

THE CURE

HOW WRIGHT L. LASSITER III SAVED AN INNER-CITY HOSPITAL PLAGUED BY MISTRUST, MISMANAGEMENT, AND MILLION-DOLLAR LOSSES

BY RUSS MITCHELL
PHOTOGRAPHS BY ROBYN TWOMEY



A

doctor is beaten and strangled to death by a patient, the body left on the floor for half an hour before a janitor happens across it. A mental patient hangs herself with her own clothes tied to the top of a toilet stall. HIV-infected blood is tossed out with the regular trash. *Wright L. Lassiter III was thinking, Why should I take this job?* There was more: Nurses who followed doctors' orders only when they felt like it. Millions of dollars in losses year after year. A culture that favored blame over accountability. A sad parade of feckless executives—10 CEOs in 11 years. *It was 2005 and Lassiter was next in line.*

Lanky, charismatic, and a rising star in the health-care industry, Lassiter could have become just one more executive casualty when he took the job as CEO of the Alameda County Medical Center in Oakland, California, and its flagship, Highland Hospital. Instead, he did what seemed impossible: He turned a shockingly mismanaged urban safety-net hospital system in one of America's most violent cities into a model for other public hospitals. He trimmed costs without any significant cutback in services—in fact, services have been greatly expanded. A new \$668 million hospital building is under construction. Six years on, the center has turned a positive margin every year but the last, when a new auditor required it to set aside more money for pension costs; so far, it is on target to break even this year.

No one is pretending that APMC is immune from the severe financial problems facing public hospitals. Atlanta's Grady Health System is facing a \$30 million shortfall. Miami's Jackson Health System is in even worse straits: It lost \$93 million in fiscal 2010 and is on track to lose another \$78 million this year; cash on hand is down to 19.6 days. Over the past 20 years, the number of public hospitals has declined by more than 25%, to 1,072. With federal budget cuts

looming, states going broke, and local governments preparing for the worst of it to roll downhill and bury them, public institutions are going to have to learn to manage better. Forty-seven-year-old Lassiter and his team's accomplishment in Oakland shows it is possible for even the most dysfunctional public hospitals to shake themselves awake, serving the public and respecting taxpayers' dollars at the same time. Says Thomas Rundall, a health-policy and management professor emeritus at the University of California, Berkeley: "It's a model for how a publicly owned hospital with a challenging payer mix can be profitable."

HIGHLAND SITS on a small hill above a low-income residential neighborhood in inner-city Oakland. Hidden by trees from the nearby freeways, it's barely visible to suburban commuters heading toward the Bay Bridge to jobs in San Francisco.

The site is an architectural hodgepodge: the cream-colored Spanish baroque towers of the oldest building, erected in 1927; a recently built clinical center wrapped in green glass; a huge gray block in the Brutalist style, slated for a teardown as the new hospital rises.

Walk inside, past the ever-present county-sheriff squad cars, and you may see some gangbangers and gunslingers, crackheads and crazy people, and the other stock characters who lend drama to every inner-city public hospital. Mostly, though, you'll just see sick poor people—mainly blacks, Latinos, Asians—the unemployed, and the working poor sitting under fluorescent lights, waiting for their turn to see a doctor or nurse.

"Ten years ago, if you said in 2011 I'd be working in a public-hospital system, I would have said, 'Not likely,'" Lassiter says. "A worthy cause, yes, but not my kind of thing." At 6-foot-5, he is scrunched against a little round conference table in his office at Highland; papers are strewn across his desk, reports and journals piled on the floor. It looks more like an academic's college office than the lair of a corporate CEO.

In 2002, he was climbing the executive ranks at a large private-hospital system in Dallas. Then the CEO of JPS Health Network in Fort Worth, which serves the poor and uninsured in Tarrant County, recruited him as VP of operations and charged him with making a system that never turns anybody away as good as any private one. A challenge that big, Lassiter decided, could be his kind of thing.

The son and grandson of ordained ministers, Lassiter had what he calls a "small-town Southern upbringing" in Tuskegee, Alabama. His father is an educator, his mother a nurse. Tuskegee in the 1970s remained starkly segregated, which Lassiter realized at age 12, when his family moved to Columbia, Maryland, outside of Washington, D.C. "My first day driving around, I saw blacks and whites holding hands as couples," he recalls. "I asked my mom, very innocently, 'Is that okay, what they're doing?'"

His own life revolved around the Baptist religion, school, and sports. He credits one basketball coach, "a white guy in his sixties who chewed tobacco and spewed expletives," with teaching him the joys of hard labor. The coach drove the team out to help on his farm. "Today, a white coach taking a truck full of black kids to work on his farm would get fired," he says. "But I got a lot of discipline from that."

He remembers the two months he lived with his father at a YMCA in Schenectady, New York, as the most formative period of his youth. His father had just taken a job as president of the local community college, and the family had yet to move into their new house. A star basketball player, he was greeted at his new high school as what the newspapers called "the Jumping Jack from Wilde Lake," and, according to his father, a red carpet "lined with pretty girls on both

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A HOSPITAL HEALS ITSELF

From top: In Dr. Taft Bhuket's two-and-a-half years at Highland, waiting times have been slashed. COO Bill Manns examines plans for a new \$668 million building. CEO Lassiter began by giving diverse teams of managers 16 weeks to save \$21 million.

IN HIS FIRST MEETING WITH THE UNION, LASSITER SAYS, "SOME OF THEM LOOKED AT ME LIKE I'D JUST LANDED IN A SPACESHIP."

sides" was rolled out. Living at the YMCA embarrassed the young Lassiter at first, but he now says it turned into "an unusual bonding experience" that kept him from getting a big head.

"I'm a professor of business ethics," says his father, Wright Jr., 77, chancellor of the Dallas County Community College District. "I've always emphasized he needs to be a good 'servant leader,' someone who's not into work simply for the personal benefit, but for the greater good."

Although Lassiter takes his father's advice seriously, he says that the "servant" idea can be misapplied in a public-hospital setting. "The attitude at a public hospital often is 'We're doing God's work. We get to feel good about being a martyr. Don't worry about execution. Don't worry about service. We're doing God's work.'"

As soon as he made his move from Fort Worth to Oakland, Lassiter made clear that God's work wouldn't get done unless the place stopped losing money and shaped up fast.

ACMC WAS A POSTER child for public-hospital dysfunction. The doctor's murder and the patient's suicide pointed out serious operational lapses, but the core problem was financial: Year after year, according to the Alameda County Grand Jury, the place lost millions beyond what it took in from the government, charities, paying customers, and other sources. (California is one of a handful of states that make grand juries the watchdogs of county government.) The grand jury described management as "a shambles."

CEO after CEO failed to stanch the bleeding, even after Alameda County voters passed a half-cent sales-tax hike to stabilize the system's finances. In 2004, the hospital board brought in Cambio Health Solutions to rescue the institution. Cambio's plan to cut 300 jobs and slash patient services was a political nonstarter. A one-day strike was energized by a visit from Jesse Jackson. Highland already was overcrowded; nobody in the community wanted services reduced. After 18 months and a fee of \$3.2 million, Cambio departed. When Lassiter signed on in 2005, the place was still losing \$1 million a month.

He quickly began building a new management team, including COO Bill Manns, who was hired from Providence Hospital in Southfield, Michigan, near Detroit. At Manns's suggestion, they immediately commenced a grassroots money hunt, which Lassiter now calls "the foundation of our success." The pair gathered the top 85 managers, formed them into a dozen teams, and gave them 16 weeks to find \$21 million in cost cuts and new revenue. Lassiter says he told them: "It's up to you. We barely know where the restrooms are, so we're not going to solve

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The Sharing Economy

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work for any car—not just a Daimler-made vehicle. Last September, Daimler's innovation group in Germany started piloting Car2Gether, which offers an app to match local drivers with people looking for a ride. Riders submit a request to a driver—who can be driving any kind of car, not just a Daimler—and both profiles are linked to their Facebook pages and Twitter feeds. After the ride, both driver and passenger rate each other. “We want to make this a social network on wheels,” says Michael Kuhn, project manager of Car2Gether, who doesn't even know if Daimler will—or can—commercialize the service. “It's all about access trumps ownership,” says Kuhn, sounding far more Silicon Valley than Stuttgart, Germany.

The carmaker realizes that sharing systems are going to be created whether it joins the party or not. “If you don't build a value cycle,” says economist Haque, “one will be self-organized. And it will commoditize you.” Whether it's moms opting to buy baby clothes from other moms through ThredUp rather than visiting Baby Gap, or neighbors borrowing a drill through NeighborGoods instead of going to Target, consumers—or, perhaps

more appropriately, citizens—are being connected in a way that cuts out the corporate middleman. “We often think about this stuff purely as secondary markets,” says Haque, “but I think there's a deeper truth here, which is we're learning we don't have to obey these industrial rules of producer versus consumer. We can take the stuff we have and cycle it.”

The sharing economy is at one of those interesting junctures where no one knows how big it might get or how many industries and companies it might affect. Best Buy and Lowe's, to cite two relatively unlikely candidates, have started to contemplate how it might impact retail. “I would say this notion of sharing is something we've been talking about in the last 12 months,” says Lowe's VP of new business development Jay Rebello. “Social networking is impacting the definition of what a community is, and, in the past, people wanted to accumulate more stuff. More recently, we're seeing people view that differently.” And in sectors like banking, where Wall Street's behavior has led to immense consumer distrust, disintermediation via sharing is becoming a reality. “We benefited enormously from the banking crisis,” says Giles Andres, CEO of Zopa, one of the several peer-to-peer lending sites, like Lending Club, that have emerged over the

past several years. “That was the catalyst for going from early adopters to a more mass-market crowd.”

“I think P-to-P banking is going to be hugely disruptive to the banking industry,” says Haque. He may be right. Still, it's hard to envision a big peer-to-peer market in \$1 million mortgages, for example. As he himself says, “The finance guys are proficient on maintaining their stranglehold on the status quo, trying to convince us that without them we'll fall apart.” But Haque's faith is based on the principle that's at the very heart of the new sharing economy: the resilience of distributed systems. He offers as parable the way that villages and communities survived the Irish banking crisis of the late '70s, during which bankers—yes, bankers—went on strike. They warned the public that the economy would collapse without a banking system. “What happened instead,” says Haque, “was a P-to-P banking system emerged out of nowhere. The local pubs became the de facto banks, lending money to their customers. If you think about it, who is a better judge of character in Ireland than the bartender?”

He laughs. “The economy did not stop growing—it didn't even falter.” ☺

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this problem. You're going to solve it.”

To encourage fresh thinking, Lassiter and Manns devised “odd-couple arrangements,” putting together doctors, nurses, techs, and other managers. The teams drilled into vendor contracts and challenged their own habits. Take the kit used to test newborns' umbilical-cord blood, a \$96.50 item. A simpler tool does the same job for 29¢. Is the more-expensive device better? How much better does it have to be to be worth the extra \$96.21? APMC had been choosing the premium option, at a cost of \$322,000 a year. Now, the teams decided, APMC could not afford it.

Looking for new revenue, they identified areas the system was especially good at—like rehabilitation and diabetes care—and came up with ways to treat more patients more efficiently. Lassiter also pushed the

creation of an electronic network that links dozens of community clinics to the health center, significantly boosting referrals to its best services.

Only after the teams had found every dollar in savings and new revenue did Lassiter and Manns consider layoffs. As a result, instead of the service reductions and hundreds of job cuts the consultant Cambio had recommended, APMC sliced only about 80 positions, found other work for many employees whose jobs had been eliminated, and began expanding services. Together the cuts and the revenue increases amounted to \$23 million.

“That's what really got the buy-in” from the unions on layoffs, Manns says. “We looked at everything else first. What can you say to that?”

“**WE KNOW** you're from Texas,” a union chief said to Lassiter at their first meeting. “Texas is not union friendly.” This was early 2005. Lassiter had been offered the job, but he hadn't officially started. There was still time to back out.

“Let me tell you my view, and I think we could really work well together,” Lassiter remembers responding. “At the end of the day, I'm more accountable to the employees than to the union. I've got to treat them well because there are a lot of places they can go work. If our focus is on the best care for patients—knowing employees have to be treated well to get

there—we won't have a lot of fundamental disagreement.” He recalls that “some of them looked at me like I'd just landed here in some spaceship. Like it was complete BS.”

Lassiter had never had to deal with unions in Dallas or Fort Worth because workers there weren't organized. Manns, with his Michigan experience, was steeped in union issues. In Oakland, the two men inherited a history of hostility between management and labor, represented by the Service Employees International Union (SEIU), and collective-bargaining agreements so restrictive that nurses could not be transferred from a department with a decreased workload to one that was understaffed. That meant hiring temps at significant cost.

Jim Hubbell was an emergency-room nurse at Highland in the 1980s when AIDS was on the upswing. Like many who choose to work in an inner-city ER, he enjoyed what he calls “cowboy medicine.” But “the place was completely dysfunctional,” he says, largely because it seemed impossible to fire anyone. “I had to leave because of conditions—blood-caked gurneys, soaked mattresses from a variety of bodily liquids. The housekeeping guys usually had a card game going.”

“It was hard to do something as simple as mount a TV monitor on the wall of a waiting room,” says UC Berkeley professor

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Rundall. "The question wasn't when it would get done; it was whether it *would* get done." When it finally became clear that the county might sell, decimate, or even close the system, he says, workers suddenly became more flexible. "It was a real fear of God."

As a result, management could make a case based on hard-core reality: We've raised wages to rough comparability with the private market. We've cut costs all we can and laid off as few as possible. We're not seeking high margins to please shareholders; we're seeking positive margins so we can remain in operation.

The unions gave some ground. For example, employees were filling up the multi-story parking garage connected to the hospital in the morning, leaving no spaces for clinic patients, who would circle the neighborhood hunting for spots, then arrive late. The patients fumed about parking; the doctors fell behind on appointments; the patients fumed more. After Manns made a case for putting patients first, the union agreed to use an off-site lot with free shuttles.

Both management and union leaders are reluctant to talk much about the biggest human-resources problem ACMC faced: how to get rid of people who refused to work. A longtime physician at Highland, who prefers to remain anonymous, says the major impediment to improving management and quality on the hospital floor was nurses who wouldn't do their jobs: "I'd say, 'Nurse, draw this man's blood,' and she'd say, 'Why don't you do it yourself?' And I would. This kind of thing happened every day before [Lassiter] got here." Most nurses at ACMC are highly professional, this doctor says, and "even they wanted those nurses gone."

Manns says that he and Lassiter would not use the layoffs as a cover to get rid of bad performers; the layoffs were made for strategic reasons. The firings were a separate matter. Neither Lassiter nor Manns will be specific about the terminations, but a hospital spokesman says that "dozens" of nurses were fired, a change that "made all the difference in the world," says the veteran doctor.

Fran Jefferson, field director and 28-year veteran at SEIU, declines to say how many employees were let go. "There has certainly been a trend toward much harder and much more frequent disciplinary action, including termination—not just the nurses but hospitalwide," she says. "In some cases, our members are not perfect and [the actions] are warranted. In other cases, we go to arbitration and have won several cases with back pay." She adds, though, that with "public hospitals closing all over the place," workers at

ACMC in general are a lot better off now. "The revolving door of CEOs was terrifying," she adds. "One after another, we had people with no vision who wouldn't stay. Wright Lassiter has done an amazing job. He has a vision about where public hospitals need to go."

TERRIE SCOTT, a thin-framed 61-year-old woman wearing a baseball cap, sits in the waiting room at Highland's endoscopy clinic. She's there to support a friend who's in for a colonoscopy. A lifelong Oakland resident, Scott has depended on Highland for health care for years. She'd come and wait and wait. "Oh, this place has really improved," she says, raising her eyebrows and nodding with enthusiasm. "The wait is so much shorter. The time is cut in half now."

Dr. Taft Bhuket, the 40-year-old gastrointestinal specialist who is treating Terrie's friend, was lured to Highland two-and-a-half years ago from a partnership in a private practice. "People thought I was crazy," he says. The public-hospital mission appealed to him, as did the chance to help Lassiter improve and expand services at Highland.

Shorter waits don't only make for happier patients, Bhuket points out. They also boost hospital income. The more patients that safety-net institutions serve, the more money they receive from the government. When he came to Highland, the wait for a routine colonoscopy could be as long as a year. Some 1,750 procedures were performed each year. Now, the department does 3,000 annually, an increase of 70%, and has cut the backlog in half, to four to six months, while ousting expenditure by just 15% to 25%.

Identifying the bottlenecks that made the improvement possible required Highland doctors, nurses, and technicians to do something they weren't used to: collaborate with one another. "Everyone was working on his own Gilligan's Island, doing his own thing," says Bhuket. "But people wanted that catalyst that Lassiter provided. The docs and nurses have been here for decades. The administration is bringing all the pieces of the puzzle together to get that synergy."

WITH MOUNTING pressure on Medicare and Medicaid spending, and with the stubborn recession pushing more patients into safety-net medicine, Lassiter and crew cannot breathe easy. "Cutting costs is going to be an ongoing struggle," says professor Rundall. "They'll have to take millions, perhaps tens of millions, out of the cost structure. That's going to be difficult to do."

The new federal health-care law is another wild card. If the individual mandate requiring everyone to have insurance survives court challenge, many ACMC patients will be free to switch to private doctors and

hospitals. So Lassiter must position his institution not just as a place that satisfies captive customers but also as one that attracts and retains customers who have a choice.

Ask Lassiter what his ultimate goal is, and he hesitates. He's afraid he'll come off as presumptuous, audacious. "I want to make this place as good or better than the private hospitals," he finally blurts out. Two hospital groups, Kaiser Permanente and Sutter Health, now dominate the Oakland area. "I believe ACMC has to be a real third choice in this community, a place where an elected official or a corporate executive would come for care," Lassiter continues. "It's not just the quality of medical service; it's the helpfulness. Are people looking you in the eye and saying, 'What can we do for you?'—anticipating your needs, instead of saying, 'Just go in the corner and wait. We have too many people to deal with today.'"

In other words, he wants to provide a level of service people don't expect when they enter a public hospital, or most public institutions, for that matter. So far, he seems to be on his way. **©**

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