National
Family Planning
& Reproductive Health Association

IMPROVING ACCESS AND QUALITY FOR ALL

Assessment Tool

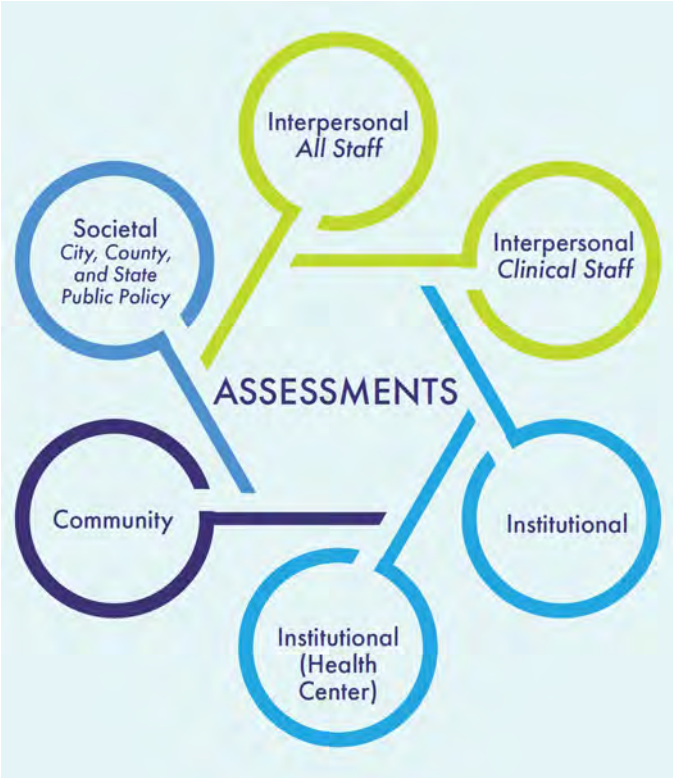
Eliminating inequities in the health care system can be achieved only by responding to systemic racism and all forms of oppression, which are root causes of adverse social determinants of health, especially among historically oppressed communities and other peoples experiencing inequities. As providers strive to marry their intentions to dismantle racism and white supremacy while improving access to quality health care, they must examine their current practices, programs, and policies with a critical eye.

Navigating the Assessment Tool

How to Use this Assessment Tool with the Resource Guide

The assessment tool can be used to obtain a baseline measure of progress to date and/or to identify activities and interventions that organizations may wish to prioritize. The assessment tool is comprised of six different assessments based on the type of intervention each organization is planning to implement.

The tool aims to assess the extent to which entities have implemented evidence-based and promising practices, programs, and policies to mitigate the negative impact of social determinants of health and improve access to quality health care.



When conducting the assessments, remember that the audiences may include staff, community partners, and organizations/agencies that fund or deliver family planning and sexual health care and education. After completing the assessment tool, revisit the resources in this guide to explore the various interventions listed and how they can be adopted or adapted by your organization. Each section of the guide includes community- and policy-level interventions, recommended readings, and highlighted organizations that provide a range of tools and resources to assist with the implementation and evaluation of the organization's efforts to improve access to quality health care.

First, identify the level(s) of intervention that your organization may want to work on to improve access to quality health care. These levels of intervention are informed by the social ecological model[38, 39, 40] which recognizes that multiple levels of influence impact health behaviors and health. By incorporating evidence-based programs and best practice strategies at each selected level, there is opportunity to mitigate those social determinants of health that have the biggest adverse impact on sexual and reproductive health outcomes. The levels in which to begin to strategize are as follows:

- Interpersonal Level: This level of the assessment seeks to ask staff, at all levels, about areas that may need improvement within the organization. This level aims to build knowledge and skills and shape the attitudes of people who interact with priority populations.

- Institutional Level: This level of the assessment targets the institutional environments in which individuals access health care, health information, and related social services.

- Community Level: Embedded in larger social and economic structures, this level of the assessment addresses the unique environments in which the individuals live, spend much of their time, and access services.

- Societal Level: This level of the assessment addresses larger, macro-level factors such as laws and policies that influence the behaviors of the individuals—with emphasis on people with low incomes, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.

Depending on the needs of the organization, there may be multiple levels of the assessment that will be useful for the project, program, or policy. To find the assessment(s) that best suits your program, project, or policy goals, the assessment tool is divided into the following sections:

- Interpersonal (All Staff): Interactions that occur in institutional environments are, by nature, social. At the same time, they are inherently different than those between friends or family members, particularly when considering issues of equality, power balance, and specific interests or expected outcomes. This area of the assessment relates to all individuals who work at the institution or the institution(s) that are funded by your agency, from the front lines of service delivery to executive leadership. The quality of these individuals' interpersonal interactions with other staff, including team members and leadership staff, has the potential to shape overall experience and ultimately can serve as facilitators or create barriers to access.

- Interpersonal (Clinical Staff): Power imbalances are especially pronounced during interpersonal interactions between patients and their clinical service providers. By their very nature, these interactions are asymmetrical: clinicians possess legitimized and expert power; patients are reliant on clinicians to receive the care and services they need. Furthermore, during exchanges, patients often need to hand over some level of control of their bodies and psyche. Such power imbalances can introduce bias into interpersonal interactions between patients and clinicians, especially when they are differences in race, culture, gender, gender identity, and religion. The section of the assessment will address the practices of clinical service providers that serve patients at your institution or the institution(s) funded by your agency. Quality interactions between a patient and their clinical providers rests on seven basic principles: mutual respect, harmonized goals, a supportive environment, appropriate decision partners, the right information, full disclosure, and continuous learning.[41]

- Institutional: Many institutions prioritize internal-facing activities, recognizing that meaningful external-facing work cannot occur until equity and justice are centered in their own environments, policies, and services. This section of the assessment will relate to your institution and the progress it has made to advance internal work.

- Institutional (Health Center): Another subset of institutional-level interventions focuses on the environments where individuals access health care, health information, and related social services. Both formal guidelines, such as written policies and rules, and informal guidelines, such as practices and environmental culture, in these spaces govern individuals' access to health care by shaping service availability, cost, and quality.[42] This area of the assessment may relate to the environment, policies, and services at a single health center, health system, or network of health centers. The social ecological perspective draws attention away from the intra-individual factors and processes to which health disparities historically have been attributed, shifting focus on environmental determinants.

- Community: "Community" is defined in many ways and used in different contexts. Within the social ecological model, "community" typically refers to relationships within and amongst organizations and groups in a civic or geographic region (neighborhood, political district) or social network (faith-based association, leisure association or club); it also may be defined in demographic terms (Black community, LGBTQ+ community).[43] Community-level interventions, therefore, typically focus on improving coordination between organizations and coalition building, with the goal of influencing political dialogue, public policies, and funding. They include interventions to increase the involvement of community members in larger civic and power structures; build social and organizing capital to address the social determinants of health; and implement changes to improve community environments, services, and capacities.[44] When assessing your work, consider the civic or geographic region where your institution resides, the organizations and groups your institution sits in community with, or a combination of both.

- Societal (City, County, and State Public Policy): Public policy interventions, including laws, regulations, and rules to improve population health, make up the broadest level of the social ecological model. To improve access to quality health care, these interventions focus on the local, state, and national levels; maternal and child health-related services; and access to the full range of sexual and reproductive health services, including contraception and abortion care.[45] There is an important link between the social ecological model's public policy level of intervention and concepts of community addressed at the community level. Communities serve as critical connections between individuals and larger social environments; without them, broad-based efforts to advance access to sexual and reproductive health care cannot "trickle down" to the individual level and to smaller networks (e.g., families, friend groups) that influence individuals' health-related behaviors. Therefore, to minimize issues of paternalism and coercion, public policy interventions should be designed to strengthen—and never to replace—the role of communities while improving access to quality health care.[46] In this section of the assessment, this is an opportunity to review both policies and the policymaking processes in your city, county, and state.

After completing the assessment tool, revisit the resource guide to explore the various interventions listed and how they can be adopted or adapted by your organization to improve access to high-quality health care.

Assessment Instructions

1. Identify the level(s) of intervention that your organization may want to work on to improve access to quality health care.
   - **Interpersonal Level**
   - **Institutional Level**
   - **Community Level**
   - **Societal Level**
2. Next, which assessment best suits your needs? Descriptions are above.
   - **Interpersonal (All Staff)**
   - **Interpersonal (Clinical Staff)**
   - **Institutional**
   - **Institutional (Health Center)**
   - **Community**
   - **Societal (City, County, and State Public Policy)**
3. Next, identify key stakeholders that will be involved in the assessment process such as colleagues, partners, community leaders, patients, and community members.
4. Review each prompt and determine the **level of progress** based on where the organization is today. It is best to do this individually so that each person can see from various perspectives how they view the progress of the organization. Stakeholder and community involvement is key to gathering more accurate information.

LEVEL OF PROGRESS						
1	2	3	4	5	N/A	UNK
1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree						

   - **Scoring your organization an N/A** means that it does not apply.
   - **Scoring your organization UNK** means that progress is unknown, which could be due to lack of knowledge or communication, it may apply to another department that is not represented in the assessment process, or more information is needed to fully answer the question.
5. **Stakeholder involvement** and additional comments will be at the bottom of each assessment to review.
6. The **Reference** column includes links to the resource guide that will direct you to various practices, programs, and/or policies referenced in each statement. It connects you with information to consider whether a specific intervention aligns with your needs, current resources, capabilities, and organizational culture.
7. After completing the self-assessment, reflect on responses using the **processing questions** on the next page.

Processing Questions

The following questions will provide a starting place for considering opportunities for improvement at your institution and/or the institution(s) you fund. After completing the assessment tool and reflecting on the following processing questions independently, compare your responses with a multidisciplinary team of colleagues, as well as patients, partners, community leaders, and community members. A structured approach to gathering feedback from individuals with different backgrounds and perspectives will ensure maximum impact on your goals.

8. What was it like for you to assign values to each of the statements in the assessment?
   - What, if anything, was challenging about completing the assessment? Why do you think that is?
9. Which statements did you strongly disagree or disagree with (i.e., assign a "1" or "2" value)?
   - What factors might have contributed to your institution or the institution(s) you fund not being as far along with these opportunities to improve access to quality health care? Why do you think that is?
10. What, if any, patterns did you see among the statements that you strongly disagreed or disagreed with?
    - To what extent were you more likely to strongly disagree or disagree with statements at some levels of intervention (e.g., interpersonal, institutional, community, public policy) than other levels? Why do you think that is?
    - To what extent were you more likely to strongly disagree or disagree with statements related to certain types of activities (e.g., structural racism interventions, cultural humility, organizational health literacy, data and evaluation)? Why do you think that is?
11. Which statements did you agree or strongly agree with (i.e., assign a "4" or "5" value)?
    - Moving forward, how might your institution or the institution(s) you fund leverage these areas of strength when implementing new priority activities and interventions?
12. To what extent do you need more information to complete this tool?
    - What steps might you take to gather this information?
13. To what extent do you predict that the values assigned on this assessment will vary among your colleagues and partners?
    - How will your institution or the institution(s) you fund benefit from these differences of opinion?

TIP: Consider making a priority matrix to determine which item to begin with. Here are some tools to get you started:

- Advancing Health Equity Root Causes Analysis
- Health Quality Innovation Network Priority Matrix
- Minnesota Department of Health Prioritization Matrix
- Eisenhower Matrix Templates

Assessment Tools

Interpersonal (All Staff)

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that funds or delivers and/or school- or community-based programming with a sexual and reproductive health component.

The following statements may relate to staff and leadership teams that work closely together to implement policies and practices that impact the organization such as departments, senior staff, project teams, etc.

	LEVEL OF PROGRESS							REFERENCE
1. Improving access to quality health care is incorporated in the team's strategic planning.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
2. The team has a plan for tracking progress of programmatic interventions and reviewing data with team members and leadership staff.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural Humility • Data and evaluation
3. The department provides training for staff on anti-racist strategies, skills, and best practices.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
4. Anti-racist and equitable practices are a part of the hiring process, decision-making, and included in the job description.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
5. Leadership teams articulate the importance of addressing the health system's role in dismantling racism and other forms of oppression.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
6. Formal opportunities for team members to engage in conversations about how racism and other forms of oppression impact their services, their lives, and the communities they serve.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
7. Team members review policies, practices, and norms in each organizational area to assess for potential inequitable impact on communities of color and other marginalized populations, and redesign where needed.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
8. Anti-racist conflict resolution support is provided for all team members.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
9. Anti-discriminatory policies and practices are reviewed and updated by all team members regularly.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A	☐ UNK	• Structural racism • Cultural humility
10. The team has a process to hold leadership and team members accountable to address discrimination and bias in the workplace.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A	☐ UNK	• Data collection

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.

◯ **Somewhat.** Recommendations and input fr om those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

Who is missing?

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Interpersonal (Clinical Staff)

Audience: Any institution that delivers or funds the delivery of sexual and reproductive health services.

The following statements relate to the practices of clinical service providers who serve patients at your institution or the institution(s) you fund.

	LEVEL OF PROGRESS							REFERENCE
1. All clinical staff have the necessary knowledge and skills to provide high-quality, evidence-based sexual and reproductive health services to all patients, including the most vulnerable populations in the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Organizational health literacy • Search by population
2. All clinical staff are comfortable providing care to all patients, including the most vulnerable populations in the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Organizational health literacy • Review by population
3. All clinical staff receive training aimed at raising self-awareness of their biases and their impact on patient experiences with ongoing monitoring of progress.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
4. Clinical staff are committed to building patient trust, particularly among people of color and individuals from historically and currently marginalized communities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Search by population
5. Clinical staff express attitudes and behaviors that are consistent with person-centered care.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection • Structural racism • Cultural humility
6. Clinical staff have received training on how to meaningfully engage patients in their care.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
7. Clinical staff work to reduce stigma by reframing conversations with patients towards sexual health promotion.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Review populations • Addressing health disparities with BIPOC communities

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
8. The organization reviews and updates clinical policies and practices to identify and address inequities affecting communities of color and other marginalized groups.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
9. The organization collects and uses data to identify clinical areas where inequities exist, has set aims to address major gaps, and is implementing efforts to close those gaps.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input fr om those who are most impacted were involved throughout the entir e process.

◯ **Somewhat.** Recommendations and input fr om those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Institutional

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization.

The following statements relate to your institution and the progress it has made to advance internal work.

	LEVEL OF PROGRESS							REFERENCE
1. My organization's leadership communicates, both verbally and in key organizational documents (e.g., strategic plan, annual report), that health equity is an organizational priority and inextricably linked to its mission and values.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism.
2. My organization's leadership models our commitment to improving access to quality health care and anti racism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
3. My organization includes clients and community stakeholders with the identification, planning, implementation, and evaluation of health equity priorities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Community engagement
4. My organization engages in discussions about its institutional history, including history of racism, and recognizes that it has a responsibility to remove any legacies of bias, discriminatory practices, and treatment without consent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
5. My organization has dedicated meaningful financial resources and staff time to understanding the negative impact of institutional and structural racism on communities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
6. My organization has dedicated meaningful financial resources and staff time to building staff skills to engage in health equity and anti-racism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
7. My organization's leadership ranks are familiar with the reproductive justice framework and can articulate the importance of advancing reproductive justice as part of our organization's health equity and anti-racism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Anti-racism • Cultural humility

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
8. My organization has significant representation of people of color and individuals from historically and currently marginalized communities in leadership positions.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
9. My organization has significant representation of people of color and individuals from historically and currently marginalized communities on its Board of Directors, if applicable.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
10. My organization is committed to creating a more equitable workplace by evaluating hiring and advancement requirements that may ignore systems of inequities and reinforce white dominant culture.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
11. My organization is committed to creating a more equitable workplace by reviewing organizational practices and policies with an equity lens.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
12. My organization is committed to creating a more equitable workplace by establishing mechanisms to track and respond to discriminatory behavior in the workplace.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
13. During its recruitment, hiring, and promotion processes, my organization considers diversity, equity, and representation.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
14. Formal opportunities for staff to engage in conversations about how racism and other forms of oppression impact their services, their lives, and the communities they serve.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A	☐ UNK	• Cultural humility • Structural racism
15. The organization reviews policies, practices, and norms in each area to assess for potential inequitable impact on communities of color and other marginalized populations, and redesign where needed.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A	☐ UNK	• Cultural humility • Structural racism

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.

◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.:

Institutional (Health Center)

Audience: Any institution that delivers or funds the delivery of sexual and reproductive health services.

The following statements may relate to the environment, policies, and services at a single health center, health system, or network of health centers.

	LEVEL OF PROGRESS							REFERENCE
1. My health center is open during times that are convenient for patients, including evening and weekend hours.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
2. My health center offers timely access to advanced appointments and makes walk-in and same-day appointments available for sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
3. My health center's facility is accessible to people with disabilities and systems are in place to ensure that additional reasonable modifications are available to people with disabilities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• People with Intellectual, Developmental, or Physical Disabilities
4. My health center uses translated forms, signage, and educational materials that are culturally and linguistically appropriate for commonly spoken languages among patient populations.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Organizational Health Literacy • People with Limited English Proficiency (LEP)
5. My health center offers timely language access services though hiring bilingual/multilingual staff or accessible language services for patients with limited English proficiency.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Organizational Health Literacy • People with Limited English Proficiency (LEP)
6. My health center ensures that cost and ability to pay are not barriers to accessing sexual and reproductive health services, including contraception services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Financial inequities
7. My health center collects data to examine potential health inequities between patient populations.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation
8. My health center regularly collects data about patients' experience of care, including qualitative data and the Person-Centered Contraceptive Counseling (PCCC) measure.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
9. My health center has quality improvement teams comprised of leaders, staff, and patients to review data and creates resources for them to develop and implement equity-focused quality improvement efforts.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation
10. My health center frames quality improvement goals from a strength-based perspective to avoid reinforcing racism and white supremacy.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
11. My health center communicates data effectively and respectfully to the broader community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation • Community engagement
12. My health center safeguards the privacy of patients that need confidential sexual and reproductive health services, including, but not limited to, adolescents.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
13. My health center has systems to ensure billing practices and use of electronic health records (EHRs) do not lead to confidentiality breaches.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A	☐ UNK	
14. My health center uses standardized intake forms and EHR templates with prompts to facilitate the provision of person-centered care.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
15. My health center is a physical space that is welcoming to patients across the gender spectrum.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
16. My health center is a physical space that is welcoming to patients who identify as LGBTQ+.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• LGBTQ+ populations
17. My health center is a physical space that is welcoming to young people.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• LGBTQ+ populations
18. My health center is a physical space that is welcoming to patients with larger bodies.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	☐ UNK	• Adolescents and young adults
19. My health center has adopted an approach for measuring health equity that includes indicators on the social determinants of health.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	Data and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
20. My health center has adopted an approach for measuring indicators of unmet needs and the extent to which our programs address them.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data and evaluation
21. My health center has adopted an approach for measuring equitable access, high-quality clinical care and programming.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.

◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Community

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization.

WHICH COMMUNITY ARE YOU PLANNING TO ASSIST, COLLABORATE WITH, OR CREATE POLICIES FOR (select all that apply):

- ◯ Asian American, Native Hawaiian, and other Pacific Islander
  Please specify:
- ◯ Black Americans
  Please specify:
- ◯ Indigenous Populations
  Please specify:
- ◯ Latine
  Please specify:
- ◯ Adolescents and young adults
  Please specify:
- ◯ Immigrants/refugees
  Please specify:
- ◯ People experiencing Intimate Partner Violence (IPV)
  Please specify:
- ◯ People with intellectual, developmental, or physical disabilities
  Please specify:
- ◯ People with Limited English Proficiency (LEP)
  Please specify:
- ◯ People with substance use disorders
  Please specify:
- ◯ LGBTQ+ Populations
  Please specify:
- ◯ Low income or uninsured
  Please specify:
- ◯ Men and young men
  Please specify:
- ◯ People living with HIV and HIV prevention
  Please specify:
- ◯ Religious communities
  Please specify:
- ◯ Rural/Frontier Areas
  Please specify:
- ◯ Sex Workers
  Please specify:
- ◯ Unhoused communities
  Please specify:

	LEVEL OF PROGRESS							REFERENCE
1. Community leaders express a shared vision and improving access to quality health care services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
2. Community leaders come together to identify common needs and build social and political capital to address the social determinants of health and advance health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
3. My community's publicly funded safety net can deliver no and low cost sexual and reproductive health services to all community members who need them.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Address financial inequities
4. My agency currently has relationships with the safety net organizations referenced above in #3.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population
5. My community has a network of community health workers and health support workers that connects individuals from historically and currently marginalized communities with health services, including sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy • Language justice • People with Limited English Proficiency (LEP)
6. My community has a community-based service referral system to address social determinants of health, behavioral health, and social service providers.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
7. My community has a coalition focused on improving sexual and reproductive health services for historically and currently marginalized groups, which includes community members, leaders, and reproductive justice advocates.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
8. My community's sexual and reproductive health coalition has a strong, positive image in the community, a good track record, and a history of involvement of the broader community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility
9. My community has at least one multi-sectoral (e.g., health, labor, transportation, education, corrections, economic development, housing, philanthropy, public safety) coalition that addresses the complex factors that influence health equity in the community .	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism
10. In community coalitions, there is understanding and acknowledgment of the history of racism and other forms of oppression in both the US and the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
11. Community coalitions actively work with community leaders, elected officials, and policymakers to shift community norms that drive stigma and discrimination.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
12. My community has evidence-based, program-level interventions in schools that can be leveraged to improve access to quality health care services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Adolescents and young adults
13. My community has interventions in community-based settings that can be leveraged improve access to quality health care services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

- ◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.
- ◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.
- ◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Societal: City, County, and State Public Policy

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization.

The following statements relate to both policies and the policymaking processes in your city, county, and state.

SOCIETAL (CITY OR COUNTY LEVEL)	LEVEL OF PROGRESS							REFERENCE
1. Elected officials and policymakers at the city and county levels reflect the diversity of the people they represent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
2. Communities of color and other historically and currently marginalized communities play a key role in shaping policy discourse and ideas for elected officials and policymakers at the city and county levels.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
3. Policymakers at the city and county levels have taken steps to increase recruitment and retention of diverse local public health professionals that reflect the communities they serve.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
4. Policymakers at the city and county levels meaningfully engage and incorporate communities of color and other historically and currently marginalized communities in the policymaking and policy evaluation processes.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
5. Policymakers at the city and county levels target funding to communities and areas where it is needed most.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

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Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
1. State agencies and policymakers apply reproductive justice in their messaging and do not use language that undermines or devalues the reproduction of low-income individuals and individuals from historically and currently marginalized communities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
2. Elected officials and policymakers at the state level reflect the diversity of the people they represent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
3. Communities of color and other historically and currently marginalized communities play a key role in shaping policy discourse and ideas for elected officials and policymakers at the state level.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
4. State policymakers have taken steps to increase recruitment and retention of diverse public health professionals.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
5. State policymakers meaningfully engage and incorporate communities of color and other historically and currently marginalized communities in the policymaking and policy evaluation processes.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
6. State policymakers target funding to communities and areas where it is needed most.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
7. State policymakers have invested in telehealth infrastructure, prioritizing projects in unserved and underserved areas in the state and at "anchor institutions" including health centers, schools, and libraries.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
8. State policymakers promote income stability for individuals and families by increasing eligibility for and facilitating enrollment in public benefit programs.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
9. My state has adopted the Affordable Care Act's (ACA's) Medicaid expansion.	◯ Yes				◯ No			• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
10. My state has expanded eligibility for coverage of family planning services under Medicaid.	◯ Yes					◯ No		• Structural racism: Reproductive justice civic engagement
11. In my state, Medicaid covers all contraceptive methods, including over-the-counter methods, without quantity or time limits.	◯ Yes					◯ No		• Structural racism: Reproductive justice civic engagement
12. In my state, Medicaid covers all pre-exposure prophylaxis (PrEP) services without cost sharing.	◯ Yes					◯ No		• Structural racism: Reproductive justice civic engagement
13. My state has enacted laws to increase access to contraception (e.g., pharmacist dispensing, 12-month supply coverage).	☐ Yes					☐ No		• Structural racism: Reproductive justice civic engagement
14. My state requires commercial insurers and Medicaid to provide reimbursement for services delivered via telehealth (when those services would have been covered if delivered in person).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
15. State policymakers dedicate state funding for sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
16. State policymakers do not impose restrictions on the allocation of public funds for sexual and reproductive health services (e.g., restrictions that prohibit abortion providers or their affiliates from receiving funds, age restrictions).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
17. My state has enacted policies to secure individuals' right to abortion care without gestational age limits.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
18. My state does not impose restrictions on abortion coverage by commercial health insurance plans.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
19. My state provides state funds for abortion care for Medicaid enrollees.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
20. My state provides state funds for Medicaid coverage for people who are undocumented.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
21. In my state, pregnant and postpartum people do not face criminal charges for experiencing miscarriages and stillbirths, self-managing abortions, using both criminalized and lawfully prescribed substances, or engaging in other acts perceived as creating a risk of harm to their pregnancies.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
22. Minors in my state have the explicit authority to consent to family planning and sexual health services, including contraceptive services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
23. Minors in my state have the explicit authority to consent to family planning and sexual health services, including STI services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
24. My state has laws that protect the confidentiality of sensitive health care information for all patients, including minors.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
25. My state promotes access to best practice medical care for transgender individuals, including transgender youth.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

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