Hi, everyone. My name is Ashley Peddicord-Austin with the Centers for Medicare and Medicaid Services, Office of Minority Health or CMS OMH. We thank you for joining us today for our webinar in recognition of National Rural Health Day, we're just a few days in advance of the observance and we know there's a lot of activities going on this week, so we're glad you could join us.

So, in addition to hearing about rural health happenings here at CMS, you'll also hear about our recently released CMS Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities and that'll be a bit of the focus for today's webinar. But we hope that you'll find that and the other points useful in your work and to share with colleagues and partners. We can go ahead to our first slide.

So, before we get started, we want to share the transcription access for today's webinar. So, in order to access this feature, go to the menu at the bottom of the screen and click on the live transcript icon. After you click this icon, click on view full transcript which will allow closed captioning to appear on the bottom of your screen and the transcript will show on the right-hand side. In addition, our ASL interpreter should be pinned to your screen.

To start us off today, first we'll begin with an overview of the CMS Office of Minority Health, the CMS Strategic Pillars, and our CMS Framework for Health Equity. Following this brief overview we will discuss available rural health resources, including those that were published just this month, before diving into the Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities. And then we'll have a presentation from our CMS Division of Tribal Affairs, followed by remarks from the co-chair of the CMS Rural Health Council. We'll go ahead and advance one more slide and you can see today's speakers.

So, in order, we'll hear from Dr. LaShawn McIver, our director here at the CMS Office of Minority Health. My colleagues, Dr. LaShanda Glasgow and Darci Graves, also with the CMS Office of Minority Health. And from elsewhere -- joining us elsewhere in CMS is Dr. Susan Karol of the Division of Tribal Affairs. And our final speaker will be John Hammarlund who is the deputy director for local engagement administration with our Office of Program Operations and Local Engagement and of course he and Darci are co-chairs of the CMS Rural Health Council. All right, we'll go ahead and advance one slide as I'll now turn it over to Dr. LaShawn McIver who will provide us with a brief overview of CMS OMH, the Strategic Pillars, and the Framework for Health Equity to help set the stage for our newest framework for advancing rural health. Thank you.

Thank you, Ashley. Welcome everyone and thank you so much for joining us for this important webinar today. Before we start, I wanted to share an overview of America's rural communities. More than 1 in 7 Americans live in rural, tribal, or geographically isolated areas. As vital sources of water, food, energy production, and outdoor recreation, rural communities play an important role in the in the health and well-being of all Americans.

CMS recognizes that the approximately 61 million Americans living in rural, tribal and geographically isolated areas face unique challenges regarding time and distance to facilities, health professional shortages, and more. And these challenges can differ dramatically among and across different kinds of rural and geographically isolated areas. Rural residents tend to be older and in poorer health than their urban counterparts and rural communities often face challenges with access to care, financial viability, and the critical link between health care and economic development.

Compared with their urban counterparts, residents of rural counties have a higher prevalence of chronic conditions, such as diabetes, chronic obstructive pulmonary disease and obesity, higher rates of substance use, including opioids tobacco and alcohol use, and higher rates of preventable death, including from suicide. People in rural communities also have a higher prevalence of serious mental illness, which is often associated with chronic conditions and can lead to shortened lifespans. To address these many challenges CMS Office of Minority Health is working on a number of initiatives devoted to improving the health of rural Americans, which I will discuss shortly. First, I wanted though to start off by giving you a brief introduction to our agency and the work that we do. Next slide.

CMS is the largest provider of health insurance in the United States responsible for ensuring that more than 150 million individuals supported by CMS programs are able to get the care and health coverage they need and deserve. Our office, the CMS Office of Minority Health, is 1 of 8 minority health offices within the larger department of Health and Human Services.

We serve as the principal advisor to the entire CMS agency on the needs of minority in medically underserved populations, including people of racial and ethnic communities, people with limited English proficiency, lesbian, gay, bisexual, transgender and queer persons, persons with disabilities, persons who live in rural areas, and persons otherwise adversely affected by persistent poverty or inequity. Next slide.

On this slide we have listed our office's mission and vision statements. Our mission is to lead the advancement and integration of health equity in the development, evaluation and implementation of CMS's policies, programs, and partnerships. Our vision is to see all those served by CMS achieve their

highest level of health and well-being and we have eliminated disparities in health care quality and access. Next slide.

I will now discuss the CMS Strategic Pillars and the Framework for Health Equity. Next slide please.

On this slide we have to CMS strategic pillars, which help to inform the work that is done across the agency. Each of these pillars on the screen represent a critical priority of our administrator. The first pillar is health equity, and it speaks to the level of commitment and investment the administration intends to make to address the health disparities that underlie our health care system. CMS OMH is leading a data-driven approach to identifying structural barriers in uniting the agency to eliminate them. We do this using a framework for health equity and a set of priorities put forward by our stakeholders and partners to help us align and focus our work. Next slide.

On this slide you'll see our one pager for the framework which is available in both English and Spanish on our website. This one pager provides our agency's definition of health equity, as well as a list of the five priority areas included in the framework for health equity.

On April 22, CMS released the CMS Framework for Health Equity. The CMS Framework for Health Equity is an update to the previous Medicare focused CMS equity plan for improving quality in Medicare and is an enhanced and more comprehensive 10-year approach to further embed health equity across all of CMS's programs, including Medicare, Medicaid, CHIP and the health insurance marketplaces. While the initial equity plan identified high-impact priorities based on stakeholder engagement, a review of evidence-based and discussions across HHS, CMS and among federal partners, this framework refines CMS's health equity priorities and broadens the agency focus beyond Medicare. The CMS Framework for Health Equity is informed by stakeholder input, evidence review and a knowledge and understanding gained through our agency's work. Next slide.

The five priorities included in the framework encompass both system and community-level approaches to achieve equity across CMS programs. Each of the priorities are complementary and their integrated adoption and implementation is central to the elimination of barriers to health equity for all Americans.

The first priority is expanding the collection, reporting and analysis of standardized data. The second priority area is assessing causes of disparities within CMS programs and addressing inequities and policies and operations to close the gaps. The third priority area is building capacity of health care organizations and the workforce to reduce health and health care disparities. The fourth priority area is

advancing language access, health literacy, and the provision of culturally tailored services. The fifth priority area is increasing all forms of accessibility to health care services and coverage. Those looking to learn more about the framework can visit go.cms.gov/framework. Next slide, please.

I will now be turning it over to Dr. LaShanda Glasgow to provide an overview of the rural health work currently occurring at the agency, including some of the resources that have recently been released. So, thank you again for joining us today

Thank you, Dr. McIver. Next slide please.

This slide depicts the front page of our Advancing Rural Health Equity report, which we developed to highlight the agency's work to advance rural health equity over the past year. In collaboration and consultation with national, state, tribal and local partners, CMS is developing and implementing innovative payment and policy solutions designed to meet the needs of rural communities.

In this way, we are leading the way to facilitate transformation and improvement in the rural health care system, integrating its focus on rural health equity across all agency centers, programs, policies, and activities. CMS activity highlights of the past year include postpartum coverage expansion and quality. For postpartum coverage expansion, as of September 2022, a total of 24 states and the District of Columbia have adopted new options to extend Medicaid and CHIP postpartum coverage to 12 months. Improving access to essential health care for an estimated 361,000 pregnant and postpartum individuals.

For quality, CMS has proposed policies, conducted research and engaged partners to improve quality of care provided in rural communities. In fiscal year 2022, CMS released its national quality strategy, health equity strategy, and several crosscutting initiatives, all of which outline the agency's commitment to advance health equity, expand coverage and improve health outcomes, including for rural and underserved communities. Next slide please.

This slide shows images of two materials, Advancing Rural Maternal Health Equity and Rural-Urban Disparities in Health Care and Medicare. These materials are products of some of the key initiatives and studies that CMS OMH has taken part in over the past year to advance rural health equity. I'll briefly share an overview of some of the key activities and findings highlighted in each report. Next slide, please.

This slide shows cover of our Advancing Rural Maternal Health Equity report developed to provide a high-level summary of the activities that CMS OMH implemented as part of our rural maternal health initiative.

Over the past decade, the need to improve world maternal health care has gained increasing recognition due to rising maternal mortality rates and a disproportionate effect they have on non-Hispanic, Black, American Indian, and Alaska native women. CMS OMH has made it a priority to collaborate with rural partners and stakeholders at the national, regional, state, and local levels to reduce rural maternal health disparities and improve access to high-quality maternal health care for women and their babies living in rural communities.

For example, CMS hosted an interactive communication on maternal health care in rural communities charting a path to improve access, quality, and outcomes in Washington DC. To increase understanding and awareness of the difficulties women in rural communities face and highlight the need for a coordinated and collaborative roadmap to improve access to maternal health and improve health outcomes.

In addition, building on the Rural Maternal Health Forum, CMS released an issue brief titled, Improving Access to Maternal Health Care in Rural Communities, which focuses on access to care for women in rural communities before, during, and after pregnancy. The issue brief was developed to describe the scope of challenges rural women encounter accessing high-quality maternal health care, including maternal health care disparities faced by racial and ethnic minority women and to focus attention on the need for national, state, and community-based organizations to collaborate on developing an action plan to improve rural maternal health care access and outcomes.

We also hosted a rural obstetric readiness group and rural maternal health workgroup to better understand the challenges faced by our partners working in rural maternal health. We encourage you to read the full report for more information on each initiative and the outcomes and recommendations they resulted in. Next slide, please.

The Rural-Urban Disparities in Health Care in Medicare report presents summary information on the quality of health care received by people with Medicare nationwide. The report highlights rural-urban differences and health care experiences in clinical care, how rural-urban differences in quality of care vary by race and ethnicity, and how racial and ethnic differences in quality of care vary between rural and urban areas. The report is based on an analysis of two sources of information.

The first source is the Medicare Consumer Assessment of Healthcare Providers and Systems, or CAHPS Survey, which is conducted annually by CMS. The survey focuses on the health care experiences,

including ease of getting needed care, how well providers communicate, as well as getting needed prescription drugs of people with Medicare across the country.

The second source of information is a Healthcare Effectiveness Data and Information Set, or HEDIS, which is composed of information collected from medical records and administrative data on the clinical quality of care that people enrolled in Medicare Advantage plans receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease.

Overall, the analysis found that people with Medicare living in rural and urban areas had experiences with care that were similar to the national average. In the area of clinical care, Medicare Advantage enrollees living in rural areas were found to have results that were below the national average for a quarter of all measures examined.

The report also identified noteworthy variation in patterns of rural-urban differences by race and ethnicity. For example, Asian American and Native Hawaiian or Pacific Islander Medicare advantage enrollees living in areas had CAHPS scores -- living in rural areas had CAHPS scores that were above the national average for all Asian and native Hawaiian or other Pacific Islander Medicare advantage enrollees on 3 of 7 patient experience measures. Whereas as Asian American and Native Hawaiian or other Pacific Islander Medicare advantage enrollees living in urban areas had CAHPS scores that were consistently similar to the national average for all Asian American and Native Hawaiian or other Pacific Islander Medicare Advantage enrollees. Next slide, please.

On this slide we've outlined where on the OMH website you'll find additional rural health resources. Our health observances webpage was recently updated in recognition of National Rural Health Day. This page highlights rural health disparities and highlights CMS OMH rural health resources with an emphasis on the advancing rural health equity and framework.

Our Rural Health Webpage offers links to a number of studies that CMS OMH has developed around rural health, including the reports we have just discussed on maternal care, rural-urban disparities in health care and Medicare, and our rural health strategy.

Our chronic care management and connected care page offers resources to support patients with multiple chronic conditions and provide health care professionals with resources to implement chronic care management. Next slide, please.

I will now turn it over to Darci Graves to discuss the Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities. Darci.

Thank you, Dr. Glasgow and thank you everyone for being here today. Now it's time to finally dive into our CMS Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities.

One of the key advancements of this framework is the expansion of its geographic footprint to be more inclusive and allow CMS to expand its health equity reach to rural, tribal and frontier communities, as well as the U.S. territories. To ensure that CMS's approach is responsive to the unique needs of rural, tribal, and geographically isolated communities, we engaged with individuals from across the nation with lived experience receiving supporting or providing health and health care services in these communities to help shape the CMS Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities.

The framework focuses on six priorities over the next five years. In the next few slides, I will dig deeper into each of these priorities, but first I will share an overview of how and why we developed this framework. Next slide, please.

The CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities updates and builds upon the CMS Rural Health Strategy released in 2018 to reflect changes in the health care landscape since its development. In alignment with the CMS Framework for Health Equity 2022 to 2032 that Dr. McIver mentioned earlier, this framework supports CMS's overall efforts to advance health equity, expand access to quality, affordable health coverage and improve health outcomes to all those we serve.

CMS's approach to operationalizing this framework over the next five years will be informed by ongoing public engagement and continued monitoring of trends in health and health care that uniquely impact rural, tribal, and geographically isolated areas. Through the adoption of and implementation of this framework, CMS will continue to work to promote policies and programs that help make high-quality health care in these communities available and affordable.

In 2022, building on what we learned from the original strategy, the CMS Rural Health Council held a series of listening sessions to inform a framework that continues to reflect the current needs and priorities of rural, tribal, and geographically isolated communities and is responsive to changes in the healthcare landscape, such as those resulting from the COVID-19 pandemic. Through these listening sessions, as

well as discussions with federal partners, the CMS Rural Health Council received feedback from individuals across the nation with lived experience receiving health care or supporting health care delivery in rural, tribal, and geographically isolated communities. This feedback was used to help identify the key priorities which make up the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities. Next slide, please.

The first priority is to apply a community-informed geographic lens to CMS programs and policies. CMS recognizes the importance of engaging with individuals that have experience receiving or supporting the delivery of health care services in these communities. Individuals from across the country emphasize the importance of engaging those with lived experience receiving or supporting the delivery of health care services in rural areas to better understand their needs and the impacts of CMS programs and policies in these geographic areas.

Among the key supporting activities included under priority one is regularly and meaningfully engaging individuals living and working in rural, tribal, and geographically isolated communities, so that we can understand how CMS programs and policies can meet their unique needs. Through listening sessions, townhalls, tribal consultations, open-door forums, and other events, we will continue to gather regular feedback from those with these experiences to inform new and existing CMS programs and policies.

For example, for the last several years CMS OPOLE has hosted approximately 30 listening sessions per year with rural leaders and organizations, including those serving tribal nations and the US territories across all 10 CMS and HHS regions. Next slide, please.

The second priority is to increase the collection and use of standardized data to improve health care for rural, tribal, and geographically isolated communities. Despite the importance of increasing in the collection of standardized data, many rural providers lack the resources and infrastructure necessary for data collection and reporting, with these providers also highlighted the need for CMS to share its own data.

Increasing available standardized data across settings and programs enables CMS and its partners to address changes in populations over time and leverage information to connect individuals living in rural, tribal, and geographically isolated communities to appropriate, needed health care services. Among the key supporting activities included under priority two is supporting the seamless exchange of health care data to better inform decision-making for individuals and their providers and fostering a more connected health care system.

For example, CMS collaborates with the HHS Office of the National Coordinator for Health Information Technology through the USCDI+ initiative to advance interoperability and bring administrative and clinical data together. In addition, CMS actively participates in the Gravity Project, a public collaborative that develops national data standards to support the exchange of SDOH or social determinants of health data and facilitate care coordination. Next slide, please.

The third priority is to strengthen and support health care professionals in rural, tribal, and geographically isolated communities. Strengthening the health workforce in rural areas remains imperative with rural providers and listening session participants detailing the importance of improving recruitment and retention of health care professionals and allied health professionals strengthening provider capabilities and reducing administrative and financial burden for workers.

Among the key supporting activities included under priority three is exploring and collaborating with federal, state, tribal, territorial, and local entities to assist in the promotion and recruitment and retention of health and health care professionals in rural, tribal and geographically isolated communities. CMS will collaborate with these entities to amplify education and training opportunities for the rural health workforce and will implement new legislation, such as increased Medicare graduate medical education residency slots to support rural health care professionals.

As an example, CMS implemented statutory changes to its graduate medical education policies allowing additional cap slots for urban hospitals that establish “rural training tracks” now called Rural Training Programs with rural hospitals. This policy will further promote workforce development and training in rural areas. Next slide, please.

The fourth priority is to optimize medical and communication technology for rural, tribal and geographically isolated communities. As reliance on technology, including telehealth, patient portals and other medical technology and communication technology continues to grow, CMS acknowledges that rural providers and community organizations in underserved and technology under-resourced areas must not be left behind.

Building on lessons learned from the COVID-19 pandemic, CMS will collaborate with rural organizations and government agencies to optimize medical and communication technology for people living in rural, tribal, and geographically isolated communities. Within its collaboration, we will also explore ways to address barriers to use these services and facilitate broader uptake of medical and communication

technology to enable access to remote health care services for individuals living in rural, tribal, and geographically isolated communities. Among the key supporting activities included under priority four is collaborating with federal, state, tribal, territorial, and local organizations to amplify efforts to expand broadband access in these areas and communities and overcome barriers to adoption of health information technology.

For example, CMS is continuing to build awareness for the Federal Communications Commission's Affordable Connectivity Program, which helps to lower the cost of broadband service and connective devices like a laptop or tablet. Next slide, please.

Our fifth priority is to expand access to comprehensive health care coverage, benefits and services and supports for individuals in rural, tribal, and geographically isolated communities. CMS recognizes that potential connection between a lack of health care coverage and health outcomes contributing to disparities. As such, we will work to ensure that individuals in rural areas can access necessary support and services.

In alignment with the feedback we have received, the agency will also work to improve access to a full continuum of care, including integration and coordination of care by exploring opportunities to enhance Medicare, Medicaid, CHIP, and Marketplace coverage of many different services and supports, including those that address transportation challenges and other SDOH concerns in rural communities. Among the key supporting activities included under priority five is considering opportunities to expand health coverage and benefits within CMS's authority that improve access to and the delivery of a broad array of services and supports for rural, tribal, and geographically isolated communities.

For example, the agency is supporting various state plan options, including the opportunity to extend Medicaid and CHIP postpartum coverage to 12 months. Next slide, please.

And our sixth and final priority is to drive innovation and value-based care in rural, tribal, and geographically isolated communities. Rural providers have experienced various barriers to participating in value-based programs due to low case volumes, which do not always allow them to accurately report on quality measures.

CMS will explore opportunities to advance innovations in care that support health care providers to participate in innovative models, address the unique needs of rural, tribal, and geographically isolated communities and respond to public health emergencies and disasters with greater agility. Among the key

supporting activities included under priority six is ensuring inclusion of providers serving rural, tribal, and geographically isolated communities and CMS models, programs, demonstrations, and quality improvement initiatives.

For example, CMS is examining innovation-center model applications and participant selection processes to address barriers to the inclusion of safety net providers and individuals in historically underserved and under-resourced communities. Next slide, please.

I will now turn it back to Ashley to provide some additional information on our Health Equity Technical Assistance Program and how you can stay in contact with us. Thank you again for being here today.

Thank you, Darci. I appreciate your thorough presentation there. I know we're all very excited about the advancements and about having that framework be released this week. So, thank you for advancing the slide as well.

So, as you can see here, our office operates a Health Equity Technical Assistance Program. So, on the slide you'll see an image of people who are working on different types of media as we have different ways of assisting people with this. So, we all work together to achieve health equity and we know that you all are part of that, and our office is here to assist.

So, the Technical Assistance Program is ongoing, that folks here at CMS, some of them on the phone now, but others in our office and throughout CMS work to help people utilize those to ask questions and maybe just to make equity as part of your work. It's offered to anyone, whether you're part of government or you're external it does not matter. All you have to do is reach out to us, the email is listed there on the screen, HealthEquityTA@cms.hhs.gov.

And you can submit questions or if there' a particular piece of data that you are curious about or you want to know how to get equity started, do a disparities impact statement, etcetera, go ahead and submit a question and we'll get under way. Every piece of TA is a little bit different, so you know we respond to each person individually. We can go ahead to the next slide.

This is the, lots of contact information for our office if you are trying to write down something to me when you can just simply write down is OMH@cms.hhs.gov, but we've listed that as well as our TA email and our rural health emails here. But lots of ways to reach out to us and please feel free to visit our website, which would also include the rural health website for CMS as well, so you'll find it through there.

All right, so with that we're going to continue the conversation of health equity-related initiatives and what's going on throughout CMS. So, we are now going to turn it over to Dr. Susan Karol from our CMS Division of Tribal Affairs.

Good afternoon, everyone. This is Dr. Susan Karol. I am the chief medical officer for the CMS Division of Tribal Affairs. I'm an enrolled member of the Tuscarora Indian Nation, which is located in upstate New York right near Niagara Falls.

The Division of Tribal Affairs, or DTA as we call it, is part of CMS, specifically we're part of the Children & Adults Health Programs Group which is within the Center for Medicaid and CHIP services. A list of the division staff and our associates in MCOG, the Native American contacts, are posted on our website at go.CMS.gov/AIAM. We serve as the point of contact and subject matter experts for tribal issues that happen across the agency.

Even though we're located in Medicaid, we still work on all tribal issues that come up at CMS. We work with our partners in Medicare, Survey & Certification, the Marketplace, data and information technology offices, and of course the Office of Minority Health, among others. In addition to the Division of Tribal Affairs, the Native American contacts that reside in MCOG also serve as points of contact for CMS components. Along with tribal leaders, they also work with tribal health directors, urban Indian organizations, and the Indian Health Service to provide technical assistance or help answer any questions that you might have about CMS programs.

The Native American contacts are assigned to the different CMS regional offices and their areas that they cover are associated with the Indian Health Service areas. In the IHS there are 12 separate areas, and the Native American contacts help us by working in those local areas. For example, Nancy Grano is part of the Nashville and Bemidji IHS areas. We have Stacey Shuman who works with Albuquerque, Oklahoma, and the Great Plains area. Cindy Lemesh works with California, Navajo, Phoenix, and Tucson areas. And Justyna Redlinski covers Alaska, Portland, and the Billings area.

I also wanted to mention that we are presently working this month celebrating the National American Indian and Alaska Native Heritage month. I will at the end of my presentation post a link to our lecture series that is ongoing.

We have five lectures this month, the latest one which will happen at 2 o'clock this afternoon if you're free, is understanding how American Indian and Alaska Natives can achieve health equity. Our next discussion next Tuesday at 2 will include health equity with tribal self-governance, which will feature the new Director of the Indian Health Service, Roselyn Tso, along with two of her tribal self-governance specialists. And finally, the last lecture for the month will be indigenous foods benefiting in health outcomes for American Indian and Alaska Native people, which features Chef Sean Sherman from the Oglala Sioux tribe. So, we're very excited about that Heritage Month Lecture Series and please do join us if you can.

I'd like to tell you a little bit more about what we're working on this week. The Division of Tribal Affairs meets with the CMS Tribal Technical Advisory Group that is composed of 12 tribal leaders from across the country. They represent the Indian Health Service areas with us as tribal technical advisors. And in addition to those 12 individuals, we have representation from the National Indian Health Board, the National Council on Urban Indian Health, the National Congress of American Indians, along with the Indian Health Service and their tribal advisory group for self-determination.

This week on Wednesday and Thursday, we'll be discussing a variety of interesting topics, which include American Indian and Alaska Native Medicaid data. We've been searching for this information and Mathematica will join us with a great presentation. We'll also have Dr. Barry Marx from CCSQ who will review the behavioral health strategic plan. And also working with Jean Moody-Williams on how Medicare hospitals will prepare for the end of the PAG.

Most exciting is the work that we have been doing on health equity. The TTAG has a subcommittee, a health equity subcommittee, it meets monthly, and we have been working diligently over the last year with listening sessions, a summit, and involvement with the National Indian Health Board's National Tribal Health Conference to do listening sessions on health equity and what health equity means specifically to American Indians and Alaska Natives. So, if you're free this week please join us for TTAG to hear some of these exciting reports and we will be looking forward to our final report on our work on what health equity means to American Indians and Alaska Natives.

And I'll stop there and turn it back to Darci for further information and thank you for allowing us to tell you today a little bit about the Division of Tribal Affairs. Thanks, back to you.

Thank you, -- I started to say captain doctor. Thank you, Dr. Susan Karol, for your presentation there. So, we will now continue across to CMS to hear from John Hammarlund who joins us from the Office of Local Engagement and is of course co-chair of the Rural Health Council. Go ahead, John.

Thanks, Ashley and thanks to all of you for joining us today on this call. So, I'm speaking to you on behalf of the CMS Rural Health Council, which I proudly co-chair in conjunction with Darci Graves from whom you heard earlier. And the CMS Rural Health Council is so proud that we are launching today the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities.

It's an important document, a set of guiding principles really, that informs our efforts moving forward. And what I'm especially proud about is the fact that it was built upon feedback from providers and organizations and community numbers like you. So many stakeholders contributed to our thinking and as you heard earlier from Darci. And that's a concrete manifestation of one of the six strategic pillars that Dr. McIver mentioned earlier, engaging partners and the communities we serve through the policymaking and implementation process.

We are committed to ensuring that stakeholders, particularly those who are underserved or most impacted by our policies or are underheard, have a voice. And by elevating those voices and listening to them, CMS has a more informed process for decision-making and a better understanding of how our policies play out in the real world. And that's the message I want to leave you with, please engage with us. Let's go to the next slide.

So, it shows some of the many ways that you can provide feedback to us, stay in touch with us, keep engaged with us.

First, consult the rural health page on our website often. We mentioned earlier all of the resources that we provide on the website, and it is continuously updated. It's a great resource to you and we hope you will consult us by visiting our website.

Second, subscribe to our CMS Rural Health Listserv. We push out a lot of information of particular interest to rural stakeholders and I assure you, you do want to be on that mailing list.

Third, participate in the Rural Open Door Forum calls. So, we know that keeping up with all of the policies and initiatives that come out of CMS can be daunting, it's like drinking from a fire hose. What we try to do every six weeks on that open door forum call is to distill down for you those policies and initiatives that are most relevant to you operationally as you deliver care in your rural communities. And each call features an opportunity for you to provide real-time commentary to CMS policymakers and ask your questions. So, please make room on your calendars to participate in those Open Door Forum calls. You also can help us

shape the agenda; we always invite you at the end of each call to suggest what we should address on the next call. The next call by the way is this Thursday, November 17, so we hope you'll join us.

Fourth way to stay engaged, take the time if you possibly can to provide us with your feedback when we send out requests for information. Likewise, and I realize this is a big ask, please provide written comments on our proposed rules. And I say that's a big ask because we know you are busy providing care to your communities, you're resource strapped. We know it takes a lot of time to read the proposed rules and the print is small if you're reading it from the Federal Register. But we specifically ask for providers like those on this call to comment because you can help see us see the way to a final decision.

We read every single comment that comes into our proposed rules and the comments inform our thinking and we are especially attuned to how our proposed policies will work or not work in rural communities. And the most helpful comments are the ones that tell your story, that tell us essentially four things. One, how the policy will affect for better or for worse your ability to provide quality care to your patients. Two, how it will affect your bottom line. And three, how it will affect patient access in your community. The fourth thing we want to hear from you when you comment on a proposed reg is your suggestion on how we could have met the goal differently.

In other words, what alternative approach would you suggest that gets to the same goal that we're trying to achieve but is better for your practice or your clinic or hospital or your patients. So, I want to emphasize it's really important that you tell your story when you have an opportunity to comment on our regs. The national association, there's a National Rural Health Association for example, will do a great job commenting on behalf of you and the state associations will too and other advocacy groups. I think there's nothing more important for us than when we get to hear your individual voice and understand what it means for you and your community.

The final way to stay engaged with us is to get to know your region's rural health coordinator and it's a reflection of our commitment to rural communities that we designated one staff member in each of our 10 regional offices, as well as our office in Puerto Rico, to be your point of contact. They provide outreach to you when we can, when COVID will allow us we'll come to your community and meet with you, we'll take your questions. And the rural health coordinators try to best to solve your problems when we can. The point is to get to know your coordinator.

The next slide shows the coordinators in the first five regions. I'll pause for a moment, so you have a chance to reflect on their email addresses.

And then the next slide shows the remainder of the rural health coordinators and our coordinator in Puerto Rico. Now when you get to know them, they can provide you with their phone numbers as well so that you can be on speed dial, as well as an email correspondent. But it's really important that you get to know; that you feel like you have somebody who is an empathetic ear and who is eager to help you. You can certainly call our headquarters and others, but I think it's especially useful for you to go directly to the person in your region who knows you best.

So, those are the ways we'd love to have you stay in touch with us and engage with us. We hope you'll take us up on all of those offers. And again, it's because of feedback that we've received from you in the past that we are able to build the framework which we're so proud to announce today. Thank you again for being on this call. Thank you for engaging with us and we look forward to hearing from you. With that, I'll hand it back to Ashley.

Thank you so much, John and thank you everyone for joining us today, all of our speakers, as well as our audience. So, as we will be wrapping up at this point, we just want to thank you for joining. We hope that the information was helpful to you and we'll kind of leave this last couple of slides here on the screen for you to write down some of the email addresses and things. But there is also a website that has that, and I think there might be a couple of new names there, so we'll work on getting those updated this afternoon and tomorrow, but that link is in the chat as well.

So, thank you for joining us. We hope that today's webinar was able to help demonstrate our commitment to our nation's rural, tribal, and geographically isolated communities. But if you have any questions that weren't able to be answered, we had a lot that came in through the chat that I think we were able to address or at least give you a little bit of information. But if anything is lingering, do feel free to reach out to us at omh@cms.hhs.gov. And if it's not meant for us or it's meant for John or Dr. Karol, you know we'll be happy to direct that as well.

But with that, we thank you all again for joining and hope you have a wonderful continuation of National Rural Health Day when it actually happens on Thursday, and you can use this information in any of the outreach and things that you're doing this week. So, thank you so much and thank you for all the good work that you all do. Take care.