Artificial Intelligence and Nursing: Priorities for Action

Proceedings from the Nursing and AI Innovation Consortium Launch Summit

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The authors extend appreciation to the expert participants who contributed their insights during the Nursing and AI Innovation Consortium (NAIIC) Launch Summit. This conference proceeding synthesizes the collective expertise of nursing leaders, educators, researchers, practicing clinicians, and technology innovators who gathered to establish priorities for nursing's role in artificial intelligence adoption and governance.

We are grateful to the Florida State University College of Nursing for organizing the summit and to the organizing team for facilitating the collaborative sessions that generated the priorities documented in this report. Special thanks to the facilitators who led working group discussions and to all participants who engaged in the priority-setting exercises that inform these recommendations.

The participant roster appears in Appendix A. Any opinions expressed in this paper reflect the synthesis of summit discussions and do not necessarily represent the official positions of participants' affiliated institutions.

Executive Summary

The Nursing and AI Innovation Consortium convened national leaders in nursing practice, education, innovation, entrepreneurship, and research to establish priorities for the responsible integration of artificial intelligence in healthcare. The summit brought together over 50 experts representing academic institutions, health systems, technology companies, and professional organizations to answer a fundamental question: What must nursing do now to ensure AI enhances rather than compromises patient care?

Participants identified three urgent priorities that demand immediate action. Workforce development emerged as the foundational priority, with consensus that role-based AI skills and faculty development must be established before meaningful progress can occur in other domains. Governance structures ranked as the second priority, recognized as essential for coordinating evaluation, procurement, and implementation decisions. Education and curriculum integration formed the third priority, encompassing both pre-licensure preparation and continuing professional development.

These top three priorities share a critical interdependency: nurses cannot safely engage with AI tools without appropriate competencies; competencies cannot be developed without governance structures that define expectations; and governance requires an educated workforce capable of informed participation. The summit participants emphasized that addressing these priorities while recognizing their interconnections will enable nursing to move from reactive accommodation to intentional stewardship of AI adoption.

Key Findings:

1. **Patient safety and nursing leadership remain non-negotiable.** Clinical judgment must remain primary, with clear protocols for situations where AI outputs conflict with bedside assessment. All recommendations build on this safety foundation. Nursing leadership is essential in ensuring patient safety and workflow integration.

2. **Workforce readiness is the most urgent need.** Participants identified competency development for nurses, educators, and leaders as the prerequisite for all other work. Short, case-based modules and simulation allow practice with AI tools in safe environments before clinical deployment.

3. **Governance provides essential coordination.** Effective oversight requires clear decision rights, transparent evaluation criteria, and defined interfaces with existing institutional structures. A governance framework will coordinate pilot programs, vendor partnerships, and scaling decisions.

4. **Education must span the continuum.** From pre-licensure curricula through continuing education, nurses at all levels require AI literacy appropriate to their roles. Faculty development enables this educational transformation.

Critical Recommendations for Working Group Action:

1. **Establish a working group structure** with clear membership, decision-making authority, and accountability mechanisms to translate summit priorities into operational deliverables.

2. **Develop role-based AI competency frameworks** for nurses in practice, education, leadership, and research roles, with implementation guidance for diverse settings.

3. **Create governance charter templates** that institutions can adapt, including decision rubrics for pilot evaluation, vendor engagement criteria, and scaling thresholds.

4. **Design faculty development programs** using train-the-trainer models to build capacity for AI education across nursing programs.

5. **Establish evaluation frameworks** that enable comparison across pilot sites while maintaining flexibility for local adaptation, with particular attention to safety monitoring and risk mitigation.

This report documents what national nursing leaders identified as essential for near-term action. The priorities reflect consensus on where nursing must focus resources to ensure AI serves nursing's core commitments to patient safety, clinical judgment, and equitable care. The recommendations provide direction for working groups that will develop the operational tools, guidance, and implementation supports needed for practice, education, research, innovation, and policy. We remain nimble as AI continues to evolve, while staying anchored in nursing's

enduring responsibility to protect patients, support clinicians, and shape technology in service of human care.

Introduction

Artificial intelligence (AI) has entered clinical practice at a pace that outstrips nursing's preparedness to engage with it safely and effectively. Nurses encounter ambient documentation systems, predictive clinical alerts, and decision-support tools daily, often with minimal training and unclear accountability pathways. While AI promises to reduce documentation burden and enhance clinical decision-making, its integration without appropriate governance, education, or evaluation frameworks poses risks to patient safety and nurse autonomy.

The Nursing and AI Innovation Consortium (NAIIC) was established to address this challenge. NAIIC convened its inaugural summit, bringing together national leaders to move nursing from reactive accommodation to proactive stewardship of AI integration. The summit participants, representing academic institutions, health systems, technology companies, and professional organizations, undertook a systematic priority-setting process to identify what nursing must address immediately versus what can be deferred to later phases of work.

Purpose of This Report

This report documents the priorities established during the NAIIC Launch Summit and provides direction for the working groups that will translate these priorities into actionable guidance, tools, and frameworks. Unlike a comprehensive review of AI applications in nursing or a detailed implementation manual, this document serves three specific purposes:

1. **Priority Documentation:** Record the consensus priorities identified through structured deliberation by national nursing leaders, with a clear indication of which items demand immediate attention versus those that can be addressed in subsequent phases.

2. **Working Group Direction:** Provide sufficient context and rationale for working groups to develop operational deliverables, including competency frameworks, governance templates, evaluation criteria, and implementation guidance.

3. **Stakeholder Communication:** Articulate nursing's strategic priorities to external partners, including technology vendors, health system executives, accrediting bodies, and policymakers, to align expectations and facilitate collaboration.

Summit Structure and Priority-Setting Process

The summit employed a facilitated, multi-stage process to identify and prioritize action items. Participants engaged in working group discussions organized around five thematic areas: education and workforce development, governance and accountability, research and evaluation, clinical practice and patient safety, and partnerships and resources. Each working group generated ideas through structured brainstorming, then presented its findings to the full summit for collective review.

In the priority-setting phase, participants used a dot-voting method to indicate their assessment of urgency and importance. Each participant received three colored dots representing different priority levels: green indicated top priority items requiring immediate action, orange for secondary priorities to be addressed after foundational work is established, and red for items participants believed should not be pursued. This method allowed rapid convergence on consensus priorities while capturing the full range of perspectives present in the room.

The analysis presented in this conference proceeding synthesizes both the working group transcripts and the visual priority-setting artifacts. Items receiving multiple green dots across participant groups form the core recommendations for immediate working group action. Items with substantial orange dot support are documented as secondary priorities for subsequent phases.

Context: AI in Nursing Practice Today

Nurses interact with AI-enabled technologies across multiple domains. Ambient listening systems capture clinical conversations and generate documentation. Predictive algorithms alert clinicians to deterioration risk or sepsis likelihood. Clinical decision-support tools embedded in electronic health records suggest diagnoses, treatment options, or medication adjustments. Smart room technologies monitor patient status and environmental conditions. These applications promise efficiency gains and enhanced clinical insight, yet their integration often occurs without adequate preparation of the nursing workforce or establishment of governance structures to ensure safety and accountability.

Current challenges include inconsistent training on AI tools, unclear protocols for situations where AI outputs conflict with clinical judgment, limited transparency about how algorithms are trained and validated, insufficient attention to bias and equity implications, and fragmented governance that leaves decisions about AI adoption distributed across multiple organizational units without coordination. These challenges create risks for patients and nurses while potentially limiting the benefits that thoughtful AI integration could provide.

The NAIIC Launch Summit addressed these challenges by bringing together the expertise needed to establish priorities and develop solutions. The following sections present the findings from the summit deliberations and the recommendations for working group action.

Panel Presentation Summaries

The summit featured four expert panel discussions that examined the current landscape and future opportunities for AI in nursing across research, education, practice, and innovation/industry domains. These panels provided the foundation for the working group deliberations and priority-setting exercises that followed. The following summaries capture the key themes and insights from each panel presentation.

AI and Nursing Research

Panelists for this presentation included George Demiris, PhD, FACMI from the University of Pennsylvania School of Nursing, Rob Fraser, MN, RN, NSWOC, from Swift Medical, Max Topaz, PhD, RN, MA, FAAN, FIAHSI, FACMI, from the Columbia University School of Nursing and VNS Health, and Jing Wang, PhD, MPH, RN, FAAN, from Florida State University

College of Nursing. Conversation highlighted the unique opportunities for nursing research in the AI era while acknowledging significant challenges. The research landscape encompasses both nurses who study AI as a focus of investigation and those who use AI as a powerful methodological tool to advance other research agendas. Panelists emphasized that generative AI has transformed research processes, enabling the creation of multilingual patient education materials at various reading levels, facilitating clinical trial management, and potentially serving as virtual interventionists. These applications demonstrate AI's capacity to enhance research efficiency and reach. However, speakers stressed that nursing research brings essential contributions to AI development that cannot be replicated by engineering or computer science alone. Nurse scientists are uniquely positioned to center the patient voice, ensure outcome-oriented research, address algorithmic bias, and evaluate how AI impacts the patient-clinician relationship. The challenge lies in rapid industry developments that often outpace traditional research timelines, creating tension between rigorous evaluation and practical implementation needs.

Educational preparation for nurse scientists emerged as a critical concern. Rather than merely adding AI courses from computer science or engineering programs, panelists advocated for designing integrated educational opportunities that prepare the next generation of scientists and practitioners to be intelligent consumers of AI while maintaining nursing's core values. This requires interdisciplinary collaboration that leverages existing training opportunities in informatics and data science while ensuring nursing perspectives remain central. The panel discussion acknowledged that existing certificate programs and online resources provide some foundation, but systematic integration into PhD curricula is essential for building research capacity. Partnership with industry offers opportunities for translating research into clinical practice and education, though such partnerships must be structured to preserve nursing's independent voice and research integrity.

The research working group identified several priorities including the need for common AI terminology across nursing research, frameworks for addressing confirmation bias, strategies for studying AI's impact on patient-clinician relationships, and approaches for ensuring research timelines match AI's rapid evolution. Participants emphasized that nursing research must be recognized as contributing meaningfully to AI development, not merely applying tools created by other disciplines. The group advocated for a national research agenda that communicates nursing's unique contributions to funders and the public, positioning nurses as essential partners in developing trustworthy AI systems for healthcare.

AI and Nursing Education

The education panel, comprised of Delaney La Rosa, EdD, MSN Ed, RN. from Florida State University College of Nursing, Kenya Beard, EdD, AGACNP-BC, ANEF, FAAN, FADLN, from Mercy University, Sally Carlisle, DNP, MSN (Ed.), RN, CNE, also from Mercy University, and Danica Sumpter, PhD, RN, CNE, FADLN, from Contract Service Innovations, addressed the urgent challenge of preparing nursing students and faculty for an AI-enabled practice environment. La Rosa noted that Florida State University offers one of the first AI-focused MSN degrees in the United States, providing a laboratory for understanding what AI literacy means in nursing education. A recurring theme centered on student literacy challenges: many students face

AI tools with uncertainty about how to engage effectively. When presented with AI-generated outputs, students often struggle to formulate appropriate questions, evaluate results critically, or integrate AI insights with clinical judgment. This reveals a gap not merely in technical skills but in the fundamental cognitive processes required for effective AI partnership. The panel emphasized that AI literacy extends beyond learning to operate tools; it encompasses understanding capabilities and limitations, recognizing bias, protecting privacy, and maintaining clinical reasoning primacy.

Faculty readiness emerged as perhaps the most pressing concern. Many nursing faculty lack the AI literacy needed to integrate these concepts into curricula or model appropriate engagement with AI tools. Without faculty development, nursing education programs cannot prepare the next generation, regardless of how well-designed competency frameworks may be. The panel highlighted the need for incentivized faculty development that includes reduced workload during training periods, immersive learning experiences that demonstrate organizational commitment, and recognition through promotion and tenure systems. Participants discussed creating faculty communities of practice that can accelerate movement forward through peer support and shared learning. The concept of bidirectional mentorship between students and faculty gained traction, acknowledging that students' existing facility with technology platforms offers learning opportunities for educators.

Resistance and readiness across the faculty spectrum required explicit attention. Participants advocated for creating space for late adopters, ensuring they feel heard and included rather than alienated by rapid change. This approach recognizes that faculty retention matters for educational continuity and that inclusive change management produces better outcomes than forced adoption. The education working group identified nursing-centric models and theories as essential frameworks for AI integration, responsible use policies tailored to higher education contexts, and strategies for increasing connections between academic programs and practice/industry partners. Equity considerations threaded through the discussion, with emphasis on ensuring AI access does not exacerbate existing disparities in nursing education. The panel concluded that education transformation requires simultaneous attention to students, faculty, curriculum content, and organizational systems that either enable or constrain change.

AI and Nursing Practice

The expert panel of David Marshall, JD, DNP, RN, CENP, NEA-BC, NHCDP-BC, FAONL, FAAN, from Cedars-Sinai, Monique Bouvier, PhD, ARNP, CPNP-PC, from Emory Healthcare and Nell Hodgson Woodruff School of Nursing, Tera Gross, DNP, RN, NEA-BC, CENP, FACHE, from Mayo Clinic in Florida, Jennifer Shepherd, DNP, MHA, RN, NEA-BC, NPD-BC, Alumnus CCRN, from the American Nurses Association, and Joni L. Watson, DNP, MBA, RN, OCN, from the American Organization for Nursing Leadership, brought the perspective of large health system implementation to discussions of AI in nursing practice into the conversation. Marshall emphasized that clinical practice integration must prioritize patient safety above all other considerations, with clear protocols for situations where AI outputs conflict with bedside clinical assessment. The promise of AI for reducing documentation burden and cognitive load resonates strongly with practicing nurses who experience these burdens daily. However, Marshall cautioned against assuming AI will automatically deliver on this promise without thoughtful

implementation that preserves rather than undermines nursing judgment. Ambient documentation systems, predictive alerts, and clinical decision support represent the AI applications most immediately relevant to practice settings, yet their integration often occurs without adequate nurse input into design, testing, or deployment decisions.

Governance emerged as essential infrastructure for practice integration. Marshall described the need for clear decision-making authority about which AI tools to pilot, how to evaluate them, when to scale, and when to discontinue. Practice settings require rubrics that assess clinical safety, equity implications, workflow integration, and cost alongside technical performance. The lack of standardized evaluation approaches means organizations cannot learn effectively from each other's experiences, repeatedly encountering similar challenges without benefit of shared solutions. Competency development for practicing nurses must address their specific needs: understanding how to interpret AI-generated alerts, knowing when to trust versus question AI recommendations, recognizing situations requiring escalation, and maintaining skills that might atrophy with AI assistance. Marshall noted concerns about de-skilling risks, though participants reframed this as protecting clinical reasoning capacity rather than merely preserving procedural skills.

Empowerment of nurses in AI development and implementation decisions represented another key theme. Nurses' proximity to patients and intimate knowledge of care processes position them as essential contributors to AI tool evaluation, yet they are frequently excluded from procurement and deployment decisions made by IT departments or executive leadership. Creating pathways for nurse participation requires both structural changes (governance committees with nurse representation) and cultural shifts (valuing nurses' experiential knowledge alongside technical expertise). The practice working group emphasized the need for AI tools that support rather than replace nursing judgment, clear guidelines for human oversight of AI recommendations, and strategies for maintaining the nursing skills foundational to patient safety even as AI takes on more routine tasks. Participants advocated for industry standards that ensure AI tools meet nursing practice needs, not merely technical specifications defined without clinical input.

AI and Nursing Innovation/Industry

The discussion from Rebecca Love, RN, FIEL, from Florida State University, Nelson Hurtado, RN, from LearNCLEX, Amy McCarthy, DNP, RNC-MNN, NE-BC, CENP, from Hippocratic AI, and Jean Ross, MHA, BSN, RN, from Primary Record, provided the innovation and industry perspective, highlighting both opportunities and challenges at the intersection of nursing expertise and AI development. Panelists emphasized that nurses possess invaluable insights into clinical workflows, patient needs, and care delivery challenges that AI developers desperately need but often cannot access. Industry moves rapidly with product development cycles measured in months rather than the years typical of academic research, creating tension between speed and the thorough evaluation nursing values. However, this rapid pace also offers opportunities for nurses who engage early in development processes to shape tools before they reach market. The challenge lies in creating pathways for productive nurse-industry collaboration that neither compromises nursing values nor stifles innovation.

A significant portion of the discussion focused on regulatory and policy challenges affecting AI innovation in healthcare. Panelists noted the problematic trend toward classifying generative AI tools as medical devices, a regulatory approach that increases costs, restricts access, decreases innovation speed, and paradoxically reduces trust by forcing tools through frameworks designed for different technologies. The consortium could take a policy stance that generative AI for documentation, education, and clinical decision support requires new regulatory frameworks rather than application of existing medical device regulations. Such a position would require careful articulation of appropriate safeguards while arguing against regulatory approaches that impede beneficial innovation. This represents an area where nursing's unified voice could influence policy in directions that serve both innovation and patient safety.

Partnership models between nursing and industry required attention. Panelists advocated for transparent relationships where nurses maintain independent evaluation capacity while engaging collaboratively with developers. The concept of a nursing "seal of approval" or scorecard system emerged as a mechanism for nurses to evaluate and endorse AI tools that meet established criteria for safety, efficacy, equity, and usability. Such a system would require development of evaluation frameworks, training of nurse evaluators, and organizational infrastructure to manage the endorsement process. However, it could provide valuable guidance to healthcare organizations making procurement decisions while incentivizing developers to engage meaningfully with nursing perspectives. As AI tools proliferate in patient-facing interactions, nurses' expertise becomes indispensable for ensuring these technologies actually serve patients safely and effectively. Beyond clinical settings, nurses often guide patients through portals, apps, and digital documentation workflows, making them essential co-designers for any technology that touches the bedside or the home. Nursing's presence in these conversations is not optional; it's foundational to patient-centered innovation The innovation working group emphasized available resources including funding opportunities, training programs, professional associations, industry partnerships, and social media networks that nurses can leverage. Participants acknowledged the need for nursing to speak with an authoritative voice about AI in healthcare, positioning the profession as trusted experts rather than passive recipients of technology developed by others. The innovation panel concluded that nurses must claim their role as essential partners in AI development, not merely end-users of tools created without their input.

Summary of Findings

Priority 1: Workforce Development and AI Competencies

Workforce development emerged as the highest priority across all summit working groups, with strong consensus that preparing nurses to engage safely and effectively with AI tools is the prerequisite for progress in all other domains. Working group discussions revealed that nurses currently encounter AI technologies in practice without adequate preparation, creating risks for patient safety and nurse autonomy. The rapid pace of AI deployment has outstripped the capacity of nursing education programs and healthcare organizations to develop and deliver appropriate training. As articulated by one education working group participant, many students face AI tools without understanding even how to formulate appropriate prompts or questions—they stare at blank interfaces not knowing where to begin.

Participants identified role-based competency development as essential, recognizing that nurses in different roles, bedside clinicians, educators, administrators, informaticists, and researchers require different knowledge and skills related to AI. A one-size-fits-all approach will fail to meet the diverse needs across nursing roles and practice settings. Competencies must be specific enough to guide curriculum development and assessment while remaining adaptable to different contexts and levels of practice. The education working group explicitly called for nursing-centric models and theories to support AI decision-making and practice, emphasizing that AI literacy must be grounded in nursing's unique epistemology and values rather than imported wholesale from computer science or business contexts.

Faculty development received particular emphasis as a critical enabler. Working group participants noted that many nursing faculty lack the AI literacy needed to integrate these concepts into curricula or to model appropriate engagement with AI tools. Without faculty development, nursing education programs cannot prepare the next generation of nurses, regardless of how well-designed competency frameworks may be. The need for train-the-trainer models and accessible professional development opportunities was repeatedly highlighted. The education working group called for incentivizing faculty development through decreased workload during training, taking faculty out of their regular environments to demonstrate organizational commitment, and recognizing AI integration in promotion and tenure systems.

Simulation and case-based learning were identified as effective pedagogical approaches that allow learners to practice with AI tools in safe environments before encountering them in clinical settings. These methods enable exploration of scenarios where AI outputs conflict with clinical assessment, discussion of appropriate escalation pathways, and reflection on the role of clinical judgment in AI-enabled workflows. Several working groups emphasized the importance of bi-directional mentorship between students and faculty, recognizing that students often bring facility with technology platforms that can inform faculty learning while faculty contribute clinical wisdom and evaluative frameworks.

The integration of AI literacy into education was framed as requiring connection to practice and industry communities. Working groups called for increased partnerships that bring real-world AI applications into educational settings and provide students with exposure to cutting-edge developments. However, participants also emphasized the need to create space for late adopters among both faculty and students, ensuring that the pace of change does not leave behind those who need more time or support. This inclusive approach recognizes that sustainable transformation requires bringing the community along rather than creating a divided faculty with AI champions on one side and disengaged resisters on the other.

Recommendations for Working Group Action

Immediate Actions (0-6 Months):

1. **Establish a Competency Development Working Group** with representation from practice, education, administration, informatics, and research domains. This group should have clear deliverables, timelines, and accountability structures.

2. **Develop responsible use policies** for AI in higher education nursing contexts, addressing student privacy, faculty intellectual property, appropriate versus inappropriate AI applications, and academic integrity considerations. These policies should be adaptable for diverse institutional contexts while maintaining consistent ethical standards.

3. **Define core AI literacy competencies** applicable to all nurses regardless of role or setting. These foundational competencies should address understanding of AI capabilities and limitations, recognition of bias and equity concerns, appropriate use of AI-generated outputs, and knowledge of when to seek additional guidance.

4. **Develop role-specific competency frameworks** for the following categories:

    - Bedside clinicians (RN, LPN/LVN, APRN)
    - Nurse educators (faculty, clinical instructors, staff development specialists)
    - Nurse leaders and administrators
    - Nursing informaticists
    - Nurse researchers and scientists

5. **Design a faculty development program** using a train-the-trainer model that builds capacity for AI education across nursing programs. Initial offerings should focus on faculty who will serve as local champions and resources for their colleagues. Programs should include incentives such as workload reduction, stipends, or course releases to enable meaningful participation.

6. **Create a repository of case studies and simulation scenarios** that educators can adapt for their contexts. Cases should represent diverse clinical settings, patient populations, and AI applications. Include teaching notes, debriefing guides, and assessment rubrics.

Secondary Actions (6-18 Months):

7. **Pilot test competency frameworks** in diverse settings to assess feasibility, clarity, and utility. Gather feedback from faculty, practicing nurses, and administrators to refine frameworks before broader dissemination.

8. **Develop assessment methods** that enable measurement of competency attainment at individual and program levels. These methods should align with existing nursing education assessment practices while addressing AI-specific content.

9. **Partner with accrediting bodies** to explore integration of AI competencies into accreditation standards and requirements. Early engagement will ensure alignment and reduce the burden on nursing programs.

10. **Establish continuing education pathways** for currently practicing nurses who completed their education before AI literacy was integrated into curricula. Micro-credentials and stackable certificates may provide accessible options.

11. **Create nursing-centric theoretical frameworks** that situate AI within nursing knowledge development, clinical reasoning, and patient care models rather than treating AI as purely technical content.

Rationale

Workforce development must precede other priorities because nurses cannot participate meaningfully in governance, evaluation, or implementation decisions without appropriate knowledge and skills. As explicitly articulated by working group participants, attempting to establish governance structures or pilot programs before the workforce is prepared risks perpetuating current patterns of inadequate training and reactive engagement. Conversely, a well-prepared workforce enables more effective governance, more rigorous evaluation, and safer implementation.

The emphasis on role-based competencies reflects recognition that nursing is not a monolithic profession. Different roles require different depths and types of AI knowledge, as discussed extensively in working groups. Bedside nurses need to understand how to interpret AI-generated alerts and integrate them into clinical judgment. Educators need pedagogical strategies for teaching AI literacy. Leaders need frameworks for assessing AI tools and making adoption decisions. Informaticists need technical understanding of algorithms and data flows. Researchers need methods for studying AI impacts on care processes and outcomes. Competency frameworks must reflect these differences while maintaining coherence around core concepts.

Faculty development received priority status because faculty are the leverage point for systemic change in nursing education. Working groups emphasized that investing in faculty capacity enables sustainable integration of AI content across nursing programs, multiplying impact through the nurses they educate. Train-the-trainer models further multiply this effect by creating local champions who can support their colleagues. The explicit call for incentivizing faculty development—through workload reduction, dedicated training time, and promotion/tenure recognition—reflects practical understanding that without addressing faculty capacity and motivation, curricular change will not occur.

The emphasis on creating space for late adopters demonstrates sophisticated change management thinking. Sustainable transformation requires inclusive processes that bring the community along rather than dividing it into champions and resisters. By explicitly making room for those who need more time or support, the consortium signals commitment to the full nursing education community rather than only early adopters.

Priority 2: Governance Structures and Decision Rights

Governance emerged as the second priority, with participants emphasizing that clear structures, decision rights, and processes are essential for coordinating AI-related activities across organizations. Working group discussions revealed that current governance for AI in healthcare is often fragmented, with decisions distributed across IT departments, clinical departments, legal counsel, procurement offices, and executive leadership without clear coordination or consistent criteria. This fragmentation leads to duplicative efforts, inconsistent standards, vendor capture, and missed opportunities for organizational learning. As one practice working group participant

noted, the lack of coordinated governance means the same challenges get encountered repeatedly across organizations without benefit of shared solutions.

Participants advocated for governance structures that bring together diverse expertise while maintaining clear decision-making authority. Effective AI governance committees typically include representatives from clinical practice, nursing leadership, informatics, ethics, legal, privacy and security, quality and safety, and patient engagement. Some organizations may benefit from adding expertise in data science, health equity, and clinical research. The committee composition should reflect the scope of decisions it will make and should include individuals with authority to commit resources and make binding decisions. Working groups emphasized that governance is not merely advisory; it must have real authority over pilots, procurement, implementation, and discontinuation decisions.

Decision rights must be explicit. Working groups stressed that governance structures fail when stakeholders are unclear about who makes which decisions. Participants emphasized the importance of documenting decision rights for tool evaluation, pilot approval, procurement, implementation, monitoring, and discontinuation. These rights should align with existing organizational authority structures while ensuring appropriate nursing input at each decision point. The practice working group specifically called for clear guidelines about when nurses can override AI recommendations, how escalation pathways function, and who makes final decisions when clinical judgment conflicts with algorithmic outputs.

Interfaces with existing committees require definition to avoid duplication and conflict. AI governance must connect with quality and safety committees, privacy and security committees, ethics committees, informatics steering committees, and others. These interfaces should clarify when issues are referred from AI governance to other bodies, when other bodies refer issues to AI governance, and how information flows between groups. Working groups noted that without explicit interface agreements, AI governance either duplicates existing committee work or gets bypassed by established decision-making channels.

Several working groups called for development of evaluation rubrics that bring consistency to pilot assessment while remaining flexible enough to accommodate different AI applications and organizational contexts. These rubrics should address clinical safety and effectiveness, equity and bias implications, privacy and security requirements, workflow integration and usability, cost and resource implications, and vendor transparency and partnership quality. The practice working group emphasized that rubrics must prioritize patient safety above all other considerations while also ensuring that AI tools support rather than undermine nursing clinical judgment.

The innovation working group raised the question of whether the consortium should establish a nursing "seal of approval" or certification process for AI tools. Such a mechanism could guide procurement decisions while incentivizing developers to engage meaningfully with nursing perspectives. However, participants acknowledged the complexity of creating and maintaining such a system, including questions about evaluation standards, who conducts evaluations, how to handle proprietary information, and whether endorsement creates liability. This idea merits continued discussion but was not advanced as an immediate priority given the foundational work needed first.

Recommendations for Working Group Action

Immediate Actions (0-6 Months):

1. **Establish a Governance Framework Working Group** tasked with developing template governance charters that organizations can adapt to their contexts.

2. **Create governance charter templates** that specify:

    - Committee purpose, scope, and authority
    - Membership composition and selection processes
    - Meeting frequency and decision-making procedures
    - Interfaces with other organizational committees
    - Reporting relationships and accountability mechanisms
    - Explicit documentation of decision rights for pilot approval, procurement, implementation, monitoring, and discontinuation

3. **Develop decision-making rubrics** for evaluating AI tools during pilot phases. Rubrics should address:

    - Clinical safety and effectiveness
    - Equity and bias considerations
    - Privacy and security requirements
    - Workflow integration and usability
    - Cost and resource implications
    - Vendor transparency and partnership quality
    - Support for nursing clinical judgment and autonomy

4. **Define minimum requirements for pilot proposals**, including objectives, success criteria, safety monitoring plans, equity assessment plans, escalation pathways, and stopping rules. Standardized proposal templates will enable consistent evaluation while reducing the burden on pilot leads.

5. **Create pilot protocol templates** that embed safety checks, equity monitoring, escalation pathways, and incident reporting procedures. These templates should be adaptable across different AI applications while maintaining consistent quality standards.

6. **Document decision rights explicitly** for all governance functions, specifying who makes which decisions and under what circumstances nursing input is required, advisory, or determinative.

Secondary Actions (6-18 Months):

7. **Develop procurement guidance** for evaluation-phase partnerships with AI vendors. Guidance should address expectations for transparency, data access for validation, collaboration on fairness testing, and avoidance of contractual lock-in during pilot phases.

8. **Establish evaluation frameworks** with shared outcome measures that enable comparison across sites while allowing local adaptation. Core measure families should include safety, equity, workflow impact, and cost.

9. **Design dashboard templates** that present pilot results to governance committees in accessible formats, facilitating evidence-based decisions about whether to proceed with implementation, modify approaches, or discontinue tools.

10. **Create scaling decision frameworks** that specify criteria for moving from pilot to broader implementation, including required evidence thresholds, stakeholder approval processes, and resource allocation mechanisms.

11. **Explore consortium-level mechanisms** for sharing governance learnings across organizations, potentially including a governance community of practice, case study repository, or peer consultation network.

12. **Investigate the feasibility** of a nursing endorsement or certification process for AI tools, including exploration of evaluation standards, organizational models, funding mechanisms, and liability considerations.

Rationale

Governance provides the coordinating structure through which all other AI-related work proceeds. As emphasized throughout working group discussions, without governance, workforce development efforts lack direction about which competencies matter most for organizational priorities. Pilot programs proceed without consistent evaluation criteria or learning across sites. Procurement decisions reflect individual relationships with vendors rather than systematic assessment of organizational needs and tool capabilities. Implementation happens through momentum rather than evidence. Governance transforms these disconnected activities into a coherent, learning-oriented approach.

The emphasis on templates and frameworks reflects participants' desire for practical tools that organizations can adapt rather than abstract principles that leave implementation details unspecified. Working groups repeatedly asked for concrete examples, sample charters, and decision rubrics that could accelerate governance establishment. Templates reduce the startup burden for organizations establishing governance and promote consistency that enables cross-organizational learning and comparison. However, templates must balance specificity with adaptability, providing enough structure to guide decisions while allowing customization for organizational context, size, and resources.

Decision rubrics received attention because governance fails when criteria are implicit or inconsistent. Explicit rubrics enable transparent, defensible decisions and reduce the influence of

vendor marketing or individual preferences. Rubrics also facilitate organizational learning by creating a record of what factors influenced decisions and how those factors were weighed. Over time, rubrics can be refined based on experience with their application. Working groups emphasized that rubrics must prioritize patient safety and support for nursing judgment, ensuring that efficiency or cost considerations do not override fundamental nursing values.

The emphasis on interfaces with existing governance structures reflects practical experience that new committees either duplicate existing work or get bypassed by established channels unless interfaces are explicitly defined. AI governance touches multiple domains already covered by other committees, and success requires coordination rather than competition. The recommendation to document these interfaces in governance charters ensures that coordination happens by design rather than accident.

Priority 3: Education and Curriculum Integration

Education and curriculum integration emerged as the third priority, closely connected to workforce development but distinguished by its focus on systematic integration into nursing education programs rather than competency definition alone. Working group discussions emphasized that AI literacy cannot remain an add-on or elective topic; it must be woven throughout nursing curricula from pre-licensure through doctoral preparation. Current barriers to curriculum integration include faculty capacity constraints, already-full curricula with limited room for new content, lack of consensus on what AI content is essential, insufficient teaching resources and case materials, and uncertainty about how to assess AI literacy. Despite these challenges, participants expressed urgency about beginning integration now rather than waiting for perfect conditions. As one working group participant noted, the rapid deployment of AI in clinical settings means that newly licensed nurses will encounter these tools immediately upon entering practice, and they must be prepared.

The education working group articulated specific priorities that emerged from table discussions. Participants called for identifying nursing-centric models and theories to support AI-related decision-making and practice, recognizing that AI literacy must be grounded in nursing's disciplinary foundations rather than borrowed uncritically from technical fields. The group emphasized creating responsible use policies specific to higher education nursing contexts, addressing student privacy, academic integrity, and appropriate AI applications in learning environments.

Participants advocated for integration across the curriculum rather than creation of standalone AI courses. AI concepts should be embedded in existing courses where they naturally connect to content. For example, pharmacology courses can address AI-enabled clinical decision support for medication selection and dosing; leadership courses can address governance structures and implementation decisions; ethics courses can address algorithmic bias and equity concerns; research courses can address AI methods and their appropriate application. This integrated approach recognizes both practical constraints (limited curriculum space) and pedagogical principles (transfer of learning is enhanced when concepts are taught in context).

Pre-licensure programs received particular attention because they represent the opportunity to establish foundational AI literacy for the entire nursing workforce. However, working groups also

emphasized the need for graduate-level content appropriate to advanced practice, leadership, informatics, and research roles. Doctoral programs must prepare the next generation of nurse scientists to conduct rigorous research on AI impacts, develop and evaluate AI tools, and lead the scholarly discourse on AI in healthcare. The research panel highlighted the need to design new educational opportunities that integrate nursing and AI rather than merely adding computer science courses to nursing programs.

Continuing education pathways are essential for currently practicing nurses who completed their education before AI content was integrated into curricula. Working groups called for these pathways to be accessible, affordable, and available in formats that accommodate working nurses' schedules. Micro-credentials and digital badges may provide recognition of learning without requiring extensive time commitments. The education working group specifically recommended increasing industry and practice community connections around AI use, bringing real-world applications into educational settings while providing students exposure to cutting-edge developments.

An important theme across discussions was the need for bidirectional mentorship between students and faculty. Working groups acknowledged that students often bring facility with AI tools and digital platforms that can inform faculty learning, while faculty contribute clinical wisdom, critical thinking frameworks, and evaluative capabilities. This bidirectional approach recognizes AI literacy development as a collaborative process rather than unidirectional knowledge transfer. However, participants also emphasized creating space for late adopters, ensuring that neither students nor faculty feel alienated by the pace of change.

Recommendations for Working Group Action

Immediate Actions (0-6 Months):

1. **Establish a Curriculum Integration Working Group** with representation from pre-licensure, graduate, and doctoral education, as well as continuing education and staff development.

2. **Map AI competencies to existing curriculum standards** (e.g., AACN Essentials, NLN Competencies) to identify natural integration points and avoid creating the perception that AI requires entirely new content areas.

3. **Develop curriculum integration guidance** that provides concrete examples of how AI concepts can be embedded in existing courses across the pre-licensure curriculum. Include sample learning objectives, teaching strategies, and assessment approaches for each major content area.

4. **Create a shared repository of teaching materials**, including:

    - Case studies with teaching notes
    - Simulation scenarios with debriefing guides
    - Assessment items and rubrics

- Multimedia resources
- Guest speaker suggestions and connection protocols
- Examples of student AI literacy assignments

5. **Design faculty development workshops** focused specifically on curriculum integration strategies, teaching methods for AI content, and assessment approaches. Use case-based learning that models the pedagogical approaches being recommended.

6. **Establish interdisciplinary partnerships** connecting nursing education programs with informaticists, data scientists, ethicists, patient advocates, and other clinical disciplines. Create mechanisms for shared curriculum development, joint faculty development, and collaborative student learning experiences that position nurses as essential partners in AI development while maintaining nursing's disciplinary identity.

Secondary Actions (6-18 Months):

7. **Pilot test curriculum integration approaches** in diverse program types (ADN, BSN, accelerated programs, RN-to-BSN) and gather feedback on feasibility, student learning outcomes, and refinements needed.

8. **Develop graduate-level curriculum guidance** for master's and DNP programs, with role-specific content for advanced practice, leadership, informatics, and education tracks.

9. **Create doctoral-level curriculum guidance** that prepares nurse scientists to conduct AI-related research, including methods courses, seminars, and dissertation support.

10. **Partner with NCLEX developers** to explore appropriate integration of AI content into licensure examinations, ensuring that entry-level preparation aligns with examination content.

11. **Establish continuing education pathways** through partnerships with professional organizations, health systems, and educational technology companies. Explore micro-credential and digital badge programs.

12. **Increase industry and practice community connections** by creating partnerships that bring AI developers, practicing clinicians, and students together for mutual learning and real-world exposure.

13. **Develop nursing-centric theoretical frameworks** that situate AI within nursing's disciplinary knowledge, connecting AI concepts to established nursing theories and models.

Rationale

Education transforms workforce development from a one-time training event into sustainable capacity-building that persists across cohorts of nurses. While competency frameworks define what nurses need to know, curriculum integration ensures that nursing programs systematically prepare students to meet those competencies. This approach builds long-term capacity rather than

requiring perpetual catch-up training for practicing nurses. As working groups emphasized, the rapid deployment of AI in practice settings means waiting for perfect integration plans is not an option; newly licensed nurses are encountering AI tools immediately upon graduation.

The emphasis on integration rather than standalone courses reflects both practical constraints (limited curriculum space) and pedagogical principles (transfer of learning is enhanced when concepts are taught in context). Integration also signals that AI literacy is fundamental to nursing practice rather than a specialized area of interest for a subset of nurses. Working groups stressed that this integrated approach requires explicit mapping to show how AI concepts connect to existing content rather than competing with it.

Pre-licensure programs received attention because they represent the foundation of nursing education, and establishing AI literacy at entry to practice will reduce the need for extensive continuing education as AI tools become more prevalent. However, the focus on pre-licensure education should not be interpreted as diminishing the importance of graduate and continuing education, which address different learning needs and serve nurses in different roles and career stages. The working group explicitly called for attention across the educational continuum.

The recommendation to increase industry and practice connections addresses working group concerns that nursing education can become divorced from the rapid evolution occurring in practice and technology development. However, these connections must be structured to preserve nursing education's independence and values rather than becoming vehicles for vendor marketing. The working group's emphasis on responsible use policies indicates awareness that industry partnerships require careful boundary management.

The elevation of interdisciplinary partnerships to immediate action status reflects the strong support this received during dot-voting exercises. Summit participants recognized that nursing cannot develop AI literacy in isolation from other disciplines. Informaticists bring technical understanding of algorithms and data structures; data scientists contribute methodological expertise; ethicists provide frameworks for analyzing moral dimensions of AI use; patient advocates ensure perspectives beyond professional concerns; and other clinical disciplines offer comparative insights into AI integration challenges. These partnerships enrich nursing education while positioning nurses as equal partners in interdisciplinary work rather than passive recipients of expertise developed elsewhere.

Supporting Priorities: Additional Areas for Future Work

The priority-setting process identified several additional areas that received substantial support as important but secondary to the three urgent priorities detailed above. These areas should be addressed by working groups once foundational work on workforce development, governance, and education is underway. They are documented here to ensure they remain visible for future planning.

Research and Evaluation

Participants emphasized the need for nursing-led research on AI impacts, including studies of clinical outcomes, workflow effects, nurse satisfaction, patient experiences, and equity implications. Evaluation frameworks should enable comparison across sites and applications

while remaining adaptable to local contexts. Shared outcome measures would facilitate meta-analyses and systematic reviews. Research priorities should be documented and communicated to funding agencies. The research working group specifically called for common AI terminology, frameworks for addressing confirmation bias, strategies for studying AI's impact on patient-clinician relationships, and approaches for ensuring research timelines match AI's rapid evolution. The group emphasized that nursing research must be recognized as contributing meaningfully to AI development rather than merely applying tools created by other disciplines.

Vendor Partnerships and Transparency

Effective partnerships with AI vendors require clear expectations for transparency, data access, collaboration on validation and fairness testing, and avoidance of contractual lock-in during evaluation phases. Procurement guidance should address these expectations while recognizing that specific contract language must be developed with institutional legal counsel. Vendor engagement should support learning rather than create premature commitments. The innovation working group discussed the potential for a nursing endorsement or scorecard system but recognized this would require substantial infrastructure development and careful consideration of standards, liability, and governance.

Policy and Advocacy

Nursing must engage in policy development at institutional, state, and federal levels to ensure that regulations support safe, equitable AI adoption while avoiding barriers to innovation. Advocacy priorities include securing nursing representation in AI governance, protecting clinical judgment autonomy, ensuring adequate training requirements, and promoting transparency and accountability standards. The innovation working group raised concerns about classifying generative AI as medical devices, arguing this regulatory approach increases costs, decreases access, slows innovation, and paradoxically reduces trust. However, participants recognized that effective policy engagement requires the foundation of competencies, governance, and evidence that the top three priorities will establish. Nursing's authoritative voice in policy discussions depends on demonstrated expertise and coordinated messaging that the consortium can help develop.

Equity and Bias Mitigation

Equity considerations must be embedded throughout workforce development, governance, education, research, and implementation rather than treated as a separate workstream. Participants emphasized the need for explicit equity checks in pilot protocols, stratified outcome monitoring, transparent performance reporting, and clear stopping rules when disparities are detected. Equity frameworks should inform decision rubrics, competency standards, and evaluation criteria. The education working group specifically called for democratization of AI access, ensuring that tools and training are equally available across diverse settings and populations. Several working groups discussed bias in AI training data and the need for nurses to understand how algorithmic bias emerges and can be detected.

Interdisciplinary Collaboration

AI challenges cannot be solved by nursing alone. Effective approaches require collaboration with informaticists, data scientists, ethicists, patient advocates, and other clinical disciplines.

Interdisciplinary working groups, shared governance structures, and collaborative research projects will strengthen AI adoption efforts. Summit participants emphasized that nursing must establish clear positions and priorities before entering interdisciplinary collaborations, ensuring the profession brings an authoritative voice rather than defaulting to technical experts from other disciplines. The foundation provided by the top three priorities—workforce development, governance, and education—will position nursing to engage as equal partners in interdisciplinary work, contributing unique perspectives grounded in clinical expertise, patient advocacy, and systems thinking while learning from complementary disciplines.

Conclusion

The NAIIC Launch Summit identified three urgent priorities for nursing's engagement with artificial intelligence: workforce development, governance structures, and education integration. These priorities emerged from structured panel presentations and facilitated working group discussions that brought together over 50 national leaders representing diverse perspectives and expertise. The priorities are interdependent: competency frameworks inform governance decisions about what matters most; governance structures define expectations that guide competency development; and education builds sustainable capacity for both.

Working groups will translate these priorities into operational deliverables. The Competency Development Working Group will produce role-based frameworks and assessment methods that specify what nurses need to know and be able to do with AI across different roles and practice settings. The Governance Framework Working Group will create charter templates, decision rubrics, and pilot protocols that organizations can adapt to coordinate AI evaluation, procurement, and implementation. The Curriculum Integration Working Group will develop implementation guidance, teaching resources, and faculty development programs that enable systematic integration of AI literacy across nursing education programs.

The urgency of these priorities reflects the reality that AI tools are already in clinical environments. Nurses encounter ambient documentation systems, predictive alerts, and clinical decision support daily, often without adequate preparation or clear protocols for situations where AI outputs conflict with clinical judgment. Nursing must establish the infrastructure—competencies, governance, and education—to engage with these tools safely and effectively. The priorities documented in this report provide the foundation for that work.

The path forward requires coordinated action across academic institutions, healthcare organizations, professional associations, and technology partners. No single entity can address these priorities alone. The consortium model enables sharing of resources, coordination of efforts, and learning across contexts that will accelerate progress. By establishing clear priorities and developing practical tools that organizations can implement, NAIIC positions nursing to move from reactive accommodation of AI to proactive stewardship that ensures technology serves nursing's core commitments to patient safety, clinical judgment, and equitable care.

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Appendix A: Summit Participant Roster

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