

Assessing the Effectiveness of Policies to Improve Access to Primary Care for Underserved Populations

CASE STUDY ANALYSIS: DETROIT, MICHIGAN

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ABSTRACT

This case study of Detroit, Michigan, the fourth in a series, assesses the effectiveness of various policy initiatives to expand access to primary care in the region, particularly for underserved populations. Several parts of the city are classified as primary care health professional shortage areas, and many policy initiatives have been implemented to make primary care more accessible, but barriers persist.

State and local governments have been proactive in increasing the number of graduate medical education spots in the city, and some of these residents have continued to practice in the area following completion of their training. At least one state workforce development program intended to recruit fully trained physicians in underserved areas like Detroit is showing promise. Despite these efforts, there is still a lack of primary care clinicians serving low-income populations in the city.

Though state and health insurer investment in primary care transformation has helped some local private primary care practices remain sustainable, not all of them accept Medicaid patients. Federally qualified health centers (FQHCs) and other safety net clinics trying to gain FQHC status remain a key source of primary care for low-income populations in the city. However, FQHCs in Michigan receive limited state funding, and outpatient clinics offering safety net services are facing barriers to converting to FQHCs. Consistent state funding of school-based health centers (SBHCs), outpatient primary care clinics providing services in schools, and a recent boost in funding for SBHCs could create more points of access for primary care in the city.

Several interviewees specifically identified lack of access to transportation as a key barrier to accessing primary care in the city. An innovative local mobile health program is taking primary care directly to the communities most impacted by this lack of access to affordable and reliable transportation. Local providers have also taken advantage of federal flexibilities under the COVID-19 public health emergency period to build up their audio-only telehealth capabilities, allowing them to further connect with people in hard-to-reach communities.

While Medicaid expansion under the Affordable Care Act has helped improve affordability, local clinicians still find that low-income patients struggle to afford care because of high cost-sharing. Further, the inability of certain immigrant populations in the city to sign up for insurance has put primary care out of reach for many people.

Local providers serving vulnerable populations remain committed to providing culturally responsive care and building trust within the communities they serve. These goals are furthered by Michigan's policies supporting the expansion of the community health workforce in the state and in Detroit.

Finally, though many providers and nonprofit groups are doing important work to improve access to primary care for underserved populations in Detroit, the catastrophic privatization of the local health department in 2012 has made it difficult for them to organize the various

stakeholders and plan for the population health needs of Detroit. As the Detroit health department continues to rebuild, it will have the opportunity to leverage all these resources and expand its effectiveness.

INTRODUCTION

It is difficult to overstate the importance of primary care to ensure robust population health outcomes. Evidence shows that not only can primary care prevent illness and death,¹ but it is also associated with a reduction in health disparities.² Countries with strong primary care systems experience better health outcomes than those with weak primary care systems, including reduced unnecessary hospitalization and less socioeconomic inequality,³ as well as improved management of chronic diseases.⁴ Unfortunately, the United States falls short on many indicators that demonstrate the strength of a nation's primary care system.⁵

Improving access is key to strengthening a primary care system. The primary care access problem can be divided into five composite and interconnected dimensions, known as the five As: (1) *availability* of primary care clinicians, (2) *accessibility* of primary care services geographically, (3) *accommodation*, such as appointment availability and hours, (4) *affordability*, and (5) *acceptability*, such as comfort and communication between patient and clinician.⁶

In a Milbank Memorial Fund issue brief⁷ and five accompanying fact sheets,⁸ we assessed the evidence to determine whether policy initiatives that target primary care access have reduced health care disparities. Now, in this series of five case studies, we assess the impact of these policy initiatives at a local level to better understand implementation challenges and successes. The first three case studies focused on Grant County, New Mexico;⁹ Baltimore City, Maryland;¹⁰ and Columbia County, Arkansas.¹¹

This case study, the fourth in the series, focuses on efforts to improve access to primary care in Detroit, Michigan. The final case study will focus on a rural primary care health professional shortage area with a relatively large low-income population.

BACKGROUND

Geography and Demographics

Detroit, situated in Wayne County, is the most populous city in Michigan, with about 630,000 residents.¹² The city is separated from Canada by Lake Saint Clair and is considered an inland port city.¹³ There are two enclave cities within the city limits of Detroit: Highland Park and Hamtramck.¹⁴ These cities are administratively separate from the city of Detroit.¹⁵

The vast majority of Detroit's residents (78%) are Black (by comparison, the national average is about 14%).³⁰ Recently, the Hispanic/Latino population of Detroit has grown.³¹ According to a state agency official, Detroit's neighborhoods remain fairly segregated: Southwest Detroit has a large Hispanic/Latino population, Northwest Detroit has a large Black population, and areas like Downtown Detroit, Hamtramck, and Highland Park have larger white populations.

The History of Detroit

Detroit's population started growing in the early 1900s¹⁶ when it served as the hub for the burgeoning US automotive industry.¹⁷ In 1950, at its peak, the city was home to almost 2 million people.¹⁸ In the 1960s, the industry began moving facilities away from the city, which was seen as a union stronghold, to the suburbs to save costs and find a cheaper workforce.¹⁹ Automobile manufacturers also began turning to automation and slashing their workforce numbers.²⁰ In the 1970s, competition from foreign manufacturers led to further shrinking of the U.S. auto industry.²¹ All these changes resulted in the deindustrialization of Detroit, job losses, and a marked decline in Detroit's population.²²

Over the decades, Detroit's demographics have been significantly shaped by its racial history. In the 1940s, the population of Detroit was mostly white,²³ and many were unionized workers of the automotive industry.²⁴ Between the 1940s and 1960s, Detroit saw an influx of Black people escaping oppressive southern Jim Crow laws and seeking well-paid jobs in the thriving auto industry.²⁵ This demographic change contributed to Detroit's population boom in the 1950s.²⁶ The new Black residents of Detroit were subject to significant discrimination and shut out of affluent white neighborhoods, creating a heavily segregated city.²⁷ In the 1970s, when the Supreme Court required desegregation of public schools, Detroit, like many other cities in the country, experienced "white flight," or the exodus of white populations from urban to suburban areas to avoid desegregated public schools.²⁸ The decline of the U.S. auto industry and white flight both contributed to the city of Detroit declaring bankruptcy in 2013.²⁹

Many Detroit residents experience significant economic hardship.³² The median household income is around \$35,000, which is about half the national median household income.³³ One-third of the population is in poverty, compared with one-tenth of the national population.³⁴ Detroit was identified as 32nd in a list of 150 of the biggest US cities with the greatest levels of income inequality developed by the University of Southern California Equity Research Institute,^{35,36,37} and a recent report found a \$6 difference between the hourly wages of white workers and workers of color in Detroit.^{38,39,40}

Detroiters have a significantly lower life expectancy (72 years) than the rest of Michigan (78 years).⁴¹ Detroit also has a high incidence of chronic illness⁴² and sexually transmitted infections,⁴³ conditions that can benefit from better access to preventive and primary care. Three areas within Detroit are designated as primary care health professional shortage areas (HPSAs).⁴⁴ Two of these areas, Southwest and Northwest Detroit, are designated as high-need geographic HPSAs.⁴⁵ The neighborhoods of East Detroit, Highland Park, and Hamtramck are low-income population HPSAs.⁴⁶ About 94% of Detroit residents live in HPSAs, compared with the state average of 53%.⁴⁷

Primary Care Provider Shortage Designations

HPSA scores provide a basis for determining eligibility and resources for several federal and state programs targeting primary care access across the country. The federal government designates areas as primary care HPSAs when they have (1) a high ratio of population to primary care providers, (2) a high percentage of population below the federal poverty line, (3) poor infant health quality, and (4) longer travel times to the nearest source of care. The federal government scores HPSAs from 0 for the areas with the lowest need to 25 for those with the highest need. HPSA designations can be geographic HPSAs (where the entire population living in that area is experiencing a provider shortage), population HPSAs (where specific populations like low-income populations or Medicaid enrollees in an area are experiencing a provider shortage), or facility HPSAs (facilities like federally qualified health centers [FQHCs] are automatically designated as HPSAs, making them eligible for federal and state assistance programs). Detroit has three primary care HPSA designations, with scores ranging from 8 to 19.⁴⁸

Medically underserved area/population (MUA/P) designations are the basis of eligibility for the FQHC and FQHC look-alike programs. MUA/P designations depend on an Index of Medical Underservice (IMU) score, which is calculated from the (1) number of primary care providers per 1,000 people, (2) percentage of population at the federal poverty level, (3) percentage of population over 65, and (4) infant mortality rate. IMU scores fall between 0 and 100, and a score of 62 or below results in a MUA/P designation. Detroit has three MUA designations, with IMU scores ranging from 42.4 to 60.3.⁴⁹

In 2013, prior to the passage of the Affordable Care Act (ACA), the uninsured rate in Detroit was close to 20%.⁵¹ Today, it is just over 9%, better than the national average of 9.8%.⁵² About a third of Detroiters are enrolled in insurance through work or school, and more than half are enrolled in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).⁵³ However, uninsured rates continue to be high for certain populations in the city: 22% of Hispanic residents and 21% of part-time workers are uninsured.⁵⁴ Despite generally high levels of coverage, about a third of Detroiters still struggle to access health care, and 10% of insured Detroit residents find copayments and prescription drugs to be financially burdensome.⁵⁵

FQHC Look-Alikes

The term *FQHC look-alikes* refers to organizations that meet all the same eligibility requirements that FQHCs meet to receive federal grant funding, but do not themselves receive such funding. They are, however, eligible for enhanced Medicaid and Medicare reimbursements and prescription drug discounts, as FQHCs are.⁵⁰ In many cases, the reason FQHC look-alikes have not transitioned into full FQHC status is that they are waiting for the federal government to open a grant cycle.

Key Stakeholders

A significant number of state and local entities play a role in the provision of primary care services to Detroit residents.

Governmental Agencies

The **Michigan Department of Health and Human Services** (MDHHS) has a few offices that participate in primary care-related initiatives.

- The **Workforce/Access & Grants Management Section** within MDHHS is the state's designated Primary Care Office.⁵⁶ Its responsibilities include (1) periodically publishing the statewide primary care needs assessment, (2) managing federal and state health care workforce recruitment and retention programs, and (3) coordinating federal and state primary care shortage designation processes.⁵⁷ The office also supports health centers and free clinics, and collaborates with other statewide entities on primary care-related issues.
- The **Child & Adolescent School Health Section** is responsible for administering the Child and Adolescent Health Center Program, which provides funding and technical assistance to 86 Child and Adolescent Health Centers (CAHCs) across the state. (The state uses the term *CAHCs* to describe school-based health centers as well as other non-school-based health centers that serve school-age populations.)⁵⁸ The program is funded through the Department of Education's budget⁵⁹ and is intended to serve uninsured, underinsured, and Medicaid-enrolled children and adolescents from ages five to 21.⁶⁰ For fiscal year (FY) 2023, the Michigan legislature significantly increased the funding for this program from \$8 million to \$33 million.⁶¹

The **Detroit Health Department** has had a turbulent history. In 2012, responding to budgetary shortfalls, the city made the decision to privatize and outsource the majority of the department's services to a nonprofit.⁶² The department's workforce dropped from 700 employees to five employees.⁶³ The lack of a real health department resulted in significant hardship for the residents of Detroit because the nonprofit scaled back a number of public health and preventive care services that the department provided directly.⁶⁴ Further, the lack of staff made oversight of the nonprofit and its use of public funds very challenging, and the city's residents lost their ability to influence how these dollars were spent.⁶⁵ In 2014, under a new mayor, the Detroit Health Department started reclaiming management of public health services and has been working on building back its capacity.⁶⁶ Today, the department has 270 employees, but the city still has a long road ahead to fully rebuild the department.⁶⁷ The Detroit Health Department is mainly funded through state and federal funding or grants,⁶⁸ and it has a budget of about \$43 million.⁶⁹ In 2021, the department received an additional one-time grant of \$8 million from the U.S. Centers for Disease Control and Prevention to aid its response to the COVID-19 pandemic.⁷⁰

In response to a state task force's recommendation to create a "health authority for the purpose of preserving the health care safety net," the Detroit city council, Wayne County Commission, and State of Michigan Department of Community Health together created the Detroit Wayne County Health Authority in 2014.⁷¹ Authority Health, as it is known today, focuses on a variety of primary care-related activities, including (1) providing insurance navigation and enrollment assistance, (2) providing graduate medical education in community-based primary care through its teaching health center, and (3) operating three primary care clinics in high-need areas, including a school-based health center that also provides care for adults in the community.⁷² According to a stakeholder familiar with the organization, two of these clinics were in danger of closing until Authority Health started running them.

Primary Care Providers

- The city of Detroit has 12 hospitals,⁷³ many of which operate primary care clinics. For instance, **Henry Ford Health** operates at least two medical centers in Detroit offering primary care services, as well as some locations offering same-day primary care appointments.⁷⁴ **Detroit Medical Group** also runs at least two primary care clinics in the city,⁷⁵ and at least three of the **Ascension Health System** outpatient locations in the city of Detroit offer primary care services as well.⁷⁶
- Seven FQHC systems operate in Detroit,⁷⁷ running over 20 service delivery sites.⁷⁸ Wayne County operates an additional FQHC in Hamtramck, one of Detroit's two enclave cities.⁷⁹ Detroit also has one Indian Health Service center.⁸⁰ Health Centers Detroit, founded in 2004, is an FQHC look-alike that operates three clinical service sites. Authority Health also operates three clinics that serve as safety net sites even though they are not currently FQHCs or FQHC look-alikes.⁸¹
- There are 24 SBHCs operating in Detroit schools.⁸² Nine of them are operated by the **Henry Ford Health System**, 14 are operated by the **St. John Community Health Investment Corporation** (Ascension Health System), and one is operated by the FQHC **Covenant Community Care**.⁸³
- The Detroit Health Department provides reproductive health services to the teens of Detroit at the **iDecide Clinic**.⁸⁴ These services are mostly funded through the federal Title X family planning program.⁸⁵
- There are 13 free clinics in the Detroit area.⁸⁶ Twelve are in the city of Detroit, and one is in Highland Park, one of Detroit's two enclave cities.⁸⁷

Other Organizations

- Several associations within Michigan play a significant role in advocating for and providing technical assistance to the primary care-related entities they support. The **Michigan Community Health Worker Alliance (MiCHWA)** advocates for community health workers while also running an accreditation program for them.⁸⁸ The **Michigan Primary Care Association (MPCA)** represents 40 community health centers serving 715,000 individuals in the state of Michigan.⁸⁹ In addition to policy advocacy, the association provides operational, revenue cycle, clinical, and technological support to FQHCs, FQHC look-alikes, and some Indian Health Centers.⁹⁰

- **The Michigan Community Health Network**, co-owned by the MPCA and 36 community health centers, is an entity that negotiates value-based contracts with the state's Medicaid managed care plans that go beyond the standard FQHC payment system.⁹¹
- **Michigan Area Health Education Center (MI-AHEC)** was founded in 2010 under the federal Area Health Education Center (AHEC) grant program to improve access to primary care.⁹² MI-AHEC is run through five regional program offices, including the **Southeast Regional Center**, which serves the Detroit region.⁹³ The Southeast Regional Center supports and encourages high school students from communities underrepresented in medicine to explore health care career options, provides community-based clinical rotation opportunities to medical students, and provides continuing education support to medical professionals.⁹⁴

Methodology

To better understand how the efforts of the various stakeholders to improve primary care access for underserved Detroit residents have fared, we conducted 14 qualitative interviews with local primary care providers, local and state officials, advocates, and experts in the Detroit area who are knowledgeable about the state of primary care in the city. Interviews occurred between September 26 and November 22, 2022.

DESCRIPTIVE ANALYSIS AND FINDINGS

1. Availability of Primary Care Providers

State Embarks on Efforts to Increase Number of Primary Care Residency Spots in Underserved Areas

Established by the Michigan legislature in 2019, Michigan Doctors Improving Access to Care (MIDOCs) is a residency expansion program operated by a consortium of four Michigan medical schools that aims to recruit and retain primary care residents in underserved areas of Michigan.⁹⁵ Funded through the state, the universities themselves, and the federal Graduate Medical Education Innovations program, the MIDOCs program supports additional residency spots in the existing primary care residency programs at four Michigan medical schools. The residency spots are reserved for individuals who commit to practicing primary care in underserved areas, including Detroit, for two years after completion of their program. Eligible residents can also receive up to \$75,000 in loan repayment.

The MIDOCs program has already funded an estimated 100 new residents since the program began. In the Detroit region, MIDOCs allowed Wayne State University to fund additional spots in the urban track of its family medicine residency program. This program provides clinical rotations in Detroit FQHCs as well as opportunities for public health research with local stakeholders such as the Detroit Health Department.⁹⁶

Outcome data for the program are limited given that the first class of MIDOCs residents graduated in 2022. However, one stakeholder familiar with the program predicts that a majority of these residents will continue to practice in the underserved areas of Michigan even after they

complete their two-year service obligation. The stakeholder attributed this to MIDOCs' recruitment of candidates who have strong ties to the state as well as a demonstrated commitment to working with underserved communities, such as through membership in a student organization focused on urban or rural health.

Local Program Highlights: Authority Health

Authority Health, officially known as the Detroit Wayne County Health Authority, is a community-based organization created “for the purpose of preserving the health care safety net” in the Detroit region. It was established in 2014 as a collaboration between the Detroit city council, Wayne County Commission, and State of Michigan Department of Community Health. Authority Health engages in a variety of programs and activities to expand the availability of primary care clinicians in the Detroit region.

Through its new Future Docs program, Authority Health emphasizes the importance of supporting high school students who might want to enter the health care workforce. The organization seeks to educate students early that being a doctor is “not just about the end stage of the disease [but about] connecting with the community.” Authority Health also plans to collaborate with Black and Hispanic student organizations at local colleges and universities that have connections with teen groups to recruit them into the program.

As a teaching health center federal grant recipient, Authority Health also provides graduate medical education for medical school graduates interested in providing primary care to underserved communities in Detroit. This residency program is based in Authority Health's outpatient primary care clinics and is not part of the MIDOCs program, which is focused on increasing the number of primary care residency spots at traditional university-based medical schools.

Leaders of Authority Health understood early on the importance of having a diverse class of medical residents and were intentional about making sure that they were attracting a diverse pool of applicants. They looked at the residency program's website to “make sure it had images and messages that people of color and women would connect to.” They also reached out to historically black colleges and universities. Two years after initiating these efforts, Authority Health finds that its resident class is “very, very diverse,” as one leader described it.

The program specifically educates residents about providing and billing for high-value preventive care, like discussing tobacco cessation or providing nutrition counseling. Program leadership said that this kind of education is not always common, and that “it gets [the residents] excited,” because not only do these services improve their patients' outcomes, they are also eligible for additional reimbursement.

In light of their efforts, the program's leadership has found that the number of its residents who choose to practice in an underserved area in Michigan, whether in Detroit or other underserved areas in the state, after completing residency is “pretty high.” The leadership credited the federal teaching health center grant in keeping the program sustainable, especially as they continue to wait for the federal government to open the grant cycle that will allow them to convert the three clinics that Authority Health currently operate into FQHCs.

The Michigan AHEC Program Struggles with Lack of Adequate Funding

The federal AHEC program was established in the 1970s to “develop and enhance health professional education and training networks within communities, academic institutions, and community-based organizations.”⁹⁷ In turn, these networks are meant to “increase diversity among health professionals, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery” to underserved areas and populations.⁹⁸

Michigan’s AHEC program is relatively new compared with those in other states, and it completed its first 12-year Health Resources & Services Administration grant cycle in 2022. Wayne State University sponsors the program and runs it through five regional centers. The Southeast Regional Center operates out of an FQHC look-alike, Health Centers Detroit (HCD), and has served the Detroit area since 2017.⁹⁹ The Southeast Regional Center offers (1) pipeline programs to increase interest in health care careers among younger students (particularly those from communities underrepresented in medicine), (2) community-based education for college students through clinical rotations at local community health centers, and (3) continuing education programs for professionals. One program administrator emphasized the importance of “exposing students early” to health-related careers in underserved areas through these programs and helping them build networks of Detroit-based mentors and peers.

Unfortunately, stakeholders familiar with the regional center find that the lack of sufficient funding for Michigan’s AHEC program makes it difficult for the center to expand its work. For example, the regional center launched a pilot program called HCD Scholars using some surplus federal funding to bring together students from different health professional fields and introduce them to team-based care, but the center will not be able to sustain this program without additional funding. Funding from the federal government declined from \$1.2 million per year at the beginning of the grant cycle to \$720,000 per year, which stakeholders find to be inadequate to meet the needs of the communities they serve. Further, Michigan’s AHEC currently receives no additional state funding; stakeholders noted that the most successful AHEC programs in other states tended to be funded by both federal and state governments. While efforts to petition the state legislature for additional funding are underway, supporters of the program have so far not had success. Perhaps one contributing factor is the difficulty that program administrators experience in documenting long-term program outcomes, because program graduates can be hard to track over the years. The Southeast Regional Center is in the process of increasing routine communication with graduates to build a community and improve data collection, but limited funding remains a challenge.

State Has Some Success Recruiting Primary Care Providers Through Its Workforce Programs

MDHHS operates two key state-level primary care workforce development programs in addition to administering the federal National Health Service Corps loan repayment and scholarship programs.

Under the **Michigan State Loan Repayment Program (MSLRP)**, primary care clinicians who choose to work in the state's underserved areas are eligible for up to \$300,000 in tax-free funding over the course of 10 years (contracts are signed in two-year increments).¹⁰⁰ In FY 2019, the program received a "record-breaking" 185 applications and had funds to accept only 84. Of these 84 applicants, 25 were physicians and 44 were either nurse practitioners or physician assistants.

MSLRP is funded through federal, state, and local employer contributions. In 2019, the federal government contributed about \$1 million, while the state contributed about \$1.4 million and local employers about \$600,000.¹⁰¹ Among the 43 states that run state loan repayment programs, Michigan has the second largest program in terms of the number of participating clinicians. State officials attribute this to the state going above and beyond the 1:1 required state match for federal funding, requiring employers to contribute about 20% of program funding, and calculating award amounts based on educational debt amounts instead of a flat dollar amount.¹⁰² Retention data collected through employer surveys show that about half the clinicians in the program continued to work with their sponsoring employers even after their service obligations were fulfilled.¹⁰³ However, this program has a predominantly rural focus, with about 70% of awardees ending up in rural practice sites and Wayne County getting only a small proportion of the funding every year.¹⁰⁴

On the other hand, state officials found that the **J-1 visa waiver program** has had more success than the MSLRP in recruiting and retaining physicians in the Detroit region specifically. This program is a federal-state collaboration that eases certain immigration restrictions on foreign-trained physicians in return for a three-year commitment to practice in an approved underserved area. Each state can request up to 30 waivers per year, and state officials said that Michigan generally fills all 30 spots every year. In analyzing applications, the state gives preference to primary care clinicians and those intending to work in HPSAs. In 2021, 10 of the applications were for positions in Detroit, with state officials describing the city as a "hot zone" for the program. State officials find that two to five of the 10 or so Detroit applicants every year tend to practice primary care. Further, officials noted that most of these physicians tend to stay in Detroit even after fulfilling their obligations. However, most of these physicians tend to be recruited by large hospital systems or medical groups that have the resources to pay for foreign physicians' immigration applications. Community health centers rely on a different federal program that also provides immigration waivers for foreign physicians.¹⁰⁵

Low-Income Populations Struggle to Find a Primary Care Provider

The state and local efforts to recruit and retain primary care clinicians in Detroit have increased the number of clinicians, and according to a state official, some parts of Detroit have shed their geographic HPSA designation, which applies when an entire population within an area is experiencing a provider shortage. However, according to the official, some of these areas continue to be designated as low-income population HPSAs, which means that shortages persist for low-income populations.

One clinician and director of a safety net clinic blamed this ongoing shortage on low Medicaid reimbursement rates in the state; they found that many primary care physicians employed in health systems and private practices refuse to accept Medicaid patients because of a lack of financial incentive. Yet Michigan was one of the few states that continued to require enhanced Medicaid payment rates for primary care physicians even after the federal funding for these payments under the ACA ended in 2014.¹⁰⁶ Specifically, Michigan funded an increase in Medicaid primary care rates up to 78% of Medicare rates.¹⁰⁷ For FY 2023, the legislature approved a further increase in funding up to 95% of Medicare rates.¹⁰⁸ At the same time, there tends to be a smaller discrepancy between commercial and Medicare rates for physician services in Michigan than in other states.¹⁰⁹ Further study is needed to understand why local providers are not necessarily seeing the benefits of these state-level efforts to improve payments for primary care services.

Another potential contributor is the inability of FQHCs to compete with other employers when recruiting clinicians. One stakeholder familiar with FQHCs in the city said that while FQHC salaries along with federal and state loan repayment program benefits can be an attractive package in other markets within the state, in Detroit they can fall short. The stakeholder described how nurses and physicians in the city “can very easily go and get three or four offers simultaneously and then compete those offers against one another.” FQHC directors have found two primary ways to attract talent in this environment. First, one director spoke about the importance of recruiting candidates who are aligned with the FQHC mission and see the job as a “calling.” Second, FQHC directors have found that opening their doors to medical or nursing school students and residents to come and train in their clinics has also helped them improve long-term recruitment.

[A New Model to Boost the Recruitment of Support Personnel](#)

Several stakeholders familiar with primary care practices and FQHCs in the Detroit area expressed concern about the significant shortage of medical support personnel, such as medical assistants and entry-level billers. They find that a lot of medical support roles, unlike similarly paid roles in other industries, require front-end investment to get trained and certified before a person can start earning. The COVID-19 crisis and the related burdens on the health care sector have only exacerbated this problem. One advocate who works with FQHCs has said that they are now testing a new model in which they hire people first and “pay them while they’re going through training and getting certified.” At least one FQHC provider said that they have decided to absorb these costs. This approach “doesn’t ask a person to take time away from a job where they’re earning money to support their families to [undergo] training.” They find that they are having “much more success” hiring medical and dental assistants after transitioning to this approach and that starting in 2023, they plan to expand it to pharmacy technicians and community health workers as well.

2. Improving Access to Outpatient Clinics for Underserved Communities

State and Payer Support for Private Primary Care Practices Has Helped Lessen Their Flight from Detroit

Several stakeholders familiar with the primary care landscape in Detroit found that private primary care practices without connections to larger health systems have “struggled to keep their doors open” in the city. As a result, many have “flooded away” from Detroit and into the suburbs. They did find that practices tend to be more successful when they are supported by physician organizations. Generally speaking, physician organizations were created by the state-run Michigan Primary Care Transformation (MiPCT) program to assist practices in building their capabilities to convert to patient-centered medical homes (PCMHs). Stakeholders also credited a similar and longer-running program operated by Blue Cross Blue Shield of Michigan, the Physician Group Incentive Program, with helping primary care practices move away from fee-for-service and toward value- and team-based care. One health policy researcher familiar with state and local payer-provider issues credited these programs with improving the sustainability of primary care practices in Detroit and encouraging them to see more Medicaid patients. However, researchers noted that the priorities of different physician organizations can vary, and some of them have not been supportive of their participating practices serving Medicaid populations.

Michigan Primary Care Transformation Project and the State Innovation Model PCMH Initiative

MiPCT “was a three-year, multi-payer, statewide demonstration project [funded by the U.S. Center for Medicare and Medicaid Innovation] aimed at reforming primary care payment models and expanding the capabilities of the state’s patient-centered medical homes” that ran from 2012 to 2016.¹¹⁰ MiPCT was the largest PCMH project in the nation,¹¹¹ bringing together three major private payers as well as Medicare and Medicaid.¹¹² These payers agreed to pay participating primary care practices monthly fees per member for care coordination, population management, and administrative costs, while also providing practices with data support.¹¹³ The project reached 1 million people served by 1,900 clinicians in 400 practices.¹¹⁴ MiPCT also supported the creation of physician organizations to assist practices in building up their PCMH capabilities.¹¹⁵

MiPCT became the basis for the Michigan State Innovation Models Patient-Centered Medical Home initiative, which ended in 2019.¹¹⁶ The federal State Innovation Models initiative was designed to advance multipayer health care payment and delivery system reform models.¹¹⁷ Michigan’s model included a PCMH initiative that focused primarily on the Medicaid plans in the state.¹¹⁸ Participating providers were required to improve access to primary care in the following ways: (1) ensuring that patients have 24/7 access to a care manager, (2) regularly offering at least one alternative to traditional office visits such as telehealth, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends, and (3) ensuring that 30% of available appointments are reserved for same-day care across the patient population.¹¹⁹ However, this program has not been evaluated to assess whether it succeeded in improving access to primary care.

State Offers Little Direct Funding to FQHCs but Supports Them in Other Ways

FQHCs are community health clinics that primarily serve underserved communities with high rates of uninsured and Medicaid-, CHIP-, and Medicare-eligible individuals.¹²⁰ They receive federal grants to provide no- or low-cost primary care services, and they are also eligible to receive enhanced payments for services provided to patients covered under Medicare, Medicaid, and CHIP.¹²¹

Detroit is home to seven FQHC systems¹²² running over 20 clinical sites,¹²³ which served about 81,000 patients in 2021 (this patient total excludes the FQHC operated by Wayne County in Hamtramck, and it may double count patients who visited more than one FQHC and may include some people who reside outside the Detroit city limits).¹²⁴ On average, close to 86% of the patients receiving services at these sites are either uninsured or covered under Medicare, Medicaid, or CHIP, and almost all are at or below 200% of the federal poverty level.¹²⁵ Combined, these FQHCs see almost one-quarter of the estimated 347,000 people in the city who are at or below 200% of the federal poverty level, which makes these clinics a key source of health care for the low-income population in Detroit.¹²⁶

Michigan is one of the 29 states that provides funding for FQHCs,¹²⁷ but a stakeholder who works with FQHCs in the state said that Michigan falls on the lower end among states in terms of how much funding it provides.¹²⁸ The stakeholder said that the state distributes a small amount of money to about one-quarter of the state's FQHCs, including one in Detroit. However, the stakeholder claimed that Michigan supports FQHCs in a few other important ways: (1) being proactive in setting rules for how Medicaid managed care organizations (MCOs) interact with FQHCs or pay them, (2) coordinating on a number of disease prevention and public health initiatives, and (3) providing support through health care workforce initiatives.

Local Program Highlights: CHASS

Community Health and Social Services Center (CHASS) is an FQHC operating a clinic in southwest Detroit, which has a large population of uninsured immigrants from Mexico and Central America. The clinic was created 52 years ago through a collaboration of city and state leaders and grant funding to improve access to health care in Detroit.¹²⁹ After operating as a community health center for many decades, CHASS became an FQHC in the 1990s.¹³⁰ Over the years, CHASS has partnered closely with Henry Ford Health System, which not only shares clinicians and funding with CHASS, but also provides free specialty care to patients referred to the system by CHASS.

State officials and researchers alike described CHASS as an “impressive facility” that provides “very culturally sensitive care” and “effective population health management.” For example, CHASS has employed community health workers for more than 20 years. Initially, the clinic funded these positions through a variety of disease-specific grants, but recognizing their value, CHASS has now integrated these positions into its operating budget. Further, responding to the needs of the community they serve, almost all of CHASS's staff, including physicians and nurse practitioners, speak both Spanish and English. To help patients overcome transportation-related barriers, CHASS also operates a van that picks up patients and “brings them to their appointments, not only ... at CHASS, but also to their appointments at Henry Ford.”

Recent State Investments in the SBHC Model Could Significantly Expand Access to Primary Care

SBHCs help children from underserved areas and their families overcome barriers to primary care such as lack of transportation, inability of parents to get time off from work, and unaffordability.¹³¹ About 24 of the 106 schools in Detroit have an SBHC,^{132,133} and a majority of them are operated by two major hospital systems in the city, Henry Ford and Ascension Providence health systems. Stakeholders familiar with the city's SBHCs described different motives for hospitals sponsoring SBHCs: some were established "for the good of the community" with no expectations of generating revenue, while others employ more "sophisticated billing" structures that can be profitable.

According to state officials, the state's Child and Adolescent Health Center program provides grant funding for 11 SBHCs (locally referred to as CAHCs) in Detroit. Grant applicants have to demonstrate both community need and community readiness. CAHCs that receive funding are required to adhere to a number of requirements. For example, they are required to bill Medicaid and private insurance for services and to offer a sliding fee scale based on family income. State-funded CAHCs are also required to provide Medicaid enrollment assistance. CAHCs that do not receive state grant funding are generally not under the purview of the state or required to follow the same requirements, but one state official noted that from what they have heard and noticed over the years these CAHCs still tend to align with the program's objectives and requirements.

Michigan's CAHCs have enjoyed relatively stable funding over the years. Stakeholders pointed to consistent bipartisan political support of the model as a principal reason for why funding "feels really secure." Recently, the state increased the funding for CAHCs from \$8 million to \$33 million, a significant additional investment in the model.¹³⁴ Stakeholders familiar with the legislative process found that a statewide evaluation of CAHCs' impact conducted by Michigan State University helped demonstrate a positive "return on investment" to policymakers responsible for funding the program.¹³⁵ They emphasized the importance of not just touting the improved health outcomes but also demonstrating a reduction in health care costs to appeal to the widest group of legislators.

State officials stated that expanding the number of CAHCs in the state has the potential for significantly improving access to primary care for underserved populations in the state, but their enthusiasm is tempered by concerns about potential workforce shortages.

City Offers Some Nontraditional Entry Points to Primary Care

City-Run Clinics

For patients without an established primary care provider, city-run clinics can provide some preventive care services as well as help make connections to additional sources of care. For instance, one public health official described the iDecide Detroit Health Clinic, which provides reproductive health care services, as a "point of entry to the health care system." The clinic's patient population is mostly made up of low-income Black girls and women under the

age of 25. The official found that the clinic's decisions to employ Black clinicians and offer confidential services has helped establish a "trusting environment" that has in turn helped patients feel more comfortable engaging with the broader health care system. The city has plans to establish a second clinical site as well as a mobile unit to provide immunizations, testing, and other services beyond reproductive health care. This could further help bring primary care services into the lives of the younger low-income populations in the city.

Emergency Departments

According to a stakeholder familiar with the primary care landscape of the city, Detroit has many emergency departments (EDs) that over the years have "frequently advertised short wait times on billboards by bus stop[s] or [the] expressway" in a bid to compete with outpatient clinics that traditionally have long wait times. Because of these short wait times, 24-hour availability, and the fact that EDs cannot turn anyone away for their inability to pay, many low-income people in Detroit, some without a usual source of care, end up going to EDs for otherwise preventable care.

In 2014, CMS awarded a Health Care Innovation grant to the Detroit Medical Center to embed primary care clinics within four major inner-city EDs.¹³⁶ The "Gateway to Health" program targeted Medicaid fee-for-service patients who utilized the ED five times or more annually. The program diverted these patients to a team to help them manage chronic conditions and schedule follow-up appointments at primary care clinics right next to the ED. From 2015 to 2017, Detroit Medical Center reported that the program enrolled 6,500 patients, who completed 16,000 outpatient primary care visits. Data also showed a 70% reduction in ED visits for the targeted population.¹³⁷ Though this pilot program ended after its three-year grant cycle, some large health systems in Detroit continue to offer easily accessible primary care services, with some even providing same-day appointments.¹³⁸

3. Removing Structural Barriers to Primary Care

Lack of Transportation Is One of the Key Barriers to Primary Care Access in Detroit

Many low-income residents of Detroit rely on the city's public transportation system.¹³⁹ According to a 2018 survey, Detroit's Black residents make up 86% of its public transportation ridership,¹⁴⁰ and several reports have found that the system is highly unreliable.¹⁴¹ Further, a 2019 study found that Black users of Detroit public transportation spent an average of 23% of their income on transit, compared with the 12% spent by the city's white residents.¹⁴² These are symptoms of long-term underinvestment in the city's public transportation system and an important contributor to racial inequity. Reports show that Detroit falls below almost all other U.S. cities in terms of how much the city spends on public transit.¹⁴³ Multiple stakeholders emphasized that lack of access to affordable and reliable transportation is one of the biggest barriers to accessing primary care in Detroit.

Clinicians also expressed frustration with Medicaid's non-emergency medical transport (NEMT) benefit, which is specifically intended to help get people to their health care ap-

pointments. Clinicians described the service as “very spotty,” with scheduled pickup times sometimes being several hours ahead of the appointment time or vans arriving hours after the scheduled pickup time. Another barrier to utilizing the NEMT benefit is the way it conflicts with childcare needs. Clinicians pointed out that the NEMT services sometimes prohibit children of enrollees to join them for the ride. One clinician attributed these limitations to low Medicaid reimbursement for these services and the fact that NEMT service providers are frequently “inundated” with service requests.

In response, several providers have taken it upon themselves to fill the gaps where they can. One clinician said that their clinic provides Lyft rides to patients at no cost to them. Another clinician said that their health center (like a few others in the city) operates its own van and that the demand is very high for the service. Both clinicians said that these services are funded through the clinic or health center’s core funding and that they do not currently seek reimbursement from public or private payers for these services.

Local Program Highlights: Wayne Health Mobile Unit

The Wayne Health Mobile Unit launched in 2019 to “meet the needs of as many people as possible in the least intrusive and barrier-free manner.” The program director said that the program is not only meant to offer easy access but also to allow patients to feel more comfortable because mobile health allows them to receive services within their own communities. The unit currently operates eight vans and employs a team of almost 100 people, including patient service representatives, medical assistants, community health workers, and nurses. Together, they provide a variety of screening and preventive services such as measuring blood pressure, drawing blood for lab work, and providing COVID-19 testing and vaccination. Patients do not need an appointment or insurance to receive services. Since the program’s launch, the units have logged more than 82,000 encounters with more than 56,000 patients. The program has conducted significant marketing and outreach with community organizations and church groups to develop a presence and build trust.

To determine how to best deploy its fleet, the program relies on an information exchange system that identifies “hotspots” for cardiovascular and other chronic disease risks. The system incorporates multiple data sources including data on 2 million emergency room visits and data on social vulnerability, such as low life expectancy, low high school graduation rates, significant income disparity, and historic redlining. This mapping work began in 2015 and was incorporated into the mobile health strategy when it launched in 2019. When COVID-19 hit, the program was well situated to layer on COVID-related data to best understand which communities would be at the highest risk and face the worst outcomes.

According to the program’s director, 40% of Medicaid managed care organization (MCO) clients do not utilize health care services, and that the program is working on ways to target these communities of people who underutilize services to bring preventive care to them. One barrier has been the unit’s inability to bill for preventive services when a patient has already been assigned another primary care provider through their MCO, frequently without the patient’s knowledge. The program is working with the state Medicaid agency to change this.

Currently, the program is funded through grants and philanthropic dollars, but the unit staff are working with MCOs as well as employers to develop a sustainable financial strategy. Going forward, the program staff intend to establish a base screening fee with specific add-on charges when a patient ends up needing medical and/or social services. The director said that employers also have a lot to gain from a mobile unit visiting their sites, such as decreased absenteeism, and the employees benefit by not having to take half a day off for care. Program staff is working on making this business case to employers.

COVID-19 Flexibilities Have Highlighted the Possibilities of Audio-Only Telehealth

Given the transportation barriers the residents of Detroit face, telehealth offers one alternative avenue for patients to access primary care. Some clinicians were specifically enthusiastic about the possibilities of expanding access through audio-only telehealth, which eliminates the need for a smartphone or broadband internet. As one clinician put it, “we can often get a person in an audio-only telehealth encounter that maybe we wouldn’t be able to get back into the health center for a very long time because [they are dealing with] transportation issues, challenging child care issues, [and managing their work schedules].”

The COVID-19 pandemic brought flexibility by allowing reimbursement for audio-only telehealth, but one provider noted that since this flexibility was set to expire at the end of the public health emergency period, it had been challenging to make long-term plans incorporating audio-only telehealth. (Since the time of that interview, Congress enacted the Consolidated Appropriations Act, 2023, which extended these telehealth flexibilities to the end of 2024 regardless of the status of the public health emergency period.) One payer told us about a telehealth payer policy group that has been convening payers on a monthly basis to discuss the most effective ways to deliver and pay for telehealth, especially once the pandemic ends.

Walk-In and After-Hours Appointments Are Critical for Improving Access

Several clinicians found that the inability to get a timely primary care appointment is a consistent barrier to access. One clinician said that they are “very, very busy” and that “it is hard to get [patients] in to see [them].” Patients frequently struggle to get someone on the phone, let alone find an appointment. Even when they are able to schedule an appointment, they often have to wait three to four months. Evidence suggests that walk-in options can help improve access to care,¹⁴⁴ and one provider advocate generally concurred based on what they hear from the providers they represent.

In addition to having same-day and walk-in appointment availability, several primary care clinics in the city have expanded their hours to see patients outside of traditional business hours. One stakeholder familiar with the community health centers in the state said that most of them offer some evening, early morning, or weekend hours. However, at least one provider found that they had to scale back their after-hours appointments because of a lack of demand.

4. Making Primary Care More Affordable

Studies show that some Detroit residents with health insurance continue to find health care unaffordable because of high cost-sharing, particularly for prescription drugs. A 2018 University of Michigan study found that while only 8.7% of Detroit residents were uninsured that year, 11.8% of residents reported that they were unable to afford either a copayment or a prescription. In Detroit, one stakeholder highlighted the importance of keeping prescription drug costs manageable for low-income patients through the federal 340B program, which allows patients at one FQHC to obtain all their prescriptions at the clinic for less than \$10. One longtime provider in the area said that while Medicaid expansion resulted in an uptick in patient visits, they have not seen nearly the level of increase in utilization they would have expected, and that these barriers might be the reason why.

Several providers also expressed concern about the lack of health insurance coverage options for Detroit's growing immigrant population. One FQHC director lamented that the patient uninsurance rate at a health center located in a predominantly immigrant community "probably won't get much lower" than 50%. Detroit residents lacking health insurance face greater affordability barriers, with 20.9% of uninsured Detroit residents saying that they had been unable to afford care over a 12-month period.¹⁴⁵ The uninsured group was also disproportionately likely to utilize the ED as a typical source of care.¹⁴⁶

In addition to limits on insurance eligibility based on immigration status, providers described how other Detroit residents may "fall through the cracks" because they have income slightly above Medicaid's upper eligibility limit (133% of the federal poverty level). Though many members of this group may be eligible for subsidized coverage through the health insurance marketplace, stakeholders involved in enrollment assistance have found that many patients do not prioritize signing up for health insurance.

5. Improving Comfort and Communication between Providers and Patients

Recent State Investments in Community Health Workers Could Help Expand the Reach of Primary Care Providers into High-Needs Communities

A community health worker (CHW) is a "frontline public health worker who is a trusted member of, and or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison to, link to, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."¹⁴⁷ Evidence links CHWs to improved health outcomes, increased trust between patients and providers, and reduced costs.¹⁴⁸ Michigan has an estimated 1,600 CHWs,¹⁴⁹ and over 600 of them work in the Detroit metropolitan area.¹⁵⁰ An advocate for CHWs told us that the COVID-19 pandemic "increased the demand" for CHWs in the state because of their ability to connect "hard-to-reach populations" to resources.

While Michigan does not regulate the training or certification of CHWs, the state's CHW association, MiCHWA, has stepped in to establish a curriculum, offer certification, and maintain a registry of certified CHWs. A CHW advocate told us that often CHWs receive their certification after they have already been hired, and frequently their employers pay for them to receive this training. The state has, however, been proactive in supporting CHWs in other ways. First, the state included CHWs in its State Innovation Models initiative by incorporating them into primary care offices. Many were tasked with helping patients navigate issues related to social determinants of health. A CHW advocate claimed that this model was so successful that even once it ended, several primary care organizations chose to maintain their CHWs. Second, Michigan Medicaid requires its MCOs to either hire CHWs or partner with a community-based organization to provide CHW support to their members. MCOs must make one CHW available per 5,000 members, and while this is an improvement over the past requirement of one CHW per 20,000 members, a CHW advocate still described this new ratio as "ridiculous."

Michigan Medicaid's CHW requirement for MCOs does not mandate specific levels of reimbursement. Currently, CHWs in Michigan are not allowed to bill for their services, but several stakeholders informed us that this will be changing soon. Recently, the Michigan legislature enacted a bill requiring the state to seek federal authority to enroll CHWs as providers, and allocated \$28.3 million for Medicaid reimbursement of CHWs for FY 2023.¹⁵¹ In 2023, Michigan will join the nine states that currently authorize payment for CHW services under the Medicaid state plan and add CHW services as a covered benefit.¹⁵² Several clinicians we spoke to, particularly at safety net sites, ardently supported allowing CHWs to bill for services. Many of them currently hire CHWs through a patchwork of grants, which sometimes tend to be tied to specific diseases instead of allowing CHWs to broadly support primary care practices. At least one provider has recognized the value of CHWs and added their salaries to their operating budget, but allowing reimbursement for CHW services will allow more providers to follow suit.

CHW advocates credited the significant number of studies in Michigan and Detroit, many of them conducted by the University of Michigan,¹⁵³ demonstrating the ability of CHWs to generate cost savings as being instrumental in convincing legislators to devote more funding to these frontline workers.

Providers Highlight the Importance of Providing Culturally Responsive Care

Several stakeholders indicated that there is significant mistrust between communities of color and primary care providers in Detroit, and for good reason. For example, one clinic director reported that the majority of Black women they see have experienced discrimination while receiving prenatal care and during their delivery process. The clinical director emphasized the importance of patients having access to a clinician who understands their culture and lived experience, and said that they have been "very intentional in hiring." The clinic's two primary care clinicians are both "Black women who were born and raised in Detroit." The director noted that this hiring choice has positively impacted their patients' care experience. A manager of safety net clinics in the city found that creating a "community advisory committee," in which stakeholders discuss how to conduct community outreach in a culturally responsive manner, has also proven valuable.

Stakeholders also spoke of the importance of reducing language barriers between patients and primary care providers. One FQHC provider said that a majority of the clinic's staff is fluent in Spanish to ensure better communication with their patients, who are predominantly native Spanish speakers. This staffing decision has helped improve their patients' ability to comfortably communicate with their clinicians. According to one medical school professor, Detroit's next challenge is finding interpreters for Detroit's increasing number of refugees who speak languages that, unlike Spanish, are not common in the Detroit area. The professor noted that since interpretation services are expensive and insurance companies do not take interpretation service costs into consideration when determining reimbursement rates, providers are finding it difficult to provide these services to certain refugee populations.

6. Building a Local Table to Plan for Population Health and Primary Care Needs

Several providers and researchers advocated for the importance of having a central convener to bring together providers, community organizations, state and local government officials, patient representatives, and payers to plan for the city's population health and primary care needs. Multiple stakeholders spoke of efforts in the past to pull such a local table together. We heard of monthly meetings of local FQHC directors; pre-ACA collaborations between hospital systems, FQHCs, and community organizations; and a group of providers meeting to discuss access to reproductive care. However, stakeholders found that these efforts have either ended or been limited in scope. According to one local clinician, "there's a lot of people doing incredible work in Detroit, but [their work] is siloed and [they] are [often] fighting for the same resources."

One state-level researcher said that the Detroit Health Department could be the right fit for the role of convener, but given the "massive blow or series of crippling blows" the department has experienced over the years, it will take "a lot of time to rebuild the proper bridges and connections." Multiple stakeholders also worried about the constant turnover or "revolving door" in the department's staff, making it harder to pull off large-scale projects. However, those familiar with the local public health landscape find that if the Detroit Health Department "created a space" and "prioritized this [work] as something that is important," they might still be able to develop the infrastructure for citywide collaboration.

CONCLUSION

Detroit is a majority-minority urban city with a diminishing population that has experienced several setbacks in the recent past, including bankruptcy and disinvestment in public health services. Even as the local health department has started rebuilding its capacity, a lot of the city's primary care resources remain siloed. The city's major health systems, FQHCs, and other safety net clinics work hard to make primary care more accessible to low-income populations of Detroit, but gaps persist.

State and local governments and providers have done many things right to improve access to primary care for underserved populations. For example, state and local governments have embarked on ambitious efforts to increase the number of primary care residency spots in the city, while prioritizing diversity in their resident classes. Many stakeholders remain hopeful that these efforts will increase the availability of primary care providers serving underserved populations in the city. Michigan's recent decision to significantly increase investment in the SBHC model has the potential to increase the number of primary care access points in the city. A local provider's recent deployment of a sophisticated mobile health strategy has been a promising development in Detroit and has the potential to mitigate several barriers to primary care that underresourced communities in the city face. The state's decision to expand Medicaid has helped remove some financial barriers to accessing primary care. Michigan has also been a leader among states in its support of its CHW workforce. Allowing CHWs to seek reimbursement will likely increase the number of CHWs in the city. Aside from employing CHWs, a number of the city's safety net providers have also increased the diversity of their clinicians and are working on providing culturally competent care to build trust with the communities they serve.

Some efforts are not necessarily making the expected impact on access to primary care for the underserved populations in Detroit. State-run workforce development programs targeting newly minted physicians have had mixed success in retaining primary care providers in Detroit, with the J-1 visa waiver program demonstrating more success than the state's loan repayment program.

Finally, the lack of state and local investment or action in some key areas has hindered efforts to improve access. For example, the lack of state investment in MI-AHEC and its efforts to improve the diversity and size of its health care workforce by conducting outreach to K-12 students remains a missed opportunity. FQHCs are a key source of care for underserved populations, but lack of sufficient state funding might be holding them back from further expanding their reach in the city. The automobile-centric history of Detroit and underinvestment in its public transportation system has made the city's transportation services unreliable and unaffordable for many low-income Detroiters who rely on those services. Further, the lack of broader planning by the local government has prevented siloed provider and community efforts from achieving their full potential. Creating and sustaining a space for local providers, public health officials, and patient advocates to coordinate and plan for population health and primary care goals on a citywide basis could help leverage all available resources to improve access to primary care for underserved populations.

NOTES

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