Emerging Technology Committee Meeting Summary

June 18, 2026

1:00 p.m. – 3:00 p.m.

Agenda

- Welcome and Opening Remarks – Sheena Schmidt, KHI
- Meeting 1 Recap – Shelby Rowell, KHI
- ETC Charter Review and Finalization – Wyatt Beckman, KHI
- Emerging Technology Program Updates – Matt Lara, KDHE, and Martie Ross, CCA
- Ambient Listening AI RFP Feedback Session – Sheena Schmidt, KHI, and Kristin Ebert, Bio STL Center for Rural Health Innovation
- Q&A and Next Steps – Sheena Schmidt, KHI

Participants

ETC Members	
Scott Rohleder, Great Plains Health Alliance	Monte Coffman, Windsor Place
Terri Kennedy, Community Care Kansas	Kyle Kessler, Association of Community Mental Health Centers of Kansas
Dick Flanigan, Digital Health KC	Aaron Wootton, Stormont Vail
Alisha Herrmann, Edwards County Medical Center / HIMSS Kansas Chapter Chair	Chris Harper, University of Kansas Health System
L. Nathan Gause, MD, University Health	Chad Austin, Kansas Hospital Association (KHA)
Andrew Eichinger, Office of Information Technology Services (OITS) – State Liaison	Dr. Derek Totten, KDHE / Rural Provider, Colby, KS
State Partners	
Matt Lara, Chief of Staff and RHTP Program Director, KDHE	Martie Ross, UKHS Care Collaborative Association (CCA)
KHI Staff	
Sheena Schmidt	Shelby Rowell
Wyatt Beckman	
BioSTL, Center for Rural Health Innovation	
Kristin Ebert	

Meeting Materials

- Emerging Technology Committee Agenda
- ETC Charter (Draft for Review)
- Emerging Technology Grant RFA (KDHE)
- RHTP Program Overview Slides (Martie Ross, CCA)
- Ambient Listening AI Overview and Padlet Feedback Tool

Welcome and Opening Remarks

Sheena Schmidt, KHI, welcomed participants to the second meeting of the Emerging Technology Committee (ETC). She reviewed group agreements, recapped the committee's shared purpose, and noted that the meeting was being recorded and live-streamed.

Schmidt welcomed two new members joining for the first time: Monte Coffman (Windsor Place), who brings experience running a long-term care HCBS program and a remote patient monitoring program for KanCare members; and Dr. Derek Totten, Chief Medical Officer at KDHE and a rural family medicine physician in Colby, Kansas. Andrew Eichinger, Chief Information Technology Architect for the State of Kansas, joined as the OITS state liaison. Schmidt noted that two additional rural providers have been approved to join and are expected to participate at Meeting 3.

Key upcoming dates: Meeting 3 is July 9, 1:00–3:00 p.m. (virtual). Meeting 4 is July 29 (in-person hybrid at KHI in Topeka), focused on Year 2 work plan and budget development and final RFP feedback.

Meeting 1 Recap

Shelby Rowell, KHI, provided a brief recap of Meeting 1 to orient returning and new members.

Twelve members completed the post-meeting registration survey, representing six statewide organizations and eleven rural hospitals and facilities. All respondents indicated willingness to serve as a section lead or content reviewer. Areas of expertise represented include healthcare technology implementation, AI and data systems, healthcare administration, research and evaluation, and writing and documentation.

Key themes from the Compass Points exercise conducted at Meeting 1:

- Excitement around technology's potential to keep rural Kansans in their communities by bringing specialty, primary, and behavioral health care directly to them
- Ambient AI as a high-priority opportunity to ease clinician burnout and reduce documentation burden

- Interest in the pace of digital health innovation and what it now makes possible for rural communities
- Commitment to whole-person solutions that address both medical and non-medical drivers of health

Key challenges identified: financial sustainability after the grant period, broadband and infrastructure gaps, EHR fragmentation and integration barriers, workforce adoption challenges, cybersecurity risks, and reimbursement uncertainty in telehealth.

Rowell also summarized charter feedback themes from Meeting 1: ensuring the committee represents all those affected by the technology, grounding decisions in CMS rules and the RHTP project narrative, and keeping the full program visible to the committee.

ETC Charter Review and Finalization

Wyatt Beckman, KHI, walked the committee through the updated charter, highlighting revisions made in response to Meeting 1 feedback. New and revised sections are noted below. The charter is a living document and will be distributed for formal ratification via a Qualtrics survey prior to Meeting 3.

Key updates included:

- Strengthened references throughout to the CMS award, including explicit language that the committee's work will not conflict with the terms of the award
- Broader committee structure description to reflect the full range of healthcare professionals and clinicians bringing rural provider perspective
- Added member expectation to identify a proxy when unable to attend and to serve as ambassadors for the committee's work
- New community engagement process allowing the committee to seek direct input from community members and individuals outside regular membership
- Clarified decision-making process: consensus is the primary approach; if a vote is required, decisions are made by majority of voting members present, with KDHE state agency liaisons serving as tiebreaker; committee recommendations are advisory, with final authority resting with KDHE
- Added charter amendment process with version tracking
- Added an appendix capturing key themes and opportunities surfaced at Meeting 1

Member feedback during the session: spell out UKHS fully in the first paragraph, and add page numbers. Both will be addressed in the final version.

Emerging Technology Program Updates

Emerging Technology Grant – Matt Lara, KDHE

Matt Lara, RHTP Program Director, presented the Emerging Technology Grant request for applications (RFA) currently open. The program provides up to $9.5 million in Year 1 funding, with 5 to 10 grants anticipated in the range of $1–$3 million. Year 1 is expected to be the first of multiple funding rounds.

Key dates: informational webinar June 22; applications due July 10; awards announced August 7. Applications are scored on a 100-point rubric with dedicated sections for technology overview (evidence of effectiveness and scalability) and sustainability. The program requires proven technologies, defined as already implemented in a real-world setting with documented outcomes, rather than early-stage pilots. All technologies must meet applicable compliance and security standards. Links to the RFA were shared in the meeting chat.

RHTP Program Overview – Martie Ross, CCA

Martie Ross, CCA, provided an orientation to technology-related investments across the Kansas RHTP plan, noting that technology is embedded across all five initiatives and not concentrated solely in Initiative 5. The Kansas plan comprises 24 programs and 55 work streams, with multiple technology funding streams that intersect and overlap — something the ETC will help align over time. Ross described the current year as a “launching and learning” phase.

Technology investments highlighted across the plan include:

- Consumer-facing technologies (Initiative 1): Computerized cognitive behavioral health therapy (the Thrive program, led by KUMC Wichita), LEAP brain health and dementia prevention (KUMC), a fitness/nutrition/lifestyle app (RFP expected in early July), and an asynchronous Diabetes Prevention Program (CCA). My LZ Journey, an Alzheimer’s support tool, is deferred to Year 2.
- Ambulatory remote patient monitoring: Integrated across three programs — Accountable Food as Medicine/Community Health Workers (KDHE and K-State), Integrated Care for Dual Eligible Beneficiaries (including PACE expansion), and Virtual Integrated Behavioral Health (Sunflower Foundation).
- Initiative 5, Harnessing Data and Technology: Telehealth navigators supporting rural specialty care coordination; the Datadoc program (KUMC/Children’s Mercy) applying AI to diabetes patient data for predictive analytics; a health data utility proposal under development; and the Emerging Technology Program, which includes the ET Grant, the ETC, and the Oracle Clinical AI Assistant ambient AI implementation for Oracle-based facilities.
- Anchor Hospital Advancement Program (AHAP): Ten identified anchor hospitals are implementing Bio IntelliSense wearable vital signs monitoring, and a $9.8 million AI EHR Optimization Fund is available for AHAP hospitals to improve AI and EHR capabilities with an eye toward supporting surrounding hospitals.

Ambient Listening AI RFP Feedback Session

Sheena Schmidt and Kristin Ebert (BioSTL Center for Rural Health Innovation) led the committee's first feedback session on the Ambient Listening AI RFP. The RFP will identify ambient AI solutions for rural providers not using Oracle systems. For Year 1, scope is limited to in-person encounters in ambulatory settings. Ebert noted that additional functionality — including clinical decision support and predictive modeling — will be layered in during Year 2 and beyond as the committee better understands current infrastructure across constituent facilities.

Members contributed feedback through Padlet and open discussion across several topic areas: landscape, eligibility and funding priorities. Key themes from each are summarized below.

Landscape: Current State of Ambient AI Adoption

Members described a mixed adoption landscape. Tools in use or previously piloted by committee members include Microsoft Dragon Copilot and Playback Health. Vendors report that rural clinics and hospitals not affiliated with larger health systems have been slower to adopt than urban providers.

EHR integration emerged as a central theme. Members noted that tools acquired through or embedded in the EHR vendor tend to work more seamlessly than third-party solutions, though even non-integrated tools, requiring copy-and-paste into the EMR, deliver meaningful value to providers. The consensus was that tight workflow integration is the goal, but imperfect integration is far better than no tool at all.

Members also noted a market shift underway from per-user/per-license pricing to utilization-based (token or AI unit) pricing, which has implications for how Year 2 budgets should be structured. Members raised the question of whether Year 2 funding could support providers who have already begun ambient AI rollouts; the group noted that funding cannot replace existing expenditures but could potentially support expanded functionality such as clinical decision support or coding assistance.

The committee agreed that a request for information (RFI) would be a useful tool both to gather landscape data (EHR systems in use, intent to apply, size and capacity) and to communicate upcoming funding opportunities to potential applicants. A member also noted the value of leveraging rural health networks such as Pioneer Health Network, which maintains lists of what member organizations use across technology categories. KHA offered to help reach out to critical access hospital networks to identify systems in use.

The committee also discussed the need for a current-state inventory of EHR and infrastructure across facilities, to identify vendor partners capable of working across the range of systems represented.

Eligibility

The Padlet surfaced several eligibility questions for the committee to work through at the next meeting:

- Rurality: How should rurality be defined, federal or state designation, or a Kansas-specific definition? Should eligibility be limited to entities in rural areas or facilities serving rural populations from a non-rural location? Are there degrees of rurality (e.g., frontier or remote areas) that should be prioritized or weighted?
- Multi-site grantees: Should entities operating multiple sites apply on behalf of all locations or each site separately? If a multi-site entity is eligible, should funding or scope be tied to the number of qualifying sites? How should eligibility be handled when a system includes both rural and non-rural sites?
- Type of facility: Which facility types should be eligible (hospitals, long-term care facilities, primary care clinics, behavioral health providers)? Should eligibility depend on the setting where the Ambient AI solution will be used, given Year 1's focus on in-person ambulatory encounters? Are there facility types that should be excluded or phased in later?
- Implementation partnerships: One member noted that a pure tech solution as the appropriate technology may vary depending on resources and infrastructure and suggested the option of funding an implementation partner alongside or in addition to a tech solution.

Funding Priorities

Padlet responses identified the following as potential funding priority considerations:

- Geographic distribution: Ensuring awards reach a spread of regions across the state rather than concentrating in a few areas
- Technical and organizational readiness: Should applicants demonstrate clinician buy-in or a plan for staff training and change management?
- Workforce and clinician engagement: How should applicant readiness be assessed and weighted?
- Patient volume, financial need, and populations served: Should there be a minimum or maximum volume of ambulatory encounters? Should an entity's financial position or the degree to which it serves underserved or high-need populations be taken into account?
- Commitment to data sharing and evaluation: Should grantees be required to participate in program evaluation, share outcome data, or report on implementation?

Vendor Requirements

The Padlet included vendor requirement categories for the committee to define at the next meeting. Members emphasized the value of developing clear, reusable standards through this first RFP that can be carried forward to future use case RFPs:

- Transparency for patients: Vendors should be able to clearly explain to patients and providers how the technology works and where data is stored
- Financial stability: Assurance that vendors have sustainable business models and are not early-stage companies at risk of closure
- Integration with existing workflows: Solutions should work within or alongside existing EHR systems without adding burden
- Rural proofing: Solutions must be designed for or demonstrated in rural settings, not just adapted from urban implementations

- Reporting standards: Vendors should provide standardized reporting on usage and outcomes
- Accuracy standards: Clear benchmarks for documentation accuracy and a defined clinician review process
- Bias mitigation: Vendors should address how their models are tested for and mitigated against demographic bias
- Cost guardrails: Pricing should be transparent and within defined affordability thresholds
- Privacy standards: Including data retention requirements for raw recordings and transcriptions; members noted the legal implications of dual records and the importance of vendors being able to articulate their data handling policies
- Externally validated effectiveness: Evidence of outcomes from real-world implementation, not just internal product claims

Members noted that a common set of accepted standards and contract terms would benefit not only the ETC's work but also vendors, by lowering the cost of engagement and simplifying contracting for rural organizations, ultimately making the Kansas rural market more accessible and affordable.

Next Steps and Upcoming Meetings

The next meeting is July 9, 1:00–3:00 p.m. (virtual). The committee will continue RFP feedback, focusing on eligibility criteria, funding priorities, and vendor requirements. The July 29 in-person hybrid session at KHI offices in Topeka will serve as the final working session on RFP feedback and will include Year 2 ETC work plan and budget development.

Members who have not yet completed the registration survey were asked to do so using the link or QR code provided at the meeting.

Action Items

ETC Members

- Complete the member registration survey if not yet done
- Review the updated charter when distributed and submit ratification via Qualtrics survey prior to Meeting 3
- Association-based members: expect to hear from KHI regarding how to support the landscape information-gathering effort and RFI development

KHI

- Distribute updated charter (with minor edits applied) and ratification survey to members prior to Meeting 3
- Work with BioSTL Center for Rural Health Innovation to develop an EHR and systems inventory tool for distribution to committee members and networks
- Potentially develop and distribute a request for information (RFI) to prospective applicants; coordinate timing and content with committee members
- Distribute meeting summary and Padlet responses to members

KDHE

- Share updates on Emerging Technology activities, including Grant RFA applications and awards with the ETC as they become available

CCA

- Further develop the crosswalk of RHTP activities that align with ETCs work.