



# **Rural, Grassroots Community Organizing Brings a Dental Home to Those in Need**

*By Jeanne Edevold Larson, M.S.*

*June, 2009*

*Bemidji, Minnesota*

## Northern Dental Access Center: Rural, Grassroots Community Organizing Brings a Dental Home to Those in Need

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### Abstract

When community leaders in and around Bemidji and Beltrami County, Minnesota identified an increasing shortage of dental providers serving low income children and families in the region, they worked to develop a community access dental clinic. Limited resources in this rural and economically-depressed part of the state made it impossible for any single entity to take on such a large project, so collaboration across multiple community sectors was pursued. While the outcome has been a resounding success—a clinic now open and serving 20-40 patients per day—it is the broad-based community organizing that has elicited the most interest from our peers. Our ability to raise more than a million dollars to open the Northern Dental Access Center can be credited to a structured and disciplined planning process rooted in best practices. With this, we galvanized the frustration among health and human service providers, educators, business owners and elected officials, and energized each other with a common vision.

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**Limitations**

This paper discusses processes and experiences during a community collaborative effort in Bemidji-Beltrami County, Minnesota to address a critical shortage of dental access by low income children and families. This analysis does not encompass a needs assessment that would substantiate the need for a community access dental clinic; that research and data would amount to another paper in itself. For the purposes of this discussion, the reader can accept that sufficient evidence is in place that documents:

- Compelling economic and demographic data,
- Minority status of the population in and around the Bemidji area,
- Linkages between demographics, economic hardship and barriers to oral health care, and the subsequent public health implications,
- Quantitative and anecdotal data from regional health and human service agencies regarding the shortage of dental care access,
- Documentation of the shortage of dental health professionals in the region and a private practice dental community which is overburdened with low income patients, and
- Evidence that the creation of a community access clinic follows best practice models for addressing access issues.

**Introduction**

In 2003, a small group of people met to discuss the increasing need for more dental care options in northern Minnesota, specifically to serve low income children and families. Representatives from Beltrami County Health and Human Services, MeritCare Clinic, and a private practice dentist attended. Over the course of several months, the group expanded and the myriad of issues and challenges were identified.

There was pervasive agreement about the need, but less clarity about appropriate and manageable strategies to address that need. Among several goals was the strong desire to create a community access dental clinic, similar to those recently opened in Park Rapids, Hibbing, Brainerd and Grand Forks. The geographic and economic challenges of this rural region meant that few large resources were available to start up or maintain such a clinic. Other community clinics in the region were directly linked with a hospital or larger university. It was clear that for this concept to work in Bemidji, the entire community would need to come together; and that this would require substantial work to build an effective coalition.

**Problem**

Stakeholders of this new venture recognized early on that collaboration requires more than good intentions and they were committed to achieving our desired outcome—a community access dental clinic—while preserving relationships, trust and processes that would ensure long term success, community ownership and the resiliency to overcome future obstacles.

The Bemidji area and surrounding northwest Minnesota region has a mixed history of community collaboration—some successful collaborations have built long standing, cross-sector relationships and a common understanding of the strengths a collaborative approach brings to solving significant community problems. Other attempts at community-wide collaboration have involved processes, or a lack of processes, resulting in the alienation of a segment of the community and the subsequent outcomes have been compromised.

There was a common belief that for this project, community health is at stake and the magnitude of the challenge would require years of work – failure was not an option and we had to get it right the first time.

**Literature Review**

Community collaboration and processes to achieve it have been noted in professional and academic literature for decades. A comprehensive review of that literature was conducted and published in 1992, titled: “Collaboration: What Makes it Work—A Review of Research Literature on Factors Influencing Successful Collaboration” by Paul W. Mattessich, Ph. D. and Barbara R. Monsey, M.P.H. (Wilder Research Center, in association with Wilder’s Community Collaboration Venture).

Here, COLLABORATION is defined as “a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to: a definition of mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards” (Mattessich and Monsey).

In 1989, Barbara Gray, professor of organizational behavior and veteran mediator, noted that the quality of results often increases when a community problem is addressed through interagency collaboration. “This happens because organizations working jointly (rather than independently) are likely to do a broader, more comprehensive analysis of issues and

opportunities. They also have complementary resources which ‘diversify’ their capability to accomplish tasks.”

Winer and Ray in 1994 developed a process manual for community collaboration, grounded in best practice. They agree, noting, “working together provides opportunities to achieve results we are more likely to achieve together than alone” (Winer and Ray, 1994).

Mattessich and Monsey’s intensive review of the literature revealed commonalities among successful community collaborations. Those most commonly noted include:

*History of collaboration in the community*, where potential collaborative partners have experienced and observed other collaborative efforts in the community. They have an understanding of the roles and expectations required that will bring trust to the process. Collaborative efforts will most likely succeed where cooperative or collaborative activity has a history or is encouraged.

*Mutual respect, understanding and trust*, where time is set aside at the beginning of the effort to get to know stakeholders and hear their interest, intentions and agendas; form common language; and identify agreed-upon parameters for the project. “Building strong relationships takes time” and it is important to “set aside time to understand cultural context and membership.”

*Appropriate cross-section of members*, where the collaborative group includes representatives from each segment of the community who will be affected by its activities. A group should take time to identify the people who have either explicit or unspoken control of issues and these people should be invited to participate.

*Members see collaboration as in their self-interest*, where collaborating partners believe the benefits of collaboration will offset costs such as loss of autonomy or ‘turf’ issues.

*Members share a stake in both process and outcome*, where stakeholders feel ownership in the way the group works together, as well as the product of the work. Adequate time must be devoted to developing ownership among members about decisions and outcomes.

*Willingness to compromise*, because decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly. Participating organizations must give their

representatives some latitude in working out agreements among partners. Time should be allowed for deliberation, especially when decisions are made, recognizing when to seek compromise or common ground and when to work through major decisions.

*Multiple layers of decision-making*, where every level within collaborating organizations participates in decision making. Successful groups recognize the multiple layers of decision making within organizations and the community, and create mechanisms to involve each. It is important to have talented, key people in an organization assigned to work on the collaborative project and that they are interested in its success.

*Open and frequent communication*, where group members interact often, update one another, discuss issues openly, and convey all necessary information to one another and to people outside the group. A system of communication should be set up at the beginning and efforts should be made to avoid selective distribution of oral and written communication, since this can splinter the group.

*Concrete attainable goals and objectives*. Success requires that goals and objectives of the group are clear to all partners and can realistically be attained. Goals lacking in clarity will diminish enthusiasm. Success will be more likely if both short term and long term goals are identified and progress is recognized. It is helpful to have a progression of ‘successes’ during the process to maintain energy and a sense of momentum.

*Shared vision*, where members agree upon a sense of purpose and a focus; and that a common language articulates that vision to all constituencies. This vision guides the group so that its attention is not diverted.

*Skilled convener*. It is important to have a convener who has organizing and interpersonal skills and carries out the role with fairness. The convener must have process skills to balance process with task activities, leadership skills to enable members to maintain their roles within the collaborative group, and communication skills to openly address any imbalances of power.

*Sufficient funds*. The collaborative group needs an adequate, consistent financial base to support its operations, and obtaining continued financial means for existence must be a priority.

Winer and Ray (1994) take a metaphoric approach to explaining the collaborative processes necessary to ensure success. “Collaboration is a journey, and, like many roads, it is full of twists and turns.” They recommend using “the language of ‘we’ and ‘our’ and ‘us.’—You and I cannot achieve what *we* can achieve,” and they warn: “embrace complexity and ambiguity.” Collaboration is not an easy fix; it requires complex, long-term thinking and conflict management. “Building trust, organizing the effort, evaluating the results, and involving our communities are all part of collaboration. Yet these elements remain ambiguous, requiring continual redefinition.”

Winer and Ray outline a triad of elements that must exist for success: a destination (goal), the travelers (stakeholders) and the road or journey (process). They set out steps for a community to address the needs of all three.

The destination (what Winer and Ray call the ‘community benefits’) is the agreed-upon end result.

Travelers are the collaborative partners with different customs, languages, preferences and powers. “A healthy collaboration acknowledges that the group needs a diversity of preferences and that all these preferences are valuable. Only then can the collaboration plan a sequence of actions to best use the preferences each member.”

The most complex element of the triad is the road, or process. To reach a destination, Winer and Ray note that a good road is needed. “Not one of gravel or concrete, but of relationships to build and work to do.” Along this road are four distinct terrains corresponding to four stages of collaboration, each with challenges and opportunities:

*Hill Country (Stage 1) Envision Results by Working Individual-to-Individual.* Here is where collaboration usually starts, with a conversation between 2-3 people.

*Marshland (Stage 2) Empower Ourselves by Working Individual-to-Organization.* This stage requires some authority from stakeholder organizations for the individual participants to act—the two or three people have to sell their own agencies and become empowered.

In these early stages, specific process guidance is offered, such as:

Set ground rules and rituals to assure equality, respect and that everyone is heard. This requires agreement on a decision making process, participation expectations and more.

Inviting participation is also important. “Successful collaborations need to involve minority, grassroots, and end-user groups. This can be difficult when the initiators are from the mainstream. Such initiators can attract these groups by making personal contact, building relationships, and making sure that participation truly benefits them. Even so, mainstream initiators may have to wait until the collaboration is closer to taking specific actions...then involving the end users is often easier.”

Collaborators must make time to build relationships; this will ease confusion and competition, and create a common language for clearer communication. They can also build trust by holding effective meetings, staying with the agenda, reporting openly to the group about activities (accountability), adhering to ground rules, making time for open discussion, celebrating success and always keeping an eye on the next steps. Having a neutral convener is key to building trust.

Additional recommendations to make these early stages successful include: disclose self interests; affirm the vision; think strategically; take action; confirm organizational roles; get letters of support; expect conflict; clarify issues; stay organized; secure resources; reward and celebrate. Specific tactical tips are included in the text and provide a helpful roadmap through the intense work of establishing a solid foundation for collaboration.

*Fertile Plains (Stage 3) Ensure Success by Working Organization-to-Organization.* At this stage, the collaborative builds relationships and formal ways for stakeholder agencies to interact within defined systems and processes. This is where much of the leg work occurs. Winer and Ray suggest that stakeholders:

- Meet with end users so that tactical solutions will be effective in achieving desired results.
- Benchmark best practices to save resources and time.
- Develop action plan so that attention is not diverted.
- Build collaborative work habits among stakeholders.
- Create agreements and memorandums and confirm the legal status of the collaboration.
- Begin to evaluate results by determining measurable outcomes and collecting baseline data.
- Renew the effort to energize stakeholders who may have been less interested in the planning but are ready to help with tasks.

Retire appropriate members so that those who may be exhausted by planning efforts can gracefully exit to make room for those energized by tasks.

Add new members to round out skills and resources necessary for implementation tasks.

Celebrate successes along the way, and share the credit with all who were involved at any stage of the collaboration.

*Broad Forest (Stage 4) Endow Continuity by Working Collaboration-to-Community.* For lasting impact, the collaborative must institutionalize success in the community by adding help from more people and organizations and increasing support, so that efforts will bring about new and continuing successes along the road. Recommended tools for this stage are:

Maintain high visibility of the effort throughout the community.

Communicate results to all constituencies whenever possible.

Involve the community, even those who seem unlikely, so everyone feels this new effort belongs to them.

Teach the value of collaboration so that the community can recognize the results and be open to taking on the next big challenge.

Build leadership among stakeholders to assure continuity in the vision and long term ownership of the community commitment.

Change the system wherever possible to support collaborative solutions.

Winer and Ray offer tips on meeting the challenges of each stage and summarize with this advice:

“If we travel alone, we choose our own route and our own timetable. If we travel with others, we need to blend and hone and modify our routes and our timetables. When our whole group gets together, we may not end up exactly where each person wanted to go. And even if we end up where each of us wanted to be, how we got there will not be precisely as planned and will usually take longer than imagined. But think of the community benefits and the self-satisfaction! We may not see the sight we set out for. Instead, we may discover the eighth wonder of the world—and we do this together.”

Another theme in the literature is the importance of benchmarking to determine best practices and avoid missteps others have experienced by capitalizing on lessons learned.

According to Jason Saul in “Benchmarking for Nonprofits” (2004) “best practices are the products of benchmarking. They are the innovative processes of other top-performing organizations that make them so successful...the most successful and efficient means of achieving a particular outcome for an organization.”

Benchmarking is an entrenched process in the corporate world and Saul notes dozens of examples where nonprofits benefit from the same disciplined approach. Benchmarking is especially helpful for nonprofits because, as he writes, “resources are tight. Time is even tighter.” This is especially true for groups “without the luxury of resources or staff,” and benchmarking is the tool that assures maximum leverage of what resources are available and allows a group to have more control over its destiny and helps build confidence among stakeholders.

Additional literature has also been consulted during the collaborative process including the role of leadership, such as noted by Peter F. Drucker in his book, “Managing the Nonprofit Organization, Principles and Practices” (1990). Drucker advises careful management of community relationships, in addition to clients. This requires listening, telling the story, measuring impact, sharing the credit for successes. Leadership must make decisions that are information based and data driven; outside focused, rather than inside focused; and must build a team that understands the community nature of the agency. It is important to recognize the “multitude of constituencies” involved and lead in a way that elicits trust and compassion.

Final points in the literature considered are noted in the “Good to Great” paradigm of author and researcher Jim Collins in his monograph, “Good to Great in the Social Sectors,” (2005). Here Collins lays out a number of characteristics that are necessary for an agency to achieve greatness including:

Having Level 5 leadership at the top, defined as people who have ambition for the cause, rather than personal ambition. The blend of personal humility with professional will creates legitimacy and influence in the social sector; these traits can be recognized by the consensus-building surrounding decisions rather than the exercise of power.

Maximizing the Flywheel concept, “success breeds support and commitment, which breeds even greater success, which breeds more support and commitment, round and round it goes” and there is no single, defining action, rather a series of motions in the same direction until a point of breakthrough and beyond.

Discipline is pervasive. “Greatness is a matter of conscious choice and discipline,” which will take an agency beyond good intentions and good people by harnessing those resources into forward, strategic motion.

Together, this collection of literature provided a framework for our community collaborative venture throughout five years of planning, recent implementation tasks, and future growth.

## **Methodology**

Planning sessions over the course of five years included a number of process tools based on best practice for building community and collaboration. Winer and Ray’s description of the journey has been accurate, as the idea to establish a community access dental clinic began as a conversation between two or three people, who represented various health and human service sectors of the community, and a private practice dentist—each of whom were seeing increases in need for low income people to access oral health care, and a decreasing availability of that care throughout the region. Extensive resources were being expended to get families to other parts of the state for care, and more alarming was the number of people simply not getting oral health care at all, jeopardizing the long term public health of our community.

As conversations progressed, it was clear that additional stakeholders needed to be included in the conversation. One of the first agreements was that this issue must be defined as a community health issue, rather than a dental shortage issue—in order to build the broad base of support necessary for success.

The list of participants and stakeholders grew quickly and through a variety of deliberate processes over the course of five years, the community collaboration was secured. Below is an outline of the process tools utilized during that time:

From Winer and Ray, we used simple tools such as membership rosters (both to keep accurate notes, and to record volunteer time that could be leveraged for later funding proposals); clear meeting agendas and meeting notes; we developed clear and agreed-upon vision-mission statements; and created a communications plan to keep the entire community apprised of our efforts.

Additional elements for success noted in the literature have been present during our process; from Mattessich and Monsey:

*History of collaboration in the community.* Bemidji had a number of successful collaborations in years prior to the inception of this project: an arts and culture nonprofit collaborative (a seamless, community-wide strategy to create a vibrant arts community); Healthy Community Healthy Kids (employing the Search Institute's asset building model to create a community that puts kids first); Beltrami Area Service Collaborative (bridging the nonprofit and government health and human service agencies to leverage resources and create a gap-free continuum of family services); B-TEAM (a county wide effort to develop Minnesota's first ever smoke free ordinances for restaurants, bars and public places); and more.

Additional community collaborative efforts coincided with our project, including Bemidji Leads! (a systematic approach to creating and pursuing a community identity); B-WELL (the next phase of B-TEAM to encourage community wellness); and Churches United (a single point of entry for community members in need to access the charitable efforts of all congregations).

*Mutual respect, understanding and trust.* We set aside time at the beginning of the effort to get to know stakeholders and hear their interests, intentions and agendas; to form common language, and identify agreed-upon parameters for the project. In many respects, we were blessed to not get the money to build the clinic right away—we had the time to lay the foundation for a solid collaboration. The overwhelming challenge of raising enough money was a coalescing element that fueled the fortitude of the group.

One simple, effective tool was to open each meeting with a “tell us your favorite ...something” While some found this mildly annoying, in the end, most agreed that it allowed unique bonds to form and for humor to set a comfortable tone.

*Appropriate cross-section of members.* Early in the planning process, we conducted a stakeholders analysis in order to identify the spectrum of people that would best assure success. We also identified potential people or agencies who might be roadblocks to success and developed specific strategies to include them, hear from them, and build bridges so that we could move forward on those things with which we could agree. This turned out to be very effective.

As the months of planning progressed, our community advisory group continued to grow.

Initiating organizations included:

MeritCare Clinic

Beltrami County Health and Human Services

North Country Health Services Northern Medical Clinic

People's Church

Private Practice Dentists

Within a few weeks, this list grew to include:

Northwest Technical College Dental Assisting Program

Medsave Family Pharmacy

Boys and Girls Club of Bemidji

Additional private practice dentists and hygienists

Legal services of Northwest Minnesota

Bi-County Community Action Program (HeadStart)

Area legislators

Bemidji Area Schools

Indian Health Service

Today, this list includes more than fifty area agencies, employers, educators and individuals who remain committed to the success of this project.

*Members see collaboration as in their self-interest.* It was important that partners believed the benefits of collaboration would be worth their time and resources. Those at the table all had clients, employees, parishioners, or students who needed increased access to dental care or improved educational opportunities for community health. The team of community advisors was (and is) made up of active and talented people and everyone brings unique strengths and communication styles. With an open process, we made room for different styles of learning and different levels of participation to suit individual interests and strengths. Planning drove some people crazy and we waited to call on them until we needed action; others would thrive in the philosophical discussion and planning, but were less available for implementation. Some were

writers and researchers; others were schmoozers or number crunchers—letting each determine what they can do for the common vision allowed for a greater sense of personal satisfaction.

*Members share a stake in both process and outcome.* By employing a disciplined planning process, we were able to assure decision-making that diffused power and transcended hidden agendas. In addition, because there was no staff in place to accept delegated tasks, members had to take on assignments and be accountable to each other. In this way, no one could really complain about the outcome. With confidence and ownership in the process, stakeholders were strong ambassadors for the vision.

*Willingness to compromise.* Since the first conversations about this project, many ideas emerged about what this clinic should be, how it should be operated and who must be served. Advisors invested considerable time in structured discussion to determine elements that everyone could agree on, identify what was financially feasible, and map out future steps to accommodate those ideas that could not be addressed in the start up stages. Many people had to let go of their strong desire for certain features of the project in order to pursue the primary, agreed-upon objectives. Things like specialty care, sliding fee scale, charity care, insurance counseling, treatment coordination, etc.—all had to be put on hold in the beginning. Long term strategies include reconvening to address these issues when we are on a firm financial and operational footing.

*Multiple layers of decision-making.* We worked to include directors and owners of stakeholder groups, as well as front line staff and mid-level managers so that we had a broad spectrum of experience and input. If the necessary decision makers were unavailable, the group took the time to get them involved at critical decision points. Within the advisory group, there was a fundraising team, a speakers bureau for public relations/presentations, policy and procedure advisors, and financial forecasters.

Community awareness presentations were geared to different groups to keep them informed and involved, i.e. elected officials, area dentists, front line human service providers and others. Several representatives continued to support efforts ‘in spirit’ but did not attend meetings at all. We developed a listserv for meeting notes for anyone wanting to keep up with our activities. We continually treated them in every way as if they were at each meeting, knowing that at some point we could call upon them for a specific task if necessary. This was very effective when it

came time to collect data, letters of support and in making connections for potential grant sources. Overall, advisors shared the credit among the entire community for each success.

*Open and frequent communication.* The advisory team met twice monthly for a while, monthly after that. It was agreed that communication for meeting reminders, and reports on action, could be managed via email. Meeting agendas were clear, but allowed for freeflow conversation. Humor, food and structure were key, along with an agreement to end on time. Everyone was relaxed enough to have fun because they knew, in the end, the meetings would result in specific forward movement.

Among other topics, advisors had several frank conversations about the role of private practice dentistry and the core issues surrounding lack of access by low income people in our region. Over time, we were able to break down some stereotypes and misunderstandings and find our common ground: most believed this was beyond dentistry, and represented a greater public health issue that has become a growing concern. We found tension between medical and dental professions, between dental and hygiene professions, philosophical differences surrounding the concept of charity care and more. Open conversation to hear individual perspectives and holding each other accountable to the ground rules of the collaboration—were all key to building trust and mutual respect.

There was consensus early on that this must be a transparent process with no hidden agendas; ‘behind close doors’ meetings or negotiations at any step of the process would chip away at trust. This got dicey at times, especially when dealing with competing interests in facility selection, funding expectations and possible competition for funding dollars among stakeholders. Transparency required much discipline and continues to be one our best and most challenging characteristics.

*Concrete attainable goals and objectives.* In order to maintain energy and a sense of momentum over such a long period of planning, we needed a progression of ‘successes’ to celebrate. Getting the first planning grant, and the next; having a community presentation go well and lead to others; donation of used equipment or small financial gifts from area dentists; getting recognition for our efforts—each was a small success that we celebrated along the way, and each helped us believe we could really do this. Solid benchmarking efforts validated that the goals and objectives were attainable. Advisors visited other community access dental clinics and

spoke with dental leaders statewide about different models of public health dentistry. Most exploration centered on Park Rapids Community Dental, Valley Community Dental Clinic in Grand Forks, and Hibbing Community Clinic. We have been grateful to the mentoring of Dr. Dan Rose, as well, who has advised us at all levels of development.

Financial planning was also instrumental—although not very accurate as we look back. Significant energy was spent identifying fee structures, reimbursement rates, production potential, staff/provider costs etc. These exercises were necessary to build confidence among stakeholders that a business model would work. Long term sustainability could not be at the mercy of grants and fundraising efforts, especially in this region where those resources are minimal and the number of nonprofit agencies competing for them continues to increase.

*Shared vision.* Stakeholders spent time with vision, mission, and core values statements, which all involved intensive philosophical discussion and debate, as well as an understanding of the current environment for the people we wanted to serve. Members struggled to agree on parameters such as geographic area, and patient eligibility; even the name of the new organization took several discussions.

*Skilled convener.* It was clear early on that moving from an informal lunch by a handful of people passionate about the issue, to a structured journey required a facilitator skilled in collaborative processes with an understanding of the collaborative challenges and opportunities in the Bemidji area. Through a partnership with two local community foundations and Bemidji State University Center for Research and Innovation, we were able to access Jeanne Edevold Larson, a nonprofit consultant who has stayed with us through all these years. Jeanne was the process hound, organizing and coordinating meetings and processes, while the stakeholders were responsible for regular tasks, reporting to each other, and for decision making. Jeanne's role expanded into grant writing and pursuing the legal work for the development of the IRS nonprofit application—always as a ghostwriter for the collaborative.

*Sufficient funds.* The early infusion of planning funds can be greatly credited for the success of this project. This started with a modest financial commitment from Beltrami County Health and Human Services and the subsequent community foundation investments. Without having the time to plan, the facilitation expertise or the donut money and such—we might still be having lunch once a month discussing how we can build this clinic. Most participants come from this

region which is short on resources, and they all operate within the health and human service fields where there are huge financial challenges. No one expected “sufficient funds” and all were accustomed to doing much with few resources and were skilled at finding creative ways to leverage minimal resources. As mentioned, the convener role expanded to include assistance in the preparation of grant proposals to support the planning and start up phases of the project and subsequent funds were attained.

Additional processes were used throughout the planning stages of this collaboration. A number of quality tools borrowed from manufacturing and lean concepts provided purely analytical discussions to avoid political, cultural or other missteps.

At the first formal, facilitated planning session, an Affinity Diagram was conducted asking, “what are the issues related to developing a successful, accessible public dental program?” Hundreds of sticky notes with answers were categorized into themes. Then, we conducted an Interrelationship Diagram (a complementary quality tool), where the key themes from the Affinity Diagram were analyzed to determine which things drive the others. These two tools revealed this sequential list of issues to be addressed:

1. Develop governance/organizational structure
2. Generate positive community and professional support for program
3. Identify the scope of clinical services
4. Create sustainable financial systems
5. Identify facility needs
6. Overcoming difficult provider/staff issues
7. Effectively serve the intended population

Work assignments were made from there, beginning with the top three items. Subcommittees worked on the governance structure, naming the agency, and identifying legal requirements for nonprofit setup. A team met with community agencies, fraternal organizations, elected officials, and health care facilities, to present information about the planning of this dental clinic and to build awareness about the critical need and its overall impact on public health. Dozens of these were made, including an open house discussion with area private practice dentists.

Process Mapping and the Stockdale Paradox. More than half way through planning efforts, we reached a standstill where it seemed there were too many loose ends stalling

progress—we couldn't find a dentist, we couldn't find the right facility, start up funds weren't coming in like we had hoped and projected, and several timelines were missed. The group started over by listing everything that still needed to happen and put those tasks in order of what must happen first, next and next. This was the 'deal breaker' session. It was clear the obstacles were great and a choice needed to be made. Do we quit because momentum was lost and no clear path remained? Or do we take a leap of faith and continue? The leap of faith was chosen, despite all logical evidence advising the contrary. We used an "as if" approach, or the Stockdale Paradox—the unwavering faith that one will ultimately prevail while simultaneously confronting the brutal facts of current reality. We were determined to move forward 'as if' we knew we would succeed.

Weighted Decision Analysis. This tool was used to determine the criteria for a clinic facility. We weighed each desired criteria (such as centralized location, adequate parking, proximity to other family services, etc.) to identify which were most important; information was gathered for available facility options and the criteria was scored appropriately for each. This assured that personal or professional biases were not at play; several of the potential facility sites were owned or operated by stakeholders and selection needed to be purely an analytical choice, not a political one. The result was that the most desirable options were to find facility space connected to either health care campus in our community (MeritCare Clinic or North Country Health Services) or to build on our own. We went down several paths exploring all options that surfaced over two years.

Much of Drucker's advice was taken as well. From the beginning, we worked hard to manage community relationships, in addition to our staff and patients. This required listening, telling our story, measuring our impact, and sharing the credit for all our successes. We continue to be information based and data driven, outside focused, not inside focused...and we are working to build a team who understands who we are as a community agency, in addition to who we are as caregivers. We are diligent in recognizing our "multitude of constituencies" including educational institutions, health providers, patients, community service providers, dental professionals, elected officials, funding agencies, state plan administrators, , and others.

In the later planning stages, we met with a group of community members who will be eligible for dental services and would likely become patients of the new clinic. With the help of an objective facilitator, our purpose was to understand patient barriers to care and their

perceptions of community agencies working to serve their needs. This helped guide our policies and procedures, and shaped our clinic environment so that it would be welcoming. We enlisted their help, as well, to begin the dialog about personal responsibility for oral health.

## **Results**

Successes of this collaborative mirror Jim Collin's observations, including the value of Level 5 leadership. Key stakeholders were clear from the very beginning that the importance of a community dental clinic far outweighed any one agency's agenda, or who should take credit if it worked (or blame if it didn't). They led by example, with openness and honesty, communicating and listening to every constituency, and encouraging the development of leadership skills among each other.

We also experienced Collin's flywheel effect, with each new step forward spinning off additional movement, and the continued branding of the concept throughout the community spun off new support from an array of sources. One dentist commitment led to two; sharing that with others prompted additional interest and two more joined. The same incremental successes occurred with fundraising and support from elected officials.

Overall, Collin's emphasis on discipline in process, communication, data collection, and focus has been an effective guide for this collaboration.

In the last months of planning, the collaborative formed a formal board of directors and completed the legal work for nonprofit status. Communication and feedback from the larger advisory team continued, but day to day legal and financial decisions needed to be made by a smaller, more agile group of decision makers. By this time, these leaders had the trust and confidence of the larger group and they took seriously their role as representatives of that larger group. Remaining capital and start up grants flowed in, piece by piece and in 2008 there was enough to make a final commitment on a facility. Of the several sites that were explored, one clearly had the right mix of feasibility and affordability. In January of 2009, the entire Bemidji/Beltrami County community was invited to tour the Northern Dental Access Center and celebrate its opening. More than 120 people came and the subsequent press coverage reiterated the excitement and pride shared by everyone involved.

We continue to communicate regularly with advisors, funders and stakeholders as well as provide news and updates to the greater community.

The Vision of the Northern Dental Access Center *is to be a not-for-profit, non-competitive dental service for the underprivileged and underinsured, providing access and education for emergency and preventive care, paying particular attention to children. We believe all clients deserve comprehensive quality and respectful care in a timely manner.*

The Mission—*is to provide access to a dental home for those in need.*

Northern Dental Access Center pursues its vision through these strategic goals:

- Eliminate pain
- Reduce disease and infection
- Provide referrals for specialty care
- Provide preventative care
- Educate patients on preventative care
- Expand public health programs regarding oral health
- Follow-up and track target population

### **Discussion –Lessons Learned**

Many lessons were learned along this collaborative journey and we enthusiastically share them with those interested in how Bemidji/Beltrami County achieved this successful outcome. These include (in no particular order):

Money is not a driver. For several months we were convinced that we just needed money to build the clinic. What our process illuminated was that money comes only after other, more foundational tasks are accomplished.

As noted by Drucker, we are different than a for-profit enterprise—even though our services are similar to private practice settings. We must continually manage community relationships, in addition to our staff and patients; and recognize our “multitude of constituencies” including, educational institutions, health providers, patients, community service providers, elected officials, funding agencies, State plan administrators, and the private practice dental community. This requires listening, telling our story, measuring our impact, and sharing the credit for all our successes.

We did not become exactly what we thought we were going to be—and that’s okay and working well. We have learned to embrace the chaos and make it appear seamless—this takes agile management so that opportunities are captured and obstacles are seen as challenges to overcome; and patients see only calm and attention to their needs. We relate to the duck metaphor—look calm and serene above the surface, but paddle like heck beneath.

The breadth of our support is pervasive and comes from every corner of the community. Taking the time to formulate our messages, and getting them to anyone who would listen with a disciplined communication plan—was well worth our efforts. We've encountered many obstacles, delays, and sidetracks—yet, because the road is paved with so many supporters...a pot hole here or there did not deter our travels. When one of us got discouraged, another would pick us up—we took turns rallying our collective energy and passion for the mission. It took longer than we hoped, but we're here nonetheless.

Taking Drucker's advice on piloting was a good idea. We tested three patient days to make sure everything worked. Then the doors burst open and it's been busy ever since.

Our internal frustrations are fodder for onlookers. With so many stakeholders interested in our every move, and so many volunteer and contract providers in and out of our facility, we do exist in a fishbowl. Unlike the Disney model with 'on stage' and 'off stage' options for staff—we are always 'on stage' and must be very disciplined at all times.

Strong Leadership has been key. We have embraced the Good to Great philosophies of building a strong team through high energy, remaining focused and disciplined, staying motivated by the greatness of the mission, being consensus builders and using diplomatic skill to empower others to become leaders.

Who could have imagined that something as simple as starting each meeting with "what's your favorite childhood memory?" or "make /model of your first car?"—could elicit such quick bonding among a disparate group?

Dentist recruitment has been harder than we thought, and we were prepared for next to impossible; but it hasn't been the huge roadblock we feared. So many have come forward to help and we enjoy the diversity of multiple providers, and it further cements our broad base of community support. We built it, we are optimistic that they will come.

Waiting until we could afford cutting edge equipment and technology has helped us become a regional leader in efficiency and quality, and has been a huge help in the recruitment of volunteer providers. We are hopeful that, as more providers tour our facility, we will find the right dentist(s) to sign on full time.

Contracts and credentialing with MHCP administrators has become the most complicated part of doing business. We are a square peg squeezing into bureaucratic round holes. Each new dentist interested in volunteering or contracting to work for us requires 59 pages of forms and

signatures sent to four different administrators. From the very start, our motto has been —to never let paper or bureaucracy get the better of us. We can manage any process as long as we have patience, tenacity and a sense of humor.

The group’s desire for autonomy was a driving factor for many decisions. We were proud of our consensus building among diverse stakeholders and the group did not want to jeopardize that by becoming a program or subsidiary of a larger entity. Still, it was a serious temptation on more than one occasion. Looking back, and given the current economic environment, it has proven to be a wise move, as we might now be facing cuts from a larger parent agency, rather than the exponential growth we are experiencing.

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### **About the Author**

Jeanne Edevold Larson is the Executive Director for the Northern Dental Access Center and has been with the project since the early planning stages when she worked for Bemidji State University Center for Research and Innovation. Jeanne holds a Master’s Degree in Organizational Development and has guided the strategic planning, legal development and grant writing for this new organization. In her 25 years in the nonprofit sector, Jeanne has raised more than \$7M for area agencies and provided leadership for half a dozen major community collaborative projects.

## **ADDENDUM**

### **Northern Dental Access Center Today**

Northern Dental Access Center (NDAC) opened on January, 2009, to some of the coldest most brutal weather seen in northern Minnesota history. Two and three days per week we delivered care with local contract and volunteer dentists. As of June 1, 2009:

- 1,000 patients have been seen
- 40% male 60% female 40% children 10% people over 50
- 1,000 additional patient appointments scheduled into October, 2009
- 20-40 patients per day

NDAC is a critical access clinic, located in Bemidji, Minnesota, a rural community 100 miles from the Canadian border. NDAC serves children and families who are enrolled in Minnesota Health Care Plans (MHCPs). No money exchanges hands with the patients; we rely solely on the reimbursements from these programs. We provide basic dentistry and we rely on a network of referrals to find specialty care our patients need; we hope patients return to NDAC as their dental home.

We estimate 10,000 people within a 100 mile radius are eligible for services here; and the need for care has met and exceeded our expectations. Scheduled appointments are already running into December, although we can accommodate emergency and immediate care patients much sooner.

Dentists from all over the state have joined in providing care. As of this writing, ten dentists are now fully credentialed and approved to provide care (they are one site a day a month or more). The addition of locum tenens assignments has helped us move to full time operations starting in April and we have a full time schedule through Labor Day. Four more dentists with varying levels of interest are in the pipeline, with room for more. We will continue to recruit for staff dentists, as well.

We address this mix of providers by ensuring a strong core team of auxiliary providers who build the long term relationships with patients. A set of patient and treatment protocols are in place so that we can maintain continuity of care.

The 6,000 square foot clinic formerly housed MeritCare's eye clinic and is adjacent to the MeritCare and North Country Health Services campuses. With their plans to relocate the eye practice, MeritCare offered one year rent free to help us get on our financial feet. A ten year lease with the building owners will take effect this fall.

We have five dental operatories outfitted with new equipment and digital x-ray. Two additional overflow hygiene suites are furnished with gently used equipment donated from area dental offices. Many days see all seven operatories full with patients.

NDAC is commitment to maximizing technology to ensure accurate and efficient patient care: digital radiography; electronic medical records and patient scheduling; and community terminals in each operatory and a computer kiosk for electronic patient check-in.

We receive weekly inquiries from dentists looking to volunteer, contract a few days here and there, or to tour the clinic. Our facility capacity comfortably accommodates for two dentists and two hygienists each day. We can provide dental assistants, or dentists can bring someone with them, if they prefer.

Two large waiting rooms accommodate patients and their families; one being furnished especially for children through a partnership with our local Sunrise Rotary Club. We are in the process of developing resources to offer childcare for caregivers who need someone to watch a little one while they are receiving treatment. Additional support services for transportation needs are in place, as well.

Beltrami County Health and Human Services is on site to provide Child and Teen exams, immunizations, lead checks, family service referrals and more. A satellite office of Community Resource Connections is also located at the clinic, providing service access to families and to help them enroll in Medical Assistance or Minnesota Care.

We have reframed our language so that patients experience a welcoming and dignified environment. For example, we don't ask anyone if they are 'on MA'. We ask if you are enrolled in a Minnesota Health Care Program.

Dental Assisting students from Northwest Technical College and Central Lakes College are placed on site for internships and community service opportunities.

NDAC is an appointment-based clinic, rather than an emergency clinic. This is based on the feedback from a patient advisory group, who asked that we not engage in assembly-line dentistry. It has worked well with an agile staff who are able to juggle a complicated schedule effectively, and with a flexible patient base who are willing to accept short-notice to help us fill no-show appointments.

We are excited about the recent addition of a treatment coordinator who will be a patient advocate to help patients overcome barriers to care and succeed in their treatment plan, so that they can be free of pain and disease.

Cash flow projections were off by quite a bit, but luckily they were extremely conservative. So far, we are making ends meet with the support of some remaining start up grant funds. MHCP reimbursement rates are between 42%-52%.

**Future Goals:**

- Additional capital funds could help us add another six operatory chairs
- Visiting pediatric, endodontic or other specialty dentists
- Develop a hospital dentistry program in the community
- At least one dentist who will take on the clinical leadership of this organization. This would allow us to expand through collaborative practice agreements, to pursue longer term prevention and community education efforts and provide a solid and consistent schedule for patients into the longer term.
- Additional clinic sites or mobile delivery of care.

Over the long term, this organization will strive for viability and resilience so that we can maintain a continuity of care for those in need for generations to come.

**For further information, a tour, or to learn how you can join our efforts, contact:**

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Building Front  
1405 Anne Street NW  
Bemidji, Minnesota



Funders and partners are recognized on this wall located in the clinic entry



Main waiting room area, looking toward the entrance and reception desk



One of the overflow hygiene suites furnished with portable, used equipment



One of five, identical operatories furnished with all new cabinetry and equipment. A pass-through digital xray unit sits between two operatories



This is the patient referral center located within the space utilized by Beltrami County Health and Human Services