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I would focus on a strengths perspective to look for coping strategies and examples of resilience that can inform his current situation. It can be helpful to incorporate his life experiences and work history, which likely includes crises *and successes*. Some possible questions to ask include: Could you describe a time when you lived through a period of uncertainty? Have you experienced any silver lining in the disruption?

Although the PHQ-9 was completed with the first Minimum Data Set, I would readminister this screening tool outside of the regularly scheduled MDS dates and evaluate the scores across time. I would also talk with his wife and daughter to determine whether they share his concerns around medical management at home, and explore solutions. Mr. G also should be screened for trauma using the PC-PTSD-5 (s://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf) and the information gained should be incorporated into a care plan based on Mr. G's goals and hopes.

Likewise, contributing to a capacity assessment would be helpful to determine his ability to make his health care decisions. The discussion around his health care preferences needs to include several elements and also be documented in the medical record: conversations about risks and benefits, attempts to make the situation more agreeable for Mr. G, all efforts at education and interventions implemented, and the care and services Mr. G accepts.

Director of Nursing

Robyn Eaglen, RN, BSN, LNHA

Ms. Eaglen has worked in a variety of nursing roles for the past 24 years and is currently working as a Director of Nursing at a post-acute and long-term care facility outside Tucson, AZ.

From a nursing perspective, it would be helpful to teach Mr. G about the benefits of long-acting insulin and assess whether he is able to check his own blood sugar and self-administer a preset dose of insulin. To optimize his quality of life, nursing should encourage the family to bring his computer from home as well as other items he might find useful and comforting. Further, the increased use of video or phone chats with his family could be encouraged and facilitated, as well virtual games online with friends.

Physical Therapist

Jim Patten, PT

Mr. Patten is a graduate of the University of Vermont (1990) and has enjoyed 30 years of geriatric care in the acute and sub-acute rehabilitation settings. He currently works in a post-acute and long-term care facility outside Tucson, AZ.

Physical therapy would focus on improving Mr. G's functional activity tolerance, supported by appropriate use of energy conservation techniques to facilitate a more consistent level of performance. Coordination of the therapy schedule with the care team would help eliminate his prolonged periods without positive social interaction.

Use of communication technology between scheduled therapy or care requirements would permit visits with his spouse and family and provide a way for him to update the family on his progress. He could also use the computer for participation in self-identified leisurely activities and to pursue personal interests and educational opportunities.

When discussing his options for the discharge plan, the therapy goal will be to minimize functional mobility deficits and the amount of physical assistance required to manage fall risk.

Nutritionist

Rebecca Myrowitz, MHS, RDN, LDN, CSOWM, CPH

Ms. Myrowitz is a clinical dietitian nutritionist who serves in a leadership role in the CCRC Roland Park Place.

In caring for Mr. G, we need to optimize his nutrition-related quality of life given the restrictions of the nursing home during COVID-19, especially since his feeling of isolation can lead to a decreased appetite. When he was in independent living, his evening meal was more of a social activity involving an alcoholic beverage as well as company. It would be helpful to mimic that as much as possible in the nursing home. An example would be a video dinner date with his wife or daughter. If Mr. G is medically allowed, the team may request an order from the medical provider to add a drink with his dinner.

To optimize Mr. G's intake, we need to update his food preferences regularly. His family may consider ordering food for him from his favorite restaurant as an occasional treat. Furthermore, he may want to have some of his favorite spices at his bedside so he can add them to his meal to increase its palatability. If he tolerates juicier foods better than dry foods, ordering dark meat and stews may help as well as having gravy, sauce, or condiments to add as needed. It also may be helpful to have him eat in areas outside of his room, if possible. Enjoyable supplements can be offered such as Glucerna as well as some preferred sweets in reasonable portion sizes.

Dr. Resnick is the Sonya Ziporkin Gershowitz Chair in Gerontology at the University of Maryland School of Nursing in Baltimore. She is also a member of the Editorial Advisory Board for *Caring for the Ages*.

Ms. Hector is a clinical educator and professional speaker specializing in clinical operations for the interdisciplinary team and other topics. She is a member of the Editorial Advisory Board for *Caring for the Ages*. She is passionate about nursing homes and supporting staff to care for the most vulnerable people in their communities.

KEY POINTS

The interdisciplinary approach was important in combining each discipline's unique (and sometimes overlapping) perspective in a balanced set of recommendations:

- The team was consistent about addressing some of the pharmacologic issues and options and about using internet-based resources to connect him with his family and to provide entertainment and social interactions.
- The team offered recommendations to assess his decision-making capacity for care preferences, to honor his choices, and to help him achieve his goals.
- The physician and pharmacy providers recommended changes to his medication regimen. The results of these changes should be observed before his discharge. Further, the differences in approach between the two in recommendations need to be discussed first with each other and then with Mr. G to explore changes and alternatives.

Expert Urges Providers to Implement New Hypertension Guidelines

By Christine Kilgore

Many guidelines take four to six years to be understood and implemented, but at the Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine, Thiruvinvamalai S. Dharmarajan, MD, cautioned against any further delay in implementing the 2017 Hypertension Clinical Practice Guidelines, which recommend lower blood pressure targets and more intensive treatment for most patients with hypertension.

"For those with high [cardiovascular] risk, which is 90% of your patients, try to get them toward 130 [mm Hg]" using lifestyle and pharmacologic therapy, said Dr. Dharmarajan in his review of the guidelines. "In practice," he added, "if you've got them to 140, you're in great shape. And 130 will be wonderful if tolerated."

The new guidelines — developed by the American Heart Association, the American College of Cardiology, and eight other professional societies, including the American Geriatrics Society — define hypertension as an average systolic blood pressure (SBP) of 130 mm Hg or greater and an average diastolic blood pressure (DBP) of 80 mm Hg or greater, with hypertension stage 1 being 130–139 SBP or 80–89 DBP and hypertension stage 2 being ≥140 SBP or ≥90 DBP. Normal blood pressure is now defined as <120 mm Hg systolic and <80 mm Hg diastolic.

The landmark Systolic Blood Pressure Intervention Trial (SPRINT), which helped inform the 2017 guidelines, showed that achieving a lower blood pressure goal of 120 mm Hg (instead of 140 mm Hg) reduced the rate of cardiovascular events by about 25% and overall mortality by 27% after four to five years of therapy (*New Engl J Med* 2015:373;2103–2116). Last year, investigators reported less cognitive impairment ("probable dementia") in the intensively treated group at about seven years of follow-up observation (*JAMA* 2019;321:553–561).

Despite SPRINT's limiting exclusion criteria — living in a nursing homes or having diabetes, dementia, or a low glomerular filtration rate — the opportunity to substantially reduce adverse cardiovascular outcomes and mortality is a real one, said Dr. Dharmarajan.

Intentions

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more requirements has become enormously complicated, expensive, and time consuming. It has only worked partially, and continuing the current approaches has limited upside potential. There is no way that combining separately derived and implemented approaches to a complex problem will somehow add up to solving any problem related to the care of individuals or the improvement of systems of care.

Ironically, almost everything that is needed to improve nursing home care already exists, but much of it is either being buried or is not being used properly. Ultimately, the first step to moving nursing homes toward the future is for everyone to stop trying to fix them until we rethink the entire situation without predispositions and recognize and address all the key issues that have been mistakenly ignored, misunderstood, and mismanaged.

Dr. Levenson has spent 42 years working as a PALTC physician and medical director in 22 Maryland nursing homes and in helping guide patient care in facilities throughout the country. He has helped lead the drive for improved medical direction and nursing home care nationwide as author of major references in the field and through his work in the educational, quality and regulatory realms.