



UPSON
Regional Medical Center

Upson County, Georgia

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN 2025-2027



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INTRODUCTION AND PURPOSE

Upson Regional Medical Center (URMC) collaboratively continues to strive in identifying and meeting the health and medical needs in our community. In October of 2024, various community stakeholders gathered to learn the status of the previous implementation plan, review the primary and secondary data collected, establish priorities, and brainstorm how to address the priorities established. The Community Health Needs Assessment (CHNA) was approved by the board in December of 2024 and is available via URMC's public website.

The purpose of this implementation plan is to describe how Upson Regional Medical Center (URMC) plans to address the prioritized health needs from its current CHNA report. The significant health needs that the hospital does not intend to address are identified and a rationale is provided. For each of the prioritized needs that URMC will address, this implementation plan describes the actions to address the prioritized needs, the anticipated impact, the hospital resources allocated, outcomes to measure, and community organization collaborators identified.

ACKNOWLEDGEMENTS / EXECUTIVE STATEMENT

The 2024 CHNA represents a true collaborative effort in order to gain a meaningful understanding of the most pressing health needs across Upson County. URMC board members and administrative team members are exceedingly thankful to the many community organizations and individuals who shared their views, knowledge, expertise, and skills with us. A description of the 2024 CHNA process, as well as the names and organizations involved are found in the CHNA report on URMC's website. We look forward to our continued collaborative work to make this a better, healthier place for all people.

URMC contracted with HealthTech to assist in conducting the 2024 Community Health Needs Assessment and implementation plan. HealthTech is a healthcare consulting and hospital management company based in Brentwood, Tennessee. HealthTech principal consultant was Julie Haynes.

The CHNA implementation plan steering committee included the following people:

- Dan Owens, CEO
- Jessica Hudson, Marketing Director
- Marsha White, Executive Assistant

We would also like to thank you for reading this report, and your interest and commitment to improving the health of Upson County.



ABOUT OF UPSON REGIONAL MEDICAL CENTER

Upson Regional Medical Center is a full service, DNV Healthcare accredited organization located in Thomaston, Georgia. We are committed to providing exceptional, safe and compassionate care to our patients and families. We have proudly served a multi-county area of middle Georgia for over 70 years, constantly growing and expanding our facilities, technology and expertise, all in an effort to better serve those who need us. On behalf of our boards, medical staff, volunteers, and over 700 dedicated employees, we are honored you have chosen us.

Upson Regional Medical Center is community-based hospital with more than 40 providers bringing expertise in multiple specialties.

MISSION OF UPSON REGIONAL MEDICAL CENTER

The mission of Upson Regional Medical Center (URMC) follows.

Upson Regional Medical Center is committed to providing quality health care services to all patients based on the health needs of our population. Our goal is to be the employer of choice for healthcare workers, by creating a culture where employees feel valued and are inspired to be advocates for patients.

VISION OF UPSON REGIONAL MEDICAL CENTER

To Be A Top 100 Hospital

VALUES OF UPSON REGIONAL MEDICAL CENTER

- Constancy of Purpose
- Integrity & Honesty
- Quality Care & Professionalism
- Respect & Teamwork
- Customer Service
- Patient Safety

BOARD APPROVAL

The 2025-2027 CHNA Implementation Strategy was approved and adopted by the URM Board of Directors in April 16, 2025. This report, as well as the previous reports, can be found at our public website.

IRS 501(R)(3) AND FORM 990, SCHEDULE H COMPLIANCE

The CHNA and IS satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act are described in Code Section 501(r)(3), and include making the CHNA report (current and previous) widely available to the public. In accordance with this requirement, electronic reports of both the CHNA report and the current implementation strategy can be found at <https://urmc.org/about/community-health-needs-assessment>. Paper copies of both the CHNA report and implementation plan may be obtained at no charge from either Administration or the Public Relations department by calling (706) 647-8111 or contacting the hospital at the following address. Upson Regional Medical Center, 801 W Gordon St, Thomaston, GA 30286.

PROCESS TO PRIORITIZE NEEDS

The CHNA report available in URM's public website provides all the primary and secondary data considered, the stakeholders involved, the criteria used, and details about the process to determine the priorities.

NEEDS THAT WILL AND WILL NOT BE ADDRESSED

Based on the results of the CHNA, URM has selected the following two identified significant health needs to address with an emphasis of education since it received third highest number of votes. The votes associated with education are evenly divided into the top two priorities listed below:

- Mental Health
- Chronic Disease – including stroke/heart disease, cancer, diabetes, obesity, and prevention of chronic disease

Due to resource and expertise limitations plus, since it has the fourth highest number of votes, URM does not intend to address the following significant health needs:

- Poverty/Under Insured

CHNA PRIORITY 1: MENTAL HEALTH

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Bring awareness to mental health so community members of all ages know how to identify and treat mental health disorder that considers promoting the 9-8-8 line, provides presentations, exhibits at local health fairs, provides support group meeting venue and facilitation	- Increased awareness and use of mental health information; - More community members are educated to identify and respond to individuals in need of mental health (Mental Health First Aid (MHFA); We Cope; Question, Persuade, Refer (QPR))	- URM Staff: leadership, education department, Silver Care, and marketing - URM meeting space - Market 9-8-8 promotional material in hospital	- Increased awareness and use of 9-8-8 line (as measured by the improved ranking of Upson County from 51st regarding prevalence of calls); - Provide at least 7 community events that promote or treat mental health (such as education or support groups)	- Police - Religious organizations - Schools - Electrical Member Coop (EMC) - Georgia Crisis and Access Line (GCAL) - Local health department - Local government agencies (city and county)
Continue services and create awareness of URM's Silver Care Unit	- The awareness of URM's Silver Care Unit increases; - Physical expansion URM's Silver Care Unit is explored; - Further enhanced patient care via upgrading the telehealth equipment for mental health assessments is explored	- URM Staff: leadership, education department, Silver Care, marketing, and clinical/case management	- URM's Silver Care Unit average daily census of 13 is maintained or improved; - Successful discharges to home vs. elsewhere; - Capacity to serve additional patients is improved	- Referring providers/locations

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Continue to provide Comprehensive Psychosocial Assessments through Emergency Department (ED)	- Use motivational interviewing for focused discussions to engage the patient in open exchange related to presenting problems; - Increased knowledge and appropriate use of clinical alcohol and opiate withdrawal scale that is utilized as needed to determine active withdrawal scale numbers for inclusion with referral documents for treatment; - Increased knowledge and appropriate use of the MSE, mini-mental status exam primarily used to determine the extent of cognitive decline in those patients with issues relative to cognitive decline such as dementia or traumatic brain injury.	- Assessors with Masters level training in mental health along with continuing education and training; or an RN with experience in mental health assessment and treatment	- Increased ability to provide the correct level of care for patients experiencing mental health or substance abuse issues	- ED staff - Multidisciplinary Assessment Team (MAT)

CHNA PRIORITY 2: CHRONIC DISEASE

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Provide monthly diabetes education on disease management and nutrition - Provide blood glucose screenings at community health fairs - Provide insulin to uninsured/underserved patients.	- Decrease hospital admissions from appropriate management of diabetes. Diabetes requires daily care and attention/compliance by the patient in addition to healthcare providers providing medical oversight. More than many pharmacological therapies, diabetes education is fundamental and improves A1c (a laboratory measure of blood glucose control) by as much as 0.76% and Certified Diabetes Educators discusses patients' recent results and levels of control.	- Budgeted Certified Diabetes Care and Education Specialist (CDCES), RN and a Registered Dietitian Nutritionist. - Utilize 340b program to provide insulin for persons in need of insulin therapy. - Blood glucose meters, strips, supplies, and insulin syringes are also available as needed for persons with diabetes.	- Increase in quality of life, changes in A1c results, reduced ER visits and reduced hospitalizations. - Number of attendees at the monthly diabetes classes.	- Area physician offices, - Upson County Health Department, - area dental offices, and - locally owned pharmacies - Pharmaceutical vendors to provide syringes and supplies for blood glucose monitoring.

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Offer Cardiovascular Services and Education - Furnish Cardiac CT scan for Coronary Calcium Studies - Provide educational material related to the recognition of stroke (BEFAST) and stroke prevention which includes risk factors. - Provide educational sessions with community groups (i.e. church, civic, etc.) to promote early stroke recognition and stroke risk factors - Have regular meetings with local ambulance provider(s) to review pre-hospital stroke measures - Continue to expand our cardiology interventional services - Provide chest pain education to the community	- Increased early detection; - Improved community awareness around stroke signs and symptoms; - Further developed ability to treat patients locally; - Heart Scan coronary CT program designed to identify those at high risk for heart disease further expanded; - Increase community knowledge of BEFAST acronym used to help identify and recognize the signs of a stroke and stroke risk factors; - Improve performance of Prehospital Stroke Measures as identified with the American Heart Association's Get With The Guidelines	- Stroke Coordinator, Chest Pain Coordinator, Marketing/ Communications team, Interventional cath lab staff, Cardiology clinic staff, Physicians, Providers, - Deep discounted global fee for technical and professional fees	- Reduced mortality; - Treating more patients locally; - Increased numbers of interventions performed; - Increased numbers of Cardiac CT Scans performed; - Improved heart disease, reduced ER visits, and unscheduled hospital visits. Number of patients with previously undetected heart disease scanned and heart disease found; - Number of Educational AHA's GWTG Pre-hospital Stroke Measures: (5) - On scene under 5 min - Blood glucose documented - Stroke screen completed - Stroke with hospital pre-alerted; - Last known well time documented	- Local schools - Churches - Health Fairs

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Develop community-based education programs on nutrition, physical activity, and healthy weight maintenance to reduce the prevalence and impact of obesity - Provide healthy eating education material at community health fairs with special emphasis on weight management and chronic conditions. - Promote use of URMCC Wellness Center - Improve awareness and use of “Nutrition for a Healthy Start” that provides education for obesity and/or excessive weight gain during pregnancy	- A more educated community about the effects of proper nutrition and physical activity; - Better understanding of material presented during pre/post assessment conducted at health fairs to show education is effective; - Improved weight status and eating habits; - Desire to have participants learn healthy strategies for nutrition during pregnancy that lead to a safe and healthy delivery. Gestational diabetes, hypertension, large babies, increased risk for C-section are discussed.	- Registered Dietitian Nutritionist, Clinical Resource Team, the Wellness Center, Certified Diabetes Care and Education Specialist (CDES), OB/GYN providers & Staff	- Increased number of nutrition consults; - Number of gestational diabetes consults; - Percentage of patients with gestational diabetes; - Improved glucose control, blood pressure control, hydration, and digestive health; - Decrease percentage of obese adults.	- Upson Women’s Services - Upson County Health Department - Southern Rivers Energy - Health Fairs - Churches/Civic Organizations - EMS providers

Actions/ Tactics	Anticipated Impact	Hospital Resources (Programs, Staff, Budget)	Outcomes to Measure	Community Organization Collaborators (if applicable)
Increase education and promotion of regular wellness visits and the importance of preventative care to community members - Promote Chronic Disease Management (CDM) - Promote discounted services offered at URM; including screenings - Explore technology for screening reminders - Create awareness of age-related recommendations (ie: colonoscopy, mammogram, immunizations, etc.)	- Increased awareness around appropriate ages to begin specific screenings; - Early diagnosis of cancers and other health issues	- Clinic staff and providers, Education/educational materials, Radiology, Technology for patient reminders	- Increased participation in screening exams; - Increased utilization of discounts offered; - Increased scheduling of yearly screenings/ wellness visits	- Health Department - Health Fairs - News/Media - Churches/Civic Organizations