THANK YOU

Your partnership with Rosalind Franklin University transforms healthcare education, discovers new knowledge and improves the health and wellness of our communities.
IDEALS ARE LIKE THE STARS: WE NEVER REACH THEM, BUT LIKE THE MARINERS OF THE SEA, WE CHART OUR COURSE BY THEM.

CARL SCHURZ
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AIM HIGHER

Rosalind Franklin University has been setting the standard for the alignment of health professions education with national goals for improving care since our founding in 1912 as a medical school determined to make the profession more inclusive of practitioners from diverse ethnic, racial and socioeconomic backgrounds.

Our aim, from bench to bedside, is to educate professionals who can help solve society’s biggest health challenges. We were an early adopter of the forward-thinking models of interprofessional education, team-based care and collaborative practice, which put us years ahead of the curve in adapting to the recommendations of the Institute for Healthcare Improvement’s Triple Aim for health system optimization developed in 2007. We continue to make strong investments in community outreach, partnering across sectors to increase access to care for the underserved and improve the health of populations and community well-being. We strive to educate practitioners and scientists who practice population-based health approaches to clinical care and research.

Over the next decade, we will focus on meeting the needs of our society by advancing the team approach to health care and pursuing innovation and leadership in education, research and community engagement. We are committed to creating the resources that can support our aspirations, which are grounded in our understanding of access to the highest standard of health care as a fundamental human right.

To that end, we’re accelerating and honing our efforts under the expanded Quadruple Aim of Health Care, which acknowledges the inherent pressures and challenges involved in the achievement of ambitious goals for healthcare reform. The fourth aim, improved practitioner and care team well-being, goes to the heart of our work in the education and formation of future health professionals. It speaks to our ability to achieve each of the other three aims: improved health of populations, improved individual experience of care and reduction in the per capita cost of care.

The arc of the Quadruple Aim bends to a new understanding of health and wellness, to continuous healing relationships. We are training clinicians and scientists who will go beyond the treatment of disease to high-quality primary care and discoveries that prevent disease. Our graduates will work to promote health equity and wellness and encourage patients to manage their own health through lifestyle changes and healthy behaviors. To succeed, they must prioritize human connection and practice with compassion, which forms the foundation for both the healing relationship and the collaborative care team. RFU is putting renewed effort into teaching the skills of caring — communication, empathy, shared decision-making and team-building — because our experience and the evidence clearly demonstrate that these skills allow us to deliver better care with better outcomes at lower costs.

Our students also need to understand systems of care so that they can lead innovations in healthcare delivery and health promotion, including new payment models, new approaches to ending health inequities, to preventing and blunting the effects of adverse childhood experiences and to the design of population- and community-wide strategies that reckon with the social determinants of health.

There have never been greater expectations — or opportunities — for crossing our nation’s quality chasm. RFU is committed to modeling interprofessionalism, compassion and clinical and biomedical excellence that combined can heal that chasm and create a new future of health.
“...WE ARE MOLDING OUR CURRICULUM TO MORE DEEPLY REFLECT THE HUMANISTIC ASPECTS OF CARE, LIKE COLLABORATION, COMPASSION AND WELLNESS.”
AIMING FOR A FUTURE OF HEALTH AND WELLNESS

RFU’s mission to educate, discover and serve is inextricably bound to the ever-evolving healthcare environment. Across generations, new discoveries and technologies change the way health care is delivered and increase patient expectations for the care they receive. Those changes, which aim to make health care safer, more affordable, efficient and effective, grow from the shared knowledge and discovery seeded by institutions of higher learning.

At RFU, our academic excellence and student achievement, curricular innovations and investment in research are not only crucial to our institutional well-being, they are key to the national effort to improve the delivery of care. And so we plan our future path with great deliberation and in alignment with national goals for improving health. As health care has a Quadruple Aim, so does higher education. The success of both aims is closely correlated.

The Quadruple Aim of Higher Education serves as our framework for improving admissions goals, student achievement, employee and student experience, and the affordability of the education we offer. Guided by this framework, our strategic actions and investments help move the needle forward on care that is evidence- and outcome-based, more accessible, better coordinated and more responsive to our patients.

For example, interprofessional education (IP) and its translation by our students, faculty and alumni into IP collaborative practice is helping to deliver better, safer, more affordable care that is more satisfying to patients and practitioners. We’re providing numerous on-campus IP clinical learning environments, including the student-driven Interprofessional Community Clinic for the uninsured, which serves our community while also supporting classroom learning. We are committed to the development of more sustainable IP clinical rotations at partner sites supportive of our approach.

As technology, including the addition of more artificial intelligence (AI) and robotics, continues to change care delivery, we are molding our curriculum to more deeply reflect the humanistic aspects of care, like collaboration, compassion and wellness. Our educational offerings will further reflect our values through a focus on the art of caring, the science of systems of care and lifestyle medicine, which together create a powerful antidote to the dramatic rise in lifestyle-related chronic diseases that cause untold suffering and inflate costs.

We are determined to build a learning community that reflects a concern for all constituents, including patients, students, faculty, staff and alumni through numerous other strategies that include: new academic partnerships that create learning pathways; scholarship that advances IP; industry partnerships through our Innovation and Research Park; advancement of our culture of philanthropy; cost-sharing with clinical partners; and assessment and accreditation practices that give us actionable data and maintain academic rigor.

What does success look like by the end of the next decade? It looks like a diverse community of students and faculty, learning and discovering in a financially supported environment on multiple fronts — campus, clinic, community, home — enriched by continual advancements in IP and simulation. An innovative and flexible curriculum, informed by the humanities and powered by technology and AI, will help our students and faculty dive more deeply into how IP and other models and strategies can help solve the current and looming challenges of care delivery.

Ultimately, our students are the measure of our success. We are teaching and showing them how to affect change. It’s our hope and expectation that they will go out into other clinical and community environments to apply what they have learned at RFU; that they will translate all the knowledge, care and concern they received here into better patient care and improved well-being.

Opposite page: Nancy L. Parsley, DPM, MHPE, provost
IT IS MORE IMPORTANT TO KNOW WHAT SORT OF PERSON HAS A DISEASE THAN TO KNOW WHAT SORT OF DISEASE A PERSON HAS.

HIPPOCRATES
The national and global movement to transform health and health care, now underway for two decades, is fueled by an expansive vision of health that looks beyond patient care, beyond systems, beyond the individual oath to do no harm. The need for health reform becomes more urgent, as populations at home and around the world confront a complex cascade of forces, including those that threaten their well-being: a dramatic rise in chronic diseases, including mental health, stress-related and substance use disorders; gun violence; persistent health inequities; and the many deadly impacts of climate change, including food insecurity, air and water pollution and other environmental degradations that cause forced migration and civil conflict.

Rosalind Franklin University is educating a future healthcare workforce that, despite national and global uncertainties, believes in the power of social responsibility to affect positive change. RFU-educated clinicians and scientists are grounded in the understanding that health is the product of a complex interplay of social determinants, including income, employment, education and physical environment — all often shaped, according to the World Health Organization (WHO), by “the distribution of money, power and resources at global, national and local levels.”

Research shows that social determinants influence more than 80 percent of health outcomes, while just 10 to 20 percent of those outcomes are related to health care and medical services. We are preparing, in collaboration with our many community and clinical partners, dedicated professionals who will use the Quadruple Aim as a roadmap in redefining health care as a lifelong quest for health and wellness. Our graduates are helping to propel a sea change from visit-based care and procedures to continuous healing relationships.

A focus on the health of populations is key to systemic change in healthcare delivery. Defined by health services researchers in 2003, the population health approach includes consideration and study of health outcomes and patterns of health determinants, in addition to interventions and policies that link the two. RFU identifies population health as the cornerstone of the Quadruple Aim that since its inception in 2007 has provided a system of linked goals for improvement initiatives aimed at better, safer, more affordable care. The aim’s central focus on the “population as a unit of concern” offers targets for measurement and accountability, health professions education and guidance on healthcare spending. It reveals the big picture of the continuum of health. A hard look at that picture is the first act of leadership and the first step in designing better, more coordinated systems of medical care and social services that help both populations and individuals live healthier lives.
RFU Trustee Lee Sacks, MD, retired chief medical officer of Advocate Aurora Health, was an early and nationally-recognized advocate of population health management strategies, including the targeting of high-risk groups, coordination of care, better management of disease and an emphasis on keeping people well. He also oversaw the hiring of community health workers to help address unmet social needs for vulnerable patients.

“We used to take care of one patient at a time,” Dr. Sacks said during a “Population Health Under the Microscope” symposium held at RFU in 2016. “We didn’t think about how we were doing with our other patients with diabetes. But now we’re tracking data and that changes everything. It allows us to see how well we’re controlling disease across a population, which helps us keep people out of acute care.”

“IF WE WANT TO KEEP PEOPLE WELL, WE HAVE TO WORK TOGETHER ACROSS A CONTINUUM TO PROVIDE VALUE-BASED HEALTH CARE, TO DELIVER THE BEST OUTCOMES AND THE BEST EXPERIENCE FOR OUR PATIENTS.”

Population health management continues to spread across the nation as the standard of care and as key to achievement of the Quadruple Aim.

“If we want to keep people well, we have to work together across a continuum to provide value-based health care, to deliver the best outcomes and the best experience for our patients,” Dr. Sacks said.

RFU’s 2019 commencement speaker, the crusading pediatrician Mona Hanna-Attisha, MD, MPH, is a model for practitioners who aim to reach beyond treatment to disease prevention, health promotion and the recognition that “Health is justice, especially for the youngest among us.” In 2015, Dr. Hanna-Attisha exposed a tainted water supply in Flint, MI. In her book, “What the Eyes Don’t See: A Story of Crisis, Resistance, and Hope in an American City,” Dr. Hanna-Attisha discusses a deeper understanding of the social determinants that include the life-threatening impact of “adverse childhood experiences” (ACEs) including poverty, racism and violence. Research shows, she says, that prolonged exposure to ACEs “activates stress hormones and reduces neural connections” in the brain during a vulnerable window of brain development.

“This new understanding of the health consequences of adverse experiences has changed how we practice medicine by broadening our field of vision — forcing us to see a child’s total environment as medical,” Dr. Hanna-Attisha writes. “We aren’t just looking at a child’s physical condition on the day of an exam or clinic visit. We are looking for the larger factors in the child’s world that can impede development and diminish an entire life — and may put her at risk as an adult for diabetes, heart disease or substance abuse.”

WHO has pushed the healthcare sector for more than a decade to embrace a “stewardship role” for health equity — “the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically, or by other means of stratification.”
RFU recognizes that health inequities pose a growing burden for populations, health systems and all stakeholders in a nation where 50.1 percent of the population under age 15 is non-white, according to a 2019 U.S. Census population estimate. We are committed to pipeline and pathway programs aimed at preparing a diverse healthcare workforce. By educating individuals who have been traditionally underrepresented in the health professions, we can expand perspectives, advance knowledge, increase access and help achieve health equity.

The country’s changing demographic calls for a proactive, health-equity approach for populations with above-average risk for chronic disease. RFU is modeling participation in highly-inclusive, multi-sector, community-based health initiatives, including Live Well Lake County.

Led by the Lake County Health Department and Community Health Center (LCHD), Live Well Lake County continually assesses the needs of communities across the county to understand, zip code by zip code, the scope and burden of disease in an attempt to coordinate the delivery of care and make data-informed decisions on funding and resource allocation. Live Well has prioritized prevention and intervention efforts aimed at chronic health issues, including cardiovascular disease and hypertension, obesity, behavioral health and diabetes. While those conditions harm health across the county, they affect low-income populations at a disproportionate rate. In RFU’s home community, North Chicago, 36 percent of residents struggle with obesity, while the disease affects just 12 percent of people just a few miles south in Lake Forest.

RFU works in support of Live Well’s Community Health Improvement Plan, offering health services and resources across its clinics and Community Care Connection mobile health vehicle. LCHD and RFU also collaborate through data and information-sharing that informs the university’s population health curriculum.

Improving the health of populations requires a reorientation in the skills, knowledge and experience of health professionals toward prevention, wellness and health literacy, and increased opportunities for interprofessional training. We’re working to align workforce needs by ensuring access to educational opportunities in the healthcare professions within our community and across our region through our lead partnership in the Health Professions Education Consortium.

RFU is committed to the education of professionals who understand that health goes beyond individual choice and access to medical care; that it requires intentional actions, including the creation of evidence-based policy, community-based solutions and cross-sector collaboration. Our collective health relies on our collective effort to see and understand the populations we serve.
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ALICE WALKER

LOOK CLOSELY AT THE PRESENT YOU ARE CONSTRUCTING: IT SHOULD LOOK LIKE THE FUTURE YOU ARE DREAMING.
RFU OBJECTIVE
LEARNING TO PRACTICE
POPULATION HEALTH

RFU's pro bono interprofessional Community Clinic (ICC) is an incubator for students who are interested in developing new and better processes of care in the service of vulnerable populations.

Initiated in 2013 by three Chicago Medical School students in response to a significant uninsured and underinsured local population, the ICC in 2018 served 136 patients, 64 percent of them Spanish speakers, across 549 clinical encounters that took place one night each week in the Rosalind Franklin University Health Clinics.

Interprofessional teams of student clinicians and supervising faculty give a level of attention to patients unseen in other student-driven health clinics. They work to understand their patient populations, the conditions in which they live, work and raise their families. They work to build rapport and trust. Writing a prescription or recommending a treatment option is only the beginning of care. Students learn how to discuss the reality behind the visit: Can patients pay for their medication? Do they have transportation to pick it up? Are they convinced of the need for it? Is there a plan for follow-up in case of issues?

Student clinicians continue to apply the knowledge they learned from local community health workers (CHWs) through the RFU-sponsored series of workshops and presentations, “Connecting our Comunidades: Latino Health and Culture.” Topics included barriers to care, delivering care in a culturally specific and sensitive manner, and how immigration policies affect health and health care.

ICC patients are often in what CHWs call “survival mode.” Many work two or three jobs, often part-time and seasonal, and live in households that fall below the poverty line. Health is not prioritized until problems become severe. It’s not uncommon to see men and women with untreated diabetes and its calling card: neuropathy and a foot ulcer. Patients who live in the shadows are suddenly front and center at the ICC during visits that average two hours and offer four co-located services — medicine, podiatric medicine, physical therapy and behavioral health — with additional consults available from pharmacy and nursing.

“As a group, all our knowledge is gathered together and we can act as one provider,” said Nicole Delino, SCPM ’22, president of the Interprofessional Clinic Initiative, the student organization that operates the ICC. “We really see how together we are so much stronger.”

Other ICC population health interventions include education in support of patient self-management and the cultivation of community and clinical partnerships to help meet patient needs for housing, food, legal assistance and more complex medical care.
PERCENTAGE OF U.S. ADULTS AGED 18 OR OLDER WITH DIAGNOSED DIABETES
by Racial and Ethnic Group, 2013-2015

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<th>Race/Ethnicity</th>
<th>2013-2015 Percentage</th>
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<tr>
<td>WHITE</td>
<td>7.4%</td>
</tr>
<tr>
<td>ASIAN/PACIFIC ISLANDER</td>
<td>8.0%</td>
</tr>
<tr>
<td>HISPANIC</td>
<td>12.7%</td>
</tr>
<tr>
<td>BLACK</td>
<td>12.1%</td>
</tr>
<tr>
<td>AMERICAN INDIAN/ALASKA NATIVE</td>
<td>15.1%</td>
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Source: The Centers for Disease Control and Prevention

AGE-ADJUSTED DEATH RATES
per 100,000 for Selected Diseases by Race/Ethnicity, 2014

- **Diabetes Death Rate**
  - WHITE: 19
  - ASIAN/PACIFIC ISLANDER: 15*<sup>1</sup>
  - HISPANIC: 25*<sup>1</sup>
  - BLACK: 38*<sup>1</sup>
  - AMERICAN INDIAN/ALASKA NATIVE: 41*<sup>1</sup>

- **Heart Disease Death Rate**
  - WHITE: 170
  - ASIAN/PACIFIC ISLANDER: 86*<sup>1</sup>
  - HISPANIC: 116*<sup>1</sup>
  - BLACK: 211*<sup>1</sup>
  - AMERICAN INDIAN/ALASKA NATIVE: 153*<sup>1</sup>

- **Cancer Death Rate**
  - WHITE: 171
  - ASIAN/PACIFIC ISLANDER: 103*<sup>1</sup>
  - HISPANIC: 115*<sup>1</sup>
  - BLACK: 194*<sup>1</sup>
  - AMERICAN INDIAN/ALASKA NATIVE: 141*<sup>1</sup>

* Indicates statistically significant difference from the White population at the p<0.05 level.

Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data for Native Hawaiians and Other Pacific Islanders were not separated from Asians. Data for some groups should be interpreted with caution; see http://wonder.cdc.gov/wonder/help/ucd.html#Racial. Source: Centers for Disease Control and Prevention, National Center for Health Statistics, WONDER Online Database, Underlying Cause of Death, 2014.


55% OF THE 32.3 MILLION NON-ELDERLY UNINSURED ARE PEOPLE OF COLOR

Source: Kaiser Family Foundation
RFU OBJECTIVE DATA POINTS

ICC CLINIC VOLUNTEERS

40 CLINICIANS
500 STUDENTS

ICC STUDENT PARTICIPANTS
in 2018

33% Allopathic Medicine
28% Physical Therapy
14% Podiatric Medicine
12% Pharmacy
6% Physician Assistant
4% Psychology
3% Nursing

TOTAL PATIENT ENCOUNTERS/
MOST COMMON DIAGNOSES

41.2% (435) Allopathic Medicine
(hypertension, Type 2 diabetes,
dyslipidemia, preventive medicine)

36% (380) Physical Therapy
(low back pain, shoulder pain, ankle
and knee pain)

15.4% (162) Podiatric Medicine
(onychomycosis, tinea pedis, foot pain,
plantar fasciitis)

7.4% (78) Behavioral Health
(anxiety, depression, lifestyle changes,
PTSD)

Note: Interprofessional Community Clinic 2016–2018, 100 service days
Source: EMR data and records maintained by the Interprofessional Clinic Initiative

ICC PATIENT DEMOGRAPHICS

1,055 PATIENT ENCOUNTERS
224 UNIQUE PATIENTS
61% FEMALE
51 AVERAGE AGE
68% PREFERRED SPANISH

INDIVIDUAL SERVICE UTILIZATION

55%
121 patients utilized more than one service
178 patients used ICC Medicine as primary service
39 patients used ICC Podiatry as the primary service
CAN I BE PART OF A TEAM THAT WANTS TO REALLY CHANGE HOW PEOPLE AND PATIENTS INTERACT WITH THEIR OWN HEALTH AND WELLNESS, AND WITH TIMES WHEN THEY’RE SICK?

DAVID FEINBERG, MD ’89, MBA
Ensuring affordable, quality health care for all is one of the great challenges of our time. Most Americans — 71 percent according to a recent Gallup poll — recognize that the U.S. healthcare system is in crisis. Millions lack access. Many who can access care are burdened by medical expenses and express a lack of trust in their healthcare payers, providers and institutions.

Millions struggle to cope with preventable, chronic conditions. Millions can’t afford the treatment and medicines they need. Fragmented care, poor communication and provider burnout threaten the healing relationship between health professional and patient.

RFU is determined to help lead the transformation of our system of care and make it work for all people. We’re educating clinicians who are resilient and flexible, who can keep abreast of the changes in science and apply those changes to patient care. We’re training health professionals who can collaborate across disciplines, help lead interprofessional teams, and treat their patients, colleagues and all people with fundamental respect.

Improving the individual experience of care begins with clinicians who are at their core, healers; who possess the compassion of healers but also the knowledge and skill set to meet patients where they are in terms of the care they need and expect. We have incorporated the study of humanities into our new medical school curriculum as a means to help our students connect with and better understand their patients’ lived experiences, the social determinants that impact their health. We are also strengthening our focus across the university on the art of caring, which includes the honing and practice of interpersonal skills such as communication, empathy, shared decision-making and team-building.
The Art of Caring is central to the six aims defined by “Crossing the Quality Chasm” for care that is safe, effective, patient-centered, timely, efficient and equitable. Only interprofessional healthcare teamwork, RFU’s model of education since 2004, can achieve the excellence and quality embodied in those aims.

RFU is heeding the call by the Institute for Healthcare Improvement for a new era of person- and family-centered care and partnership between clinicians and individuals, in which “the values, needs and preferences of the individual are honored; the best evidence is applied; and the shared goal is optimal functional health and quality of life.”

Buoyed by our DeWitt C. Baldwin Institute for Interprofessional Education, whose faculty and staff work to build knowledge and develop the application and teaching of IP, we emphasize from year one that patients and their family members are central to the healthcare team.

CHRONIC CONDITIONS CALL FOR VIGILANCE IN PATIENT MANAGEMENT AND CLINICAL EFFORTS THAT CAN ONLY BE PERFECTED THROUGH THE SKILLS OF CARING: COMMUNICATION, EMPATHY AND COMPASSION, SHARED DECISION-MAKING AND TEAM-BUILDING.

A team approach to diabetes management calls for sitting down, creation of a plan, a careful, motivational dialogue between the physician, physician assistant or nurse practitioner and the patient on what the disease means, what they can do to maximize their treatment and improve their health, and what can happen if they don’t change their behavior. A nutritionist should educate on proper eating and the importance of exercise. The pharmacist should discuss medications, make sure the patient understands why the meds are important and how to take them. The physical therapist should discuss any barriers to mobility and work with the patient to help correct them.

Chronic conditions call for vigilance in patient management and clinical efforts that can only be perfected through the skills of caring: communication, empathy and compassion, shared decision-making and team-building.

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A mountain of evidence reveals that compassionate care is associated with better patient outcomes, improved practitioner satisfaction and lower costs. In their book, “Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference,” physician scientists Dr. Stephen Trzeciak and Dr. Anthony Mazzarelli synthesize decades of studies that show a multitude of ways in which compassion in health care promotes healing, including: lowering blood pressure; reducing back pain; reducing the complications of diabetes; enhancing immune response; alleviating anxiety and depression; improving quality of life; and making “the unbearable bearable.”

“We have seen the data for having no hope and how it can have a major negative effect on one’s health, even survival,” the authors write. “When patients have a reasonable chance for recovery, but have already given up hope, it is a healthcare provider’s responsibility to do something about it, to go the extra mile to get patients the help they need.”
“Science shows that hope matters. And science shows that compassion can be a powerful restorer of hope.”

The authors discuss numerous studies that show compassionate communication motivates patient self-care, including adherence to prescribed therapy. A meta-analysis funded by the National Institutes of Health and the Robert Wood Johnson Foundation found that across 127 published studies, patient-centered communication correlated to a 62 percent higher probability of patient adherence to treatment. Other studies showed positive talk by providers, versus negative talk, expressed concern for patients’ well-being, respect and interest in their healthcare experience facilitated the exchange of information, a sense of partnership and interpersonal trust.

WE HAVE TO MANAGE OUR POPULATION PROACTIVELY. AS A TEAM

The patient-practitioner relationship is key to the primary care-led, high-value clinical model that is driving achievement of the Quadruple Aim across the nation. Clive Fields, MD ’88, co-founder of VillageMD, a leading provider of primary care management services for healthcare organizations moving toward that model, recently told RFU that consistent, coordinated, personal medicine and an attitude of “for vs. to” helps build a positive experience of care for both provider and patient.

“Primary care serves the greatest purpose in continuous care over a long period of time and over the evolution of diseases,” Dr. Fields said. “But we have to remember that we take care of people, not diseases. The idea that doctors wait for patients to come in and see them is archaic. We have to manage our population proactively, as a team. Educators, nurse practitioners, physician assistants can visit sick and elderly patients in their homes. They don’t have to be referred out. It allows us to integrate their care and provide transition of care in a much more seamless way.”

At RFU, we’re preparing future clinicians who see the health professions as a sacred calling. They have a deep desire for the well-being of their patients and they will translate that desire into compassionate communication and action that can help rebuild trust in our systems of care.

The skills of caring can help transform our professional behaviors and workplace culture through consistently respectful and effective communication, by inviting input on treatment decisions, offering and accepting constructive feedback, and learning and collaborating across disciplines.

Improving the experience of care demands that, first and foremost, we engage in respectful, continuous healing relationships with our patients, their families and our fellow practitioners in the shared goal for the highest-quality care, the best outcomes and good health.

THE GREATEST REWARD FOR DOING IS THE OPPORTUNITY TO DO MORE.

JONAS SALK, MD
“Science shows that hope matters. And science shows that compassion can be a powerful restorer of hope.”

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RFU OBJECTIVE
CREATING ACCESS TO CARE IN OUR COMMUNITY

Rosalind Franklin University Health Clinics’ mobile health vehicle embodies the university’s commitment to health equity and access to compassionate, quality care. The Community Care Connection (CCC) travels throughout Lake County to reach underserved populations and offer treatment, prevention and education. The CCC also serves as a powerful educational environment for RFU students who volunteer to assist the licensed physician assistants (PAs) and nurse practitioners who staff the mobile unit.

Andrew Martin, CMS ’22, who boarded the CCC with other RFU students on a hot summer day during a festival in North Chicago, said he frequently sees patients who don’t have the means to prioritize their health.

“We catch people with blood pressure and blood sugar levels over 200 or crazy high cholesterol and we connect them to care right away,” Andrew said. “We understand that people are making tough choices. Do they buy groceries or pay for a doctor visit? Patients tell me they can’t remember the last time they were seen. It’s important as a future physician to understand how pervasive that is, to really let it sink in: so many people are living on the edge.”

The CCC is fueled by a multitude of partnerships, including seven health clinics and more than 30 community organizations that host and promote site visits. More than half of the vehicle’s approximately 216 visits in fiscal year 2018-2019 were to North Chicago, Waukegan and Zion, municipalities where poor health-related measures reveal disparities in care.

While patients in urgent need are quickly connected to care, the CCC also focuses on helping people find a primary care home in service of prevention and wellness.

CCC students learn, and licensed clinicians practice the skills of care that are hallmarks of community health: communication, empathy, shared decision-making and teamwork. Aboard the CCC, RFU students connect with patients as individuals. They make eye contact. They learn to listen, to encourage, to show they care.

“So often in health care, time is in short supply,” said Marie Luke, PA-C. “Inside the CCC, we’re able to sit with our patients and explain why it’s important to take their medication, explain the reality behind the numbers — hemoglobin A1C, blood pressure or cholesterol. Once they understand the numbers, a light turns on and they begin to take responsibility for their health. They join the team. That’s the power of patient education.”

The CCC also partners on RFU student-led community health efforts. It works closely with the Lake County Health Department’s Live Well Lake County initiative, a community health improvement plan that targets prevention and treatment of the county’s top chronic conditions: cardiovascular disease and hypertension, obesity, behavioral health and diabetes.
Rosalind Franklin University Health Clinics this summer put a brand-new mobile health vehicle on the road, thanks to the generous support of The Grainger Foundation and the federal New Markets Tax Credit program. CCC operations are supported by the Healthcare Foundation of Northern Lake County, North Shore Gas, the Grace Bersted Foundation and an anonymous contribution.
### NATIONAL AIM DATA POINTS

**PERCENTAGE OF ADULTS WHO HAVE EXPERIENCED MEDICAL, MEDICATION, OR LAB ERRORS OR DELAYS**
in past two years, 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>19%</td>
</tr>
<tr>
<td>Sweden</td>
<td>17%</td>
</tr>
<tr>
<td>Canada</td>
<td>15%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>14%</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>12%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>11%</td>
</tr>
<tr>
<td>Australia</td>
<td>11%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>10%</td>
</tr>
<tr>
<td>France</td>
<td>8%</td>
</tr>
<tr>
<td>Germany</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Unpublished data from 2016 Commonwealth Fund International Health Policy Survey

### COUNTRY COMPARISON OF CLEAR COMMUNICATION

Age-sex standardized share of patients who reported having received easy-to-understand explanations by their regular doctor, age 16+, 2016 or nearest year

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>96.9</td>
</tr>
<tr>
<td>Australia</td>
<td>93.5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>90.7</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>90.6</td>
</tr>
<tr>
<td>United States</td>
<td>89.5</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>89.2</td>
</tr>
<tr>
<td>Canada</td>
<td>89.0</td>
</tr>
<tr>
<td>Germany</td>
<td>85.9</td>
</tr>
<tr>
<td>France</td>
<td>83.7</td>
</tr>
</tbody>
</table>

Note: Data for France are for 2013. Data unavailable for Austria, Belgium and Japan.
Source: KFF analysis of OECD data

### COUNTRY COMPARISON OF SHARED DECISION-MAKING

Age-sex standardized share of patients who reported having been involved in decisions about care or treatment by their regular doctor, age 16+, 2016 or nearest year

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>88.9</td>
</tr>
<tr>
<td>Australia</td>
<td>87.9</td>
</tr>
<tr>
<td>Germany</td>
<td>87.6</td>
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<tr>
<td>Netherlands</td>
<td>87.1</td>
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<td>Switzerland</td>
<td>86.5</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>85.0</td>
</tr>
<tr>
<td>United States</td>
<td>85.0</td>
</tr>
<tr>
<td>Canada</td>
<td>84.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>84.3</td>
</tr>
<tr>
<td>France</td>
<td>79.0</td>
</tr>
</tbody>
</table>

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Source: KFF analysis of OECD data
CHRONIC DISEASES IN AMERICA

THE LEADING CAUSES OF DEATH AND DISABILITY and Leading Drivers of the Nation’s $3.3 Trillion in Annual Healthcare Costs

6 in 10
ADULTS IN THE U.S. HAVE A CHRONIC DISEASE

4 in 10
ADULTS IN THE U.S. HAVE TWO OR MORE CHRONIC DISEASES

Source: CDC's National Center for Chronic Disease Prevention and Health Promotion

RFU OBJECTIVE DATA POINTS

3,647 UNIQUE PATIENTS SERVED

1,620 HOURS OF COMMUNITY SERVICE

1,986 MEDICAL REFERRALS

715 MEDICAL HOME REFERRALS

548 STUDENT VOLUNTEERS

19 SITE VISITS PER MONTH on average

Fiscal years 2017–2018 and 2018–2019

CCC PATIENT DEMOGRAPHICS

51% LATINX

16% AFRICAN AMERICAN

16% WHITE

10% OTHER/NO RESPONSE

7% ASIAN

Fiscal year 2018–2019
BY DOING OUR BEST WE SHALL COME NEARER TO SUCCESS AND THAT SUCCESS IN OUR AIMS (THE IMPROVEMENT OF THE LOT OF MANKIND, PRESENT AND FUTURE) IS WORTH ATTAINING...

ROSALIND FRANKLIN, PhD
The Quadruple Aim has been likened to the setting of “intellectual goal posts” for healthcare transformation, but lowering per capita costs may be the most difficult play to execute. Health consumption expenditures per capita in the United States were $10,224 in 2017 — more than twice the average of other developed countries. And yet, Americans on average continue to fare poorly in terms of quality, equity and life expectancy. While progress has been made under the Affordable Care Act, millions still lack access to primary and preventive care, in part because they struggle to afford the high cost of health insurance, co-pays and prescriptions.

National health expenditures are projected to reach $3.8 trillion in 2019 and nearly $6 trillion by 2027, according to the Centers for Medicare & Medicaid Services. The culprits are many: faster projected growth in Medicare spending, growth in prices, rising administrative costs, expanded eligibility for Medicaid and lower private health insurance enrollment related to the repeal of the ACA’s individual mandate. Compounding those system delivery problems are aging populations, the rise in chronic health conditions and social determinants that manifest in exposure to environmental toxins, poor nutrition, smoking and untreated addiction.

RFU STANDS STRONG IN ITS CONVICTION THAT HEALTH IS A RIGHT, NOT A PRIVILEGE...

The Institute for Healthcare Improvement’s (IHI) national aims for optimizing health system performance, if pursued simultaneously, hold promise for reducing per capita costs by harnessing the social determinants of health and broadening the role and impact of primary care and other community-based services that focus on prevention and promote health and wellness.
RFU stands strong in its conviction that health is a right, not a privilege, as it prepares students to take a population health approach that, according to the IHI, should include the integration of social workers and services in primary care and on complex care teams. The institute highlights the Ambulatory Integration of Medical and Social (AIMS) program at RFU clinical partner Rush University Medical Center in Chicago. AIMS integrates medical and non-medical services to address social needs, thereby improving patient outcomes, the patient experience of care and reducing the use of costly healthcare services.

Dr. Mona Hanna-Attisha is incorporating social services in the care of her young patients in Flint, MI, who were poisoned by lead in their drinking water. Children who suffer adverse childhood experiences (ACEs) carry long-term risk for negative impacts on learning, behavior and health, according to the Centers for Disease Control and Prevention. The CDC conservatively estimates the economic burden of ACEs, based on 2015 data, at $428 billion.

In addition to addressing preventable health disparities in high-risk and vulnerable populations, which according to some estimates cost $102 billion per year in direct medical costs, systems around the country are driving down costs through strategies that include: accountable care organizations, bundled and value-based payments, integration of information technology, system integration and execution, and new models of primary care that center the patient within coordinated, thoughtfully managed services.

A study on the efficacy of a new payment model at Blue Cross Blue Shield of Massachusetts, published in July 2019 in the New England Journal of Medicine, shows that cash bonuses for providers who improved the quality of their care overall, resulted in an 11.7 percent savings on medical claims over eight years when compared to populations outside the program. The Alternative Quality Contract, based on the idea that healthier patients cost less, offers up-front bonuses for practice upgrades and staffing aimed at prevention and early intervention.

THE IRP AND HELIX 51 INCUBATOR ARE FUELED BY THE HARNESSING AND SHARING OF KNOWLEDGE, DATA AND EXPERIENCE ACROSS DIVERSE DISCIPLINES. THAT’S THE FUTURE OF SCIENCE AND THE FUTURE OF HEALTH.

Medical research and development (R&D), historically a contributor to rising costs, can play a key role in lowering costs by focusing on the needs of patients. The U.S. Food and Drug Administration (FDA) in 2016 began to push for investment in patient-centric R&D. A 2018 survey of 104 patient groups in the United States showed demand for: clinical trials with patient-friendly protocols and post-trial follow-up; consideration of the patient perspective throughout the clinical trial process; improved awareness of and ability to participate in clinical trials; and an examination of how R&D output affects the entirety of the patient’s life experience.
As a research university dedicated to the advancement of knowledge and the translation of that knowledge for the improvement of human health, RFU is committed to highly relevant and responsive R&D. We see enormous potential in our basic and clinical science to speed progress in the treatment of disease. Through the development of drug therapies, diagnostics and clinical applications, we can improve the experience of care and drive down the cost for individual patients and society at large. Our new Innovation and Research Park (IRP) and Helix 51 incubator represent forward-thinking investment in healthcare innovation and entrepreneurship.

The IRP and Helix 51 incubator are fueled by the harnessing and sharing of knowledge, data and experience across diverse disciplines. That’s the future of science and the future of health.

Strategic, interdisciplinary collaboration is key to research at the nation’s top research institutions, including UCLA Hospital System, formerly led by David Feinberg, MD ’89, MBA, now vice president of Google Health. UCLA researchers developed positron emission tomography (PET) scanning, an imaging test that helps reveal how human tissues and organs are functioning, sometimes detecting disease before other imaging tests. “Prescription for Excellence: Leadership Lessons for Creating a World-Class Customer Experience from UCLA Health System” outlines how scientists first conceptualized an outcome — the use of cellular metabolism to discover early signs of cellular pathology — developed innovations to attain the outcome, then solicited input from colleagues with diverse skill sets to help refine the technology and broaden its applications.

“You have to understand that progress in many things in medicine cannot be accomplished in one specialty,” said Dr. Jean DeKernion, chair of the system’s Department of Urology. “Cancer is one example. Somebody who is studying the genetics of cancer in a lab may not have the full understanding of how to apply that knowledge in the clinical setting or may not be aware of the real problems that patients experience. The key to innovation in cancer, then, is to bring people together so that you can identify the important questions, try to answer those questions and bring possible answers back to the patient.”

RFU’s strong investment in R&D and its determination to collaborate on discovery propels us into the patient-centric future of health care where innovations around artificial intelligence, data sharing, cell-based therapies, gene editing, immunotherapy and precision medicine will personalize care and customize treatments that are tailored for patients, for treatment and for prevention.

We will continue to strive to improve wellness and lower the cost of care by working with companies and other knowledge partners who align with our mission and bring value and diversity to our research. We will continue to keep the Quadruple Aim in mind at all times as we educate future healthcare and biomedical professionals who are dedicated to transforming health.
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I WAS TAUGHT THAT THE WAY OF PROGRESS WAS NEITHER SWIFT NOR EASY.

MARIE CURIE
RFU OBJECTIVE
SYNTESIZING KNOWLEDGE AND EMPOWERING COLLABORATIONS

RFU’s new Innovation and Research Park (IRP) and Helix 51 bioscience incubator, designed for collaboration between academic and industry scientists, will help speed the translation of discoveries aimed at lifting the burden of disease and improving health and wellness.

Our efforts to foster innovation will ultimately, we believe, help lower the cost of care, including the enormous custodial and treatment costs for patient populations afflicted with devastating neurological disease. A paper published in the Annals of Neurology in 2017 estimates the annual U.S. cost of the most common neurological diseases as $789 billion in 2014 dollars. The conditions include Alzheimer’s disease, and other dementias, low back pain, stroke, traumatic brain injury, migraine, epilepsy, multiple sclerosis, spinal cord injury and Parkinson’s disease.

Grace “Beth” Stutzmann, PhD, who has studied Alzheimer’s disease (AD) for more than 16 years, is investigating upstream, searching for early changes in the brain that precede the onset of AD.

“The challenge is to find early mechanisms, because by the time memory lapse occurs, the damage to the brain is often too extensive to reverse,” said Dr. Stutzmann, founder of the nationally recognized startup NeuroLucent and director of the Brain Science Institute’s Center for Neurodegenerative Diseases and Therapeutics.

Molecular biologist Judith Potashkin, PhD, an investigator in the same center, is making progress in the search for biomarkers of Parkinson’s disease (PD), a chronic, debilitating, often misdiagnosed illness that affects 1 to 5 percent of the population over the age of 60. Her research is helping to distinguish atypical Parkinsonian disorders and subcategories of PD patients, which may make the disease easier to diagnose.

Dr. Potashkin and other RFU scientists and partners, including Michelle Hastings, PhD, are helping to drive precision medicine, which can increase the value of care through precise diagnosis, individualized treatment and the identification of optimal populations for the testing of new drugs. Dr. Hastings, director of the Center for Genetic Diseases, is working to develop gene-directed therapies that more precisely target aspects of rare, inherited diseases, including Usher syndrome, Batten disease and cystic fibrosis (CF). Our work on CF, which is caused by a defect in the CFTR gene, consists of a multi-pronged investigation among multiple labs within the center with expertise in the mechanism of disease and approaches for treating disease conditions.

Scientists and innovators are working across RFU’s six disease-focused therapeutic centers of excellence and Helix 51 incubator to translate discoveries that can help decrease the cost of R&D and reduce overall healthcare costs driven by hospitalizations, ineffective treatments and the growing need for long-term care.
SHARE OF SPENDING BY DISEASE
Distribution of total medical services expenditures (US $ billions) by disease category, 2015

Note: Spending on dental services, nursing homes and prescriptions that cannot be allocated to a specific disease not included above.
Source: KFF analysis of BEA Health Care Satellite Account (Blended Account)

ELIMINATING UNWARRANTED VARIATIONS IN MEDICAL CARE can reduce the cost of patient management by at least 32%, research shows.

HEALTH SPENDING AND THE ECONOMY
17.9% of the GDP
Source: Peterson Kaiser Health System Tracker

HEALTH & WELL-BEING
TEEN PREGNANCY ▼65%
down from 1980 to 2017
QUALITY OF CARE
IMMUNIZATION RATES 70.4%
of children aged 19–35 months received combined 7-vaccine series
Source: Peterson Kaiser Health System Tracker
RFU OBJECTIVE DATA POINTS

40+ RESEARCH LABORATORIES

35 FACULTY, 100+ SCIENTISTS recruited over the past 16 years

56% INCREASE IN FUNDING over the past 11 years

$12.1M EXTRAMURAL FUNDING

5 BIOMEDICAL STARTUP COMPANIES GENERATED with 2 on the horizon

5.7M Americans are living with ALZHEIMER’S DISEASE

50K new cases of PARKINSON’S DISEASE diagnosed annually in the United States

30K Americans and 70,000 people worldwide living with CYSTIC FIBROSIS

30K Americans diagnosed and 200,000 at risk of inheriting HUNTINGTON’S DISEASE

2–4 births per 100,000 affected by BATTEN DISEASE

4 babies (est.) in every 100,000 born with USHER SYNDROME

RFU INTELLECTUAL PROPERTY TREND

24 PATENTS ISSUED since fiscal year 2010–2011

18 PATENTS PENDING

0.56M RFU RESEARCH funding filings/million dollars

0.24M TOP 90 U.S. UNIVERSITIES average research funding filings/million dollars

AIM HIGHER | REDUCING THE PER CAPITA COST OF CARE

2018–2019 YEAR IN REVIEW | 37
WE HAVE
PURPOSES
LARGER THAN
OURSelves.

ATUL GAWANDE, MD
One of the great challenges of healthcare reform is the integration of human connection, which is the essence and the joy of care. RFU is among a growing number of medical institutions that have embraced the Institute for Health Improvement’s “Joy in Work” initiative in recognition of the high expectations and resulting pressures that transformative change places on healthcare professionals, practices and systems. We are prioritizing the health and well-being of providers alongside national aims for the health of populations, patient experience and reducing costs in recognition that, as one doctor says, “Healers need to be healthy first.”

Scientific evidence, in addition to our lived experience, tells us that the well-being of the care team is crucial to the well-being of our patients.

A study by Johns Hopkins University first sounded the alarm of a new kind of national health epidemic. Published in 2016, it found medical errors were the third leading cause of death in the United States — as many as 250,000 avoidable deaths per year. Researchers at Stanford University, intent on discovering the reasons behind the errors, surveyed nearly 7,000 physicians across the United States, 55 percent of whom reported symptoms of burnout. The study, published in Mayo Clinic Proceedings in 2018, found that burnout levels played an equal or greater role than work unit safety scores in the occurrence of medical errors, which cost billions each year in lost health, life and revenue. Researchers also found that physician burnout is a factor in quality of care, patient safety, turnover rates and patient satisfaction.

Senior author Dr. Tait Shanafelt noted that while healthcare organizations are making substantial investments in system-level approaches to improve safety, very few are paying attention to system-level factors that drive burnout, which is characterized by feelings of exhaustion, cynicism and reduced effectiveness.
“We need a holistic and systems-based approach to address the epidemic of burnout among healthcare providers if we are truly going to create the high-quality healthcare system we aspire to,” Dr. Shanafelt said upon release of the study.

RFU works to imbue students with a resilience that springs from their own competence and belief in the power of interprofessional collaborative learning and practice. We’re keeping pace with changes in provider roles, system structures and the rapid advancement of knowledge and new technologies through a finely-honed focus on individualized learning. Our simulation-based methods and technology include standardized patient encounters, high-fidelity manikins programmed to simulate medical scenarios, web-based and patient simulations, and clinical skills and procedure training.

WE WANT OUR STUDENTS TO TRULY OWN THE INFORMATION AND THE SKILL.

In each simulation experience, we help our students understand that they each come to RFU with different strengths and challenges. We help them gain proficiency through feedback processes on what they need to work on most, whether mastering professional competencies or honing the quality of their practice, including communication skills. Simulation, hands-on application of knowledge and small-group learning spur greater retention, greater satisfaction and joy in learning. We want our students to truly own the information and the skill. That brings the confidence to impact their patients’ lives and impact the team.

The Quadruple Aim, which prioritizes a better experience for health professionals, is key to sustainable success in health care say Dave Chase and Leonard Kish, authors of “95 Theses for a New Health Ecosystem.”

“Layering more bureaucracy on top of an already-overburdened clinical team ignores that the underlying processes are frequently under-performing and that a bad professional experience negatively impacts patient outcomes,” argue Chase and Kish.

The causes of burnout and stress among health professionals include increased patient expectations and patient populations that are older and sicker. The demands of the electronic health records (EHRs) have been widely reported as a major source of frustration among clinicians, including physicians who are required by payers to make lengthy medical notes. Burdensome documentation, a study by Mayo Clinic found, is a strong predictor of burnout.

Kish, a health IT strategy consultant, predicts that EHR patient portals “will eventually give way to solutions from consumer-focused companies as the business case for patient engagement becomes more understood.

“Once upon a time,” he adds, “search was an afterthought on web portals such as MSN and AOL as there wasn’t a business case for search. Clearly, Google has proven that wrong.”

Google is focusing on rebuilding data-sharing systems for providers and payers, in addition to AI research and data applications to improve the diagnosis, management and prevention of disease.

David Feinberg, MD ‘89, MBA, VP, Google Health, said in a recent Beryl Institute podcast that while the EHR can be improved, the real solution to burnout is helping providers address the social determinants of health for the people in their care.
“A patient comes in to you, and they have a lot of rat bites, and you just keep fixing the rat bites, but you can’t go in the community and kill the rat,” he said. “That leads to burnout. Or a diabetic who comes in and can’t get food, and you keep giving him meds, but you know he’s living in an environment where it’s not safe to walk. That leads to burnout… You need a team-based approach. You need a real population-based approach, so you can go out and kill the rat, so you can get people healthy food.

“Then the docs and other providers are going to find joy because actually, their patients are going to get better.”

The 2014 Annals of Family Medicine offered early insight into burnout as a consequence of the gap between societal expectations for better health care and the realities of the profession.

RFU recognizes that the training of students to practice interprofessional collaborative care — one of our defining educational strategies — is key to workforce satisfaction and helps achieve the Quadruple Aim.

“Health care is a relationship between those who provide care and those who seek care, a relationship that can only thrive if it is symbiotic, benefiting both parties,” according to the article “From Triple to Quadruple Aim: Care for the Patient Requires Care of the Provider,” which reported on high-function primary care practices. Systems that make room for joy by affording health professionals the time to practice the art of care, the authors found, make gains in clinical quality, cost reduction and patient experience. They also show decreased rates of burnout.

RFU recognizes that the training of students to practice interprofessional (IP) collaborative care — one of our defining educational strategies — is key to workforce satisfaction and helps achieve the Quadruple Aim. Interprofessional healthcare teams, which include the patient and their family, are defined by respect and shared responsibility and decision-making across the team. That understanding of care protects against isolation, another factor in burnout, and builds resilience and strength.

The authors of “Educational Innovations to Foster Resilience in the Health Professions,” from the journal Medical Teacher, express it well: “Health professionals make a unique and critical contribution to the health and well-being of those they serve. While being a physician or a nurse has long been considered a noble profession, it is now understood that a career in health care is also laden with significant risks as well as rewards.”

RFU is determined to help mitigate the risks and expand the rewards for health professionals so that they, and their patients, can discover the joy in healing and in health.
“A patient comes in to you, and they have a lot of rat bites, and you just keep fixing the rat bites, but you can’t go in the community and kill the rat,” he said. “That leads to burnout. Or a diabetic who comes in and can’t get food, and you keep giving him meds, but you know he’s living in an environment where it’s not safe to walk. That leads to burnout... You need a team-based approach. You need a real population-based approach, so you can go out and kill the rat, so you can get people healthy food.

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RFU OBJECTIVE
BUILDING A FOUNDATION OF TEAMWORK

RFU teaches the art of caring in numerous ways, including practice with standardized patients, simulation-based training and interprofessional (IP) small team-learning, as a means to achieving better patient outcomes and as an antidote to burnout — which threatens the health of both our patients and our professionals. Our students are trained to lead the IP paradigm of practice within their professions and within systems that lag in patient-centric care and other innovations that help achieve the Quadruple Aim.

We are continuously improving our coursework and academic approach to foster a healthy learning environment that builds resilience and promotes wellness among our students and faculty. We give our students the opportunity to build a healthy lifestyle in myriad ways, including the teaching of skills for stress management, messaging aimed at destigmatizing mental illness and encouraging the use of our robust student counseling services.

RFU first-year students are engaging in a redesigned Foundations for Interprofessional Practice curriculum that focuses on lifestyle health care — reducing the risk factors that contribute to disease, promoting health and preventing chronic disease. We’re teaching our students how to care for their own health through proper nutrition, sleep and exercise.

We are educating future health professionals who will feel good about the work that they do and find joy in their profession. As our nation struggles with a high burnout rate among many high-pressure occupations, including medicine, we’re raising awareness of the need to recognize the early signs of burnout and we’re sharing a powerful message that it’s okay to reach out for help. We continue to focus on work-life balance at RFU and helping our students develop strategies for coping and maintaining balance that can be applied in the workplace.

Working in IP healthcare teams, we use the evidence-based framework TeamSTEPPS as a foundation for teaching team performance optimization in four core areas: leadership, situation monitoring, communication and mutual support, all skills that can help reduce student and faculty burnout.

Our model of interprofessional education teaches our students that the burden of care is a team effort. Shared responsibility helps protect against provider burnout and results in a better experience of care for both the patient and the team.

Today’s students come to us with a strong understanding of their own personal challenges and how they might cope with their challenges, and that holds great promise for a future in which compassionate care by highly-skilled, empathetic professionals is the expectation and the norm.
NATIONAL AIM DATA POINTS

TURNOVER

$12B
Conservative estimate of the
ANNUAL COST OF PHYSICIAN TURNOVER
in the United States

Source: “Creating the Organizational Foundation for Joy in Medicine,” American Medical Association

BURNOUT

50%+
MORE THAN HALF OF U.S. PHYSICIANS
are experiencing substantial
symptoms of burnout

30–40%
data showing burnout of other frontline providers,
including REGISTERED NURSES, NURSE
PRACTITIONERS AND PHYSICIAN ASSISTANTS.

Source: “Burnout Among Healthcare Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care,” National Academy of Medicine, 2017 discussion paper

SUICIDAL IDEATION

25%
INCREASED ODDS OF
ALCOHOL ABUSE/
DEPENDENCE
associated with burnout
among physicians

200%
INCREASED ODDS OF
SUICIDAL IDEATION
associated with burnout
among physicians

Source: “Burnout Among Healthcare Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care,” National Academy of Medicine, 2017 discussion paper
RFU OBJECTIVE DATA POINTS

20% EXPANSION IN SIMULATION TRAINING
serving 7 core academic programs and university partners

40K CONTACT HOURS (EST.) IN SIMULATION EDUCATION, 2019-2020 academic year

ACCREDITATION BY SOCIETY OF SIMULATION IN HEALTHCARE.

7 SIMULATION LABS between 2 centers

2K LEARNER CONTACT HOURS (EST.) OF SIMULATION across 400 Northwestern Medicine employees 2018-2019

600+ WELLNESS ACTIVITIES were offered on campus during the 2018-2019 academic year, including:

<table>
<thead>
<tr>
<th>YOGA</th>
<th>MINDFULNESS MEDITATION</th>
<th>STRESS MANAGEMENT</th>
<th>HEALTH SCREENINGS</th>
<th>WALKING CLUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUNCH AND LEARN</td>
<td>HEALTHY COOKING</td>
<td>PAINTING CLASS</td>
<td>DOG THERAPY</td>
<td>LATE-NIGHT BREAKFAST</td>
</tr>
</tbody>
</table>
Rosalind Franklin University’s Board of Trustees is the governing body of our institution, responsible for our mission as well as the financial health and welfare of the university. Our trustees bring a vast range of knowledge of higher education, medicine, health care, business, law, government, the U.S. military, nonprofit management and marketing. The board provides leadership and guidance to RFU while shaping its goals, policies and practices.
FINANCIAL REPORT

Fiscal year ended June 30, 2019

OPERATING REVENUES
$ in millions

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Amount (in millions)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET TUITION AND FEES</td>
<td>82.9</td>
<td>71%</td>
</tr>
<tr>
<td>GRANTS AND CONTRACTS</td>
<td>13.4</td>
<td>12%</td>
</tr>
<tr>
<td>PATIENT CARE</td>
<td>8.9</td>
<td>8%</td>
</tr>
<tr>
<td>ENDOWMENT SUPPORT</td>
<td>4.4</td>
<td>4%</td>
</tr>
<tr>
<td>CONTRIBUTIONS</td>
<td>1.7</td>
<td>1%</td>
</tr>
<tr>
<td>OTHER</td>
<td>4.7</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$116.0</td>
<td></td>
</tr>
</tbody>
</table>

OPERATING EXPENSES
$ in millions

<table>
<thead>
<tr>
<th>Expense Source</th>
<th>Amount (in millions)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTRUCTION</td>
<td>64.5</td>
<td>55%</td>
</tr>
<tr>
<td>RESEARCH</td>
<td>21.3</td>
<td>18%</td>
</tr>
<tr>
<td>PATIENT CARE</td>
<td>11.1</td>
<td>9%</td>
</tr>
<tr>
<td>INSTITUTIONAL SUPPORT</td>
<td>20.8</td>
<td>18%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$117.7</td>
<td></td>
</tr>
<tr>
<td>EXCESS OVER EXPENSES</td>
<td>$(1.7)</td>
<td></td>
</tr>
</tbody>
</table>
CHANGE IN TOTAL NET ASSETS

Reflects, on an annual basis, the increase or decrease of assets minus liabilities.

RESEARCH AWARDS

STUDENT ENROLLMENT
Wendy Rheault, PT, PhD, FASAHP, FNAP, DipACLM
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Executive Vice President for Research, Interim Dean, Chicago Medical School

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Vice President of Partnerships

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Associate Vice President for Technology and Learning Resources, Chief Information Officer

Bret Moberg, JD, LLM
Compliance Counsel

John H. Nylen, MBA
Executive Vice President for Finance and Administration

Benjamin Parker, CMS ’22
Executive Student Council President

Nancy L. Parsley, DPM, MHPE
Provost and Vice President for Academic Affairs

Chad B. Ruback, MEd, MBA
Vice President for Institutional Advancement

Judith Stoecker, PT, PhD
Vice President for Faculty Affairs

John Vitale, PhD ’13, MHS, PA(ASCP)
Dean, College of Health Professions

Carl White, PhD
Faculty Senate President

Stephanie Wu, DPM, MS, FACFAS
Dean, Dr. William M. Scholl College of Podiatric Medicine
IMPACTING THE FUTURE OF HEALTH CARE

Fortified by your support, we're forging a path to the brightest possible future by:

• **Strengthening programs and partnerships:** We are teaching future health professionals how to transform systems of care through our innovative curriculum, use of state-of-the-art technology and expansion of clinical affiliates and community partnerships.

• **Impacting the community:** We are committed to improving health, wellness and access to educational opportunities in underserved communities.

• **Expanding biomedical research:** We are continually investing in the discovery of new treatments and therapeutics, including in the fields of neuroscience, cancer, proteomics and genetic and infectious diseases.

• **Improving scholarship support:** We are removing economic barriers to our students’ aspirations.

Here’s how you can increase your impact on the future of RFU and healthcare education.

• **Recognize the urgency** of healthcare education by helping our students overcome hurdles to the health professions.

• **Deepen your commitment with a new level of financial support.**

MAKE YOUR GIFT TODAY: [https://rfu.ms/impactrfu](https://rfu.ms/impactrfu)
EXTEND YOUR IMPACT

ADDITIONAL WAYS TO GIVE:

1. **Make a gift of appreciated stock**: Many of your investments are likely worth more now than when you originally purchased them. By donating appreciated stock directly to a nonprofit like Rosalind Franklin University, you will qualify for an income tax deduction and avoid capital gains tax that would apply if the securities were sold rather than donated.

2. **Make a gift from your Donor Advised Fund**: If you have established a Donor Advised Fund (DAF), you may be able to contribute from that fund to support Rosalind Franklin University. Since each DAF functions differently, please contact your individual DAF manager to see how to make a donation in support of RFU.

3. **Make a gift from your IRA assets**: These assets are taxable when distributed to a loved one, but are tax-free when gifted to a nonprofit like Rosalind Franklin University. **If you are 70½ or older**, you can transfer directly up to $100,000 ($200,000 may be the limit for married couples) to a charity tax-free each year — even if it is more than your required minimum distribution (RMD). The charitable gift counts as your RMD but isn’t included in your adjusted gross income, and that could lower your tax burden. **Note**: Charitable contributions can only be made from IRAs, not 401(k)s or similar retirement accounts.

There are many ways you can contribute that will make an impact at RFU. Please consult with your tax or financial advisor to determine the best charitable giving strategies for your personal situation.

HELP US PARTNER WITH YOU TO MAKE AN IMPACT.

Please contact George Rattin at george.rattin@rosalindfranklin.edu or 847-578-8345 to discuss how you can make the most meaningful impact at RFU.
THANK YOU

Your partnership with Rosalind Franklin University transforms healthcare education, discovers new knowledge and improves the health and wellness of our communities.