Asian Health Services: Rediscovering a Blue Ocean

Too Many Ideas for the Future

In a brief pause during a meeting with her direct reports to prepare proposals for the summer board meeting, Sherry Hirota, chief executive officer at Asian Health Services (AHS), a not-for profit community health center in Oakland, California, glanced out the window at the container ships embarking on travel across the Pacific Ocean. "What was that book you read about blue and red oceans?" Hirota asked her chief operating officer Deepak Maitra.

Maitra explained, "In 2015, authors Kim and Mauborgne named their idea *Blue Ocean Strategy*. The blue ocean is a metaphor for the desire to create large, wide open, and uncontested markets in contrast to red oceans that are bloodied from markets that are intensely competitive and characterized by losses and participants who get hurt. The objective is to shape corporate strategy to create markets where customers believe there is only one best provider, and in so doing, the business avoids costly incentives to match competitors' offers."

Hirota reflected on the idea after she heard reports of AHS's major achievements over the past year. AHS had secured a $3 million anonymous donation to expand primary care services. They decided to expand a few new programs and services such as pediatric dental, a bilingual Burmese patient care team, and cemented a partnership with a local community development agency to build a new dental clinic.

Her executive staff made various proposals for new or enhanced efforts to better serve their constituents (see Exhibit 1 for the AHS organization chart). Customer services needed more multilingual staff. The chief medical officer made a plea to improve incentives to retain physicians and other providers, as well as expansion of medical and dental clinics. There was no shortage of good ideas from others for new advocacy campaigns and additional health services.

Although everyone was relieved that their first full year was profitable after the Affordable Care Act (ACA) came into effect, no one believed that the challenges ahead were less threatening (see Exhibit 2 for AHS's Income Statements from 2010 to 2015 and Exhibit 3 for AHS's Balance Sheets from 2010 to 2015). The chief financial officer was adamant that a plan needed to be in place to better manage expenses to meet ever-decreasing reimbursements. Maitra was

concerned about the changing mix and character of their members, suspecting that gentrification might be displacing and harming them.

Hirota's attention returned to the task at hand: she needed to decide what proposals to include in a coherent strategy to present at the upcoming board meeting. She had to ensure that the proposals addressed the challenges that were ahead and confirmed a well-articulated strategy that was consistent with AHS' dual mission of service and advocacy while generating sufficient revenue (see Exhibit 4 for the AHS mission statement).

Background on Asian Health Services

Founded in 1974 by a group of Asian American college students from the community, AHS drew inspiration from national and international efforts to change the world during the 1960s, such as the civil rights movement and student movement at University of California at Berkeley against the war in Vietnam. In particular, they lamented the lack of health care in the Oakland Chinatown area, and that "the existing health bureaucracy felt there was no problem in the Asian American community" (Zia, p. 3).

"Our purpose wasn't to replace Kaiser Hospital or the public health system, but rather to provide a model of basic health care that wasn't being delivered and to do it in a way that was bilingual and culturally sensitive. Our plan was to use that as an entry to get into people's lives and help organize something bigger" (Zia, p. 4).

Initially a one-office operation with all volunteers, in 2014 AHS offered primary health care services through more than 66 exam rooms in five sites, two dental clinics with 9 chairs, and served over 27,000 patients totaling over 117,000 patient visits annually. AHS was a federally qualified health center (FQHC) that required 51 percent of its board members to be patients. Its staff was fluent in English and over eleven Asian languages, including Cantonese, Vietnamese, Mandarin, Korean, Khmer (Cambodian), Mien, Mongolian, Tagalog, Lao, Burmese, and Karen (see Exhibit 5 for language preferences of AHS patients). Its annual budget of nearly $40 million included a unionized workforce of about 300 employees. AHS had seven office sites and three owned and operated properties. As part of 1,600 other community health centers throughout the United States, AHS was a member of a variety of regional and national networks.

Impact of the Affordable Care Act

Five years after the historic passage of President Obama's Affordable Care Act (also referred to as "Obamacare" or the ACA) that required all US legal residents to have health coverage, the law had wide ranging impacts on health clinics. ACA ushered in a new era of health care: launching a primary care revolution, reinventing the delivery system to emphasize prevention and primary care, and pushing the health care system to deliver more accessible, patient-centered, and comprehensive care. FQHCs were projected to serve 40 million patients (Rosenbaum et al, 2010), save $122 billion in total health care costs, generate $54 billion in total economic activity, and create 284,000 new full-time equivalent jobs in local communities (NACHC, 2011).

As a FQHC, AHS treated patients regardless of immigration status, income, or insurance status. The biggest change for AHS was the introduction of 8,000 uninsured patients, 50 percent of whom transitioned into Medicaid in January 2014. This anticipated influx of new patients required two years of advance preparation of systems and operations.

AHS implemented a new electronic health records system to improve quality of health care and comply with a provision in the ACA. The system, a "short term pain" for a "long term gain," initially required AHS to reduce its patient services (and thus revenue generation), but ultimately enhanced its future services.

After the two years of preparation, AHS increased its patient and membership level by 25 percent and was signing in about 150 people per day. Georgina Tran, member services manager, remarked that once patients became members they did not want to leave. Staff members in her department were cross-trained; they became nimble enough to work either in various other departments or in other companies in patient services, accounting, or billing. Tran made it clear that what set AHS apart from its competitors was that working at AHS was really for those "who like working to help people, have a good heart, want to empower the community, and have cultural pride."

Although some of her staff had taken cues from a Massachusetts health advocate who went through that state's "Romney Care" (the initial legislative precursor to ACA), Hirota was inspired by a 2004 conference that AHS organized entitled "The Power of Community in Health." The conference helped highlight the role of community health centers (CHCs) in ensuring coverage for all immigrant families.

Quality Access and Patient Treatment

In addition to the challenges of serving a growing number of patients, ACA emphasized quality of care and a movement toward pay for performance rather than pay for visits. AHS was recognized by the federal Health Resources and Services Administration (HRSA) and received additional funding for being in the top 5 percent for high quality among clinics nationally (see Exhibits 6 and 7 for indicators of AHS quality). AHS's brand of service was known for its high quality care that was preventive in nature for low income, uninsured, and underinsured Asian immigrants.

The AHS care-team model focused on supporting patients before, after, and in-between physician visits to improve their overall health. The care team consisted of physicians, health coaches, nurses, mental health counselors, and case managers. However, HRSA noted that AHS's cost per patient was higher than other CHCs in the country. Although AHS needed to continue to justify the labor intensive care model, internal and national reports showed that the *total* cost of care was lower through high efficiency and prevention that helped lower patients' use of expensive emergency room service and hospital stays. As a result of their timely and appropriate care, health centers saved $1,263 per person per year, lowering costs across the total delivery system.

During the 1980s many people became concerned that Asian American issues were not receiving enough attention because of racial stereotypes of Asian Americans being the "model minority." Societal acceptance of this myth meant that doctors and government officials often believed that Asian Americans had no health problems and no need for special health programs or funding (Zia, p. 60). AHS' cultural approach counter-balanced the stereotype and ensured there was quality access and thus healthier patients.

AHS board member and patient, Rebecca Rosario, shared her experience. "There were few doctors that would see my case for specialized diabetes care. I ended up at Stanford Medical, where I was told that I needed a local pulmonologist, and so I went to Asian Health Services for treatment. After going to AHS, my diabetes level was reduced from 14.0 (an A1c level which could have resulted in losing a limb) down now to 6.8 (the recommended A1c level for diabetes patient is 7.0)."

The education component of the clinic's system was critical and was carried out through a team prevention approach. AHS used the Teamlet model that trained medical assistants to focus on effective communication and patient service skills, placing patients at the center of everything AHS did. Coupled with a Patient Navigator system that utilized the various language services and culturally specific

nuances of the patient, AHS delivered high quality experiences and service (see Exhibit 8 for an example of the process used).

Balancing a Dual Mission

Sustaining itself as a non-profit organization required AHS to delicately balance raising money on the one hand with providing quality social and advocacy services on the other. AHS strategically identified and cultivated new markets by establishing complementary advocacy campaigns that ultimately increased the organization's revenue, strengthened its mission, and provided for long-term sustainability.

One major strategic plan to enhance the lives of its members was to address the issue of public safety in the neighborhood by organizing a successful pedestrian safety campaign, *Revive Chinatown*! (Liou & Hirota, 2005). AHS galvanized local businesses, neighborhood groups, advocacy groups, public interest researchers, and politicians to regulate increased traffic and pedestrian safety at crosswalks in Chinatown. This sophisticated program drew on state and city funding for enforcement and renewed attention to the area's impact on the city's well-being. Therefore, AHS patients would feel safer getting to and from health clinics in one of the nation's largest cities. Next Revive Chinatown was focused on countering the effects of gentrification on AHS patients and the community.

Other new services added by AHS included caring for and advocating on behalf of nail salon workers, expanding pediatric dental services at schools, and treating Burmese patients in Oakland. The Burmese patients were mostly members of a refugee community that had been challenged trying to access the health care system, but became dependent on multilingual care and services available at AHS (Chang et al, 2014).

Sally Nguyen's work as director of community health and research perhaps exemplified this balance in the organizational mission. A daughter of a nail salon worker who developed cancer, Dr. Nguyen's passion to work at AHS helped start the nail salon collective that brought resources to improve the health and education of many low-wage workers in this industry, many of whom were Vietnamese immigrants. Subsequently, an expansion into new patients from Myanmar (formerly Burma) required Dr. Nguyen and her team to advocate within AHS and outside in the public health community. She assembled the institutional resources necessary to provide comprehensive primary care to a new patient population. Although internally funded, this project opened up a new area to seek grant funding and sharpened AHS advocacy position by better understanding the social determinants of health.

Strong Bonds with Stakeholders

One of the key stakeholders in AHS success was the employee union. In 1998, a union drive occurred because of the organization's growing pains and was intended to open up communication of front line staff's concerns to management. The vote to join Services Employees International Union (SEIU) was intended to re-open communications reminiscent of the consensus driven camaraderie of the early days.

Stella Han, the first president of the employee union explained: "I joined the union and decided to run for president because I felt that was the only channel to express to executive management that people care and we wanted to have communication and work collaboratively. When we started growing so rapidly during all the changes, AHS didn't communicate well with staff members. People had a really hard time understanding the changes" (Zia, p. 86).

Maitra explained, "The traditional relationship between management and union is typically one of a zero-sum game where gains are made at the other's expense. Furthermore, few community health centers are unionized." He continued, "One potential threat to stability is that a union may increase employee benefits at the expense of community health." Therefore, in the process of unionization, AHS leadership established a memorandum of understanding with the union that outlined important issues relevant to its employees, patients and the broader community including advocacy for immigrants, culture, and language needs. The agreement revealed management's desire to ensure that the broader community's issues would not be overlooked as the organization transitioned to a unionized workforce. This understanding, too, bound the union not only to employees but also to the local community. Employee satisfaction, enhanced benefits, and the union collective bargaining allowed AHS to sustain its operations with minimal turnover (Zia, p. 89).

In addition to the union, AHS senior managers routinely sought input from various community leaders. As required by law, more than half of the board members were patients and thus patients had formal representation in shaping goals and operations. AHS managers typically consulted with church pastors in the neighborhood, civic leaders, the city district representative, East Bay Asian Land Development Corporation (EBALDC), Chinatown Crime Prevention Council, and the Chinatown Chamber of Commerce. "Very often," Maitra began, "senior managers also met with the police department and the regional transit authority (Bay Area Rapid Transit or BART), to advocate on behalf of members and the local community. Recently, Sherry Hirota met with police and local businesses to coordinate efforts to curb graffiti and vandals."

Growth Breeds Challenges

Another of Hirota's biggest challenges was recruiting and retaining physicians, physician assistants, and nurse practitioners even though they were satisfied with the workplace. The providers tended to stay for 10 years before departing for either a higher paying job or one with a more generous retirement plan.

As part of the executive management team, Mike Wong was the chief medical officer. He had been at AHS for over 20 years, starting after residency from University of California, San Francisco, as a staff physician. He shared some insights into the organization's approach to hiring: "AHS recruits doctors who are idealistic, high-energy people. In particular, we recruit those who are early in their careers. We also have an internship program for medical students. Finally, we try to keep within 90 percent of the salary levels of our competitors, and make up for this 10% by offering benefits such as schedule and administrative flexibility, and adding people as co-authors for research grants," according to Wong.

When asked what factors went into assessing the staffing needs for AHS, Wong replied, "The primary factor is patient demand and then determining what ability a facility has – or needs – to provide for full support of services. Whereas AHS primary care has typically been provided for adults – particularly with the increase in demand for adult medicine in the past 5 years – now pediatrics has become in high demand."

He continued, "More recently, AHS's ability to retain staff has come under assault from rapidly rising pay in the area. AHS loses between one and two physicians per year from a pool of about 40 providers. Therefore, AHS is focused on hiring mid-level providers (nurse practitioners and physician assistants) but that has its own unique challenges. One challenge is how to support mid-level providers. The mid-level supervision support team is a gap here. AHS usually recruits early career people, develops them, and may lose them after 5 or so years to the larger agencies. Furthermore, AHS is expanding into the behavioral health field; the demand for the licensed clinical social workers (LCSW) providers is acute for us, because our patients require bilingual staff, and this is a difficult position to fill." Wong cautioned, "Hiring of fresh graduate students is ok, but at the supervisory management level we tend to lose out to other competitors."

The unique dual mission attracted some doctors to AHS, however. Esther Li-Bland, a family practice physician who came from Toronto, Canada was an example. Dr. Li-Bland's own family emigrated from Taiwan to Toronto when she was five years old. A high-school class on world issues opened her eyes to inequalities and injustices in the world. She bemoaned, "There are the endless hurdles we face trying to get our patients access to medications, tests, specialist

consults, and medical equipment." Nevertheless, as exhausted as she was at the end of each clinic day she said, "I feel a sense of satisfaction and peace because I feel I'm doing what I'm supposed to be doing, and fulfilling the reason I went into medicine."

Capitation and Alternate Payment Systems

Faced with financial pressure, AHS needed to find a way to compete more effectively to survive. In the past, clinics billed insurers for each service rendered but capitation in the future promised no more such payments. Instead, clinics were paid a fixed sum at the beginning of each period for each enrolled member (patient). Each clinic was therefore responsible for keeping the patient healthy. An unhealthy patient would quickly deplete the "capitated" revenue.

"Right now, we're still primarily on fee-for-service, though many of our patients are on managed care (see Exhibit 9). The trend is toward a fixed payment per patient with no reimbursement for additional visits. We are planning to become a pilot site for a state level program. We want to stay on the forefront and not be caught off guard. We're not sure what this means for us as a community health center and as a patient advocate," said Hirota.

A major factor that affected all managed care organizations was panel size – defined as the number of individual patients a provider cared for. Factors that affected panel size for AHS were the patient's age, gender, and health on one side and the provider's interest and acuity (skill, knowledge, and support) on the other side. Exhibit 10 contains a calculation for the ideal panel size for AHS. Panel size affected patient happiness and health outcomes and clinic workload and performance. Ideal panel size did vary by medical specialty as well (see Exhibit 11 for ideal panel size for the medical specialties at AHS). The actual data for AHS is provided in Exhibit 12.

Hirota stated, "One of the team's ideas was to join forces with other federal qualified health clinics in a network, which AHS helped create in the 1990s, to negotiate with the managed care organizations. In terms of capitation, the clinic is focused on primary care alone, or about 20 percent of the total healthcare costs." Hirota wondered, "Can AHS reorganize its care to reduce the number of face-to-face visits with providers, and provide services with other types of staff and instead use phone calls, email, and other means while maintaining the same level of quality? This is a delicate balance to manage with capitation. It is a simpler payment and billing method, yet a challenge when patient demand seems to

perpetually increase while revenue stays the same." See Exhibit 13 for a comparison between the payment models.

Board member Rebecca Rosario added another layer to the issue of a flat payment. Rosario honed in on the impact of doctor retention. Flat payments might eventually mean less competitive compensation to providers and when those providers leave, the capacity for patients to be seen would be jeopardized.

One approach that addressed capitation challenges was to use care teams to manage and prevent chronic conditions such as diabetes. Financially accounting for it, however, remained a delicate yet necessary balance.

Sustainable Financial Strategy

AHS was positioning itself to add new layers of financial sustainability. The new electronic health records system lowered the capacity to see patients last year but the current upsurge in ACA insured patients and expense reduction strategies helped move AHS from a deficit to a small surplus.

A former banking executive, chief financial officer Jeff Chang explained the future financial sustainability philosophy and noted a key distinction between not-for-profit and for-profit financing. "Our future concern is always sustainability and developing the tools to monitor this in advance – to not be reactive, but constantly being proactive and looking ahead. Relative to larger businesses, our resources are limited. The for-profit world has more flexibility. In the non-profit sector your financial creativity is limited to government funding and grants, mainly. It becomes a treadmill for us to maintain the balancing act. Productivity is another issue. Here we are trying to generate return based on quality of care and mission rather than profits for shareholders as a business." See Exhibit 14 for the decline in accounts receivables from private insurance over the past three years).

Chang used various strategies and benchmarks to maintain financial health. These included:

1. 90 days of cash on hand.
2. Generate revenues at 3 percent above the operational costs each year for sustainability.
3. Reduce patient appointments per day for the providers to prevent burnout while maintaining productivity benchmarks.
4. Maintain the current ratio of at least 1.5.
5. Focus on reducing expenses and increasing cost savings. For example, AHS converted its health insurance for employees to a Health Reimbursement Arrangement and reduced health insurance premiums for employees by over 10 percent and eliminated nearly all of out-of-

pocket cost for employees. The changes were projected to generate over $300,000 annually in savings.

6. Use tax credit financing to support capital expenditures. For example, AHS purchased its latest clinic site through new markets tax credit.

Challenges in Geographical Growth and Changing Demographics

The majority of AHS's 27,000 patients resided in the city of Oakland; however, a sizable proportion lived in nearby cities such as San Leandro, Alameda, and in southern Alameda County. Hirota remarked on the challenge of expanding into other cities: "We've submitted applications for a site in another city but the overall health shortage in that city is not as great as other parts of the state or country for us to be funded."

Dr. Wong nodded in agreement, "I remember too that the county board of health didn't allow a new clinic we tried to open in (neighboring) San Leandro. They explained that the Tiburcio Vasquez Health Center was already adequately serving the community."

Hirota continued, "As the Bay Area grows and Oakland in particular endures the newest phase of the exploding real estate boom, what is the long term prospect for our patients? Will they be forced out of here? For AHS, what if a big chunk of our patients is forced to locate somewhere else? Transportation is a key for senior patients. We need affordable housing. We need to grasp the depth of impact on our patients."

Georgina Tran, in charge of member services, added that a city economic development staff report showed that foreclosure rates were 10-20 percent in the city's District 2 (where Chinatown was located). In addition, census demographics reported sharp declines in children, minorities, and home ownership. Oakland is the 7th highest in the nation in terms of inequality," she concluded (see Exhibit 15 for information about Oakland).

The changing demographics raised a concern for Mike Wong as well. Many patients had gained insurance because of the ACA and they could choose to see any physician. He explained. "Older members used AHS in the past because they were poor and uninsured but now that they have the same insurance coverage as those in higher income groups, they may migrate to other physicians without worrying about additional out-of-pocket payments" (see Exhibit 16 for the changes in uninsured patients at AHS).

Others suggested adding child-care or hospice services into the mix of services AHS should offer. They reasoned that AHS might not be able to keep residents if they were forced out by landlords but the services would make it easier if work and care for children and aging parents were all in the same neighborhood.

Can AHS Find the Another Blue Ocean?

When operations first started in the early 1970s, language challenges and lack of health coverage were the greatest barriers to medical services. A blue ocean was created and generated out of racial inequality in the U.S. healthcare industry. Asians comprised 3 percent of the population in Oakland's Alameda County; thirty years later the Asian population was nearly 30 percent (Zia, p. 109). After decades, AHS was still striving to forge ahead with innovative strategies to ensure that it stayed relevant to its patients, the shifting demographics, and the relentless demands of a free market economy.

In an industry analysis, authors Shari J. Welch and Bob Edmondson (2012: 256) provided a *Blue Ocean* idea on the need to invent the future: " Intuitively, we know the areas in which the industry underperforms: overutilization, avoidable readmissions, poor communication, high infection rates, and service fragmentation. The strategic imperative before us is to anticipate future competitive forces and, looking across time horizons, to build the foundation for tomorrow's delivery system. We need to create markets rather than simply responding to existing demand."

In the End, Patients Come First

Throughout her thought process and decades of work at AHS, Hirota demonstrated an understanding that AHS had to be run not just as a not-for-profit bleeding heart operation, but also as a progressive business. The basic core principle of running a successful business – putting the customer first and ensuring the highest degree of satisfaction, came out as she thought about the intersection of operations and finances while delivering high quality health care. Additionally, it was about the social factors that affected the patients' health and employing approaches within the clinic to meet the patients' needs (e.g., interpreters to address language barriers) as well as policy advocacy (e.g., pushing government to better regulate workplace chemical exposures within nail salons).

After absorbing all the comments from her staff, Hirota closed the meeting with a remark: “The key for AHS is to have operations and programs such that patients choose us because they want to choose us, and not because there is no other option for care.” She had to decide which of all the ideas could be developed into proposals that merited board attention and how they could fit together coherently. Could AHS develop another blue ocean strategy?

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