NANCY HOWELL AGEE
In First Person: An Oral History

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In First Person: An Oral History

Interviewed by Kim M. Garber

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EDITED TRANSCRIPT

Virtual Interview from Roanoke, Virginia, and Chicago, Illinois

KIM GARBER: Good morning! Today is Friday, March 31, 2023. My name is Kim Garber and I'm going to be interviewing Nancy Howell Agee, who has served in leadership at Carilion Roanoke Memorial Hospital and later at Carilion Clinic in Roanoke, Virginia, where she is currently the President and CEO. Nancy has also served in many different leadership positions in organizations such as the American Hospital Association, where she was board chair in 2018. Nancy, it's great to meet you and talk with you today.

NANCY HOWELL AGEE: Thanks, Kim. It's a pleasure to be here and to talk a little bit about the things that are important to health care both now and in the past.

GARBER: We usually start these interviews by talking about your childhood and the formative influences of your family. Did you know your grandparents? What did they do for a living?

AGEE: I got to know my grandparents, in particular my grandmother. My parents were young when they had me and we lived with my grandmother. She was formative in my upbringing. My grandmother was widowed early. She had four children and she went to work, which was unusual at the time. During the war, she managed the largest grocery store in our area. She was an impressive, pioneering woman.

GARBER: How did your parents make a living?

AGEE: My father was a meat cutter in a grocery store. My mother babysat and she took in ironing. Later she worked in a drug store as a clerk for, I guess, thirty years.

GARBER: In what way did the values of your grandparents and your parents shape you?

AGEE: I was always close to my grandmother. She imparted a strong work ethic, being kind, high integrity – all those things. Being curious, having courage, being bold as a woman, recognizing you can do anything – were all things I got from her.

From my parents, I would have to say the value of unconditional love. When I was about fifteen, I had surgery on my leg, which was serious. I ended up having five surgeries and being in a wheelchair for a while. My mother worked every day but spent the night every night with me because I was afraid to be alone in the hospital. In hindsight, I think about how tired she must have been, how hard the work was and she had two other children – I had two brothers. My parents just did that.

We never realized that we didn't have a lot of money – we always had everything we needed and had a lot of fun. Both my parents enjoyed laughing, practical jokes, having a lot of people over. We always had a lot of family and friends at our house. Our house was the place everybody came to for Sunday dinner, for holidays. That was a joyous time.

GARBER: I had seen reference to the lengthy recovery that you had due to your surgeries. Was your care given at Roanoke Memorial Hospital?

AGEE: It was. I was born at Roanoke Memorial Hospital, as were my brothers, and I had all my surgeries there.

GARBER: Roanoke Memorial has had a major influence in your life. Did you find that the experience of being taken care of during your surgeries was helpful in discerning your calling?

AGEE: Unquestionably. I had wanted to be a nurse since I was five years old. I have a picture of myself holding the telephone and talking to my grandmother – with a nurse's hat on and a little nurse's outfit, and a puppy. The nurse's outfit and the puppy were Christmas presents. That's what started two lifelong passions: I love animals and I wanted to be a nurse.

When I had my surgery and saw how remarkable the staff were, I wanted to be like them. I especially wanted to be like two nurses who recognized that as a teenager, there were things I needed. Somebody had given me a little stuffed animal, and they took this little stuffed teddy bear on rounds with them. Each morning they would come in and get the little teddy bear. By the time the teddy bear got back to me, she had little notes with greetings from other patients. She had her little paw bandaged. Back in the day, they wrote out little cards for all the treatments. She had her little card cataloged with all of the treatments for the day. They did that day after day.

I was a teenager and I was used to washing my hair often. I hadn't been able to and I was embarrassed about that. They moved me on to a gurney, took me into the utility room and washed my hair – with Phisohex – it wasn't exactly shiny. They recognized me as a person and I wanted to be just like them. That solidified my interest in going into health care.

GARBER: This time of many treatments came when you were a teenager in high school.

AGEE: That's right.

GARBER: You must have been angry to have this happen during a time when you wanted to be thinking about socializing with your friends and so forth.

AGEE: I don't recall being angry at all. I was afraid for my family. I didn't want them to hurt, so I would try to protect them. I was confused when I didn't get the information that I felt like they were getting. For instance, the night before surgery, I phoned my dad to see what time he would be there the next day and he choked up and started crying and hung up. I thought, "What is going on here? What don't I know?"

That's an interesting perspective, since my area of interest, my passion, is now oncology. At that time, cancer was considered contagious. It was also considered a death sentence. That was one incident. The second was, to prep for surgery my leg had to be shaved. The nurse's aide came in and handed me the razor and a little box with some soap in it. She didn't want to touch me. Through that period of time, people didn't want to touch me.

I was very confused about what was happening because nobody had said to me, "You may have cancer," or "We're going to do serious surgery" – I just didn't know all that. When you're fifteen you should know what's going on. We don't do that today.

GARBER: If your surgery took place today would your care be different?

AGEE: Yes. First of all, I was walking when I came into the hospital and was immediately put into a wheelchair and told I couldn't walk. Today we would not do that. I had major surgery on my leg the first day and I was in bed without being able to get up for several weeks, then moved to a wheelchair, then moved to crutches. I was on crutches for a better part of a year. Today we would have you up and walking, I guess, the

second day.

There has been so much change in health care. We used to keep patients with heart attacks in the hospital for weeks. With patients who had had cataract surgery, you had to sandbag their heads and logroll them and they were in the hospital for a couple of weeks. It's very different now and continues to evolve. I'm pleased about how we're moving towards more and more care outside the hospital where I think we can do it safely.

There were different issues. Not only did we not understand some of the pathophysiology, but we didn't have the medications, the anesthetics, things that can keep people safe outside the hospital. There has been huge change since I was fifteen.

GARBER: What does logroll mean?

AGEE: Logroll means you roll the patient's body like a log The whole body moves at the same time.

GARBER: Is this to prevent bedsores?

AGEE: At the time when you logrolled the patient for cataract surgery, it was because we assumed that somehow jerky motions would harm the cataract surgery.

GARBER: Let's talk about the Roanoke area, which is your hometown and where you've served as a clinician and in leadership.

AGEE: Roanoke is a relatively young town, started in the late 1890s. It was a railroad town – the major employer was Norfolk and Western Railway. Everything revolved around that. Today, Norfolk Western still stops here but they no longer consider this their headquarters. We have lots of smaller businesses. We've grown, but not appreciably. We're more spread out.

Carilion is the largest employer west of Richmond, Virginia. We're seeing a whole ecosystem around biomedical and science that's very different than our old railroad town.

GARBER: I've seen reference to Roanoke as "a train city to a brain city."

AGEE: Yes. Somebody coined that, and we still say it. That's about right.

There is a very large farmer's market that started a hundred years ago. When I was a girl, that area had declined. It wasn't someplace you went to often, but it remained a farmer's market. Today, that is a vibrant area where we take visitors. There's vibrancy and downtown is a place where people like to live.

GARBER: Aren't you near the Blue Ridge Parkway?

AGEE: Yes, the Blue Ridge Parkway goes right through and we're surrounded by the Blue Ridge Mountains. It's a beautiful part of the country.

GARBER: Do you think of yourself as a Southerner?

AGEE: Oh, of course! My goodness, what a question!

GARBER: I've spent my entire adult life in the Chicago area, yet I don't wake up in the morning and think to myself, "Oh, I'm a Northerner!" It made me wonder whether people who were born and raised in the South wake up and think, "Oh, I'm a Southerner!"

AGEE: I don't wake up and think of what I am, but it is an interesting question. Some people in the Deep South don't necessarily think of Virginia as being Southern. In Northern Virginia, there is a large population and many people who didn't grow up there. If you asked them if they thought they were Southerners, they might have to think twice about it but, definitely, we believe we are Southerners.

GARBER: I'd like to ask you about segregation.

AGEE: One of the first Black mayors in America was the Mayor of Roanoke City, Noel Taylor, an amazing man.[1] Growing up here, I was probably unaware of segregation to some extent. We moved to the county when I was in middle school and the county schools were integrated. There was only one school so everybody went there.

Roanoke Memorial Hospital was one of the first hospitals in the state to get certified in order to get Medicare. I think the data show that there were only 25% of the hospitals in the country at that time that got certified in order to get Medicare funds – you had to be certified from a civil rights perspective. It's been very much a part of at least our health care for a long time.

GARBER: I'm glad you mentioned the importance of the Medicare legislation in quickly causing hospitals to desegregate because they did want to be part of the new program.[2]

AGEE: Here's some interesting history about Roanoke Memorial. I mentioned that Roanoke was a railroad town. The people who built the railroad were immigrants and immigrants weren't welcome to come to the local hospitals. A group of women got together and went to the head of the railroad and said, "We think there ought to be a hospital that will take all comers." I'll bet it wasn't a hard sell because the railroad administration wanted their workers to be healthy. That's how Memorial was birthed. It was intended to be a place for all comers.

Having said that, it wasn't common then for African Americans to be in the hospital. After doing some research, I found that even at the beginning of Roanoke Memorial, they did have African American patients, albeit in the basement. It was a two-story building. They were segregated. I did a lot of research on this, and I'm proud that even from the beginning, we welcomed all comers. That's a legacy of which we're proud. Today, as a not-for-profit, we take all comers, regardless of their ability to pay, their gender, their religion, and certainly the color of their skin.

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[1] Noel C. Taylor (1924-1999) served the city of Roanoke, Virginia, as pastor of High Street Baptist Church, as the first Black member of the City Council and for 17 years as the first Black mayor. [Virginia House of Delegates. House Joint Resolution No. 50: On the Death of Noel Calvin Taylor. (2000). http://leg1.state.va.us/cgi-bin/legp504.exe?001+ful+HJ50ER]

[2] [Sternberg S. Desegregation: The hidden legacy of Medicare. US News & World Report. (2015, July 29). https://www.usnews.com/news/articles/2015/07/30/desegregation-the-hidden-legacy-of-medicare]

GARBER: This would have been before your time as a hospital leader but can you imagine what it would have been like to manage a segregated hospital?

AGEE: It would be hard to imagine – that's not my background at all. We had a really fine Black hospital in town and it was nearby. Memorial ended up buying that hospital and running it later. The ethical dilemma for caregivers is this – if someone showed up in your emergency room or came to your office ill, what did you do? The stories are that we took care of everyone.

You may remember that the polio epidemic started just down the road from here in Wytheville. The name of the hospital was changed to Memorial and Crippled Children's Hospital – the hospital was overrun, overwhelmed, had more patients with polio in the hospital than there were beds. We thought about that a lot during COVID.

GARBER: There is a saying that "all health care is local." In what ways do the local culture and the local circumstances affect the way that health care services are provided in Roanoke today?

AGEE: I've spent a lot of time in the last ten years all over the country. Every day we hear about what somebody else is doing and there's a lot to learn. At the same time, we have to look at – what does our population look like? What are the needs in our region?

We're a regional health system. We care for urban, suburban and very rural. From the Blue Ridge to the Appalachians there is a lot of rural. We have hospitals there. Last evening, I was at one of our smaller hospitals – a 25-bed hospital in a rural area. There is a real sense of community, a real sense of pride. The care is a little different than you would have in a big academic medical center like we have in Roanoke.

It's increasingly common to own an insurance company at the hospital or the health system. We tried that. We lost our shirts. We should have known because we don't have the population mass here to do some of the larger things like own your own insurance company.

I think health care is relatively local. We tend to have an older population that we serve. A lot of our services are related to an older population. We have a lot of chronic illnesses. We've been very involved in value-based care because it made sense to us and it's the right thing, but also our thinking is impacted by serving a rural area. How do we assure services for communities in which there is maybe not a physician, not OB, not pediatrics – small hospitals? How do we provide services there?

We have three helicopters, we have a large ground transport fleet of about 38 ambulances. When you go anyplace else in the state, they don't have that. Trauma centers may have one helicopter or a state helicopter. That's pretty expensive to do. It's not like we get reimbursed very well for that, but it's because our coverage area is so large and there's not a lot of people in between. We serve a fairly rural population, and we have to provide services that make sense for that population.

GARBER: Is it hard to find helicopter pilots?

AGEE: We've been very lucky. One of my favorite things to do is to fly, so I love going on a helicopter. I feel very safe. It's amazing. It's really a flying ICU and it's phenomenal.

GARBER: As we leave this discussion of what it's like in the Roanoke area, past and present, I wonder if you could tell me what the term "New South" means.

AGEE: That refers to having been a train city – a blue collar city. You said a segregated area. We're now pretty sophisticated, bringing in a lot of new industry, a lot of education, very integrated. We have a new way of thinking of ourselves.

GARBER: I'd like to talk about education, both your personal education and then your work in making educational opportunities available for others. What did you do after you graduated from high school?

AGEE: I went to a diploma nursing school for three years at Roanoke Memorial. As soon as I graduated, I started working here at Roanoke Memorial. At that time, we didn't get much college credit so I started going to our local community college full time as well to get credits and then went to the University of Virginia. I graduated from the University of Virginia with a bachelor's degree after that. From there, I went to Emory in Atlanta and received a master's degree, then came back to Roanoke to work.

GARBER: Hospital diploma schools don't exist anymore.

AGEE: There are some.

GARBER: Up until the 1960s, three-quarters of nursing schools were diploma schools. You mentioned that yours was a three-year program. What was it like to go through the diploma program?

AGEE: It was hard. You had to live in the dorm. We had curfew with lights out at nine o'clock. We had a dorm mother. We had a forty-hour work week. We had classes every day. We were in the clinical area from the beginning, which is a distinction and a good one.

It was a full three years. We had four weeks off and the first summer off and then August off that second year, and then you graduated in June. We went a lot longer than if we were at college. There were a lot of expectations and I'm glad that I had that opportunity. It was to some extent supervised, but a lot of the time, you were part of the staff. We had 47 students in our class and we graduated 32. It was a very different time. You couldn't be married. If you got married during school, you either didn't tell or you weren't allowed to finish.

I went here in the '70s, the era of miniskirts. That was a total no-no. Even if it was 95 degrees outside, we'd wear a long raincoat so we could get out of the building, and then have our miniskirts on underneath.

GARBER: Did you have the formal starched nursing caps?

AGEE: Oh, yes. They had a laundry for us. We picked up our uniforms on Sunday evening. The uniforms buttoned with buttonholes with little connectors that you had to put your cuffs on, you had to put all the buttons down the front, and you had a bib, an apron, a starched cap. You would set them up – literally, they were so starched – you put all that together and set it up by your bed so you could hop into it the next day.

GARBER: The National League for Nursing (NLN) and the American Nurses Association (ANA) jointly issued guidelines supporting baccalaureate education. And that was one of the factors that caused the decline of the diploma schools. Why was it decided that this model would not work anymore?

AGEE: A professional nurse is part of a team of professionals – physical therapists, pharmacists, physicians, nurse practitioners, physician assistants. There was a sense of equity among the team that didn't make sense in a diploma program. There was a lot of misunderstanding of the education of a diploma program,

and it began to tilt toward the bachelor's degree as the primary degree. There are still some diploma programs. We got an excellent education. We were prepared to work right afterwards. Our education was all in science and nursing. It wasn't as well-rounded, I think, as a bachelor's degree would now give you. I'm supportive of the migration to a bachelor's degree but I do think we got a really excellent education.

In the middle of COVID, there were times when I thought, why don't we open another diploma program because we need nurses so much. We need nurses who really know how to function. Unfortunately, people who graduate from baccalaureate programs now aren't as prepared to work in the clinical area, especially the inpatient clinical area, so you have nurse internships, you have long orientations. When I graduated, literally the next day, we were running units. I don't know if that was good or bad but you felt competent to do that.

GARBER: There was an advantage to the hospital that had a diploma nursing program in that those graduates would be very loyal to the institution.

AGEE: Yes, you do have a nice pipeline of workers. You have essentially no orientation because they're used to working. You have people who know the values, who know the culture, who can move right into the work environment easily. We try in a way to replicate that because we have a relationship with Radford University. Now we've had our own college, the College of Health Sciences, here for 15 years or so. While we have graduated a few with baccalaureate degrees, they did all their clinical with us, and in some ways we tried to replicate that. We've since merged that college with a state university but are continuing to offer, to the extent possible, clinical education within our facilities.

GARBER: This seems like a good partnership. I saw also that there is a new campus of the Galen College of Nursing coming to Roanoke.

AGEE: Yes, Galen College is a school that HCA has partnered with in multiple places across the country. They just recently opened up a facility here over towards Salem.

GARBER: Does the supply of nurses in a service area affect the ability to hire other types of professionals, particularly physicians?

AGEE: Oh, I think so. Roanoke Memorial is a magnet facility. I'm always impressed when physicians know about a magnet facility. I think that physicians and other health care providers as well want a full-service team. You can't do your work unless you have that team. Nursing is incredibly important. We understood more than ever with COVID what the whole team needs to do.

Physicians used to be taught to be "the captain of the ship." While we talked about teamwork, it was really everybody working in silos. I am impressed with the evolution we've seen in health care, where everyone is working together. It makes a lot of sense, whether it's a nutritionist or a pharmacist, a physician, a nurse – you need to respect and work together so that we do the best we can for those that we serve.

GARBER: What is a magnet facility?

AGEE: It's a designation from a nursing association to recognize hospitals that go the extra mile with nursing. It involves a lot of things – nursing research, nursing governance, the importance of nursing in an organization – and it also looks for a team approach and the recognition and respect in an organization. It's a very rigorous process to become certified as a magnet facility. We're very proud of Roanoke Memorial having

been certified for the fourth time just recently.[3]

GARBER: It's like the Baldrige award except that it applies just to nursing?

AGEE: That's right. That's a good analogy.

GARBER: When you were in school, were you involved in political activism? This was a contentious time for the country but perhaps there was not so much activism at the hospital diploma schools generally.

AGEE: I was an officer in the Student Nurses Association of Virginia. We had a lot of conversation about the Vietnam War. They were considering drafting nurses and we were dead set against that. We did go to Washington to express our views. We may have been a diploma school, but we were still engaged and involved in various activities.

GARBER: When did you meet your husband?

AGEE: My husband and I graduated from the same high school in the same year so we knew each other in school. Later, he was in the House of Delegates in Virginia. We had just opened up the Cancer Center and, at that time, the House of Delegates and the Senators did tours. They were doing a tour of Roanoke and I was on the host committee. When Steve came by the Cancer Center on the tour, we remembered each other. A couple weeks later, he called and asked me out.

GARBER: He is an eminent attorney and judge. If I have it correctly, he is a judge in the U.S. Court of Appeals for the Fourth Circuit, having been appointed by President George W. Bush?

AGEE: That's right.

GARBER: As a couple with a lot of accomplishments between the two of you, do you find that you have social roles in each other's sphere? Do you have social responsibilities as the wife of a justice and does he have responsibilities as the husband of a CEO?

AGEE: He would probably tell you yes. We complement and support each other well but we have our own separate worlds. He was a lawyer, was in the House of Delegates, then was a justice in the Supreme Court of Virginia then became a judge on the Fourth Circuit. We've had very busy lives – I was on a trajectory in administration and then as a CEO. We're respectful of each other's time and are complementary but we don't spend as much time in each other's world as you might think.

GARBER: You got your first job at Roanoke Memorial Hospital because of your relationship with the diploma school. You graduated and there was a job available.

AGEE: There's been a shortage of nurses since I was a student. I worked three-to-eleven. I loved that shift – loved the nursing care during three-to-eleven, at the time only two of my friends, one nursing supervisor,

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[3] Magnet facilities are certified by the American Nurses Credentialing Center, a subsidiary of the American Nurses Association. [American Nurses Credentialing Center. ANCC Magnet Recognition Program. https://www.nursingworld.org/ancc/about-ancc/]

who was a Filipino nurse, were RNs in the hospital for evening shift except in the ICUs. Can you imagine? So, there were three of us RNs, and other than two nurses in the ICU, we were the only RNs in the hospital. That's hard for me to believe now. So yes, I got a job right after I finished school.

GARBER: What happens during the three-to-eleven shift that makes it interesting?

AGEE: It was a quieter time than during the day. You got to know your patients well. You made rounds, you visited with your patients. At that time, you gave all the medication, so you spent quality time with your patients. You gave treatments. It was also when families were visiting, so you got to know the family. You got to see the person as a whole person. I loved that kind of nursing care.

GARBER: The beginning of your career overlapped the end of the career of long-time administrator Ham Flannagan – William Hamilton Flannagan.[4] He served there for over 30 years. Do you have memories of him, his leadership style and the way he shaped the early development of the health system?

AGEE: Mr. Flannagan was a big personality. He took Roanoke Memorial, this little hospital on the hill, and brought it out of financial trouble, recruited physicians, opened up ORs and in 1972 opened a 200-bed addition that was all private rooms – unique for the time.

He had an amazing vision for high quality care and for doing the right thing for all employees. He loved the employees. He made rounds every day throughout the hospital. The other administrators also made rounds but he was first. He was here at 5:30 or 6 in the morning making rounds. Everybody was expected to make rounds every day. He had a great relationship with the business community, was an activist in health care. I remember him fondly.

GARBER: What does it look like when a CEO or another executive from the hospital leadership team makes rounds?

AGEE: Interesting question, because I make rounds frequently, and I expect all of the administration to make rounds frequently. We're mostly talking to the staff, asking them how they're doing, do they have any needs, how the patients are doing. We're also looking at ceiling tiles and the floor and cleanliness. We're looking for issues that may be coming up. We're very visible – we walk the talk. I feel comfortable going into patient rooms, asking patients how they're doing, if that's okay. I'll always ask staff first. You don't just want to pop into a patient's room.

I usually make connections, make a list of things that might be needed. Do we need cubbies on the oncology unit, when patients are there for induction therapy? In our system, we have seven hospitals and we have about 200 other sites, physician offices and home health agencies. I make rounds in multiple places.

Some of the old-timers will say, "You ought to be making rounds like Mr. Flannagan did," and I think to myself, well, he had a 300-bed hospital and maybe a couple thousand employees. We have 13,500 employees now in a pretty big system. It's not like when Mr. Flannagan was here but the important thing is the value of our employees. They're the ones who make it happen, so how do you support your staff and your physicians

[4] William Hamilton (Ham) Flannagan, Sr. (1920-2010) served as president of Carilion Roanoke Memorial Hospital for 32 years prior to his retirement in 1986. [William Hamilton Flannagan Sr. Roanoke Times. (2010, May 5). https://www.legacy.com/us/obituaries/roanoke/name/william-flannagan-obituary?id=27903355]

so they can do that magical work that is taking care of patients?

GARBER: The hospital, Roanoke Memorial, became the flagship of a system. As you mentioned, there are other hospitals, many located out in rural areas. But as the system was being put together, initially, I believe, the hospitals were contract-managed. Would you reflect on the advantages and disadvantages of a contract-management approach versus merger, for example, as a way of building a system.

AGEE: Tom Robertson,[5] who became the CEO after Mr. Flannagan retired, was responsible for creating the system, the horizontal integration, if you will. The first hospital to join us was Franklin Memorial Hospital.[6] We managed other hospitals in Southwest Virginia.

The difference is a little bit hands-off. While you're managing them, there's not a whole integration. There are some pretty important distinctions that you can do legally. We have a group purchasing company that we belong to. The managed hospitals couldn't necessarily belong. Over time, we migrated to eliminating contract management and having full ownership.

Roanoke Memorial Hospital and Community Hospital of Roanoke Valley were about a mile apart – pretty much shared the same medical staff. Physicians that were at one would have privileges at the other. When Tom Robertson was the CEO, those two hospitals merged. We were the first system in the country that the Justice Department sued. There was another one in Rockford, Illinois, which got sued shortly thereafter. After protracted consideration and a three-week trial, we won. That's how two big hospitals came together to create the system we now call Carilion.[7]

GARBER: You've mentioned horizontal integration. How does this differ from vertical integration?

AGEE: A lot of places are vertically integrated. They have hospitals, they have other businesses, they have insurance companies. Horizontal integration means an accumulation of like things. The terms are a bit obsolete because we do both. We're both vertically and horizontally integrated and you're seeing more and more of that with more merger and acquisition activity and, in some ways, going the other direction. For most of my career it was felt that you had to own everything. You had to have everything right there. Over time we've come to realize that others can do things better. Whether it's IT services or housekeeping, it's okay to lease out services, to contract for services. We're seeing a change in how we provide services, getting to some extent to what only we can do and then looking for others to help with things only they do.

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[5] Thomas L. Robertson served for 32 years at Carilion Health System, including 15 years as President/CEO prior to his retirement in 2001. [Carilion Clinic now accepting applications for nursing scholarships. Roanoke Times. (2019, June 6.) https://roanoke.com/community/swoco/carilion-clinic-now-accepting-applications-for-scholarships/article_1765521b-39ee-59f7-b329-0056a4181d0a.html]

[6] Carilion Franklin Memorial Hospital is located in Rocky Mount, Virginia, about 20 miles south of Roanoke. [https://www.carilionclinic.org/locations/carilion-franklin-memorial-hospital]

[7] Beveridge D. VA hospital merger battle could set national precedent. Washington Post. (1988, June 13). https://www.washingtonpost.com/archive/business/1988/06/13/va-hospital-merger-battle-could-set-national-precedent/c0887fa4-31cd-4be3-84d8-a338f55baf2c/ Also, Court upholds ruling that antitrust laws apply to non-profit hospitals. UPI Archives. (1990, October 15). https://www.upi.com/Archives/1990/10/15/Court-upholds-ruling-that-antitrust-laws-apply-to-non-profit-hospitals/7279655963200/]

GARBER: A "stick to your knitting" approach.

AGEE: Yes, that's right, "stick to your knitting" – we use that phrase here.

GARBER: Another phrase that's been used over the years when looking at the health care delivery system is the "hub-and-spoke model." What does that mean?

AGEE: The hub-and-spoke is a traditional way of serving the tertiary care facility, the place that's doing the higher-end activities. Other hospitals refer in. That's how this system was built, a hub-and-spoke. Whether these were contracted facilities or owned facilities, the idea was that you've got a wheel and that you've got migration between the referral sites. That's changing now because hospitals aren't the only referral sites – so is an emergency room to the tertiary or to the quaternary service – instead, it's primary care physicians and other physicians.

We bought a large primary care group in the early '90s. That became expensive for a variety of reasons. A lot of people got rid of their primary care practices but we kept ours and in some ways that's our secret sauce now because we have this large primary care group that helps to refer in to our higher-end services.

GARBER: What makes the hub-and-spoke model work is that the referrals go in to the tertiary care center but then the patients return out to the referring physicians. That's a key point – a big deal.

AGEE: That's right, that's a big deal.

GARBER: I'd like to ask about your experiences related to oncology nursing and how that leads to the new cancer center. You had worked for Dr. Charles Crockett[8] early on in your clinical career to secure funding from the National Cancer Institute to develop a community hospital oncology program. What were the objectives of the program? Is it still around?

AGEE: In the late '70s, early '80s, there were very few medical oncologists who weren't just with a comprehensive cancer center or university setting. We had cobalt therapy early on but we didn't do much in terms of medical oncology. Dr. Crockett, who was a hematologist, had a vision involved with graduate medical education, but he was also instrumental in us having more community cancer care. I was also interested in community cancer care.

We recruited a medical oncologist who came from the National Cancer Institute and established a practice here. We applied for this grant from the National Institutes of Health and the National Cancer Institute, looking at developing cancer programs in a community that wasn't a comprehensive cancer center. Comprehensive cancer centers are places like Memorial Sloan Kettering or MD Anderson.[9] We won that contract. There were only fourteen in the country and I became the administrator of the contract. When we would go a quarterly meeting of the administrators – someone would say, "I'm from Chicago," "I'm from L.A."

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[8] Charles L. Crockett, Jr., M.D., (1922-2001), a hematologist, served for over 30 years as director of medical education at Roanoke Memorial Hospital. [Dr. Charles Lucian Crockett. FindaGrave. https://www.findagrave.com/memorial/83679553/charles-lucian-crockett]

[9] Memorial Sloan-Kettering Cancer Center is located in New York City and University of Texas M.D. Anderson Cancer Center is in Houston.

and I'd say, "I'm from Roanoke!" Everybody would go, "Where's that?" It was a pretty big deal.

There were four main hospitals in the Roanoke area, including a V.A. and we pulled people together to look at oncology services. How could we have similar services? We created oncology units and the inpatient nursing units, certifying the nurses. We created a hospice unit in each of the hospitals. It was looking at how to enhance cancer care in a community. There were three iterations of that grant. We won all three, and by the end of that time, some eight years later, community cancer care was much more common across the country.

How does that relate to today? We built an avant-garde cancer center forty years ago with gardens in each of the radiation therapy rooms and skylights – which were unusual because radiation therapy was usually located underground to protect against radiation scatter. We had people coming from all over the world to look at our cancer center. We've grown many cancer services here but we didn't have a new building for radiation therapy and infusion therapy.

Capital isn't always easy to come by. We've needed a variety of capital improvements here. We had a long-term plan for replacing the cancer center but we needed to do a variety of other things first and it seemed like that this was going to take a long time. My husband and I started a campaign to develop a new cancer center and that campaign is going very well.

Interesting story – and this started with Mr. Flannagan. When Mr. Flannagan came, he promised the community that they would figure out how to get the hospital out of financial trouble but that they wouldn't ask the community for money. That became a standard for us for a long time. When I became the CEO, I was so used to that idea that I didn't realize that philanthropy was common in hospitals. As I started talking to colleagues, I found we were very much alone in not having philanthropy. Carilion started a foundation to accept funds and the cancer campaign is two years old now. We've raised about $54 million heading towards a $100 million campaign. I'm really proud of that. We will break ground on a new cancer center this fall.

GARBER: Did the pandemic slow this process down?

AGEE: It didn't slow the fundraising down. As a matter of fact, we started during the pandemic. It wasn't optimal to do a campaign during the pandemic but we pushed through that. We had a variety of building projects, including a new cardiovascular institute and a much-enlarged emergency department, a new tower at Roanoke Memorial, a variety of other smaller capital projects. Some of those were slowed a bit. Thankfully, we bought a lot of the supplies we needed for our large project just before the pandemic, hedging that we would just go ahead and buy those things. I remember thinking, "What are we thinking? We don't need all these supplies right now." I'm awfully glad we did because we haven't had the cost overruns or delays in the big project at Roanoke Memorial.

GARBER: Where did you put all those supplies?

AGEE: We bought a warehouse and we have an open field so the things that can be outside are on that open field.

GARBER: You were speaking about Mr. Flannagan and his promise to the community that there would not be fundraising campaigns – how did he accomplish a turnaround at the hospital?

AGEE: Good question. I don't know because I wasn't here then but I suspect that he did things that were the usual. He recruited more physicians, they did more surgery, they tightened the belt with expense

control. Remember, too, that's when Medicare happened. Despite the great hue and cry at that time that Medicare was going to ruin hospitals and that it might cause physician offices to not get paid, it was a blessing to the hospital. That was cost-plus reimbursement. I would love to have that now – where you were paid for what it cost you, plus a little more. Today, Medicare and Medicaid pay less than what it costs you.

The other thing that happened at the time was the Hill-Burton Act.[10] There were resources for new buildings, for capital management that I know the predecessor of Carilion took advantage of. Our rehab facility that built the tower that I mentioned was built with Hill-Burton funds.

GARBER: What was the intent of the Hill-Burton program? Was it good legislation?

AGEE: At least for us, we wouldn't have a lot of the capital projects that are very important to the care that is provided for our communities absent the Hill-Burton funds.

GARBER: Another federal initiative that had a big impact on the state and local provision of health services was certificate of need.[11] What effect has the CON program had on health providers in Virginia?

AGEE: We believe that certificate of need done well provides a healthy perspective wherein you look at need. While it's an onerous process and a bit of a "Mother, may I?" – you have to prove your need. It prevents unmitigated growth in profitable services. It levels the playing field, for those entities that have need but perhaps don't have the financial wherewithal versus those that have a lot of financial wherewithal. We think certificate of need actually helps decrease the cost of care and therefore is a value to the citizens of Virginia.

GARBER: You were board chair of the American Hospital Association in 2018. Thank you for your service! What were the significant issues that the board was working on during your time as chair?

AGEE: It was my great honor and privilege to be a part of the American Hospital Association's board and leadership. I will forever consider that as one of my highest honors. It was amazing. You got to see all sorts of hospitals, what their needs were and what people were thinking. We are all devoted to serving a population and providing high quality care. It's heart-warming to being with the folks who are involved in health care across the country.

When I worked with the American Hospital Association my personal passion and what we were focused on was value-based care – trying to understand what that means. Why do we say that health care is

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[10] The Hospital Survey and Construction Act (P.L. 79-725), enacted in 1946, is more commonly known as the Hill-Burton Act after sponsoring senators Lister Hill, D-Ala., and Harold Burton, R-Ohio. The legislation provided capital funding to help modernize hospitals nationwide in exchange for the provision of uncompensated care in the future. Between 1946 and 1997, when funding ended, $6.1 billion in grants and loans were made. [U.S. Health Resources & Services Administration. Hill-Burton Facilities Compliance. (2022, March). https://www.hrsa.gov/get-health-care/affordable/hill-burton/compliance]

[11] Certificate of need programs were established in most states pursuant to requirements of the 1974 National Health Planning and Resources Development Act (P.L. 93-641), which was passed in 1974. [American Health Planning Association. CON Overview. (2023). http://www.ahpanet.org/copnahpa.html]

expensive in America and are we getting value from our care?[12]

We took a deep dive into understanding value and from whose perspective. It's one thing to think about hospitals getting paid. There is a value in that. There is the perspective of, are we frustrated because pharmaceuticals cost too much, because insurance agencies cost too much, because we're not getting reimbursed like we feel like we should. Is it related to the government payers?

We began to think about what does this mean to a consumer trying to understand out-of-pocket cost. Backing into that, how do we provide the best value for care? That was the issue that we spent an awful lot of time on – still do – trying to reorganize care so that we were doing more than sick care. What we were doing was wellness. We were providing value so that we could help people not spend their precious dollars on sick care.

GARBER: It's nice that your personal passion lined up with what you were able to work on during your board service at AHA. Did you have latitude in influencing this topic for study?

AGEE: Yes. The Chair-Elect could pick their project. There was growing concern about the cost of health care in America. That was important to me, and that trajectory then happened. I was able to take us to what I thought we ought to be working on. There was no pushback, of course, because that also was what many others were considering, and the leadership, especially Rick Pollack[13] and others at the American Hospital Association were very concerned about.

GARBER: It must have been a terrific experience for you to have that opportunity to concentrate on studying something you cared so much about. Still, it was hard because of the travel and you had to leave your organization in good hands. It was a burden in some ways for you and your staff. Why should a busy executive consider board service?

AGEE: It was a burden and a joy. I don't think you can appreciate how much time it takes until you're in it. There was that. My board was fully supportive that I would be going on to the board of the AHA. My direct reports and EVPs were excited and ready. My husband was supportive. The American Hospital Association does an incredible job of being inclusive with family because they understand the amount of travel that's involved.

It really is an honor to be involved at that level. It is what I would encourage anybody to do because you get so much more than you give. Getting on an airplane is not always fun but what's valuable is the opportunity to engage in meaningful ways with people from all across the country. The AHA is organized such

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[12] Pasia N. Q&A w/Carilion Clinic president and CEO Nancy Howell Agee on moving towards value-based care. State of Reform. (October 7, 2021). [https://stateofreform.com/news/virginia/2021/10/qa-w-carilion-clinic-president-and-ceo-nancy-howell-agee-on-moving-towards-value-based-care/]

[13] Richard J. Pollack has served as president and CEO of the American Hospital Association since 2015. Previously he served as executive vice president at AHA since 1991. Previously, he served for over 20 years as executive vice president for advocacy and public policy. [https://www.aha.org/bios/2021-09-02-richard-j-pollack]

that you have regional meetings quarterly.[14] As a member of the board, you are expected to go to those regional meetings. You can choose, so you maybe do a couple at a time. Nothing is more powerful than seeing the questions, the concerns, the issues, the opportunities and the solutions that are happening throughout the regions and being able to bring that back to your home organization, too.

It's an opportunity for you to shape health care at the national level and to bring back information. Sometimes I think our staff were thinking, "Don't go to any more meetings!" because from there I was sending back emails, "Have we tried this? Have we tried that? Take a look at this. This is way cool." There was a lot to be gained from that.

GARBER: What is the role of the American Hospital Association today? How can the AHA add value to member hospitals?

AGEE: The important role that the American Hospital Association has is that of advocacy. That is its primary purpose, to help us navigate, particularly at the national level, federal legislation that can be very supportive to consumers, to patients and to hospitals. I think the American Hospital Association is amazing in its efforts to understand what's happening across the field, to get ahead of where the field is going, to help shape that and to help protect and encourage the field.

GARBER: Is the COVID pandemic over?

AGEE: It depends on your definition. Is COVID still with us? Absolutely. Will COVID be with us for a long time to come? I think unquestionably. Are we better prepared now to care for infectious disease? Not so sure. COVID is a set of mutated viruses. Much like other viral disease, I don't think there is going to be an ending to it. It's going to be part of our future ecosystem.

Maybe the saddest part of the pandemic for me was how much information was either withheld or incorrect. Now that we're coming out of that part of the pandemic and learning more about things that perhaps should have been known or shared at the time, it's regrettable and it's having a profound impact on consumers' trust in science, in health care and in the government.

Going forward, we need integrity and we need to respect people's ability to understand confusing and sometimes disconcerting information. In preparation, we'll do a better job now understanding what our supply chain is and where it is not and bringing things closer to home. I think that the pandemic helped us see how to do things quickly. I hope we don't lose that because we made a lot of decisions and a lot of things happened very quickly. We were able to innovate and work together in ways that we perhaps had never done before. Whether it's artificial intelligence or machine learning or telehealth or moving to the ambulatory space or moving to care at home – all those things were happening right before the pandemic but certainly accelerated during the pandemic.

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[14] Regional Advisory Boards, later renamed Regional Policy Boards (RPBs), were established by the American Hospital Association in 1968 in each of the nine regions of the country to help foster discussion of issues and to advise AHA staff and board members. [American Hospital Association. Regional Advisory *(now Policy)* Boards. https://www.aha.org/about/history]

I hope we never have another pandemic like this one. We probably will have something and hopefully we will be better able to take care of it next time.

GARBER: What has Carilion done well during the pandemic?

AGEE: We've done so many things well. I can't even describe how proud I am of our folks. We became the public health department. We set up vaccine clinics for thousands of people. We set up all the activity. We were the referral source. We got negative pressure rooms in our rural hospitals.

Perhaps what I'm most proud of has been the resilience of our staff. Despite what they've been facing every day, they've had the courage to come back and deal with it again and again. It's been hard and has taken a toll. We've had turnover like a lot of places, but in general, person after person has given me feedback like, "We got this. We're going to get through it."

GARBER: Let's talk about governance. How does the board of a stand-alone hospital differ from the governance structure of a health system?

AGEE: If you are the fiduciary, whether for a stand-alone hospital or a system, you have responsibility for financial success, for regulatory, credentialing, quality of care.

Small stand-alone hospitals have a deep connection to their communities. That's also true of our hospitals in our smaller communities. They all have their own boards. They're not fiduciary but they're very engaged in the community and in identifying community needs, serving as, I suppose, cheerleaders for the hospitals.

In a small hospital it's hard to have the resources that you need. A system usually has more resources and can share between and among their services like purchasing, the legal department, human resources, corporate secretary support to governance. Whether you're on a small board or a large board, it's an awesome responsibility. It takes a lot of effort to understand our language in health care because most of the board members are not in health care, to try to understand our crazy financial reimbursement system. It's hard work. I have tremendous respect for people who are willing to serve on hospital boards, big or small.

GARBER: What are the characteristics of a good board member and of a good board chair?

AGEE: The important thing about being on a board is that you're not management. The important thing about being a CEO is that you're not governance. Your roles are different. A good board member doesn't try to get into the weeds but keeps things at a higher level and pays attention to strategy, vision and bringing forward what the communities need. A good board and a good management team together have a lot of conversation, strategy, discussion. It's not just listening to reports.

Similarly, a good board chair is the top advisor to the CEO – helpful in asking the right questions, serving in a way to identify concerns, being sure that you're paying attention to the important things. My board chair is a phenomenal colleague. He has high expectations but he never fails to say, "Thank you." He is wonderful at being encouraging. I think good board members and a good board chair do their homework, come prepared for meetings, ask good questions. I'm lucky that I have a wonderful board.

GARBER: Who is your board chair?

AGEE: His name is James Hartley.[15] He's an attorney. He lived in one of our smaller communities and was on the board of one of our smaller hospitals when he came to the fiduciary. He's been on our fiduciary board for fifteen years or so and has been the chair for about ten years.

GARBER: Have you seen any changes in hospital governing boards over the course of your career, as far as the organization or structure?

AGEE: When I came back after earning my master's degree, I was asked to head up an educational program for the board. I went into a board meeting at the request of the administrator and they were all men. They said, "Are you in the wrong meeting? You don't belong here, girlie." Yes, we've seen some changes since then.

The board was a lot more social. The board meeting was usually over a meal. It seemed not as intense, except when big concerns arrived. Our boards today have a lot to think about and it's a big responsibility. You go deep into a lot of the regulatory and financial and quality activities and concerns. It's hard work to be on any board these days.

GARBER: There was an article published in *JAMA Network Open*[16] just a couple of years ago that found that roughly fifteen percent of health system CEOs were women and, as far as the board chairs, it was slightly higher. What does this relatively low proportion of women who are leaders have on the services offered or key leadership decisions in hospitals?

AGEE: If you look at Fortune 500 companies, the number of female CEOs is about the same as in health care so we've got work to do. Traditionally, nurses were women, physicians were men. There's been a sea change in that, but to have the experience to move into administrative roles is more a phenomenon of the last twenty years than it was of the last forty years. You will start seeing more women in key roles – Chief Financial Officer, Chief Operating Officer, Chief Executive Officer – but it's still a work in progress.

I think there are differences between men and women but not for good leaders. Having a clinical background, I understand what it means to be at a patient's bedside. I understand what it means for a patient to get bad news. Or good news – to have a baby. I bring that forward to every decision. It's who I am. That matters not just because I have a clinical background, but also we tend to be more comfortable being inclusive, expressing passion and joy and love. This is a human business that we're in. Things like courage and passion and joy and love are what we're about – and healing and hope. It's not that men don't have those same feelings and can't express them, but in general, it seems more comfortable and common for women to do so. And I think we bring that into our decision-making.

We're also good at working in teams. Teamwork is what we should be doing. Everybody has value

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[15] James A. Hartley, Esq., began his board service at Giles Memorial Hospital (Pearisburg, VA) in 1980 and currently serves as chair of the Carilion Clinic Board of Directors. [Carilion Clinic. Welcome from James Hartley. (2019). https://vimeo.com/342363744]

[16] Odei MC, Seldon C, Fernandez M. Representation of women in the leadership structure of the US health care system. JAMA Network Open. (2021, November 29). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786684]

here, and how do we bring the team together? We're quintessential and stronger as a team than we are as one.

GARBER: Do you have any particular stressbusters or spiritual practices that have sustained you during these difficult past few pandemic years?

AGEE: I love to read. I love to walk. Most importantly, I had two grandchildren during this period. I have the great joy of having a husband, a son, a daughter-in-law, who I think of as a daughter, and a little grandson and a little granddaughter. They're all just amazing. They have sustained me. That's why we do what we do.

GARBER: Do you have any other concluding thoughts?

AGEE: The story of my life is that I have been from birth shown great love and, hopefully, I've been able to give back. I am privileged to do what I do and to have the support of many dear friends, of a wonderful family and in particular the great people that I work with here at Carilion as well as across the country.

EDUCATIONAL & PROFESSIONAL CHRONOLOGY

1952	Born in Roanoke, Virginia	
1979	University of Virginia (Charlottesville)	
	Bachelor of Science: Nursing	
1980	Emory University (Atlanta)	
	MSN	
1980-1996	Carilion Roanoke Memorial Hospital	
	1980-1981	Clinical Nurse Specialist
	1981-1984	Oncology Practice Administrator
	1984-1994	Director, Health Education
	1993-1996	Assistant Vice President
1999	Northwestern University Kellogg School of Management	
	Executive semester	
1996-present	Carilion Health System / Carilion Clinic (Roanoke, Virginia)	
	1996-2000	Vice President, Medical Education, Carilion Health System
	2001-2011	Chief Operating Officer/Executive Vice President, Carilion Health System
	2011-present	President & CEO, Carilion Clinic
2018-present	Virginia Tech Carilion School of Medicine (Roanoke, Virginia)	
	Adjunct Professor	

2019-2022 Griffith University (Queensland, Australia)

Adjunct Professor

SELECTED MEMBERSHIPS

American Cancer Society (national)

Member, Advisory Group on Volunteer Involvement

Member, Medical Affairs

American Cancer Society (Roanoke Valley unit)

Member, Board

American Cancer Society (Virginia division)

Member, Board of Directors

American College of Healthcare Executives

Member

American Hospital Association

Chair, Board

Chair, Coalition to Protect America's Health Care

Liaison, The Future of Rural Health Care Task Force

Member, Committee on Nominations

Member, Committee on Strategic Innovation

Member, Committee on Health Strategy and Innovation

Member, Executive Committee

Member, Future of Rural Health Care Task Force

Member, Health Care Systems Council

Member, Operations Committee

Member, Regional Policy Board

American National Bank & Trust

Member, Board of Directors

Member, Capital Management Committee

Member, Corporate Governance Committee

Association of Community Cancer Centers

Member, Board of Directors

Center for Medical Interoperability

Member, Board of Directors

Governor's Advisory Council on Revenue Estimates

Member

GOVirginia

Chair

Vice Chair

GOVirginia Foundation

Member

Health Alliance

Member

Health Evolution Forum

Co-Chair, Committee on Digital Health and App Experience

Founding Senior Fellow

Healthcare Realty Trust, Inc.

Member, Audit Committee

Member, Board of Directors

Hometown BankShares Corp. / HomeTown Bank

Member, Board of Directors

Member, Investment Committee

Member, Shareholder & Community Relations Committee

Hospice Association of American Hospital Association

Member, Board of Directors

The Joint Commission

Chair, Final Review and Appeal Committee

Chair, Standards & Survey Procedures Committee

Member, Board of Commissioners

Member, Strategic Issues Work Group

Mytonomy, Inc.

Chair, Board of Directors

National Academy of Medicine

Clinician Well-Being Co-Lead, Implementation Work Group

National Association of Corporate Directors Certification

Fellow

Radford University

Vice Rector, Board of Visitors

RGC Resources, Inc.

Member, Board of Directors

Chair, Compensation Committee

Member, Governance and Nominating Committee

Rockingham Group Insurance

Member, Board of Directors

Member, Finance Committee

Scottsdale Institute

Member, Board of Directors

Solstas Lab

Member, Board of Directors

VA Ready

Member, Board of Directors

Virginia Business Council

Chair

Virginia Business Higher Education Council

Member, Board of Directors

Treasurer

Vice Chair

Virginia Chamber of Commerce

Member, Blueprint Virginia 2030 Steering Committee

Virginia Economic Development Partnership

Member, Rural Virginia Action and Legislation and Policy

Voting Member

Virginia Foundation for Independent Colleges

Chair

Member, Board of Trustees

Member, Executive Committee

Virginia Governor Glenn Youngkin's Medical Advisory Team

Member

Virginia Hospital & Healthcare Association

Chair, Board of Directors

Secretary/Treasurer

Virginia Tech Carilion School of Medicine

Member, Academic Committee

Member, Board of Directors

Member, Finance Committee

Virginia Tech Foundation

Member, Board of Directors

Member, Development Committee

Vizient Health Care Executive Forum

Chair

Wall Street Journal

Member, Council of CEOs

SELECTED HONORS & AWARDS

1976 Miss Hope of Virginia, American Cancer Society

1977 Outstanding Nurse, Virginia Nurses Association District 2

1980 Sigma Theta Tau (National nursing honorary society)

1985 Outstanding Young Woman of the Year, Jaycees of Roanoke Valley

1986 to 1991 Certification, Oncology Nursing Society

2008 Meritorious Service, American Cancer Society Virginia Division

2008 Silver Hope Award, Multiple Sclerosis Society, Blue Ridge Chapter

2012 Hall of Fame, March of Dimes

2012 Paladin Award, Carilion Clinic (award for quality)

2013 Ann Fralin Award, The Taubman Museum of Art

2015 Doctor of Humane Letters, *Hon. Caus.*, Jefferson College in Health Sciences (Roanoke, Virginia)

2015 Doctor of Humane Letters, *Hon. Caus.*, Roanoke College (Salem, Virginia)

2015 50 Most Influential Virginians, *Virginia Business* (also 2016, 2017, 2018, 2019, 2020, 2021)

2015 Outstanding Alumni, University of Virginia

2016 100 Great Leaders in Healthcare, *Becker's* (also 2017, 2018, 2019)

2016 100 Most Influential People in Healthcare, *Modern Healthcare* (also 2017, 2018, 2019)

2017 Top 25 Women Leaders, *Modern Healthcare* (also 2019)

2017 Business Person of the Year, *Virginia Business*

2018 Gail L. Warden Leadership Excellence Award

2018 Key to the City of Roanoke (Virginia)

2020 Distinguished Alumnae Award, University of Virginia Maxine Platzer Lynn Women's Center

2020 Distinguished Nursing Achievement Award, Emory School of Nursing, Nurses Alumni Association

2020 Virginia 500 Power List, *Virginia Business*

2021 Cabell Brand Hope Award, Total Action for Progress

2021 Top 25 Women Leaders' Luminary Award, *Modern Healthcare*

2022 Doctor of Humanities and Letters, *Hon. Caus.*, Virginia College of Osteopathic Medicine (Blacksburg, VA)

2022 50 Most Influential Clinical Executives, *Modern Healthcare*

2022 Women in Leadership Award, *Virginia Business*

SELECTED PUBLICATIONS

Agee NH. A Proposed Clinical Cancer Program of Southwest Virginia: A Multi-Hospital Consortium Approach to the Development of a Clinical Oncology Program in the Roanoke Valley. 1979. [Contract submitted to the National Cancer Institute; approved and funded]

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INDEX