One Impact

Coming together, one community at a time.

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One Impact:
Looking at Vital Conditions from a Different Lens

Governance Institute faculty member Kevin Barnett, Dr.P.H., M.P.H., M.C.P., of the Center to Advance Community Health and Equity at the Public Health Institute, recently spoke with Nancy Agee, CEO Emeritus, and Shirley Holland, Vice President of Planning and Community Development at Carilion Clinic, as part of our ongoing One Impact campaign to improve the financial health of patients and communities. The following article features highlights from their conversation.

This article is part of a series of interviews we have conducted with executive leaders from hospitals and health systems who have demonstrated both courage and a commitment to better serve our communities and our nation. In this troubling time for the healthcare sector, there are a growing number of observers who have concluded that there is a lack of internal will to make necessary changes to proactively address improving the health of our communities. We're looking to leaders such as Nancy Agee and Shirley Holland to help us chart a path forward.

Kevin Barnett (KB): *When we launched this inquiry, we sought to more systematically document how hospitals across the country were addressing the social determinants of health, what are now increasingly referred to as vital conditions. In the 20th century, hospitals focused primarily on the delivery of clinical services, but there has been growing attention, particularly among non-profit hospitals, to more proactive efforts to address the drivers of poor health. While our progress has been limited to date, policy initiatives to move towards risk-based payment offer at least the potential to reward both providers and payers for reducing the demand for costly preventable clinical services.*

Then we were hit by the COVID pandemic. It both exposed us to the profound inequities in our communities and created immense financial and workforce challenges, particularly for hospitals and health systems. If that weren't enough, these institutions face growing public scrutiny about their relative commitment to serve those with financial challenges in our country. Given these dynamics, we decided to hold a number of conversations with the executive leadership of select large national systems, regional health systems, standalone rural-serving hospitals, and critical access hospitals to better capture how you are grappling with these issues, and how do we move forward from here.

Nancy Agee (NA): You've captured what we're feeling and what we're faced with, and I appreciate the inquiry.

Nancy Howell Agee is Chief Executive Officer Emeritus of Carilion Clinic, a nearly $2 billion not-for-profit integrated health system headquartered in Roanoke, Virginia, serving more than 1 million people in Virginia and West Virginia. She retired as CEO in fall 2024 and will continue as CEO Emeritus through September 2025.

Before becoming CEO in 2011, Ms. Agee served as Executive Vice President and COO. During her tenure as COO, she co-led Carilion's reorganization from a collection of hospitals to a fully integrated, physician-led clinic. The reorganization resulted in a partnership with Virginia Tech to create an allopathic medical school and research institute.

Shirley Holland is Vice President of Planning and Community Development at Carilion. She has been with Carilion Clinic since the mid-1980s and spearheaded the development of the Carilion brand for many key programs and community health investments including assessing the community's health, developing health improvement plans, forming new partnerships and coalitions, improving access to mental health services, and co-creating HeartNet of the Virginias, a successful cardiac referral and transfer program.

Carilion Clinic includes seven hospitals ranging from the third largest in Virginia to mid-sized community and small rural or critical access hospitals. Carilion also operates complementary business lines, including home health, imaging services, pharmacies, and freestanding surgical clinics; and has a large physician group with more than 1,000 employed physicians.

KB: *Can you talk a little bit about your thinking and vision of the optimal role for Carilion in addressing the drivers of poor health in local communities?*

NA: It's a good question. It is so much a part of our DNA that it's hard to parse it out. In the largest sense, we view ourselves as a not-for-profit that is owned by the community. We talk about that all the time. We don't have stockholders.

Carilion is based in an urban area with a large academic medical center, with the third largest hospital in Virginia and all the usual services you would expect from a large tertiary, quaternary medical center. We also have urban issues such as limits to access, violence, poverty, and so on. We also have two critical access hospitals, four rural hospitals, and one large community hospital. There is significant diversity in terms of our geography and the communities we serve.

We value deep engagement in the community. Both our administrative leaders and many of our clinicians are engaged in community service, whether it's the free clinics, water authority, or the local Rotary. These are important vehicles, not just to give back but to gain information about community needs.

We started doing community health assessments many years before they were required—one of our core values is collaboration. That said, not only do I think we shouldn't do everything; I also think it's patronizing to others to imagine that we have all the answers. There are so many other community resources that must be leveraged.

So how do we collaborate and partner? To improve health, we need to pull information together as we design care, set strategy, and we roll that all the way up to the board. Each of our hospitals has a board and takes strategic direction, both from management and board members.

KB: *Say more about your governance structure, in terms of board composition and the relationship between hospital boards and your system board. I assume you have a fiduciary board and the hospital boards play an advisory role.*

NA: Yes, that's exactly right. Each of the hospitals has a community board and their core responsibility is credentialing and quality. But it doesn't stop there with the community boards because they're deeply involved in the community. They are leaders in their communities. They are the cheerleaders for the hospital and they serve as the conduit between the community and the hospital.

The fiduciary board has overarching responsibility, but it is essentially a representative board. In almost every case, each of the hospital board chairs serve on the fiduciary board, and all of our community hospitals and the academic medical center have terms. Board members serve three, three-year terms. There are no term limits for the fiduciary board, and as a result, we tend to have more longevity and more experience. About two

board seats turnover each year, for whatever reason, giving us the opportunity to add talent to the fiduciary board.

KB: *Can you talk about the breadth of skills and competencies you look for on the board? From my observations over the years, it is important to have diversity of not just race and ethnicity, but also a breadth of expertise and experience and a culture of engagement to ensure that that the right kinds of questions are raised in board meetings.*

NA: In every case our board members are leaders in the region, and we have members with skills ranging from real estate, law, and businesses in multiple sectors. We're disciplined about looking for what we need and recruiting the right people with the right kind of expertise. Where we've gotten stuck a bit on is technology. I've been reluctant to add a technology expert because technology is changing so much. And I think we can get that expertise in different ways. We just added our first "fly-in"—a board member from New York who is a former executive for a bond rating agency.

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—Nancy Agee, CEO Emeritus, Carilion Clinic

KB: *Can you share the views of your senior leadership about social determinants of health? I'm reminded of a conversation I had some years ago with the CEO of Kaiser Permanente at the time, David Lawrence. We were talking about the importance of having people around you in key decision making and he noted, "I'm just one person. I may be the CEO, but I have a senior executive team with an array of views and expertise. They don't necessarily bring to the table expertise and passion around things like the broader drivers of poor health." How do you ensure those conversations happen at the C-suite level?*

NA: Again, it's so much a part of our DNA. We're very mission-driven. We expect to understand what our communities need. There's a deepening awareness, not only at the local level, but nationally. The pandemic has driven home how and where the inequities are concentrated, and we have gained a deeper understanding of all of that. We have assembled a senior management team that is like-minded. That doesn't mean we always agree, but we're all mission-oriented. It's important not to conflate social determinants of health or health equity with racial issues. We try hard to cleave that because the health problems here in urban Appalachia are more related to poverty, level of education, and geographic access than race. You may recall that during the pandemic, *The New York Times*, *Washington Post*, the media were all saying the people in rural areas weren't able to get vaccines. In the beginning, we had to deep freeze the vaccines, and in most regions, they were distributed through CVS and Walgreens. We don't have CVS and Walgreens in rural Virginia.

Given the skepticism of the vaccine's efficacy and faced with a two-hour drive on a curvy road to get it, many chose to pass. It was an "in your face" example of the widespread lack of understanding about rural America. I live in a sparsely populated rural county.

Although our population is only 5,000, the county is one of the largest by geography in Virginia. During the pandemic, two *New York Times* reporters approached me at our community's only grocery store. They stuck a microphone in my face and asked, "Do you believe in vaccines? Why do you think people won't get vaccines? What's wrong?" The way they asked the question was typical. Issues of access, social determinants of health, and health equity are a lot more complicated, and certainly more than can be explained in a sound bite.

Broadband access also continues to be a significant issue. We found telemedicine to be critically important during the pandemic and are encouraged about its future role in rural health. The near-term challenge is that many of our rural areas don't have broadband service. In Virginia, the commission responsible for distributing the proceeds from the national tobacco settlement is funding the expansion of electronic services to rural Virginia, but it's been inconsistent. In many areas the "so-called" broadband is, in reality, just dial-up.

That's what I have in my home in Bath County. Supposedly I have internet access, but it's slow and inconsistent. You probably saw media coverage of people assembling in Walmart parking lots so they could get internet access. As we grapple with these issues, we're discovering that part of leadership is being influencers, conveners, working with others to find practical solutions to problems. We need to help people understand what the issues are and connect with those who can make a difference, like our politicians. Shirley Holland is better able to answer that question because she's our boots on the ground. She lives and breathes these issues every day.

Shirley Holland (SH): I'd go back to what you were saying, Nancy, about a deepening of understanding over the years among our senior leadership team. I think part of that comes from looking at the data differently, looking in a more thoughtful way for health disparities. To Nancy's point, when we look at health inequity, it's not so much along racial or ethnic lines, although there is some of that. It's more a function of vital conditions in our rural areas, which are predominantly white, but there's a high level of poverty, and a low level of education. A lot of what we're dealing with in our rural areas has more to do with socioeconomic factors.

We're learning more and more as we go along. Among the learnings has been the significant impact of community health workers and peer recovery specialists. We are integrating those roles into our clinical operations, and it's encouraging that CMS and the Joint Commission are beginning to recognize their benefit. It will be key to have some reimbursement from CMS to screen for social determinants. Movement on these issues will help our senior leadership more broadly embrace our health equity work.

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> *—Shirley Holland, Vice President of Planning and Community Development, Carilion Clinic*

Our newest clinic is in Bluefield, a town evenly divided between Virginia and West Virginia, where the local hospital recently closed. Folks there asked if we would do something, so we opened our first intentional hybrid clinic. We have a nurse practitioner there, if you want to see a live person. But more than 50 percent of the care is being done via telehealth.

KB: *Who are Shirley's partners on the executive leadership team in looking at how you address the social determinants of health?*

NA: We have a senior management team with a portfolio of responsibilities and direct reports. Shirley reports to our chief administrative officer. Each of our hospitals has a lead at the vice president level. We're a pretty flat organization. Shirley works directly with the vice presidents and their boards to talk about health equity issues. We all collaborate.

SH: I do a lot of work with our chief quality officer, who is also a physician. We're partners in this health equity work and we work closely with each of the hospital administrators.

KB: *Given the increasing public scrutiny of non-profit hospitals, what do you think the American public is missing? What is it that we need to better communicate as it relates to the roles and contributions of non-profit hospitals?*

SH: I would point to the IRS definition of community benefit, which is too narrow. I look at all the community and economic development work that we do, addressing social determinants to help our communities in so many ways, but none of it counts. *This is advocacy work we need to do.* I know the Catholic Hospital Association is very active, but we have a much bigger story to tell of how we impact the health of our community. That's one message.

I think most communities think a lot about the social determinants of health. If we just highlight what is insufficient, we won't get very far. Instead, we need to work at a local level with community leaders, politicians, businesses, and schools to understand what the issues are and design and implement solutions that are practical. We need to get engaged in the communities in ways that make a difference.

Most communities have something like Meals on Wheels. We know nutrition is incredibly important. We have a farm near a school where we provide cooking lessons. We have a farmer's market for our own employees and visitors. It's being a little bit more practical than just shining a light. As I noted earlier, we can be strong influencers in most communities. We are one of the largest employers, if not the largest employer. Despite the national fragility of not-for-profit hospitals, most local people love their hospital. They love their nurses and doctors, and they have a much more influential voice than I do.

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—Nancy Agee

NA: Partnerships and collaborations are really important, yet you can't be all things to all people. We can't collaborate with every not-for-profit out there. It leads us in frenetic directions, and so often it doesn't move the needle. I focus on a few areas where we can make a meaningful difference. We have a strong ecosystem of businesses and organizations committed to better health.

KB: *I appreciate that response and it goes to a final issue that you've partially addressed. As you know, I've been working with Shirley and partners in the City of Roanoke on a project that captures the way you're describing the role of engaging in the local policy arena. Anything you would add about hospitals' understanding of what is possible and how and why we should engage our local elected officials? What is it we need to know as a sector?*

NA: We're as guilty as any other healthcare institutions in our tendency to leapfrog to the federal and state level as it relates to the engagement of policymakers. Maybe that's because there's almost a natural infrastructure there. You know who to engage, and how to insert yourselves. It's harder and, in a lot of ways, a more diffuse task when you want to act at the local level.

Some years ago, we sat around a table with the chief of police, superintendent of our school system, and other local leaders in Roanoke, and asked about the health needs of the community. This was separate from our health needs assessment; we were trying to decide where to put our precious dollars, but we also knew from state data that health status in the zip code where our hospital is located was among the worst in the state. I went to our board and said, if our role is to improve the health of the communities we serve, we've totally failed. When we met with these folks. I anticipated they would say, look, you really need to focus on a zip code that was predominantly Black. To my surprise, the school superintendent said you need to focus on the city's southeast quadrant. Why? Because 100 percent of the children there qualify for free lunch and free breakfast. It's a decaying area with huge need.

SH: I think it points to the value of place-based initiatives and working with the local government. With Nancy's leadership, we began to work with our neighbors right here in our backyard. We worked with the city to get [the southeast quadrant] named as a community development block grant target area for investors that has attracted considerable dollars. Thus far, 21 homes have either been built or renovated. We have three different developers with plans to build affordable housing in that area. New businesses have opened, lured by growing investments. We still have a long, long way to go.

But it has made a difference. There's hope in that neighborhood, and our involvement has attracted the attention of other stakeholders. We built a pediatric clinic in that neighborhood's elementary school, which includes mental health and wraparound social support services. It has expanded hours for the nurse practitioner who staffs the clinic. It is going really well.

We have also invested in soccer fields and bike systems, an urban farm, and pop-up clinics. When you work "on the ground" like this, over time it begins to build trust and hope in communities where both were previously in short supply. Having an anchor institution like Carilion do things that clearly communicate a message that this is a worthwhile community makes a difference. There's still a long way to go and takes a lot of work. It's not magic.

KB: *Finally, do you have any closing thoughts about the role of non-profit hospitals as we emerge from this pandemic?*

NA: It has been a bittersweet time in so many ways. We've learned a lot, have had a lot to think about, and we continue to learn about ourselves. Perhaps the most important thing that we've learned is that we are resilient. People are still hurting. That said, there's a new sense of power, of resiliency, that we can do this.