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:
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> 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?

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