How to apportion finite money to regions however those boundaries are finally determined.

1. Use the current totals.

2. Use straight per capita

3. Use per capita adjusted by age and sex.

4. Use age sex per capita, but add for members with chronic disease.

5. Use age sex per capita, but add for members with chronic disease with stage for particular disease.

    a. *Your Disease Risk* is one of the longest running, publicly available health risk assessments on the Internet. Launched in early 2000 and continually updated to the present time, the site offers risk assessments for 12 different cancers plus four other important chronic diseases: heart disease, stroke, diabetes and osteoporosis.
    https://publichealthsciences.wustl.edu/community-focus/your-disease-risk-assessment-tool/

6. Other commercial individual and population based tools for standardizing health risk.
    a. Resources in Oregon OHSU
    b. Canadian HRUPORT https://pubmed.ncbi.nlm.nih.gov/29189576/
    c. HHS approved AAPC https://www.aapc.com/risk-adjustment/risk-adjustment.aspx

7. Add in Adjustment for Social Determinants of Health.

Requiring initial input by part of medical care team.

Three tools for screening for social determinants of health

Several screening instruments can aid physicians in identifying social determinants of health in a primary care setting:

1. The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool(www.nachc.org) (PRAPARE) includes 15 core questions and 5 supplemental questions. The data can be directly uploaded into many electronic health records as structured data. It is generally administered by clinical or nonclinical staff at the time of the visit, but a paper version can be given to the patient to self-administer.

2. The American Academy of Family Physicians offers a social determinants of health screening tool, available in short- and long-form in English and Spanish, as part of The EveryONE Project(bit.ly). The short-form(bit.ly) includes 11 questions. It can be self-administered or administered by clinical or nonclinical staff.

3. The Centers for Medicare & Medicaid Services Accountable Health Communities' 10-question Health-Related Social Needs Screening Tool(innovation.cms.gov) (AHC-HRSN) is meant to be self-administered.

Rather than expecting physicians to add "just one more thing" to their daily practice flow, social determinants screening and follow up must not be the sole responsibility of the physician but rather a team-based effort integrated into the practice's care management workflows.

Using precompiled indices

Community Measures and Mapping Tools to Assess SDOH

There are an increasing number of resources that can help people understand how SDOH affects the health of a community. Many of these resources include measures, indices, and mapping tools to assess social conditions in a given population or location. Several of these tools are described below:

- Based on a measure created by the Health Resources & Services Administration (HRSA), the Area Deprivation Index(ADI) accounts for income, education, employment, and housing quality at the neighborhood level. The ADI was adapted by the research team at the University of Wisconsin-Madison and allows users to rank neighborhoods by socioeconomic disadvantage at the geographic (state or national) level.
- The National Equity Atlas provides data on demographics, racial inclusion, and the economic benefits of equity at the city, state, and national level. The tool was designed to help create a new, resilient, and equitable economy.
- Developed by Opportunity Nation and Child Trends, the Opportunity Index uniquely combines indicators and the national, state, and county levels to show opportunities for improvement. The indicators are housed in four domains: economy, education, health, and community. The index employs a unique formula to provide users with a big-picture view and localized perspective on the conditions influencing their neighborhood.
- The 2019 Healthiest Community rankings provide a breakdown of the top 100 rural, high-performing communities. Identified by experts through a collaboration between U.S. News & World Report and the Aetna Foundation, cities are assessed based on 10 categories: population health, equity, education, economy, housing, food

& nutrition, environment, public safety, community vitality, and infrastructure. The platform includes an interactive Data Explorer for users to further explore data and trends.

- County Health Rankings & Roadmaps is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that measures important health factors in communities around the U.S. in an effort to drive change towards improving health. The program provides snapshots of community health as well as a community ranking system.

https://www.ruralhealthinfo.org/toolkits/sdoh/4/assessment-tools

What are social determinants of health?

Social determinants of health (SDOH)external icon are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Healthy People 2030 uses a place-based framework that outlines five key areas of SDOH:

https://www.cdc.gov/socialdeterminants/about.html

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources