Outmoded Myths Masking the Rise of Aging's Community Leadership*

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Summary

Shifting frail-aging care from institutions to a neighborhood-based, networked community model is a true paradigm shift. Such a shift becomes possible when (1) society recognizes the existing institutional framework as inadequate and unsustainable, and (2) a credible alternative path is visible. Both conditions are now present. Industrial-era healthcare expertise may not translate. Communities must develop new forms of coordination, responsibility-sharing, and effective leaders who can mobilize local influence, communication, and collaboration.

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The idea that a neighborhood, in a modern networked community, can appropriately address in situ the needs of its older citizens, and particularly its frail older citizens, is a paradigm shift, a fundamental change from the institutional framework that has dominated aging and chronic care for the past half century.

In order for a paradigm—a settled way of seeing or doing something— to shift to a new way, two necessary conditions must be present. First, a recognition that the current approach or framework is inadequate, perhaps unsustainable; second, that there is a possible new way, a new path forward that addresses the problem more fully, more satisfactorily. Both conditions must be present for change to occur. With no convincing new way forward, the unsatisfactory status quo remains. It is simply accepted that things are what they are. And on the other hand, if there is a new solution but insufficient recognition of the importance of the problem, or even that a problem exists, it isn't obviously worthwhile to expend energy to make a change.

A new paradigm for aging care, and especially for frail aging care in the community, has particular challenges with both necessary precedent conditions. The primary challenge is in our historic understandings of aging, that the losses correlated with long life are natural, immutable, simply fate or God's will, that aging and its increasing incapacities is simply part of the human condition. It is only relatively recently that the concepts and interventions of an activist approach to losses associated with older age have become available to the general public. It is difficult to recognize that the current program for aging, while unhappy, unpleasant, even painful, is a problem at all, and one that can be addressed. Note that this may generate resistance from providers of the current aging care regime, and their backers, who have financial and emotional commitments to the current state of play. For them, the recognition of the current inadequacy maybe experienced as a personal affront.

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The second condition precedent necessary for paradigm shift in our aging care delivery system—that there is a possible new path forward—presents its own problems because the new approach is so different from the one that it promises to replace, in these four respects:

- It seems incomprehensible that the new delivery system can do the job.
- The shift to the community and the devolution of responsibilities appears to be perilous.
- The nature of the replacement of the old system sounds frightening—but isn't.
- It requires fresh leadership to get us from the past to the future.

1. It appears incomprehensible that the new delivery system can do the job.

New is difficult. The features of the new replacement system are so different that it may appear fatuous to believe that it can address the historic set of aging challenges. And of course, in certain respects this is correct—the new paradigm resets, reshapes the problems themselves. This has occurred in virtually all the network era approaches that are replacing industrial-era delivery systems throughout American life: retail/Amazon, entertainment/Netflix, transportation/Uber and GPS, communication/cell phones, mammoth factories/algorithm-driven supply chains for manufacturing. In each, the heft, the weight, the palpable, visible power of the old regime disappears into networks and clouds and hand-held devices, if not altogether.

I experienced such a reaction to a paradigm shift in the aging delivery system. Thirty-five years ago, I replaced a traditional nursing home with shared bedrooms, residents lined up in the corridor (along with bins of dirty linen) for batch toileting and bathing, that resulted in a frenetic competition for attention against a background of apathy, if not depression. The new nursing home had private rooms and bathrooms arrayed around a living room where the nurse aide had her own desk and all of her supplies were hidden in the walls. Every resident lived on her own schedule, there were no lineups of people and stuff in the halls, no offensive sights or smells. It took over eight years to plan, fund, build, and then train staff to operate. It took one day to move the residents of the old facility to the new, from a madhouse to a quiet, comfortable setting with private bedrooms and bathrooms.

But what we didn't anticipate, we didn't consider, was that we were moving the families, the attentive daughters, as well. Within a week of the move, families were complaining, expressing outrage to our board of directors and to anyone who would listen in the community, that so much money had been spent on a pretty building, but there was no care.

I met with the families. I asked, is mother complaining? No, but there is no care. Does she appear to be uncomfortable? No, but there is no care. Is she dirty or wet? No, but

there is no care. I realized what had happened was that we had taken the intimate care that had been so frenetic, so public, so visible, and reset it quietly in private settings. What they knew as care, had disappeared.

What had appeared to be aging care was not actually a response to aging, but an artifact of an inappropriate delivery system. Simply put, it can be anticipated that initially, with the new networked community approach to aging, stripped of so many of the experiences that had always defined care for the aging, people will feel that it does not care.

In relatively short order, the new more commodious regime was metabolized. We had created an acceptance and expectation of dignified care. The old way slipped into the past as if it had been in a different age.

2. The shift to the community appears to be perilous

The paradigm shift to community-based aging care is not just a physical relocation, but also a profound redistribution of responsibility. In the industrial era, the people, equipment, personnel, and expertise for frailty were all congregated in one place, the facility. When the time came, mom was dropped off and the rest of the family returned home. Over the two decades after the 1965 passage of Medicare, Medicaid and the government funding to build new old age care facilities, the pervious personal and community financial and programmatic responsibility for the entire frailty undertaking was replaced. It was outsourced to government, insurers, facilities shaped by labyrinths of inaccessible regulations, and a potpourri of healthcare providers who generally marched to the demands of “the system,” not to the intended beneficiaries, the older people.

Now, with the withering of the fifty-year old aging care system built upon institutional care, frail older people will remain outside industrial-era government facilities, and perhaps shockingly, largely beyond government responsibility. As facilities that depended on government reimbursements tighten and close, older people are left in the community, mostly outside government notice or responsibility, albeit with access to some residual, shallow programs that will require major revamping. Since government has neither the funds nor the will to pass new legislation to care adequately for the deluge of aging boomers now outside the existing programmatic frameworks, the primary responsibility for older people will devolve back to families, and if they can organize, to community.

With the frail person, and all the associated equipment, community engagement, network communication and coordination residing in the community, the family will retain a primary role, a participating and coordinating responsibility for the frail family member. After decades when the standard practice was that the older person had been whisked away, suddenly the family no longer outsources primary responsibility. Over time, their initial shock and fear regarding their care of this fragile, frail life will subside

as community supports develop, the range of interventions employed and integrated expands, and there is acceptance and recognition of frailty as a commonplace and natural feature of community living.

3. The nature of the replacement of the old system sounds frightening—but isn't

How is it possible to substitute community-based aging care for nursing home care without completely disrupting that care? Does the community take over running nursing homes? Does the community close its nursing homes?

The way that the new network system for aging care replaces the historic facility-based one is a surprise. Just as Amazon did not inhabit the retail stores it replaced, Airbnb did not inhabit the hotels in replaced, and Uber did not take possession of the traditional cabs or purchase their medallions, the community aging network will not take possession of the traditional hospitals, nursing homes, and assisted living facilities. Because new customers will merely stop applying for admission to those facilities, the shift will not require confrontation, a takedown of the old system. A new replacement arrives quietly, in a different form, leaving behind physical, real estate, and human resources that need to be repurposed. But, although the nature of the replacement may be undramatic, it nonetheless can result in human and economic dislocations that, if not addressed appropriately, can interfere with the vitality of the community and the development of its new network.

4. It requires fresh leadership to get us from the past to the future

The leadership necessary to effect the paradigm shift to community network-based care will be different from the familiar healthcare leaders. Today's healthcare is a mature industry, heavily regulated and financed, with set leadership whose careers entailed moving up through layers of fixed corporate departments within an industrial ecosystem. Philip Tetlock, University of Pennsylvania psychologist and political science, found that existing experts are generally poor at making predictions about future events because their views are too locked in and they use their knowledge to support false visions of the future. Their experience and skill sets are often not suited for leadership in the new, unfolding field of frail aging in the community.

The rapid metamorphosis of the field will attract leadership whose involvement had previously been foreclosed by the tedious technical and regulatory barriers to entry, the field's off-putting, arcane language, the stultifying mechanics of the industry, and the sad, seemingly fixed result. While some of the new leaders will come to aging issues because of personal experience with parents or grandparents, others may not have had prior healthcare involvement. They may have had prior professional experience with a paradigm shift in another industry that makes them aware of the real possibility of fast, successful innovations that can dramatically transform a delivery system, indeed, an entire sector. The new avenues in aging offer the possibilities of open-field running, bringing to bear accessible, common-sense resources to great effect, with a direct impact on people they know in the community. The result may awaken a leadership

engagement that not only resets the aging experience but reset the expectations of and possibilities for community itself.

The ideal new leaders in the enterprise of community development to support frail aging will have these resources to bring to the community undertaking: influence, the ear of others, the ability to articulate, to adapt the message to critical audiences, an enthusiasm about being involved with an issue that can transform the living experience of many in their community. They see the opportunity to devote their training, skills, expertise and professional networks to a deeply meaningful challenge.

In summary, a paradigm shift in aging care is possible because the two conditions precedent necessary to make change are clearly present. The Covid epidemic exposed the programmatic inadequacy of the existing approach, and recent legislative rollbacks leave large holes in the already creaking care system. Only by avoiding the issue entirely could one not be aware of the current dire problems with aging care.

And the components we need to make a new path forward, also exist. New delivery systems are available all around us. The network era changes the conditions on the ground and formerly insoluble challenges melt away. The call for changing roles of family and community can be met with robust communication tools that are already proven in other sectors of commerce and society. For those inurned to the constant struggles to initiate even small, incremental changes to existing regimes, the shock will be that there is so little resistance, so little pushback. The world is ready for this. The new approach fundamentally changes the venue and nature of the delivery system, and fills such a desperate unmet need, that the previous dominant industrial-era health care behemoth will merely shrink and reform around the new way of aging. Once leadership sees the advantages of applying network era productivity to aging care, new approaches will rise throughout our communities.

The community aging network is a paradigm shift that has the potential to address America’s largest socio-economic and demographic challenge. The transition will reframe not only aging, but community in America.