Interview with a Nursing Policy Leader:
A Hopeful Look at a Changing Profession

Julie Sochalski reflects on her role at the HRSA.

Joyce Pulcini (JP): Can you describe your roles at the Health Resources and Services Administration (HRSA), first as director of the Division of Nursing and then as principal advisor for health workforce policy?

Julie Sochalski (JS): As the director of the Division of Nursing, I had responsibility for Title VIII of the Public Health Service Act, which supports nursing workforce development by implementing programs to carry out its provisions. Title VIII, which was reauthorized with the Patient Protection and Affordable Care Act (ACA), invests in advanced education, faculty support, workforce diversity, and strengthening nursing practice.

It was a perfect preparation for my role as principal advisor for health workforce analysis, which focused on integrating our workforce development activities with implementation of the ACA and asking the questions: Are we ready to deliver on the promise of the ACA? Are we not only responsible stewards of our dollars, but also responsible partners and stakeholders in workforce development? Are we ready to transform health care? How are we innovating? Are we fully using everyone that we have—the specialty physician, the community health worker, the advanced practice nurse (APN), and the dental hygienist? So it means looking critically at how we can better integrate workforce development into every single innovation across the Department of Health and Human Services (DHHS) and across the federal government.

WORKFORCE DEVELOPMENT AND INTERPROFESSIONAL PRACTICE AND EDUCATION

JP: What would a typical day look like when you were in your office or at home?

JS: I spent each day integrating workforce development into the programmatic portfolio of HRSA and other agencies across the department. For example, HRSA funds support health centers across the country. The Bureau of Primary Health Care, which does an outstanding job of bringing services to the underserved, is looking at workforce issues. I worked closely with the new Center for Medicare and Medicaid...
Innovation and at the DHHS with the National Quality Strategy on how we should integrate workforce—
we’ve had a very strong priority from the ACA and from the administration around interprofessional practice and education. Does this mean just getting a group of people around a table and making sure that they’re talking to one another? Who is included in this group? Are we working not just within or across federal government, but also with our entire stakeholder community? We’re one partner . . . with others in trying to transform care.

**Better Distribution of Primary Care Providers to Meet Actual Needs**

**JP:** What were the most challenging and most rewarding aspects of each role, and can you give examples?

**JS:** Yes, sometimes the most challenging is the most rewarding. I think the most challenging was trying to go to bed at night seeing all that still needed to be done. I think one of the most rewarding was seeing strong colleagueship across professions . . . working much more collaboratively with many of the constituency groups in and outside of nursing.

Also, the commitment is to population health and seeing workforce development as a tool to get there. So when people ask me if we have a shortage of nurses, that’s a hard question to answer. But do we have a shortage of nursing care? You’re darn right. And how do we build more of that? I would say the same thing about primary care. Do we have a shortage of primary care providers? We know we have a maldistribution . . . so we absolutely have a shortage of primary care. How can we take our primary care workforce, grow it, move it, shape it to where we can deliver the best primary care? It’s that focus—on producing the right set of services in the right places with the right quality and with the right people. We will move the needle on health disparities if we address the distribution as well as the need for better services. We have a lot to do, and we had better use everybody in the whole system to do that.

**JP:** As you look back, would you identify one or two things that are your most important contributions?

**JS:** The biggest, or the thing that I’m the most proud of, is being able to really push . . . on building ways to look at interprofessional practice—and through that, on improving quality and providing a pathway to improve upon health disparities. This includes advocating for what I think is so important . . . focusing on the proper role of practice: having practice and the improvement of health driving the educational enterprise. We have figured out interprofessional education, [but] we have to build the settings for people to train in this area, and that involves faculty and practice settings.

**Integrating the Frontline Workforce Into the Policy Process**

**JP:** Is there anything that you wish you had been able to do in your previous position as director of the Division of Nursing?

**JS:** I would like to continue to do more in the area of really understanding and integrating the frontline workforce, beginning with the community health worker and right on through all the direct support workers. The individuals who do that noble work are in many instances volunteers, or often don’t have good wages and may not have health benefits, but are such a critical part of people being able to live healthy lives in their communities. I know that the administration is very committed to that. A number of groups are out there and HRSA and the DHHS and other parts of the government have funded a number of initiatives in this area. I would like to see much better inclusion of frontline workers in all health settings.

In addition, I see clinicians and other people who work in health care as incredibly committed, really trying to do the right thing. They are advocating for people’s health on a daily basis. Yet they are not always adept about policy because it is not a world they travel in. So I would like to see more clinicians integrated into the policy process—in part because they have such a rich voice.

**Politics and Health Care Reform**

**JP:** The former surgeon general Richard Carmona said that he had not anticipated how much of a role politics played in everything at all levels of his job. Has this been your experience?

**JS:** When are politics not influencing [policy]? I came from academia, where there are academic politics. I have been in positions interacting with city governments, state governments, and the private sector. I do not think of politics as big P or little p—just always there. We are getting ready to enroll people in health insurance through the ACA. [Editor’s note: This interview took place prior to the October 2013 start of the ACA enrollment period for the uninsured.] What we are trying to do is titanic. I say this in nursing groups all the time . . . you have got to lead the charge on this. You need to get out there and educate yourself, and educate the public on what this opportunity is. If we believe health care makes a difference, then getting yourself in the door, which [is what] coverage does, is critical. What we have to do is tee up the best possible system. Politics are always the context of what we do and I don’t quite frankly think about it. But when I do think about it, [I think] ‘Oh, what a nice problem to have!’ We have to enroll 20 million people—as problems go, give me that one any day.
JP: I just read an article that said it took 20 years for Medicaid to be fully implemented. How does that relate to the ACA?

JS: You know, there are going to be a lot of bumps in the road and many of us have been at this for a while. Something had to be passed to get started, and if we never passed anything, then we would never get started. I do not think anyone passed the ACA thinking it is a perfect product. It was definitely a step in the right direction, but it was implemented three years ago and we’ve got 17 to go on your Medicaid example.

NURSES AND LEADERSHIP

JP: I want to talk a little bit now about nurses. More nurses are needed to provide leadership in today’s health care system. What do we need to do as a profession to improve that leadership role for nurses?

JS: We need to mentor the next generation of nurses, first and foremost. We need to make sure that every person coming out of nursing school (at the entry level all the way up) is ready to understand and act on the leadership role that they have. You have leadership in your staff role because you are a critical member of a team in a hospital, in a public health setting, in a community health center, in a nursing home, in a home health agency, in a school, in a community, in every setting where you have been given the privilege of having a license to care for people’s lives. We teach and prepare nurses for many roles, and we cannot afford to not build that leadership. You can be in a leadership job and not lead, and conversely you can lead in many places. We really need nurses at every level to lead. To lead is not being number one, but leading is seeing where opportunities are. Nurses are in an incredible position to be able to lead and that should be as important as every other clinical experience. Every single person who is working needs to see where opportunities for leading are. We particularly need to look to the next generation coming out of our schools and build strong leaders in this group.

BRINGING THE VOICES OF ‘GROUND TROOPS’ TO THE POLICY TABLE

JP: Do we still need more nurses to be at stage four of the policy process? [Editor’s note: This is a reference to “leading the way,” the last of four stages described in a 1996 article by Cohen and colleagues, “Stages of Nursing’s Political Development: Where We’ve Been and Where We Ought to Go,” Nursing Outlook, November–December 1996.]

JS: We need ground troops. You can be the president and you still need ground troops. Your role shifts, so you shift to having a voice that is different. It is the same thing if you are president of the university, dean of the nursing school, head of a major organization: you have a voice, a forum, a different set of responsibilities and accountabilities. You also see what you do not have, which is the capacity to be at the ground level. We need nurses at stage four and we need to build the opportunity for that, but we’ve got to build the ground all the way up. I think those ground troops are probably as important as nurses at stage four. So nursing would bring a voice that is different to the table and very needed. I think you can bring that, but you better have your ground troops with you because [otherwise] you’re not going to deliver on the voice.

ON NPs: ‘WE HAVE ARRIVED . . . WE ARE THE ARCHITECTURE OF THE ROOM’

JP: Let’s switch to APNs. Is it a really important time for APNs and, as a key player in the workforce arena, what role do you see for APNs in the future?

JS: I’ve got to tell you, it is wonderful to have the word NP uttered on the average television program, on the news—you hear it from the secretary, from the president. It is just part of the conversation. We have achieved, we are there. We’re the architecture of the room. That is who we are and who we have been, but now APNs are not just the exception to the rule. They are the rule and such a huge achievement.

I think the bigger challenge we face in nursing is to ask, what are we doing with this opportunity? What does it mean to practice at the advanced practice level? What are our responsibilities in transforming care and in building strong collaborative teams? . . . So I would say for midwifery, for anesthesia, for each advanced practice role: how do we develop the profession in a strong way? How do we develop inter- and intraprofessional collaboration in effective ways and step up and help transform the health care system, which is now transforming nursing, . . . [in order to] improve the population’s health? So, what are we doing to improve the population’s health, and what role are we taking on that moves nursing forward in that quest?

WHERE NURSES WILL BE IN 20 YEARS: CARE COORDINATION, CHANGING ROLES

JP: In 10 or 20 years, where are RNs, not just APNs, going to be? What is [nursing] going to look like, and what do we need to leave behind in order to move to where we should be?

JS: There is no place where health care occurs that you do not have a nurse, and that is all the way up and down the health care chain. I think nursing is very well positioned . . . to play a very important role in transforming how that care looks and is accomplished. [Nurses] see the entire complex of health care workers and people who work to improve health and can bring them together to increase the dividend of
health and produce more with what’s there. I expect the role in 10 years will look somewhat different because of these collaborations. We are moving to build on care coordination, transitional care, to move care out of just one setting in order to make care continuous. To do that, you have got to have people like nurses who can move across settings.

Assuming that the role of care coordination is not a small task, we need to figure out what that care coordination is, which strategies are the most effective, with whom do you work and how. How do you work better with families, with home health aides and certified nursing assistants, and with people in communities? How do you harvest the wonderful information and observations from communities and shift how you are caring? How do we communicate better with schools, with community leaders, as well as with the other health occupations? I don’t think we will continue to have 60% of RNs working at hospitals—and if we don’t, how are we training them differently to be in different roles? I see nothing but incredible enthusiasm in the group coming out of schools now.

THE WIDENING INFLUENCE OF THE IOM’S FUTURE OF NURSING REPORT

**JP:** How are we doing in implementing the Future of Nursing initiative of the Robert Wood Johnson Foundation and the Institute of Medicine (IOM)?

**JS:** The foundation, through the Center to Champion Nursing in America, has done an incredible job with the action coalitions across states. That is probably the most important thing that’s come out of this effort, and these groups are to be commended. Within states you have organizations that have never spoken to one another now working with one another. So you are building these new alliances, which are important not only to educate people about where nurses are, what they do, but also to educate nurses about the entire health enterprise that’s going on in their state, what agencies are out there, and how can they be responsive. It has gotten nurses to also look really critically at where we are as an occupation and how our occupation is contributing to improving the health of the future. It is really impressive.

For an IOM report like *The Future of Nursing: Leading Change, Advancing Health* (2010) to come out and to say: these are not just recommendations that are sitting on a shelf, but we are going to live them because they were made with incredible thought. You hear that from Donna Shalala and other health care leaders who have come out afterward and have spoken out passionately about these recommendations. You see things coming out of the Bipartisan Policy Center. These are former legislators who have come together as a consensus group. I hear so many things coming out of that which echo a lot of what we have heard from the Future of Nursing initiatives. So you are seeing the report have tremendous reach.

ADVICE TO NEW NURSES: ‘ONLY WORK YOUR PASSION’

**JP:** What would you tell a young nurse just entering the field if she or he were seeking your advice to advance professionally? What kinds of leaders are needed to help this young nurse?

**JS:** The best advice is to tell each nurse to find that person who is doing that thing you wanted to do when you came out of a nursing program. There is probably no place in health care you cannot work. There are some positions you are going to feel more comfortable working in. There are some positions that most of your friends are going to go and work in—but I would find the most innovative, interesting job out there and talk to someone who is doing it and ask them how they got there. Only work your passion. Do not work because someone said you need to do a year here, someone said you need to do something else. You have just a wealth of knowledge, and never forget you have a social obligation to your license to deliver better health. You are going to do that best when you are working in that challenging, engaging setting or location, doing that thing that you feel really helps make a difference. As I often say to my students: the reason that a registered nurse gets a license is not because they have passed the NCLEX; that is what you have to do to get the license.

But you are entitled to sit for the NCLEX not just because you graduated from a nursing program but because the public has decided that the provision of nursing care, that social contract that one engages in with an individual to deliver health care, is so important that they are willing to share it with you through that license. The public is willing to share that sacred trust with you and entitle you with the privilege of being able to get a license.

**JP:** Is there anything I should have asked you that you wanted to say?

**JS:** This is a great time to be in nursing. It has a glorious past. It has a tremendous future, and I think . . . anybody who is choosing this has chosen wisely. ▼

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