Adultspan Journal

Volume 10 | Issue 2 Article 1

10-1-2011

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ARTICLES

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The Community Readiness Model (CRM) is a change model that measures the readiness of communities/institutions to meet the needs of diverse clientele and to guide strategy development. This article presents model implementation with one long-term care facility interested in enhancing their ability to serve gay, lesbian, bisexual, and transgender older adults.

Today, there is an estimated 1 to 3 million gay, lesbian, bisexual, and transgender (GLBT) individuals over the age of 65 in the United States (Grant, 2010). This number may reach 4 million by the year 2030, and it seems that our social institutions might be ill-prepared to provide the necessary services to this aging population (Grant, 2010). Historians generally regard the Stonewall Riot in Greenwich Village on June 29, 1969, as the start of the gay liberation movement when gay rights became an emergent social issue in the United States. Many modern day older adults spent their young adulthood before the Stonewall years and carry with them internalized shame and fear because, during their formative years, homosexuality was highly criminalized, pathologized, and stigmatized (Grossman, D'Augelli, & Connell, 2003; Hollibaugh, 2004). In addition, many GLBT older adults continue to report trepidation and fear about their treatment within societal institutions, particularly retirement facilities and long-term care facilities (Brotman, Ryan, & Cormier, 2003; Heaphy, Yip, & Thompson, 2004; McFarland & Sanders, 2003). Seventy three percent of GLBT adults in one recent study perceived that discrimination against GLBT older adults exists in retirement care facilities (Johnson, Jackson, Arnette, & Koffman, 2005). This means that perhaps up to 2,920,000 GLBT older adults

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in the year 2030 will be seeking services from facilities that they believe do not have their best interests in mind. Therefore, it is imperative that counselors and other service providers understand the culture of these institutions and their openness to serving GLBT older adults.

Relatedness, or connection to others, has emerged in recent research as an important protective factor for older adults facing transitions into long-term care facilities (Jungers, 2010). GLBT older adults are less likely to have others available to assist in advocacy because of their diminished social networks (Brookdale Center on Aging and SAGE [Senior Action in a Gay Environment], 1999). GLBT older adults are twice as likely to face aging alone, 4.5 times more likely to have no children to call on in a time of need, and are 2.5 times more likely to live alone than are their heterosexual peers (Hollibaugh, 2004). This lack of formal and informal social support leads to a myriad of problems for these older adults, including depression, substance abuse, unnecessary institutionalization, and premature death (Hollibaugh, 2004). Disconnection from a social network introduces a conundrum in which GLBT older adults find themselves relying more heavily on historically heterosexual institutions, the institutions that they fear because of discrimination and bias (Brotman et al., 2003; Grant, 2010; McFarland & Sanders, 2003).

Gay and lesbian older adults are 5 times less likely to access services than are their heterosexual peers, albeit this underuse of services is not likely to continue as the Stonewall GLBT baby boomer generation, who has acquired significant advocacy skills, emerges (Grant, 2010; Hollibaugh, 2004).

OLDER ADULT DEVELOPMENT

Even though the landscape of service access is changing, the needs of older adults, including GLBT individuals, remain rather constant. Several developmental aspects of aging are salient to successful transition to long-term care. It is essential that those who care for older adults recognize the importance of both the physical and the emotional well-being of these individuals as they progress through continued stages of human development. Generally speaking, older adults have demonstrated a positive trajectory involving emotional control and adaptation in the face of social vulnerability (Blanchard-Fields, 2009). Charles (2010), in his model of strength and vulnerability integration, recognized this as a basal premise, yet posited that older adults who experience more sustained levels of emotional arousal may experience a decreased ability to attenuate emotions and may subsequently struggle to regain emotional stability. These characteristics regarding the social and emotional well-being of older adults seems especially salient within the context of service provision to GLBT older adults because of the emotionality and strong societal norms surrounding sexuality. The eight primary areas of need as identified by GLBT older adults are (a) services to maintain physical and mental health, (b) economic and financial security, (c)

legal and civil rights, (d) social and community involvement, (e) familial and partner support, (f) spiritual well-being, (g) support with caregiving, and (h) intervention in the face of abuse and neglect (Butler, 2004; Orel, 2004). It is imperative that GLBT older adults are included in ongoing dialogue and research that strives to identify and accommodate the emerging needs of a diverse aging population (Cahill, 2004; Donahue & McDonald, 2005).

GLBT SERVICE PROVISION AND SERVICE PROVIDERS

Although progress continues regarding the availability of facilities serving exclusively GLBT older adults, the integration of diverse services into traditional settings and further development of specialized facilities must be continued (Adelman, Gurevitch, de Vries, & Blando, 2006). Current literature indicates that GLBT older adults desire services to support them as they age, and, at the same time, they fear the intolerance, ridicule, neglect, and sometimes even violence of the professionals and social institutions that provide those services (Boulder County Aging Services Division [BCASD], 2004; Brotman et al., 2003; Heaphy et al., 2004). A majority of GLBT older adults in one qualitative study indicated that they feared the reception they would receive if they sought admission to a traditional long-term care facility (Orel, 2004). Other barriers to service access include institutionalized heterosexism, oppressive legislation and public policy, and the residual effects of growing up in a different social climate (Butler, 2004).

The GLBT Health Access Project (www.glbthealth.org) outlines 10 standards with corresponding indicators regarding appropriate health care services to GLBT individuals (Clark, Landers, Linde, & Sperber, 2001). In short, these 10 standards can be accessed online and are organized into five broad categories: (a) personnel, (b) clients' rights, (c) intake and assessment, (d) service planning and delivery, and (e) confidentiality. According to the BCASD (2004), an organization can take solid steps toward meeting these standards by creating an inclusive infrastructure (policies), establishing a welcoming environment, developing effective communication skills, asking open-ended questions, and using gender-neutral language.

Institutions that serve older adults historically have a one-dimensional view of these individuals and are not comfortable with client sexuality much less client sexual orientation (BCASD, 2004; Nay, McAuliffe, & Bauer, 2007). Considering this and the sociopolitical nature of the issue of sexual orientation, systemic change such as those indicated earlier might be very difficult. What is known is that unless a community is aware of the issue or problem and ready for change, innovation will not be attainable and sustainable (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Plested, Edwards, & Jumper-Thurman, 2006). The challenges that inhibit forward movement include the reality of institutional discrimination, the varied context of service providers,

the diverse needs of the GLBT community, and the lack of formal structures for examining existent characteristics and implementing appropriate change strategies. Facilitating improved service provision to GLBT older adults calls for a sound theoretical model that has been tested in a variety of applications.

THE COMMUNITY READINESS MODEL (CRM)

The CRM was developed by the Tri-Ethnic Center for Prevention Research at Colorado State University; the model integrates an assessment of the community's culture and readiness for change and provides suggested change strategies (Edwards et al., 2000; Plested et al., 2006). Considering the sensitive nature of service to and advocacy for GLBT individuals, it is particularly salient to use a model that explores and is sensitive to the readiness of the organization when trying to enhance such services. The CRM examines six dimensions of readiness known to be key factors in a community's ability to initiate and sustain positive change. Plested et al. (2006) provided a clear description of these six dimensions as follows:

Community Efforts: To what extent are there efforts, programs, and policies that address the issue?

Community Knowledge of the Efforts: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

Leadership: To what extent are appointed leaders and influential community members supportive of the issue?

Community Climate: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

Community Knowledge about the Issue: To what extent do community members know about the causes of the problem, consequences, and how it impacts the community?

Resources Related to the Issue: To what extent are local resources – people, time, money, space, etc. available to support efforts?

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The CRM uses seven steps in the assessment of these dimensions and in the implementation of change strategies. These seven steps are (a) identify your issue, (b) identify your community, (c) conduct a CRM, (d) analyze the results of the assessment, (e) develop strategies to pursue that are stage appropriate, (f) evaluate the effectiveness of your effort, and (g) use what you have learned to apply the model to another issue. For the sake of demonstration, we are concerned with the provision of service to GLBT older adults (the issue) in a long-term care facility (the community). This statement encapsulates Steps 1 and 2 of the model.

Step 3 of the model involves the implementation of the community readiness assessment tool. The community readiness assessment tool is a 36-item structured interview (see Appendix) with an anchored rating scale, which is scored independently by two raters who then reference their individual scores to arrive at a

consensus score for each item. The interview takes between 30 and 60 minutes to complete, with participant responses typically recorded in the moment through transcription. Because this protocol quantifies the content of responses and does not rely on in vivo quotes or rich narrative description like more traditional qualitative research, there is little need to actually audiotape participant responses. In addition, this protocol helps to limit recorder interpretation or elaboration (Plested et al., 2006). Interviewees, chosen on the basis of their connection to the issue, should represent different segments of the community. Generally, only four to six interviewees are necessary for accurately assessing community readiness. The specific questions, constructed by the authors of the CRM, closely tie into the scoring process, and one must attend to the question's core meaning when modifying them to meet the needs of any particular project application (Plested et al., 2006).

Step 4 in the overall implementation process involves scoring and analyzing the interview responses. Ideally, at least two people should be involved in the scoring process to increase the validity of the results (Plested et al., 2006). The scoring of the interview involves the following: (a) each scorer independently reads through each interview in its entirety before scoring any of the dimensions; (b) each scorer independently reads the anchored rating scale for the dimension being scored and highlights in each interview statements that refer to the anchored rating statements; (c) each scorer records his or her independent scores on the form for individual scores; (d) the two scorers discuss their independent scores, and when consensus is reached, they fill in the table for combined scores and then add rows to yield a total for each dimension; (e) the team then determines the calculated score for each dimension and divides it by the number of interviews; (f) the team calculates the overall stage of readiness; (g) the overall stage of readiness scores are rounded down; and (h) any impressions or comments are recorded (Plested et al., 2006).

Step 5 of the implementation process is the development of strategies or interventions based on the assessed community's readiness level. The strategies as introduced in the CRM manual and those articulated by the researchers are not intended to be answers for the community but examples of different approaches that might be used by that community to address the issue or need in question (Plested et al., 2006). When working with a community, whether it is a long-term care facility or a social service agency, it is important to be sensitive to the expressed concerns and needs of that organization. Even if the CRM assessment indicates that an organization is at a certain level of readiness, organizational representatives always have the ability to give input regarding the accuracy of the assessment results and to articulate possible adjustments to the assessed stage of readiness.

The last two steps of the model involve working with the organization to evaluate the effectiveness of the model and to use what one learns during the model utilization to apply the process to a new issue. One may

also choose to reassess the community's readiness following a period of intervention or growth.

PROCEDURES

The CRM provided the framework for consultation with one local long-term care facility interested in improving their service to a diverse resident base, specifically GLBT older adults.

The Setting

The facility is a 130-bed skilled nursing facility that is part of a larger health network providing care and services to older adults within a metropolitan population of approximately 278,000 (U.S. Census Bureau, 2007). Within this metropolitan area, there are 29,500 residents who are 65 years and older. The population of this metropolitan area reported a high level of educational attainment, with 93.7% reporting that they were at least a high school graduate and 41.5% reporting that they had earned a bachelor's degree or higher (U.S. Census Bureau, 2007). The health network employs over 1,100 professionals who provide nursing, living options, rehabilitation, therapy services, home care, pharmacy, and medical equipment to the older adults they serve. The locally owned health network has been a part of the larger community for over 35 years.

The Consultative Process

Because of the facility's reputation in the community for collaboration and education, the researchers approached it to determine its openness to engaging in the CRM related specifically to service for GLBT older adults. An administrator of the facility served as the primary gatekeeper, offering access to interviewees as well as serving as the main contact for model implementation and program planning. With the consideration that the purpose of this project was not to generate research that could be widely generalized, but to help one facility grow in its ability to serve GLBT older adults, the main contact invited particular employees to serve as interviewees. Individuals, deliberately selected with the intention of creating a diverse pool, represented a variety of positions, years of employment, gender, ethnicity, age, and sexual orientation.

Six employees of the facility participated in the readiness assessment interviews. Job duties of the interviewees were nurse, admissions coordinator, business administrator, social worker, aide, and nurse coordinator. The interview pool included two men and four women who had worked at the facility anywhere from 3 weeks to 16 or more years. Four interviewees self-identified as Caucasian, one as Black British, and one as Chinese. One interviewee self-identified as homosexual. All interviews were conducted face-to-face in the training room at the facility, lasted between 40 and 60 minutes, and were recorded in vivo on a laptop computer.

The two authors independently rated the interview transcripts, using the anchored rating scales for each dimension as outlined in the CRM handbook.

RESULTS

Scoring of the interviews yielded rather consistent readiness scores across all dimensions. Each of the six dimensions in the CRM is within one of nine stages:

1. *No Awareness.* The issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2. *Denial/Resistance.* At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.
3. *Vague Awareness.* Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. *Preplanning.* There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5. *Preparation.* Active leaders begin planning in earnest. Community offers modest support of efforts.
6. *Initiation.* Enough information is available to justify efforts. Activities are underway.
7. *Stabilization.* Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. *Confirmation/Expansion.* Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. *High Level of Community Ownership.* Detailed and sophisticated Knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

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Community efforts, knowledge of community efforts, leadership, community knowledge about the issue, and knowledge of resources related to the issue all generated readiness scores of 2. The community climate dimension generated a readiness score of 3, with an overall readiness score across all dimensions of 2. An overall community readiness score of 2 indicates that there is recognition of the issue as a problem, but there is no ownership of it as a local problem or that if there is some idea that it is a local problem, there is a feeling that it does not necessarily affect local policy.

In examining the language within the interviews, and through talking with the main contact at follow-up, it became clear that the first characteristic was more appropriate for this particular facility. Four of the six interviewees articulated, "We treat all residents equally" and that the facility would attend to the issue if there actually were GLBT residents in the facility. It is not entirely surprising that the interviewees did not recognize the possibility that GLBT residents resided in their facility, considering the longstanding invisibility of GLBT older adults in society (Langley, 2001). This invisibility is likely to continue as long as GLBT older adults experience heterosexism and oppression within institutions and society as a whole (Langley, 2001).

First Contact With Results

It is critical at this stage to remember that the consultant must attend to the unique characteristics and needs of the community. The community always owns the process and outcomes within the CRM. The community's perception of their own readiness, and their unique understanding of factors that contribute to the readiness score, provide the foundation for strategy planning and implementation. The facility contact person for this project indicated clearly that he and his staff members desired to be sensitive and responsive to the needs of diverse residents but that there were many issues of diversity to be addressed (e.g., ethnicity and physical disability) and that most of the other areas were more visible to the facility staff members. Dialogue at that point leaned toward information dissemination and education. It became important at this point in the process, to share with the contact person minimal information regarding the rate of GLBT individuals within the aging community, the extensive historical factors promoting invisibility of this population, and the resources readily available to him and his facility as they begin to address the issue.

One of the first realizations for the contact person was that perhaps the lack of GLBT residents in the facility related to heterosexist or noninclusive policies and practices automatically built into the operation protocol of long-term care facilities. For the main contact person and the interviewees, there seemed to be some growing awareness that oppressive policies and environments affect not only GLBT residents, but also GLBT family members of residents and any GLBT staff working in the facility. This growing awareness appeared to foster an impetus to take action despite initial interviews that indicated little need for concern based on the perception that there were no GLBT residents living in the facility.

The ultimate goal of this process was not to merely generate new research knowledge, but to use the results in consultation with the facility director and generate possible facility-driven change strategies. The CRM manual provides generic lists of sample action strategies based on a community's readiness score (Plested et al., 2006). The list for communities at Level 2 includes (a) continuing and expanding strategies used for communities at Level 1; (b) providing educational opportunities for staff; (c) putting up flyers and brochures; (d) putting information in staff newsletters, publicity material, and so on; and (e) providing low intensity but visible media to address the issue within the facility/community (Plested et al., 2006). Sperber (2006) also offered extensive suggestions for organizations wishing to meet the specific needs of GLBT older adults. At the post-interview-meeting with the contact person, he requested some possible resources for addressing the issue and indicated that he desired to work with select members of his staff to independently make decisions and create strategies for change. The two authors, serving as consultants, provided information about materials and programs, such as Project Visibility (BCASD, 2004) and Senior Action in a Gay Environment (www.sage.org), as well as

names and contact information for professionals in the local area serving as trainers/educators on the issue.

Follow-Up With Contact Person

Follow-up with the main contact person occurred 8 months after the initial community readiness project. The contact person indicated that strengths of the CRM included objectivity and seemingly reliable results with a small sample. On the other hand, the contact person indicated that using the CRM required a substantial time commitment on his part. Two significant events have occurred at the facility subsequent to this consultation. The first involved an all-staff in-service presentation of the Project Visibility Program (BCASD, 2004). The second event included staff attendance at a Community Senior Program on GLBT issues. In addition to the events that have already occurred, the facility plans to conduct an annual in-service on the issues of GLBT older adults. These initiatives demonstrate bold action by a facility steeped in traditional service and nestled within a relatively conservative geographical region. It appears that the process surrounding the CRM helped this facility community move beyond Stage 2 of the model and initiate action. The next step in the process is to engage the facility in a second round of community readiness assessment interviews to determine the new stage of readiness and to guide the facility into even more community-appropriate action.

CONCLUSION

Service provision to GLBT older adults is a dynamic and sensitive area, requiring rigorous and extensive inquiry and action. Examining the readiness and assets of organizations serving GLBT older adults requires not only heart and sensitivity but also resources and a clear vision. The CRM, as developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, is one tool that helped one long-term care facility critically examine their practices and culture with the ultimate goal of enhancing service to GLBT older adults.

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APPENDIX

Community Readiness Assessment Interview Questions

Note. Items in bold are essential for scoring.

A. COMMUNITY EFFORTS (Programs, Activities, Policies, etc.)
AND
B. COMMUNITY KNOWLEDGE OF EFFORTS.

First, how would you define GLBT (Gay, Lesbian, Bisexual, and Transgender) elders?

1. **Using a scale from 1 to 10 (1 = *not at all* and 10 = *a very great concern*), how much of a concern are the needs of GLBT elders at ____? Please explain your answer. (D)** *(Note. This figure between one and ten is NOT figured into your scoring of this dimension in any way—it is only to provide a reference point.)*
2. **Please describe the efforts/activities that are available at _____ to address the needs of GLBT elders? (A)**
3. **How long have these efforts been going on in your facility? (A)**
4. Using a scale from 1 to 10 (with 1 being *no awareness* and 10 being *very aware*), how aware of these efforts are those in your community? Please explain. (B) (*Note. this figure between one and ten is NOT figured into your scoring of this dimension in any way—it is only to provide a reference point.)*
5. **What does your community know about these efforts/activities? (B)**
6. **What are the strengths of these efforts/activities? (B)**
7. **What are the weaknesses of these efforts/activities? (B)**
8. Who do these efforts/activities serve? (For instance, residents, families, administrators, employees, etc.) (A)
9. Would there be any segments of your community for which these efforts/activities may appear inaccessible? (A)
10. Is there a need to expand these programs/services? Why or why not? (A)
11. Is there any planning for more efforts/activities going on at _____ surrounding the needs of GLBT elders? If yes, please explain. (A)
12. What formal or informal policies and practices related to GLBT elders are in place in your facility, and for how long? (*Prompt:* An example of formal policy/practice would be a nondiscrimination code in place that addresses GLBT, GLBT Safe Zone stickers on aides, nurses, and administrators office doors; and an example of informal policy would be a nurse not responding to hate speech regarding GLBT residents, etc.) (A)
13. Are there segments of your community for which these policies and practices may not apply? (*Prompt:* For example, ethnicity, age, being "out," etc.) (A)
14. Is there a need to expand these policies and practices? If yes, are there plans to expand these policies and practices? Please explain. (A)
15. How does your facility view these policies and practices? (A)

C. LEADERSHIP

16. Who are the leaders specific to GLBT elders in your facility? (If different from the leaders mentioned above.)
17. **Using a scale from 1 to 10 (1 = *not at all* and 10 = *of great concern*), how much of a concern is the issue of service provision to GLBT elders to the leadership of _____? Please explain.** *(Note. This figure between one and ten is NOT figured into your scoring of this dimension in any way—it is only to provide a reference point.)*
18. **What "leaders" in your facility are involved in efforts regarding the needs of GLBT elders? Please list. How are these leaders involved? If involved in a committee, task force, club, etc., how often do they meet?**
19. **Would the leadership support additional efforts designed to meet the needs of GLBT elders in your facility community? Please explain.**

(Continued on next page)

APPENDIX (*Continued*)

Community Readiness Assessment Interview Questions

D. COMMUNITY CLIMATE

20. Describe the _____ Facility.
21. Are there ever any circumstances in which members of your community might think that lack of service provision to GLBT elders should be tolerated? Please explain.
22. **How does your facility support the efforts addressing GLBT elders?**
23. **What are the primary obstacles to efforts addressing GLBT elder issues in your community?**
24. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding GLBT elders?

E. KNOWLEDGE ABOUT THE ISSUE

25. **In general, what does the facility community know about issues facing GLBT? (*Prompt:* For example, barriers to access of services, legal issues, medical concerns, family issues).**
26. **What type of information is available about GLBT elders at _____?**
27. **Is local data available about GLBT elders in your facility?**
28. **How do people obtain this information in your facility?**

F. RESOURCES FOR PREVENTION EFFORTS

29. **Who would a GLBT identified elder or ally first turn to for help in _____? Why?**
30. On a scale from 1 to 10 (with 1 = *very low* and 10 = *very high*), what is the level of expertise and training among those working to address GLBT issues in your facility? Please explain. *(Note. This figure between one and ten is NOT figured into your scoring of this dimension in any way—it is only to provide a reference point.)*
31. Do efforts that address issues related to GLBT elders have a broad base of volunteers?
32. Do local businesses and/or industries support the facility's efforts with such things as time, money, and/or space for GLBT elders?
33. Are you aware of the funding sources for the current efforts that address GLBT elders in _____? Please explain.
34. **Are you aware of any proposals or action plans that have been submitted for funding that address the needs of GLBT elders in your facility community? If yes, explain.**
35. **Are you aware of any strategies to evaluate the efforts or policies that are in place? If yes, on a scale of 1 to 10 (with 1 = *not at all* and 10 = *very sophisticated*), how sophisticated is the evaluation effort?** *(Note. This figure between one and ten is NOT figured into your scoring of this dimension in any way—it is only to provide a reference point.)*
36. **Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?**

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