Emerging Technology Committee Meeting Summary

July 9, 2026

1:00 p.m. – 3:00 p.m.

Agenda

- Welcome and Overview – Wyatt Beckman, KHI
- Charter Approval – Wyatt Beckman, KHI
- Continue RFP Feedback – Shelby Rowell, Sheena Schmidt (KHI) and Kristin Ebert, Center for Rural Health Innovation (CRHI)
- Rural Health Summit Discussion – Kristin Ebert, CRHI
- Wrap Up and Preview of In-Person Work Session – Sheena Schmidt, KHI

Participants

ETC Members: Chad Austin, Kansas Hospital Association (KHA); Dick Flanigan, Digital Health KC; Alan Wamser, Hays Medical Center; Aaron Wootton, Stormont Vail; Alisha Herrmann, Edwards County Medical Center; Chris Harper, University of Kansas Health System; Scott Rohleder, Great Plains Health Alliance; Kyle Kessler, Association of Community Mental Health Centers of Kansas; Terri Kennedy, Community Care Kansas; Robert Fireham, Newman Regional Health; Sarah Irsik-Good, KFMC Health Improvement Partners; Doug Stacy, Labette Health; Dereck Totten, KDHE; Monte Coffman, Windsor Holdings

New Members: Emily Brown, PMO Manager, KDHE; PK Gugnani, MD, Chief Informatics Officer and Chief Medical Informatics Officer, CHCSEK

CCA/KDHE Representatives: Martie Ross, CCA; Leland Bardsley, HIE Project Manager, KDHE; Andrew Eichinger, KDHE

KHI Staff: Wyatt Beckman; Shelby Rowell; Sheena Schmidt; Tatiana Lin; Theresa Freed; Karsen DeWeese

Center for Rural Health Innovation (CRHI): Kristin Ebert

Meeting Materials

- Meeting Agenda
- ETC Meeting 3 Presentation Slides
- Padlet: ETC Meeting #2 & 3 – Ambient Listening AI RFP Discussion (used across Meetings 2 and 3)
- Zoom Polls: The Problem and What Success Looks Like; Barriers and Governance; Barriers and Governance 2; Webinar Topics
- Emerging Technology RFA and Grant Application
- Kansas RHTP Application to CMS (Initiative 5) and Year 1 Approved Budget

Welcome and Overview

Wyatt Beckman, KHI, opened the meeting and welcomed participants to the third ETC meeting. He noted the session was being livestreamed and that a recording would be posted on the ETC's dedicated webpage. Members were reminded to use the Q&A feature and chat throughout the meeting.

Beckman welcomed two new members:

- Emily Brown, PMO Manager at KDHE, also oversees the HIT Advisory Council. Leland Bardsley, HIE Project Manager at KDHE, also introduced himself as reporting to Emily Brown
- Dr. PK Gugnani, practicing physician in Southeast Kansas and Chief Informatics Officer and Chief Medical Informatics Officer for CHCSEK

Beckman briefly reviewed the ETC's timeline of key activities. The charter was due for completion by July 1, with the Year 2 work plan and budget to be finalized by September 30. The next major milestone is the in-person working session on July 29 at KHI in Topeka.

Charter Approval

Beckman led a charter approval vote. Members were asked to raise their virtual hands to signal approval, with those who had already provided approval via survey acknowledged. A show of hands confirmed consensus to move forward. Beckman noted that a few comments on specific activities and evaluations had been received and would be addressed in the Year 2 work plan. The ETC charter was approved.

Meeting 2 Recap

Shelby Rowell, KHI, provided a brief recap of key information and discussion from the June 18 meeting.

Program Updates

Matt Lara and Martie Ross provided an overview of technology-related activities across the RHTP at the prior meeting. Key points:

- The Emerging Technology Grant totals $9.5 million in Year 1, focused on proven technologies only. Grants range from $1–3 million each, scored on a 100-point rubric, with applications due July 10 and awards expected August 7
- Technology is embedded across all five RHTP initiatives, not only Initiative 5. Consumer tools include Thrive CBT, LEAP, a lifestyle app, and a diabetes prevention program; remote patient monitoring appears in three programs; and the Anchor Hospital Advancement Program includes wearable vitals at 10 anchor hospitals plus a $9.8 million AI/EHR fund
- The AI/EHR fund is a separate funding stream from the $9.5 million Emerging Technology Grant
- Year 1 is characterized as a "launching and learning" phase; ETC work will shape the program in future years

Ambient AI RFP Landscape Themes from Meeting 2

Four themes emerged from the Meeting 2 discussion on the ambient AI RFP landscape for non-Oracle providers:

- Mixed adoption: Rural clinics not affiliated with larger health systems may be slower to adopt AI systems than urban providers, influenced by resources, affiliation, and capacity
- Integration matters: EHR-embedded tools tend to work best, though an imperfect tool beats no tool
- Pricing is shifting: Vendors are moving from per-user licenses to pay-per-use models, affecting how Year 2 budgets are built

- Survey the field first: A needs assessment will be conducted by CRHI; the committee also saw value in a potential RFI to better understand EHR systems in use and who plans to apply

Padlet contributions from Meeting 2 added the following landscape context:

- Terri Kennedy: Members prefer EHR-embedded tools, noting that tools acquired through the EHR vendor integrate into the software more effectively and cost less than standalone third-party solutions
- Alisha Herrmann: Edwards County Medical Center has used Microsoft Dragon Copilot (their current EHR's partner tool) and previously Playback Health, both of which were well received
- Dr. Gause (submitted via KHI): Integrated tools are preferred for workflow efficiency, but a lesser-integrated tool with extra steps is still preferable to no tool at all when seeing patients
- Chris Harper (submitted via KHI): General primary care settings have seen better early results from ambient tools; specialty and surgery care initially performed less well. Tools have improved, but these settings require more provider technical assistance and early provider engagement
- Dereck Totten: On-site support must be perceived as better than the current process; providers also want more than basic narrative generation — they want assistance with medication orders, lab orders, and other workflow functions
- Andrew Eichinger: Raised questions about liability language, dual records, and records retention rules surrounding raw ambient recordings and transcriptions — areas that should be addressed in vendor requirements
- Most members' providers predominantly work out of the EHR, though a mix of systems is common and improving over time. External systems tend to be used by care teams for clinical guidelines (e.g., UpToDate) rather than by providers directly
- Technology rollout approaches vary widely by facility and provider culture; no one-size-fits-all implementation process exists
- Terri Kennedy and Martie Ross both expressed support for issuing an RFI to better understand the vendor landscape and which providers intend to apply

Open Questions Carried into Meeting 3

Topics not fully resolved in Meeting 2, addressed today:

- Eligibility: Multi-site entity eligibility, qualifying facility types, and how to weigh readiness, need, geography, and data sharing
- Requirements: Transparency, privacy, bias mitigation, rural-proven vendors, accuracy benchmarks, clinician review workflows, and reusable standards for future RFPs

Ambient Listening AI RFP Feedback

Sheena Schmidt, KHI, and Kristin Ebert, CRHI, co-facilitated the RFP feedback session, which constituted the bulk of the meeting. The Padlet used in Meeting 2 was carried forward and continued in Meeting 3, capturing member input across both sessions. Ebert first clarified key terms to align the group's shared vocabulary:

- Interoperability: The ability of systems and data to connect for the purpose of completing a defined job
- Use case: A plain-language story of who uses the tool, to do what, where, and when — the "job to be done" before any specification is written

- Requirement: A precise, testable specification a vendor is scored against, covering technological, operational, and cultural dimensions
- Interpretability: Whether users can understand and verify what the technology produced, including tracing a note back to what was said and flagging uncertainty
- Data sharing: How patient data moves and is retained between the vendor, the EHR, and third parties — a privacy and governance question distinct from technical integration

Ebert clarified the RFP process and the committee's role. The scope for this RFP is limited to in-person ambulatory encounters at non-Oracle facilities. Once requirements are finalized, CRHI will release the RFP, receive and score vendor responses, conduct demos, and bring a curated vendor list back to the committee for final recommendation. The full process runs through October 2026.

A member asked whether the goal was one vendor or multiple. Ebert confirmed the preference is one vendor, but more than one may be needed depending on how requirements align across different EHR systems. Dr. Gugnani raised a question about whether a field inventory of EHR systems had been completed. Ebert confirmed this is a focus of the forthcoming post-meeting assessment, which will also capture what tools providers are already using and what is or is not working.

Eligibility: Rurality and Priority

Members discussed what entities should be eligible to receive funding. Key points from live discussion and Padlet submissions:

- Strong agreement across members that priority should be given to providers located in and directly serving rural areas. Members noted that larger urban systems often already have the resources and infrastructure to pursue these tools independently
- Martie Ross clarified that the NOFO permits urban facilities to receive funds if the primary beneficiary is a rural facility, as demonstrated by the Children's Mercy Regional Partnership Grant award, where funds are deployed exclusively in rural areas
- Members agreed on a tiered approach: preference first for frontier and rural-designated sites, then secondary consideration for urban systems with documented rural service
- Leland Bardsley added a consideration not raised in verbal discussion: specialty providers that rural communities can only access remotely should also be considered in the eligibility framework
- Aaron Wootton suggested the committee consider funding an implementation partner over or in addition to a pure technology solution, given that appropriate technology may vary widely depending on each organization's resources and infrastructure

Eligibility: Multi-Site Entities

Members discussed whether entities operating multiple sites should be eligible to apply on behalf of all locations:

- Dick Flanigan: Multi-site entities should be eligible to apply on behalf of their locations if they are the controlling management entity — a documented management agreement is the appropriate threshold, not just an affiliation or MOU
- Chad Austin: Entities should be able to apply on behalf of multiple sites, and the application process should be easy to complete
- Dick Flanigan: For urban systems with rural components, any funding should be specific to the costs of rural implementations only, not absorbed into shared system overhead

- Chad Austin: Networks such as the Great Plains Health Network have meaningful partnerships without formal management control that should also be considered eligible pathways
- Chris Harper: Using rural-practicing provider counts and user types as a more precise eligibility and allocation measure than patient volume alone

Eligibility: Facility Types

Members discussed which facility types should be eligible. Key points from live discussion and Padlet:

- Broad consensus that hospitals, primary care clinics, and community mental health centers should be core eligible facility types
- Dr. Gugnani: Behavioral health facilities would benefit especially from ambient listening, as documentation is particularly burdensome in that setting. He also noted that long-term care facilities may not need separate funding since visiting providers often carry their own ambient tools from their home organizations
- Dentistry and chiropractic care were identified as outside current scope, consistent with definitions used in prior RHTP grant programs
- Martie Ross: Licensed providers operating within FQHCs or CCBHCs would be covered through entity-level eligibility for those organizations
- Dereck Totten: Advocated for keeping eligibility criteria as broad as possible for this first round, recognizing that the 5-year program allows for refinement over time. He also cautioned against excluding organization types based on high-level criteria that might later prove to have been a mistake
- Dick Flanigan: Drew a parallel to the HITECH Act era, cautioning against repeating the mistake of excluding behavioral health, public health, and other provider types from early rounds of technology investment

Eligibility: Geographic Distribution

Members discussed how geography should factor into funding priorities. Padlet responses corroborated and extended the verbal discussion:

- Dick Flanigan: Awards should map against community need in every geographic area of the state
- Terri Kennedy: There should be a method for ensuring awards are spread throughout the state; she supported Dr. Totten's suggestion to use distance to nearest provider as a data point
- Chad Austin: Ideally, recipients would be represented in all geographic districts across Kansas
- Dereck Totten (verbal): Proposed incorporating distance to the nearest specialty provider as a scoring criterion, similar to how obstetrical desert designations are assessed
- Dick Flanigan (verbal): Emphasized that demonstrating geographic diversity in early awards is critical for building public confidence that RHTP dollars are serving all of Kansas

Eligibility: Technical and Organizational Readiness

Members discussed what signals of readiness should be required of applicants. Padlet responses were unanimous in supporting readiness requirements:

- Dick Flanigan, Sarah Irsik-Good, and Chad Austin all indicated strong support for requiring applicants to demonstrate clinician buy-in and a plan for staff training and change management
- Terri Kennedy added a baseline readiness criterion not raised verbally: applicant organizations should have an EHR already installed
- Aaron Wootton cautioned that requiring applicants to attest to readiness will not be a reliable signal — no site will claim they are not ready. He suggested building change management and implementation support directly into RFP requirements on the vendor side rather than relying on grantee attestation
- Dick Flanigan noted that vendors must be able to demonstrate both on-site initial implementation capability and sustained remote training and support capacity, given the cost and logistical barriers to repeated on-site visits in rural communities

Eligibility: Patient Volume, Financial Need, and Populations Served

Members discussed whether volume or financial thresholds should factor into eligibility. The verbal discussion pointed toward a broad, accessible approach:

- Dick Flanigan: Financial viability should not be an eligibility criterion for this committee to assess — if an entity is eligible to receive Medicare and Medicaid and is a going concern, that is sufficient. Financial health determinations belong with other oversight bodies
- Members agreed that community need — rather than organizational financial position — should be the lens for prioritization
- The group reached general consensus on keeping the application as accessible and broad as possible while maintaining the rural focus. For this first round, the need across rural Kansas is sufficiently widespread that granular financial or volume thresholds are unlikely to add value
- No written Padlet responses were submitted on this topic; the verbal discussion captured the full input

Eligibility: Interoperability, Sustainability, and Evaluation Commitments

Martie Ross introduced the concept of an interoperability pledge as a condition of funding, consistent with CMS priorities. Members were broadly supportive. Padlet submissions and chat added specific evaluation measures:

- Terri Kennedy (Padlet): Grantees should be required to participate in evaluation activities. Suggested measures include accuracy of the tool and improved efficiency
- Terri Kennedy (Padlet): Reduction in documentation time is a concrete and practical measure
- KHI / Tatiana Lin (Padlet and chat): Note quality and accuracy should be explored as a measure — not just speed of documentation but the completeness and reliability of what the tool produces
- Aaron Wootton (chat): The most meaningful long-term metric is the number of providers still actively using the tool — sustained adoption indicates the tool is genuinely adding value
- Members noted CMS has been receptive to qualitative measures (surveys, opinion-based data) alongside quantitative reporting
- Chris Harper shared that KU Health System tracks documentation time, after-hours charting (“pajama time”), cognitive burden using an adapted NASA measurement

methodology, and unique user counts and note volume. He offered to share the methodology and relevant policy documents with CRHI

Vendor Requirements: Standard and Additional

The Padlet presented two categories of vendor requirements for member review across Meetings 2 and 3. No written comments were submitted on individual requirements, indicating general acceptance of the proposed framework as a starting point. Standard vendor requirements identified for inclusion in the RFP include:

- Transparency for patients
- Financial stability
- Integration with existing workflows
- Rural proofing
- Reporting standards
- Accuracy standards
- Bias mitigation
- Cost guardrails
- Privacy standards
- Externally validated effectiveness

Additional potential requirements, raised by KHI for Meeting 3 discussion and presented as prompts for further development at the July 29 in-person session:

- Rural proofing: How do we confirm the tool performs reliably for rural, low-volume, and critical access patient populations, not just the settings it was built or tested on?
- Workforce augmentation: How should the solution support smaller care teams and off-hours staffing realities that differ from a large urban health system?
- Commitment to values: How could commitment to values be defined and measured in practice?

RFP Feedback: The Problem, Success, and Barriers

Poll Results: Problems to Solve with Ambient Listening

Members completed a Zoom poll ranking the problems they most hope to solve with ambient listening (11 respondents, ranked 1–3, with 1 = most important):

- Documentation burden and provider burnout: Top-ranked by 91% of respondents (ranked #1 by 10 of 11)
- Patient experience and more face-to-face attention: Ranked first or second by 91% of respondents
- Quality and completeness of clinical notes: Ranked in the top three by all respondents
- After-hours charting (“pajama time”): Ranked first or second by 81% of respondents
- Provider recruitment and retention: Ranked second or third by the majority of respondents
- Coding accuracy and revenue capture and visit throughput also received notable rankings

Ebert asked Chris Harper to describe how KU measures cognitive load as a success outcome. Harper described a published research methodology adapted from a NASA framework applied through provider surveys, and offered to connect CRHI with the team that developed it.

Discussion: What Would Make This a Failure?

Members discussed factors that could cause providers to abandon ambient AI tools:

- Inadequate feedback loops: Ambient AI tools are learning systems; backend model updates can change tool behavior in ways that frustrate users if there is no informatics process to quickly identify and address issues
- Poor performance in specialty contexts: Tools trained primarily on primary care may underperform for specialists. Providers with a poor early experience may disengage before the tool's learning improves for their context
- Workflow mismatch: Ambient listening requires providers to structure patient conversations somewhat differently. Some adapt easily; others struggle. Aaron Wootton noted that providers at Stormont Vail who struggled either sought help or reverted to prior documentation methods
- Patient pushback: Members noted patient concern about recording has been minimal where proper consent is in place. Dick Flanigan encouraged making sure frontline staff are equipped to answer patient questions about data use and protections

Discussion: Long-Term Value and Sustainability

Ebert asked members what provider response would be if ambient listening were taken away tomorrow. Chris Harper shared that providers at KU have said they would pay out of pocket to keep it, and that several have cited the tool as a key factor in reversing burnout. The committee broadly agreed that sustained provider adoption rates are the clearest indicator of long-term value. Dr. Gugnani predicted that within five years ambient documentation will be a standard expectation for all providers, and that ambient listening is already becoming a provider recruitment differentiator.

Poll Results: Biggest Internal Barrier to Adoption

Members completed a Zoom poll on the biggest internal hurdle to adopting ambient listening (10 respondents):

- Provider skepticism or change fatigue: 40% (top response)
- Compliance, legal, or governance review of AI tools: 30%
- IT bandwidth or integration complexity: 20%
- Patient privacy concerns and consent workflows: 10%
- Leadership or board buy-in: 0%

Leland Bardsley noted that compliance and governance concerns often center on where data goes, particularly when AI tools use third-party cloud processing for clinical decision support versus simpler in-house speech-to-text applications. Chris Harper shared that KU addressed this by embedding AI review into their standard cybersecurity and IT assessment framework using a NIST-based approach, partnering closely with legal counsel from the outset, which prevented compliance from becoming a barrier.

Poll Results: Existing AI Policy or Process

A second Zoom poll asked whether members' organizations have an existing policy or process for AI tools and patient encounter recording, including patient consent (7 respondents):

- Yes — established policy in place: 5 of 7 respondents
- In development: 2 of 7 respondents
- No / Unsure: 0 respondents

Ebert noted the opportunity to leverage established policies from early adopters as resources for organizations still developing their frameworks. Dick Flanigan encouraged packaging existing best-practice documentation from organizations like KU and making it available to

smaller facilities to adapt rather than start from scratch. Chris Harper and Aaron Wootton both offered to share their organizations' policies and patient consent approaches with CRHI. CRHI will explore how to incorporate shared policy resources into the July 29 in-person session.

Rural Health Summit and Upcoming Webinars

Rural Health Summit – October 7–8, St. Louis

Ebert announced a two-day Rural Health Summit hosted by CRHI in St. Louis on October 7–8, 2026. The summit will bring together RHTP state participants, rural health providers, CMS representatives, and innovators. Up to 75 registrations are available at no cost to ETC members through the CARE Collaborative partnership. A registration link was shared in the meeting chat.

Panel topics for the summit will be informed by themes and pain points emerging from ETC meetings. Members were encouraged to register and to share the link with rural providers they support.

Poll Results: Upcoming Webinar Topics

CRHI will host two webinars for ETC members and their networks. Members voted on the most valuable topics (7 respondents, select top 2). Four topics tied at 43% each:

- How to make vendor decisions about AI
- Best practices for authoritative decisions with AI
- Harnessing data to deliver real-time decision-making: what is possible
- Change management: why it's the most undervalued step in innovation

CRHI will use these results to select the topic for the first webinar, to be hosted within the next one to two months.

Wrap Up and Next Steps

Sheena Schmidt previewed the July 29 in-person working session at KHI (212 SW 8th Avenue, Topeka). Lunch will be provided. A virtual attendance option will be available for those who cannot attend in person. Members were asked to RSVP via a registration link to follow. The session will be used to finalize RFP feedback, set the vision for Year 2 ETC work, and begin drafting the work plan and budget.

Action Items

ETC Members

- RSVP for the July 29 in-person working session at KHI once the registration link is distributed
- Complete the post-meeting needs assessment distributed by CRHI (covers technical background, current technology landscape, and field assessment questions)
- Review Rural Health Transformation Program resources prior to the July 29 meeting
- Register for the Rural Health Summit (October 7–8, St. Louis) using the link shared in the meeting chat; share the link with rural providers in your networks

KHI

- Distribute meeting summary, presentation slides, Padlet responses, and poll results to members
- Send RSVP registration link and logistics details for the July 29 in-person meeting

- Continue compiling and synthesizing RFP eligibility and requirements feedback for use at the July 29 session

CRHI

- Distribute the post-meeting needs assessment to ETC members
- Follow up with Chris Harper and Aaron Wootton to obtain ambient AI policy, patient consent, and success metrics documentation to share with the broader group
- Determine topic and speakers for the first CRHI webinar for ETC members and networks, informed by poll results
- Incorporate shared policy and governance resources into the July 29 in-person meeting agenda