Do Organizational Readiness Scores in Federally Qualified Health Centers Differ by Urban/Rural Characteristics?

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Introduction

Measuring organizational readiness can identify areas for targeted assistance when implementing evidence-based interventions (EBIs), but a comprehensive, valid, and reliable tool is needed.

We distributed a readiness assessment based on the R=MC^2 heuristic, which conceptualizes organizational readiness as a combination of 3 components: motivation, innovation specific capacity, and general capacity.

Survey data were gathered from federally qualified health centers (FQHCs) to assess their readiness to implement colorectal cancer screening (CRCS) initiatives. FQHCs serve vulnerable populations, especially in rural areas where geographic isolation inhibits access to health care and community resources.

Objective

This cross-sectional study analyzes differences in readiness survey scores for rural and urban FQHCs.

Methods

Participating FQHCs were categorized as rural (n=20) or urban (n=36) using Rural Urban Commuting Area Codes (RUCA) zip code classifications. Staff at each FQHC completed a series of questions for each component on a Likert scale ranging from 1-7. FQHC level average scores for each readiness survey subcomponent were calculated from the individual staff level data.

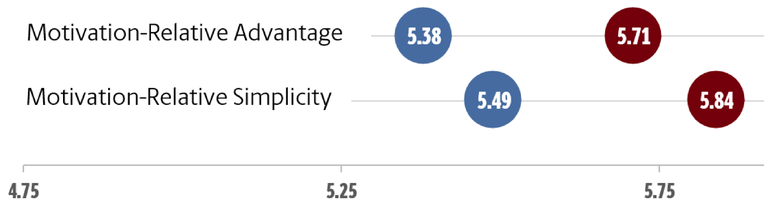
Findings

Significant (p<=0.05) differences between rural and urban FQHCs were observed for motivation and innovation specific capacity, but not general capacity.

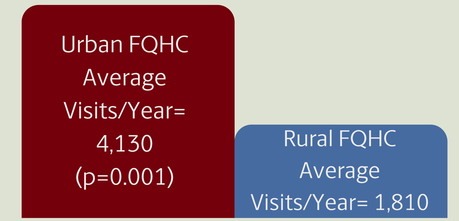
Rural FQHCs rated their organization significantly higher than urban on (mean scores):

- Knowledge, skills, and abilities for implementation (rural=5.82, urban=5.48)
- Implementation climate (rural=5.63, urban=5.24)
- Inter-organizational relationships (rural=5.66, urban=5.33)

Rural FQHCs rated motivation subcomponents 'relative advantage' and simplicity' significantly higher than urban FQHCs.



Urban FQHCs Reported More Annual Medical Visits Per Year Than Rural



Implications for D&I Science

While high readiness scores were observed across both groups, rural clinics scored higher than urban clinics in motivation and innovation specific capacity. This may be due to the higher patient volume in urban clinics, which may diminish perceptions of readiness. Data for specific subcomponents of organizational readiness can inform targeted assistance to support EBIs implementation. Attending to organizational differences in readiness may be key in efforts to improve implementation in low resource healthcare settings and ultimately achieve greater health equity.

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