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Seven years later: What long-term care saw coming

James Lomastro March 13, 2026

In 2018, McKnight's published a piece predicting that artificial intelligence would transform healthcare not from within medicine's established institutions, but from outside them, through digital forces that would "radically alter the way in which we operate the system." The response was modest.

The prediction felt speculative at a moment when the field had more immediate concerns: workforce shortages, reimbursement pressures, regulatory complexity. AI was something happening in frontier and research labs, not nursing homes.

Seven years later, I want to revisit that argument to reflect on what practitioners in long-term care have always understood that the broader healthcare world is only now catching up to.

The view from the sector that gets overlooked

Long-term care has always operated at the margins of healthcare's innovation narrative. It serves the oldest, most medically complex patients. They run on the thinnest margins depending disproportionately on Medicaid reimbursement and a workforce that earns wages that rarely reflect the skill and compassion the work demands.

When venture capital imagines healthcare's future, it tends to imagine hospitals, precision medicine and employer insurance markets, not the nursing home down the road. Yet practitioners in this sector have long possessed something the innovation narrative undervalues: an intimate, operational understanding of what care actually requires. Not in the abstract, but day after day, resident by resident, family conversation by family conversation. That understanding turns out to be exactly what responsible AI deployment in healthcare needs most.

What the 2018 prediction got right

The core thesis was that healthcare's transformation would be driven by external digital forces rather than internal reform efforts and that the sector's hierarchical, linear model of care delivery would be fundamentally incompatible with interactive, iterative digital systems. Both proved accurate.

Amazon's $3.9 billion acquisition of One Medical, digital health venture capital surging from $8 billion in 2018 to $29 billion in 2021, AI start-ups reshaping clinical workflows from outside traditional healthcare institutions and the disruption came from exactly the direction the 2018 article suggested it would. The tension between hierarchical

medical models and adaptive digital technologies materialized across care settings, driving both resistance and transformation simultaneously.

The pattern recognition predictions also proved out. AI systems now outperform clinicians in specific radiologic tasks, predict sepsis hours before clinical symptoms emerge, and identify drug interactions that human review misses. The observation that digital technologies "feed on themselves" — each iteration improving on the last — anticipated the foundation models and large language systems that arrived in 2022 and changed the entire landscape of what AI could do.

What needed refinement

Honest retrospection requires acknowledging what the 2018 analysis didn't fully anticipate. The emergence of large language models shattered assumptions about task-specific AI. GPT-4 and its successors introduced general-purpose reasoning systems that could converse, synthesize and advise across domains — a capability that fundamentally altered deployment possibilities and ethical questions alike.

The analysis also underweighted data quality as a constraint. Interoperability failures, the cost of data cleaning, and critically, the absence of adequate data on underserved populations including many of the people long-term care serves have slowed adoption and, in some cases, introduced new disparities rather than reducing existing ones. This is a challenge the long-term sector is particularly positioned to understand and to help solve, given how thoroughly well it knows our patient populations.

COVID-19 accelerated AI adoption in ways no one predicted, while simultaneously demonstrating something long-term care practitioners have always known — that technology augments care but cannot replace the irreplaceable human judgment and relational knowledge that direct care workers bring. The pandemic made that truth impossible to ignore.

The practitioner advantage

Long-term care's experience with AI's early deployment reveals what makes the technology work well and what makes it fall short: the difference between systems that help practitioners do their jobs better and systems that bypass practitioners altogether.

In settings where experienced staff have been treated as implementation partners and where their workflow knowledge, clinical judgment and awareness of individual residents has shaped how AI tools are designed and deployed, the outcomes improve. Monitoring systems surface information that aides and nurses act on. Documentation tools free up time for direct care. Predictive analytics prompt earlier interventions that prevent hospitalizations.

In settings where technology is imposed as an efficiency mechanism without genuine practitioner input, resistance emerges — and it is not technophobia. It is the legitimate professional judgment that the tools don't account for clinical complexity, that they

generate alerts that don't reflect what the caregiver observes, that they create new administrative burdens while claiming to reduce them.

Experienced practitioners in this sector are "wisdom practitioners" — practitioners whose decades of pattern recognition, contextual judgment and relational knowledge represent exactly the kind of intelligence that AI systems most need to be paired with. The question for our field is not whether we can adapt to AI, but whether we can insist that AI adapt to us — or more precisely, that it be designed to enhance what we bring rather than bypass it.

What comes next

The tipping point has passed. AI is not coming to long-term care; it is here, in documentation platforms, in monitoring systems, in clinical decision support tools, in medication management. The question for McKnight's readers — for administrators, directors of nursing, care coordinators, and the workforce they lead — is what kind of deployment serves residents and supports staff, and what governance structures make that more likely.

Three observations from seven years of watching this unfold. First, AI tools designed with direct care worker input consistently outperform tools designed without it. This is an empirical finding, not a political preference. The people closest to residents know things about care delivery that no algorithm derived from aggregate data can fully replicate.

Second, the distinction between augmented intelligence and artificial intelligence matters enormously in our setting. Tools that support and enhance clinical judgment — surfacing information, flagging patterns, reducing documentation burden — have a fundamentally different relationship to care quality than tools that replace or override human judgment.

In long-term care, with its complexity, its vulnerability, and its dependence on relational trust, that distinction is not academic. It is the difference between technology that serves residents and technology that creates the appearance of doing so.

Third, the governance frameworks that determine how AI is deployed in the healthcare sector are still being written. That is an opportunity. Long-term care practitioners, advocates and organizations have the operational knowledge, the ethical clarity, and the track record to be central voices in those conversations — not afterthoughts to a process driven elsewhere.

Seven years ago, this sector saw something coming that much of healthcare hadn't yet turned to face. The same practitioner perspective — which is grounded, experienced, and clear-eyed — to shaping what AI becomes in the places we serve.

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