Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

Organizational Readiness to Change

Instructions

This survey asks questions about how you see yourself as a team member and how you see your health clinic. It begins on the next page with a short demographic section that is for descriptive purposes only. The *Anonymous Linkage Code* is requested so that information you give now can be "linked" to your responses to similar questions you may be asked later.

To complete the form, please mark your answers by marking the appropriate circles. If you do not feel comfortable giving an answer to a particular statement, you may skip it and move on to the next statement.

The anonymous linkage code below will be used to match data from different evaluation forms without using your name or information that can identify you.

Please complete the following items for your anonymous code:

First letter in mother's first name: |___| First letter in father's first name: |___|

First digit in your social security number: |___| Last digit in your social security number: |___|

Today's Date: |___|___||___|___||___|___|
MO DAY YR

Are you: ○ *Male* ○ *Female*

Your Birth Year: 19 |___|___|

Are you Hispanic or Latino?

○ *No* ○ *Yes*

Are you: [MARK AS MANY AS APPLY]

○ *American Indian or Alaska Native*
○ *Asian*
○ *Native Hawaiian or other Pacific Islander*
○ *Black or African American*
○ *White*

Highest Degree Status: [MARK ONE]

○ *No high school diploma or equivalent*
○ *High school diploma or equivalent*
○ *Some college, but no degree*
○ *Associate's degree*
○ *Bachelor's degree*
○ *Master's degree*
○ *Doctoral degree or equivalent*
○ *Other (medical assistant, RN, post-doctorate)*

Discipline/Profession: [MARK ALL THAT APPLY]

○ *Physician*
○ *Physician's Assistant*
○ *Nurse Practitioner*
○ *Nursing (LVN, RN)*
○ *PCT, NA*
○ *Social Work/LCDC*
○ *Other Human Services*
○ *Resident*
○ *Intern*
○ *Student*
○ *Administration*
○ *Manager*
○ *Clerk*
○ *RT, PT, EKG*
○ *Pharmacy*
○ *Interpreter*
○ *Other (specify)* _____

If Appropriate, List Area of Specialization:
(Ex. Internal Medicine, OB-GYN, etc.) _____

How long have you been in your <u>present job</u>?

○ *less than 1 year* ○ *1 to 3 years* ○ *over 3 years*

EVIDENCE ASSESSMENT

Based on your assessment of the evidence basis for this statement, please rate the strength of evidence in your opinion:

Very Weak	***Weak***	***Neither Weak nor Strong***	***Strong***	***Very Strong***	***Don't Know/ Not applicable***
O	O	O	O	O	O

Now, please rate the strength of evidence basis for this statement based on how you think respected clinical experts in your institution feel about the strength of evidence:

Very Weak	***Weak***	***Neither Weak nor Strong***	***Strong***	***Very Strong***	***Don't Know/ Not applicable***
O	O	O	O	O	O

EVIDENCE ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

	Strongly Disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly Agree 5	Don't know/ Not applicable 6
(Research) The proposed practice changes or guideline implementation:						
1. Are (is) supported by RCTs or other scientific evidence from the hospital	O	O	O	O	O	O
2. Are (is) supported by RCTs or other scientific evidence from other health care systems	O	O	O	O	O	O
3. Should be effective, based on current scientific knowledge	O	O	O	O	O	O
(Clinical Experience) The proposed practice changes or guideline implementation:						
4. Are supported by clinical experience with hospital patients	O	O	O	O	O	O
5. Are supported by clinical experience with patients in other health care systems	O	O	O	O	O	O
6. Conform to the opinions of clinical experts in this setting	O	O	O	O	O	O
(Patient Preferences) The proposed practice changes or guideline implementation:						
7. Have been well-accepted by hospital patients in a pilot study	O	O	O	O	O	O
8. Are consistent with clinical practices that have been accepted by hospital patients	O	O	O	O	O	O
9. Take into consideration the needs and preferences of hospital patients	O	O	O	O	O	O
10. Appear to have more advantages than disadvantages for hospital patients	O	O	O	O	O	O

CONTEXT ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

	Strongly Disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly Agree 5	Don't know/ Not applicable 6
(Culture) Senior leadership/clinical management in your organization:						
1. Reward clinical innovation and creativity to improve patient care	O	O	O	O	O	O
2. Solicit opinions of clinical staff regarding decisions about patient care	O	O	O	O	O	O
3. Seek ways to improve patient education and increase patient participation in treatment	O	O	O	O	O	O
(Culture) Staff members in your organization:						
4. Have a sense of personal responsibility for improving patient care and outcomes	O	O	O	O	O	O
5. Cooperate to maintain and improve effectiveness of patient care	O	O	O	O	O	O
6. Are willing to innovate and/or experiment to improve clinical procedures	O	O	O	O	O	O
7. Are receptive to change in clinical processes	O	O	O	O	O	O
(Leadership) Senior leadership/clinical management in your organization:						
8. Provide effective management for continuous improvement of patient care	O	O	O	O	O	O
9. Clearly define areas of responsibility and authority for clinical managers and staff	O	O	O	O	O	O
10. Promote team building to solve clinical care problems	O	O	O	O	O	O
11. Promote communication among clinical services and units	O	O	O	O	O	O
(Measurement) Senior leadership/clinical management in your organization:						
12. Provide staff with information on hospital measures and guidelines	O	O	O	O	O	O
13. Establish clear goals for patient care processes and outcomes	O	O	O	O	O	O
14. Provide staff members with feedback/data on effects of clinical decisions	O	O	O	O	O	O
15. Hold staff members accountable for achieving results	O	O	O	O	O	O

CONTEXT ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

	Strongly Disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly Agree 5	Don't know/ Not applicable 6
(Readiness for change) Opinion leaders in your organization:						
1. Believe that the current practice patterns can be improved	O	O	O	O	O	O
2. Encourage and support changes in practice patterns to improve patient care	O	O	O	O	O	O
3. Are willing to try new clinical protocols	O	O	O	O	O	O
4. Work cooperatively with senior leadership/clinical management to make appropriate changes	O	O	O	O	O	O
(Resources) In general in my organization, when there is agreement that change needs to						
5. We have the necessary support in terms of budget or financial resources	O	O	O	O	O	O
6. We have the necessary support in terms of training	O	O	O	O	O	O
7. We have the necessary support in terms of facilities	O	O	O	O	O	O
8. We have the necessary support in terms of staffing	O	O	O	O	O	O

FACILITATION ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

(Characteristics) Senior leadership/clinical management will:						
1. Propose a project that is appropriate and feasible	O	O	O	O	O	O
2. Provide clear goals for improvement in patient care	O	O	O	O	O	O
3. Establish a project schedule and deliverables	O	O	O	O	O	O
4. Designate a clinical champion(s) for the project	O	O	O	O	O	O

FACILITATION ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

	Strongly Disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly Agree 5	Don't know/ Not applicable 6
(Characteristics) The Project Clinical Champion:						
5. Accepts responsibility for the success of this project	O	O	O	O	O	O
6. Has the authority to carry out the implementation	O	O	O	O	O	O
7. Is considered the clinical opinion leader	O	O	O	O	O	O
8. Works well with the intervention team and providers	O	O	O	O	O	O
(Role) Senior Leadership/Clinical Management/staff opinion leaders:						
9. Agree on the goals for this intervention	O	O	O	O	O	O
10. Will be informed and involved in the intervention	O	O	O	O	O	O
11. Agree on adequate resources to accomplish the intervention	O	O	O	O	O	O
12. Set a high priority on the success of the intervention	O	O	O	O	O	O
(Role) The implementation team members:						
13. Share responsibility for the success of the project	O	O	O	O	O	O
14. Have clearly defined roles and responsibilities	O	O	O	O	O	O
15. Have release time or can accomplish intervention tasks within their regular work load	O	O	O	O	O	O
16. Have staff support and other resources required for the project	O	O	O	O	O	O
(Style) The implementation plan for this intervention:						
17. Identifies roles and responsibilities	O	O	O	O	O	O
18. Clearly describes tasks and timelines	O	O	O	O	O	O
19. Includes appropriate provider/patient education	O	O	O	O	O	O
20. Acknowledges staff input and opinions	O	O	O	O	O	O

FACILITATION ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

	Strongly Disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly Agree 5	Don't know/Not applicable 6
(Style) Communication will be maintained through:						
21. Regular project meetings with the project champion and team members	O	O	O	O	O	O
22. Involvement of quality management staff in project planning and implementation	O	O	O	O	O	O
23. Regular feedback to clinical management on progress of project activities and resource needs	O	O	O	O	O	O
24. Regular feedback to clinicians on effects of practice changes on patient care/outcomes	O	O	O	O	O	O
(Style) Progress of the project will be measured by:						
25. Collecting feedback from patients regarding proposed/implemented changes	O	O	O	O	O	O
26. Collecting feedback from staff regarding proposed/implemented changes	O	O	O	O	O	O
27. Developing and distributing regular performance measures to clinical staff	O	O	O	O	O	O
28. Providing a forum for presentation/discussion of results and implications for continued improvements	O	O	O	O	O	O
(Resources) The following are available to make the selected plan work:						
29. Staff incentives	O	O	O	O	O	O
30. Equipment and materials	O	O	O	O	O	O
31. Patient awareness/need	O	O	O	O	O	O
32. Provider buy-in	O	O	O	O	O	O
33. Intervention team	O	O	O	O	O	O
34. Evaluation protocol	O	O	O	O	O	O

FACILITATION ASSESSMENT

INSTRUCTIONS: For each of the following statements, please rate the strength of your agreement with the statement.

(Evaluation) Plans for evaluation and improvement of this intervention include:	**Strongly Disagree 1**	**Disagree 2**	**Neither agree nor disagree 3**	**Agree 4**	**Strongly Agree 5**	**Don't know/ Not applicable 6**
35. Periodic outcome measurement	O	O	O	O	O	O
36. Staff participation/satisfaction survey	O	O	O	O	O	O
37. Patient satisfaction survey	O	O	O	O	O	O
38. Dissemination plan for performance measures	O	O	O	O	O	O
39. Review of results by clinical leadership	O	O	O	O	O	O

Thank you for your time and thoughtful responses. We value your input.