

Accepting New Patients for a High Needs Population ACO

Upward Health is forming a High Needs Population ACO in your community. We deliver 24/7 in-home and virtual healthcare, including comprehensive social support, all while ensuring adherence to treatment plans. Our team of local healthcare professionals includes physicians, nurses, social workers, pharmacists, counselors, paramedics, and medical assistants.

What is the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)?

The ACO REACH model from CMS provides the next great opportunity in moving a healthcare payment system toward paying for value and rewarding preventive care and keeping patients healthy.



Encourages healthcare providers to improve the coordination and quality of care offered to traditional Medicare beneficiaries



Focuses on improving the health of individuals in underserved communities and those not particularly well-served by the current system



Pays for services that Medicare doesn't typically pay for



Allows healthcare to be delivered in settings that Medicare doesn't typically allow



Does not restrict individuals' choice to see their current or new providers who accept Medicare



We had an individual who was discharged from the ED and had the start of pressure ulcers. The Upward Health doctor was involved in calling the pharmacy, conducting a telehealth visit, and fixing an error with the prescription called in. He stayed with the problem until it was fully resolved. This was all after 5 PM on a Friday. The PCP wouldn't have done this.

It is clear that the Upward Health doctor is committed to providing exceptional service.

– Partner staff

Benefits to Partners



Improve health of the individuals served by providing more preventative care



Reduce burden on staff caring for high-need individuals – including reduction in transport burden for acute care services – through medical care in home



Increase Medicare reimbursement due to new services covered under benefit enhancements, such as care management home visits and post discharge home visits



Improve access for staff / caregiver to medical provider for help with medical decisions



Increase flexibility in practice / reimbursement opportunities for nurse practitioners



Avoid hospital stay as a required first step to get patients into a nursing home, when appropriate



Increase staff compensation and professional development through identifying patients, scheduling visit, participating in care delivery / coordination process



Create competitive differentiation because access to ACO REACH services makes partners more attractive to individuals / families or long-term care partners



Create improved positioning with local Department of Health stakeholders for value-based care arrangements

Contact Us Today!

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