Betty Irene Moore Speaker Series
Sheila P. Burke in conversation with David Vlahov
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Section 1: The Importance of Mentors

David: when I think about education, there is the influence of teachers and even after school you get mentors. That's an important area for you. Can you tell us a little bit about mentors and what that means to you?

Sheila Burke: I think it is-, at the heart of all of our success, and that is the ability to identify people who can help guide you along the way. They may be people who have a similar background, they may be someone else. It is someone with whom you can consult; it's someone with whom you seek guidance. It is someone with whom you can talk about your concerns and the direction that you are going, to do a course correction. I was blessed at USF. I had a remarkable faculty. I was not-, I was sort of like George Bush, I wasn't exactly at the top of my class. [*People Laughing*] That's an understatement. [*People Laughing*] And there were a couple of my faculty members here, Jane and others who would confirm that in fact that was the case. But it was people who essentially fundamentally believed that you could do it and provided you support along the way. And I have had mentors in every single instance.

Certainly at USF Mary Geraldine was remarkable. Lexi Woodruff was one of my faculties. Jane and others who really helped guide me along the way. When I went into practice there was a nurse at Alta Bay, Diane Cooper, who was the head nurse on my floor; I was in a sub-acute unite. And Diane held us-; I mean, we were new grads, we were doing all the things new grads do in terms of the anxiety of transition to a clinical setting; but Diane held us to the absolute top level of expectations but, supported us in the decision making. Supported us in learning what it is we needed to know in how to access information; gave us permission to say, "I don't know." Gave us permission to seek her guidance. When I went to the Student Association, Marion [00:22:39] was the CEO, one of the finest managers I have ever experienced in terms of the discipline in the work force but, her ability to engage everybody in the environment, in sort of decision making. We all thought like we were part of it; and when I went to the senate, exactly the same thing. I was in an environment that it was unfamiliar to me. I was one of the very few women at the time in the environment; there were no other chief-of-staff that were women; there were no other senior staff people that were women. And so I'd sought out people that had expertise that I didn't have. And you go to your weakness. I mean, as someone who has also done a lot of hiring and a lot of managing, you hire your weakness in my view. You want people around you who are smarter than you and know about the things that you don't know about. And it's finding that person in the environment-.

My first mentor in the senate was the fellow who ultimately became my predecessor in Dole's offices, Chief-of-staff at the Senate Finance Committee and then, I replaced him as

Chief-of-Staff Deputy Staff Director at Senate Finance and ultimately, Chief-of-staff in the Majority Leaders' Office. And he was a lawyer, tax lawyer by background, but knew that process and knew that environment.

So, it is finding someone who can help guide you and who whenever things are going to hell in a hand basket, you can go to and say, “What is it that I did wrong or how do I move forward?” So, I think it is enormously important. And I also think it is a responsibility of all of us to do that; to be willing to do that when people come to you who are new to the environment and are seeking advice. I think everyone of us really should in fact agree to be or should seek opportunities to be mentors. I think that's part of sort of payback that we all give.

David Vlahov: So, what I’m hearing is more than one mentor.

Sheila Burke: Oh, absolutely.

David Vlahov: Mentors who can respond to you in areas that maybe you don’t feel strength.

Sheila Burke: Certainly that but, also mentors who can be absolutely direct and honest. And when you screw up, tell you, “You screwed up.” I mean, what you don’t want is someone who says, “Oh, that’s fine. You were fine, not a problem; move on.” You want someone who is honest enough to be able and whom you trust to say, "This is what you might have done differently. And this is the path you might take going forward."

You really need someone who will give you honest feedback. You don’t need someone who would simply confirm that you have done the right thing when in fact, you haven’t.

David Vlahov: ;how do I go about finding a mentor? How does one go about? What do you look for in a mentor?

Sheila Burke: I mean, first of all, you look in your close environment. You know, who are you working with? Who have you been exposed to? Who have you observed and admired? Essentially, how did they deal with other people? You look at sort of what are their skills; what is it that you need to be able to acquire? What is it that is essentially your weakness? And I've never had experience when I approached someone to seek advice or counseling where I was not positively received. I think we are often hesitant to approach people but, I think in fact most people are quite happy to be asked. Most people are quite happy to have you consider them a source of information. It is the rare person who essentially will reject that overture and if they do, you know that essentially it is not the right person. It’s not the direction you want to go. But I’ve not had an experience where I’ve sought out that counsel on advice that I wasn’t in fact, received positively.

David Vlahov: So, thinking about our audience here, there are students as well as faculty in the audience. What advice might you give them in terms of networking? Finding mentors, as they are starting out their careers.

, I think the first thing to do is to find someone in your own environment; it maybe a faculty member in your area; maybe in another area or if you are in a clinical setting, someone in your area of practice or someone who you’ve observed in a related area of practice. You know, you are in an acute care setting but, you are interested in moving into ambulatory

care; find that person and develop a relationship. You know, I think we are reluctant to do that. Instinctively I was hesitant to do it with people but, again I've not found an instance where someone has in fact discouraged me for doing that. There will be people who will not have enough time. There will be people who would otherwise engage and if that is the case, you just move on; it is not a rejection of you, it is just a question of priorities. But again, I think those relationships are often long standing. I still go back to many of the people that I knew, partnered with; essentially worked with, to this day. You know, whether it's-. And it's one of the-, when we get to the sort of tank top suggestion.
One of the things you don't ever want to do is burn bridges; you don't ever want to break a relationship with someone with whom you had a disagreement; they may well be the person you have to go back to it at some point. That certainly has been my experience.

Section 2: Why Policy is So Important for Nursing

you've got involved with the National Student Nurses Association, that when you were a student there.

David Vlahov: And what drew you to that?

Sheila Burke: It became increasingly apparent to me that a great deal of what we were going to be able to do and where we were going to practice, what we were going to be permitted to do, who was going to pay us was going to be a functional public policy process. The Student Nurses Association at the time was quite active, and also engaged with the California Nurses Association. And it was-. I found it interesting that that sort of mixture of policy and practice. They were involved at the time in a lot of the issues around the financing health man power education. It was relatively early on in the passage of Medicare and Medicaid; there were a lot of conversations taking place about the public programs; and it was an opportunity to meet with other students around the state and ultimately students from around the country, who really had a common interest and common goals. And it was really an extraordinary experience and opportunity. And really, I think, exposed me to a broader set of conversations, different circumstances. I mean, the nurses in the state of Mississippi, the students were in similar circumstances but different. And it was, I think a tremendous training ground for sort of public policy and leadership going forward.

David: looking at the new grads that are out here today, why is policy has been such a passion for you? And why do you think it should be for them?

Sheila Burke: Well, it became very clearly to me, very early on, as I indicated, where I practiced; what I was permitted to do; who was going to pay me to do it; the environment in which I could work was going to be a function of somebody else's decision, it wasn't going to be mine. It was going to be either the licensee boards or the state legislator or federal policy. You know, if you think about the Medicare law and the fact that the fundamental Medicare law is-, and I don't mean this as negative as it's going to sound, it is physician dominated and hospital controlled. It is the way we structure the financing

program when we created the program in 65. And so, we are incident to a physician service. We are in collaboration with the-. Moving forward in the 80's and 90's to recognize essentially nurses practicing in rural areas, sort of a _____ It's all being pain staking progress. And so, again the money-. Practice goes to certain extend where the money goes. And that is the reality. I mean, when you have big purchasers like Medicare and Medicaid or the big private insurance, who and what they paid for, and how they pay for it in that they permit in terms of service, will essentially make what we do a reality or not. And so, to ignore that, to ignore the process that leads to those decisions at a local level, at a state level, or the federal level, I think it's to essentially give up the responsibilities for deciding and directing the way care goes in the future. There are huge number of things in the ACA that attempt to try and move us forward; that attempt to move us out of institutional into clinical facilities that are ambulatory in nature. That are-. I mean, the introduction of-. As you move back, any of us who's done any sort of public policy, you sort of thinking, "What was the thing that I was most proud of? What was the one sort of policy or two or three sort of policies." And I look back and you know, two of them were: 1) getting Dole to support fetal tissue research. And the other was, the introduction of the hospice program in the Medicare program. And again, you know, how we can do things that we could not have done before. So, I think the reason to be involved at some level, at some level of understanding-. I mean, not to preps gone as far as track as I did but, to be engaged in those conversations, I think is part of our responsibility. And I think to not do so is to leave it to somebody else to decide what you are going to do.

David: if the congress and the president were standing in front of you, what would you say to them about building collegial relationships?

Sheila Burke: I think you have-. Correctly identified one of the challenges I think nursing has faced historically; and that is the inability to speak with a single voice on many of the issues about which we care deeply. In fact, people will take advantage of the division within-, within us to limit our progress. David and I chatted briefly in advanced of our meeting about the current debate over the doctorate and the role of the doctorate, the presence of a doctorate, the requirements for a doctorate.

My experience will suggest to me that you begin with the things about you can agree. And I think there is growing understanding of that and appreciation for that. It is about access; it is about financing; it is about quality; it is about outcomes. And I think you agree around those things and speak with a common voice. The internal dynamics about what degrees are required by whom to do what; I think to the extend we can't we keep that alternately and we don't take that into a public conversation. We don't need other people watching us essentially eat each other alive, around those kinds of very serious questions; whether there are legitimately opinions; but, there are so many other things about which way to agree.

So I think the answer is to come to a common understanding and agreement on what it is we think is most important. Is it financing? Is it the expansion of Medicaid? Is it the sort

of the development of quality outcomes? Is it the world of nursing as primary care providers? I think we find the things that we agree on and then, we essentially attempt to deal with the others. And I think that's what the circumstances call for today, because the ACA is really only the beginning. It is not the end of a conversation. And much of what is occurring today is a slow implementation and we are learning as we go. The absence of regular order and in the way the bill was passed, the deep political divisions; you know, the slow acceptance by some, complicate that implementation; complicate our ability to go back and correct the things that are wrong.

So, I think nursing responsibility is to figure out what are the common themes and the things we need to worry about. In California, it is about expansion, it is about the exchanges; and then, sort of take on the other issues as we can but, keep it internal. That's how I would deal with it.

Section 3: Nursing as Preparation for a Role in Policy

David: Going into this position where you are in a national platform, how did nursing school prepare you for that? What kind of lessons did you take away from school that would have been helpful or were helpful in making this move?

Sheila Burke: I think it was not only nursing school but, it was also practice. Senator Dole used to laugh and suggest that it was my time in the psyche ward that prepared me for working in the senate. [*People Laughing*] I actually thought it was more pediatrics. [*People Laughing*] little more child-like in their behavior, which it's certainly clear today. [*People Laughing*] But the fundamental skills, I think we acquire in nursing school and I think in practice are quite unique and I think, particularly applicable to public policy environment.

One is the ability to communicate. One of the most complicated things that I think we have to do is to figure out how you translate complicated information to patients and their families. How you essentially help them make decisions. How you essentially form them, make them partners in what it is that you are doing. How you translate what the physician has told you into understandable language for the patient. How you develop a care plan. I mean, how do you essentially draw on the assets that you have around you; how do you put in place a team which seems to be a new concept in health care but, it's one that is fairly fundamental to the way we were trained; and that it's: how do you develop a team to essentially address the needs that need to be dealt with? So, that the skills as I moved into a public policy arena were those skills; that it was: how do you talk about complicated information? I will never forget the first day that I sat in front of the senate finance committee. 20 members of the finance committee arrived before me, you know, Bob Dole, Herman Talmadge, Ed Bibicoff, Russell Long, you know, extraordinary people and thought I was going to throw up. I mean, I was essentially asked to explain a very complicated provision in the Medicare law. And you know, you click back into: what is it that they need to understand and how do I talk about it in a language that they understand. I mean, these are people who-, you know, when you are talking about tax law are at the

edge of their seats and you talk about health care policy and they are kind of dozing off. And so, the question was, how do you translate that? How do you make it real? How do you put a human face on the questions that are before you? How do you work with other staff to essentially build a coalition to get the results that you hoped to achieve? So, all those things-. You know, how do you manage disagreement? How do you manage differences in terms of approach? All of those are things that I think in fact, I was prepared to do as a nurse.

what about nursing prepared your for tough times?

Sheila Burke: You know, we have always in situations where someone has challenged your judgment; someone has called into question something you've done in a clinical setting, it could be a colleague, it could be a physician, it could be a patient, or a family. And I think you are prepared to deal with that. You are prepared to stand your ground, admit a mistake when you've made it. The ability to say, "I was wrong," or "I didn't know," are all things that are inherit. And I think the ethics of care; I mean, to do anything other than that essentially it's to-, I think, not care for your patient in the right way. And so I think, we're all prepared for those kinds of conversations to occur.
You know, it's a terrible thing to say but, I used to laugh when things got really horrible. You know my reaction was, "Well, nobody died." [*People Laughing*] You know, I used to get into some stupid policy fight, at the end of the day nobody died. You know, you have this conversation and you disagree but, you kind of moved on. Well, in the real world people do die. And if we are not able to admit our mistakes, admit-. You know, to learn from essentially our experience, and then I think we do a disservice to our patients. So, I think it is fundamental to our training, it is fundamental to our practice; it is fundamental to our ethics. And I think that prepares you for these conversations. You know, I don't think lawyers have nearly those instincts. [*Laughing*] But I think people that are health professional do.

<u>Section 4: The Changing Role of the Nurse</u>

David: we've got a lot of change going on with the Health Reform going into play here. And for the students who are here in particular, how is it that they can step up? What other roles are? They might not go directly into policy, although some are inspired to go in that way. But, how should nurses be stepping up to the plate during Health Reform?

Sheila Burke: Well firstly, knowing what's going on. I mean, California is really a laboratory for an awful lot of what is taking place; whether it's on the creation of the exchange; whether it's in the development of the essential health benefits; in the movement to more ambulatory care. To be alert to the conversations that are taking place in your own community. There are conversations taking place here about: How the exchange will work? Who is going to participate? There are conversations taking place about the Medicaid program or Medical program.

There is a lot of experimentation, for example, in southern California about how you manage certain populations and some of the initiatives in the NCA are particularly focused on what you do with people that are dully eligible for Medicare and Medicaid, they are old, they are poor, they are frail. And they are people we see all the time.

The fact that we are now trying to understand rather than thinking in silos, how we began to care for patients over the full continuum of care; From the point of admission to the point of discharge, to essentially post its charge. We don't pay that way, we pay in silos, we practice in silos; But I think the growing appreciation for what it's occurring in term of the management of the patients, and it may only be in your own institution. A number of institutions are getting engaged in being accountable care organizations or medical homes.

In understanding what those terms mean, understanding what your own community is beginning to do, to create these environments where patients are cared for, essentially across this full continuum rather than, just an acute patient, and essentially nobody knows what happens when they go home; particularly true with chronic illness, particularly true with the elderly. But just knowing what the language is; knowing what's taking place in your own community. It doesn't mean you have to be on the forefront of-, you know, going to Sacramento, but you certainly ought to know when those questions arise.

But it is having people understand that you are part of the community; you are part of the decision making. We all tend to-. I mean, I sat on my kids' school board for the school that they all attended. You know, I've got involved in a bunch of local community activities. And it is that first identification that helps begin to create the relationship and establish you as part of the decision making process in a matter that we can all do. And whatever it is that we choose to do, it need not be a full public policy, you know government kind of job but, it's just an awareness of your community in decisions. I mean, there is now a conversation taking place around, how we make neighborhoods healthier. How we make it more accessible. How we make sure that in the inter-city that there are markets where we can buy fresh fruits and fresh fish and vegetables. How when we are creating green space, we also create the opportunity for kids to walk to school, for the elderly to walk to, you know, to some sort of local services, rather some of these concrete jungles.

Those conversations that are occurring in cities, Philadelphia, lots of different places. You know, nurses ought to be involved in all of that. I mean, there is no reason that we can't bring the unique experience and knowledge we have to those kinds of conversations.

David: Let me add something from a slightly different perspective. And that is what I see as the growth and the increasing sophistication of palliative care. And so, that represents an individual in cap with the patient and family, that there are options that are available and that can be exercise. So, if you look at some of the issues of people being re-admitted to the hospitals, that's drawing a lot of attention. And you look at patients with congestive heart failure-. You know, should they be re-admitted? Are there somewhere-. This is the

time to really be planning and putting into place some palliated care. And I think it's really working with people, as policies are developing. So, that's-.

Sheila Burke: I think David is exactly right. And again, I think this is a unique opportunity for nursing in terms of how you engage the patient in these decisions. How you have conversations with the families. You know, your relationship with the physician and essentially, where those conversations occur and when? And not simply waiting for, you know, the inevitable to occur but, to actually you know, engage early enough so people can make those decisions. And I think people increasingly are looking to palliate care and those opportunities as being more readily available; but what we have found and I'll not side the data correctly but, directionally-. The length of staying hospice is in some respects-, kind of by model, it's longer in some case and shorter in others. The entering into hospice tends to occur relatively late. When you have people come in and essentially be in hospice for 3 days or a week or 2 weeks; and then, you have the other extreme. So, we are trying to understand how the benefit is structured. The decisions originally when we inactive the benefit was to make sure-, you were acquired to make a choice between sort of palliate care and acute directional care. And many people were uncomfortable. Physicians were uncomfortable sending their patients, you know, curative or not. And so, we're trying to understand what are the inhibitions to essentially access those services. So, we make it more radically available and knowledgeable. But it's hard.

David: Let me throw my 2 cents and that is: I had a rally with the faculty when I first stared - I don't like the word retreat. And at the end of the day there was a person from the medical school, he had been there all day long. And he said, "You know, we use different langue but, we actually do the same thing." He says, "We did disease management, you do symptom management." And everybody sat there and thought, "Well, that's not really the same thing. It's disease and people's experiences." So then, he said, "We do handoff and you talk about transitions." And to me that was very telling because it isn't where you cut off and just pass along. In this system we are really looking at continuity of care, coordinated care. And that's something that's been in our vocabulary all along. And so for us, this is a natural opportunity, I think, to step up to the plate.

Now, that means not just working in acute care settings but, coordinating out into community; community based organizations. I think really thinking about population help. How is affordable care going to work? Part of that is, you have to have a lot of people in care so, that those with pre-existing illnesses, the offset are the people that are very healthy, right? So, you see larger systems. And that means the role for the nurses' practitioners, in terms of keeping people well. So, health promotion, wellness; that's really I think, more part of-, I think how we're going to be seeing health.

The third point is that we have to grapple with technology. We certainly think about that in the acute care settings, and in the _____ and so forth; But we are also looking at tele-health. And that is 1/3 of the cost of the nurse doing a home visit is getting there and coming back so, can we use technology effectively in putting people together for follow up visits? So, I see a lot of excitement and opportunities for nursing and also,

to embrace technology in the world around us in order to deliver that care to the most people and to help people live independently in communities.

Section 5: Leadership for New Nurses

David: nurses here are going to be in practice in different settings, but we're also looking at leadership. What advice might you convey in terms of thinking about leadership for the students that are coming out and as they are moving forward?

Sheila Burke: I think what you need to do is just do it. You know, volunteer. I mean, we all have jobs; we all have commitments but, it is you know, being part of the school board, being part of some community group. Within nursing, you know, choosing to participate in some of the government issues in nursing in the associations. I mean, leadership is simply a function of standing up and taking ownership of a decision making process. And I think we're all giving those opportunities in lots of different settings. I mean, certainly I did this as a student, as part of the Student Association; that is one opportunity but, there is any number of them. You know, all of-, none of my children had chosen health care [*Laughing*] I can't imagine why. [*People Laughing*] None of my children have chosen to follow my footsteps but, each in their own way, I've encourage them to take the opportunity in whatever their interest happened to be and essentially leading something. Even if it is only a discussion group; but it is something that requires you to learn to speak publicly. Stand up in front of a group of people; I think it is one of the most important skills you can acquire. It is essentially to help achieve an end in terms of the decision making process. So, leadership may not be the head of some big group, it may only be a small setting in which you are taking ownership of essentially helping people work through a process. Could be in a clinical setting; could be in other setting. And I think we all have those opportunities and it is a function to make the time to do it. You know, the down side is, and I'm certainly guilty of this, it's taking on too much or saying yes to everybody who comes along. And the rule is: you really should do those things where you know you can commit the time, because it's neither fare to you nor to them to do otherwise. But it's really to take the opportunity when it arises.