August MNORN Member Meeting - Thursday, August 20th

Program: Supporting New Graduates and Transition to Practice

Presenter: Annette Hines. Annette Hines is the Executive Director of the University of St Thomas Susan S. Morrison School of Nursing.

Objectives:

By the end of this presentation, participants will be able to:

1. **Describe** the respective roles of academic institutions and healthcare organizations in preparing and supporting new graduate nurses.

2. **Examine** evidence-based strategies that improve transition to practice, nurse confidence, competency, and retention.

3. **Identify** collaborative academic-practice partnership models that promote successful transition, professional development, and workforce sustainability.

Attendees will receive 1.0 continuing education credit
There is no charge for this meeting

Register Here

The topic of the June MNORN meeting was "The Importance of Being Human in Today's Modern World "

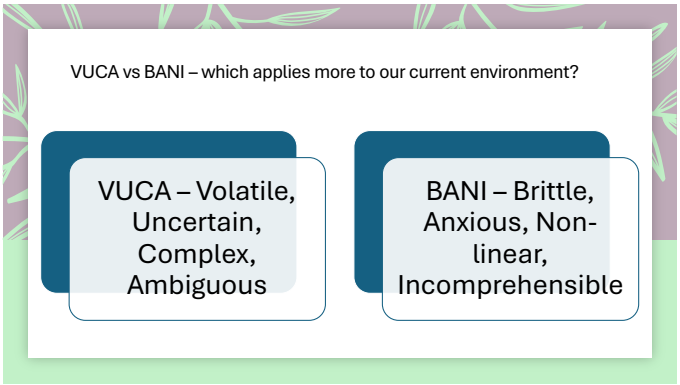
Oriana Beaudet was the presenter. She facilitated a fascinating discussion among participants, Unfortunately, this presentation was not recorded.

Plan for the session: Healthcare is evolving quickly and innovation is required to move forward. This session explores how nurses make impact amidst ambiguity and across disruption, emerging technologies, and the evolving nature of care. Transformational change is possible across healthcare's high-tech future but only if humanity is at its heart.

Objectives:

- Broader clarity around trends across the impacting healthcare landscape.
- Apply innovation exemplars across nursing, healthcare, and society.
- Identify the transformational opportunities to navigate into the future.

We were reminded that innovation begins with a problem that is endemic for nurses that nurses need to solve. This is especially true in this churning environment we are in the midst of. Oriana introduced two acronyms that describe this kind of environment- VUCA and BANI



VUCA was developed by the War College in the 1980's - the acronym stands for "Volatile, Uncertain, Complex, and Ambiguous."

BANI was created by futurist Jamais Cascio to explain modern global chaos and unpredictable systems.

Today's environment with polycrisis, omnicrisis, and metalocalypse seems to favor BANI over VUCA. Brittle, anxious, non-linear, incomprehensible…. Certainly an environment that requires the strengths and talents of the nursing profession.

Considerations:

- How do we anticipate change?
- Being human is critical to the future.
- The present moment used to be the unrecognized future.

> Oriana ended her presentation with the famous R. Buckminster Fuller quote:
>
> "We are called to be the architects of the future, not its victims."

Core Ideas of the Quote

- **Action over reaction:** Do not wait for bad events to happen. Take steps now to fix problems before they grow.
- **Design thinking:** Use smart planning, science, and tools to make life better for everyone on Earth.
- **Personal power:** Every person can make choices that guide where society goes next

After the meeting, Oriana shared a reading list for us to to continue our exploration around our shifting world. All these resources exemplify why nurses are critical to future direction of health, healthcare, and our country!

Ori's Reading List for MNORN

American Nurses Association Nursing Innovation Website

American Nurses Association | Culture of Innovation and Quality Model Publication Article

Brookings | Has United States Bent Health Care Cost Curve Research Podcast

Daniel Pink | A Whole New Mind: Why Right-Brainers Will Rule The Future Book

Fortune | Healthcare Is the One Profession Growing Right Now Article

Gallup | U.S. Adults' Ability to Afford Healthcare at a Five-Year Low: An estimated 2.8 million more Americans reported inability to afford healthcare in 2025 compared with 2024. Article

Kaiser Family Foundation Eight Trends Shaping 2026 Healthcare Costs article

LinkedIn | Anatomy of Best-in-Class Healthcare Hiring Report

Neuronal cultures playing Pong: First steps toward advanced screening and biological computing

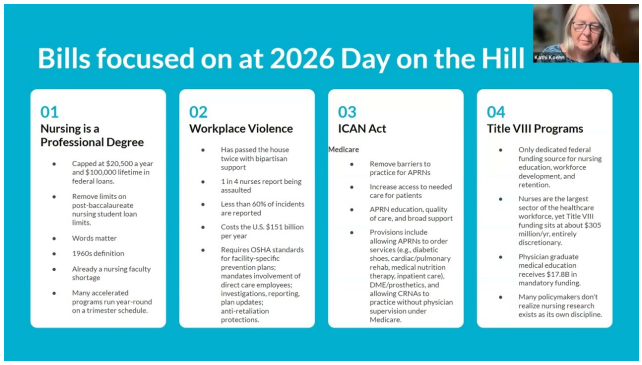
The Commonwealth Fund | Health System Data Center: Minnesota 2025 Ranking Website

Wall Street Journal | Healthcare Jobs Have Become the Engine of America's Labor Market: Demand for Healthcare Workers Outstrips All Other Sectors Article

Washington Post | If Not for This One Industry, the U.S. Labor Market Would Look a Lot Worse Article

World Economic Forum | The Future of Jobs Report 2025 Report

Recording of the July MNORN Member Meeting: Report of the ANA Membership Assembly, given by MNORN representatives and attendees.



Background: The ANA Membership Assembly is the governing and official voting body of the American Nurses Association (ANA). It identifies and discusses issues of concern to members and provides direction to the ANA Board of Directors.

One of the key responsibilities of the ANA Membership Assembly is to determine policy and positions for the Association. The meeting of the ANA Membership Assembly provides a forum for discussion of critical nursing practice and policy issues and input from a broad cross section of nursing leaders.

Objectives:

At the conclusion of the presentation the participant will be able to:

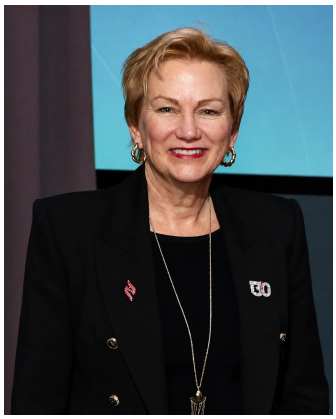
- Discuss key national health policy initiatives impacting nurses.
- Review the ANA Bylaw Amendment process and 2026 outcomes.
- Describe the outcomes of the policy dialogue forums.
- Describe the process for ANA elections and know who was elected to serve ANA in the 2026 election.

Congratulations to MNORN member Seth Schweiger who was elected to the ANA Nominations and Elections Committee!

Seth Schweiger is a nurse of 2 years. His current area of work is in the Cardiovascular Intensive Care Unit at Essentia Health St. Mary's Medical Center in Duluth MN. He was just elected this June to ANA's Nominations and Elections Committee as well as being one of the first 15 nurses selected as an ANA NextGen Ambassadors. He is a current DNP student at the College of St. Scholastica with a focus in Adult Gerontology Acute Care. With a nursing background in CVICU and clinical academia he has been involved in advocacy, policy, and research. He has enjoyed widening his knowledge on the individual, state, and national level and is eager to continue his involvement.

American Nurses Association Membership Assembly Elects Dr. Anita Girard as President

The American Nurses Association (ANA) announces that the voting representatives of its Membership Assembly elected Anita Girard, DNP, RN, CNL, CPHQ, NEA-BC, of the American Nurses Association\California, as the new president to represent the interests of the nation's more than 5 million nurses.



As ANA's 39th president, Dr. Girard will lead the ANA Board of Directors and guide the association's work to advance nursing and healthcare. Her leadership will be central to ANA's implementation of its 2026–2030 Strategic Plan and to the organization's continued service to nurses, the profession, and the public.

"I am deeply honored to be elected to serve as the next president of the American Nurses Association and to help lead this organization into its next chapter," said Anita Girard, DNP, RN, CNL, CPHQ, NEA-BC. "For more than 30 years, I have served this profession across clinical, operational, executive, and association leadership roles, and that experience has reinforced one enduring belief: nurses must be supported, respected, and empowered in every setting where they are educated and practice. As president, I look forward to listening to our members, advancing ANA's strategic priorities, strengthening the profession, and ensuring nursing continues to be a trusted force in improving healthcare for all."

Dr. Girard is the current vice president of the American Nurses Association and most recently served as the president of the American Nurses Association\California. Prior to her association leadership roles, she spent four years as the chief nursing officer and vice president of nursing at Cedars-Sinai Medical Center in Los Angeles, California, and over 30 years across multiple staff and leadership roles within the Stanford Health Care system.

Dr. Girard's two-year term of service is set to begin on January 1, 2027.

Alliance of Nurses for Healthy Environments

The 5th Annual Environmental Health Nurse Fellowship Program Is Now Accepting Applications

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The Alliance of Nurses for Healthy Environments (ANHE), a national nursing organization focused solely on the intersection of health and the environment is excited to launch the 5th cohort of the Environmental Health Nurse Fellowship Program from January 2027 - December 2027! Please share widely with your networks.

This Fellowship is intended to train nurses to work with communities in tackling serious environmental health issues, with an emphasis on climate and health equity, as well as to provide them with mentorship and skills-building opportunities so that they can take on increasing leadership roles in the communities that they serve.

Applications for the program open on August 4th and the submission deadline is September 4th, 2026. Participants will be notified of acceptance by October 16th. There are a total of 18 spots for nurse fellows.

We are especially looking for nurses from the following areas (these locations are not a requirement): Miami, Houston, Portland, Austin, Detroit, Fresno, New Orleans, Memphis, San Diego, Boston, Pittsburgh, Atlanta, Buffalo, Oakland, Los Angeles, Springfield, New York City, Cleveland.

Examples of nurse-community partnerships and projects from past cohorts include:

- Mia McPherson, a public health nurse in Detroit Michigan, partnered with the East Side Community Network to create a guidebook that talks about why heat resilience is an important issue for residents living in the area ECN serves. The guidebook is designed as an educational tool for ECN that breaks down the medical jargon around environmental impacts so their team can use it to better educate the largely Black community as to why and how the resilience hubs can be utilized.
- Jennifer Rasmussen, a home care nurse, partnered with the Fairmount Indigo CDC Collaborative (FICC). Through this partnership Jennifer helped to coordinate a series of 3 quarterly community discussions around the intersection of health and climate justice with the goals of providing education and increasing the number of residents

in FICC neighborhoods engaged in the Fairmount Climate Justice Initiative policy advocacy campaigns and activities.

Apply to become a nursing fellow in environmental health here!

Benefits of participating in the program include:

- *An opportunity to partner with an organization on a project that will address environmental health challenges in their community*
- *Mentorship from a senior nurse to support each fellow in their efforts*
- *Access to a network of nurses committed to advancing health equity for their communities*
- *Peer-to-peer learning and new relationships with 17 other amazing nursing fellows, with immersion experiences via a virtual and in-person convening (travel/ accommodation expenses covered by ANHE for in-person convening)*
- *A stipend of $1,000 to support your project work*
- *Free nursing continuing education for participation in webinars and convening events*

Strengthening professional identity to address the nursing workforce crisis

Associate Professor Erica Schorr evaluates how reflection based on Nine Domains of Acute and Critical Care Practice strengthens students' professional identity

Building on the framework of Nursing Outlook's Blueprint for Change, Erica Schorr's research examines how to strengthen students' understanding of why nursing matters.

A multi-site study involving the University of Minnesota, Rutgers University, and California State University-Fresno evaluated educational interventions designed to strengthen nursing students' professional identity and facilitate their transition to practice.

The research addresses a critical workforce challenge: high turnover rates among new nurses, many of whom leave the profession within their first year.

The study examined whether intentionally connecting students' clinical observations to the Nine Practice Domains of Acute and Critical Care Nursing as outlined in the Nursing Outlook article Call to action: Blueprint for change in acute and critical care nursing could strengthen their professional identity and facilitate their transition to practice.

A key contributor to leaving the profession is that many nursing students struggle to develop a clear professional identity during their education, seeing themselves primarily as task-completers rather than as health care professionals who fundamentally impact patient outcomes.

"Without understanding why nursing matters and how their actions uniquely impact patients, students risk becoming disillusioned technicians rather than engaged professionals. Literature in a variety of fields supports that people don't just need to know what they do and how they do it, they also need to understand why it matters," says Associate Professor Erica Schorr, PhD, RN, who led the Minnesota study that focused on strengthening professional identity.

The study focused on Master of Nursing (MN) students in their final semester of nursing school. Half of the student cohort took part in structured conversations after their clinical shifts, where they talked about specific care they had provided or witnessed. They connected those actions to the Nine Practice Domains of Acute and Critical Care Nursing, like creating safe healing environments, collaborating with an interprofessional team, and advocating for patients. The other group completed the semester as usual.

At the start and end of the semester, all students completed the MacLeod Professional Identity Scale, which is a survey designed to measure how strongly students identify with the nursing profession. They also kept reflective journals throughout the semester, using a validated journaling framework.

The intervention group showed favorable changes. Most notably, the study found a statistically significant reduction in professional shame among students who engaged in the domain-based reflections.

"By helping students see and name the sophisticated, meaningful work that nurses do, through the lens of the Nine Practice Domains, we're not just teaching them what nursing is. We're helping them become the nurses they aspire to be, with the professional identity, confidence, and clarity of purpose needed to thrive in practice and consistently deliver care that improves patient outcomes," says Schorr.

A call to action

Blueprint for change in acute and critical care nursing, published in the November 2024 issue of Nursing Outlook, proposes a significant shift in how nursing care is measured within acute and critical care settings and identifies nine domains of practice and core elements of hospital environments that support nurses' capacity to provide optimal care.

Retrieved 7/31/2026 https://nursing.umn.edu/news-events/strengthening-professional-identity-address-nursing-workforce-crisis

NINE DOMAINS OF ACUTE AND CRITICAL CARE PRACTICE—WHAT NURSES DO

1. Create safe healing environments
2. Build caring relationships with patients and families
3. Assess and manage patient symptoms
4. Administer physical, therapeutic, preventative, and end-of-life care
5. Provide surveillance, vigilant of patient risks, and are ready to intervene
6. Teach patients and families what they need to know to actively participate in their own care and decision-making and manage their own care after hospital discharge
7. Collaborate with, and coordinate care within the interprofessional team
8. Advocate for the patient and family ensuring that their needs and preferences are known and respected within the interprofessional care team
9. Navigate patient transitions in care across and out of the healthcare system

Retrieved 7/31/2026 https://www.nursingoutlook.org/article/S0029-6554(24)00164-7/fulltext

Every nurse is now an informatics nurse.

By Robin Austin

Remember when nursing informatics was considered a specialty? Something "those informatics people" did?

Those days are over.

Today, every nurse documents data.
Every nurse uses technology.
Every nurse interacts with clinical decision support.
And increasingly...every nurse works alongside AI.

Whether you're in the ICU, community health, pediatrics, labor and delivery, public health, research, education, or leadership—you are practicing in a data-rich, AI-enabled environment.

So here's my hot take:
Nursing informatics is no longer a side dish. It's the main course.

(And AI is definitely not dessert.)

The future of nursing isn't about learning to use one more app. It's about developing the skills to ask better questions, understand data, evaluate AI recommendations, recognize bias, protect our patients, and ensure technology enhances—not replaces—the art and science of nursing.

We don't need every nurse to become a programmer.

We do need every nurse to become AI-ready, data-literate, and informatics-aware.

That means investing in:

✅ AI literacy

✅ Data competency

✅ Digital health

✅ Clinical informatics

✅ Human-centered design

✅ Responsible AI leadership

The next generation of nurses deserves these skills from day one. Our current workforce deserves opportunities to up-skill. And our patients deserve nurses who can confidently lead in an AI-enabled healthcare system.

Because if nurses aren't helping design the future of AI in healthcare…
Someone else will.

And trust me—we want nursing at the table when the menu is being written.

The AI CPT Code Issue: What Nursing Must Build Now: The Infrastructure That Makes RN Work Visible and Valuable

By Stephanie Witwer.

- RN work can't be measured, valued, or reimbursed until it can be named: nursing lacks the standardized taxonomy that every other billable profession has.
- RNs already deliver direct clinical services, including assessment, chronic disease management, triage, and care coordination, but they can't bill for them. The work is either credited to another provider or shifted to higher-cost clinicians entirely, because care that can't be billed is care a health system loses money delivering.
- CMS is currently asking the public what could replace or improve the CPT/RUC valuation process, and comments are open to anyone through September 14, 2026.

Part of Nurse.org's Nursing AI Watch, our ongoing investigation into how artificial intelligence is reshaping nursing practice. In her first piece, nurse leader Stephanie Witwer explained how a billing language created in 1966 left nursing out. In this piece, she lays out the fix: the taxonomy and infrastructure that would let the payment system finally see, measure, and pay for the work nurses already do.

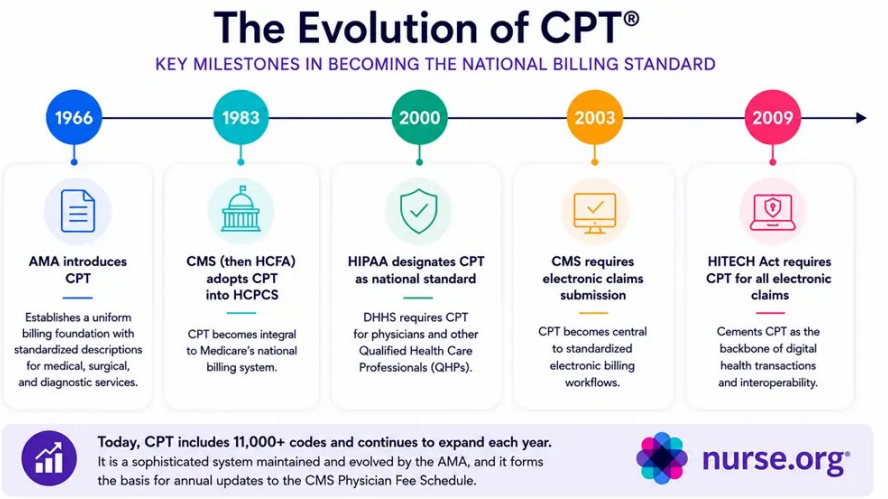
Ambulatory care nurses deliver some of the most complex, preventive, and relationship-centered care in the U.S. health system. We stabilize chronic disease, prevent avoidable ED and hospital visits, manage transitions, coordinate care, teach, coach, and triage, intervening long before a crisis emerges. Yet the reimbursement system treats RN labor as overhead rather than value.

This is not because nursing lacks impact. It is because nursing lacks the **infrastructure and reimbursement mechanisms that convert impact into visibility, measurement, and value.** The valuation system built by and for physicians and uniformly adopted by CMS and all major payers was never designed to include nurses.
To elevate the value of ambulatory care nursing, we must build structures that make our work visible.

1. Nursing Must Name Its Work

Nurse leaders June Clark and Norma Lang said it best more than thirty years ago: "If we cannot name it, we cannot control it, practice it, teach it, finance it, or put it into public policy."

Right now, RN practice is buried in nonstandard documentation. We lack a unified taxonomy that describes what nurses do across settings, populations, and interventions. Without standardized descriptors, RN work cannot be measured, compared, valued, linked to outcomes, linked to cost, or represented in national coding systems.
Taxonomy is not academic. It is the foundation of reimbursement, regulation, and national visibility. Without a way to name the work, the system cannot recognize and value it.



2. **Nursing Must Capture Both Direct Services and Avoided Cost**

A common misconception is that nursing value is primarily about avoided cost. Yes, RNs prevent ED visits, hospitalizations, complications, and care fragmentation. But RNs also deliver **direct clinical services** that fall squarely within RN scope and are essential to modern ambulatory care:

- Assessment
- Education
- Chronic disease management, including implementation of evidence-based treatment pathways
- Preventive care
- Care coordination
- Symptom management
- Transitional care
- Telephonic and virtual triage

These are not "support tasks." They are billable services. Unfortunately, RNs who provide these services can't bill for them though. The system simply refuses to recognize them and attributes the RN work to others. The service is only valued when a physician or other billable provider performs it, even when the RN delivers it.

3. Nursing Must Confront the Structural Inefficiency Created by Reimbursement

Current reimbursement rules actively prevent RNs from practicing at the top of their scope.

Because RN services cannot be billed directly:

- Health systems lose money when nurses deliver care.
- RN practice is artificially constrained by billing regulations that do not match RN licenses or state scope of practice. Physicians are forced to perform services RNs could safely deliver, at far higher cost.
- Access bottlenecks worsen amid physician shortages.
- Efficiency gains cannot be realized.

No other industry forces its most expensive labor to perform work that qualified, lower-cost professionals can safely deliver.

But if RNs could bill for the services they already deliver, everything changes.

4. Reimbursing RNs Would Transform Access, Cost, and Quality

Direct RN reimbursement wouldn't just correct an accounting problem. It would change what the health system can deliver:

- **Expand access.** RN-delivered visits and RN-managed protocols ease the access bottlenecks caused by physician shortages.
- **Free up tens of millions of physician and APP visit slots for higher-complexity care.** McKinsey Health Institute and West Health model U.S. adult demand for primary care at roughly 1.2 billion visits a year, against a workforce able to deliver just over 1 billion, a gap of 170 million visits, equivalent to 45 million people whose primary care needs are not fully met. If payment policy eventually allowed RNs to independently furnish and bill for even a fraction of appropriate primary care services, RNs could help close that gap while redirecting tens of millions of physician and APP appointment slots toward patients with more complex medical needs. That represents potential billions of dollars in savings for Medicare, other payers, and the American people.
- **Improve quality.** RN-delivered care is evidence-based, relationship-centered, and highly effective. When RNs manage preventive, chronic, and transitional care,

physicians and others can focus on new and more complex patients, building the plan of care that RNs implement. RN reimbursement is not a cost. It is a capacity multiplier.

5. Nursing Must Build the Infrastructure for Valuation

To fix this, nursing needs:

- A national taxonomy of RN practice
- Standardized descriptors of RN-delivered services
- Documentation that captures RN work
- Outcome linkage
- Cost linkage
- Representation in national coding and valuation systems
- A foundation for future RN billing models

This is the infrastructure that converts nursing practice into measurable, comparable, billable value.

This work has already begun. Through AAACN's newly launched Center for Innovation and Excellence, we are building exactly this foundation: a shared national language for what ambulatory care nurses do, and, in partnership with Oculi Data, the taxonomy will be explicitly linked to the national measures and benchmarking tools that connect RN work to outcomes, cost, and value.

The Future: From Origins to Outcomes

Ambulatory care nurses have always been essential. What has been missing is the infrastructure that makes our work visible, measurable, and valued.

Now is the moment to build it.

Nursing must create the national taxonomy, standardized descriptors, documentation standards, outcome linkages, cost linkages, and coding structures that allow RN practice to be recognized the way every other clinical profession is recognized.
This is not about asking for permission. It is about claiming our place in the modern health system.

When nursing names its work, measures its work, and links its work to outcomes and cost, RN practice becomes visible, and it becomes valuable. And when it becomes valuable, the system can finally invest in the workforce that delivers the preventive, chronic, transitional, and relationship-centered care the nation depends on.

The timing could not be more urgent. In its proposed 2027 payment rule, CMS is formally asking the public what could replace or improve the current CPT and RUC processes. The agency that pays the bills is, right now, requesting exactly the kind of infrastructure nursing needs to build. Comments are open to anyone through September 14, 2026. Nursing should answer.

The next era of ambulatory care will not be built by expanding physician capacity. It will be built by unleashing nursing.

Stephanie G. Witwer, PhD, RN, NEA-BC, FAAN, is a nurse leader, researcher, and consultant to the American Academy of Ambulatory Care Nursing's Center for Ambulatory Care Nursing Innovation and Excellence, and the immediate past president of AAACN. She serves as secretary of the Federal Advocacy Committee for the Commission for Nurse Reimbursement and is the architect of the Ambulatory Nursing Taxonomy, a national framework linking nursing practice to outcomes, reimbursement, and value. Over a career spanning more than three decades, she spent nearly 16 years as a nurse administrator at Mayo Clinic, where she led a team of 450 RNs and LPNs and holds emeritus staff status, and previously served 12 years as chief nursing officer of a community hospital. Her research and clinical interests include the role of the RN in primary care, academic-practice partnerships, and demonstrating the value of nursing. Stephanie is a member of MNORN.

Retrieved 8/5/2026 https://nurse.org/news/nursing-taxonomy-reimbursement-infrastructure/

ANA's Position: AI billing codes spotlight nursing's payment gap: ANA

Published by Beckers Hospital Review 7/30/2026

By: Alan Condon

The push to establish billing codes for AI-enabled clinical analyses is intensifying a longstanding debate over how the healthcare system values nursing work.
The American Nurses Association is closely reviewing proposed federal payment policies for emerging technologies, but it cautions that several separate issues are being conflated: CPT code development, CMS reimbursement rules, and hospitals' use of AI tools.

The proposals have raised a legitimate concern among nurses: Healthcare may be moving toward reimbursing technology while much of nurses' work remains financially invisible.

"The issue is nuanced," Sarah Gray, DNP, RN, senior vice president of nursing impact at the ANA, told *Becker's*. "But the North Star is certainly clear that AI must be built with nurses,

governed with nurses and used to support — and never replace — professional nursing judgment, while advancing patient outcomes and the value of nursing care."
The American Medical Association has proposed a framework for "clinically meaningful algorithmic analyses," which could create a pathway for certain AI-generated analyses to receive billing codes. The proposal has sparked concern across nursing because registered nurses generally cannot bill Medicare independently for their work.

Nursing services are commonly folded into hospitals' broader inpatient payments rather than reimbursed as individual services. The prospect of creating a payment mechanism for AI has therefore sharpened questions about why the healthcare system has struggled to identify and reimburse nurses' contributions separately.

The ANA is not calling for blanket opposition to the billing frameworks AMA or CMS are proposing.

Instead, ANA urges stakeholders to distinguish what the proposed codes would do now, what they could allow later and how future payment policies may affect nursing practice.

The codes are not autonomous — yet
The current proposals largely focus on tools that help qualified practitioners analyze clinical information, including diagnostic imaging. They do not represent a broad shift toward AI independently providing nursing care, according to the ANA.
That distinction matters because the phrase "autonomous AI" can suggest technology making clinical decisions without meaningful human involvement. The framework could accommodate more autonomous uses in the future, but the immediate proposals center on tools that assist clinicians.

The CPT coding process and CMS payment policy are also separate. CPT codes describe services and procedures, while payers determine who may bill for them and under what circumstances they will be reimbursed.

The ANA participates in the CPT process to ensure nursing perspectives are considered when proposed codes could affect practice. It is also reviewing AI-related provisions in CMS' proposed 2027 Medicare Physician Fee Schedule and plans to submit comments before the September deadline, Dr. Gray said.

"We are already in this space," she said. "This isn't new."

Dr. Gray also emphasized that virtual nursing, telehealth and AI should not be used interchangeably. Virtual nursing is generally a telehealth-enabled care model in which a

nurse provides care remotely. AI may support that model, but virtual care is not inherently AI-provided or AI-driven care.

That distinction is particularly important as nurses' concerns about technology receive greater attention. Recent labor actions have focused on AI's potential effects on staffing, workload, safety and job security, expanding nurses' resistance to hospital AI policies into a broader national debate.

"Virtual care is not the same as AI care or AI-supported care, and nurses' roles will evolve with technology, and our profession has adapted and been agile in the past," Dr. Gray said.

AI may reduce work — or simply move it

Hospital leaders often make the business case for AI around efficiency, time savings and lower administrative burden. For nurses, however, eliminating one task can create several others, according to Dr. Gray.

Nurses may need to redesign workflows, complete training, explain tools to patients, obtain consent, monitor outputs and respond when their clinical judgment conflicts with an algorithm's recommendation. Health systems also need governance structures and processes for maintaining integrations between AI platforms and EHRs.

"The implementation of AI would ideally reduce the burden of care for nursing, not add to it," Dr. Gray said. "But what we have seen in so much other technology that's been implemented within healthcare is that it really is just shifting burden."

The EHR offers a cautionary example.

Digital records became foundational to care delivery, but their adoption required substantial work from nurses serving as trainers, superusers, workflow designers and end users. That work was necessary, but it did not create an independent source of nursing reimbursement.

AI could follow a similar pattern.

Dr. Gray described AI as a process embedded in care rather than a single procedure performed on a patient. Hospitals do not bill for using an EHR itself. In the same way, AI may shape how a nurse documents, monitors or coordinates care without becoming a discrete nursing service that can be billed separately.

That creates a paradox: AI may generate reimbursable clinical output while the work nurses perform to implement, supervise and correct the technology remains hidden within broader hospital payments.

Ambient documentation is among the most common AI applications entering clinical settings, Dr. Gray said. Such tools may reduce manual note-taking, but clinicians must still verify their output.

Any time spent correcting errors, reconciling discrepancies or documenting why a clinician rejected an AI recommendation should be included when health systems calculate the technology's return on investment.

"AI is not the be-all and end-all to solve all of the problems in healthcare," Dr. Gray said. Build with nurses, not around them.

The ANA's overarching message to hospital leaders is that nurses should be involved before an AI product is selected, not asked to validate it after major decisions have already been made.

That involvement should begin with identifying the clinical problem and continue through design, testing, procurement, implementation and optimization.

"Nurses aren't against AI," Dr. Gray said. "Nurses want to be involved in the development and the problem identification, so that we're not just doing AI for AI's sake."

A technically sophisticated product can still perform poorly if it does not reflect how care is provided in a hospital unit. Nurses are positioned to identify where an alert may create duplication, where a consent process could interrupt care or where an algorithm lacks clinical context.

Bringing nurses in late forces hospitals to correct those problems after implementation. "You can spend the money cleaning up, or you can spend the money on the front end and have the buy-in of nurses," Dr. Gray said.

Some health systems are already handling AI implementation well because nurses have been involved from the beginning, she said. In those organizations, nursing participation is part of the technology strategy rather than late-stage validation.

Co-design may also ease concerns about job displacement. Dr. Gray acknowledged that some nurses fear increasingly sophisticated AI systems could threaten their roles, particularly as the technology advances quickly.

She does not expect AI to eliminate the need for nurses, but she does expect roles to change. Health systems will need more nurses in informatics, AI governance and workflow design. Nurses may also move into positions focused on evaluating outputs, identifying safety risks and integrating technology into patient care.

Nursing has repeatedly adapted to changes in medicine and care delivery. AI presents another moment in which the profession will need to evolve while protecting human judgment, advocacy and connection at the center of nursing.

"We do need more efficiency in healthcare," Dr. Gray said. "But we also don't want to take that human touch away from the profession."

For the ANA, the billing-code debate is about more than whether a particular technology receives a CPT code. It is an opportunity to reconsider how healthcare recognizes the value nurses create, including the work required to make AI safe, effective and usable.
"We have an opportunity to do things differently," Dr. Gray said. "But we have to work together."

American Nurses Association

Introduction of the Nurse Overtime and Patient Safety Act

ANA has some exciting news: Sen. Jeff Merkley (D-OR), and Reps. Jen Kiggans (R-VA) and Doris Matsui (D-CA), are reintroducing the Nurse Overtime and Patient Safety Act! Many of you endorsed this legislation last Congress.

The Nurse Overtime and Patient Safety Act would help protect patients and nurses by prohibiting healthcare employers from requiring nurses to work beyond their scheduled shifts, except in genuine emergencies and other limited circumstances. The legislation recognizes that fatigue from excessive work hours can compromise patient safety, contribute to medical errors, and drive nurse burnout and workforce shortages. Importantly, the bill does **not** prohibit nurses from voluntarily working overtime if they choose to do so. By establishing national safeguards against mandatory overtime, the legislation supports safer staffing practices, healthier work environments, and high-quality patient care.

The locations cover hospitals, psychiatric hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, home health agencies, rehabilitation agencies, clinics (including a rural health clinics) and FQHCs.

MDH Project Firstline (PFL): Fresh Resources. Flexible Learning.

The PFL team has been busy creating new resources to help support frontline staff with practical, easy-to-use infection prevention and control education.

New Draining Wound Education Bundle

Our new **MDH Project Firstline Draining Wound Education Bundle (PDF)** makes it easy to access education when and where it's needed—whether it's providing routine staff education, onboarding new team members, or responding to a specific infection prevention challenge.

Inside the bundle you'll find:

- ✅ Quick-reference tools for just-in-time refreshers
- 🎥 Recorded trainings (20–40 minutes)
- 🌎 Resources available in English and Spanish
- 📱 Multimedia learning resources
- 🖨️ Printable handouts and job aids

Draining Wound Bundle

New Trainings
Add these new training courses to your infection prevention and control toolkit:

- Environmental Cleaning and Disinfection Refresher
- Register now to view the recorded training
- Leading Through Containment: What Leaders Should Know About Carbapenemase-Producing Organisms (CPOs)

- Calling all leaders! Join us for a live training featuring CPO containment response actions and leadership checklists on July 28 or July 30.
- If you cannot attend one of these dates, register to view the recorded version of this training

Perfect for individual learning, team meetings, or refresher training sessions.

Coming Soon!
Mark your calendars! Live Project Firstline trainings are on the way:

- Cracking the Code on CPOs
- Cleaning and Disinfection Refresher
- Hand Hygiene Refresher

Watch for registration details in upcoming communications.

Thank you for partnering with us to strengthen infection prevention and control knowledge and practices across Minnesota. We hope these resources make training easier, more engaging, and more accessible for your teams!

Website: MDH Project Firstline (health.mn.gov/projectfirstline)
PFL mailing list: Subscribe to MDH Project Firstline Updates
Email: Project.Firstline.MDH@state.mn.us
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