ENGAGEMENT PLAN · PATIENT EXPERIENCE · HEALTHCARE

Lodestar: *where a patient-experience budget* should actually go.

Across 3,956 US hospitals and 2.3 million CMS surveys, the dimension that scores worst is the one that matters least. Hospitals that start with their lowest number are spending on the weakest lever they own.

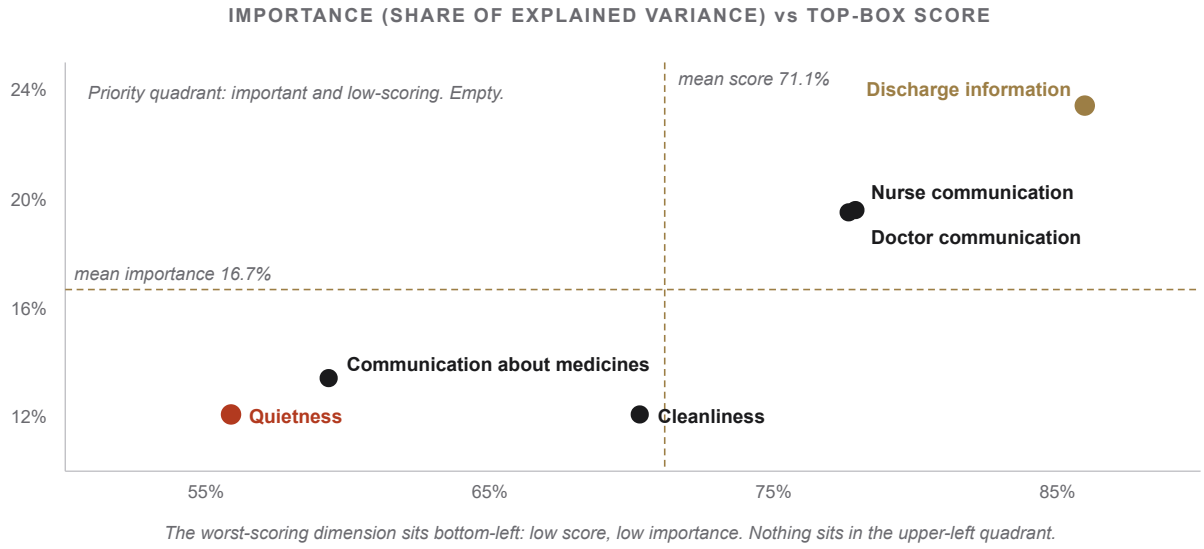
Author S. Ize-Iyamu **Audience** Provider / health-system partners **Length** 4 pages **Status** Engagement plan

The Problem

Hospitals read the patient-experience scorecard as a to-do list and start at the bottom. That instinct is expensive, because HCAHPS feeds CMS Hospital Value-Based Purchasing and a quality budget therefore has a payment consequence. Nationally, **quietness at night scores lowest** of the six dimensions at **55.8%** top-box, which is why it attracts attention.[1] It is also **tied for the weakest driver** of whether a patient would recommend the hospital, at **12.1%** of explained variance. The strongest driver is **discharge information** at **23.4%**, and it already scores highest at 85.9%.

This is easy to get wrong. The six dimensions are strongly correlated, so raw regression coefficients are unstable and can flip sign. The analysis uses **Johnson relative weights**[2], which split the model R-squared (0.57) into non-negative shares per driver. That is a standard correction for a collinear key-driver problem.

FIGURE 1 · IMPORTANCE AGAINST PERFORMANCE, SIX EXPERIENCE DIMENSIONS



Importance is the Johnson relative weight, the share of the model's explained variance (R-squared 0.57) attributable to each dimension. Performance is the survey-weighted top-box score. Source: CMS Provider Data Catalog, HCAHPS (dgck-syfz), retrieved 29 June 2026.

Sizing the opportunity

CMS withholds **2.00% of base operating MS-DRG payments** under Hospital Value-Based Purchasing and redistributes the whole pool, about $1.7B, on measured performance.[3] Person and Community Engagement, built entirely on HCAHPS, is one of four domains and carries **25% of the Total Performance Score**.[4] Patient experience is a payment line, not a soft metric. Nationally **70.3%** of patients sit in the top box of the reported measure.[5]

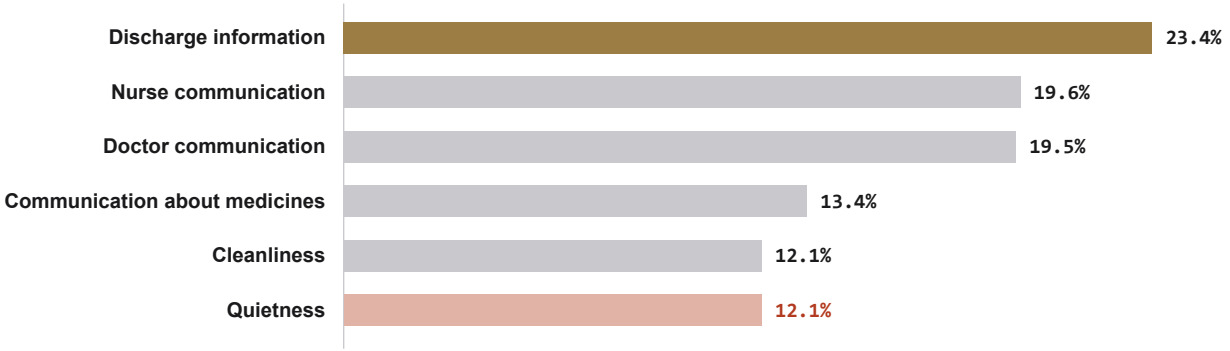
> **THE CLAIM**
> A hospital that opens its improvement programme on quietness is buying a 12.1% share of the model, tied for the smallest of the six. The same money spent protecting and extending discharge information reaches the 23.4% that moves recommendation most. Communication dimensions together account for over half the explained variance.

Engagement architecture

Four workstreams, run so that the model is defensible before anyone is asked to spend against it. The order matters: the client's instinct will be to act on the lowest score in week one, and the engagement has to earn the right to say no to that.

WORKSTREAM	WHAT IT DOES	OUTPUT
A. Driver model	Build the key-driver model on the hospital's own survey file, benchmarked to the national set. Use relative weights, not raw coefficients, because the dimensions are collinear.	Ranked drivers with a stated R-squared
B. Priority map	Place every dimension by importance against current score. Identify what to defend, what to fix, and what to leave alone.	Importance-performance map
C. Peer read	Compare against state and peer-cohort performance to separate a local operations problem from a national pattern.	Peer gap and early-warning list
D. Intervention design	Design the discharge-information and communication interventions, and the measurement that will show whether they moved the score.	Costed intervention plan

FIGURE 2 · DRIVERS RANKED BY IMPORTANCE



Relative weights sum to 100% of the variance the model explains. Quietness, the dimension hospitals most often target first, is tied for last at 12.1%.

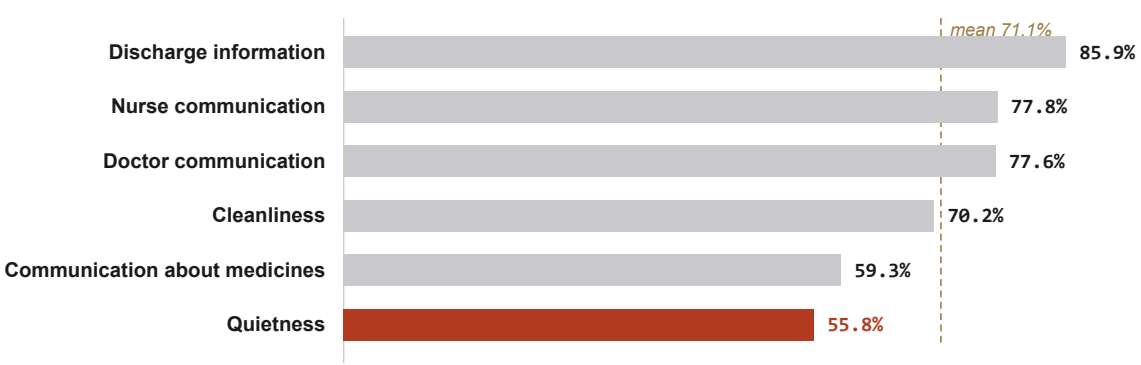
Sequenced delivery (eight weeks)

WEEKS	WORK	DECISION GATE
1 to 2	Pull the hospital's survey file and the CMS national set. Reconcile definitions, fix the complete-case rule, agree the outcome metric.	Baseline signed off
3 to 4	Build the driver model. Test collinearity, run relative weights, report R-squared honestly.	Model accepted or rejected
5 to 6	Map importance against performance. Name what to defend and what to leave alone.	Priority list agreed
7 to 8	Cost the interventions, design the measurement, and set the review cadence.	Budget authorized

Metrics that matter

One outcome metric, and it is the one Fred Reichheld argued for in 2003: would you recommend.[8] Everything else in the model is a means to it. The national top-box mean is 70.3%, so a hospital's position against that number is the first thing on the page.

FIGURE 3 · CURRENT PERFORMANCE BY DIMENSION (TOP-BOX SCORE)



Read against Figure 2. The two lowest scores belong to the two weakest drivers, which is the trap this engagement exists to avoid.

Risks & mitigations

HIGH **The client wants to fix the worst number anyway.**

Quietness is visible, cheap to talk about, and scores badly, so it has political pull. Mitigation: put the importance-performance map in front of the board in week six, before any budget is committed, and make the trade-off explicit in dollars against the value-based purchasing line.

HIGH **Correlated drivers produce a confident, wrong ranking.**

Raw coefficients on collinear survey dimensions are unstable and can invert. Mitigation: relative weights throughout, with the collinearity diagnostics reported alongside the ranking rather than buried.

MEDIUM **Importance is association, not proof of causation.**

A driver model ranks what moves with recommendation, not what would move it if changed. Mitigation: treat the top-ranked driver as a hypothesis and pilot the discharge-information intervention on a unit cohort with a control before scaling.

MEDIUM **Case mix and response bias distort the read.**

Survey respondents are not a random draw of patients. Mitigation: use the survey-weighted scores CMS publishes, keep the complete-case rule explicit, and benchmark within peer cohort rather than against the national mean alone.

30 / 60 / 90

DAY 30

Model on the table

- Baseline agreed against the CMS national set
- Driver model built and stress-tested
- R-squared and collinearity reported

DAY 60

Priorities named

- Importance-performance map signed off
- Quietness formally deprioritized
- Discharge information intervention costed

DAY 90

Pilot running

- Unit-cohort pilot live with a control
- Measurement cadence in place
- Board review against the recommend score

The decision asked

DECISION

Authorize an **eight-week diagnostic** with a three-person team, fixed fee, before any improvement budget is committed. The engagement earns its keep if it stops one wasted programme. On the national numbers, the programme most hospitals would start with is the one worth the least.

SOURCES

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2. 42 CFR 412.165 (current as of **11 Jul 2026**): four domains weighted 25% each (Clinical Outcomes; Person and Community Engagement; Safety; Efficiency and Cost Reduction). Person and Community Engagement is built entirely on HCAHPS. The Health Equity Adjustment was removed from HVBP scoring beginning FY2026.
3. HCAHPS measure H_RECMND_DY; survey item Q25 on the Updated HCAHPS Survey (discharges from **1 Jan 2025** forward), "Would you recommend this hospital to your friends and family?"; top-box response "Definitely yes." Accessed 11 Jul 2026.
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5. Johnson, J. W. (**2000**). "A heuristic method for estimating the relative weight of predictor variables in multiple regression," *Multivariate Behavioral Research* 35(1), 1-19. See also Grömping, U. (**2007**), *The American Statistician* 61(2), 139-147. Accessed 11 Jul 2026.
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8. HCAHPS measure H_RECMND_DY; survey item Q25 on the Updated HCAHPS Survey (discharges from **1 Jan 2025** forward), "Would you recommend this hospital to your friends and family?"; top-box response "Definitely yes." Accessed 11 Jul 2026.
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