

ASSESSING ORGANIZATIONAL READINESS FOR HOSPITAL TRANSFORMATION: EVIDENCE FROM PROGRAM HASIL TERBAIK CEPAT IMPLEMENTATION AT RSUD RUPIT

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Abstract. Limited achievement of service indicators and organizational resources indicates a readiness gap within RSUD Rupit in facing the implementation of the Program Hasil Terbaik Cepat (PHTC). This study examines organizational readiness for the implementation of the Program Hasil Terbaik Cepat (PHTC) at RSUD Rupit using a quantitative approach based on the R = MC² framework. A cross-sectional survey was conducted involving 183 respondents selected through proportional stratified random sampling. Data were collected using the Readiness Diagnostic Scale (RDS) and analyzed using descriptive statistics, z-score standardization, and comparative analysis across readiness dimensions. The results indicate that organizational motivation is the strongest dimension (79.00%), followed by general capacity (66.23%), while innovation-specific capacity remains the weakest (51.48%). Z-score analysis confirms a readiness imbalance, where high motivation is not supported by adequate technical capacity. Further analysis shows that leadership and organizational innovativeness contribute significantly to readiness, whereas staff capacity and technical competence are the main limiting factors. The study concludes that strengthening innovation-specific capacity is the primary priority for improving organizational readiness. These findings provide empirical evidence for policymakers and hospital management to design targeted interventions for accelerating hospital transformation programs.

Keywords: Program Hasil Terbaik Cepat; organizational readiness; hospital transformation; R=MC²

I. INTRODUCTION

National health system transformation places district public hospitals as strategic actors in ensuring equitable access to safe, quality, and affordable referral services, particularly in rural and underserved regions [1]. In this context, RSUD Rupit serves as the only district-owned referral hospital in Musi Rawas Utara Regency, South Sumatra, and plays a pivotal role in delivering secondary healthcare services. Despite this strategic function, the hospital remained a class D facility in 2024, with only 88 active beds, far below the estimated ideal requirement of 199 beds based on the World Health Organization benchmark of 1 bed per 1,000 population [2]. This gap reflects a substantial mismatch between institutional capacity and regional healthcare demand, particularly in geographically remote communities.

The hospital's service performance indicators further illustrate this structural challenge. Although several indicators improved between 2022 and 2024, the Bed Occupancy Rate (BOR) remained below the ideal standard, while Length of Stay (LOS) also failed to meet expected benchmarks. Low utilization, persistent external referrals, infrastructure constraints, limited specialist services, and suboptimal bed utilization indicate that RSUD Rupit's operational capacity remains in transition toward national service standards [3], [4].

These structural limitations have contributed to low service utilization, continued referrals to hospitals outside the district, and under-optimized financial performance under the Regional Public Service Agency (BLUD) scheme [5], [6]. In addition, recurring financial gaps, where realized revenue consistently remained below projected targets, continue to constrain reinvestment in infrastructure, medical equipment, and service innovation [3]. Collectively, these conditions indicate that the hospital's capacity has not yet aligned with the growing healthcare needs of the population.

At the same time, the hospital is required to respond to multiple strategic national policies, including the implementation of Standard Inpatient Class (*Kelas Rawat Inap Standar / KRIS*) [7], strengthening of KJSU-KIA service networks [8], and the Program Hasil Terbaik Cepat (PHTC) as a rapid policy instrument for accelerating referral service transformation and district hospital upgrading [9]. RSUD Rupit has been designated as one of the national PHTC loci, with the policy target of upgrading from class D to class C hospital status [10]. This policy pressure makes organizational readiness a critical determinant of successful implementation.

Previous studies in healthcare policy implementation consistently show that the success of organizational transformation is not determined solely by policy design but is strongly influenced by internal readiness factors, including

staff capacity, organizational autonomy, interorganizational relations, institutional priorities, leadership, culture, and communication [11], [12], [13], [14], [15], [16], [17], [18]. Inadequate readiness may generate resistance, weak commitment, implementation barriers, and policy–capacity mismatch, ultimately reducing the probability of successful change [19], [20].

In this regard, the $R = MC^2$ framework conceptualizes organizational readiness as a function of motivation, general capacity, and innovation-specific capacity [21]. This framework has been widely applied to predict the successful implementation of policy-driven interventions across public service and health settings [12], [22], [23]. However, measuring readiness alone is insufficient without a complementary strategy to identify the forces that facilitate or inhibit implementation. Studies in implementation science emphasize the importance of systematically mapping barriers and facilitators to ensure sustainable policy execution [24], [25], [26].

Therefore, this study aims to quantitatively assess organizational readiness for the implementation of the Program Hasil Terbaik Cepat (PHTC) at RSUD Rupit using the $R = MC^2$ framework. Specifically, the study seeks to identify the dominant and weakest dimensions of readiness and to examine the extent of readiness imbalance across organizational components. By focusing on quantitative measurement, this study contributes empirical evidence to support data-driven decision-making in hospital transformation policies, particularly in resource-constrained and rural healthcare settings.

II. RESEARCH METHODS

This study employed a quantitative cross-sectional design to assess organizational readiness for the implementation of the Program Hasil Terbaik Cepat (PHTC) at RSUD Rupit. [32]. The research was conducted at RSUD Rupit, Musi Rawas Utara, South Sumatra, Indonesia, from November 2025 to January 2026, during the hospital's transition toward Class C status through *Program Hasil Terbaik Cepat* (PHTC). Organizational readiness was measured using the $R = MC^2$ framework, which comprises three main dimensions: motivation, general capacity, and innovation-specific capacity [21]. The study population consisted of 338 hospital employees. A total of 183 respondents were selected using proportional stratified random sampling based on the Slovin formula with a 5% margin of error. In addition, all hospital leaders ($n = 4$) were included using a census approach to ensure representation of managerial perspectives.

Data were collected using the Readiness Diagnostic Scale (RDS) with a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). Instrument validity was tested using Pearson product–moment correlation, while reliability was assessed using Cronbach's alpha, with a minimum acceptable threshold of 0.70. Data analysis was conducted using descriptive statistical techniques. Mean scores and percentage indices were used to determine the level of organizational readiness across each dimension. Z-score standardization was applied to examine the relative position

and distribution of each dimension, allowing identification of dominant and weakest components within organizational readiness. Based on the standardized scores, readiness levels were classified into low, moderate, and high categories. Ethical considerations were maintained throughout the study, including institutional approval, informed consent from all participants, and confidentiality of responses.

III. RESULT AND DISCUSSION

The organizational readiness for PHTC implementation at RSUD Rupit was assessed using the $R = MC^2$ framework, covering motivation, general capacity, and innovation-specific capacity. The findings are presented sequentially from the overall readiness profile to the subcomponent level in order to identify the strongest and weakest organizational dimensions influencing program implementation.

Table 1. Overall Organizational Readiness for PHTC Implementation

Dimension	Score (%)	Z-score	Interpretation
Motivation	79.00	0.975	Above average
General capacity	66.23	0.048	Near average
Innovation-specific capacity	51.48	-1.023	Below average

Discussion. The overall readiness profile indicates that motivation was the strongest dimension, suggesting that staff perceived the Program Hasil Terbaik Cepat (PHTC) as valuable, relevant, and strategically aligned with the hospital's upgrading agenda. This finding is theoretically consistent with the $R = MC^2$ framework developed by Scaccia et al. (2015), which conceptualizes readiness as the interaction between motivation, general capacity, and innovation-specific capacity, with motivation serving as a key driver of change commitment. It also aligns with subsequent applications of the model in healthcare implementation studies showing that high readiness motivation improves the likelihood of successful program uptake and reach [33], [34]. By contrast, innovation-specific capacity showed the weakest score, indicating that technical readiness, implementation champions, and program-specific operational support remain insufficient. This pattern is in line with recent evidence that technical capability gaps often become the dominant barrier in complex health service innovations, even when organizational commitment is already strong. The finding therefore suggests that while strategic willingness to change is high, operational execution remains the principal implementation bottleneck.

Table 2. Motivation Readiness Subcomponents

Subcomponent	Mean	Z-score	Interpretation
Relative advantage	4.27	0.974	Above average
Compatibility	4.21	0.784	Above average
Complexity	3.54	-1.236	Below average
Trialability	3.95	0.003	Near average
Observability	3.55	-1.203	Below average
Priority	4.17	0.678	Above average

Discussion. Motivation readiness was mainly driven by relative advantage, compatibility, and priority, indicating that

respondents considered PHTC superior to previous practices, aligned with organizational needs, and worthy of strategic prioritization. This pattern strongly reflects the motivational constructs emphasized by Scaccia et al. (2015), particularly perceived value and innovation–organization fit as determinants of readiness. The result is also supported by more recent healthcare implementation studies, which report that perceived strategic relevance and compatibility significantly strengthen change commitment among hospital staff [33], [35], [36]. However, complexity and observability remained below average, implying that staff still perceived implementation procedures as complicated and short-term outcomes as insufficiently visible. This partially contrasts with studies reporting that high motivation may offset procedural complexity during early implementation phases (Bringsvor, 2025; Sumner et al., 2025). In the RSUD Rupit context, however, the relatively low observability suggests that visible short-term wins and rapid feedback mechanisms are still limited. Therefore, clearer communication pathways, phased implementation pilots, and stronger monitoring-feedback systems are required to sustain motivational readiness.

Table 3. General Capacity Subcomponents

Subcomponent	Mean	Z-score	Interpretation
Organizational culture	3.38	0.087	Near average
Organizational climate	3.36	0.061	Near average
Organizational innovativeness	4.04	0.937	Above average
Resource utilization	3.41	0.122	Near average
Leadership	4.08	0.993	Above average
Organizational structure	3.17	-0.181	Below average
Staff capacity	1.75	-0.202	Below average

Discussion. The general capacity dimension highlights leadership and organizational innovativeness as the main institutional strengths supporting PHTC implementation. Strong leadership commitment is particularly important for mobilizing cross-unit coordination, allocating strategic resources, and sustaining policy momentum. This finding is highly consistent with the broader organizational readiness literature, which places leadership as a central enabler of implementation climate and collective efficacy [19], [23], [37]. Nevertheless, organizational structure and staff capacity emerged as weak points, indicating unresolved issues related to role clarity, coordination mechanisms, workforce adequacy, and technical workload distribution. This finding supports prior hospital-based studies that identify workforce shortages and bureaucratic coordination barriers as persistent challenges in district hospital transformation [38], [39]. At the same time, it contrasts with studies suggesting that strong formal structures may accelerate implementation when paired with effective communication systems [40]. In RSUD Rupit, the evidence suggests that structural formalization alone is insufficient without adequate staffing reinforcement and clearer operational workflows.

Discussion. Innovation-specific readiness remains the most critical challenge area. The strongest subcomponent was interorganizational relationships, demonstrating that RSUD Rupit benefits from strong external collaboration networks, including government stakeholders, referral facilities, and policy partners. This finding is consistent with implementation studies showing that interorganizational networks improve

access to technical support, legitimacy, and external resources [41], [42]. However, technical competencies and the absence of program champions were the weakest elements, indicating that the hospital still lacks dedicated technical actors capable of driving day-to-day implementation. This supports previous findings that competency deficits and the absence of formally legitimized champions reduce implementation fidelity in complex hospital reforms [43], [44]. It also helps explain why high motivation and leadership support have not yet translated into equally strong operational readiness. The gap between strong external support and weak internal execution capacity suggests that future readiness strengthening should prioritize competency-based training, formal appointment of program champions, and innovation-focused operational supervision.

Table 4. Innovation-Specific Capacity Subcomponents

Subcomponent	Mean	Z-score	Interpretation
Innovation-specific knowledge, skills, and abilities	1.72	-0.726	Below average
Program champion	1.57	-0.854	Below average
Specific implementation climate	2.92	0.294	Above average
Interorganizational relationships	4.09	1.287	Above average

Taken together, the findings suggest that RSUD Rupit has a favorable psychological and strategic environment for PHTC implementation, but the success of sustained implementation depends on strengthening its operational core. The readiness pattern reflects a classic imbalance within the $R = MC^2$ model: high motivation and leadership support are not yet matched by adequate innovation-specific capabilities. Therefore, the most critical strategic priorities include staff technical capacity building, clarification of cross-unit implementation roles, establishment of formal program champions, and strengthening innovation-specific support systems. These interventions are essential to accelerate hospital upgrading and ensure sustainable PHTC outcomes.

IV. CONCLUSIONS

This study demonstrates that organizational readiness for the implementation of the Program Hasil Terbaik Cepat (PHTC) at RSUD Rupit is characterized by an asymmetrical pattern across its core dimensions. While organizational motivation has reached a relatively high level, indicating strong commitment and perceived value of the program, this is not yet supported by adequate general capacity and innovation-specific capacity. The findings highlight that the main limitation of organizational readiness lies in innovation-specific capacity, particularly in terms of technical competencies, workforce capability, and program-specific support. The results also indicate that although institutional support and leadership are relatively strong, these strengths have not been fully translated into effective operational readiness. The z-score analysis further confirms the presence of a readiness imbalance, where motivation exceeds the overall average while innovation-specific capacity remains below it. This suggests that the organization is more prepared at the strategic and psychological level than at the technical and operational level.

Therefore, improving organizational readiness should primarily focus on strengthening innovation-specific capacity, including competency development, optimization of workforce capacity, and enhancement of program-specific support systems. These efforts are essential to ensure that high organizational motivation can be effectively translated into sustainable implementation performance.

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