

Special Issue: Aging - It's Personal: Forum

Who Knew? Hospice Is a Business. What that Means for All of Us

Anna N. Rahman, PhD

Gerontology Research Consultant, Santa Monica, California.

Address correspondence to Anna Rahman, PhD, 519 Stassi Lane, Santa Monica, CA 90402. E-mail: rahmananna1@gmail.com

Received December 17, 2015; Accepted February 23, 2016

Decision Editor: Nicholas G. Castle, PhD

Abstract

A seasoned gerontologist whose work has explored end-of-life care, I thought I knew what I was getting into when I undertook care for my brother Jim. In April 2014, Jim, whose health was then declining rapidly due to liver cancer, moved from his apartment in Minneapolis to my house in Santa Monica. Jim had come for a liver transplant evaluation at the University of California, Los Angeles (UCLA). When the UCLA team declined to list him—his cancer was just too widespread—Jim elected to stay with my family and me, enrolling in hospice. I did my homework when shopping for a hospice provider. Colleagues in the field gave me referrals. I googled their recommendations and read the reviews. I interviewed admissions counselors. When Jim signed the admission papers, I was confident that we were in good hands with the agency we selected. For the most part, we were. Hospice is widely considered an effective program. Studies show that it prevents pain and suffering among dying patients and increases satisfaction with care. Although other health care programs are regularly pilloried in the press, hospice programs are often lauded. Indeed, they sometimes appear so mission driven that one might mistake them for charities. They are not. Whether for-profit or not-for-profit enterprises, they are businesses—and concerned about their bottom line. Through Jim's story and mine, this article highlights the implications of this business orientation for patients and providers. Methods for evaluating hospice programs nationally are critiqued. Finally, recommendations for improving the business of hospice care are offered.

Keywords: Hospice, Caregiving, End-of-life care, Quality improvement

Background

It is unsettling for a dying person and his family to think of hospice as a business, but in my experience, it is foolhardy not to.

In April 2014, my brother Jim, whose health was then declining rapidly due to liver cancer, moved from his apartment in Minneapolis to my house in Santa Monica. Jim had come for a liver transplant evaluation at the University of California, Los Angeles (UCLA). When the UCLA team decided against recommending Jim for a transplant—his cancer was just too widespread—Jim elected to stay with my family and me, enrolling in hospice.

As a seasoned gerontologist whose research has explored end-of-life care, I did my homework when shopping for a

hospice provider. Colleagues in the field offered local referrals. I googled their recommendations and read the reviews. I interviewed hospice staff. When Jim signed the admission papers, I was confident that we were in good hands with the agency we selected.

For the most part, we were. Hospice is widely considered an effective program. Studies show that it reduces pain and suffering among dying patients and increases satisfaction with care ([Institute of Medicine, 2014](#)). Although other health care programs are regularly pilloried in the press, hospice programs are often lauded. “Hospices are known and trusted in their communities,” a clinician told an Institute of Medicine committee that recently examined end-of-life care in the United States ([Institute of Medicine,](#)

2014). Indeed, hospices sometimes appear so mission driven that one might mistake them for charities. I learned they are not. Whether for-profit or not-for-profit enterprises, hospice programs operate as businesses and so must be concerned with their bottom line.

“Business” is often viewed as a dirty word by patients and their advocates, including some health care researchers. Rather than shun this aspect of health care, however, I believe we—patients, caregivers, and advocates—will fare better if we acknowledge it and strive to manage it accordingly. Through Jim’s story and mine, this article highlights the implications of this business orientation for patients and providers. Methods for evaluating hospice programs nationally are critiqued. Finally, recommendations for improving the business of hospice care are offered.

My Brother Jim

I cannot report on our experiences without first introducing my brother. Jim, a shorter, stockier version of Paul Newman, was beloved by family and friends as a “good guy,” “kind soul,” “the best of the best.” He was the oldest of six siblings, all of us born within a span of 8 years. After completing high school in the rural Minnesota town in which we grew up, Jim moved to Minneapolis, where, until the last 3 months of life, he lived by himself in various apartments. He never married, never had kids. He almost always lived within a short car ride of our brother Julius, a lawyer in Minneapolis.

Jim was a cook, a trade that he learned he loved in a high school Home Economics class. Until the last 2 years of his life, when his cancer diagnosis effectively disabled him, Jim supported himself by cooking for various restaurants in the Twin Cities. He was extremely hardworking, nearly obsessive in his desire to be the best cook possible. I remember once serving Jim’s turkey stew to my mother-in-law, a sweet, rather old-school lady who has always wished I were a better cook than I am. One bite of this savory stew and her eyes brightened: “Now I know my daughter-in-law is an excellent cook!” she declared. I was sorry to disappoint her but happy to credit Jim.

Although he was a genius in the kitchen, Jim in other respects was cognitively slow. Today, a kid like Jim would probably have a learning disability diagnosis but not back then. None was needed, however, for us siblings (our parents had both passed by 1991) to know that Jim would need our help whenever his life got complicated.

And his life got very complicated after he was diagnosed with liver cancer in 2012, at the age of 57. For the purpose of this article, I will skip over the details of that 2-year rollercoaster, focusing instead on how Jim and I experienced the business context of hospice in the last 3 months of life. That aspect of the hospice benefit was apparent even before Jim’s enrollment in a program.

The Medicare Hospice Business Model

In the course of being evaluated for a liver transplant at UCLA, Jim developed an infection that required hospitalization. He learned during that stay that UCLA could not recommend him for the transplant list because of his extensive tumor mass. When the doctor asked whether he understood what she had just told him, he replied, “I’m a goner.” Then he stopped eating and taking his medicines. Soon after, he developed hepatic encephalopathy, which results in serious confusion from the toxins that accumulate in the body. The behaviors I saw scared me: Jim was combative, almost immobile, inarticulate, and incontinent of urine and bowel. It took a team of nurses to manage him. When the confusion finally cleared (it required a nasogastric tube and physical restraints to prevent Jim from yanking the tube out), we began talking of discharge, and I began exploring hospice.

Even when no one recommends curative measures—Jim’s doctors were unanimous that more chemotherapy or radiation would do more harm than good—electing hospice can be difficult. Medicare’s hospice benefit requires that patients not only have life expectancy of 6 months or less but that they also forego curative care. But what qualifies as curative? Suppose, for example, that Jim developed internal bleeding, which is common among seriously ill liver cancer patients. Could the bleeding be treated under hospice?

The hospital social worker’s answer surprised me. If you need to, you can opt out of hospice at any time to pursue curative care, she explained, and then opt back in following care delivery. She was right; you can. But this strategy did not sound *right* to the gerontologist in me. It struck me as improper. Others concur. In a recent study, Teno and her colleagues (2015) define discharges from hospice that are followed by hospitalization and then readmission to hospice as “problematic,” for this pattern suggests a problem with advance care planning.

Such practices may occur for financial reasons. Consider that Medicare’s hospice program, the model for most other U.S. hospice programs, pays a daily rate to hospice providers. In return, providers assume “all financial risk for costs and services associated with care for the patient’s terminal illness and related conditions” (Medicare Payment Advisory Commission, 2015, p. 289). That daily rate, then, pays for nurse visits, durable medical equipment, medications, on-call services, ambulance fees—all patient services—as well as the providers’ administration and management costs. Medicare patients pay virtually nothing out of pocket for hospice services. In 2015, Medicare’s rate for routine hospice care, which accounts for almost 98% of all hospice care days, was \$159.34 per day per patient (Medicare Payment Advisory Commission, 2015). The Centers for Medicare and Medicaid Services recently enacted payment reforms that take into account that hospice care costs more to deliver in the first 60 days of a stay. Thus, in 2016, the per diem rate for hospice care will change to \$187.54 for

Days 1–60 and drop to \$145.14 per day thereafter (Centers for Medicare and Medicaid Services [CMS], 2015b).

In practice, although it may sound crass, this capitated payment structure means that hospice providers lose money on some patients and make money or break even on others. As a general rule, the key to staying in business is to serve more of the latter than the former. One way hospice providers do this is by helping their patients manage pain and symptoms so that they avoid unnecessary hospital stays, for care provided in these settings is very expensive. Although Medicare pays a higher daily rate for hospice patients who require hospitalization, its rate is far lower than the cost of most hospital stays. In 2015, the Medicare hospice rate for inpatient care was \$708.77 a day (Medicare Payment Advisory Commission, 2015). By comparison, in 2010, the average cost of a hospital stay was \$11,600 a day for Medicare patients (Pfunter, Wier, & Steiner, 2013).

Given this discrepancy, most hospice providers cannot afford to cover even short hospital stays for even some enrollees. Consequently, if a patient needs hospitalization, the hospice may urge disenrollment, with an offer to re-enroll the patient following hospital discharge. For consumers, this practice appears to offer the best of both worlds, at little or no extra cost. A Medicare patient who opts out of hospice is again covered by regular Medicare, so any hospital stay would be mostly covered. Jim and I later learned that switching Medicare status is not as convenient as it sounds, but the ability to do so can serve as a selling point for hospice providers.

For-Profit Versus Not-for-Profit Hospices

Ultimately, Jim elected to enroll in hospice. I invited him to move into my home, with my daughter, husband, and me, and he accepted our invitation. Hospice is a holistic modality of palliative care and as such—and in accordance with Medicare regulations—cares for not only the individual enrolling but also that person's family members or other caregivers. As Jim's primary care provider, I knew hospice services would benefit me as well as Jim. In all likelihood, I would not have offered to oversee my brother's care had a hospice team not had my back.

I had a gerontologist's advantage in selecting a hospice provider in that several of my colleagues specialize in the study of end-of-life care. They steered me away from for-profit agencies and toward not-for-profit programs, in part because recent studies have found higher rates of questionable practices among for-profit programs (Medicare Payment Advisory Commission, 2015; Teno et al., 2015; Wachterman, Marcantonio, Davis, & McCarthy, 2011).

In recent years, the number of hospices in the United States has increased steadily, from 2,255 in 2002 to 3,925 in 2013. Most of this growth is due to an increase in the number of for-profit hospices (Medicare Payment Advisory Commission, 2015). Between 2012 and 2013,

for instance, the number of for-profit hospices increased by more than 9%, whereas the number of not-for-profit hospices remained relatively flat (Medicare Payment Advisory Commission, 2015). In 2013, most hospices in the United States—61%—were for-profit businesses (Medicare Payment Advisory Commission, 2015).

In and of itself, this rapid increase in for-profit hospices is not troublesome. What is unsettling is the emerging evidence that these hospices are more likely than not-for-profit hospices to engage in practices that have raised concerns among federal regulators and policymakers (CMS, 2014; Medicare Payment Advisory Commission, 2015). Consider, for example, that long-stay hospice patients historically have been more profitable than short-stay patients (Medicare Payment Advisory Commission, 2015). This is because hospice patients use the most services, and thus cost the most, at the start and end of their stays. The care provided between times, which is maximized with longer stays, is less expensive to deliver, and thus more profitable for the hospice. A recent analysis found that patient length of stay is substantially higher at for-profit hospices than at not-for-profit hospices (105 days vs 68 days, respectively, in 2013; Medicare Payment Advisory Commission, 2015). This finding raises concerns that for-profit hospices may be selectively enrolling their patients to maximize profits (Medicare Payment Advisory Commission, 2015; Wachterman et al., 2011).

Teno and colleagues also found that for-profit hospices were more likely than not-for-profit hospices to engage in problematic live discharges, including discharging patients after very short stays, within 7 days of admission, or very long stays, exceeding 180 days in hospice (Teno et al., 2015). Very short stays are commonly thought to offer only limited benefits to patients and their caregivers (Medicare Payment Advisory Commission, 2015; Wachterman et al., 2011). Very long stays may indicate that the patient was inappropriately enrolled in hospice, for Medicare requires that hospice patients have a life expectancy of 6 months or less if the terminal illness follows its normal course (Medicare Payment Advisory Commission, 2015; Wachterman et al., 2011). Medicare further requires that hospice physicians recertify patients after 90 days and, again, after 180 days. Thereafter recertification is required every 60 days. Other studies have found that for-profit hospices are less likely to provide discretionary services to patients than are not-for-profit hospices (Jarosek, Virnig, & Feldman, 2009).

Our Experience of the Hospice Business Model

Although this research helps describe how the hospice industry is evolving, it cannot reliably describe how any one hospice will perform. There are good for-profit hospices just as there are bad not-for-profit hospices. In Jim's case, the not-for-profit agency that we selected after careful vetting engaged in a few practices that troubled me, sometimes a little, sometimes a lot.

One such practice jarred me from the start. It involved medication management, a practice that varies among hospices. Our hospice in the first week of service switched all of Jim's medicines from a 1- to 3-month supply to a 2-week supply. This change resulted in my having to vigilantly monitor and more frequently reorder Jim's medicines, for fear we would run out of one or another. On the plus side, the hospice arranged for home delivery of Jim's meds. What bothered me is that we were not given a choice in delivery schedules, possibly because this change was cost effective for the hospice. A 2-week delivery schedule aligns well with the median length of stay for hospice patients: 18 days in 2013 ([Medicare Payment Advisory Commission, 2015](#)). I concur that it would be fiscally irresponsible to waste money on medications that might never be used. I also agree that hospice providers should work to prevent such waste, for doing so helps preserve resources for the benefit of all patients. I wonder, however, if both my needs as a caregiver and the budgetary needs of the hospice could have been better served through greater attention to individualizing care. A conversation about the delivery schedule would have helped. Additionally, none of us involved in Jim's care, including the hospice providers, believed death was imminent in that first month. Given this, a month-long transition to the abbreviated delivery schedule might have been a viable and fiscally responsible option.

I also was baffled by the abundance of personal and health care items that the hospice sent us. Initially, I was impressed. Soon after Jim returned home from the hospital, we received a box full of facial and body cleansers, hand sanitizers, absorbent pads, incontinence briefs, protective gowns, healing ointments, shaving cream, and more. I felt fortified by these supplies—until we started to use them. In general, their quality was poor. The incontinence briefs, for instance, were ill fitting and looked more like diapers than underpants. Jim tried one and almost immediately asked whether he could switch to the "old ones," which fit better, and so worked better, and whose design maintained Jim's sense of dignity. They also were the most expensive brand available at our local drugstore. We paid out of pocket. They were well worth their price.

I did not think much about the costs for all the supplies we received until 1 day I offered our hospice nurse—I'll call her Kathy, not her real name—a bottle of hand sanitizer to cleanse her hands. "Here, use this," I said. "I prefer this brand to the kind your agency gave us. That sanitizer leaves a sticky film on my hands." Kathy concurred, adding that the hospice tended to purchase whatever was cheapest.

Now, with hindsight, and with all those unused products donated to a local charity, I wish the hospice had been more strategic in its purchases on Jim's behalf. Here again, as with the medication delivery schedule, I wish the hospice had worked harder to individualize care. Resources were wasted while other needs went unmet. What Jim really would have liked was a wider hospital bed, not because he was particularly big, but because all his adult life he had

slept in a queen-size bed. I believe we would have traded all the aforementioned supplies the hospice "gave" us for a bigger bed.

I recently asked a colleague who owns a small hospice whether it were economically feasible to offer patients such fine-grained choices. I envisioned the hospice giving us a supply allowance and a product catalog from which we might shop. She did not believe that strategy was practical; for it to work, hospices would need to crunch more data than most of them can presently manage. I understand the challenge, yet hope some hospices will take it on.

For me, the most disturbing event that illuminated the hospice's business model was a family meeting Kathy convened about 4 weeks after Jim's enrollment. Kathy was concerned that we—Jim and me as his caregiver—were not really ready for hospice. She recommended that we all meet with her agency's social worker. This recommendation followed so closely on two discussions that Kathy and I had about Jim's care that I could not help but link the two.

The first discussion concerned treatment of Jim's expanding belly, a condition known as ascites marked by fluid accumulation resulting from liver failure. I advocated for paracentesis, essentially a belly tap, because Jim's strained abdomen caused him considerable pain and discomfort. Jim's UCLA doctors had said the procedure was low-risk, common, and could be done as an outpatient. I recalled that the hospice's admissions nurse had said before Jim enrolled that the procedure would be covered. Increasingly, however, I felt we were victims of a bait-and-switch tactic, because Kathy kept stalling. Two weeks had passed since I requested the procedure and still we had not received a go-ahead from the hospice.

The second discussion was about the best medicine to prevent hepatic encephalopathy. The UCLA hepatologist had prescribed rifaximin, a comparatively expensive antibiotic that I later learned from an evidence-based review was more "promising" than alternative antibiotics in preventing hepatic encephalopathy ([Rothenberg & Keeffe, 2005](#)). With Jim's hospital supply of rifaximin dwindling, the hospice proposed to substitute a cheaper antibiotic. I balked and then pushed back, armed with the research review's conclusions.

In our family conference, Kathy cited both requests—for paracentesis and rifaximin—as evidence that we were not hospice-ready. She suggested we would be better served by the agency's palliative care program, which offered fewer, less intensive services. She also informed us that Jim could dis-enroll from hospice, undergo paracentesis as a regular Medicare beneficiary, and then re-enroll in hospice.

Jim, whose coping strategy was to leave these decisions to me, sat passively listening, while I grew emotional. Dis-enroll? Disrupt our lives *now*? Really? My message to Kathy was emphatic: We need your help and want your services; why would you even think about abandoning us?

Kathy responded by raising again our dispute over rifaximin. Silently, I recalled that the study in my hand had

found the alternative antibiotics to be effective, just not as effective as rifaximin (Rothenberg & Keeffe, 2005). With this in mind, I told Kathy we would drop our request and accept the hospice's alternative medication. I would closely monitor its effect on Jim.

At this point, the social worker weighed in, declaring us fit for hospice. Soon after, our conference concluded.

Within a week, I dropped our request for paracentesis, not as a concession to the hospice, but because Jim's ascites resolved, possibly due to his use of a prescribed diuretic.

So we successfully resolved our disagreements. But that family conference profoundly altered my view of the hospice. From then on, I saw it as patient centered and family oriented only up to the point that those patients and families did not demand services deemed too expensive. At the same time, I did not fault the hospice for protecting its business. After all, it did not serve Jim only; it served others as well. For it to continue to do so, I knew it had to limit outlier spending on potentially expensive services, medicines, and supplies.

Hospice Regulation, Quality Measurement, and Consumer Power

Hospice is a business, increasingly a for-profit business. So what can we consumers—patients and caregivers alike—do to ensure that this industry meets our needs?

Unlike, say, retail businesses, where the customer is purportedly king, hospices operate in a health care market highly regulated by third-party overseers and payers, including the federal CMS. If undesirable provider practices emerge in health care, reforms typically result not from changes in consumer behavior, as they often do in conventional markets, but from new regulations imposed by those third parties. Examples abound in the business context of the hospice benefit. CMS, for instance, enforces caps on hospice payments as a strategy for discouraging hospices from enrolling substantial numbers of long-stay (and more profitable) patients (Medicare Payment Advisory Commission, 2015). In 2016, CMS began offering "service intensity add-on" payments to hospice agencies that provide up to 4 hours per day of direct nursing or social work care during a patient's last 7 days of life (CMS, 2015b). Hospices that provide this extra patient care receive \$38.75 per hour for up to 4 hours per day. This reform was enacted to incentivize hospices to do what many were found not to be doing: Providing the skilled care that patients often need at the end of life (CMS, 2015b). It also now offers a financial incentive for providers to report a small number of quality measures, in part to ensure that hospices provide critical services to patients who need them (CMS, 2015b).

This regulatory process for ensuring high quality care for hospice patients is necessary and inevitable, given the structure of our health care system. But it is problematic because it is slow moving and often ineffective. CMS, for instance, has not yet set a date for publicly reporting

Medicare's hospice quality measures (CMS, 2015a). Once these measures are publically available, they may have minimal effect on consumer decision making, for studies investigating whether CMS hospital and nursing home ratings influence consumer choice find mixed results (Grabowski & Town, 2011; Rothberg, Morsi, Benjamin, Pekow, & Lindenauer, 2008).

What I find most objectionable about this quality improvement process, however, is that it relegates me, those I care for, and others like us—health care consumers and caregivers—to largely passive roles as "beneficiaries" and care "recipients."

Others have written about the privatization of risk in our society, especially with respect to health care (Thomas & Applebaum, 2015). Increasingly, patients and caregivers must shoulder responsibility at home for care management and treatment tasks that not long ago were delivered by professional health care providers. We are meeting that challenge valiantly. Up to 65 million Americans—29% of our population—provide care for someone who is ill, disabled, or aged, with most of that labor unpaid (AARP Public Policy Institute, 2015). The cost to replace us informal caregivers with paid skilled and unskilled workers would be \$863 billion annually (Chari, Engberg, Ray, & Mehrotra, 2015). Given our critically important contribution, what power do we—patients and those close to them—possess to influence meaningful change? Based on Jim's and my experience with hospice, I would say almost none.

For all the talk these days about fashioning a health care system that is patient directed and family oriented, the mechanisms for shaping this system rest largely with regulators and third-party payers. Granted, these parties work to elicit our feedback through patient experience and satisfaction surveys (CMS, 2015a). But here, too, they largely determine what topics to address. In doing so, they decide what is of most importance to us consumers.

As hospice beneficiaries, Jim and I held consumer power over two major decisions. The first concerned our choice of hospice provider. Here, I believe, consumers are most empowered when they are well informed and can comparison-shop. In practice, however, many make this choice under great stress and time pressure, with little knowledge of hospice. I, for instance, study end-of-life care, yet did not know until researching this article that hospices can provide continuous home care for "brief periods of crisis" (Department of Health and Human Services, CMS, 2015, p. 26) and receive a higher daily Medicare rate for doing so. Of course, not all hardships qualify as covered crises, and Medicare regulations preclude hospices from providing continuous care if their assessment finds it clinically inappropriate or unnecessary; this holds true even when a patient or caregiver believes otherwise. Still, had I known about it, I would have requested such help in the very last days of Jim's life, when we met with a crisis that devastated us and left me as Jim's caregiver near collapse. My colleague who owns a hospice said some hospices do not disclose this

benefit for fear that all their patients will request it and drive up provider costs. In short, our incomplete knowledge limits our consumer power.

The other source of potential power is the consumer's ability to fire providers. At any point during Jim's hospice stay, he and I could have dismissed our hospice provider and shopped for a new one. Such a move, however, can be extremely disruptive at a time of great need. For us and, I suspect, for many hospice users, the choice to switch providers is more theoretical than practical.

A Recommendation for Strengthening Consumer Power

In recent years, another source of considerable consumer power has emerged: our customer reviews, as posted to such sites as Yelp, Google, and Caring.com, which focuses exclusively on reviews of services for older adults, including hospice. Opinions about these sites vary. Consumers tend to like, trust, and use them, despite skepticism that some reviews are rigged (Lusky, 2013; Neilsen, 2012). Businesses increasingly are on board, despite misgivings that poor reviews can have outsized negative influence, especially on start-ups and small businesses (Matt, 2013). Like them or not, however, most business experts agree these sites *do* influence consumers' decisions (Blanding, 2011). Indeed, recent studies have found that a half-star to one-star increase in a business's Yelp rating translates into more business and revenue (Luca, 2011; Yang, 2012).

With respect to hospice care, greater use of these review sites could help transform care quality in several ways. First, because these reviews matter, they motivate business owners. The hospice owner I consulted for this article, for instance, recalled that a poor Yelp review spurred her and her staff to action to correct the mistake mentioned by the reviewer. And who among us has not received stellar customer service followed by a request to review the provider online. Although some cringe at this behavior—for it so clearly links a business's customer service with its hopes for a good review—I often reward it with five stars. In my view, excellent service is excellent service. Consumer reviews also help educate other consumers about a particular service or product. Many of us, for instance, consult TripAdvisor reviews when planning vacations, for these reviews often disclose useful information that some of us otherwise would never have thought to inquire about or could not have obtained from other sources. In the same way, detailed hospice reviews could be especially useful for potential patients and caregivers who know little about what to expect from providers. Some hospices, for example, cover paracentesis for patients who, as Jim did, suffer from extended bellies. That information disclosed in an online hospice review would have helped me advocate better for Jim. Also, because consumers write about what matters most to them (here, I think about the bigger hospital bed Jim would have liked), their reviews can spotlight aspects of care that might otherwise be overlooked

by providers or third-party payers. In other words, these reviews truly capture the consumer voice. Finally, although hospice users likely will review providers following receipt of all services—and so may not receive improved care as a result—some may benefit directly nonetheless, for they may find closure in writing their review and gain comfort from helping others.

In my view, the benefits of review sites for hospice consumers far outweigh what some assert is the biggest consumer downside to these sites: that the reviews are untrustworthy because businesses game them. Few would dispute that some businesses try. Estimates of fake or biased reviews range from 16% to 40% (Guynn & Chang, 2013; Seligson, 2013). In response, and because their livelihood rests on their credibility, the review sites employ numerous strategies to prevent and weed out fraudulent reviews (Guynn & Chang, 2013). Their efforts appear to be paying off: According to a Nielsen study, “70% of consumers worldwide trust online reviews, compared to just 47% who believe traditional broadcast and print ads” (Nielsen, 2012; Lusky, 2013).

Conclusion: A Call to Action

Presently, health care services are less frequently reviewed than many other businesses, such as restaurants and shopping venues (Yelp, 2015b). When I looked online, I found just three reviews across three websites for the hospice Jim and I used. This gap is unfortunate because more reviews yield a more meaningful average rating of a business and provide more feedback for consumers to consider (Luca, 2011). I would like us to close this gap to empower us consumers.

With this article, I call on all of us—as gerontologists and, possibly, as patients and caregivers—to use or promote the use of online review sites as a strategy for igniting quality improvement in the hospice industry. This effort is not intended to replace present efforts to improve care quality. Rather, I recommend it as a supplement to those efforts, one that can be pursued immediately at virtually no extra cost to our health care system. My review of the hospice that served Jim will not help my brother now. It may, however, help others like Jim and me. I find that comforting and, even now, empowering.

It has been more than a year since Jim died. When the hospice recently asked me to consider a donation in his name, I sent one, for there is no question that the staff's help improved Jim's quality of life. Jim experienced relatively little pain and discomfort for most of his last days. Soon after sending my donation, I posted reviews of the hospice on three sites. Yes, it took me that long to gather my thoughts. In each, I gave the agency four stars, dinging it one star in part for events reported in this article, but mostly because no one from the hospice visited Jim in the last week of his life, despite desperate calls from me that we needed help. In keeping with recommended review guidelines, I explained in detail the reasons for my rating in each review. I hope the hospice takes note (Yelp, 2015a). I hope

other consumers do as well. I want the hospice to improve so that the oversight we experienced does not recur and distress other patients and caregivers.

References

- AARP Public Policy Institute. (2015, June). *Caregiving in the U.S.: 2015 Report*. Retrieved December 17, 2015, from <http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf>
- Blanding, M. (2011, October 24). *The Yelp factor: Are consumer reviews good for business?* Working Knowledge, Harvard Business School. Retrieved December 17, 2015, from <http://hbswk.hbs.edu/item/the-yelp-factor-are-consumer-reviews-good-for-business>
- Centers for Medicare and Medicaid Services. (2014, August 22). *Medicare program; FY 2015 hospice wage index and payment rate update; hospice quality reporting requirements and process and appeals for Part D payment for drugs for beneficiaries enrolled in hospice*. Federal Register 79, no. 63. Retrieved February 5, 2016, from <https://www.federalregister.gov/articles/2014/05/08/2014-10505/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting>
- Centers for Medicare and Medicaid Services. (2015a). *Hospice quality reporting—Centers for Medicare & Medicaid Services*. Retrieved December 17, 2015, from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-reporting/>
- Centers for Medicare and Medicaid Services. (2015b, August 6). *Medicare program; FY 2016 hospice wage index and payment rate update and hospice quality reporting requirements*. Federal Register 80, No. 151. Retrieved February 5, 2016, from <https://www.federalregister.gov/articles/2015/08/06/2015-19033/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>
- Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2015, May 8). *Medicare benefit policy manual*. Retrieved February 5, 2016, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>
- Chari, A. V., Engberg, J., Ray, K. N., & Mehrotra, A. (2015). The opportunity costs of informal elder-care in the United States: new estimates from the American Time Use Survey. *Health Services Research*, 50, 871–882. doi:10.1111/1475-6773.12238
- Grabowski, D. C., & Town, R. J. (2011). Does information matter? Competition, quality, and the impact of nursing home report cards. *Health Services Research*, 46, 1698–1719. doi:10.1111/j.1475-6773.2011.01298.x
- Guyonn, J., & Chang, A. (2013, October 4). *Yelp reviews: Can you trust them? Some firms game the system*. Retrieved December 17, 2015, from <http://articles.latimes.com/2012/jul/04/business/la-fi-yelp-reviews-20120704>
- Matt, H. (2013, March 19). *Study: Yelp drives real revenue to small businesses*. *Yelp Official Blog*. Retrieved December 17, 2015, from http://officialblog.yelp.com/2013/03/yelp_survey_findings.html
- Institute of Medicine. (2014). *Dying in America: Improving quality and honoring individual preferences near the end of life*. Retrieved December 17, 2015, from <http://www.nap.edu/read/18748/chapter/1>
- Jarosek, S. L., Virnig, B. A., & Feldman, R. (2009). Palliative radiotherapy in Medicare-certified freestanding hospices. *Journal of Pain and Symptom Management*, 37, 780–787. doi:10.1016/j.jpainsymman.2008.05.003
- Luca, M. (2011, October 4). *Reviews, reputation, and revenue: The case of Yelp.com*. Working Knowledge, Harvard Business School. Retrieved December 17, 2015, from <http://hbswk.hbs.edu/item/reviews-reputation-and-revenue-the-case-of-yelp-com>
- Lusky, M. (2013, August 29). *Online reviews, word-of-mouth and recommendations generate the most marketing trust*. The Business Journals. Retrieved December 17, 2015, from <http://www.bizjournals.com/bizjournals/how-to/marketing/2012/11/online-reviews-word-of-mouth-and.html?page=all>
- Medicare Payment Advisory Commission. (2015). *Report to the Congress: Medicare Payment Policy*. Retrieved December 17, 2015, from http://www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0
- Nielsen. (2012, April 10). *NewsWire | Consumer trust in online, social and mobile advertising grows*. Nielsen. Retrieved December 18, 2015, from <http://www.nielsen.com/us/en/insights/news/2012/consumer-trust-in-online-social-and-mobile-advertising-grows.html>
- Pfuntner, A., Wier, L. M., & Steiner, C. (2013, January). *Costs for hospital stays in the United States, 2011*. Statistical Brief 168. Retrieved December 17, 2015, from <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.jsp>
- Rothberg, M. B., Morsi, E., Benjamin, E. M., Pekow, P. S., & Lindenaer, P. K. (2008). Choosing the best hospital: The limitations of public quality reporting. *Health Affairs*, 27, 1680–1687. doi:10.1377/hlthaff.27.6.1680
- Rothenberg, M. E., & Keeffe, E. B. (2005). Antibiotics in the management of hepatic encephalopathy: an evidence-based review. *Reviews in Gastroenterological Disorders*, 5(Suppl. 3), 26–35.
- Seligson, S. (2013, October 4). *Yelp reviews: Can you trust them?* BU Today, Boston University. Retrieved December 17, 2015, from <http://www.bu.edu/today/2013/yelp-reviews-can-you-trust-them/>
- Teno, J. M., Bowman, J., Plotzke, M., Gozalo, P. L., Christian, T., Miller, S. C., ... Mor, V. (2015). Characteristics of hospice programs with problematic live discharges. *Journal of Pain and Symptom Management*, 50, 548–552. doi:10.1016/j.jpainsymman.2015.05.001
- Thomas, K. S., & Applebaum, R. (2015). Long-term services and supports (LTSS): A growing challenge for an aging America. *Public Policy & Aging Report*, 25, 56–62. doi:10.1093/ppar/prv003
- Wachterman, M. W., Marcantonio, E. R., Davis, R. B., & McCarthy, E. P. (2011). Association of profit status and diagnosis with hospice care. *The Journal of the American Medical Association*, 305, 472–479. doi:10.1001/jama.2011.70
- Yang, S. (2012, September 4). *Crowd-sourced online reviews help fill restaurant seats, study finds*. Retrieved December 17, 2015, from <http://news.berkeley.edu/2012/09/04/yelp-reviews-boost-restaurant-business/>
- Yelp. (2015a). *Content guidelines* | Yelp. Retrieved December 18, 2015, from <https://www.yelp.com/guidelines>
- Yelp. (2015b). *Factsheet* | Yelp. Retrieved December 18, 2015, from <https://www.yelp.com/factsheet>