PROMISE, PERIL & OPPORTUNITY

Examining and addressing the impact of structural and social determinants of health equity for MHSUD care and services

Rishi Manchanda MD MPH
CEO, HealthBegins

Enhancing Care and Services for Mental Health and Substance Use Disorders A Workshop
NASEM
July 1, 2025

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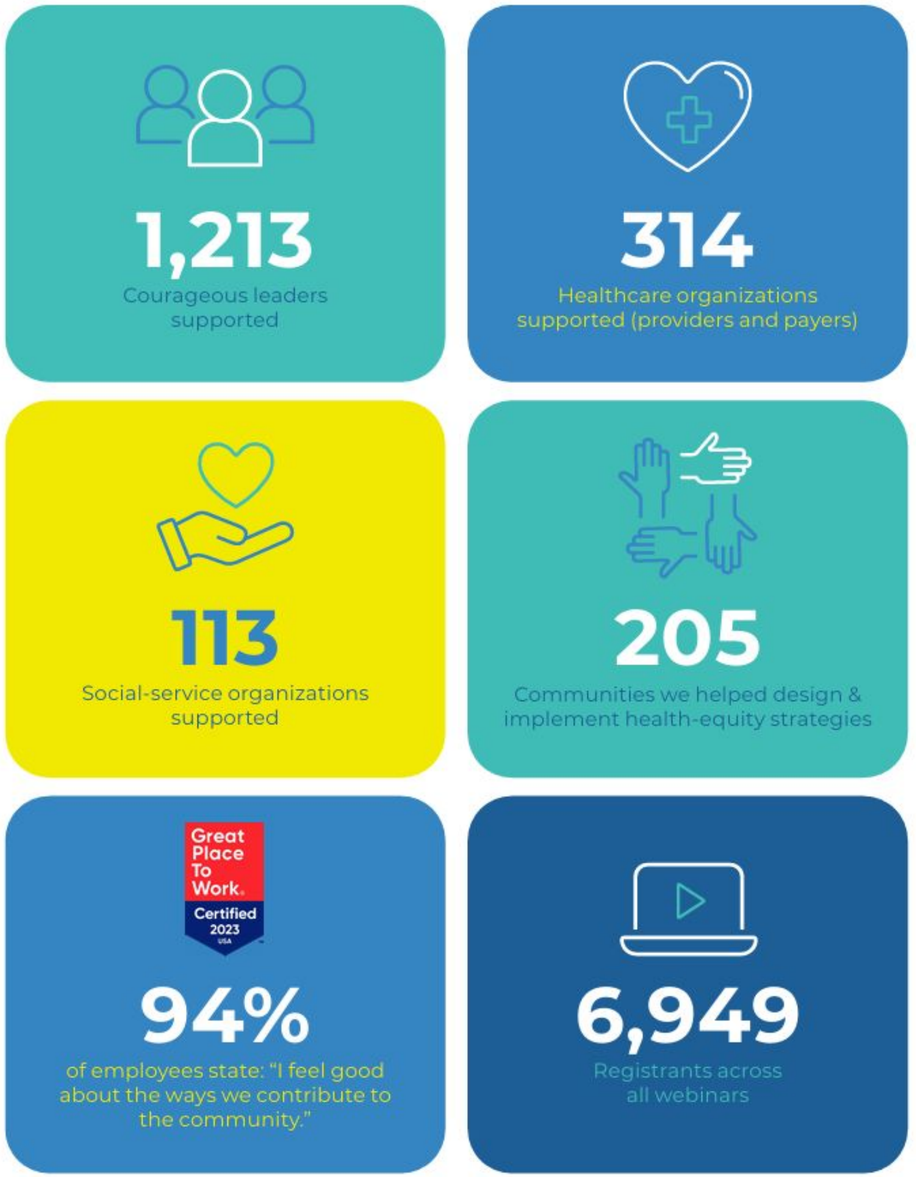
ABOUT US

HealthBegins is a national mission-driven strategy and implementation firm that helps Medicaid-serving health plans, health systems, and CBOs to exceed health care equity and social needs requirements and achieve long–term impact for people and communities harmed by societal practices.

To date, we've helped hundreds of courageous leaders and staff move upstream to improve health outcomes and advance health equity in over 350 communities across the country.



Meet Mrs. M

Mrs. M is in her mid-40s. She cares for her young daughter, and her frail mother.

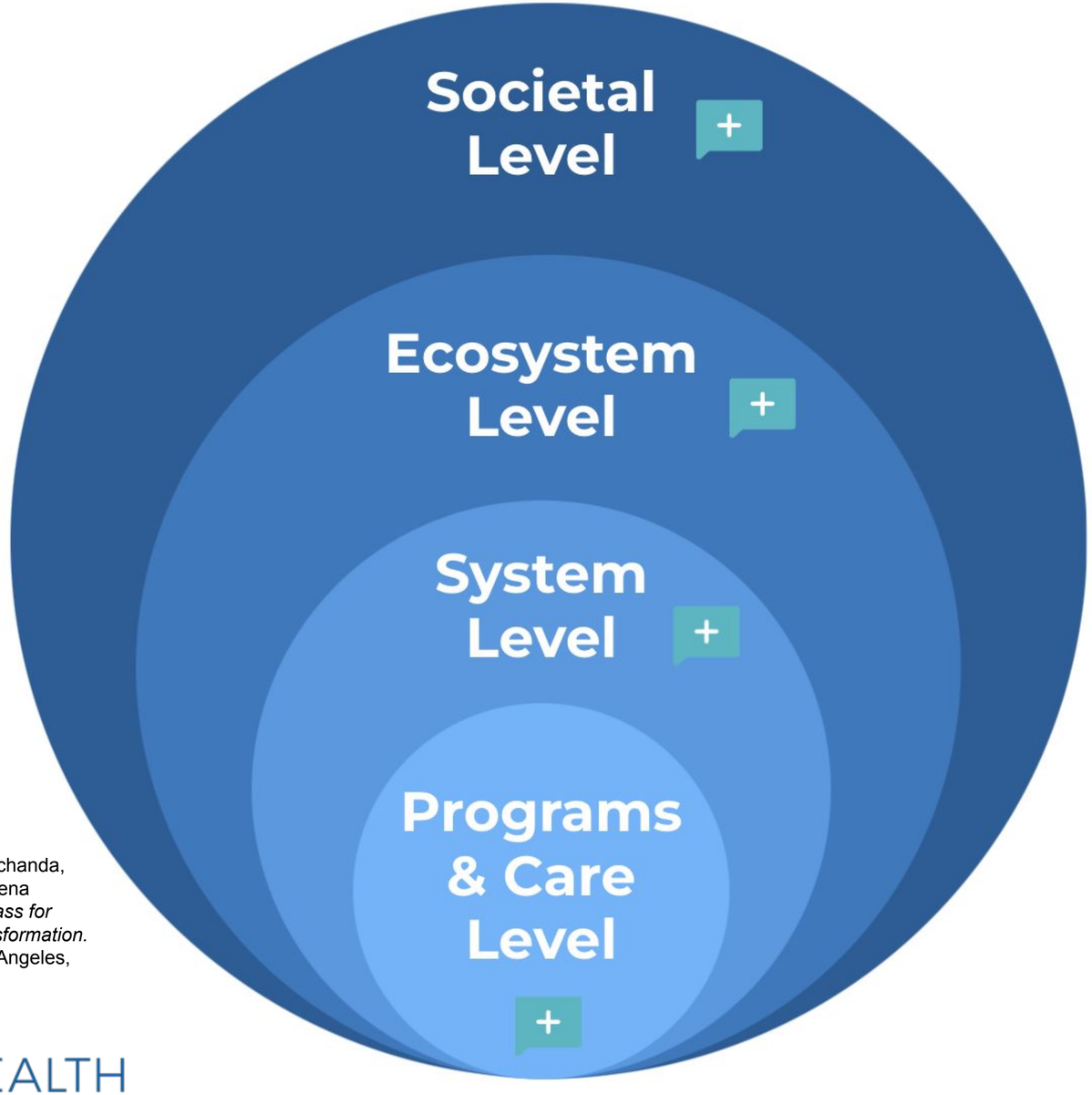
Mrs. M has type II diabetes that is not well controlled. She injured her neck at work 4 years ago – after a delay in treatment, she was prescribed opioid pain medications several times and developed an opioid dependence. She's had a hard time accessing MAT.

She has a low-wage job and typically spends at least $2000 a year on premiums and out-of-pocket costs.

At the end of last month, Mrs. M was admitted to the hospital after nearly passing out at work,

Diagnosis: Low-blood sugar
Social driver: Food insecurity

Advance health equity with multi-level strategies



GOAL

Help replace social policies and structures that cause ongoing harms, and support policies that promote healing and justice.

GOAL

Help build a high-performing, just, and equitable cross-sector ecosystem for health in your community

GOAL

Drive institutional transformation and culture change to create a more effective, just, equitable, and inclusive institution.

GOAL

Surpass performance goals for health care equity & social needs for patient populations

Citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Compass for Health Equity Transformation.* HealthBegins. Los Angeles, May 2023.

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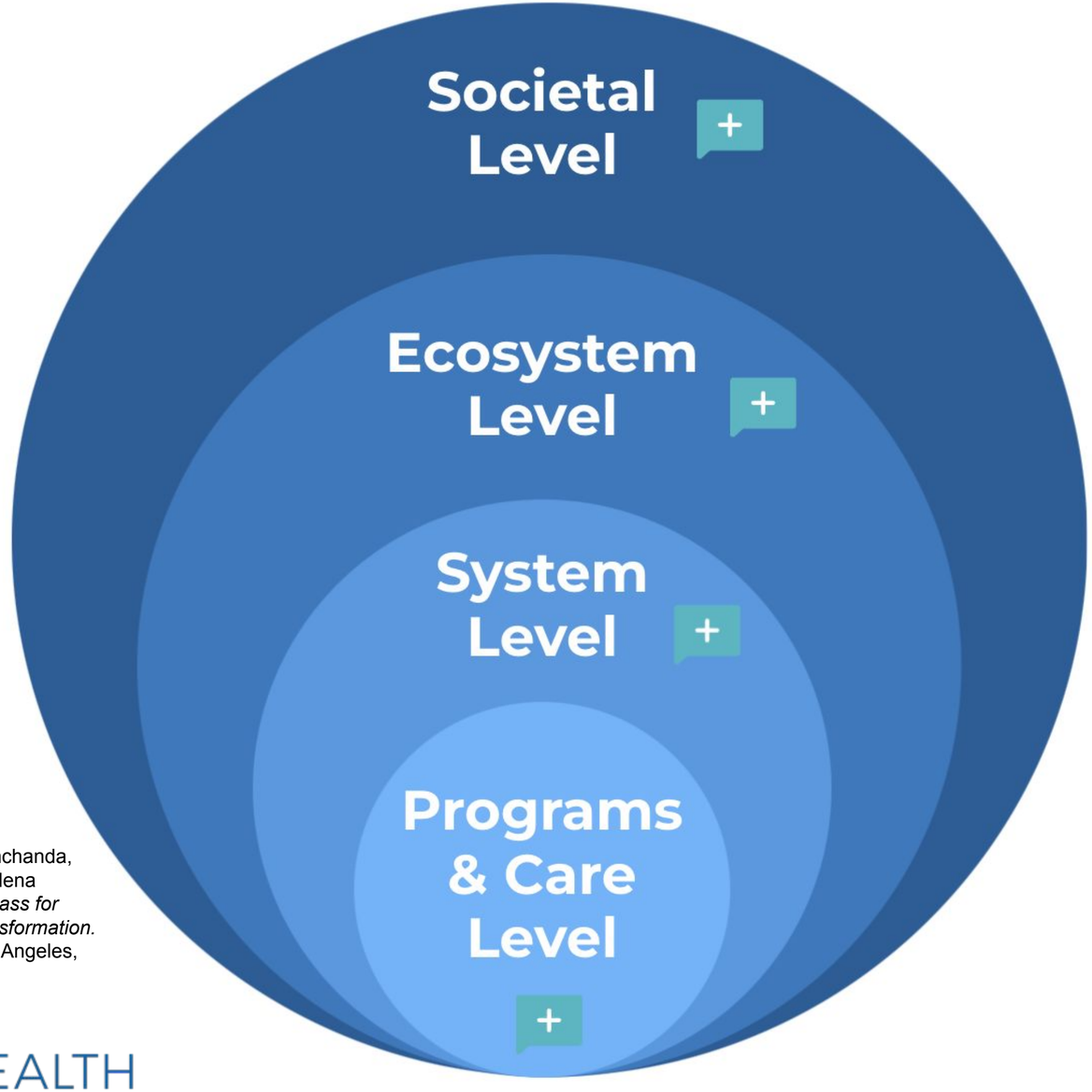
Compass for Health Equity Transformation

When it comes to enhancing **MHSUD care and services**, an understanding of social and structural drivers of health equity offers key lessons:



Citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Compass for Health Equity Transformation.* HealthBegins. Los Angeles, May 2023.

- **Respond to structural violence and policies that undermine "care and services"**
- **Recenter "care and services" strategies in the community**
- **Reimagine how to define the value of "care and services"**
- **Reposition "care and services" in a social and structural context**

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Compass for Health Equity Transformation


Reposition “care and services”
in a social and structural context

“Moving upstream” means

“Continuously working to improve the social and structural drivers of health equity at all levels –

- *Individual health related social needs & networks,*
- *Community-level social determinants of health, and*
- *Broader structural determinants of health equity*

Definition of moving upstream. HealthBegins Upstream Communications Toolkit. 2021

The purpose of defining social and structural drivers is to identify and counteract the social arrangements and structures that cause harm and inequities

Individual-level

Social Risk Factors & Social Needs:

Social risk factors are specific individual-level adverse social conditions (i.e., adverse material and psychosocial circumstances) that are associated with poor health. Behavioral risk factors are not social risk factors. Social needs are the social risk factors that individuals (e.g., patients, clients, beneficiaries) identify and prioritize.
Example: Food insecurity

Community-level

Social Determinants of Health:

Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. These conditions shape the distribution, chronicity, and severity of individual social risk factors and social needs. **Example: Food desert**

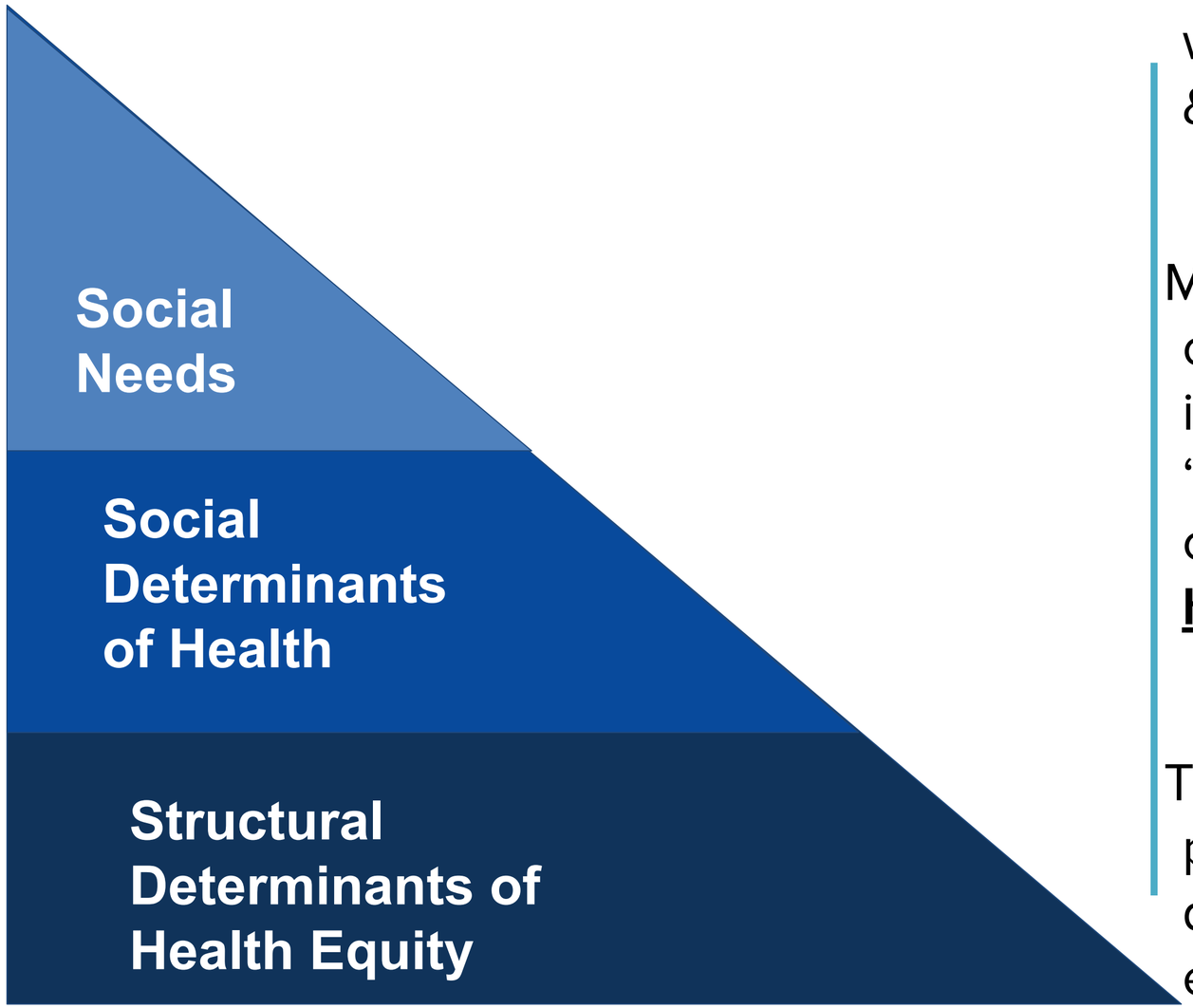
Societal-level

Structural Determinants of Health Equity:

The societal norms; macroeconomic, social & health policies; and the structural mechanisms that shape social hierarchy and gradients (e.g., power, racism, sexism, class, and exclusion), and, in turn, the distribution, quality, and chronicity of social determinants of health and individual social needs.
Example: Supermarket redlining Structural racism

Source: HealthBegins Upstream Communications Toolkit. February 2022.

Let's look at MHSUD



Mrs. M and her family experience food insecurity as a household-level **social need,** which influences her physical, mental health, & SUD.

Mrs. M's family and many others live in a community in which local prescribing practices increase risk for SUD. She's also living in a "food swamp" and a "MAT desert." These are community-level **social determinants of health,** another driver of inequity.

Those food swamps, MAT deserts, harmful prescribing and criminalization practices exist due to structural racism and exploitative economic policies, which are **structural drivers** (or "determinant") **of health inequity**


Reimagine how to define the value of
“care and services”
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The Limits of Conventional ROI Analysis for Population Health, Health Equity, & Social Needs Interventions

- **ROI often lacks an equity analysis**
  - Is the estimated ROI for a health intervention truly meaningful if we haven't valued health equity, or at least identified the costs of inaction?
- **Asymmetry of power in ROI conversations**
  - ROI conversations between healthcare and community-based social service organizations can be distorted by the power differentials and structural inequities between them
- **"Leaving money on the table" ROI analyses may not reflect full value and impact**
  - The financial ROI models and methods often used to assess health and social needs investments often underestimates their full value (financial, economic, social) and impact for institutions and communities

https://healthbegins.org/beyond-roi-understanding-value-on-investment-in-social-needs-partnerships/
https://healthbegins.org/finding-value-faster-a-new-roi-one-stop-shop-for-clinical-community-partnerships/

We Adapted “Blended Value” for Health Equity

Blended Value is a conceptual framework first introduced in the field of impact investing.

- “While all organizations attempt to create value of one kind or another, the central premise of the blended value proposition is that ***value is itself a combination, a “blend” of economic, environmental and social factors***, and that ***maximizing value requires taking all three elements into account.***”
- Focus ➔ “maximize the *total* value creation potential and performance of organizations”

HealthBegins adapted this framework and developed pioneering equity-focused “Blended Value” financial models and methods to:

- Provide **a better way** for health and social sector professionals **to think and talk** about the blend of financial, economic, and social value and impact that they generate
- **Calculate the full value** that social needs and health equity interventions generate for “investing” organizations and communities
- **Unlock** collaborative **financing** mechanisms and public/private investments to improve upstream social and structural drivers of health equity

Jed Emerson, Sheila Bonini and Kim Brehm. The Blended Value Map Report—2003, Oct 2003. www.blendedvalue.org

Antony Bugg-Levine and Jed Emerson, *Impact Investing: Transforming How We Make Money While Making a Difference*, San Francisco: Jossey-Bass, 2011.

The Blended Value Approach Reflects Three Measures of Value

Return on Investment (ROI)	**Assesses financial performance:** the ratio of a program's net financial benefits to its costs.
Value on Investment (VOI)	**Quantifies intangible economic benefits**: longer-term outcomes, considering both financial and non-financial benefits.
Social Return on Investment (SROI)	**Measures social value or impact**: across sectors, social, environmental, and community benefits.

Blended value models can assess financial returns (ROI), economic value (VOI) and impact (SROI) for health equity and population health investments

Report Summary

Participant Summary	
Target Population Size	1,400
People Engaged (%)	27%
Total Program Participants	380
Sub-Population Size	1,400
Sub-Population Engaged (%)	27%

Intervention ROI Estimate Summary	Gross	NPV	ROI %
ROI	-$285,490	$16,295	0%
VOI	$639,904	$891,033	15%
SROI	$934,319	$1,151,925	19%

Discount Rate 5%

Staffing Needs	FTEs Need	Avg. Salary
Health System - Management Staff	0.9	$250,000
Health System - Admin Staff	1.8	$75,000
Health System - Program Staff	3.2	$95,000.0
Partner - Management Staff	0.7	$150,000
Partner - Admin Staff	1.1	$50,000
Partner - Program Staff	6.5	$75,000.0

Intervention Financial Summary	Year 1	Year2	Year 3	Year 4	Year 5	Years 6+
Startup Costs	$150,000					
Fixed Annual Costs	$455,000	$455,000	$455,000	$455,000	$455,000	
Variable Costs	$889,643	$889,643	$889,643	$889,643	$889,643	
Total Cost of Program	$1,494,643	$1,344,643	$1,344,643	$1,344,643	$1,344,643	
Additional Revenue	$114,000	$114,000	$114,000	$114,000	$114,000	
Net Cost	$1,380,643	$1,230,643	$1,230,643	$1,230,643	$1,230,643	
Benefits	$3,135,738	$2,295,502	$2,292,678	$51,850	$27,205	$4,560

ROI Ranges

	Gross ROI			NPV			ROI%		
	Low	Base	High	Low	Base	High	Low	Base	High
ROI	-$5,110,714	-$285,490	-$5,614,286	-$3,065,753	$16,295	$5,255,249	-69%	0%	108%
VOI	-$4,957,992	$639,904	-$3,910,918	-$2,921,621	$891,033	$6,861,690	-66%	15%	141%
SROI	-$4,949,832	$934,319	-$3,769,558	-$2,876,673	$1,151,925	$7,331,234	-65%	19%	150%

Population Summary

					Subpopulation Return			Return/Member		
Payer/Plan	Sub-Population	Population Size	Engagement Rt	Units/Month	ROI	VOI	SROI	ROI	VOI	SROI
PHP Medicaid Standard	Black	500	30%	1.5	-17%	-4%	1%	-$790.3	-$165.5	$48.4
PHP Medicaid Maternal Bundle	Non-Specified	500	30%	1.5	16%	29%	34%	$762.0	$1,386.9	$1,581.2
BCBSMI Medicaid Maternal Bundle	Black	200	20%	1	2%	22%	27%	$76.0	$700.8	$842.7
BCBSMI Medicaid Maternal Bundle	Non-Specified	200	20%	1	2%	22%	27%	$76.0	$700.8	$842.7

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ORIGINAL RESEARCH

Community-Partnered Cluster-Randomized Comparative Effectiveness Trial of Community Engagement and Planning or Resources for Services to Address Depression Disparities

Kenneth B. Wells, MD, MPH[1,2,3,4], Loretta Jones, MA[5,6], Bowen Chung, MD[1,2,7], Elizabeth L. Dixon, RN, PhD[8], Lingqi Tang, PhD[2,4], Jim Gilmore, MBA[9], Cathy Sherbourne, PhD[1], Victoria K. Ngo, PhD[1], Michael K. Ong, MD[10], Susan Stockdale, PhD[2,12], Esmeralda Ramos, BA[2], Thomas R. Belin, PhD[2,11], and Jeanne Miranda, PhD[2,4]

"that a collaborative model had benefits spanning health and social determinants of health may have important implications for the design of health homes that activate community partners to co-manage depressed clients".

"**Community engagement** to build a collaborative approach to implementing depression QI across diverse programs **was more effective than resources for services for individual programs in improving**

- mental health-related quality of life,
- physical activity
- homelessness risk factors,

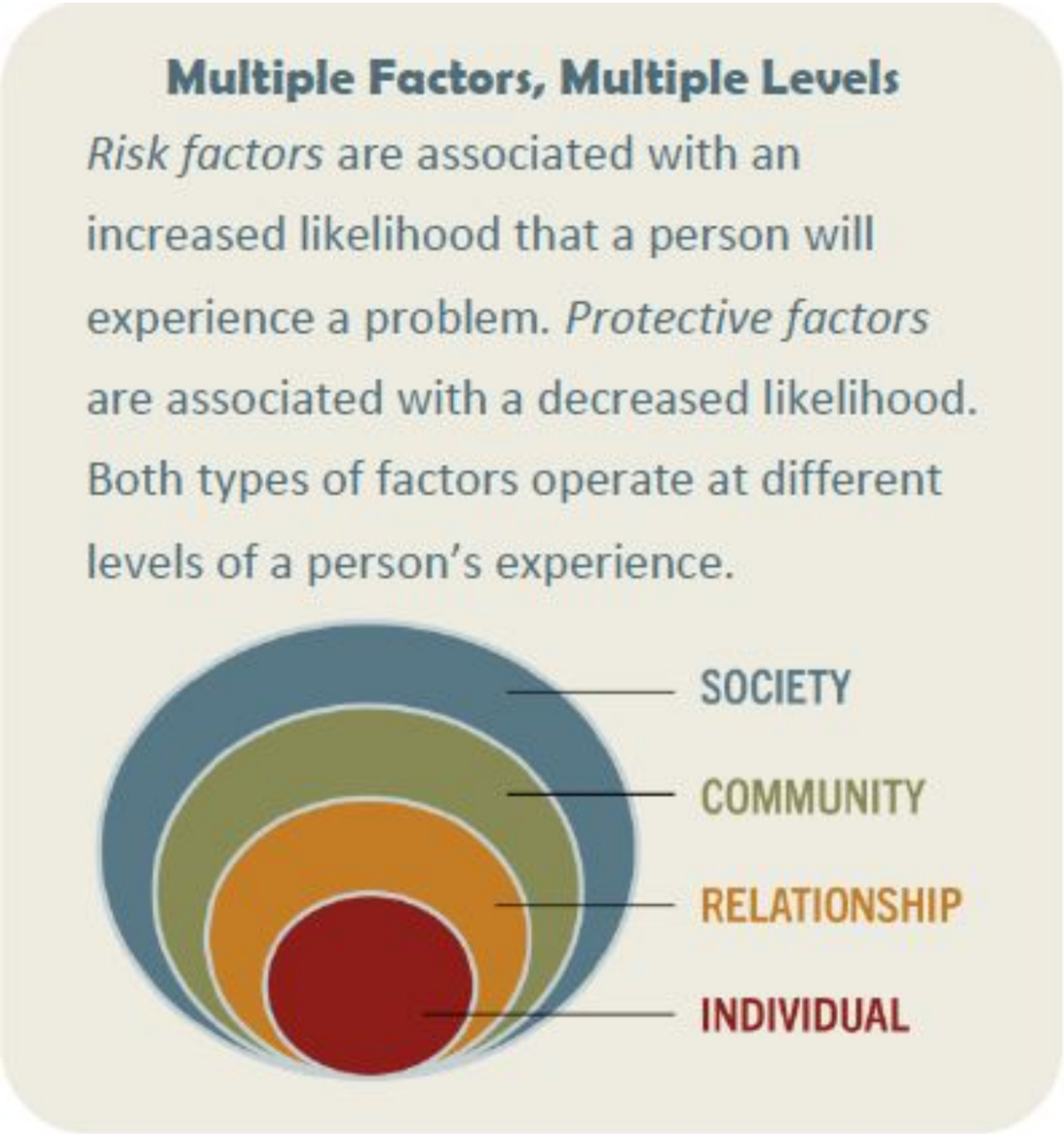
and shifted utilization away from behavioral health hospitalizations and specialty medication visits toward primary care and other sectors"

Wells KB, Jones L, Chung B, Dixon EL, Tang L, Gilmore J, Sherbourne C, Ngo VK, Ong MK, Stockdale S, Ramos E, Belin TR, Miranda J. Community-partnered cluster-randomized comparative effectiveness trial of community engagement and planning or resources for services to address depression disparities. J Gen Intern Med. 2013 Oct;28(10):1268-78. doi: 10.1007/s11606-013-2484-3. Epub 2013 May 7. Erratum in: J Gen Intern Med. 2013 Nov;28(11):1534. PMID: 23649787; PMCID: PMC3785665.

Multi-level action is required

“But a community cannot address a substance use-related problem directly; it must work through the underlying factors that influence this problem”

- SAMHSA Guidance for Substance Misuse Prevention Practitioners



Instead of a patchwork of programs,
we must design and manage community-level portfolios of equity-focused strategies to drive value and increase opportunities for everyone to live the healthiest lives possible.

Benefits of portfolio management for enhancing care and services for MHSUD

- Align programs and investments with strategic priorities
- Optimize resources and lower organizational risks and inefficiencies
- Balance and operationalize strategic plans
- Coordinate programs & investments that generate value and impact on health, social and economic outcomes across multiple levels of intervention and prevention, and over different time horizons.

Portfolio management systems should identify and balance opportunities to advance health equity across levels of prevention, intervention and across different time horizons.

Sample Upstream Strategy Map™

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Click on interactive elements to see one health system's balanced portfolio of investments to **reduce racial inequities in diabetes** among adults living in heavily impacted zip codes by addressing economic and food drivers of inequities and poor outcomes.

Levels of Intervention

Levels of prevention

	Programs & Care	System	Ecosystem	Societal
Promotion	+	+	+	+
Primary Prevention	+	+	+	+
Secondary Prevention	+	+	+	+
Treatment	+	+	+	+

genially

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A Portfolio Planning Tool for Health Equity; The Upstream Strategy Map.(HealthBegins. 2023)
https://healthbegins.org/from-a-patchwork-to-a-portfolio-of-health-equity-investments-the-upstream-strategy-map/


Respond to structural violence and policies that undermine “care and services”
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Moving upstream means reducing harmful policies, exposures, vulnerability and consequences for communities and patients

"Health disparities arise from disparities in **exposure, vulnerability** (which is shaped by social advantage/ disadvantage), and **consequences**."
(Braveman p.14)

Paula Braveman The Social Determinants of Health and Health Disparities

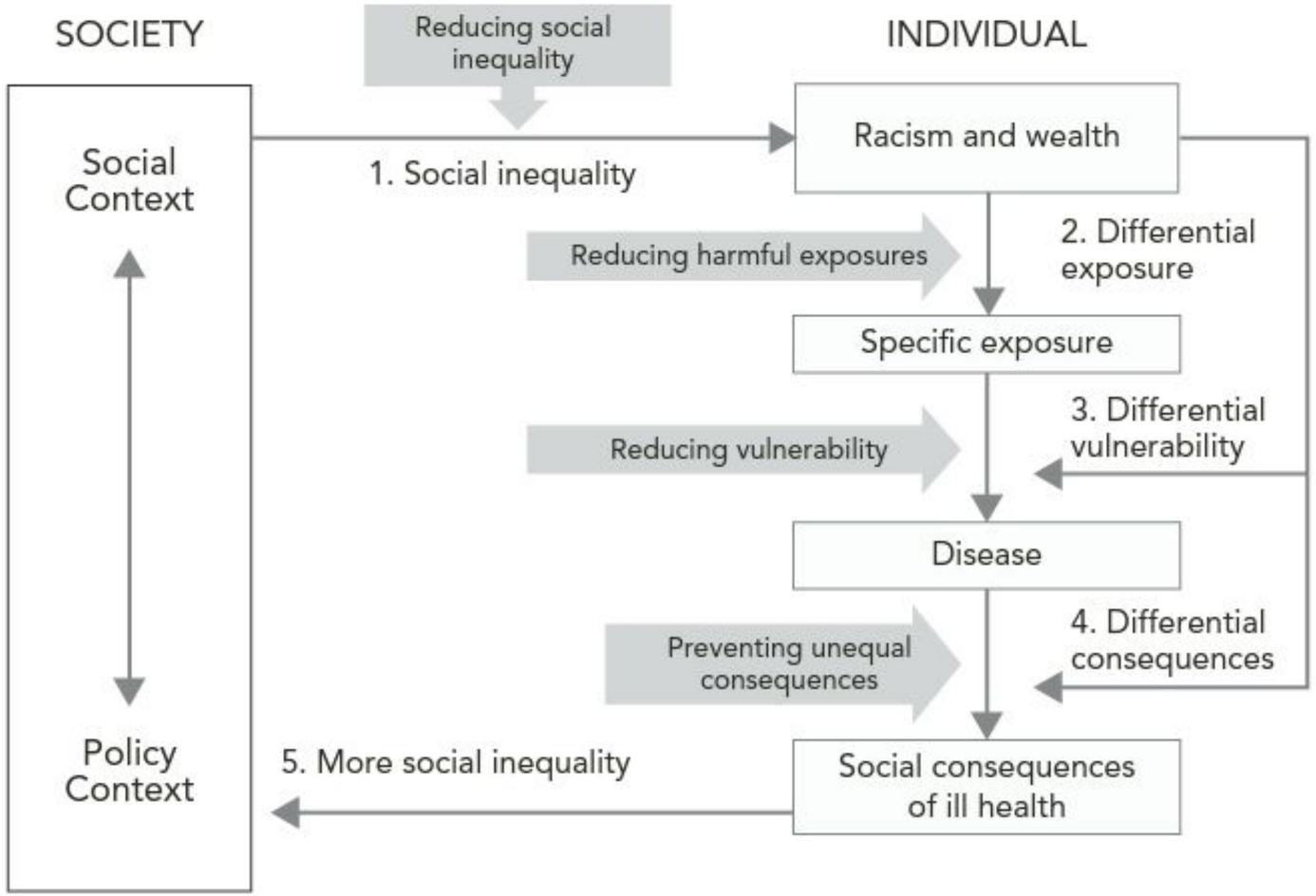

FIGURE 1.4 What produces health disparities across the life course and across generations? Adapted from Diderichsen (1998) [Google Scholar].

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Kvist, Jon. (2014). A framework for social investment strategies: Integrating generational, life course and gender perspectives in the EU social investment strategy. Comparative European Politics. 13. 10.1057/cep.2014.45.

Life course **transitions** increase harmful exposures, vulnerabilities and consequences driven by structural policies.

Portfolios should assess and prioritize opportunities to advance health equity, reduce harm, and promote healing at these transitions.

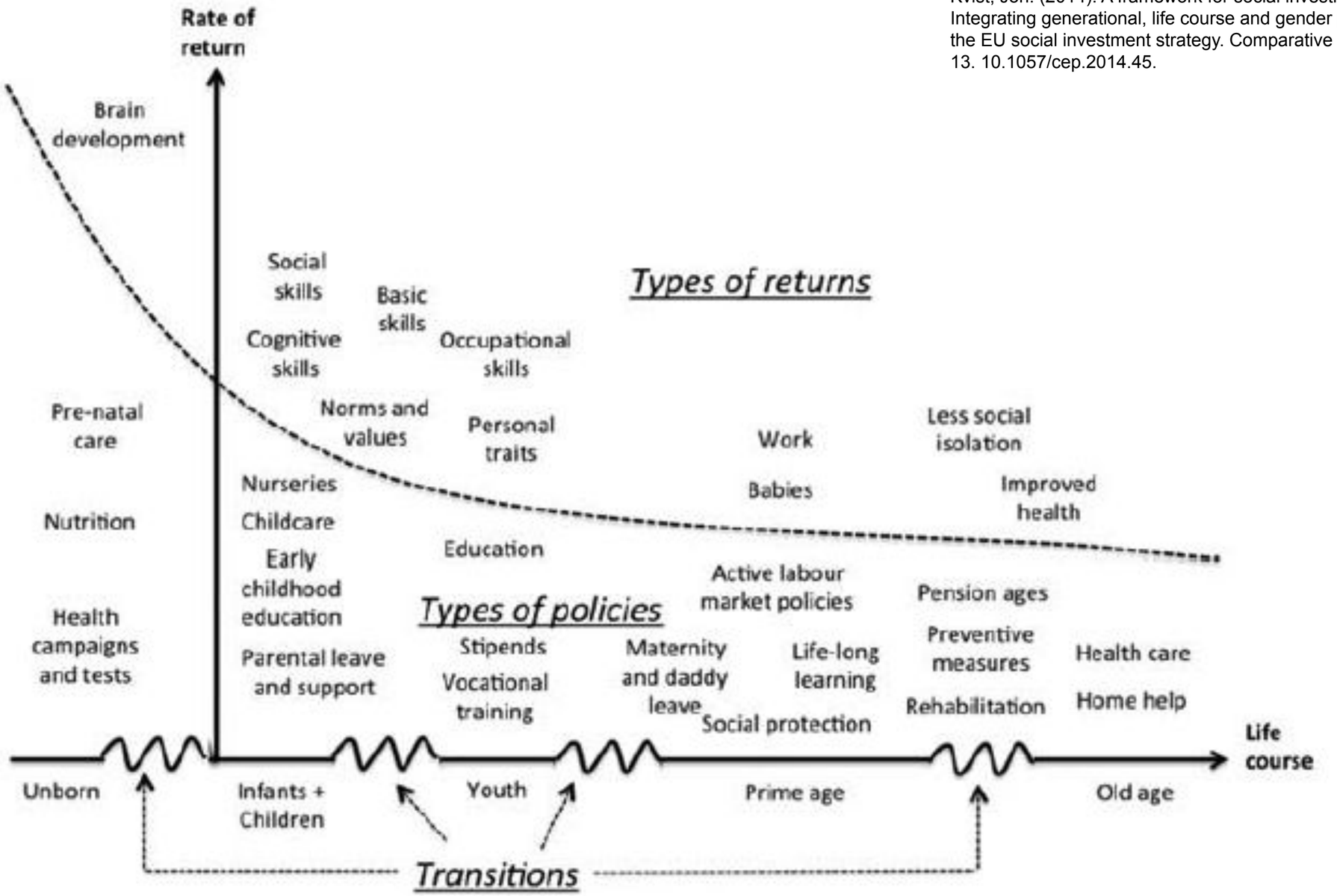

Figure 2: A life course perspective on social investment policies and their returns.

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In a time of policy shifts and state-driven assaults on the integrity of institutions,

how can healthcare institutions and professionals maintain their mission, protect vulnerable patients, and mitigate risks?

Federal research on social and structural drivers of health equity, including structural racism, and SUD was ramping up prior to 2025.

NIDA was interested in supporting **research to address the impact of structural racism** and discrimination on substance use, substance use disorders, substance use consequences, and comorbid conditions including HIV.

Topics of interest included but were not limited to:

- Research on the extent to which racial discrimination, **systematic inequities**, and segregation in housing, education, employment opportunities, and health resources contribute to and perpetuate disparities in access to substance use and HIV prevention, addiction treatment, and recovery services
- Research on the effects of **systematic racism** and discrimination on behavioral, cognitive, and neurobiological markers known to increase vulnerability to substance use, substance use disorders, and HIV across the lifecourse.
- Studies of how **bias in the criminal justice system**, including arrest, incarceration, probation and post-sentencing practices, affect substance use trajectories, HIV/HCV risk, addiction-related health outcomes, and health disparities experienced by communities of color.
- Targeted efficacious, effective and scalable, culturally specific interventions to address **social determinants of health** by promoting resiliency and confronting structural racism, with a focus on stigma, discrimination, and prejudice in the context of SUD and HIV prevention and treatment services.
- Research partnerships with state and local officials to determine the **impact of administrative and legislative measures to improve equity** within housing, education, employment, and other areas of public policy on substance use outcomes in youth and adolescents.
- Research partnerships with state/local agencies and private or public health systems to develop **models to eliminate systemic barriers to addiction care** or addiction and HIV care, particularly those rooted in racism or structural discrimination

Proposed policy shifts impacting social service integration and health equity

Proposed rules to CMS Prospective Payment System (PPS) will remove

- The "Hospital/Facility Commitment to Health Equity" and "Screening for Social Drivers of Health" measures in each quality reporting program
- Health Equity Adjustment in both the Hospital Value-Based Purchasing (VBP) and SNF VBP programs
- Voluntary health equity plan reporting through the new TEAM payment model

Rescission of Guidance on Health-Related Social Needs (March 2025)

- CMS withdrew previous guidance on HRSN from November 2023 and December 2024. This guidance from the Biden administration established many parameters of the federal HRSN framework.
- CMS notes it will assess state applications for HRSN services on a case-by-case basis moving forward to determine whether they comply with federal Medicaid and CHIP program requirements.
- Previous CMS guidance on leveraging In Lieu of Services as a vehicle for providing HRSN still stands.

Reminder: When equity is not a priority, inequity persists

"many value-based payment programs have been regressive, which has hampered the pursuit of health equity.

For example, Medicare's Merit-Based Incentive Payment System (MIPS) has disproportionately penalized outpatient clinicians who care for poor adults. Similarly, **all three of Medicare's hospital value-based programs** — the Hospital Readmissions Reduction Program, the Hospital Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program — **have transferred resources away from safety-net hospitals and potentially widened inequities in care**....

Value-based payment initiatives have failed to advance health equity in large part because equity wasn't prioritized during their design and implementation."


The NEW ENGLAND JOURNAL of MEDICINE

SPECIALTIES TOPICS MULTIMEDIA CURRENT ISSUE LEARNING/CME AUTHOR CENTER PUBLICATIONS

PERSPECTIVE

"REACHing" for Equity — Moving from Regressive toward Progressive Value-Based Payment

Authors: Suhas Gondi, M.D., M.B.A., Karen Joynt Maddox, M.D., M.P.H., and Rishi K. Wadhera, M.D., M.P.P.

"**Of the 152 studies** conducted in multiracial or multiethnic populations within this review, 44 studies included race or ethnicity in their analyses, but these analyses were informative in only 21 studies (14%)...

Only 4 (9%) were conceptually thoughtful about what race or ethnicity means."


JAMA Network Open

January 19, 2023

Racial Health Equity and Social Needs Interventions

A Review of a Scoping Review

Crystal W. Cené, MD, MPH[1,2]; Meera Viswanathan, PhD[3]; Caroline M. Fichtenberg, PhD[4,5]; et al

Reminder: In integrating healthcare & social services, we risk worsening structural and social arrangements that put people in harm's way

- **"Bridges to nowhere"**
  - Without equitable re-allocation of resources, underfunded social service providers may not be equipped to meet growing demand from healthcare
- **"Free-rider problem"**
  - Benefits of health & social care integration may not accrue to institutions that make initial investments
- **"Wrong-pockets"**
  - Accumulating benefits to healthcare without sharing benefits or reinvesting in the social or public health sectors

- **Extractive practices undermine health**
  - Profiteering (unfair, excessive profit-making) and other extractive practices contribute to and depend upon poverty, inequality, and dispossession.

T. Schrecker, A.-E. Birn, M. Aguilera. How extractive industries affect health: political economy underpinnings and pathways Health Place, 52 (2018), pp. 135-147, 10.1016/j.healthplace.2018.05.005

Reminder: Extractive practices undermine health equity and commitments to racial justice

- "The pursuit of profit is not inherently negative *unless it compromises the patient–physician relationship, worsens health outcomes, or exacerbates health disparities*" – American College of Physicians Position Paper

- More than 100 million U.S. residents have been pushed into debt by medical bills, forcing some to cut back on food, burn up their savings, or even forgo needed medical care—with the burden falling heaviest on Black, Latino, and other racially minoritized communities.

- Medical debt is associated with a 1.7 to 3.1-fold higher risk of worsening housing and food security.

Himmelstein DU, Dickman SL, McCormick D, Bor DH, Gaffney A, Woolhandler S. Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US. *JAMA Netw Open.* 2022;5(9):e2231898.

Financial Profit in Medicine: A Position Paper From the American College of Physicians. Position Paper. Oct 2021.

Reminder: A lack of accountability undermines health equity

Our approaches still largely lack accountability

- to local stakeholders (including patients, populations and places most harmed by structural violence)
- to reinvest in place-based, upstream interventions where harms are concentrated
- To challenge inequitable policies that only seek to accumulate structural advantages for institutions and communities that already have it

Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19

Leora I. Horwitz, Carol Chang, Harmony N. Arcilla, and James R. Knickman

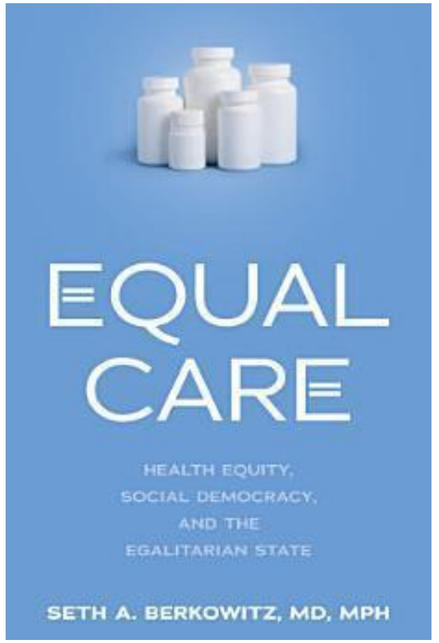
"health systems in the US publicly committed $2.5 billion toward directly addressing social determinants of health. This figure is dwarfed by health systems' overall community benefit spending, estimated to be over $60 billion per year. "

Reminder: The role of the government is to ensure everyone has the essential capabilities for health

"In a market economy, income is principally distributed through ownership of productive assets or working for wages."

- ***Factor income*** – income from land, labor or capital
  - But factor income is inadequate to ensure essential capabilities.

- **Welfare state** = "policies and programs that provide income support and social services necessary to meet basic needs"
  - can provide ***Transfer income*** – income received without exchange of goods or services.
    - Universalism / "social rights" approach: provides first-line programs to be used by all who need them.
    - Residualism / "backup" approach: views states benefits as backup plans, to be used for residual needs not met for by the market, family support or private charity. Frames support as "public charity" and uses "means testing". This is not consistent with promoting equality of social standing or opportunities.

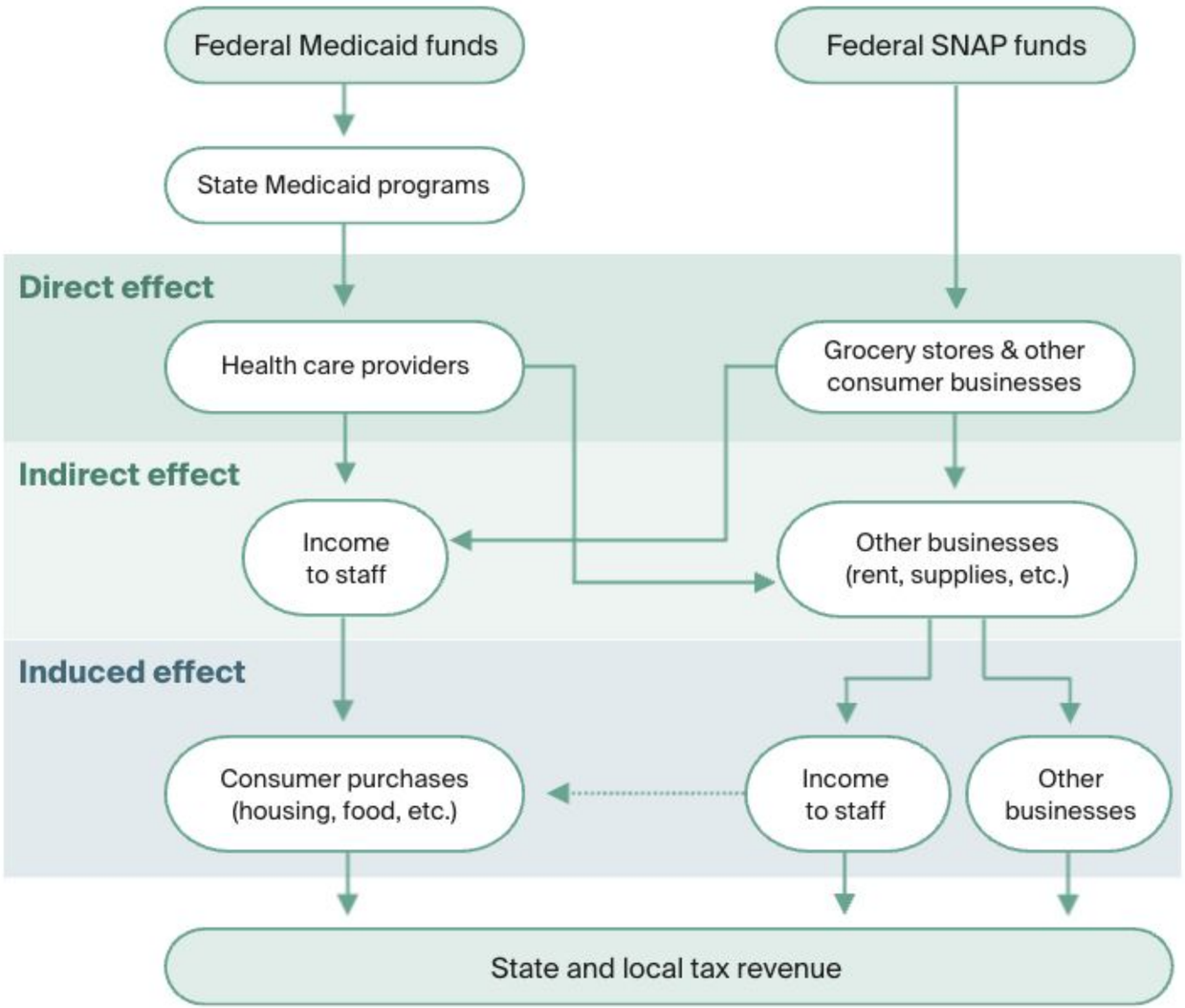


"A welfare state is essential to the egalitarian state"

What happens to states if Medicaid and SNAP are cut?

- **Combined losses from proposed Medicaid and SNAP cuts would reach $1.1 trillion over a decade**
- **State gross domestic products (GDPs) would be $113 billion lower**, exceeding federal budget savings.
- **1.03 - 1.3 million jobs would be lost nationwide**

How Reductions in Medicaid or SNAP Affect State Economies



Source: Leighton Ku et al., *How Potential Federal Cuts to Medicaid and SNAP Could Trigger the Loss of a Million-Plus Jobs, Reduced Economic Activity, and Less State Revenue* (Commonwealth Fund, Mar. 2025).
https://doi.org/10.26099/x2q9-7027

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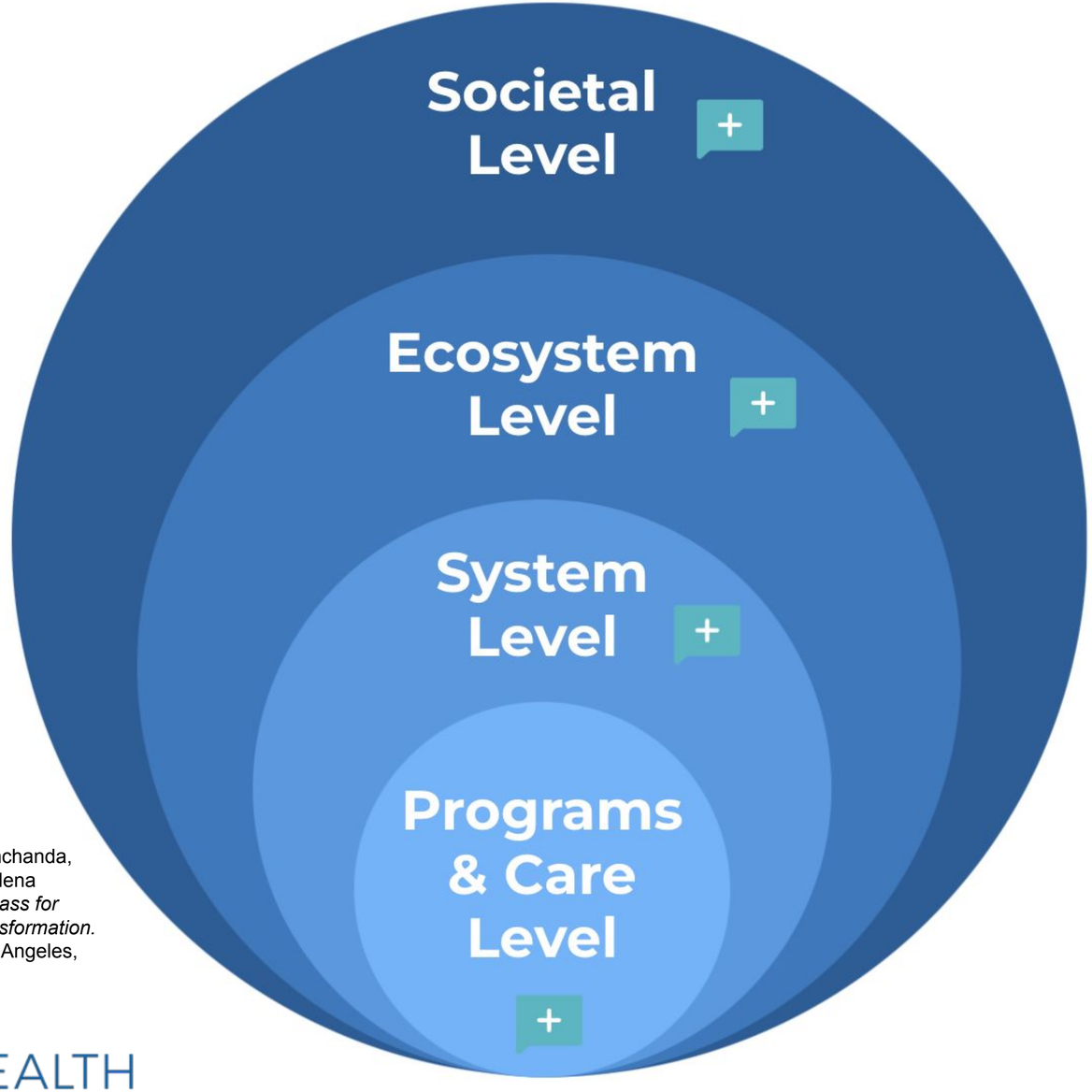

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Compass for Health Equity Transformation

At this critical point in our health equity journey,

we have an opportunity to define the next ten years.

To defend institutional integrity,

To reallocate power and resources,

To counteract harmful structures and policies
that drive health and social inequities,

and

To reimagine our relationships and our institutions