Life Services Network

WeeksNews

Cathy Nelson, Editor

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POLST Illinois Task Force Gears up for Training as New DNR Form Released!

The POLST Illinois Task Force together with the Illinois Department of Public Health announces the release of the new IDPH Uniform DNR Advance Directive, also known as a POLST form. The POLST form was developed to assist people in making their own health care decisions and is a revision of the current form used throughout Illinois. Cathy Nelson and Jason Speaks represent LSN on the POLST Task Force.

POLST stands for "Physician Orders for Life-Sustaining Treatment." A POLST form is a signed medical order that travels with the patient to assure that a patient's treatment preferences are honored across settings of care. The POLST model is new to Illinois, but is recognized nationally as a best practice.

According to Dr. Julie Goldstein, physician at Advocate Illinois Masonic Medical Center and co-chair of the POLST Illinois Task Force, POLST represents a way for patients to be empowered about their choices at the end of life. "POLST gives patients and their families more control of the treatments they may or may not want in the setting of advanced illness. Task Force members stand ready to assist healthcare providers, emergency responders, and others in understanding the new form," said Goldstein.

Dr. Goldstein notes that the POLST form is not for everyone; it is intended specifically for patients with advanced illness to be able to express their wishes for life-sustaining treatment in the context of their current conditions. "Completing the new document gives patients the chance to discuss their wishes with their loved ones along with health care professionals, and put them in writing. Once the doctor signs the form, it becomes a set of actionable medical orders. Like all adults, these individuals should also appoint someone to be their healthcare power of attorney. POLST goes the next step to let all healthcare providers, from the nursing home to the hospital, know your wishes." Use of the POLST form is voluntary. Health care professionals and providers are required by law to honor treatment choices shown on a POLST, and are protected from liability if they do so in good faith.

The original state legislation was sponsored by Assistant Majority Leader, Rep. Sara Feigenholz and co-sponsored by Rep. Robyn Gabel, who serves as the Vice-Chair of the Human Services Appropriations Committee. The law sought to supplement the existing IDPH Uniform DNR Advance Directive with more detailed treatment plan options.

The revision of the IDPH Uniform DNR Advance Directive form by IDPH is an important step in helping Illinoisans with advanced illness clarify their wishes for life-sustaining treatment. Next steps include training for physicians, nurses, and emergency personnel.

The POLST Illinois Task Force is a volunteer coalition of doctors, nurses, clergy, social workers, attorneys, paramedics, and administrators from hospitals, emergency medical systems, hospices, and long term care facilities. Task Force members helped to promote the initial legislation, assisted in creating the Illinois POLST form, and are now helping to launch training sessions for medical professionals all across the state.

With partial funding from the National POLST Paradigm Task Force and the Retirement Research Foundation, the POLST Illinois Task Force is supporting pilot sites in Springfield and Hinsdale and is planning training sessions across the state over the next weeks and months.

FOR MORE INFORMATION:
http://www.cecc.info/resource-links/physicians-order-for-life-sustaining-treatment-polst

http://blog.lifemattersmedia.org/2012/10/polst-coming-to-illinois/

http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-programs/polst.cfm

POLST ILLINOIS KEY CONCEPTS

1. **POLST stands for Physician Orders for Life-Sustaining Treatment.** A POLST form is a signed medical order for documenting the life-sustaining treatment wishes of seriously ill patients. It travels with the patient to assure that treatment preferences are honored across settings of care.
2. **POLST is designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care.** POLST allows patients to choose all possible life-sustaining treatment, limited life-sustaining interventions, or comfort care only. **Comfort measures are always provided no matter what other choices patients make.**
3. **POLST is intended for persons of any age for whom death within the next year would not be unexpected.** This includes patients with advanced illness or frailty. POLST is not intended for persons with chronic, stable disability. Such individuals should not be mistaken for having an end-of-life determining illness. POLST would only be appropriate for such persons if their health deteriorates such that death within a year would not be unexpected.
4. **Having a POLST is completely voluntary. POLST orders can be revoked or changed by patients at any time.**
5. **In Illinois*,** the **POLST form is a revised version of the IDPH Uniform DNR Advance Directive.**
6. **POLST forms are completed after patients discuss their preferences with health care professionals who can explain to them what may happen if different treatments are tried.** The POLST form itself serves as a guide for these discussions related to each person's unique medical condition and goals.
7. **POLST forms are signed by the patient or patient representative, an attending physician and a witness.** The completed POLST form is an actionable medical order.
8. **Health care providers and professionals are required by law to honor treatment choices shown on a POLST**. Because the form travels with the patient, it provides an immediate guide for first responders and emergency department staff about whether to even begin life-supporting care.
9. **Without a POLST or IDPH Uniform DNR Advance Directive, emergency medical personnel are required to do everything they can to attempt to save a person's life.**
10. **When a patient's condition changes significantly, earlier decisions about treatment should be revisited and a new, updated POLST completed.**

11. **The POLST Illinois Task Force is a volunteer coalition of doctors, nurses, clergy, social workers, attorneys, paramedics, and administrators from hospitals, emergency medical systems, hospices, and long term care facilities.** The Task Force supports every person in exercising his or her right to accept or decline medical treatment. For more information, go to: www.polst.org or www.cecc.info.

Feel free to contact Cathy Nelson or Jason Speaks at any time for more information.

CMS Issues Memo Addressing Adverse Events and Luer Connectors

Last week CMS released a memo addressing adverse events and Luer misconnections resulting in patient deaths. The intent of the memo is to raise awareness of this issue.

The CMS memo reports that a "Luer connector is a conical fitting with a six percent taper for syringes, needles, and certain other medical equipment" used worldwide to connect a variety of vascular, enteral, respiratory, epidural and intrathecal medical devices, components, and accessories. Luer connectors have a male and a female component joined by use of a friction push and twist fitting (a Luer slip) or a screw-in threaded fitting (a Luer lock) to form a secure yet detachable leak-proof connection." More than 100 reports of Luer misconnections have been found in the literature since 1972. The Association for the Advancement of Medical Instrumentation, FDA, The Joint Commission, the Institute for Safe Medication Practices, United States Pharmacopeia, ECRI Institute have received reports of misconnection errors.

As providers, the following actions include, but are not limited to:

- Changing to devices already on the market with alternative connector designs which reduce the likelihood of misconnections of incompatible lines;
- Tracing lines back to their origins when reconnecting devices;
- Positioning catheters and tubes that have different purposes on different sides of the patient's body or in unique and standardized directions; and
- Implementing a multidisciplinary facility approach to address Luer misconnections.

Further Information from the memo for surveyors and providers includes:

- During complaint investigations for adverse events "…involving delivery of an incorrect substance or utilization of an incorrect delivery route, surveyors must investigate whether the event involved misconnection of devices with Luer connectors or similarly designed connectors that allow for misconnection."
- If so, surveyors must determine whether the facility has taken actions to ensure systems are in place to prevent recurrence.
- During standard surveys, surveyors should consider asking healthcare personnel and managers interviewed what steps are taken to prevent Luer misconnections.
- Surveyors can also encourage facilities to report problems involving Luer misconnections to the FDA, even if an adverse event did not occur. General information on reporting a Luer misconnection problem is found at
- http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/TubingandLuerMisconnections/ucm313323.htm

- Health care personnel subject to the FDA's user facility reporting requirements should follow the reporting procedures established by their facilities:
- http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/PostmarketRequirements/ReportingAdverseEvents/ucm2005737.htm,
- Information on user facility reporting: http://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm
- Healthcare professionals may also file a medical device report through MedWatch

CMS Releases S & C Memos with Additional Revisions to Feeding Tubes, Advance Directives and Clarification of Physician Delegation of Tasks in SNF's

Last week the Centers for Medicare and Medicaid Services (CMS) released several Survey and Certification memos clarifying regulatory language and adding definitions. Most of these changes are minor and have little regulatory impact. Still others (**in bold font**) have the potential to impact the survey process and therefore deficiency citations. The memos address F 322 (Feeding Tubes), F 155 (Advance Directives) and physician delegation of tasks in Skilled Nursing Facilities.

First, with respect to feeding tubes, CMS made very minor revisions in this memo including formatting the regulatory language and clarification of the expanded definition of naso-gastric tubes. Specifically, CMS has added the following language: "**the term 'naso-gastric tubes' is considered to include any feeding tube used to provide enteral nutrition to a resident by bypassing oral intake.** Since the regulation was promulgated, use of naso-gastric tubes has become extremely rare, and use of other types of enteral feeding tubes (such as those listed in the definitions section) has become prominent". Surveyor training slides were adjusted for this clarification language. Again, this change only clarifies that the regulation applies to all types of feeding tubes through which enteral nutrition is administered.

The second memo addresses F 155 and advance directives. The changes include:

- Removal of the term "right to accept" preceding language specific to medical and surgical treatment to correlate with the regulatory language at §483.10 (b) (4) and replaces previous language of "right to accept or refuse medical treatment…"
- Language specific to experimental research has been added to the Interpretive Guidance. The section emphasizes the following:
  - The resident has the right to refuse to participate in experimental research
  - A resident being considered for participation must be fully informed of the nature of the research and possible consequences of participation.
  - Residents must give informed consent for the experimental research. If incapable, but legal representative gives proxy consent, **the facility has a responsibility to ensure that the proxy consent is properly obtained and that essential measures are taken to protect the individual from harm or treatment**.
  - Also, the resident (or legal representative) must have the opportunity to refuse to participate both before and during the experimental activity.
  - **Finally, any facility participating in experimental research must have a process for committee oversight (example: Institutional Review Board).**
- A definition for investigational and experimental drugs has been added to the experimental research section: "Investigational or experimental drugs refer to drugs that have not yet been approved by the FDA or approved drugs that have not been approved for a new use, and are in the process of being of being tested for safety and effectiveness".

- Clarifies that section §483.10 (b) (8) applies only to adult residents, however, CMS offers that some states have laws that govern the rights of parents or legal guardians of children to formulate an advance directive. CMS encourages surveyors to refer to state law in cases where concerns arise regarding advance directives in non-adult populations.
- The Investigative Protocol has been updated to include experimental research and record review considerations relative to a physician's basis for conscientious objection and/or need for additional information related to a resident's decisional capacity. This is direction offered particularly for surveyors when determining compliance related to experimental research and F 155.
- Finally there is specific guidance provided to surveyors on which records the Investigative Protocol should be used. They are directed to review records when specific complaints have been made regarding a resident's right to refuse treatment or participate in experimental research; residents with a condition potentially related to provision of life sustaining treatments; those who are participating in experimental research or those who refused medical or surgical treatment.

This last memo replaces the Survey and Certification memo of 11/13/03, addressing physician delegation of tasks in SNFs and NFs.

Clarifies Federal guidance for physician delegation of certain tasks in SNFs and NFs to non-physician practitioners (NPPs; formerly "physician extenders") such as nurse practitioners, physician assistants, or clinical nurse specialists;

It implements section 3108 of the Affordable Care Act (ACA), which adds physician assistants to the list of practitioners that can perform SNF certifications and re-certifications; and clarifies policy on co-signing orders in SNFs and NFs.

- §483.40(e)(2) provides that, "A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies."

SNF's

- §483.40(c)(3), mandates that all required physician visits be made by the physician personally and not delegated.
- A required physician visit includes the initial comprehensive visit and every alternate required visit thereafter.
- The initial comprehensive visit in a SNF is the initial visit, no later than 30 days from admission, "…during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident."
- The physician may not delegate the initial comprehensive visit. Non-physician practitioners may perform other medically necessary visits prior to and after initial comprehensive visit.
- Alternate visits may be delegated to a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) licensed by the State and performing within the scope of practice.
- Alternate visits, as well as medically necessary visits, may be performed and signed by the NPP (physician co-signature is not required).
- Section 424.20(e)(2) states that NPs and CNSs who are not employed by the facility and are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under the State scope of practice.
- Effective with services furnished on or after January 1, 2011, in accordance with section 3108 of the ACA, physician assistants who are not employed by the facility may perform the required initial certification and periodic re-certifications of a SNF beneficiary.

NF's

- Similar to SNFs, the initial comprehensive visit in a NF is the initial visit, no later than 30 days from admission, "…during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident."
- 483.40(f) provides that "At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician."
- At the option of the State, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under §483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits.
- The physician is not required, other than under State law, to verify and sign orders written by NPPs employed by the facility for other medically necessary visits.
  - Medically necessary visits may not take the place of physician required visits, and may not count towards meeting the required physician visit schedule.
- In contrast to the initial SNF visit, NPPs may provide initial NF visits and other required visits under §483.40(c)(3) and (f) if the State permits.
- Required physician tasks, such as verifying and signing orders in an NF, may be delegated to a PA, NP, or CNS who is **not** an employee of the facility but is working in collaboration with a physician.
- Orders written by an NPP employed by the NF during visits that are not required visits, and are "other medically necessary visits," do not require physician co-signature except as mandated by State law.
- The Federal requirements restricting NPPs employed by the NF from performing a *required visit*, do not apply to *other medically necessary visits*.

SNF's/NF's

- In dually-certified facilities, the facility must determine the payment source. For a Part A Medicare stay, the NPP must follow the guidelines for services in a SNF. For residents in a Medicaid stay, the NPP must follow the provisions outlined for care in NFs.
- The Letter includes '*Table 1: Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certifications/Re-certifications When Permitted by the State'*, summarizing the requirements for non-physician practitioners to perform visits, sign orders, and sign certifications / re-certifications, as permitted under the State scope of practice.

HUD Releases New EIV Requirements

A revised EIV Notice H 2013-06 was issued on March 12, 2013, and notification was sent via RHIIP Listserv Posting #298. The notice, which supersedes all previous EIV notices (H 2011-21, H 2008-03, H 2009-20, and H 2010-10).

Bonnie Wilpon from PAWA House of Florida / PMCS shared with us the following summary:

While there were few significant changes in this notice. Changes were:

1. Section 811 PRAD projects are included and must use EIV.

2. The 3 reports added by HUD since Notice 2011-21 are included. None have HUD requirements for being printed or used, either in the text or in Appendix 6. Your EIV Policies and Procedures must mention them and indicate if/how you will use them. These reports are:

(a) No Income Reported on 50059 (if you use it, it must be run for “all tenants”)
(b) No Income Reported by HHS or SSA (if you use it, it must be run for “all tenants”)
As before, HUD would like the No Income Reports to be used to identify zero-income households, and recommends that properties have zero-income policies and that tenant income be reviewed at least quarterly. However, no requirements have been added.
(c) Number of Households Not Verified (Verification in Process)

The notice states that the Not Verified Report is provided as a courtesy so that management knows why there is no EIV data for these residents, and that there are no use or retention requirements.

3. The notice acknowledges the fact that the New Hires Report can now also be accessed from the Verification Reports menu. There are no changed requirements.

4. The notice acknowledges the fact that the Multiple Subsidy Report now searches both PIH and MF, and does not need to be run twice.

5. Section XI (B) states that EIV violations can be identified during an MOR and will cause a finding. New with the notice is the stipulation that an EIV violation can be identified at times other than during an MOR, and any appropriate voucher penalty and APPS flag will last until the violation is cured (whether it was related to an MOR finding or not).

6. The notice updates the annual online Security Training Requirement to the proper CyberAwareness Challenge link.

Interestingly, Attachment 8, showing MOR Findings related to EIV, was not updated, and is not consistent with the newly-released Form 9834, which details much more stringent review requirements for EIV.

Avoiding Re-Hospitalization by Monitoring Activity In The Elderly Post-Discharge

A new study has found a link between the activity levels of elderly people who have just been released from the hospital and the risk that they will require readmission within 30 days.

The investigation draws on data collected from 111 patients aged 65 and older, each of whom was fitted with a "step activity monitor" during his or her hospital stay. Worn on the patient's ankle, the pager-sized device counted every step the person took during hospitalization and for a week after discharge.

"We're using activity here as a biomarker, similar to the way you might use blood pressure," said University of Texas Medical Branch at Galveston assistant professor Steve R. Fisher, lead author of a paper in Journals of Gerontology Series A. "While we can't say whether activity is a cause or effect in these cases, we can use it as a marker to tell us whether a person is at high risk and we need to intervene."

Geriatricians want to reduce readmissions among the elderly because hospitalization can actually endanger their health by reducing activity levels and contributing to debilitating muscle loss. Hospitals have an additional motivation: In October 2012, Medicare began financially penalizing hospitals with higher than expected 30-day readmission rates for certain diagnoses.

Fisher envisions hospitals using inexpensive electronic pedometers to monitor elderly patient activity in the hospital and for a brief period after discharge.

"If you suffer congestive heart failure, a nurse will call you during the first week home to ask how whether you've gained any weight, because an increase in water retention can be a sign that CHF is exacerbating," Fisher said. "This is the same kind of principle: We want to

know how much people are moving around, because we want to know whether they're going downhill. The key is to avoid re-hospitalization, which often starts a cascade of events that leads to debility."
Source: Medical News Today, March 15, 2013

Section 8 Renewal and Funding Levels Under Sequestration

On March 12, U.S. Department of Housing and Urban Development (HUD) Deputy Assistant Secretary Marie Head sent LeadingAge and other stakeholders a memorandum on the agency's plans to manage the funding of Section 8 project-based rental assistance (PBRA) under the cuts imposed by the Fiscal Year (FY) 2013 sequestration, or across-the-board cuts, applicable to all HUD programs.

To minimize the potential impact of sequestration and ensure that HUD is able to fund all Housing Assistance Payments (HAP) contracts coming due during FY 2013, the memorandum states the Department has developed the following plan of action:

- All Section 8 contracts expiring in FY 2013 will be renewed if eligible under current program rules and will receive full 12-month funding.
- All existing multi-year contracts that expire after FY 2013 and have anniversary dates in the first quarter of FY 2013 (October-December) will receive full 12-month funding, ensuring sufficient funding to carry them into the first quarter of FY 2014.
- All other multi-year Section 8 contracts will receive less than 12-month funding, but will be provided sufficient funding to carry them into the first quarter of FY 2014.

This should ensure that all Section 8 contracts receive subsidy payments through Dec 31, 2013. Further funding will depend on congressional action and funding levels for the FY14 HUD budget.

Following is full text of the HUD memo:
FROM: Marie D. Head, Deputy Assistant Secretary
TO: Industry partners, Section 8 Owners
DATE: March 11, 2013
RE: FY 2013 Section 8 Project Based Rental Assistance Under the Sequestration

This is to update you, as an owner of a project assisted by the Section 8 Project Based Rental Assistance Program, of the Department's plans to manage the funding of this program under the cuts imposed by the Fiscal Year 2013 Sequestration.

In order to minimize the potential impact of the Sequestration, and to assure that HUD is able to fund all HAP payments coming due during the current fiscal year, the Department has developed the following plan of action:

- All Section 8 contracts expiring in FY 2013 will be renewed if eligible under current program rules and will receive full twelve month funding.
- All existing multi-year contracts that expire after FY 2013 and have anniversary dates in the first quarter of FY 2013 (October-December) will receive full twelve month funding, assuring sufficient funding to carry them into the first quarter of FY 2014.
- All other multi-year Section 8 contracts will receive less than 12-month funding, but will be provided sufficient funding to carry them into the first quarter of FY 2014.

There are about 11,000 Section 8 contracts that fall in this last category, and on average, they will receive roughly 8.5 months of funding. The actual amount will vary, depending on anniversary date. For example, a multi-year contract funded in March 2013 might receive ten months of funding (March-December), while a contract funded in September 2013 might receive four months (September-December).

The overall goal is to avoid payment disruptions during FY 2013 or early in FY 2014. Funding after that point will depend on Congressional appropriation action for FY 2014.

Thank you for your partnership and cooperation as we work through this challenging budget environment.

Please contact Colleen Bloom or Nancy Libson from LeadingAge with any questions.

New Bill Would Close "3-Day-Stay" Loophole for Medicare Coverage

A bipartisan bill that would close the "three-day-stay" loophole for Medicare coverage was introduced Thursday, March 14, 2013 in the House and Senate.

The *Improving Access to Medicare Coverage Act of 2013*, which eases access to Medicare coverage in skilled nursing facilities following a hospital stay under observation status was introduced in the Senate by Sen. Sherrod Brown (D-Ohio) and in the House by Reps. Joe Courtney (D-Conn.) and Tom Latham (R-Iowa).

As it is now, seniors who need skilled nursing care following a hospital stay with an "observation" classification face the possibility that their care won't be covered by Medicare Part A, as current coverage requirements call for three days under an "in-patient" status, known as the "three-day-stay" rule.

What often happens is that individuals aren't told while they're in the hospital whether they're being admitted as an inpatient, or under observation. Then when they transition to a skilled nursing facility, they're forced to pay for those services out of pocket because Medicare won't cover their care.

The new legislation would change the requirement so that time spent under observation status in a hospital would count toward satisfying the three-day stay minimum and ease the burden on patients to qualify for Medicare coverage.

"When an individual is in the hospital, the only thing that should be on her mind is a healthy recovery," said Mark Parkinson, President and CEO of the American Health Care Association/the National Center for Assisted Living (AHCA/NCAL). "We should not allow technical tasks such as coding interfere with providing the best care possible in all facilities. As an advocate for seniors and those individuals requiring skilled nursing care, our Association commends Sen. Brown and Reps. Courtney and Latham for supporting this effort and focusing on the most important matter: quality care."

Similar legislation was introduced in 2011, but didn't end up receiving committee consideration. Last August, a CNN:Money article called the rule "ripe for elimination" in light of the shortening length of hospital stays due to medical advances and hospitals trying to cut costs.

"My legislation says, 'Three days is three days.' We don't care how it gets coded between the government at the hospitals—that's an issue for them to work out between themselves," said Rep. Courtney at the time. "But Medicare should be able to cover rehabilitative services

Source: Senior Housing News, March 15, 2013, Written by Alyssa Gerace

Brief Examines Money Follows the Person Program

Money Follows the Person: A 2012 Survey of Transitions, Services and Costs is a new report from The Kaiser Commission on Medicaid.

We currently have 46 states including the District of Columbia in the Money Follows the Person Program that transitions nursing home residents back to the community. Over the past year, 16 states have been approved to participate in Money Follows the Person. As of August 2012, over 25,000 individuals have transitioned back to the community as MFP participants since 2008.

The states of Ohio, Texas and Washington had 43% of the total Money Follows the Person participants that transitioned during this period. The average monthly cost of serving an MFP participant was $4,432, $7,723 for a person with a disability and $3,286 for an older adult. Twenty-four states said that it was less costly to provide care in the community compared to a nursing home.

The main challenge for Money Follows the Person have been the lack of affordable senior housing. Twenty-six of the state's employee housing coordinators in their Money Follows the Person program to address this barrier to transitioning.

Some additional facts on Money Follows the Person

- Average age of MFP participant 56 years old.
- Average re-institutionalization rate was 8%.
- Average amount of time to transition back into the community- 3.5 months

As states apply for additional programs that augment Medicaid revenue, such as the Balancing Incentive Program and the Community First Choice program, there will be further successes with transitioning nursing home residents through Money Follows the Person. MFP started off slow, but there has been significant improvements over the past three years as states implement programs to improve assessment, service delivery and quality improvement of long-term services and supports in the community.

The Importance of Testing Your Media Plan

With all the mass media options available today, it can be daunting to decide where and how to allocate your media budget. Your best bet is to stretch those dollars to provide maximum impact for reaching your audience and providing the ROI needed to help meet your sales goals. You can do this by negotiating added value to accompany all paid media, or by making a data-driven assessment of your primary marketing area (PMA) and seeking out opportunities to zone your placements within a specific portion of the overall coverage area of a given vendor. These efforts, while encouraged, may not provide the best results when used alone.

"If you always do what you've always done, you'll always get what you've always gotten." With this in mind, as you start to utilize the results/data from past media efforts to plan ahead, your data pool will be limited by the fact that you've targeted specific geographic areas or segments of the population (such as heavy newspaper users), or possibly both. Depending on how limited your budget is, this could cause you to miss a portion of your target audience, as they may not have been exposed to your message and thus can't be included in your overall results. So it's wise to incorporate "testing" at least a small percentage of your marketing budget when putting together media plans.

There are many ways to test performance within a media plan. Best practices say to budget about 10%-15% of your media dollars for testing. This will keep 85%-90% of your dollars with proven media options and not result in a "bet the farm" scenario. It's also important to commit to testing by setting up the framework to gather the data needed to judge performance. This will include items such as dedicated call tracking numbers and dedicated tracking URLs (or even better, landing pages). To accurately gauge performance, response mechanisms for the test shouldn't be shared by anything else on the plans. Inform everyone involved in the process the test is taking place. This will alert them to a possible increase in calls or any special scripting that may need to take place as a result of the phone call. Testing should also be ongoing, with results being analyzed and used to update current plans to maximize efficiency.

Now it's time to decide what you want to test. Testing options are unlimited. Test a specific vendor or medium that you haven't utilized recently or at all. Test creative with your second-highest-performing vendor to see which message gains a greater response. You

may also want to test response mechanisms – do they prefer to submit an online request, or call the dedicated phone number? Test new geographical areas or ZIP codes that haven't been included in other areas of the overall plan. Any test you choose will help you gather data and ultimately increase the efficiencies and performance of your media plan, which should translate into stretching your budget even further while helping to reach your overall goals for occupancy. Any test you complete, if done effectively, will result in a "win" for your organization. Even if a test doesn't generate leads, it shouldn't be viewed as a failure. You've still learned something from your efforts, and can move on knowing that your dollars are being better utilized elsewhere.

Now there's only question left to answer: Where will you begin with your testing program?
Source: GlynnDevins Blog, March 13, 2013, By John Carmichael

This Week at LSN

Learn, Connect and Discover at LSN Annual Meeting & Exhibition

Don't miss out on this opportunity to learn, network and be inspired at the 2013 LSN Annual Meeting and Exhibition at Navy Pier, May 1-3. This event will bring over 150 educational sessions to choose from, guaranteeing *something for everyone*. Sessions are available in the following tracks:

- Care and Service Innovations
- Environment and Design
- Financial Management and Revenue Enhancement
- Leadership and Strategy
- Life Enrichment and Wellness
- Management and Operations
- Marketing and Sales
- Professional Development
- Public Policy and Legal Issues
- Workforce Development

Wednesday evening the Keynote speaker, John O'Leary, will amaze the audience with his story of hope and inspiration during the General Session. In addition, the Expo Floor will be filled with innovative solutions and cutting edge technology for the senior living industry. Lastly, don't miss out on the opportunities to network with your peers at the Pier!

Click here to register or here for more details on the 2013 Annual Meeting & Exhibition.