

REPORT

**Improving Home Care Employment Opportunities:
Assessing the Feasibility of Home Care Cooperative
Development in the Detroit Region, Michigan**

Just over five years since declaring bankruptcy, the city of Detroit now boasts a range of new businesses and amenities. Despite this remarkable economic rebound, Detroit remains the country’s poorest big city. There are two key ways to address this entrenched poverty: build pathways into work, and increase the number of jobs that promote economic self-sufficiency. The home care sector presents a unique case for enacting these strategies—given that there are a growing number of home care jobs available, but few pathways out of poverty for home care workers. This raises a question: can cooperative development help address these employment challenges in Detroit’s home care sector? This report examines the feasibility of cooperative development in Detroit’s home care sector as a strategy for improving job opportunities in the region, addressing the home care workforce crisis, and strengthening access to quality care for those who need it.

INTRODUCTION

In 2013, the city of Detroit submitted the largest municipal bankruptcy filing in American history, with an estimated debt of \$18 to \$20 billion.¹ Five years on, the city is showing remarkable signs of recovery. Through commercial and philanthropic investment, the city boasts a range of new businesses, housing stock, arts and cultural institutions, and other amenities. According to one journalist: “Detroit is reasserting itself as Michigan’s largest city, its economic and cultural hub. Businesses that left the city decades ago are returning. People who vowed never to enter the city limits again are coming back.”²

The city’s economic rebound is beginning to show an effect on Detroiters’ incomes: after not significantly increasing since 2000, the median household income in Detroit grew by 7.6 percent from 2015 to 2016, and 5.9 percent from 2016 to 2017.³ Despite this promising trend, median household income levels still remain lower than before the Great Recession (\$30,344 in 2017, compared to \$33,109 in 2007, adjusted for inflation)—and Detroit remains the country’s poorest big city, with a poverty rate that is nearly three times the national average, at approximately 35 percent.

There are two key ways to address entrenched poverty in Detroit: build pathways into work for those who are currently outside the labor force, and increase the number of jobs that promote economic self-sufficiency. The home care sector presents a unique set of opportunities and challenges in this regard. On the one hand, due to the region’s rapidly growing older adult population, there are more and more home care jobs available. With low barriers to entry, these jobs are a viable option for many workers who face challenges entering or re-entering the labor force. On the other hand, given persistently low wages and few advancement opportunities, most home care jobs do not offer a reliable pathway out of poverty.

There are promising examples of efforts in the Detroit region to change this status quo, however, including nascent initiatives to promote worker-ownership as a way to empower home care workers, improve their job quality, and ensure that they reap the financial rewards of providing high-quality services. Drawing on public survey data, stakeholder interviews, and published literature, this report examines the feasibility of cooperative development in Detroit’s home care sector overall. The report considers the composition of Detroit’s home care sector and the factors that influence it—including the local labor market, the home care workforce, and a range of other issues—to identify levers for cooperative development, as well as potential barriers or challenges.

This is one of three reports on cooperative development in home care that has been made possible by generous funding from the Ralph C. Wilson Jr. Foundation. The other reports focus on Rochester and Buffalo, New York.

METHODOLOGY

In the research informing this report, PHI integrated quantitative analyses of public datasets with qualitative interviews to develop a multi-dimensional understanding of home care in Detroit and the feasibility of cooperative development. The investigation was built around the following core

factors, identified from the research team’s prior experience with cooperative development in home care and the literature:

- Consumer demand for home care, to assess the scope of need relative to workforce supply;
- The home care sector, to understand the current configuration of services, regulatory environment, and payment streams, and the implications for new entrants to the market;
- Labor pool characteristics, to draw out issues that may impact the home care workforce;
- The home care workforce, including current size, projected growth, and demographic characteristics;
- Home care workforce development, including the training landscape and other workforce development initiatives;
- Recruitment and retention factors, including wages and benefits and the availability of full-time hours, opportunities for advancement, and other supportive factors;
- Employment and social supports, to assess the availability of supportive services for jobseekers and incumbent workers; and
- Business development resources, to evaluate the availability of specialized support for cooperative business development and operations.

Quantitative analyses drew primarily from the U.S. Census Bureau’s American Community Survey and the Bureau of Labor Statistics (BLS)’s Occupational Employment Statistics and Employment Projections programs. The American Community Survey was used to estimate consumer demand for home care services, as well as home care workers’ demographics, employment status, annual earnings, poverty status, reliance on public assistance, and health insurance status. The BLS Occupational Employment Statistics were used to analyze home care workers’ wages, calculated as a weighted average of median hourly wages by occupation. Median wages are preferable to mean wages, which are skewed by a small proportion of atypically highly paid home care workers. The BLS Employment Projections were used to estimate future demand for home care workers. The U.S. Census Bureau’s County-Based Business Patterns data were used to estimate the size and number of home care establishments, and the Economic Census was used to analyze revenue among for-profit and nonprofit home care businesses.

Unless indicated otherwise, all analyses using national datasets in this report focused on the Detroit-Dearborn-Livonia metropolitan division as defined by the BLS, which only covers Wayne County. Hereafter, this report refers to the area as “Wayne County,” the “Detroit region,” or simply “Detroit.”

Of note, because it was necessary to draw from several different public datasets to develop a comprehensive understanding of the home care sector in Detroit, the data presented in this report are not all from the same year. In every case, the most recent data available were used to offer the most accurate and current profile of the economy and home care landscape in Detroit. Endnotes are used to indicate the dataset and year for each data point.

Analyses included personal care aides (PCAs), home health aides (HHAs), and certified nursing assistants (CNAs) who are employed in the home care sector.⁴ These three occupational titles are

defined by the BLS Standard Occupational Classification system. Please refer to the Key Terms on page 5 for brief definitions of these occupations and industry codes.

In addition, the research team interviewed 10 stakeholders representing local government agencies, labor unions, home care providers, and nonprofit organizations and membership groups representing consumers and workers. Stakeholders were identified through existing PHI contacts, online searches, and snowball sampling, whereby each interviewee was asked to suggest other potential interviewees. Conducted by telephone during November and December 2018, the interviews were guided by a set of semi-structured questions developed at the outset of the research and then adapted for each interview according to the stakeholder's interests and expertise. Extensive notes were taken during the interviews, capturing verbatim quotes when possible, and then analyzed thematically using the core factors listed above as *a priori* codes. Italics are used throughout the report to denote direct quotes.

Finally, PHI selectively reviewed a range of local reports to enhance their understanding of the Detroit landscape and the feasibility of home care cooperative development in the region.

WHY HOME CARE COOPERATIVES?

Across the United States, a small number of agencies are setting a powerful example of democratic ownership within the home care industry. These include Cooperative Home Care Associates, founded in the Bronx in 1985 and now the country's largest worker-owned company, and 10 other home care cooperatives (7 of which have been established since 2012, indicating increased momentum in the sector). By embracing a worker-centric approach, home care cooperatives challenge the status quo in their industry: empowering workers as decision-makers, investing in their jobs and careers, and encouraging their long-term commitment to the business. As a result, home care cooperatives experience turnover rates that are less than half the national average (at 29 versus 67 percent).

Alongside other high-road employers, home care cooperatives are leading the way in improving job quality for direct care workers—and quality of care for the individuals they serve. However, their impact on the national home care landscape remains modest at this time. Home care cooperatives employ approximately 2,600 workers in total, which is only 0.1 percent of the nation's home care workforce. Just 2 out of 11 coops employ more than 100 people, while 6 have fewer than 20 employees. The two largest (Cooperative Home Care Associates in New York and Home Care Associates in Philadelphia) are the only cooperatives able to offer health insurance and other advanced benefits, and few are able to pay regular patronage dividends.

Overall, these figures indicate the inherent difficulty in launching home care cooperatives and bringing them to scale. But they also suggest an opportunity for leadership for entities committed to overcoming these challenges through collaboration and innovation, particularly through business conversions.

Source: Kazda, Katrina. 2018. "Home Care Overview." Presentation at the National Homecare Cooperatives Conference, Dulles, DC, November 14, 2018.

KEY TERMS AND SOURCES

The Home Care Industry in Michigan

Home Health Agencies: These organizations provide nursing care, home health aide services, and a range of other services (such as physical therapy, occupational therapy, speech therapy, medical supplies and equipment, social work, and/or nutrition services) on an intermediate or long-term basis, with reimbursement through Medicare, Medicaid, private payment, or certain health insurers. Home health agencies must be certified to participate in Medicare, but additional state licensure is not required in Michigan.

Non-Medical Home Care Agencies: Non-medical home care agencies provide personal care, homemaker services, and other non-medical supports to individuals who pay privately or with long-term care insurance and to Medicaid enrollees. The state of Michigan does not license non-medical home care services.

Home Care Occupations and Industry Titles in Government Data

Home care workers are classified into the following three occupations within the Standard Occupational Classification (SOC) system developed by the Bureau of Labor Statistics:

Personal Care Aide: Personal care aides assist individuals with activities of daily living (such as bathing, dressing, and eating), and often help with housekeeping, meal preparation, medication management, and/or other instrumental activities of daily living. Personal care aides may also help individuals maintain employment and other types of social engagement.

Home Health Aide: As well as assisting with activities of daily living, home health aides perform clinical tasks such as wound care, blood pressure readings, and range-of-motion exercises. They also provide dietary support and observe for changes in individuals' health and social conditions. Their work is supervised by licensed nurses or therapists.

Nursing Assistant: In the context of home care, nursing assistants perform the same work as HHAs (although nursing assistants are primarily employed in skilled nursing homes).

Data Terms and Sources

American Community Survey: This annual U.S. Census survey captures responses from millions of American households on a range of indicators, from demographic characteristics to education and employment.

County Business Patterns (CBP): This annual data report draws from several U.S. Census programs to provide industry-level data from counties and zip codes nationwide.

Economic Census: Administered every five years, this survey by the U.S. Census is the most extensive collection of data related to business activities, capturing responses from four million businesses across industries and geographic areas. Data are released four years after the survey is complete.

Employment Projections Program: This Bureau of Labor Statistics (BLS) program uses past industry data and expert guidance to make 10-year projections about the demand for workers by occupation and industry. Projections for even-numbered years are released every two years with a one-year lag time.

Metropolitan Division: Metropolitan divisions comprise one or more counties within a metropolitan statistical area (MSA; see below) containing a single core with at least 2.5 million residents. Detroit-Dearborn-Livonia, which only includes Wayne County, is a metropolitan division within the Detroit-Warren-Dearborn MSA.

Metropolitan Statistical Area (MSA): A geographic region with a high population density at its core and close economic ties throughout the region. The Detroit-Warren-Dearborn MSA comprises six counties: Lapeer, Livingston, Macomb, Oakland, St. Clair, and Wayne.

Occupational Employment Survey: This BLS survey reaches 200,000 businesses semi-annually. Each year, three years of pooled data are released for every occupation and industry from local metropolitan statistical areas to the national level.

Quarterly Census of Employment and Wages (QCEW): This BLS program publishes a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs available by detailed industry from counties to the national level.

KEY FINDINGS ON THE FEASIBILITY OF COOPERATIVE DEVELOPMENT IN THE DETROIT REGION

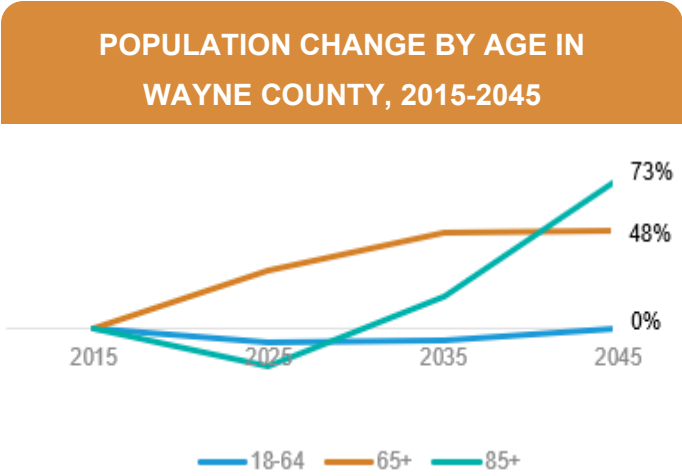
Consumer Demand for Home Care

Across the country, the need for home care is increasing rapidly as our population grows older and the balance of long-term services and supports shifts away from institutions to home and community settings.⁵

In the Detroit region, approximately 140,000 residents (8 percent of the population) experience difficulty with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).⁶ This estimate includes 1 percent of children under age 18 (5,400 individuals), 7 percent of adults aged 18 to 64 (79,900 individuals), and 22 percent of those aged 65 and older (54,700 individuals). While most of these individuals are likely to rely on unpaid support from family members or friends, research suggests that up to 23 percent or more may require paid assistance.⁷

Although there are currently more working-age adults than older adults with disabilities in Detroit (in absolute numbers), that balance will shift significantly as the population grows older. From 2015 to 2045, the population of adults aged 65 and over in Wayne County is expected to increase by 115,000, or 48 percent—and the number of those aged 85 and older will increase by 73 percent. During the same period, the population of working-age adults (aged 18 to 64) in the region is not likely to increase. Although economic growth in the region may affect this latter prediction—as new jobs attract more working-age individuals—there is still likely to be a mismatch between the escalating demand for home care, as the population grows older, and the diminishing supply of adults who can provide that care.

One workforce training stakeholder referred to this demographic shift as a “*crisis point*,” and suggested that population projections provide “*a clear data-based argument*” for undertaking collaborative action in an otherwise fragmented sector. Another stakeholder made a similar comment, stating that the scarcity of workers to meet consumers’ growing needs (described further below) represents a shared experience among home care providers, yet there are few spaces for these providers to problem-solve together. Such observations indicate an opportunity for a progressive provider, particularly one with a built-in democratic governance structure like a worker-owned cooperative, to convene other home care employers to identify strategies for addressing the workforce shortage in the region.



Source: Southeast Michigan Council of Governments (SEMCOG). “Wayne County - 2045 Forecast Summary.” <https://maps.semco.org/Forecast/>. Accessed 12/18/19.

The Home Care Sector

According to Medicare.gov, there are currently 40 certified home health agencies in Detroit, Dearborn, and Livonia (including 11 in Detroit alone). Because non-medical home care agencies are not licensed in the state of Michigan, it is not possible to get a reliable count of those agencies currently in operation in the Detroit region. As a proxy for this figure, national survey data from the U.S. Census Bureau shows there were 324 home care establishments in Wayne County in 2016, representing a 69 percent increase within a decade (up from 192 establishments in 2006).⁸

The Economic Census provides information about ownership status and revenue in Detroit’s home care sector. As this survey is only conducted every five years and released three to four years later, data from the 2012 survey are the most recent available. These data cover the entire Detroit-Warren-Dearborn MSA, as data are not available at the single county level. The Economic Census shows nonprofit establishments constituted just 13 percent of the home care industry in this region in 2012 (Table 1).⁹ On average, these nonprofit organizations had 39 employees and \$4.7 million in annual revenue. They were much larger compared to for-profits in the sector, which averaged 18 employees and \$848,900 in annual revenue.

Several factors differentiate nonprofit agencies from for-profit agencies. First, research suggests that for-profit agencies tend to have higher administrative costs but also larger profits than nonprofit agencies.¹⁰ Nonprofit home care agencies tend to offer better job quality, including higher wages, better access to full-time work, and higher annual earnings.¹¹ These findings support the notion that nonprofit agencies may be more worker-centered—and thus more amenable to transitioning to a worker-ownership model—than for-profit agencies.

Table 1: Characteristics of the Home Care Sector in the Detroit Region, 2012

	Percent of Industry	Revenue	Average Revenue
For-Profit Establishments	87%	\$918,358,000	\$849,000
Nonprofit Establishments	13%	\$770,200,000	\$4,725,000
All Establishments	100%	\$1,688,558,000	\$1,356,000

Source: U.S. Census Bureau. 2015. 2012 Economic Census of the United States, Health Care and Social Assistance: Geographic Area Series: Summary Statistics for the U.S., States, Metro Areas, Counties, and Places. <https://www.census.gov/data/tables/2012/econ/census/health-care-social-assistance.html>.

Agency size is also a factor when considering cooperative development in home care. The federal County Business Patterns survey collects annual data on business size. This survey shows that more than two-thirds (77 percent) of home care establishments in Wayne county in 2016 employed fewer than 20 workers, while 18 percent employed 20 to 99 workers and just 5 percent employed 100 or more workers.¹² The conditions for cooperative development in this region thus appear to favor consolidation and conversion of multiple smaller agencies into one or two large cooperatively structured home care agencies.

The sizeable and growing number of small home care establishments indicates a highly competitive home care system in the county, as noted by a number of stakeholders. One workforce researcher and advocate stated, “Michigan is no different than any other state—there is a proliferation [of agencies] here too, and they are all in competition with each other.” The workforce training

stakeholder quoted above said further that “*the home care agency landscape is so incredibly fragmented, it can be difficult to get steam built up*” to drive systemic changes in workforce development and service delivery.

In conversations with stakeholders, the Detroit Area Agency on Aging (DAAA) came up frequently as a key lever for improving the coherence and quality of the region’s home care sector. The DAAA is a nonprofit agency that serves approximately 300,000 consumers, including older adults and family caregivers, through a range of programs and services.¹³ The DAAA’s revenue of just over \$71,500,000 includes funding from the Older Americans Act of 1965, the Older Michiganians Act of 1981, Michigan’s MI Choice Medicaid home and community-based waiver, and MI Health Link (a program for consumers who are dually eligible for Medicare and Medicaid).¹⁴ Stakeholders noted that because the DAAA administers services through a network of providers, the organization is well-placed to promote certain standards and practices with regards to training, job quality, and so on. As one workforce training provider stated, “*they have a preferred network, they have complete autonomy over where to refer folks who don’t choose their own provider.*”

Given stakeholders’ comments about the role of the DAAA in the home care sector in Detroit, contracting with the agency may be an important way for a home care cooperative to generate revenue and advocate for higher standards in job quality and service delivery in the sector.

A small number of stakeholders mentioned managed care as a trend that may affect the home care sector in the near future. Medicaid LTSS have not transitioned yet to managed care in Michigan, but one home care agency stakeholder said, “*it’s a hot topic among service providers,*” with questions about when it may be introduced and who will be most impacted. A labor stakeholder raised managed care as an “*opportunity*” to invest in job quality in the long-term services and supports sector using “*not so much sticks as carrots,*” for example by using the procurement process to incentivize best practices. Consideration of a transition of Michigan’s long-term services and supports to managed care should be incorporated into planning efforts for a home care cooperative in Detroit, to ensure that the agency is prepared for any shifts in revenue dispersal—and primed to seize opportunities to promote cost savings and improve care outcomes through quality employment practices.

Labor Pool Characteristics

Within recent years, the Detroit region has seen significant job growth—adding, for example, 95,000 private sector jobs since the recession, after losing nearly 92,000 jobs during the recession.¹⁵ Health care and social assistance has become the largest industry in the area, accounting for nearly 19 percent of all private-sector employment.¹⁶

However, labor force participation remains relatively low in the region. In the Detroit region, the American Community Survey estimates that 59 percent of the adult population (aged 16 and above) is currently participating in the labor force (817,140 people).¹⁷ Among those participants, the unemployment rate was 5.4 percent in October 2018, which was 1.9 percent higher than the national average for the same month (and 0.1 percent higher than the unemployment rate for Wayne county in the previous year).¹⁸

With the population of working-age adults in Detroit contracting overall, this combination of low labor participation and high unemployment rates has further shrunk the city’s labor pool,

exacerbating the challenges employers face in filling open positions. Effective recruitment strategies must therefore take into account the factors influencing workforce shortages in the region. Labor force participation and employment rates vary considerably by demographics in Detroit, including by age and race/ethnicity.¹⁹ Unemployment rates are highest among young people: 25 percent of 16 to 24-year-olds are unemployed, compared to 12 percent of adults between the ages of 25 and 54.

Black/African-American residents of Detroit are less likely to participate in the labor force than white residents (56 percent participation compared to 61 percent) and they are nearly three times more likely to be unemployed (22 percent versus 8 percent).²⁰ Hispanic/Latino residents have a higher labor force participation rate (63 percent) but also relatively high unemployment (12 percent), while Asian residents also have a higher labor force participation rate (62 percent) but lower unemployment rates (8 percent) relative to other people of color.

Educational attainment is also a key driver of labor force participation and employment rates. Among people aged 25 to 64 without a high school diploma, a full 53 percent are not in the labor force, and 23 percent are unemployed. Those with only a high school education are still at a major disadvantage in this region: 34 percent are out of the labor force, and 15 percent are unemployed. Collectively, people with a high school education or less constitute 54 percent of unemployed adults aged 25 to 64. By contrast, 85 percent of residents with a Bachelor's degree participate in the labor force, and only 5 percent are unemployed—but it should be noted that only 30 percent of employed adults aged 25 to 64 years old in Detroit have a Bachelor's degree.

Comments from stakeholders suggest that the poor quality of public education in Detroit means that many students are leaving school without the basic literacy and numeracy skills that they need to succeed in employment; one local government stakeholder stated that half of all working-age adults *“have foundational skills gaps in math or reading.”*

Immigrants also constitute a significant but underutilized segment of the labor pool in Detroit. According to the American Community Survey, there are nearly 147,000 foreign-born residents in the Detroit area (8 percent of the population).²¹ Just over three-quarters of this population are of working age (16 to 64), while nearly 16 percent are 65 and over. According to the New American Economy, a bipartisan research and advocacy organization, Detroit is the tenth most welcoming city in America for immigrants (among the nation's largest 100 cities), ranking particularly high on measures of quality of life, economic empowerment, and job opportunities.²²

New immigrants who arrived in Detroit in 2010 or later are more likely to be unemployed than earlier immigrants who arrived before 2010, at 6 versus 4 percent.²³ Among recent immigrants, just 51 percent participate in the labor force, compared to 58 percent of earlier established immigrants. To note, language barriers may affect employment among this group: in the Detroit metro area, 46 percent of all immigrants speak English less than “very well,” including 59 percent of immigrants who arrived in 2010 or later.

Taken together, these figures suggest clear and pressing opportunities to reach out to workers who are not optimally engaged in the labor force, including young people, workers of color, and immigrants.

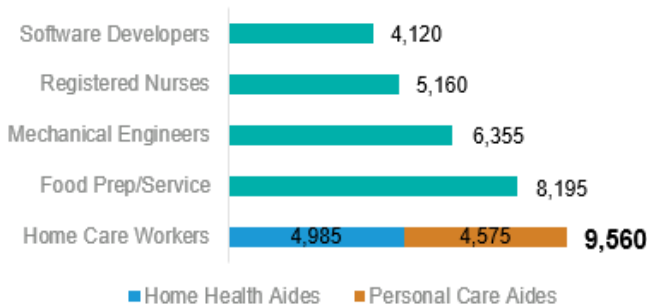
The Home Care Workforce

According to the most recent data from the BLS (2016), there are nearly 9,430 home care workers in the Detroit region, including approximately 3,490 home health aides (HHAs) and 5,940 personal care aides (PCAs).²⁴ Among Detroit’s home care workers, more than one-quarter (29 percent) are independent providers, which means that they work through a publicly funded consumer-direction program or through private hiring arrangements, rather than working for a home care agency.²⁵ (It is difficult to determine a full count of independent providers, however, as workers in private arrangements may not report their occupation on official surveys.)

The Detroit area home care workforce is predominantly female (86 percent) with a median age of 45.²⁶ Three-quarters of Detroit’s home care workers are people of color, primarily Black/African-American (70 percent). The majority are U.S. citizens by birth (95 percent). Fifty-three percent of Detroit’s home care workforce has a high school education or less.

Because the BLS only produces state-level employment projections, we turned to the Michigan Department of Technology, Management, and Budget for regional projections for this workforce. This state agency uses a geographic definition called a “prosperity region,” in this case the Detroit Metro Prosperity Region, which comprises Macomb, Oakland, and Wayne counties. These counties are expected to add 9,560 new home care jobs between 2016 and 2026, including nearly 5,000 HHAs and 4,600 PCAs.²⁷ This will include 4,815 new HHAs and 2,545 new PCAs. Home care occupations will collectively add more new jobs to the region than any other occupation.

PROJECTED EMPLOYMENT GROWTH FOR THE DETROIT METRO PROSPERITY REGION, 2016-2026



Source: Michigan Department of Technology, Management, and Budget. “Michigan Regional Long-Term Employment Projections 2016-2026.” <http://milmi.org/datasearch/projections-excel>. Accessed 12/18/19. (Occupational employment projections are not available at the single county level.)

Although the region’s home care sector is quickly adding jobs, the supply of workers to fill those jobs is limited by several factors, including a decreasing number of working-age adults and the demographic variations in labor force participation and employment, as well as job quality. As a result, as noted by several stakeholders, the region is already experiencing a home care workforce shortage.

The workforce shortage exacerbates competition between providers, on the one hand: in the words of a home care agency stakeholder, “*they are all vying for home care workers who are going to stay put, who won’t turn over.*” On the other hand, because this “*scarcity*” is the “*common thread*” between them, the workforce

researcher and advocate that we spoke with suggested that providers “*also understand that something has to shift if they’re going to get a qualified workforce*” and would likely be willing to share their experiences and ideas to help find a solution. For that reason, there appears to be room in the market to introduce new ways of conducting business as a home care agency, offering an opening to cooperative development.

Home Care Workforce Development

This section explores the training and workforce development landscape for home care workers in the Detroit region.

Training requirements and programs

Following the federal minimum standard, Michigan requires HHAs to complete 75 hours of training before obtaining certification, including 16 hours of supervised practical training. In contrast, there are no standard training requirements for PCAs beyond a two-hour safety and CPR training. The state's only stipulation is that PCAs who provide services through the Medicaid State Plan's Home Help program or the MI Choice home and community-based services waiver program must be trained to properly perform each task required for a given program participant.

Despite the lack of statewide training standards, there is both historical and current momentum in Michigan around training for PCAs. Michigan was one of six states awarded a three-year grant by the federal government to develop a training and credentialing program for PCAs through the Personal and Home Care Aide State Training (PHCAST) program, a provision of the Affordable Care Act. PHCAST partners in Michigan—which included the Michigan Office of Services to the Aging, Michigan State University, and PHI—created Building Training, Building Quality (BTBQ), a 77-hour competency-based training that targeted PCAs who provide long-term services and supports to older adults and people living with disabilities in the community. The curriculum was tested with nearly 400 workers in six regions of Michigan, and according to one workforce researcher and advocate, the *“findings were stunning in terms of increasing skills, knowledge, and job satisfaction”* but *“everything came to a stop when the grant ended.”*

The lack of funding for entry-level training remains a barrier to building a sustainable training system for home care workers in Michigan, including in Detroit. The same stakeholder said that although *“there's a lot of will”* to improve training, *“we have yet to identify a sustainable training model.”* She went on to say that *“agencies' margins are absurdly tight”* and they are struggling just *“to keep their doors open,”* much less invest in training and other job quality measures. Another workforce training stakeholder noted that there is a need to *“legitimize”* a training certificate for PCAs because otherwise, without statewide training requirements, there is no incentive for workers or providers to invest in it. One option would be for the city or the DAAA to *“put a stamp of value”* on such training.

Despite these challenges, there are a number of promising training initiatives in progress in Detroit and more broadly in Michigan that could help strengthen the pipeline of job candidates for a new or converted home care cooperative in the region. The PHCAST momentum has been sustained by the IMPART Alliance (Integrated Model for Personal Assistant Research and Training), which is based at Michigan State University. Initially funded by a two-year grant from the Michigan Health Endowment Fund, the IMPART Alliance aims to build an infrastructure in Michigan to support the development of a well-trained PCA workforce that is sufficient to meet growing demand. According to a workforce researcher and advocate from the IMPART Alliance, the organization aims (among other activities) to establish a caregiving training academy to provide BTBQ training for home care workers, as well as a certificate program for BTBQ “master trainers” and family caregiver training.

The IMPART Alliance stakeholder also noted that a community-based organization called Community Social Services of Wayne County is developing a high school technical training program that will implement the BTBQ curriculum, as well as incorporate job readiness training, job shadowing, and other workforce development components. Although the program will be piloted in Grand Ledge, Michigan, it may serve as a model that could be replicated in Detroit as well.

The Apprenticeship Institute (AI) is developing another potential home care training initiative in the Detroit area. Certified by U.S. Department of Labor as a Community-based Nonprofit Intermediary Registered Apprenticeship Sponsor, AI aims to develop an apprenticeship program for direct care workers that includes the following components:

- 20 hours of pre-apprenticeship training as needed;
- Initial placement as Medicaid-funded PCAs;
- 125 hours of training to become certified as HHAs;
- Additional training to become certified as CNAs;
- Monthly continuing education components for workers and family caregivers; and
- The option for HHAs to become worker-owners of a new home care agency, CompassionUS (described further in the “Business Development Resources” section).

AI proposes to partner with the nationally accredited Michigan Career and Technical Institute to deliver the 145 hours of training. Stakeholders from AI interviewed for this study emphasized the need to demonstrate best practices for staged credentialing for home care workers, given that there is currently “*no appetite*” for new legislation on training standards and career pathways for this workforce. They propose to fund their apprenticeship initiative through philanthropic support and workforce development funds, including from MI Rehabilitation Services and the Workforce Innovation and Opportunity Act (WIOA).

Comprehensive training and employment programs like those being planned by the IMPART Alliance and AI would be well-suited for partnerships with a cooperatively structured home care agency in Detroit, given the shared values between the organizations; through these programs, a cooperative agency would be able to access well-trained home care workers, and in turn offer quality employment opportunities. Scaling this work would also allow the organizations to track program outcomes and strengthen the case for the benefits of higher quality training and career development programs in home care.

Recruitment and Retention Factors

Michigan has a history of successful advocacy to promote home care workers’ rights and job quality, which includes forming a union of independent providers in the mid-2000s and passing wage increases for home care workers through the legislature in 2008. However, home care workers in Detroit continue to struggle to achieve financial security given their low wages, often part-time schedules, and low annual earnings. Additional barriers to maintaining stable and sustainable employment include a lack of affordable child care, transportation, and other employment supports.

Wages, hours, and benefits

According to 2017 data from the BLS Occupational Employment Statistics program, median hourly wages are \$9.64 for HHAs and \$10.33 for PCAs in the Detroit region.²⁸ Based on self-reported data in the American Community Survey, the median annual earnings for these workers is \$11,100,²⁹ as compared to \$31,100 for all workers in the region.³⁰ The median family income for home care workers is \$35,000. Statewide, home care workers' median annual earnings are \$12,700 and the median family income is \$43,500.

Low annual earnings in the region's home care sector are affected by workers' employment status as well as their hourly wages—given that a full 68 percent of workers in Detroit work part time. This is similar to the statewide average for home care workers (66 percent of whom work part time), but much higher than the national average for this workforce (which is 40 percent).

Given these figures, it is unsurprising that poverty rates are high among Detroit's home care workers. Approximately one-third (32 percent) live below the federal poverty line, while 63 percent live below 200 percent of the poverty line.³¹ Two-thirds (67 percent) rely on some form of public assistance, including food and nutrition assistance (56 percent), Medicaid (38 percent), and cash assistance (3 percent). Statewide, 26 percent of home care workers live below the federal poverty line and 55 percent rely on public assistance.

Notably, one in four home care workers in Detroit does not have health insurance,³² which is slightly higher than the state average for this workforce (21 percent), but significantly higher than the uninsured rate for all Detroit area workers (13 percent).³³ Among home care workers with health insurance, 44 percent have public coverage (including 38 percent who rely on Medicaid; the remaining 6 percent has Medicare or another form of public coverage); 30 percent have health insurance through their employer or union; and 8 percent purchase insurance directly. Offering health benefits to workers is one clear way for an employer to obtain a competitive advantage in Detroit's home care services sector—ideally through a collective purchasing agreement with other home care cooperatives or high-road employers, given the cost burden on individual employers. To note, health benefits do not necessarily substitute for a wage increase; one home care agency stakeholder reported that although their agency offers affordable medical, dental, and vision to all employees who work more than 30 hours a week, some workers opt to keep their Medicaid coverage (and work fewer hours) instead.

Several stakeholders stated that low wages drive turnover within the industry, despite many workers' commitments to the caring profession. For example, one home care agency stakeholder—a high-road employer that offers a range of benefits, supports, and services to its employees—said that turnover in their agency occurs “*not because people don't want to stay*” but because “*they have to exit, because they can't raise a family on the wages.*” The stakeholder from a Detroit-based youth program said that young people entering home care jobs share the same experience: “*we often find that [those who have been placed in home care jobs] show up here within first quarter of placement and want to look for jobs that make more money. [They say], 'Forget my hopes and dreams, I need to pay the rent.'*”

While higher compensation—without loss of benefits—is critical to improving home care jobs, it is not the only determinant of job quality that affects recruitment and retention in this sector. Among

the home care employers interviewed for this study, child care and transportation were named as the two key barriers to employment among their workforces, as well as the most challenging to address.

Transportation

Stakeholders reported that transportation was a key barrier to employment for many low-income Detroit residents. According to the Corporation for a Skilled Workforce: “even while 176,000 people commute into the city for work each day, a large majority of workers who live within the Detroit city limits (64 percent) commute outside the city to their jobs. Among workers who live in Detroit, 36 percent of those who leave the city for work earn in the lowest wage bracket (less than \$1,250/month as defined by data source), compared to 23 percent of those who live and work within the city.”³⁴ These figures indicate that the burden of private transportation in the region falls disproportionately on those who can least afford it. This includes home care workers—74 percent of whom drive to work, versus just 2 percent who use public transit (additionally, 5 percent walk to work).³⁵

Several stakeholders noted that the limited reach of the public transportation system in Detroit is a significant barrier for home care workers, given that the bulk of their services are provided in the suburbs. One home care agency stakeholder noted that transportation investment often “*gets on the ballot, but is voted down every time.*” Nonetheless, public transportation is one of the issues that the Mayor's Workforce Development Board (MWDB) is addressing in their efforts to move more Detroit residents into work. As the stakeholder from the MWDB's health care team noted, the number of buses in the city's fleet has increased, and the goal is to get even more buses running regularly “*so that people can reliably expect buses to come and get to work on time.*”

One recent success in addressing transportation barriers has been the Drivers Responsibility Fees Forgiveness program. Introduced in 2003, Drivers Responsibility fees were additional fines added to traffic tickets for certain violations, such as driving without proof of insurance. If drivers did not pay the fees, their licenses were revoked. The MWDB organized a statewide coalition to advocate for the forgiveness of outstanding fees, which were identified as a barrier to work for many residents. Bipartisan legislation was passed in October 2017 that would remove all such fees as of October 1, 2018.³⁶

Similar rule changes and investments at the city level, as well as employer-led programs, that are designed to improve access to work in Detroit could go a long way toward ameliorating barriers for incumbent workers and job seekers in the city's low-income communities. Given the amount of travel required of home care workers to get to, and between, client assignments, this growing workforce would benefit substantially from such initiatives.

Employment and social supports

Many low-income Detroit residents—including current and prospective home care workers—face multiple barriers to success in employment in addition to transportation, including foundational skills gaps, precarious housing, lack of affordable childcare, physical or behavioral health concerns, criminal records, and more.

While a variety of community-based organizations in the Detroit area provide assistance in navigating these barriers, their services are not centralized. The lack of coordination among these

groups was referred to as one of the “*main compression points*” by a workforce development stakeholder, resulting in a system that is “*incredibly fragmented*” and limited in its ability to comprehensively meet residents’ needs. The same stakeholder pointed to the fact that, for publicly funded services, “*there is not a one-stop shop,*” meaning that the services an individual receives depends on where he or she enters the system.

One high-road Detroit home care agency offers a promising example of support-services coordination: the agency employs a benefits eligibility coordinator who serves as a resource for employees—as well as their clients—in navigating an array of public assistance programs. As a stakeholder from the agency put it, their investment in benefits coordination for employees “*shows that we care about [our workers] as individuals.*” The agency also operates a 24/7 hotline that is available for any employee (regardless of hours worked) and their family members to receive support for challenges faced on-the-job or in their personal lives. Other agencies can follow suit in providing one-on-one assistance with a range of factors impacting participants’ employment, including assistance with transitioning from precarious to stable housing, accessing affordable transportation and child care, and developing financial literacy.

While implementing each component of an in-depth service provision program may not be feasible for a new home care agency in Detroit, leaders committed to building a strong home care workforce could learn from the success of existing community-based programs and employers. By implementing some onsite supports and links to other service providers in the region, a cooperatively structured home care agency would further strengthen its value proposition to job candidates and existing workers—giving it a better chance to succeed as a business and to meet the critical needs of its community.

Business Development Resources

Conversations with Detroit stakeholders yielded overwhelmingly positive responses to the prospect of home care cooperative development in the region. A labor representative said that the cooperative model “*fits the ethos of the place,*” including Detroiters’ interests in “*getting together and doing things on their own.*” Some stakeholders said that they did not think that people were aware of the cooperative model, with one adding, “*I think it has the potential to make an impact, I just think it’s not on people’s radars.*” A few stakeholders shared the sense that any resistance would stem from concerns about increased market competition, with a home care cooperative seen as potentially posing a business threat to existing home care agencies.

Detroit has networks in place to support cooperative development and the integration of a home care agency into the region’s business community. The leading resource for cooperative development in Detroit is the Center for Community-Based Enterprise (C2BE), a nonprofit organization that provides legal, business-planning, marketing, and employee-training expertise for worker-owned cooperatives and other community-based enterprises.³⁷ The organization aims to build a network of such businesses in Detroit, especially in historically underserved communities. According to the C2BE stakeholder that PHI spoke with, the organization considers worker-ownership an “*important tool in the toolbox*” for job quality that can be promoted from a number of different angles: “*It’s about job retention and job stabilization as well as community wealth development.*”

C2BE is a small firm with modest resources, but considers itself well-connected to a network of groups that can provide technical assistance and funding for new cooperatives. C2BE is currently supporting two home care cooperative development initiatives.

- For its first project, C2BE intends to launch a worker-owned certified home health care agency to provide employment opportunities for interested individuals who complete an HHA training and certification process. Their long-range plan is to incubate the agency, CompassionUS, then hand it off to its worker-owners. C2BE is interested in potentially replicating this model in other Michigan cities, including Pontiac and Flint. By providing a wage for cooperative worker-owners that exceeds the Michigan Works! requirement, the plan's stakeholders hope to secure WIOA funding for their training, as well as state funding from Michigan Rehabilitation Services, tuition funds for non-college-bound Aging-Out Foster Youth, and Supplemental Nutrition Assistance Program, Employment and Training funds (SNAP E&T).
- The second initiative supported by C2BE is being led by JARC, a nonprofit organization that primarily serves individuals with developmental disabilities through group homes, independent living supports, and in-home respite care. Its plan is to develop a primarily private-pay cooperative agency that provides respite care to families for children with special needs and in-home personal assistance services for older adults and adults with developmental disabilities. JARC aims to grow the cooperative to support 200 to 250 employees providing 500,000 to 600,000 hours of care per year (large enough as "*a force to be reckoned with*" but small enough to "*remain nimble, and still know everyone*," according to its representative). This could result, according to JARC, in a \$4 million annual profit, with workers seeing \$15,000 to \$16,000 more in their annual earnings than they would working for another agency. JARC's home care cooperative will launch with several factors in its favor, including JARC's status as a longstanding long-term care provider, its ability to deliver culturally competent services in Detroit's Jewish community, and access to an immediate pipeline of workers. Existing JARC employees will be able to supplement the 30 hours per week they currently work at the agency with 10 hours of care at the new coop.

The preliminary development of two home care cooperatives in the Detroit region could benefit new entrants into this space, helping to reduce any initial community resistance to the worker-ownership model and building momentum that other agencies can capitalize on. The launch of the C2BE-supported organizations could provide lessons for new businesses to learn from, as well as opportunities to collaborate to ensure that multiple layers of Detroit's client and worker base are appropriately served.

There are other resources that could be accessed to support the development of a home care cooperative in Detroit. One example is ProsperUS Detroit, which offers entrepreneur training, business services, and a micro-lending program "to empower low and moderate income, immigrant and minority individuals." Additionally, the Detroit Economic Growth Corporation provides expertise on Detroit's economic development landscape for both emerging and expanding businesses. There is also a local chapter of SCORE, a national network of organizations dedicated to educating entrepreneurs and helping small businesses start, grow, and succeed in partnership with the U.S. Small Business Administration.

DISCUSSION AND CONCLUSION

This report has examined core factors in the Detroit region that affect the demand for home care, the supply of home care workers, job quality and worker retention in this sector. This final section draws from these findings to identify key considerations for cooperative development in the region's home care industry.

Concerns about recruitment and retention dominate Detroit's long-term care employment landscape. More jobs are being added in home care than in any other occupation, yet due to a combination of demographic changes and poor job quality, home care employers cannot find enough workers to fill open positions. In addition to the challenges of supporting themselves and their families on low wages, Detroit's home care workers face a number of obstacles to sustained employment, including an inadequate public transit system that makes it difficult to travel the distances required to reach clients in neighborhoods surrounding the city.

Home care jobs have the potential to be a source of economic empowerment; the field has few barriers to entry, and demand for workers is high and only expected to grow. Elevating earnings, working conditions, and opportunities for growth in this field could positively impact hardworking Detroiters, alleviating workforce shortages and turnover costs, and in turn stabilizing care for those receiving long-term services and supports. Cooperatively structured home care agencies present viable opportunities for improving wages and job quality for workers in Detroit, and new ventures to convert existing agencies to this model would build on existing momentum in the region.

To promote quality jobs and quality care in the Detroit region through investment in home care cooperatives, the following are some important considerations.

- **Pursue a conversion strategy.** Converting an existing agency to a cooperative model minimizes the time and capital required for start-up, as operational elements like licensing, internal systems, contracting relationships—and potentially even a pipeline of experienced workers—would already be in place. Converting *profitable* businesses also maximizes financing possibilities.
- **Leverage existing training models.** With the BTBQ curriculum and other high-quality curricula and training models already in place and compliant with state regulations, a home care cooperative would do well to leverage these resources to prepare their workforce. Partnerships with workforce development organizations to develop training and job placement pipelines would help to offset a converted agency's training and recruitment costs and ensure a well-prepared workforce to support the success of the business.
- **Target supports to the needs of the labor pool.** This report outlines the array of barriers faced by low-income job seekers in Detroit that limit their ability to enter and sustain home care employment, including challenges with child care, transportation, and a fragmented social services system. Offering supports for job candidates and employees that address these barriers would distinguish a cooperatively owned home care agency from its competition, strengthen and stabilize its workforce, and reduce costs associated with vacant positions and high turnover.
 - Child care: By establishing partnerships with community-based organizations that offer affordable child care and assistance accessing child care subsidies, the home care agency will be able to refer job candidates and workers who are unable to afford market-rate care to access these resources as they build their work schedules.

- Transportation: New and innovative approaches are required to ensure Detroit home care workers can affordably reach their clients. In the near term, employers could offer solutions piloted in other states, such as an affordable car-leasing program or agency-sponsored van service, to help lower workers' costs, maximize their hours, and ensure consumers have access to stable, consistent services. Over the long term, home care agencies should leverage the size of their workforce and businesses to join advocacy efforts in support of greater investment in public transportation at the city and state levels.
- Connections to community supports and benefits: Navigating public benefits and the patchwork of community-based organizations that support low-income Detroiters is a significant challenge for home care workers as identified by multiple stakeholders in this research. By establishing relationships with organizations that help to streamline residents' access to these services, such as Community Development Advocates of Detroit (CDAD) and SER Metro-Detroit (for younger workers), a home care cooperative could integrate referrals to these services into its recruitment and retention support systems. Another option is to follow the example of one local home care employer and create an in-house staff position dedicated to assisting workers in maximizing their use of available benefits and community supports.
- Engaging immigrant communities: Detroit is home to a growing immigrant population, but workforce participation rates among this group are relatively low, despite the city's reputation as welcoming to those born outside the United States. Recruiting immigrant workers to home care employment could help address the region's workforce shortage and increase the availability of culturally and linguistically appropriate care to those needing long-term services and supports in Detroit's immigrant communities. To support this effort, a home care cooperative could establish partnerships with community-based organizations that provide support with English language and literacy development, cultural competency training, and legal assistance.
- **Demonstrate career pathways.** By creating career advancement opportunities, and thereby improving home care workers' compensation through higher wages as well as profit-sharing, a cooperative home care agency could gain access to workforce development programs and funding sources. Career advancement can take a variety of forms, such as promotion into senior aide roles and other positions that leverage home care workers' contributions to care in innovative ways, as well as promotion into administrative and clinical compliance roles.

In conclusion, the findings in this report demonstrate how a home care cooperative could help the Detroit region attract and keep workers at a time when a workforce shortage in the region is already hindering quality of life older adults and people with disabilities. The cooperative employment model would also offer Detroit's home care workers better jobs and opportunities to achieve economic stability, enhancing the appeal of this sector for those seeking work. Through a strategy of converting existing agencies to a cooperative structure and implementing a range of worker-centered employment practices, investors seeking to improve opportunities in Detroit could meaningfully impact quality of life for the local home care workforce and those they serve.

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PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care. Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

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