

ATTACHMENT F

RAND LETTERHEAD

DATE

Dear [NAME]:

Our records show that you visited the emergency room at [HOSPITAL/ER NAME] on or around [INSERT ER VISIT DATE]. [HOSPITAL/ER NAME] is one of many hospitals working with the Centers for Medicare & Medicaid Services, a federal government agency, and the RAND Corporation, a private non-profit research company. Together, we are conducting a survey about the health care services that patients receive in emergency rooms. The information from this survey will be used to help ensure that all Americans get the highest quality medical care when they need it.

Your name was selected at random from among individuals who recently visited [HOSPITAL NAME]. Some questions in the survey will ask about your experiences in the emergency room, others will ask about your hospital stay. We would greatly appreciate it if you would take the time to fill out the survey. It should take you less than 15 minutes. The accuracy of the results depends on getting answers from you and other people selected for this survey. This is your opportunity to help hospitals improve the care patients receive.

We will hold your identifying information and all information you provide in confidence, and your information is protected by U.S. federal law under the Privacy Act of 1974. We will not share your information with anyone other than authorized persons at the Centers for Medicare & Medicaid Services, except as required by law. We will not share your individual survey with any of your health care providers. **You do not have to participate in this survey. Your help is voluntary, and your decision to participate or not to participate will not affect your health care in any way.**

We hope that you will take this opportunity to help the Centers for Medicare & Medicaid Services learn about the quality of care you receive. If you have any questions about the survey, please call RAND's survey line toll-free at XXX-XXX-XXXX, any time from 9:00 am to 9:00 pm Pacific time, Monday through Saturday. Thank you in advance for your participation.

Sincerely,

[SIGNED BY DR. ROBIN M. WEINICK, Project Director]

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **XXX-XXXX**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

ER Patient Experience Survey Initial Letter - Admitted (HCAHPS Add-On)