



ROBERT L. HARMAN
In First Person: An Oral History

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ROBERT L. HARMAN

In First Person: An Oral History

**Interviewed by Kim M. Garber
On September 18, 2014**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Petersburg, West Virginia

KIM GARBER: Today is Thursday, Sept. 18, 2014. My name is Kim Garber, and I'm going to be interviewing Bob Harman, who served for over four decades as the chief executive officer for Grant Memorial Hospital in Petersburg, West Virginia. At the time of his retirement, it was noted that he held the record for the longest tenure with one hospital of any hospital CEO in the nation. Bob, it's great to have the opportunity to speak with you this morning.

BOB HARMAN: It's very good to be here, and I appreciate the fact that you have come here to the hospital and are taking the time in your day to talk to me.

GARBER: Tell us about Grant County, West Virginia. What's it like in this part of the country?

HARMAN: It's extremely rural. You never can hide that fact. When I was recruiting physicians to come here I would tell them, "If you come to this facility, you must come with the understanding that it is rural – and rural in the greatest sense of the word. You have to like rural. You have to want to be here in order to make it work."

Grant County was created at the time of the Civil War from neighboring Hardy County. At that time, folks in this area were primarily Union sympathizers, while Hardy County residents were Southern sympathizers – and never the twain shall meet. To some extent, that's still the case today. Although the communities have worked together over the years to do a number of different things, they are two distinct communities.

The hospital serves Grant County, Hardy County and Pendleton County. That's been true since the hospital started in 1958. Over the years, this community has done very well in some instances. More recently, like a lot of rural communities throughout the country, this area has declined. You can go through downtown Petersburg and see stores that have closed. You can drive through other small communities in West Virginia and see the same thing. It's distressing to see this happening.

At one time, Petersburg was the center of everything going on. There were several physicians here in private practice. A lot of people came here to get their medical care. It was a central hub for the three counties. Today that's not the case. Petersburg itself has become a bedroom community. However, the community has grown physically. Pictures taken from this site in 1957, when the hospital was being built, show the area below the hospital as an open field. From the main street in town you went back one street and that was it. Today, this whole area is built up with homes. The community itself has grown, but industry coming into this community has not grown to the same extent.

Moorefield is the county seat of Hardy County, as Petersburg is the county seat of Grant County. In Moorefield, they were fortunate to have three industries that developed over the past 50 years. At one point, American Woodmark, which manufactures kitchen cabinets, had three large plants down there, employing probably 1,500 people.

Poultry, cattle and farming are big in this area. There was a poultry processing plant in

Moorefield in the '50s. Hester Industries was started by a gentleman who moved into the area from out of state and built a food processing plant, which employed about 800 people. Rockingham Poultry employed about 2,500 people. In Moorefield, you had employment opportunities of probably 4,000 jobs.

Up here in Petersburg, we had a printing forms plant, a sewing plant and a poultry processing plant (Perdue) at one time. The primary employers today are Allegheny Wood Products, which employs a couple hundred people, Grant County school system, Grant County Mulch, Virginia Electric and Power Company and Grant Memorial Hospital with over 300 employees. The employment base in Moorefield was dramatically different from up here. I don't know how many years ago it's been that Walmart came into Moorefield. There was opposition to them coming in. It was the old thing: if Walmart comes in, small businesses will close. That has not necessarily proven to be true. Walmart is a very busy place. I don't know how many people they employ down there now, but it has been an asset in this community. Petersburg itself has become a bedroom community for the most part, with most business and employment opportunities – with few exceptions – being in the service industries.

The third county that the hospital serves is Pendleton County, a rural county of about 9,000 people. The county seat is Franklin, with maybe 1,000 or 1,500 people in that little community. It's even more rural than Petersburg and Moorefield. They had a couple of plants up there which are no longer functioning. In addition there is a Naval Base at Sugar Grove that is scheduled to close. Probably half of Pendleton County folks come down here to this community for their medical care.

Pendleton County is separated by a mountain range. Historically, people from the western side of the county tended to come down in this direction for services. They shopped here, they got their medical care here. People from eastern part of Pendleton County tended to go over the mountain to Harrisonburg, Virginia. As the hospital developed here, there was an accumulation of services that tended to keep folks coming here.

Grant County is basically a Republican county. Hardy County is primarily a Democratic county. Pendleton County is probably evenly split, maybe a little more on the Democratic side. They are conservative in Pendleton County, though. It seems like they are opposed to almost anything and everything that may change the character and atmosphere of their rural community. They want industry, they want a better life, but they didn't want the windmills to come in up there. They've opposed a lot of different things that would probably have been beneficial to the county, but that is the mindset of people in that county. My ancestors, particularly on the Harman side, came from Pendleton County. I originated in Pendleton County. It gives me a right to talk about it!

I was born in Cumberland, Maryland, simply because there was no hospital here, and my mother didn't want to deliver at home. There was a small clinic that would deliver babies, but she didn't want to do that. I was born in a hospital in Cumberland, but from that time on, I spent my entire life here. It's been interesting to watch this community grow, have its heyday, and now it appears to be in decline. There's always a hope that they can recruit industry in here, though.

I mentioned before how Grant County split from Hardy County at the time of the Civil War. Prior to the war it was all Hardy County. There is still competition between the Moorefield and the Petersburg communities, in sports, in everything. However, the people in the two communities like to point to a shining example of a time when they did come together. Halfway

between the two communities, which are about 12 miles apart, they built a golf course. People in both communities got together, collectively purchased the land and built the golf course. It has developed into an 18-hole course, well used. It is an example of how they can work together, but they're still competitive.

GARBER: When was the heyday?

HARMAN: The heyday was probably late '50s through the decade of the '60s. That's when there were a couple of plants employing upwards of 150 employees, and people did tend to stay here rather than go somewhere else. It was also when Virginia Electric and Power Company (VEPCO) built their mine mouth electrical generating plant at Mount Storm.

GARBER: What has the impact of mining been on this area?

HARMAN: In the northern part of the county, up in the mountain area, there has always been coal mining – deep mines as well as surface mines. It's not like in southern West Virginia, where coal was king, but it was something that contributed to the county.

In the '60s, VEPCO built a power plant at what is now Mount Storm up in the northern part of the county. They built a huge cooling lake for the plant and built the power plant. I understand that they built it there primarily because they could get their coal directly from the mine. They had big, elevated pipes that moved the coal directly from the mine to the plant.

That was a boon to this county. It brought in a huge amount of tax revenue. It brought in employment and jobs, not only in the plant itself, but also in the mines out there. The plant's still operating. You can see it, at least the steam coming out of the stacks, from here. There was no objection to it being built here, and everybody looked at it as a very positive thing, which it has been.

West Virginia residents are basically not supporters of President Obama because of coal. People here think the regulations that have been put in place to regulate air emissions have affected the coal industry drastically and negatively. In southern West Virginia, in McDowell County, 25,000 to 30,000 people were supported by the mines at one time. That population today is probably less than 10,000. Part of that is due to the fact that mining went mechanical, but the coal industry has taken a hit in West Virginia.

With the fracking that they do in gas wells today, they may start investigating not just the Marcellus shale, but another formations where gas can be extracted that can be found in this area. Even before they started fracking the Marcellus shale, there were gas wells over in the middle part of West Virginia. There were a lot of people who had gas wells on their farms. In the North Fork area of Pendleton County, which is west of us, there is a huge gas transmission line that goes through there running from south to north. Moorefield has gas service available there.

There was a survey done at one time that said, "Would you like for us to run a supply of gas to Petersburg, to the area?" There wasn't much interest. People didn't have an interest in having gas as an energy source in their homes. I don't know why, because it is relatively cheap. Natural gas is much cheaper than propane, generally.

When we did an expansion project here at the hospital in the early 1990s, we went to Chillicothe, Ohio, to look at a hospital project. A builder out of Charleston that we were

considering here had worked on the Ohio hospital. I remember going into the mechanical room there. Our hospital here has used furnace oil for all its heat and hot water. We had two huge boilers. In the mechanical room in this hospital in Ohio, which was serviced by natural gas, they had a boiler there that was probably this wide [gesturing with his arms], stood about this tall and was about this deep. It heated the whole hospital, provided all the steam for sterilization, everything. I thought, "This would be great!" When that survey came through that said, "Do you want gas up here?" I said, "Yes, indeed! We want gas!" It didn't go anywhere. Maybe, at some point, the attitude will change.

Energy has been important here. It's been a source of revenue for the county, for the school system. When VEPCO came in here we were able to build new schools. It was a remarkable period in this county's life to do those kinds of things, because it did have a resource for additional revenue.

GARBER: Tell about your parents.

HARMAN: My parents were born and raised in this county, although my grandparents on the Harman side came from Pendleton County. My grandparents on my mother's side came from Mineral County, which is north of here – Keyser. They were both educated here in this county and grew up here. My grandfather on my mother's side was the stationmaster here in Petersburg. The B&O Railroad had a spur that ran into Petersburg, and it terminated here. He was also a justice of the peace, a judge, in the magistrate court.

My grandfather Harman started in the mercantile business in around 1926 and had a large store here in town. His father before him had a country store in a little community called Pansy. He also had a farm. My understanding is that my great-grandfather took my grandfather out of school when he was 12 years old, and put him to work on the farm and in the store. My grandfather had no formal education beyond when he was 12, but he was a very good businessman. He was astute and well-versed, he could write well, he could do a lot of different things. My grandmother Harman valued education and had attended a small college in Harrisonburg, Virginia, which has now evolved into James Madison University.

My grandfather and grandmother Harman were probably the main influence on my life as we were growing up. They taught me the basic things – how to treat people, how to be honest and empathetic, and how to work. My grandfather opened the store at 7:30 in the morning, closed at 6:30 in the evening, and then went home and worked in the garden. He lived across the river, and had a smaller store over there where he had a gas station – like a mini-convenience store.

When my father came out of service in World War II, he worked for my grandfather for a while and then got into the poultry business. He built a couple of poultry houses where they grew baby chicks to market size. I can recall the first poultry house that he built. I was about seven years old at the time, and I had a job. I had to fill up the gallon-sized watering cans. He had me fill them up every day, twice a day.

My grandfather put me to work in the store. He sold everything. He had meats and groceries and produce and clothing, shoes, paint, toys. I was the stock boy in the store for a lot of years. As I got older, I got promoted. I got to be a cashier. I got to handle the money. My grandfather taught me not only how to work, and the value of work, but also how to treat people. I always say that he taught me that you treat people like the customer is always right. Now, we know

that the customer is not always right, but that's the approach you take in dealing with a customer. I tried to apply that principle all my adult life.

I worked for my grandfather throughout my high school years. Alternately, he had me working over at the service station. This was frustrating after I got to be 16 and could drive. We had an outdoor movie theater. On the weekends, I wanted to go to the movies on Saturday night. I had to work the service station, and I didn't get out of there until 9:00 or 9:30. That's just exactly the way it was.

My grandparents were devout Christian people. They taught me the value of church, the value of God, the application of the principles of Christ in everyday life. My grandfather was a Methodist by virtue of the fact that his family was in that church. My grandmother and her family were Presbyterians. I've been a Presbyterian forever and still am. They taught me some of the basic lessons of life that have stuck with me throughout.

My father was in the poultry business until I was about 20. He had always had an inclination for construction, so he got into the construction business. He started his own contracting company, and he built a lot of structures here in this community that still stand today. He built private homes and commercial buildings.

My mother was a housewife. She graduated from Catherman's Business School, Cumberland, Maryland, then came back to Petersburg and worked for an attorney for a couple of years as a legal secretary. After she started having kids, she was a housewife. I say "just a housewife," but she had plenty of work and all of the responsibility of that position.

GARBER: I understand there were six children in your family?

HARMAN: Yes, and I am the oldest. I had a sister who died at the age of 20 months who was next to me. She was diagnosed with spinal meningitis. At that time, there were no antibiotics. I don't know how they treated spinal meningitis then, but she did pass away. Next in order is my brother, John, who worked for the General Accounting Office in Washington for his entire career. Another brother after that took up after my father. He was an excellent finish carpenter. I have two younger sisters – one who became a medical transcriptionist. My youngest sister works over here in one of the doctor's offices, and she's had a varied career. She worked in a sewing factory. She worked in a couple of different places. There's a 20-year difference between me and my youngest sister. My youngest brother passed away at age 50 because of a stroke. When I spoke at his service, I said that our family is like two chapters of a book, because of the age difference.

We had a great family. We had a lot of fun growing up in Petersburg. Life was not particularly easy in the 1940s. Coming out of the Depression, money was not flowing down the middle of the street. I ran across a tax return that my father filed. It might have been when I was 20 years old. I was in college. His gross income for that year was \$3,000. How did we live on \$3,000? But, we did.

GARBER: You went to Petersburg High School, graduating in 1958. I understand that you did very well academically and that you participated in sports.

HARMAN: Oh, yes, that was my lifeline. From the time I was very small, I was involved in sports. There was always a group of kids who wanted to get together and play. We played

whatever was in season, but basketball was my sport. We lived up over my grandfather's store. My dad put up a basket on the garage there. There might be 15 kids back there all playing basketball.

I went to Potomac State College. I did not try out for sports the first year, but I did go out for the basketball team the second year and made it. We had a great team, probably one of the best teams that the college ever had. We lost only three games that year, but then lost in the regional tournament in Binghamton, New York, by four points. We were four points away from going to the national NAIA tournament in Kansas City.

Potomac State is a small school. At the time, it was about 800 students. It's affiliated with West Virginia University, an accredited college. It was close to home – 40 miles away. I am a homebody. Home is important to me. I went there for two years and then transferred to Fairmont State in Fairmont, West Virginia, where I completed undergraduate work. From there I went to George Washington University.

GARBER: Why did you transfer?

HARMAN: Potomac State is just a two-year school. Fairmont was a small school, too. In 1960, WVU had maybe 12,000 students. Fairmont had 2,500 or 3,000 students, maybe. I liked the smaller schools. You get to know more people. You get to know the professors better. The classes are smaller. That's primarily the reason that I went to Fairmont.

GARBER: What was your undergrad degree?

HARMAN: My undergraduate was in Business Administration. Like my father, I was interested in construction. I seriously thought about engineering. At Potomac State, I changed and went into business administration. I liked accounting. I liked the numbers. I liked the process of accounting. I was going to be a CPA.

How did I get into this work? There was a professor at Fairmont named Neil Frye, who was the dean of students. He had been, I think, the superintendent of schools here. His older son was a year ahead of me in school, and his younger son was a year behind me in school. I knew him. We went to the same church.

One day towards the end of my junior year, he said, "Why don't you come into the office and talk to me a little bit?" I went in, and he said, "What are you going to do?" We talked about it. He said, "Have you ever thought about going into health care?" I said, "No, not specifically." He said, "Health care is an interesting profession to start with, but it's going to be a growing profession, too. It might be good if you take a look at that." He started the thought process going. I went back and talked to him a couple of times.

He made an appointment for me to meet with the administrator of the hospital in Fairmont, and I went over and talked to him for a good while. He suggested that I go up to WVU. At that time, the WVU Medical Center was brand new. Gene Staples¹ was the administrator. He spent a

¹ Eugene L. Staples (1926-2006) became the first director of the newly-built West Virginia University Hospital in 1960 and remained in that position until 1982. [First WVU Hospitals CEO to receive distinguished service award at graduation. (2004, Apr. 26). *WVU Today*. Retrieved from <http://wvutoday.wvu.edu/n/2004/4/26/4047>]

fair amount of time with me, gave me journals to go through. He said, “Come back and we’ll talk about it some more.” He was influential in making me decide this is where I want to go. This is what I want to do. That’s how I got into health care, primarily.

GARBER: The education that enabled you to become involved in hospital administration was getting your masters at George Washington University.

HARMAN: Right. At that time, there weren’t a huge number of schools that offered programs in hospital administration. The number 17 sort of sticks in my mind. The University of Minnesota had the premiere program.

GARBER: James Hamilton started that program.

HARMAN: Jim Hamilton² was up there. Medical College of Virginia in Richmond and Pittsburgh had programs. I don’t think Duke had a program at that point, but there were about 17. Gene Staples said, “In your last year at Fairmont, you need to get some classes about the process of medicine.” I did adjust my schedule. I took some classes. I had really no great desire to take microbiology before that, but I took a microbiology class. I did change to classes related to medicine.

I applied at GW. It was a very new program – a couple years old. I also applied to Medical College of Virginia – those two places because they were close to home. I was a young man who grew up here in the mountains, who was a homebody, who had never been anywhere except Washington, D.C. I was having to strike out and get involved in something that was far bigger than anything I had ever envisioned.

MCV had 400 applicants, of which they interviewed 80. I was one of the 80. It was probably the most interesting interview that I’ve ever participated in. Interviews started at eight o’clock in the morning with the director, Robert Hudgens,³ and then progressed through eight hours talking to seven other people. I talked to a personnel administrator, I talked to a professor of anatomy, I talked to a hospital director. It took until 5:30 in the evening. They were going to select 12 people out of the 80. I would have loved to have gone there. It just didn’t work out.

I did get accepted at GW, and it was a big program. There were 50 students in my class, which was the third class to go through. I knew some of the folks who had gone through ahead of me. Frank Gabor⁴ had gone to school with me at Fairmont. He spent most of his career in the

² James A. Hamilton (1899-1985) founded the Program in Hospital Administration at the University of Minnesota in 1946. His oral history, Weeks, L.E. (Ed.). (1983). *James A. Hamilton in first person: An oral history*. Chicago: American Hospital Association, is in the collection of the American Hospital Association Resource Center.

³ Robert O. Hudgens, M.D. (1928-2010) was a pediatrician who practiced in the Richmond area and taught at the Medical College of Virginia. Dr. Hudgens is particularly remembered for his work related to the prevention of polio. In 1963, he was given responsibility for organizing the distribution of the Sabin polio vaccine, which was administered in doses on sugar cubes, in Richmond. Over a quarter of a million people were vaccinated on one day in local schools, churches, and fire stations. [Robertson, (2010, Jan. 23). Retired Richmond pediatrician Robert Oscar Hudgens dies at 81. *Richmond Times-Dispatch*. Retrieved from http://www.timesdispatch.com/entertainment-life/retired-richmond-pediatrician-robert-oscar-hudgens-dies-at/article_69f0ffde-03a8-562d-ae39-d048c34594a7.html?mode=jgm]

⁴ Frank R. Gabor was president of Montgomery General Hospital, Olney, Md., from 1977 until 1990. [Alumni Frank and Jane Gabor named homecoming parade marshals. (2011, Oct. 13). *FSU Now*. Retrieved from

Washington area, including a number of years at the hospital in Olney, Maryland.

At that time at GW, there were two avenues that you could take. One was basic hospital administration; the other was nursing home administration. You didn't have to select right away what focus you wanted. It was a two-year program. I started in the fall of '62 and graduated spring of '64. It was indeed an experience going from living in West Virginia to Washington, D.C.

My wife and I had gotten married at that point. We lived out in Fairfax, Virginia, which is just west of D.C. She had gotten a teaching position at a high school in Vienna, just outside of Fairfax city. I drove into town every day. I had a lot of night classes, so that was not a particular problem. Living in the city was an adjustment. It was really different.

The second year was the residency year, in which you worked in a hospital setting under a mentor or supervisor. In my case, that was at Prince George's Hospital in Cheverly, Maryland,⁵ which was on the other side of D.C. It would take me an hour and a half to get to work because I had to go all the way through Washington to get over to Cheverly. There was no way to do that other than right straight through. The beltway was being built.

GARBER: What did you think of the residency year?

HARMAN: It is important. You cannot get in the classroom what you can get working in a hospital. It's important to have that experience. However, during the first year, I think we visited every hospital in the city. In one class, a classmate and I had a project at the Anne Arundel General in Annapolis.⁶ It was an actual project that we had to go over there and conduct. We were in every single hospital except St. Elizabeths,⁷ which was the mental hospital.

It is important to have that experience in a facility. I know some programs say a year is not enough – that's debatable. There was a man who worked here as the bookkeeper when I came to work here. His son many years later enrolled in GW's program. His son called me one day and wanted to come up. He said, "I need to do a hospital project. Can I do it up at your place?" I said yes. We talked a little bit about the curriculum that's in the program now – and it is dramatically different from what I went through. We studied basic things – personnel, administrative principles, social interaction and a lot of things like that. He told me that he was doing analytical studies that involved statistical development, comparisons and what-not, which we didn't get to when I was in

<http://www.fairmontstate.edu/fsnow/alumni-pride/alumni-frank-and-jane-gabor-named-homecoming-parade-marshals>]

⁵ Prince George's General Hospital, Cheverly, Md., was established in 1944. In the early '60s, it was a county hospital operating 385 beds. [Guide issue. (1963, Aug. 1). *Hospitals, Journal of the American Hospital Association*, 37(15, Part 2), 108.]

⁶ Anne Arundel General Hospital, Annapolis, Md., was established in 1902. In the early '60s, it was non-governmental not-for-profit hospital operating 200 beds. [Guide issue. (1963, Aug. 1). *Hospitals, Journal of the American Hospital Association*, 37(15, Part 2), 107.]

⁷ Social activist Dorothea Dix was influential in establishment of the Government Hospital for the Insane, which was a federal government facility that opened in 1855. Later renamed St. Elizabeths Hospital, this long-stay facility could house over 7,000 patients. [McMillen, F.M., and Kane, J.S. (2010, Summer). Institutional memory: the records of St. Elizabeths Hospital at the National Archives. *Prologue Magazine*, 42(2). Retrieved from <http://www.archives.gov/publications/prologue/2010/summer/institutional.html>]

those programs. I don't know whether that's critical at this stage, with the organizations we have now, or not. I found it interesting that the program content had changed that much in 30 years.

GARBER: What were your duties at Prince George's?

HARMAN: Primarily we were assigned to different departments, and we went to work in each department. We had projects to do. Maybe they had a problem in Central Supply. "Go check it out. Detail for me what the issues are, what's actually happening there, and what you think the possible solution is." Those kinds of things – throughout the whole hospital. We touched everything. We got into every single department.

GARBER: Did you find that you enjoyed one department more than another?

HARMAN: Not particularly. I had to go into surgery. You had to gown up, and you had to go into surgery. That didn't particularly bother me. You didn't get involved in actually putting hands on patients. You were primarily an observer. One issue was that surgeries were not starting on time. That's an age-old problem. Why weren't surgeries starting on time? You started on the floor asking why the patients weren't getting ready. Why weren't they getting delivered to surgery? Why? Why? We did those kinds of things in surgery. You got to see some of the process that took place in surgery, but you didn't touch patients.

GARBER: Did you feel you made a contribution?

HARMAN: I think so. You're there to learn. If you contribute something positively and it shows that you've done something positive, you get respect. You get respect, and the next time, the department manager will say, "Have Bob Harman check that out." It all depends on how you approach it and what kind of an outcome you achieved.

GARBER: I understand that the administrator at the time at Prince George's was Harry Penn, Jr.,⁸ who spent a long time there in leadership. Did you work directly with him?

HARMAN: As far as the school was concerned, Mr. Penn was my supervisor, but Mr. Penn passed me down to his assistant, Bill Parker. Bill was a teacher at GW. I worked more with Mr. Parker than with Mr. Penn. Mr. Penn had worked at the hospital a long time, starting in the storeroom and working his way up. He eventually became an administrator. He was very authoritative. You didn't question a lot of things. If he said, "You do this," you did it.

GARBER: This was the early to mid-'60s. Do you think that that was common for administrators at large hospitals?

HARMAN: No, I don't think so. I think it was his personality. It was his way of managing. He had started in that particular hospital and the way he came up is the way he managed the whole place.

GARBER: What was it like living in Washington at that time, with the Kennedy

⁸ Harry W. Penn, Jr. (1908-1996) was administrator of Prince Georges Hospital (Cheverly, Md.) for 25 years. [Obituaries. (1996, Jan. 5). *Fort Lauderdale Sun Sentinel*. Retrieved from http://articles.sun-sentinel.com/1996-01-05/news/9601050221_1_john-michael-funeral-chapels-pompano-beach/4

assassination, with the Johnson administration, with the Civil Rights activism – it must have been an incredible time to live there.

HARMAN: It truly was. The day that Kennedy was assassinated, I had been up to the National Library of Medicine in Bethesda researching some things for a project I was working on and heard the news on the way home. It was a devastating, traumatic thing, not only for the family, but for the country. However, the scariest time was the Cuban Missile Crisis. That created more apprehension among the people living in D.C. than Kennedy's death, because every day it was on the news about the current status of the missile crisis in Cuba. What were the Russians going to do? Were they going to bomb? What were they going to do? We lived in the capital. Where would they bomb? Miami? It was a little hairy, to say the least, a little scary.

GARBER: Did you and your wife have concerns about this?

HARMAN: No more than anybody else. At that period, everybody was building a bomb shelter in their backyard, but I was not building a bomb shelter. I did not do that. You had to accept some things on faith, that there were good people out there working for your benefit to try to solve this problem. You still have to do that today. We all have our thoughts whether they're doing it right or not, but you have to have faith that somebody is going to work through the process and get it done.

GARBER: After you received your master's degree from GW, you were looking for a job. How did you happen to come home?

HARMAN: My wife and I knew that we would like to come back to this area. There were limited opportunities back here with hospitals. You have the hospitals in Cumberland and Harrisonburg and Winchester, and there was a hospital in Keyser at that point.

We had a child at that point. I said, "Until I land at a certain place, you go ahead and see if you can get a teaching position at home, and then we'll go from there." She did get a teaching position here in the high school. I was approached by one of the county commissioners who said, "We think Mr. Breathed⁹ is going to be leaving the hospital. Is that something you might be interested in?" I said, "Absolutely, I'd be interested in that." He did leave the hospital. I applied, was interviewed by the board and was employed here. I was almost 25 years old at the time. It was ideal. It was what I was looking for. I have never regretted it, not for an instant.

GARBER: This was when Petersburg was in its heyday. It must have been fun to come home to a community that was thriving economically. Grant Memorial Hospital was opened in 1958. What's the story of how it came to be?

HARMAN: It's a very interesting story. The editor of the paper seemed to be the one who floated the idea. The Kiwanis Club took it on as a project, talking to people, and putting the whole concept together. From my understanding, they put together a committee to investigate the possibility. That committee went on from there and involved the county commission. The county commission became the sponsoring agency.

⁹ James F. Breathed (1901-1980) was administrator of Grant Memorial Hospital from 1959 until 1965. [Guide issue. (1960, Aug. 1). *Hospitals, Journal of the American Hospital Association*, 34(15, Part 2), 219.]

West Virginia state code gives counties the ability to create and operate hospitals within their jurisdiction. It goes on to talk about the process, what kind of governing authority there may be, and what the size of the governing authority may be and all that. The county commission went to Charleston and received whatever approvals were required and decided to build a hospital.

There were a couple of different mechanisms to do funding. They put a vote out to the people for a bond issue, and then also an excess levy to generate funds to construct a hospital. At that time, the Hill-Burton program was a big program.¹⁰ In working with the state, they did complete their application for Hill-Burton funds to build a hospital. I don't remember the exact cost to construct the building. This all started in 1955 or '56. The community approved the bond issue and the excess levy.

They went through the process of getting an architect, getting the drawings in place and getting bids. I think construction started some time in '56. I was in the band in high school and there is a picture of the band at the cornerstone laying in front of the hospital. There's Bob Harman in the band at the cornerstone laying of the hospital, 1957. They used that picture a number of times throughout my career here. It was opened in April 1958.

It started with a community effort on the part of a service club to create it. I had to work with the Hill-Burton program here in dealing with another expansion project that we did later. I understand the effort that the community people put in to creating this facility here. The next closest hospital was 40 miles away in Keyser.

At about the same time, Romney, which is east of us in Hampshire County, was going through the same process. They built a hospital about the same time that our hospital was built. It was the same architect that built the two hospitals. After I came back here, I made a visit down to Hampshire Memorial, and when I walked into that building, it was the same as walking into our hospital. This architect made money on this project, because all he did was take blueprints from one, and make some minor modifications. The two facilities were identical. You could have built one foundation and set either one of them on that foundation. When I walked into the lobby, the tile was the same, the walls were the same, the stone work was the same. I thought, "Holy mackerel, this guy made out like a bandit!"

GARBER: He got it right the first time.

HARMAN: Whatever. I do remember playing for the laying of the cornerstone. When this hospital was built here, this was called Fort Hill. It was always called Fort Hill because of the old Civil War fort. They machined a lot of it off to level it out. When we added to the building in 1969, I think it was, in the area in front of the hospital, we took off more of the hill over here and built a gully up. There are some pictures I have that show the hill before anything was done to it. It's remarkable what a piece of machinery can do to a piece of ground.

GARBER: I imagine that voting for a bond issue has little direct impact on people but the

¹⁰ The Hospital Survey and Construction Act (P.L. 79-725), enacted in 1946, is more commonly known as the Hill-Burton Act after the sponsoring senators. The legislation provided capital funding to help modernize hospitals nationwide in exchange for the provision of uncompensated care in the future. [U.S. Department of Health and Human Services, Health Resources and Services Administration. *Hill-Burton Facilities Compliance & Recovery*. Retrieved from <http://www.hrsa.gov/gethealthcare/affordable/hillburton/compliance.html>]

excess levy would.

HARMAN: The excess levy would, but if it's a general obligation bond, that creates a general obligation on the part of the county, so you have to levy in your annual levy of taxes enough money to pay off the bonds. In either case, there is money that comes from the taxpayer to pay the bond obligation.

GARBER: That was generous of the community then to vote in favor of that. They perceived a need.

HARMAN: Yes. There was a need because the hospital in Keyser was a privately-owned facility, not very big, owned by a doctor. In this community at that time, there were two clinics – I use the word loosely. One was a single practitioner who had three or four beds in his clinic that he would use primarily for elderly patients. He had an x-ray. There was another clinic that consisted of three physicians. They had six or eight beds, maybe. The only patients who would stay in that clinic were OB patients. They would deliver babies there, but that's all they would do. If you had an emergency, they would do whatever was necessary to patch you up and send you to Cumberland, primarily, which was probably pushing an hour and a half or two to get to another hospital.

There was a need here for some kind of facility. The physicians who had the clinic delivering babies supported building a hospital. I think they had a certain degree of exposure – of course, at that time, the legal system was different. There was liability out there, but I don't know that the people were as stringent in looking for the pot of gold at the end of a suit. They would deliver a good many babies at their clinic. They had an x-ray machine, and they eventually had four physicians working there. The community was a central point for medical care because there were six physicians practicing in this community at one time. There was a need for this facility, there truly was.

GARBER: Did the opening of the hospital close that OB clinic?

HARMAN: Yes. Dr. Lysle T. Veach,¹¹ was in World War II, and when he came back from the service, started his practice. He and his partners set it up, and they set up beds. It was probably more efficient for them to do it that way. When they had patients there, they had a nurse there 24 hours. They had nursing coverage. If they had a particular problem that required a C-section, I honestly don't know how they handled that, whether they did the C-section themselves. They were probably capable of it. That's where it gets a little scary in a clinic.

GARBER: What was the name of the physician who owned the other clinic?

HARMAN: Dr. Clarence E. King.

GARBER: The Hill-Burton program was immensely important nationwide. Would you tell a bit more about the purpose of Hill-Burton and how it impacted you?

HARMAN: The purpose of Hill-Burton was to be able to get more health care facilities out there in areas where there were none. It was a mechanism by which you could help support the

¹¹ Lysle T. Veach, M.D. (1917-2004) established the Veach Townsend Clinic in Petersburg. [Dr. Lysle Trenton Veach. Retrieved from <http://www.findagrave.com/cgi-bin/fg.cgi?page=gr&GRid=73776358>]

building of these facilities. I mean, you got government funds to do this. If you were a recipient of Hill-Burton funds, you created in perpetuity an obligation to provide services and, if necessary, free services to patients.

People in this community would come in here and say, if they had a bill, “Well, Hill-Burton will pay for this.” No, that’s not the case. We don’t get Hill-Burton funds to pay for your hospital bill. That’s what they understood it to be, though, so you’d have to explain that Hill-Burton funds were basic construction monies that created an obligation for you to provide service. That obligation never goes away. As long as this facility is here, that obligation is here and will continue to be here.

Hill-Burton was a boon to many, many parts of this country. There were a lot of facilities built with funds from the program. The expansion that we did here in 1969 was with Hill-Burton funds. They don’t hand you the total amount of money that you want in order to build, but it’s a pretty good portion of the total cost that comes through Hill-Burton. The rest has to come from the community. In 1969, we doubled the size of the hospital and added long-term care beds because long-term care was where money was available.

The Medicare program, with the reimbursement that it’s brought to facilities, increased utilization. We were running extremely full. The board said we needed to have an expansion. We needed more beds. That’s the direction we went in, and we used Hill-Burton funds to do that. There was, again, a general obligation bond issue and excess levy which, again, had to be voted on by the people in the county. At that time, the hospital was 96 beds.

GARBER: I see that my question about Hill-Burton funding led you into a little bit later in your career here at the hospital, and I don’t want to leave your early days without commenting on the fact that you were very young when you started as CEO here. You were not yet 25 years old.

HARMAN: Very close to it, but not quite.

GARBER: How did you learn your craft? Did you have a mentor here who taught you what you needed to know?

HARMAN: When I came here, I had had a year at Prince George’s Hospital. You learn a lot of things in your residency program. You don’t learn it all, but one of the things you pick up is where to go find answers to things. That was instrumental and beneficial when I came here.

There was no one local to be a mentor as far as running this facility. There really wasn’t. You used the knowledge base that you had to get started. There is a certain process that you go through. In the first couple of years here, I learned to know a couple of administrators from other hospitals who I could call to get advice and counsel on how to handle a particular problem, or what approach they may have taken, and if they had the same problem at their facilities.

It’s interesting to note that the first administrator here was Bill Anderson. He came here in 1957, prior to the hospital opening, and did all the necessary things to get it finished and equipped. He was here for two or three years and then left. I don’t know why he left. I don’t know his educational background. I know that he was a lab technician. He would give ether to patients, so he may have been something of an anesthetist. I don’t know what other skills he may have had, but he obviously had some administrative skills.

He left, and Mr. Breathed was on the board of trustees. Mr. Breathed was a long-term member of the board and a long-term member of the community. He ran a car dealership here in town. It was one of those things, I think, that when Mr. Anderson left, the board looked around the room asking, “What are we going to do?” (This is speculation on my part.) “What are we going to do? Well, Jim, will you run it for a while?”

He was a very nice gentleman and a businessman. He ran a car dealership. He ran the hospital for four or five years until I came along. He went back to his full-time car dealership. The two gentlemen I called frequently, who served as mentors for me, were Harry Harner¹² at Charles Town and Robert Hale at Berkeley Springs.¹³ They both had been at their hospitals a number of years. Interestingly enough, Harry Harner had been a car dealer over in the middle part of the state in Tucker County and had gotten involved with Tucker County Hospital in Parsons. Bob Hale had been a representative of Blue Cross down in Bluefield, West Virginia, and somehow or another got involved in hospital administration.

They were very helpful. They brought a different perspective and were running hospitals that were relatively successful. I would call them. Right here, there was nobody that I could call. These two gentlemen also got me involved in the state hospital association. They also started me along the road to association activities and work. I’m indebted to them from that standpoint, and for their assistance in getting me started here.

GARBER: We’re going to talk about your association service a little bit later. Do you recall who the first Director of Nursing was and the first Chief of Staff that you worked with?

HARMAN: When I came here, the total number of employees was somewhere between 65 and 70. My wife made me a scrapbook when I retired and, for one of our annual celebrations, we listed all of the original employees. When I came here, Bernice Shrader¹⁴ was the director of nursing. Josephine Armstrong may have been before her. Mrs. Armstrong was also an anesthetist.

The first surgeon here was Dr. Carl A. Liebig. When he came here, he was just out of a surgical residency in Cincinnati, I believe. He’s a gentleman that I have a great deal of respect for – still living. He practiced surgery here. He left here before I came. He came in 1958, practiced surgery here for three or four years and then went back to Ohio. He told me stories about Josephine Armstrong which are too numerous to mention.

Mrs. Shrader was director of nursing when I came. We had a total of about twelve RNs and LPNs out of the 70 employees. That was the nursing staff. That was the med-surg staff, the OB staff, the surgery staff – that was it, twelve people. We had one person in the lab, Lois Jean Jordan. She worked here for many years. If you’re running a small hospital, you have “onesies.” She was among the first employees that were hired and ran the lab. She was on call for whatever. Eventually

¹² Harry C. Harner (1918-2003) served as administrator of three West Virginia hospitals, including Charles Town General Hospital (Ranson, W.Va.) [Obituary. (2003, Aug. 27). *Parsons Advocate*. Retrieved from <http://www.rootsweb.ancestry.com/~wvtucker/obits/PA082703.htm>]

¹³ Robert L. Hale was administrator at Morgan County War Memorial Hospital (Berkeley Springs, W.Va.) from 1964 to 1979. [Guide issue. (1965, Aug. 1). *Hospitals, Journal of the American Hospital Association*, 39(15, Part 2), 253, and later editions.]

¹⁴ Bernice S. Shrader (1931-2002). [Obituary. (2002). *Grant County Press*. Retrieved from http://www.grantcountypress.com/Obit%20page%20folder/archives_for_jan_june-2002.html]

we got a second person in the lab.

To put it in perspective, though, you can't compare today to 1958 in terms of workload. There wasn't the volume of work after hours in 1958 that there is today. One person could do it for a while. When I came, there were perhaps two people in the lab, with one person in x-ray. We didn't have a lot of people. There were probably three or four people in housekeeping. It was a different facility; you cannot compare it to today. The maximum number of employees that I ever had here was probably 350. Today, we have 70 nurses working here. The changes that you see over 40 to 50 years are just phenomenal, in the context of the people, the technology, the whole scheme of things. Those were the people who were here when I came. My job was to manage 70 people and to keep the facility as good as I could keep it.

GARBER: Do you recall what the challenges were in your early years?

HARMAN: There were challenges, all right. The surgeon who was here when I came was Dr. John Stauffer.¹⁵ I came in '65. I worked with him probably a year, or a year and a half. He was a nice man, obviously a pretty good surgeon. He couldn't decide whether he wanted to stay here or not. He would come in one day and say, "I'm going to be around for a while." Three weeks later, he'd come in and say, "I think I'm going to leave." I was dealing with: Do I recruit a surgeon? Do I not recruit a surgeon? Back and forth, back and forth.

The other physicians on the staff, which were primarily four general practitioners, were pretty stable. It was an interesting time. The challenges were in the context of staffing. Always in this facility over the years that I've been here, our base has been surgery. You really need a surgeon. You need a good general surgeon. It was difficult dealing with Dr. Stauffer and his fluctuations between leaving and not leaving. At one point I wound up with two surgeons here wanting to occupy the same office because I did get a second surgeon to come in, and then Dr. Stauffer decided he wanted to come back. He hadn't emptied out his office yet. Quite frankly, that was a nightmare.

GARBER: How did you resolve it?

HARMAN: It resolved itself because eventually Dr. Stauffer left. There were a lot of unpleasantness because the county commission got involved, the board got involved. It was not a pleasant separation. The surgical situation did not settle down for about two years. I recruited a surgeon out of Chrisfield, Maryland. His name was Robert Roberts,¹⁶ and he was here 30 years. He was an excellent general surgeon. He would do orthopedics, he'd do urology, he'd do GI. He did it all.

GARBER: What happened to the surgeon who came in while Dr. Stauffer was still there?

HARMAN: That was a no-win situation. Dr. Stauffer left, and I guess there was so much acrimony involved that he and his wife decided, "We don't need to be here." He was an older

¹⁵ John H. Stauffer, M.D. (1908-1994) was a surgeon who had trained on the east coast and returned to practice in New York state after leaving Petersburg in 1965. [Dr. John H. Stauffer, 86, died at his home in Palm City, Fla. After a brief illness. (1994, July 12). Retrieved from <http://www.geocities.ws/gchgs/ObitsS.html>]

¹⁶ Robert E. Roberts, M.D., was a surgeon on staff at Grant Memorial Hospital from 1966 until he retired in 1996. [Obits. (2005). *Grant County Press*. Retrieved from http://www.grantcountypress.com/Obit%20page%20folder/obit_archive-july-oct2005.html]

gentleman, a good surgeon, but he said, “We don’t need to be in this.” Dr. Stauffer had a base of support in the community. I had two situations when I was here that were very stressful. That was the first one.

GARBER: Do you feel that you could have done something differently that would have made the situation better or resolve more quickly?

HARMAN: I don’t know that I could have. I’m not a confrontational person. If I had been more forceful with him and said, “Look, Dr. Stauffer, what are you going to do? You’re driving me nuts. What are you going to do?” I didn’t do that. If I had been a little more forceful with Dr. Stauffer, would it have turned out differently? I don’t know. It’s conjecture at this point.

GARBER: What was the second challenging situation?

HARMAN: A good many years later, there was a circumstance around the provision of ambulance services. From the time I came here until this time in question, the ambulance services were provided by the local funeral homes. They had a station wagon kind of vehicle that would hold a cot, and they kept somebody on call. That was the ambulance. There were two funeral homes, and each one of them provided that service.

It got to be controversial between the two funeral homes. The county commission got involved, and it got nasty. The county commission came to me and said, “We think the obvious place for an ambulance is at the hospital. That’s where we want it, and that’s what we want you to do.” It wasn’t, “Will you do it?” They didn’t talk to the board and say, “Will you do it?” They said, “You go do it.” That got very difficult.

You had to have the approval of the planning agency in Charleston to add a new service and all that. They came here and had a hearing here. It was nasty. It was very, very nasty. It was stressful for everybody involved, and it was a period of time that was probably the highest stress level I had here, bar none.

GARBER: When was this?

HARMAN: It was late ‘70s, I think. I attended hearings in Charleston. This was one of those things where this funeral home had its supporters, and that funeral home had its supporters. The third element was a private provider. He had purchased an ambulance and was providing services. What precipitated the whole thing was that he wanted the county commission to take care of his bad debts. Each funeral home had its supporters, and this private provider had his supporters, and the county commission in the middle. The county commission’s answer to the situation was, “We’ll just have the hospital do it.” It got very stressful.

GARBER: How did it all work out?

HARMAN: We ran the ambulance service. We had the certificate of need hearing, and eventually the health systems agency granted us the certificate of need to start the ambulance service here, which we did. It was a paid service. I mean, we hired EMTs to staff the ambulance. They worked out of the emergency room. In theory, it was not bad to have these folks working in the hospital. They’re there, a call comes in, they can go. In practice and in the relationship with the community it wasn’t so great, at least for a long, long time.

GARBER: Was part of the issue that it was low volume, that the EMTs had a lot of down time?

HARMAN: They did. In the period of time that the hospital ran the service out of the emergency room, there were days when you had six calls, but there were days when you had two calls. There were more days when you had two calls than days when you had six calls. There were times when they did transports – transferring a patient to Cumberland or to Winchester.

In the long-term, this particular service by the hospital was very, very costly. Initially, the county commission was to supplement the cost to the hospital for providing this service. That worked for a while. Then the county said, “Well, we’re short of funds. You’ll just have to carry this.” They stayed short of funds, and it became the hospital’s baby to finance and support the service ongoing.

GARBER: That’s the way it is today?

HARMAN: This has been a 30-year ongoing story. Today, the hospital does not provide the ambulance service. The county provides the ambulance service through a contractor. They bid it out and contract with a company to provide the service. They subsidize it to the tune of a hundred-and-some thousand. It was probably six or seven years ago that a new commissioner came in, and they worked on it. We convinced them that the hospital could not afford to subsidize this thing. The regulations are such that you can’t provide an ambulance service and include that in your cost. We convinced them that it wasn’t working up here. They said, “Okay, we’ll do this.” If they would have subsidized the hospital to the tune of what they are subsidizing this private company, it would probably still be here, but they wouldn’t do that. That was a long-standing situation that we had here. It was very difficult.

GARBER: You came on board here about the time that the Medicare/Medicaid programs were established. What were things like for the small rural hospital in West Virginia before the Medicare/Medicaid program?

HARMAN: It was a very difficult time, and I suspect it was perhaps not any more difficult than it would have been for the larger hospital. Before Medicare, there was private insurance, which some people carried. There was cash. There was a program that was called Old Age Assistance, which was available to some of the elderly patients. That was about it until Medicare and Medicaid came along. The state didn’t have any program other than this Old Age Assistance that was available to folks who could be put in a situation where they had huge medical expenses. When you had a patient come in for hospitalization, they were expected, if they didn’t have health insurance of some sort, to pay the bill.

When I came here, room rates were \$11 a day. Room rates were what we would term relatively cheap. Both my sons were born here. For the first son – I don’t remember how many days my wife was in here, three, four days maybe – the total bill was \$100. Now \$100 in 1962 was \$100! It got to be a difficult situation for folks because they did not have any programs available that would help them with this kind of cost.

Medicare came along, which changed the whole situation. The concept of Medicare had been proposed for a long time. President Truman had pushed it and maybe others after him. It has

made a big difference. It came in as a cost-based program. You had restrictions on what your costs were, but it brought a new revenue stream to hospitals.

Later on, Medicaid came in. Probably 70 percent of the obstetrical patients delivering here are Medicaid patients. If there was no Medicaid, that would be a big hole to cover in terms of cost. Both of these programs made a significant difference to the reimbursement that hospitals received. It made a difference for us. It made a difference for everybody.

GARBER: Initially, as the program was conceived, it was pretty good for hospitals under cost-based reimbursement. Things changed in the early '80s, when the prospective payment system came in, and then a few years later, West Virginia adopted rate setting. Could you talk about that period?

HARMAN: Medicare did bring a lot of changes. I tried to look at this in the way I looked at a lot of things – I've always said you have to be able to deal across the table from both sides. If you come to me and you have a problem with this facility, and it's a problem that you think is critical and you're pretty steamed about it, I have to be able to sit here and listen to your problem and understand where you are coming from, why you have the position that you have. And that's the same with anything else. You have to be able to know both sides of the table to be able to talk about it and to negotiate it.

I can understand the position of the government because cost-based reimbursement was costing a ton of money. Even with all the restrictions on what was "cost" and what wasn't "cost," it was costing a ton of money. I could understand what their side of the table looked like because they had a budget that they were trying to control. The DRG system saved them money, but it cost hospitals money.¹⁷ It made a huge change in cash flow to all hospitals. You had to adapt. You had to figure out: What is the system like? What is it doing? It's just like we talked about bundling payments in recent years. How do we make sure our costs are covered, and we're still providing the service? It was a challenge. At this facility, we did pretty well under DRGs. We adapted to whatever it was necessary to do to make sure that the system worked for us.

In '97, when financial crisis again hit facilities, the CAH came into effect.¹⁸ Up to that point, our auditors were telling us, "You as an individual facility are doing well. You're not losing money on DRGs. You're okay." This was great – it meant that we were managing our process. When the CAH system came into being, a lot of smaller facilities went to it. We decided not to look at it at that time. We were doing okay under DRGs. That changed later on but, at that time, we were

¹⁷ Diagnosis-related groups (DRGs) are the building blocks of a classification system that groups together patients with similar illnesses or types of surgical procedures. Although not originally developed for reimbursement purposes, implementation of a DRG-based reimbursement system in New Jersey served as a model for nationwide adoption of DRGs as the heart of the Medicare prospective payment system which went into effect in the mid '80s. [Bushnell, B.D. (2013). The evolution of DRGs. *AAOS Now*. Retrieved from http://www6.aaos.org/news/PDFopen/PDFopen.cfm?page_url=http://www.aaos.org/news/aaosnow/dec13/advocacy_2.asp]

¹⁸ The Critical Access Hospital (CAH) designation was established as part of the Balanced Budget Act of 1997 (BBA). Small rural hospitals that qualified to become critical access hospitals were to be exempt from the prospective payment system put into place for other U.S. hospitals. [U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2014, Sept.). *Critical access hospitals* (ICN 006400). Retrieved from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsh.pdf>]

doing okay under DRGs. There were some facilities who were not. As long as my auditors and my financial people were telling me, “You’re doing a good job on the DRGs. You’re making money. You’re not losing money. You’re not getting rich, but you’re not losing money on the DRGs.” I said, “That’s fine. That’s what we’ll do.”

GARBER: What adaptations did you make? How did you manage to do well under DRGs?

HARMAN: We looked at whatever cases generally occur here. We treat a lot of pneumonia, we treat a lot of chronic obstructive pulmonary disease and those kinds of things. We looked at them and said, “What are our costs in these categories?” You had to work with the doctors and say, “Look, here’s what we get for a pneumonia case.” We had a physician practicing here who, when the patient came in with pneumonia, he put him in the hospital and kept him there. He did a chest x-ray every single day. I can understand why he wants to know – what’s it look like today? The quality assurance people were saying, “You don’t need to do a chest x-ray every day.” You try to work with your doctors to follow standards and to tell the doctor – we want you to practice to a certain standard of quality. But, it doesn’t work very well to tell a doctor, “Here’s the way you’re going to practice medicine.” It just doesn’t work.

We basically showed the medical staff, here’s what we are getting in terms of reimbursement for these different categories of DRGs, and here’s what falls in those DRGs. We tried to educate them to that effect. We did fairly well in that respect because they did understand dollars. They did understand that, and I think we just managed to get through it, and did very well.

GARBER: How did you handle this communication with the physicians? Was it you delivering the message, or did you have a chief of staff who was doing this?

HARMAN: We did it pretty much as a team. Mary Beth Barr,¹⁹ who succeeded me here, came to work at the hospital about the time DRGs came into play. She came in as a staff nurse and worked her way up. She, as well as some other staff people, were able to sit down with me to talk to physicians and say, “Here’s what it is. We can’t control what they’re going to pay us.” There are a lot of other factors involved, the urban/rural differential and all these other things that come into play in what makes your DRG rate for West Virginia at this point. Our experience has been that physicians understand written information. What the consequences are of not having reimbursement enough to pay your bills – they understand that. Of course, they always want cuts to be made where it doesn’t affect them. But if you sit down with them and explain the rationale and consequences, then it’s very helpful. You will have those who are more helpful than others. That’s always the case. It’s a time-consuming process, and it’s basically an educational process because it constantly changes, for the government’s budget doesn’t get any smaller.

GARBER: That’s true. There is always pressure to contain the cost of health care. West Virginia jumped into that in 1985 with the rate setting program. Rate setting is unusual in the United States. There are currently just two states, Maryland and West Virginia, involved in rate setting. There were more than that at one time, but not a whole lot more. What’s it like to be in a

¹⁹ Mary Beth Barr served as chief operating officer and director of nursing at Grant Memorial Hospital prior to becoming CEO in 2011. [Carlson, J. (2010, Nov. 24). Harman to retire from Grant Memorial. *Modern Healthcare*. Retrieved from <http://www.modernhealthcare.com/article/20101124/NEWS/311249959>]

rate-setting state?

HARMAN: It's not fun. It was always one of those things where you pull your hair out and say, "Well, how do we do this?" It was like doing the Medicare Cost Report at the end of the fiscal year. For the first three or four or five years, I did the Medicare Cost Report myself. It was that simple. I could do it. Over time, they added this schedule, they added that schedule, they added this regulation, they added that regulation, and it became so complicated that I didn't have time to do all that.

That's sort of like rate setting. Our rate setting application – and we had to apply every single year for rates – that application would be about this thick. With all the schedules and all the supporting documents and everything that you had to submit, it would be about an inch thick. In addition to rate setting, the West Virginia Health Care Cost Review Authority, handles the CON program.

It was definitely a culture change for hospitals, particularly small hospitals, because we didn't have the resources and the staff. Rate setting has become just like the Medicare reports at the end of the year. They get bigger and more complicated as time goes on. I left all that up to the finance officer that I had. You fill out all these forms. You file it, you put everything in place. As you got more sophisticated and computers got more sophisticated, a lot of that was generated through computer and your bookkeeping process.

Rate setting in West Virginia was basically structured on the thinking that the state could save money. It could control its cost in Medicaid and others with rate setting. Maryland had a waiver from the federal government because Medicare is covered under their system. That's not the case in West Virginia. In West Virginia, about 65 to 70 percent of services are provided to government entities, which the rate setting authority has no control over. Rate setting in West Virginia applies only to your insurance and cash patients.

Now as with most programs, those who work in those programs will absolutely be able to document for you that they're saving you money. They're saving money in the context that they're slowing the rate of increase. I'm not saying that that is not somewhat the case. I'm not a fan of rate setting. If you remember back in Richard Nixon's term as president, wage and price controls were put in place. From the hospital perspective, that did nothing. It just stopped everything for a year, two years, whatever it was. When the government took them off, it didn't change anything.²⁰

There have been efforts on the part of the hospital association to do away with rate setting in West Virginia. For some legislators, if you document an argument, they'll agree with it. But the insurance industry feels that it is a mechanism that controls costs – at least, the rate of increase in costs. Under rate setting in West Virginia, this hospital has to negotiate a contract with Blue Cross, which spells out what rates they will pay you for your services. That has to be submitted to the Health Care Cost Review Authority for their approval. In most cases, they approve it. You still have to go through a negotiation process with the insurer for your rates. You just can't go to that

²⁰ In an effort to control inflation, the Nixon Administration implemented an Economic Stabilization Program (ESP) which was in effect nationwide from 1971 to 1974 in four phases governed by different regulations. The ESP included a wage and price freeze. [Ozminkowski, R.J., Gaumer, G., Coit, A.J., and Gabay, M. (1994, Winter). Hospital wage and price controls: lessons from the Economic Stabilization Program. *Health Care Financing Review*, 16(2), 13-43. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193497/pdf/hcfr-16-2-13.pdf>]

insurer and say, “The Health Care Authority has set our rates. This is what you’ve got to pay.” It doesn’t work that way.

The unions in West Virginia feel that it has been beneficial to them. They are probably the biggest supporter of keeping it in place. Whether it will stay in place, I don’t know. You’re right, it’s only Maryland and West Virginia who have rate setting at this point. Obviously, the hospitals would like to get rid of it, more so because it is such an onerous process than anything else at this point, because you have to negotiate rates with your insurance companies anyway.

GARBER: Before the critical access hospital designation, was Grant Memorial a sole community hospital or a Medicare-dependent hospital or a rural referral center?

HARMAN: Two of the three. We were a sole community hospital and we were Medicare-dependent.

GARBER: What do those designations mean for the hospital?

HARMAN: With the sole community hospital designation, you did get a small percentage bump in your reimbursement rate. I don’t remember exactly how much it was. Same thing with the Medicare-dependent hospital. I don’t remember the specifics, but it may have been that you could not get a reimbursement bump for both. You qualified for both, but you only got one. We were designated as a sole community hospital and a Medicare-dependent hospital.

GARBER: There were some things that you particularly wanted to talk about having to do education and networking with other hospitals.

HARMAN: One of the major issues here has been manpower, principally nursing. We always had issues with having enough nurses and, particularly in the later years, had to use traveling nurses fairly extensively. A good many years ago, we partnered with Shepherd College.²¹ There was a lady at Shepherd College who expressed an interest in seeing if she could help us out, particularly with nursing. She talked with the nursing department at Shepherd College about how we might be able to implement a nursing program off-campus over here. She was able to get the provost at Shepherd to agree to implement that program, if it was at all possible to do so, which we did. It started out with approximately eight students in this program.

This was not a program aimed at students who were just graduating from high school and wanted to go into a degree program. These were primarily women and men in the community – it turned out to be mostly women – who were interested in getting started in nursing, but who were working mothers, who were older ladies who had not had the opportunity to go to college or do this kind of thing.

We did get the program started. We took one of our nurses who met the qualifications for an instructor in the Shepherd program. These had to be master’s-level RNs. It was very efficient because we had one nurse over here in charge of eight students. What took place was maybe the first implementation of distance learning over here. Shepherd would videotape the class given at Shepherd to their on-campus students. The tape would come over here, and the nurse here would play the tape and answer questions and help the students understand.

²¹ Currently known as Shepherd University (Shepherdstown, W.Va.)

You had to have a certain number of teaching aids. Obviously, they had to learn how to make beds and perform procedures. We provided them with the teaching aids that they required. They had to rotate through psych, pediatrics, OB, medical/surgical nursing and all other nursing areas. Most of that was done here. Although we had a pediatrician, they wanted pediatrics done in the Baltimore area. Our nurse would take those eight students to Baltimore for a day or two days, whatever the requirement was, for them to do their rotation in pediatrics. Psych was somewhere else, too. Medical/surgical and OB were done here.

It was set up so that these folks, when they finished the program, would have a two-year degree in nursing. Of course, they had to take the state board, just like all nurses. We had an excellent pass rate. We started with eight students. We had those eight students for two years before they graduated. When they graduated, we started another class, so that you didn't have two different classes going at the same time.

Through that program we were able to alleviate some of our staffing problem. It didn't mean that those students had to work here. We did not pay their tuition. However, we paid the nurse who did the instructing. That program went on for a number of years.

Then Eastern West Virginia Community and Technical College²² came into being. They wanted to incorporate this program into their curriculum. As in everything else, there's always politics involved. Because the state had created this community college here, they wanted to use every avenue possible to ensure its success. This is speculation on my part, but I think Shepherd was told, "You're not going to offer this class in Petersburg any more. It's going to be done through Eastern." The program did shift to Eastern.

These programs have to go through a national accreditation process. For a few years – it might have been two classes of students going through – they were actually students of Southern West Virginia Community College. They took everything up here with Eastern, but they were actually Southern students. The instructor that we had been using declined to go to Eastern, so we had to find somebody else. We had a pediatric nurse practitioner who was a master's-level nurse. She was willing to do it, but she would have to be an employee of the college, not the hospital. The problem was that what the college paid was nowhere close to what she was making here as a practitioner. We told her, "You do this because it's important to us, and we'll supplement you. We'll make sure that you don't lose any money, you'll stay at the same level." That is what we did.

Over the next two cycles, Eastern got their accreditation. They now have an accredited nursing program. We continued to supplement the instructor's salary. It's to our benefit because it does help keep our flow of RN staff consistent.

GARBER: Would you say that half of those who go through the program end up employed here?

HARMAN: Yes. It's been a great success as far as I'm concerned.

The other thing I wanted to mention is the Rural Health Initiative program. That was a

²² Eastern West Virginia Community & Technical College is located in Moorefield, W.Va.

program that was shepherded through the legislature by Governor Caperton²³ a number of years ago. It is all directed toward manpower issues in small rural hospitals. This program, which was set up to be administered and run through the three medical schools, was intended to establish rotations in rural areas for students in nursing and medical school, PT school, any of those professions like that.

I took the initiative to write the application to apply for the consortium that we were going to build. That included nine counties – all of the eastern panhandle plus the five counties here, and Tucker County, up in the mountains. We got approved, and we were coordinators for that program here for 20 years. These students rotated through our hospital, with either department heads or, in the case of medical school students, with physicians practicing in the local communities.

They had a weekly sit-down of all these students with a physician, who lectured them on a particular subject. This was to illustrate and encourage interdisciplinary practice opportunities. That proved successful. These are all students in undergraduate programs. They are not students who are ready to go out to work. The focus was to create a situation where they have an opportunity to see what it's like to practice in a rural area. It worked very well.

We were required to have what they call learning resource centers. The one building back here in the corner came with that program. We were able to get that through that program. We had another building over here that was the original learning resource center that we converted into student housing, because we had to provide them housing when they were here if they weren't from this area. We did the same thing in Martinsburg, which is 100-some miles from here. We created the learning resource center and bought a house and made it into student housing. The whole program worked very well for us. There were some other areas in the state that it didn't quite cut the mustard. It didn't seem to work out as well. But for us, it worked very well.

The School of Osteopathic Medicine in Lewisburg rotates their students out in physician practices. These are third-year med students. In recent years, they've created what they call a statewide campus, and they put third-year medical students out with physicians. Dr. Leslie and Dr. Thompson here have had a number of medical students that have come up here and rotated.²⁴ What they did different from the RHI program was that these students stayed for six months. They lived here. They worked in the office every day with these physicians, and they stayed here for six months. We have an internist over here now, she came a little over a year ago, who came through that program. She came here, loved it, and Dr. Leslie and Dr. Thompson loved her. We offered her a stipend for the period of time that she was in residency at the university, stipulating that if you come back here, we're going to give you this money. She did, and she's back here practicing.

I think it's a great program. It's a great way to build your staff. Many times, it will be with people who have been to a rural area, who have practiced in a rural area, who know what it's like, versus a physician that a recruiter comes up with who gets here and thinks, "Oh! Where is everybody?" These are two programs of which I'm very proud, and I think we've done a great job in being able to alleviate some of our staffing issues.

GARBER: Following up on the thought about the challenges to physicians who practice in

²³ Gaston Caperton served as the 30th governor of West Virginia from 1989 to 1997. The Rural Health Initiative Act was passed in 1991. [*Encyclopedia of West Virginia*. Somerset Publishers, 1999, 113.

²⁴ Bruce W. Leslie, M.D. and Stephen C. Thompson, D.O., practice in Petersburg, W.Va.

rural areas – the current administrator here, Mary Beth Barr, mentioned that physicians need to be resilient to practice in rural areas. What do you think she was getting at?

HARMAN: In a rural area, you don't have all the resources that you have in a medical center. For example, for the most part, the anesthesia here is by CRNAs.²⁵ It's permitted in the state, and that's just the way it's always been. It's safe, it's efficient, and it's a good process. I've had a surgeon come in here and say, "Where's your MD anesthesiologist?" "Well, we don't have one." "Oh, I can't function without an MD anesthesiologist." I don't know whether it's a comfort level with these individuals, or when you have a CRNA who is giving anesthesia, the surgeon is the responsible party. He's the one responsible for that CRNA. Whether it's that, and they just don't want to take on that responsibility, I don't know. They have to understand that in an area like this, you don't have a cardiologist next door that you can run over and ask. You've got the phone, but that's still different from being able to bring him over and show him this patient. You have to be resilient to be able to function in an area like this, because sometimes you're the Lone Ranger. You're it. Doctors who have been here for a number of years will tell you, "That is the way it is." You have to have a high level of confidence in your own abilities.

I had a pediatrician here who came from Peru. He came to us through the J-1 program, which is another great program.²⁶ I've had a number of J-1 physicians here. The problem with the J-1 is that they stay for two years or three years, or whatever their obligation is, and then they're gone. I've had a couple of these physicians who came and stayed, which is what you're looking for. This gentleman was very intelligent, an excellent pediatrician – he was boarded in infectious diseases also. To say he had no fear is stretching the point, but he would take care of anything, and he knew he was it. He had no compunction whatsoever about calling the university and talking to people he knew out there, but he was it, and he had no problem taking care of people.

The obstetrician we have here, Dr. John Hahn²⁷ came in the 1980s. For the most part, he has practiced solo, delivering 300 babies a year himself. He did have a midwife who worked with him for a number of years. He is a little different insofar as he is local. He comes from the little community of Wardensville in neighboring Hardy County. He and his brother, who is also a physician grew up in the woods – their father was a logger. They know what hard physical labor is like, and they approach medicine that same way. I mean, they are pure hard workers, period. They are gems, you know, when it comes to being willing to go out there and work. They take excellent care of their patients. We now have a second obstetrician who works with Dr. John Hahn.

GARBER: You talked about the partnerships you had with educational institutions. I'd like to ask you to talk a little bit more about other types of networking in this area. Grant Memorial is a stand-alone hospital. The hospital is not part of a multi-hospital system, I believe.

²⁵ Certified registered nurse anesthetists are advanced practice with master's level training. In many rural hospitals, they are the sole providers of anesthetics. [American Association of Nurse Anesthetists. (2015). *Certified registered nurse anesthetists fact sheet*. Retrieved from <http://www.aana.com/ceandeducation/becomeacrna/Pages/Nurse-Anesthetists-at-a-Glance.aspx>]

²⁶ The J-1 Visa program allows foreign students to study in the United States. After completion of their training, students are expected to return to their home countries. However, physicians may apply for a waiver that allows them to stay in the U.S. if they agree to practice in areas of the country that have been designated as having a shortage of physicians. [Rural Assistance Center. (2014). *Rural J-1 visa waiver*. Retrieved from <http://www.raconline.org/topics/j-1-visa-waiver>]

²⁷ John L. Hahn, M.D., practices in Petersburg, W.Va.

HARMAN: No, it's not.

GARBER: It's a county-owned hospital.

HARMAN: Yes.

GARBER: It's tough being a stand-alone hospital. Why is that so, and what is the nature of the networking in this area?

HARMAN: We've always been stand-alone. It's always been 60 or 70 miles to the next largest facility. Hospitals our size, Romney and Keyser,²⁸ are 40 miles away. Looking at their location, the one hospital is only 20 miles from Cumberland. The other one is probably 28 miles from Cumberland and maybe 30 miles from Winchester, maybe less than that. They are in a little different situation. This has always been a stand-alone facility. I've always contended that this facility is going to be here for a long time because it's an isolated facility, and it's needed. It's essential to the area, so it's going to be here. It's going to be around.

WVU had a program called "Partners Program" that we participated in for a few years. WVU was working with small hospitals in their service area, and we're on the fringe of their service area. They had periodic meetings. The principle thing that they used in their program, which they installed here, was a program called MDTV. They got it through a grant.

There are two brothers on the Med School staff – Drs. Jim and John Brick.²⁹ Both of them had worked here in the emergency room many years ago. They were involved in getting this MDTV program in place, and it served those partner hospitals. We had a room across the hall where the camera was set up. You could put a patient in front of the camera, and the physician here could confer with a physician in Morgantown.

That was very helpful. I know that the emergency department used it several times, primarily with orthopedic cases. If they had an x-ray where they couldn't determine if there was a fracture, they'd call Morgantown. They would get somebody on call who would go to the MDTV room. You could show them the x-ray, and they would tell you. In that context, it was very helpful. It was not used all that much here. It was a great concept and great in theory, but our doctors didn't use it that much, for whatever reason. We used it more for conferencing with hospital staff than anything else.

The other networking program that we were involved with was with the hospital in Winchester.³⁰ They were a member of Premier, which is a purchasing group, and through them, we

²⁸ Hampshire Memorial Hospital (Romney, W.Va.) has 44 beds and Potomac Valley Hospital (Keyser, W.Va.) has 25 beds. [American Hospital Association. (2015). *AHA Guide to the Health Care Field* (pp. A696, A699). Chicago: AHA.]

²⁹ James E. Brick, M.D., a rheumatologist and John F. Brick, a neurologist, are professors at West Virginia University's Robert C. Byrd Health Sciences Center. [West Virginia University. (2015). *Directory*. Retrieved from <http://directory.hsc.wvu.edu/>. See also: Mazzella, D. (2012, Jan. 11). 'It's the right thing to do:' WVU physicians care for West Virginians through 21st century house calls. *WVU Today*. Retrieved from <http://wvutoday.wvu.edu/n/2012/01/11/it-s-the-right-thing-to-do-wvu-physicians-care-for-west-virginians-through-21st-century-house-calls.>]

³⁰ Winchester Medical Center (Winchester, Va.) [American Hospital Association. (2015). *AHA Guide to the Health Care Field* (pp. A696, A699). Chicago: AHA.]

joined the Premier program. That enabled to get us price breaks on purchases and was very beneficial. There were probably eight to ten hospitals involved in that group. They had a management engineer that Winchester employed through Premier who was stationed in Winchester. Each hospital was permitted to have one study a year within their hospital that this management engineer would come out and conduct the study.

They had meetings, no less than quarterly, with different departmental groups. Surgical services managers met together, purchasing managers met together, medical records people met together. I found that to be very beneficial. Number one, it gave people an opportunity to communicate with peers, gave them a chance to listen to problems they were experiencing, and out of that whole conversation, they came up with a solution to somebody's individual problem – not a group problem, but somebody's individual problem. That went on for a number of years.

In addition, we would submit data to Premier, which they would compile and then bring back to the group. We could all see – how many x-rays was your department producing per employee – or whatever number we were looking for. What was the efficiency of the staff? Things you could look at and compare. It's great to do that. That's the other aspect of networking that's been very beneficial for us.

GARBER: Has that program been discontinued?

HARMAN: Yes.

GARBER: Why?

HARMAN: Simply because the majority of the hospitals that participated in that program have been bought by Winchester, so there was no incentive to do it anymore. The one hospital, which was up in Charles Town, now is tied in with WVU – WVU East.³¹ It was a great program. We still participate with Premier through Winchester. We purchase through Winchester Memorial's warehouse. They make a delivery up here twice a week, where otherwise you're getting deliveries every day from different suppliers. It's advantageous to get into this cooperation and collaboration movement because there are savings to be had in that.

GARBER: What was the Eastern Panhandle Integrated Delivery System?

HARMAN: This was a program that developed out of the Rural Health Initiative that we were involved in. We took it one step further and said to these hospitals that were participating in our area, "What can we do to help us be more efficient, to help us work together to be able to get more favorable contracts?"

In that group, we had health departments, primary care centers and hospitals. There was a mental health guild in Martinsburg that was involved. We put that together, and it was in existence for a number of years. It eventually evolved down to a group of hospitals over in the Martinsburg

³¹ Jefferson Medical Center (Ranson, W.Va.), formerly known as Charles Town General Hospital, is part of West Virginia United Health System. [American Hospital Association. (2015). *AHA Guide to the Health Care Field* (p. A699). Chicago: AHA.]

area that kept it going. They were able to negotiate some contracts that were beneficial to their group of hospitals. It didn't affect anybody else. It withered on the vine as far as that larger network was concerned. It got down to be a small network over in that part of the state, and they eventually closed it down.

GARBER: What was the South Branch Valley Business Coalition?

HARMAN: Yes, that was a local group. At one point, we were using a personnel consultant out of Elkins, who was doing some consulting with some of the plants in Moorefield and some of the banks. They had a huge issue with workman's compensation in the poultry plants in Moorefield. You would get an employee who'd got on workman's comp and stayed there. They didn't want to come back to work. They wanted to continue to draw their compensation through that program. What we worked out with the two plants down there was a program where we would case manage. We had a nurse up here who would case manage those problem cases that they had in their workman's comp program. She would make sure they got to their appointments, they received their prescribed treatments. The goal was to get them back to work as soon as possible. We charged them so much per employee per month to do that. It was very successful. The number of employees who were off work on worker's compensation went down dramatically.

Out of that initiative, we developed the South Branch Business Coalition, which was a group of businesses primarily in Moorefield and one up here, that would meet once a month to discuss ways in which they could handle common problems that they had within their businesses. Our involvement with them was primarily on the workman's comp issue. We worked with them to see if they would help us support a wellness center in Moorefield, primarily by a monthly fee for the employees to go there. They did not perceive an appropriate return on investment for participation in wellness activities and did not buy into the program, but it was those kinds of things that we worked with them to achieve.

GARBER: Why did it not work out?

HARMAN: They didn't want to spend the money to put their employees on a prevention program. What we were talking about is doing a health profile on each employee. What is your potential for developing high blood pressure? What's your potential for developing diabetes? Then you could design a program for each individual that says, "Here's what you need to do to make sure you don't get these things." It was on a basis of so much per month, which would include a membership in the wellness center. I think they put pen to paper and decided it was too expensive to do that. These are long-term solutions. It was a little expensive for them to put out money now for a return some years down the road. They wanted to see a return on their health insurance costs today.

GARBER: It's always interesting in these interviews to talk about governing boards. I wonder if you could describe the composition of the board, whether that's changed over the years, what your governing board is like.

HARMAN: This is a county-owned hospital. The governing board is appointed by the County Commission, always has been. State code says there must be at least five members. It's open-ended. You can have 105, if you want, but no less than five. The code doesn't take it much further than that in terms of how you will function. There were about nine people on the board

when I came here, and we have had as many as 18 on the board. How did it get to 18? A County Commissioner decided somebody needed to be on the board, so he just put him on.

I would like to see somewhere between nine and 11, and perhaps even less in a small hospital. Boone Memorial down in Madison, West Virginia – for many years, they were county-owned – and for many years, they had five members. In the last two or three years they’ve gone to private non-profit status, and I think they’ve increased the number of members on their board as a result. But for me, nine members is a pretty good number.

GARBER: What do you think is the ideal length of a term?

HARMAN: When I came to this facility, there were no board by-laws. There were minimal medical staff by-laws. We had to write them. That’s another case where I called those two guys and said, “What do you use as by-laws?”

In the 46 years I was here, I had seven people who served as board chair. From 1958 to 1990-something, two people were chair. Mr. Geary³² came on the board in 1960-something. He was chairman of the board. He resigned from the board because of a conflict that he saw between his board membership here and his board membership on the local bank board. There was something in the code that he interpreted as a conflict, so he resigned from the hospital board.

The board, led by a couple of the medical staff members, said, “We need to have term limits.” The board then instituted term limits. We set it up so that people could be members of the board for 12 years. They could serve two six-year terms, and then they were off. In terms of officers of the board, when Mr. Geary resigned, we revised those by-laws to say that you can be board chair for two years. You can be reelected board chair for another two years, then that’s it – four years total. That’s the way it currently functions, and that’s the same for the vice-chair.

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

HARMAN: It’s someone who has served on the board for a period of time; who has a good basic knowledge of the hospital and its functions and what’s here; who has a good feel for all the members on the board; who is willing to listen to all the opinions on the board; who is willing to make decisions, to enforce decisions, to adhere to the by-laws. I think those are the things you would like to see.

GARBER: What did you learn about the most effective ways to work with your board?

HARMAN: Be open. I think they look to the administrator as the person who brings ideas to them. They expect that individual to operate the hospital, to enforce their policies, to adhere to regulations. They also expect you to be on top of things in the context of the industry, and to bring ideas of what we should be doing or should not be doing. That’s what I tried to do.

The board here has been very generous to me over the years in permitting me to work with

³² James Paul “Buck” Geary is an attorney in Petersburg. [Ashley, J. (2010, Nov. 23). Longtime Grant Memorial Hospital CEO retiring. *The Inter-Mountain*. Retrieved from <http://www.theintermountain.com/page/content.detail/id/538894/Longtime-Grant-Memorial-Hospital-CEO-retiring.html?nav=5294>

the hospital associations, both national and state, and the other groups that I've been involved with over the years. Those are important. That's where you learn what's going on. That's where you learn what the cutting edge is and where things are going. That's where you learn what to bring back to your board and say, "We need to go here."

GARBER: What a wonderful segue into our next topic, which is your service with the state hospital association and with the American Hospital Association. Would you talk about those, please?

HARMAN: Oh, I'd love to. These two associations have given me opportunities over the years that I'd never dreamed of possibly having. The two gentlemen I mentioned earlier got me involved in the state hospital association early in my career. It took a number of years before I really got into the state and national hospital associations.

One of the things that I found out is what I said before, that there are opportunities that don't come your way otherwise. If you're at an isolated hospital, you can isolate yourself and not talk to anybody and not do anything and run the place, but that may be exactly where you are five years or ten years from now. You have to do these kind of things in order to do keep yourself up to date and on the cutting edge of things.

I've enjoyed tremendously the work with both the West Virginia Hospital Association and the American Hospital Association. I don't know how I was fortunate enough to have all of this occur in my career. The state hospital exec called me one day and said, "The AHA is putting together a group of small hospital people from each of the AHA regions that they would like to come to Washington and discuss things and see what's going on. Would you be interested?" I said, "I'd be interested." That was my start with AHA. That was the group that pre-dated the Advisory Panel for Small or Rural Hospitals. We met in Washington a number of times for a couple of years. There was a gentleman from Maine, Derek Bush,³³ who chaired our group. That group evolved into the Advisory Panel for Small or Rural Hospitals, which then evolved into the Section for Small or Rural Hospitals.

It gave me an opportunity to meet with people from other small rural hospitals. It opens your vista, your vision, to what's going on and what things you may be missing and, by the same token, you may be able to offer some things that you have experienced. I have met so many great, smart people in this process. After that experience with the small or rural hospital group, I served as a delegate to the Regional Advisory Board and the Regional Policy Board (RPB). That's not only the small rural hospitals – that's all hospitals. It was a great experience, really great. Hopefully, at some juncture, I can look at it and think I contributed something, maybe not a whole lot, but I contributed something to this process.

GARBER: Do you have any suggestions about ways that either the state or the national hospital associations could be more helpful to executives in small rural hospitals?

HARMAN: I don't have anything specific to offer. I've always been satisfied with the AHA's approach to the way they work with hospitals. I worked on the RPB and then in the

³³ Derek V. Bush was head of the Maine Coast Memorial Hospital (Ellsworth, Maine) from 1969 to 1980. [1984 *Directory*. Chicago: American College of Healthcare Executives, 1984.

advisory capacity with the small or rural section. I was on the Advisory Panel and in the Constituency Section when small rural was just sort of an “in the corner” kind of thing. All of the focus was on big hospitals. I can remember the politics that went on when the Constituency Section for Small or Rural Hospitals, was fighting for more voice, more recognition, and particularly when the state legislatures and Congress began to pay attention to the small rural needs. AHA began to pay attention to small rural needs. They’ve done a great job in representing us out there.

GARBER: Good. Thank you for your service. As we near the close of this interview, I wonder if you have reflections about your personal leadership style and whether it has evolved over the years?

HARMAN: Those who have spent time with me at meetings will tell you that Bob Harman says very little. That’s true. I believe that you have to be a great listener, and if you’re talking all the time, you’re not learning anything. I am not an individual, personality-wise, that hogs the conversation. I’m just not. I’ve been in meetings where those kind of folks are there, and it’s very easy to sit back and just let them do the talking – just let them roll.

As far as how I’ve changed, I’ve become a little more aggressive in meetings and speaking up. My grandmother said, “Don’t you dare interrupt your seniors.” I took that to heart. Sometimes I interrupt people. Somebody is talking and I tend to interrupt them because I’ve got something I want to say, which is not normally my personality trait.

In terms of leadership, I still approach things the same way. I still believe that when you’re a leader in an organization, you have to lead by example. You have to listen to people. Like the illustration of working on both sides of the desk – I truly believe that. I have to be able to understand why this person is taking this position. They can tell me, but I have to try to cross the table, to put myself in that position and understand why that’s the position being taken. I know many times, that position is one that’s purely self-serving. I understand that. You have to understand all these things in order to be able to see the whole picture to be able to work out a solution.

GARBER: Could you talk about the contributions that your wife has made to your career?

HARMAN: Joanie is an exceptional person. I’ve known her since the fifth grade. We went to high school and college together. She was a high school teacher. She taught English, French, Speech, Literature at both the high school level, and at the college level. In 1996, she was chosen West Virginia’s Teacher of the Year, of which I’m very proud, and I know she is.

She is a woman who doesn’t stop, has been very supportive to me over the years. She is involved, period. She’s just involved. If there is a community organization that needs some help, she’s involved. She’s there. She is the kind of person that was born without a reverse gear. She didn’t take “no” from her students, she doesn’t take “no” from anybody, because she thinks there’s always a way to accomplish what you need to accomplish. In teaching, she sees the positive in every student where others may see just the problem child. She can develop the gifted student into a more gifted student and the problem student into an achiever.

She’s been very supportive of me. The old adage, “Behind every successful man is a good woman,” that’s more than the case in my instance. I also want to say that it was not just her. In the

success that I may have had here at this hospital, I have had a lot of women behind me – some that worked in the office, some that worked out on the floor, all through the place. In the hospital field, the majority of employees are women. I've spent my entire career working with a majority of women.

Mary Beth Barr is an example. She came here in the '80s. She's another local person who grew up here. In many ways, she reflects my thoughts. We don't always agree, but in many ways, she is reflective of some of my thinking. This pleases me, because I think she's going to carry on the tradition of this hospital and this community. There have been a lot of women behind me, but nobody's going to replace my Joanie.

GARBER: Is there anyone else that you'd like to mention?

HARMAN: When I looked over the list of those individuals that have been interviewed over the years, there were a couple that stood out. I am very much appreciative to Dick Davidson.³⁴ I spent a number of years on the RPB with Dick. I always respected his intellect. He could sit through a meeting, and after everybody had had a say, he would come up with almost a single-sentence summary of what was said and ask the most cogent question that needed to be answered. I've seen a lot of talented people in my career, and I really respect Dick.

I also wanted to mention Kirk Oglesby.³⁵ I met Kirk the first time in New Mexico. AHA was doing this program, sort of like accreditation, where they would go in and look at state hospital associations and see if they were doing it according to the standards. I was asked to go to New Mexico, and Kirk was out there with our group. I was impressed with him and remain impressed with the work that he has accomplished in his career. He is in a special class of gentlemen.

GARBER: Is there anything else that you would like to talk about?

HARMAN: The debate on national health insurance contentiously continues and on the Affordable Care Act. I am a long-term supporter of Senator Rockefeller.³⁶ I think the position he took supporting the Affordable Care Act is the right position.

I don't know if you've seen a PBS program that was aired a few years ago, "Sick Around the World." It is a look at six countries with a national health insurance program – universal coverage. Maybe we're the wealthiest country in the world, but these countries are not paupers. They have programs that cover the population. They're not all the same. They're not all like Great Britain, where everybody is covered, irrespective of where you are or where you go. You don't pay anything. That's not true, because you pay taxes. We read in the literature that these countries have coverage that, for the most part, the population is satisfied with their coverage. The statistics show that they have good outcomes, and they're spending far less than what we spend.

³⁴ Richard J. Davidson was president and CEO of the American Hospital Association from 1991 to 2007. [*Richard J. Davidson in First Person: An Oral History*. (2010). Chicago: American Hospital Association and the Health Research & Educational Trust. Retrieved from <http://www.aha.org/research/rc/chhah/Davidson>]

³⁵ D. Kirk Oglesby, Jr., led Anderson Area Medical Center (Anderson, S.C.) from 1967 to 1997. [*D. Kirk Oglesby, Jr. in First Person: An Oral History*. (2012). Chicago: American Hospital Association and the Health Research & Educational Trust. Retrieved from <http://www.aha.org/research/rc/chhah/Oglesby--FINAL--011112.pdf>]

³⁶ John D. Rockefeller IV ("Jay") served as governor of West Virginia from 1977 to 1985 before being elected to the U.S. Senate for five terms. [Rockefeller, John Davison IV (Jay), (1937-). *Biographical Directory of the United States Congress*. Retrieved from <http://bioguide.congress.gov/scripts/biodisplay.pl?index=R000361>]

I showed it to the hospital staff here. I've showed it to a couple other people. To me, the question still remains, why and how? I've heard our own CEOs and execs talk about this. I've sat in RPB meetings where everybody seems to beat the desk that a national health insurance program, a single-payer system is the way to go. I'll never see it. I don't know what the right answer is, except other countries have insurance programs that are tied in to this concept of universal coverage. Why can't we?

The other thing I wanted to mention is a 2013 issue of *Time* magazine – dedicated to why our medical bills are killing us.³⁷ I read that and I thought, “This is a ton of questions that we as an industry need to ask ourselves.” Steven Brill, who wrote the article, concluded that maybe the answer is Medicare for all. I don't know if that's correct or not. I've been a recipient of some medical procedures recently and when I look at what was charged, I look at what Medicare allowed, and think, “Wow.” I used to look at the charge master here and think “Wow. We're charging this?”

I don't know the answer to all this. It's a question that I have to ponder every once in a while, and I get frustrated thinking about it. At AHA, you have to get a consensus on something to get an answer, and it's really hard. It really is hard. I know that. It's still the question of how can other countries do this, and we can't.

People will say, “We have the premier system of any health care system in the world. For some people, that's absolutely true. I served on the National Advisory Committee for Rural Health – that was also an interesting experience that I appreciated. We met in different parts of the country. I remember going to McAllen, Texas. It's just about as far south in the States as you can get. I can take you to places in West Virginia and show you poverty. There is poverty down there in McAllen – they showed us pictures of patients who had lost all of their teeth. They didn't have any dental care. These people don't have any way to pay for their care.

We do have a premier system. We have technology that you and I can get that is bar none. I've been the recipient of it and am grateful for it. For the most part, we have people who come in here who don't have the ability to pay. We take care of them. People don't see the whole picture insofar as: we provide them care, we charge for it, somebody's got to pay for it. That “somebody” is everybody else. It's either through the insurance companies and the prices we charge them, or taxes or something – somebody is paying for it.

I sat in an AHA meeting many years ago. There was a gentleman there who practiced in Canada. At that time, the population that lacked health coverage in this country was 20 million. He said, “How can you all go to bed at night with that many people with no coverage?” Later it had gotten up to 50 million or whatever. Even with the Affordable Care Act, it's only going to bring it back down maybe to 20 million. I don't know what it's going to go to. I hope it's going to be reasonably successful in doing that.

GARBER: Your last comment made me think of something that Mary Beth Barr had suggested asking you: If you were still sitting in the CEO's chair here, what issues would keep you up at night?

HARMAN: I don't think the issues that would keep me up at night have changed that

³⁷ Brill, S. (2013, Mar. 4). Bitter pill: how outrageous pricing and egregious profits are destroying our health care. *Time*, 181(8), 16+.

much if I were still running this place, because it's still a matter of being able to provide a quality service to everyone that comes here and being able to afford to do that, which involves everything we've talked about. It involves running the hospital, staffing the hospital, purchasing supplies, everything. All that's what keeps you up at night.

GARBER: However, based on your success here and having spent a few hours with you, I doubt that you really stayed up all that many nights.

HARMAN: Well, not really, but there were some nights, yes. Yes, there were.

GARBER: Thank you very much for your time.

HARMAN: Thank you.



Grant Memorial Hospital (Petersburg, West Virginia) in 2014



Three generations of the Harman family

CHRONOLOGY

- 1940 Born January 28 in Cumberland, Md.
- 1962 Fairmont State College, Fairmont, W.Va.
Bachelor's degree, Business Administration
- 1962 Married June 17 to JoAnn Snyder of Lahmansville, W.Va.
Children: Kent and Brent
- 1963-1964 Prince George's Hospital Center, Cheverly, Md.
Administrative resident
- 1964 The George Washington University, Washington, D.C.
Master's in Business Administration, Health Services Administration
- 1965-2011 Grant Memorial Hospital, Petersburg, W.Va.
Administrator/CEO

MEMBERSHIPS AND AFFILIATIONS

- American College of Healthcare Executives
Fellow
- American Hospital Association
Committee service
Member, Section for Small or Rural Hospitals
- National Advisory Committee for Rural Health
Member
- West Virginia Hospital Association
Chair, Board

AWARDS AND HONORS

- 1993 Outstanding Achievement in Support of Rural Health, Governor's Award
- 1994 Excellence in Leadership Award, West Virginia Hospital Association
- 2002 Excellence in Leadership Award, West Virginia Hospital Association
- 2004 Distinguished West Virginian Award, Governor Bob Wise
- 2008 Senior Level Healthcare Executive Regents' Award, American College of Healthcare Executives
- 2006 Board of Trustees Award, American Hospital Association

- 2010 A Career of Outstanding Leadership, American Hospital Association
- 2010 Distinguished West Virginian Award, Governor Earl Ray Tomblin
- 2010 Outstanding Community Partner Award, West Virginia Rural Health Education Partnerships
- 2013 Alumni Achievement Award, Potomac State College of West Virginia University

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