In speaking with prospective clients, Buettner tells them: “Our workers have opportunities to have a voice. It’s their business and so they’re highly invested in making the business successful and providing high-quality care. Happy caregivers provide really high-quality service.”

In addition to its deep connection with Deborah Craig and NWCDC, Circle of Life is part of a local Cascade Cooperatives network of cooperative businesses in Whatcom and Skagit Counties. Buettner attended the National Home Care Cooperative Conference of the Cooperative Development Foundation in 2019 and reflects: “I think that’s the beauty of the co-op world. There’s this network and incredible support that’s getting stronger and stronger.”

Peninsula Homecare Cooperative: “All Major Decisions Made by Member Vote”

http://phc.coop/

Peninsula Homecare, located in Port Townsend on the Olympic Peninsula, has operated since 2016. Co-founder and co-op administrator Kippi Waters saw a need for greater cooperation and organization among the area’s caregivers, having worked as an independent private caregiver for decades herself. “The word got to me that there were funds available through the USDA Rural Development program” for cooperatives, that could be used to start a cooperative for caregivers, she says.

She connected with Deborah Craig and the NWCDC for help with laying the organizational groundwork for the cooperative, for example, establishing a budget and submitting paperwork to the state. They modeled the cooperative structure to some extent on Circle of Life, which had operated for several years successfully in Bellingham.

With help from a local lending network (the Local Investment Opportunity Network) which provided a low-interest startup loan with favorable terms allowing interest-only payments initially, Peninsula grew rapidly. Revenue for the first year (2016), in which it operated for 10 months, was $150,000.[76] In 2021, the cooperative’s total annual revenue was $551,000. In early 2022, there were 18 employees on the payroll, two-thirds of whom worked 40 hours per week. (The proportion working full time varies, however.) Of the 18 employees, 14 were members of the cooperative.

Peninsula has an intergenerational staff ranging in age from 29 years to 79 years. Earlier in its history, the members consisted mostly of older women, but now “the demographic of our staff is moving toward a younger age,” says Waters, with more gender mix. There were five men

[76] Peninsula quickly became profitable and repaid the loans after 18 months. See “A Start-up Case Study of Peninsula Home Care Cooperative”: https://e0055355-4a1d-4b7e-9bc2-bf949532c037.filesusr.com/ugd/98a0e1_4f5f514e55614348a2225fb0d4382d2e.pdf

on staff in 2022.

While the cooperative has an elected board of five worker members, at Peninsula all major decisions go to the full membership for a member vote. That includes all significant financial decisions, including decisions to change the rates they charge clients or increase pay and decisions that might impact the cooperative culture. For example, the membership voted in 2022 to raise the hourly wage from $18 to $20 per hour in response to the rising cost of living.

The co-op paid its first patronage dividend, or profit share based on hours worked, at the end of its first full year of operation in late 2017. It has remained profitable in the years since, paying dividends to its members twice per year, on June 30 and December 30 each year.

How much was the profit share that was distributed in 2021? In 2021, every member, part-time or full-time, received the equivalent of $6.50 per hour in patronage dividends, added to their $18 per hour wage. "So really, the members made $24.50 an hour last year, including profit shares," Waters says.

> During the pandemic, Peninsula received two PPP loans. Through a member vote, they decided what to do with the funds democratically. The members voted to earmark funds from the first loan, in 2020, to pay home care workers who had to quarantine and were, therefore, unable to work and earn pay. Strict coronavirus protocols in 2020 required quarantine after any possible exposure. It turned out, however, that there was little need for quarantine pay. Therefore, once the loan had been forgiven and became income on the books, the co-op was able to divide the funds and distribute them to the members.

According to Waters,

> The caregivers deserved that bonus because they got up every morning amid the fear that we all felt in 2020. March. April. May. June. When we first went into lockdown, the whole world was locked down, but we were getting up in the morning and driving down the empty streets to take care of our clients before there were masks available. I understood how fearful it was for our staff. So, it was without even a hesitation that we distributed 100% of the PPP loan.

She adds:

> It was a real community effort to keep Peninsula home care going through the pandemic. The women in the community sewed masks for us. The grocery store clerks and I had a special deal—if ever any Clorox wipes came in, they would hide some in the back for me.

Kippi Waters manages administration alone but utilizes the talents of members to do "special projects" in the office—for example, refining the emergency preparedness plan or entering all the medical information for clients into the scheduling software for the first time. They gain new skills and get paid for the work. This approach—having a single worker covering administration supplemented, as needed, by help from members—saves costs and keeps the profit higher. They refer to the special projects as "cooperator time." "We say that in a

democratic workplace you can gain a lot of career skills and life skills, and I'm trying to make that real."

Waters describes Peninsula as a "team-based company" in that teams of two or three people are often assigned to a single client. Good communication is, therefore, essential. In considering a potential new member, they consider that candidate's record in communicating with their colleagues and the office. Of paramount importance is a person's "ability to stay connected with their team about the care of their client."

Peninsula lowered their membership fee to just $25, the lowest fee of all five cooperatives. Initially, it had been $300, but members realized that such a large sum was "difficult in home care because a person is not really guaranteed stable hours." Waters herself used to be a member sharing in the profits. However, because the board changed her status to salaried, she is no longer a member. At first, she was worried that she might lose her drive without the profit share. What she has realized, instead, is that she is "just as driven as ever" because she wants to build profits for the member caregivers as much or more than she ever wanted them for herself.

Looking to the future, Kippi Waters says:

> With the baby boomers aging out, there's no choice but for us to grow because our community will need more care. So, we will step up to meet that demand. That's what we're here for.

Capital Homecare Cooperative: "Prioritizing Wages"

https://capitalhomecare.coop/

Capital Homecare Cooperative in Olympia, the third home care cooperative to be established, was founded in 2018 with help and fiscal sponsorship from the NWCDC.

It has grown considerably since its founding. The cooperative's total annual revenue in 2021 was about $366,000. This is up from 2019, the first full year in operation when revenue was $252,474. The cooperative has oscillated between 13 and 19 employees since its founding. In January 2022, the co-op employed 17 people. Of them, 11 were members. (The employees who were not owners were newer hires who had not yet completed the six-month probationary period.) The pandemic hit in Capital's second full year of operation. "Covid made an already not-attractive job that much less attractive," said founding administrator Nora Edge. PPP loans in 2020 and 2021 helped buoy the agency through that challenging period.

Of the five Washington home care cooperatives, Capital has the youngest workforce with 95% of employees being "millennials" under the age 40 of years. While predominantly female, the staff includes nonbinary members and male members. The board includes an Indigenous member.

In January 2022, about eight of the 18 workers worked full-time, meaning 32 hours per week or more. Only the two members of the administrative staff are guaranteed full-time hours.

For caregivers, hours can be unpredictable. Many Capital Homecare workers, therefore, have two jobs, e.g., they work with Capital and somewhere else. “A lot of people have a few side hustles; they are used to puzzle-piecing it together every week,” said Edge. Some may have a massage license or do hospice work on the side. Others have partners who have better-paying jobs. “It takes a scrappy industrious person” to be a home caregiver at Capital.

At CHC, ownership is not optional. If you want to stay at the cooperative past the six-month probationary grace period, you must apply for membership. In other words, “employment is contingent on ownership,” says Edge. The membership fee is $100; that equals four $25 preferred stocks in the agency. During the grace period, a prospective member also must attend at least one board meeting and one committee meeting.

To date, there have been no patronage dividends. The board has prioritized wages and recognizes that, as a startup agency, they need to build a capital reserve.

One advantage to working for Capital Homecare is that caregivers “have a lot of control.” We ask them to work a shift and “they can say yes or no.”

That said, schedules change depending on client needs. “You might get a bunch of 24-hour clients, with 12-to-18-hour shifts guaranteed until the person passes away. Then you may have two-hour shifts until you get a new schedule together,” explains Edge.

Why do people do this difficult work? Former administrator Nora Edge explains:

> They certainly don’t do it for the money. The moral benefit is huge. It seems to pull in people who have people skills and who take value from being generous or giving. Many had donated time to a friend or a loved one and find that the skill set makes it an easy entry point into a career.

Another benefit of the work is the autonomy it provides from direct supervision. Some workers don’t like to be closely supervised all the time. Caregiving work, and success, are more reliant on the home care worker’s relationship with the client, “which has its pitfalls too,” says Edge.

The way Capital Homecare handled its PPP funds illuminates how differently a cooperative makes decisions compared to traditional companies. “When we got the PPP, we went to our workers and everyone voted on how to use it. In most workplaces, workers have no idea what happened to that money,” asserts Edge. “When we got our PPP reimbursement in January 2021, we gave everybody who had worked over the winter a $1,500 bonus.” They reserved the rest of the funds to provide pay to workers who were forced to quarantine. Caregivers drew on those funds. That was a vital safety net for their home care workers during the pandemic.

The overarching goal of the Capital Homecare board is to get the cooperative to pay a wage that they “all agree is a good wage.” Rather than prioritize patronage, their board wants to build a strong normal operational budget.

“Happier caregivers mean happier clients,” says Edge, adding:

It's standard in the industry that caregivers are at odds with the people who manage them, and that's seriously reflected in the client experience. With a cooperative, you are more likely to have a worker who is committed to being there and committed to the work. We sell it to clients as, 'You have access to the owner of the business.'

Ridgeline Homecare Cooperative: "Endless Demand & Full-Time Work"

https://www.ridgeline.coop/

Ridgeline Homecare Cooperative, serving Port Angeles, Washington, and neighboring Sequim, began operations in 2020 as the fourth home care cooperative in the state. Alicia Campion, the current administrator, was hired in August 2021. By spring 2022, the cooperative had doubled in size from nine to 18 employees, was profitable, and had a long waiting list of clients requesting its services. Sequim is known as a retirement town. About a third of its roughly 8,000 residents are 65 or older.

Ridgeline serves 20 clients. Five have long-term care insurance and 15 pay for the home care services out-of-pocket, out of their personal assets. The most intensive clients require 24-hour care. Most require less, for example, daily care or twice per week.

At Ridgeline, all but two of the 18 employees work full-time. (They define full-time as 32 or more hours per week.) The two individuals who work part-time do so voluntarily, to go to school. For most caregivers at Ridgeline, this home care job is their primary income. That makes the experience working for Ridgeline unlike many other home care agencies (cooperatives and not) that typically provide fewer hours.[77]

Ridgeline differs from the other cooperatives in the state in that the work is steady and predictable. They are located in an exceptionally high-demand market with a large number of elderly people and a shortage of caregivers. Alicia Campion describes Port Angeles and Sequim as a "dream area for this work" marked by "endless demand."

To become a member, one must be employed for three months, then purchase a share at the cost of $150. New members undergo a short "New Member Orientation" to introduce them to the workings of the cooperative and the member role.

Because the cooperative was already profitable in its second year of operation in 2021, all members received a profit share in early 2022. The profit share totaled about $15,000 in aggregate; it was divided among its 14 members in proportion to hours worked.

The board consists of five elected members and meets once per month. Board Training is conducted by Deborah Craig of the Northwest Center for Cooperative Development. Board terms last for three years and there is a stipend of $25 per month for board service.

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[77] According to PHI, two in five home care workers work part-time. See http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/.

Any member can bring a concern or request for policy change for the board to deliberate and decide. Board decisions are made by majority vote.

Of the 18 employees, 15 are caregivers. The three office staff employees are Alicia Campion, her assistant, and a registered nurse who is a cooperative member serving as an advisor on medical-related questions such as interpreting care plans and other documents related to clients' medical needs. (The RN does not give care to Ridgeline clients but does use her expertise in the office.)

The Ridgeline workforce is overwhelmingly female and predominantly white (reflecting the area's racial makeup as Port Angeles is 86% white, according to the U.S. Census.) In 2022, they had one male and one Black employee.

To Alicia Campion, who is herself a member of the cooperative:

Being a member is very beneficial, not just the pay increase and profit share, but being able to talk to board members about policies they don't like and things they want to see happen, and those things are heard and taken into consideration.

In addition to the wage, profit share, and state-required sick time, members receive eight hours of paid time off on their birthday, which can be used anytime.

How does she approach administration differently from management in conventional home care agencies?

As the administrator I put the caregivers first, always. They get to choose what schedules they'd like… This is not 'We just want the money from the client so you need to go.' It's 'Does this time work for you, does this day work for you? It works for the client. Let's find a time that works for both of you.' It's very much about the caregivers.

How do they manage to provide full-time work to such a large proportion of their employees?

At this time, my potential client list is outrageously long. So, finding a client that works best for the caregiver is extremely easy at this time because there is such a wait. We choose our clients based on what our caregivers can do. When a caregiver comes to me with, 'I need more hours,' I go through the waiting list.

Their competitors include Korean Women's Association (KWA) Home Care, a nonprofit home care agency that has operated in Washington State for decades, and Caregivers Home Health, a private corporation. In addition, Home Instead, the senior care franchise headquartered in Omaha, Neb., operates in the area. Unlike some of her competitors, "I don't have a sign-on bonus," says Campion.

Nevertheless, Campion says, demand is so great that she has never needed to do any marketing.

Recently, a caregiver who had been employed by a competitor signed on to join Ridgeline. According to Campion,

She was just really unhappy about how the franchise office would change her schedule

without checking with her. Me, I talk to caregivers to confirm that a change is going to be OK. It's about understanding that caregivers are people. They have lives as well.

"I've worked in places where they just don't care about employees," says Campion. "And that's been so disheartening. Here, it's all about the caregivers. It's about their voice being heard, and it's not just because 'I said so.'"

Heartsong Homecare Co-op: The Newest Cooperative

https://www.heartsong.coop/

Heartsong is the newest and smallest home care cooperative in Washington State. It opened in September 2021 and is finding its stride. Kathie Rivas serves as administrator, having worked for years in management for another care company, a franchise. Jessica Holland serves as the assistant administrator and president of the board. Their service area covers Skagit County and Island County. They were generating $700 in billable hours per month as of spring 2022.

Rivas, Holland, and Heartsong's three other board members, who are their daughters, had all worked together previously at the franchise home care company. They decided to leave that business together to be part of building the new cooperative.

At the previous franchise they "lived and breathed" low compensation and poor working conditions.

Unlike a cooperative where profits are shared by worker owners, in a franchise the profits go to the franchise owner. There is an incentive, therefore, to keep wages low. Holland recalls: "As a caregiver there, I was making $12.50 per hour, and I had worked seven days a week for five years."

The franchise managers would "preach about a team, but then not let the caregivers talk to one another," she recalls. Caregivers were not even allowed to communicate freely about their clients. "That was not conducive to good care for the client." By contrast, at Heartsong "there is a caregiver portal so that all the caregivers can freely talk with each other about their clients, to coordinate care."

Thinking back, they believe that the franchise owner may have been afraid that worker communication would lead to a unionization campaign. At Heartsong, "We're not afraid of that." If worker members in the future want a union, they think the board should consider it, to see if it's possible. After all, it's their company.

In February 2022, nine people worked at Heartsong Homecare Cooperative. Five were members—Rivas, Holland, and their three daughters. Four other employees were not yet members. Two had almost completed the six-month probationary period and would become members soon. The other two were in their first 90 days on staff. The required member fee of $200 can be paid through a 2.5% payroll deduction.

The work volume varies, as do schedules. Some people work full time for a while, then reduce their hours and then increase them, as clients and client needs fluctuate. Many employees

have second jobs, given the fluctuating hours.

At Heartsong, the goal is to build a more stable base of long-term clients so that they can offer more steady, predictable hours to the staff, and thereby grow.

Scheduling can be a balancing act at this early stage in their organizational development. On the one hand, they would like to "give flexibility to the caregivers about what schedule they want to work." That being said, with such a small staff, that flexibility, "can make it really hard to get a good schedule for clients. Some caregivers don't want to work on Friday night—but some patients need to be put to bed." We always try to "work with" the caregivers, they say. But adds: "As a team, everybody's got to cover the schedule when the schedule needs to be covered."

Both Rivas and Holland serve as caregivers in addition to their administrative duties. They also fill the gaps when someone quits or is unavailable to work certain shifts. "Our goal is to get us back to the office so that we can do the outreach and marketing" needed to build the business. Rivas says, "I can't be on the phone calling companies while caring for somebody."

Resistance to vaccination has hindered recruitment. The governor required that all caregivers be vaccinated, and clients want vaccinated caregivers. Heartsong lost a few caregivers who chose not to be vaccinated. Clients passing away also creates unpredictability.

Since they operate in an area with many armed services retirees, Rivas is taking steps to apply to Veterans Affairs (V.A.) in hopes of seeking qualifications to care for veterans reimbursed through the V.A. If approved, they believe they could provide in-home care, including hospice care, to veterans, contracting with the individuals who would, in turn, be paid through the V.A. This could potentially open up a large new market of clients.

Rivas and Holland believe their first-hand experience of work within a home care franchise has sharpened their understanding of what not to do in managing a home care business. The low pay, abusive scheduling, and disrespect for caregivers in the franchise were, in their eyes, unacceptable.

It also compromised patient care. Their vision for Heartsong Homecare Cooperative is to grow it over time to 25 to 35 members, to give many more caregivers the opportunity to experience dignified work and better pay in a democratic setting.

Conclusion

The story of the Washington State cooperatives confirms that small cooperatives operating in the face of structural headwinds can gain resilience from supporting one another, and from the support, training, and resources of a cooperative development organization. The NWCDC's support was cited by administrators in all five co-ops as being important to either their start, their survival, or their successes.

By sharing profits *with* workers rather than extracting profits *from* workers, the cooperatives have distributed significant profits to low-wage caregivers on top of wages, through patronage and occasionally bonuses. The cooperative administrators have respectful approaches

to coordination and scheduling that differ markedly from hierarchical management styles common in conventional agencies. Worker members have substantial governing authority, electing and serving on their co-op boards and, in some cooperatives, voting directly on major issues.

Even the most values-driven worker cooperatives in the United States must operate within larger societal systems—including the U.S. system of employer-based benefits provision. That system requires small businesses to shoulder the benefits burden and makes it difficult for employees of any small business, regardless of ownership structure, to access benefits. It must be acknowledged that the fact that worker cooperatives are unable to provide workers with health or retirement benefits continues to pose an obstacle to fully actualizing their dreams of caregiver justice.

Reflecting on the rapid growth of the Washington State network of cooperatives, Deborah Craig acknowledges that "the existing co-ops are small, and many are in rural areas." She says, "It's great that they exist. But we recognize that the work we have done to date doesn't speak to all different kinds of community needs in Washington."

Because these are private pay co-ops, they exclusively serve clients with the resources to pay out of pocket. "To be able to really extend the reach of the cooperative model," Craig says, "they need to figure out how to take Medicaid." She adds, "I have two projects in the next year to look at Medicaid. We'll see about that." In several years the new "WA Cares Fund" long-term care benefit will provide most Washingtonians, regardless of income, a $36,500 benefit—enough to cover about 20 hours of care per week for a year. That may also enable the home care cooperatives to reach new client demographics and serve people without the savings to pay out of pocket.

Changes in practices and systems internally may be required. As they expand cooperative home care into new communities, cultures, and demographics, "We may need to approach cooperative development differently," Craig says.

According to PHI: "The home care workforce is projected to add one million new jobs from 2019 to 2029—more new jobs than any other occupation in the U.S. This workforce will add more new jobs than fast-food workers and cooks combined, which are ranked as second and third occupations with the most projected growth over the coming decade."[78]

The experience of the Washington State network of home care cooperatives adds another data point to the accumulating evidence, suggesting that businesses structured as worker cooperatives center caregivers and improve respect, voice, working conditions, and pay. This, in turn, can support superior care.

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[78] See "Direct Care Workers in the United States 2021" (PHI) https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2.

Summary Table: Five Washington Home Care Cooperatives

	2021 Annual Revenue	No. EEs	No. Owners	Cost of a share	Wait	Patronage	Wage	PPP funds
Circle of Life (2009)	$700k	34	30	$300	6 mo.	2019, 2020	17.50 starting wage 19.50 members	Quarantine pay + Bonuses
Peninsula (2016)	$551k	18	14	$25	6 mo.	Twice/yr. 2017, 2018, 2019, 2020, 2021, 2022	$18 start $20 members	Bonuses
Capital (2018)	$366k	17	11	$100	6 mo.	None	$18 start $20 members	$1500 bonuses + covid protection
Ridgeline (2020)	$479,574 (2021)	18	14	$150	3 mo.	2021	$18 start $20 members	None
Heartsong (2021)	NA	9	5	$200	3 mo.	None	$18 start, $20 members	N/A

Cooperative Home Care Associates

Sanjay Pinto, PhD

Overview

Cooperative Home Care Associates (CHCA) holds a significant place within the U.S. worker cooperative and long-term care landscape. For decades, it has been the largest worker cooperative in the country by some distance. CHCA workers are also members of the largest union in the country, 1199Service Employees International Union-United Healthcare Workers East (1199SEIU). Through its own developmental path and partnership with the union, CHCA has established itself as a key touchstone for others seeking to build cooperative models at scale. But it also faces ongoing challenges reconciling its mission with the structural inequalities and profit-driven imperatives of the home care and larger healthcare systems. This profile charts CHCA's efforts to advance workplace democracy and job quality internally and shift a broader set of conditions that devalue home care labor, contributing to serious workforce shortages in the field.

Linking Two Approaches to Confronting Inequality

Disproportionately women and people of color, frontline healthcare workers have long seen their labor devalued and rendered invisible.[79] Those providing in-home support services to seniors and people with disabilities comprise a particularly invisible and undervalued segment of this workforce.[80] Even with the expansion of home care facilitating the "deinstitutionalization" of long-term care in publicly funded health systems,[81] public policy has frequently reinforced this dynamic. Home care workers continue to be excluded from key labor and employment rights due to exclusions dating back to the New Deal era,[82] and policymakers have long set government

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[79] Alethia Jones, "Agents of Change: How Allied Healthcare Workers Transform Inequalities in the Healthcare Industry," *Structural Competency in Mental Health and Medicine* (2019): 191-209, https://doi.org/10.1007/978-3-030-10525-9_16.

[80] In addition to medical care that home care workers provide, often under the supervision of other healthcare professionals, much of their work often includes support for activities of daily living (ADL) such as bathing and toileting, and and instrumental activities of daily living (IADLs) like home maintenance and managing medications. For more detail on how these categories are defined, see "What are Activities of Daily Living (ADLs) & Instrumental Activities of Daily Living (IADLs)?," Better Health While Aging, https://betterhealthwhileaging.net/what-are-adls-and-iadls/.

[81] Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (Oxford University Press, 2015).

[82] Juan F. Perea, "The Echoes of Slavery: Recognizing the Racist Origins of the Agricultural and Domestic Worker Exclusion from the National Labor Relations Act," in *72 OHIO ST. L.J. l 95* (2011). Despite some progress towards addressing these exclusions, implementation within states remains challenging. See "The USDOL Home Care Rules: What does good implementation look like?," National Employment Law Project, 2016, https://www.nelp.org/wp-content/uploads/Fact-Sheet-USDOL-Home-Care-Rules-Good-Implementation.pdf.

reimbursement rates at low levels based on the assumption that those doing the work - disproportionately women of color - can supply these services cheaply.[83]

Unionization and worker co-op development have helped to improve conditions for home care workers. In recent decades, home care workers working in the publicly funded system have unionized across a number of states.[84] Though government reimbursement rates limit the room for maneuver on pay, unionized workers tend to earn higher wages and enjoy better fringe benefits, resulting in lower turnover rates.[85] On a smaller scale, several home care worker cooperatives have formed around the country. According to a recent report, 14 of these co-ops were active in the U.S. in 2020, operating in both the private pay and publicly funded systems. Like unions, worker cooperatives are associated with higher wages and lower turnover.[86]

CHCA sits at the intersection of these two approaches to improving conditions for home care workers. Combining "democratic" and "stakeholder" modes of governance, it is both a worker cooperative governed through representative channels by its broad membership base and a "model employer" for 1199Service Employees International Union-United Healthcare Workers East (1199SEIU), its union partner.[87]

CHCA's Path to Scale and Power

Launched in 1985, CHCA was founded in the Bronx, New York, with the intention of creating a scalable model that would expand voice and improve job quality for home care workers, serving as an example for other industry players. Establishing its first contract with Montefiore Hospital, the co-op had a dozen workers when it launched - around the size of the average worker co-op in the U.S.[88] It had grown to 60 workers by the end of its first year.

CHCA's formation was supported by an initial $485,000 investment from Community Service Society of New York, a charitable organization that seeks to strengthen the social safety

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[83] Boris and Klein, *Caring for America.*

[84] In many cases, unionization has occurred under a "public authority model" whereby government authorities (e.g., county health commissions) are established as the relevant bargaining partner of record. In others, home care agencies operating largely in the publicly funded system have been unionized. See Eileen Boris and Jennifer Klein, "Organizing Home Care: Low-Waged Workers in the Welfare State," *Politics & Society* 34, no. 1 (2006): 81-108.

[85] John Schmitt, Margy Waller, Shawn Fremstad, and Ben Zipperer, "Unions and Upward Mobility for Low-Wage Workers," *WorkingUSA* 11, no. 3 (2008): 337-348.

[86] "2020 Home Care Cooperative Benchmarking Report," ICA Group, 2020, https://icagroup.org/wp-content/uploads/2021/09/5465_HC_2020-BenchmarkingReport_9.20.21.pdf.

[87] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs: A Collaboration Between Organized Labor and a Worker Cooperative," *Employee Ownership and Shared Capitalism: New Directions in Research* (2011): 59-89; Sanjay Pinto, "Economic Democracy, Embodied: A Union Co-op Strategy for the Long-Term Care Sector,"*Organizational Imaginaries: Tempering Capitalism and Tending to Communities Through Cooperatives and Collectivist Democracy,* (Emerald Publishing Limited, 2021).

[88] "Employee-Owned Cooperatives," Ohio Employee Ownership Center at Kent State University, https://www.oeockent.org/cooperatives/worker-owned-cooperatives.

net and advance greater access and inclusion in healthcare, transportation, housing, and other systems. The co-op also received significant support from foundations.[89] In addition to supporting basic business operations, external support helped CHCA to develop a training program that today provides free-of-cost home care job training to hundreds of local residents annually.[90] CHCA's state-of-the-art training focuses on both hard and soft skills and is rooted in an "adult learner" methodology.[91]

CHCA has also helped to develop an ecosystem to support its growth and advance high-road practices across the home health care system nationally. In 1991, CHCA created a separate organization, now known as PHI, to help develop its training programs and conduct research on training and other issues relevant to raising standards for the home care workforce.[92] Leaders at CHCA and PHI were also involved in launching Independence Care System, a managed care organization with which they could contract.[93] Over time, CHCA has established ties with a variety of managed care organizations, helping drive its expansion to 2,400 workers at its high point.

From the time of its founding, CHCA has been organized around a "quality jobs/quality care" philosophy, seeking to constitute good quality jobs as a foundation for better-quality services. Touting high-quality services has been leveraged, in turn, to help CHCA grow its business. And the co-op has also inserted itself into larger conversations about how improved job quality can help to address workforce shortages in the field. In the late 1980s, CHCA convened a working group in New York City that brought together employers and representatives from labor and consumer groups to work together in pushing a quality jobs/quality care agenda.[94]

CHCA workers unionized with 1199SEIU in 2003. CHCA leaders recognized the union's ability to influence policy and leverage its scale to provide members with a variety of valuable benefits. Union leaders saw CHCA as a "high road" employer with a record of innovating in ways that improved conditions for home care workers.[95] Despite early tensions reconciling the role of a union in a cooperative, the two organizations have forged a robust partnership that

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[89] This included ongoing support from the Mott Foundation and Ford Foundation.Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach. Sectoral Employment Development Learning Project Case Studies Series* (The Aspen Institute, 2002).

[90] Cooperative Home Care Associates, https://www.chcany.org/about.

[91] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

[92] PHI, http://www.phinational.org/.

[93] Independence Care System, https://icsny.org/. For more on the role of managed care organizations, see Joseph Heaton and Prasanna Tadi, "Managed Care Organization," 2022, https://www.ncbi.nlm.nih.gov/books/NBK557797/

[94] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

[95] CHCA's leadership thought the union was being too adversarial at times and too dismissive of the fact that the cooperative already had democratic structures in place. Union representatives were concerned that their advocacy on behalf of members would clash with a view that the co-op's ownership and governance model already sufficiently safeguarded worker interests. See Sanjay Pinto, "Economic Democracy, Embodied."

includes joint work on policy campaigns, training initiatives, and strategies for workforce recruitment.[96]

For some time now, CHCA has been the largest fully functioning worker co-op in the country. In the 2021 fiscal year, CHCA brought in nearly $57 million in service revenues. 96% of this went to covering payroll and other related expenses for frontline home care workers, and 4% went to administrative overhead. CHCA's workforce continues to reflect the demographics of the home care workforce in the Bronx – 99% of home health aides and personal care aides working at CHCA are women and three-quarters are Latina, with 1 in 5 identifying as Black.[97] Amid the challenging conditions of the Covid-19 pandemic,[98] CHCA has been engaged in a variety of initiatives aimed at better supporting home care workers. And, with its own workforce dipping down to 1,800, the co-op has been working closely with the union on strategies for workforce recruitment.

Ownership and Governance

As a worker co-op, CHCA gives workers the opportunity to become members by purchasing a share for $1000, with new recruits attending a 3-hour workshop on the benefits of membership.[99] Currently, just under half of CHCA's workers are members - a proportion that dropped when CHCA absorbed other agencies and has generally ebbed over time. Staff and worker leaders at the co-op have been engaged in ongoing conversations about how to boost the co-op's membership rate. Those workers who are members receive dividend payments in years when the co-op is profitable. To help build retirement security, all workers are eligible for enrollment in a 401k plan - a benefit to which many home care workers do not have access.[100]

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[96] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs"; James M. Maniberg and Seon Mi Kim, "A Matrix Form of Multi-Organizational Hybridity in a Cooperative-Union Venture," *Organizational Imaginaries: Tempering Capitalism and Tending to Communities Through Cooperatives and Collectivist Democracy,* (Emerald Publishing Limited, 2021).

[97] Denise Hernandez, interview with the author, May 5th, 2022.

[98] Sanjay Pinto, Chenjuan Ma, Faith Wiggins, Sarah Ecker, Michael Obodai, and Madeline Sterling, "Forgotten Front Line: Understanding the Needs of Unionized Home Health Aides in Downstate New York During the COVID-19 Pandemic," *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy* 31 no. 4 (2022): 460-468.

[99] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs." The buy-in is $1000 for one share and one share equals one vote. After an initial payment of $50 the co-op lends the remaining $950 for the rest of the buy-in share. This loan can be paid off over 5 years making sure that it is not cost-prohibitive for anyone to join." See "Not Just a Small Business," Cooperative Home Care Associates. https://www.co-opsnow.org/examples/cooperative-home-care-associates-chca.

[100] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs." Comparing CHCA to another for-profit agency of similar size, Berry and Bell (2018) found that CHCA had near 100% enrollment in its 401k plan, versus around ⅓ for its peer agency. A non-profit agency that served as a second point of comparison had no 401k plan available for its workers. See Daphne Berry and Myrtle P. Bell, "Worker Cooperatives: Alternative Governance for Caring and Precarious Work," *Equality, Diversity and Inclusion: An International Journal* (2018).

As CHCA has grown in size, democratic control has been wielded more and more through representative rather than direct channels. Worker representatives hold 8 of 13 seats on CHCA's board of directors, and all members are eligible to vote for these representatives. The board has substantial authority, including hiring and firing power over the co-op's CEO. Workers also have a variety of channels for sharing their input with supervisors and administrative staff and direct lines of communication with the CEO, who holds regular office hours. In a recent study comparing CHCA with a conventional for-profit agency and a nonprofit agency of similar size, workers at CHCA report significantly higher levels of participation in decision-making. They also reported higher levels of trust in management, feeling like supervisors were helpful, and overall job satisfaction.[101]

In a number of ways, 1199SEIU's role at CHCA embodies the traditional functions that unions play in relation to employers. Union representatives address worker grievances; indeed, leaders at CHCA have acknowledged that the union has helped to surface important issues that might otherwise go unaddressed.[102] That said, 1199SEIU's relationship with CHCA is less agonistic than its interactions with most other employers, reflecting CHCA's co-op structure and ethos.

Following unionization, a labor-management committee was formed with representation from management, the union, and the general workforce. The committee has served as a venue for problem-solving and conflict resolution - for example, after seeing that large numbers of CHCA's workers were not using their healthcare benefits, the committee established a healthcare working group that implemented measures to boost healthcare utilization rates.[103]

CHCA's mission-driven status became formalized in 2018 when the co-op was certified as a benefit corporation – a for-profit entity legally required to consider the impact of its decisions on different stakeholders.[104] Unlike most social enterprises that formally commit themselves only to addressing their impact on different stakeholders, leaving traditional decision-making structures largely intact, CHCA's status as a unionized worker co-op provides a variety of ways that workers can exercise voice and demand accountability.

Job Quality and Mobility

From its early days, CHCA has striven to pay higher wages than its competitors.[105] It has also consistently worked to increase the government reimbursement rates that constrain its ability

[101] Daphne Berry and Myrtle P. Bell, "Worker Cooperatives."

[102] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs."

[103] M. Knopf, Cooperative Home Care Associates & 1199SEIU Labor Management Committee Program Evaluation Report, 2011.

[104] Daphne Perkins Berry and Stu Schneider, "Improving the Quality of Home Health Aide Jobs."

[105] Starting in its early days, CHCA paid $.50 more than its competitors. Presentation by Adria Powell, CHCA CEO, U.S. Federation of Worker Cooperative National Conference, September 10th, 2022. presentation. Contractual and subcontracting relationships with organizations like the Visiting Nurse Service of New York that pay higher rates than others in the industry have also helped CHCA to

to provide higher pay.[106] Recently, the co-op worked alongside 1199SEIU and others in a "Fair Pay for Home Care" campaign in New York state. Kim Alleyne, a long-time CHCA member, was among those playing an active role in the campaign, which included meeting with elected leaders to share her perspective on the difference a pay increase could make in the lives of home care workers across the state.[107] Although the campaign did not achieve the full pay increase the coalition was seeking, it did win a $3 per hour total pay increase phased in over the course of 2022 and 2023.[108]

In a field lacking in well-defined career ladders,[109] CHCA has also worked to create opportunities for upward mobility. It has piloted a senior home care aide role, for example.[110] Although funding for the pilot was limited, CHCA leaders have been part of conversations with others in New York City and New York State around institutionalizing such a role - a move that would require increased public investment. Also notable is the fact that 45% of CHCA's administrative staff started out as home care workers - a proportion that CHCA staff believe to be significantly higher than at most other home care agencies.[111]

Even while trying to extend job ladders, leaders at CHCA have long been clear-eyed about the limitations imposed by prevailing structure of reimbursement rates and regulations around what functions home care workers are permitted to perform. Given these realities, the co-op has focused significant attention on making entry-level home care work a viable and sustainable career. State-of-the-art training and greater scope for worker input help to counter the tendency to undervalue the contributions of home care workers and render them invisible within larger care teams. With erratic scheduling a common challenge for home care workers, the co-op has focused on ensuring that workers are able to secure a steady paycheck. And, in the early stages of their time at CHCA, new recruits have regular check-ins with coordinators and access to peer mentoring. Though CHCA is limited in the size of the pay premium it can provide to workers, these factors may help to explain why its turnover rates are lower than at most other comparable agencies.[112]

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pay somewhat higher wages than many competitors. Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associate.*

[106] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

[107] Kim Alleyne, interview with the author, June 6th, 2022.

[108] "Final State Budget Includes Minimum Wage Increase for Home Care Aides," Home Care Association of New York State, 2022, https://hca-nys.org/final-state-budget-includes-minimum-wage-increase-for-home-care-aides/.

[109] Paul Osterman, *Who Will Care for Us?: Long-Term Care and the Long-Term Workforce,* Russell Sage Foundation, 2017.

[110] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

[111]Hernandez, interview. According to Hernandez, administrative staff at CHCA also play a more cross-functional role than at many other agencies, which helps to keep the work interesting and provides unique opportunities for growth. CHCA cannot compete with more profit-oriented agencies on pay for administrative staff, she says, but there is a strong core of staff who have been with the organization for many years and are highly invested in the mission and culture of the organization.

[112] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

Expanding the Footprint

Establishing itself as a leader and role model, CHCA has helped to inspire the development of numerous co-ops in the direct care arena and other parts of the economy. It has also backed replication efforts in other cities.[113] In 1993, it helped to shepherd the creation of Philadelphia-based Home Care Associates, which currently has a workforce of around 170.[114] Cooperative Home Care of Boston was formed the following year, but it shut down five years later amid a home care industry crisis in Massachusetts induced by the 1997 federal welfare reform.[115]

Closer to home, CHCA is trying to expand its own footprint by growing its existing business, moving into the private pay market, and expanding its presence in the publicly funded consumer-directed program that is currently expanding across New York. The CHCA model has also helped to inspire a group of leaders at 1199SEIU to form a committee exploring further co-op development in the long-term care sector. 1199SEIU remains a powerful force in New York and other states where it has members. However, as structural changes including privatization undermine the position of the union and contribute to the closure of long-term care facilities in underserved communities, these leaders see co-ops as a tool for consolidating worker power and creating more stable, aligned, and community-oriented bargaining partners over the long term.[116]

Looking Ahead

CHCA holds an iconic status across multiple circles, from long-term care advocacy to solidarity economy and cooperative economy movements. Despite this well-warranted attention, the challenges facing the organization and its members are real. Indeed, even with all the rhetoric around valuing essential workers, Covid-19 brought into stark relief a host of long-standing problems including low pay, unstable hours, and challenges to physical and mental health - issues that were reflected in the recent workforce attrition experienced by CHCA and many other agencies. As it seeks to recruit workers and expand its client base, the co-op must also compete with larger and more profit-oriented agencies that are able to invest more resources into branding and marketing.[117]

For CHCA and its workforce, the struggle is one waged at multiple levels. Workers are trying to carve a path to economic security; the organization as a whole is seeking to model a

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[113] Maureen Conway, Anne Inserra, and John Rodat, *Cooperative Home Care Associates.*

[114] "Home Care Associates of Philadelphia, Inc," B Corporation, https://www.bcorporation.net/en-us/find-a-b-corp/company/home-care-associates-of-philadelphia-inc.

[115] CHCA is also a partner in administering the mission-driven "Trust for Workers" in Washington State – part of a joint venture that will employ more than 40,000 home care workers after its launch in 2022. The Trust for Workers, https://trustforworkers.org/.

[116] Thanks to Camille Kerr for clearly articulating this point to me. As large numbers of nursing homes shut down and change hands to more hostile ownership, the Co-op Exploratory Committee has focused particular attention on converting existing nursing homes to worker ownership. Sanjay Pinto, "Economic Democracy, Embodied."

[117] Hernandez, interview.

high-road approach while nudging the larger system in the direction of greater fairness. Disappointingly, recent federal legislation providing for increased public investment in healthcare did not include measures to improve home care reimbursement rates - a struggle that is ongoing for CHCA and its allies. Creating a more hospitable environment for organizations like CHCA to flourish will not be solved by increased public investment alone, however. With low-road actors cutting corners to boost their profit margins, there are also important questions around how policy as well as organizing among progressive allies can be leveraged to favor models like CHCA that help to advance quality jobs and quality care together.[118]

Building on the kinds of alliances CHCA has helped to cultivate, transforming both the funding landscape for home care and models of delivery will require mobilizing broad coalitions predicated on solidarity and cooperation.

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[118] One policy that members of the 1199SEIU have discussed is a "right of first refusal" for workers in cases where existing owners plan to exit. For more on the right of first refusal as it applies to transitions to worker ownership, see Saoirse Gowan, "Right to Own: A Policy Framework to Catalyze Worker Ownership Transitions," The Next Systems Project, 2019, https://thenextsystem.org/rto. And CHCA's CEO, Adria Powell, has noted that unions and other progressive allies could help to support unionized, high-road actors like CHCA but helping to send business in their direction through referrals and other means.

PART II: Professionalized Health Practices

PT360

Vermont Physical Therapy Cooperative

Adria Scharf, Ph.D

> *We knew what we wanted. We knew what we envisioned. We knew that the 12 of us wanted to be equal owners. We all wanted to have a voice. We wanted to have equal votes. We all wanted to put in money. We just did not know what it was called.*
>
> –Deborah Harris, Executive Director and President of PT360

In 2009, the 12 coworkers were all working for a sole proprietorship owned by someone else, and they were growing increasingly frustrated. Deborah Harris had developed a new health and fitness program for youth clients, only to discover that the extra time she had invested in creating the program would be uncompensated. Others experienced rigid scheduling. “We found that there was not any flexibility,” even for parenting obligations. “It was suffocating” working for someone else. “After we had worked there for a year and a half, a bunch of us decided ‘this is not what we envisioned,’” recalls Harris.

The group of 12 included nine physical therapists, a manager, a billing staff person, and a scheduling staff person, ranging in age from 26 to 58 years. Many had worked together for more than a decade in various settings—in sole proprietors, large national corporations, hospital-based outpatient clinics, and physician-owned practices.

They wanted to create something new and different.

“We knew what we wanted. We knew what we envisioned…We just did not know what it was called,” recalls founding co-owner Deborah Harris, who stepped into the role of Executive Director in January 2022.

The group met with Vermont-based attorney Stephen Magowan to explore their options. He had experience working with employee stock ownership plans and had more limited experience with worker cooperatives. After hearing the group describe their vision, Magowan put a name to the structure they described but at the time had no language for: *worker cooperative*. A worker cooperative is a type of business where the employees directly own and control the firm on a democratic basis of “one person, one vote.” Magowan made the case to the group that a worker cooperative structure would best reflect their vision. Don Jamison, founder of the Vermont Employee Ownership Center, which also provided initial information and assisted the group with their bylaws, recalls founding group members being excited to learn about the worker cooperative structure because it so embodied their sense of “we’re all in this together.”

Participatory Planning

For several months the group met together once a week in their basements to carefully plan how their new worker cooperative would work. They had committees and subcommittees. They divided up tasks. Everybody contributed in some way to planning the business in order to launch. For example, Harris and founding Executive Director and President Mary Steiger were responsible for branding and the logo, so they met with branding specialists and then brought proposals back to the full ownership group for a vote. Other committees focused on developing the business plan, ordering equipment, interior design, and pool design. "We had a lot of trust in each other and in the skills we all brought to the table," Harris recalls. "We were like family when we first started."

Start-up funding, the initial capital contribution, was a top priority. The co-founders each paid for their member shares and each personally guaranteed the initial bank loan. Additional seed funding was secured from three individuals, family members of cofounders, who became preferred shareholders. Those three individuals invested $400,000 in initial funding, with the expectation that they would be repaid over time. (The co-op has already fully paid back two of the preferred shareholders who provided initial seed funding is expected to buy out the final shareholder in 2022—at which point it will be free of debt.)

Once all the pieces were in place, the 12 coworkers, now co-owners of the new cooperative, left their previous employer. They staggered their departures from the sole proprietorship that had employed them all, but still, it was a collective "mass exodus," says Harris.

First and Only Physical Therapy Worker Cooperative

PT360 began treating patients in 2010. It was the first, and remains the only, employee-owned physical therapy cooperative in the United States. For its first 11 years, Mary Steiger, PT, served as Executive Director until retiring at the end of 2021. On January 1, 2022, founding co-owner Deborah Harris, PT, CLT, stepped into the role.

There exists a stereotype of a worker co-op. According to the stereotype, co-ops are small informal "fringe" businesses. That's not PT360. PT360 is a complex, efficiently run, and profitable organization operating at scale—and looking to expand further. It bills out a large volume of sales and consistently turns a profit. PT360 is the largest privately owned PT clinic in Vermont, as measured by volume and number of practitioners.[119] Its success proves that *"worker cooperatives can make money,"* declares Harris.

The company started in 2010 with a single clinic and then rapidly grew. Today it operates four bustling facilities across Chittenden County, Vermont, the state's most populous county. The 8,500 square-foot facility in Williston is the largest site. Both Williston and the clinic in Shelburne have heated salt-water aquatic therapy pools where patients exercise.

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[119] Not including hospitals.

Today 36 people work at PT360, 33 in a full-time capacity.[120] Eighteen of the 33 full-time staff are members, or co-owners, of the cooperative.[121] It is a predominantly white and predominantly female-identified workforce; 30 employees identify as female and six identify as male. Approximately 34 are white and two employees are Asian or Pacific Islander.

Eleven employees serve as administrators and are not physical therapists. Three of those administrators are owners.[122]

As its name suggests, PT360 aims to give "360-degree" physical therapy services, by providing a wide variety of different therapy and rehabilitation services for orthopedic, neurological, cardiovascular, pre-and post-surgery, as well as chronic pain patients and cancer survivors. In addition to aquatic therapy, other treatments offered include manual therapy, exercise, and training.

Profit Sharing

In conventional businesses, owners earn profits based on the percentage of company equity they own. In worker cooperatives, by contrast, profits are shared instead based on "patronage." At PT360, patronage is measured by time worked. That is, the number of hours a member works forms the basis for determining the share of the cooperative's net margins, or surplus, they will receive. In cooperatives, profit shares are known as "patronage dividends."

In the last five years, PT360 has dispersed patronage dividends four times—every year the company was profitable. The sole exception was the first year of the pandemic, 2020. The 2021 profit share was disbursed in the spring of 2022.

The amount received is always the same for every member who works the same hours, regardless of pay level. Therefore, a senior physical therapist at 40 hours accumulates the same profit share as a receptionist working 40 hours. This makes patronage dividends a more egalitarian approach to profit sharing; for profit allocation, everyone's contribution of time to the business is valued equally.[123]

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[120] At PT360, 32 hours per week is considered "full time." To be an owner, one must work at least 32 hours per week.

[121] After two years, employees have the option of becoming an owner. Most of the 15 employees who are currently not owners remain employees simply because they have not completed the two-year eligibility period. Only two employees who have been employed for the requisite two years have opted not to be owners. Both are members of the administrative staff. According to Deborah Harris, for one administrator, it was personal; her sister was the founding president. The other administrator is caring for an ailing parent and does not have time to devote to ownership responsibilities.

[122] Two of the 11 administrators have opted not to become an owner despite being eligible. The other six do not yet qualify for ownership; two have not worked long enough and four do not work enough hours.

[123] Because the amount of one's profit share is based on the number of hours worked, owners who worked, for example, 32 hours per week over the year receive a smaller proportional amount to those who work 40 hours per week. Members who worked 32 hours per week in 2019, for example, would have received 80% of the profit share sum.

Members receive 60% of their patronage dividend in the form of a check. The remaining 40% goes into their capital account, which includes accumulated profit shares plus their initial pay-in.[124] When a member retires or leaves, they are normally paid out immediately if the departure occurs during the year. If the departure takes place at the end of the year, they may wait until the patronage is determined and pay the full amount in February.[125]

Physical therapist and co-owner Amy Sheridan, who has worked at PT360 for six years and has a child, says this about what getting patronage dividends means to her and her family: "For us personally, it is a good cushion. It also allows me to work fewer clinic hours because I make up for it with the patronage."

The profit shares come on top of a good wage. Physical therapists at the cooperative earn $33 to $48 per hour, which equates to $68,640 to $99,840 per year before patronage. Pay level varies by years of experience. The wages are market rate in the area and the higher end is comparable to the overall mean and median wages of physical therapists nationally, according to the Bureau of Labor Statistics.[126]

The starting pay for the lowest-paid nonprofessional job is $17 to $18 per hour. A typical administrative staff person or front desk employee earns around $18 per hour, which is higher than the average in Vermont, but much lower than physical therapist pay levels.[127]

In addition, all employees receive health insurance, retirement benefits, and life insurance.[128] They also get both short-term and long-term disability insurance.[129] This year, the company added a parental leave benefit for fathers or married partners, so that employees who are new parents, regardless of gender, will receive two weeks of paid time off.

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[124] In the worker cooperative, each member-owner has an individual capital account to keep track of their portion of the firm's net worth and the member's equity in the corporation. If the organization needs to utilize a portion of the internal capital accounts for working capital, they may transition funds to the operating account.)

[125] Legally they have up to two years to pay out the capital account but have not needed that time.

[126] Nationwide the median physical therapist earns $43.75 per hour or $91,010, according to the BLS. See: https://www.bls.gov/oes/current/oes291123.htm#nat. Employment estimate and mean wage estimates for Physical Therapists in 2020: Employment: 220,870; mean hourly wage: $44.08; mean annual wage: $91,680.

[127] See Bureau of Labor Statistics 2020: https://www.bls.gov/oes/current/oes_vt.htm#43-0000.

[128] The company pays most of the health insurance premium. Employees pay roughly $40 per pay period toward their premium and PT360 pays the rest. An HSA and HRA are also offered. The HSA provides $1,000, which PT360 puts in employee accounts. The HRA provides up to $3,000.

New employees receive two weeks of paid vacation with three personal days. At five years employees get three weeks. At 10 years employees have four weeks off. They provide a SIMPLE IRA retirement benefit with a 3% match, into a 401(k) account.

[129] If someone had to stop working for a medical reason they would be paid 60% of their wages immediately, the day they leave work, according to Deborah Harris.

Patient Care

PT360 is rare in that its clinicians spend an entire hour with their patients. Harris estimates that these days, "at least 70%, if not 90%, of physical therapy practices give a half-hour to 45-minute treatment sessions."

Insurance companies typically reimburse for shorter session times.[130] Most patients, about 95%, have insurance coverage. In effect, therefore, PT360 practitioners spend more time with many patients than they are fully reimbursed for from insurance.[131]

"But for us, it's about the quality of our patient care and we have so many patients that come back," explains Harris.

As physical therapist and cooperative member Amy Sheridan observed: "I think with the changing healthcare market, slim margins, costs rising, and reimbursement worsening, many companies are looking for ways to increase revenue and cut costs. One way others do this is to alter patient care, whether by adding in aides to help or decreasing patient care time. Here, because we have so many clinician owners, we have really fought hard to maintain the best patient care while finding other ways to generate revenue. This is not the easiest route, but I think it reflects our commitment as a co-op to maintain the best patient care, which is our goal."

How do they remain profitable if they are giving more care than they are being reimbursed for?

"It's getting harder and harder," says Harris. "I'll be totally honest."

Cash-based offerings are generating supplemental revenue streams. Pool passes, massage therapy, dry needling, and various group classes are all offered to patients on a cash basis. These services generate revenue that partly offsets low reimbursement rates.[132]

Culture

"We wanted it to feel different," explains Deborah Harris. "We want people to immediately feel the difference in the vibe when they come in." The staff greets patients by name; "'Hey Sue, how's it going?' It's like Cheers," says Harris about the welcoming spirit of their clinics. The website says, "we work hard and play harder."

The warm culture may, Harris believes, tie back in part to the worker cooperative structure because staff people genuinely want to be there and feel invested. The worker members have the freedom to set the tone, which allows for a friendly environment for patients. "The

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[130] Harris reports that reimbursement rates vary by insurance company, but increasingly, more insurance companies will either pay for only up to 45 minutes of service or a dollar amount equivalent to three units of care.

[131] A 40-hour-per-week therapist would see about 36 patients per week, one hour per session (most PTs are at least 90% productive).

[132] Patients get a pool pass and may use the gym for a $5 charge. These offerings for patients extend the benefits they receive beyond their PT sessions. The extension can be particularly helpful for patients with insurance requiring a high co-pay.

patients look forward to some of the goofy things we do," she says. For example, at the clinic in Williston, they hold a "polyester power hour," turning up disco music on Fridays at noon.

Governance

A defining feature of a worker cooperative is that its major decisions are made democratically by the people who do the work, either directly or through some system of representation. At PT360, co-op members elect a board of directors that holds ultimate responsibility. Elections of the board take place annually and each member has one vote. The board currently has five worker members. All five worker members on the board serve as officers.[133] In addition, the board includes four non-voting advisory members who are not owners. The advisory board members provide valuable guidance and expertise; they include an attorney, an accountant, and an entrepreneur.

In addition to quarterly board meetings, regular "Owner Meetings" take place every four to six weeks. Any owner-member can add an item to the agenda, which is shared ahead of time. The director facilitates these meetings. The 18 members discuss and then vote on each agenda item. Decisions are made based on the majority rule.

In Owner Meetings, every member's perspective can be aired and every voice can be heard.

How do the Owner Meetings go in practice? "There are strong personalities, and the meetings can get heated, depending on the topic," says Harris. In a group of all different ages and circumstances, different people want different things. Some want more time off. Others want fully funded maternity leave. Others want the maximum patronage.

To physical therapist and co-owner Amy Sheridan, this is what makes working in a worker cooperative different from the clinics and hospitals where she worked as a physical therapist previously.

> I think the difference with a cooperative really comes down to the vision-making role we have. It comes down to the bigger policy decisions. We discuss strategic planning, we discuss big picture questions about how we want to move forward as a company. We look at the next five years and decide we want to buy another clinic, open new clinic locations. That kind of big decision-making is made altogether, with one vote per person. We all can present policy. We have committees to explore policy. We all vote on policy.

By comparison, in a hospital where she had previously worked: "Everything came top-down. You didn't have any input. If they say, 'you're working later,' you work later." She also experienced working in a private practice where physical therapists "did have input into how we would like the clinic to be run, but the two owners of the company made the final decision. We

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[133] The slate of officers is registered with Vermont's Secretary of State.

could say, 'Hey we think this should happen. But we had no real decision-making ability." In a cooperative, "especially as a professional, it feels better to be part of the decision making, and to know that I can sway or be swayed by other people's opinions."

The "one person-one vote" quality of making decisions "levels the playing field" when it comes to policy decisions. "It really doesn't matter what your title is, because everyone has one share and one vote," explains Harris.

Worker Owners Initiate a Policy Change

Amy Sheridan and other worker owners recently initiated and voted through a significant policy reversal. "We passed a parental leave policy that I had really pushed," Sheridan says.

Earlier, the company had given six weeks of paid time off as maternity leave. In that arrangement, 60% of the leave was covered by short-term disability and the company contributed additional pay on top of disability. In 2018, the owners voted to change the maternity leave benefit, taking away the company contribution. As a result, women received just 60% of pay for six weeks after having a child.

Amy Sheridan was employed at PT360, but not yet an owner, at the time of the 2018 vote. She recalls:

> People didn't like it. We had members who were affected by the change—at least four females experienced a reduced benefit and a male employee whose wife had a child also did not get any benefit. I already had a child so wasn't personally affected, but I thought, 'I wouldn't have come to this company had I known the decision to reduce parental leave would be made.' And I was concerned: We have a lot of new parents here, and we were going to lose them. We had lost a few. How does that look financially? How does that look from a human and an HR perspective?

How did the policy reversal come about?

Amy Sheridan and other concerned worker owners "formed a group to look at it and came up with ideas. We presented the ideas to the big group [at the Owners' Meeting]. We all discussed it. We voted unanimously in January 2022 to change the policy."

> We brought the issue back around. We said that not only do women need to have better parental leave, but our male counterparts need to too. That's important. We came up with something equal across gender.

Today, as a result of the change, employees who qualify for the disability receive 60% of their pay for six weeks, then PT360 pays an additional two weeks of full pay after the six weeks are completed. All PT360 full-time employees and owners, administrative and clinical, who give birth are eligible to receive this benefit. Fathers or parents who do not give birth and therefore do not qualify for disability get two weeks of paid leave.

This worker-owner-initiated policy correction reflected changing member demographics. In 2018 there had been more owners over 50 years of age, and owners with older children. Some were nearing retirement age. Many of that older cohort of owners have since retired or left the company. They have been replaced with worker-owners who are 40 years of age or younger and who have young families. The younger members are growing more vocal and are demonstrating their capacity to organize and initiate change.

This example highlights something important: In a worker cooperative, the democratic structure gives worker-owners the ability to organize around the needs of current members. At PT360, Owner Meetings provide space for democratic deliberation over such matters as personnel policies and benefits that in many more traditional companies are decided wholly by a member of the management team, often without substantive input from workers. The cooperative structure attunes the business to the vocalized needs of current members and provides mechanisms for worker-owner-initiated change.

Deborah Harris recalls: The change in parental leave policy came in direct response "to the concerns voiced by current owners—they identified a gap where we were falling short and loudly vocalized a need for change."

Sheridan, thinking about the process, shares: "My vision, the specific proposal, kind of got blown away in the Owners' Meeting because other people had better ideas. I thought, 'Oh, wow, that's a better way!' I think collaborative thinking is great. My thoughts are only my own. But we have almost 20 owners. You can come up with some cool things as a larger group."

Supervision and Hierarchy

While all member owners have equal votes at the Owner Meetings and in selecting board members, in day-to-day operations a clear authority structure exists. There must be oversight, checks, and a final decision-maker in a physical therapy practice such as theirs, says Harris. "We do have supervisory relationships and accountability. We have to."

The role of the director is to oversee the whole company, its finances, its large capital expenses, and to supervise the clinic managers. Clinic managers at each site, meanwhile, deal with daily functions. In other words, the director and site managers direct and coordinate other people, even their fellow co-owners.[134]

Amy Sheridan, as a nonsupervisory worker, does not see big differences in her experience of supervision and management at PT360 compared to other outpatient clinical settings.

> As far as supervision, we still have a director of the clinic who manages, to make sure that the clinic is running properly. We still have a President. That ensures the smooth running of the cooperative. Your vacation time still needs to be approved. The hierarchy is still present.

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[134] The Executive Director is evaluated by the site managers and the board of directors.

> Even if I, say, have an open hour, a paperwork block for an hour, I still need to ask my supervisor, 'Can I do that work at home because the kids are home from school today?' We still have to have that communication with higher ups.

Still, compared to some more traditional corporate settings, Harris thinks the quality of hierarchy can operate and feel different in a worker cooperative.

"We care about each other, that's the first thing," says Harris. "The way I supervise and correct other people, I do it in conversations. It is nonjudgmental." I might say, "'This is a learning experience but this can't happen again,' or 'This does not feel like it's a good decision.'" We use that kind of respectful communication." In her communications she aims to be clear and respectful, and sometimes tinges her comments with humor.

The shared ownership structure helps. "When people know that they and their other owners are all in the same boat, people just trust more."

Today, just three of the original co-founders remain on staff. The founding group of owners has been replenished with new members. New members may join after working for two years; they are voted in with the approval of the current owners. New members must put up a certain amount of funds for their member share, an amount the cooperative prefers not to disclose publicly. New members can finance a portion of the sum.

Since their founding longtime director retired on Dec. 31, 2021, PT360 has completed an important transition into its next phase of leadership and continued operation.

With the worker cooperative, physical therapists and office staff put in place an ownership structure that enables more voice and freedom at work, and a share in profits—a model that is otherwise unheard of in the physical therapy sector nationwide.

Amy Sheridan believes the worker cooperative structure "gives individuals a sense of control over their work environment, as well as the financial benefit that comes with ownership—without carrying the amount of risk that would come with being a single proprietor owner."

Conclusion

Might PT360 have pioneered a prototype that could be replicated or expand? The company is in fact looking to acquire additional clinics in the future, bringing those enterprises into their cooperative structure.

There are currently 233,350 physical therapists registered in the United States, with one-third working in private outpatient offices.[135] The physical therapy industry is worth $40 billion. Job growth in the sector is expected to reach 21% from 2020 to 2030. The industry is

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[135] See the American Academy of Physical Therapy (AAPT) website: https://www.aaptnet.org/facts-about-the-industry.html#.

increasingly important as the baby boomer generation ages, since the use of physical therapy can lower overall patient treatment costs dramatically.

Patient retention, and practice and staff management, rank among the most common challenges that PT practices face nationwide.[136] PT360, through its cooperative structure, appears to be addressing both challenges—as evidenced by its self-reported patient retention and its unique governance and management practices. Given the number of physical therapists in search of new business models and the importance of strengthening the job quality of practitioners and administrative staff in the industry, PT360's pioneering path may offer lessons for others in the field.

Don Jamison, founder of the Vermont Employee Ownership Center, believes that the company's sheer success and growth have already helped to give the cooperative model greater credibility in the eyes of other business owners.

"More and more business owners in Vermont and beyond are expressing interest in worker cooperatives," he says. The fact that the Vermont Center can point to PT360, along with other successful cooperatives, has already begun to increase this model's appeal.

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[136] "7 Biggest Issues Facing Physical Therapists in 2020." *MWTherapy.* 2020; "The PT Patient Experience Report: A study of physical therapy patient expectations, preferences, and the drivers of satisfaction in 2022." WebPT & Clinicient. 2022.

Summary Table: PT360

Employees	36
Members	18
Year Founded	2010
Governance	Board elected by members
	-Five officers, all worker-members
	-Nonvoting outside advisory members
	Owner Meetings
	-Facilitated by director/CEO
	-Any owner-member can add an agenda item
	-Discussion followed by vote; majority rules
Profit Sharing	5 of the past 6 years
	-Members receive 60%. The remaining 40% goes to their capital account.
Membership	Considered after two years of employment
	Pay member share
Compensation	Market pay, health benefits, retirement benefits, life insurance, short and long-term disability insurance, parental leave
Seed Funding	Family investors & loan co-signed by the 12 founding members in 2010

Alliance Collective

Adria Scharf, PhD

Alliance Collective's newest clinician, Claudia Maisch, worked in a group private practice before joining the nonhierarchical therapy practice. She recalls:

> "I experienced a lot of difficulty with the hierarchical structure and the way that the practice was run. It was very profit-driven in a way that felt not aligned with how I value mental health work."

She joined Alliance, one of the only psychotherapy practices in the country to be structured as a worker cooperative, in early 2022, because its approach felt more respectful, less exploitative, and more authentically aligned with her values as a mental health practitioner.

History

Alliance has evolved rapidly through three organizational stages since 2018 when it was founded as a solo practice by Billy Somerville. In its second phase, from 2019 through mid-2021, Alliance functioned as a horizontal organization, a collective of therapists working together in a nonhierarchical cooperative way, but without the formal legal framework of a cooperative. Since July 2021, it continues to operate as a collective, but now "all of our operating agreements and business entity filings match the way that we are actually organized," says Somerville.

They are a worker cooperative, albeit one with a bifurcated structure as required by the corporate practice of medicine laws in the state of New York (see below).

Billy Somerville had seen the mental health bureaucracy up close. He had been immersed in the system as a doctoral student in clinical psychology when as part of his training he worked in three New York City hospitals, a counseling center, and community mental health and outpatient clinics.

"Some of my training experiences" in traditional mental health institutions were "pretty traumatizing." As a graduate student in training, Somerville's work was overseen by clinical supervisors at each site. He was "eager to get out from under the thumb" of what he at times experienced as "abusive power" by supervisors who, recognizing something different and radical in his approach, seemed to be trying to "forcefully break that" in him, in order to socialize him into the dominant professional practice paradigms of clinical psychology.

A desire for autonomy was his motivation for starting a solo private practice. He soon realized, however, that he could not work alone over the long term. "I was going to wither and die in isolation," he says. He wanted to try to turn the sole practice into a group, a community. "It just took some time to build the community aspect of the work, in addition to the autonomy," Somerville says.

A key development came in February 2019, when Somerville co-organized an "NYC Anarchist Mental Health Conference Event" at a church near Washington Square Park in Manhattan.[137] Almost 100 people attended, mostly New York-based mental health practitioners and students.

It was at the conference that he met Juliet Spier, who had recently finished social work school. "I was disillusioned," she says, having found social work school to be "another institution that was enforcing the status quo." They decided to work together to form Alliance Collective, together with part-time administrator Kara O'Brien, to organize the work of therapy in a radically different way. In the collective, all major decisions would be made through consensus and each worker would earn the same hourly wage in a spirit of mutual support and solidarity. They would intentionally prioritize individual autonomy but get the benefits of connectedness too. The design would be grounded in anti-authoritarian values and a fundamental recognition that systemic oppression is "the cause of most mental health problems."[138] Since then, three more clinicians—Dawn Sánchez, Teresa Shen, and Claudia Maisch—have joined the nonhierarchical organization.

Juliet Spier reports feeling fortunate to have joined Alliance directly out of social work school. "Here are people who want to collaborate with me, who want to share power, who want to dismantle hierarchy and capitalism. And they're really life-giving as well," she says. She knows graduate school colleagues working in more traditional private practice and agency settings who describe being exhausted and burned out, and who are struggling to make ends meet. "They put in so much labor, and so much of the profit of their labor, it just goes straight to their boss's vacation home while they don't know how they're going to pay for groceries. That's the private practice experience. I talk to people who are in agencies, and just really struggling with their mental health, because of all the vicarious trauma that they're experiencing and the overwhelming ridiculous caseloads, especially during the pandemic. It's really hard to see."[139]

Juliet Spier, Claudia Maisch, and Teresa Shen are Licensed Master Social Workers (LMSWs). They are qualified to work directly with patients, but are still completing the supervised practice hours that the state of New York requires to become Licensed Clinical Social

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[137] One event announcement said: "Attention anarchist/leftist mental health workers and students! Please join us for a free one-day conference to resource- and skill-share, build community, and strategize how to better incorporate anarchist values into our work. Topics to be addressed include: mutual aid self-therapy (MAST), radical case conferencing, non-hierarchical peer supervision, anti-capitalist private practice, and whatever else you would like to share in your own break-out session."

[138] See the Alliance Collective website here: https://alliancecollective.coop/.

[139] A 2018 review and meta-analysis found burnout prevalent among mental health workers. See O'Connor, Karen, Deirdre Muller Neff, and Steve Pitman. "Burnout in Mental Health Professionals: A Systematic Review and Meta-Analysis of Prevalence and Determinants." *European Psychiatry* 53 (2018): 74–99. doi:10.1016/j.eurpsy.2018.06.003..

Workers (LCSWs).[140] Remembering when she first graduated from social work school, Claudia recalls:

> "I was looking at my options in the field. I found that in private group practices, often there is maybe one LCSW and then they hire a bunch of LMSWs and pay them 'fee for service,' which means you only get paid a percentage of your fee per clinical hour and you don't get paid for any of the other kind of work that you do for your patients."

In Alliance Collective, by contrast, practitioners are not exploited in the sense that their labor is not generating profits for someone else. They make decisions jointly. They hold one another in a circle of mutual support. That in turn, they argue, improves the quality of patient care.

Today, the cooperative has six workers, four full-time and two part-time. All of its workers are members of the cooperative. The clinicians include a Licensed Clinical Psychologist, a Licensed Clinical Social Worker, and three Licensed Master Social Workers. In addition, there is one part-time administrator, Kara O'Brien. The total annual revenue is $200,000. There is no cost to purchase a worker-owner share.

The cooperative is predominantly female and half BIPOC (Black, Indigenous and people of color). Five of the six worker owners are cisgender women; one individual, Billy Somerville, is a cisgender man. Three of the five therapists are BIPOC; the cooperative includes one Afro-Latina member, one Latina member, one Asian member, and three White members, including the administrator. The therapists expressly use anti-racist, LGBTQIA-affirming, and feminist models of care in their work.

Compensation is organized on an hourly pay system, as opposed to salaries. Unusually even among worker cooperatives, Alliance Collective makes no distinction between a clinical hour versus an administrative hour, versus something else; "work is work." That rule of thumb extends to the work of the administrator Kara, who earns the same pay rate as the therapists. All collective members receive the same hourly pay rate, period. "That has been a central aspect of our model so far–the idea that labor is labor and should not be valued differently," collective members say.[141][142] To log their work hours, worker members use apps on their phones and then share them once a month, for transparency and to catch any clerical errors.

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[140] LMSWs must operate under the supervision of a licensed psychologist, psychiatrist or LCSW, while an LCSW can independently provide these services.

[141] The administrator's role has shifted over time. She used to respond to voicemails, set up initial consultations, and do other direct service work with clients and potential clients, but now serves as more of a financial advisor and occasional bookkeeper. (Email correspondence from Alliance Collective received June 14, 2022.)

[142] Cooperatives overall have markedly more egalitarian pay structures than conventional companies. Flat and equal pay is not required by the worker cooperative model, however. According to the 2017 Census of Individuals in Worker Cooperatives, a national survey of 1,147 people employed in 82 worker cooperatives across the country, the median pay ratio in worker cooperatives was 1.5 to one,

The hourly pay rate is $40 per hour in 2022.[143] Billy Somerville, as the owner of the psychology practice, is the only individual who is not paid as a contractor. Everyone else receives an IRS form 1099, rather than a W-2, in an intentional decision intended to retain more autonomy from the state. Pay had been just $30 per hour before 2020. "That wasn't quite feeling like enough, so we had a meeting about it. We decided that we would bump it from $30 up to $40. … We can probably do that again soon," Somerville says.

They serve about 70 clients altogether. Somerville, as a clinical psychologist, takes insurance clients; about 75% of his client roll pays with insurance. Dawn Sánchez, an LCSW, also sees insurance clients. It is harder for LMSWs to qualify for insurance. All LMSWs can, however, see Medicaid clients if they are being supervised by a Medicaid provider. Many of the LMSWs' clients pay out of pocket. The rates are flexible depending on a client's ability to pay. Very low rates must be approved by the collective, which considers the overall finances of the cooperative in making the decision.

Patient Demographics: Working Class Clientele

Each clinician serves a different demographic and class mix of clients; they strive intentionally to work with working-class people and people marginalized through systems of oppression.

Claudia works primarily with White and LatinX people in their 20s and 30s.-"I am trying to bring in more folks who are Latinx and immigrant-identifying because that's an area of the work that I feel like I can offer the most," she says, as a Latina social worker. She offers couples therapy as well as individual therapy. A lot of her clients are couples who are working on "relationship conflict, communication, parenting and co-parenting." A handful is queer or polyamorous. She has chosen to cap her caseload at 26 clients, a decision that would have been discouraged or forbidden in other more profit-driven settings.

Juliet's clients range in age from 20 years into their forties. Most have gig jobs or working-class jobs; some are artists or care workers. Many of Billy and Juliet's clients are working-class people who live or lived in the Bushwick-Ridgewood area of Brooklyn and Queens, near where the Alliance offices were located before the pandemic hit and they began primarily doing telehealth.

Legal Structure

Many health professionals who wish to start worker cooperatives in the United States face a statutory challenge: Corporate practice of medicine laws generally ban licensed medical

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meaning the highest paid employee received just 50 percent more than the lowest paid in the typical cooperative studied. Eight co-ops in the sample had completely flat wage scales in which every individual in the company earns the same amount of pay (Schlachter and Prushinskaya 2021).

[143] Nationwide the median Social Worker earned $24.23 per hour or $50,390 in 2021, and the median psychologist earned $38.96 per hour or $81,040, according to the U.S. Bureau of Labor Statistics. See: Social Workers: https://www.bls.gov/ooh/community-and-social-service/social-workers.htm; Psychologists: https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm.

professionals and nonprofessionals from co-owning an entity that provides professional medical services; the laws vary by state and are particularly strict in New York. These laws are intended to protect consumers by keeping outside investors without medical credentials from diluting the quality of patient care in the health practice. Unintentionally, these laws present a block to the formation of worker cooperatives in health care, because in a cooperative all workers—including the administrative and other nonmedical staff—become co-owners together with the employees with medical licenses. Indeed part of the express intention of the cooperative model is to include worker-owners of all ranks and skill sets together as equal owners. A workaround to this barrier is to bifurcate the business into two entities by creating a separate management services organization (MSO), which operates as a worker cooperative. Nonprofessionals and people with different licenses can legally own the MSO, which conducts most of the functions of the business—except for the provision of clinical care. The MSO is contracted to serve the health practice, which continues to employ the professional staff in compliance with the laws.[144]

In 2019, wanting to turn the collective formally into a worker cooperative, they received free assistance from the ICA Group, the Massachusetts-based consulting and research organization that assists businesses in converting to worker ownership, thanks to discretionary funds from New York City Council administered through NYC Small Business Services Agency for the Worker Cooperative Business Development Initiative.[145]

They also received a small grant for legal work from Sustainable Economies Law Center (SELC). An attorney connected with SELC produced a memo of recommendations for Alliance in December 2019. The memo addressed "what structure Alliance should consider to operate as much like a cooperative as possible while avoiding violations under the above laws that can be implicated when non-professionals and professionals work collaboratively and share profits." In addition to describing New York state's restrictions on the corporate practice of therapy and prohibitions on splitting fees with non-professionals, the memo also describes federal and state anti-kickback statutes and laws as statutory barriers to the creation of worker cooperatives in the mental health sector.[146]

As a solution, the memo recommended that Alliance create a Management Service Organization (MSO). "By keeping the management entity separate from the professional entities, the practice can avoid the prohibition of the corporate practice of the professions," the memo states, and include licensed professionals and nonprofessional staff.

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[144] Additional rules ban mental health professionals with different licenses, for example, psychiatry and social work, from co-owning the same business. Specific laws and restrictions vary by state. Federal and state anti-kickback statutes and laws pose additional statutory barriers to the creation of worker cooperatives in the mental health sector.

[145] The Worker Cooperative Business Development Initiative is funded through New York City Council discretionary funding and administered through New York City Small Business Services (SBS).

[146] "Memo re: Legal cooperative structure with professional members by Law Office of Sara Stephens," Dec. 24, 2019, to ICA Group.

Alliance Collective followed this recommendation, creating an MSO that would be structured like a worker cooperative. In effect, therefore, they bifurcated the practice into two legal entities.

First, there remains the psychology practice, Alliance Psychological Services of New York, a Professional Limited Liability Company (PLLC), a business structure designed for licensed professionals. Legally, Billy remains the sole owner of the Alliance Psychological Services of New York because he is the only one allowed to own a practice as a psychologist. All other Alliance clinicians are contractors with the PLLC.

Then there is a new entity, the MSO, which is shared equally and democratically, called Alliance Collective. Legally, the Alliance Collective MSO is an LLC. It is taxed as a corporation. Alliance Collective could have opted to make the MSO a cooperative corporation, but it opted to be an LLC because its members saw the LLC structure allowing more freedom and flexibility.[147]

"Our structure was, at every step, designed towards minimizing intervention from the State," says Julia Spier. Collective members wanted the freedom to operate in ways that felt comfortable to them internally without having to conform to certain externally imposed rules. They wanted the freedom to "establish relations to each other and ways of doing business that felt good to us."

The idea, however, is that within the LLC, all worker members—practitioners and administrative workers—are equal members and owners, each with an equal say and a right to a share of the profits. Every worker is currently a legal member—except for new therapist Claudia, because formal membership only begins after six months on staff.

What is the relationship between the MSO and the PLLC? What is the role of each?[148] The therapists contract with and are paid by the PLLC. Administrator Kara O'Brien contracts with the MSO and is paid through the MSO.[149]

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[147] Worker cooperatives may choose from several options when it comes to their legal structure. According to the Democracy at Work Institute: "When forming, worker cooperatives have an important choice to make regarding their legal entity. The business entity types most commonly used by worker cooperatives are the cooperative corporation (which is not available in every state), the limited liability company (LLC), and the C corporation. Worker cooperatives may also choose to operate as an S corporation or general partnership. Each entity type has implications on important issues including taxation, employment law, and access to capital" (https://institute.coop/sites/default/files/ChoicofEntityFinal.pdf).

[148] Two legal documents available for download on Alliance website provide additional detail: the "LLC Operating Agreement" and "The LLC Operating Agreement and LLC↔PLLC Management Services Agreement." See https://alliancecollective.coop/for-therapists.

[149] Individual therapists do their own scheduling and billing through the PLLC, using practice management software that includes electronic medical record, video conferencing, calendar, insurance claim processing and billing services. Clients and insurance companies pay the PLLC. All revenue goes into the PLLC checking account. Billy Somerville is the legal owner of that account but all of the cooperative members have the password and can log into it.

The PLLC currently pays the MSO $5,000 a month for management services.[150] In the future, surplus could gradually accumulate in the MSO over time that way. As of 2022, however, the value of patronage accounts remains zero and the cooperative has not disbursed any patronage dividends.

If the MSO did accumulate a surplus, it could be distributed to members' internal capital accounts. Each member of the cooperative would receive a portion of the surplus in their account through a formula based on hours worked. If a member then leaves, they would receive a check or bank transfer for the amount.[151]

Consensus Decision-Making in Matters Small and Large

Worker cooperatives across the country vary in their internal organizational, governance, and authority structures.[152] Alliance Collective's commitments to eschew hierarchy in its internal workings and make decisions through consensus for both routine and governance matters, reflect a pure collectivist approach to its worker cooperative structure.

There are no elections and there is no separate elected board of directors. The collective in effect serves as its own board. All worker owners are direct participants in decision making, therefore, around key governance issues including how much to pay themselves and organizational goal-setting.

Importantly at Alliance, decisions—not just governance decisions but all collective decisions—are made by consensus rather than majority vote or top-down directive. (A brief

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[150] One benefit of this that is consistent with their values is that Billy Somerville's tax burden for the PLLC is reduced, since the expense of the MSO service fee greatly reduces (and in theory eliminates) the PLLC's profit.

[151] The collective says by email: "The main thing to know about the MSO-PLLC relationship is that it is an imposition of New York State legal requirements on our collective, and is not representative of our values or practices….Adding a separate non-clinical entity allowed all of us to co-own something equally, which felt like a worthwhile objective when we started down that road." Additional reflection is provided on their website. See "Afterthoughts on 'Legal' Co-Ownership": https://alliancecollective.coop/for-therapists, which states in part:

> We went through a long, expensive process to find and create a structure that allowed all of us to legally co-own together. At the beginning, that effort seemed right and good. In hindsight, we have mixed opinions … if you are reading this and wondering if it might be possible for a group of people to have a different relationship to each other than the State sees or recognizes, we affirm that that is not only possible but quite likely the most elegant and cost-effective solution to the problem.

[152] Meyers, Joan S. M. Working Democracies: Managing Inequality in Worker Cooperatives. Cornell University Press. 2022.

experiment with majority vote early on was quickly abandoned.[153]) The operating agreement states: "The Members will make all decisions based on consensus."

The intention behind consensus is for everyone at the table to be heard so the expressed needs of all accounted for. In contrast to majority-vote decision making, consensus decision making requires that every single individual in the circle consent to a decision.

When asked if the group had faced conflicts that are difficult to resolve through consensus and without hierarchy, worker members indicated no. "We're all in agreement that addressing conflict resolution through consensus and without hierarchy has not been difficult for us, if anything it has created trust between us!" they shared. If a member expresses disagreement with an idea under consideration, the group will change positions to accommodate that person's needs and wishes. "In our four-year history we have had intense disagreements about things but have always been able to arrive at a decision that everyone is OK with, even if the endpoint is significantly different from where one or more of us started," collective members said.[154]

Juliet Spier said: "The use of hierarchy to respond to conflicts is not a resolution to me. It's sort of a thwarting of true resolution. I think when we've had conflicts, we have been able to come to resolutions more through the fact that we're able to build consensus rather than have some people's words supersede others."

Internal discussions take place in Friday staff meetings, which are currently held on Zoom. Large and small topics are discussed, and sometimes a single discussion continues over multiple weeks.[155] Legal documents specify that an Annual Meeting of Members takes place each March.

Various formal processes "felt a bit forced in a small group," and have fallen away for now. They used to prepare an agenda in advance, but no longer do; cooperative members bring up topics in the meeting itself. There is no assigned facilitator in the meetings. They used to take notes and keep them in a shared folder, but that practice has fallen off since the pandemic began. If a member is missing when an important decision is being made, they will be consulted about the decision afterward. If the individual does not agree with a decision that was made, then the topic is brought up in the next meeting.

Formalized practices found in many worker cooperative collectives for planning, coordinating, running meetings, making decisions and documenting decisions, are not practiced

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[153] With the then-small group of three, making a decision based on a majority vote made it clear that one person was the loser in the decision and had to consent to the will of the other two; that immediately seemed wrong to those present, according to Juliet and Billy.

[154] Email correspondence received June 14, 2022.

[155] Often in cooperatives, there is intentional differentiation between board-level decision making and routine decision making, with board members doing traditional "board governance" decision making in specifically designated board meetings; at Alliance to date, governance-type questions and smaller questions may surface at any weekly meeting, and all cooperative members participate in those discussions.

by the Alliance Collective.[156] With a small committed group with a shared vision, high levels of trust, shared norms, and stable group membership, such practices are not perceived by the collective as necessary to their functioning at this time.

Sociologist Katherine Chen argues that in some collectivist organizations there can be a risk of "under-organizing." Over time a nonhierarchical collectivist organization may find that it needs to develop more formal practices and systems to function, provide support to its activities, protect safety, sustain itself through staffing changes, and navigate complex environments particularly if it engages in more complex activities.[157]

From Alliance Collective's perspective, a more pressing concern than the risk of under-organizing has to do with the possibility that power can hide and become problematic in the absence of explicit structure, a phenomenon known as masked hegemony and described decades ago by political scientist Jo Freeman in "The Tyranny of Structurelessness."[158]

It remains to be seen whether and how the nonhierarchical consensus-based collective's internal organizational, management or governance practices will evolve in the future as the collective's circumstances evolve, and if the collective grows.

Its current practices express the collective's desire to create an organization that works profoundly differently from the dominant societal models of organization. For them the worker cooperative structure was intended as a means to a larger end; the end of actualizing a liberatory collectivist form of organization that eschews domination—within a society that expects and demands it.

"Nonhierarchy"

As a nonhierarchical workplace, Alliance members always strive for "nonhierarchy," even if they fall short. As Juliet says:

> My understanding of hierarchy is that it's something that we can't eradicate fully, being people that are socialized in this highly hierarchical society. That being said we identify ourselves as a nonhierarchical organization. We don't have any kind of structural hierarchy. We haven't formalized any chain of command. Our ownership and the way that we pay ourselves, it's all horizontally structured. Hierarchy is something that we have an active intention and practice around dismantling and disrupting whenever it comes up, either formally or relationally.

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[156] A few examples include pre-planned meeting agendas agreed to by consensus, rotating meeting facilitators, a specified and differentiated time for governance decision making, and written minutes.

[157] Chen, Katherine. *Enabling Creative Chaos: The Organization Behind the Burning Man Event.* Chicago: The University of Chicago Press, 2009.

[158] Freeman, Jo. "The Tyranny of Structurelessness." 1972. See https://www.jofreeman.com/joreen/tyranny.htm.

For new analysis of organizational structures in worker cooperatives see: Joan Meyers, *Working Democracies: Managing Inequality in Worker Cooperatives.* ILR Press. 2022.

Billy adds: “We try to notice that when it rears its ugly head, and just be real about that and speak to it, to recognize those socializing forces.”

Their practice is inspired by the values of anarchism, which to Billy Somerville means “a rejection of all coercion control and domination and a real belief in the human ability to relate to each other horizontally.”

Patient Care

How do their values translate into patient care?

Juliet says, “I do think the quality of the care that I’m able to provide is a lot better. I’m able to offer a level of transparency and authenticity…that my clients have commented that they recognize and appreciate.” As an example she shares that a client who contracted COVID-19 recently was unable to work for a month. The client told Juliet that she had to stop therapy for the next month because she hadn’t made any money and could not pay rent if she paid for therapy. The collective felt it could afford to offer services to this client for free for a month. When Juliet let the client know, she was concerned that Juliet would not get paid. Juliet was able to say “no, I am going to get paid. We have it set up so that I will because we were not going to have me doing free labor. And also we want to be able to continue working with you.”

Juliet says: “It feels good just to have that kind of degree of transparency and realness around money, but it feels good to be able to foster the kind of relationship with a client, where we can say, ‘Please do let us know what your actual needs are,’ and then we, in turn, can be very transparent about what we can offer. Sometimes we can do it, and sometimes we can’t. And that is a question that is decided in our weekly meetings.”

The answer to the question is subject to the consensus of the collective, and it may depend on whether they have enough spare cash on hand to be able to subsidize someone at a given time.

“I think that’s good for the therapeutic relationship with clients. It does engender a lot of trust between us over time,” Juliet observes.

About how the cooperative structure affects patient care, Billy adds personally: “My nervous system is much more available to my clients because I don’t feel tense at work. I’m not worried. I’m not second-guessing myself. I’m not preoccupied by conflict. I’m not avoiding somebody at the water cooler. I’m not worried about what my boss is going to say, or how I’m going to do on my quarterly performance review. None of that stuff enters my mind or my body. So it just gives me a lot more availability to do the work I do.”

Professional Supervision

Their antiauthoritarian commitments have meant rethinking the traditional dynamics of hierarchical supervision that collective members had experienced in other clinical work and apprenticeship settings.[159]

As one collective member shares about a previous workplace, which they describe as founder-centric, there the founder of the practice was seen as the lone expert and everyone else as learners needed to be taught. “My relationship with my supervisor was largely corrective and punitive. I was not encouraged to have critical thoughts … and many parts of my lived experience were not valued or were even pathologized.”

At Alliance, by contrast, they use the word “consultation” rather than supervision and recast the model from a hierarchical relationship into a collective relationship of mutual support and mentorship in which a variety of experiences are valued. Each cooperative member can go to anyone else in the practice for consultation—although only the PhD and LCSW in the group can provide state-sanctioned supervision to the LMSWs.

“I can go to anyone in our collective to get advice to work through different cases. That circle of trust and mutual respect allows me a lot more confidence and to trust myself,” shares one therapist.

There’s something healthy, they say, in “being able to not just have one relationship with one person who gets to determine the type of training you get or the type of advice. You can seek that advice from one another.”

That said, within the collective, they recognize and are honest about the differences in years of experience among members. Billy Somerville, as the most experienced practitioner, directs disproportionate consultation time to members who are earlier in their careers. “Whenever we’re talking about something there’s just statistically a better chance that I’ve run into it because I’ve been doing this work longer.” Cooperative member Dawn Sánchez, as an LCSW, also has extensive clinical experience and formal certification.

But underlying that recognition, there remains an intention of “non-hierarchy,” by which they mean that “no one in this room is more important than anyone else. No one in this room gets to have the final word or tell anyone else what to do. But because some of us have more experience than others there’s a natural curiosity about ‘What would you do in this situation?’ or ‘What has been your experience when you have run into these kinds of clinical issues?’” Juliet Spier says. “I’ll talk to Billy quite frequently about how to work better with my clients, because I know he’s been a therapist for a lot longer, but there are also things that I bring to the table, from lived experience, that are valuable that are recognized.”

Therapists’ experiences related to their identities, sexual orientation, and lived experiences in society are radically valued within the collective as forms of expertise that in

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[159] New York state requires LMSWs be supervised in order to qualify for licensure as an LCSW. See http://www.op.nysed.gov/prof/sw/lcsw.htm.

traditional mental health settings may not be viewed as clinically relevant or valid forms of knowledge.

In addition to individuals seeking out consultation from one another as needed, once a month the Friday collective meeting is dedicated to group consultation for all the therapists.[160]

Access to Benefits

Alliance Collective had made the deliberate choice to treat workers as contractors rather than employees in order "to keep more money in our own coffers, so that we can distribute it in the ways we want to in ways that are open to us instead of outsourcing the worker protection to the government."

An unintended consequence of treating workers as contractors, they have found, is that it has blocked their ability to provide health insurance to staff. The rules in place governing the private employer-based health insurance system in New York require an organization to have at least one W-2 employee in order to offer an employer-based health plan. An additional obstacle to providing worker members with health insurance is simply the cost; the expense is too high to be feasible for Alliance right now.

What do its members do without employer insurance?

Some have health insurance through a partner. Others buy their own insurance through the exchange. Another got Medicaid when they finished grad school. "I am concerned about when it's going to end," they shared. The affordable plans on the exchanges don't have the coverage that they need.

In an important development, Alliance introduced paid leave in 2022. The plan pays $160 a day for any "unplanned time off," which equals half of what one would earn for an eight hour workday. It covers not only illness, but also child-care crises or other emergency circumstances. There is no predetermined cap on the amount of sick leave that a member can use; the worker owner is simply asked to stay in communication with the collective, so that the collective can monitor its financial capacity. A member needed to take extended time off this year to address a health issue, and is using this new benefit to do so.

As contractors, it is up to each individual cooperative member to pay Social Security and Medicare taxes as well. Whereas W-2 employees have FICA taxes taken out of their paycheck, with the employer covering a portion of the tax, independent contractors pay Social Security and Medicare taxes themselves based on the net income of the business.

Several members have named as a goal increasing the hourly rate of pay again, above $40 per hour. The collective also plans to revisit how they could offer health insurance in the future.

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[160] Administrator Kara O'Brien, as the sole nonclinical cooperative member, does not attend those clinical consultation-focused monthly meetings.

There is a tension between their commitment to keeping rates affordable and their need to pay themselves and care for themselves sufficiently. “It is a struggle because we value being accessible. We don’t want to just serve wealthy clients. We want to be accessible to working class and poorer people—-and we also believe in our folks making a fair living wage,” says one collective member.

Vision

What do they envision for the future?

“Since we’re not profit-driven we’re not trying to continue to grow and grow and grow until we can retire and have like 10 beach houses. That’s not the goal,” says Juliet.

They do think about expanding into different types of services in a way that’s not exploitative or harmful.

Their new legal structure allows for the addition of different kinds of healing services, arts, and entities. The cooperative MSO could become a hub. If the social workers wanted to get together and create Alliance Social Work, they could create different service spokes connected together through this MSO hub. Theoretically, they could have nutritionists or acupuncturists, bodyworkers, or offer pharmaceuticals like psychopharmaceuticals, or other different kinds of healing approaches as part of the MSO cooperative. It remains to be seen how their consensus based decision making would function or evolve in the context of growth and organizational complexity.

Others dream about creating a community space where folks can gather, and maybe organize, possibly with a garden and a kitchen.

“If individual therapy is advancing this problematic idea that we heal as individuals rather than in community, I think we wanted to find ways of healing that happened more in community and find ways to bridge the gap between healing and social justice, I think we wanted to kind of blend those more, and soften the division between those things. We wanted to move beyond the idea of healing as an individual healthcare pursuit. That’s something we can do more dreaming about in the future,” says Billy Somerville.

For now, Alliance Collective worker cooperative provides a vehicle for its members to enact an anti-authoritarian collectivist horizontal organization that seeks to resist replicating hierarchy and oppression internally as they provide therapy and support the mental health of the community.

Summary Table: Alliance Collective

Employees	6
Members	6
Year Founded	2018
Governance	Direct decision making by workers through consensus in weekly meetings
	All collective decisions made by consensus
Profit Sharing	None to date
Membership	6 months employment
	No member share
Compensation	$40 per hour contract pay, paid leave.
Seed Funding	None

Data reflects August 2022.

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Five Point Holistic Health

Adria Scharf, PhD

"We wanted equality and democracy built into the business model."

–Founding Worker Owner Celeste Levitz-Jones

Five Point Holistic Health is a bustling community healthcare clinic in the Logan Square neighborhood of Chicago specializing in acupuncture, psychotherapy, and bodywork. The clinic has grown so busy over the past two years that its co-owners are taking a leap: They have signed a lease on a space almost five times larger than their current clinic and will relocate there by fall. The larger space will allow Five Point Holistic Health to better meet the community's growing demand for its treatments and services, providing enough room for more individual psychotherapy services, new group psychotherapy programs, expanded acupuncture offerings, and new classes and workshops. Today the clinic employs 15 people including its worker-owners.

As a worker cooperative, a business owned and governed by its employees, Five Point is owned and led by its three worker-owners, who are also known as the "members" of the cooperative. Since its founding in 2014 the number of owners has fluctuated, ranging from three to five.

From the start Five Point's worker-owners have wrestled with the tensions between their desires to serve the community, pay their staff, and ensure they, as worker-owners, were compensated sufficiently.

Navigating the balance between these differing goals, they have repeatedly refined their practices. Now Five Point has entered a new phase of financial stability and organizational growth, a phase that will expand its staff and its reach dramatically.

Origin Story

Five Point's founders met as students in a master's degree program in acupuncture at the Pacific College of Health and Science in Chicago. There were five of them originally, hence the name of the business.

The students were required to take a "practice management" course intended to prepare them to start their own acupuncture practices. Celeste Levitz-Jones remembers how unappealing the pathways presented to them in class seemed.

"You were expected to immediately start a business on your own, but you're leaving this program in a lot of debt. It felt completely prohibitive based on our financial situations," recalls Levitz-Jones. Alternatively, students were told, they could become independent contractors, working for example for a chiropractor's office without benefits. Either way, they learned, the typical path out of acupuncture school was to "rent a room and hustle up clients" alone. Very few

group practices existed in the city of Chicago at the time, and there were precious few opportunities for employment with good wages with benefits. “The options were slim,” she says.[161]

The five students shared a desire to build something different and they wanted to build it together rather than go it alone. Two had previous experience with cooperatives: Celeste Levitz-Jones had lived in a housing cooperative and Ryan Palma had learned about worker cooperatives from a professor as an undergraduate student at Ohio University.

The worker cooperative was the business structure that the group believed would best embody their vision for organizational democracy. “We really liked that there is equitability built into the business structure” with a worker cooperative model, says Celeste Levitz-Jones. “We knew we wanted the five of us all equal co-owners. We did not want someone who put in more money to have more control than others. We wanted equality and democracy built into the business model.” In the worker cooperative, they would all be co-investors, they would make decisions jointly, and they would all share in the profits.

From the start, the goal of expanding access to acupuncture treatment by making it more affordable was central to Five Point’s mission and of utmost importance to the owners, who share a deep commitment to making treatment affordable and widely accessible to people of all backgrounds.

The group of five planned for a year before they opened the doors, receiving guidance on their founding documents from the Chicago-based Center for Workplace Democracy and later working with an accountant who specializes in cooperatives.

Initial seed money came from personal capital investments and small loans, some of which were informal loans.

First, the five cofounding owners each made personal capital investments of $7,000 to generate the initial $35,000 they projected was required to open the doors. “I would say that was a big stretch for all of us,” recalls Celeste Levitz-Jones. “Starting

> Acupuncture is a system of integrative medicine originating in China whose core practice involves penetrating the skin with thin needles which are activated through gentle and specific movements. The human body is understood to have more than 2,000 acupuncture points on 12 meridians or channels, through which Qi (sometimes translated as energy or life force) flows. (Some western interpretations, seeking to apply western understanding, have suggested that acupuncture points stimulate the central nervous system, affecting the muscles, spinal cord, and brain and producing biochemical changes.)
>
> National Institutes of Health studies have shown that acupuncture is an effective treatment alone or in combination with conventional therapies for treating a variety of conditions.
>
> Major healthcare providers (including Johns Hopkins Hospital, Mayo Clinic, and Memorial Sloan Kettering Cancer Center) are incorporating acupuncture treatment, and more major insurance carriers are offering coverage.

[161] Indeed to this day, the vast majority of acupuncturists nationwide are self-employed, according to the National Certification Commission for Acupuncture and Oriental Medicine, a certifying body. 2019 https://www.aiam.edu/acupuncture/acupuncture-career/.

this business was a huge leap of faith. None of us had any significant financial cushion if it didn't work out." She and Ryan Palma took out extra student loan money during their last year in school to cover the payment. "It was the only option we had at the time besides putting it on a credit card." Another founder borrowed money from their family. One of the founding owners who could only generate $6,000, not the full $7,000, initially, paid the remaining $1,000 out of his patronage dividends over time.

Second, the cooperative obtained loans, most significantly a loan for $16,000 from Accion Chicago, a nonprofit microfinance and impact investor that helps smaller businesses with good interest rates. In addition, it negotiated an arrangement with a landlord to lend them funds to help cover the cost of building out their space; they would pay an extra few hundred dollars a month in rent as repayment. Lastly, two of the original owners had access to sufficient savings that they were able to loan sums over and above their $7,000 capital investments to the business at the start, then were repaid out of profits over time.

Without these loans, twice the amount of initial capital contributions would have been needed, which would have been cost-prohibitive. "We know we were lucky to receive these loans since it is difficult for co-ops to get financing," says Celeste.

Looking back at their startup process now, they recognize that when they predicted their initial costs would be $35,000, they did not take into account their own pay. They had included six months of operating costs in their calculations—but those costs did not include wages for owners.

"I remember taking home my first paycheck of about $100 for a month of work," recalls Celeste. "It took us almost a year before we were even making minimum wage. Most of us were working multiple jobs during our first few years of business ownership, and I can say that I personally racked up a few thousand dollars of credit card debt that took me years to pay down. Had we been able to raise several thousand dollars more, we could have paid ourselves a bit more during our first months in business and offset our debt burden."[162]

Worker Ownership

Nathan Paulus joined Five Point Holistic Health as a yoga instructor and bodywork practitioner in 2014, soon after the worker cooperative formed. There's a process to becoming an owner—a path to ownership—and he knew immediately that he would follow it. "You start to come to meetings, you start to do a little bit, and then in my case, it took a year and a half" to become a member of the cooperative.

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[162] Initially, Five Point structured itself as an LLC while internally functioning as a co-op. It officially became a worker cooperative that files its taxes as a C Corporation when the state of Illinois expanded the definition of worker co-op businesses with the "Limited Worker Cooperative Association Act in the State of Illinois." The law went into effect on January 1, 2020. As an LLC in the early years, they paid themselves as owners less than the minimum wage. In a legal worker co-op, however, worker-owners are employees of the business and are protected by minimum wage laws and other protections. Five Point was not initially profitable enough as a start-up to pay the co-owners even a minimum wage; that would have required more capital in advance.

“I was excited,” he said. Before joining the cooperative, his work life had required “doing everything by myself.” When he joined the Five Point Holistic Health worker cooperative, Nathan found himself now “collaborating with people reasonably, with people you feel are accountable and who you can trust. I saw the big advantages of combining the work with other people.” For Nathan, working in the cooperative was also a way forward career-wise, “creating something stable” and “expanding my skill sets in new ways.”

The advantages of having mutual support and collaboration are all the more evident now that the current group of co-owners undertakes the large task of planning for the build-out of their new space, relocation, and expansion. Their cooperative structure means “not everything is on one person's shoulders,” he says.

At the cooperative, the worker owners serve in effect as the collective CEO. They are managers and they can discuss and vote on key issues, chart the strategic course, and keep a share of the company’s profits.

The owners have weekly “check-in meetings” to assign tasks, get input from one another, and address issues that have arisen during the week. Each owner is required to participate in two of four owners’ “teams”—Finance, HR, Operations, or Marketing—whose roles and responsibilities are spelled out in a document the group developed two years after the founding in order to increase role clarity.

They hold longer “owners’ meetings” to do real planning, discuss processes, and make bigger decisions. Those have an agenda, a facilitator, a timekeeper, and a note-taker. Each meeting opens by reviewing the agenda and meeting norms. Historically these strategic owner meetings took place about once per month. Right now, however, as Five Point’s owners plan the move and expansion, they are meeting more frequently.

At Five Point, the “Path to Worker Ownership” is spelled out in its Operating Agreement. To become a member, an employee must undertake a candidacy period of six months in which they attend owner meetings and participate in management teams. They must purchase a member share of $5,000, up to half of which can be worked off (meaning repaid from pay).[163] Member owners must also be accepted by a unanimous vote of all current member owners. The Operating Agreement, some cooperative members say, needs revision. Some of these details, which were put in place at an earlier stage, will be revisited and perhaps altered after additional deliberation in the future.

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[163] Workers become owners in a cooperative when they purchase a membership share. Some worker cooperatives set the cost low to ensure that membership is accessible. Others require a larger fee in order to capitalize the business and encourage worker owner commitment. The 2017 Census of Individuals in Worker Cooperatives found that cooperatives reported member shares in 2016 ranging from $0 to $18,000 with a mean of $1,979 and a median of $500. Three-fourths of worker owner respondents reported purchasing their share for $1,000 or less. See Schlachter, Laura Hanson and Olga Prushinskaya. Democracy at Work Institute and the United States Federation of Worker Cooperatives, March 2021, https://institute.coop/resources/how-economic-democracy-impacts-workers-firms-and-communities.

In worker cooperatives, surplus profits are distributed through a form of profit-sharing known as patronage dividends. The last distribution of patronage dividends was for 2019 and was distributed to owners in early 2020; it was a small amount.

In the current phase of expansion, however, generating profit is not the top priority or realistic. Their priority in the coming year is to invest—in preparing the new space, adding staff, and increasing people's pay and benefits. They do not anticipate that their books will reflect a profit in the coming year, but they see these investments as building a stronger foundation for the business in the future.

"A Good Job": Pay and Benefits

When you work with Five Point, "it's a good job," says Nathan Paulus. "We'll hire part-time workers if it's temporary or if we're in dire straits in some way," but in general they try to keep everyone full-time, "because it's better for the patients. It's better for the business. It's better for the culture. It's just much better all around."

Earlier in the cooperative's development, they had relied primarily on independent contractor practitioners. In early 2019, they realized that "every person who works here should be an employee," recalls Celeste. They intentionally transitioned all independent contractors into employees at that time. Today 12 of the 15 current employees work full-time.[164]

Pay is above market rate. The average gross pay in 2021 for full-time Five Point practitioner workers (including owners) was $65,000 plus benefits.

Nationwide the median acupuncturist earns $29.12 per hour which the BLS projects would be $60,570 per year for a 40-hour work week.[165]

Note that at Five Point, full-time practitioners work 32 hours per week, not 40 hours.

The average gross pay for full-time administrators was $40,000. Pay for both categories of workers—practitioners and administrators—will increase in 2022. Pay for the small number of part-time administrative staff, many of whom only work one or two days per week, is $17.50 per hour without benefits.[166] Soon they plan to add an official "Office Manager" who will gross around $55,000 to $60,000 per year, with the other full-time administrative staff grossing

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[164] What "full time" means varies by role. For office administrative employees, including working the front desk, full time work means a 35 to 40 hour workweek. Acupuncture practitioners work four days, actively caring for patients for seven hours per day, which amounts to an eight-hour shift with breaks. Therefore, full time practitioners have a 32 hour workweek which includes 28 hours of patient time. Body workers such as massage therapists whose work is more physically demanding, work 6 hours per day.

[165] Occupational Employment and Wages (May 2021) https://www.bls.gov/oes/current/oes291291.htm.

[166] The actual details are more complicated; acupuncturists earn about $20 per hour, plus a 25% commission, and typically work with two private patients, or staff a community room, at one time. Owners, who are themselves also practitioners, pay themselves $50 per hour for performing their management work. This year they are typically each paying themselves for about 12 or 15 hours of this "owners" time per week.

between $40,000 and $45,000.

Acupuncturists, owners and non-owners alike, earn about $20 per hour plus a 25% commission.[167] The owners, who are themselves also practitioners, now pay themselves $50 per hour for performing the management work required to direct the organization. This year for example they are typically each paying themselves for about 12 or 15 hours of this "owner's" time per week.[168]

Five Point provides health benefits to all full-time employees. The Blue Cross PPO "silver" plan is fully covered by Five Point as an employer.[169] At Five Point providing health insurance was a priority.

"Cooperatives are the only form of business centered around membership," according to the U.S. Federation of Worker Cooperatives. They "operate for the benefit of" their worker-members.[170] Therefore as a cooperative, says Nathan Paulus, "when we started to bring in money, we asked everyone what they wanted. We did surveys in which we asked, 'What do you want: health benefits or more money?'" It is more advantageous for the members and other employees to receive health benefits, because it costs so much to secure health benefits if you're paying out of pocket for yourself, versus if you are an employer. "For us as workers, it's more advantageous." In a sense, "you're actually getting paid much more when the health benefits are covered." Prioritizing health benefits also reflects the fact that "We take the cooperative principles seriously."

Offering health insurance to all full-time employees is also a way to make the jobs they offer more compelling, and it helps to attract and keep full-time employees. They became financially stable enough to offer health benefits only in 2018. "Luckily today we're busy enough, and we make enough money where we can offer reasonable jobs with health and dental insurance, and that helps us to keep people," says Nathan Paulus. Staff also have a Flexible Spending Account (FSA) that enables them to buy medicine and certain other health-related supplies pre-tax.

Employees get two weeks of vacation or sick time, plus they take the week off between Christmas and New Years Day, so in effect, they have three weeks off total, plus holidays.[171]

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[167] In one session period, they typically schedule two private patients in separate rooms at once or they treat an entire community room consisting of up to four patients.

[168] Previously the owners had compensated themselves for administrative work at the same rate as practitioner work (approximately $20 to $25 per hour) and were paid per hour of tracked administrative time. In 2019 they changed this practice to provide the owners an administrator "salary" of $50 per hour for 12 fixed hours per week.

[169] If a worker chooses one of the more premium health plans, then they must contribute to the cost of the premium.

[170] "What Is a Worker Cooperative?" Democracy at Work Institute. Accessed July 1, 2022. https://institute.coop/what-worker-cooperative.

[171] Acupuncturists get paid a base salary combined with commission. When they take time off they do not receive commissions, just the base salary. Some practitioners therefore choose to work rather than take all of their available leave time.

A relatively young group of owner members, they are just now starting to think about retirement benefits. (Nathan Paulus, the oldest of the owners, is 42, and the other owners are in their late thirties.) There is not yet any company-sponsored retirement benefit but the owners plan to offer one by the end of 2022.[172]

Financial Model

Five Point Holistic Health has grown from a budget of $220,000 in 2015 to annual revenue of $605,000 in 2021 as they were pulling out of a covid pandemic-related slow-down. In 2022 they are on pace to bring in about $750,000 and anticipate providing between 9,000 and 10,000 treatments and sessions.[173] They expect to have three to six months of operating expenses saved in the bank when they open in their new location, as a cushion.

Their plans project significant future growth. They envision nearly doubling the number of treatments and sessions they provide through their acupuncture, psychotherapy, bodywork, and other service offerings within two years.

"Our whole business model is based on being affordable and accessible," says Celeste.

Five Point has always held as its core value a desire to make its services accessible financially.

It has taken some trial and error to find the right balance between their commitment to keeping their services affordable, and their need to bring in enough revenue to pay good wages both to the owners and the rest of the staff, provide health insurance, and grow.

"In the beginning, we were undercharging by a massive amount," recalls Nathan. He recalls owners earning approximately $30,000 one year while working five days a week. It quickly became clear to the worker-owners that that approach was unsustainable.[174]

Until recently, the owners were still catching themselves up from the cost of investing their initial seed capital and their early years of low pay. "We have finally just in the past couple of years gotten to a place where we're starting to feel comfortable in the money we are making," says Celeste. "It feels like big money for us but is not huge money for what we do. That's

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[172] They explored doing a 401(k) but found that their cooperative structure came up against the IRS rules against "top heavy" plans. Because of their structure and the level of staffing at the time, there were too many owners relative to employees. (A plan is top-heavy when the owners and key employees own more than 60% of the value of the plan assets.) The owners continue to research retirement benefits. The state of Illinois passed legislation in 2021 requiring that all small businesses of their size offer a retirement plan to employees by the end of 2022. They are exploring the possibility of offering employees an Illinois state-sponsored plan.

[173] In 2020, despite the pandemic, Five Point provided about 5,000 treatments. In 2021 they provided about 7,500 treatments.

[174] "There were times when our independent contractors were taking home more money than we were," recalls Celeste. "They were being paid a split on their treatments and were busy. Because they were doing acupuncture full-time, they were making more than we were as owners, because so much of our time was necessarily focused on business-owners' work. We weren't able to pay ourselves enough" then.

allowing us to feel less burned out as owners and more excited about the future. We've always really prioritized paying our employees, while also trying to be affordable and accessible. We've had to learn to also make sure that we as owners are fairly compensated for the hard work that we do."

A "Game Changer"

A key development, something that has helped the cooperative tremendously, and "literally changed the business" is that Blue Cross Blue Shield expanded coverage for acupuncture about two years ago. Billing treatments to insurance is a "game-changer" for their financial model. Now, many people who have Blue Cross Blue Shield PPO in the Chicago region, including Chicago public teachers, firemen, policemen, and other city of Chicago public servants, have acupuncture coverage. This makes private treatments accessible to the wider population.

Insurance reimbursement rates for acupuncture treatments are generally between approximately $110 to $145. That price is a market price, but because of their commitment to affordability, the insurance rate is higher than the highest price they ask from patients who pay out-of-pocket. Billing a portion of acupuncture treatments to insurance, and receiving the higher reimbursement rate of pay, allows the health clinic to earn revenue just like any other health practice offering insurance-covered services. Most insurance plans also cover psychotherapy.

While billing to insurance is undeniably boosting the cooperative's financial stability, Five Point's owners remain steadfastly committed to affordability and accessibility.

"We don't want people just to pursue insurance patients, or get obsessed about that," says Nathan.

They take several steps organizationally to protect the continuation of their "community care" services, which are key to accessibility and affordability. For example, Five Point offers a "community acupuncture room" where individuals receive lower-cost acupuncture treatments, remaining clothed, in a room together with up to three other patients, rather than in a private room.

In scheduling, they take steps to ensure that approximately the same number of community patients are scheduled as private patients. They plan to increase community care treatments in their new space.[175]

They use an unusual tiered-pricing system for all of their services for the patients who pay out of pocket. The cooperative sets the highest-tier fees for services at the average market rate in Chicago. They call this the "supportive rate." The next tier is discounted, and the most

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[175] When the worker owners of Five Point refer to "community care patients" they mean patients who utilize the service of "community acupuncture." Typically, these patients choose community acupuncture because they have lower incomes. Higher-income people may also opt for community acupuncture if, for example, their insurance doesn't cover acupuncture treatments. Practitioners see acupuncture patients at the rate of two an hour in private rooms, and if a practitioner is just seeing community patients, they see three or four per hour.

affordable tier, discounted, even more, is intended for needs-based clients. It is a trust-based system, with no documentation of income level required. "We explain, as people are checking out, 'hey, we have this system where you just pay basically what you're comfortable with,'" describes Nathan.

"We believe it's better for them to self-select. When you create a culture that's honest and transparent, people tend to honor that," says Nathan. Celeste Levitz-Jones adds, "I was surprised at how many people pay our supportive rate, the highest tier. … People were paying more without blinking. It was a good reminder that if you are doing the right thing, and people are feeling like they are helping a good business if they can pay more they will."

Recently Five Point Holistic Health started offering psychotherapy. They see psychotherapy as a good integration with and complement to their other services. They plan to have a team of at least four psychotherapists on staff in the new space.[176]

They will begin offering group work in addition to individual therapy sessions later this year.

Five Point is also part of a pilot program with Howard Brown Health, a health service organization that serves people who experience being "othered" in traditional medical care settings and provides LGBTQ+-affirming health care. The program pays for its program participants to utilize Five Point Holistic Health for as many services as they want. Howard Brown Health reimburses for the equivalent of their middle-tier fees. Approximately 10 people are part of the program now. "We hope that more partnerships like the Howard Brown Health pilot will happen in the future," says Nathan Paulus.

Conclusion

Looking forward to the expansion and larger space, the co-owners continue to engage in self-reflecting as they always have. Indeed, their pace of growth is lifting to the surface some important organizational questions for the future.

"I struggle with the fact that most of our workers are not co-owners now," acknowledges Celeste Levitz-Jones.

Up until now, "for the most part the people who want to become owners have, and the people who haven't are those who just aren't interested," says Celeste Levitz-Jones. But since they converted their independent contractors into employees on the payroll, and expanded the number of staff people, we now "have more staff now than we have owners."

This is a product of the way they defined ownership long ago. At Five Point, "owners are CEOs in addition to practitioners. In the past, the people who have become owners are interested in the higher-order business stuff and have skills." But in Celeste's experience, "a lot of people

[176] "We've sort of flirted with psychotherapy several times," says Nathan. "But in the past, it was the problem of hiring people part-time…and it never felt great." They did not have the physical room. Their new bigger space, however, will make it possible to hire psychotherapists full-time.

just want to practice. They don’t want to do marketing or HR!” Another obstacle to membership, for some, is the size of the required member share.

“I will be honest,” she says. “I am starting to become uncomfortable with the model” we have evolved, even if in many ways it has served us and the cooperative well in its first eight years. “I now think there should be an easier way for those who are just practitioners to become owners.”

“We’re still figuring it out,” she says. “I’d like to be able to design a model that allows for more people to become owners,” and “as someone who founded the business, I also acknowledge that it would be hard and feels risky to give up all control to people who just got here. It’s this balance.”

“We have this kind of conversation” within Five Point Holistic Health all the time, she says.

“It’s something that we want to figure out a solution to. But probably, right now, we have to focus first on our move.”

Summary Table: Five Point Holistic Health

Employees	15
Members	3
Year Founded	2014
Governance	Members govern directly
	Committees
	Owner Meetings
Profit Sharing	Most recent in 2019; small
Membership	Considered after 6 months of employment
Compensation	Above-market pay, health benefits, paid leave
Seed Funding	Personal capital investments, loans from Accion Chicago and landlord

Sources:

Candon M, Nielsen A, Dusek JA. "Trends in Insurance Coverage for Acupuncture, 2010-2019." JAMA Netw Open. 2022;5(1):e2142509. doi:10.1001/jamanetworkopen.2021.42509

Schlachter Laura Hanson and Olga Prushinskaya. "How Economic Democracy Impacts Workers, Firms, and Communities." Democracy at Work Institute and the United States Federation of Worker Cooperatives. March 2021.

PART III: Case Studies in Systems Change

AlliedUP

A Worker-Owned Healthcare Staffing Cooperative Transforms Temporary Work

Minsun Ji, Ph.D.

Introduction

When health care providers need temporary medical staff, they often turn to a temporary staffing agency to deliver short-term nurses, lab technicians, or other specialists: 96% of health care facilities hired such temporary workers in 2021.[177] These contingent workers are typically lowly paid, have no vacation or health benefits, and have minimal voice over their working conditions. Unsurprisingly, such contingent healthcare workers report higher anxiety, depression, and financial stress than workers in most other occupations.[178] Turnover among health care workers is high (the industry has an annual quit rate of about 23%), and growing reliance on contingent staff means that the average hospital turned over 90% of its workforce between 2016 and 2021.[179] Although nearly 20% of healthcare workers quit their jobs in the first year of the pandemic (and another 31% said they considered quitting),[180] finding a better healthcare position is difficult, so these demoralized workers often just end up in another contingent healthcare position soon after quitting. The CEO of AlliedUP, a worker-owned healthcare staffing cooperative dedicated to changing these dynamics, calls it a burnout cycle of "wash, rinse, and repeat"[181] that serves neither healthcare workers nor their patients well. "How can you take care

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[177] Rodriguez, Sarai. "96% of Healthcare Facilities Hired Temporary Health Professionals." Recycle Intelligence, January 4, 2022. Accessed at https://revcycleintelligence.com/news/96-of-healthcare-facilities-hired-temporary-health-professionals.

[178] "PHI Launches Institute to Address Inequities in the Direct Care Workforce," PHI. 2022. Accessed at http://www.phinational.org/news/phi-launches-institute-to-address-inequities-in-the-direct-care-workforce/; Also see, Center for Medicare Advocacy. 2022. Structural Racism in Health Care Workforce: Black Women More Likely to Work in Low-level Health Care Jobs. Accessed at https://medicareadvocacy.org/structural-racism-in-health-care-workforce-black-women-more-likely-to-work-in-low-level-health-care-jobs/

[179] "The Cost of Nurse Turnover in 2022: How the Great Resignation Impacts Your Organization." ROAR for Good. 2022. Accessed at https://www.roarforgood.com/blog/cost-of-nurse-turnover?hsLang=en.

[180] Ibid.

[181] Podcast. 2022. E.P. 224-01-Transformational Employment Ecosystem. Interview with Alliedup CEO Carey Carpineta. See https://www.spreaker.com/user/techzone/ep-224-01-transformational-employment-ec.

of someone else if you're not healthy?" asks the AlliedUP Facebook page,[182] citing research on how "America isn't taking care of caregivers."[183]

Instead of fueling this destructive burnout cycle, healthcare providers have a choice. Instead of the typical, lowly paid contingent labor option, providers can now turn to AlliedUP, America's only worker-owned health care staffing cooperative, which launched operations in 2021. AlliedUP provides temporary workers to healthcare providers, but only at high wages and robust benefits. The company is also owned by the healthcare workers themselves, who serve as full-time employees of the cooperative, rather than as contingent/temporary staff of the hospitals where they are dispatched. "We strongly believe that offering higher wages, and paths to career success, helps move the nation towards equality" says Carey Carpineta, AlliedUP's CEO. "Our flexibility allows workers to manage their lives and realize their aspirations as parents and community members. More than anything our workers are respected."[184] The fact that health care providers and individual workers have this humane alternative to typical burnout jobs is due to the social vision and entrepreneurial risk-taking of grassroots activists in union and worker cooperative communities who came together to demonstrate just how powerful the united strengths of worker coops and unionized workplaces can be to the cause of worker empowerment.

Workers in Crisis: A Dysfunctional Healthcare Industry

Contingent workers, mostly supplied by temporary staffing agencies, make up a large part of today's healthcare workforce. In fact, healthcare is America's most contingent worker-dependent industry, with more than double the rate of contingency in the professional and business services industry.[185] On average, these contingent workers earn much lower pay and rarely receive health care benefits, vacation time, or sick pay. Furthermore, their part-time jobs allow them no voice in their working conditions and dim prospects to transition into a career pipeline. All of these challenges fall most heavily on women of color, due to deep race and gender-based inequalities that have long plagued the healthcare profession. A recent PHI study found that 87% of direct care workers are women, 61% are people of color, 27% are immigrants, and 44 % live in or near poverty.[186] At the same time, women of color hold only about 5% of healthcare leadership positions.[187]

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[182] 2021. "How can you take care of someone else if you're not healthy?" Facebook, August 4, 2021. https://www.facebook.com/AlliedUPcoop/posts/how-can-you-take-care-of-someone-else-if-youre-not-healthythe-challenges-facing-/198210048990237/.

[183] Courage, Katherine Harmon. "America Isn't Taking Care of Caregivers." Vox, August 4, 2021.

[184] Herrera, Manuel. "New job opportunities for Hispanic communities in the health sector." Al Dia, May 16, 2022.

[185] Kosanovich, Karen. "A Look at Contingent Workers." U. S. Bureau of Labor Statistics, 2018. Accessed at https://www.bls.gov/spotlight/2018/contingent-workers/home.htm.

[186] "PHI Launches Institute to Address Inequities in the Direct Care Workforce." PHI, 2022. Accessed at http://www.phinational.org/news/phi-launches-institute-to-address-inequities-in-the-direct-care-workforce/.

[187] Stewart, Mariah. "Women of Color Continue to Be Shut Out of Leadership Positions in Health Care." Insight Into Diversity, April 19, 2021. Accessed at https://www.insightintodiversity.com/women-

In such an environment, it is little surprise that 2020 surveys by the Centers for Disease Control found that 40% of caregivers reported anxiety and depression, and 10% reported thoughts of suicide[188] (among caregivers with young children of their own, thoughts of suicide reached 50%).[189] Besides being a crisis for the workers themselves, extraordinary anxiety and depression of healthcare workers undermine the quality of patient care.[190]

Many of these overstressed and underpaid workers are simply dropping out. Between 2020 and 2022, 18% of healthcare workers quit their jobs, while another 31% reported serious consideration of quitting. The U.S. BLS reported a loss of 500,000 healthcare workers over this time, with the result that demand for new workers is substantially outstripping supply.[191] These numbers are especially alarming when considering that an aging U.S. population will only balloon the need for quality healthcare workers in the years ahead,[192] and already 80% of Americans report difficulty in scheduling care without delays due to acute healthcare staffing shortages.[193]

Roots of Reform: United Health Workers Think Beyond the Union

The roots of the AlliedUP alternative to the contingent healthcare burnout model trace back to the offices of SEIU-UHW (Service Employees International Union-United Health Workers West). In the last decade, staff at this union were constantly pondering how to organize increasingly contingent workers spread across multiple healthcare centers, and how to improve their dire working conditions. A traditional union organizing campaign was a challenge among scattered and contingent workers, while union staff also struggled with what AlliedUP Board Chair (Rebecca Miller) calls "so much legal and ideological opposition to the union," among healthcare providers. Thus, staff at SEIU- UHW started batting around the idea of going beyond the union and building a broader ecosystem of worker empowerment in the community, specifically by supporting a worker-owned cooperative of healthcare workers. A healthcare staffing cooperative owned and managed entirely by workers themselves might be able to attract the support of hospital managers, officials, and even foundation funders, in a way the union

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of-color-continue-to-be-shut-out-of-leadership-positions-in-medicine-and-health-care-but-one-school-is-working-to-change-that/.

[188] Courage, Katherine Harmon. "America Isn't Taking Care of Caregivers." Vox, August 4, 2021.

[189] Czeisler, M. et al. "Mental Health Among Parents of Children Aged <18 Years and Unpaid Caregivers of Adults During the COVID-19 Pandemic—United States," December 2020 and February–March 2021. Morbidity and Mortality Weekly Report. Accessed at https://www.cdc.gov/mmwr/volumes/70/wr/mm7024a3.htm.

[190] Hall, Johnson, Watt, Tsipa, O'Connor. "Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review," 2016. NIH.11(7): e0159015. Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4938539/;

[191] Herrera, M. "New job opportunities for Hispanic communities in the health sector." Al Dia, May 16, 2022. Accessed at https://aldianews.com/en/leadership/advocacy/job-opportunities-latins.

[192] Urban. Project: "The US Population Is Aging," 2022. Accessed at https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging

[193] Advisory Board. "How health care's labor shortage is affecting patients," 2022. Accessed at https://www.advisory.com/daily-briefing/2022/03/14/health-care-shortage

could not. "The co-op was a way we thought about how we grow the union and have an equitable workplace through a worker organization, even if that organization was not a union," recalls Miller.

The concept grew that if a worker-owned healthcare staffing cooperative could be established, it could become the employer of record. The cooperative would hire and train all its healthcare workers, take care of human resource (HR) matters like workers' compensation, taxes and payroll, and could deploy its full-time, well-paid workers to hospitals and medical centers when needed on a contractual basis. This staffing cooperative would be owned by healthcare workers themselves and would be value-aligned with the SEIU- UHW mission of quality jobs, so it would also be a natural fit for a partnership with the Union. A pro-worker ecosystem would begin to emerge, anchored by both the worker-owned cooperative business and a possible onsite healthcare union representing its workers. "We sort of married the two ideas," uniting the idea of a worker cooperative with a growing union, Rebecca Miller recalls.

A key staffer during this conceptualization phase was SEIU-UHW's Deputy Director of Research, Ra Criscitiello, who remembers how she "did a lot of research, wrote a white paper, and presented the concept" to executive SEIU-UHW staff. Long before AlliedUP launched operations in 2022, there were many meetings among union staff and member leaders about the idea. "We looked at it like a whole ecosystem," Criscitiello notes. "We thought that this was a perfect way to help health care workers, through a workers cooperative that was aligned with the union…And it would also be a growth strategy for the Union as well as advancing equity where workers could democratically govern their own business…This co-op was something unions don't do, but it was a very exciting idea."

Supporting a co-op launch was a risky step for SEIU-UHW because the idea of mobilizing resources, educating workers, getting legal affairs in order, and launching a worker-owned business would take serious time and resources, even before any of these (potential) co-op owners were union members. Months, even years, of SEIU-UHW staff time would have to precede a serious co-op launch. Consultations with securities attorneys, co-op developer consultants, and tax experts would all cost substantial resources, running into the hundreds of thousands of dollars. It all came with inevitable risk and had to be deemed "worth the union's time and resources," Criscitiello recalls.

In the end, SEIU-UHW executive staff shared a vision of building an ecosystem of worker power, even beyond the union itself, so they agreed to a trial run by incubating and launching a small, licensed vocational nurses' cooperative in 2017 called NursesCan. As Criscitiello describes it, the NursesCan cooperative "was sort of a proof of concept, both internally to socialize union leadership to the idea, and also to make sure it was viable." The worker-owned vocational nurses cooperative partnered with a federally qualified health clinic to provide services, and several healthcare quality indicators at that facility began to improve.[194]

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[194] Coca, N. "Nurses Join Forces With Labor Union to Launch Healthcare Platform Cooperative," 2017. Accessed at https://www.shareable.net/nurses-join-forces-with-labor-union-to-launch-healthcare-platform-cooperative/.

Although this cooperative did not last for a long time due to the lack of hospital clients, this pilot project led SEIU-UHW to believe that something bigger was possible.

Another critical factor supporting the AlliedUP launch in 2021 was that SEIU- UHW had recently completed successful contract bargaining between Kaiser Permanente and tens of thousands of unionized Kaiser workers. As part of the negotiations, the Union managed to negotiate a sizable pot of money to support worker education and training for good healthcare career pathways, even for workers who were not part of the union. "This was very unusual," Criscitiello notes. "I don't know of any other union that has a non-incumbent Education Fund." Through this 501(c)3 education and training fund (which became Futuro Health), SEIU-UHW was able to establish training programs for medical assisting CNAs, respiratory technicians, phlebotomists, pharmacy technicians and related health care workers. Though the people entering those programs did not have to belong to the union, they naturally learned of the benefits of union-negotiated training programs like this. In addition, SEIU-UHW was able to use what Criscitiello calls "the organizing engine of the Union" to recruit union-friendly workers into these training programs. "We could have our union members go out to their friends and family and say, you know, 'you're fresh out of college…would you be interested in this education program that will get you a credential that will get you a good job.'" In this way, the training program became part of the broader worker empowerment ecosystem that SEIU-UHW was aiming for: it became a pathway for funneling credentialed workers into the new AlliedUP staffing agency, and these workers would be highly qualified, ready to work, and friendly to the message of worker control and unionization.

A final component breathing life into this worker empowerment ecosystem was the support of community leaders and philanthropic foundations. For example, the Irvine Foundation awarded AlliedUP $750,000 over two years to help pay for services from supportive organizations. Several other foundations also stepped up with low-interest loans or outright multi-million-dollar grants to help sustain AlliedUP in its critical early stages. With this kind of support, AlliedUP was able to launch and sustain operations throughout 2021.

First Steps: Value-Aligned Leadership

Confronting an industry largely made up of poorly paid and long-exploited women of color, AlliedUP says a core goal is "overcoming workforce inequalities across race, gender, age and sexual orientation."[195] Similarly, one industry report summarized the aspirational goals of the coop: "through its combination of quality jobs, ongoing training opportunities, and cooperative ownership structure, AlliedUP expects to increase worker retention, improve patient outcomes, and raise living standards for thousands of women of color, including single parents, who dominate this workforce."[196]

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[195] See AlliedUp Website, https://alliedup.com/about.html.

[196] "AlliedUP combines quality staffing jobs with worker-ownership." Alternative Staffing Alliance, 2021. Accessed at https://www.altstaffing.org/news/alliedup-combines-quality-staffing-jobs-with-worker-ownership.

Ultimately, the success of the AlliedUP experiment depended on operating a revenue-generating business that could support good wages with benefits and growth opportunities for worker-owners. The union organizers helping to launch the co-op realized that noble values would not be enough—the co-op would also need hard-headed business skills. "And so we hired a CEO from the staffing industry," SEIU-UHW's Criscitiello noted, but one whose values aligned with the social equity mission of AlliedUP.

Carey Carpineta, AlliedUP's CEO, was a skilled and experienced manager who came from the business world, but who was increasingly alienated from common practices of worker exploitation. She was an 18-year veteran of the staffing industry, where she won several industry awards as a top performer in client services, sales and operations growth. Carpineta also had leadership experience in the technology industry and with start-up organizations, raising seed capital and assisting with company public offerings.[197] Though a successful business manager, Carpineta noticed a common practice of employee exploitation so common in the temporary staffing industry. "I just wasn't satisfied with the level of pushback I was getting on equal pay for equal jobs," she remembers. "I was witnessing what amounted to a lack of equitable treatment in terms of pay, responsibilities, and promotions, specifically for Hispanic females who are giving their heart and soul to the business."

When AlliedUP recruited Carpineta for the CEO role, Carpineta immediately began a new initiative to create a new set of working values that support worker-owner culture.

> One of my first initiatives was to create a set of core values and operating principles that supported a worker-first culture. AlliedUP's core values of Inclusivity Integrity, Empowerment, Accountability and Value (for all) sets the culture from the very first interview. Our Leadership team authored AlliedUP Operating Principles, which include
> 1) Do what you say you will do, 2) Treat everyone with courtesy, dignity and respect, and 3) Embrace and Incorporate radical honesty.

Putting Values Into Practice: Building a Cooperative Business

From the start, AlliedUP set high goals for itself. The co-op intended for all its healthcare jobs to pay above industry average and come with health care, vacation, and sick-pay benefits. AlliedUP also sought to offer free or low-cost training and education programs to all workers, so that they could build their healthcare credentials and climb career ladders. As entry-level workers became owners of the business over time, the hope was that they would also receive an equity stake in the business, so that they could earn annual dividends and build wealth in their patronage account.

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[197] Podcast, 2022. E.P. 224-01-Transformational Employment Ecosystem. Interview with Alliedup CEO Carey Carpineta. See https://www.spreaker.com/user/techzone/ep-224-01-transformational-employment-ec.

Achieving such high-minded goals depends above all on robust business revenues, which ultimately depend on the ability of AlliedUP to break into the industry and win contracts from healthcare providers who are willing to partner with a staffing agency providing good wages and benefits to their employees. There are many larger and well-established staffing agencies, the AlliedUP Board Chair Rebecca Miller admits, "and we're a small company." In the end, Miller says, our core challenge is can we win contracts and "can we stand up as a business? Can we really break through and have a real business here?"

To meet this challenge, AlliedUP has to focus on client development, which requires hiring professional staff and sales development teams dedicated to winning contracts from healthcare providers. To this end, AlliedUP has hired numerous administrative staff, such as a Vice-President of sales, who vigorously advertises AlliedUP opportunities both to potential workers and to healthcare hiring authorities, using traditional in-person outreach as well as developing a robust presence on social media like LinkedIn and Facebook. "We have to break into the business," Rebecca Miller says, "so we just go to clients all the time. We go to hospitals, to their sales or workforce department, their recruiting department, and we say 'Hey, use us right here.' We always make the case that we are a high-road employer," Miller notes. "We have great workers and pay them benefits.…so you should hire us because we don't exploit workers."

By promising qualified, well-trained and highly engaged workers who are more likely to stay on due to the high wages and good benefits paid by AlliedUP, the co-op is increasingly gaining employer clients. "They like our mission," says Carpineta. "They love the benefits of retention that we're experiencing with our workers…[Our workers] are staying on, whereas turnover in the traditional staffing business can easily reach 50%, monthly. But we're experiencing just 10.7%, annually." Through robust advertising, strategic marketing of their high-road employment model, and a record of dependable, quality employees, AlliedUP is placing more workers. In its first year of operations (2021-2022), the co-op placed about 1,000 new workers, and it aims to hit 3,000 placements in the 2022-2023 cycle.[198]

AlliedUP also hopes that some of the seriously big employers like Kaiser will ultimately come to rely on their high-road staffing model, which is proven to produce better patient results. "I can tell you our competitors are paying attention" Carpineta maintains. "We get calls from some of their employees, asking about what it would take to come over to you and not work here, saying that 'we think what you are doing is great.'" As a sign of their growth, the AlliedUP Facebook feed is constantly filled with ads for registered nurses (RNs), medical lab technicians, licensed vocational nurses (LVNs), and more. Ads promise "competitive, above-market wages," "100% paid medical, dental and vision," "Vacation, Sickness and Personal Time Off," "Free or Low-Cost Upskilling Opportunities," and "Company ownership with annual profit dividend payments." With these kinds of good jobs, Carpineta describes how more of AlliedUP workers

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[198] Political Cortadito. 2022. New Approach To Growing Healthcare Worker Crisis Offers Opportunities For Hispanic And Blacks Workers In California & Nationwide. Accessed at https://www.politicalcortadito.com/noticias-newswire/?l=alliedup-opportunities-for-latin-workers.

"are giving referrals to other workers themselves....And then we also have a larger community of graduates, referring people they know to enter our workforce."

Developing a Culture of Worker Ownership

AlliedUP has a dual mission to serve not only as a profitable, revenue-generating business with good wages, but also as an enduring agent of worker empowerment, providing democratic decision-making to its worker-owners and an organizational structure that will protect workers' rights over the long run. To achieve this worker empowerment goal, a key element of AlliedUP's success has been the role of an organized union, which has been involved from the very start of AlliedUP's work.

Ensuring worker advocacy and ownership was embedded in AlliedUP from the start, SEIU- UHW organizers played a key role in establishing a "workers' culture" committee as part of the organization's early governance structure, even before a unionization campaign started at AlliedUP. The point of the committee was to develop a better understanding of cooperative principles, worker leadership skills, and a better understanding of the possible role of unions in the workplace. "Some people who have never been in the Union don't understand the benefits immediately," Carpineta notes. "Some people who have never been in a co-op don't even know what a co-op is. So we're really starting the very entry-level conversation on both of those things…Helping them understand the benefit of being a worker-owner, helping them understand how they are eligible for a union."

Other discussions in this workers' culture committee focus on issues like anti-racism, and how AlliedUP can develop an anti-oppression culture across the organization. These discussions directly inform how the co-op conducts targeted outreach and affirmatively markets its job training and worker management opportunities to Latina and Black communities that are so dominant in the industry.[199] "How do we make sure that our workers of all races feel like they have a safe voice or a safe place at the table where their voice can be heard?" Carpineta asks. A regular workers' culture committee helps make that happen and lays the groundwork for inclusive worker governance. Carpineta describes her excitement that AlliedUP workers who have benefitted from that committee, especially women of color, "are thrilled to actually be making decisions and will soon be serving as the majority of the Board of Directors."[200]

As Carpineta describes it, the workers' culture committee was important to develop basic worker-ownership skills, "but really I think it's so much more than that. It's about what are the roles and responsibilities of worker-owners? What does democratic governance look like? What does a voice at the table look like? And what are good ways that you can grow confidence to express your voice?" This kind of worker education and leadership development has helped

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[199] Herrera, M. 2022. New job opportunities for Hispanic communities in the health sector. Al Dia, May 16. Accessed at https://aldianews.com/en/leadership/advocacy/job-opportunities-latins.

[200] Podcast.2022. E.P. 224-01-Transformational Employment Ecosystem. Interview with Alliedup CEO Carey Carpineta. See https://www.spreaker.com/user/techzone/ep-224-01-transformational-employment-ec.

prepare workers for full worker-ownership and majority control of the Board of Directors as AlliedUP matures, and helps workers stay focused on a mission of workplace equity and inclusivity, even as workers become revenue-seeking business owners.

In addition to supporting the coop's workers' culture committee, SEIU-UHW offers its own regular trainings to workers, focusing on leadership development, healthcare skills training, or the nature of workplace rights like collective bargaining. AlliedUP's first Board Chair, Rebecca Miller, described how these union "training pods" are popular with workers who might be between jobs, as they can access a "career ladder" to improve their healthcare training and credentials. "Like we have one worker who is a medical assistant and now through the union, she's going to school to become a Licensed Practical Nurse," Miller explains.

All of this training and education helps prepare workers to become full owners of their AlliedUP coop, including serving as a majority of the Board of Directors, which is required in co-op bylaws. Another step towards becoming a full worker-owner is that any worker has to work 350 hours in a year, in their healthcare job classification, to become eligible to join AlliedUP as a full worker-owner. The equity buy-in required of such a candidate is set at a low level of $250, but even this amount can be waived for struggling workers, or paid in five installments. To ensure candidates know what they are getting into, cooperative staff and existing worker-owners organize intake meetings. "We set up a call with the potential worker-owners and have discussions about what it means to be worker owners," Carpineta notes. "They're provided with a membership agreement and if they're interested, they need to sign it…We want to make this as inclusive as possible, but we [also] want to stabilize all worker-owners [by making sure new owners really are committed to staying]."

Taking this step and becoming a worker-owner expands possibilities for long-term wealth-building as every worker-owner gains a patronage account into which annual dividends (when available) can be paid from the profits of the business. But because organizational profits and possible annual dividends will expectedly be thin in AlliedUP's early years, the real benefit of worker-ownership at this point is less financial and more about acting upon one's ideological commitment to the worker-owner concept, as well as gaining a voice in worker governance. "There's no equity right now," Board Chair Miller admits. "It's just so early. But they will get to vote on the Board, and have access to budget documents, [so] there are benefits."

AlliedUP has been in operation for just more than a year and the number of active worker-owners has fluctuated between 40 and 60. The initial Board was set up by AlliedUP's founding principles and included union retirees and an appointed Chair with a long labor movement history. But as AlliedUP workers have met the requirements to become worker-owners, the Board will be converting to elected membership, with the first election scheduled for November 2023 (this newly elected worker-majority board will be installed in January 2024). This elected Board will then be responsible for hiring and overseeing the work of co-op managers, such as the company CEO and all her administrative staff.

Worker-Owned and Union-Friendly

AlliedUP is not only worker-owned, and soon to be wholly worker-governed (through its elected board), but it is also a union shop, operating under a collective bargaining agreement

negotiated between AlliedUP's hired management and workers' representatives with the SEIU-UHW Union. AlliedUP couldn't be unionized from the very start, partly because the Union cannot legally act as a key business incubator while at the same time seeking to be the union representative of workers at the new business. As AlliedUP began to launch, therefore, the union had to step back from management and hiring processes and give the new business room to grow. Also, there simply were no workers to unionize until AlliedUP stabilized and had a regular workforce. But once the co-op had a stable set of regular workers, SEIU-UHW was allowed to engage these workers with a unionization campaign, and to hold a union election.

"After the workers dropped cards and unionized, they were recognized by the co-op as being in a union," Criscitiello notes. "After that, it was like a regular collective bargaining process." The management team of AlliedUP was represented by their hospital division director, who hired a labor attorney to help negotiate. On the union side, there were staff from SEIU-UHW and also a bargaining committee of workers, just like standard union negotiations. There were about five bargaining sessions held over Zoom, with drafts of proposals sent back and forth between workers and management. There were difficult discussions regarding exactly how much the co-op could afford (e.g., could it afford full family health coverage for dependents? Could there be a pay bonus for bilingual workers?), but because management was on board with the idea of union representation, Criscitiello remembers that things weren't contentious, everything was very transparent, and "it was very collaborative."

In the infancy of AlliedUP, this first collective bargaining agreement was fairly basic. The contract was kept short (18 months) and focused on the fundamentals: job security, good wages, health care benefits and establishing a labor-management partnership to handle future workplace relations. The key issue of wages was resolved by benchmarking Allied wages to Kaiser Permanente wages in Southern California, which is the second highest paying health care provider in the state, and pays far above the national average. As an example of how meaningful this wage benchmarking can be in improving workers' income, Carpineta shares the example of one medical assistant who had originally come to AlliedUP to earn $20 an hour instead of the $17.50 she was earning from other staffing agencies. But after successful union negotiations, this AlliedUP worker immediately found her Kaiser-benchmarked pay increased to $33 an hour: "a 64% increase just by entering into the collective bargaining agreement." The agreement also established robust health, vision, and dental care benefits for all employees. However, these first-year labor negotiations were unable to secure full health care benefits for family members of employees, or win a wage differential for bilingual speakers, or establish a retirement plan for employees. AlliedUP is a new business with limited resources, and such goals became financially out of reach for the time being.

Even though workers themselves are the owners of their coop, and value-aligned staff is hired to manage it, the existence of a collective bargaining agreement provides a structured way to keep AlliedUP true to its worker empowerment commitments, even when facing standard business challenges. AlliedUP's CEO Carpineta admits that sometimes the co-op faces business challenges when clients don't want to pay high wages. She describes how managers can be "100% on board with union scale wages, right up until the clients push back and say 'but we're not going to give you the business if we have to pay those sort of bill rates.'" In that moment,

the pressure can be great to accept a lower wage in order to help the business thrive. But "because we have a collective bargaining agreement in place, there's no need to [even consider] lower wages. So when we bump up against the agreement, we know we are still doing the right thing because it's always there to remind us."

If a client argues that they won't pay that bill rate, the collective bargaining agreement makes it clear that the only choice for AlliedUP management is either to turn down the client, or to take the lower billing rate in the interest of generating business revenue and jobs. But in that case, AlliedUP must still pay the worker the full benchmarked wage, paying the difference between that wage and the client's bill rate out of company operating expenses or profits. Paying the wage differential out of other business accounts could be a reasonable business decision for the coop, but by a collective agreement, the hit can not come out of an individual worker's wages. In this way, the collective bargaining agreement protects workers' interests and helps keep even a worker-owned business true to its high-minded values.

As with standard collective bargaining agreements, AlliedUP's agreement also establishes a Labor-Management Committee, which Criscitiello says provides workers and their hired managers with a "structured venue for routine meetings, making sure things like worker safety or other concerns are getting raised properly and heard." This committee has equal representatives from co-op management and from workers, who are selected by their peers to represent labor on the committee. This labor-management partnership allows workers a regular, structured voice in ongoing business concerns, and also helps workers to learn the day-to-day challenges of managing a business.

Lessons Learned

One key lesson of the AlliedUP story regards the role of visionary risk-taking by SEIU-UHW. Launching a worker cooperative of this scale is a heavy lift in terms of financial and staff investment. It is a tricky challenge for union leaders to support non-unionized workers taking on a risky enterprise, and it requires what Criscitiello calls "a specific mindset and a risk tolerance to be able to take on a new organization like this…the executive board of the union has to say 'yeah, this is a priority, so let's invest in it and allocate some of our organizing money or whatever resources towards this.'"

A second lesson is that when unions take on this kind of risky leadership, it has the potential to revitalize a struggling labor movement. Union density continues to shrink, but there is growing interest in building a broader community ecosystem that can support worker empowerment through innovative partnerships between worker cooperatives, local foundations, educators, officials, unions and large employers like healthcare centers. SEIU-UHW recognized this interest in broader "social unionism" or worker-friendly ecosystems and maximized the opportunity by launching the AlliedUP project. "We have to be smart and innovative because the traditional organizing situation is not working," Criscitiello argues. "It hasn't been working for twenty years. We're shrinking….So, we need to have partnerships with employers and figure it out. I think the co-op is a very innovative way to think about how to grow unions and also take away the pressure from the employer to have to fight the union."

A third lesson is that these union-co-op relationships can work, and workers can gain deep fulfillment in becoming hard-headed business owners while still standing up for high-road employment practices. Workers at AlliedUP earn industry-leading wages and benefits, and enjoy career ladders and workplace democracy, even as the business grows and remains profitable. Providing worker-owners with multiple opportunities to engage and manage a business in labor-friendly ways (e.g., through collective bargaining, the Board of Directors, the Workers' Culture Committee, and the Labor-Management Committee) can help develop what Carpineta calls "pride and ownership in the idea of a coop." Carpineta describes how "we have workers who have been offered full-time positions with our clients where they are working on an assignment, but because they have amazing pay with us, and full medical…and are involved in the decision-making process, they are declining positions that in the past would have meant everything to them, in order to keep a position through us that offers better than what they were being offered."

Yvette Romero, a medical assistant with a LA health center is one of those workers. "I love working with AlliedUP," Romero says. "In fact, I have had other opportunities to leave my current job but have stayed. Basically, the private practices do not provide the same opportunities as I have now. It's very flexible and has a lot of opportunities to learn a lot more so I can make a better living. There are also benefits in this job, which I would not have at the private practice."[201] David Ngo, a registered nurse, agrees. "I am so grateful to be on the AlliedUP team. It's a refreshing, new approach to working in healthcare, and the caring culture really sold me. Because of the union-scale pay, full benefits, education, and an online support community, I have referred several of my travel-nurse friends who are joining the team too."[202]

AlliedUP is taking the high road to build the right kind of healthcare business that can take care of its workers. And as AlliedUP's Board Chair Rebecca Miller rightly reminds us, taking care of caregivers is ultimately taking care of ourselves.

> How do you provide good quality patient care? I think the core of that is having worker empowerment around their job and [society] taking care of health care workers. Really take care of people. The stronger they are economically and the stronger they are with their ability to control their work, the better health care they will provide. And I think the co-op and the union offer us a way to get there.

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[201] "New Approach To Growing Healthcare Worker Crisis Offers Opportunities For Hispanic And Blacks Workers In California & Nationwide." Political Cortadito. 2022. Accessed at https://www.politicalcortadito.com/noticias-newswire/?l=alliedup-opportunities-for-latin-workers.

[202] PRNewswire. 2022. Alliedup Offers New Approach to Growing Healthcare Worker Crisis in California & Nationwide. Accessed at https://www.prnewswire.com/news-releases/alliedup-offers-new-approach-to-growing-healthcare-worker-crisis-in-california--nationwide-301512862.html.

AlliedUP: Portrait of a Worker-Owned Healthcare Staffing Cooperative			
Description	**Timeline**	**Vital Statistics (approx)**	**Path to Worker-Owner**
AlliedUP is a worker cooperative that provides healthcare professionals to hospitals and healthcare systems. AlliedUP's healthcare workers are employed by the co-op itself, and receive with good wages, robust worker benefits, and opportunities to become worker-owners with an equity stake in the coop. Healthcare providers partner with AlliedUP when they need temporary medical staff, paying a ticket to AlliedUP, which then pays the wages of dispatched healthcare workers, who remain employees of AlliedUP.	Several years of planning and development work preceded 2021 launch United Health Workers West (UHW) Union played a key early role, conducting research and arranging consultants, attorneys, CPAs, etc. to develop the concept. In 2017, UHW helped launch NursesCan, a small cooperative of licensed vocational nurses, to test whether a larger healthcare staffing co-op was viable. In 2021, AlliedUP launched as a for-profit worker-owned co-op under California law	40-60 active worker worker-owners (2022) 1000 job placements in 2021-22, the goal of 3000 placements in 2022-23 20 full-time admin. staff (CEO, director of hospital division, VP of sales, etc.) Operating Budget approx. $2.2 million (2022), on revenues of $10 million Key early support: $750,000 from Irvine Foundation & several million in grants and low-interest loans from other foundation funders	Become an employee of AlliedUP, who dispatches workers to healthcare providers After 350 hours in one's job classification (e.g., as RN or lab tech), receive a "welcome letter" as a candidate for worker-owner; Participate in interviews & education to learn about co-op over a 90-day candidacy period Contribute $250 in equity to become full worker-owner Retain status with 100 hours of work a year in job classification.

Benefits of Worker-Owner	Cooperative Governance	CBA	Education/ Training
Able to participate in general governance of the coop Able to vote for members of the Board of Directors (and serve on the Board) Right to receive and review organizational information (e.g., the budget documents) Gain a patronage account and equity stake in the coop. Annual profits are distributed into individual worker-owner patronage accounts.	Registered as for-profit co-op under CA law Initially, an appointed Board of Directors. Worker-owners have first vote for Board members in Nov. 2023; Bylaws stipulate a majority of board must be worker-owners; Board oversees admin. staff, such as CEO and division directors. Unionized workplace, represented by UHW and with a Collective Bargaining Agreement Labor-Management Committee is a venue for joint discussion of issues/ opportunities.	A Collective Bargaining Agreement (CBA) was negotiated with United Health Workers Union. The first CBA is for 18 months. CBA benchmarks wages to Kaiser Permanente union-negotiated wages in Southern California, which are the second highest health care provider wages in the state, far above the national average. CBA provides robust employee benefits, including health, dental and vision care, paid vacation/sick time. Labor-Management committee established	Co-op partners for regular worker education & training through partnership with Futuro Health, which provides free or low-cost training and credentials to healthcare workers. UHW union partnership makes leadership development, political education, and other union training programs available. "Workers Culture" committee within co-op meets regularly to allow workers to explore co-op and union principles, business management skills, etc.

Evergreen Cooperative Laundry and Cleveland Clinic

Adria Scharf, PhD

Cleveland, Ohio, once ranked second only to Detroit among American cities in the percentage of its workers employed in manufacturing. As deindustrialization and suburbanization emptied out the city's manufacturing job base over the second half of the 20th century, the hospital industry expanded its footprint as an employer.[203] This is evident in the position of the Cleveland Clinic and University Hospitals, ranked as Cleveland's largest employers today.[204] The Cleveland Clinic has become the single largest private employer in the state of Ohio, generating nearly 120,000 direct and indirect jobs in the state.[205]

Anchor Institutions

The Evergreen Cooperative Laundry's partnership with Cleveland Clinic is perhaps the best-known model of an "anchor institution" approach to economic development in the United States. "Anchor institutions" are large locally rooted entities with economic power, such as hospitals, that intentionally align and deploy their institutional resources—i.e., hiring, purchasing, and investment—to meet community needs.[206]

According to the Democracy Collaborative, which designed the initial blueprint for the Evergreen Cooperatives and has been its longtime partner, the "Cleveland Model" represents the country's "first attempt to bring together anchor institution economic power to create widely

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[203] In *The Next Shift: The Fall of Industry and the Rise of Health Care in Rust Belt America* (2021), University of Chicago historian Gabriel Winant documents how the hospital industry enlarged while unionized steel work declined in Pittsburgh, Pennsylvania, in a detailed historical analysis of this broad dynamic in that city.

[204] "List of Cuyahoga County's largest employers proves Cleveland is a health care town." *Crain's Cleveland Business*, 2022; "Major Employers." 2022. City of Cleveland Economic Development. See: https://makeitincleveland.org/this-is-cleveland/major-employers.

[205] Cleveland had the highest poverty rate among large U.S. cities in 2019 at 30.6% according to census data. More than 6,500 of adults in poverty worked full time for the full year but remained below the poverty line. See "Cleveland now ranks as the poorest big city in the United States." September 22, 2020. *Ohio Capital Journal*. See: https://ohiocapitaljournal.com/briefs/cleveland-now-ranks-as-the-poorest-big-city-in-the-united-states.

[206] The Evergreen cooperatives were born out of the "Greater University Circle Initiative," convened by the Cleveland Foundation in 2005, which included the Cleveland Clinic, University Hospitals, Case Western Reserve University, and the city of Cleveland. While the University Circle area of Cleveland was home to museums, educational institutions, hospitals, and arts venues, the majority-Black neighborhoods surrounding University Circle (Glenville, Hough, Fairfax, Buckeye/Shaker, Little Italy, and the eastern portion of East Cleveland) remained economically marginalized. The Cleveland Foundation sought to unite and leverage the economic power of anchor institutions, some of whom were competitors, to create jobs, build wealth, and stimulate reinvestment in the neighborhoods that surrounded University Circle. The Cleveland Foundation contracted with the Democracy Collaborative to complete initial design work for the Evergreen cooperatives as a network of worker-owned business.

shared and owned assets and capital in low-income neighborhoods."[207]

Evergreen Cooperative Laundry

Evergreen Cooperative Laundry is one of five worker-owned businesses that are part of the current Evergreen Cooperative Corporation (ECC), the umbrella nonprofit holding entity that holds a small stake of ownership in the Evergreen organization, and provides administrative support and business services to the businesses in its network, including the Evergreen Cooperative Laundry.[208] With expected revenue of $10.5 million in 2022 and about 150 employees, Evergreen Cooperative Laundry is by far the largest of the five "Evergreen cooperatives." All of Evergreen's businesses combined employ about 320 workers.[209]

A Critical Strategic Vendor to the Hospital System

To Stephen Downey, Cleveland Clinic's Chief Supply Chain & Patient Support Services Officer, the hospital system's four-year-old strategic partnership with Evergreen Cooperative Laundry has been good for the health system. "Laundry services are an important piece of the supply chain and overall operations" of Cleveland Clinic's $12 billion health system, he says. Laundry is essential "because without it you can't take care of patients. All the patient linens, the bed sheets, and the gowns run through the laundry. Imagine not being able to put a patient into a bed because you don't have sheets." Having a reliable well-functioning laundry process is necessary and such a process must operate well at a very high volume. Cleveland Clinic has a

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[207] The initial vision for centering worker cooperatives within an anchor institution approach is grounded in the thinking of Gar Alperovitz, whose "Next System Project" explores alternatives to capitalism and state-centralized socialism. For background, see: Ted Howard, Lillian Kuri and India Pierce Lee. "The Evergreen Cooperative Initiative of Cleveland, Ohio: Writing the Next Chapter for Anchor-Based Redevelopment Initiatives." The Cleveland Foundation. (See https://democracycollaborative.org/sites/default/files/downloads/paper-howard-et-al.pdf.)

[208] The other longtime Evergreen cooperative is Evergreen Energy Solutions, a solar panel installation company. Green City Growers, an industrial greenhouse, one of the original cooperatives, was recently sold to Local Roots Cleveland, according to the Evergreen Cooperative Corporation website (https://www.evgoh.com/). Three small businesses—Berry Insulation, R-Tek, and Phoenix Coffee Co.—have been bought out by Evergreen's Fund for Employee Ownership, converting from traditional structures of ownership into worker ownership. Berry Insulation is now called the BI Cooperative. Other parts of the Evergreen Cooperative Corporation organization are the Cooperative Development Fund which oversees the Fund for Employee Ownership, a partnership with the Democracy Collaborative which acquires existing businesses and converts them to employee-owned co-ops. Business Services provides back-office support, providing human resources, payroll, and accounting risk management, insurance, legal representation, and related business services to the operating companies in the network. There is also a real estate division.

[209] Each of the five cooperatives is an independently incorporated business in which worker owners have at least 80% ownership in the business where they work. "We're committed to making sure that any given co-op is at least 80% owned by the employees and it can never be less than that," says John McMicken. The ECC holding company has partial ownership in each business, with its percent of ownership stake ranging from 10% to 20% depending on the business. Each cooperative business has its own board of directors that includes employee-owners. The holding company has one seat on the board of each company.

170-acre campus, plus 11 affiliated hospitals and 19 family health centers in Northeast Ohio alone, and requires 18 million pounds of laundry processed per year.[210]

A large international facility management corporation previously provided laundry services to Cleveland Clinic before Evergreen Cooperative Laundry. In late 2017, that corporation's fulfillment rate—meaning the rate of clean linen provided on demand—was less than half of the volume the Cleveland Clinic needed. At one point, the fulfillment rate dropped to about 30%, meaning that if the health care system requested 1,000 sets of clean linen, they received only 300 sets. "Try to run a huge hospital with 30% fulfillment rates," says Downey. There were also turnaround and cost challenges, as well as accounts of poor pay and working conditions. A change of laundry service vendors was urgently needed.

The procurement office sent out requests for proposals to prospective providers. Evergreen Cooperative Laundry, the worker-owned commercial laundry business that started operations in 2009 with 12 employees as the first of the "Evergreen Cooperatives," was selected for the Cleveland Clinic opportunity. Evergreen Cooperative Laundry signed a three-year contract in 2018 with Cleveland Clinic and renewed the partnership with a new five-year contract in 2021.

Today, Evergreen Laundry remains the primary laundry vendor for Cleveland Clinic's entire northeast Ohio area. It maintains a 99% fulfillment rate while managing a large scale of operations, serving 200 sites with 162 delivery points, and processing 60,000 pounds of laundry per day and 1.5 million pounds per month. The hospital values the laundry's reliability and its performance on key performance indicators, and secondarily, it values the fact that, by contracting with the worker owned business, the hospital system is advancing its social mission.[211]

Evergreen Cooperative Laundry

The cooperative operates out of two locations. First, there is a newly renovated facility known as Collinwood, which is owned by Cleveland Clinic but managed by Evergreen. Cleveland Clinic renovated the site and upgraded the equipment there. Second is the original Glenville site a few miles away, which is owned by Evergreen Cooperative Laundry itself.

The 2018 contract with Cleveland Clinic necessitated rapid growth. When Evergreen Cooperative Laundry took over management of the Collinwood site, workers from the previous vendor were integrated, quickly growing the business from 50 to about 150 workers. Many of the new hires soon became co-owners.[212] The business has grown from $2.9 million in 2017 to $9.2

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[210] In 2021, the Cleveland Clinic served 2.9 million patients and generated over $12 billion in revenue. In addition, it runs hospitals in Florida, Nevada, Abu Dhabi, and London, and two clinics in Toronto.

[211] This statement is informed by 2022 interviews with Stephen Downey and Andrea Jacobs of the Cleveland Clinic.

[212] Wynette Bryant was Human Resources Director when they began operations at Collinwood. She says, "We hired over 100 people in 30 days, most of whom were former Sodexo employees. Many of them are still employed today and are cooperative worker owners."

million in 2021.

Workers and Owners

About 80% of the Evergreen Cooperative Laundry's workforce is African American. (Smaller percentages of the workforce are LatinX and white.) Workers range in age from 19 years to 73 years. A disproportionate number of employees are in their 40s, 50s, and 60s. Nearly 60% of the workforce is male and nearly 40% is female. Just 21% of workers own a home. About 55% own a car. Jobs include "laundry workers," drivers, technicians, leads, and production managers.[213] More than half of the 150 workers are owners.

Seventy percent of workers reside in the city of Cleveland; many are from the neighborhoods surrounding University Circle. Melissa Tate, who works at the Collinwood site, says, "A lot of neighborhood people work here. That's a great thing." Carla Beasley, who is based at the Glennville facility about 10 minutes away, agrees: "We're right in the neighborhood. We put a big sign up, and sometimes people just walk up and say 'Hey, can I put in an application?'" she says. "Some people walk to work." There are few or no other employers in the neighborhood offering good jobs. "You'd probably have to go into a different area of the city other than your own community" to find a good job, says Tate. One of the biggest community benefits of the Evergreen Cooperative Laundry, according to Tate and Beasley, is how it employs people from the immediate neighborhood.

About 20% of employees are returning citizens re-entering the workforce after incarceration. Wynette Bryant, an ordained minister and longtime prison minister, is the Manager of Culture & Wealth Building at Evergreen Cooperative Corporation. She is personally aware of the challenges that formerly incarcerated returning citizens face in finding employment. Wynette Bryant appreciates that at Evergreen Cooperative Laundry, "anyone is welcome to interview, and that includes those who were previously incarcerated." Evergreen is willing to consider giving job opportunities to people "who most people wouldn't hire," she says. So many returning citizens have been employed at Evergreen over the years, says Bryant, that she has had the experience more than once of new hires recognizing her from her volunteer work in prison.

Stephen Downey at Cleveland Clinic also notes the advantage that Evergreen, as an offsite service provider, has in being able to "hire folks who may not make our employee guidelines" which prohibit hiring people with jail time records. Indeed, many successful worker owners of Evergreen are ineligible to be hired directly by Cleveland Clinic under its current policies.[214]

New hires at the Evergreen Cooperative Laundry are trained to perform all jobs; no prior laundry-related skill or knowledge is expected or required.

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[213] According to demographic workforce data collected by The Evergreen Cooperatives; information provided by John McMicken, 2022.

[214] Evergreen workers do not come inside certain Cleveland Clinic facilities; they pick up and drop off the laundry on the docks outside at these facilities.

Path to Ownership

New hires start as workers and not as owners. The profit shares, patronage distributions, and many of the company benefits are reserved for worker owners only. To become an owner of the laundry, also known as a cooperative member, a worker must complete one year of employment and be in good standing with Human Resources. All proposed new members must be approved by the current members at the quarterly meeting. Once an individual is approved as a member by the existing members, she then has the opportunity to buy a share in the cooperative.

The cost of a share of Evergreen Cooperative Laundry is $3,000. How do relatively low-wage workers pay $3,000? First, members may pay for the share over time through a payroll deduction of as little as 50 cents per hour. Second, when an employee is elected into the membership, they receive a pay increase that covers the 50-cent deduction. This way, their paychecks often remain the same or increase even after the deduction.

Most worker owners take 2.5 to three years to build the $3,000.[215] Once a worker signs the paper to begin the process, they are immediately considered worker owners (members of the cooperative) with full rights. They share in profits even before paying a penny of their member share.

A worker owner retains the right to the accumulated value in their member share account. “That's always your money,” says Evergreen Cooperative Corporation CEO John McMicken. Upon any type of exit, 100% of that share value is refunded to the worker. “It's protected at 100% of value; if you put $1,000 in, you're getting $1,000 back,” he says.[216]

In addition to their member share account, each worker owner has a “patronage account” that accumulates profits over time.

Wealth Building through Profit Shares

Profit shares are known as “patronage dividends” in worker cooperatives. Patronage dividends are distributed to the worker owners of the cooperative laundry each year in March, once the end-of-year books have been finalized and the net profit for the previous year has been determined. Currently, 75% of this profit share goes into worker members’ patronage accounts and 25% goes home as cash for members to spend as they wish.[217] Only worker owners, not non-owner employees, receive patronage distributions.

Every employee owner has an account on the company's balance sheet that tracks their patronage over time; that value measures how much financial wealth each worker owner has

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[215] The $3,000 member share is specific to the laundry. Other Evergreen cooperatives have opted for different sized member shares; some have opted to make the buy-in less.

[216] The member share account is not adjusted for inflation, however. This works differently from many other cooperatives, where member shares are used to capitalize the business.

[217] The percentage breakdown is determined by the co-op board. Including profit bonus payments which are always paid via payroll, in addition to patronage, the ratio of profits placed into patronage accounts versus spendable is about 60% to 40%, according to John McMicken.

accumulated in profits.[218]

Patronage amounts are tiered based on tenure. The amount that a worker owner receives depends on how long they have been members of the cooperative. The amounts do not vary based on rank, salary level, or hours worked.[219]

Patronage Distribution per Worker Owner by Tier

2021 Patronage (paid in 2022)	
Tier 1 (owners two years or less):	$3,300
Tier 2 (owners two to four years):	$5,100
Tier 3 (owners four-plus years):	$6,800

Building worker-owner wealth through profit sharing is central to the ECC's mission. CEO John McMicken says it is the informal goal of his board and himself to see worker owners in all Evergreen cooperatives, including Evergreen Cooperative Laundry, each accumulates $65,000 in their patronage accounts over 10 years. They factor that goal into their feasibility studies, assessments of business plans, and strategic decision-making. For example, when they consider whether to invest in a prospective business to convert it into a worker-owned Evergreen cooperative, they look at that company's business plan and ask: Can this business model garner profits adequate to get its employee owners to $65,000 in one decade? Some businesses they have considered have had the potential for smaller amounts of profit sharing, but nowhere near enough to meet the goal of moving the worker wealth needle to $65,000 over 10 years. For that reason, they opted against acquiring them. "We look at a lot of business plans where that just doesn't work," he says.[220]

Profit Bonuses

In addition to the annual patronage distributions, profit bonuses tied to financial success criteria are distributed in paychecks twice per year. Worker owners only receive the bonus if they have collectively met the financial goal. "We wanted to move the money a little bit more

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[218] Patronage dollars are held in a capital account on the books for each owner. They are not invested. The capital account does not earn interest, but it is always protected at 100% value.

[219] This is unusual among worker cooperatives; many cooperatives allocate patronage distributions based on hours worked.

[220] The $65,000 goal does not include profit bonuses, or the portion of patronage distributions paid out as spendable. It refers only to the accumulated surplus in patronage accounts. One retiree who left a little over a year ago had been with the company for almost 11 years. The accumulated profit distributions in his patronage account cashed out for roughly $36,000, according to John McMicken. Those funds were tax free because taxes were paid when the money was deposited. Note, however, that for the first 5 years of this retiree's tenure, there had been no profit distributions because the company was not yet generating surplus. The laundry started to distribute patronage only in 2014. Therefore, the $36,000 represented the accumulation of only about six years of profit sharing. Today, longtime worker owners should accumulate more.

frequently," says McMicken. The bonus was implemented as part of the open book management approach they adopted in 2016 called the "Great Game of Business."

Two conditions must always be met, and sometimes three, for a bonus to be distributed to worker owners. The first condition is exceeding the budgeted net operating profit. The second is having sufficient available cash on hand to pay out the bonuses. Sometimes an additional financial goal tied to efficiency or quality must also be met. (Such a goal could, for example, relate to sales, customer satisfaction, or something else.)[221]

Financial goals are recommended by CEO John McMicken and approved by the laundry board. In most years since adopting this practice, the laundry has paid two bonuses, one in July and another in November. Only worker owners receive profit bonuses, although in some years they have voted to include non-worker owners in a profit bonus payout. [222] In 2021, the total profits paid out per worker were about $10,000 total, including patronage and profit bonuses, with some variation based on tenure.[223]

<u>Total Profits Paid to Worker Owners in 2021</u>

March 2021 Patronage Distribution (of 2020 surplus):	$560,000
July 2021 Profit Bonus:	$70,500
November 2021 Profit Bonus:	$129,900
2021 Average Total Profits Paid Per Worker:	$10,000*

* Includes patronage distributions and profit bonuses. The figure is approximate.

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[221] Weekly "huddles," meetings attended by staff with responsibility for specific numbers on a financial score card, help keep the company on the path toward its goals. Business-wide "huddles" take place monthly. Each employee with control over a "line," meaning a line with a target number on the financial scorecard, is present. These individuals are called "line owners." They review the actuals from the prior month. At site specific huddles at Glenville and Collinwood, staff members responsible for lines join a huddle for that site and report their numbers. Line owners are sometimes, but not always, lead or supervisory employees. "It could just be someone who actually knows the flow of what's going on," says Wynette Bryant. "We have a maintenance tech who comes to huddles who has been with the company for a very long time and knows what it takes, and he's the line owner for the maintenance. He knows if we've had a subcontractor come in; he knows the cost of that subcontractor in any subcontractor parts. We want someone like that, someone who's responsible. We would prefer it to be a co-op member, but it doesn't have to be." Huddles are key to the Great Game of Business approach, which was introduced to the Evergreen cooperatives by GGOB business coach Anne-Claire Broughton. Broughton points out that implementing Great Game of Business open book management "is a step toward self-governance for the worker owners. The financial scoreboards are basically condensed profit & loss statements focusing on metrics to which the worker owners have line of sight, in other words, areas where they can make a difference."

[222] Profits are shared across both work sites. Whether you work at Glenville, which employs just 43 worker owners, or at the larger Collinwood site, the same formula applies.

[223] Information provided by CEO John McMicken by e-mail in August 2022.

What does it mean to worker owners to get a share of the surplus on top of their wages?

To Melissa Tate, a laundry worker at the Collinwood site, "you save some money, then the other part you can spend. It's nice to have—you've got something to use now and something to look forward to." To Carla Beasley, a lead worker at the Glenville site, "It means a lot to me because I plan to join my family in Texas in five years. It's helping me reach a goal as a retirement account. It's like an extra savings. Every year I'm very grateful for our patronage."

Recent bonuses have been lower as a result of lower profit margins. That said, Carla Beasley remembers working for Evergreen Laundry before it partnered with Cleveland Clinic. At that time, they processed smaller volumes of laundry with fewer members and worked out of only the Glenville site. "I was here under our old co-op, and the profits were not what they are now. It was a smaller amount because it was only the Glenville plant at the time." The partnership with Cleveland Clinic and the profit sharing that resulted has overall been "wonderful" for her and other Evergreen Laundry worker owners, Beasley says.

Cashing Out

When a worker owner retires or leaves, in most cases the cooperative tries to pay their patronage accounts out to them within 60 days, although legally the company has discretion if needed.[224]

The company has 90 days to refund their member share (which will be less than or equal to $3,000), according to the company's bylaws.

Worker owners cannot access their patronage or membership accounts until they retire or leave the company. On the one hand, this preserves these accounts as sources of accumulated wealth. On the other hand, however, for low-wage workers navigating medical costs, housing costs, transportation needs, and emergencies with limited disposable income, having the ability to benefit from one's cushion of wealth can be essential.

Worker owners can borrow against their patronage account up to $1,000 per year, in two $500 loans, to address financial emergencies such as medical emergencies or utility shut-offs through a "micro-loan program."[225] They also have access to a loan program that allows employees to receive loans up to a maximum of $3,000, which are repaid over one year with no credit check. No more than 8% of their income may be deducted for repayment. This program has helped some workers to establish or improve their credit.

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[224] A rule that was designed in the lean early years to protect the company from a mass exodus technically gives the company up to five years to refund the patronage account.

[225] About half of the workforce is not yet an owner. How do these workers remain aligned with the work and motivated, without profit shares? Wynette Bryant explains that "mini games," a Great Game of Business technique, help to align the entire workforce with performance goals, including newer workers who have not yet become worker owners. These mini games include and reward everyone. However, the reward for a mini game is not financial. Rather, it's often something fun. Examples include an ice cream truck, a meal, or a bowling party. Also, if new employees have been there more than six months and are showing some potential, "We try to engage them in the huddle to learn what the line items are and how what you do affects it," explains Bryant.

Governance

A defining feature of a worker cooperative is that its major decisions are made democratically by worker owners, either directly or through some system of representation.

At Evergreen Cooperative Laundry, worker voice in governance works through two channels:
1) cooperative meetings for all members, and 2) worker owner representation on the cooperative's board of directors.

First, "Co-op Meetings" are open to all members and take place three times per year. The agenda is prepared in advance by a subgroup of worker owner representatives at a "pre-co-op meeting."

At co-op meetings, members vote on new board members and discuss and vote on questions on the agenda. One issue voted on at a recent co-op meeting involved whether to share profits with non-owners. The members voted against doing so because they saw that this removed the incentive for ownership. At another co-op meeting, worker owners voted to increase pay. The board, however, then reversed that decision because it was not feasible budgetarily. At cooperative meetings, management also reports a financial update. Both the CEO and general manager will speak.

Second, the nine-person board of directors, which includes four elected worker owners, also meets at least three times per year. Board meetings take place following every co-op meeting. Worker owners elect those workers who serve on the board of directors. The board includes worker representatives from both sites, Glenville and Collinwood, even though Glenville is a much smaller site. Elections take place annually, with each member casting one vote using paper ballots. Board terms are one year.

The board composition is as follows. Of the nine Evergreen Cooperative Laundry board members, four are worker member board representatives elected directly by the worker members. One board member is appointed by the Evergreen Cooperative Corporation. The four other board members are elected by the Evergreen Cooperative Laundry board. One such board member is a Community Representative and three are external stakeholders, typically industry experts.[226]

The board votes on the budget and financial goals drawn up by the CEO, and approves the new members who have been voted in by the full membership.

Wynette Bryant, the Manager of Culture and Wealth Building for the Evergreen Cooperative Corporation, schedules and facilitates all these different types of meetings—board meetings, co-op meetings, and the pre-co-op meetings—for all Evergreen cooperatives.

Wages and Benefits

The starting wage for a laundry worker, the lowest-paid job at Evergreen Cooperative

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[226] E-mail communication from CEO John McMicken, August 2022.

Laundry, is just $12 per hour. The wage rises to at least $12.50 per hour after six months and $13.50 at the one-year mark of employment. At five years, pay is approximately $15.00 per hour. The average pay across the laundry for hourly workers is currently $16.50 per hour.

Starting wage levels for Evergreen laundry workers are lower than typical pay for laundry workers in "general medical and surgical hospitals" nationwide. (Their median hourly wage was $13.91 in 2020.)[227] The average wage of $16.50 for all hourly workers remains lower than wages of the broad category of "laborers and freight, stock, and material movers" in Cleveland, who earn $17.02 per hour on average overall.[228]

Profit bonuses, which vary, typically add the equivalent of $2 to $4 per hour on top of wages. (Only members typically receive such bonuses. Non-member employees are not included.)

All employees work full-time, which is defined as 32 hours or more. In general, though, employees work 40 hours per week. While schedules are fairly predictable, specific schedules vary; some workers work from 9:00 a.m. to 5:30 p.m. Monday to Friday. Others work four 10-hour shifts, for example from 8:00 a.m. to 6:00 p.m. Others arrive early in the morning to prepare the pack room by delivering the linen before other staff arrive so that the work can start promptly. Under certain situations, employees may be expected to work longer hours if the need arises. Workers receive extra pay for working on holidays or overtime.

In addition to wage and profit shares, other benefits include:

- 401(k) with a company match up to 6% of pay contributed by the employee[229]
- Health insurance, including medical, dental, and vision
- Life insurance
- Long-term disability insurance
- Low-interest loans
- Paid time off (sick leave, personal days, and vacation which varies by years of service)
- Legal subscription services
- Credit, counseling, free tax preparation, financial literacy training

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[227] See: "Occupational Employment and Wages, NAICS 622100 - General Medical and Surgical Hospitals," May 2020 at https://www.bls.gov/oes/2020/may/naics4_622100.htm.

[228] "Cleveland Economic Summary." August 3, 2022. U.S. Bureau of Labor Statistics. See https://www.bls.gov/regions/midwest/summary/blssummary_cleveland_oh.pdf.

[229] Employee owners are automatically enrolled in the 401(k) with a 1% payroll deduction, which is matched by the company. That 1% increases over time, but employees can control it or choose to opt out if they wish. A home-ownership program previously assisted about 20 employee owners in purchasing homes, but has been paused.

- Criminal record expungement services
- On-site banking enrollment

There is no childcare or elder care assistance.

Straight wages are low, but when patronage distribution and profit bonuses (which combined averaged $10,000 per worker in 2021), plus benefits are added in, the total pay package and wealth accumulation potential are more substantial.

Wynette Bryant acknowledges, however, that it can be hard to retain workers who now have opportunities to earn $18 per hour at Amazon and other employers.

When three workers were asked what they liked about working for the laundry, Carla Beasley, a lead employee, said she appreciated that Evergreen Cooperative Laundry promotes from within. "I've worked in various positions" at the cooperative laundry, she says. "I appreciate how far I've come, from where I started to where I am now. They're always watching and they saw an opportunity for me. Instead of finding someone from outside, they let me know about it." Whenever a job comes available, qualified inside employees are offered the opportunity first.

Donald Lappin, a production supervisor, agrees: "Take me, for example. I started on the production floor. I worked the pack room. I drove a truck."[230]

Melissa Tate, who works in production and has been a worker owner for two years, appreciates that they have central air every day. The machines can reach 300 degrees. The central air conditioning helps "to maintain our cool. That really makes a difference." The temperature in the new facility is something "I really enjoy," says Ms. Tate.

Coordination

Given how integral the laundry services are to its operations, how does Cleveland Clinic coordinate with the Evergreen Cooperative Laundry?

First, key performance indicators (KPIs), metrics of efficiency and performance, are agreed to in advance and spelled out clearly in contract provisions. The KPIs cover: 1) fill rates, 2) on-time delivery, 3) quality and 4) percent of maintenance completed. There are also cost targets.

Second, a Cleveland Clinic liaison is designated to coordinate with the Evergreen Cooperative Laundry. That liaison, who has industry-specific knowledge, visits Cleveland Clinic in the morning to learn the hospital's needs and priorities for the day, then spends much of the rest of their work time at Evergreen Cooperative Laundry. That individual is available to Evergreen whenever the cooperative needs to know something about the hospital side and vice versa. When the hospital has a question about activities on the laundry side, the liaison is the

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[230] Wynette Bryant describes promoting from within, when possible and appropriate, as "a goal. Not all good workers make successful supervisors; however, we do our best to train and mentor."

bridge.

Third, at quarterly business reviews, Cleveland Clinic and Evergreen Cooperative Laundry review the KPIs for the quarter and discuss any challenges. “The cooperative laundry has met their KPIs historically, very well,” says Downey.

As an example of the fine-grained coordination that can take place between Cleveland Clinic and the Evergreen Cooperative Laundry, Downey shares this story: “We had a patient tell us that they lost a phone in their linen,” he recalls. The patient reported this to the hospital immediately. “The liaison gets in touch with Evergreen. They tracked it down to the actual room bag, wherever it was in the laundry process. They found the phone and we were able to return it to the person.” The liaison is an employee of Cleveland Clinic. Liaisons do not manage the laundry. In other words, liaisons don’t tell laundry employees what to do. Rather, the liaison performs vendor management with a service provider that Downey considers a critical strategic vendor.

What Makes it Work from the Hospital Perspective?

Other healthcare institutions have shown interest in Cleveland Clinic’s partnership with the worker-owned Evergreen Cooperative Laundry. If Stephen Downey were to advise a supply chain head peer in another hospital system about adopting a similar arrangement, what would he say are some of the necessary preconditions for success?

From his perspective on the hospital supply chain side, success first requires cost competitiveness. , says Downey. “It may not have to be the cheapest option, but it does need to be cost-competitive. You can justify a small additional expense, but you can't justify, say, paying twice the going rate of another laundry facility.”

Second, he recommends having the KPIs clearly established. “Set up the KPIs upfront. Make sure that they are measurable. Run the business through them. Having good measures of performance allows everybody to stay on the same page,” says Downey.

Next, he believes it is important to focus on a labor-dependent area of work. From Downey’s perspective on the hospital side, the greatest value the cooperative model brings is “having an aligned and incentivized workforce.”

Finally, setting up a communication liaison—an employee to go back and forth with very clear communication pathways—is key. That person should have specific industry knowledge; the liaison to ECL is a laundry expert. “They know their way around the laundry business, and so when Evergreen has a challenge, our person understands what that is,” Downey says.

“I highly recommend this model,” he says, even if it requires a lot administratively for them, and from the laundry, to meet the KPIs and cost targets. “For us,” says Downey, “it was a commitment to community development and community success. Cleveland Clinic wanted a program that would help build the community, and we're willing to take the time and effort to set this up and make it work.”

Could Downey imagine expanding its anchor institution role into other areas of the supply chain, besides laundry?

"We've been in a number of conversations," he says. "We don't have an answer yet, but there are other areas in the health system that are labor dependent, for example, furniture repair or sterile processing." Cleveland Clinic is also looking at how to grow the Evergreen model in Florida, where they run five institutions.

Stephen Downey says this about Evergreen Cooperative Laundry worker owners: "They will tell you, 'It's *our* business. We are the ones delivering this contract and if we don't perform, our business won't survive, so we hold ourselves accountable to the KPIs because that's what's making our business successful with you.'" They hold themselves and their coworkers accountable for their performance to make sure they hit the targets. You get the best performance possible because of that," Downey believes. It's not that somebody somewhere, a boss, is enforcing the rules. "It's that the people are incented to hit the metric itself. It's their livelihood that is tied to it."

Limitations

The process of building the Evergreen cooperatives has been challenging. The cooperatives have at times been targets of criticism by observers.[231]

Some argue that there is a gap between practice and aspirations; that the reality on the ground has not lived up to proponents' dreams.

There is a second criticism. While a true worker cooperative is governed by its worker owners, worker owners at Evergreen Cooperative Laundry do not hold a majority of seats on the board of directors. In that sense, the laundry is not a model of pure worker control, nor does the CEO of ECC claim that it is.

A third criticism is that the starting wage rates for most jobs are lower than the $15 per hour minimum wage that Cleveland Clinic pays its own employees, and which is the minimum wage it recommends for its contractors. It is true, when the sizeable take-home profits are added to base wages, the resulting total combined pay is normally above $15 per hour for the worker owners—but profit shares vary and they do not extend to newer workers who are not yet owners.

Still, in a city with a 30.6% poverty rate, the model has grown a worker-owned business that employs workers from economically and racially excluded neighborhoods, many of whom are re-entering citizens who face barriers to employment.

Conclusion

The relationship between Cleveland Clinic and the Evergreen Cooperative Laundry has also attracted praise and interest as an anchor institution model. It shows that a large hospital system in a high poverty city can, through a long-term contract and close coordination, buoy a worker owned company that gives its hard-working worker-owners the opportunity to accumulate profits while having a voice in governance.

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[231] See a 2016 response from Ted Howard, President & Co-Founder of The Democracy Collaborative, here: https://democracycollaborative.org/learn/blogpost/correcting-record-evergreen-cooperatives.

In the context of persistent racialized poverty and the job quality crisis in the deindustrialized Rust Belt, and given the rising dominance of health systems as economic powers, the model captures the imagination. It shows that hospital systems can support worker owned companies in ways that benefit workers and communities through their contracting choices. It also shows just how much effort and intentionality such an arrangement can require.

By sharing considerable profits with its worker owners, the Evergreen Cooperative Laundry directs economic resources to workers who have been largely excluded from job opportunities generated by the hospital system that remains the state's largest employer. Worker owners who stay employed at Evergreen Cooperative Laundry over many years have the potential to accumulate tens of thousands of dollars in wealth.

The Evergreen Cooperative Laundry and its relationship with Cleveland Clinic are important foci for critical study in post-industrial America. The partnership is worthy of examination, not as a model of perfection, but as a serious attempt to redress deep structural failings of capitalism and bring tangible financial benefits to workers on the ground—through an anchor institution partnership with a worker-owned business.

Summary Table: Evergreen Cooperative Laundry

Employees	150
Members	Approximately 75
Year Founded	2009
Governance	Worker Representation on Board
	Cooperative Meetings
	Open Book Management
2021 Patronage Distributions (paid out in 2022)	
2021 Total Average Profits Paid Out per Worker	$10,000, varies by tenure
Starting wage for new laundry workers	$12.00
Average hourly wage for all hourly workers	$16.50

Obran Cooperative, LCA

Camille Kerr, J.D.

Obran is structured as a cooperatively owned holding company with a related financing arm. In the healthcare industry, Obran recently acquired a 50-person home health care business based in Los Angeles and the cooperative is under letter of intent (LOI) for a 100-person home health business serving the Bay Area. Outside of healthcare, Obran has acquired a logistics company based in Hawaii and owns two companies that it launched: a payment and benefits platform for freelancers and a staffing firm focused on placing workers impacted by the criminal justice system. With this unique model, the cooperative's leadership seeks to create quality jobs at scale, and in the process demonstrate the viability of building a cooperatively structured, worker-centered version of a multinational corporate conglomerate.

Structured for Growth

Joseph Cureton sowed the seeds of Obran Cooperative in 2016, when he co-founded Core Staffing, a Baltimore-based staffing company focused on placing formerly incarcerated individuals in employment. Core (which stands for [co]llective [re]-entry) offers staffing services in food service, warehousing, and light manufacturing to mission-aligned clients, primarily local nonprofits and foundations. In 2018, Cureton and a team of Black technologists in Baltimore launched a second enterprise, Tribeworks, a payments and employment platform designed to support freelancers of color and especially creatives.

Together, the members of Core Staffing and Tribeworks formed the founding cohort of 35 worker-owners who - in partnership with the operational staff - co-designed membership eligibility requirements and other aspects of governance design that are still in place at Obran today.[232]

Since then, Cureton and the Obran team have developed the cooperative into an ambitious, multi-sectoral conglomerate that owns four operating companies in three states, employing nearly 300 people and growing. Currently, the annual earnings at Obran are 90 times greater than the median revenue for a worker cooperative in the US today.[233] "This is just the beginning," says Cureton. "We want to be the largest worker cooperative conglomerate in the world."

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[232] For example, the founding worker-owners set the eligibility requirements for cooperative membership. Workers are eligible to become members after 90 days of employment by purchasing a $250 member share, which can be paid for with payroll deductions. On an ongoing basis, worker-owners are also required to contribute 1% of their payroll into their internal capital account.

[233] *The 2021 state of the Sector Report*. US Federation of Worker Cooperatives. (2022, April 20). Retrieved September 20, 2022, from https://www.usworker.coop/blog/2021-state-of-the-sector-is-available-now/

To achieve this lofty goal, every aspect of Obran is designed for growth. At the center of the cooperative is Obran Shared Services, which provides infrastructure for the conglomerate, including payroll and accounting services, a fund, and a real estate holdings company. Obran leverages these shared services to support each of its portfolio industries, of which there are currently three: health care, logistics, and employment services. Each industry has its own holding company (e.g. Obran Health) and a director that is responsible for the success and growth of that group.

Scale is built into the company's legal structure as well. The parent corporation is registered as a Limited Cooperative Association, a legal entity available in seven states as well as the District of Columbia[234], which combines characteristics of the limited liability company (LLC) and more traditional cooperative structures[235], allowing more flexibility than traditional co-ops for attracting investors while maintaining member control. For example, the board of directors at Obran currently includes five directors, one of which is chosen by investors. In a traditional cooperative, investors do not have any governance authority.

The parent company, Obran Cooperative LCA, is the only cooperative entity in the system. It is co-owned by Obran workers; both workers at the operating companies and those employed by the holding companies are eligible to become members. All of the subsidiary companies are LLCs or traditional corporations. However, the operational businesses have worker representation baked into the governance structure. As a result, workers at the operating companies vote for both the board members at the company where they work day-to-day as well as for the board of directors at the parent organization.

Onboarding New Industries

While Core Staffing and Tribeworks developed organically during the cooperative's start-up phase, Obran now has a formal process for introducing new subsidiaries. For each new industry, the group lead must prepare a thesis, which makes the case for adding that line of business into the cooperative's portfolio. Key considerations include: (1) the cooperative's ability to manage companies in that industry successfully; (2) the health and growth profile of the industry; (3) the potential for Obran to transform the jobs in the industry; and (4) the relationship of the potential industry to the existing portfolio and potential synergies. Once the board has approved a new industry, the group lead may bring proposals for acquiring or launching companies in that line of business.

Obran sources new deals in multiple ways. In some cases, an Obran team member with experience and passion in a particular industry drives the cooperative to identify potential

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[234] *Limited Cooperative Association act*. Limited Cooperative Association Act - Uniform Law Commission. (n.d.). Retrieved September 20, 2022, from https://www.uniformlaws.org/committees/community-home?CommunityKey=22f0235d-9d23-4fe0-ba9e-10f02ae0bfd0

[235] Pitman, Lynn. *Limited Cooperative Association Statutes: An Update*. University of Wisconsin Center for Cooperatives. Retrieved September 20, 2022 from https://resources.uwcc.wisc.edu/Legal/LimitedCoopAssoc.pdf

acquisition targets in that sector. In other cases, Obran's strategic partnerships lead to potential deals. For example, in 2020, Obran entered a partnership with Kaiser Permanente—one of the nation's largest healthcare plans with more than 12 million members[236]—to identify companies within Kaiser's supply chain that were a strong fit for acquisition. The purpose of the partnership is to promote resiliency and racial equity within Kaiser's vendor network. This partnership led to the creation of Obran Logistics and the acquisition of Courier Corporation of Hawaii (CCH), a 70-employee logistics company based in Honolulu.

Building the Thesis for Obran Health

Adam Rose joined the Obran team in the summer of 2020 after hearing Joseph Cureton speak on a podcast about Obran's innovative cooperative model. Bringing an MBA from Yale University, leadership experience at multiple Federally Qualified Health Centers (FQHCs), and an interest in social enterprise models that disrupt the inequities in our current system, Rose proposed home-based healthcare as a new portfolio industry for Obran, which he was prepared to lead.

In his thesis, Rose points to the deep flaws in the current healthcare system—high costs, low care quality, low patient satisfaction, and a burnt-out, underpaid workforce—as factors driving significant industry reform. Rose argues that this reform, which is largely focused on how payments can be structured to align incentives, is driving two major trends in healthcare. The first trend is a shift from inpatient to outpatient care. The second is a shift from medical care to whole-person care that integrates preventative care and social services. Both of these trends, according to Rose, support the proposition that the home-based healthcare sector, which is growing faster than any other part of the healthcare industry, is a good investment.

In addition to the market trends, the thesis argues that home-based healthcare will have a powerful social benefit, both for worker-owners and those receiving care. Mirroring the arguments made by other cooperatives in the healthcare industry,[237] the thesis states that Obran's opportunity is to create better care quality through better jobs. Rose also focuses on the potential for the cooperative model to "chip away at" the structural racism that affects both job quality and health outcomes for people of color.

Obran Health Acquisitions

Obran Health made its first acquisition in the Spring of 2022. The successful acquisition followed almost two years of pipeline building, due diligence, and one deal that failed to close at the last minute. The new portfolio company, Physicians Choice, is a home health agency based

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[236] *Kaiser Permanente: Year in Review*. (2022, August 15). Retrieved September 20, 2022, from https://about.kaiserpermanente.org/who-we-are/annual-reports/2021-annual-report/2021-the-year-in-review

[237] For example, PHI is the training and advocacy organization affiliated with Cooperative Home Care Associates, the largest worker cooperative in the US. PHI's tagline is "Quality Care through Quality Jobs." PHI's website states, "We believe that caring, committed relationships between direct care workers and their clients are at the heart of quality care. Those relationships work best when direct care workers receive high-quality training, living wages, and respect for the central role they play."

in Los Angeles with fifty workers. Founded in 1991, the company was an early adopter of managed care, and has established its reputation as a high-quality provider with its insurance clients. The selling owner of Physicians Choice was not interested in staying on long-term in her previous role. As a result, Adam Rose hired and now oversees a new lead of the company, who replaced the founding owner after a brief transition period.[238]

On the heels of this first acquisition, Obran is in the due diligence phase with a second home health company. This second agency, which is also based in California, has more than 100 workers, some of whom are based outside the U.S.

And Rose has reason to grow Obran Health even further. To align the incentives of Obran leaders with the scale-orientation of the co-op, each holding company director is eligible to receive significant incentive-based pay for growing the value of their portfolio. For example, Adam Rose can receive up to 20% of the increase in value of Obran Health in long-term incentive pay. That is, if Obran Health goes from a $5 million portfolio to a $15 million portfolio over the next three years, Rose could receive up to $2 million (20% of $10 million).

However, hand in hand with Obran's commitment to growth is its commitment to benefiting workers. In line with that value, workers at Obran Health portfolio companies must have at least 5% of their paycheck be disposable income for Rose to receive any incentive pay. Twenty-five percent of each worker's paycheck must be disposable income for Rose to receive the full incentive. Disposable income is one of the key metrics Obran considers when determining whether its workers are making a living wage, which is a core value of the cooperative's compensation policy. However, this metric, while clear and specific, is difficult to capture in practice; Obran has yet to fully determine how best to gather the data necessary to accurately measure disposable income.

Beyond disposable income, Obran has a set of metrics it measures to calculate member benefit across four categories: (1) Member Use Value: the tangible benefits (direct goods and services) that members receive from participation in the cooperative; (2) Financial Impact: the financial or monetary benefits that members receive from participation in the cooperative; (3) Experience and Power: members' lived experience at work that is derived from the cooperative's democratic structure and culture, and defined by quantifiable group-level measures relative to the occupation or industry average; and (4) Scale: total number of workers, businesses, and stakeholders reached. Each category has specific metrics, such as days of PTO per employee, health s per employee, worker participation in governance, wage ratios, and more.

Obran Capital

In each of its portfolio areas, Obran is targeting acquisitions from $5 million to more than $20 million. To finance these acquisitions, each deal has a unique blend of capital, including seller financing, senior debt, and preferred equity. Part of every deal, however, is Obran's

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[238] Obran will either "acquihire" (hire existing leadership through the acquisition process) the management of a newly acquired company or recruit and hire new management. In the case of Physicians Choice, the new manager was recruited and hired from outside.

internal capital source: Obran Acquisition Fund I. The fund, which has a target size of $30 million, is looking to make 7-10 investments over a 10-year period, with an average investment size of $700,000 - $2 million. Having an internal capital source allows Obran to fund uncollateralized working capital, which is often difficult capital to access. In a typical transaction, the group holding company (for example Obran Health) takes a loan from the Acquisition Fund, and uses that capital, along with loans, to purchase a majority stake in the company being acquired.

For example, Obran Health purchased Physicians Choice with a mix of equity capital from the Obran Acquisition Fund, senior debt, and preferred equity from Capital Impact Partners, a community development finance institution with a long history of cooperative financing. Obran's internal fund, alongside mission-aligned debt and equity providers, like Capital Impact Partners, allow Obran to combine a cooperative structure with an aggressive growth model.

Conclusion

Obran is an outlier in the worker cooperative community. Its unabashed focus on growth bucks against the "small is beautiful" approach embraced by many worker co-ops in the US. Through its unique holding company model and acquisition strategy, Obran has the potential to bring democratic worker ownership to the US healthcare industry (and other sectors) at an unprecedented scale. In its pursuit of becoming the largest worker cooperative in the world, Obran has adopted more conventional practices - significant incentive-based pay for executives, for example - that many worker cooperatives would not be comfortable with. The Obran leadership embraces the ways in which it varies from typical worker cooperatives, however. Existing in a hybrid space, Obran faces challenges distinct from those faced either by worker cooperatives or traditional holding companies. The innovative legal structure, impact measurement strategies, and compensation policies are just a handful of the ways that Obran is navigating these uncharted waters.

About the Authors

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