

## Sentinel Event at the JCAHO

Clay Sherman, EdD  
Chairman, Management House

Modern Healthcare's stinging editorial of December 10, 2001 ("Time for a sentinel event at the JCAHO") called for the resignation of Dennis O'Leary, saying, "After 15 years of doing very little to make hospitals and other healthcare facilities safer for patients, the time has come for O'Leary to step down." It's hard to argue with the fact that most organization executives with so little to show by way of mission achievement would be so kindly preserved in their position. The high turnover rate among hospital executives shows that tough hospital boards understand what Peter Drucker said was their primary task—knowing when to fire the CEO. Has that time come for O'Leary?

The frustration Modern Healthcare voices with the JCAHO is understandable, and remains widespread throughout the industry. Since the 1995 revolt of several state hospital associations against JCAHO there has been little done to change the underlying fallacies in the logic that drives a long line of failed JCAHO programs. Driven by the agency's requirements, the industry has had to spend resources it could ill afford on various initiatives that went nowhere. Example: the Healthcare Advisory Board reported that JCAHO's much ballyhooed initiative for TQM resulted in an 85% failure rate. Mandating programs in organizations that were incapable of sustaining them is misdirection of the worst sort, notwithstanding the need for healthcare providers to radically improve quality.

There are really two problems here, the *management issue* of why JCAHO approaches don't work, and the *political issue* of why non results-getter O'Leary remains in place in one of the nation's most important healthcare organizations. Fixing the management problem of how to improve work processes is entirely doable. However, fixing the political blockage of the JCAHO-hospital-medical complex may be nigh impossible, especially when Tommy Thompson allows this brain-dead entity to be kept on economic life support.

### The Management Issue

Shockingly, the single biggest barrier to improving standards in American healthcare is the obsolete and inappropriate management standards promulgated by JCAHO. In my book, *Raising Standards in American Health Care*, I make the extended case of why old 20<sup>th</sup> Century ways of thinking no longer apply. Quality via accreditation is a ludicrous concept, with no evidence of its existence. For the hospital industry, JCAHO's "minimal standards" have resulted in a continuous stream of media scandals, and a declining image of healthcare in the public mind. When low standards are set, and when the higher standards requested by customers and professionals are not met, then the organization is doomed. As a result, many hospitals find themselves to be in a kind of K-Mart death spiral— following a losing business model, with too little change, too late. It is time to Think Different.



In other knowledge management industries like the internet, computers, and consumer electronics, standards groups are routinely convened to decide such things as HDTV standards. These are industry wide decisions made by producers out of the intellectual capital of those who do the work, not those of a sanctioned association group or government agency. The approach that has worked for them is two-fold: aggressively move toward *continuously higher standards* (a consumer driven objective favoring better and better products), and to require *standardization* in such things as connectors for memory. Standardization leads inevitably to higher quality, lower cost, and it encourages high innovation rates off a common platform. Rather than competing on the basics, the race is on for value added innovations that exceed those minimums.

Were the hospital industry to move in this direction, each profession would convene panels made up of researchers and field practitioners. Their task would be to reach a consensus of current best practices for all procedures—a far different list than practices recommended by JCAHO.

Those practices would then be posted to a national clearinghouse with computer updaters alerting field units weekly of any changes and automatically downloading of appropriate materials for communication and training. This is not unlike what a number of health systems have already started doing. Teach people what the best current practice is, then require them to do it. The widespread variation from best practices nationally is a patient killer, and the variation among producers a huge creator of cost. Even now, there is a strong movement among physicians to establish defined clinical protocols that are forcing corresponding changes among support professionals. Why isn't JCAHO at the forefront of this effort? Where is the leadership?

O'Leary has correctly stated that compliance with standards can no longer be voluntary. Were Secretary Thompson to tie reimbursement to compliance with best practice standards, organization behavior would change. The key to quality and cost control is to combine best practices, financial reward, and inspection worthy of the name. Whether JCAHO will be a player is questionable if they remain quiescent.

## **The Political Issue**

Certainly it is appropriate to ask why a chief executive with little results to show remains in place. The answer of course is that Dr. O'Leary *has* produced results in terms of quadrupling revenue growth. Modern Healthcare raises the deeper question of whether JCAHO's board really wants to improve patient care quality, or just field a window dressing campaign that substitutes an ounce of image rather than a pound of results. JCAHO's new headquarter's building suggests the affluence that derives from extracting ever increasing charges at the expense of organizations providing indigent care. But is this the success that these leaders really wanted to achieve? Is that all there is, or did they lose their way?

If JCAHO is to have a future, a new direction tied to the real world of managing is desperately needed. The shame of the overseers is that their lack of vision is derailing



the true glory of achievement that is there for the taking. Unless JCAHO's board is willing to put some new leadership into the organization, then one's worst suspicions are clearly confirmed—not the aggressive offense of substantive change for the betterment of care is wanted, simply a feeble effort at mediocrity with a defensive PR campaign.

What apparently has occurred at JCAHO is what besets most failed organizations: In the search for outcomes they have settled for some internally defined myth of success at the expense of their external mission. They have substituted activity for results, busyness for business. Such organizations do not survive. George Westinghouse wrote

No enterprise can exist for itself alone. It ministers to some great need, it performs some great service, not for itself but for others, or failing therein it ceases to be profitable and ceases to exist.

I've never been able to figure out why anybody in healthcare leadership would ever tolerate losing performance. All I know is that many do, including Mr. O'Leary.

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