Prioritized Health Needs

McLaren Oakland is committed to addressing the significant health needs identified through the 2026 Community Health Needs Assessment (CHNA). This Implementation Plan outlines strategic priorities, goals, key partners, evidence-based practices, and evaluation measures that will guide the hospital's efforts over the next three years.

The plan focuses on three priority areas:

1. **Promotion of Healthy Behaviors**
2. **Chronic Disease Prevention, Management, and Treatment**
3. **Access to High-Quality Health Care and Prevention Services**

By concentrating resources on these targeted priorities, McLaren Oakland aims to maximize community impact, strengthen partnerships, and improve measurable health outcomes across Pontiac and the broader service area.

Priority Area 1: Promotion of Healthy Behaviors

Goal: Increase access to healthy food resources and promote nutrition education to reduce diet-related chronic disease.

Strategies

1.1 Expand Access to Nutritious Foods by Strengthening Community Partnerships

- Formalize partnerships with local food banks such as Forgotten Harvest, Oakland County Health Division, Oakland County Farmers Market, and mobile food pantries to increase distribution of fresh produce in underserved neighborhoods.
- Support school-based and community garden initiatives to increase access to fresh fruits and vegetables.
- Participate in countywide coalitions focused on food insecurity and healthy lifestyle promotion.

1.2 Increase Nutrition Education and Awareness

Provide evidence-based nutrition workshops at community centers, schools, and faith-based organizations.

- Develop culturally relevant educational materials on healthy eating, meal planning, and food budgeting.
- Integrate nutrition counseling into primary care visits for high-risk patients.

Evaluation Measures

- Number of residents served through food distribution programs.
- Number of nutrition education sessions delivered and attendance rates.
- Reduction in food insecurity indicators in targeted ZIP codes.

Priority Area 2: Chronic Disease Prevention, Management, and Treatment

Goal: Reduce the burden of cancer, diabetes, chronic respiratory disease, and tobacco use through prevention, early detection, and improved disease management.

Strategies

2.1: Strengthen Cancer Prevention and Early Detection

- Expand screening programs for breast, lung, colon, and prostate cancer through community events and mobile units.
- Increase provider referrals for eligible patients using evidence-based screening guidelines.
- Offer patient navigation services to reduce barriers related to transportation, insurance, and follow-up care.
- Start or partner with local organizations like, American Cancer Society and Karmanos Cancer Institute, to promote smoking cessation, a key cancer risk factor.

Evaluation Measures

- Number of cancer screenings that are completed annually.
- Screening rates among high-risk populations.
- Number of patients receiving navigation support.

Objective 2.2: Improve Diabetes Prevention and Management

Strategies

- Implement Diabetes Prevention Programs (DPP) in collaboration with community partners.
- Offer free or low-cost A1C screenings at community events.
- Provide diabetes self-management education (DSME) classes in English and Spanish.
- Integrate nutrition and physical activity counseling into primary care workflows.
- Partner with local food organizations to connect diabetic patients with healthy food resources.

Evaluation Measures

- Number of participants enrolled in DPP and DSME programs.
- Changes in A1C levels among program participants.
- Increased access to healthy food for diabetic patients.

Objective 2.3: Reduce the Impact of Chronic Respiratory Disease

Strategies

- Expand asthma and COPD education programs.
- Increase access to smoking cessation programs, nicotine replacement therapy, and behavioral support.
- Provide education through partner organizations like the American Lung Association to reduce asthma triggers at home.

Evaluation Measures

- Reduction in asthma-related emergency department visits.
- Number of residents enrolled in smoking cessation programs.

Objective 2.4: Address Smoking and Vaping

Strategies

- Launch a communitywide anti-tobacco and anti-vaping campaign, with targeted messaging.
- Partner with OB/GYN providers to integrate smoking cessation counseling into prenatal care.
- Collaborate with schools and youth organizations to deliver vaping prevention education.
- Increase access to Quitline referrals and cessation resources by partnering with American Heart Association and the Oakland County Community Health Network.

Evaluation Measures

- Decrease in adult smoking rates in Pontiac.
- Reduction in smoking during pregnancy.
- Number of youths reached through prevention programs.

Priority Area 3: Access to High-Quality Health Care and Prevention Services

Goal: Improve access to medical, behavioral health, and preventive services by addressing systemic, cultural, and logistical barriers.

Objective 3.1: Improve Access to Medical Care

Strategies

- Expand clinic hours, including evenings and weekends, to improve appointment availability.
- Increase telehealth services for primary care and specialty visits.
- Provide transportation assistance through rideshare partnerships or shuttle programs.
- Develop a community resource guide to increase awareness of available services.

Evaluation Measures

- Reduction in no-show rates.
- Increase in primary care visits among uninsured and Medicaid patients.
- Number of patients utilizing transportation support services.

Objective 3.2: Expand Access to Behavioral Health Services

Strategies

- Integrate behavioral health screenings into emergency and primary care visits.
- Increase availability of culturally sensitive and linguistically appropriate mental health services.
- Partner with community mental health agencies to expand crisis intervention, trauma-informed care, and veteran-specific services.
- Support school-based mental health programs and youth resilience initiatives.

Evaluation Measures

- Number of behavioral health screenings completed.
- Increased access to mental health appointments.

Health Needs Not Addressed and Rationale

The Implementation Strategy planning process requires McLaren Oakland to conduct a health needs selection process based on critical criteria including health need severity, magnitude and inequity and the extent to which McLaren Oakland can meaningfully address the need.

Additional areas of focus included health needs that will not be addressed by the McLaren Oakland CHNA and Implementation Strategy report. These include:

- Access to affordable housing
- Access to safe spaces for victims of domestic violence

SDOH: While social determinants of health are a very important part of our community profile, addressing these needs is beyond the scope of hospital services. However, we will continue to monitor and address disparities that affect access to health care (e.g., race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location).

Cross Strategies

Across all priority areas, McLaren Oakland will:

- Strengthen community partnerships with nonprofits, schools, faith-based organizations, and public health agencies.
- Use data-driven decision-making to monitor progress and adjust strategies.
- Promote health equity by prioritizing high-need ZIP codes and vulnerable populations.
- Increase community outreach and communication to raise awareness of available services.

McLaren Oakland remains committed to improving the health and well-being of Pontiac and surrounding communities through strategic, collaborative, and measurable action.

Adoption

The Implementation Strategy was adopted by the McLaren Oakland Board of Trustees on January 20, 2026.

McLaren Oakland Board of Trustees Approval:

_____ _____

Dr. Lorenzo Suter, President and CEO Date