

The goal of the **Targeted Cost Challenge Investments** is to support innovative delivery and payment models that are poised to be taken to scale and make a meaningful impact on the Health Care Cost Growth Benchmark in years to come. Eligible applicants and their partners proposed initiatives that will reduce the cost of care to the health care system while improving quality and access in eight priority areas of high spending.

The HPC is funding 10 Targeted Cost Challenge Investments totaling \$6,614,881. Awards range from \$420,000 to \$750,000, for an 18-month period of performance.

| Name | Focus | Target Population | Operational Approach | Award Cap |
|---|--|--|--|-----------|
| Behavioral Health Network | Social Determinants of Health | 250 homeless or formerly homeless adults (18 years or older) with behavioral health (BH) and/or SUD diagnoses who are responsible for children | High-touch care coordination between BH treatment, primary care, housing supports, and vocational services to provide stability and continuity of care | \$750,000 |
| Berkshire Medical Center | Behavioral Health Integration | 1,500 high-risk primary care patients with BH and/or SUD primary diagnoses (no age band) | Care coordination hub to integrate BH care into primary care, and connect primary care physicians (PCPs) to experts via telemedicine and an embedded clinical navigator | \$741,920 |
| Boston Health Care for the Homeless Program | Social Determinants of Health | 60 high cost and high need homeless patients (adults, aged 40-60) treated on a rolling basis | Care coordination hub comprised of cross-sector providers of primary and BH care, housing, shelter, and social services to support the full spectrum of patients' needs | \$750,000 |
| Boston Medical Center | Social Determinants of Health | 300 high risk, high cost ED patients (18 years or older) with low primary care utilization | Place-based, high-touch care coordination and patient navigation deploying community health workers (CHWs) trained by legal practitioners to engage patients with community services and PCPs | \$747,289 |
| Brookline Community Mental Health Center | Behavioral Health Integration | 1,142 adults (18 years or older) with a serious chronic medical condition and a BH comorbidity | High-touch care management multidisciplinary team within the BIDCO care management structure integrating behavioral health, primary care, and community services | \$418,583 |
| Care Dimensions | Serious Advancing Illness/End-of-Life Care | 528 high-risk patients with life-limiting illness (~70% are adults 18-65, ~30% are 65+) | Embeds palliative care support into primary care practices, providing a resource for PCPs in early identification of patients with serious advancing illness | \$750,000 |
| Commonwealth Care Alliance | Site and Scope of Care | 980 dual eligibles enrolled through CCA (~80% are in One Care; ~20% are 65+ and low income) | Disability-focused ambulatory ICU which includes deploying community paramedics to provide palliative and behavioral health consults through telemedicine, and integrating dental care into a primary care setting | \$598,860 |
| Hebrew SeniorLife | Social Determinants of Health | 300 older adults (62 years or older) living in affordable housing | Care coordination team embedded in affordable housing sites to provide a link between housing and health care, regularly assess wellbeing of older adult residents, and promote self-care | \$421,742 |
| Lynn Community Health Center | Site and Scope of Care | 169 adult patients (20 years or older) with SMI enrolled in MassHealth PCPR | Intensive care coordination program deploying CHWs and providing remote medication monitoring supported by clinical pharmacy | \$690,000 |
| Spaulding Hospital for Continuing Medical Care Cambridge | PAC | 300 chronically critically ill patients (no age band) | Transitions of care support for long-term acute care patients utilizing a continuity team of an RN case manager and a social worker to step patients into a lower level setting of care | \$746,487 |