Care Coordination Quality Measure for Primary Care (CCQM-PC)

Mail Materials

Cover Letter for Survey Mailing #1

{INSERT LOGO FOR PRACTICE AND/OR SURVEY VENDOR}

{FIRST AND LAST NAME}
{LINE ONE OF ADDRESS}
{LINE TWO OF ADDRESS (IF ANY)}
{CITY, STATE ZIP}

Dear {Mr./Ms.} {LAST NAME}:

We would like your help. {SURVEY VENDOR} and {PRACTICE NAME} are working together to better understand how people feel about their health care and how it is coordinated. We have enclosed a survey that asks about the care you got from {PRACTICE NAME}. By answering the questions in the survey, you will give this doctor's office information they can use to better meet the needs of their patients.

You have been chosen at random from a list of patients receiving care from your doctor's office to be a part of this scientific sample. You were chosen only because you received care at this office, not for any other reason. To get accurate results, we need to get answers from you and the other people we ask to take part in this survey. We hope you will take the time to answer these questions.

What you have to say is private. Your answers will be part of a pool of information from others like you. What you write will be used only by this study. {PRACTICE NAME} will not know your individual answers, and they will not know if you answer the survey or not. Your survey will **not** be returned to your doctor(s). It will be returned to survey researchers at an independent research firm. Your answers will be combined with the answers we get from others and reported as a group. **You may choose to fill out this survey or not. Your decision will not affect any care you may get from this doctor's office now or in the future.**

Your name and contact information have been provided to the {SURVEY VENDOR} for the purpose of carrying out this study only. Your name and contact information will not be shared with anyone other than the team conducting the survey. Your name and contact information will not be used for any purpose other than conducting this study. Access to the names and contact information of potential participants in the study by the survey team is in accordance with confidentiality and data security procedures governed by the Health Insurance Portability and Accountability and Act (HIPAA). If you have any questions or concerns about this, please refer to the contact information provided below.

We hope you will take this chance to tell us about the coordination of the care you received from this doctor's office. Please review the information on the included "Participant Informed Consent" sheet and return the completed survey in the enclosed postage-paid envelope. If you prefer not to participate, please return the blank survey in the enclosed envelope so that we may remove you from the mailing list.

If you have any questions, please contact our study team at {HELP DESK TELEPHONE NUMBER}.

Sincerely,

{INSERT SIGNATURE FROM SURVEY VENDOR EXECUTIVE}

[TO BE PRINTED ON BACK OF COVER LETTER FOR BOTH SURVEY MAILINGS]

PARTICIPANT INFORMED CONSENT

What is this survey about?
We are interested learning about patients' experiences of the health care services that they receive. Attached is a survey that will ask you to answer a series of questions about your experiences with your doctor's office. The survey should take you about 25 minutes to complete.

Who is doing this survey?
{INSERT INFORMATION ABOUT SURVEY SPONSOR}

Do I have to complete a survey?
No. It is your choice whether to participate or not. Your primary care provider will not know if you complete a survey or not.

What are the risks and benefits?
There are no anticipated or known risks for you for completing this survey. There are no direct benefits to you for completing this survey. However, the answers you provide will help researchers, health care providers, and policymakers better understand how doctors can best meet the needs of their patients.

How will you protect my privacy?
Your responses will only be reported as a group. Your individual responses will never be viewed by your doctor or insurance/health plan and your name will not be connected with your completed survey.

More Information
{INSERT CONTACT INFORMATION FOR HELP DESK AND INSTITUTIONAL REVIEW BOARD (IRB) - IF APPLICABLE}

Agreeing to Complete the Survey
Completing this survey and sending it back to us means that you are giving your "informed consent" to participate in this effort. This means that you:

- Have read and understood the information on this form,
- Have information about where you should direct any questions you may have, and
- Are willing to participate under the conditions we have described.

Text for Reminder Postcard

You are receiving this postcard because you recently received a survey asking you about your health care and how it is coordinated.

If you have already completed and returned the survey, please accept our sincere thanks. At this time there is nothing further you need to do. If you have not returned the survey, please do so at your earliest convenience.

If you did not receive the survey, or if it was misplaced, please call {HELP DESK TELEPHONE NUMBER} and another survey will be sent to you.

Thank you for your time.

Sincerely,
{SURVEY VENDOR}

Cover Letter for Survey Mailing #2

{INSERT LOGO FOR PRACTICE AND/OR SURVEY VENDOR}

{FIRST AND LAST NAME}
{LINE ONE OF ADDRESS}
{LINE TWO OF ADDRESS (IF ANY)}
{CITY, STATE ZIP}

Dear {Mr./Ms.} {LAST NAME}:

We recently mailed you letter asking about the care you got from {PRACTICE NAME}.

We have enclosed another copy of the survey along with a description of "Participant Informed Consent" describing the study and your rights as a participant. If you feel this survey does not apply to you, or that it was sent to you by mistake, please contact our team at {HELP DESK TELEPHONE NUMBER}

What you have to say is private. Your answers will be part of a pool of information from others like you. What you write will be used only by this study. {PRACTICE NAME} will not know your individual answers, and they will not know if you answer the survey or not. Your survey will **not** be returned to your doctor(s). It will be returned to survey researchers at an independent research firm. Your answers will be combined with the answers we get from others and reported as a group. **You may choose to fill out this survey or not. Your decision will not affect any care you may get from this doctor's office now or in the future.**

You have been chosen at random from a list of patients receiving care from your doctor's office to be a part of this scientific sample. You were chosen only because you received care at this office, not for any other reason. To get accurate results, it is important that you return this survey. We hope you will take the time to fill out the survey and send the completed survey.

Your name and contact information have been provided to the AIR research team for the purpose of carrying out this study only. Your name and contact information will not be shared with anyone other than the team conducting the survey. Your name and contact information will not be used for any purpose other than conducting this study. Access to the names and contact information of potential participants in the study by the survey team is in accordance with confidentiality and data security procedures governed by the Health Insurance Portability and Accountability and Act (HIPAA). If you have any questions or concerns about this, please refer to the contact information provided above.

We hope you will take this chance to tell us about the coordination of the care you received from this doctor's office. Your answers can help this doctor's office better meet the needs of its patients.

Thank you in advance for your help!

Sincerely,

{INSERT SIGNATURE FROM SURVEY VENDOR EXECUTIVE}

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