Triage at Group Health: What Should Cheryl Scott Do?

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Executive summary

When Cheryl Scott took over as CEO of Group Health Cooperative (GHC) in 1997, the prognosis was not good. GHC was reeling from changes to a healthcare landscape that was shifting radically under its feet, and the organization was hemorrhaging money. These problems were compounded by the uncertainty of a pending alliance with Kaiser Permanente, difficulties stemming from an earlier alliance with Virginia Mason and the technology revolution that was taking place at the time. Additionally, GHC's membership enrollment and participation, at the core of its mission, had dropped precipitously. In this case study we look at how new leadership at Group Health could respond to these problems and usher in a new era of prosperity.

Problem identification and analysis

Group Health Cooperative was incorporated in 1945 by a group of consumers and physicians who modeled the organization on farmers' coops (Crowley, 1996). For years its members were very actively involved in GHC's operations. For example, in 1954, the plan's medical staff had to go to the state Supreme Court to be able to practice medicine in hospitals other than its own. "'The medical society wouldn't allow them to have privileges in hospitals,' [Cheryl] Scott says. 'Group medical practice was seen as a semi-communist plot, but our members stood by [our providers]. It's corny, but that was the kind of partnership they had, and it got them all through some tough times'" (McCue 2001).

Cheryl Scott became CEO of GHC in 1997. Scott was born and raised in Seattle, then studied journalism as an undergraduate. "But a four-year stint at a local crisis center-where she was shot at, had knives drawn on her and watched people die-changed her mind about how she wanted to earn her living (Benko, 2004). The field of healthcare had piqued her interest. "It was

clear to me that there was a real need for more leadership in healthcare," Scott says. "There were great doctors, nurses and therapists, but the management was uneven. By the time I left the clinic, I knew I wanted to pursue a career in healthcare ... because I saw it as a business with a heart" (Benko, 2004).

Scott returned to the University of Washington and earned an MHA. In 1979, she went to work as an associate administrator for Group Health. While there, she "developed a training program for middle managers and automated the information system, and established new cost-containment and quality-assurance measures" (Benko, 2004). She subsequently held several other high-level positions in the GHC organization.

When then-CEO Philip Nudelman left to become chairman of the Kaiser/Group Health holding company in 1997, discussed below, Scott took over as CEO. According to James Hereford, who was the Director of Service Quality at the time, “Cheryl had been groomed to be Phil’s successor, so she was the natural choice” (Interview, Hereford). The organization reacted very positively to Scott’s appointment. “Cheryl was viewed as the logical choice, and she was a capable, bright, energetic leader with tremendous people skills. She really knew everybody and had cultivated those relationships” (Interview, Hereford).

The magnitude and volume of the problems facing Scott were staggering. In 1997, GHC posted a $48 million loss (Lim, 1995). Poor planning decisions led GHC to rapidly expand its member base into sparsely populated (and therefore unprofitable) areas. At the same time, GHC's organizational structure left it vulnerable to intense price competition from other healthcare providers, including for-profit companies. "Many of these organizations are in better shape to compete" because they "contract services with networks of physicians and hospitals, giving them greater reach and flexibility" (Lim, 1995). Group Health, on the other hand, had

higher expenses because it was "the only HMO that owns everything it operates and employs all its doctors" (Lim, 1995). Increased competition allowed employers to resist GHC attempts to raise premiums.

Another important cause of GHC's dismal financial situation was the unfriendly climate of the healthcare industry. After a long process of studies by the Washington Healthcare Commission, "[i]n 1993, the Washington State legislature enacted the [Health Services Act (HSA)] to guarantee universal access to health care for all Washington residents, with caps on premiums as one of the primary cost-control mechanisms" (Jacobson, 1995). Part of that reform was to be implemented by shifting patients into managed care plans run by Certified Health Plans (CHPs), which would be the only option for purchasing healthcare. "The Act contemplates a significant expansion of managed care. In fact, CHPs will only be able to offer managed care plans - no traditional fee-for-service option will be available after July 1995" (Jacobson, 1995). GHC assumed that the healthcare reforms of 1993 would be permanent and planned accordingly.

These state-mandated changes to the healthcare market had a profound impact on GHC's business model, as many of the reforms were rescinded two years later. "In 1995, the Legislature acted to undo the governmental controls in the Health Services Act by passing ESHB 1046, the Health Care Simplification Act" (Washington Resource Council, 1999).

This massive upheaval in the marketplace invalidated Group Health's strategic plan. As discussed in Dessler, a strategic plan needs to provide "a comprehensive overview of the firm's situation today and of its companywide and departmental goals and plans for the next three to five years" (Dessler, 2004). As a cooperative, GHC's plan needed to reflect the goals detailed in the bylaws of the Coop, as well as the organization's bottom line. According to GHC's bylaws:

The Cooperative shall endeavor:

a) To develop some of the most outstanding hospitals and medical centers to be found anywhere, with special attention devoted to preventive medicine.
b) To serve the greatest possible number of people under consumer cooperative principles without discrimination.
c) To promote individual health by making available comprehensive personal healthcare services to meet the needs and desires of the persons being served and to reduce cost as a barrier to healthcare.
d) To place matters of medical practice under direction of physicians on the staff employed by the Cooperative and to afford strong incentive for the best possible performance on their part.
e) To recognize other employees of the Cooperative for purposes of collective bargaining, and to provide incentive, adequate compensation and fair working conditions for them.
f) To educate the public as to the value of the cooperative method of health protection, and to promote other projects in the interest of public health. (Crowley, 1996)

One of the ways in which GHC chose to deal with the changing landscape of healthcare was by forming alliances with other healthcare providers. These alliances, however, presented their own set of problems. One of GHC's pre-existing alliances was not sitting well with participating physicians. "The alliance between Group Health and Virginia Mason goes back five years, when the companies agreed to share staff and facilities to help cut health-care costs" (Beason & Batsell, 1998). But different philosophies and working styles, as well as facility-sharing issues had been frustrating for doctors. Hereford noted that the Virginia Mason deal "was carried along by momentum" rather than because it was necessarily "a good business deal. This lack of clarity led to a lack of execution which led to a lack of belief [in the partnership]" (Interview, Hereford).

As Scott took over, GHC was entering into an even broader alliance with Oakland-based Kaiser Permanente, one of the country's largest not-for-profit HMOs (Levine, 2003). This meant that in her first year on the job, Scott had to turn the company around financially while integrating portions of the two organizations. Additionally, many senior staff left to take

positions in the new holding company, Kaiser/Group Health, while others left because they felt the alliance conflicted with GHC's core values (Interview, Scott).

Another problem faced by GHC during this time was how to incorporate emerging technologies like the Internet and email into its business. Technology is expensive, and employees don't like changing their workflows for the latest computer fad. Also, members were beginning to demand more from GHC on its website. GHC was "tempted to listen to some really well-funded, well-intentioned people with poorly thought-out ideas about how healthcare could be delivered over the internet," according to Hereford (Interview, Hereford). The newness of the medium combined with GHC's recent financial woes to create a real leadership dilemma for Scott. Should she invest in unproven technology and risk wasting money or wait and see where things went and risk missing an opportunity to connect with members in a new way?

By the 1990s membership enrollment and participation had declined significantly. "The biggest challenge for our board is that people today don't have time to go to meetings," Scott says. "We don't have time to sit for three hours and figure out health policies and budgets. We are picking up the laundry, taking care of our kids, and in many cases, taking care of our parents. But the end result is that our form of consumer governance is being threatened because we aren't replenishing it with new members and new ideas" (McCue, 2001). In order to run as a coop, GHC needed its members to participate. It also needed them to enroll as and remain members. Being a member of Group Health was more expensive than comparable health care plans. GHC needed to figure out a way to give its members greater value.

Statement of major problems

As the new CEO, Cheryl Scott needed to figure out where to take Group Health from its current position. She needed to articulate her vision for the future of Group Health while

addressing the most critical threats facing the organization. First, GHC had lost a significant amount of money by expanding beyond its reach and banking on a shaky healthcare climate. Second, GHC was in the midst of negotiating an alliance with Kaiser Permanente, a not-for-profit company that was very successful financially but had a drastically different culture and worldview. Third, massive technological changes were presenting an unprecedented opportunity to connect more deeply and conveniently with GHC's members. Finally, membership enrollment and involvement had dropped significantly, threatening the structure and future of the cooperative model. What should Cheryl Scott do?

Generation and evaluation of alternative solutions

Financial crisis

- Scott can pull GHC out of areas that don't have a large enough membership population to be profitable. This means breaking a contract with people in a very personal, delicate area – people's relationships with their doctors. But if Group Health collapses as an organization, no one will have access to healthcare.
- Scott can search for ways to reduce GHC's overhead by cutting staff costs, consolidating operations and/or cutting member services and benefits. Perhaps some work can be outsourced. However, many of these cost-cutting measures would strike at the heart of GHC's core values and commitment to its employees and members. Also, GHC had some costly, divisive labor disputes in the late-1980s that really harmed staff morale. Cutting too deeply could permanently damage the relationship between the organization's administration and staff.

- Increasing premiums is another option. Scott could raise the rates either for employer-sponsored health plans or individual health plans, or both. This could be a gold mine or it could drive members to other health plans and be the death of GHC.
- Scott can transform GHC into a for-profit company and begin to run GHC as a business whose primary focus is on the financial side of healthcare rather than on bringing maximum benefit to members. This would mean completely severing ties with GHC's past. It is likely that many of the staff and members would leave due to philosophical objections. Benefits would have to be reduced or eliminated, alleviating many of the reasons for choosing GHC as one's health plan.

Unhealthy alliances

- If she evaluates the current alliances and decides they are worth preserving, Scott can work to fix the problems in these alliances. In order to do this, Group Health would need to align the goals of different organizations more closely and eliminate those areas of stress.
- If Scott decides the alliances are not working and not worth trying to fix, she can pull out of one or both alliances. This means throwing away all the hard work and financial investment already made in the alliances, but could save time and money going forward.
- One of the simpler things Scott can do is to try to communicate with members and staff about the alliances, seeking to alleviate some of the ill will and improve the alliances going forward. Because the issues surrounding the alliances are differences of such a fundamental nature, it is unlikely that just talking about things is going to make them better. But this strategy could buy Scott time to do a more thorough analysis before making any decisions regarding the alliances.

Technological crossroads

- Scott can encourage GHC to jump on the internet bandwagon and dive in to the new technologies. This would require a substantial investment at a time when the company is focused on returning to profitability. These new technologies do, however, offer an unprecedented ability to connect with members, improving member satisfaction and drawing in new members. Perhaps this investment will translate directly into higher revenues. There is also a possibility that an increase in productivity could lower operating costs. Because the technologies are so new, there is a substantial risk of making bad decisions and having to revamp completely as technology evolves.
- Scott can hold back and wait for others to take the lead. This is the fiscally cautious route, but presents a risk of being left behind. Members could defect to other health plans that offer easier and better access to information. By not acting, GHC also runs the risk of being seen as stodgy and not cutting-edge. This image could seep into its health care operations, leaving members unsure of whether or not they're getting the best health care. For most Americans, more technology equates to better medicine.
- Group Health's core competency is its focus on integration. Because it has access to all of a member's health information, GHC can leverage that strength and create a technology solution that gives members easy access to their doctors, as well as their health records. It can also create an information resource that truly benefits members' health, presenting them with user-friendly literature they can utilize at their convenience. As noted above, this requires a substantial investment in information technology. There are also serious concerns about privacy and information security. Providing members with such a rich information portal could make GHC a true leader in the healthcare industry.

Membership decline

- Scott can actively work to draw in more members. Having a larger number of members probably means more will actively participate, plus the additional revenue can be used to alleviate the financial crisis, as well as offer more services.
- Scott can focus on encouraging more people to participate as active members. As more members participate, it is likely that GHC's overall service will improve as input is gathered and changes are made to GHC's way of doing business. If Group Health pushes too hard, however, members may decide it's not worth it to be a member.
- Scott can change the structure of the organization such that GHC is no longer a cooperative. This, too, would mean completely severing ties with GHC's past and possibly alienating staff and members. It could, however, mean that GHC no longer has to expend energy on trying to encourage members to participate, but could instead focus on strengthening its customer service.

Recommendations

While improving the unhealthy alliances, bringing new technology into the organization and increasing member enrollment and participation can benefit the bottom line, Cheryl Scott's initial focus needs to be on returning Group Health to profitability. Once that goal has been accomplished, she can focus on the three remaining problems.

Financial crisis

To deal with the financial crisis facing Group Health, Cheryl Scott needs to first make a strategic change and pull out of unprofitable membership areas (Dessler, 195). GHC can no longer afford to expend resources in regions that are losing money. At the same time, with a completely new staff in place, GHC can generate some fresh ideas and new ways of doing

business, possibly allowing for some financial savings in operating costs. This is an area where Scott needs to have a clear vision and articulate that vision to her staff.

Unhealthy alliances

Scott needs, with the help of her executive team, to reexamine the existing alliance with Virginia Mason and use the lessons learned from that experience to decide how – and if – the alliance with Kaiser Permanente should proceed. The Virginia Mason deal is not really benefiting GHC, so it should be stopped. There seems to be a real mismatch between the core values of GHC and Kaiser, which raises some real red flags. This alliance is headed for disaster unless Scott and her team can find a way to align these values and goals more closely. This is another area where the organization's mission and goals need to be clear to everyone involved and Scott, as its leader, needs to show real vision and focus.

Technological crossroads

While Scott needs to keep GHC on the cutting edge, she should not overextend GHC in order to keep up with every technology fad. GHC needs to adopt technology solutions that leverage its core competency of integration and that satisfy staff and member needs. Implementing technology solutions could have a significant effect on both the financial issues and the membership issues by saving money and possibly improving member satisfaction.

Membership decline

While the financial problems are the most serious and could cause the immediate demise of Group Health Cooperative, the decline in both enrollment and membership participation is almost as serious and deadly. GHC members pay a premium to belong to the cooperative and need to get something in return. Scott needs to get more members enrolled by improving services and leveraging GHC's integration. Scott also needs to find a way to make GHC

relevant to its members' lives so they feel compelled to participate in the governance of the coop. In many ways, this requires Scott to focus on concepts of teamwork, as she needs to work directly with members to figure out how to get them more involved. As discussed in Dessler, "[u]sually, no one knows the job as well as the employees themselves" (Dessler, 342). The members themselves will probably have great ideas as to what would help them get more involved.

Implementation

Financial crisis

The first step toward solving the financial crisis is to pull out of the unprofitable areas. A thorough financial analysis needs to be done in order to be sure that coverage is eliminated in the correct areas. In conjunction with her new management team, Cheryl Scott needs to figure out what the precise priorities and goals of Group Health are. Expenditures that fall outside of these prioritized areas need to be examined closely and perhaps cuts can be made there to save GHC money. GHC should also try to raise rates, if at all possible. Market research that includes both primary and secondary data could be used to make this decision (Dessler, 103).

Unhealthy alliances

The first step is to pull back from the Virginia Mason alliance, as it clearly is not working. Next, Scott and her team need to examine the potential Kaiser alliance carefully and identify where the mismatches are. If GHC and Kaiser can agree on a structure for the alliance and the goals and values of the two organizations can be aligned, then the alliance should proceed. If not, then GHC should end the alliance as quickly as possible.

Technological crossroads

Cheryl Scott needs to focus on ways that GHC can leverage its core competency, integration, using technology. She should form a team of technology and operations experts who can examine where technology could help GHC connect more deeply with members, as well as increase the efficiency of its operations.

Membership decline

GHC's first step should be to find out what brings people to GHC as members and focus on improving on those core strengths. One thing GHC could do is to add additional benefits for members, such as easier access to doctors, better access to their health records and better access to health information. In order to encourage existing members to participate, perhaps GHC could offer incentives. For example, perhaps people who serve on the board receive a small discount on their premiums. Other possible incentives Scott could try are holding meetings at more convenient times, providing childcare, holding raffles, serving dinner and holding meetings online instead of only in-person.

In this area, perhaps a little communication could go a long way. Scott needs to convince GHC members that they really do benefit from being involved. A marketing campaign aimed at explaining why members should participate may produce strong results.

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