Training staff members on HIPAA is tough because two things are certain: You have to train nearly every staff member within your organization at least once annually, and you know they will hate every minute of it.

HIPAA may not be fun to teach, learn, or execute because of its complexity, but it needn’t be boring. It can be tolerable, and, if you’re good at your job, interesting and thought-provoking as well.

This requires some creativity on your part and investment by your organization, says Brandon Ho, HIPAA compliance specialist at Pacific Regional Medical Command and Tripler Army Medical Center, part of the Military Health System, in Honolulu.

“It essentially comes down to this: You can take care of things beforehand or you can spend your time mitigating a complaint, dealing with an HHS audit, or deal with attorneys and lawsuits,” Ho says. “You’re going to pay one way or the other.”

Custom training, not classic training

Tripler first contracted with Ho for his services when he was working for Bearing Point, Inc., in 2004. His first task was helping Tripler decipher the HIPAA security rule.

However, one year later, the increased weight of federal regulations, such as the privacy rule, convinced the Army that it needed Ho to serve as its full-time HIPAA specialist for the Pacific Region.

Ho now works primarily at Tripler, but he also oversees compliance operations at the 121st Medical Group in Korea and Camp Zama in Japan.

He took the job knowing that his ultimate challenge would be managing the training of more than 6,000 staff members without lulling them to sleep. He also wanted to buck the trend of training simplification (i.e., across-the-board training for all departments) because
he knew it wasn’t the most effective way to educate staff members.

“People want a one-stop shop for all training, but I believe that is the biggest problem with training today,” Ho says. “The exact same booklet training or video training or classroom training shouldn’t be given to everyone. People have all different HIPAA concerns, and because of that, you need more focused training.”

That’s not easy when hospitals are cutting costs by not investing in training. But Ho sees firsthand how an alternative approach can make all the difference.

In most healthcare environments, the HIPAA specialist has other responsibilities and doesn’t have time to adequately train staff members. “People [pass HIPAA compliance training] over to others with other responsibilities,” he says. However, Tripler’s investment in its compliance program means that Ho can focus on HIPAA compliance. “It allows me the ability to reach out and affect everyone,” he says. “For that, I’m very fortunate.”

So is Tripler.

HIPAA training that’s made to order

Many organizations are required to conduct HIPAA training annually, and some do so only during orientation. The material, sometimes updated with developments, often remains unchanged from one audience to the next.

Ho’s approach at Tripler is different. He has developed HIPAA training material specific to the approximately 30 departments within the post.

For example, Ho’s materials for nutrition specialists and psychologists don’t look or sound the same. “I ensure that the classes are germane to the students,” he says. “You don’t need to tell housekeepers about computer security.”

Ho waits for department heads to request specific training for staff members and is always ready to respond on short notice. He estimates that he conducts several hour-long training sessions each month.

Ho updates training materials whenever a regulation changes, and he maintains a running dialogue with department heads so he can incorporate solutions into specific training modules. “The funny thing about HIPAA is that people thought it would make things easier, but instead, it’s getting more challenging,” he says.

Department-specific training also provides staff members an opportunity to engage with the HIPAA expert in an intimate, unintimidating classroom environment.

“I leave plenty of time for questions because I know people will have them,” Ho says.

Training doesn’t stop when class ends

Because he focuses on HIPAA, Ho has time to devote to the subject beyond his classroom. He conducts routine audits and inspections to determine whether staff
members are compliant. “We need to live compliance,” according to Ho.

Ho also offers weekly inservice training sessions. The session content is general, but it gives staff members an opportunity to take a HIPAA 101 refresher course.

Approximately 100 people attend each training session. This is an indication that people heed HIPAA’s importance—even if it’s more to avoid the Military Health System’s culture of punitive measures than to embrace the culture of compliance, Ho says. The punitive measures are real, and the Military Health System enforces the rules when people don’t take the rules seriously, he says.

HIPAA compliance is ripe with the potential for fines and jail time, says Patrice M. Jackson, RHIT, CHP, CCS, director of HIM and privacy officer at Tripler.

Staff members must attend at least one training session annually and the army tracks attendance with an online system. “And we do chase them down if we need to,” says Ho.

But that rarely happens. The army will not grant leave to staff members who don’t comply with the annual training requirement. “Plus, I send constant e-mail reminders that seem to irritate them,” says Ho. “When the Military Health System gives me responsibility, they also give me the authority to make sure it’s carried out.”

In addition to hour-long classroom sessions and inservice training, Ho employs another subtle approach—e-mail education blasts he calls HIPAA tips.

“He’s able to take a topic and train the reader in bite-size portion e-mails,” says Jackson.

Entertaining the masses

Ho was previously a history teacher at a parochial school in Hawaii. “His background was education and healthcare, and that’s where he’s made inroads,” says Jackson.

“I have experience taking material that’s boring and highlighting the interesting parts,” says Ho. He considers this a significant qualification for his current position, and he tries to inject a bit of comedy into his training sessions.

“I’m always trying to entertain them,” says Ho, adding that pop culture references have proven to be a successful way of doing so. “People always like to hear the lascivious details. So I talk about what happened to Britney Spears and Farrah Fawcett and the Octomom [Nadya Suleiman], because whenever you talk about money and fame, people get interested.”

‘The HIPAA guy’

Staff members’ recognition of him as “the HIPAA guy” is the only validation Ho needs. “I know they know who to call when they need help,” he says. “That tells me that we’re not likely going to make the mistakes that will attract the [Office of Civil Rights]. That means everyone is doing their job.”

Jackson sees a change in culture and largely credits Ho for the success. “He is really the face of HIPAA,” she says. “He is relatable, and employees and patients alike are comfortable … speaking with him. As we all know, one of the keys to any compliance program is to solve issues at the lowest level possible, and Brandon is great at problem solving, too.”

Ho doesn’t confine his leadership role to the 40-hour work week. He ensures that everyone knows he’s accessible 24/7, because privacy doesn’t punch in and punch out on the clock.

Everyone has Ho’s office number, and his voice mail greeting includes his cell phone number. Rather than feeling annoyed by late-night telephone calls from staff members, Ho feels assured that their willingness to call him at any time is proof that protecting personal health information (PHI) is important to them. It’s all about being visible within the organization, he says.

“I honestly believe that management should take patient confidentiality and the protection of PHI serious enough that they’d consider an approach like this,” Ho says. “It has grown to more than just a medical records or IT issue; it’s part of the overall care for our patients.”

Source

Adapted from Briefings on HIPAA, August 2009, HCPro, Inc.
Evidence-based practice

Make EBP as easy as 1-2-3

Editor’s note: Nurses can be intimidated by evidence-based practice (EBP) and unsure how to search literature or evaluate evidence. The following excerpt from the book Quick-E! Pro Evidence-Based Practice, published by HCPro, Inc., provides tips and tools that can help nurses overcome their fear.

Getting started

Perhaps one of the biggest challenges in conducting EBP projects is learning how to search the literature. There are a variety of ways to approach this challenge.

Asking a librarian or an educator to explain how to conduct literature searches gives an overview and understanding of the process. Doing a computer-based real-time search together builds confidence in the process of searching electronic resources and provides a real-life learning opportunity.

If your organization has partnered with a local college, you can take advantage of the facilities made available to it. Schedule an appointment with the college reference librarian and ask for an overview of how to access the library’s resources. If there is no dedicated medical or nursing library readily available in your area, the local community library may have resources, such as PubMed, that can help you begin to build EBP resources.

Nurses who have experience or the inclination might want to learn to navigate electronic databases and investigate journals that are available in print or electronic copy in your organization. Contact other healthcare facilities in your area and consider visiting one that is doing an EBP project to see what journals and electronic databases they are using for the project.

Once you are comfortable reading and discussing articles you find in your literature searches, then you are ready to start doing formal critiques of the nursing literature. Organize your findings so that you can easily compare and contrast the conclusions or recommendations from the articles. Using a table format to summarize the research articles helps others review the conclusions you reach. (See “Evaluating the strength of the evidence” on p. 6 for a sample table.)

Evaluating Web sites

Not all Web sites are created equal. Nurses need a discerning eye to make sure that the Web sites used for finding literature are reputable. Look for evidence that the Web site is monitored and evaluated by experts and run by a respected person, organization, or institution in which you already have confidence. When you’re on a Web site, click on its About Us page to find out more about who runs the site.

Most reputable Web sites are run by:
➤ Federal government agencies
➤ Universities
➤ Medical associations
➤ Reputable healthcare-related organizations

Less reputable Web sites (in terms of literature findings) are run by companies trying to sell products and services, bulletin board sites (where anyone can post
can decide to move forward with the practice change in all the applicable units or modify or reject the change.

After you have instituted a practice change based on the best evidence, remember that ongoing monitoring is important. Set up a process to continue monitoring the change at specific intervals of time, evaluate the findings, and determine whether the change has sustained value over the long term. Even if the implementation is successful at the outset, the project is not completed because it is not known if the success will continue over time. Any evidence-based project requires clinicians to monitor the findings in an ongoing fashion. New knowledge or information may be developed that will need to be integrated into the practice change.

Evidence-based projects are never complete; they require the ongoing efforts of dedicated professionals who are willing to question their practice and continually find ways to improve patient outcomes.

Introducing staff members to EBP

Here are eight questions to start with:

➤ What is EBP?
➤ Why is EBP important to me?
➤ Why is EBP important to my patients and our organization?
➤ How do we find time for developing EBP projects?
➤ How do I get started?
➤ How do I undertake a literature search?
➤ What resources do I need?
➤ What resources are available?

When examining Web pages and the content within these resources, one way to avoid taking them at face value is to look for the primary source of the evidence and evaluate how conclusions were reached. Conduct a systematic evaluation of the information’s worth.

Putting research into action

Once you have developed your EBP question, thoroughly searched the literature, and determined the strength of the evidence, you have to evaluate whether the EBP changes worked. When deciding to make EBP changes, always evaluate the outcomes of any changes. Never assume that changes in clinical practice will have the anticipated outcomes. Therefore, test pilot the changes on one or two clinical units to help detect unexpected outcomes and to understand any implementation-related problems. Based on findings from the pilot units, you

Online access to nursing CEs

Take your quarterly continuing education (CE) quizzes online and receive instant access to your CE certificate! The Strategies For Nurse Managers’ continuing education quarterly quizzes are now available online. Visit www.StrategiesForNurseManagers.com and go to the online learning page. The Q3 quiz is available now.

Forgotten your username and password? Call HCPro’s customer service representatives at 800/650-6787.
### Evaluating the strength of the evidence

<table>
<thead>
<tr>
<th>Question</th>
<th>Article 1</th>
<th>Article 2</th>
<th>Article 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where was the study conducted? What was the setting (e.g., academic medical center, community hospital, rural hospital, or long-term care facility)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who was in the study population? Were study participants similar to patients cared for in your organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does the study contribute to the body of nursing knowledge? Do the study findings make sense?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the implications for nursing practice, education, and research?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What additional questions does the study raise?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the empirical evidence presented in this article support a change in practice?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What resources would be required to implement the change?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would the benefits of this practice change or outweigh the risks to patients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What will be the outcome of this practice change on nurses, patients, or the organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will the practice change be evaluated?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: *Quick-E! Pro Evidence-Based Practice: A Guide for Nurses*, HCPro, Inc.
We received close to 200 nominations for the two categories in the HCPro 2009 Nursing Image Awards—and all the candidates exemplified professionalism and compassion that made them stand out to their peers.

The image of nursing is a collective expression of the pride and professionalism each nurse feels, and then portrays to members of the healthcare team and society. The purpose of the search was to identify and recognize those nurses who demonstrate pride, professionalism, and excellence, and thereby embody a positive image of nursing that elevates the profession as a whole.

The 2009 Nursing Image Awards honor nurses whose leadership, teamwork, and clinical expertise embody an image of nursing excellence and who make a difference in improving patient care, quality outcomes, nurse satisfaction, and the healthcare environment.

A panel of nurse leaders and senior editorial staff from HCPro served as judges for the awards, which will be presented at the 2009 Excellence in Leadership seminar in Boston September 21.

Image of nursing in clinical practice

The first category recognizes the image of nursing in clinical practice. It was open to individual nurses or nursing teams who portray a positive image of nursing through their clinical excellence and have made significant contributions to improve patient outcomes, patient safety/quality initiatives, staff member satisfaction, practice changes, research or evidence-based practice projects, interdisciplinary collaboration, or organizational goals.

The neonatal ICU (NICU) team at University Hospital of Brooklyn (NY) SUNY Downstate Medical Center was selected as the winner in this category.

The nurses were recognized for their outstanding teamwork and pursuit of quality improvement. One of the initiatives noted by the judges was a project in which the staff developed and implemented a bundle of care measures to reduce central line-associated bloodstream infections. Other notable projects included post-discharge phone calls to check up on patients and a patient satisfaction survey given to all parents so RNs can benchmark how their team is perceived.

“This team demonstrated that the image of nursing goes beyond the bedside,” says judge Shelley Cohen, RN, BSN, CEN, president of Health Resources Unlimited in Hohenwald, TN, author, and speaker at Excellence in Leadership. “Their post-discharge follow-up process and proactive education for the parents are truly excellence in clinical practice. Their overt support for their professional organization and recognition of the value of specialty certification are essential elements for nursing’s professional image. This combination of factors provides role modeling for the future of the profession.”

Sharon Courage, RN, MPH, vice president of hospital services and a senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, was similarly impressed.

“The NICU team has chosen important improvement strategies that not only affect the health of the NICU baby while in the hospital, but also the long-term health and safety after discharge,” Courage says. “The decrease in [central line-associated bloodstream infections] is quite impressive, but they didn’t stop there. In considering the health and welfare of the baby, they embarked on projects that educate parents on techniques such as
Image of nursing

CPR, choking baby, and first aid that can save an infant’s life after discharge.”

Laurie Anderson, RN, MIS, manager of informatics at Southern New Hampshire Medical Center in Nashua, earned an honorable mention in the category.

The judges wrote that Anderson is an “example of our image at its finest, demonstrating professional growth as an individual nurse, as well as ongoing mentoring through recognition of others. This nurse has demonstrated pivotal actions in a short period of time that have truly affected patient care within her organization.”

The second honorable mention went to Maribel Falzone, LPN, wound care certified quality first coordinator at Provena Pine View Care Center in St. Charles, IL.

Image of nursing in leadership

The second category recognizes the image of nursing in leadership. This category honors a nursing leader who embodies a positive image of nursing through his or her leadership excellence and has served as an inspiring leader, mentor, and role model to nurses as they strive to portray an image of professionalism in all they do, whether by overcoming significant challenges, spearheading change, or inspiring teamwork that resulted in achievement of operational goals and objectives.

Dianne Aroh, RN, MS, NEA-BC, CNO at Hackensack (NJ) University Medical Center was selected as the winner in this category. Aroh was recognized for her abilities as a transformational leader. Her colleagues who nominated her noted that under Aroh’s continued guidance, mentoring, coaching, listening, and visionary leadership, she transformed the organization into a culture of creativity that supports professional growth and conscious, deliberative, and contemplative risk taking.

Under Aroh’s guidance, the department of patient care developed a blueprint for nursing leadership that emphasized distributed responsibility, nonstop skill development, and hardwired accountability. In addition, she developed a management mentorship program to develop the next generation of nurse leaders. A strong advocate and champion for the empowerment of staff nurses, Aroh encourages all nurses to participate fully in decisions that affect their practice.

“As a nurse travels up the corporate ladder, leadership becomes more of a challenge than ever,” says judge Kathleen Bartholomew, RN, RC, MN, author, consultant, and speaker at the Excellence in Leadership. “What inspired me to pick this CNO as the winner is two things: Her success is documented by measurable outcomes and the following description is very unique and embraces the essence of what nursing needs to succeed: culture of creativity, supporting professional stretch, conscious, deliberative, and contemplative risk taking.”

Cohen noted similar attributes in the winner.

“Empowering nurses at the staff level not only promotes excellence in patient care, but role models excellence in leadership,” says Cohen. “What an inspiration this leader is. Her ability to transfer her vision to staff is highly commendable. This nurtured collaborative work force is the foundation for promoting the image of nursing today and tomorrow.”

Kathy Schuler, MS, RN, NE-BC, CNO at Winchester (MA) Hospital earned an honorable mention in this category. Schuler was nominated by the entire team of nursing directors at her hospital, which was noted by the judges.

“The very fact that the nursing directors came together to nominate their leader speaks volumes in today’s hospital culture,” says Bartholomew. “The amount of risk taking required to defend nursing in these economic times speaks of her commitment and dedication. As a leader, her clear and passionate vision has resulted in hardwired improvements and earned respect beyond her hospital’s walls.”

A second honorable mention went to Debbie Pusateri, MSN, RN, assistant vice president nursing people officer/critical care services/education, at Florida Hospital in Orlando.
Building an antimicrobial stewardship program

Simple steps for better antibiotic management can save money and reduce the IC burden

After reading this article, you will be able to:

- List ways an antimicrobial stewardship program can help lower your hospital's infection rate
- Illustrate low-cost methods of implementing a program

Preventing the spread of multidrug-resistant organisms (MDRO) in your facility is increasingly important. With close attention from The Joint Commission through the National Patient Safety Goals and an increased cost association with these organisms, infection prevention efforts have never been more vital.

But infection prevention may not be the only way to reduce MDRO infections in your facility. Although hand washing will always remain the most effective way to halt the spread of diseases, you may find that appropriate use of antibiotics can provide additional support in lowering your infection rate.

Judicious and regulated use of antibiotics can reduce infections, save your facility money, and provide much more control over infections, says Richard H. Drew, PharmD, MS, BCPS, professor at Campbell University College of Pharmacy and Health Sciences and associate professor of medicine (infectious diseases) at Duke University School of Medicine in Durham, NC.

“To use [antibiotics] optimally relative to dose, and relative to selection and duration, obviously is all already part of that equation,” Drew says. “There is no question whatever we are doing wrong now we are going to pay for and we are already paying for.”

Starting the program

Allison V. Tauman, PharmD, MPH, implementation manager at VHA Performance Services in Irving, TX, helped establish an antimicrobial stewardship program at Hospital of Saint Raphael in New Haven, CT.

Tauman published the results in the May Hospital Pharmacy, and recommends organizing a collaborative group dedicated to antimicrobial stewardship. She suggests setting goals to reduce antibiotic usage, which means establishing baseline data and measuring progress as the program develops.

“To quantify the problem, it’s important to know where you start and where you go, and how much progress you have made, so I think the first step would be to measure your utilization or your utilization patterns in the hospital, usually based on defined daily doses per 1,000 patient days,” Tauman says.

Drew says it also helps to evaluate the resources available to your hospital. Although larger hospitals typically have the expertise and funding for a more extensive program, even smaller community hospitals can initiate stewardship measures.

“There are ways that hospitals can do stewardship in an expertise-limited environment, can still do the basics of stewardship,” Drew says. “So in those particular settings, we do things like IV to oral programs and dose optimization. Sometimes you can run preapproval programs where you establish appropriate criteria for use. And certainly things like surveillance and feedback on antibiotic prescribing habits; that can be done largely without necessary dedicated resources and not necessarily focused expertise.”

Switching from IV to oral, and dose optimization

One simple measure facilities can take is establishing a system within the pharmacy department that allows a switch from IV to oral ingestion of antibiotics.

Prescribing antibiotics intravenously exposes the patient to potential bloodstream infections. If the drug can have the same effect when taken orally, the risk of infection decreases, and the patient often spends less time in
More judicious use of antibiotics not only decreases money spent on drugs, it can also reduce infections, patient days, and staff resources, which can indirectly save money. The Hospital of Saint Raphael focused specifically on automatic conversion from IV to oral antimicrobials and appropriate antimicrobial use. According to Tauman’s article in *Hospital Pharmacy*, the percentage of patients receiving oral fluconazole increased from 63% to 77%, and the percentage of those receiving oral linezolid increased from 54% to 71%. As a result, the hospital saw a 6% decrease in total antibiotic use and a cost savings of approximately $874,000 annually, based on the 60-day trial.

Although antimicrobial stewardship programs often provide cost savings, Drew says that this isn’t always the case, nor should it be the focus of the program. “Giving someone an expensive antibiotic may result in saving their lives and having to stay for several days to recover, and so you’ve spent a lot of money on antibiotics and hospital resources, but certainly that’s the outcome that you’re going after,” Drew says. “So the goal in the scorecard of costs can certainly be a motivator, but it shouldn’t be the primary driver. So when you start to get more elaborate programs, you do focused programs on education, you do probably more elaborate safety monitoring programs because one of the goals of this program is safe use of antibiotics, not just effective use.”

The safe use of antibiotics is also important for the control of antibiotic-resistant organisms. As more resistant organisms surface, infection preventionists and pharmacists have to keep up with prevention efforts and antibiotics. “The pipeline is not very exciting for new antibiotics, especially in the gram-negative pathogens, so we have these multidrug-resistant gram-negative pathogens, but we cannot see the light of day in terms of new drugs,” Drew says. “There’s really no potent new class of gram-negative drugs coming out.”

**Achieving cost savings**

An added benefit of this program that will please your hospital administration is the potential cost savings that an antimicrobial stewardship can provide.

---

**Source**

Adapted from *Briefings on Infection Control*, September 2009, HCPro, Inc.
Researchers at Brigham and Women’s Hospital (BWH) and Massachusetts General Hospital (MGH) in Boston have found that the use of a better integrated computer system and process redesign could reduce the number of potential medication errors present in the medication reconciliation process. The study, published in the April 27 Archives of Internal Medicine, took place May–June 2006 and focused on using existing technology to compare patients’ medication lists to prevent adverse events.

“We know that good medication reconciliation is not occurring,” says Jeffrey Schnipper, MD, MPH, senior author of the study and hospitalist at BWH. There were 1.44 errors with potential for medication harm in the control group, says Schnipper, and his team’s randomized controlled clinical trial lowered that number to 1.05 during the course of the study.

Of the 322 patients who were part of the study, 160 in the control group receiving the hospital’s normal medication reconciliation processes could have suffered 230 potential adverse events; the 162 patients who were part of the intervention could have suffered 170 potential adverse events.

BWH and MGH were using computerized physician order entry (CPOE) systems already, so researchers designed the study around using the existing system and work flow. The study took the existing system and made it easier for staff members to compare a patient’s preadmission medication list with the inpatient and discharge medication lists. This is one area in which many hospitals create medication reconciliation problems, says Schnipper.

“In many hospitals, a lot of people take a patient’s medication history, but it’s done in silos—all of these people keeping separate, different lists,” says Schnipper. The goal of the study was to reduce redundancy by creating a single in-hospital medication list that could be refined by staff members, but with increased attention on verification and communication among caregivers, he says.

Since the study ended, BWH and MGH staff members have worked on further refining the computer application, so that it can detect even more detailed differences in the three medication lists, such as distinctions in the class and dose of medications, says Schnipper. The application alerts caregivers to any such differences, which could help prevent adverse drug events.

Another part of the study involved redefining the roles certain caregivers play in reconciling medications, specifically concerning the home and discharge medication lists. Pharmacists and nurses were given a larger role in checking to ensure that patients’ preadmission medication lists were accurate.

“Pharmacists get this, and they were thrilled to be involved,” says Schnipper. Prior to the study, Schnipper’s team found that pharmacists were spending more time finding and questioning discrepancies between patients’ preadmission medication lists and the inpatient medication lists. However, it turned out that creating inaccurate home medication lists was a bigger problem.

Now, pharmacists at BWH and MGH are doing whatever they can to make sure a correct and up-to-date home medication list is created when a patient enters the hospital. That might mean speaking with family members or calling patients’ home pharmacies to discover their most recent home medications, says Schnipper.

Additionally, nurses, who often are in charge of educating patients about their medication regimens after discharge, have found that because there is one concise list to refer to, they can improve their discharge counseling. ■
Economic challenges abound for the healthcare industry, leaving nurse leaders hanging on to every dollar in their budgets. There is still much uncertainty awaiting us in the coming months and years.

But now is not the time to get freaked out. Instead of worrying too much about the unknown, shift your leadership focus to what you know for sure.

Ensure that you are focused on the realistic things you can do to solve your economic challenges.

Consider the following ideas when addressing budgetary concerns:

➤ Encourage staff members to come up with cost-saving ideas. Examples of things they might have noticed include instances when the lab prints two copies of a report and one is thrown away.

➤ Work with a school of nursing to find graduate students to help implement an evidence-based practice.

➤ Find the person in your organization involved with obtaining grants and learn about the process.

➤ Barter. Offer to do a presentation on your specialty area for a local school of nursing in exchange for having one of its faculty members provide your staff members with an educational opportunity.

➤ Educate staff members on the value or cost of all equipment and supplies. Post a listing of commonly used items, what the organization pays for the item, and the average amount you get reimbursed.

**Source**

Shelley Cohen, RN, BS, CEN, Health Resources Unlimited, (www.hru.net). Adapted with permission.