Committee on Industry, Business and Labor

Representative George Keiser, Chairman

May 27, 2010

Mr. Chairman and Members of the Committee: My name is Karen Larson, deputy director of the Community HealthCare Association of the Dakotas, also referred to as CHAD. Our organization is the primary care association for both North and South Dakota serving the community health centers (CHC's) in both states. We have offices in Bismarck, ND and Sioux Falls, SD. Our mission is to assure that our health centers are in a position to deliver high quality primary health care through community driven services. CHAD staff provide training, technical assistance, advocacy, and support to the health centers in both states.

While community health centers are a relatively new presence in North Dakota, the community health center model actually began forty-five years ago. The health center model has experienced broad-based bi-partisan support in Washington over the years. Indeed, former President George W. Bush was a strong proponent of CHC's, and was committed to doubling the number of health centers throughout the country, which he did. Today there are more than 1,150 CHC's throughout the country providing care to more than 17 million patients. The centers are required to be located in high-need areas, to be open to all residents regardless of ability to pay or insurance status, and to provide access to cost-effective, high-quality primary health care. Each organization applies through a rigorous process for funding from the Health Resource Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). Those centers approved for funding as Community Health Centers are required to provide a sliding fee discount based on 200% of the Federal Poverty Level. While it is often erroneously believed that CHC's are free clinics, they are not. The federal grant received generally accounts for approximately 25-29% of the center's budget. The centers are also reimbursed by Medicaid, Medicare, and

private insurance. I have included a fact sheet on the unique features of community health centers in your packets.

There are currently five community health center organizations in North Dakota delivering care at 23 sites. Most of these sites are actual clinic sites; others are approved services being delivered at locations such as local nursing homes. They are non-profit, community-directed centers also referred to, in many instances, as federally qualified health centers (FQHCs). Family Health Center in Fargo is our oldest North Dakota health center, beginning its work in 1990. Migrant Health Services, based in Moorhead, has a permanent site in Grafton, and reports sending its mobile units beyond its traditional Red River Valley area into North Dakota during the growing and harvesting season. The remaining North Dakota health centers were conversions from rural health clinics to community health centers in 2004-2005.

In addition to comprehensive primary health care access, preventive care, and assertive chronic disease management, the North Dakota health centers are required to make provision for or to directly provide dental and behavioral health care (including both mental health and substance abuse needs). Today, three of the ND centers provide dental services, one is providing direct behavioral health services, and all are in referral arrangements when necessary. We continue to explore additional ways to help patients access those services as we strongly believe that services for the whole person are necessary in providing comprehensive primary health care.

The 2009 Uniform Data System (UDS) reports that the health centers in North Dakota served a total of 28,215 patients in that calendar year. I have attached for your information the 2009 North Dakota Health Center Fact Sheet.

For additional information and data about community health centers:

- bphc.hrsa.gov
- www.nachc.com
- www.communityhealthcare.net

The recent passage of comprehensive health care reform has great significance to community health centers. I have attached several fact sheets prepared by the National Association of Community Health Centers (NACHC), and will direct your attention specifically to the fact sheet on funding growth. As a result of the potential for communities in North Dakota to explore applying for funding to become a community health center, CHAD is working with its member health centers on a plan for growth. Depending on the opportunities for service expansion, new access points, or complete new starts, CHAD is prepared to assist communities in that exploration.

Mr. Chairman and Members of the Committee, this concludes my prepared remarks, and I would be more than happy to respond to any questions you may have.

Karen Larson, Deputy Director
Community HealthCare Association of the Dakotas (CHAD)
1003 East Interstate Avenue Suite 6
Bismarck, ND 58503
(701) 221-9824
karen@communityhealthcare.net

Community HealthCare Association of the Dakotas

Unique Features

Community Health Centers

1. Must be located in a Medically Underserved Area (MUA) defined by higher than normal rates of poverty, infant mortality, and elderly in addition to a lower primary care physician to population ratio.

2. Must provide services to all residents of their service areas regardless of the patient's ability to pay.

3. Must provide a defined set of comprehensive primary and preventive care services and have referral arrangement with specialists and hospitals.

4. Must provide or arrange for emergency medical care after normal business hours on a 24-hour basis.

5. Must have an on-going quality assurance program that identifies and takes actions necessary to correct problems.

6. Must submit regular financial reports, including comprehensive OMB 133 agency audits on an annual basis.

7. Must have a governing board of which at least 51% of the members must be patients of the community health center.

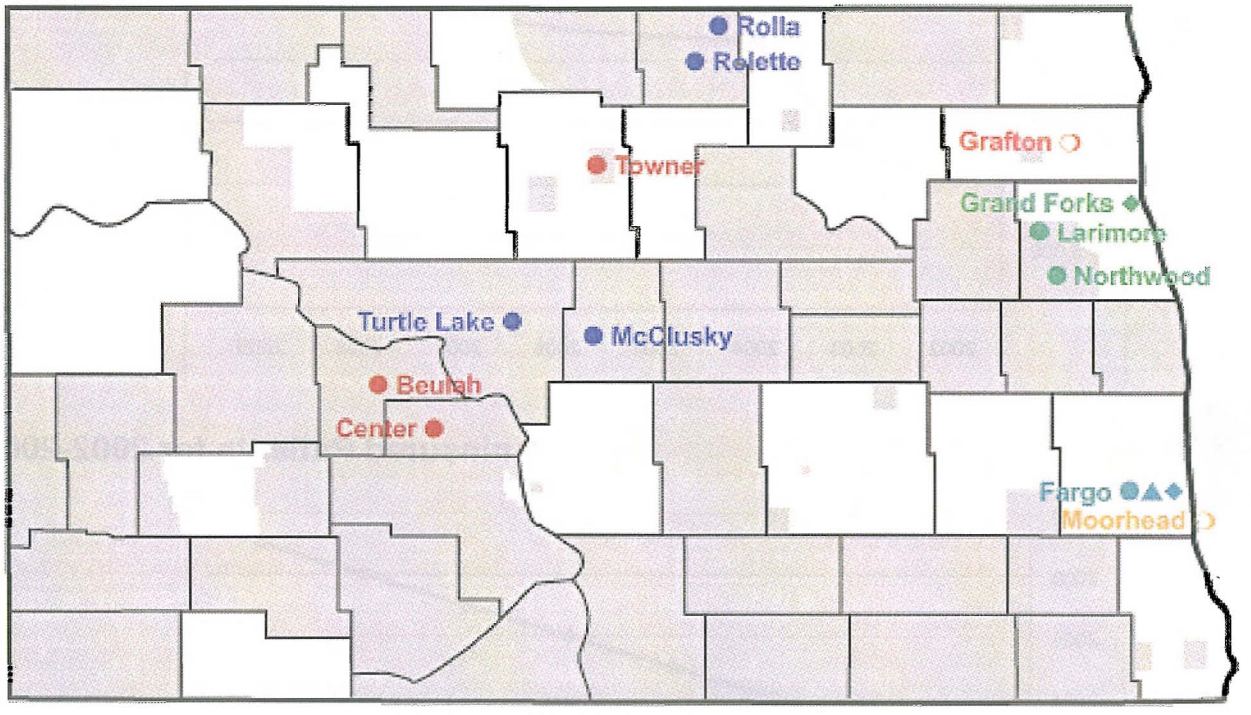
8. Must be either a public or private non-profit entity

9. Must participate in the federal (DHHS-HRSA) Uniform Data Reporting System which tracks patient characteristics, user and encounter data, and performance data (clinical and administrative).

10. Must agree to periodic on-site reviews by federal agency authorities.

March 25, 2010

Community Health Center Sites in the Dakotas



☐ Medically Underserved Areas

NORTH DAKOTA
Coal Country Community Health Center
Family Health Care
Migrant Health
Northland Community Health Center
Valley Community Health Center

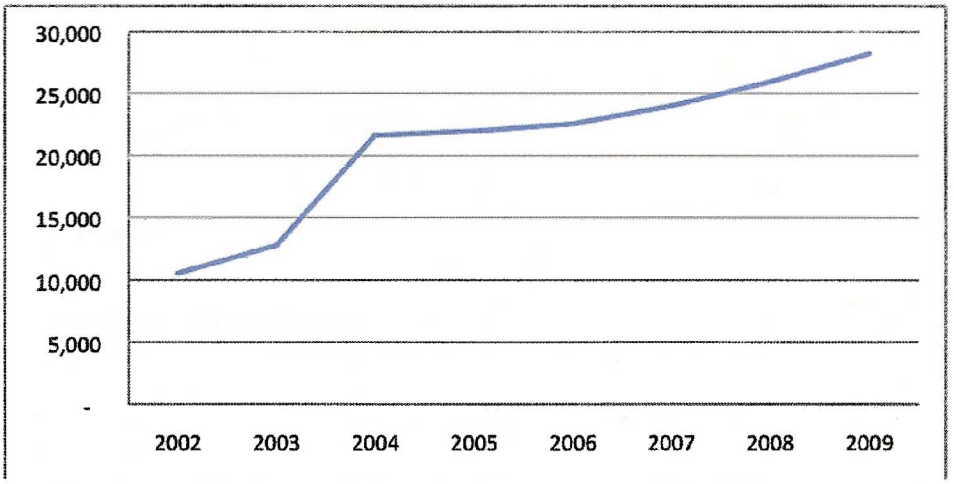
● Federally Qualified Health Centers
○ Migrant Health
◆ Dental Clinic
■ School-based Health Centers
▲ Healthcare for the Homeless

Patient Demographics

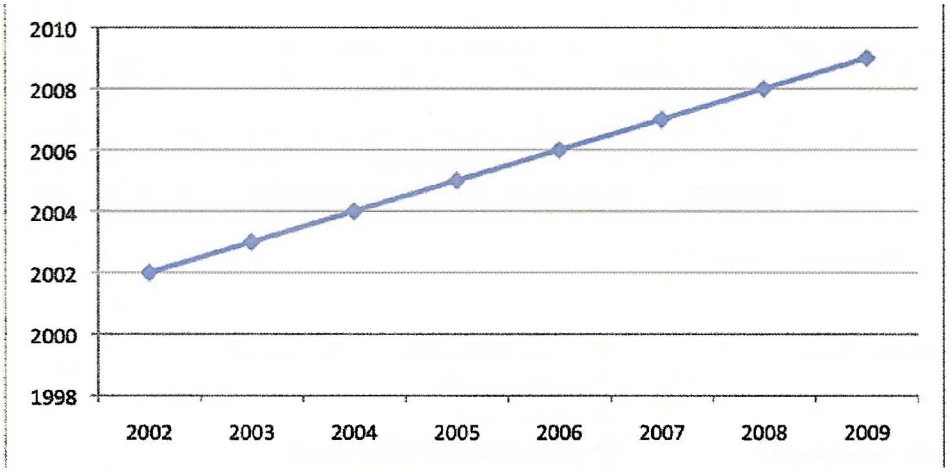
Total Patients	28,215
Total Encounters	
Medical	67,356
Dental	17,273
Patients by Age	
Under Age 5	2,320
Age 5-19	6,484
Age 20-64	16,369
Ages 65+	3,042

Patients by Race	
White	26,186
American Indian/Alaska Native	1,560
Black/African American	1,914
Asian	694
Total Hawaiaan/Pacific Islander	76
More than one race	226
Income as a percent of Poverty Level	
100% and Below	10,709
101-150%	2,347
151-200%	1,115
Over 200%	739
Unknown	13,305

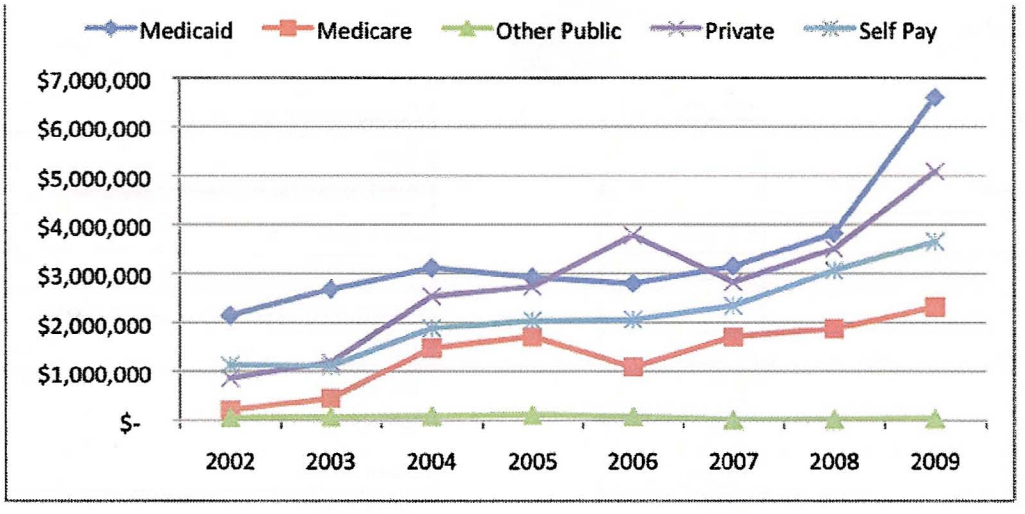
Patient Numbers for 2002-2009



Uninsured Patients for 2002-2009



Patient Revenue by Source for 2002-2009



NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTERS AND HEALTH CARE REFORM:

HEALTH CENTER FUNDING GROWTH

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

The health reform package contains provisions that will significantly grow the Health Centers program over the coming years. These provisions include both dedicated, direct funding through a new Trust Fund and a permanent authorization.

THE COMMUNITY HEALTH CENTERS TRUST FUND

Operations

The health reform package contains a total of $11 billion in *new, dedicated funding* for the Health Centers program over five years. $9.5 billion of this funding will allow health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral, and behavioral health services. The Community Health Centers Trust Fund is in addition to existing discretionary funding, which was $2.19 billion in FY 2010.

Community Health Center Operations Funding, 2011-2015				
FISCAL YEAR	**Trust Fund +**	**Discretionary Funding (est.)**	**Total Annual Funding (est.)**	**Total Annual Increase**
FY 2011	$1 Billion	$2.19 Billion	**$3.19 Billion**	$1 billion
FY 2012	$1.2 Billion	$2.19 Billion	**$3.39 Billion**	$200 million
FY 2013	$1.5 Billion	$2.19 Billion	**$3.69 Billion**	$300 million
FY 2014	$2.2 Billion	$2.19 Billion	**$4.39 Billion**	$700 million
FY 2015	$3.6 Billion	$2.19 Billion	**$5.79 Billion**	$1.4 billion

Capital

In addition to funding for operations, the Community Health Centers Trust Fund also includes $1.5 billion that will allow health centers to begin to meet their extraordinary capital needs, by expanding and improving existing facilities and constructing new buildings. While the capital funding is also available from FY 2011 to FY 2015, annual allocations for this spending are not outlined in the law. NACHC will continue to work with Congress and HRSA to ensure that the potential of these funds are fully maximized.

PERMANENT AUTHORIZATION

The law also reauthorizes the Health Centers program at significantly increased levels permanently. For FY2010-2015, the law authorizes specific funding levels (more than $8 billion in FY2015) and then in the succeeding years it authorizes increased spending based on a formula. The formula is based on cost and patient growth. The authorization levels, which typically serve as a ceiling on funds that can be provided by Congress, will remain well above the actual funding levels needed to sustain and continue to grow the Health Centers program.

NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTERS AND HEALTH CARE REFORM:

NATIONAL HEALTH SERVICE CORPS

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

THE NATIONAL HEALTH SERVICE CORPS TRUST FUND

The health reform package contains a total of $1.5 billion in *new, dedicated funding* for the National Health Service Corps over five years. This funding will place an estimated 15,000 primary care providers in provider-short areas. The National Health Service Corps Trust Fund is in addition to existing discretionary funding, which was $142 million in FY 2010.

National Health Service Corps Funding, 2011-2015				
FISCAL YEAR	**Trust Fund +**	**Discretionary Funding (est.)**	**Total Annual Funding (est.)**	**Total Annual Increase**
FY 2011	$290 Million	$142 Million	**$432 Million**	$290 million
FY 2012	$295 Million	$142 Million	**$437 Million**	$5 million
FY 2013	$300 Million	$142 Million	**$442 Million**	$5 million
FY 2014	$305 Million	$142 Million	**$447 Million**	$5 million
FY 2015	$310 Million	$142 Million	**$452 Million**	$5 million

PROGRAMMATIC CHANGES

Changes to Loan Repayment

The award Corps members can receive is increased from $35,000 to $50,000, plus beginning in FY2012 the award amount can be increased annually by the Secretary to reflect inflation.

Teaching as Eligible Service

The health reform package allows Corps members to count up to 50% of their time spent teaching towards their full-time service obligation.

Part-time Clinical Practice

Corps members may satisfy their service obligation through part-time clinical practice (a minimum of 20 hours per week). The Corps member must enter into a written agreement to either double the period of obligated service or receive 50% of the full-time loan repayment amount.

PERMANENT AUTHORIZATION

The National Health Service Corps is also reauthorized permanently under the Act. For FY2010-2015, the law authorizes significantly increased spending on the program and then for each succeeding year after that authorizes increases the authorization based a formula.

NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTERS AND HEALTH CARE REFORM:

PAYMENT AND PARTICIPATION

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

The participation and payment protections included in the health care reform package ensure that health center patients will not be excluded from new insurance products nor will they be underpaid for their services. Furthermore, these provisions will ensure that health centers can continue to provide affordable, accessible, high quality care for their patients, regardless of payer source.

WHAT IS AN EXCHANGE PLAN?

The health reform package creates regulated, consumer-oriented state-based health insurance marketplaces – or exchanges – through which individuals and small businesses can purchase coverage. These exchanges will be operational in 2014 and the Congressional Budget Office estimates that within five years, by 2019, 24 million people will carry an exchange plan as their health insurance. Individuals who purchase private insurance through the exchange and earn between 133% - 400% of the Federal Poverty Level (that's $29,460 - $88,600 for a family of 4 in 2009) are eligible for premium and cost-sharing credits.

Insurance plans that are sold through an exchange are referred to as "exchange plans." These plans must offer a minimum, standardized level of benefits and will be regulated to meet cost, quality and other guidelines set by Congress and the Administration.

HEALTH CENTER PAYMENT IN EXCHANGE PLANS

The health reform package aligns health center payment within private insurance plans with reimbursement under the Medicaid program to ensure that Federally Qualified Health Centers (FQHCs) do not lose revenue when they treat patients insured under the new Exchange-based plans.

Bipartisan majorities in Congress have widely recognized the importance of the FQHC Medicaid Prospective Payment System (PPS) and have also created a similar payment structure under CHIP. The new health reform law requires that, starting in 2014 when insurance exchanges are operational, health centers receive no less than their Medicaid PPS rate from private insurers offering insurance plans through the new exchange. This requirement applies to all FQHCs (including grantees and non-grantees, also called Look-Alikes).

HEALTH CENTER PARTICIPATION IN EXCHANGE PLANS

The health reform package also includes a provision that mandates full participation by safety-net providers in Exchange plans, requiring Exchange plans to contract with all safety net providers. Safety net providers are defined in the new law as those eligible to participate in the 340B drug discount program – including all FQHCs and other entities that serve predominately low-income, medically underserved individuals.

This requirement will ensure that as uninsured patients gain coverage through the new insurance Exchanges, the plans covering them will not exclude those low-income communities and individuals most in need of access to care.

NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTERS AND HEALTH CARE REFORM:

PUBLIC INSURANCE PROGRAMS

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

MEDICAID EXPANSION

The health reform package expands Medicaid, beginning in 2014, to all individuals under age 65 with incomes up to 133% of the federal poverty level (FPL, $24,352 for a family of three in 2010) without categorical restrictions. This expansion is estimated to insure an additional 16 million citizens and legal residents. States are required to maintain their current Medicaid and CHIP eligibility levels for children until 2019, and to maintain their current Medicaid eligibility rules for adults until new health insurance exchanges are fully operational in 2014.

Federal Medical Assistance Percentage (FMAP) is used to determine the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and medical insurance expenditures. In health reform, States will receive federal Medicaid matching payments for the cost of services to expansion populations at the following rates: 100% in 2014, 2015, and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% there after. States that had already expanded eligibility to adults with incomes up to 100% FPL (known as expansion states) will receive a phased-in increase in FMAP for non-pregnant childless adults beginning immediately (in 2010) and lasting until 2019, when their federal matching rate will be the same as other states.

The new legislation also raises the caps on federal Medicaid funding for each of the territories, by providing $6.3 billion in new Medicaid funding for the territories to almost double their current federal funding. The reconciliation bill gives Puerto Rico and the other territories flexibility to determine how best to use this funding to expand coverage and improve services.

MEDICARE REIMBURSEMENT

The new legislation expands the scope of preventative services provided at Federally-Qualified Health Centers to the Medicare payment rate and eliminates both the outdated Medicare payment cap on FQHC payments and harmful provider productivity screens. Reporting requirements begin in January of 2011, with full implementation of a new payment system scheduled for January of 2014. This provision is based on the NACHC endorsed **Medicare Access to Community Health Centers Act** (MATCH Act), however the payment methodology has been significantly altered from original legislation. NACHC continues to examine the legislation to ensure it benefits Federally-Qualified Health Centers, and if any changes to the legislation are in needed.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The new law requires states to maintain their Children's Health Insurance Program (CHIP) income eligibility levels until 2019, and it extends funding for CHIP through 2015. The CHIP benefit package and cost sharing rules remain unchanged. Beginning in 2015, states will receive a 23% increase in their federal Medicaid matching rate for CHIP expenses up to a cap of 100 percent.

NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTERS AND HEALTH CARE REFORM:

MEDICARE REIMBURSEMENT FOR HEALTH CENTERS

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

The Medicare Federally Qualified Health Center (FQHC) program was created in 1990 to ensure that America's medically underserved populations have access to a number of services, including Medicare-covered preventive and primary health care benefits. In 1992, regulations established a cap on Medicare FQHC payments. This cap has not been reviewed since its implementation 15 years ago. A 2003 NACHC analysis found that the payment cap adversely affects nearly 75% of all FQHCs.

PREVENTIVE SERVICES EXPANSION

Section 5502 of the Patient Protection and Affordable Care Act expands the scope of services provided at FQHCs to include all preventive services covered under Medicare, for services provided on or after January 1, 2011.

DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM (PPS)

The Secretary *shall* develop a prospective payment system for payment for FQHC services furnished by FQHCs. This system shall include a process for appropriately describing the services furnished by FQHCs and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. This system *shall* take into account the type, intensity, and duration of services furnished by FQHCs. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary. In addition, both the outdated Medicare payment cap on FQHC payments and provider productivity screens are eliminated.

COLLECTION OF DATA AND EVALUATION

By not later than January 1, 2011, the Secretary *shall* require FQHCs to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system, including the reporting of services using HCPCS codes.

IMPLEMENTATION

The Secretary *shall* provide, for cost reporting periods *beginning on or after October 1, 2014,* for payments of prospective payment rates for FQHCs furnished by FQHCs under this title in accordance with the prospective payment system developed by the Secretary.

INITIAL PAYMENTS

The Secretary *shall* implement such prospective payment system so that the estimated aggregate amount of prospective payment rates, determined prior to the application of section, FQHC services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs determined without the application of a per visit payment limit or productivity screen that would have occurred for such services under this title in such year if the system had not been implemented.

PAYMENTS IN SUBSEQUENT YEARS

Payment rates in subsequent years shall be the payment rates in the previous year increased, in the first year after implementation by the percentage increase in the MEI for the year, and in subsequent years by the percentage increase in a market basket of FQHC goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI for the year involved.

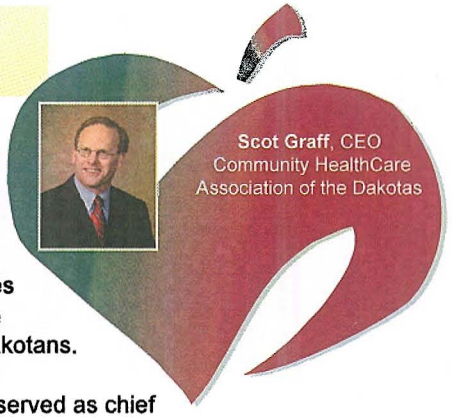
Guidebook

to community health centers in North Dakota

In the Know on Health Care

CHAD Community HealthCare Association of the Dakotas

In the Know



The Community HealthCare Association of the Dakotas (CHAD) would like to take the opportunity to introduce you to our health care community and extend an invitation for you to utilize our staff and resources to stay *in the know* on health care reform and access issues affecting Dakotans.

You may know Scot Graff who has served as chief executive officer for the ***Community HealthCare Association of the Dakotas (CHAD)*** since its beginning in 1986.

His previous work experience brings a broad range of knowledge in various facets of the health care industry. He began his community health center adventure as the executive director for the Clay-Union County Health Foundation (now Union County Health Foundation), a community health center serving the communities of Alcester, Elk Point, and Vermillion, SD.

He then became the director of the Section of Rural Health within the Department of Family Medicine at the Sanford School of Medicine, University of South Dakota.

where wellcare begins
CHAD
Community HealthCare
Association of the Dakotas

You may know ***CHAD*** as the primary care association serving the 50 community health center sites located in rural and urban areas across North and South Dakota.

These community health center clinic sites served nearly 26,000 patients in 2008. Of those, nearly 13,500 (almost 52%) were either uninsured or on Medicaid.

There is a community health center clinic site located in 18 North Dakota legislative districts and in 23 South Dakota legislative districts. Because of the large geographical area of the Dakotas many community health centers serve more than one district.

Would you know a community health center (CHC) in or near your legislative district?

The **Community HealthCare Association of the Dakotas** (CHAD) is a bi-state, non-profit membership organization that serves as the primary care association for community health centers in North and South Dakota.

Community health centers serve ALL patients regardless of their ability to pay for services.

CHAD works with community leaders to find solutions to lack of access to health care due to barriers such as geography, culture, or language.

Staff provide membership support through various areas of expertise including clinical quality, communications, data management, finance, human resources, recruitment, and risk management.

For additional information on the role of CHAD, please explore our web site.

www.communityhealthcare.net

CHAD Staff

Business Ventures Development	Deanna Fuller, MBA/MIS, JD	(605) 357-1451
Clinical Quality	Ann Skoglund, RN	(605) 223-2262
Communications	Stacie Fredenburg	(605) 357-1509
Data Management	Melissa Craig	(701) 221-9824
Finance	LaVonne Linneman, CPA	(605) 357-1481
	Amy Cravaack	(605) 357-1563
Human Resources	Shelly Hegerle, PHR	(701) 250-9197

He is active in many health and leadership organizations and was awarded the 2008 Norton-Wilson State/Regional Leadership Award from the National Association of Community Health Centers.

You may know Karen Larson who has served as deputy director for the ***Community HealthCare Association of the Dakotas (CHAD)*** since 2003.

She is a registered nurse and worked in the child and maternal health field before heading up the Division of Mental Health and Substance Abuse Services at the North Dakota Department of Human Services.

Throughout her career, Karen has lectured and provided training on various subjects and continues to be involved with various national and regional health care organizations.

She is active with health care policy issues and a vital member of the CHAD advocacy and legislative affairs committee.

Five characteristics of a community health center:

1. Located in a high-need area
2. Comprehensive primary health care services
3. Service to all regardless of the patient's ability to pay
4. A board of directors made up of a majority of active patients of the clinic that represents the members of the community served
5. Federal administrative, clinical, and financial operations requirements must be met.

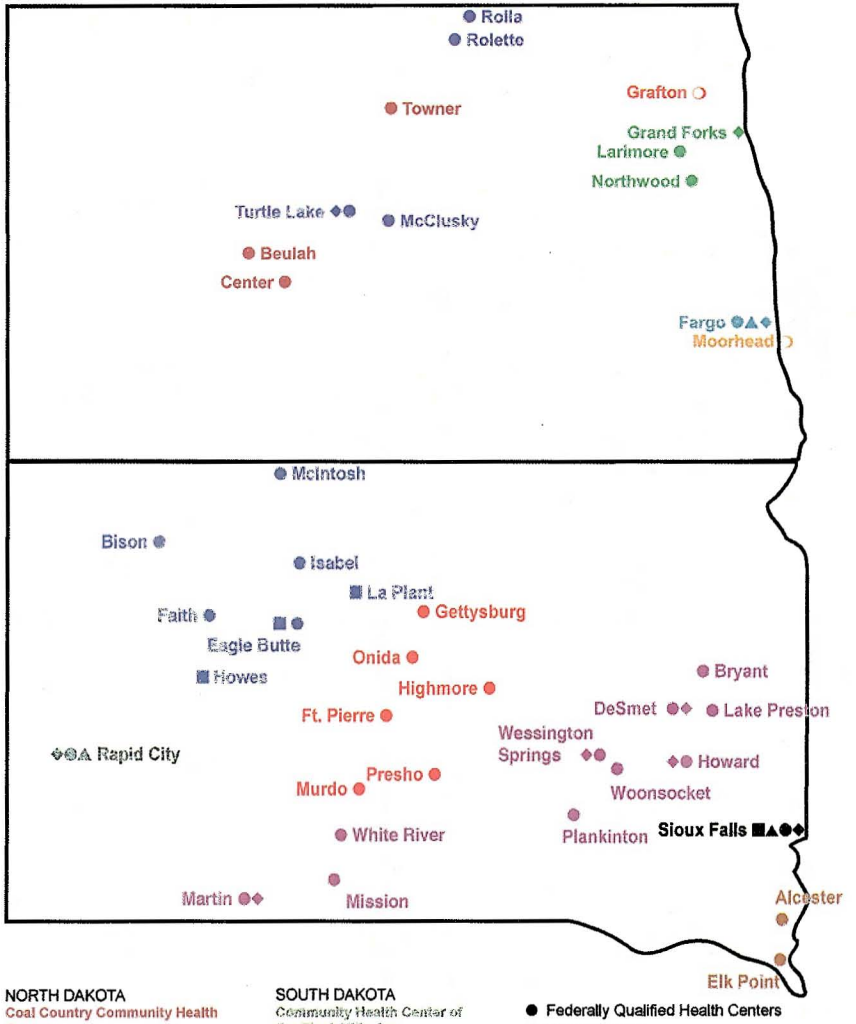
Community health centers *know* the need for primary health care in the Dakotas through public policy and community-driven health services.

We encourage you to *get to know* North Dakota community health centers and plan a tour of a facility near you. Feel free to contact **Scot** at **(605) 357-1515** or **Karen** at **(701) 221-9824** to make arrangements.

For information on community health center, please explore our web site.

www.communityhealthcare.net

Community Health Center Sites in the Dakotas

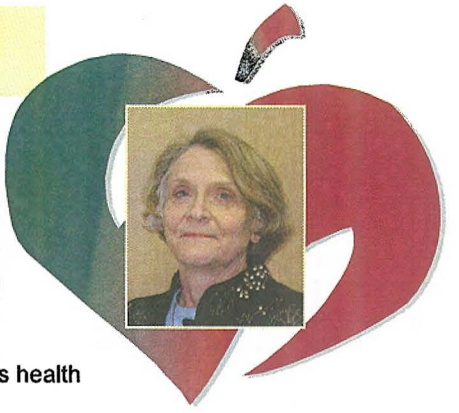


NORTH DAKOTA
Coal Country Community Health Center
Family Health Care
Migrant Health
Northland Community Health Center
Valley Community Health Centers

SOUTH DAKOTA
Community Health Center of the Black Hills, Inc.
Falls Community Health, Inc.
Horizon Health Care, Inc.
Prairie Community Health, Inc.
Rural Health Care, Inc.
Union County Health Foundation

● Federally Qualified Health Centers
❍ Migrant Health
◆ Dental Clinic
■ School-based Health Centers
▲ Healthcare for the Homeless

Sharon Ericson
Chief Executive Officer
Valley Community Health Center



You may know Sharon Ericson who serves as chief executive officer for the **Valley Community Health Centers.**

Sharon has a masters of art in political science from the University of North Dakota. Her previous work experience includes leadership positions at various health care organizations in the Midwest.

She has presented at national, state, and local forums as well as serving in university, state government, and consulting positions in areas such as grant funding and community assessment and research.

Valley Community Health Centers

In addition, she currently serves as the board chair for the Community HealthCare Association of the Dakotas.

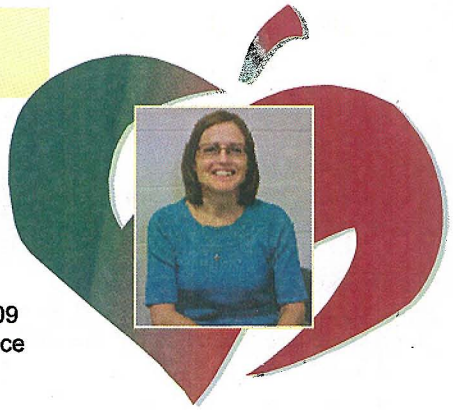
You may know **Valley Community Health Center** as the health care organization whose clinic sites served over **6,270 patients** in 2009.

Of those, **3,075 (49.1%)** were either **uninsured or on Medicaid.**

Patients by Age		**Income as a Percent of FPL**	
Under Age 5	8.5%	100% and below	8.5%
Ages 5-19	30.8%	101% - 150%	5.3%
Ages 20-44	26.8%	151% - 200%	2.6%
Ages 45-64	20.3%	Over 200%	1.5%
Ages 65+	13.5%	Unknown	82.2%

City	Clinic	Phone
Grand Forks	Dental Clinic	(701) 757-2100
Larimore	Larimore Clinic	(701) 343-6418
Northwood	Northwood Clinic	(701) 587-6000

Faye Hagen
Chief Executive Officer
Northland Community Health Center



You may know Faye Hagen as the new chief executive officer for the **Northland Community Health Center.**

Faye assumed the responsiblities of chief executive officer in August of 2009 after holding the position of chief finance officer since January of 2007.

She serves on the Community HealthCare Association of the Dakotas' finance committe, business development committee and the advocacy and legislative affairs committee.

Northland Community Health Center
Turtle Lake- McClusky- Rolette
" Our Family Caring For Your Family"

The Northland Community Health Center is a relatively new health care network and received initial funding for the three clinic sites in November 2002.

You may know the **Northland Community Health Center** as the health care organization whose clinic sites served **2,169 patients** in 2009.

Of those, **515 (23.8%)** were either **uninsured or on Medicaid.**

Patients by Age		**Income as a Percent of FPL**	
Under Age 5	5.4%	100% and below	18.7%
Ages 5-19	18.9%	101% - 150%	9.8%
Ages 20-44	22.1%	151% - 200%	8.0%
Ages 45-64	29.0%	Over 200%	11.8%
Ages 65+	24.6%	Unknown	51.7%

City	Clinic	Phone
McClusky	McClusky Family Clinic	(701) 363-2296
Rolette	Rolette Clinic	(701) 246-3391
Rolla	Rolla Clinic	(701) 477-3111
Turtle Lake	Administrative Office	(701) 448-9225

Dawn Berg
Chief Executive Officer
Coal Country Community Health Center

You may know Dawn Berg, chief executive officer for the **Coal Country Community Health Centers** since 2008.

Dawn began at Coal Country as the finance and operations officer and has 20 years of health care experience. She holds a masters of science in administration and licenses in long-term care administration and clinical laboratory practice.

She was involved with the development of three community health center access points and is a member of the Community Healthcare Association of the Dakotas, the Community Health Association of Mountain/ Plains States, and the National Association of Community Health Centers where she serves on the legislative, rural health, and membership committees. She also serves on the board for the Beulah Chamber and Beulah Job Economic Development.

Coal Country Community Health Centers
www.coalcountryhealth.com

You may know the **Coal Country Community Health Center** as the health care organization whose clinic sites served over **6,755 patients** in 2009.

Of those, over **1327 (19.7%)** were **uninsured or on Medicaid.**

Patients by Age		**Income as a Percent of FPL**	
Under Age 5	8.8%	100% and below	14.7%
Ages 5-19	18.5%	101% - 150%	4.1%
Ages 20-44	25.6%	151% - 200%	1.4%
Ages 45-64	29.1%	Over 200%	0.2%
Ages 65+	17.9%	Unknown	79.6%

City	Clinic	Phone
Center	Center Clinic	(701) 794-8798
Towner	Sandhills Community Health Center	(701) 537-2007
Beulah	Beulah Health Center	(701) 873-4445
	Administrative Office	(701) 873-7788

Patricia Patron
Executive Director
Family HealthCare Center

You may know Patricia Patron who has served as executive director for the **Family HealthCare Center** since 2007.

Patricia has had various positions within Family HealthCare Center giving her a broad range of experience in the operation of a community health center.

She has a bachelor's degree in health care administration from Concordia College in Moorhead, MN, and a bachelor's in business administration from Pontificia Universidad Javeriana in Bogota-Colombia.

Our patients mean the world to us. Family HealthCare Center

You may know the **Family HealthCare Center** as the health care organization whose clinic sites served **13,021 patients** in 2009.

Of those, **10,227 (78.5%)** were either **uninsured or on Medicaid.**

www.famhealthcare.org

Patients by Age		Income as a Percent of FPL	
Under Age 5	8.2%	100% and below	67.4%
Ages 5-19	22.2%	101% - 150%	11.7%
Ages 20-44	46.0%	151% - 200%	5.3%
Ages 45-64	20.1%	Over 200%	2.9%
Ages 65+	3.4%	Unknown	12.7%

City	Clinic	Phone
Fargo	Homeless Health Care	(701) 298-9245
	Administrative Offices	(701) 271-3344
	Fargo Clinic	(701) 271-3344
	Dental Services	(701) 271-3332
	Pharmacy	(701) 239-7132

Joan Altenbernd
Executive Director
Migrant Health Services, Inc.

You may know Joan Altenbernd who has served as executive director for the **Migrant Health Services, Inc.** for over 25 years.

Joan started her experience with this organization as an intern over 30 years ago and held positions as health educator and administrative coordinator before moving into the executive director role.

Her health care experience within her organization is broad and she has continued her formal education through graduate work at Moorhead State University and the Health Care Executive Leadership Training through the University of Southern California.

Migrant Health Service, Inc.

You may know **Migrant Health Services, Inc.** as the health care organization whose clinic sites served over **8,979 patients** in 2008.

Of those, **8,861 (98.7%)** were either **uninsured or on Medicaid.**

www.migranthealthservice.org

Patients by Age		Income as a Percent of FPL	
Under Age 5	19.6%	100% and below	89.5%
Ages 5-19	31.5%	101% - 150%	3.8%
Ages 20-44	31.2%	151% - 200%	0.6%
Ages 45-64	15.6%	Over 200%	0.5%
Ages 65+	2.1%	Unknown	5.7%

City	Clinic	Phone
Grafton	Grafton Clinic	(701) 352-4555
Moorhead, MN	Migrant Health Services, Inc.	(218) 236-6502