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Dimensions of Community and Organizational Readiness for Change

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Abstract

Background: Readiness can influence whether health interventions are implemented in, and ultimately integrated into, communities. Although there is significant research interest in readiness and capacity for change, the measurement of these constructs is still in its infancy.

Objective: The purpose of this review was to integrate existing assessment models of community and organizational readiness.

Data Sources: The database PubMed was searched for articles; articles, book chapters, and practitioner guides identified as references cited in the list of core articles.

Review Methods: Studies were included if they met the following criteria: (1) Empirical research, (2) identified community or organizational readiness for innovative health programming in the study's title, purpose, research questions, or hypotheses, and (3) identified methods to measure these constructs. Duplicate articles were deleted and measures published before 1995 were excluded. The search yielded 150 studies; 13 met all criteria.

Results: This article presents the results of a critical review of 13 community and organizational readiness assessment models, stemming from articles, chapters, and practitioner's guides focusing on assessing, developing, and sustaining community and organizational readiness for innovative public health programs.

Conclusions: Readiness is multidimensional and different models place emphasis on different components of readiness, such as (1) community and organizational climate that facilitates change, (2) attitudes and current efforts toward prevention, (3) commitment to change, and (4) capacity to implement change. When initiating the program planning process, it is essential to assess these four domains of readiness to determine how they apply to the nuances across different communities. Thus, community-based participatory research (CBPR) partnerships, in efforts to focus on public health problems, may consider using readiness assessments as a tool for tailoring intervention efforts to the needs of the community.

Keywords

Community health planning, organizational change, capacity building, community readiness, diffusion of innovation

Community-based prevention programming and translation of evidence-based interventions[1,2] to community settings have been recognized as mechanisms for ameliorating health disparities affecting underserved communities.[3-11] These strategies involve CBPR methods, a collaborative approach to pursue research objectives with meaningful involvement of community stakeholders, with the goal of social action leading to improved social conditions.[7,12] Gaining community participation to address local health issues can increase the likelihood of program sustainability and can produce meaningful change.[10,13] A community's readiness for change can determine whether an intervention is implemented and accepted by the community.[13-16]

Research suggests that the selection of an appropriate community-based intervention is contingent on the community's readiness and competence in addressing related social concerns.[17,18] To be effective, prevention efforts must fit with the local culture and nature of the community.[18,19] The

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implementation of an intervention with an inappropriate community fit could delay or render a project ineffective.[17] A readiness assessment is thus essential for proactively gauging the strengths and weaknesses of a community to determine what capacity building strategies are necessary for future change efforts to take hold.[20] For example, certain organizational capacities are needed to adopt innovative programs (e.g., new evidence-based strategies or public health programs), such as adequate financial means, trained personnel, and an established management structure.[15,21] Readiness assessments are important because they can inform the feasibility of implementing a prevention program[10,13,22] and help to identify the specific capacity-building strategies that will fit with the given level of readiness of the community.[17]

Several conceptions of readiness for change exist, ranging from narrow (a belief in possibility for change) to broad [a belief in the possibility and the ability (knowledge, skills, resources, social ties, and leadership) for change].[23] Readiness models also can emphasize different components of readiness.[24] Armenakis and colleagues[25p681] outlined a model of organizational readiness for change, where readiness "is reflected in organizational members' beliefs, attitudes, and intentions regarding the extent to which changes are needed and the organization's capacity to successfully make those changes." In other words, readiness is the cognitive precursor to behaviors necessary for change[25] or a state of mind about the need for change and capacity to undertake change.[26] Organizational readiness has also been defined as the extent to which members are psychologically and behaviorally prepared to implement change,[27] and the belief that one is capable of implementing change, that that change is needed and beneficial, and having leaders who are committed to change.[28] Community readiness has been defined as "the extent to which a community is adequately prepared to implement a prevention program"[18p603] or the degree to which a community believes that change is needed, feasible, and desirable.[23] Thus, readiness includes the belief that change is needed and the ability to make change happen.

Several measures of readiness[16,29] originated from stage models of behavioral change,[30] such as the transtheoretical model,[31] a model of readiness for psychotherapy used to assess addictive behaviors such as tobacco use. The transtheoretical model includes five stages that an individual cycles through until optimal behavior is realized (precontemplation, contemplation, preparation, action, and maintenance).[30] For example, the community readiness model,[16] which influenced the development of later assessments,[14,23,24,32] was developed using the work of Proschaska and colleagues and community development theory.[33-35] The community readiness model assesses the community using qualitative methods on six dimensions. The community, then, is diagnosed at one of nine readiness stages and stage-specific recommendations are made for interventions in order to move the community to the next stage until the adoption and maintenance of health programs and policies takes place.[16,22,36,37]

Although there is significant interest in readiness, the measurement of these constructs is still in its infancy.[23] Readiness assessments have been applied to disease prevention, environmental and social change, and individual behavioral change interventions.[22] Although it is still unclear which components of readiness are most important for assessment purposes, it is clear that assessments need to be comprehensive.[24] The purpose of this review was to integrate this literature and address the following questions: What is readiness for innovative health programs? Given this definition, how should it be assessed?

METHODS

Studies were selected by a comprehensive search using the PubMed online database from the National Library of Medicine. The search was then expanded to include articles, book chapters, and practitioner guides identified as references cited in the original list of core articles.

Keywords that were entered into the PubMed database included organizational readiness, community readiness, organizational readiness and community, organizational readiness and capacity, capacity building and readiness, and community organizational readiness. We scanned manuscript titles, abstracts, and subject headings, resulting in a total of 150 articles identified that matched the original keyword search criteria. A thematic assessment indicated that these articles included community and organizational readiness for emergency preparedness, diffusion of innovative technology, diffusion of innovative evidence-based public health practices/programs, health promotion/disease prevention programming, cancer prevention, HIV/AIDS prevention, drug and alcohol use prevention, intimate partner violence prevention, tobacco use prevention, bedwetting prevention, physical activity promotion, community capacity

for change, health care systems change, organizational change, building community capacity, and individual behavioral change.

The inclusion criteria were that articles must (1) conduct empirical research, (2) identify community or organizational readiness for innovative health programming in the study's title, purpose, research questions, or hypotheses, and (3) identify methods to measure these constructs. Since the first seminal work by Oetting and colleagues[16] on community readiness was published in 1995, the search was refined by deleting duplicate articles, excluding measures published before 1995, and identifying articles that met the inclusion criteria.

A total of 13 articles met all inclusion criteria, resulting in the following assessment models, of which 6 focused on community readiness and 7 focused on organizational readiness: The Community Readiness Model,[16] Self-Organizational Community Readiness Model,[24] Community Readiness for Change,[23] Minnesota Community Readiness Survey,[14] Readiness for Community Change,[29] Asian Pacific Partners for Empowerment and Leadership Community Stages of Readiness Model,[32] Getting To Outcomes,[38,39] Stages of Coalition Readiness,[17] the Integration of Newborn Screening and Genetic Services Systems with Other Maternal & Child Health Systems: A Tool for Assessment and Planning,[40] Proactive Organizational Change: Assessing Critical Success Factors,[41] Perceptions of Organizational Readiness for Change,[42] The Texas Christian University Organizational Readiness for Change Assessment,[43] and Organizational Readiness for Change.[28]

To integrate assessment models of readiness into a theoretical framework, a qualitative thematic analysis of 13 assessment models was conducted based on standardized deductive methods used in previous research.[44] The research team reviewed each assessment model and created categories[45] to describe readiness area(s) emphasized. Then, the team created a framework which summarized the list of emergent categories and grouped similar categories together into more substantive categories. The organization of this framework was also partially based on previous research that has defined readiness[18] and community capacity.[17,23,46]

RESULTS

Results from the content analysis demonstrate that readiness is multidimensional and the 13 assessment models place emphasis on four main elements of readiness, which include (1) community and organizational climate that facilitates change, (2) attitudes and current efforts toward prevention, (3) commitment to change, and (4) capacity to implement change. Each element of readiness was endorsed across the majority of the assessment models. Definitions, measures, sample items, and a frequency count for each essential readiness element are detailed in Table 1 (included here) and Table 2 (which can be accessed on the Web at http://muse.jhu.edu /journals/progress_in_community_health_partnerships_research_education_and_action/v006/6.2.castaneda_supp01.pdf).

Community and Organizational Climate that Facilitates Change

Climate is an essential feature of readiness for change that can either impede or foster change.[13] Seven of the 13 assessment models[14,16,17,32,41,43] included items or scales that assessed community and/or organizational climate, ranging from a narrow to a broad sense of climate. Community climate is defined as the degree to which current community conditions promote positive versus negative behaviors. Community characteristics, such as prevailing norms (e.g., views on teenage drinking), are critical to assess to determine if the community will accept or reject a prevention intervention.[14] Assessments of community climate direct planners to determine the prevailing attitudes or feelings in the community about the issue in question.[36,37] If the community climate is characterized by a sense of responsibility and empowerment,[36] this may serve as a catalyst for action and future change.[13] Organizational climate can be considered the degree to which the climate of the organization facilitates positive organizational change. Certain qualities of organizations, such as removing obstacles and providing incentives for innovative program adoption, can provide a successful organizational climate for program implementation.[18] It is important to determine the degree to which the current climate of the community or organization promotes positive change, because this can direct planners to where future efforts need to be targeted.

Current Attitudes and Efforts Toward Prevention

A community's level of readiness can vary with regard to attitudes about the health problem and efforts toward prevention. It is important to determine the extent to which the community is aware of the target issue as a major public

Table 1. Dimensions of Readiness for Change: Categories and Subcategories With Example Items

(1) Community and organizational climate that facilitates change
- (A) Community climate: The degree to which current community conditions promote positive versus negative behaviors.[14,32,36]
  - "Is it difficult for teens to sneak tobacco from home."
  - "It is difficult to get adult to buy tobacco."
  - "It is difficult for teens to purchase alcohol in a store."[14]
  - "What are the primary obstacles to efforts in your community?"
  - "Is there ever a time or circumstance in which members of your community might think that this issue should be tolerated?"[32]
- (B) Organizational climate: The degree to which the current climate of the organization facilitates positive organizational change.[17,41-43]
  - "Employees here are resistant to change."[36]
  - "You are encouraged here to try new and different techniques."
  - "You are under too much pressure to do your job effectively."[32]
  - "Cycle time to develop programs is usually (fast… unpredictable…low)."[41]

(2) Current attitudes and efforts toward prevention
- (A) Current awareness: To what extent members know about the causes of the problem, consequences, and how it impacts their community/organization[14,17,32,36,41]
  - "How knowledgeable are community members about this issue?"[36]
  - "Public health staff's perception of how the agency's current priorities and practices support the organization's mission."[41]
- (B) Current values: Perceived relative worth or importance that a group places on a particular health problem.[14,29]
  - "What is important to people in your sector?"
  - "What do people in your area think is critical in your community?"[29]
- (C) Current efforts: Efforts that exist currently that deal with prevention.[14,29,40]
  - "Please describe the efforts that are available in your community to address this issue."[36]

(3) Commitment to change
- (A) Hope for change: the belief that an organization, community or neighborhood can improve.[23,43]
  - "In the next year, I think that conditions on my block will improve."[23]
  - "This change will improve our organization's overall efficiency."[43]
- (B) Needed change: The extent to which members feel that there are legitimate reasons and need for the prospective change effort.[28,43]
  - "There are a number of rational reasons for this change to be made."[28]
  - "Your program needs additional guidance in assessing client needs."
  - "You need more training in assessing client problems and needs."[43]
- (C) Commitment to change: The extent to which members perceived their leadership is committed to and supports implementation of a prospective change effort.[14,24,28]
  - "This organization's most senior leader is committed to this change."[28]
  - "My community is not interested in changing."
  - "There is no sense of commitment in my community."[14]

(4) Capacity to implement change
- (A) Relational capacity: Relational attributes for change exists (includes social ties community attachment, stakeholder involvement, and collaboration/teamwork).[23,24,32,40,41]
  - "Most people who live here feel a strong tie to this community"[36]
- (B) Collective efficacy: belief in one's own or the community's ability to effectively accomplish a task or to engage in future change efforts.[23,24,28,43]
  - "In the past the community has been successful at addressing social problems."[36]
  - "My past experiences make me confident that I will be able to perform successfully after this change is made."[40]
- (C) Leadership: To what extent leaders and influential community members are supportive of the issue or to what extent leadership is effective?[23,24,32,36,40,41]
  - "Community leaders are able to build consensus across the community."[36]
  - "Community leaders are willing and able to involve community members in decision making."[36]
- (D) Resources: To what extent local resources (people, time, money and space) are available to support efforts?[32,36,40,41,43]
  - "There are enough counselors here to meet current client needs."[43]
  - "You have easy access for using the Internet at work."[43]
  - "How are the current efforts funded?"
  - "Are you aware of any proposals or action plans that have been submitted for funding to address this issue in your community?"[36]
- (E) Skills and knowledge: Necessary to implement an innovative program, including: adaptability, evaluation, technical, research and data dissemination, cultural competency, and training.[32,36,40,43]
  - "The technical support staff is adequately trained in the technology that the project team plans to use."[40]
  - "The evaluation plan includes process measures to monitor the project's performance and outcome measures to assess the effect of integration of public health programs."[40]

health concern that their community faces. In assessing readiness, it is important to not only determine whether the members are aware that the problem exists, but also to determine whether members value this as a problem. Current efforts are the efforts that exist currently in the community that focus on or deal with prevention or intervention.[37] Knowledge of current efforts is the knowledge that the community has about current efforts toward prevention.[37]

Community attitudes (consisting of awareness and values) are related to the type of prevention interventions that may "fit" with that community.[14] For example, if permissive attitudes toward teen substance use exist in a community, prevention strategies such as parental intervention may not be appropriate; instead, these strategies would be better suited for a community where teen substance use is not tolerated,[14] because the latter is more likely to be aware of the problem and values it as such.

Five models included items or scales that assess awareness of the public health issue.[14,17,32,36,41] Assessment of this awareness or knowledge of the problem involves determining to what extent members know about the causes of the problem, consequences, and how it impacts their community.[36] For example, if a given community is not aware that health disparities exist and do not believe it affects people like them, then prevention planning efforts become difficult.

Two assessment models included the extent to which communities value the particular health concern as a problem.[14,29] Valuing an issue may motivate one to want to do something about the issue. If, for example, one is aware that teen alcohol use is a problem, but does not value this as a community problem, s/he is not likely to be motivated to do anything. However, if one is aware that the problem exists and values it as a problem, s/he is more likely to be invested in wanting to make change. Thus, both awareness of and values about the target health issue are important attitudinal factors related to a motivation for readiness to change.

Current efforts aimed at prevention can be assessed by determining to what extent the programs and policies that exist address the issue in question and to what extent the community is aware of these efforts and their effectiveness.[36] Seven readiness assessment models included items or scales that assess the extent of community or organizational efforts toward prevention or knowledge of those efforts.[14,17,29,32,36,40,41] These models assessed a wide range of efforts, from specific neighborhood, community, and school-based efforts, to organizational policy, planning, evaluation, and management efforts, to policy and laws in place directed at the specific prevention effort.

Commitment to Change

Assessments of readiness are directly geared toward determining the extent to which communities or organizations are prepared or "ready" for some type of change.[18] However, readiness has also been defined as a state of mind about the need for an innovation and the capacity to undertake change.[26] According to Eby and colleagues ,[42] readiness is similar to Lewins' (1951) concept of unfreezing, "the process by which organizational members beliefs and attitudes about a pending change are altered so that members perceive the change as both necessary and likely to be successful."[42p421-2] In this way, readiness is the belief that change is possible or "the degree to which a community [or an organization] believes that change is needed, feasible, and desirable.[23p94] Believing that change is possible and being committed to an issue are essential to being ready to make change happen. In organizations, motivation for change is based on the belief that change is needed, or on external pressures. If motivation for change is not activated, organizational members are unlikely to initiate change behaviors, such as adopting innovative programs.[43]

Capacity to Implement Change

Community capacity has been used to describe the extent to which community characteristics affect its ability to identify, mobilize, and address social and health problems.[47] Although capacity is often used interchangeably with concepts such as readiness, empowerment, and competence,[47] under the current framework, capacity is considered a dimension of community readiness. Capacity has been defined as "the interaction of human, organization, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community."[48p4] Capacity-building efforts involve community-based strategies that are geared toward building the capacity within a community or organization as a means for addressing the needs of its members.[49] Capacity-building strategies are rooted in empowerment-based approaches to community change.[49]

Research has identified dimensions of capacity to implement change, such as participation and leadership, skills, resources, social networks, relational characteristics, understanding of community history, community power, community values, and critical reflection.[23,47] When these capacities exist, communities are better able to mobilize and support change efforts. Assessing capacity should be an ongoing feature of any community change effort, given the dynamic nature of communities and the organizations within them. Under the current framework, community capacity is defined as the relational characteristics, skills, knowledge, and resources necessary to implement change.

Results show that measures of community capacity generally assess the degree to which specific community characteristics necessary for the change effort to take hold exist. The following components of capacity emphasized across the models are discussed: relational capacity to implement change, active citizenry, collective efficacy, leadership, resources, skills and knowledge to implement, and change implemented/program institutionalization.

Certain relational characteristics must exist for communities or organizations to adopt change. Five assessments included relational characteristics, such as: community attachment or social ties,[23,24] stakeholder involvement,[40] and collaboration or teamwork.[32,41]

The community characteristic of collective efficacy has been defined as trust in the effectiveness of organized community action.[23] Efficacy is an essential belief about one's capacity to engage in future change efforts, and thus is an essential component of readiness. Two measures assessed the collective of community level of efficacy,[23,24] whereas one measure assessed organizational member self-efficacy for organizational change[28] and another assessed confidence in staff's skills and performance.[43]

Leadership assessment directs the program planner to determine how appointed leaders and influential members are supportive of the issue[36] or to what extent leadership is effective. Six readiness assessments included questions either about leadership support for prevention efforts,[32,36,40,41] or leadership ability and effectiveness.[23,24,40,41] Leadership support for prevention includes making the health issue a priority, protecting funds related to the program, developing policies that support the change effort, or supporting employee growth and accountability. Leader abilities crucial for adopting change include consensus building, managing intergroup conflict, flexibility, ability to communicate vision, and encouragement.

Assessing resources related to the issue directs the program planner to determine to what extent local resources, such as people, time, money, and space are available to support efforts.[36] Five readiness models included assessments of resources as a critical readiness element. Assessments of resources focused on general resources (e.g., time, money, and space),[36] organizational resources (e.g., office, staffing, training, equipment, or internet),[43] organizational technological resources,[40] financial resources,[32,40] and information and data resources.[41]

Skills and knowledge necessary to implement an innovation can include adaptability, evaluation, and technical and cultural competency skills. Four readiness models that included assessments of skills and knowledge necessary for change, focused on evaluation skills,[36,40] technical skills and training,[40] adaptability,[43] research and data dissemination skills,[32] and disease-specific trained staff.[32]

DISCUSSION

There are several research and practical implications of this paper for the CBPR community. First, our research shows that definitions of readiness for change have included beliefs about the necessity for change, capability of implementing change, and preparation for implementing change at the community and/or organizational level. Second, this review revealed four readiness domains to consider before community-based program planning, including (1) community and organizational climate that facilitates change, (2) attitudes and current efforts toward prevention, (3) commitment to change, and (4) capacity to implement change. Last, when initiating the program planning process, it is essential to assess these four domains of readiness to determine how they apply to the nuances across different communities. An example scenario is when a coalition seeks to implement a church-based healthy lifestyle intervention. First, an assessment of all four components of readiness for such an intervention would need to take place. If they discover that the church leadership is unaware of how certain health disparities affect their community and there is no commitment to change, then intervention efforts would need to be tailored to the church's stage of readiness. The intervention would have to focus on increasing awareness of

health disparities and motivation for change before determining what specific programmatic capacities are needed to implement the lifestyle program. Thus, CBPR partnerships, in efforts to focus on community public health problems, may consider using readiness assessments as a tool for tailoring intervention efforts to the needs of the community.

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