MBQIP Reports User Guide for Critical Access Hospitals

Version II - February 2025

Flex Monitoring Team | University of Minnesota | University of North Carolina at Chapel Hill | University of Southern Maine

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User Guide Overview

The Medicare Beneficiary Quality Improvement Project (MBQIP) focuses on quality improvement efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program. Through Flex, MBQIP supports more than 1,350 rural hospitals certified as Critical Access Hospitals (CAHs) in reporting quality measures that are aligned with those collected by the Centers for Medicare and Medicaid Services (CMS) and other federal programs. The Flex Monitoring Team (FMT) produces state- and CAH-level reports of MBQIP measures for State Flex Programs (SFP) and CAHs. Each year, FMT creates and releases over 11,000 reports to support CAHs and SFPs in their quality improvement activities.

This guide was created to align with updated MBQIP reports released beginning in January 2025. These changes align with new measures added to MBQIP as a part of FORHP's MBQIP 2025 initiative.

This guide describes the **two types of MBQIP reports** (the MBQIP Measures report and the HCAHPS report) to be released quarterly. Information in this guide includes:

- which MBQIP measures are included in each report type
- where the data comes from for each measure
- when the data is updated for each measure

In addition, this user guide provides examples of how CAHs can utilize the data in the MBQIP reports and highlights resources developed to assist with quality reporting, analyses, and improvement.

As part of **MBQIP 2025**, FORHP added five measures to the MBQIP core measures and organized the new and existing measures into five new domains:

Global Measures	• **(NEW)** Infrastructure: CAH Quality Infrastructure
Patient Safety	• HCP/IMM-3: Influenza Vaccination Coverage Among Healthcare Personnel • Antibiotic Stewardship • **(NEW)** Safe Use of Opioids: Safe Use of Opioids – Concurrent Prescribing
Patient Experience	• HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems
Care Coordination	• **(NEW)** Hybrid HWR: Hybrid Hospital-Wide Readmissions • **(NEW)** SDOH-1: Screening for Social Drivers of Health • **(NEW)** SDOH-2: Screen Positive Rate for Social Drivers of Health
Emergency Department	• EDTC: Emergency Department Transfer Communication • OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients • OP-22: Patient Left Without Being Seen

The MBQIP reports have changed from three report types (Patient Safety/Inpatient and Outpatient, Emergency Department Transfer Communication (EDTC), and HCAHPS) to two report types: MBQIP Measures reports and HCAHPS reports. These two types of quarterly reports are emailed to you each quarter by your SFP.

Based on the MBQIP 2025 changes, as well as feedback from SFPs and CAHs, FMT reformatted the quarterly MBQIP reports to include the new measures and improve the display of the data.

The major changes to the report formats are as follows:

- The new report layout is arranged by measure, where each data table is directly followed by a corresponding trend figure.
- Trend figures now display an additional four reporting periods for a total of eight reporting periods for each measure (when available).
- The new reports start with a brief cover page outlining which measures are included in the report and conclude with an Appendix that includes additional information including methods, report formatting, and other data notes.
- The new Appendix also provides detailed information about each measure, including how the data was calculated for presentation in the report.

MBQIP Measures Reports

Summary

MBQIP Measures reports are released quarterly. See the summary table below for report release timing as well as which MBQIP measures will be updated in the first, second, third, and fourth MBQIP Measures reports each year.

MBQIP Measures Reports: Measures Included and Annual Anticipated Timeline

	Report 1	**Report 2**	**Report 3**	**Report 4**
Quarter Released	Winter	Spring	Summer	Fall
Data Updated *All measures will be included in each report. This row shows* ***which report(s) will include new data for each measure****.*	• EDTC Q3 • OP-18b Q2 • CAH Quality Infrastructure	• EDTC Q4 • OP-18b Q3 • Safe Use of Opioids	• EDTC Q1 • OP-18b Q4 • HCM/IMM-3 • Antibiotic Stewardship • OP-22 • SDOH-1 • SDOH-2	• EDTC Q2 • OP-18b Q1 • Hybrid HWR

As quarterly measures, EDTC and OP-18b data will be updated in every MBQIP Measures report. All other measures in the MBQIP Measures reports—Hybrid HWR, CAH Quality Infrastructure, Safe Use of Opioids, HCM/IMM-3, Antibiotic Stewardship, OP-22, SDOH-1, and SDOH-2—are annually reported. Data tables and trend figures for these measures will be updated once a year as outlined above.

Report Format

All MBQIP Measures reports follow the same general format. Each quarter, FMT releases individual PDF reports for your CAH.

1. **Cover Page:** Every report has a brief cover page stating the type of report (MBQIP Measures), the report number (e.g., Report 1), and the measures included in the report. The report for your CAH shows your hospital name, CCN, city, zip code, and state.
2. **Data:** The body of each report presents data for each measure. The layout is arranged by measure, where each data table is directly followed by a corresponding trend figure. Trend figures show eight reporting periods (when available). The reports display trend lines or bar graphs for the CAH, state, and national values. Data tables are organized with the following general columns:
    - A. **Measure:** This column outlines the measure reported in the data table. For example, for EDTC, this column includes a row for the composite value as well as a row for each individual component of the measure (e.g., Home Medications, etc.). For OP-22, this column has one row (as there are no sub-components for this measure).
    - B. **Your Hospital's Performance by Reporting Period:** The columns in this section provide data for your CAH from the current and previous reporting periods (when available). For example, for a quarterly measure like EDTC, these columns show data from the previous three quarters, the current quarter, as well as a combined value for all four quarters. For OP-22, an annual measure, these columns show data from previous years and the current year.
    - C. **State Current Reporting Period:** Depending on the measure, there are either two or three columns in this section.
        - i. The first column provides the number of CAHs in the state reporting data for the current reporting period.
        - ii. The second column shows an aggregate value of the measure for all CAHs in your state that reported for the current reporting period. For some measures, this value is provided in the units of the measure. For example, for OP-18b, measured in minutes, the aggregate value is the median time for reporting CAHs in the state. For some measures, the state aggregate value is the percentage of reporting CAHs that meet each element or domain. For example,

for CAH Quality Infrastructure, the aggregate value is the percentage of reporting CAHs in the state meeting each element.

iii. For HCP/IMM-3, OP-22, OP-18b, and EDTC, an additional third column is provided. This column shows the value reported by CAHs in the 90th percentile. The 90th percentile is the level of performance required to be in the top 10% of CAHs for a given measure (e.g., 10% of CAHs perform at or better than the 90th percentile).

D. **National Current Reporting Period:** This section mirrors the previous section of columns, "State Current Reporting Period," but provides national values.
   i. The first column provides the number of CAHs nationally reporting data for the current reporting period.
   ii. The second column shows an aggregate value for all CAHs in the nation that reported. For some measures, this value is provided in the units of the measure. For example, for OP-18b, measured in minutes, the aggregate value is the median time for reporting CAHs nationally. For some measures, the state aggregate value is the percentage of reporting CAHs that meet each element or domain. For example, for CAH Quality Infrastructure, the aggregate value is the percentage of reporting CAHs nationally meeting each element.

E. **Benchmark:** The last column in each data table provides the MBQIP benchmark value for CAHs, set by FORHP. This value is provided in units of the measure. For example, for Antibiotic Stewardship, the benchmark is meeting 100% of the elements. For OP-18b, the benchmark is 85 minutes or less. Not all measures have an MBQIP benchmark and will instead show "N/A."

3. **Appendix:** Each report concludes with an Appendix. The Appendix section outlines the report—similar to this user guide but more concise. It describes the data tables, data labels, percentiles, and trend figures. Most importantly, the Appendix includes specific information on how data elements were calculated for inclusion in the report and links to measure specifications.

Measures

Each measure is briefly described in the following table. For additional information on measures or measure reporting, please visit the **Measure Specific Resources** page on the RQITA website.

Measure	Displayed As	Source	Benchmark
EDTC: Emergency Department Transfer Communications	Percentage of eligible ED patients who met all eight data elements and percentage who met each of the eight data elements	Reported to SFPs	100%

Measure	Displayed As	Source	Benchmark
OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients	Median number of minutes	Reported to CMS via HQR	85 mins
OP-22: Patient Left Without Being Seen	Percentage of patients who left the ED without being seen	Reported to CMS via HQR	0%
CAH Quality Infrastructure	Number of total core elements met and if CAH met each core element	Reported to FMT via Qualtrics portal	100%
HCP/IMM-3: Healthcare Personnel Flu Vaccination	Percentage of healthcare workers vaccinated	Reported to CDC via NHSN Survey	100%
Antibiotic Stewardship	Number of total elements met and if CAH met each element	Reported to CDC via NHSN Survey	100%
Safe Use of Opioids	Percentage of adult inpatients prescribed two or more opioids or an opioid and benzodiazepine at discharge	Reported to CMS via HQR	N/A
Hybrid HWR: Hybrid Hospital-Wide Readmission	Percentage of 65+ Medicare inpatients readmitted to the hospital	Reported to CMS via HQR	N/A
SDOH-1: Screening for Social Drivers of Health	Percentage of adult inpatients screened for all five health-related social needs	Reported to CMS via HQR	N/A
SDOH-2: Screen Positive Rate for Social Drivers of Health	Percentage of patients who screened positive for each health-related social need	Reported to CMS via HQR	N/A

HCAHPS Reports

Summary

HCAHPS, the Hospital Consumer Assessment of Healthcare Providers and Systems, is a nationally standardized patient experience survey administered to adult inpatients. FMT creates quarterly reports based on HCAHPS data received from CMS. The summary table below outlines report release timing as well as which data will be in each report.

HCAHPS Reports: Measures Included and Annual Anticipated Timeline

<table>
<tr><th></th><th>Q1 HCAHPS</th><th>Q2 HCAHPS</th><th>Q3 HCAHPS</th><th>Q4 HCAHPS</th></tr>
<tr><td>Quarter Released</td><td>Winter</td><td>Spring</td><td>Summer</td><td>Fall</td></tr>
<tr><td>Data Updated</td><td>Q1 of current calendar year</td><td>Q2 of previous calendar year</td><td>Q3 of previous calendar year</td><td>Q4 of previous calendar year</td></tr>
<tr><td>Measures Included

All measures are included and updated in each report.</td><td colspan="2">• Communication with Nurses
• Communication with Doctors
• Responsiveness of Hospital Staff
• Communication about Medicines
• Care Transition
• Discharge Information</td><td colspan="2">• Cleanliness of Hospital Environment
• Quietness of Hospital Environment
• Hospital Rating
• Recommend the Hospital</td></tr>
</table>

CMS requires a CAH to submit at least 10 months of data (within four consecutive quarters) to be considered reporting. CMS reports measure values **in rolling four-quarter time periods**. To receive HCAHPS data in FMT reports, a CAH must have at least two complete patient surveys from each quarter in the reporting period.

Note: For data collected starting in January 2025, HCAHPS has updated their survey. These changes will not be reflected in the reports until FMT receives and analyzes data from the updated surveys (data from Q1 2025). We anticipate changes to be reflected in HCAHPS reports in late 2025 and will update this user guide accordingly.

Report Format

All HCAHPS reports follow the same format.

1. **Cover Page:** Every report has a brief cover page stating the type of report (HCAHPS), the quarter reporting period, and the measure components included in the report. CAH-level reports show the hospital name, CCN, city, state, and zip code of the CAH.
2. **Data:** The body of each report presents data for each HCAHPS measure component. The layout is arranged by component, where each data table is directly followed by a corresponding trend figure. Trend figures show eight reporting periods (when available) and display trend lines for the CAH, state, and national top-box percentage. The number of completed surveys, survey response rate, and overall star rating for the CAH are presented on the upper left of the page. *(Note: 100 completed surveys are required for CMS to calculate a star rating)*. The state- and national-level number of completed surveys and survey response rates are reported on the upper right of the page. Data tables in CAH-level reports only present data from the current rolling four-quarter period. Data tables are organized with the following general columns:

A. **Measure Component:** The first column outlines the measure component reported in the data table.
B. **HCAHPS Component Star Rating:** CMS provides a star rating (0-5) for each measure component. (*See the HCAHPS Star Ratings subsection below for more details)*. The cell will show "N/C" if a star rating was not able to be calculated.
C. **Your Hospital's Adjusted Score:** For each possible survey response, these columns provide the adjusted percentages of patients who selected each response to the HCAHPS component. *(The* ***Measures*** *subsection explains how CMS calculates and adjusts the percentages).* For example, for the Care Transition component, the first column shows the adjusted percentage of patients at the CAH who responded "Disagree to Strongly Disagree", the second column shows "Agree", and the third column shows "Strongly Agree".
D. **Your State's CAH Data:** This section follows a similar structure as the previous but provides state-level data. These values are the aggregate values from all reporting CAHs in your state.
E. **National CAH Data:** This section follows the same structure as the state-level data section. These values are the aggregate values from all reporting CAHs nationally.
F. **Benchmark:** The last column in each data table provides the MBQIP benchmark for each component for CAHs, set by FORHP.

3. **Appendix:** Each report concludes with an Appendix. The Appendix section outlines the report components—similar to this user guide but more concise. It describes the data tables, measure adjustments and aggregation information, response categories, benchmarks, and data labels and exceptions. It also includes links to measure specifications.

Measures

HCAHPS Measures

HCAHPS data are submitted to CMS via HQR by a vendor. Each HCAHPS component is briefly described in the following table. For detailed information, please visit the **HCAHPS website** and/or **Technical Notes**.

CMS classifies patient responses into top-box, middle-box, and bottom-box categories. Top-box is positive responses to questions, while middle-box is intermediate, and bottom-box is the least positive. See the table below for how responses are categorized for each measure.

<table>
<tr><th>HCAHPS Measure</th><th>Q</th><th colspan="3">Patient Survey Response</th><th colspan="2">Benchmark*</th></tr>
<tr><th colspan="2"></th><th>Bottom-Box</th><th>Middle-Box</th><th>Top-Box</th><th>2024</th><th>2025</th></tr>
<tr><td>Communication with Nurses</td><td>Q-1
Q-2
Q-3</td><td rowspan="6">Sometimes or Never</td><td rowspan="6">Usually</td><td rowspan="6">Always</td><td>86%</td><td>86%</td></tr>
<tr><td>Communication with Doctors</td><td>Q-5
Q-6
Q-7</td><td>86%</td><td>86%</td></tr>
<tr><td>Responsiveness of Hospital Staff</td><td>Q-4
Q-11</td><td>77%</td><td>-</td></tr>
<tr><td>Communication about Medicines</td><td>Q-13
Q-14</td><td>70%</td><td>70%</td></tr>
<tr><td>Cleanliness of Hospital Environment</td><td>Q-8</td><td rowspan="2">77%</td><td rowspan="2">78%</td></tr>
<tr><td>Quietness of Hospital Environment</td><td>Q-9</td></tr>
<tr><td>Discharge Information</td><td>Q-16
Q-17</td><td>No</td><td>N/A</td><td>Yes</td><td>91%</td><td>91%</td></tr>
<tr><td>Hospital Rating</td><td>Q-18</td><td>6 or lower</td><td>7 or 8</td><td>9 or 10</td><td>83%</td><td>84%</td></tr>
<tr><td>Recommend the Hospital</td><td>Q-19</td><td>Probably No or Definitely No</td><td>Probably Yes</td><td>Definitely Yes</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Care Transition</td><td>Q-20
Q-21
Q-22</td><td>Disagree or Strongly Disagree</td><td>Agree</td><td>Strongly Agree</td><td>61%</td><td>-</td></tr>
<tr><td colspan="7">*MBQIP benchmarks are based on benchmarks set as a part of the CMS Hospital Value-Based Purchasing Program. For 2024, the Recommend the Hospital component does not have a benchmark, and the benchmark for Quietness of the Hospital Environment and Cleanliness of the Hospital Environment is a joint benchmark. 2025 benchmarks differ due to the updated HCAHPS survey starting January 2025. This table will be updated in late 2025 to reflect these changes.</td></tr>
</table>

CMS uses data from the current quarter to calculate **adjusted percentages of patients** who responded for each measure component. These values are then **adjusted** to account for the 1) different types and distribution of patients across hospitals (see Patient-Mix Adjustment for details) and 2) differences in how the survey was administered to patients, such as by phone or mail (see Mode Adjustment for details). The purpose of adjusting percentages for these differences is to allow for more accurate comparisons across hospitals.

The **adjusted percentages box** for the current quarter are then combined with adjusted percentages from the previous three quarters to generate a **rolling four-quarter average for each box**.

HCAHPS Star Ratings

HCAHPS reports also include one summary and ten individual measure component **HCAHPS Star Ratings** calculated by CMS. CAHs must submit at least 100 surveys for four consecutive quarters to be eligible for a Star Rating. **Measure HCAHPS Star Ratings** are calculated for each measure component, and the **Summary HCAHPS Star Rating** is an average of those ratings. More details on the CMS calculation process can be found in the **Star Rating Technical Notes** on the HCAHPS website.

Utilizing MBQIP Reports

Receiving quarterly MBQIP data provides an opportunity for CAHs to consistently review and track their performance on quality metrics. Each quarter, upon receiving notification of new MBQIP reports (via email from your SFP), CAHs are expected to:

1. **Download and Save** the reports in an accessible place for use by other CAH quality staff and leadership.
2. **Review the Reports** with staff involved in quality improvement at your CAH. Utilize the following section, ***Interpreting MBQIP Data***, as you review the data for each measure. We recommend:
    a. Comparing your CAH's performance to state and national values.
    b. Examining the data for signs of erroneous data.
    c. Identifying trends in performance across reporting periods.
3. **Develop Action Steps** to improve performance on measures, as necessary.

Interpreting MBQIP Data

As a reminder, your State Flex Program (SFP) is available to support your CAH with quality reporting and improvement activities. SFPs have many resources at their disposal to help you and your CAH. SFP contact information is available on **this webpage**. Additionally, the Rural Quality Improvement Technical Assistance Center (RQITA) at Telligen can provide specific assistance to your CAH (rqita@telligen.com). The **RQITA website** also has various resources for quality data reporting and quality improvement.

Before interpreting the data, pay attention to the type of quarterly MBQIP Report you are reviewing as data updated in each quarter varies. When interpreting MBQIP Measures reports, identify the report number (Report 1, 2, 3, or 4) and which measures are updated in that report. This is available in the MBQIP Measures section of this guide as well as on the

cover page of the PDF reports. A reminder that for some measures, such as OP-22 and OP-18b, a lower value may indicate better performance (this is noted in the Appendix of reports).

Performance Comparisons

Compare your CAH's performance on each updated measure to the state and national values provided in MBQIP Reports. As you review, consider the following scenarios:

- **Your CAH is performing better than other CAHs in your state/nationally on a measure(s)**. Work with your team to identify what the CAH is executing well and potential strategies for sustaining and increasing high performance. Consider ways to leverage your CAH's strengths to improve other quality measures as well as other aspects of quality improvement.
- **Your CAH is performing at or worse than other CAHs in your state/nationally on a measure(s)**. Work with your team to identify opportunities for improvement as well as what your CAH is executing well. Consider ways to leverage your CAH's current strengths to address the identified areas for improvement.

CAHs are encouraged to **partner with other CAHs in their state** for quality improvement activities. Partnerships are particularly useful for CAHs with high performance on some measures and low performance on others. In engaging with other CAHs, your CAH could share best practices for your high-performing measure(s) and receive best practices from other CAHs to improve your low-performing measure(s). Your SFP can assist in connecting your CAH with other CAHs.

Erroneous Data

Erroneous data are data that does not make sense for a variety of reasons. Reviewing your reports for erroneous data can help you identify potential issues in your CAH's quality reporting.

Erroneous data, or potential data errors, might not always indicate actual errors in the data, but are worth investigating. If you notice something, please check with your quality improvement staff and your SFP to understand what might be happening that is reflected in the data. Some examples of common errors include:

- **Denominator Issues:** Denominator values typically represent the total population eligible for the measure. Values that look odd are worth investigating. Some examples include:

- **The denominator is zero.** If your CAH has a zero listed for the denominator, this may be erroneous data. For example, during the initial reporting of the new SDOH-1 measure, several CAHs reported zero in the denominator. A value of zero in the denominator indicates there were no 18+ inpatients eligible for health-related social needs screening at the CAH for the entire year. This is likely not the case and suggests the CAH may have misunderstood how to report the SDOH-1 measure. Most likely, the CAH had not yet begun health-related social needs screening and meant to report zero as the numerator, which indicates no 18+ inpatients were screened. (*Note: In MBQIP Measures reports, a zero denominator for this measure will appear as "DNR" (not reporting)).*
- **The denominator is abnormally low.** If your CAH has a low denominator value compared to other CAHs or compared to other reporting periods, this might be erroneous data. For example, if the number of records reviewed for EDTC is reported as an abnormally low value, such as five or fewer records, this indicates the CAH only had that many patients eligible for EDTC over a three-month period. This is likely inaccurate and presents an opportunity to investigate these data and ask your SFP for support with the measure and reporting processes.
- **The denominator is abnormally high.** An abnormally high value in the denominator might also indicate erroneous data. For example, if your CAH typically has a denominator of about 100 patients for OP-18b but reported 1,000 patients in the denominator for the current reporting period, this may indicate an error.

- **Abnormally High Percentages:** An abnormally large percentage may indicate an error with a numerator value. For example, in initial reporting for the new SDOH-2 measure, some CAHs submitted numerator values that were the same as their denominator values. Identical numerators and denominators would result in a performance value of 100% and indicate that 100% of the patients who were screened for the health-related social need screened positively. While this is not impossible, it is unlikely (especially with a high denominator, such as 1,000 patient screened). More likely, there is an issue with incorrectly reporting this measure.
- **Large Differences from Previous Reporting Periods:** Notable differences in performance compared to previous reporting periods should be investigated for possible errors. Trend graphs in the reports may make it easy to identify these changes over time. For example, if your CAH had been consistently performing around 95% for HCP/IMM-3 and suddenly dropped to 50% one year, this may be an error or could just be an opportunity to discuss why this measure changed

significantly and offer strategies for improvement. It is also important to consider the denominator (e.g., number of patients) as changes over time will appear larger with fewer patients and may not be the result of a data error.

Trends in Performance

Review your CAH's performance—on each measure updated that quarter—across reporting periods to identify trends (when available). As you review, consider the following scenarios for potential areas for improvement:

- **Your CAH does not have consistently reported data for a measure(s).** This will show up as a "DNR" in the current or any other quarter and a missing data point or column in the corresponding trend figure. This may indicate an issue with your CAH's quality reporting process. Utilizing the resources at the end of this guide and connecting with your SFP and RQITA may be the next steps to consider to obtain clarity on reporting processes and deadlines.
- **Your CAH shows consistent improvement on a measure(s).** Identify the measure(s) that your CAH is executing well and investigate potential strategies for sustaining and increasing this improvement. Consider possible ways to leverage your CAH's strengths on one measure to improve quality improvement processes or other aspects of quality in your facility.
- **Your CAH shows consistently low performance on a measure(s)**. This trend may indicate a lack of standardized processes to perform and/or document best practices of care at your CAH. CAHs are encouraged to implement and/or work to improve standard processes.
- **Your CAH shows variable performance on a measure(s)**. A variable performance trend may appear as data with no clear trend or high performance in one reporting period, but then low performance in the next. Consider investigating the reason(s) for this variation. A common issue might indicate an opportunity to improve or standardize processes. For example, variation in performance on the Home Medications element of EDTC might indicate an opportunity to improve and/or standardize that aspect of the transfer process at the CAH. Other variations may be caused by an unusual case or situation, such as a severe weather event, and could indicate a need to develop or improve back-up plans. Low patient volume for a measure population could also result in varied performance across reporting periods.

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Tools and Resources

Several **tools and resources** have been created for CAHs to develop, implement, and augment quality improvement activities.

MBQIP Measures Resource Page **developed by RQITA (Telligen)** This webpage provides essential resources for MBQIP, including submission deadlines and details document, implementation timelines for CAHs, a comprehensive Core Measure Set guide, and FAQs on new measures.
Quality Improvement (QI) Workbook **developed by RQITA (Telligen)** This workbook includes resources to support QI efforts, including an interactive timeline to follow, a QI goal statement template, and ways to track progress in QI.
Embedding QI Into Organizational Culture **developed by RQITA (Telligen)** This webinar defines QI, discusses foundational leadership for QI efforts, identifies ways to create a culture of QI, reviews an example of how to leverage MBQIP data for QI, and overviews RQITA tools and resources.
Plan-Do-Study-Act Tools **developed by RQITA (Telligen)** These templates, diagrams, and guides support implementing the Plan-Do-Study-Act cycle to facilitate improvement efforts.
Building Sustainable Capacity for Quality and Organizational Excellence **developed by FMT, TASC, and Stratis Health** In March 2023, the national Flex partners convened a summit of national subject matter experts to identify the core elements of CAH quality infrastructure and criteria necessary for successful quality efforts in CAHs. This report has been developed to assist rural hospital leaders in creating sustainable quality infrastructure, moving beyond measures toward organizational excellence.
Quality Improvement Measure Summaries for MBQIP **developed by Stratis Health** This guide contains valuable suggested strategies and resources to improve performance on each MBQIP measure. (Note: New MBQIP 2025 measures are not included.)
CAH Quality Inventory & Assessment – CAH Resources **developed by FMT** This webpage provides CAH-specific materials that SFPs may use regarding the 2024 Assessment. Resources include Assessment Questions and Instructions, a CAH Fact Sheet, and an informational recording.
CAH Quality Inventory & Assessment – General Resources **developed by FMT** For detailed information on the CAH Quality Infrastructure measure specifications as well as the data codebook, please visit this page.
Quality Improvement Basics Course **developed by Stratis Health** This QI Basics course is designed to equip professionals with the knowledge and tools to start quality improvement projects at their facilities. The course may be completed sequentially, or individual modules / tools may be used for stand-alone training and review.
Interpreting MBQIP Reports **developed by Stratis Health** This guide contains useful information for CAHs in interpreting quarterly MBQIP reports. The guide walks through older versions of the MBQIP reports and interprets the data as an example. (Note: New MBQIP 2025 measures are not included.)

For more information, please reach out to fmtdata@umn.edu.

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