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While the “normal” stages of change include denial, resistance, exploration and commitment, hundreds of organizations are now emerging from a decade of being stuck in the denial and resistance stages. These emerging Second Curve healthcare organizations are now engaged in redesigning their core systems and processes – based on these new assumptions.

Today, issues around patient safety, adverse events and leveraged use of resources are creating extraordinary pressure for change externally. Internally, staff satisfaction rates and a desire “to do better” are adding to those external pressures to fundamentally transform the system.

Ian Morrison’s “The Second Curve: Managing the Velocity of Change” contrasts 20th century healthcare delivery systems (the First Curve) with an entirely new (Second Curve) healthcare paradigm that is still very much in its infancy in Canada and United States. The Second Curve is emerging and still unfolding.

Nevertheless, glimpses of the Second Curve are already present in a number of Canadian and American healthcare organizations – organizations that are achieving real improvements in a whole range of areas: quality, patient safety, integration, customer and staff satisfaction, etc.

The question is: what can your organization do to move further towards the Second Curve?

Organizations determined to achieve Second Curve outcomes need to think about how they would redesign their core and support systems, structures and processes – based on this very different set of assumptions and realities.

You can use the list of First Curve vs. Second Curve assumptions, beliefs and realities to provoke your organization’s thinking about the future. Is your organization, and are your local LHIN partners ready to shift to the Second Curve? 

Our existing healthcare systems, structures, processes and culture have been referred to as the “First Curve paradigm” of the health sector. From the perspective of organizational science, organizational designs in the “First Curve” of healthcare are rooted in the craft stage of system development and reflect early stage industrial designs. Today, healthcare delivery systems in both the United States and Canada are teetering on the brink of a “Second Curve” paradigm of development – a more evolved set of system, organizational and process designs that are required to satisfy the increasing demands of funders, service providers and customers in the knowledge economy. What is this shift from the First to Second Curve healthcare delivery systems, and how is the shift occurring?

Albert Einstein suggested that we cannot create solutions for today’s problems if we remain embedded in the original thinking that generated them. He was talking about paradigms. First Curve assumptions and beliefs about how to organize healthcare delivery are deeply embedded in our existing systems, structures, processes and culture. This paper provides a list of some of the assumptions, beliefs and realities that are embedded in our existing healthcare delivery system – and what each of these seem to be morphing towards in the very near future.

For the past 15-20 years, our clinician-centric craft model of medicine and our rigid bureaucratic service delivery systems with their industrial-age organizational practices have been faced with unremitting incremental change. Today, public, governmental and service provider pressure is increasingly pushing for transformational, fundamental and deep change in our healthcare system.

In Deep Change, Robert Quinn says that deep change differs from incremental change in that it requires new ways of thinking and behaving. He says “It is change that is major in scope, discontinuous with the past and generally irreversible.”
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System is fragmented. Patient fends for her or himself, moving from silo to silo.
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Hierarchical, command & control systems/structures/processes/culture creates toxic work environments.
Systems, structures and processes are designed to achieve the right balance of empowerment and accountability. High staff satisfaction rates.

“Accountability” means blame. Blame causes cover-up. Constant cover-ups mean we don’t address design flaws in our systems, structures and processes.
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CEOs manage an organization within a network of healthcare services. Managers in silos talk past each other. Despite the rhetoric of co-operation, the rewards and incentives are for “winners” and “losers” and for those who play politics.
CEOs participate in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations. Silo managers integrate their planning and system design efforts. They are rewarded for achieving integration and for excellence in management.

Governance represents the self-interests of the organization.
Governance represents the “owners” – the citizens/community.

The system is designed to be complicated.
The system’s complexities and self-organizing potential is realized in a natural complex adaptive system.
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