ORGANIZATIONAL CAPACITY ASSESSMENT

CENTER FOR COMMUNITY HEALTH AND EVALUATION
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Developed by the Center for Community Health and Evaluation (CCHE)[1]

ASSESSMENT OVERVIEW

The capacity assessment aims to assess your organization's current practice and organizational capacity related to trauma and resilience-informed care with pediatric patients ages 0-5 and their caregivers. For this initiative, trauma- and resilience-informed care refers to care in which all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on children, caregivers, and service providers.

Why are we doing this assessment? There are many factors that influence successful implementation of trauma- and resilience-informed care on teams' journeys toward becoming healing organizations. This assessment focuses on the extent to which practices and systems that contribute to effectively implementing trauma- and resilience-informed care are currently in place at your organization. The results will help identify strengths and opportunities to improve clinical practice or organizational culture.

Who will participate in the assessment? This is an assessment for individual organizations. Organizations should engage a multi-disciplinary team with various perspectives to complete the assessment collaboratively.

We have found the following steps to be most effective in completing the assessment:

1 Engage your organization's multi-disciplinary team in completing the assessment. Your team should include 4-6 representatives including a project lead, provider champion, clinical leader, front line staff, administrative leader, and other participating team members, if available. The team may include additional people if you determine other input would be useful in completing the assessment. Ideally, these same individuals will participate in the assessment at multiple-time points if possible. You will be asked to list the individuals that participated in the assessment when your response is submitted.

2 Each participant completes a copy of the assessment individually. The assessment is included in the following pages. This can be done by printing the assessment and marking your individual selection with a pencil or completed electronically by noting your individual response using the Text Highlight function in the toolbar.

3 The team comes together (in-person or virtually) to discuss responses and come to consensus on each question. Discussion should focus on questions where there was variation in response to reach agreement on a team response for that question. We hope that the process of completing this assessment will generate meaningful discussions among team members. We encourage your team to create a discussion environment where disagreement is allowed without judgement. If your team cannot reach consensus, please select "Unsure" and describe your team's variation in the comment space.

[1] Adapted primarily from the American Institute for Research's Trauma-Informed Organizational Capacity Scale, the System of Care Trauma-Informed Agency Assessment, and the Pediatric Integrated Care Collaborative framework, in consultation with subject-matter experts, program faculty and coaches, and Center for Care Innovations staff.

YOUR ORGANIZATION

1. Organization name: _____

2. Please list the names and roles of team members contributing to this assessment:

Names	Roles
a.	a.
b.	b.
c.	c.
d.	d.
e.	e.

3. Please list any other trauma- and resilience-informed care initiatives or practice communities your organization is part of (apart from RBN):

a.
b.
c.
d.
e.

4. On a scale of 0-10, please rate your organization relative to its journey to becoming a healing organization:

Trauma organized: induces trauma by being reactive, is fragmented, avoids and numbs, has authoritarian leadership, perpetuates inequity and an "us versus them" mentality

Trauma informed: understands the nature and impact of trauma and recovery, has shared language, recognizes socio-cultural trauma and structural oppression

Healing organization: reduces trauma by being reflective, makes meaning out of the past, is growth and prevention oriented, is collaborative, values equity and accountability, has relational leadership

0 1 2 3 4 5 6 7 8 9 10

Trauma organized (reactive, fragmented, inequitable)

Trauma informed (shared language, trained in trauma)

Healing organization (reflective, collaborative, relational, equitable)

5. Please provide a 2-5 sentence example that illustrates why you rated your organization as you did in the previous question.

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Please rate your organization on the following:

ORGANIZATIONAL ENVIRONMENT

Section 1: Organizational culture and commitment to trauma- and resilience-informed care and equitable practices

6. Organization reflects the racial, ethnic, and cultural diversity of our patient population

1 ☐ (Low/ Not in place)	In general, our organization does not reflect the racial, ethnic and cultural diversity of our patients. For example, our providers and staff largely identify as white whereas our patient population is primarily Black, Indigenous, and People of Color
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Front-line, administrative, and clinical support staff are largely representative of the communities we serve. However, our providers AND/OR organizational leadership AND/OR Board of Directors (if applicable) moderately reflect the patient population we serve.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization is diverse and reflects the patient population we serve from the front-line to providers to organizational leadership to our Board of Directors (if applicable).
☐	Unsure

7. Organization provides training and support to address implicit and personal biases, microaggressions, etc. among staff and in patient care

1 ☐ (Low/ Not in place)	In general, our organization does not provide training to address biases, microaggressions, etc. within the organization and with patients, nor does the organization actively support a culture of healing (e.g., reflective, collaborative, relational, equitable).
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Some departments or individual roles are provided with learning opportunities around biases, microaggressions, etc., while others are not. Our organization occasionally demonstrates support for a culture of healing (e.g., reflective, collaborative, relational, equitable).
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization embraces and provides ongoing learning at all levels and roles of the organization to address biases, microaggressions, etc. within the organization and with patients and commits financial and human resources to support a culture of healing (e.g., reflective, collaborative, relational, equitable).
☐	Unsure

8. Role of organizational policies and procedures in healing trauma and supporting equity and cultural humility

1 ☐ (Low/ Not in place)	In general, our organization's policies and procedures are not or are rarely informed by or responsive to diverse cultural and racial backgrounds. Organizational leaders are not in the habit of examining institutional power and privilege or practicing cultural humility.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Some of our organization's policies and procedures are informed by and responsive to diverse cultural and racial backgrounds. Our leaders do not consistently, or only occasionally, examine the ways our organization may perpetuate trauma and inequity or practice cultural humility. Trauma and inequity are often examined and addressed as separate issues.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization's policies and procedures are informed by and responsive to diverse cultural and racial backgrounds. Our leaders participate in ongoing facilitated meetings to interrogate the ways our organization can perpetuate trauma and inequity, discuss institutional power and privilege, and practice cultural humility. Trauma and inequity are acknowledged as harms that are interconnected and reinforcing.
☐	Unsure

9. Leadership buy-in and commitment to equity and trauma- and resilience-informed care

1 ☐ (Low/ Not in place)	In general, our organization's leaders express that trauma- and resilience-informed care is "nice to have" or an optional add-on to our primary work of delivering patient care. Leaders typically do not use the language of trauma- and resilience-informed care.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Some organizational leaders express commitment to and provide resources for trauma- and resilience-informed care AND/OR leaders express commitment to trauma- and resilience-informed care but do not provide adequate resources to implement it. Leaders may use the language of trauma- and resilience-informed care in some situations but not others.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Leaders at every level (C-suite, departmental, people managers, etc.) express commitment to and provide needed resources for trauma- and resilience-informed care (technology, staffing, protected time, etc.). Leaders consistently use the language of trauma- and resilience-informed care in all or nearly all situations, e.g., related to patients, staff, providers, and community.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
10. Non-clinical staff members' unique expertise and lived experience is acknowledged as valuable to the care of our patients and families	☐	☐	☐	☐	☐	☐
11. Different cultural norms of staff members are valued, and employees do not have to assimilate or leave a part of themselves behind when they come into the workplace	☐	☐	☐	☐	☐	☐

Notes and comments on Section 1: Organizational culture and commitment to trauma- and resilience-informed care and equitable practices

Section 2: Organization supports staff and providers' well being

12. Staff and providers reflect with supervisors and peers about challenges they experience working with trauma and adversity

1 ☐ (Low/ Not in place)	People in our organization do not or rarely acknowledge, discuss, or address how working with patients experiencing trauma and adversity can affect care team members AND/OR there is a general attitude and culture that our main priority is serving patients and staff and providers need to do whatever it takes.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	People in our organization acknowledge that working with patients experiencing trauma and adversity can affect care team members, but don't consistently talk about or normalize secondary or vicarious trauma or do anything to unpack, process, or address those affects, including providing staff and providers relevant supports and strategies.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	People in our organization acknowledge that working with patients experiencing trauma and adversity can affect care team members and build conversations around boundaries and self-care into meetings and supervision. There is regular time for individual supervision and supervisors are trained in reflective supervision practices.
☐	Unsure

13. Our organization examines and mitigates the impact of power dynamics on the relationships among the healthcare team

1 ☐ (Low/ Not in place)	Our organization does not or very rarely clearly acknowledges, discusses, or addresses power dynamics among members of the healthcare team. For example, front-line and clinical support staff rarely speak up with ideas or feedback or are not seen as leaders on our team.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	People in our organization understand and acknowledge that members of the healthcare team may hold different levels of power, especially providers, when working together to deliver patient care. However, we don't consistently do anything different to mitigate those power dynamics. Front-line and clinical support staff occasionally speak up with ideas or are engaged for feedback or act as leaders on our team.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization consistently thinks about how to effectively work within our healthcare team as equals and attempts to mitigate power dynamics by prioritizing things like relationship building, creating spaces to listen, soliciting feedback, considering our teammates' realities, and demonstrating transparency. Front-line and clinical support staff regularly speak up with ideas or feedback and are leaders on our team.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
14. Our organization has a position or positions dedicated to staff wellness and trauma-informed organizational practices	☐	☐	☐	☐	☐	☐
15. Our organization solicits formal feedback from all staff and providers on compassion fatigue, secondary traumatic stress, and burnout (e.g., staff survey)	☐	☐	☐	☐	☐	☐

Notes and comments on Section 2: Organization supports staff and providers' well being

Section 3: Systems for learning within our organization

16. Organization has a systematic strategy for seeking input on organizational strategy from patients and families	
1 ☐ (Low/ Not in place)	In general, our organization does not solicit input from patients or families regarding our organizational strategy and/or policies and programs.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization solicits ad hoc or informal feedback from patients and families about our organizational goals and/or policies and programs. Patients and families are not supported to engage in an ongoing way.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization actively recruits and regularly engages patient and family member advisers to shape our strategic goals and/or policies and programs. We commit resources to provide advisers with orientation, training, and ongoing support to participate (may include compensation).
☐	Unsure

17. Data related to trauma and resilience-informed care is tracked, analyzed and used (e.g., to make decisions or changes)	
1 ☐ (Low/ Not in place)	In general, our organization does not have a way to track, analyze, or use data related to trauma- and resilience-informed care and it is not a priority given other demands for data/IT support.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization has fragmented or informal mechanisms to track, analyze, and use data related to trauma- and resilience-informed care OR we have standardized and systemic approaches for collecting and monitoring these data, but do not use data to reflect or make changes.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization has a standardized and systemic approach for collecting and monitoring data related to trauma- and resilience-informed care, as well as regular meetings with multidisciplinary staff to reflect on data. These data are used to make changes in our practices and are shared with staff, providers, and organizational leaders.
☐	Unsure

Notes and comments on Section 2: Organization supports staff and providers' well being

PREVENTION & PROMOTION

Section 4: Screening and assessment

18. To what extent does your organization screen or assess for the following to understand patient or caregiver experience or needs related to trauma and resilience?

	1 We do not or very infrequently assess for this	2	3 We screen inconsistently, either not everyone does it or it happens sporadically	4	5 We screen as part of standard practice or for a clear segment of our population
Food security	☐	☐	☐	☐	☐
Economic security	☐	☐	☐	☐	☐
Safe and stable housing	☐	☐	☐	☐	☐
Maternal depression	☐	☐	☐	☐	☐
Caregiver anxiety	☐	☐	☐	☐	☐
Caregiver substance use	☐	☐	☐	☐	☐
Intimate partner violence	☐	☐	☐	☐	☐
ACEs in adults	☐	☐	☐	☐	☐
ACEs in children	☐	☐	☐	☐	☐

19. Our organization identifies protective factors (e.g. supportive relationships with family, friends, people in community, engagement in activities that promote hope and sense of belonging, other domains of wellness)

1 ☐ (Low/ Not in place)	Our organization does not, or very infrequently identifies protective factors.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization's practice of identifying protective factors is inconsistent, either not everyone does it, or it happens sporadically.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization systematically identifies protective factors with all patients (across all providers and clinic sites).
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
20. Patients are able to decide how, when, and if they will be screened	☐	☐	☐	☐	☐	☐
21. Providers approach assessment and screening processes (like the ones listed above) as opportunities to build relationships with patients and have healing conversations	☐	☐	☐	☐	☐	☐
22. Staff and providers are trained in the rationale for, relational language of, and workflows for screenings	☐	☐	☐	☐	☐	☐

Notes and comments on Section 4: Screening and assessment

Section 5: Supportive patient education

23. Our organization implements universal education related to current and past trauma and toxic stress, how they impact health and behavior, and the role of protective factors (i.e., education/information provided to all patients and families)	
1 ☐ (Low/ Not in place)	Our organization does not, or very infrequently implements universal education related to trauma and resilience.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization's practice of implementing universal education is inconsistent, either not everyone does it, or it happens sporadically.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization systematically implements universal education related to trauma and resilience with all patients.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
24. Healthcare teams provide information to patients and families based on individual patient/family priorities and goals for their health	☐	☐	☐	☐	☐	☐
25. Staff are available to read the material and discuss with patients and families without making assumptions about literacy	☐	☐	☐	☐	☐	☐
26. Patient education approaches and materials related to trauma are culturally and linguistically appropriate (e.g., responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, etc.)	☐	☐	☐	☐	☐	☐

Notes and comments on Section 5: Supportive patient education

Section 6: Attitudes and practices around trauma- and resilience-informed care

27. Organization demonstrates philosophy and practice intent toward increasing comfort and engagement of patients & families

1 ☐ (Low/ Not in place)	Although it may have been talked about, our organization does not have practices in place to support patients' and families' comfort and engagement when obtaining care. Though visits address patients' specific clinical concerns, they feel rushed and superficial.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization clearly expresses the philosophy and has plans or some or sporadically implemented practices in place to increase the comfort and engagement of patients and families when obtaining care. We are working on systems to make visits feel less rushed and more meaningful.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization clearly expresses the philosophy and has a variety of practices systematically integrated into our work that increase the comfort and engagement of patients and families when obtaining care, including allowing time to listen and connect so that visits feel validating and insightful.
☐	Unsure

28. Our organization examines and mitigates the impact of power dynamics on the relationships between healthcare team and patients and families

1 ☐ (Low/ Not in place)	Our organization does not or very rarely clearly acknowledges, discusses, or addresses power dynamics between the healthcare team and patients and families.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	People in my organization understand and acknowledge that we carry some power as health care professionals, especially providers, when interacting with patients and families. However, we don't consistently do anything different to mitigate those power dynamics.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization consistently thinks about how the healthcare team can effectively work with patients and families as equals in their care and engages in shared decision making. We attempt to mitigate power dynamics by prioritizing things like relationship building, creating spaces to listen, soliciting feedback, considering patients' and families' realities, and demonstrating transparency.
☐	Unsure

29. Patient and family buy-in and attitudes toward trauma- and resilience-informed care	
1 ☐ (Low/ Not in place)	In general, patients and families express reluctance or suspicion toward our organization or care teams' messaging about the ways current and past trauma and toxic stress impact health and behavior and the role of protective factors in mitigating these affects.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Patients and families express mixed feelings about our organization's messaging about the ways current and past trauma and toxic stress impact health and behavior and the role of protective factors in mitigating these affects.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Patients and families express appreciation that our organization and care teams recognize how current and past trauma and toxic stress impact health and behavior and welcome the opportunity to discuss the impact of trauma and the role of protective factors in their lives.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
30. Providers feel confident in their ability to have healing conversations with families	☐	☐	☐	☐	☐	☐

Notes and comments on Section 6: Attitudes and practices around trauma- and resilience-informed care

CLINICAL PRACTICES

Section 7: In-visit care planning and connection to resources and supports

31. Healthcare team develops care plans that build on patient strengths and address physical and emotional wellness	
1 ☐ (Low/ Not in place)	Our organization does not, or very infrequently develops care plans that build on patient strengths and address physical and emotional wellness.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization's practice of developing care plans that build on patient strengths and address physical and emotional wellness is inconsistent, either not everyone does it, or it happens sporadically.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our healthcare team consistently develops care plans that build on patient strengths and address physical and emotional wellness (all healthcare teams at all clinic sites).
☐	Unsure

32. Providers and staff recognize that resilience is inherent in the cultural experiences of many and empower families to guide their own treatment as experts	
1 ☐ (Low/ Not in place)	Providers and staff very infrequently recognize the resilience that is inherent in the cultural experiences of many. As a result, patients are patronized and there is an attitude that providers or the health care team knows better what the patient needs.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Providers and staff sometimes recognize the resilience that is inherent in the cultural experiences of many and inconsistently empower patients and families to guide their own treatment as experts, either not everyone does it or it happens sporadically.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Providers and staff consistently recognize the resilience that is inherent in the cultural experiences of many and systematically empower patients and families to guide their own treatment as experts.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
33. Processes related to responding to trauma (e.g. interactions with health care team, connection to internal services) are culturally and linguistically appropriate (e.g., responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs)	☐	☐	☐	☐	☐	☐
34. Healthcare team supports patients and families in integrating their existing personal community resources and supports into care planning (i.e., not provided by the clinic through a referral)	☐	☐	☐	☐	☐	☐
35. Clinic and community-based trauma-specific services are accessible. People can get to them easily and they are offered at times that meet their needs.	☐	☐	☐	☐	☐	☐

Notes and comments on Section 7: In-visit care planning and connection to resources and supports

AUTHENTIC COMMUNITY ENGAGEMENT

Section 8: Organizational systems to connect patients and families to community support

36. Our organization has established referral practices to connect patients to community resources

1 ☐ (Low/ Not in place)	Our organization provides general guidance to families about community-based services or resources they might consider but does not offer specific recommendations or referrals.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization provides referrals to families for specific community-based services or resources but leaves it to the family to follow up.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization provides a warm hand-off for referrals to community-based services or resources.
☐	Unsure

37. Our organization has established practices to follow up and close the loop on patient referrals to community resources

1 ☐ (Low/ Not in place)	Our organization refers patients and families to community-based resources, but we do not know if the patient was ever seen by or utilized the community support. Sometimes we hear informally from patients whether they got the support they needed.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization refers patients and families to community-based resources and we inconsistently track and follow up to know if the patient was seen by or utilized the community support (e.g., with some patient populations, with some community partners).
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization refers patients and families to community-based resources and has a system in place with our community partners to track these and follow up after referrals are made to make sure the patient was seen.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
38. Our organization has a guide to community resources that is regularly used and updated	☐	☐	☐	☐	☐	☐
39. Our network of community partners (e.g., social service agencies, schools, faith-based organizations, indigenous healers) reflect the ethnic and cultural diversity of our patients and families	☐	☐	☐	☐	☐	☐
40. Our community partners recognize how current and past trauma and toxic stress impact community members and families and use a trauma- and resilience-informed lens when offering support	☐	☐	☐	☐	☐	☐

Notes and comments on Section 8: Organizational systems to connect patients and families to community support

Section 9: Organizational engagement in the community

41. Our organization solicits input from relevant community groups on our strategic priorities and approach to care and keeps them apprised of progress	
1 ☐ (Low/ Not in place)	Our organization generally does not solicit input from community partners.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization shares our strategic priorities with community partners and asks for feedback, but either does so in a way that makes it difficult for partners to provide feedback AND/OR generally any feedback does not inform decisions. We do not circle back with updates about progress.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization engages community partners in way that allows and encourages them to provide candid feedback. Feedback is from partners carefully considered and often influences leaders' decision making. Our organization provides updates on progress in a clear and transparent way.
☐	Unsure

42. Involvement in community processes that use community data and a trauma- and resilience- informed lens to shape services	
1 ☐ (Low/ Not in place)	In general, our organization does not participate in community processes that examine community data to shape supports and services.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	Our organization participates in community processes that examine data, but these are seen as ways to validate our existing services rather than opportunities to shift or pivot toward our community's strengths or identified needs. Data related to trauma and resilience are sometimes, but not usually, part of these processes.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization builds community together with our partners. We engage in community processes that examine data in order to inform and shape services and supports available to the community, both in the clinic and in other spaces. Data related to trauma and resilience are an essential part of these processes.
☐	Unsure

43. Our organization examines and mitigates the impact of power dynamics on the relationships between healthcare team and community partners	
1 ☐ (Low/ Not in place)	Our organization does not or very rarely clearly acknowledges, discusses, or addresses power dynamics between our organization and community partners.
2 ☐	In between 1 and 3
3 ☐ (Medium/ Variable)	People in my organization understand and acknowledge that we carry some power as health care professionals, especially providers, when interacting with community partners. However, we don't consistently do anything different to mitigate those power dynamics.
4 ☐	In between 3 and 5
5 ☐ (High/ In place)	Our organization consistently thinks about how to effectively work with our partners as equals and attempts to mitigate power dynamics by prioritizing things like relationship building, creating spaces to listen to partners, soliciting feedback, considering partners' realities, and demonstrating transparency. We find ways to share our human and financial resources with community partners.
☐	Unsure

	1 Not the case	2	3 Sometimes the case, variable	4	5 Fully and consistently the case	-- Unsure
44. Our organization's leaders and staff are known and have credibility and respect among community partners	☐	☐	☐	☐	☐	☐

Notes and comments on Section 9: Organizational engagement in the community