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Descriptive Report

Chicago's South Side Free Clinic

A Medical Student-led Initiative and Community-Focused Effort to Re-engage Residents with Healthcare

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Abstract

Student-run free clinics (SRFCs) can provide primary care options for historically underserved communities. Chicago's South Side is a predominantly African American community with poor access to medical care. Previously, SRFCs did not service this patient population. The South Side Free Clinic (SSFC) is a SRFC founded to establish sustainable health services directed by community organizations and stakeholders. University of Chicago Pritzker School of Medicine student leaders conducted a clinical needs assessment (CNA) identifying healthcare barriers. Through this community-focused approach and an interdisciplinary partnership, the SSFC aimed to rebuild medical trust, to increase healthcare access, and to address health disparities. Between April-August 2022, 115 CNA responses were collected (South Side residents: 61% (70/115) versus non-South Side residents: 39% (45/115). Sixty-four percent (45/70) of South Side respondents stated they could afford their health insurance, however 72% (34/45) of respondents living outside of the South Side could not. The majority, 67% (77/115) of participants, reported that they would attend a SRFC. Since opening, the clinic has provided general medical check-ups, over-the-counter medications, point-of-care testing, routine access to primary care physicians, and preventive health services. Patient feedback, long-term surveillance, workflow efficacy tracking, and quality improvement metrics will help assess the South Side's healthcare needs and identify future clinic service requirements. Ultimately, the SSFC will highlight and address the health care disparities impacting disadvantaged communities in Chicago's South Side.

Introduction

Medical student-run free clinics (SRFCs) have served as a primary care option for historically underserved communities while simultaneously playing a critical role in medical education.[1] Through multidisciplinary and interprofessional opportunities SRFCs provide medical students the opportunity to refine clinical skills, engage in community outreach, and advocate for public health initiatives.[2] For community members, SRFCs act as a safety-net option, providing wellness visits, vaccinations, chronic disease management, and repatriating patients into the healthcare system.[3] Moreover, SRFC primary care services have been shown to reduce emergency and urgent care service utilization.[4]

Chicago's South Side is a racially homogeneous, medically underserved patient population with decreased access to healthcare, higher rates of chronic diseases, and increased mortality compared to other areas of the city and some regions of the United States.[5] Several primarily Black,

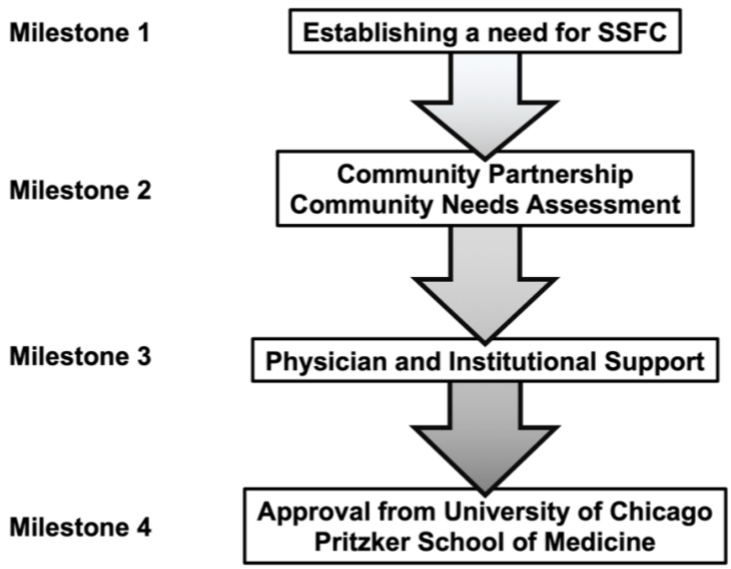
South Side neighborhoods have a life expectancy 15 years less than predominantly Caucasian areas within the city.[6] Additionally, the median household income on the South Side is substantially lower than the city average, with many residents living below the federal poverty line. In contrast, neighborhoods located north of downtown Chicago benefit from greater economic prosperity, better-funded public services, and higher educational attainment.[7] These profound inequities are the legacy of structural racism including residential racial segregation, community disinvestment, and an insufficient tax base to support essential infrastructure like public education, healthcare, and commerce.[7] Community organizations and academic institutions have worked to develop innovative programs addressing these disparities.

Recognizing the South Side's historical context, the University of Chicago Pritzker School of Medicine (PSOM) students led an initiative to develop a free clinic to serve its adult population. In this report, we outline the steps taken to identify our strategically located facility and to provide the needed health care services.

Establishing the South Side Free Clinic

The SSFC initiative's purpose was to establish sustainable community-directed health services. To ensure the SSFC adequately met and served the community's short- and long-term health care needs, we sequentially outlined several milestones (Figure 1). Many of these milestones mirrored other established student-run clinics at PSOM. Additionally, regional initiatives, such as the Chicagoland Free Clinics Consortium (CFCC), which brings together SRFCs from the six medical schools in the Chicagoland area, have offered valuable opportunities to shape our model based on the experiences of others in the metropolitan region.[8] Completion of each milestone ensured we followed a robust methodology toward the clinic's successfully development.

Figure 1. South Side Free Clinic developmental milestones



Describing Community Health Status

Characterizing Chicago's South Side's chronic disease burden was the first milestone. Publicly available 2021-2022 Chicago Health Atlas data was utilized to build and stratify neighborhoods' health profiles according to disease prevalence and medical services access.[6] These profiles revealed significant variations in health outcomes, emphasizing the geographic health disparities still prominent in the city. For example, when comparing Englewood, a South Side neighborhood, to the Loop, the downtown neighborhood, there were higher rates of hypertension (50% vs. 18%), obesity (48% vs. 21%), diabetes (12% vs. 2%), and asthma (17% vs. 3%) amongst the South Side adults.[6]

Developing Community Partnerships: Project Helping Others Obtain Destiny (H.O.O.D.)

The second milestone was establishing community relations by connecting with local leaders and creating partnerships with their affiliate organizations. Criteria for community partner selection included: mission alignment, community influence, and proximity to the medical campus (Table 1). A partnership was ultimately developed with Project H.O.O.D., a non-profit organization that works within the South Side community to reduce poverty, community violence, and incarceration. It also helps build infrastructure and resources to enhance positive life opportunities for community residents (e.g., education, employment). Located just 1.5 miles south of our institution's trauma center, and in the center of one of Chicago's most violent streets, also known as 'O-Block', Project H.O.O.D. has established itself as a safe space and mentorship resource for neighborhood members who have been impacted by community violence. In addition, Project H.O.O.D., and its affiliated faith-based entity, New Beginnings Church, have collaborated on several health-related initiatives such as the South Side Diabetes Project (SSDP). Through the SSDP, it served as a site for the Community Fitness

Table 1. Community partner selection criteria

Criteria	Description
1. Community Outreach	• Has the community partner had a measurable impact on the community through current outreach and advocacy efforts? • What resources are already offered to the community through the potential community partner? • Would a SRFC be able to leverage community relationships and serve as a partner for existing initiatives?
2. Mission	• Do the community partner's and SRFC's missions align?
3. Physical Space for a SRFC	• Does the community partner have access to a physical space or have a plan to build space to host the clinic?
4. Funding	• Can the community partner financially support the SRFC's startup costs? • Is the community partner willing to financially support the SRFC's longitudinal costs?
5. Existing Institutional Relationship	• Does the community partner currently collaborate with the SRFC's parent institution
6. Geographic Location	• Is the community partner located in an area that serves the SRFC's target patient population? • Is the community partner's geographic location proximal to the SRFC's parent institution?
7. Ancillary Support	• Does the community partner have the personnel and resources to support the SRFC?

Passport Program (a program to enhance physical activity among South Side residents with chronic disease), the Diabetes Empowerment Program (a socioculturally tailored diabetes education program), and other health-promoting activities.[9,10] Project H.O.O.D. has also been the primary sponsor of health-related events such as community health fairs, COVID-19 vaccine canvasing, and fitness programs within the community. The SSFC/Project H.O.O.D. collaboration has allowed the medical team to utilize an established and trusted community institution to help identify and recruit potential patients, offering a trusted physical place for individuals to reconnect with healthcare. This collaboration has also allowed Project H.O.O.D. to expand the range of service offerings to the community to include primary health care for the uninsured and underinsured. This partnership will also advance the University of Chicago Medicine's mission to address healthcare disparities and to engage with its surrounding community.

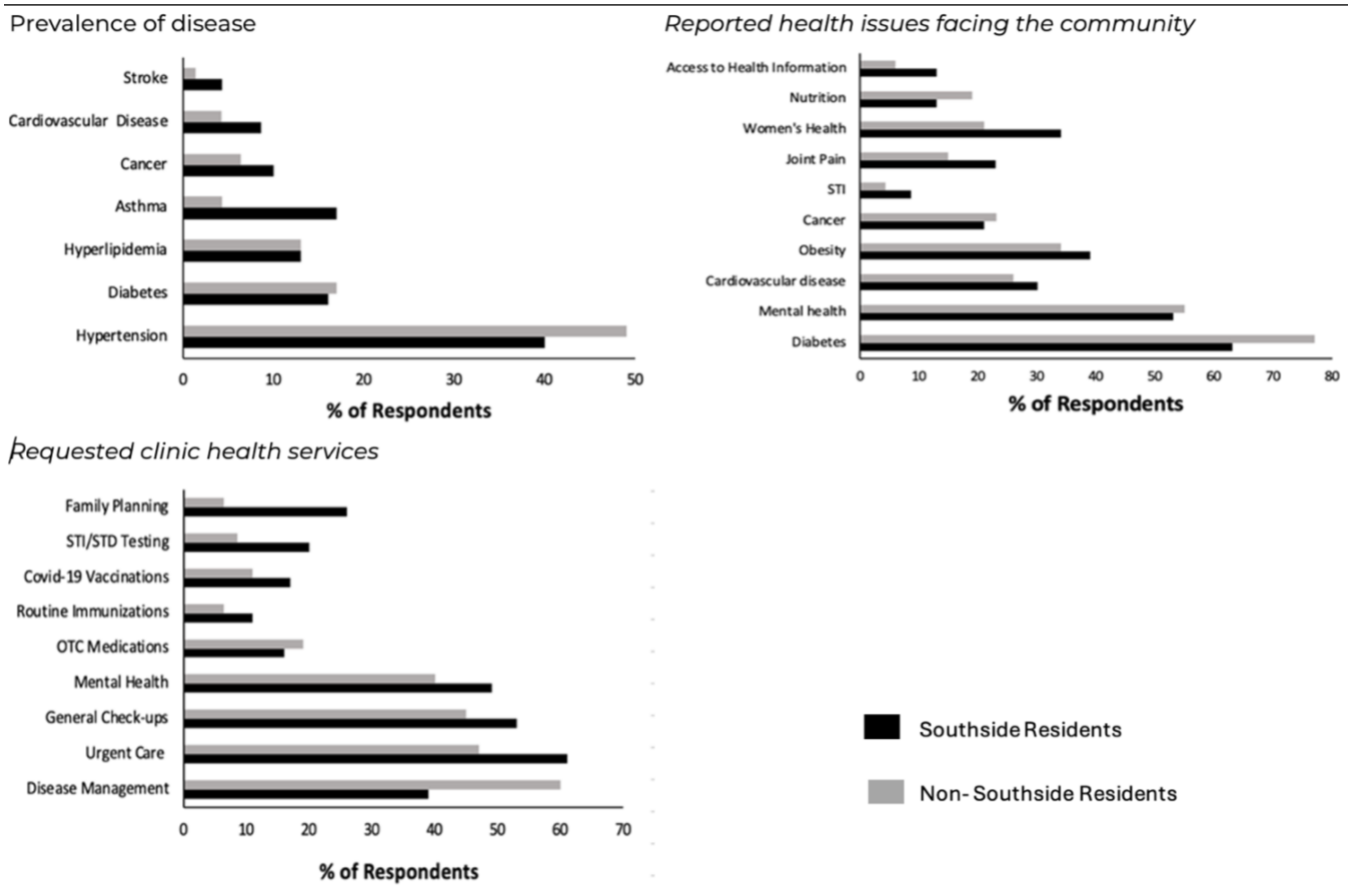
Identifying Community Health Needs

Despite the innate utility of CNAs in SRFC developments, there has been very limited research published within this area. One study that reviewed systematic usage of CNAs in SRFCs found less than three published studies that conducted needs assessments by directly going into neighborhoods and community spaces.[11] Moreover, in Southside communities of Chicago, there has been no published literature discussing the scope of care for a new SRFC. Therefore, to further characterize the community's medical needs, we developed a survey to assess self-reported healthcare needs within the community, which queried barriers and preferences for care delivery. The results helped determine the scope of SSFC's services.[12]

The survey structure was modeled after the Chicago Health Atlases published by the Chicago Department of Public Health.[6] Its development followed an iterative process, incorporating insights from University of Chicago Medicine (UCM) physicians, feedback from our community partner, and experiences gained through community engagement activities such as volunteering at local health fairs and participating in church services and prayer groups. The survey was first piloted with a small subgroup of patients to gather feedback on its structure and wording, ensuring clarity and accessibility for all respondents. During Project H.O.O.D. public events and local community health fairs, the finalized survey was administered through an in-person handout and in an electronic form through Quick Response (QR)-coded flyers. Participants were informed about the study's purpose, and verbal consent was obtained. Participation was voluntary, and individuals could withdraw at any time while completing the survey. Information collected included: sociodemographic information (i.e., age, race/ethnicity, level of education, zip code, and employment), self-reported chronic diseases (i.e., hypertension, diabetes, dyslipidemia, cancer, stroke, asthma, and coronary artery disease), access to healthcare (including having a primary care physician), perceived community health needs (i.e., women's health, gun violence prevention, mental health), and willingness to attend a free clinic sponsored by PSOM and Project H.O.O.D. To ensure confidentiality, all survey responses were anonymized, and data were stored on password-protected divisional data serves in a secure location. This study was approved by the University of Chicago's Institutional Review Board.

The community needs assessment was conducted from April to August 2022. The majority of respondents, 61% (70/115), lived in neighborhoods within the South Side. The remainder, 39% (45/115) resided in the South or Southwest suburbs of Cook County (Appendix A). Nearly all respondents had health insurance (South Side: 94% (66/70) vs. Other: 96% (43/45)). However, fewer South Side residents reported that they could afford insurance as compared to those who lived outside the South Side (South Side: 64% (45/70) vs. Other: 72% (34/40)). More South Side residents experienced barriers to medical care and reported using the Emergency Department (Appendix B). The most reported barrier to receiving medical treatment was long appointment wait times. Hypertension and diabetes were the most frequently reported chronic ailments (Figure 2). The most important health issues impacting the community were reported as diabetes, mental health, and obesity. When asked which services

Figure 2. Survey respondents' health profile



COVID-19: coronavirus disease 2019; STI: sexually transmitted infection; STD: sexually transmitted disease; OTC: over-the-counter

would be most beneficial at a SRFC, South Side residents ranked urgent care services, general check-ups, and mental health/wellness services the highest while non-South Side residents ranked disease consultations, urgent care services, and general check-ups. Sixty-seven percent (n=77) of survey participants reported that they would attend a SRFC created by PSOM students.

Institutional and Physician Support

Along with a sustainable community partnership, the third milestone of SSFC's successful establishment relied on the PSOM administrators and physicians' commitment. A faculty advisory board composed of 8 physicians was established. The Board, which was selected based on community involvement and experience, acted in a managerial capacity meeting quarterly with students, volunteering in the clinic 2-3 times a year, helping with the recruitment of other physician volunteers, and providing clinic services and operations consultations. Our recruitment goal was to build a physician volunteer workforce that would guarantee at least one clinic day per month during the 2022-2023 inaugural year. The completion of all milestones led to the SSFC receiving approval and internal financial support from the University of Chicago.

Overview of Clinic Model

The SSFC has provided PSOM students with an excellent opportunity to develop leadership skills. In our model, a student executive board is responsible for clinic administration, liaising with community partners, and ensuring adequate supplies and staffing. Similar to other SRFC models, student volunteers conduct patient interviews, measure vital signs and administer appropriate examinations and screening tests under the guidance of UCM physicians.[1] Referrals to the Federally Qualified Health Center (FQHC), Friend Health, are made to fulfill patients' unmet needs. SSFC refers patients at the end of clinic days and works with Friend Health to schedule patients within two weeks of clinic date. Friend Health patients are eligible for comprehensive care based on sliding payment scales. This referral system remains an integral component in the SSFC clinic model. Since opening, the SSFC has supported a monthly 4-hour clinic day. With increasing demand and resources, the SSFC may expand clinic offerings and increase the frequency of service days.

Current and Future Measures

Based on the CNA, institutional guidance, and the current workflow capacity, the clinic has provided general check-ups, over-the-counter medications, and point-of-care testing (diagnostic tests conducted at the site of patient care) that includes urinalyses, and blood glucose, pregnancy, Streptococcus A and B, and influenza testing. The management of chronic diseases such as diabetes was delayed for a later phase. Delaying such complex services has allowed us to establish and refine the clinic's foundational operations. To advance the clinic's services, we have implemented ongoing quality improvement (QI) efforts and identified operational gaps. Our team has already anticipated challenges such as shortages in physician and student volunteers, limited financial resources, and disruptions in clinic operations due to frequent leadership changes and a lack of student expertise in clinic administration.[1] By using regular patient feedback surveys, monitoring workflow efficiency, and tracking metrics from our intake and scheduling systems for both patients and volunteers, we aim to continuously improve existing services and expand to meet additional community needs.

Clinic Challenges and Limitations

The first year of clinic operations came with some unforeseen challenges. During the planning year, it was assumed that most patients seen at the clinic would come from Project H.O.O.D.'s client base and outreach activities. However, it has been difficult maintaining a consistent patient census for each clinic day. We inferred this might be due to the clinic's newness clinic and the community not being aware of its presence or services. In an effort to address this, the board has focused on doing more outreach in the community, such as tabling at local grocery stores, participating in resource fairs hosted by community organizations, and holding blood pressure and blood glucose screening events. In the coming year, we also plan to expand our social media presence and do more canvasing in the surrounding neighborhoods of Woodlawn and Englewood.

Selection bias and generalizability challenges are limitations to the community needs assessment survey. Many of the respondents were members of New Beginnings Church, which may mean the results do not fully represent the needs of the broader Woodlawn and Englewood communities. Furthermore, community needs are dynamic and can evolve over time due to various factors.

Next Steps

The desire to care for Chicago's South Side's underserved population has culminated in the SSFC's establishment. The initial responses have been favorable, and the clinic continues to deliver

the anticipated level of health care. Through our initial QI measures and community leader meetings, mental health and violence recovery services are two highlighted needs. As the clinic expands, these shortfalls will be addressed through future partnership with UCM physicians and ancillary services.

In summary, the development of SSFC has been a strategic initiative aimed at providing socio-culturally tailored care by physicians and medical students who are invested in the needs and growth of the community. The efforts taken to develop SSFC has enriched our medical education by giving us the opportunity to interface with the local community, better understand the role of social determinants of health and overall achieve the primary goal of serving as future physician advocates. With the networks of community partnerships and institutional support of PSOM, SSFC has built the agency to provide a safe space for healthcare delivery, and augment institutional health system improvement.

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