Measurement Issues; Population Health

Development and Pilot Test of the Workplace Readiness Questionnaire, a Theory-Based Instrument to Measure Small Workplaces' Readiness to Implement Wellness Programs

Peggy A. Hannon, PhD, MPH; Christian D. Helfrich, PhD, MPH; K. Gary Chan, PhD; Claire L. Allen, MPH; Kristen Hammerback, MA; Marlana J. Kohn, MPH; Amanda T. Parrish, MA; Bryan J. Weiner, PhD; Jeffrey R. Harris, MD, MPH, MBA

Abstract

Purpose. *To develop a theory-based questionnaire to assess readiness for change in small workplaces adopting wellness programs.*

Design. *In developing our scale, we first tested items via "think-aloud" interviews. We tested the revised items in a cross-sectional quantitative telephone survey.*

Setting. *The study setting comprised small workplaces (20–250 employees) in low-wage industries.*

Subjects. *Decision-makers representing small workplaces in King County, Washington (think-aloud interviews, $n = 9$), and the United States (telephone survey, $n = 201$) served as study subjects.*

Measures. *We generated items for each construct in Weiner's theory of organizational readiness for change. We also measured workplace characteristics and current implementation of workplace wellness programs.*

Analysis. *We assessed reliability by coefficient alpha for each of the readiness questionnaire subscales. We tested the association of all subscales with employers' current implementation of wellness policies, programs, and communications, and conducted a path analysis to test the associations in the theory of organizational readiness to change.*

Results. *Each of the readiness subscales exhibited acceptable internal reliability (coefficient alpha range, .75–.88) and was positively associated with wellness program implementation ($p < .05$). The path analysis was consistent with the theory of organizational readiness to change, except change efficacy did not predict change-related effort.*

Conclusion. *We developed a new questionnaire to assess small workplaces' readiness to adopt and implement evidence-based wellness programs. Our findings also provide empirical validation of Weiner's theory of readiness for change.*

Key Words: Readiness for Change, Measure Development, Workplace Health Promotion, Prevention Research. Manuscript format: research; Research purpose: instrument development; Study design: nonexperimental; Outcome measure: cognitive and behavioral; Setting: workplace; Health focus: fitness/physical activity, nutrition, smoking control, and weight control; Strategy: policy, culture change; Target population: adults; Target population circumstances: education/income level

PURPOSE

Organizational readiness to change is defined as "the degree to which those involved [in a change initiative] are individually and collectively primed, motivated, and technically capable of executing the change,"[1] or the "extent to which organizational members are psychologically and behaviorally prepared to implement organizational change."[2] Organizational readiness is significantly correlated with outcomes such as success in the implementation of health service programs by hospitals,[3] implementation of quality improvements for cardiac surgery programs,[4] and adoption of evidence-based treatment practices.[5] Readiness is a key construct in several dissemination and implementation frameworks.[6–8] If organizational readiness can be reliably and validly assessed at the outset of a change initiative, measures of readiness could be used prognostically to gain an accurate prediction of the likelihood of change success, diagnostically to identify specific weaknesses or deficits in readiness

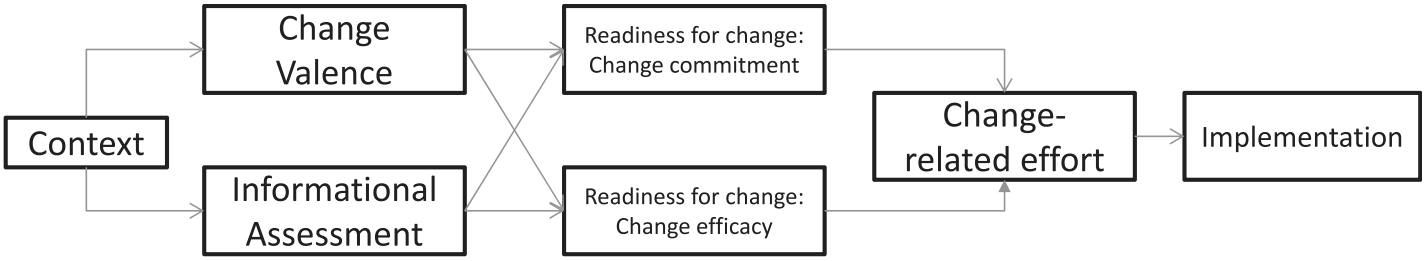
Peggy A. Hannon, PhD, MPH; Claire L. Allen, MPH; Kristen Hammerback, MA; Marlana J. Kohn, MPH; Amanda T. Parrish, MA; and Jeffrey R. Harris, MD, MPH, MBA, are with the Health Promotion Research Center (a CDC Prevention Research Center), Department of Health Services, University of Washington School of Public Health, Seattle, Washington. Christian D. Helfrich, PhD, MPH, is with the Northwest Health Services Research & Development Center of Excellence, VA Puget Sound Health Care System, Seattle, Washington. Christian D. Helfrich, PhD, MPH; and K. Gary Chan, PhD, are with the Department of Health Services, University of Washington School of Public Health, Seattle, Washington. Bryan J. Weiner, PhD, is with the Department of Health Policy and Management, UNC Gillings Global School of Public Health, University of North Carolina-Chapel Hill.

Send reprint requests to Peggy A. Hannon, Health Promotion Research Center, 1107 NE 45th St, Ste 200, Seattle, WA 98105; peggyh@uw.edu

This manuscript was submitted December 4, 2014; revisions were requested March 2, 2015; the manuscript was accepted for publication April 20, 2015.

0890-1171/00/$5.00 + 0
DOI: 10.4278/ajhp.141204-QUAN-604

Figure 1
Theory of Organizational Readiness to Change



that could be targeted with support activities, or repeatedly throughout the initiative to assess the effectiveness of support activities.

Many measures of organizational readiness to change have been developed, but virtually all were developed in health care settings, and most have important limitations.[2,9] In their systematic literature review, Weiner and colleagues[2] identified 43 unique instruments for measuring organizational readiness. Only seven were publicly available and had undergone systematic assessment of psychometric properties—meaning construct, content, and criterion validities[10–16]—and each of these had one or more limitations for broader applicability, such as being specific to information technology[15] or only assessing individual-level readiness.[13] Another recent review of measures of capacity for new knowledge and receptive context for change did not recommend any measures of these antecedents to readiness, because no measure was used in more than one study and many did not report measures' psychometric properties.[17]

A reliable, accurate assessment of organizational readiness to change could guide evidence-based interventions for workplace wellness programs that support such behaviors as healthy eating, physical activity, and tobacco cessation. Workplace wellness programs can improve employee productivity and reduce health care costs,[18] but they have low rates of penetration, particularly among small workplaces (those with fewer than 250 employees).[19,20] A national survey of small and midsized employers in low-wage industries found indicators of organizational readiness for implementation of workplace wellness, such as perceived feasibility and leadership support, were low overall and lowest among those with fewer than 250 employees.[21] The present study develops a theory-based readiness questionnaire for small workplaces and tests its reliability and validity with a sample of small workplaces in low-wage industries.

Weiner's theory of organizational readiness for change is among the few published works that lay out an explicit set of hypothesized causal relationships among readiness constructs[22] (Figure 1). The theory identifies two facets of readiness for change: change commitment (a shared resolve among organizational members to implement a change) and change efficacy (a shared belief among organizational members that they have a collective capability to implement a change). Change commitment and change efficacy are influenced by change valence (how much organizational members value the proposed change) and informational assessment (organizational members' perceptions of the task demands and resources required to implement the change). Change valence and informational assessment are predicted by broader contextual factors, such as the overall organizational culture, resources, structure, and past experiences with change. Change commitment and change efficacy predict change-related effort (coordinated efforts among organizational members to implement the change), which in turn predicts implementation success. The constructs are a useful guide for both item development and intervention development, suggesting areas that must be measured to fully grasp an organization's readiness for change. They also provide potential intervention targets for organizations that are not ready to change. Although Shea and colleagues[23] recently published scales for change commitment and change efficacy for health care settings, we are unaware of any workplace wellness readiness measures based on this theory.

The purpose of this study was to develop and pilot test a theory-based workplace readiness questionnaire appropriate for small workplaces that are considering adopting evidence-based workplace wellness strategies. In addition, we sought to empirically test the causal pathway hypothesized in Weiner's theory of organizational readiness to change.

METHODS

We conducted this study in two phases. First, we generated items and obtained feedback from small employers on all items by conducting think-aloud interviews. Second, we tested the revised items with 201 small employers and examined each construct scale's reliability and convergent validity with the implementation of current workplace wellness programs.

Item Development

Design. Weiner's theory of organizational readiness to change[22] guided item development. We developed or adapted items for each construct in the theory (context, change valence, informational assessment, change com-

mitment, change efficacy, and change-related effort). We used items developed in previous research[24–26] to measure implementation effectiveness; these items are not discussed except in the context of validating the newly developed scales and the path model to test the associations in the theory. Most items were adapted from prior readiness scales, including the Organizational Readiness to Change Assessment (36 items),[27] readiness and capacity items we developed for a prior employer survey (7 items),[21] and items based on the theory of organizational readiness to change developed by Shea et al.[23] for health care settings (16 items). We based other items on the research team's experience working with small employers (25 items) and adapted one item from the readiness scale by Holt et al.[11] The item pool was reviewed several times by a team of researchers and practitioners with experience working with small employers to implement wellness programs. We generated 85 items total.

Sample. We conducted "think-aloud" interviews[28] with nine employers (six females and three males) in King County, Washington. Participants were primary decision makers about health and wellness; all employers had 20 to 250 employees and represented low-wage industries, including accommodation and food services; arts, entertainment, and recreation; education; health care and social assistance; other services, excluding public administration; and retail trade. We chose employer sizes and industries consistent with eligibility criteria for a planned randomized controlled trial of one of our wellness program interventions. To gain perspectives from employers with different levels of experience with workplace wellness programs, we recruited five participants from employers that had participated in one of our workplace wellness studies within the past 2 years; the other four participants were from employers that had never participated in one of our projects and had little experience with workplace wellness programs. We planned to conduct up to 15 interviews but reached saturation after conducting 9 interviews.

Procedures. Interview procedures followed those outlined by Willis[29] and van Someren et al.[33] All interviews were conducted at the Health Promotion Research Center and each interview lasted 60 to 105 minutes. Two members of the research team (which included one investigator and three research staff members) were present for each interview; one person led the interview while the other took detailed notes. We explained the purpose of the interview to participants, ensured they were comfortable, and gave them two "warm-up" questions to practice the think-aloud procedure. Once it was clear that participants understood the process, the interviewer went through each question with the participant. Each question was printed on a separate piece of paper; the interviewer placed the paper in front of the participant and read the question to the participant. Participants described their thoughts about the question and answered the question. When necessary, the interviewer asked the participant for clarification (or suggestions for better wording). All interviews were audio-recorded; we listened to the recordings to ensure that notes captured all feedback for each item. Each participant received $150 at the end of the session.

Item Revisions Based on Interview Feedback. We made edits to the items throughout the think-aloud interviews based on participants' feedback (see Table 1 for examples). Generally, participants suggested three types of changes: (1) rewording an item for clarity, (2) repeating items for different types of roles within the workplace (e.g., asking a question separately for the perspectives of leaders, managers, and employees), and (3) deleting an item. Deletions were made when an item either duplicated another item with superior wording, or when participants felt that it was unlikely to yield valuable information because of social desirability. We retained 61 items for the survey pilot test, described below.

Pilot Test

Design. We pilot tested the readiness measures by conducting a cross-sectional survey of employers with 20 to 250 employees from the industries described above.

Sample. We purchased a list of employers with 20 to 250 employees from the six industries described above from Survey Sampling International (Shelton, Connecticut). In 2012, these industries had average salaries below $45,000 per year for production and nonsupervisory employees (range, $22,672 for accommodation and food services to $44,928 for education; http://www.bls.gov/iag/home.htm).

Procedures. Pacific Market Research (Renton, Washington) administered the survey by telephone to the person at each workplace who was identified as having the most knowledge about health and wellness. Pacific Market Research pretested the survey with 21 employers (not included in the final sample); the research team made minor modifications to the questionnaire based on the pretest to improve clarity and flow. Call center interviewers contacted each employer up to 15 times to attempt an interview, with the goal of reaching 200 participants (a sample size sufficient for our planned path analysis[31]). The survey questionnaire was administered with a computer-assisted telephone interviewing program that guided interviewers through appropriate skip patterns and follow-up questions. Interviews took 15 to 25 minutes to complete; all respondents were offered $25 in return for completing the survey. The University of Washington Institutional Review Board declared the study exempt from review.

Measures. The survey questionnaire included three content areas: employer characteristics, readiness items, and current workplace wellness implementation. Employer characteristics included industry, size (number of employees), for-profit vs. not-for-profit, proportion of full-time employees, and whether health insurance was offered to employees. Readiness items included the 61 items retained after the think-aloud interviews described above. Current workplace wellness implementation included measures of workplace policies, programs, and communication addressing healthy eating, physical activity, and tobacco cessation. These items were adapted from measures we developed with the American Cancer Society to evaluate

Table 1
Examples of Feedback and Item Revisions From Think-Aloud Interviews With 9 Employers*

Example	Item, Before	Example Issues Identified by Participant	Revision	Item, After
1	"The CEO/senior leaders are willing to try new things."	The "CEO" and "senior leaders" are two different entities that may differ in opinions and actions.	Deleted "CEO"	"Senior leaders are willing to try new things."
2	"Senior leaders support new policies and programs."	Policies and programs are different and cannot be lumped together.	Separated the question into two items.	"Senior leaders support new policies." "Senior leaders support new programs."
3	"Senior leaders support new programs."	"Programs" is too vague. Answer will always depend on the program.	Deleted item	N/A
4	"Employees work cooperatively with senior leaders."	Employees have no choice but to cooperate with senior leaders, so the answer will have no variation.	Deleted item	N/A
5	"Wellness programs control healthcare costs."	Not sure if question is referring to costs in the United States, in their organization, in their industry, etc.	Clarified question meaning.	"Wellness programs reduce employers' healthcare costs."
6	"We have one or more employees who are wellness champions."	Unsure about the definition of wellness champion; strong athlete vs. vocal advocate.	Added definition before the question.	"A wellness champion is an individual who openly advocates for wellness and encourages healthy behaviors."
8	"We can/could get people invested in our wellness program."	"Invested" makes people think of money.	Change invested to "participate".	"We can/could get people to participate in our wellness program."

* N/A indicates not applicable.

Workplace Solutions, and HealthLinks,[24–26] two interventions designed to help employers adopt and implement evidence-based health promotion practices presented in the Guide to Community Preventive Services.[32] A total implementation score was calculated as the average of policy, program, and communication scores across the three behaviors (scoring procedures are described in more depth in Laing et al.[26]). The complete survey questionnaire is available from the authors on request.

Analysis. We conducted an item analysis to determine whether items within scales correlated as predicted, and dropped items that did not correlate well within scales for parsimony. Two measures were considered in the item analysis: (1) Cronbach α for reliability (for the items measuring each construct), and (2) item-rest correlations to identify items that do not correlate well with others in a given scale. We used a minimum threshold of .70 for Cronbach α and .20 for item-rest correlation. Pairwise associations among scales and with current wellness program implementation were assessed by Pearson correlation. Finally, we conducted a path analysis following Weiner's theory of organizational readiness to change. Simultaneous multiple regression analysis was conducted to determine the associations between the scales, with the implementation score being the ultimate outcome. Statistical analyses were performed using STATA 11 (College Station, Texas).

RESULTS

Survey Respondents

A total of 201 employers completed the pilot readiness telephone survey (Table 2). More than half of the sample (52.2%) came from the health care and social assistance industry; the remaining employers represented other services (12.9%), educational services (12.4%), accommodation and food service (10.4%), retail (9.0%), and arts, entertainment, and recreation (3.0%). More than half (57.7%) were nonprofit organizations. Respondents' organizations employed an average of 122 (±16.48) employees. Employers completing the survey were geographically dispersed, representing all five U.S. census regions nationwide.

Scale Characteristics

The readiness items were divided among scales representing six constructs in the theory of organizational readiness to change. Scales for the first five constructs (context, 18 items; change valence, 7 items; informational assessment, 8 items; change commitment, 5 items; and change efficacy, 7 items) were scored using 5-point Likert-type scales (1 = strongly disagree, 5 = strongly agree). We eliminated items that did not meet the minimum threshold for scale reliability. Mean scale scores for each construct ranged from 3.23 (informational assessment) to 3.80 (context), and Cronbach α ranged from .75 (change efficacy) to .88 (change commitment; Table 3). The 16 change-related effort items were binary (0 = no, 1 = yes), and many employers did not respond to most of them because of skip patterns (most employers did not have wellness committees and skipped items that only applied to employers with wellness

Table 2
Pilot Survey Respondent Characteristics (n = 201)

	Value
What is your company's primary industry? No. (%)	
Health care and social assistance	105 (52.2)
Other services (excluding public administration)	26 (12.9)
Educational services	25 (12.4)
Accommodation and food service	21 (10.4)
Retail trade	18 (9.0)
Arts, entertainment, and recreation	6 (3.0)
Is your company a nonprofit or for-profit organization? No. (%)	
Nonprofit	116 (57.7)
For-profit	85 (42.3)
How many employees does your company have across all U.S. locations? Mean (SD)	121.74 (65.22)
What percentage of your employees work on-site at least one day per week? Mean (SD)	91.47 (16.48)
What percentage of your workforce is employed full-time? Mean (SD)	75.95 (20.99)
What is the average annual salary among employees at your company? Mean (SD)	39,790 (22,066)
What is the annual employee turnover rate at your company? Mean (SD)	16.42 (15.94)
Does your company offer health insurance to its employees? No. (%)	
Yes	197 (98)
No	4 (2)
Approximately what percentage of employees are enrolled in your health insurance plan? Mean (SD)	61.35 (24.54)
Is your company self-insured for health insurance? No. (%)	
Yes	39 (19.8)
No	158 (80.2)
Time zone, No. (%)	
Eastern	79 (39.3)
Central	72 (35.8)
Pacific	28 (13.9)
Mountain	21 (10.4)
Hawaiian	1 (0.5)
Respondent gender, No. (%)	
Male	33 (16.4)
Female	168 (83.6)

committees). Four of the change-related effort items (asked of all employers) met the threshold for scale reliability and were retained (mean scale score, .23, Cronbach $\alpha = .75$). The final Workplace Readiness Questionnaire includes 30 items, which are presented in Table 3.

As noted above, workplace wellness implementation measured workplace policies, programs, and communication related to healthy eating, physical activity, and tobacco cessation. Pairwise associations among scales, and between scales and implementation are presented in Table 4; all associations were statistically significant ($p < .05$). The strongest associations ($r \geq .50$) were between change valence and change commitment, informational assessment and change commitment, change commitment and change efficacy, change commitment and change-related effort, and change-related effort and implementation.

Path Analysis

Figure 2 presents paths with statistically significant standardized beta coefficients. The coefficients with workplace wellness implementation as the dependent variable indicate associations with change-related effort ($\beta = .37$, $p < .001$) and informational assessment ($\beta = .06$, $p = .003$), explaining 43% of the total variance. The variables informational assessment ($\beta = .12$, $p < .001$) and change commitment ($\beta = .14$, $p < .001$) were significantly associated with change-related effort. Context ($\beta = .38$, $p < .001$), change valence ($\beta = .57$, $p < .001$), and informational assessment ($\beta = .35$, $p < .001$) were significantly related to readiness for change commitment, and the same variables (context: $\beta = .26$, $p = .001$; change valence: $\beta = .37$, $p < .001$; and informational assessment: $\beta = .24$, $p < .001$) were significantly associated with change efficacy. Context was significantly related to change valence ($\beta = .14$, $p < .05$) and informational assessment ($\beta = .48$, $p < .001$).

DISCUSSION

We developed and pilot tested a theory-based Workplace Readiness Questionnaire for small employers that are considering workplace wellness programs. This survey may ultimately help researchers and practitioners identify workplaces that are ready for wellness program activities, and help identify key obstacles to wellness program implementation within specific workplaces. This questionnaire is now being used in a multisite implementation trial of strategies to promote and implement workplace wellness programs.

The findings also provide important empirical support for Weiner's theory of organizational readiness for change. We conducted a path analysis and found that most associations in the path analysis were consistent with the theory, with one key exception. Change efficacy, one of the two central constructs that comprise readiness in the model, was not significantly associated with change-related effort or implementation, whereas informational assessment was significantly associated with both. There are several possible explanations for this unexpected pattern of results, and they are not mutually exclusive. First, it may be that change efficacy is not in the causal pathway. The underlying theory holds that the organizational members have some understanding of what capabilities the change requires and a judgment of various members' abilities to effect that change. In the case of workplace wellness programs, change efficacy for wellness program elements (e.g., healthy food options, smoking cessation support) and confidence in

Table 3
Final Workplace Readiness Questionnaire Items*

Construct and Item	Mean	SD	Cronbach α
Context	3.77	0.63	0.83
1. The senior leaders are willing to try new things.	3.94	0.92	
2. The senior leaders seek ways to improve the work climate.	4.11	0.83	
3. The senior leaders reward creativity and innovation in the worksite.	3.80	0.95	
4. The senior leaders promote team building to solve worksite problems.	3.88	0.94	
5. The managers seek ways to improve the work climate.	4.00	0.80	
6. The managers encourage employees to participate in programs.	4.07	0.92	
7. When we want to try to something new we have the training resources to do it.	3.37	0.89	
8. When we introduce a new program or change we measure its success by asking employees to fill out a survey about the program.	2.96	1.21	
Change valence	3.79	0.60	0.75
9. Wellness programs would improve employee health in my organization.	4.07	0.80	
10. Wellness programs reduce employers' health care costs.	3.92	0.76	
11. Wellness programs help companies recruit and retain employees.	3.46	0.84	
12. Wellness programs are a good use of financial resources.	3.73	0.75	
Informational assessment	3.23	0.84	0.81
13. Most employees could take time at work to participate in wellness programs.	3.05	1.02	
14. Senior leaders would dedicate financial resources to wellness programs.	3.20	1.08	
15. Senior leaders would dedicate staff time to planning wellness programs.	3.26	1.02	
16. We have one or more employees who are wellness champions.	3.37	1.25	
17. We have one or more senior leaders who are wellness champions.	3.26	1.21	
Change commitment	3.31	0.90	0.88
18. Our senior leaders are committed to starting a wellness program.†	3.12	1.16	
19. Our opinion leaders are committed to starting a wellness program.†	3.27	1.15	
20. We are motivated to implement a wellness program.†	3.27	1.08	
21. We need to start a wellness program within the next year.†	3.37	1.05	
22. I would be willing to spend one or more hours per week on a wellness program.	3.54	1.05	
Change efficacy	3.41	0.75	0.75
23. We have the skills and expertise to implement a wellness program.†	3.43	1.02	
24. We have enough financial resources to support a wellness program.	3.01	1.10	
25. We could manage the politics of implementing a wellness program.	3.66	0.91	
26. We could get people to participate in our wellness program.	3.53	0.93	
Change-related effort	0.23	0.32	0.75
27. Not including your budget for health insurance, does your organization have a budget for wellness programs?‡	51 (25)		
28. Does your organization have established, written wellness goals?‡	34 (17)		
29. Does your organization have a wellness coordinator?‡	61 (30)		
30. Does your organization have a wellness committee?‡	38 (19)		

* Items 1–26 were answered using 5-point Likert-type scales, with 1 = strongly disagree and 5 = strongly agree.
† Wording was slightly modified for employers that already had a wellness program in place (e.g., "starting" changed to "expanding").
‡ These items were answered yes/no and scored no = 0, yes = 1. Values are given as No. (%) of the respondents who said yes. The total score presented for change-related effort comes from summing the four items and taking the mean (minimum possible score = 0, maximum possible score = 1).

collective ability may be less salient than fit with employer values, mission, and resources. Second, because most participants indicated low levels of wellness implementation at their workplaces, their change efficacy ratings may have been largely hypothetical. It is one thing to rate confidence to get people to participate in a wellness program when your organization has actually tried to do it, and another thing to rate confidence in something your organization has never attempted. Finally, only one person from each employer responded to the survey. Items for most constructs reflect perceptions of aspects of the workplace, but the change commitment and change efficacy items reflect attitudes and feelings. We framed these items in the plural (we) rather than the singular (I), but it is possible that the change efficacy items captured the individual respondent's feelings rather than overall change efficacy at the workplace level.

Limitations

This work has three potential limitations. First, as noted above, only one representative of each workplace responded to our think-aloud interviews and pilot survey. This is common practice in workplace wellness sur-

Table 4
Associations Among Readiness Constructs and Workplace Wellness Program Implementation

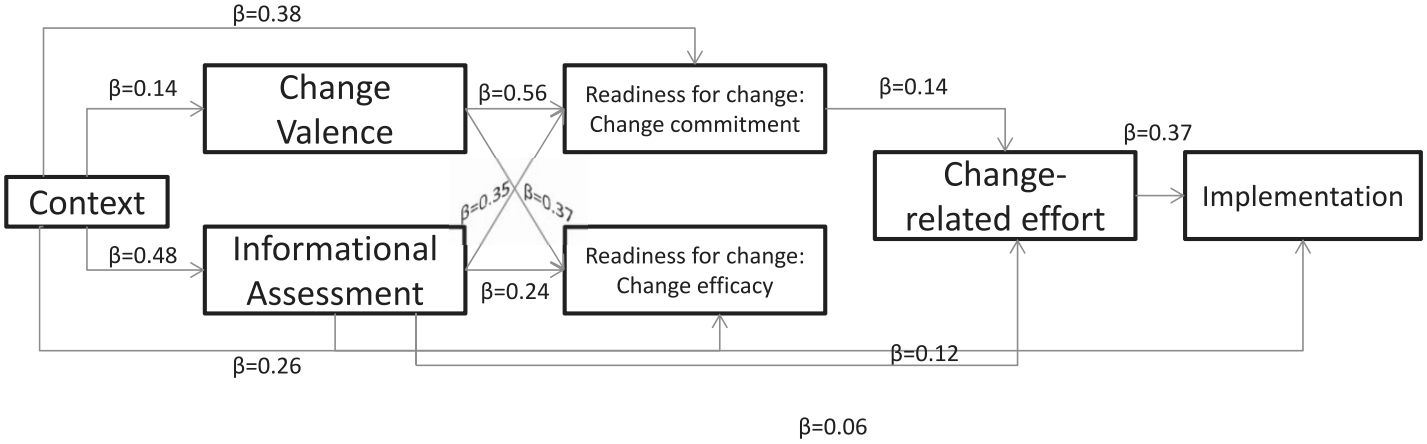
	Pearson Correlation Coefficient						
Readiness Construct	Context	Change Valence	Informational Assessment	Readiness for Change–Commitment	Readiness for Change–Efficacy	Change-Related Effort	Workplace Wellness Implementation
Context	1.00						
Change valence	0.15*	1.00					
Informational assessment	0.36*	0.30*	1.00				
Readiness for change–change commitment	0.44*	0.51*	0.53*	1.00			
Readiness for change–change efficacy	0.36*	0.41*	0.44*	0.67*	1.00		
Change-related effort	0.21*	0.28*	0.49*	0.51*	0.34*	1.00	
Workplace wellness implementation	0.19*	0.17*	0.47*	0.40*	0.27*	0.62*	1.00

* $p \leq 0.05$.

veys,[20,21,33] but it does not fit with Weiner's conceptualization of organizational readiness as a "shared" state or his recommendation that multiple people within an organization complete a readiness assessment. In our experience with small workplaces, it is common that only one or two people have the power to implement workplace wellness programs, so having multiple respondents per workplace (especially in a random telephone survey) did not seem feasible. Future research should explore administering our readiness scale to several people per workplace. This would be more feasible in an intervention study or other research context that places researchers in the worksite, and it could also shed light on the change efficacy results we described above.

The second and third limitations relate to the pilot survey sample. This was a convenience sample of employers willing to take the time to participate in a survey about readiness to implement workplace wellness programs. Employers in the health care and social assistance industry and not-for-profit employers were overrepresented in the sample. We replicated Table 4 analyses separating employers by these characteristics (e.g., health care and social assistance vs. all other industries, for-profit vs. not-for-profit) and found very similar associations among the scales and implementation (data not shown). We included six low-wage industries in this work, and it is unknown whether

Figure 2
Path Analysis



β indicates standardized beta coefficients. Lines in the figure represent significant coefficients.

the findings generalize to other industries. However, these six industries represent almost 63 million employees in the United States, or 48% of all U.S. private sector employees (http://www.bls.gov/oes/2012/may/oessrci.htm).

Strengths

Readiness is a key factor in many dissemination and implementation frameworks, yet it is often not addressed in workplace wellness. The Workplace Readiness Questionnaire is the first theory-based instrument we are aware of that was developed for workplace wellness programs and tested with small employers. Each of the subscales demonstrated acceptable internal reliability and evidence of convergent validity, in that each was significantly associated with wellness program implementation. In the United States, small employers outnumber large employers by a large margin, and the former are less likely to offer workplace wellness programs and more likely to need implementation assistance. Our readiness instrument addresses both modifiable and nonmodifiable factors that could affect workplace wellness implementation success.

Conclusion

The next step is to determine whether the Workplace Readiness Questionnaire actually predicts implementation change over time. We are currently administering the questionnaire as part of our protocol for recruiting small employers to participate in a randomized controlled trial of the American Cancer Society HealthLinks intervention. The employers will be followed for 2 years, which will enable us to test the association of their baseline readiness scores with change in implementation over time. We will be able to see which construct scales have the most predictive value and which may help shorten the instrument further (the questionnaire takes 5–10 minutes to administer). Finally, we will administer the questionnaire multiple times over the course of the study, and will be able to test whether the HealthLinks intervention has an impact on readiness score change from baseline to follow-up.

Other future research projects would be to test the questionnaire with large employers and/or employers in industries outside of the six that were included in this study. A study of workplace wellness practitioners and whether their work with employers would be enhanced by using the questionnaire would also be useful. These practitioners could help determine whether the questionnaire diagnoses key barriers to implementation early enough in the process to influence implementation success. They could also judge how useful it is in creating or augmenting their workplace wellness program. The ultimate goal is to refine the Workplace Readiness Questionnaire so that it becomes a reliable, valid, and practical tool for workplace wellness researchers and practitioners.

SO WHAT? Implications for Health Promotion Practitioners and Researchers

What is already known on this topic?

Readiness is a key construct in most dissemination and implementation frameworks, yet most of the readiness instruments developed to date were developed for health care settings.

What does this article add?

This article adds a theory-based instrument to assess readiness for change in adopting wellness programs. It was designed for and tested with small employers in low-wage industries. The Workplace Readiness Questionnaire exhibits good reliability and evidence of validity. In our pilot test, we found that small employers' scores on the readiness subscales were significantly associated with their current workplace wellness program implementation.

What are the implications for health promotion practice or research?

The Workplace Readiness Questionnaire can help wellness practitioners and researchers start a dialogue with small employers about their readiness for beginning or expanding a wellness program. The questionnaire may help identify potential limitations or barriers to implementing wellness programs. There are also research opportunities to further validate the questionnaire.

Acknowledgments

This project was supported by grant 5R01CA160217 from the National Cancer Institute. The authors would like to thank the employers who participated in the interviews and telephone survey.

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