Story of McCone Health Center
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Telling a "story" of a medical community and model of health care that one has devoted more than 35 years of life's work is rather overwhelming and to the reader daunting. Therefore the presentation will be as succinct as possible and yet it is hopeful you will hear passion and concern in pursing this hopeful “next step” in securing much needed and valued healthcare for our beloved community and surrounding rural areas for the years to come.

Having been associated in multiple medical roles in the McCone County Health Care System this rural community's fight to keep health care available for those we care about has become not merely a job but an intimate part of life. In the mid-1970s McCone County Hospital was a thriving community hospital with 20 inpatient beds, Labor and Delivery, Surgical Suite, Emergency Room, Lab, X-Ray and connecting clinic all served by one "country physician Dr. Nicholas Hastetter, MD”. This quite remarkable man would deliver a baby, take out an emergency appendix and hospitalize anyone who needed care; it could have been a bad sore throat, or a serious stroke or perhaps an end stage cancer patient. This is an important part of our story in that the community and small communities surrounding became ACCUSTOMED to having medical care 24/7 where personal and loving care was given by the devoted staff of the hospital. People were aging and the community "fathers” and long range planning groups brought about the existing early structure of McCone County Nursing Home. Then came the DRGs of the 1980s which became a "dooms day bell" for the hospital and many like rural facilities, and yet the people of this community still needed care. It was to this end that an inspired CEO saw a research program for the pilot project for a new vision of health facility the MEDICAL ASSISTANCE FACILITY (MAF). The hospital doors were closing and something had to be done to keep healthcare available and so as part of the MAF requirements, a mid-level provider (Nurse Practitioner or Physician Assistant) was needed to assist the current physician in managing the "mini-hospital" as it was coined-this writer took on that role returning to school from a job as Director of Nurses.

A mountain of work and planning later the existing nursing home was remodeled to encompass the MAF beds & Emergency Room with a clinic and ancillary services attached. By early 1991 the first MAF in the nation was opened in our community. Now, that all sounds rather easy written on paper but the scrutiny by government and state offices was intense those first few years. As the project model gleaned acceptance by the people of the community the support of our facilities services to keep needed health care at home continued.

When the MAF first opened its doors the inpatient admissions were approximately 2 per month ... now the totals of inpatients have been 208 to 291 per fiscal year over the last 3 years and skilled swing bed days 628 to 794. The services we bring to our community are often irreplaceable to the patient and family.

A few examples of services that provided quality of life for patients and families being cared for in our local facility has to do with the longevity of marriage in our rural community. In the last three years over 18 patients were given end stage life management with their family at their bedsides enjoying last precious moments with those they loved. There was no extra hotel, meal or fuel expenses because they could go home and freshen up or rest and then return to spend that quality time with their ill family member. Several of these patients were men whose wives were unable to drive due to their own disability (vision, mention, meds and pain) and because they could be in their home town precious days could be spent with their loved one. Being surrounded with people you recognize keeps spirits higher and recovery all the more surprising in some cases.

Over the years surrounding hospitals have sent patients home for end stage care only to have them survive for months longer simply because they were surrounded by who and what they have always known. One such lady was sent back from an area hospital after a serious stroke to "die in the next few days". Family conferences, care given to her by the provider and nurses she recognized, this lady continued to improve and survived another 15 months much to the astonishment of specialists knowing the case. Another lady developed bone infection after surgery in large center, she just wanted to come home and after transfer she continued to receive the same intravenous medications and specialized wound treatments for cost savings to both herself and third party payer.

After seeing the evolution of health care-in rural Montana: from the "HAY DAYS" of Medicare reimbursement to the strict enforcement of the DRG system which ultimately collapsed health care as we knew it-to the promise of a new system of the MAF which then has surged into the Critical Access Hospital model, this has been quite the roller coaster of not only a career, but of life investment. The Frontier Project has been an exciting prospect as it becomes more difficult to meet all the standards needed to continue as a CAH and yet that hope and desire to provide the needed and best health care this community has long been accustomed to and desires is still most important. One could discuss the trials of living in Eastern Montana when the heart patient arrives and needs a stent but the winter winds and blizzard conditions will not allow them to leave or the flight team is unable to land because the altimeter goes out and the motorcycle accident trauma requires emergent surgery-those stories are abundant-but what is of most importance is finding a way to keep medical care available to this unique population truly living on the frontier when compared to the modern age. Our hope in telling "our story" is that we can continue to provide affordable and needed services and be a part of this new healthcare model.