



Special Legislative Commission to make a Comprehensive
Study of Rhode Island's Healthcare Workforce related to
Educating and Retaining Primary Care Physicians and
Establishing a State Medical School at The University of
Rhode Island

Report

Submitted to the
Rhode Island State Senate
January 2026

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Special Legislative Commission to make a Comprehensive Study of Rhode Island's Healthcare Workforce related to Educating and Retaining Primary Care Physicians and Establishing a State Medical School at The University of Rhode Island

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The Honorable Valarie J. Lawson
President of the Rhode Island Senate
Rhode Island State House
Providence, RI 02903

Dear President Lawson:

At this time, we are pleased to submit this report of the Special Legislative Commission to make a Comprehensive Study of Rhode Island's Healthcare Workforce related to Educating and Retaining Primary Care Physicians and Establishing a State Medical School at The University of Rhode Island. Our report represents combined input from Commission members and those who presented before the Commission to share their expertise on the status of primary care in Rhode Island and the potential of creating a public medical school at The University of Rhode Island.

This report encompasses the discussions and presentations that began August 2024 and ended January 2026. All information provided considers the positive and negative effects upon the parties in these relationships. The recommendations are meant to provide a clear thought process to all interested groups regarding potential steps and discussion for future agreements.

We would like to take the opportunity to thank the members of the Commission for the time they took to participate and for their valuable insight. We would be remiss if we did not recognize the late Senate President Dominick J. Ruggerio. He was passionate about this issue and about all the issues for which he advocated. He is sadly missed and will always be lovingly remembered.

Respectfully,

Senator Pamela J. Lauria
Co-Chair
District 32
Barrington, Bristol, East Providence

Marc B. Parlange, Ph.D., P.Eng
Co-Chair
President – The University of Rhode Island

MEETING TIMELINE

August 28, 2024

Met for organizational purposes.

Presentation by Michael Fine on Primary care in Rhode Island followed by a Q&A from members and discussion of scheduling the next meeting date.

October 29, 2024

Met on the topic of the current state of primary care in Rhode Island.

Presentations by Eugenio Fernandez, PharmD; L. Anthony Cirillo MD, FACEP; Cory King, Commissioner of the Office of the Health Insurance Commissioner.

January 27, 2025

Met on the topic of the current state of primary care nationwide.

Presentations by Debra Hurwitz, MBA, BSN, RN, CTC-RI Executive Director; Stephen J. Spann, MD, M.B.A., Professor Emeritus-Tilman J. Fertitta Family College of Medicine at the University of Houston; Robert M. Califf, MD, MACC, US Commissioner of Food and Drug Administration (2016, 2017; 2022-2024).

March 17, 2025

Met on the topic of the URI medical school feasibility study.

Presentation by Paul Umbach and Ha Pham from Tripp Umbach consulting.

May 30, 2025

Met on the topic of the URI medical school feasibility study.

Presentation by Paul Umbach and Ha Pham from Tripp Umbach consulting.

October 9, 2025

Met on the topic of the URI medical school feasibility study.

Public Comment opportunity for community members.

October 30, 2025

Met on the topic of the URI medical school feasibility study

Question and answer with Paul Umbach from Tripp Umbach

November 18, 2025

Met on the topic of the Commission draft report

Discussion & review of Commission draft report

January 13, 2026

Met on the topic of the Commission draft report

Discussion & Review of Commission draft report

January 27, 2026

Met on the topic of the Commission draft report

Consideration of Commission draft report

INTRODUCTION & BACKGROUND

Primary care access has become a growing concern not only in Rhode Island, but across the United States. A pre-pandemic analysis has predicted that the Rhode Island primary care provider (PCP) workforce will continue to decline and most likely have a deficit of nearly 100 PCPs (caring for roughly 180,000 patients) by the end of the decade. Since the pandemic, the primary care provider crisis has worsened. Providers are seeking retirement earlier, and many are approaching retirement age. Currently, an estimate of 641-1200 primary care physicians are practicing in the state of Rhode Island, but the number of retirements post pandemic are unknown. New in-state graduates in the healthcare workforce are insufficient to balance the increased retirement, consumer need, and lack of primary care physicians in our state.¹ Of the 106 graduates from primary care residency programs in Rhode Island in the academic year 2022-2023, only 15 planned to provide primary care and remain in state. Based on these findings, the need for recruiting, retaining, training, and sustaining a diverse primary care provider workforce is necessary to bridge this gap.²

The Rhode Island State Senate passed a resolution during the 2024 legislative session to establish a special study commission to make a comprehensive study of Rhode Island's healthcare workforce related to educating and retaining primary care physicians and establishing a state medical school at The University of Rhode Island. This commission, comprised of legislators, University academic professionals, University Board of Trustee members, and community stakeholders met nine times over the course of 18 months to address the primary care crisis in Rhode Island and examine whether establishing a medical school at the University could

¹ RIDOH, Licensing Data

² Fine, Michael: Primary Care in Rhode Island 2024

help address this challenge. The Commission also held hearings for public comment to gain perspective from medical professionals, members of academia, and the community on the current primary care crisis. Additionally, utilizing funding from a state legislative grant, the Commission retained an independent consulting firm, Tripp Umbach, to conduct a feasibility study and economic impact analysis on the development of a medical school at the University. Tripp Umbach specializes in economic analysis, community development, strategic planning, feasibility studies, and impact assessments for universities, hospitals, and governments. The firm has completed feasibility studies to establish 40 new medical schools and campuses, including at the University of Houston and Washington State. Tripp Umbach analyzed the current educational and market conditions to determine whether a public medical school at the University of Rhode Island is feasible and would help address the long-term primary care workforce issues in Rhode Island.

Alongside the feasibility study, the Commission received several presentations intended to illustrate the identified needs and prevailing concerns. Following these presentations, a public comment hearing was conducted to solicit testimony from members of the community. This report presents the Commission's findings based on both the feasibility study and the testimony and offers recommendations for future action.

WHAT WE HAVE LEARNED

The Commission heard presentations from a variety of community and nationwide stakeholders who have career experience with the challenges faced with primary care access. The individuals who presented were:

Cory King, Commissioner of the State of RI Office of the Health Commissioner

Eugenio Fernandez, PharmD, Founder of Asthenis Pharmacy

L. Anthony Cirillo, MD, Retired Emergency Room Physician

Debra Hurwitz, MBA, BSN, RN, CTC-RI Executive Director

Stephen Spann, MD, MBA, Professor Emeritus – University of Houston

Robert Califf, MD, MACC, US Commissioner of the FDA (2016-2017; 2022-2024)

Michael Fine, MD, Director RI Department of Health (2011-2015)

Their varied presentation topics provided insightful views on the state of primary care locally and nationwide. Together, their insights provided the Commission with a well-rounded understanding of both the immediate obstacles and the long-term opportunities to strengthen primary care.

FINDINGS

I. The problem: state of primary care in Rhode Island

Former Director of the RI Department of Health Michael Fine, MD, gave a presentation to the Commission and provided an overview of the current state of primary care in Rhode Island, outlining the challenges and opportunities shaping the state's primary care landscape.

Rhode Island is experiencing a worsening primary care workforce shortage in the wake of the COVID-19 pandemic, driven by rising demand from an older and sicker population and a shrinking supply of clinicians. The state currently has an estimated 641–1,200 primary care

physicians, along with a similar number of nurse practitioners (NPs) and physician assistants (PAs). Despite this combined workforce, patient needs are not being met.

Testimony presented to the Commission highlighted how current workloads differ from what many clinicians consider sustainable. Commission member Dr. Michael Fine suggested that an ideal patient panel may be closer to 500 patients per clinician (compared to current patient panels which are typically over 1000 today), a benchmark that underscores the severity of the existing strain.

Although 91% of practices report accepting new patients, fewer than half accept patient transfers or newly arrived residents, indicating that true access to primary care is far more limited than these topline numbers suggest.³

Workforce sustainability is an escalating concern. Twenty-six percent of surveyed providers plan to retire within the next six years, and nearly a third of physicians—along with substantial proportions of NPs and PAs—are already over age 60. Based on current age distribution, an estimated 55–110 clinicians could retire annually. Burnout, the post-pandemic “great resignation,” and the long, costly training pathway into primary care further erode recruitment and retention. See addendum item 3.1 for current population estimates.⁴

The Office of the Health Insurance Commissioner (OHIC) and the Care Transformation Collaborative of Rhode Island (CTC-RI) warn that this shortage threatens access, affordability, and health equity. Without adequate primary care, patients face delayed preventive services, worsening chronic disease management, and increased emergency department visitation. Financial pressures compound the problem, as 60% of practice revenue goes to overhead, mostly tied to billing, while reimbursement rates remain fixed. Moreover, Rhode Island’s primary care

³ Fine, Michael: Primary Care in Rhode Island 2024

⁴ Fine, Michael: Primary Care in Rhode Island 2024

workforce does not fully reflect the racial, ethnic, and linguistic diversity of its communities, limiting cultural competence and equitable care. These racial disparities create a lack of trust amongst patients and lead to an absence of physician access. Similarly, there is an insufficient amount of public health ecosystems across the state, which reduces communication amongst providers and limits patients' access to adequate care. Rhode Island, in part due to its size, has a unique opportunity for multiple providers to work together to provide the best care possible. Rhode Island has a strong tradition of high-quality care and currently ranks fourth in primary care supply. However, the system is at a tipping point. Without accelerated investment in workforce development, diversity, and financing reform, the state risks a widening gap in access to foundational care.⁵

II. DO vs. MD Medical Education Model

Medical education in the United States follows two primary pathways, Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO), which are individually based on its own traditions and clinical philosophy. MD programs are rooted in the allopathic model of medical education, which centers on diagnosing and treating disease through evidence-based medicine, pharmaceuticals, and surgical interventions. Their curricula emphasize biomedical science, clinical reasoning, and exposure to technologically advanced diagnostics and therapies. DO programs cover the same core medical sciences and clinical rotations but incorporate an additional philosophical and practical dimension: osteopathic principles and osteopathic manipulative medicine (OMM). This includes hands on training focused on a holistic view of patient care, emphasizing the body's interconnected systems and natural ability to heal. Although

⁵ King, Cory: Primary Care in Rhode Island: The View from OHIC

these approaches differ in emphasis, both MD and DO graduates are fully licensed physicians eligible for all specialties, residencies, and clinical settings in the United States.

The feasibility study evaluated these educational models and concluded that an MD granting program would be the most effective fit for Rhode Island's needs. Stakeholders, including health-system leaders, community health providers, and academic partners expressed that an MD program provides stronger national name recognition, which would improve recruitment of prospective students and faculty, attract clinical partners, and bolster public confidence in a new state medical school. Similarly, DO programs typically enroll larger cohorts of 150–200 students. Expanding training capacity to meet their needs would place additional strain on an already limited clinical education system, making an MD program the more feasible and sustainable option for Rhode Island. The study also emphasized that URI's status as an R1 research institution, combined with its established programs in nursing, pharmacy, and health sciences, aligns naturally with the research-intensive and interprofessional expectations of MD education. Additionally, the proposed MD curriculum would be designed to embed students in community-based training sites such as community hospitals, Federally Qualified Health Centers (FQHCs), and primary care practices, helping directly address Rhode Island's urgent shortage of primary care physicians.

While the DO model's holistic philosophy and OMM training provide valuable pathways into patient-centered care, the feasibility study determined that an MD program would more effectively meet the state's workforce goals, strengthen clinical partnerships, and enhance the long-term sustainability and competitiveness of a public medical school at the University.

III. Current Mechanisms to address Primary Care access

In the short-term, Rhode Island is advancing a broad set of initiatives to address its growing primary care workforce shortage and to stabilize access for patients. One of the most significant actions has been the passage of the 2024 Primary Care Training Program legislation, which directs the Rhode Island Department of Health to develop a standardized curriculum for medical students, nurse practitioners (NPs), and physician assistants (PAs). This program is designed to expose trainees to advanced models of primary care earlier in their education and accelerate the pipeline of providers entering practice. In addition, the state is expanding residency training opportunities, with a strong emphasis on Teaching Health Center programs⁶ located in community health centers. Evidence shows that physicians and other clinicians are more likely to remain in the communities where they train, making these programs a strategic way in which to retain new graduates and build capacity in underserved areas.⁷

Alongside workforce training, Rhode Island is working to make primary care practice more attractive and sustainable. The state has invested in scholarships and loan forgiveness opportunities to help reduce the debt burden that often steers students away from primary care. To address administrative burdens, OHIC has led reforms aimed at streamlining prior authorization processes, a top source of frustration and burnout among clinicians, and proposed new rules in 2024 to reduce unnecessary medical paperwork. OHIC has also redefined and recalibrated commercial insurers' primary care expenditure requirements, improving oversight of how insurers allocate resources and ensuring a larger share of health spending is directed to front-line care.⁸

⁶ Teaching health center (THC) programs are community-based ambulatory care centers that operate accredited primary care residency programs to train healthcare professionals.

⁷ Fernandez, Eugenio: The Value of Training Medical Students in Rhode Island: And How to Keep them Here.

⁸ King, Cory: Primary Care in Rhode Island: The View from OHIC

Rhode Island is also aligning with federal initiatives to bring in additional funding and support for primary care practices. The state has applied to Cohort 3 of the Primary Care AHEAD model, which would provide participating practices with a per-member-per-month payment on top of traditional billing and require the state to establish an all-payer investment target in primary care. At the federal level, the state is in support of Senator Whitehouse’s Pay PCPs Act⁹, which seeks to create hybrid payment models for primary care physicians, lower patient cost-sharing, and reevaluation of Medicare payment rules to strengthen primary care nationwide. Together, these methods represent a complex short-term plan: expanding training and residency opportunities, improving financial incentives through scholarships and loan forgiveness, reducing administrative barriers, strengthening insurer accountability, and leveraging federal payment reforms.¹⁰

While these initiatives will not fully resolve the primary care shortage on their own, they could stabilize the system and minimize the loss of access due to retirements, burnout, and rising demand. By focusing simultaneously on training, retention, financing, and practice sustainability, Rhode Island aims to protect access to primary care for its residents while laying the foundation for longer-term solutions, including the establishment of a state medical school at the University and further expansion of community-based residency training.

IV. Long Term Outlook on Primary Care

Rhode Island is pursuing strategies that aim to fundamentally strengthen and sustain its primary care system. The General Assembly has taken decisive steps to support primary care

⁹ The Pay PCPs Act, co-introduced by Senator Whitehouse, is a 2024 bill to reform primary care provider payments in the Medicare program. It aims to address the shortage of primary care doctors by establishing a hybrid payment model (a mix of per-member-per-month and fee-for-service), reducing cost-sharing for Medicare beneficiaries, and creating a technical advisory committee to improve Medicare fee schedule rates.

¹⁰ King, Cory: Primary Care in Rhode Island: The View from OHIC

practices, targeting both funding and systemic reforms to strengthen access to care. New regulations implemented through OHIC require commercial insurers to increase primary care reimbursements, with the aim of doubling per-member primary care spending by 2029. These reimbursement efforts are part of a broader package of reforms, that includes a 20% reduction in prior authorization requirements, \$5 million in grants to bolster primary care capacity, and expanded student loan forgiveness programs for providers committing to serve in the state. Subsequently, the General Assembly passed pilot legislation eliminating prior authorization for medically necessary medications and services recommended by a primary care physician. Collectively, these initiatives are a comprehensive strategy to stabilize and expand Rhode Island's primary care workforce to better ensure long-term sustainability and improved access for patients.¹¹

A state medical school would provide transformative long-term benefits for the state's healthcare system, economy, and communities. Most critically, it would strengthen the pipeline of primary care physicians at a time when the state faces a growing shortage and an aging workforce. Studies consistently show that physicians are more likely to practice in the state where they are educated and complete residency, meaning a medical school would increase the retention of locally trained physicians. By offering a more affordable education option, a state medical school would also reduce the heavy debt burden that often drives graduates toward higher-paying specialties rather than primary care, helping to align the workforce supply with the state's most urgent needs. Beyond addressing shortages, a state medical school could actively promote diversity in the physician workforce by recruiting students from within our local communities, particularly those underrepresented in medicine, ensuring a future healthcare

¹¹ King, Cory: Primary Care in Rhode Island: The View from OHIC

workforce that better reflects the racial, ethnic, and linguistic diversity of the population. The presence of a medical school would also create opportunities to expand residency slots and community-based training programs, especially in partnership with community health centers. Economically, a medical school would generate research opportunities, academic partnerships, and health sector jobs, while attracting federal funding for graduate medical education and Teaching Health Center residencies. Over time, these combined impacts—greater retention of homegrown physicians, a more diverse and community-oriented workforce, reduced reliance on out-of-state recruitment, and a stronger academic and research presence—would not only stabilize Rhode Island’s primary care system but also enhance health equity, improve patient outcomes, and position the state as a leader in accessible, high-quality healthcare delivery.¹²

While a state medical school will not solve the primary care shortage on its own, it is a critical component in stabilizing the healthcare system long-term. Rhode Island has a unique opportunity to invest in the healthcare sector and simultaneously create a stronger academic and research presence in our state. By investing now in partnership with the current primary care initiatives, Rhode Island will achieve a significant change in the state’s primary care workforce shortage in the future.

V. Public Comment

The Commission held a public hearing on October 9, 2025, to receive testimony from community stakeholders, healthcare professionals, and state leaders regarding Rhode Island’s primary care workforce shortage and Tripp Umbach’s feasibility study regarding the establishment of a public medical school at the University of Rhode Island. The purpose of this hearing was to gather diverse perspectives to inform the Commission’s policy deliberations and

¹² Hurwitz, Debra: Care Transformation Collaborative of RI, January 27, 2025, Presentation

future recommendations to the General Assembly. The public testimony provided valuable insights grounded in professional, academic, and community experiences and offered practical recommendations for addressing the state’s healthcare workforce challenges.

State leaders, including Lieutenant Governor Sabina Matos, Secretary of State Gregg Amore, and General Treasurer James Diossa, testified in strong support of establishing a state medical school. Each emphasized that Rhode Island faces an urgent and growing shortage of primary care physicians, driven by an aging population, increasing healthcare demand, and the outmigration of newly trained physicians. They asserted that a public medical school represents a strategic, long-term investment in Rhode Island’s health system and economic future. Their testimony highlighted the potential for a state medical school to “grow our own” workforce by providing accessible, high-quality medical education within the state, thereby increasing the likelihood that graduates will remain in Rhode Island to practice. Consistent with the findings of the Tripp Umbach feasibility study, they underscored the importance of developing robust physician retention strategies and implementing targeted incentive programs—such as tuition assistance, loan repayment, and expanded residency opportunities—to strengthen recruitment and encourage post-graduate retention.

Practicing primary care physicians, including Dr. Jenna Iannuccilli and Dr. Lisa Menard-Manlove, also testified before the Commission. Drawing upon their clinical experience and personal connection to Rhode Island’s healthcare system, both physicians emphasized the critical importance of training and retaining medical professionals within the state. They described the challenges of meeting patient demand amid ongoing workforce shortages and emphasized that local training opportunities are directly linked to physician retention. Their testimony supported the establishment of a public medical school as a mechanism to strengthen the physician pipeline

and build a program intentionally focused on primary care education. They noted that a community-based curriculum aligned with Rhode Island's healthcare needs would serve as an integral component of a broader strategy to address the state's primary care crisis.

While the majority of testimony expressed support for the proposal, several stakeholders provided constructive recommendations for the Commission's consideration. Dr. Edward McGookin, Chief of Primary Care for Brown University Health, submitted written testimony acknowledging that a state university medical school could yield several potential benefits, including expanded access to medical education and strengthened workforce capacity. However, he also outlined potential challenges, noting that Rhode Island's current clinical training infrastructure already supports multiple health professions programs, including the Warren Alpert Medical School at Brown University, and may have limited capacity for additional medical trainees. Dr. McGookin further cautioned that the establishment of a new medical school does not automatically translate into an increased number of primary care physicians, as national trends show declining interest in primary care specialties. He recommended what he described as a more cost-effective approach that doubles the state's investment in primary care to ten percent of total healthcare spending, expands graduate medical education (GME) opportunities through community-based training, and increases access to Federally Qualified Health Centers (FQHCs) through targeted workforce and infrastructure investment.

Additional testimony from organizations such as the Rhode Island Medical Society, AARP Rhode Island, and individual practitioners, including Dr. N.S. Damle, echoed similar concerns and emphasized the need for concurrent policy reforms. Their testimony acknowledged that while a public medical school could serve as a cornerstone of long-term workforce development, its success will depend on addressing existing systemic barriers to primary care

sustainability. Specifically, they identified physician reimbursement, payment reform, and retention incentives as key policy areas that must be addressed alongside medical education expansion. These stakeholders recommended that any legislative action establishing or funding a state medical school include provisions to ensure that the institution contributes directly to strengthening Rhode Island’s primary care system and does not function in isolation from broader workforce strategies.

In summary, the hearing provided the Commission with comprehensive testimony reflecting broad support for the establishment of a public medical school at the University of Rhode Island. However, the testimony also emphasized that the creation of such an institution must be accompanied by deliberate, data-driven policy interventions designed to enhance recruitment, retention, and reimbursement for primary care providers. The collective input underscored that solving Rhode Island’s primary care shortage will require a multifaceted approach, one that integrates medical education reform, targeted financial incentives, and systemic investment in the primary care delivery system to ensure long-term sustainability and equitable access to healthcare across the state.¹³

THE FEASIBILITY STUDY

The Joint Committee on Legislative Services funded a feasibility study carried out in collaboration between the University and the Commission, which hired Tripp Umbach, an independent consulting firm, to evaluate the potential establishment of a public medical school in response to the state’s worsening physician shortage, particularly in primary care. Rhode Island currently lacks a public MD-granting institution and retains only a small fraction of its medical graduates, with just 14% remaining in-state after completing residency. Interviews with key

¹³ October 9, 2025: Public Comment Commission Hearing

stakeholders, including healthcare leaders, government officials, and academic administrators, confirmed an urgent need for a community-focused medical school emphasizing primary care, affordability, and local workforce retention. Ultimately, establishing a public medical school represents a transformative investment in Rhode Island’s health, equity, and economic future.

I. Long Term Projection for Rhode Island

Tripp Umbach’s financial and economic analysis demonstrates that establishing a public school of medicine at the University is both a realistic and transformative investment for the state. The model calls for an initial launch investment of approximately \$175 million, funded through a mix of philanthropic, institutional contributions, along with long-term public commitments. The model assumes \$20 million in initial state support and an annual state appropriation of approximately \$22.5 million beginning in 2029 when the first class of students arrives. While modest start-up deficits are anticipated in the early years, these are projected to be offset over time by tuition revenue, clinical partnerships, research growth, and operational efficiencies. The study projects that by the school’s third year of operation, financial stability would be achieved, and by 2037, consistent surpluses of \$16 million annually are expected, ensuring the long-term viability required by accrediting bodies. Beyond fiscal sustainability, the school is projected to have a powerful economic ripple effect, generating \$196 million in annual economic activity, supporting roughly 1,335 jobs, and contributing \$4.5 million in state and local tax revenue each year once fully operational. Importantly, it would also expand the University’s competitiveness for federal and private research funding, reinforcing its R1 research designation, while serving as a key partner in addressing pressing public health challenges such as disparities in care, rural access barriers, and population health needs. Taken together, the financial and economic benefits position the proposed medical school not only as a solution to the state’s

worsening physician shortage but also as a catalyst for strengthening the state's economy, research enterprise, and healthcare system for decades to come.

Tripp Umbach found seven key findings to address in the long-term planning of a state medical school. By attending to these areas in partnership with creating a state medical school, Rhode Island will see progress in solving primary care access. These key findings are:

1. Changing demographics requires more healthcare access
2. The growing physician gap in Rhode Island
3. Physician recruitment and retention programs are essential
4. A public MD school of medicine at the University of Rhode Island emerges as the most viable medical education model
5. Clinical partners are committed to engaging with the University of Rhode Island through its current multi-disciplinary offerings
6. Expanding graduate medical education infrastructure positions URI's school of medicine for long-term physician retention
7. The school of medicine is financially viable and will provide a strong return on investment (ROI) to Rhode Island taxpayers¹⁴

Together, these findings underscore that establishing a public medical school is not only feasible but also essential to Rhode Island's long-term health and economic future.

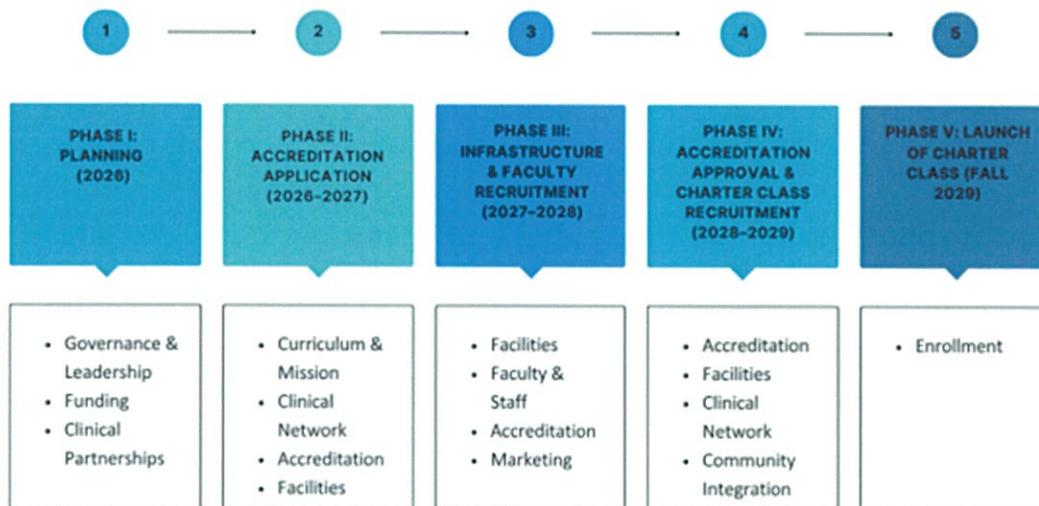
II. Needs for Implementation

Tripp Umbach recommends a carefully phased roadmap for the University to establish the state's first public school of medicine by 2029, designed to address the State's growing physician shortage while fostering long-term economic and social impact. The strategy emphasizes

¹⁴ ROI, or return on investment, is a financial metric that measures an investment's profitability by comparing its gains or losses to its cost. It is calculated using the formula: $ROI = ((Net\ Profit / Cost\ of\ Investment) \times 100\%)$.

incremental development, aligning governance, funding, accreditation, infrastructure, and partnerships to ensure the school is mission-driven, financially sustainable, and fully equipped to serve the state’s healthcare needs. By proceeding in structured phases, the University will be able to build institutional capacity, cultivate statewide collaborations, and secure the financial and operational resources necessary for enduring success.

This roadmap represents a projected timeline for the establishment of URI’s School of Medicine, and specific dates and milestones may be adjusted as planning, approvals, and other factors evolve.¹⁵



Phase I: Planning and Financial Support for 2026

This stage establishes governance structures and leadership, initiates clinical partnerships, and lays the groundwork for accreditation readiness. A School of Medicine Steering Committee, supported by advisory boards, will oversee planning, while a Liaison Committee on Medical Education (LCME) readiness task force will prepare the accreditation application. URI’s leadership will pursue university and state approvals to offer the MD degree early in 2026, and a

¹⁵ Tripp Umbach: Independent Feasibility Study into a Medical School at The University of Rhode Island

national search will identify a founding dean by mid-2026. This timeline allows three years for the dean to secure preliminary accreditation necessary to enroll the first 50 students. Financially, the University will seek \$22.5 million in recurring annual state support beginning in 2029 and launch a \$175 million philanthropic campaign. Concurrently, hospitals and community health centers will be engaged to create anchor training sites and foster public-private partnerships across Rhode Island, building upon already established relationships with the University's College of Nursing, College of Pharmacy, and College of Health Sciences.

Phase II: Accreditation Application and Curriculum Development 2026 - 2027

Under the guidance of the founding dean, the University will design a program that is focused on community-based primary care and establish academic pipelines, including BS/MD and early assurance programs. Agreements with hospitals and federally qualified health centers will expand clinical training capacity, while partnerships will be strengthened to grow in-state residency opportunities. Accreditation milestones during this period include submission of LCME "Applicant" status in 2026, followed by a self-study and attainment of "Candidate" status in 2027. Faculty recruitment and facilities planning will also begin, laying the foundation for a robust academic program and clinical network.

Phase III: Infrastructure Development and Faculty Recruitment 2027 - 2028

The University will construct and expand academic and simulation facilities while hiring department chairs, faculty, and core staff. The school will submit its LCME "Pre-Accreditation" application in late 2027 and host the first site visit in 2028. Simultaneously, a marketing and admissions campaign will launch, emphasizing recruitment of Rhode Island students committed to serving underserved communities. Scholarships and loan forgiveness programs will support these students, ensuring alignment with the school's mission to address local healthcare gaps.

Phase IV: Accreditation Approval and Charter Class Recruitment 2028 - 2029

The University will pursue LCME “Preliminary Accreditation” by fall 2028, enabling student recruitment for the inaugural class of 50. Academic and simulation facilities will be operational, clinical clerkships will be active across hospitals and community health centers, and partnerships with residency programs will link medical education to graduate medical education opportunities. Faculty research initiatives and statewide community health programs will also be launched to strengthen URI’s role as a healthcare partner throughout Rhode Island.

Phase V: Launch of the charter class in Fall 2029

The first 50 MD students will enter a mission-driven, community-based curriculum emphasizing primary care and service to underserved populations. The program is designed to scale up to 100 students per class over time, establishing a sustained pipeline of physicians for the state. Beyond the inaugural class, the University will implement a strategic plan for growth in class size, research, and residency programs into the 2030s. This phased approach positions the School of Medicine as both a healthcare and economic engine, generating hundreds of millions of dollars in economic activity and billions in long-term social benefits. By following this roadmap, the University will be able to ensure a durable, mission-aligned institution that addresses Rhode Island’s physician workforce needs, strengthens statewide partnerships, and advances healthcare access and outcomes for the community over decades. See addendum item 4 for consultant report breakdowns.¹⁶

VI. Matters that Require Further Study

The Commission acknowledges that several issues related to Graduate Medical Education (GME), residency availability, and clinical training capacity require continued examination.

¹⁶ Tripp Umbach: Independent Feasibility Study into a Medical School at The University of Rhode Island

Stakeholders, including the Rhode Island Medical Society, have expressed concerns that the state's current training infrastructure may be insufficient to support a new medical school and to retain graduates within Rhode Island. While the business plan being prepared by Tripp Umbach will provide detailed analysis, modeling, and recommendations related to these concerns, the Commission recognizes that further study will still be necessary. Ongoing evaluation of residency expansion, clinical placement availability, and long-term workforce capacity will be essential to ensure that Rhode Island can sustain a robust and effective physician training pipeline.

CONCLUSION & COMMISSION FINDINGS

The Commission supports the establishment of a medical school at the University of Rhode Island as a strategic investment in the state's healthcare workforce and long-term health outcomes. The Commission and the University of Rhode Island jointly engaged Tripp Umbach to conduct a comprehensive feasibility study assessing the need, capacity, and strategic value of establishing a public medical school at URI. The study confirmed that Rhode Island has both the clinical demand and statewide support to justify a new medical education program and that URI's existing health sciences strengths, interprofessional programs, and newly achieved R1 research status position it well to house such an institution.

Populations with better access to high quality primary care have better prevention, diagnosis and treatment of chronic conditions, fewer acute ER visits and hospital admissions, fewer health-related disparities and longer lifespans. Primary care is best delivered through interdisciplinary teams, and access to primary care can be measured by people reporting a usual source of care, the number of primary care clinicians, and the availability of appointments.

In reviewing different medical education models, the Commission concluded that an MD granting program best aligns with URI's research mission, offers stronger national name recognition, and provides a clearer pathway for recruitment of faculty, students, and clinical partners. While acknowledging the shared rigor of both MD and DO pathways, the Commission found that an MD program more effectively supports the state's goal of attracting and retaining a highly trained physician workforce and complements the established biomedical infrastructure and research-intensive environment at the University. The Commission also identified that Rhode Island has the clinical training capacity to support a community-focused MD program built across hospitals, community practices, behavioral health settings, and especially Federally Qualified Health Centers (FQHCs), which play a critical role in serving underserved populations. Expansion of clinical training capacity in the state will be necessary to meet ongoing needs for students. This distributed clinical model would expand primary care training opportunities and improve retention rates by embedding future physicians in the communities most in need.

Establishing a medical school at the University of Rhode Island represents a transformative investment in the state's future. Beyond addressing physician shortages, the school will build a sustainable pipeline of homegrown doctors trained to serve Rhode Island's unique communities, particularly in primary care and underserved areas. It will also foster innovation through interprofessional education, strengthen partnerships with healthcare providers statewide, and stimulate economic growth through research, clinical practice, and workforce development. Without action, on the other hand, Rhode Island risks falling further behind in physician supply workforce retention, and healthcare access, especially in primary care and underserved areas. By creating its own public School of Medicine, Rhode Island can secure long-

term healthcare goals, expand equitable access, and ensure that the state's residents receive the care they need for generations to come.

RECOMMENDATIONS

Building a Sustainable Public Medical School and Primary Care Workforce

Based on testimony, stakeholder feedback, and findings from the Tripp Umbach feasibility study, the Commission recommends the creation of a public medical school at the University of Rhode Island (URI) with a strong mission to focus on primary care workforce and retention. The Commission recognizes that investments in medical education must be paired with broader healthcare reforms to ensure long-term workforce stability. Improvements in reimbursement structures, administrative simplification, and expanded interprofessional training models are necessary to strengthen practice environments and enhance retention. Educating more clinicians is necessary but not sufficient for increasing supply. Clinicians stay where they train. Rhode Island must have a concrete plan to produce more primary care clinicians through a residency (i.e., postgraduate training) strategy that incentivizes training more primary care clinicians and training them in community settings like Community Health Centers. These reforms will ensure that Rhode Island's investment in establishing a public medical school is reinforced by a healthcare system capable of supporting a sustainable, community-oriented primary care workforce. Achieving this vision requires a sustained and strategic investment in medical education, as well as further study by the University and the development of the business plan.

Establishing a Primary Care Commission to Support Workforce Retention and explore GME programs

In addition to a medical school and robust residency programs, Rhode Island must continue to focus on other proven strategies to improve retention of primary care clinicians, including appropriate payment for primary care, reducing administrative burdens for clinicians, and sustained commitments to improving public health and lowering uninsured rates. The State should establish a Primary Care Commission to ensure continued focus on achieving a primary care-oriented system of care. The Commission's initial charge should be to review evidence and develop a comprehensive graduate medical education and workforce strategy to produce and retain skilled and committed primary care clinicians, along with the public policies needed to support that strategy. This work should include assessment of opportunities to expand residency and fellowship programs for physicians, as well as clinical training capacity, residency, and transition-to-practice models for physician assistants and nurse practitioners, recognizing their essential role in team-based primary care delivery. The Commission would assess opportunities to expand residency and fellowship programs within Rhode Island's hospital systems, community health centers, and FQHC networks, and evaluate the state's capacity to broaden and strengthen clinical rotation sites for medical students. Expanding clinical training locations particularly in community-based, primary care, and underserved settings is essential for preparing students for real-world practice, meeting accreditation standards, and fostering early connections between trainees and Rhode Island's healthcare delivery system. Increasing both residency capacity and clinical rotation opportunities is critical to retaining medical school graduates, improving access to care in underserved areas, and ensuring that educational pathways align with statewide workforce priorities. Public testimony consistently affirmed that without

expanded GME and clinical training infrastructure, Rhode Island risks losing newly trained clinicians to neighboring states.

Business Plan

Tripp Umbach’s initial business plan proposal outlines a structured six-month process to develop a comprehensive business plan guiding the University of Rhode Island from concept to implementation of a new, public, MD-granting medical school. Building on the feasibility study, the firm will produce an operational and financial roadmap that defines governance structures, leadership needs, accreditation timelines, facility requirements, and partnership frameworks with Rhode Island’s hospitals, health systems, and community clinics. The plan includes validating clinical training capacity, assessing opportunities for statewide Graduate Medical Education (GME) expansion, and refining a multi-year pro forma that incorporates updated assumptions for enrollment, revenues, expenditures, and capital investments. Tripp Umbach will also conduct site analyses for both South Kingstown and Providence, evaluate short-and long-term infrastructure needs, and integrate updated economic impact and ROI modeling. The process involves extensive engagement with internal university leadership and external healthcare partners to ensure alignment with state workforce needs and accreditation standards. Deliverables include a full business plan, an accreditation and implementation roadmap, governance and leadership recommendations, and final presentations to URI and state stakeholders.

Provide Initial Seed Funding and Pursue Multiple Financing Mechanisms, Including Rhode Island Capital Funds

The Commission supports the recommendation that the State of Rhode Island provide \$20 million in initial seed funding, which would serve as the critical first step in establishing a public medical school. To complement this investment, the University and state should explore

multiple financing pathways, including federal grants, a direct FY2027 budget appropriation, a statewide bond referendum, and the securing of Rhode Island Capital Funds to support early-stage development. Public testimony strongly reinforced that investing in medical education now through diversified and sustained funding mechanisms is essential to building a robust and self-sustaining medical school infrastructure.

**Establish a Dedicated and Recurring State Budget Line for Medical School Development
(Starting the inaugural year of the medical school)**

The Commission recommends that the General Assembly create a dedicated, recurring budget line to support ongoing medical school planning, accreditation, and initial operational activities. Public testimony consistently emphasized that stable, predictable funding is essential to building a high-quality program that can progress through accreditation milestones while expanding partnerships with hospitals, community health organizations, and Federally Qualified Health Centers (FQHCs). A state-backed funding stream will ensure the University of Rhode Island can build and sustain a rigorous medical education program that aligns with Rhode Island's long-term workforce needs.

Expand and Enhance the State Health Professional Loan Repayment Program and Develop further incentive-based programs

Rhode Island should expand and enhance the existing State Health Professional Loan Repayment Program and develop a Primary Care Health Professional Scholarship Program that includes a minimum five-year service obligation in primary care practice. In addition, the State should undertake a comprehensive review of the effectiveness of all existing and proposed initiatives intended to reduce healthcare education debt, including the Wavemaker Fellowship Program. Current and future loan repayment, scholarships, and tuition reimbursement programs

should be strategically aligned to attract, retain, and sustain a robust primary care workforce, while leveraging existing infrastructure to maximize efficiency and impact. The Commission further recommends evaluating targeted retention incentives, such as professional development stipends, to ensure their implementation is supported by evidence and workforce data.

Addendum 1

2024 Senate Resolution 385 Senate Bill 2024-3165

<https://webserver.rilegislature.gov/BillText/BillText24/SenateText24/S3165.pdf>

2024 -- S 3165

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LC006260
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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

SENATE RESOLUTION

CREATING A SPECIAL COMMISSION TO MAKE A COMPREHENSIVE STUDY OF
RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING AND
RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE MEDICAL
SCHOOL AT THE UNIVERSITY OF RHODE ISLAND

Introduced By: Senators Sosnowski, Ruggerio, Lauria, DiMario, Pearson, Felag, F.
Lombardi, Gu, de la Cruz, and Britto

Date Introduced: June 13, 2024

Referred To: Recommended for Immediate Consideration

1 WHEREAS, Nationally the demand for primary care physicians continues to increase,
2 however, less than one-third of the national physician workforce represents individuals in the
3 primary care sector; and

4 WHEREAS, Rhode Island is experiencing a net loss of primary care clinicians and
5 anticipates this shortage to worsen in the years ahead; and

6 WHEREAS, Rhode Island residents are struggling to find primary care physicians
7 resulting in the use of community health centers and urgent care facilities to meet their medical
8 needs; and

9 WHEREAS, Increased utilization of these health care facilities strains resources and
10 creates additional pressure on our healthcare system; and

11 WHEREAS, While Rhode Island is home to a private medical school, no new medical
12 schools have been established in the State since 1972; and

13 WHEREAS, Rhode Island struggles to retain primary care physicians upon graduation
14 and offsets these loses with physicians moving into the State; and

15 WHEREAS, Rhode Island must look toward the creation of a college of medicine to train
16 and retain the next generation of primary care physicians; now, therefore be it

17 RESOLVED, That a special legislative commission be and the same is hereby created
18 consisting of twenty-one (21) members: all of whom shall be appointed by the President of the

1 Senate.

2 The purpose of said commission shall be to make a comprehensive study of Rhode
3 Island's healthcare workforce related to educating and retaining primary care physicians and
4 establishing a state medical school at the University of Rhode Island.

5 By August 1, 2024, upon passage of the resolution, the members of the commission shall
6 be appointed and shall meet at the call of the Senate President and organize and the Senate
7 President shall appoint a chair, and a co-chair, who shall be the President of the University of
8 Rhode Island, or designee.

9 Vacancies in said commission shall be filled in like manner as the original appointment.

10 The membership of said commission shall receive no compensation for their services.

11 All departments and agencies of the State shall furnish such advice and information,
12 documentary and otherwise, to said commission and its agents as is deemed necessary or
13 desirable by the commission to facilitate the purposes of this resolution.

14 The Joint Committee on Legislative Services is hereby authorized and directed to provide
15 suitable quarters for said commission; and be it further

16 RESOLVED, That the commission shall develop and submit its findings and
17 recommendations to the Senate no later than by January 2, 2026, and said commission shall
18 expire on January 31, 2026.

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LC006260
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

SENATE RESOLUTION

CREATING A SPECIAL COMMISSION TO MAKE A COMPREHENSIVE STUDY OF
RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING AND
RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE MEDICAL
SCHOOL AT THE UNIVERSITY OF RHODE ISLAND

1 This resolution would create a 21-member commission to study RI's healthcare
2 workforce related to educating and retaining primary care physicians and establishing a state
3 medical school at URI, and would report back by January 2, 2026, and would expire January 31,
4 2026.

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LC006260
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Addendum 2
Commission Agendas

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Wednesday, August 28, 2024

TIME: 5:30 PM

PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome & Introductions
- I. Overview of commission objectives
- II. Dr. Michael Fine, Presentation on Primary Care in Rhode Island
- III. Q&A from members
- IV. Discussion of next meeting date
- V. Adjournment

There will be no public testimony at this meeting.

COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Livestreaming is available at <https://capitolvri.cablecast.tv/>

POSTED: FRIDAY, AUGUST 23, 2024, 2:00 P.M.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, October 29, 2024

TIME: 5:30 PM

PLACE: Room 313

AGENDA

- I. Welcome & Introductions
- II. Presentations
 - a. Eugenio Fernandez
 - b. L. Anthony Cirillo MD, FACEP
 - c. Cory King, Commissioner of the Office of the Health Insurance Commissioner
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Monday, January 27, 2025

TIME: 5:30 PM

PLACE: State House—Senate Lounge

AGENDA

- I. Welcome & Introductions
- II. Commission Updates
- III. Presentations
 - a. Debra Hurwitz, MBA, BSN, RN, CTC-RI Executive Director
 - b. Stephen J. Spann, M.D., M.B.A., Professor Emeritus-Tilman J. Fertitta Family College of Medicine at the University of Houston
 - c. Dr. Robert M. Califf, MD, MACC, US Commissioner of Food and Drug Administration (2016-2017; 2022-2024)
- IV. Q&A
- V. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Monday, March 17, 2025

TIME: 5:30 PM

PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome
- II. URI Medical School Feasibility Study:
 - Paul Umbach and Ha Pham – Tripp Umbach
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Senate committee hearings may also air on Channel 75 for Cox Subscribers. Livestreaming is available at <https://capitolvri.cablecast.tv/>

POSTED: THURSDAY, MARCH 13, 2025, 10:35 A.M.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Friday, May 30, 2025

TIME: 2:30 PM

PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome
- II. Feasibility Study Update and Presentation:
 - Paul Umbach and Ha Pham – Tripp Umbach
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Senate committee hearings may also air on Channel 75 for Cox Subscribers. Livestreaming is available at <https://capitolvri.cablecast.tv/>

POSTED: TUESDAY, MAY 27, 2025, 4:57 P.M.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Thursday, October 9, 2025

TIME: 5:00 PM

PLACE: Senate Lounge – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Public Comment
- I. Adjournment

There will be public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Thursday, October 30, 2025

TIME: 5:00 PM

PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Paul Umbach and Ha Pham – Tripp Umbach (Via Webex)
- III. Q&A
- IV. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, November 18, 2025

TIME: 4:00 PM

PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Discussion & Review of draft Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Thursday, December 18, 2025

TIME: 5:00 PM

PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Discussion & Review of draft Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, January 13, 2025
TIME: Rise of the Senate
PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Discussion & Review of draft Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, January 27, 2026

TIME: 5:15 PM

PLACE: Senate Lounge – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Consideration of Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

Addendum 3

Commission Meeting Presentations and Public Testimony

- 1. August 28, 2024**
- 2. October 29, 2024**
- 3. January 27, 2025**
- 4. March 17, 2025**
- 5. May 30, 2025**
- 6. October 9, 2025**
- 7. October 30, 2025**
- 8. November 18, 2025**
- 9. December 18, 2025**
- 10. January 13, 2026**
- 11. January 27, 2026**

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Wednesday, August 28, 2024

TIME: 5:30 PM

PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome & Introductions
- I. Overview of commission objectives
- II. Dr. Michael Fine, Presentation on Primary Care in Rhode Island
- III. Q&A from members
- IV. Discussion of next meeting date
- V. Adjournment

There will be no public testimony at this meeting.

COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Livestreaming is available at <https://capitoltvri.cablecast.tv/>

POSTED: FRIDAY, AUGUST 23, 2024, 2:00 P.M.

State of Rhode Island

SENATOR
ALANA M. DiMARIO
District 36

Room 209
Rhode Island State House
Providence, Rhode Island 02903

OFFICE 401-276-5568

sen-dimario@rilegislature.gov



CHAIR
Committee on
Environment & Agriculture

CO-CHAIR
Commission on Child Care

Committee on
Health & Human Services

Senate Chamber

August 28, 2024

Senator Pamela J. Lauria
URI President Marc B. Parlange
Health Care Workforce Study Commission
82 Smith Street
Providence, RI 02903

Senator Lauria and President Parlange:

I regret that I am unable to join you and the rest of the commission members today for our first meeting. To everyone who has chosen to devote their time and talent to this significant effort, I thank you for your willingness to serve.

My primary profession is working as a licensed mental health counselor in Rhode Island. From my perspective working in our healthcare system, I know what a significant role primary care providers - including pediatricians and OBGYN's - play as the key point people in all health care services delivery. After decades of work in our community experiencing the multiple challenges of our current system, I first ran for Senate with the goal of working to solve these problems.

It is both from my perspective as a mental health care provider and as a legislator committed to ensuring all Rhode Islanders have access to the health care they need that I view the work of this commission as a foundational part of fixing our system. Addressing Rhode Island's critical shortage of primary care providers, which looms as an even greater crisis in the years ahead, is urgent. Strengthening the primary care workforce pipeline in our state was a key focus of the Senate's HEALTH Initiative in the most recent session, and with the leadership of Senator Lauria we took important steps forward on short term measures. It is my hope that this commission can create sustainable solutions for the future.

I am excited that evaluating the possibility of a medical school at the University of Rhode Island is a central part of this commission's charge. A state-based medical school has enormous potential to expand our workforce and transform Rhode Island's health care landscape, helping attract future primary care providers to study, train and work in our state. It can also play a central role in our efforts to confront other health-related challenges we face, including the ongoing mental health crisis. Ideally, these goals can be combined with creating accessible pathways for Rhode Islanders to pursue a medical education that will allow them to stay right here and serve the communities they know and love best, to the benefit of all.

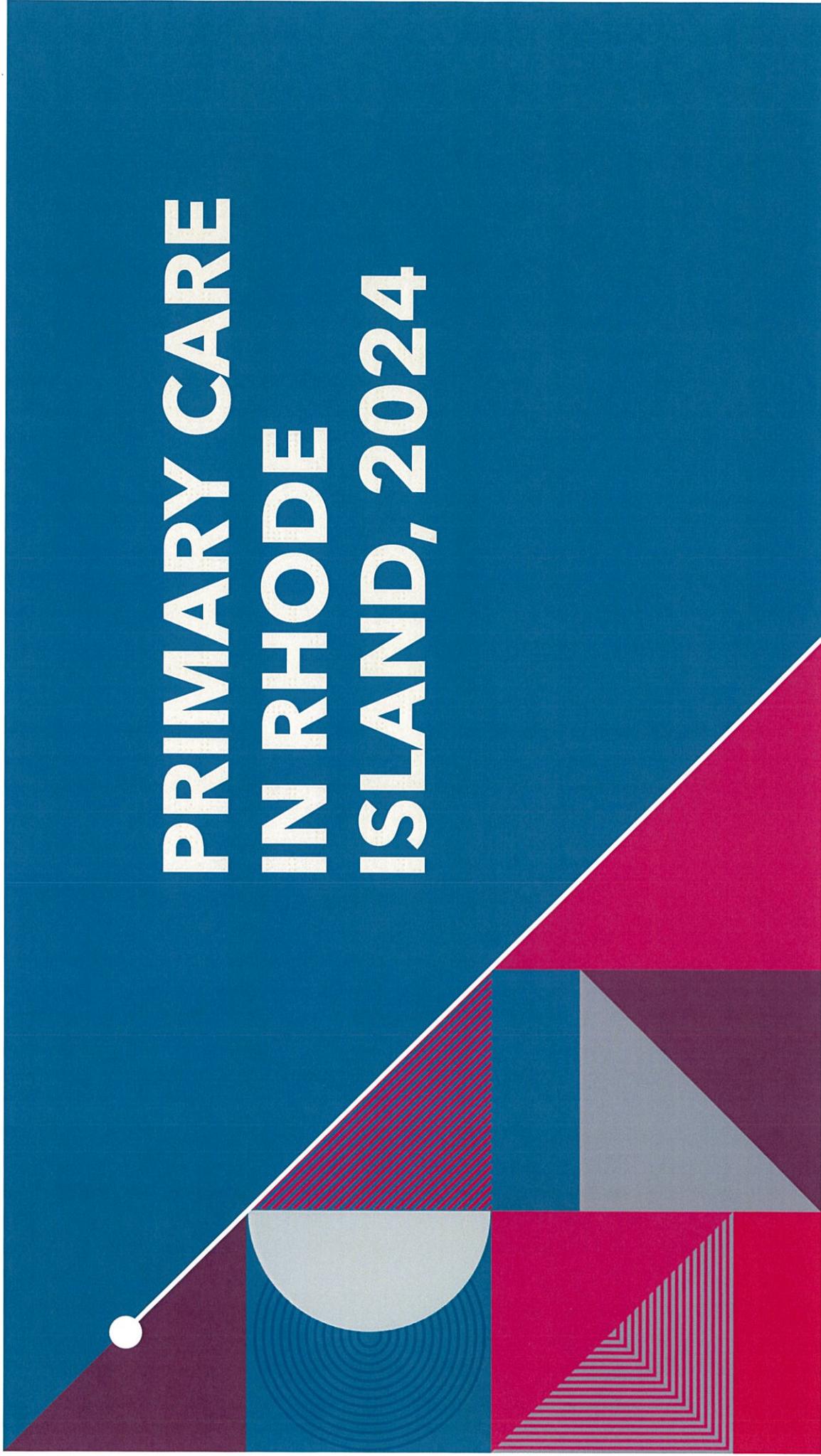
I want to thank President Ruggiero, Leader Pearson, Whip Lawson, and my Senate colleagues for their support and leadership as we have worked to make health care more accessible and affordable for Rhode Islanders. This commission's findings will be vital in setting our path forward, and I look forward to our work together.

Sincerely,

A handwritten signature in cursive script that reads "Alana M. DiMario".

Senator Alana M. DiMario

PRIMARY CARE IN RHODE ISLAND, 2024



Updated Definition of Primary Care

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

Addition to the Definition of Primary Care

At the heart of primary care is a trained medical professional who knows you, your family, and your community, and who serves as your trusted source of care for your whole health over time, whether for illness or wellness.

WHO PRACTICES PRIMARY CARE?

- **Primary Care Physicians** (29% of all physicians, 2010 and 2019 US Data, likely provide about **50-75 %** of all primary care visits)
 - Family Medicine (80-90% practice primary care, provide **45 percent** of all physician primary care services)
 - Internal Medicine (33% practice primary care, provide **31 percent** of all physician primary care services)
 - Pediatrics (53% practice primary care, provide **24 percent** of all physician primary care services)
- **Nurse Practitioners/Advanced Practice Nurses** (32-70 percent practice primary care, unknown proportion of all primary care visits, but **likely 27-33 percent**)
- **Physician Assistants/Associates** (23% practice primary care but unknown proportion of all primary care visits, likely **ten percent or less**)
- **Also: Community Health Workers, Social Workers, Psychologists, Pharmacists, Physical Therapists, Lab and Xray technologists, Substance Use Disorder Counselors** and many others

• HRSA. Primary Care Workforce Facts and Stats No.1, 2010

DATA SOURCES

- RIDOH Licensing Data (Sensitive but not specific)
- National Surveys using the AMA datafile (likely under-estimates the number of retirees)
- Robert Graham Center (AAFP), BMJ, AANP, HRSA and other studies of national surveys and databases)
- AAMC State reports - sensitive and specific
- All this data is a rapidly moving target

IDEAS AND QUESTIONS

- A position of strength: Health Care in Rhode Island
- How does primary care supply relate to cost and public health outcomes?
- How many primary care clinicians do we have?
- Demographics of primary care clinicians in Rhode Island
- How many primary care clinicians do we need?
- How many primary care clinicians are we training?
- How many Rhode Islanders apply to medical school?
- How many get in?
- Where to they go?



**A POSITION OF
STRENGTH: HEALTH
CARE IN RHODE
ISLAND**

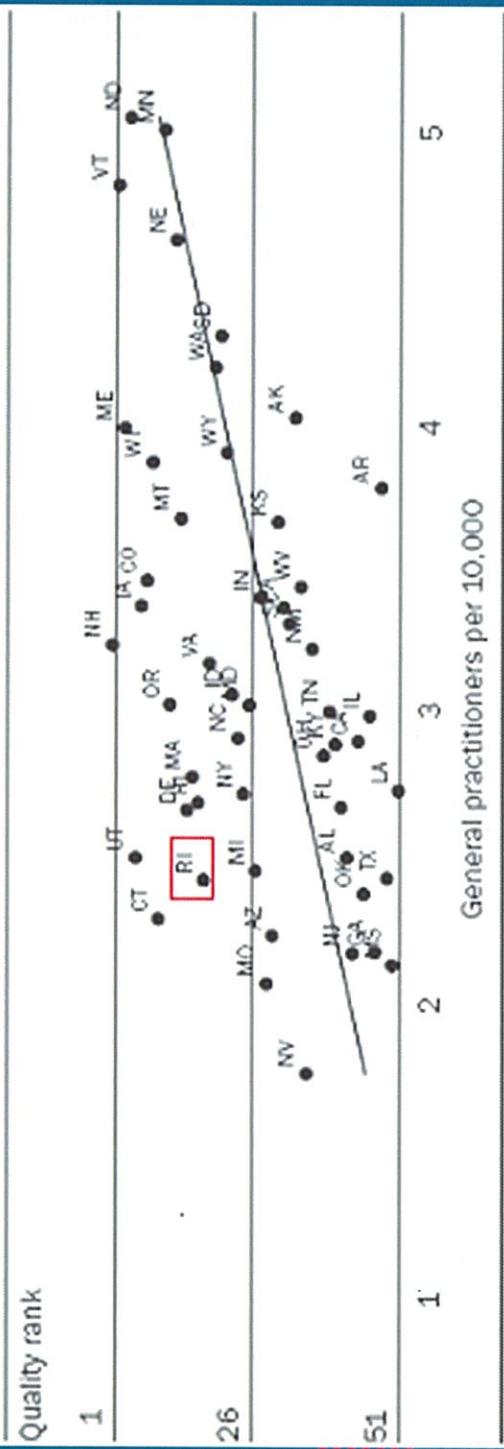
**WE RANK IN THE TOP FIVE STATES
IN THE NATION FOR HEALTHCARE
OVERALL**

**WE ARE FOURTH RANKED FOR
PRIMARY CARE SUPPLY**

HOW DOES PRIMARY CARE SUPPLY RELATE TO COST AND PUBLIC HEALTH OUTCOMES?



Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

HOW DOES PRIMARY CARE WORK TO REDUCE COST AND IMPROVE PUBLIC HEALTH?

- Lowest cost first contact care
- Evidence based preventative care
- Care coordination
- Relationship focused teachable moments

RELATIONSHIP MATTERS

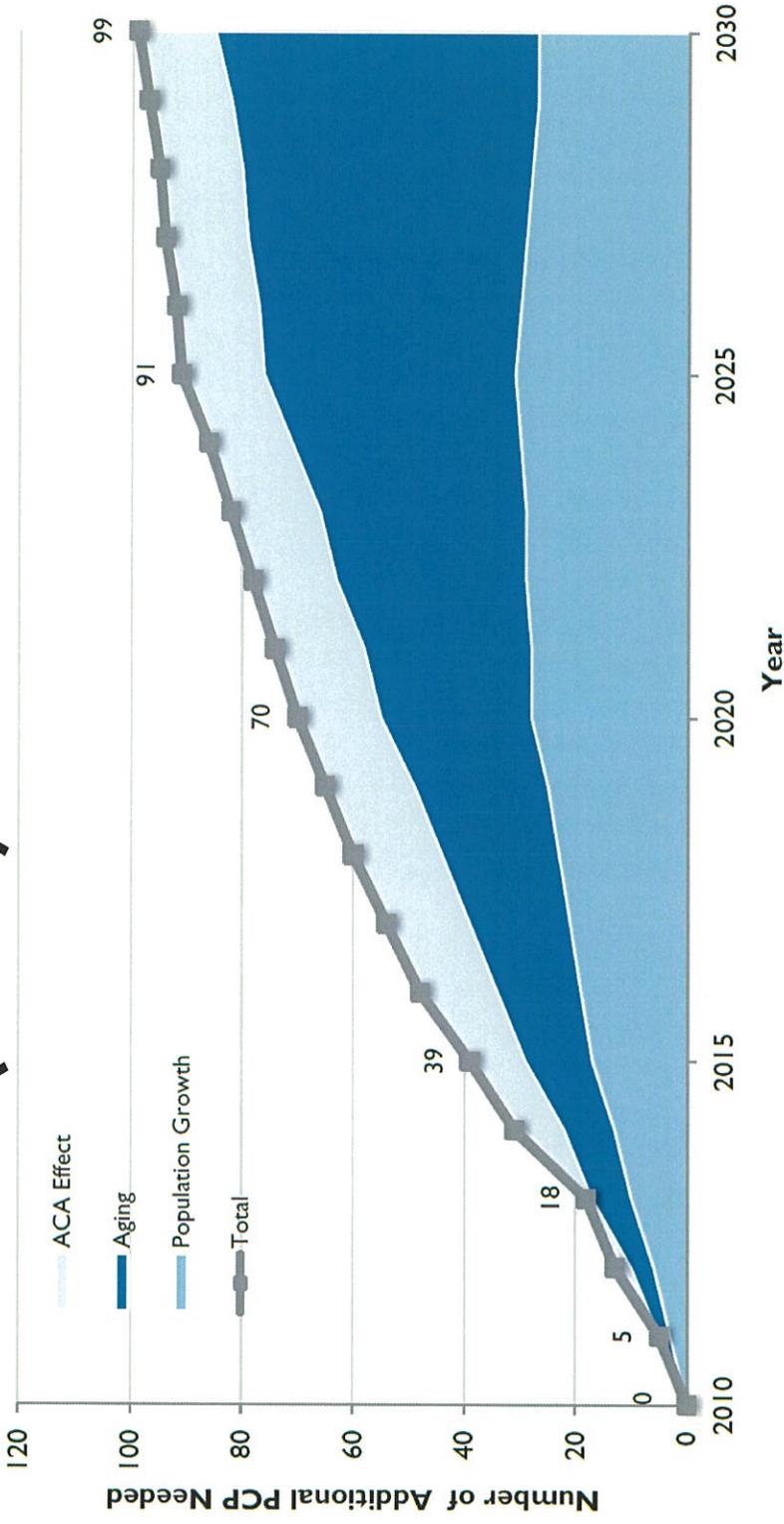


Primary Care works because of the *relationships* primary care physicians and other clinicians have with the people who are their patients

- Continuity
 - improved diagnostic accuracy,
 - improved care ordination
 - improved patient satisfaction and trust
 - fewer emergency room visits
 - fewer hospital admissions
 - fewer readmissions¹
 - higher quality
 - lower costs¹
 - and reduced mortality.
- Time
 - Sitting is associated with better communications, patient satisfaction, adherence and rapport
- Context
- Focus
- Care coordination
- Christine A. Sireky, MD, Tia D. Shanfelt, MD, Alexandra M. Bickel, MD. [Radical Reorientation of the US Health Care System Around Relationships. October 04, 2022](https://doi.org/10.1016/j.ama.2022.08.003) [DOI:10.1016/j.ama.2022.08.003](https://doi.org/10.1016/j.ama.2022.08.003) [Cohen BP. Sitting at the bedside. Patient and internal medicine trainee perceptions. J Gen Intern Med sept. 2022](https://doi.org/10.1016/j.ama.2022.08.003) [Swayden K et al. Effect of sitting v standing on perception of provider time at the bedside: a pilot study. Patient Educ Couns 2012;FEB](https://doi.org/10.1016/j.ama.2022.08.003)

HOW MANY PRIMARY CARE CLINICIANS DO WE NEED?

Rhode Island Projected Primary Care Physicians Need (2013)*



*Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.

HOW MANY PRIMARY CARE CLINICIANS DO WE NEED?

We also need primary care physicians for all the people who do not now have primary care.

That is likely between one quarter and one half of all adults. Or between 200,000 and 400,000 people.

Which means we are short an extra **133 to 266** primary care clinicians, assuming a panel size of 1500 per primary care clinician

HOW MANY PRIMARY CARE CLINICIANS DO WE NEED?

Panel size matters

Panel size is the number of people each primary care clinician cares for

Documented 25 percent decrease between 2012-2022 from 2386 to 1786 people

But the ideal is probably 500

"It you beat a dying horse, it dies."

PANEL SIZE MATTERS:

WHY IS PANEL SIZE SHRINKING ?

The electronic medical record and its capture by the billing process

Proliferation of guidelines

Number of new medications to manage

Preauthorization and other forms

Increased number of people living with chronic disease



HOW PANEL SIZE MATTERS

If the ideal panel size is 3000, then we need 333

If the ideal panel size is 2000, then we need 500

If the ideal panel size is 1500, then we need 666

If the ideal panel size is 1000, then we need 1000

**But if the ideal panel size is 500, then we
need 2000**

HOW MANY PRIMARY CARE PHYSICIANS DO WE HAVE?



Rhode Island Primary Care Physician Workforce Profile (AAMC 2019)

- Family Medicine/General Practice: 305
- Internal Medicine/Pediatrics: 20
- Internal Medicine: 615
- Pediatrics: 260

- **1200 total -- but the number of retirements post pandemic are unknown**
- **Active Patient Care Primary Care Physicians per 100,000 Population 2018: 106.6 (rank 4th by state)**

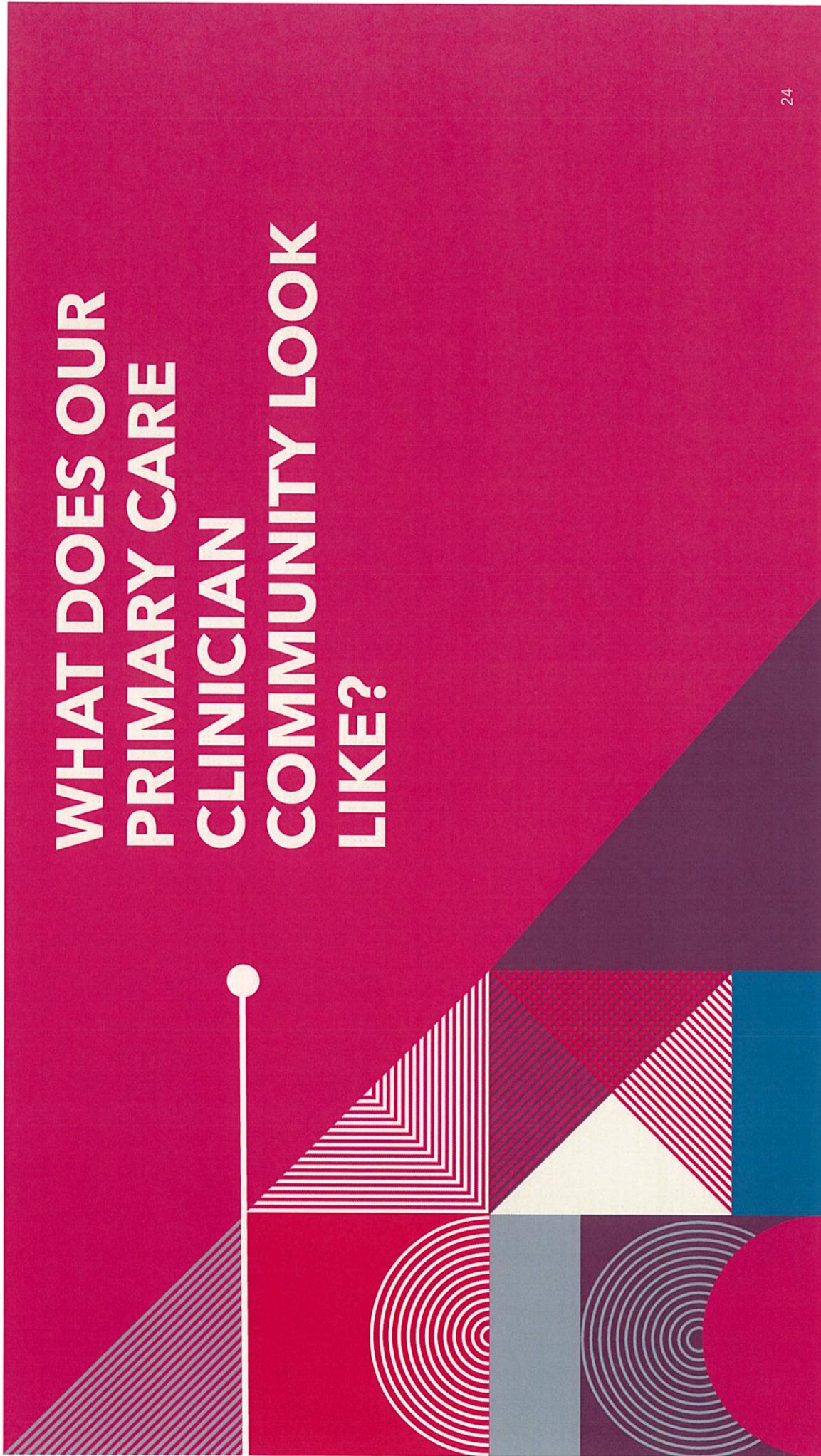
Rhode Island Primary Care Nurse Practitioner and PA Workforce Profile

- Actual FTE numbers unknown
- But nationally, about fifty percent of the primary care workforce is made up of Advanced Practice Nurses (Nurse Practitioners) and PAs
- If we assume that 50 percent of the primary care workforce are APRN/NP/Pas, then there may be as many as **1200** practicing in RI
- Panel sizes are unknown

Estimated Rhode Island Practices and Clinicians by Practice Size

Practice Size	Estimated Percentage of Practices by Size	Estimated Percentage of Clinicians by Practice Size
Small Practice (1-5 PCPs)	75%	42%
Mid-Sized Practice (6-10 PCPs)	19%	33%
Large Practice (>10 PCPs)	6%	26%

WHAT DOES OUR PRIMARY CARE CLINICIAN COMMUNITY LOOK LIKE?



Where did Rhode Island's Licensed Primary Care Physicians go to Medical School

	Family Medicine	All Primary Care
New England COM	41 (6.7%)	75
Warren Alpert/Brown	26 (4%)	148 (6%)
Ross University	19	43
Philadelphia COM	16	29
Jefferson	15	25
Boston University	14	43
UMass	12	48
Ohio State	8	15
Total	606	2362

How many licensed Rhode Island Primary Care Physicians went to medical school outside the US

	Family Medicine	Internal Medicine	Pediatrics
Total number	516	1222	406
Percent foreign trained	36%	39%	19%

What do we know about the race and ethnicity of Rhode Island Licensed Family Practice Physicians?

	Black	Hispanic	Total
Number	51	19	70
Percent	9% (6 %)	4% (16%)	12% (31%)

What do we know about the race and ethnicity of Rhode Island Licensed Pediatricians?

	Black	Hispanic	Total
Number	20	19	39
Percent	5% (6 %)	5% (16%)	10% (31%)

What do we know about the race and ethnicity of Rhode Island Licensed Internal Medicine Physicians?

	Black	Hispanic	Total
Number	52	78	130
Percent	4% (6 %)	6% (16%)	10% (31%)

What do we know about the race and ethnicity of Rhode Island Licensed Family/individual lifespan APRNs/ Nurse Practitioners ?

	Black	Hispanic	Total
Number	123/1229	57/1229	180/1229
Percent	10% (6 %)	5% (16%)	15% (31%)

What do we know about the race and ethnicity of Rhode Island Licensed Physician's Assistants/Associates?

	Black	Hispanic	Total
Number	no data	no data	
Percent			

*NA – This specialty was not among the top 20 in demand last year, average salary offers are not available.

What do Rhode Island Primary Care Clinicians Earn?

Medical Specialty	2020/2021 Average Salary Offer	2021/2022 Average Salary Offer	Year over Year Change
Orthopedic Surgeon	\$546,000	\$565,000	3%
. Cardiologist (Interventional)	\$611,000	\$527,000	-16%
Urologist	\$497,000	\$510,000	3%
Psychiatrist	\$279,000	\$299,000	7%
Hospitalist	NA*	\$284,000	NA*
Internal Medicine (Internist)	\$244,000	\$255,000	5%
Family Medicine Physician	\$243,000	\$251,000	3%
Pediatrician	\$236,000	\$232,000	-2%
Certified Registered Nurse Anesthetist	\$222,000	\$211,000	-5%
Nurse Practitioner	\$140,000	\$138,000	-1%

What are the challenges to the primary care business model?

- 60 percent of earnings go to overhead
 - Two thirds of that goes to support the billing process alone
- Prices are fixed by Medicare, Medicaid, and insurance companies

How many primary care physicians are we training?

	# New Trainees Per Year AY2023-2024	Total Resident Enrollment - All Years AY2023-2024	# of Graduates from AY2022-2023	Residents Entering PC (count/# graduates from AY2022-2023)		Residents Entered PC, Stayed in Rhode Island (count/# graduates from AY2022-2023)	
				#	%	#	%
	106	316	106	31	29%	15	14%
TOTALS							

How many primary care nurse practitioners and physician's assistants are we training?

	# New Trainees Per Year AY2023-2024	Total Student Enrollment - All Years AY2023-2024	# of Graduates from AY2022-2023	Trainees Entering PC (count/# graduates from AY2022-2023)		Trainees Entered PC, Stayed in Rhode Island (count/# graduates from AY2022-2023)	
				#	%	#	%
TOTALS	274	417	144	61	42%	48	33%

WHAT DO OUR FUTURE PRIMARY CARE PHYSICIANS LOOK LIKE?

RHODE ISLAND MEDICAL SCHOOL APPLICANTS AND MATRICULANTS, 2023

		Black (6%)	Hispanic (16%)	Multiple Race/ethni city (9%)	Total Bipoc (31%)
Total Applicants	102	7	3	7	17 (16.6%)
Total Accepted	53	1 (2%)	1 (2%)	5 (10%)	7 (13%)
Matriculate d in Rhode Island	15	unknown	unknown	unknown	unknown
Likely Primary Care (20 %)	11 3 from Brown	--	--	1	1 to 2 Max one from Brown

How many Rhode Island primary care clinicians are nearing retirement age?

- What we know:
 - **29 percent** of all RI licensed physicians, 17 percent of APRNs, and 8 percent of PAs are over 60;
 - If the age distribution of primary care physicians is about the same, then **348** RI primary care physicians and **204** NPs/PAs are over 60 -- **552** in all
 - If ten percent a year retire, then we can expect to lose **55** primary care clinicians a year to retirement
 - If twenty percent a year retire, then we can expect to lose **110** primary care clinicians a year to retirement
 - Remembering that **11** Rhode Islanders a year will likely become primary care physicians
 - We are producing **15** primary care physicians a year for Rhode Island in our residencies
 - We are producing **48** APRN/NPs and Pas a year for Rhode Island in our existing APRN/NP programs
 - Remembering that we lack at least **133-266** primary care clinicians for the 200,000-400,000 Rhode Islanders who likely don't have primary care now. And perhaps three times (300-600) that number, if only 50 percent of Rhode Islanders have a primary care clinicians and the panel size is shrinking to 500.



SO WHAT'S THE PROBLEM, EDDIE?

Shrinking panel size and retirements will intensify our primary care shortage over time

Our primary care clinicians don't look like the communities they serve - and likely don't speak needed languages

RI students from our communities are often closed out of primary care medical careers

DATA WE DON'T HAVE

How many FTE Primary Care Physicians, Nurse Practitioners and Physician Assistants are practicing in Rhode Island today, and how is that changing each year.

What's the panel size of each clinician and how is that changing over time?

Race and ethnicity of practicing primary care clinicians

What proportion of the population has a robust primary care relationship and how that varies by location, race, language spoken and ethnicity

The impact of nurse practitioner and Pa supply on cost and population health



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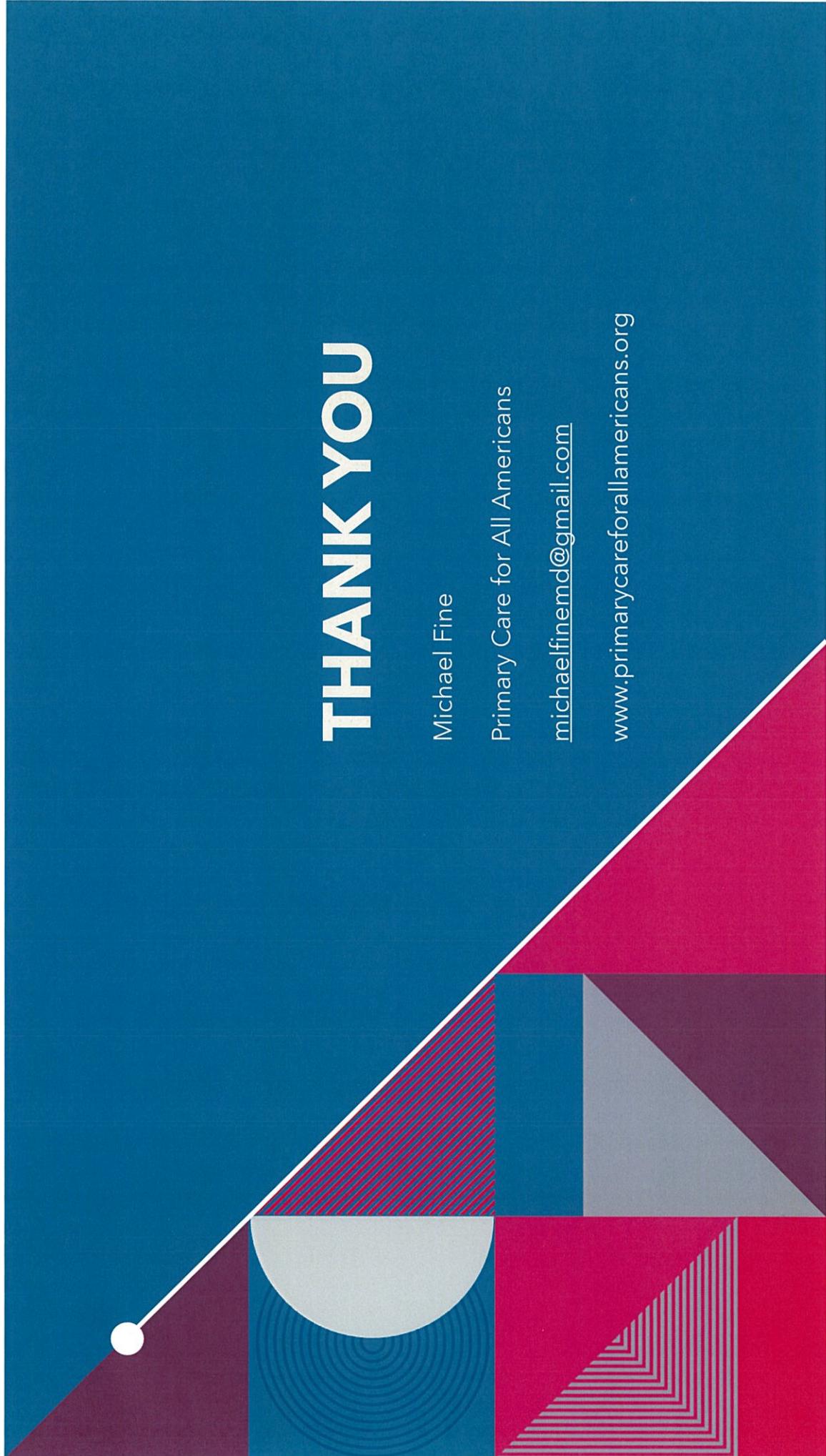
THANK YOU

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Primary Care Access for All: A Roadmap for Addressing the Primary Care Crisis in Rhode Island

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ABSTRACT

BACKGROUND: Primary care in Rhode Island is in crisis. The dearth of primary care providers is already affecting access to services and the situation is likely to worsen unless major steps are taken. There are inadequate numbers of trainees in primary care medical residencies, nurse practitioner (NP) and physician assistant (PA) training programs who plan to practice primary care in our state. The Care Transformation Collaborative of RI (CTC-RI) has assembled a broadly representative task force of physicians, NPs, PAs, and others to build a strong and robust primary care delivery system across the state that recruits, trains, retains, and sustains primary care providers.

STUDY METHODS AND DESIGN: Program directors from all primary care medical residencies, NP, and PA programs were asked to provide data on their programs, including the number of new trainees per year, total enrollment, and information on recent year graduates, including the total number, the number entering primary care, and the number entering primary care who plan to practice in RI.

PRIMARY RESULTS: Of the 106 graduates from primary care residencies in RI in academic year 2002–23, only 15 (14%) planned to provide primary care in Rhode Island. Similarly, of the 144 NP and PA graduates in primary care programs, only 48 (33%) planned to provide primary care in the state.

PRINCIPAL CONCLUSIONS: Given the high rate of primary care provider burnout, reduction in patient care hours, and retirement, primary care access will be further eroded unless major steps are taken. The CTC-RI Task Force on Primary Care Provider Workforce has produced a strategic roadmap to address these issues.

KEYWORDS: primary care; workforce; Rhode Island healthcare; training programs

INTRODUCTION

Primary Care in Rhode Island is in crisis on all levels and the primary care providers (PCPs), whether they be physicians, NPs, or PAs, are in short supply. A 2021 American

Association of Medical Colleges report shows a national and regional shortage of primary care physicians.¹ Recent articles in the *Boston Globe*² and *Providence Journal*³ report on the worsening problems patients are having when they attempt to make medical appointments with their primary care doctors and to access primary care in general. A pre-pandemic analysis by the American Academy of Family Physicians predicts that the Rhode Island PCP workforce will continue to decline and will likely have a deficit of nearly 100 PCPs by the end of the decade if nothing is done.⁴ As we have emerged from the pandemic, our healthcare workforce crisis continues to worsen. Primary care providers are retiring earlier, while many more are now approaching retirement age. A review of primary care medical residency matching and NP graduations over a 10-year period recently published in *Health Affairs* shows that primary care physician matches have remained flat, while the percentage of graduating NPs entering primary care has dropped from 89% in 2018 down to only 70% in the last two years.⁵ The entry of new graduates into the healthcare workforce cannot compensate for the retirement and loss of practicing primary care clinicians.

Several additional factors exacerbate Rhode Island's primary care shortage:

- The healthcare workforce crisis has also impacted the hiring of nurses, medical assistants, behavioral health clinicians and other key allied health staff. Managing ever-larger patient panels without adequate support increases clinician stress and leads to higher rates of self-reported burnout among primary care providers.
- Relatively lower salaries coupled with ever-higher student educational debt and increasing administrative burden leads to fewer students choosing primary care.
- Our aging population requires more intensive medical care, much of which must be both delivered and coordinated by primary care providers.

METHODS

Program directors from all primary care medical residencies, NP, and PA programs were approached in the summer and fall of 2023 to provide data on their programs. Primary care residency programs were defined as those in Family Medicine, Internal Medicine, Pediatrics and Medicine-Pediatrics.

All residency programs in these disciplines in Rhode Island were included except the Internal Medicine residency program at Landmark Medical Center in Woonsocket, which has not yet graduated any classes. All NP and PA programs in RI were included except the NP training program at Rhode Island College since it does not have a primary care track. Data categories of interest included the number of new trainees per year, total enrollment, and information on recent year graduates, including the total number, the number entering primary care, and the number entering primary care who plan to practice in RI.

RESULTS

As shown in **Table 1**, there are seven medical residency programs in Family Medicine, Internal Medicine, Pediatrics and Medicine-Pediatrics which had new enrollees and graduates in the 2022–23 academic year. These programs were all three years in length (after medical school), with the exception of Medicine-Pediatrics, which is four years in length. Total enrollment was 316. Of the 106 graduates from primary care residencies in RI in academic year 2022–23, only 15 (14%) planned to provide primary care in Rhode Island. Similarly, as shown in **Table 2**, there are five NP and PA training programs in RI with primary care tracks which had new enrollees and graduates in the 2022–23 academic year. Total enrollment was 417. Of the 144 NP and PA graduates in primary care programs, only 48 planned to provide primary care in the state. These included 31 NPs and 17 PAs.

DISCUSSION

On June 17, 2022, The Care Transformation Collaborative of Rhode Island (CTC-RI) Clinical Strategy Committee held a panel discussion on “The State of Primary Care in Rhode Island Today and in the Next 10 Years: Where Are We Now and Where Are We Going?” The panelists represented primary care provider training programs and primary care organizations. Their message was startling and clear – there is a primary care crisis in Rhode Island. Since the pandemic, the provider shortage crisis has made it far more difficult for Rhode Islanders to establish a regular source of care and this situation is expected to worsen in the coming decade.

CTC-RI serves as a voice of primary care in Rhode Island. The organization supports primary care practices to transform their clinical systems to improve their quality of care as well as both patient and clinician satisfaction – all while promoting equity, lowering costs, and developing population health strategies needed to utilize alternative payment methodologies. As a statewide learning collaborative, CTC-RI has demonstrated success in convening stakeholders to address challenges, identify best practices, and implement programs to improve primary care delivery and patient health outcomes across the state.

Given the post-pandemic exacerbation of the lack of primary care access, the CTC-RI Board of Directors collaborated with state agency partners, payers, and a well-established learning collaborative network to address the worsening access to primary care access. CTC-RI convened the directors of primary care training programs – including physicians, NPs, and PAs – to create a task force to identify

Table 1. Medical Residency Programs in Primary Care in Rhode Island

Program	Discipline	Length of Program	# New Trainees Per Year AY2023–2024	Total Resident Enrollment – All Years AY2023–2024	# of Graduates from AY2022–2023		Residents Entering PC (count/#) graduates from AY2022–2023		Residents Entered PC, Stayed in Rhode Island (count/#) graduates from AY2022–2023	
					#	%	#	%	#	%
Brown Categorial Internal Medicine Residency Program (Lifespan-RIH/TMH)	Internal Medicine	3	29	87	29	0	0%	0	0%	
Brown General Internal Medicine	General Internal Medicine	3	10	30	10	5	50%	0	0%	
Roger Williams Internal Medicine Residency Program	Internal Medicine	3	18	48	18	2	11%	1	6%	
Hasbro Children’s Hospital Pediatric Residency	Pediatrics	3	16	49	16	5	31%	3	19%	
Brown Family Medicine Residency	Family Medicine	3	16	48	16	15	94%	9	56%	
Kent Hospital Internal Medicine Residency	Internal Medicine	3	13	38	13	2	15%	2	15%	
Brown Pediatric-Internal Medicine	Internal Medicine-Pediatrics	4	4	16	4	2	50%	0	0%	
TOTALS			106	316	106	31	29%	15	14%	

Table 2. Nurse Practitioner and Physician Assistant Training Programs in Rhode Island**

Program	Discipline	Length of Program	# New Trainees Per Year AY2023–2024	Total Student Enrollment – All Years AY2023–2024	# of Graduates from AY2022–2023		Trainees Entering PC (count/#) graduates from AY2022–2023		Trainees Entered PC, Stayed in Rhode Island (count/#) graduates from AY2022–2023	
					#	%	#	%	#	%
University of Rhode Island Nurse Practitioner Program	Family Medicine and Adult Gerontology	2.5	30	31	23	19	83%	19	83%	
Salve Regina University Graduate Nursing and Professional Studies*	Family Medicine	2.5	150	170	30	10	33%	5	17%	
Bryant University PA Program	Primary Care	2.5	47	94	45	14	31%	14	31%	
Johnson & Wales University PA Program	Primary Care	2	36	70	35	7	20%	3	9%	
New England Institute of Technology	Family Medicine	2	11	22	11	11	100%	7	64%	
TOTALS			274	417	144	61	42%	48	33%	

**Table only includes NP programs that train for primary care. Specialties are excluded (e.g., psychiatric)

and address critical workforce issues. The Primary Care Provider (PCP) Task Force on workforce development began its work in February 2023. It was the first time ever that the program directors from Brown University, the University of Rhode Island, Salve Regina College, Bryant University, and Johnson and Wales University had met to discuss the state of primary care, their program capacity, challenges, and potential solutions. It was also the first substantive meeting that included the broad leadership of primary care training programs for physicians, NPs and PAs in Rhode Island.

Charge to the Task Force

The goal of the task force is to collaborate with training program leadership, state programs focusing on the healthcare workforce, and primary care experts to develop a data-driven roadmap to define and address the primary care crisis. This group seeks to identify best practices to diversify, enhance, and engage the primary care workforce – including the development of new models to train students in team-based care, creation of sustainable incentives for trainers and medical practices dedicated to education, and the promotion of strategies to improve the retention of primary care providers in Rhode Island.

Task Force Process and Findings

Over the course of nine months, the task force members used their collective knowledge of primary care provider training programs and clinical care delivery systems to identify and the address key issues exacerbating the Rhode Island primary care crisis.

Priority areas identified by the task force include:

- Recruiting, training, retaining, and sustaining a diverse provider workforce
- Correcting the disparity in pay between primary care providers regionally and compared to specialists

- Reducing student debt, especially for those wishing to practice in primary care
- Enhancing primary care clinical training, and
- Increasing the state’s overall capacity for clinical training

The group assembled and reviewed data for enrollment in primary care physician residencies and NP and PA training programs – and determining how many graduates went into primary care, and of those graduates how many remained in Rhode Island to practice (Tables 1,2). The data demonstrated the low numbers of graduates from all training programs choosing to stay in Rhode Island and provide primary care. Though current data on retirements and reductions in patient care hours by primary care providers in RI do not exist, anecdotal evidence points to large reductions in this critical sector.

The task force identified goals, objectives, and action steps to address each factor including:

- Crafting legislative proposals to fund a scholarship program for medical, NP, and PA students who commit to providing primary care in RI
- Developing a new enhanced primary care curriculum and clinical training program and paying clinical sites for teaching medical, NP, and PA students
- Requesting legislative appropriations to expand the state’s loan repayment program

The task force also drafted a strategic roadmap (Table 3). The Task Force on Primary Care Workforce Capacity roadmap attempts to frame each of these overarching goals to identify short-term objectives and action steps. We see this as an iterative document for state legislators, state agencies, and community partners that will be amended over time to reflect ongoing changes in primary care and the American healthcare system.

Table 3. Strategic Roadmap: Primary Care Access for All

Vision
Rhode Island will become the best in the nation for all measures of population health, health equity, and health system performance by providing access to Advanced Primary Care for all its residents.
Mission
Rhode Island will build a strong and robust primary care delivery system across the state that recruits, trains, retains, and sustains a pipeline of primary care providers that deliver exceptional, accessible, patient-centered care.
Defining Advanced Primary Care
"High-quality primary care is the provision of whole person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities." —NASEM Report ⁶
Recommendations
To accomplish this mission, we must address six goals: 1. Reform payments and incentives to primary care providers to create specialty and regional parity. 2. Establish baseline data and performance targets for the primary care workforce using existing and to-be-developed data sources f or ongoing monitoring. 3. Increase the recruitment of medical students, residents/fellows, nurse practitioners (NPs) and physician assistants (PAs) entering primary care. Support strategies to reduce tuition and educational debt for providers entering primary care practices in Rhode Island. 4. Expand the primary care workforce to better reflect the state's diversity while fostering healthcare equity and inclusion (DEI) for all Rhode Islanders. 5. Increase the number of high-quality primary care training sites that are willing to educate the next generation of primary care students. 6. Enhance clinical training experiences within practices using advanced patient-centered medical home (PCMH) principles such as team-based care, integrated behavioral health, population health strategies, and value-based reimbursement.

The Office of the Health Insurance Commissioner's (OHIC) recently published "Primary Care in Rhode Island: Current Status and Policy Recommendations."⁷ The report acknowledges many of the challenges facing the primary care delivery system in Rhode Island and describes primary care as the "foundation of an equitable and high-performing health care system" that is at risk due to the nationwide critical workforce shortage. OHIC seeks to ensure that primary care is a priority for state policy through its unique statutory authority to regulate commercial insurers. The OHIC recommendations align with and support many of the recommendations described by this strategic roadmap, including primary care payment enhancement, reduction of administrative burden, and efforts to attract, train, retain and sustain a primary care workforce to provide every

Rhode Islander with access to high-quality, coordinated, team-based, patient-centered primary care.

Solving the primary care crisis will require concerted efforts of all involved in healthcare and workforce training. The effort described here is a start, but more will need to be done to provide immediate and long-term relief to our primary care clinicians, and to facilitate access for all Rhode Islanders.

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Disclosures

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This document was developed through the collaboration of a large group of healthcare leaders in Rhode Island, including those from organizations that educate and train the primary care workforce, practice primary care, and create and implement primary care policies. We are indebted to them for their dedication, resourcefulness, and sense of purpose.

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**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, October 29, 2024

TIME: 5:30 PM

PLACE: Room 313

AGENDA

- I. Welcome & Introductions
- II. Presentations
 - a. Eugenio Fernandez
 - b. L. Anthony Cirillo MD, FACEP
 - c. Cory King, Commissioner of the Office of the Health Insurance Commissioner
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

Dr. Eugenio Fernandez, Jr., is a graduate of the University of Rhode Island and Harvard University and the founder of the public health hub with a built-in pharmacy named Asthenis in Providence, RI.

Dr. Fernandez was inspired to start [Asthenis](#) to help close health equity gaps by focusing solely on patient needs - something he believes sets Asthenis apart from a traditional health care system approach.

Asthenis is located within the affordable housing complex named Wiggin Village in the West End of Providence, RI. Asthenis helps organize activities centered on providing access to health education to a community where there is [currently a vacuum](#) for such services. [Its vision](#) is to be the community's source for navigating health services, with a belief that people like to take care of themselves; they just need access to reliable health information so they can make the right decisions for themselves.

During the COVID-19 pandemic, Dr. Fernandez designed and operated some of the largest [mass vaccination clinics](#) in the state of Rhode Island and was awarded the "Key to the City of Providence" by former Providence Mayor Jorge Elorza.

Dr. Fernandez operates The [Asthenis Public Health Hub](#) immunization clinic which serves as an important public health tool providing immunizations against vaccine-preventable diseases at no-cost to vulnerable members of the Rhode Island community.

The Value of Training Medical
Students in Rhode Island: And
How to Keep them Here.

Background

“Eugenio Fernandez, A Providence kid who somehow quadruple-majored at the University of Rhode Island, then got a graduate degree from Harvard, and came back to start a community pharmacy called Asthenis...”

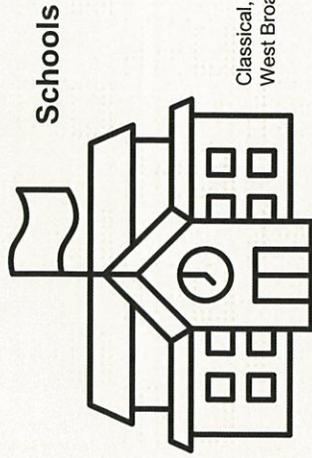


The Boston Globe

Classica High School
Doctor of Pharmacy '13 URI
Master of Business Administration '13 URI
Bachelor's Psychology '13 URI
Bachelor's Biology '13 URI
Master of Public Health '16 Harvard

First/only in school's history.

About Asthenis: Public Health Ecosystem



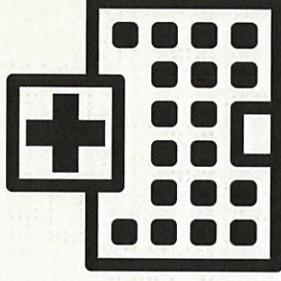
Schools

Classical, Central, Asa Messer,
West Broadway



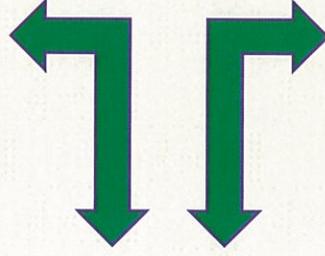
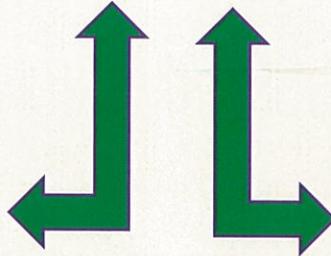
Housing

Wiggin Village, Crossroads,
Coddling Court

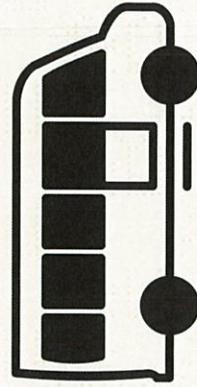


Healthcare

Asthenis, PCHC, clinics

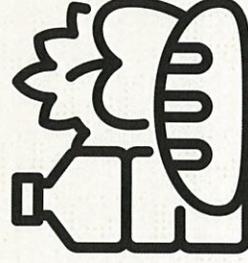


Asthenis



Transportation

RIPTA, multiple bus stops and routes



Food

Amos House, Urban Greens,
various fast-food establishments

Public Health is Preventative health

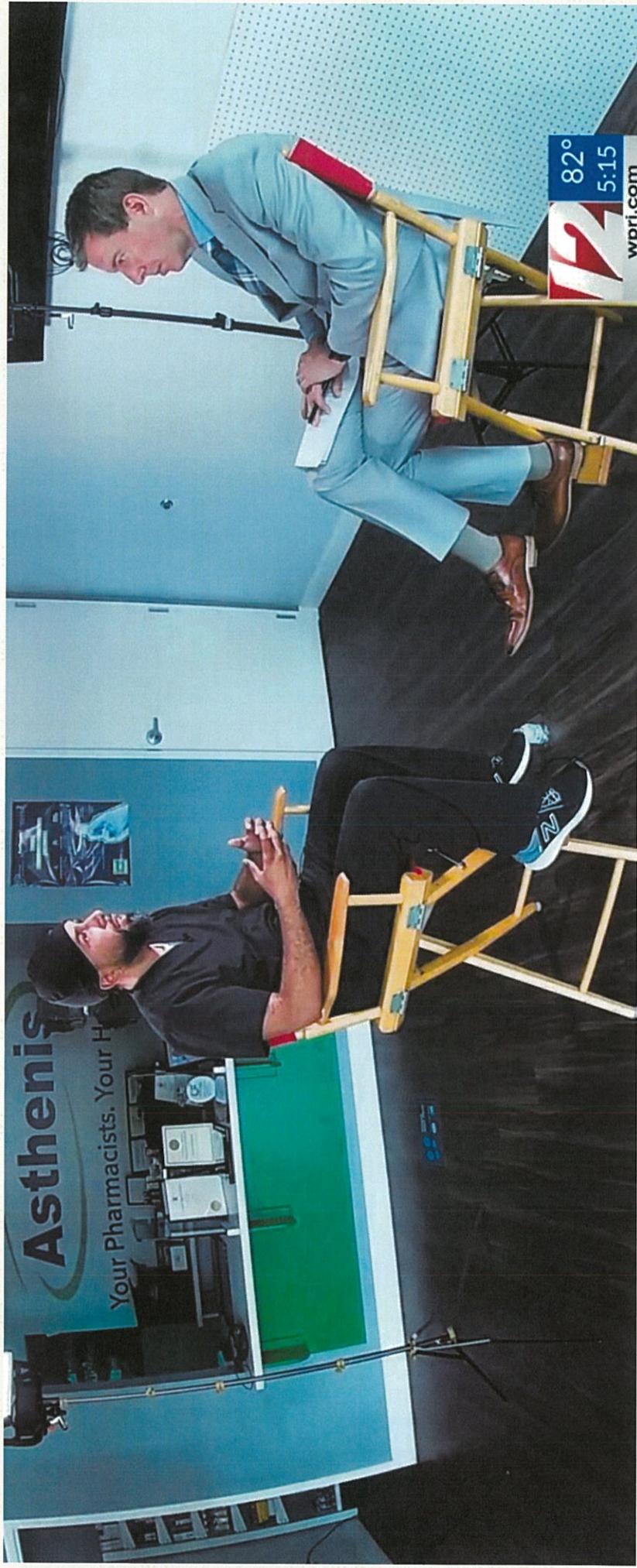
- 1) Vaccination
- 2) Health Screenings

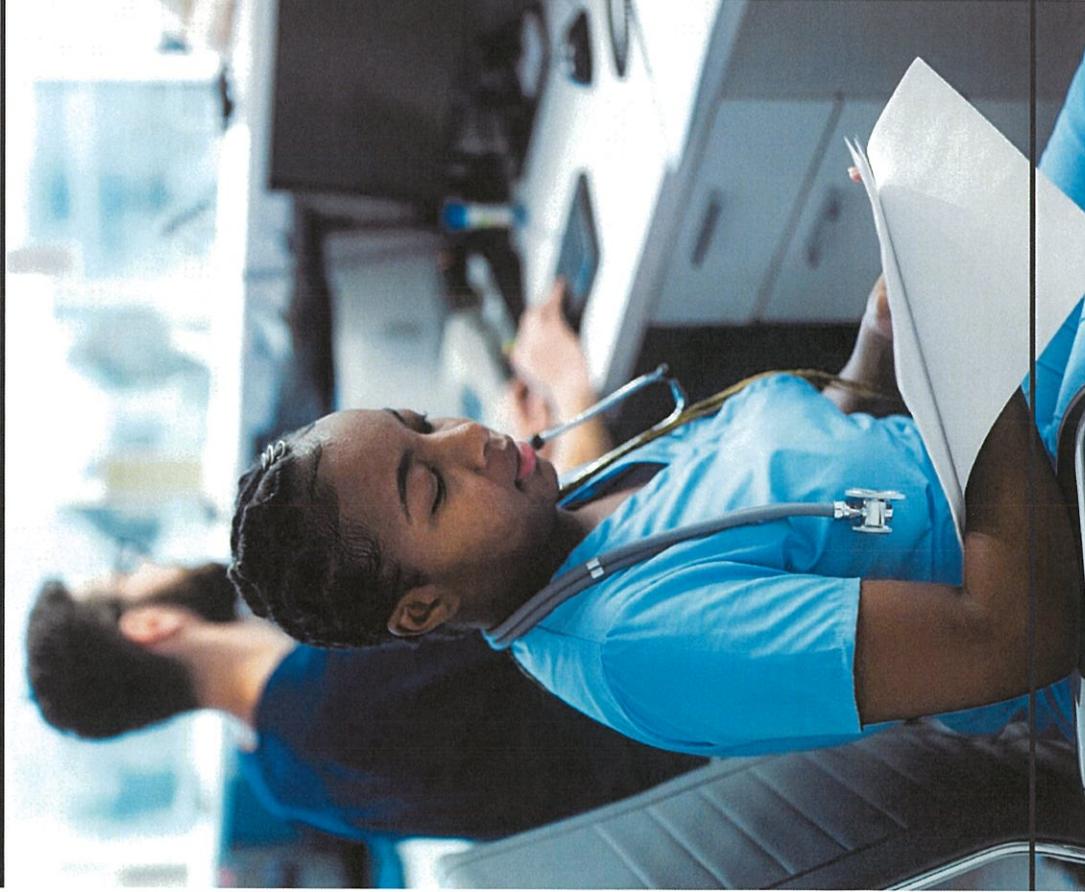
Providence: PCTA



“United States of America is the **best** country in the world,

Our Healthcare System is Not.”





One Part of the Issue is the Primary Care Crisis

RI Primary Care Providers: **641**

Defined by provider's holistic care- not training/license (obgyn/hospitalist).

Patient Case load (Panel)

If **1.5K** then RI needs **90 more** Providers
If **1.2K** then RI needs **270 more** Providers

KIDS: Watch this space
Don't forget the kids – empirical observation: an area to watch; (vaccine access).

New Medical School is Great for Rhode Island



Value:

Directly provides the trained professional workforce we need to address shortages in primary care.

How to keep them in Rhode Island:

It **starts** during their time in Medical School.

Keeping Doctors in Rhode Island

1) Attractive: Financial reimbursement and student loans.

2) Manageable – distribute the workload

3) Trust: Racial composition of class (JAMA Study). (5.7 (B) -6.9% (H) – school match population.

4) Research: Interest to study interactions b/w people and Public Health ecosystem. **Modify curriculums** by incorporating local **ongoing** impacts on healthy living.





Manageable primary care

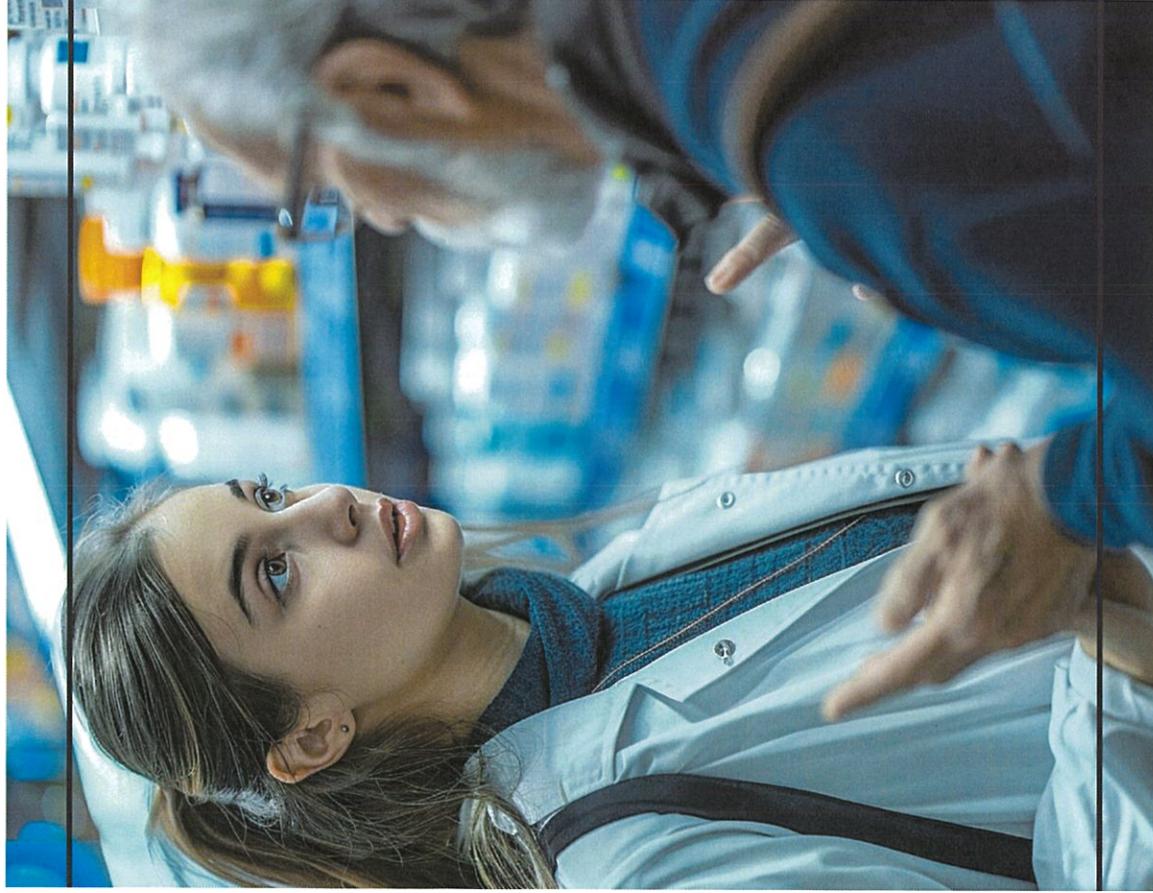
Interdisciplinary component delegates easy tasks and test to treat for primary care providers.

- **Providers are not overburden** by easy to test and treat office visits.

URI has a special opportunity to leverage pharmacists, nurses, and medical school's interdisciplinary **collaboration to make primary care more manageable.**

- Colleges of Pharmacy, Nursing, Health Sciences, et al.

How does that look like in practice?



Let's Look at What Countries Outside the US do

The Pharmacy First Model

Test to Treat are delegated to pharmacists:
Drug changes, Diabetes, Diabetes, vaccines etc.

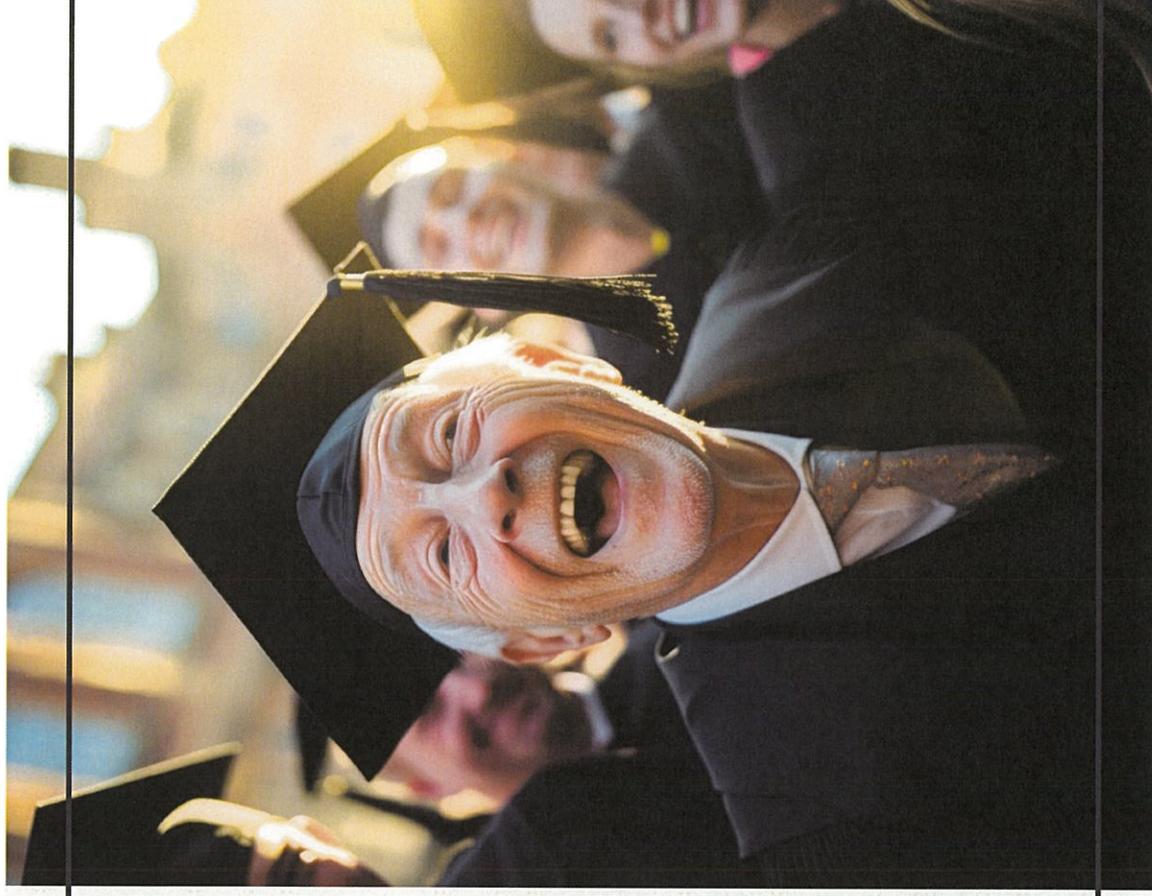
Allows providers to work collaboratively
with pharmacists **rather than in silos**

Unlike other schools – URI's pharmacy and
nursing schools are in great position for reducing
the workload and making primary care more
manageable through collaboration.

People come from other countries in our community.

Keeping Primary Care Providers in RI

- 1) **Attractive:** Financial reimbursement and student loans.
- 2) **Manageable:** Reducing the amount of burden through Interdisciplinary teaching methods and collaboration with public health providers, pharmacists and nurses.
- 3) **Trust:** Racial composition of class.
- 4) **Research:** Study interactions with Public Health ecosystem. Ongoing influence on curriculum.





Sunday TODAY's Photo of the Week

SHARE THIS —   



Dec. 12, 2021

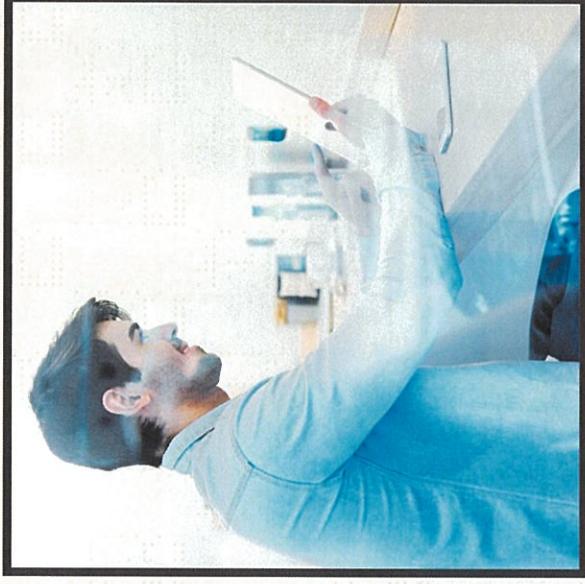
Leanna Arcila, 7, is licked by Watson, a therapy dog with the Pawtucket police department, as she receives her COVID-19 vaccination from Dr. Eugenio Fernandez at Nathanael Greene Elementary School in Pawtucket, Rhode Island, on Dec. 7, 2021.

— David Goldman / AP

Share  

Think Big – The University of Rhode Island

“Big thinking precedes great achievement” — W. Peterson



Thank you!

Efernandez@asthenisusa.com
www.Asthenis.org

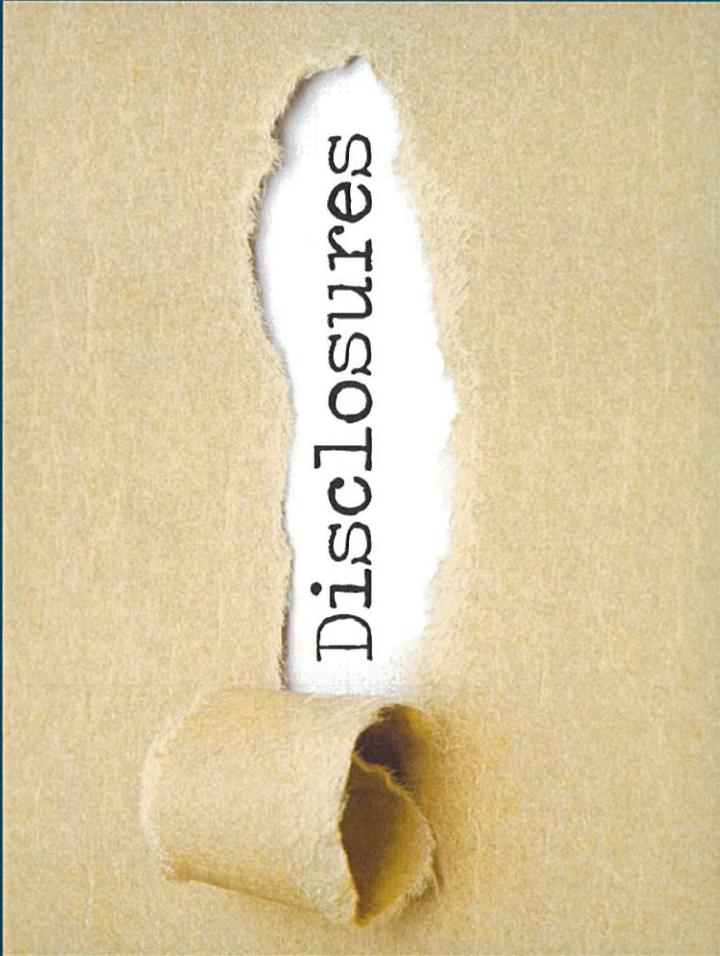
Emergency Medicine Perspective

Special Legislative Commission to Make a Comprehensive Study of Rhode Island's Healthcare Workforce Related to Educating and Retaining Primary Care Physicians and Establishing a State Medical School at The University of Rhode Island

Tony Cirillo, MD, FACEP

President-Elect
American College of Emergency Physicians (ACEP)







EMTALA – Emergency Medicine Treatment & Active Labor Act -1986



Key provisions of EMTALA

Hospitals must:

Screen any individual who shows up in the emergency room to identify any medical condition, including active labor, requiring immediate treatment, regardless of ability to pay

Provide stabilizing treatment to the full extent of the hospital's capabilities

Provide an appropriate transfer to another hospital if it cannot stabilize the patient after securing acceptance from a receiving hospital

Accept appropriate transfers from referring hospitals if the receiving hospital has the capability and capacity to treat the patient

Penalties for hospitals and physicians:

Up to a \$50,000 civil fine per incident (\$25,000 for hospitals under 100 beds)

Exclusion from the Medicare and Medicaid programs

Potential liability in civil lawsuits

Must Provide a
“Medical Screening
Exam” (MSE) by
qualified person in
order to determine if
the patient has an
“Emergent Medical
Condition” (EMC)

The Prudent Layperson Standard – BBA 1997



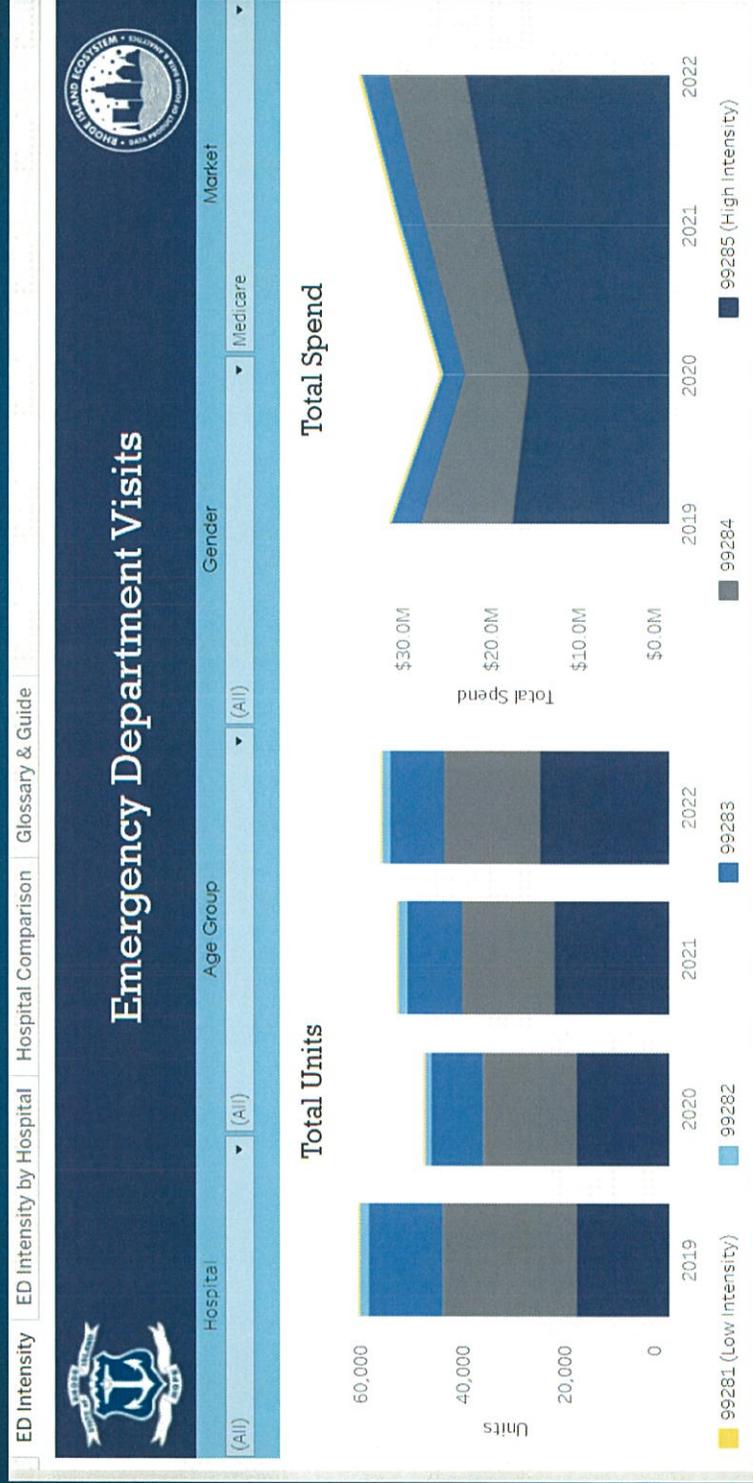
The **Prudent Layperson Standard** is a federal law that defines an emergency medical condition as a condition where a layperson with average knowledge of health and medicine would reasonably expect immediate medical attention to be necessary:

- To prevent serious jeopardy to the patient's health
- To cause serious impairment to bodily functions
- To cause serious dysfunction of any bodily organ or part

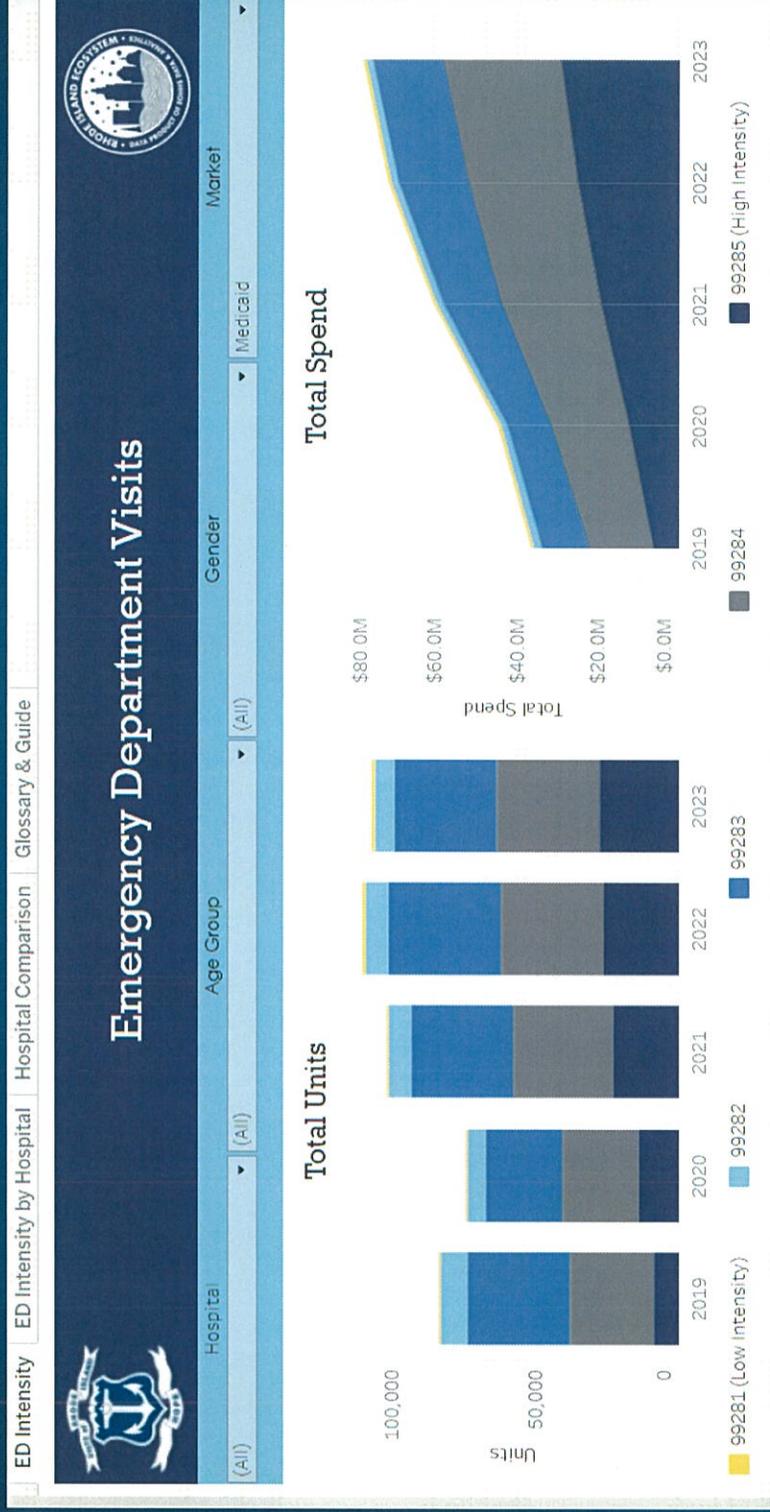
The PLS protects patients by:

- **Requiring in-network rates**
Patients can be charged in-network rates at any emergency room, regardless of which one they visit.
- **Prohibiting prior authorization**
Patients don't need prior authorization or approval from their insurance company.
- **Prohibiting out-of-network fees**
Insurance companies can't charge out-of-network fees if a patient visits an out-of-network emergency room.
- **Prohibiting denial or overcharging**
Insurance companies can't deny or overcharge a patient if their diagnosis is less serious than initially thought.

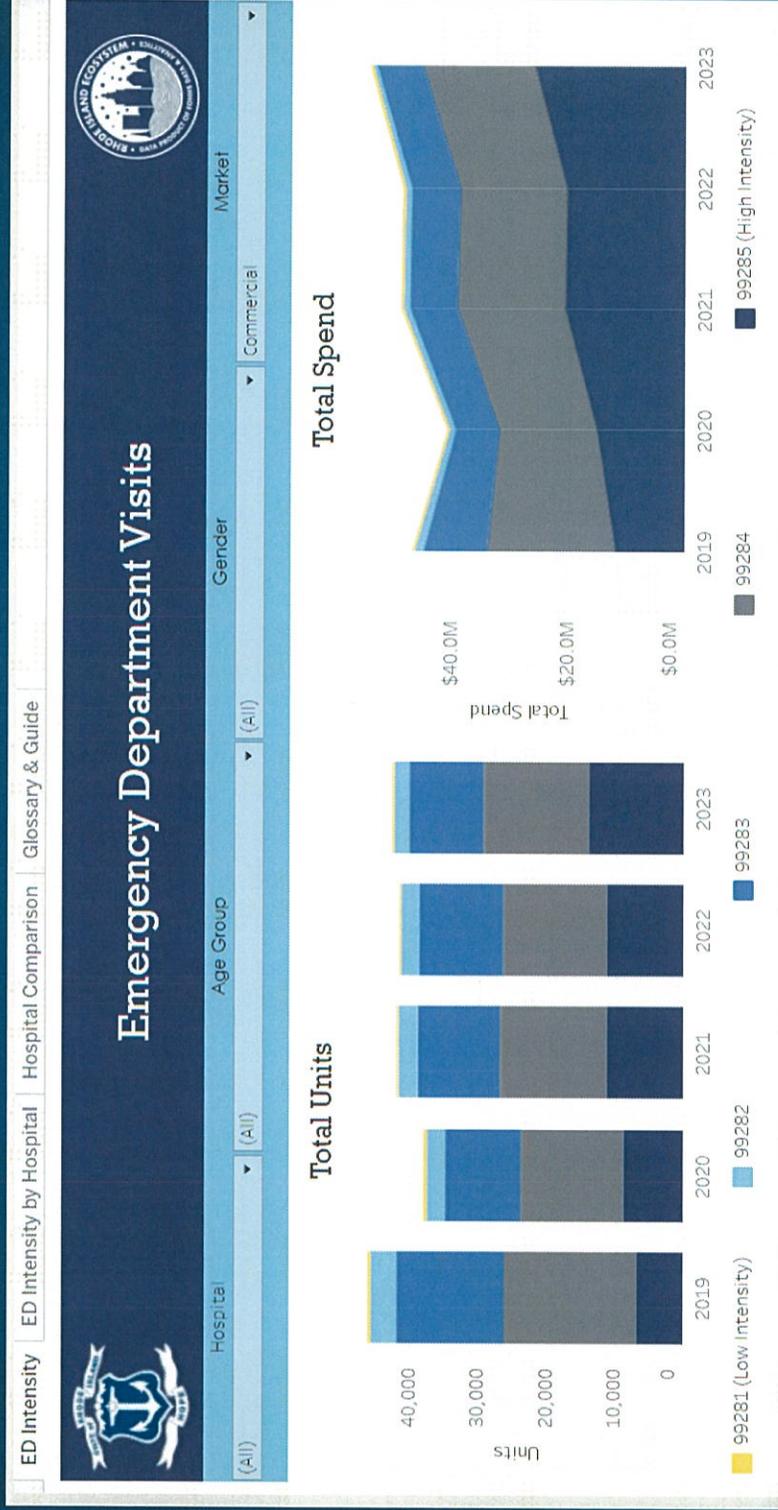
Emergency Department Visit Intensity – Medicare Patients



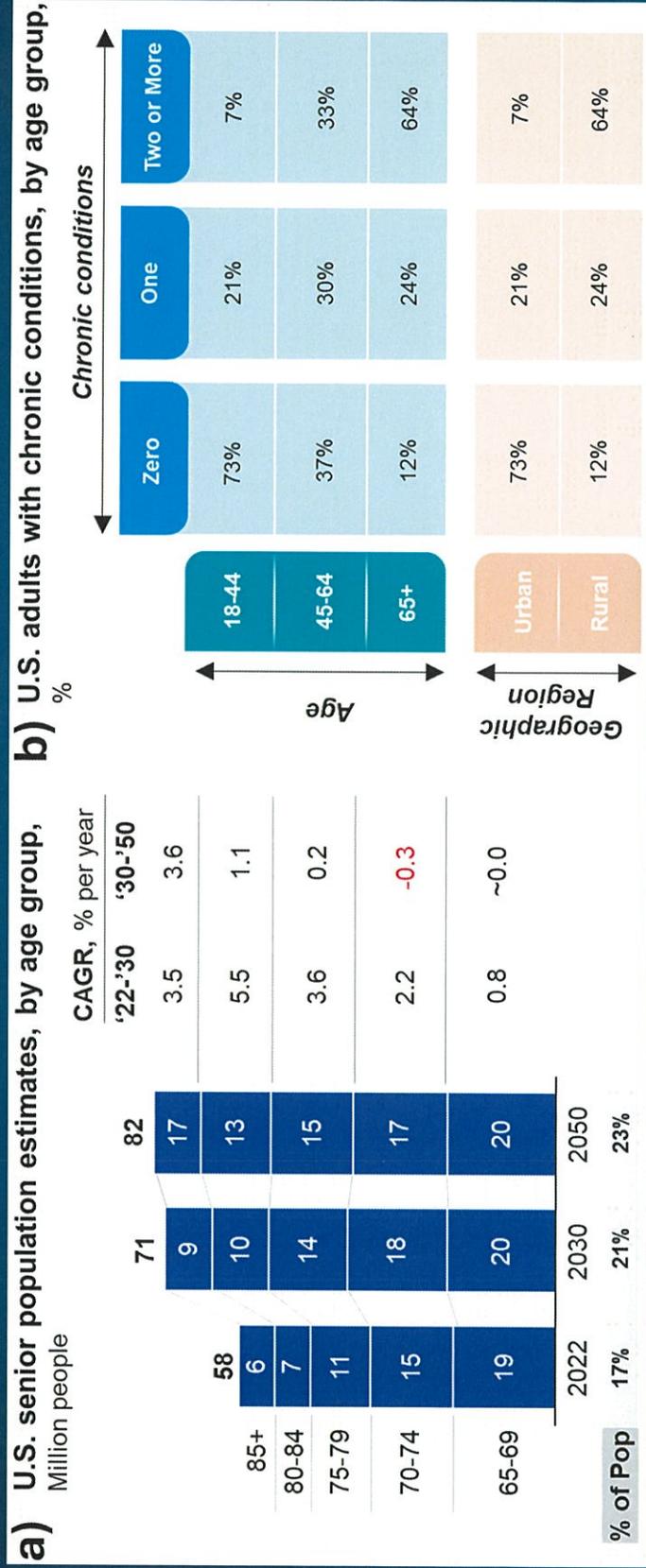
Emergency Department Visit Intensity – Medicaid Patients



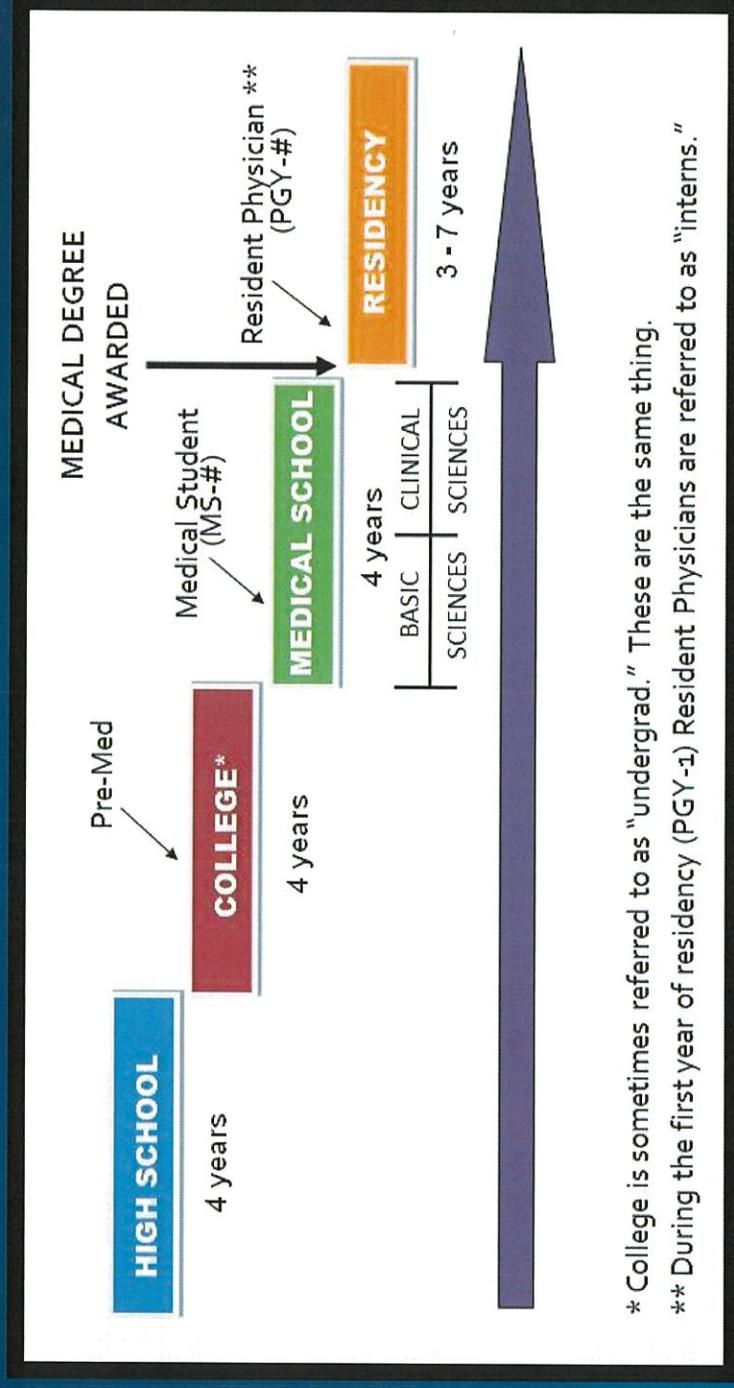
Emergency Department Visit Intensity – Commercial Patients



The Population – Older & Sicker



The Long Journey to Becoming a Physician



* College is sometimes referred to as "undergrad." These are the same thing.

** During the first year of residency (PGY-1) Resident Physicians are referred to as "interns."

MEDICARE HEALTH INSURANCE

JOHN L SMITH

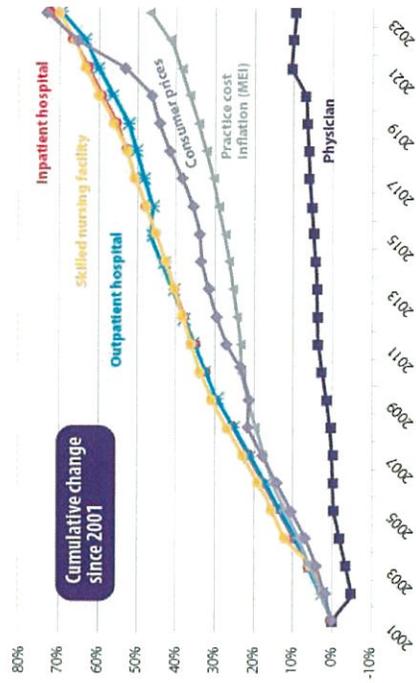
Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A)
MEDICAL (PART B)

Coverage starts/Colectura empieza
03-01-2016
03-01-2016

Medicare updates compared to inflation (2001–2023)

Adjusted for inflation in practice costs, Medicare physician pay declined 26% from 2001 to 2023.



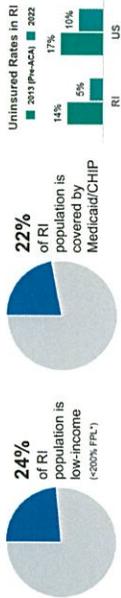
Source: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

Updated April 2023

MEDICAID IN RHODE ISLAND

August 2024

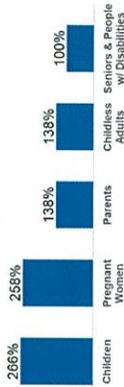
329,405 enrolled in RI Medicaid



RI Expansion Status: **Adopted**

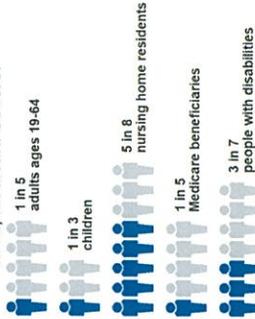
Adults in Expansion Group: **103,000**

Eligibility Levels as a % of FPL



*100% of Federal Poverty Level (FPL); \$25,020 for a family of three; \$15,060 for an individual

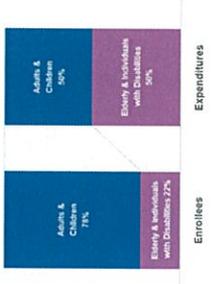
In RI, Medicaid Covers:



The independent source for health policy research, analysis, and news



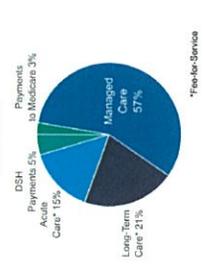
Medicaid Enrollees & Expenditures in RI



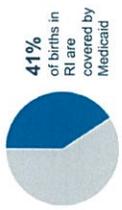
In RI, the federal government pays 56% of the cost of traditional Medicaid.



Total RI Medicaid Spending by Service: \$3.4 billion



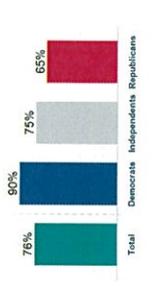
The federal government pays 89% of the cost of the Medicaid expansion.



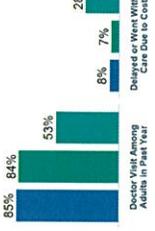
Rhode Island has adopted the Medicaid 12-month postpartum coverage extension



National Share of Those that Hold Favorable Views of Medicaid



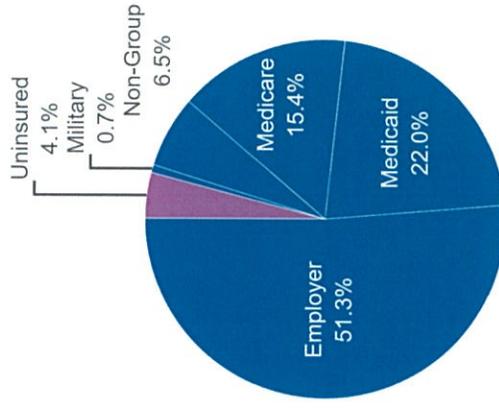
National Access Measures



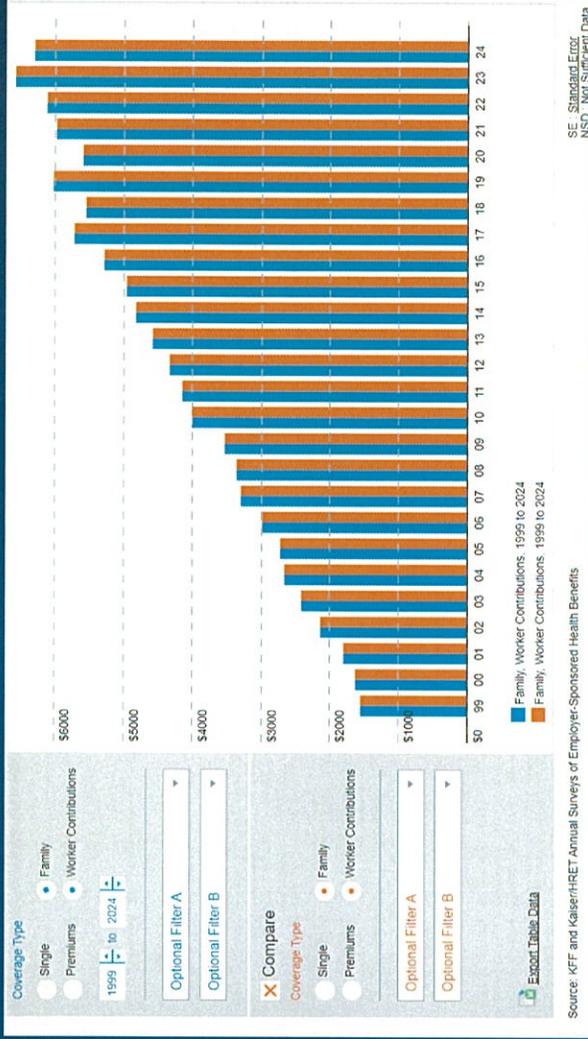
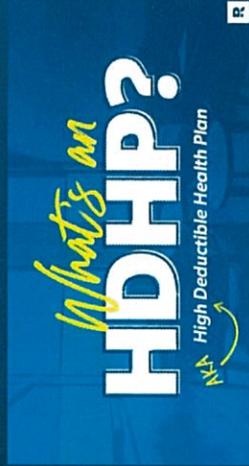
Insured

Uninsured

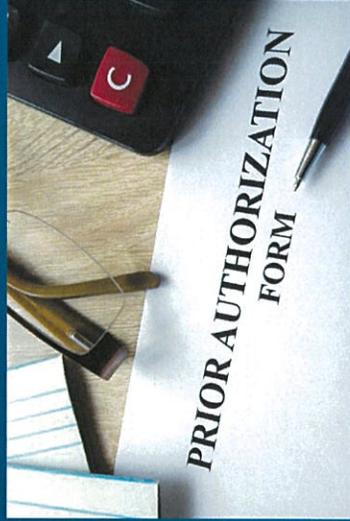
Figure 1
Health Insurance Coverage of the Total Population



KFF



Source: KFF and Kaiser/HRET Annual Surveys of Employer-Sponsored Health Benefits





OCTOBER 2023
Medical Student Education:
Debt, Costs, and Loan Repayment
Fact Card for the Class of 2023



Education Debt	Public	Private	All
Percentage with education debt	73%	67%	70%
Mean education debt of indebted only (versus 2022, %)	\$197,843 (12%)	\$222,381 (0%)	\$206,924 (11%)
Median education debt of indebted only (versus 2022, %)	\$200,000 (14%)	\$220,000 (42%)	\$200,000 (0%)

Education Debt (including premedical)	Percentage of Graduates		All
	Public	Private	
\$100,000 or more	84%	83%	84%
\$200,000 or more	51%	59%	54%
\$300,000 or more	15%	28%	20%
Planning to enter loan forgiveness or repayment program			56%

Education Debt Breakdown	Percentage of Graduates	Median Debt
Premedical education debt	28%	\$27,000
Medical education debt	67%	\$200,000

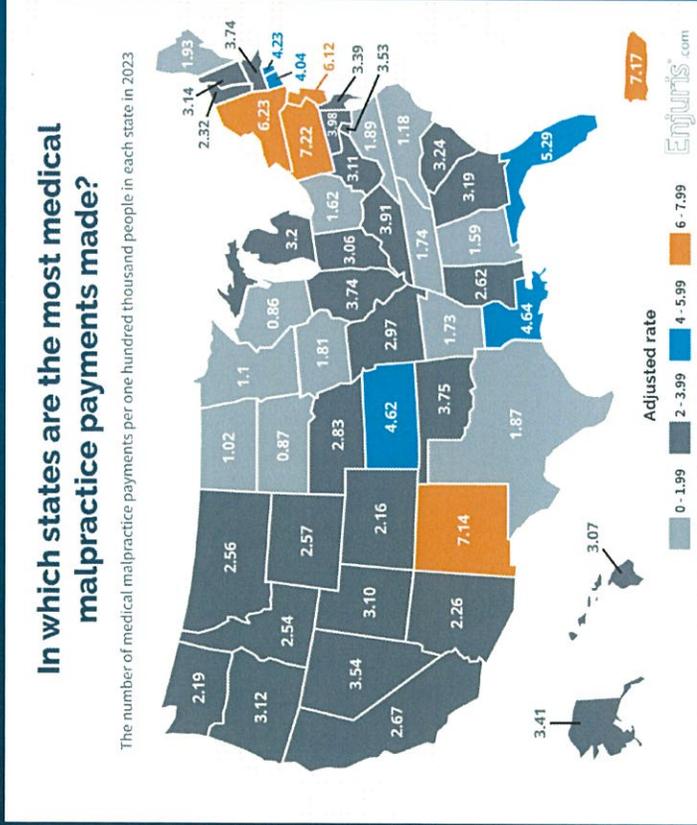
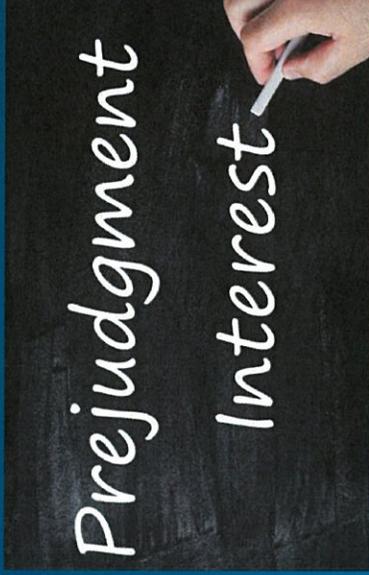
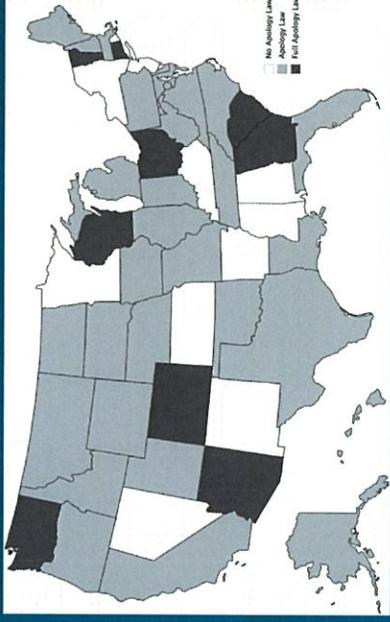
Noneducation Debt	Percentage of Graduates	Median Debt
Credit cards	12%	\$5,000
Residency and relocation loans	2%	\$10,000

Source of data in tables above: FIRST analysis of AAMC 2023 Graduation Questionnaire data. Education debt figures include premedical education debt plus medical education debt.

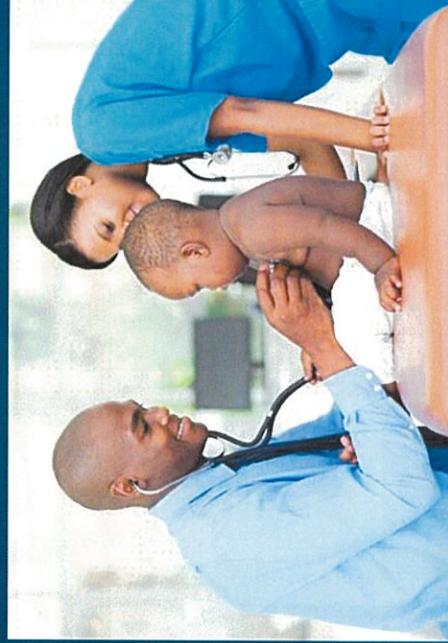
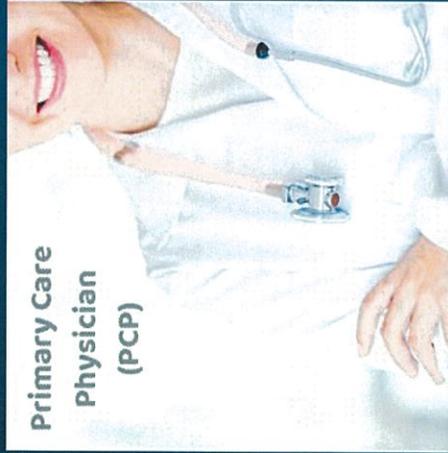
Cost, In-State, 2023-24	Public	Private
Tuition and fees, first-year median	\$41,737 (12%)	\$69,788 (14%)
Cost of attendance (COA), first-year median	\$71,005 (15%)	\$97,942 (15%)
4-year COA for class of 2024, median	\$276,006 (13%)	\$374,476 (13%)

Source: AAMC Tuition and Student Fees Questionnaire data from 94 public schools and 62 private schools.

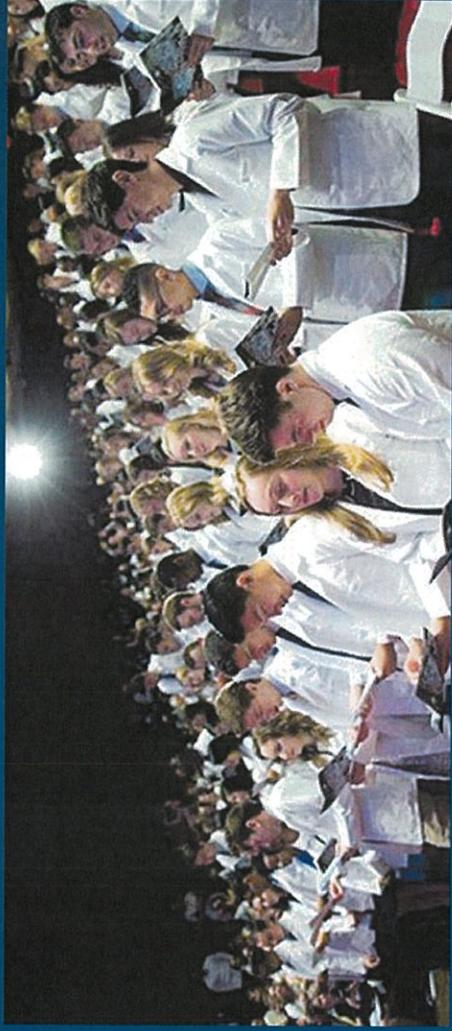
The Role of Apology Laws in Medical Malpractice



What's Needed Most?

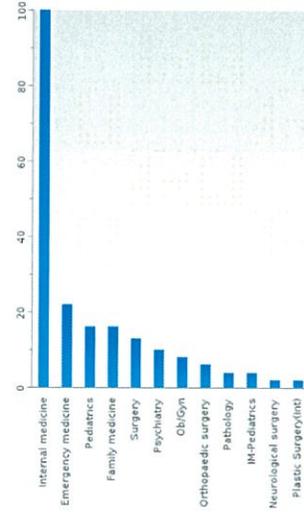


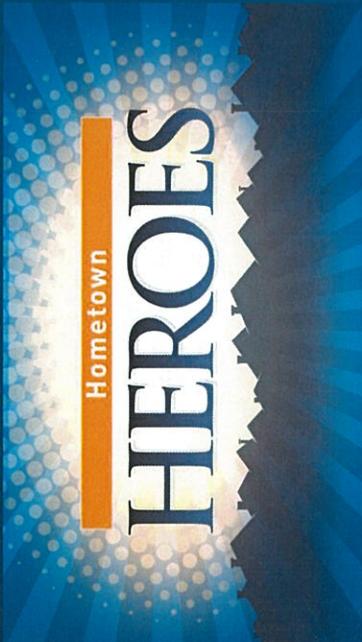
Need Both School & Residency Training Spots



PGY-1 residency positions in Rhode Island

1. Internal medicine (100)
2. Emergency medicine (22)
3. Pediatrics (16)
4. Family medicine (16)
5. Surgery (13)
6. Psychiatry (10)
7. Obstetrics and gynecology (8)
8. Orthopaedic surgery (6)
9. Pathology-anatomic and clinical (4)
10. Internal Medicine-Pediatrics (4)
11. Neurological surgery (2)
12. Plastic Surgery - Integrated (2)





**MEDICAL PREPARATORY
ACADEMY OF RHODE ISLAND**

**BE THE NEXT
GENERATION OF
DOCTORS &
MEDICAL
SCIENTISTS**

**OPENS
SEPTEMBER
2025
GRADES 6-7**

**FOR STUDENTS FROM PROVIDENCE,
PAWTUCKET, & CENTRAL FALLS**

SCAN QR CODE
CALL: 401.965.8885
Email: medprepnpr@gmail.com



"Living, learning, and working in the community that you grew up in is what makes the EIP program so special. It allowed me to pursue my passions and interests early in my medical training while still staying connected to the state that I call home."



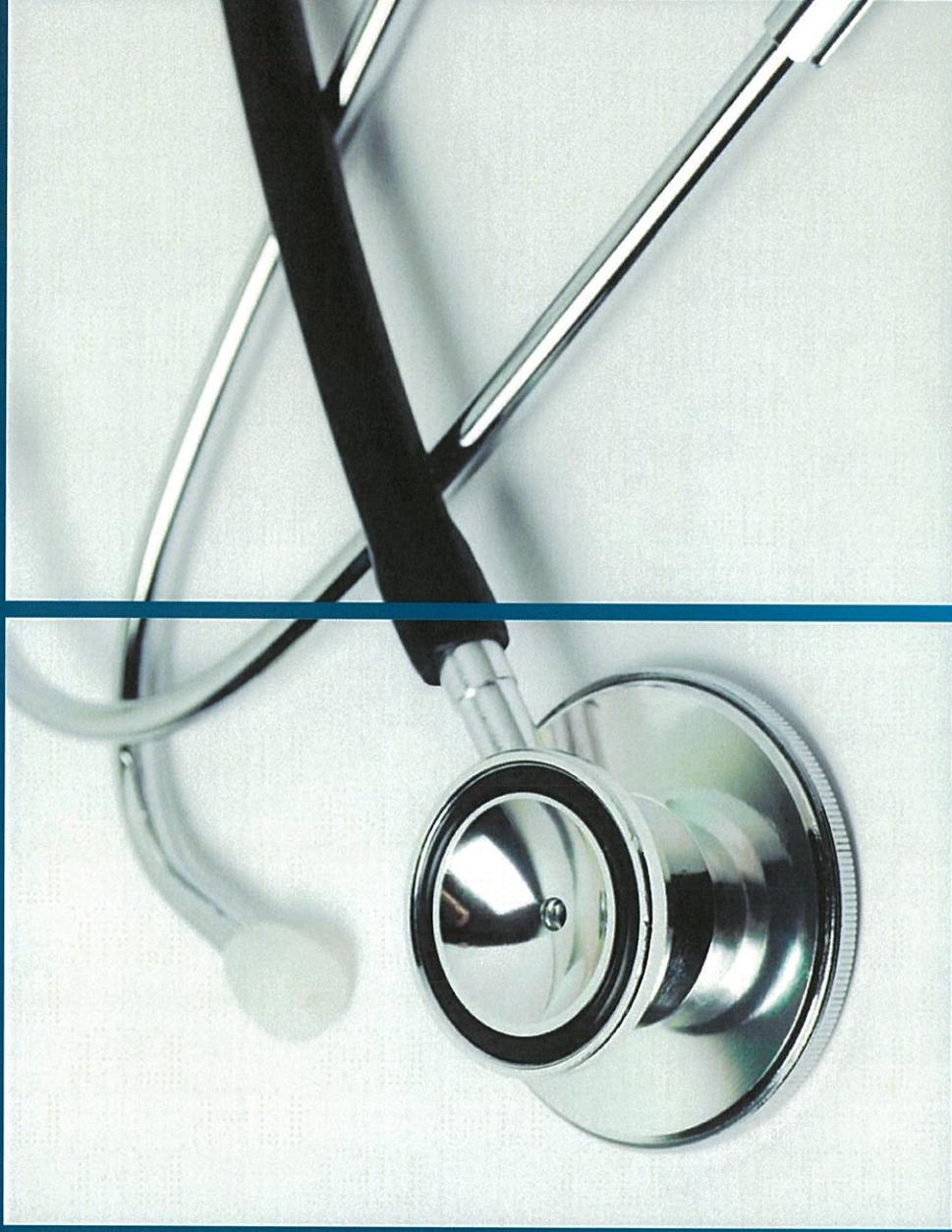
Steven Rougas, MD
Alpert Medical School '13
Providence College '09

The Rhode Island Early Identification Program

The Rhode Island Early Identification Program (RI EIP) is a selective route of entry to Alpert Medical School that allows Rhode Island residents studying at one of three Rhode Island schools to apply for early assurance during their junior year in their undergraduate program. Admitted candidates are provisionally accepted for entry in the class beginning the August following their graduation, with the option of a one-year deferral to participate in an enriching activity in the medical field. Successful candidates will receive communication from the director of Brown's Program in Liberal Medical Education (PLME) regarding potential enrichment activities between acceptance and matriculation at the medical school.

To be eligible, students must be a RI resident enrolled at Providence College, Rhode Island College, or the University of Rhode Island and be nominated by the school's Health Professions Advisory Committee or pre-professional adviser. Applications are initiated through the three undergraduate schools; for more details, speak to the pre-professional adviser at your school. For this route of entry, the MD Admissions Committee favorably considers candidates whose academics, life experiences, and extracurricular activities demonstrate some combination of the following:

- Strong commitment to the local community
- An exceptional understanding of and motivation for medicine
- Academic performance in college indicating high aptitude for success in studying medicine
- Unique life experiences that enrich a candidate's understanding of medicine or medically underserved populations



Tony Cirillo, MD, FACEP
lcirillo@acep.org
401-465-0806

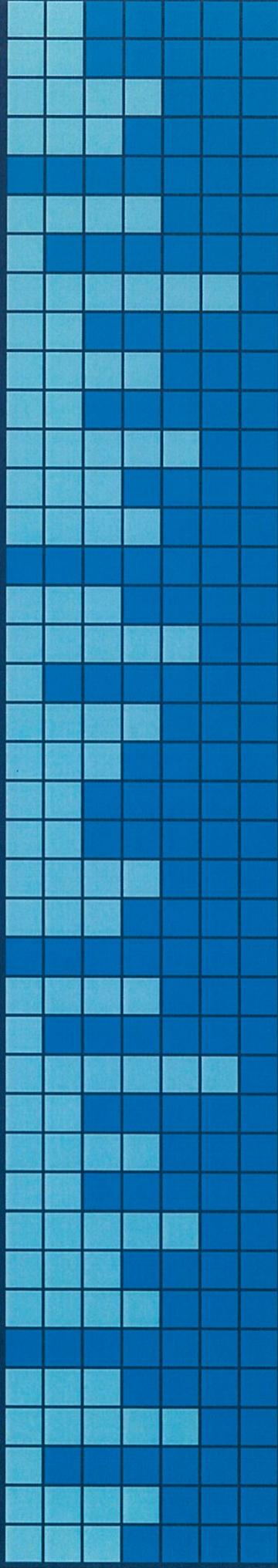


STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

Primary Care in Rhode Island: The View from OHIC

OCTOBER 29, 2024

CORY KING, HEALTH INSURANCE COMMISSIONER



Office of the Health Insurance Commissioner Overview

The State of Rhode Island Office of the Health Insurance Commissioner (OHIC) is Rhode Island's commercial health insurance policy reform and regulatory enforcement agency. OHIC seeks to improve health care access, affordability, and quality. The office does so as it:

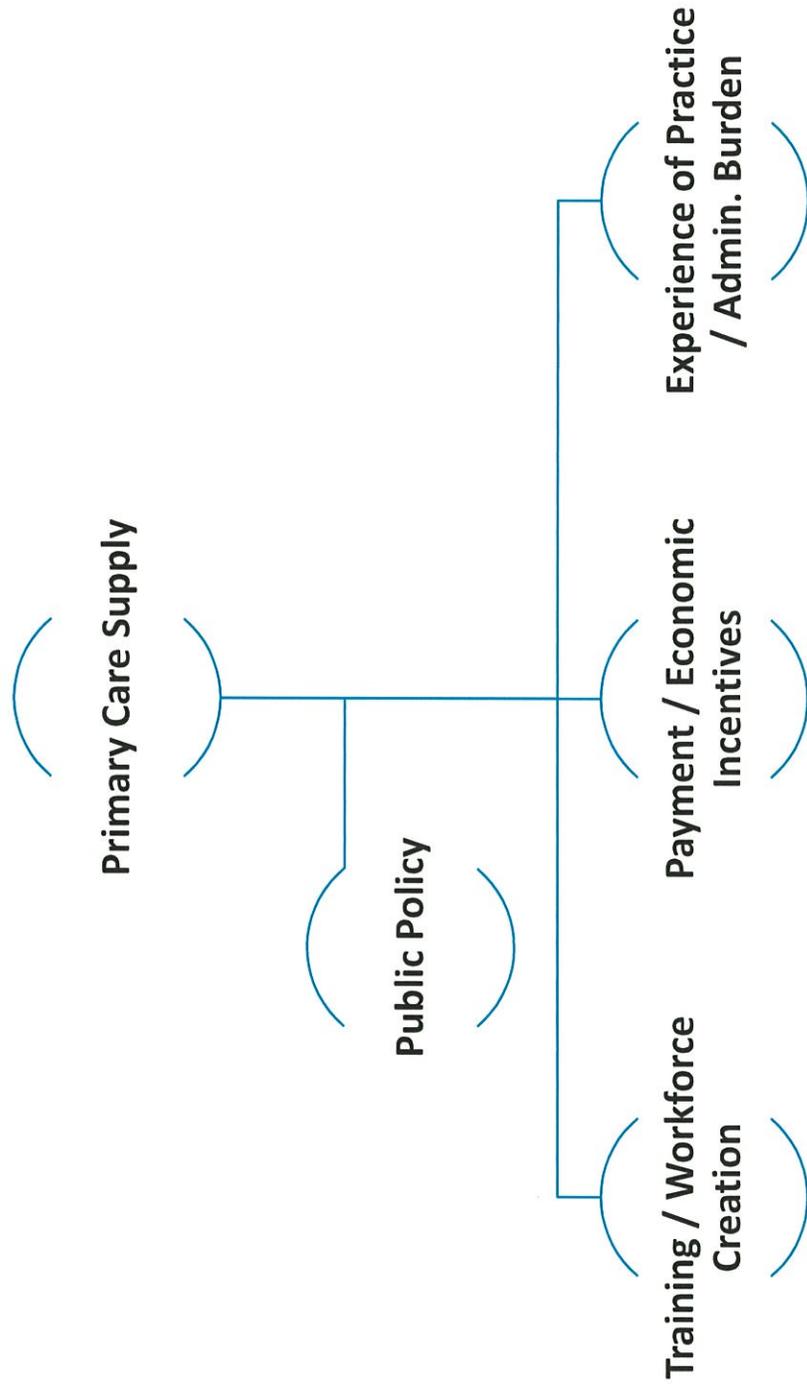
- Protects the interests of consumers of commercial health insurance,
- Encourages fair treatment of health care providers by commercial health insurers,
- Improves the health care system as a whole, and
- Guards the solvency of commercial health insurers.

The Value Proposition of Primary Care

Primary care provides comprehensive, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Primary care is unique in health care in that it is designed for everyone to use throughout their lives—from healthy children to older adults with multiple comorbidities and people with disabilities. Absent access to high quality primary care, minor health problems can spiral into chronic disease, care management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and the nation’s health care spending soars to unsustainable levels. People in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity.

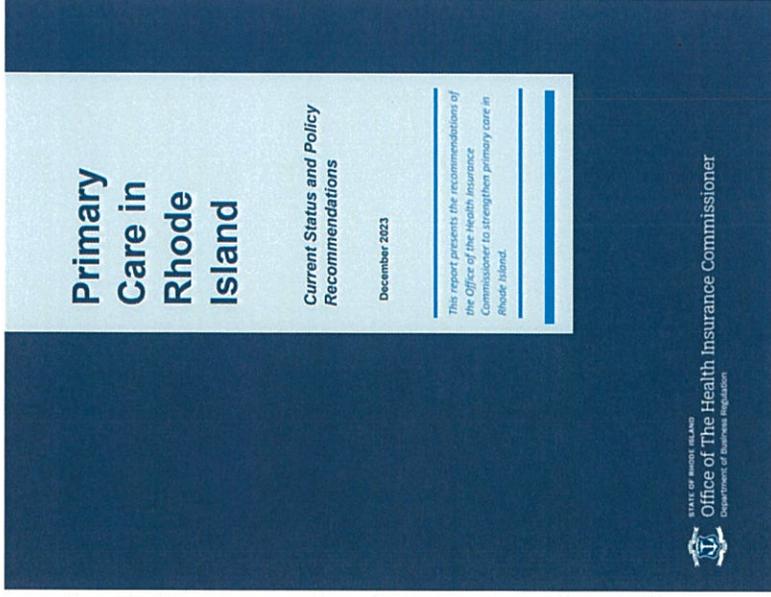
Source: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>, p.3.

Rhode Island Needs a Robust Primary Care Workforce



Assessing the Current State of Primary Care

Primary Care In Rhode Island



OHIC's December 2023 report, "Primary Care in Rhode Island: Current Status and Policy Recommendations."

The report:

- reviews the state of primary care in Rhode Island and nationally, and
- presents OHIC recommendations to strengthen primary care in Rhode Island.

OHIC's Findings

Aging workforce, with many providers contemplating retirement.

Primary care is reimbursed and compensated at rates significantly less than medical specialties.

Nationally, and locally, fewer medical students are choosing primary care as a career path.

Clinician burnout is a key concern facing the primary care workforce and is driving physicians and advanced practitioners to reduce or leave clinical practice.

Primary care providers have stated that compensation is not competitive with other states.

Attestations that patient access, in particular, new patient access, is constrained.

Rhode Island is Not Alone

THE HEALTH OF US PRIMARY CARE: 2024 SCORECARD REPORT

No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change)

BY YALDA JABBARPOUR, ANURADHA JETTY, HOON BYUN, ANAM SIDDIQI,
STEPHEN PETERSON, AND JEONGYOUNG PARK, ROBERT GRAHAM CENTER



Recent Federal Initiatives

Recent Federal Initiatives

- Proposed changes to the Medicare Physician Fee Schedule (PFS).
 - The 2025 proposed rule introduces new payment opportunities for through three new Advanced Primary Care Management codes.
- States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
 - CT, MD, HI, VT are in Cohort 1 or 2. RI & NY applied for Cohort 3.
 - Primary Care AHEAD would pay participating practices an average of \$17 per Medicare beneficiary per month, in addition to FFS billing.
 - States are required to develop an all-payer primary care investment target.
- The Pay PCPs Act, introduced by Senator Whitehouse, calls for the creation of hybrid payment methods for PCPs, lower patient cost sharing for primary care, and reevaluation the Medicare PFS for primary care.

Recent State Initiatives

Recent State Initiatives

- Senate Resolution S3165.
- Investments in Primary Care Training Programs and Scholarships. These programs were part of the Senate's HEALTH initiative.
- Senate Bill S0290 Sub A, enacted on June 22, 2023, required a Taskforce convened by OHIC to evaluate prior authorization processes.
 - OHIC submitted a legislatively mandated report in June 2024.
 - On October 11th, OHIC proposed new rules governing prior authorization.
- Redefinition and recalibration of the commercial health insurer primary care expenditure requirement under 230-RICR-20-30-4.
 - Will improve OHIC's oversight of commercial insurer primary care expenditures.

Thank You

Contact info:

Cory King, Health Insurance Commissioner

Cory.King@ohic.ri.gov

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

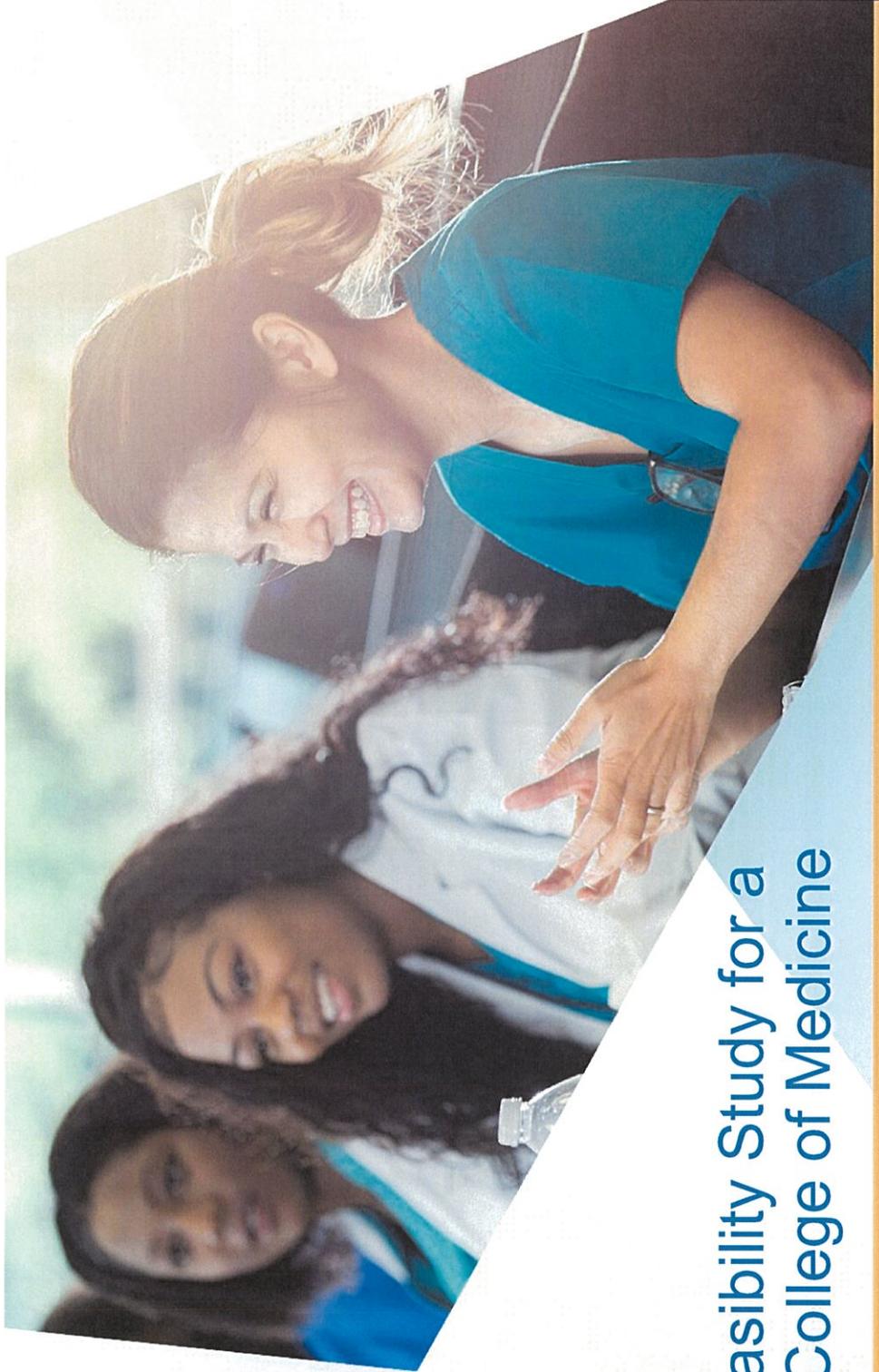
DATE: Monday, January 27, 2025
TIME: 5:30 PM
PLACE: State House—Senate Lounge

AGENDA

- I. Welcome & Introductions
- II. Commission Updates
- III. Presentations
 - a. Debra Hurwitz, MBA, BSN, RN, CTC-RI Executive Director
 - b. Stephen J. Spann, M.D., M.B.A., Professor Emeritus-Tilman J. Fertitta Family College of Medicine at the University of Houston
 - c. Dr. Robert M. Califf, MD, MACC, US Commissioner of Food and Drug Administration (2016-2017; 2022-2024)
- IV. Q&A
- V. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.



**Tripp
Umbach**
Turning Ideas Into Action

Update on Feasibility Study for a possible URI College of Medicine

The University of Rhode Island
January 27, 2025

About Tripp Umbach

Tripp Umbach Profile

- Tripp Umbach is a private consulting firm founded in 1990.
- Nationally recognized consulting firm that provides comprehensive services ranging from research and strategic planning to economic impact analyses for medical schools, hospitals, non-profit organizations, communities, and corporations throughout the world.
- Tripp Umbach has completed more than 500 Higher Education studies over the past 30 years for clients in North America, Australia, and Europe.
- Tripp Umbach has completed feasibility studies for more than 30 new medical schools and consulting for more than 75 medical schools in the United States as well as medical schools in Canada, Europe, South America, Australia, and Abu Dhabi.



Tripp Umbach
Turning Ideas Into Action

Tripp Umbach Allopathic Medical School Experience*

Baylor U. Temple SOM, Waco, TX	Carle Health System/U. of Illinois SOM, Urbana Champaign, IL	Central Michigan U. SOM, Mount Pleasant, MI	Charles Drew U. of Medicine and Science SOM, Compton, CA	Dell Medical School at the U. of Texas SOM, Austin, TX	Florida Atlantic U. SOM, Boca Raton, FL	Florida International U. SOM, Miami, FL	Florida State U. SOM, Tallahassee, FL
Geisinger Commonwealth Medical College SOM, Scranton, PA	Gonzaga U. SOM, Spokane, WA	Hackensack Meridian Seton Hall SOM, Clifton, NJ	Indiana University SOM, Bloomington, IN	Keck Graduate Institute SOM, Claremont, CA	Khalifa U., Abu Dhabi, UAE	Michigan State U. SOM, East Lansing, MI	NOVA Southeastern U. SOM, Fort Lauderdale, FL
Roseman U. SOM, South Jordan, UT	Texas A&M U. Houston Methodist SOM, Houston, TX	Texas Christian U. SOM, Fort Worth, TX	Texas Tech U. SOM, Lubbock, TX	U. of Central Florida SOM, Orlando, FL	U. of Adelaide, Adelaide, Australia	U. of Arizona SOM, Phoenix, AZ	U. of California SOM, Oakland, CA
U. of Georgia SOM, Athens, GA	Medical College of Georgia SOM, Athens, GA	U. of Houston SOM, Houston, TX	U. of Nevada SOM, Las Vegas, NV	U. of South Carolina SOM, Columbia, SC	Washington State U. SOM, Spokane, WA	Washington State U. SOM, Pullman, WA	

Tripp Umbach Osteopathic Medical School Experience*

Alabama COM Medicine, Dothan, AL	Baptist Health Sciences U. COM, Memphis, TN	Burrell COM Medicine, Las Cruces, NM	Burrell U. COM at the Florida Institute of Technology, Melbourne, FL	California Health Sciences U. COM, Clovis, CA	Duquesne U. COM, Pittsburgh, PA	Edward Via COM Louisiana Campus, Monroe, LA	Idaho COM Medicine, Meridian, ID
Indiana U. of Pennsylvania COM, Indiana, PA	Kansas City U. COM, Joplin, MO	Kansas Health Science Center Kansas COM, Wichita, KS	Lake Erie COM Elmira College, Elmira, NY	Lake Erie COM Seton Hill, Greensburg, PA	Meritus SOM, Hagerstown, MD	Montana COM Billings, MT	New York Institute of Technology COM at Arkansas State U., Jonesboro, AR
Noorda COM, Provo, UT	Ohio U. Heritage COM, Cleveland, OH	Oklahoma State U. Ctr. for Health Sciences COM, Tahlequah, OK	Orlando COM, Orlando, FL	Philadelphia COM South Georgia, Moultrie, GA	Rowan-Virtua SOM, Sewell, NJ	Rocky Vista U. COM, Parker, CO	Montana Sam Houston State U. COM, Conroe, TX
Touro COM, Great Falls, MT	Touro COM, Middletown, NY	University of New England COM, Portland ME	University of Northern Colorado COM, Greeley, CO	University Heritage COM, Dublin, OH	Xavier U. COM, Cincinnati, OH		



TEAM

INTRODUCTION



Paul Umbach
Founder & CEO

pumbach@trippumbach.com



Ha Pham
Senior Principal

hpham@trippumbach.com

Project Timetable

Project Timetable

	Tasks
<ul style="list-style-type: none"> • Project kick-off • Begin feasibility analysis <ul style="list-style-type: none"> • Market analysis 	January 15, 2025
<ul style="list-style-type: none"> • Gather data on existing medical schools and healthcare needs • Continue feasibility analysis <ul style="list-style-type: none"> • Needs assessment analysis • Clinical training evaluation • Program model feasibility analysis 	February 2025
<ul style="list-style-type: none"> • Conduct stakeholder interviews • Continue feasibility analysis <ul style="list-style-type: none"> • Site evaluation, curriculum planning, accreditation requirements, and impact assessment • Financial feasibility assessment • Analyze economic, social, and healthcare impacts • Develop preliminary budget and funding requirements <ul style="list-style-type: none"> • Conduct cost-benefit analysis 	March 2025
<ul style="list-style-type: none"> • Mid-Project Planning Session • Incorporation of feedback from planning session 	April 2025
<ul style="list-style-type: none"> • Development of draft report 	May 2025
<ul style="list-style-type: none"> • Finalize report • Final Presentation to the Special Legislative Commission 	June 2025

Stakeholder Interviews

- Commission Members
- Elected officials/government leaders
- Leaders of hospitals and healthcare systems
- Community health partners
- Charitable Foundation leaders
- URI stakeholders
- Educational leaders (i.e., Brown, CCRI, etc.)
- Research and innovation leaders
- Other strategic partners



ADVANCING INTEGRATED HEALTHCARE

Presentation to Special Legislative Commission to Establish a State Medical School at The University of Rhode Island

Debra Hurwitz, MBA, BSN, RN
Executive Director, Care Transformation Collaborative of RI
January 27, 2025

Care Transformation Collaborative of RI

3 Questions

1. Who is CTC and what is our role in primary care?
2. Why is a state medical school important to our health care and primary care landscape?
3. Why are community health clinic residency programs important for our primary care landscape?

CTC-RI: States Multi-payer, Primary Care Transformation Collaborative

- **Non-profit, public-private collaborative, co-convened by OHIC and EOHHS** to bring together key stakeholders

- **Mission**

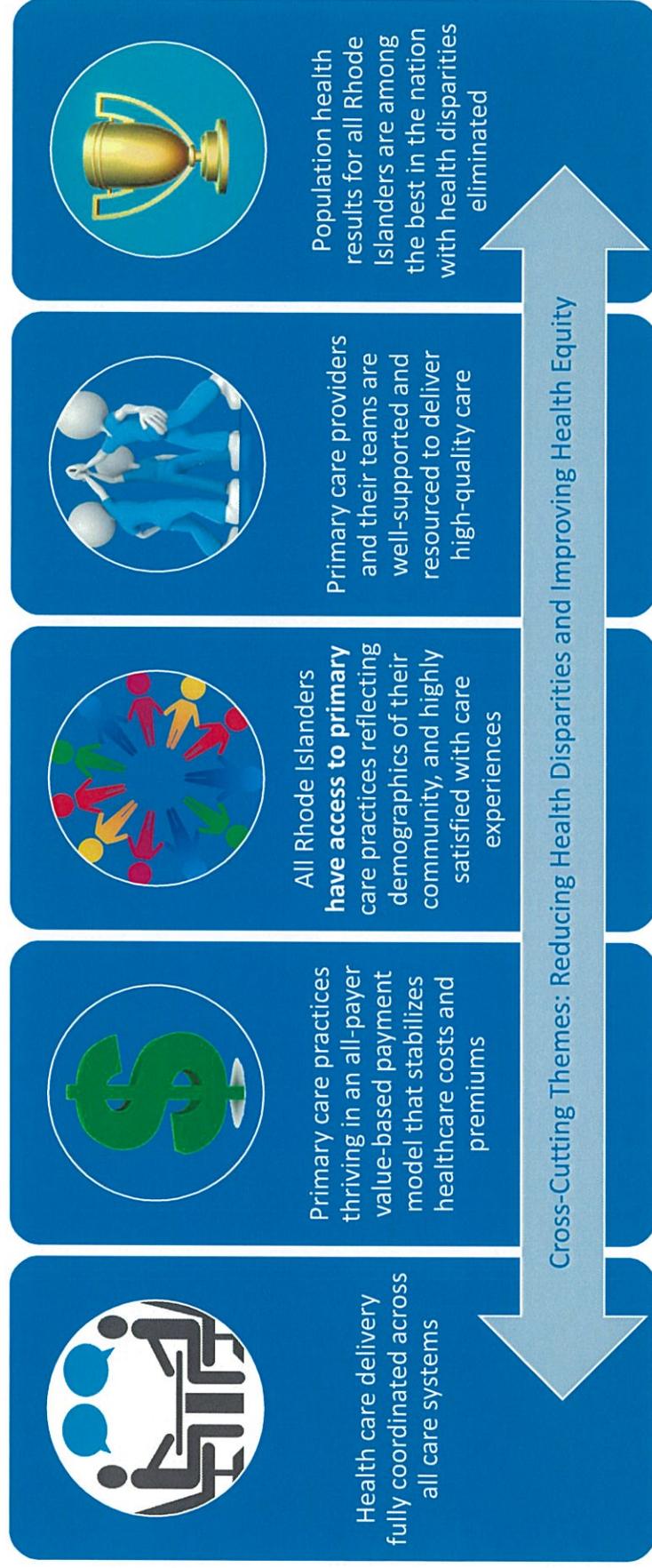
The mission of CTC-RI is to support the continuing **transformation of primary care in Rhode Island as the foundation of an ever-improving, integrated, accessible, affordable, and equitable health care system**. CTC-RI brings together critical stakeholders to implement, evaluate and **spread effective multi-payer models** to **deliver, pay for and sustain high-quality, comprehensive, accountable primary care**.

- **Vision**

Rhode Island has a **thriving primary care system** that ensures every person has **equitable and affordable access**, engages patients and families as active partners, and results in **excellent health for patients, families, and communities**.

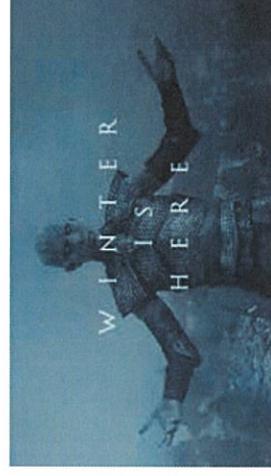
Strategic Priorities Impact Areas (5 Years – 2022-2027)

ADVANCING INTEGRATED HEALTHCARE



CURRENT STATE

- *Is the crisis coming or is it already here?*
- *What about the effects of Covid, burnout, the great resignation,*



There will not be enough primary care physicians in RI to serve the population and PAs and NPs will not be in sufficient numbers to fill the gap

What does this imply about the current primary care gap?

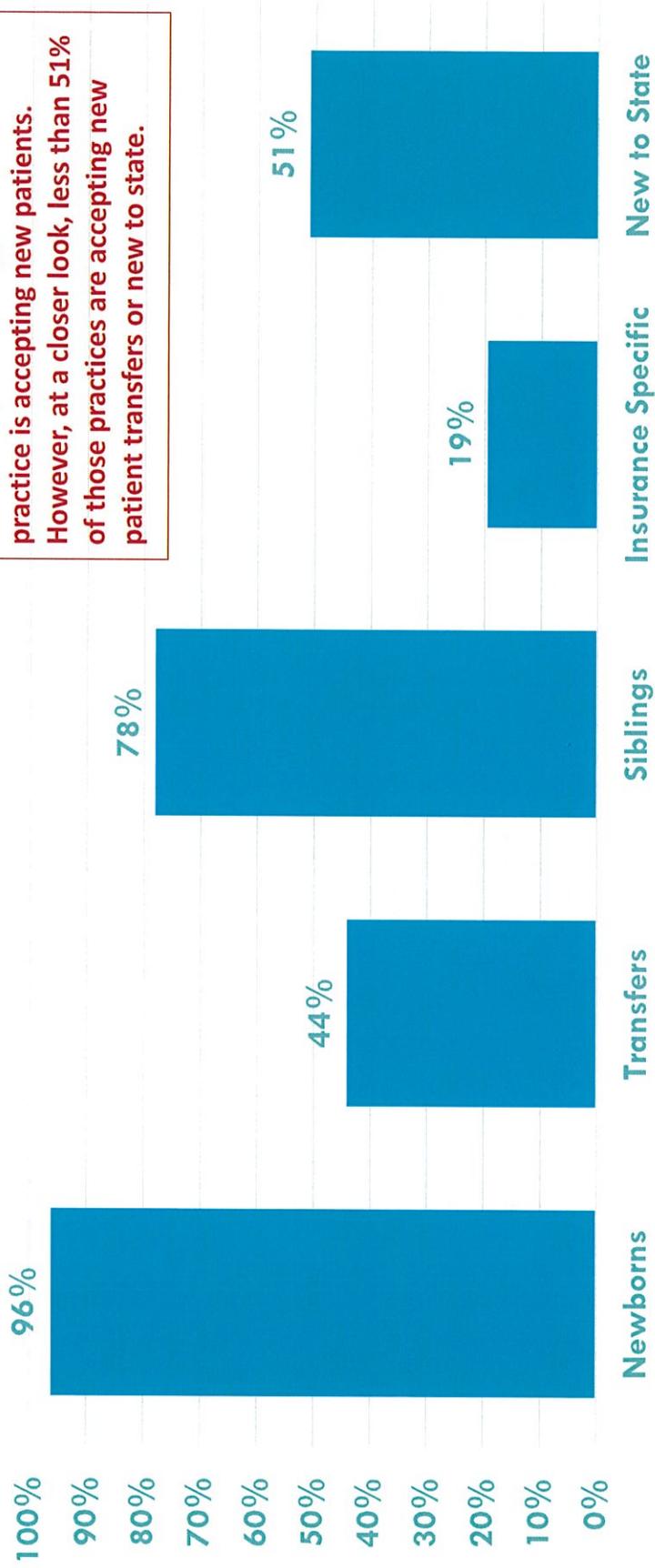
520 Physicians + 104 NPs + 36 PAs = 660 primary care clinicians

- As of 2023, there are 1,095,962 Rhode Islanders
- At a patient panel size of 1200: 792,000 patients covered, 303,962 patients without a PCP (which would require **250+ more PCPs**)
- At a patient panel size of 1500: 990,500 patients covered, 105,962 patients without a PCP (which would require **70 more PCPs**)

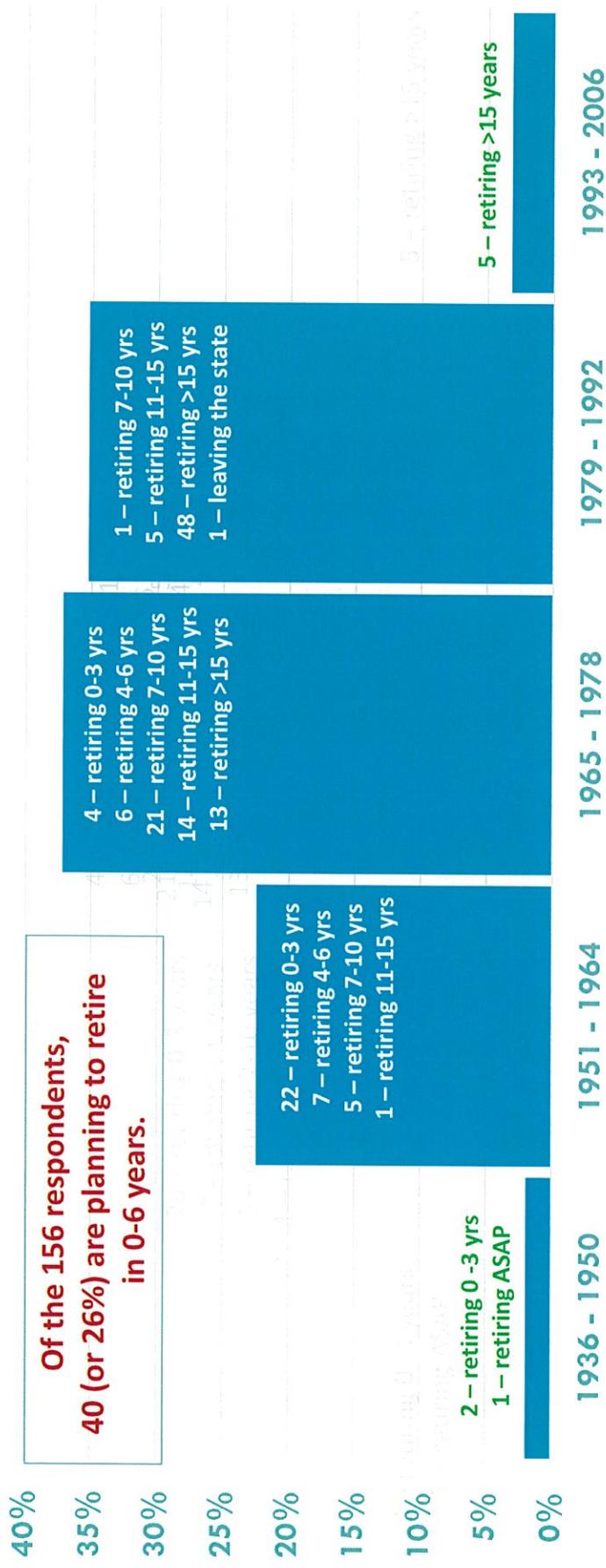
Of note, as expected based on FTE equivalent hours, these panel sizes are far larger than what APCD suggests

PERCENT RESPONDERS ACCEPTING NEW PATIENTS BY TYPE OF NEW PATIENT (N=159)

91% of responders suggested that their practice is accepting new patients. However, at a closer look, less than 51% of those practices are accepting new patient transfers or new to state.



SURVEY RESPONDERS BY BIRTH YEAR WITH YEARS TO RETIREMENT





CARE
TRANSFORMATION
COLLABORATIVE
RHODE ISLAND



patient centered medical home

ADVANCING INTEGRATED HEALTHCARE

CTC-RI Role in Primary Care (Task Force)

- Convened in 2022 by CTC-RI Board of Directors to address primary care workforce crisis
- [Primary Care Access for All – A Strategic Roadmap Report](#)
- Primary Care Training Program – Legislation Passed 2024
 - Working with RIDOH to develop standard curriculum to train MD, NP and PA students in advanced primary care and build provider pipeline



Strategic Goals Identified

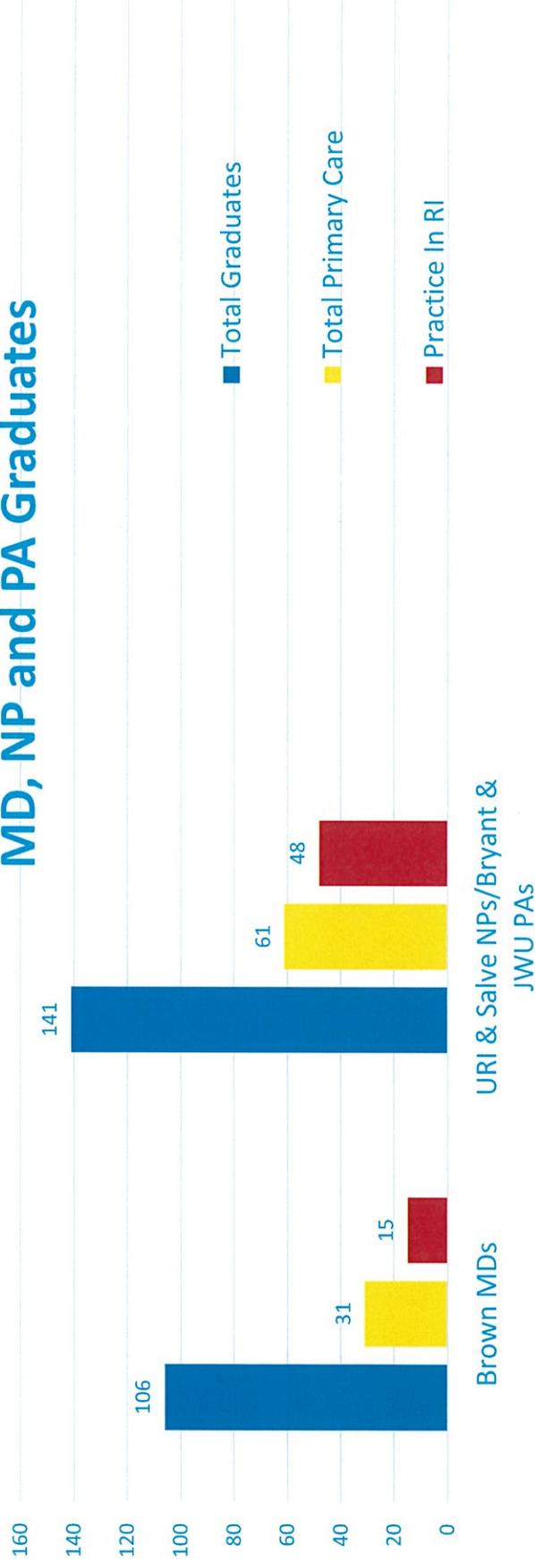


ADVANCING INTEGRATED HEALTHCARE

Goal #1	Reform and increase payments, incentives, and salaries to primary care providers to create parity with other specialties and regionally
Goal #2	Identify data sources on primary care providers to establish a baseline and provide ongoing monitoring of the effectiveness of the plan
Goal #3	Increase the recruitment of medical students, medical residents and NP and PA trainees entering primary care - Reduce Tuition and Student Debt for those providers going into Primary Care in RI
Goal #4	Expand Primary Care Provider Workforce Diversity, Equity, and Inclusion
Goal #5	Increase the funding for training Primary Care Providers and the number of high-quality Primary Care training sites
Goal #6	Enhance and standardize curriculum for onsite clinical training in advanced patient-centered medical home (PCMH) principles such as team-based care, integrated behavioral health, practice transformation, and payment reform for

Why is a state Medical School Important? Insufficient Pipeline

Academic Year 2022-2023 MD, NP and PA Graduates



Why is State Medical School Important?

- Increase medical student's training in Rhode Island
- Increase the physician pipeline and keep pace with the number of physicians leaving practice e.g., retirements
- State school makes education more affordable – lower debt burden
- Provides educational and economic opportunity for Rhode Islanders
- Increase diversity of physician workforce

Why are Teaching Health Center (THC) Residency Programs Important for PC Landscape?

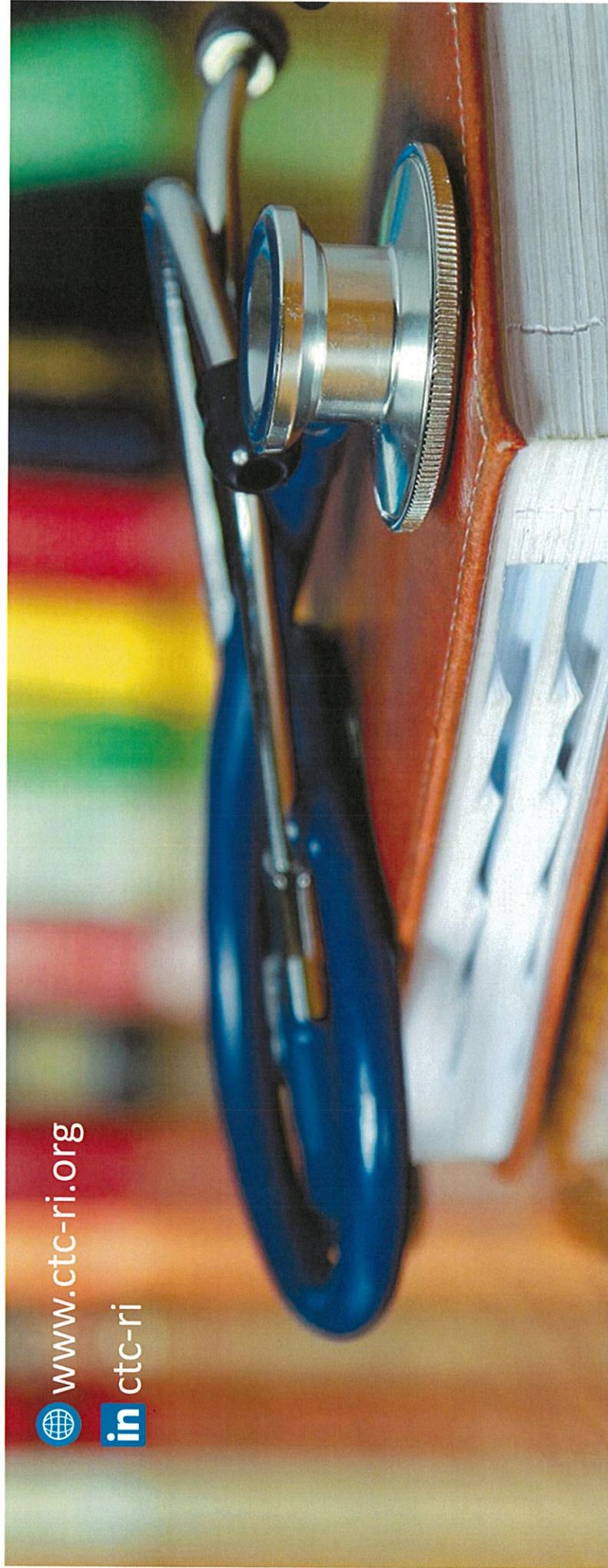
- **Studies show residents stay in state where trained**
- **Federal Funding available for CHC to become a TCH but needs state supplement**
- **Increases residency slots in Rhode Island**
- **Providers at CHCs are eligible for Public Service Loan Forgiveness**

THANK YOU Q&A

Debra Hurwitz, MBA, BSN, RN
dhurwitz@ctc-ri.org

 www.ctc-ri.org

 [ctc-ri](https://www.linkedin.com/company/ctc-ri)



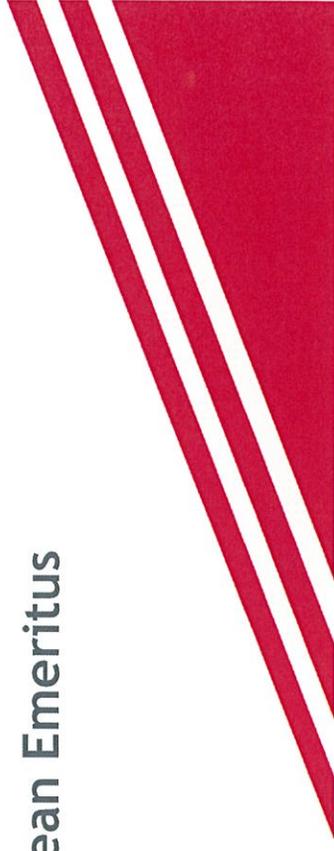


Tilman J. Fertitta Family
College of Medicine

UNIVERSITY OF HOUSTON

A New Medical School With a Different Kind of Mission

Stephen J. Spann, M.D., M.B.A.
Professor and Founding Dean Emeritus



Texas Needs More Primary Care Physicians



- Texas has a **low physician-to-population ratio compared to other states:**
 - 41st in active patient care physicians-to-population
 - 47th in active primary care physicians-to-population
- **5,800 additional primary care physicians needed in Texas today to reach national average PCP-to-population ratio**
- **Strong primary care improves health outcomes and decreases costs (improving value)**



UHCOM Mission Statement



The University of Houston College of Medicine is accountable to society for improving the overall health and healthcare of the population of Greater Houston, Texas and beyond by:

- **Educating a diverse group of physicians who will provide compassionate, high value (high quality at reasonable cost) care to patients, families and communities, with a focus on primary care and other needed physician specialties**
- **Conducting interdisciplinary research to find innovative solutions to problems in health and healthcare**
- **Providing integrated, evidence-based, high value care delivered to patients by inter-professional teams**
- **Engaging, collaborating with, and empowering underserved patient populations and community partners to improve their health and healthcare**



Tilman J. Fertitta Family
College of Medicine

UNIVERSITY OF HOUSTON

How Is Our Medical School Different?



Differentiating Features of the Medical School Curriculum



Curriculum emphasis on community and population health, primary care, behavioral and mental health, and preventive medicine



Highly integrated teaching of biomedical, clinical, behavioral and social, and health systems and population health sciences throughout the four-year curriculum



Emphasis on inter-professional education and training



Adaptive education approach



Longitudinal primary care experience across the four-year curriculum



Longitudinal integrated core clinical clerkship



Emphasis on learning about social determinants of health and health disparities



Phase 1: PRE-CLERKSHIP - Academic Year 1

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
CF51 - Our Mission Community, Our	Clinical Anatomy & Human Development	Physicians, Patients and Populations (PPP)	Scientific Foundations of Medicine	Longitudinal Primary Care (LPC)	CFS 2 - Closing the Quality Gap	Break - Winter	Integumentary System	Nervous System	CFS3 - Coping with Pain	Musculo-skeletal System	Gastrointestinal System	Break - Summer
Longitudinal Primary Care (LPC)												
		Household Centered Care (HCC)										

Phase 1: PRE-CLERKSHIP - Academic Year 2

Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
CBSE (no stakes exposure)	Cardiovascular & Respiratory Systems	Renal & Urinary Systems	Reproductive & Endocrine Systems	CFS 5 - Living & Dying with Dignity	Behavioral Medicine	CFS 6 - From Substance Abuse to Thriving Life	Transition to Clerkships	Longitudinal Integrated Clerkship (LIC)	F.I.S.	P.O.P.	Family Medicine Internal Medicine Surgery Pediatrics Ob/Gyn Psychiatry	Break - 1 Week
		CFS 4 - Transcending Borders		Break - Winter		CBSE Study / Exam						

Curriculum



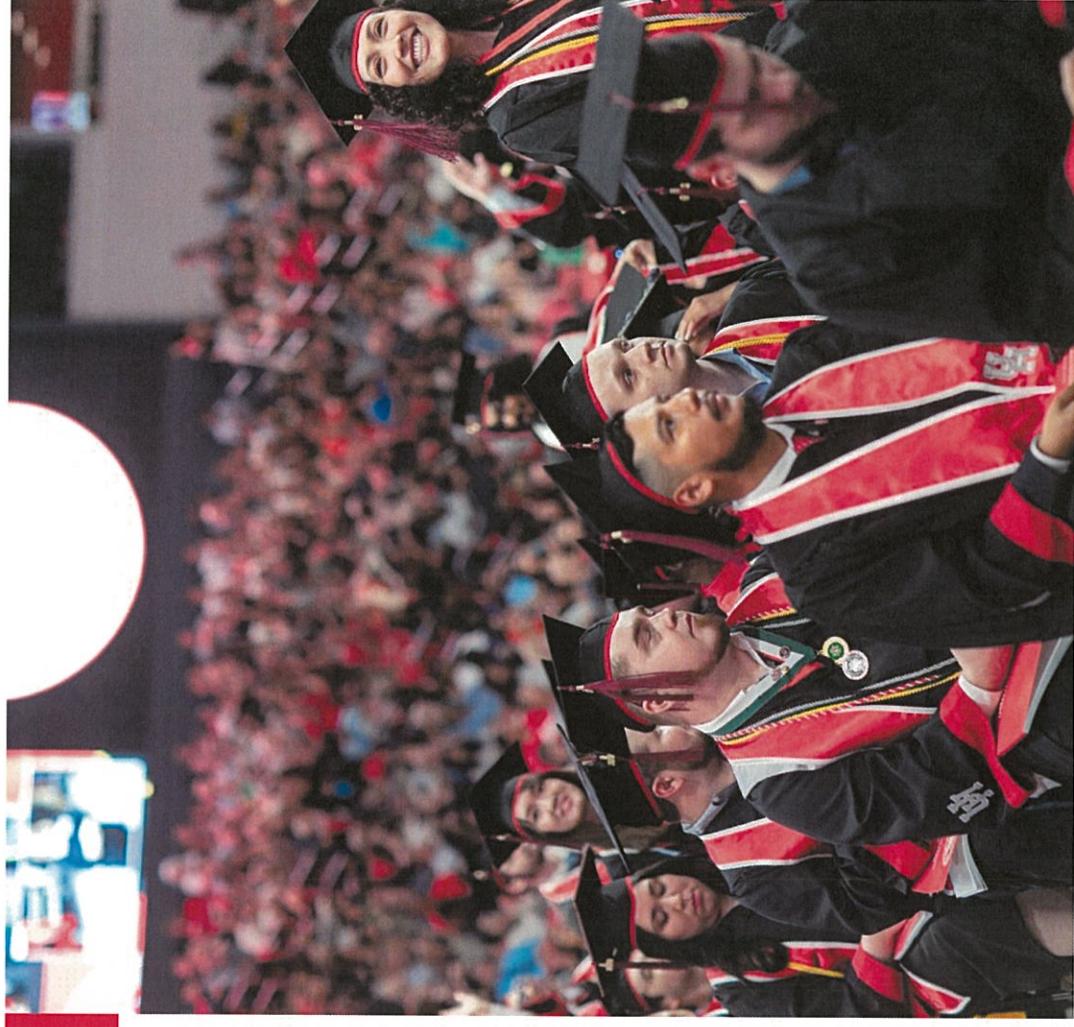
Phase 2: CORE CLERKSHIP - Academic Year 3										Phase 3: ADVANCED CLERKSHIP - Academic Year 3				
Aug	Sept	Oct	Nov	Dec	Jan**	Feb	Mar	Apr	May	Jun	July			
Longitudinal Integrated Clerkship (LIC)		P.O.P.	Pediatrics Ob/Gyn Psychiatry Family Medicine Internal Medicine Surgery	Break - Winter	STEP 1 Study / Exam	Advanced Clerkships: 4 weeks each of Intensive Care, Emergency Medicine, Sub-Internship and Rural Health	Advanced Clerkships: 4 weeks each of Intensive Care, Emergency Medicine, Sub-Internship and Rural Health	Electives: Minimum of 24 weeks of electives, to include an approved combination of clinical, educational and research	LPC	LPC				
	F.I.S.								HCC	HCC				
** Students to take CBSE at the end of Phase 2 as part of their Step 1 preparation														
** During phase 3, students will schedule themselves for up to 16 weeks for Step 2 preparation and testing, residency interviews and vacation.														

Phase 3: ADVANCED CLERKSHIP - Academic Year 4											
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Advanced Clerkships		Advanced Clerkships		Break - Winter	Advanced Clerkships		Advanced Clerkships		Transition to Residency	Graduation	
Electives		Electives			Electives		Electives				
LPC		LPC		LPC		LPC		LPC			
HCC		HCC		HCC		HCC		HCC			
** During phase 3, students will schedule themselves for up to 16 weeks for Step 2 preparation and testing, residency interviews and vacation.											

How Can We Achieve the Goal of 50% of Graduates Choosing Primary Care Specialties?



- Holistic admissions process that favors applicants with characteristics predictive of primary care specialty choice
- Curriculum with broad and deep exposure to primary care
- Culture that values primary care
- Scholarships/loan repayment programs that decrease graduate debt



Combined Student Body Demographics First Four Classes





Tilman J. Fertitta Family
College of Medicine

UNIVERSITY OF HOUSTON

Outcomes To Date



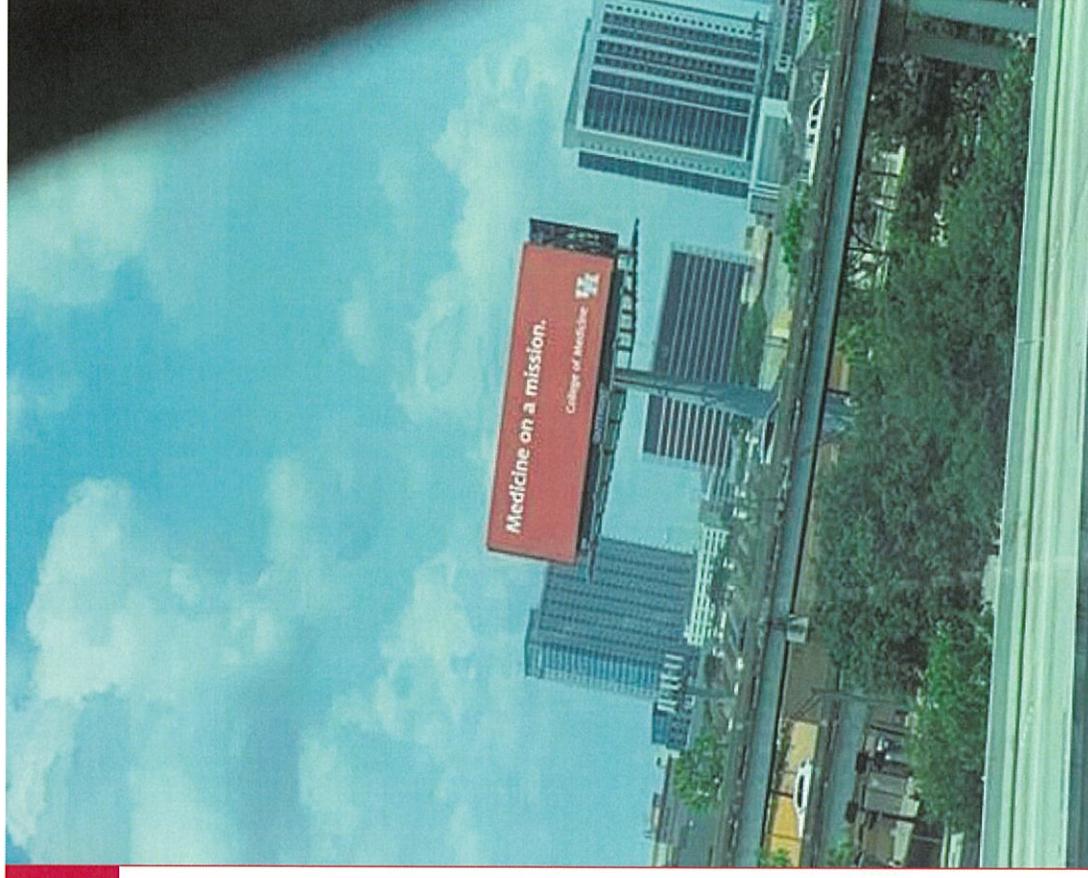
First Class Graduated May 11, 2024



- All 21 of the graduates matched in a residency program
- 57% matched in Family Medicine, Internal Medicine or Pediatrics
- 52% matched in residency programs in Texas

Medicine on a Mission

We really are.....



Tilman J. Fertitta Family College of Medicine

US Needs Primary Care

Robert M Califf MD
Professor, Duke University
“Chief Provocateur”

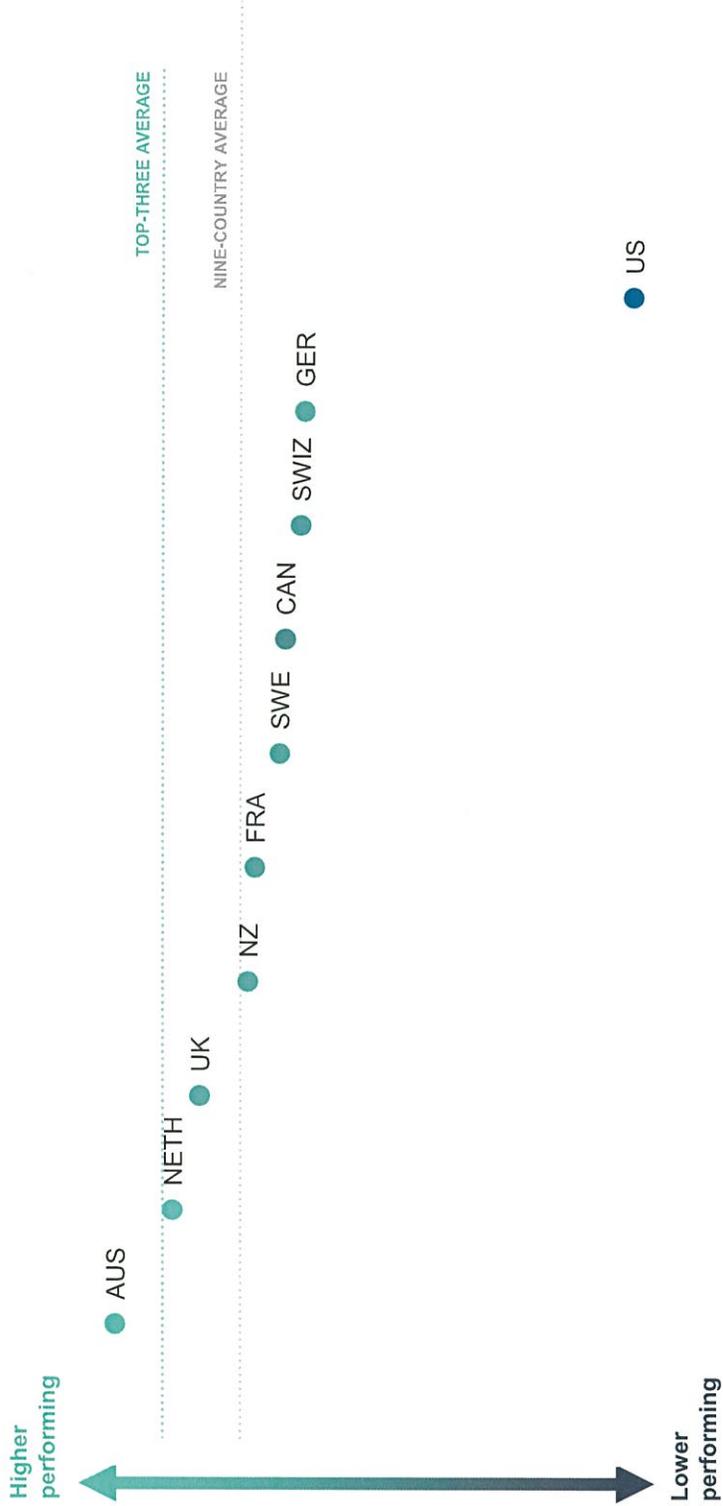
Former 22nd and 25th Commissioner of the US Food and Drugs
Administration

Health Trends

- US has worst outcomes among large, high income countries
- But spends much more \$\$

EXHIBIT 2 — Overall Performance Ranking

The United States lags its international peers considerably on health system performance.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.
Data: Commonwealth Fund analysis.

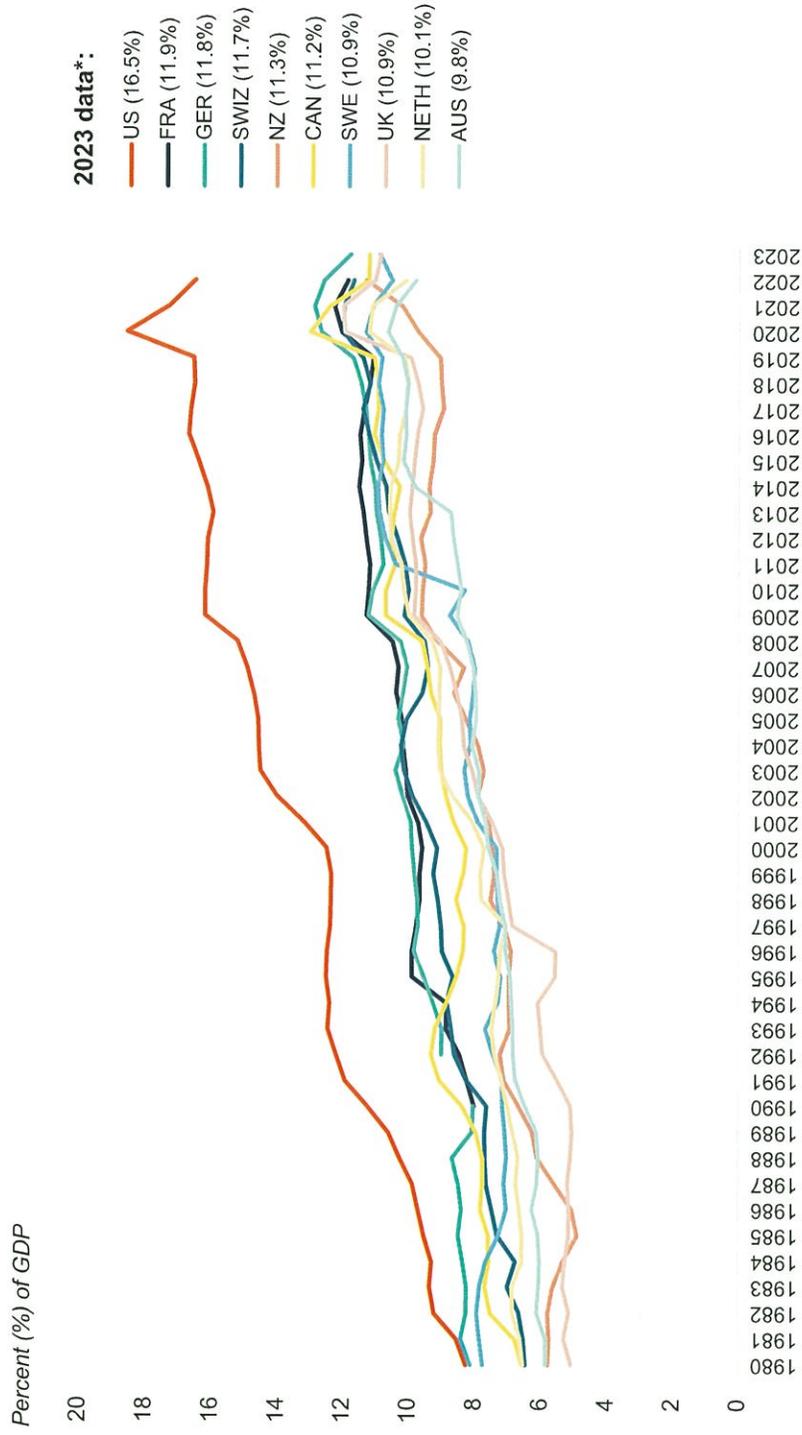
Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). <https://doi.org/10.26099/1a0g-zp66>



The Commonwealth Fund

EXHIBIT 3 — Health Care Spending

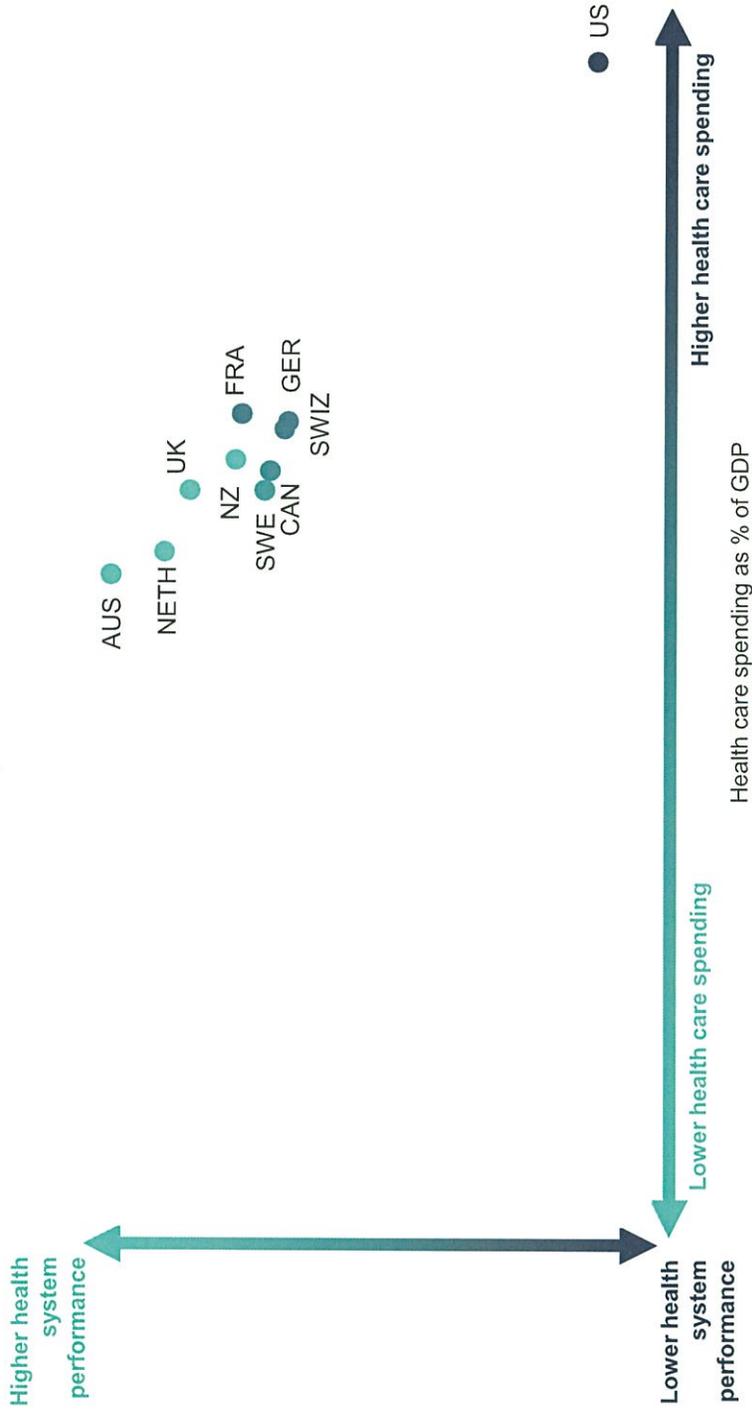
Health Care Spending as a Percentage of GDP, 1980–2023



Notes: GDP = gross domestic product. Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies.
 * Data for CAN, GER, SWE, and the UK from 2023; data for AUS, FRA, NETH, NZ, SWIZ, and the US from 2022.
 Data: OECD Health Data, July 2024.

EXHIBIT 4 — Performance vs. Spending

Health Care System Performance Compared to Spending



Notes: GDP = gross domestic product. Health care spending as a percentage of GDP. Performance scores are based on standard deviation calculated from the nine-country average that excludes the US. See "How We Conducted This Study" for more detail. Data: Spending data are from OECD for the year 2022 and 2023 (updated in July 2024).

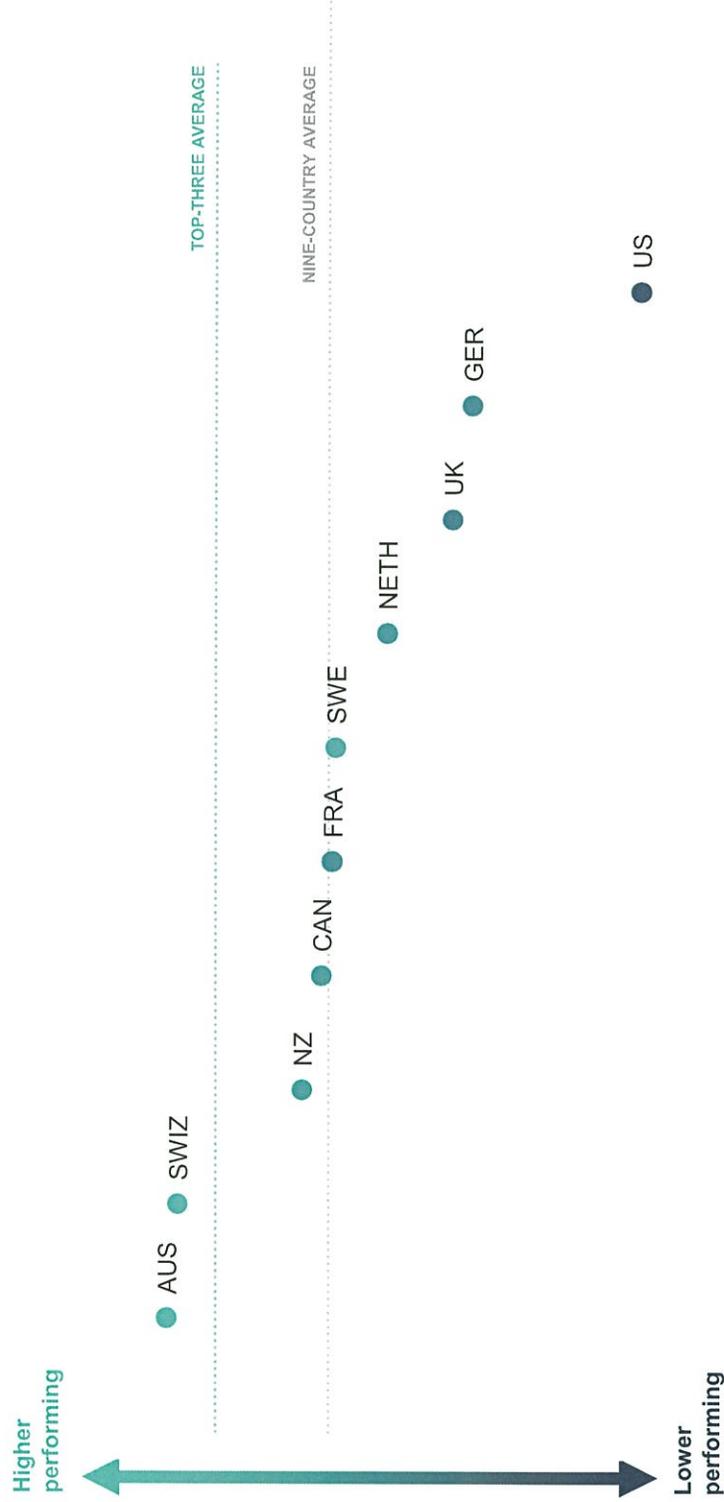
Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). <https://doi.org/10.26099/1a0g-zp66>



The Commonwealth Fund

EXHIBIT 9 — Health Outcomes

Americans live the shortest lives and have the most avoidable deaths.

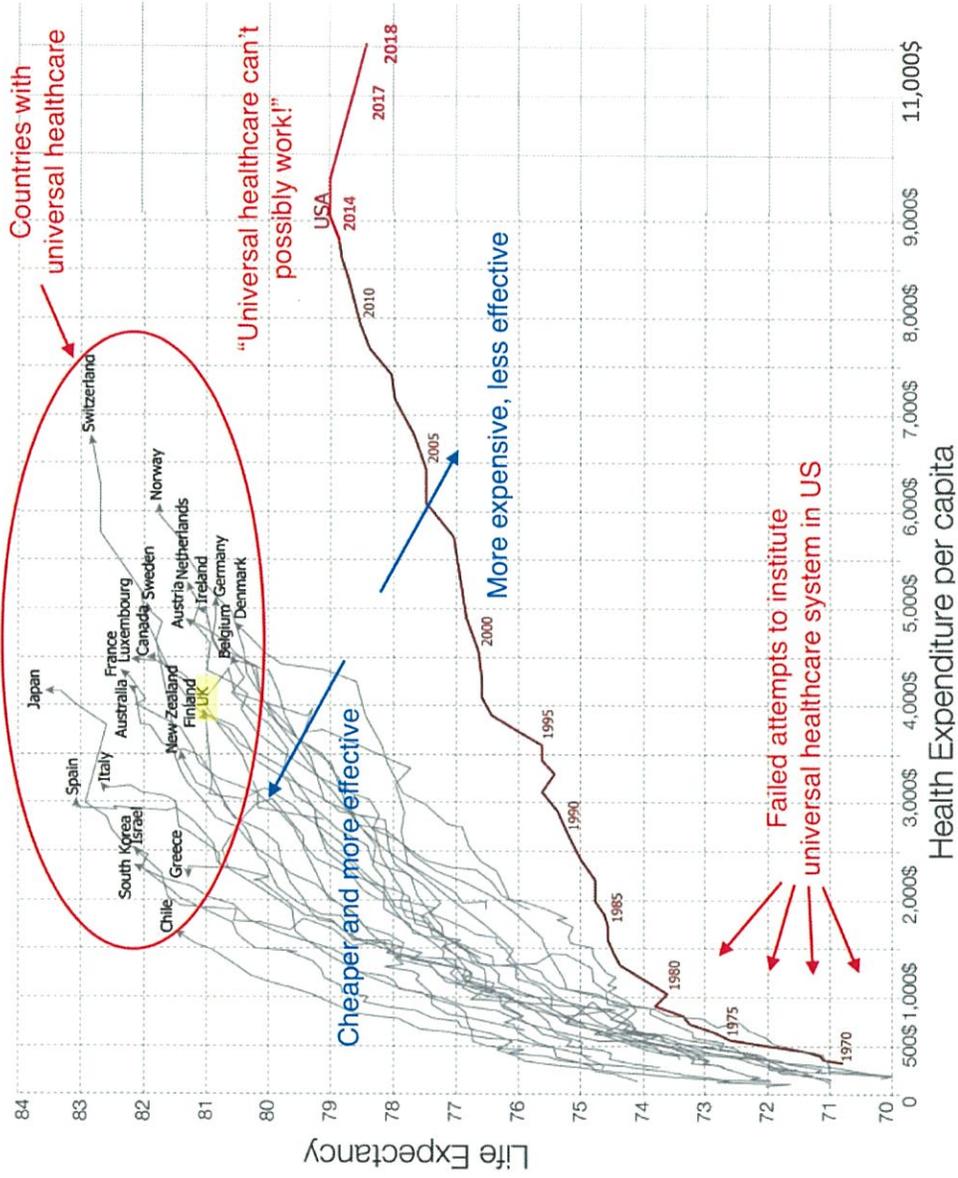


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Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). <https://doi.org/10.26099/1a0g-zp66>



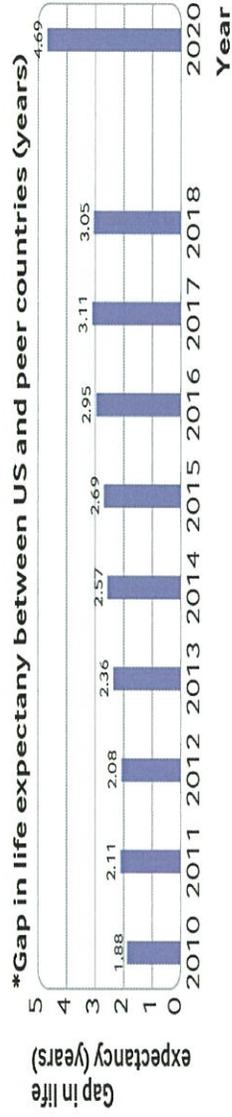
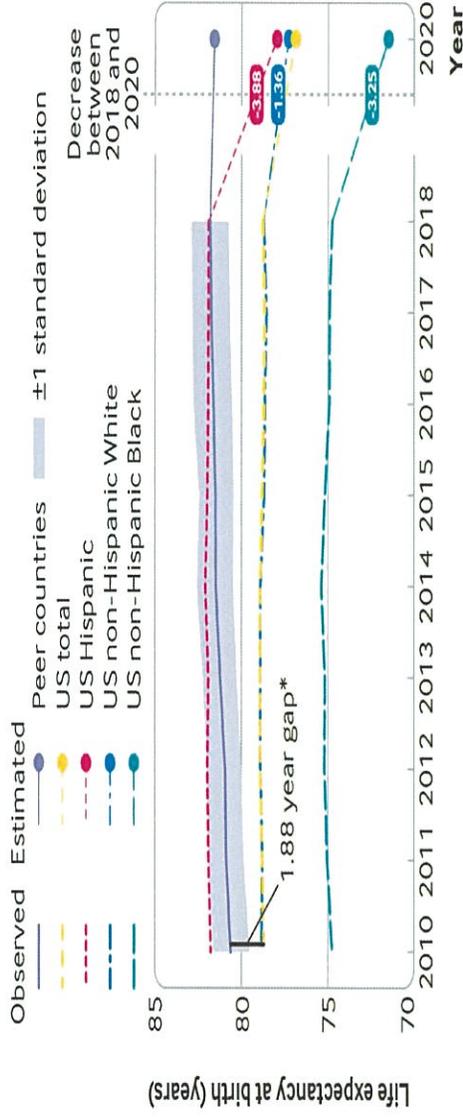
The Commonwealth Fund



Outcomes are Related to Easily Measurable Factors

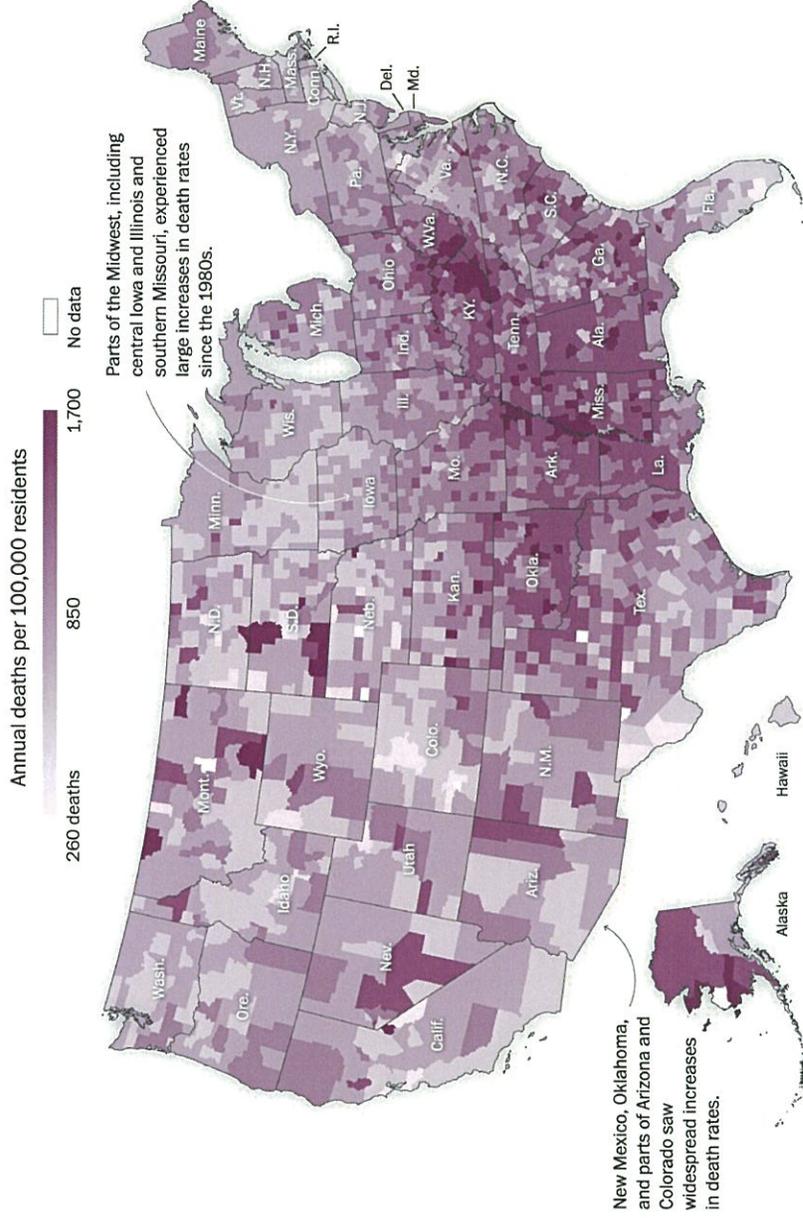
- “Traditional disparities”
 - Sex, gender, race, ethnicity
- “Social determinants”
 - Wealth, education
- Geography (“zip code trumps genetic code”)
 - Rural status is biggest changing factor
 - Urban low resource neighborhoods

Life expectancy at birth in the United States, by race and ethnicity, and in peer countries for years 2010-18 and 2020.



Where adults in their prime are dying

Deaths of adults 35 to 64 are concentrated in the nation's interior, including Appalachia, the Mississippi Delta and parts of the Midwest. In recent decades, death rates have been rising in the interior while declining in coastal regions.



Note: Age-adjusted death rates by counties for 2015-2019.

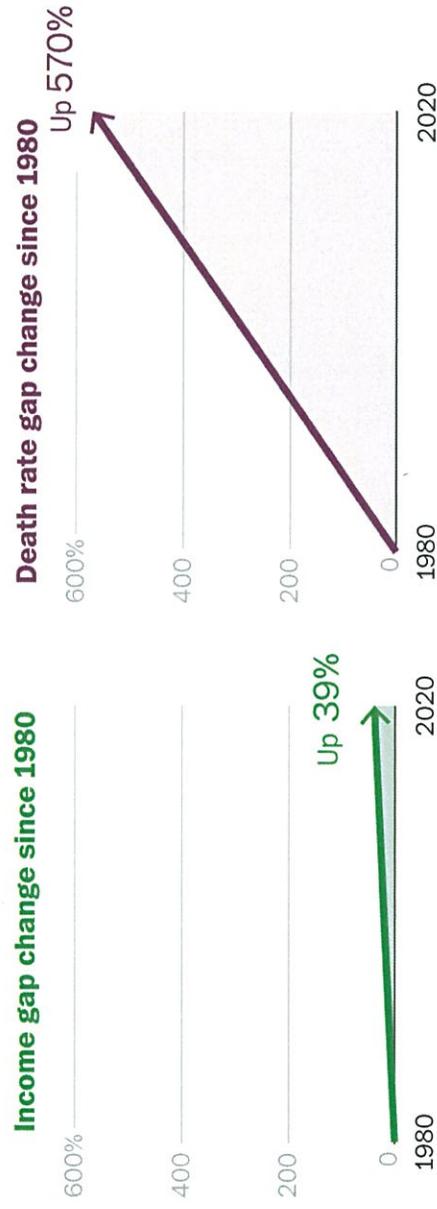
Source: Centers for Disease Control and Prevention

<https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/>
<https://www.washingtonpost.com/health/2023/10/02/takeaways-us-life-expectancy-crisis/>

Death gap widening between rich and poor

The Post compared death rates for people living in the poorest 10 percent of counties to rates for people living in the wealthiest 10 percent of counties over the past four decades. In that time, the gap between rich and poor death rates grew significantly wider, with rich communities' death rates improving for many years while poor areas largely stayed the same and then worsened. Death rates also grew many times faster than the difference in income between the poorest and richest areas.

GROWING GAPS BETWEEN RICHEST AND POOREST

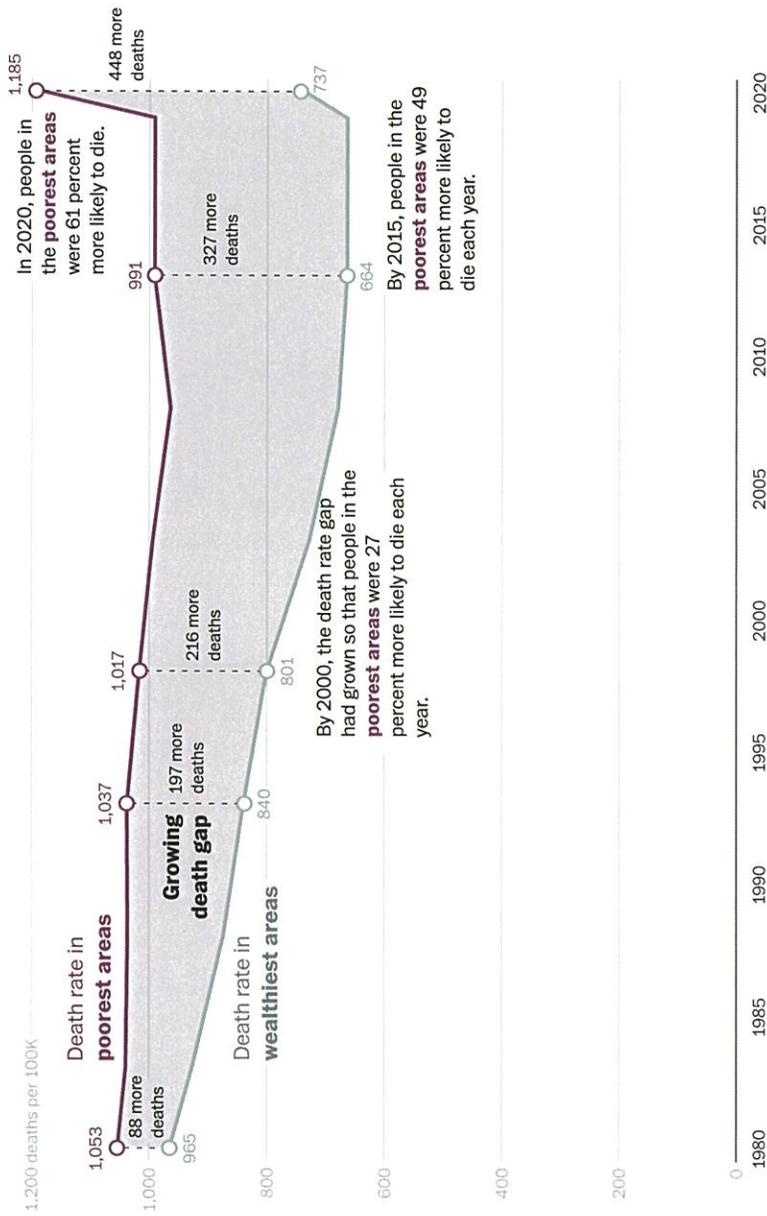


<https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/https://www.washingtonpost.com/health/2023/10/02/takeaways-us-life-expectancy-crisis/>

SMALL DEATH GAP HAS GROWN WIDE

Death rates of poorest and richest counties

In the early 1980s, people in the poorest areas were 9 percent more likely to die each year, with 88 more deaths per 100,000 people than their wealthy counterparts. That gap has widened significantly over time.



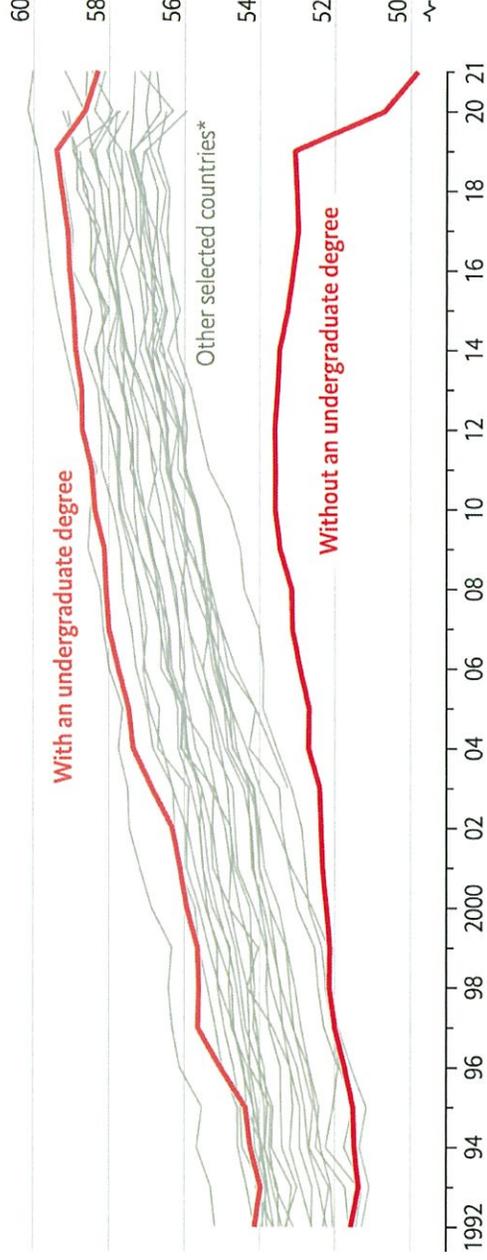
Note: Income differences are adjusted for inflation.

Sources: Centers for Disease Control and Prevention, U.S. Census Bureau

<https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/https://www.washingtonpost.com/health/2023/10/02/takeaways-us-life-expectancy-crisis/>

Survival of the richest

United States, remaining life expectancy at age 25, years



*Australia, Austria, Belgium, Britain, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Israel, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden and Switzerland
Sources: Human Mortality Database; 'Accounting for the widening mortality gap between American adults with and without a BA', A. Case and A. Deaton, *BPEA*, 2015

America's university graduates live much longer than non-graduates

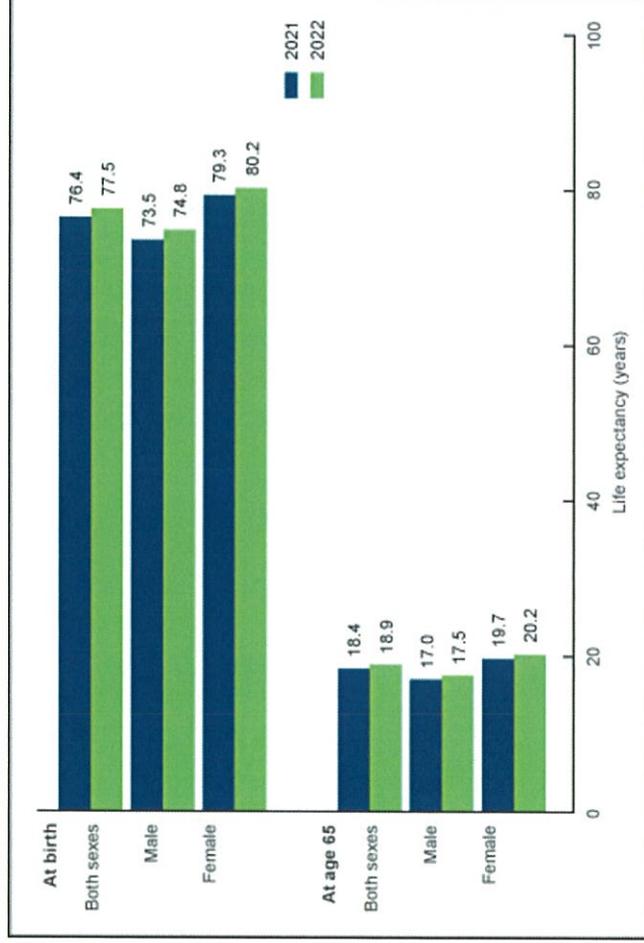
And the gap is widening

Data Looked Slightly Better in Last Year

- The big underlying health issues are basic issues, most of which are amenable to known interventions
- And many of which are preventable with fundamental attention to health habits
 - Tobacco, exercise, blood pressure, diet, adherence and persistence to effective medicines (most of which are generic)

US Life Expectancy Improved Slightly in Most Recent Data

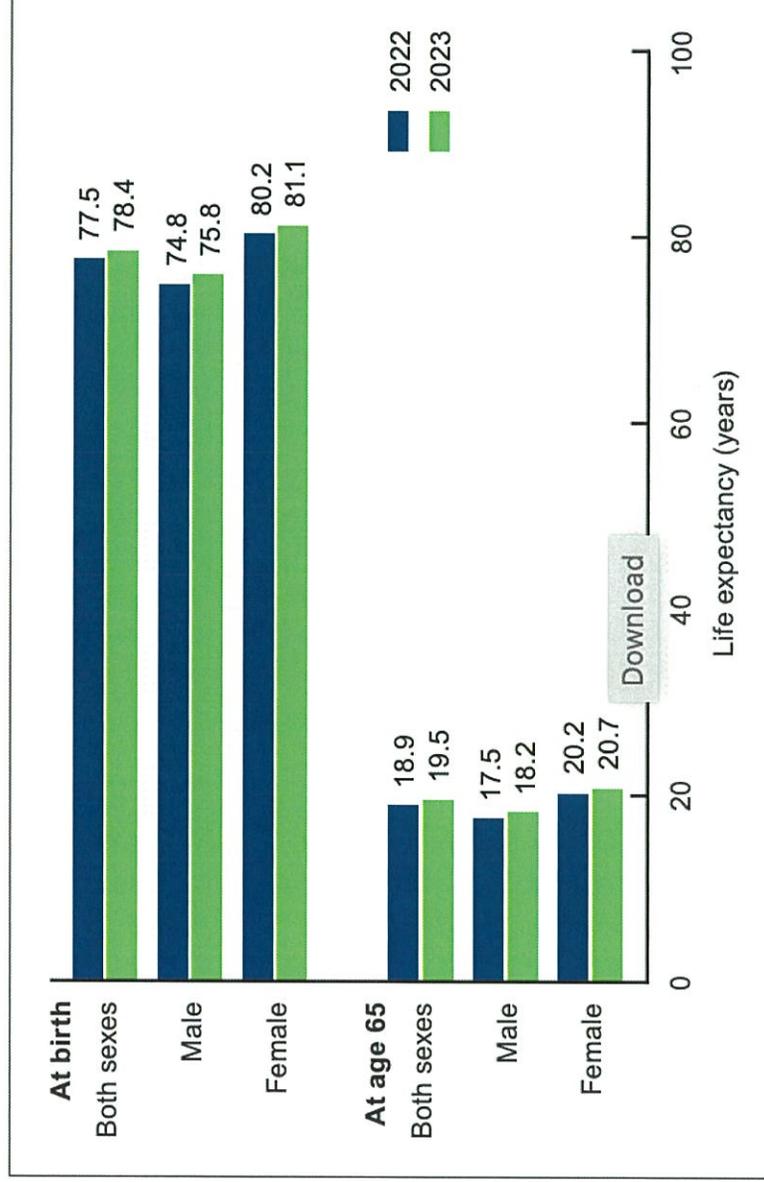
Figure 1. Life expectancy at birth and age 65, by sex: United States, 2021 and 2022



Note: [Access data table for Figure 1](#)

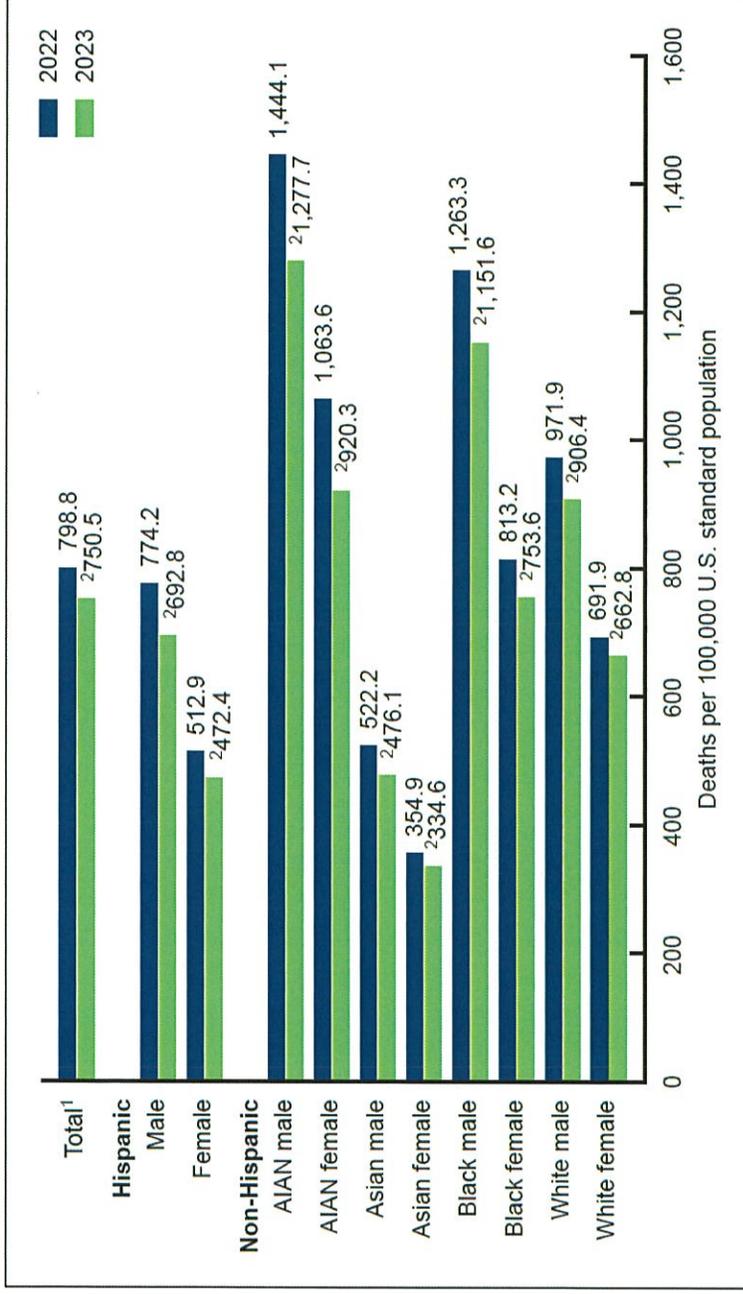
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 1. Life expectancy at birth and age 65, by sex: United States, 2022 and 2023



SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 2. Age-adjusted death rate, by race and Hispanic origin and sex: United States, 2022 and 2023



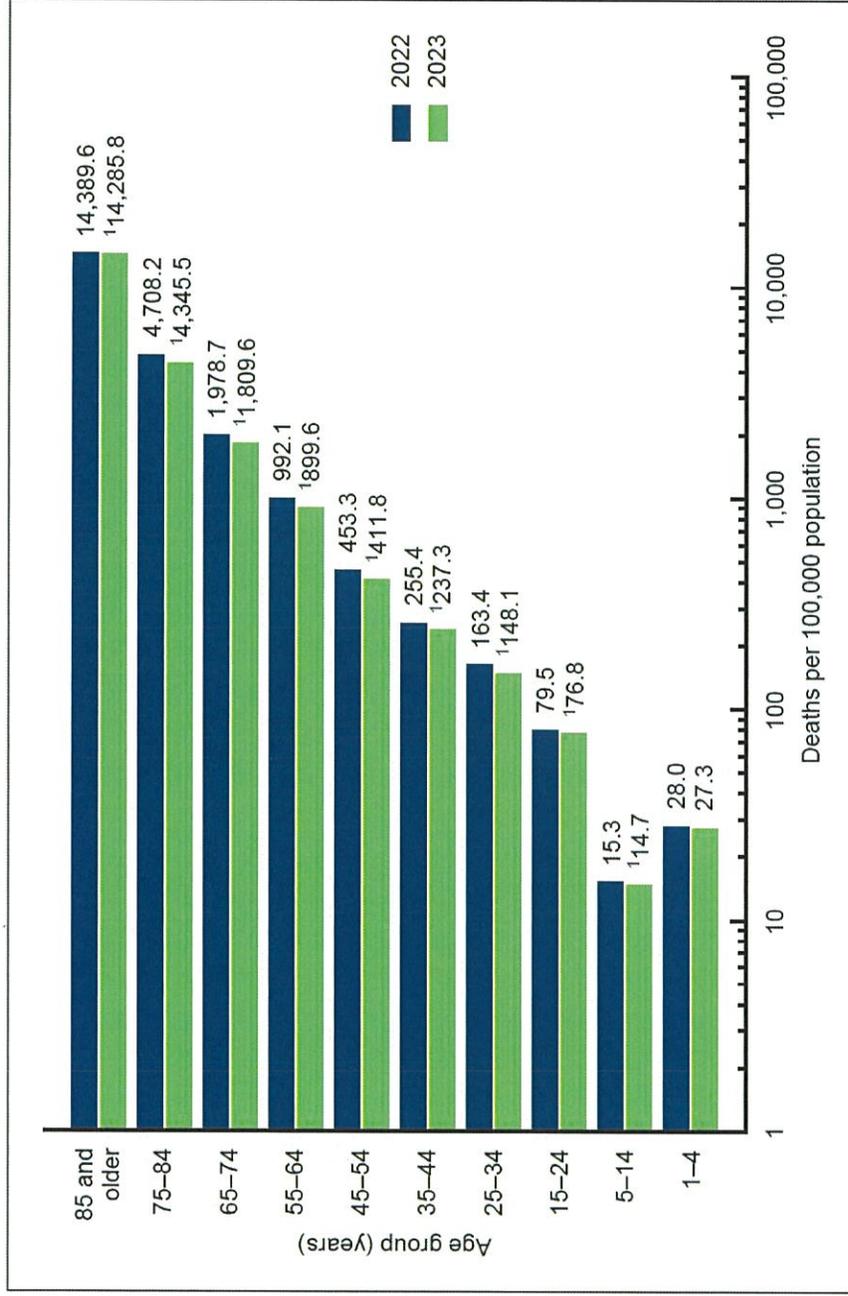
¹Includes races and origins not shown separately.

²Statistically significant decrease from 2022 to 2023 ($p < 0.05$).

NOTES: AIAN is American Indian and Alaska Native. Race groups are single race. People of Hispanic origin may be of any race. Data by race and Hispanic origin are adjusted for race and Hispanic-origin misclassification on death certificates. Adjusted data may differ from data shown in other reports that have not been adjusted for misclassification on death certificates.

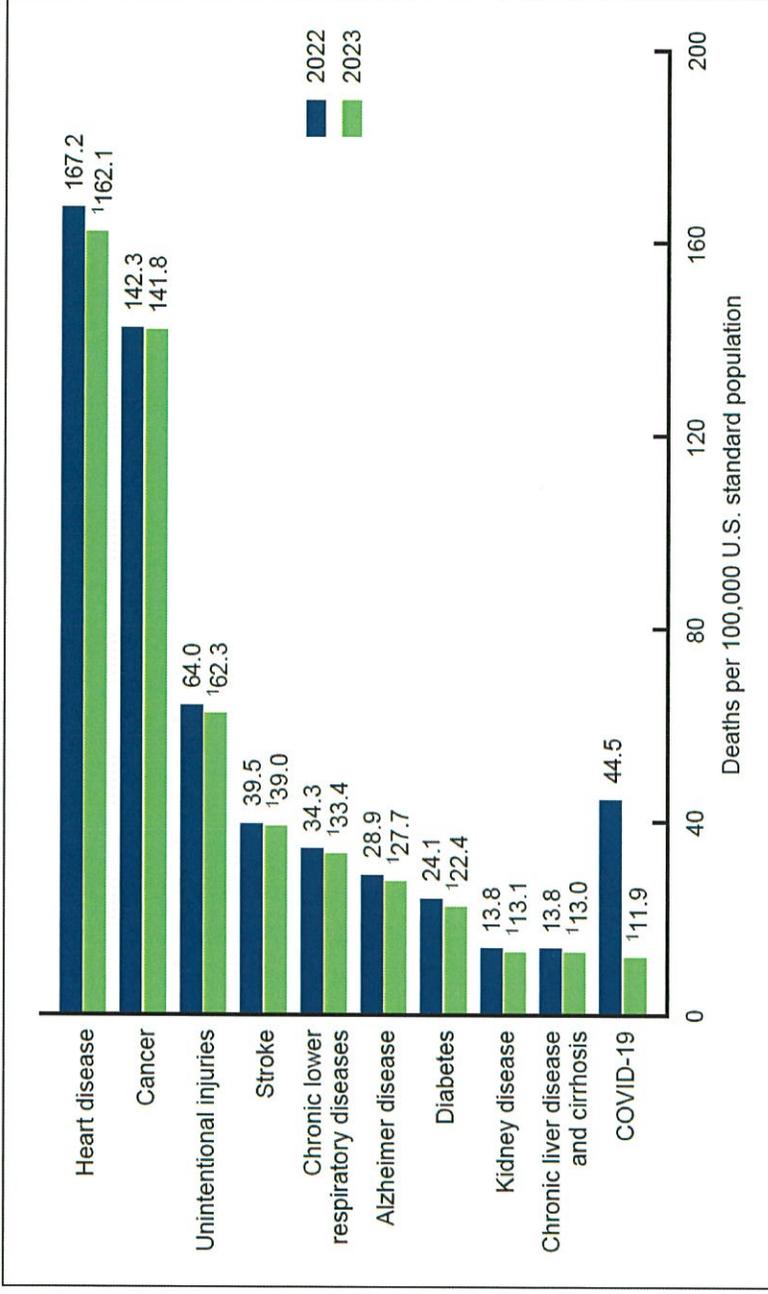
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 3. Death rate for age 1 year and older: United States, 2022 and 2023



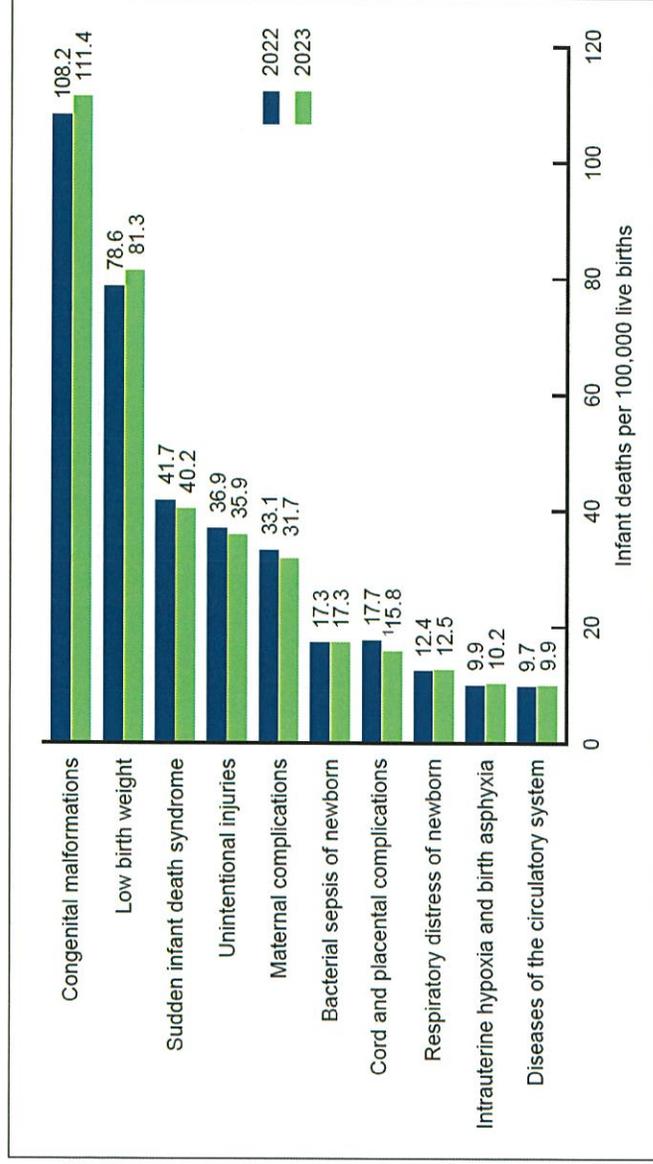
*Statistically significant decrease from 2022 to 2023 ($p < 0.05$).
 NOTES: Rates are plotted on a logarithmic scale. Data table for Figure 3 includes the number of deaths.
 SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 4. Age-adjusted death rate for the 10 leading causes of death in 2023: United States, 2022 and 2023

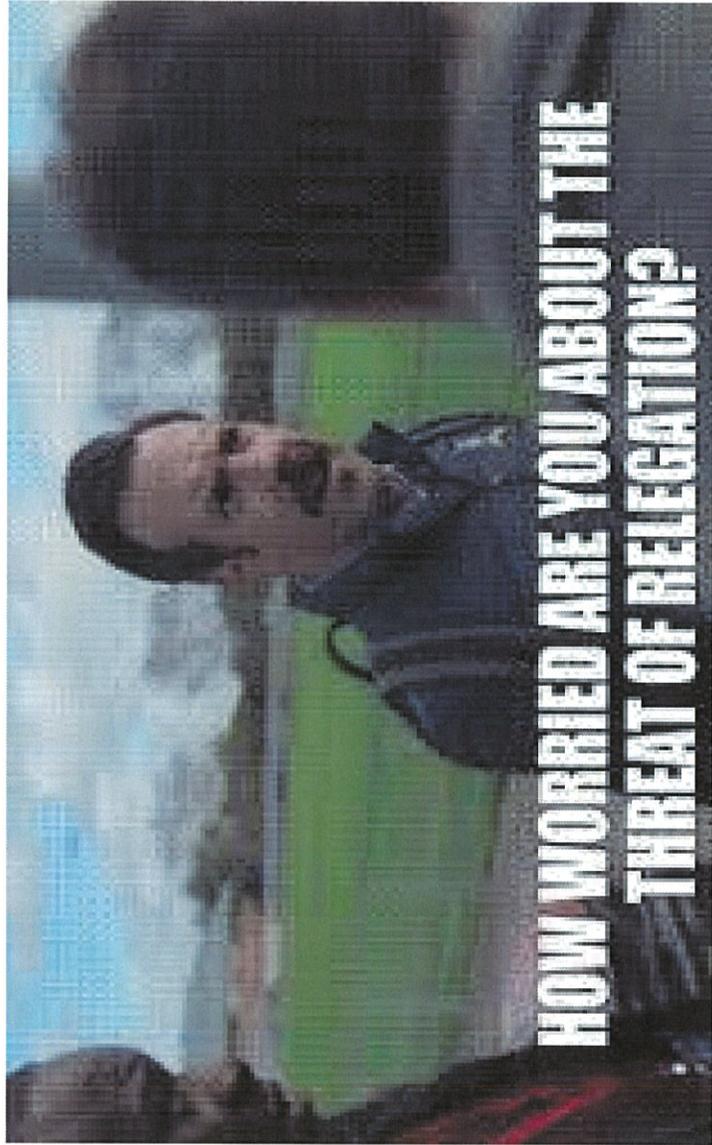


¹Statistically significant decrease from 2022 to 2023 ($p < 0.05$).
 NOTES: A total of 3,090,964 resident deaths were registered in the United States in 2023. The 10 leading causes of death accounted for 70.9% of all U.S. deaths in 2023. Causes of death are ranked according to number of deaths in 2023. Rankings for 2022 data are not shown. Data table for Figure 4 includes the number of deaths for leading causes and the percentage of total deaths.
 SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 5. Infant mortality rate for the 10 leading causes of infant death in 2023: United States, 2022 and 2023



¹Statistically significant decrease from 2022 to 2023 ($p < 0.05$).
 NOTES: A total of 20,145 deaths occurred in children younger than age 1 year in the United States in 2023, with an infant mortality rate of 560.2 infant deaths per 100,000 live births. The 10 leading causes of infant death in 2023 accounted for 65.3% of all infant deaths in the United States. A total of 20,553 infant deaths occurred in 2022, with an infant mortality rate of 560.4 infant deaths per 100,000 live births. Causes of death are ranked according to number of deaths in 2023. Rankings for 2022 data are not shown. Data table for Figure 5 includes the number of deaths in children younger than age 1 year for leading causes of infant death and the percentage of total infant deaths.
 SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.



**Americans don't feel that the
healthcare system cares about them**

How Americans Feel About Their Health Today



Elmo is just checking in! How is everybody doing?

To best solve issues affecting the well-being of future generations in the US, what specific areas should we prioritize?

Importance of investing in...

Prioritize (6-10, NET)

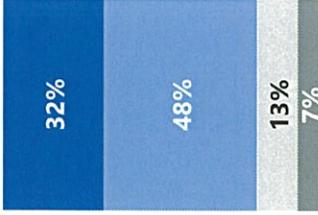
10 Highest priority

6-9 More priority

5 Neutral

0-4 No or Less priority

80%



Economic security

77%



Emotional / mental health

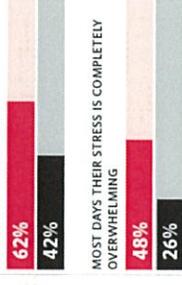


SURGEON GENERAL'S WARNING
Parents are consistently more likely to report experiencing high levels of stress compared to other adults.



PARENTS WERE SIGNIFICANTLY MORE LIKELY THAN OTHER ADULTS TO SAY

NO ONE UNDERSTANDS HOW STRESSED OUT THEY ARE



MOST DAYS THEIR STRESS IS COMPLETELY OVERWHELMING



STRESS MAKES IT HARD FOR THEM TO FOCUS



THEY ARE SO STRESSED THEY FEEL NUMB



66%

Americans

Agree, "I have to be responsible for my health because **no one else seems to care**"

(Gen Z: 56%, MLS: 77%, Gen X: 67%, Boomers: 63%)

52%

Americans

Say following social media health and wellness trends is **more accessible** than trying to connect with medical professionals

(Gen Z: 54%, MLS: 62%, Gen X: 55%, Boomers: 38%)

Source: Sesame Workshop-Harris Poll (May 2024; n=2,012; U.S.); APA-Harris Poll (August 2023; n=3,185; U.S.); The Harris Poll-Milken Institute FHS Collaboration (November 2024; n=2106; U.S.);

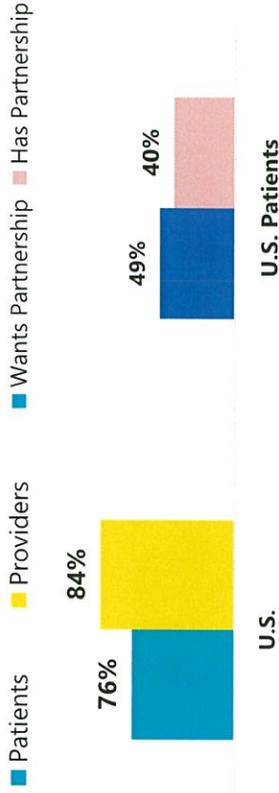
Yet, Our System Isn't Providing Necessary Support

What Patients Want, But Don't Always Receive

- Preventive care that's accessible for everyone
- Greater coordination of care between providers
- Transparent billing / easier appointments
- Seamless access to medical records / histories

70% Americans Report the healthcare system **isn't meeting their needs**

Preventative Healthcare Should Be A Priority



40% Americans Give the U.S. healthcare system an **A or B rating** (10%, 30%, respectively)

51% Americans **Directly feel the effects** of healthcare worker shortages (e.g., cancellations, delays, etc.)



Source: ZS-Harris Poll (August 2023; n=9,500 consumers, n=1,055 PCPs; U.S. U.K. Germany, Sweden, Japan, China); AAPA-Harris Poll (February/March 2023; n=2,519; U.S.); CVS Health-Harris Poll National Health Project (February 2022; n=2020; U.S.)

As Healthcare Becomes Increasingly Out Of Reach

44% Americans

Have **skipped/delayed care** in the past two years, with 40% saying the reason was **concern about cost**

51% Americans

Couldn't pay off an unexpected **\$5,000** health care out-of-pocket expense

Worries Extend Into Retirement Considerations

66% Americans

Are **terrified of what healthcare costs** may do to their retirement plans

69% Americans with Chronic Conditions

Don't have a financial plan **on how to pay** for healthcare costs in retirement



Nationwide

Source: AAPA-Harris Poll (February/March 2023; n=2,519; U.S.); Nationwide-Harris Poll (August/September 2023; n=1,260; U.S.);

AI Might Be Okay, But We Really Want Humans

Technology For Longevity

- 72% globally want advanced technology to **live longer.**
- 26% of Americans expect AI advancements in health care to **add over a decade to their lifespan.**

Leveraging Technology To Attain Balance

- 77% globally are interested in **using AI** to help **their well-being** and to **monitor burnout & stress.**

Monitoring Clinician Burnout With GenAI

- 91% of providers feel **positive** about GenAI for administrative tasks.
- Yet, 53% of Americans think the healthcare system **cares more about AI innovation** than improving patient experiences.

Keeping “Humans” In Health

- 92% of Americans say “P.A.s **should be allowed to provide care to the fullest extent** of their education, training, and experience.”
- 91% think fully utilizing P.A.s **improves patient health.**



The Harris Poll



MetLife



Nationwide



Google Cloud



ARCADIA



Source: PerLife-Harris Poll (January 2023; n=18,506; Australia, Bangladesh, Brazil, Chile, China, India, Japan, South Korea, Mexico, Turkey, U.K., U.S., Nationwide-Harris Poll (July 2024; n=1,602; U.S.); The Harris Poll-Milken Institute FHS Collaboration (October 2024; n=2,138; U.S.); Google Cloud-Harris Poll (August/September 2024; n=827 healthcare providers, U.S.); Arcadia-Harris Poll (January 2024; n=102 senior IT healthcare leaders, U.S.)

For Better American Health, Partnerships Need To Be Built Between People & Institutions

90% Americans

Say **fixing the healthcare system** – **requires everyone** – patients, doctors, experts, etc.

86% Americans

Are **ready to work** with their doctors and health professionals **to create change** in our healthcare

Yet... →

57% Americans

Worry there won't be systemic change in healthcare for many years

(BIPOC: 61%, MLS: 60%)

One key area of focus?

86%

Say we need to **shift the health system** from treatment **to prevention**

Preventative care

71%

Say they would **be healthier** if they had access to **better preventative care**



Primary Care is a Critical Force

- Countries with primary care systems achieve equal or better health status at much less cost
- USAID has done a “natural experiment” of investing in primary care in low income countries with excellent results



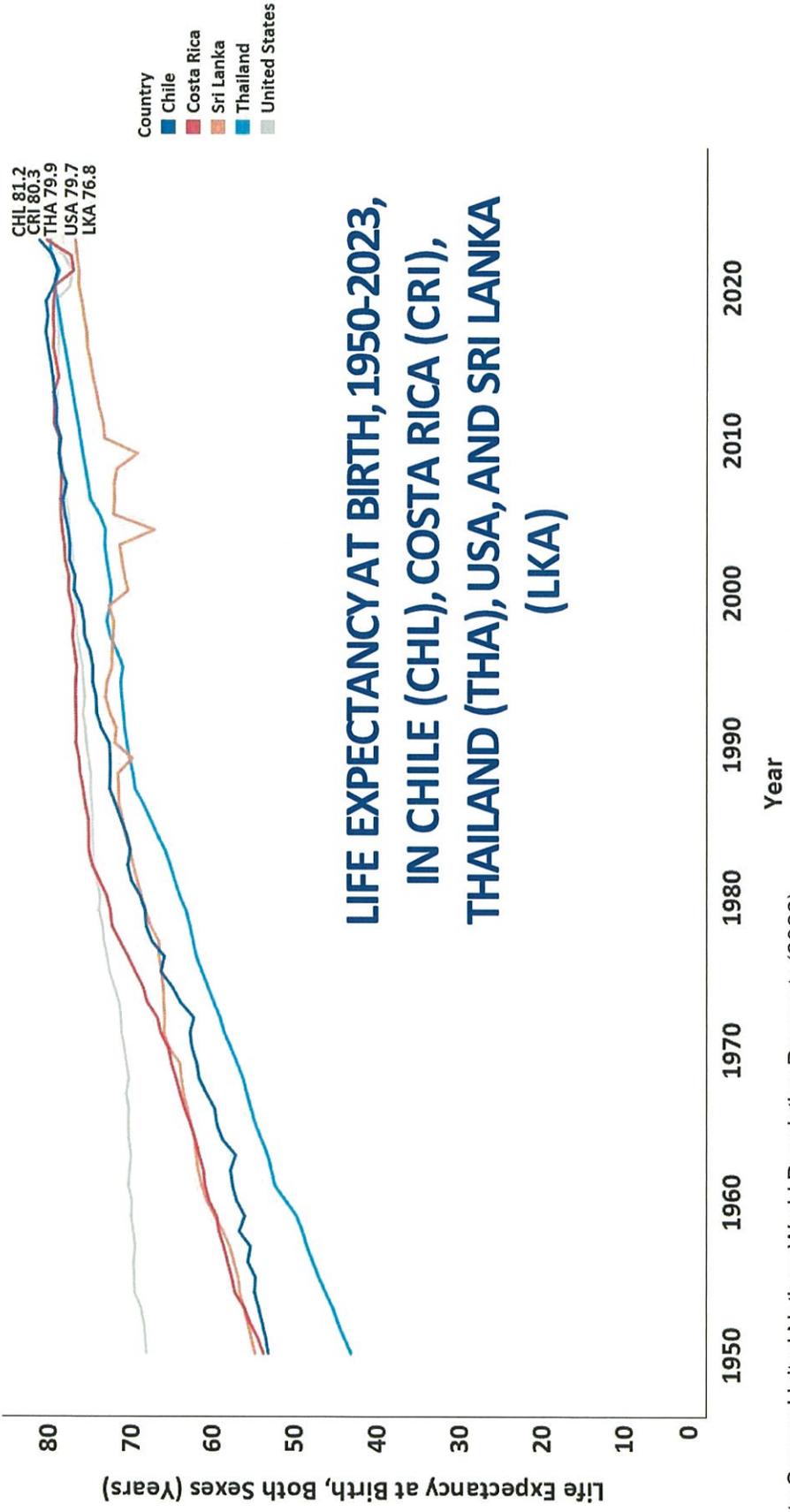
USAID, 2024

GLOBAL HEALTH FOCUS: THE MASSIVE GAP IN SURVIVAL



Data Source: United Nations World Population Prospects (2022).

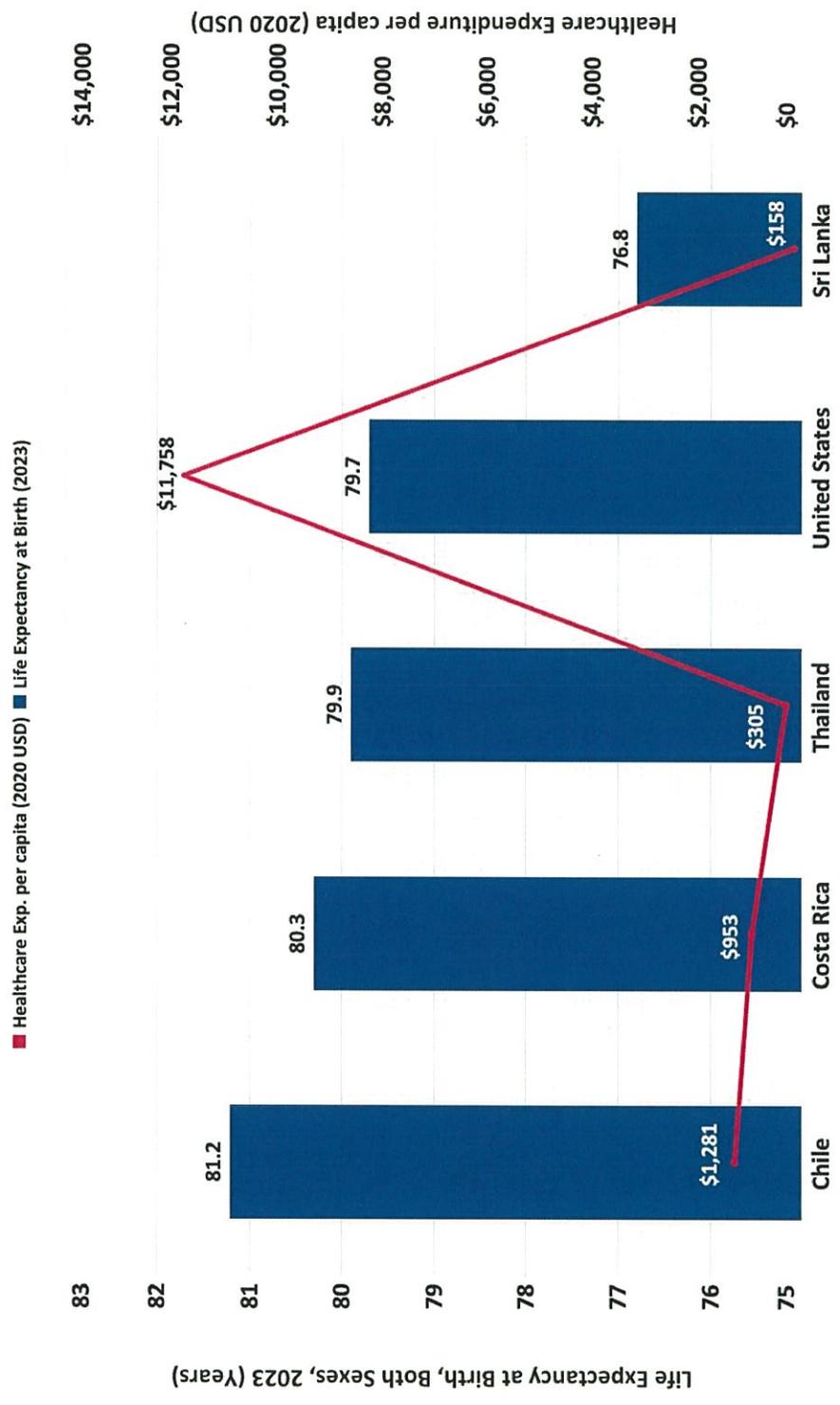
UNEXPECTEDLY, SOME USAID PARTNER COUNTRIES CAME TO MATCH OR EVEN EXCEED US LIFESPAN



LIFE EXPECTANCY AT BIRTH, 1950-2023, IN CHILE (CHL), COSTA RICA (CRI), THAILAND (THA), USA, AND SRI LANKA (LKA)

Data Source: United Nations World Population Prospects (2022).

COUNTRIES ARE MATCHING US LIFE EXPECTANCY WITH AS LITTLE AS \$300 PER CAPITA FOR HEALTH



Sources: World Bank, United Nations

THE ROLE OF PRIMARY HEALTH CARE IN DELIVERING ESSENTIAL SERVICES AND IMPROVING MORTALITY

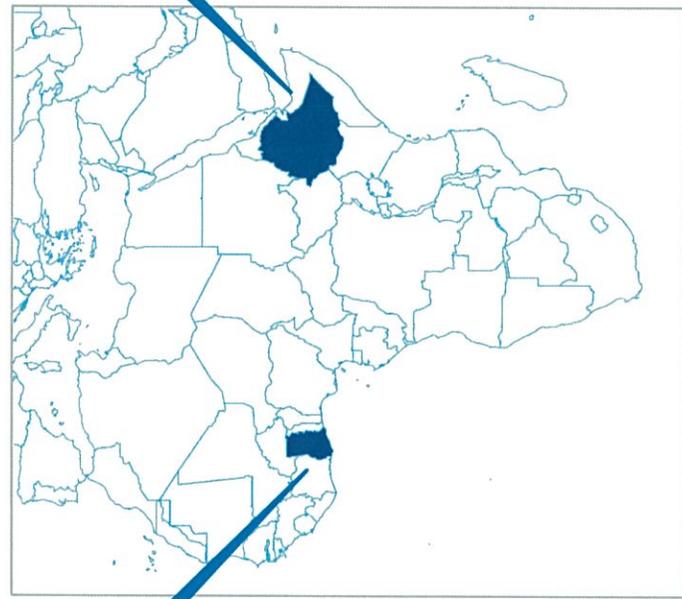
The Navrongo Randomized Trial in Ghana

Provided villages with a salaried community nurse with PHC training (e.g. FP, malaria, birth services) PLUS community outreach workers visiting every household.

Results:

-  Increased immunization, facility childbirth, use of child illness services, contraception
-  70% reduction in child mortality in 7 years, 50% in 3 years

Global Health Sci Pract. 2013;1(1):117-133
 Bull of the World Health Organization 2006;84:949-955



The Ethiopia Health Extension Program

Since 2002, the HEP employed 30,000 rural health extension workers to deliver basic health services through 18,000 health posts and home outreach on a national scale.

Results:

-  Increased service availability to 80m+ people living in rural and pastoral areas who previously had not had access to basic healthcare services
-  66% drop in under-five mortality¹

Ethiopia Demographic Health Survey data between 1990-2019

COSTA RICA'S UNIVERSAL PRIMARY CARE DESIGN

Costa Rica "Health Areas"

In 1995, Costa Rica began a staggered roll out of its World Bank-supported health reform to establish universal comprehensive, continuous, and coordinated primary care.



The Health Area intervention focused on **integrating public health services, preventive, and curative care within community-based primary clinics.** Involved geographically assigning Costa Ricans to specific units based on their place of residence (“empanelment”) and establishing **EBAIS teams with multidisciplinary capabilities and regular home-based outreach.**

THAILAND'S TRAJECTORY



LIFE EXPECTANCY AT BIRTH, 1950-2023

Data Source: United Nations World Population Prospects (2022).

Getting Reliable Information to People is a Critical Role

Varying forms of misinformation carry different levels of threat

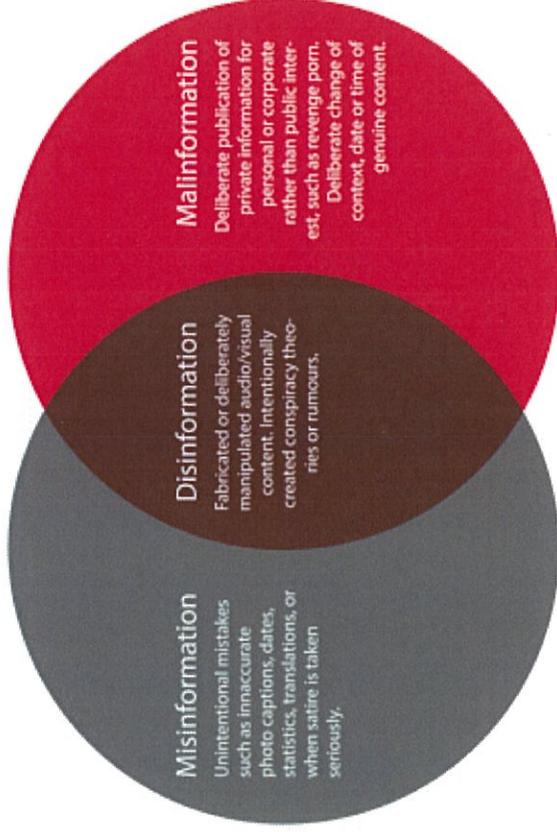


“Disinformation,” is intended to mislead and is disseminated with knowledge that those who succumb to it could be harmed

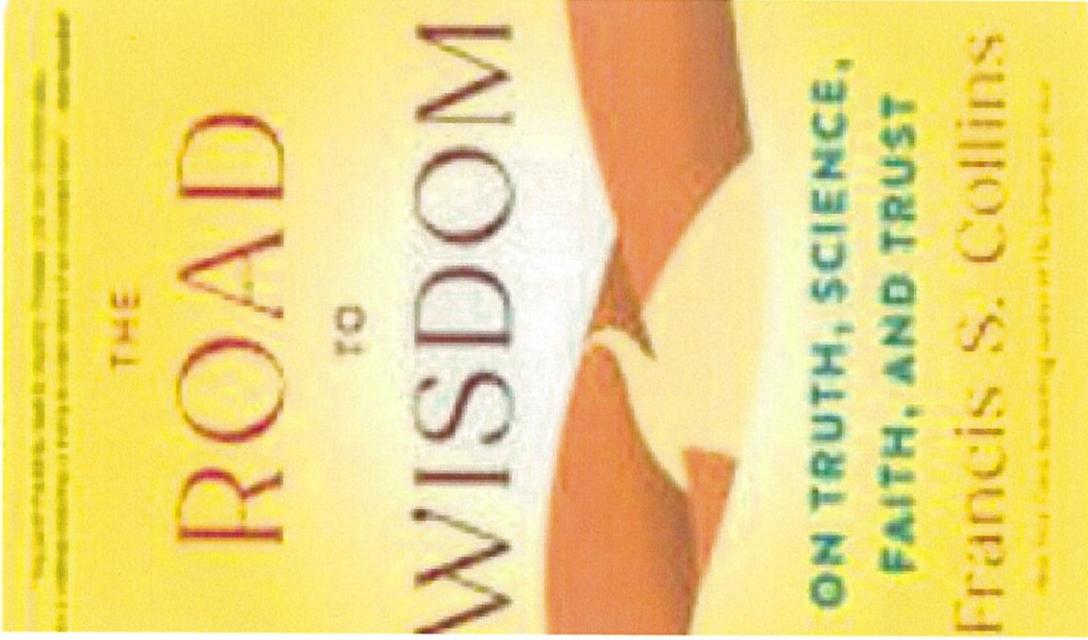
“Malinformation” is which represents a purposeful effort to harm others directly by spreading incorrect information.

TYPES OF INFORMATION DISORDER

FALSENESS INTENT TO HARM



<https://flowersforsocrates.com/2018/08/12/disinformation-misinformation-malinformation-involves-framing/>



THE DEADLY RISE OF ANTI- SCIENCE

A Scientist's Warning

PETER J. HOTEZ, MD, PhD

"Masterful and provocative." —Mustafa Suleyman

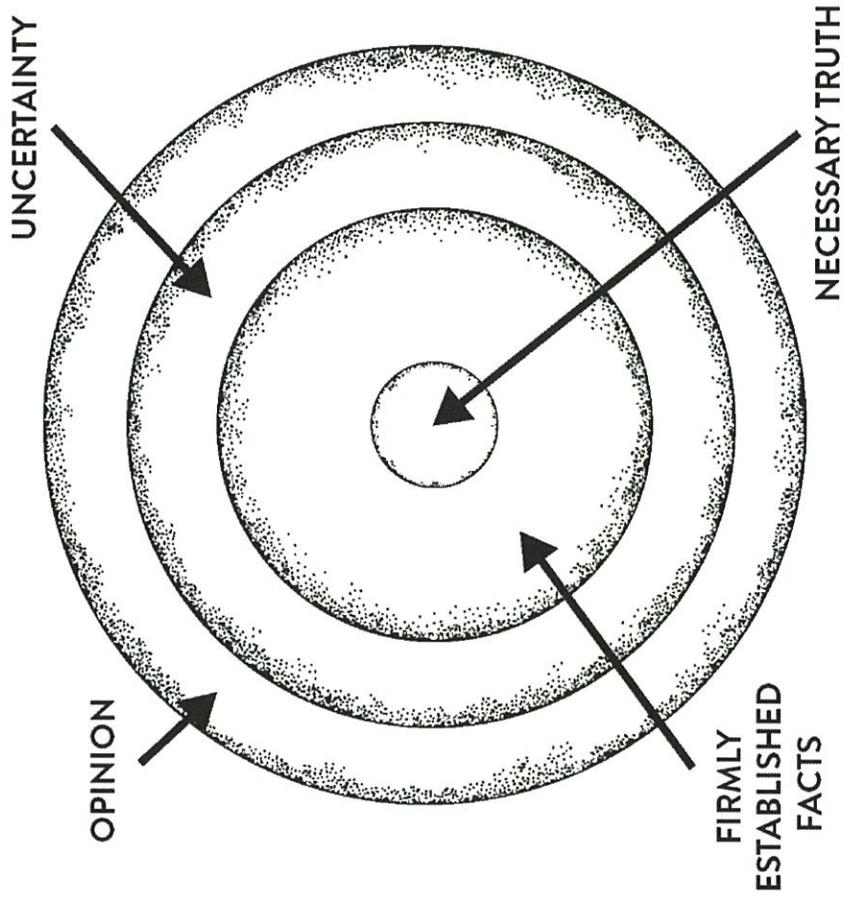
#1 *New York Times* bestselling author of *SAPIENS*

Yuval Noah
Harari



Nexus

A Brief History of Information Networks
from the Stone Age to AI



Church or organized religion



Banks



Public schools



Higher education



Medical system



A DECLINE IN TRUST ACROSS AN ARRAY OF INSTITUTIONS

Gallup regularly surveys Americans on their trust in a range of institutions, and most have shown steep declines. U.S. adults who said in 2024 they had a great deal or quite a lot of trust in:

A Community of Shared Standards



Doctors . . . **claim authority**. Not as individuals, but **as members of a community that has objectively validated their competence.**

The professional offers judgments and advice, not as a personal act based on privately revealed or idiosyncratic criteria, but as a representative of **a community of shared standards.**



Paul Starr, *The Social Transformation of American Medicine*, 1982 (p. 12):

Primary Care is Countercurrent to Several Dominant Trends in US Healthcare

- As long as the primary metric is profit, we will continue to see investment in profitable delivery approaches that cater to those with good coverage or wealth
- The fragmentation and suboptimization of the system create enormous chasms that are difficult for primary care to overcome, especially when combined with the current financial system

This Issue

Views **186,252** | Citations **39** | Altmetric **1153** | Comments **38**

Viewpoint

January 30, 2023

FREE

Salve Lucrum: The Existential Threat of Greed in US Health Care

Donald M. Berwick, MD, MPP¹

» [Author Affiliations](#) | [Article Information](#)

JAMA. 2023;329(8):629-630. doi:10.1001/jama.2023.0846

The deep pockets of health-harming industries

[Lancet Diabetes Endocrinol 2024](#)

Published Online

July 9, 2024

[https://doi.org/10.1016/S2213-8587\(24\)00196-7](https://doi.org/10.1016/S2213-8587(24)00196-7)

MEDICINE AND SOCIETY

f X in £

The Financialization of Health in the United States

Authors: Joseph Dov Bruch, Ph.D., Victor Roy, M.D., Ph.D., and Colleen M. Grogan, Ph.D. [Author Info & Affiliations](#)

Published January 10, 2024 | N Engl J Med 2024;390:178-182 | DOI: 10.1056/NEJMms2308188 | [VOL. 390 NO. 2](#)

On Suboptimization — Cadillac Care at the Mecca

Brendan M. Reilly, M.D.

After David had a stent put in his bile duct, the Tumor Board said he needed a Whipple procedure, but 3 weeks later the surgeon hadn't scheduled him, and a friend whose uncle died of pancreatic cancer said David should go to the best place. When you get on an airplane, she said, you want a pilot who does this every day. So they called three famous cancer centers and interviewed surgeons who do Whipples all the time. David hoped for the place where it doesn't snow, but that guy, when asked about his operative mortality, got huffy and hung up. The second place didn't "target the tumor" as Google recommended, so David favored the place whose surgeon agreed to see him immediately.

N ENGL J MED 382;7 NEJM.ORG FEBRUARY 13, 2020

593

The New England Journal of Medicine

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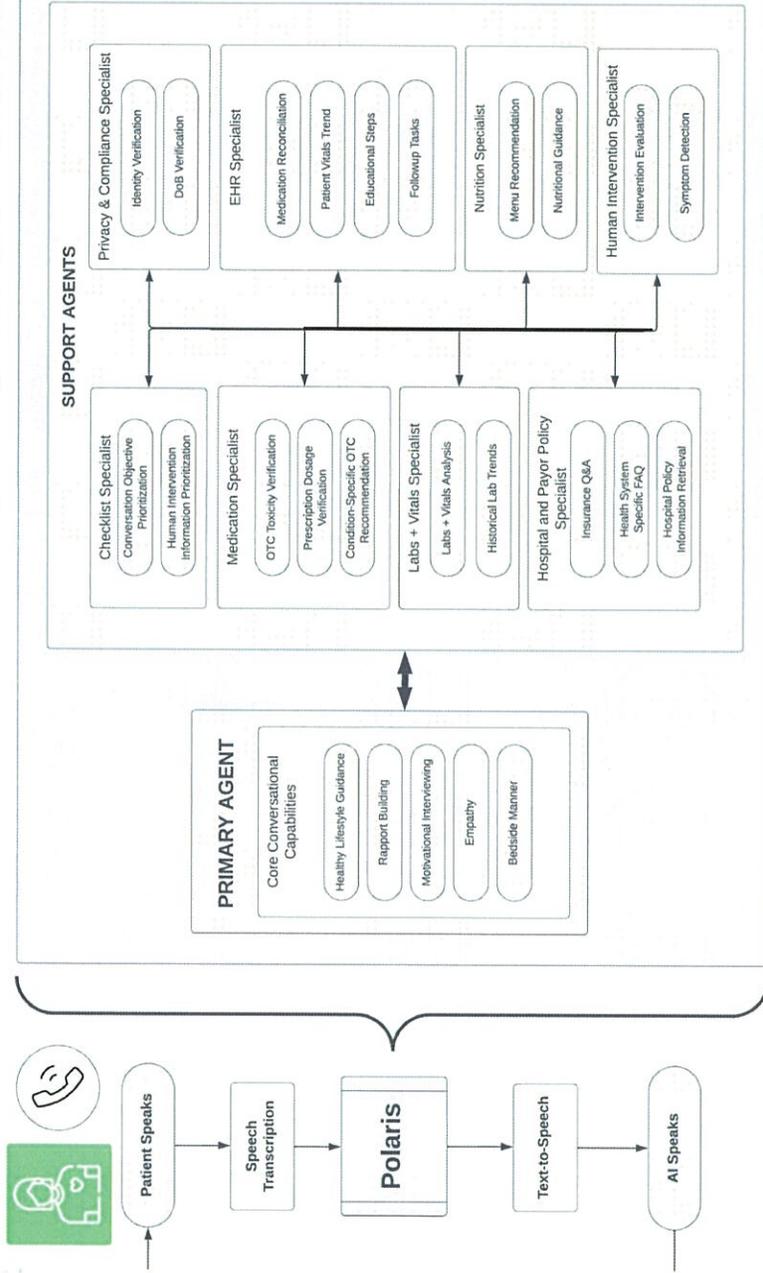
Suboptimization

A consequence of failure to integrate is suboptimization: Suboptimization is a term that has been adopted for a common policy mistake. It refers to the practice of focusing on one component of a total and making changes intended to improve that one component and ignoring the effects on the other components.

If home, primary care offices and digital health could be integrated....

- That would be an American solution to a problem that we have been unable to solve up until now

NVIDIA



“Technological solutions also tend to rise into society’s penthouses, while epidemics (diseases) seep into its cracks”

FDA

The Atlantic

SEPTEMBER 30, 2022

The Pandemic’s Legacy Is Already Clear

All of this will happen again.

By Ed Yong

The Glass Cockpit Project

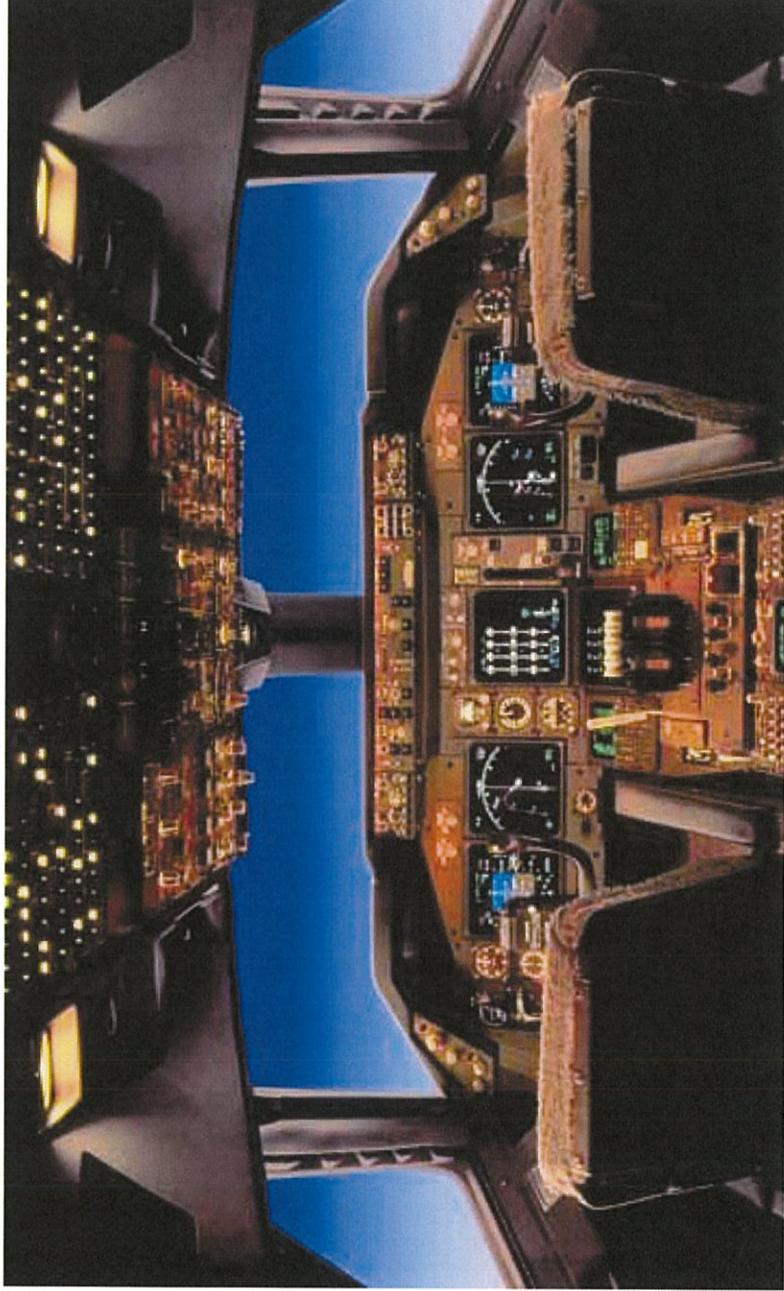


- In 1960's multiple gauges added to cockpit, causing cognitive overload for pilots
- NASA did massive project, yielding
 - Construct of the glass cockpit
 - Data standards
 - Standardized display of data
 - Autopilot for functions that could be automated, freeing pilot to perform integrative functions
- Doctor/patient pairs need a cockpit to enhance decision making by aggregating relevant information in a cognitively appealing format

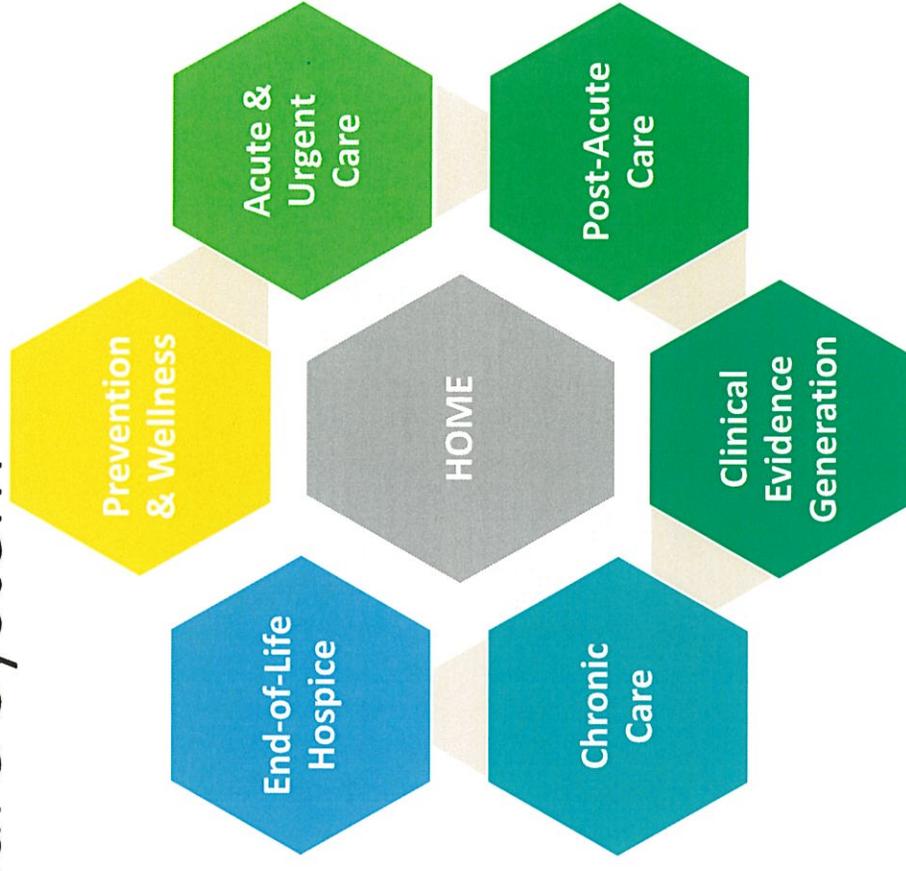
Information Overload



The “Glass Cockpit”



Transforming the Healthcare System



- No person should be left behind in healthcare
- Clinical care and evidence generation centered on the person not the system
- Health and wellness delivered at home and uniquely shaped experientially for the occupant
- Integrative medical devices and technology that are not interruptive, distracting and counter to the home experience are the way of the future
- Home is the frontier often neglected in device development and conceptualization but critical to their success

Home as a Healthcare Hub



CDRH is launching the co-creation of a **prototype home model**

- To facilitate innovation of integrated, consumer-friendly, medical-grade technology to deliver and expand access to first-class care at home
- In collaboration with an architectural firm, patient groups, healthcare providers, and medical device industry



Home as a
Healthcare
Hub



Facilitate adaptation of existing devices and development of innovative new devices to nestle unobtrusively in the home environment



Foster the discussion of frameworks and identification of missing critical elements in a precompetitive space



Pilot effort in the clinical area of diabetes given marked racial, ethnic, and geographic disparities in prevalence and burden of disease

The combination of digitization & current health trends give us a fork in the road

Use digital technology
to improve health for
populations and individuals
(rising tide raises all ships)

Use digital technology to
segment the population to
optimize finances in a balkanized
fashion (magnifies disparities)



History of Digital Disruption



Company / Industry	Core Business	Transformational Change	Digital Disruption Enhance Existing Income Model?	Successful Internal Transformation?	Digital Disrupter
	Photographic Film & Paper	Digital Photography	NO	X	    
	Selling Books from Stores	Online Book Orders	NO	X	
	Lending Money	ATMs and Online Banking	YES	✓	All Modern Banks
	Video Rental	Digital Streaming	NO	X	
	Fee-for-Service Health Care	Value-based, Digitally Enabled Medicine	NO	?	?
	Sell more medical products at higher prices	Value based reimbursement	NO	?	?

Steve Steinhubl 2019

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Monday, March 17, 2025
TIME: 5:30 PM
PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome
- II. URI Medical School Feasibility Study:
Paul Umbach and Ha Pham – Tripp Umbach
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

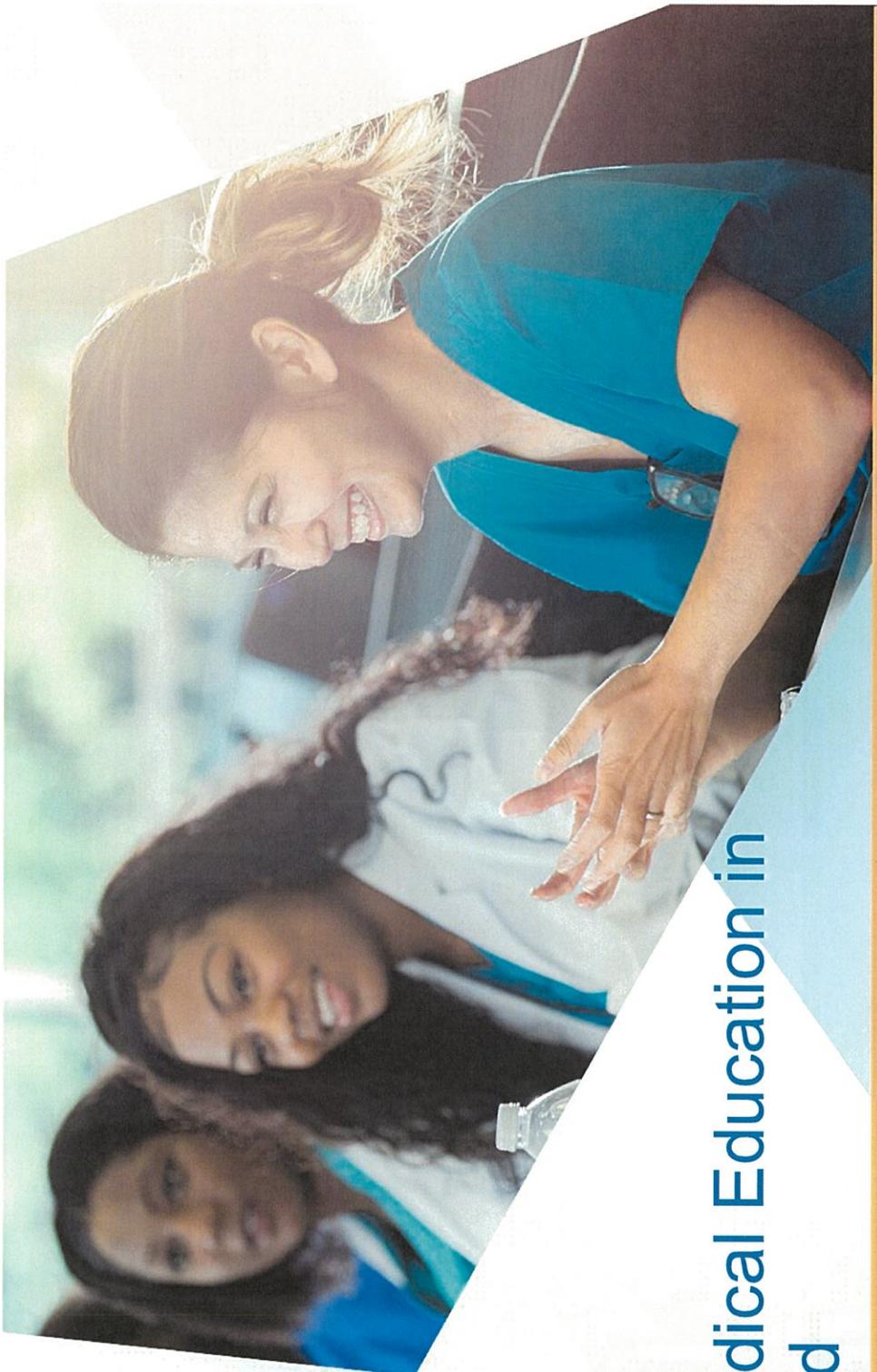
COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Senate committee hearings may also air on Channel 75 for Cox Subscribers. Livestreaming is available at <https://capitolvri.cablecast.tv/>

POSTED: THURSDAY, MARCH 13, 2025, 10:35 A.M.



**Tripp
Umbach**
Turning Ideas Into Action

Growing Medical Education in Rhode Island

The University of Rhode Island
March 17, 2025



TEAM

INTRODUCTION



Founder & CEO

Phone: 412-780-9723

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Senior Principal

Phone: 443-536-5176

hpham@trippumbach.com

Tripp Umbach Profile

- Tripp Umbach is a private consulting firm founded in 1990.
- Tripp Umbach has served more than 500 Higher Education Institutions over the past 35 years
- Tripp Umbach has completed feasibility studies to establish 40 new medical schools and campuses.
- Tripp Umbach has consulting relationships for more than 100 medical schools in the United States, Canada, Europe, Australia, and Abu Dhabi.
- Tripp Umbach has served more than 800 hospitals and health systems.



Tripp Umbach
Turning Ideas Into Action

New Allopathic Medical School Experience

Alice L. Walton
Bentonville, AK

Carle University of
Illinois
Urbana Champaign

Central Michigan
Mount Pleasant

Charles Drew
Compton, CA

Dell Medical School
Austin, TX

Florida Atlantic
Boca Raton, FL

Florida International
Miami, FL

Geisinger
Commonwealth
Scranton

Hackensack Meridian
Clifton, NJ

Michigan State
Grand Rapids

NOVA Southeastern
Fort Lauderdale

Roseman
Las Vegas

Texas A&M U. Houston
Methodist
Houston, TX

Texas Christian,
Fort Worth, TX

Texas Tech
El Paso

U. of Central Florida
Orlando, FL

U. of Arizona
Phoenix

U. of Georgia
Athens, GA

U. of Houston
Houston, TX

UNLV,
Las Vegas,

U. of South Carolina,
Greenville

Washington State
Spokane, WA

New Osteopathic Medical School Experience

Alabama COM Dothan, AL	Baptist Health Memphis, TN	Burrell COM Las Cruces, NM	Burrell Florida Tech Melbourne, FL	California Health Sciences Clovis, CA	Duquesne University Pittsburgh, PA	Edward Via Louisiana Monroe, LA
Idaho COM Meridian, ID	IUPCOM Indiana, PA	KCU Joplin, MO	Kansas COM Wichita, KS	LECOM Elmira, NY	Meritus SOM Hagerstown, MD	Montana COM Billings, MT
NYIT Arkansas Jonesboro, AR	Noorda COM, Provo, UT	Ohio U. Heritage Dublin, OH	Oklahoma State. Tahlequah, OK	Orlando COM Orlando	PCOM South Georgia Moultrie, GA	Rowan-Virtua Sewell, NJ
Sam Houston State Conroe, TX	Touro University Great Falls, MT	Touro University Middletown, NY	Ohio Heritage Cleveland	Northern Colorado Greeley, CO	Xavier University Cincinnati	

Feasibility Studies Deemed Not Feasible

Deemed NOT Feasible and Did Not Move Forward Allopathic – MD	Deemed Not Feasible and Did Not Move Forward Osteopathic – DO
George Mason University, Fairfax, Virginia	Catholic University of America, Washington DC
Health Quest/Vassar Brothers Medical Center, Poughkeepsie, New York	Northwestern University St. Paul, Minnesota
Montana State University, Bozeman, Montana	Heidelberg University, Tiffin, Ohio
Louisiana State University, Baton Rouge, Louisiana	Southern CA University Health Sciences, Whittier, CA
University of California, Merced, California	Minnesota College, Gaylord, Minnesota
Shenandoah University, Winchester, Virginia	Louisiana College, Pineville, LA
Kettering Health, Kettering, Ohio	Opelousas Health System, Opelousas, Louisiana
King University, Bristol, Tennessee	Sussex Economic Development Area Council (SEDAC), Delaware
Texas Southern University, Houston, Texas	Morgan State University, Baltimore, MD
Keck Graduate Institute, Claremont, California	Rocky Mountain University, Provo, Utah
Virginia State University, Petersburg, Virginia	Harding University, Searcy, Arkansas

Commission Interview Findings

Interview Findings

Need for a Medical School

- **Need for Physicians:** Rhode Island faces a significant shortage of primary care providers, with many patients unable to access timely care. Many stakeholders, including representatives from community health centers, government officials, and academic leaders, emphasized the critical need for primary care physicians.
- **Low Physician Retention:** The state struggles to retain medical students after graduation, with approximately 14% staying in Rhode Island. Brown University's medical graduates primarily enter specialty fields rather than primary care.
- **Aging Workforce:** Rhode Island's medical workforce is aging, with many providers nearing retirement, exacerbating the physician shortage.

Interview Findings

URI's Capability to Develop a Medical School

- **Strong Health Professions Programs:** URI already has well-regarded programs in pharmacy, nursing, and health sciences, providing a strong foundation for interdisciplinary medical education.
- **Recent R1 Research Classification:** This designation enhances URI's credibility and ability to attract funding and faculty for medical research and education.
- **Established Community Partnerships:** URI has a history of collaborating with community health centers and hospitals, which could facilitate clinical training opportunities.
- **Support from University Leadership:** URI's president and board members have expressed interest in positioning the university as a regional leader in healthcare education.

Interview Findings

Opportunities for Rhode Island if a Medical School is Developed

- **Workforce Development & Retention:** A public medical school could increase the number of physicians from Rhode Island to train and stay in Rhode Island, especially if it offers incentives like tuition reimbursement or loan forgiveness.
- **Economic Growth:** A medical school could stimulate job creation, attract research funding, and enhance the state's biomedical sector.
- **Improved Healthcare Access:** Focusing on primary care training could improve access to medical services in underserved areas.
- **Potential Philanthropic & Public Funding:** Several stakeholders, including policymakers and healthcare executives, believe a combination of state funding, private donations, and partnerships could support the school's financial needs.

Interview Findings

Preferred Medical School Model (DO vs. MD)

- Most individuals recommend a small, community-focused MD program as the most feasible option.
Stakeholders cited:
 - An MD degree has better name recognition in Rhode Island
 - Opportunity for research in AI and innovative primary care training models
 - Better opportunity for philanthropy and state support
- A few interviewees suggested a DO program because it emphasizes primary care and holistic medicine, which aligns with Rhode Island's needs.

Interview Findings

Primary Care Focus

- URI's medical school should focus on primary care, with community-based clinical training and interdisciplinary education involving pharmacy and nursing students.
- Stakeholders emphasized the need for longitudinal primary care clerkships and partnerships with FQHCs and community hospitals.
- Many recommended that the school prioritize affordability and include financial incentives to encourage students from Rhode Island and neighboring states to remain in the state.

Interview Findings

Challenges to Overcome

- Funding
- Clinical Training Capacity
- Potential pushback from Brown University
- Short vs. Long-term Solution to the problem
 - Students won't practice until 2035
 - Expanding graduate medical education (GME) must happen faster to increase the physician workforce.
 - Increasing Medicaid reimbursement rates is a higher priority.

Unviersity of Rhode Island

URI Strengths

- Strong Health & Science Programs – URI already has well-established programs in pharmacy, nursing, biomedical sciences, and public health, providing a strong foundation for medical education.
- Existing Research Infrastructure – The university has ongoing medical and health-related research collaborations, including partnerships with healthcare institutions and biotech companies.
- Partnership Opportunities – Proximity to major hospitals and healthcare systems in Rhode Island who already have relationships with URI.
- 60% of URI Students are from Rhode Island and approximately 50% remain in the state after graduation.

Medical Education in U.S. and Rhode Island

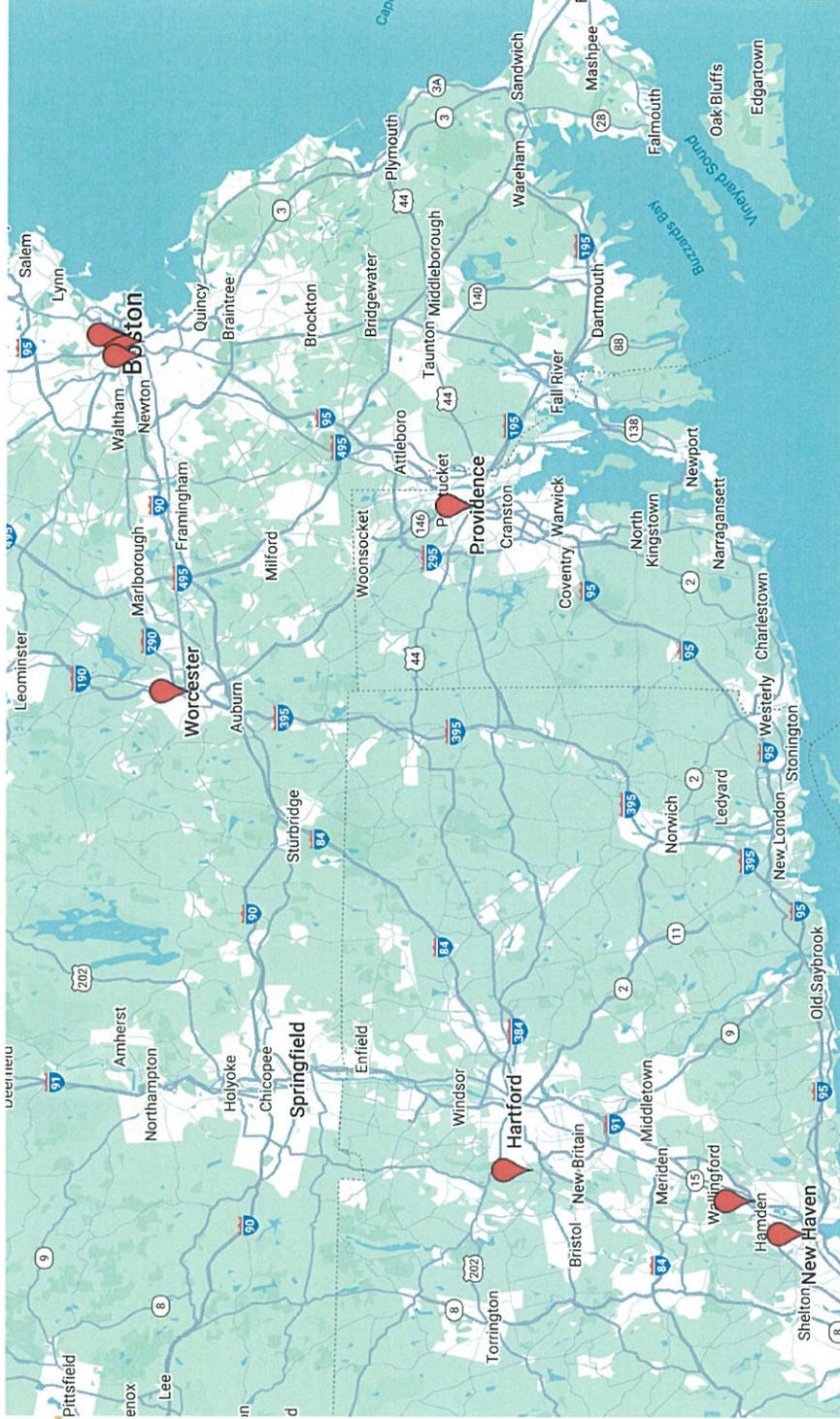
How Does Rhode Island Compare?

- There are 154 medical schools in the US offering an MD program, and 41 DO or osteopathic medical programs.
- Alaska, Delaware, and Wyoming are the only U.S. states without an independent medical school.
- Idaho, Maine, and Montana have DO programs but no MD program.
- Rhode Island is one of only two states without a public medical school – the other state is New Hampshire (note: based on states with an MD school)

Allopathic Schools in and around Rhode Island



Allopathic Schools



Osteopathic schools in and around Rhode Island



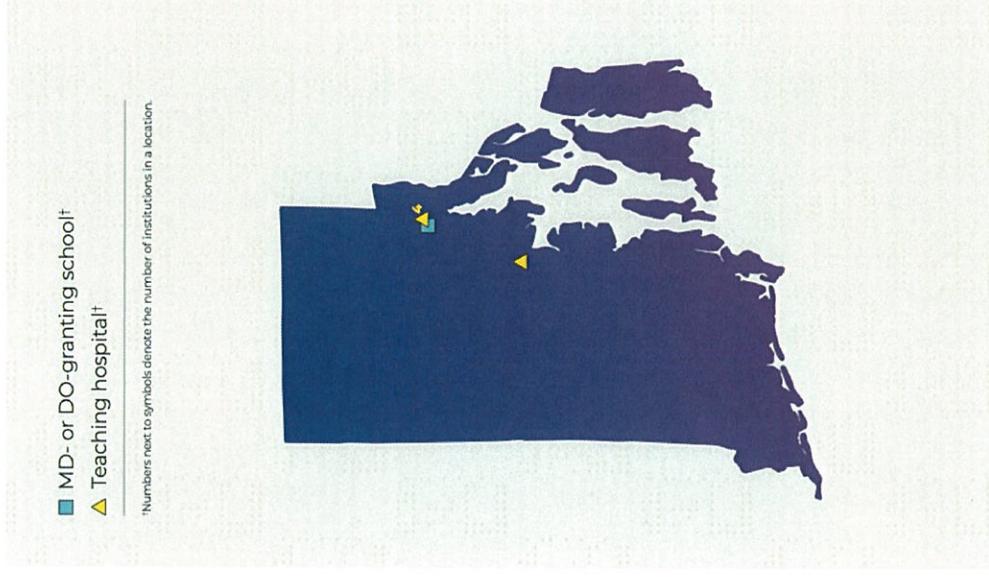
Osteopathic Schools



Medical Education in Rhode Island

Rhode Island

1 MD-DO granting Schools
6 Teaching hospitals
784 Residents in training
623 Medicare-supported GME slots
161 Residents not supported by Medicare DGME



Rhode Island Hospitals

Teaching hospitals

Hospital	Bed Size	Academic Affiliation
Rhode Island Hospital	719	Brown
Kent Hospital	359	Independent
Meriam Hospital	247	Brown
Roger Williams Hospital	220	Boston University
Women's & Infants	137	Brown
Hasbro Children's	63	Brown

Non-teaching hospitals

Hospital	Bed Size	Location
Our Lady of Fatima Hospital	312	North Providence
Landmark Medical Center	214	Woonsocket
Westerly Hospital	129	Westerly
Newport Hospital	125	Newport
South County Hospital	100	South Kingstown

Community Assessment Needs

Community Health Needs in Rhode Island

Top Needs Identified in Community Health Needs Assessments

1. Access to Healthcare Services (Especially Primary Care)
2. Mental and Behavioral Health Services
3. Social Determinants of Health
4. Chronic Disease Prevention and Management
5. Community Health Education and Prevention
6. Navigation Assistance in Finding Care

Physician Shortages

Physician Workforce Shortages Nationally

- Projected Shortage: The Association of American Medical Colleges (AAMC) projects a shortage of 37,800 to 124,000 physicians by 2034.
- Primary Care Shortage: There could be a shortfall of 17,800 to 48,000 primary care physicians by 2034.
- By 2034, over 77 million people in the U.S. will be 65+
- Physician Retirement: Over 40% of active physicians are retirement age. Rhode Island Physicians 65 years and older (2023): 77.6%

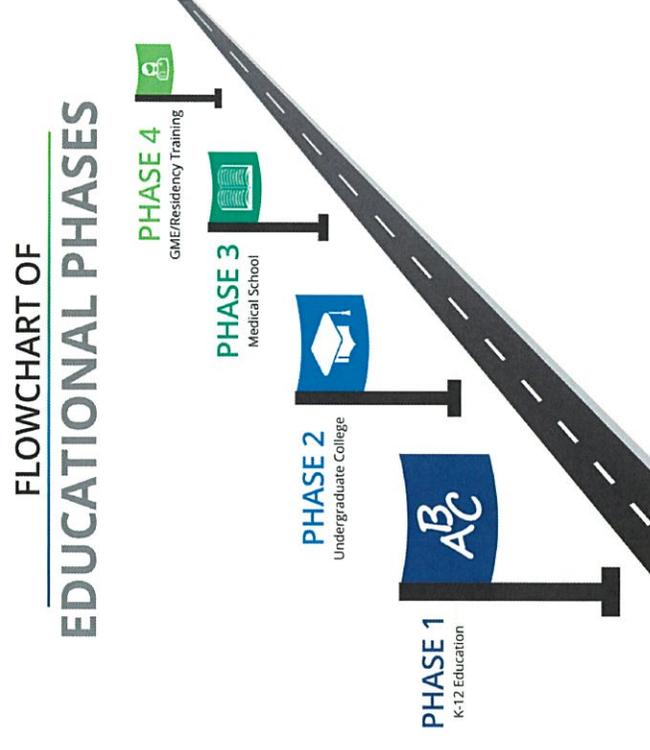
Physician Needs in Rhode Island

- There are nearly 700 primary care providers for Rhode Island's population of about 1.1 million — or roughly one clinician for every 1,700.
- If every active physician saw 1,200 patients yearly, approximately 343,000 would still be without a provider.
- Rhode Island needs approximately **300** additional physicians to meet healthcare needs.

Physician Workforce

- 39.8% of medical students completed GME in Rhode Island.
- 14% of residents remain to practice in RI after completing residency.
- 18% of residents enter primary Care Residencies in Rhode Island*

* Not including Internal Medicine residents who continue into specialty programs.



Primary Care Physician Production

Public Universities — Allopathic	Percentage entering primary care residencies
U. of North Carolina – Chapel Hill	70%
U. of Nebraska Medical Center	62%
U. of North Dakota	60%
East Carolina U.	57%
West Virginia U	55%
Florida State U.	54%
U. of Kansas	52%
U. of Hawaii	50%
U. of Arkansas for Medical Sciences	48%
U. of New Mexico School of Medicine	47%

Primary Care Physician Production

Private Medical School	2024 MATCH in Primary Care
University of Pennsylvania	13%
Yale University	16%
Dartmouth University	16%
Brown University	18%
Harvard University	20%

* Not including Internal Medicine residents who continue into specialty programs.

Primary Care Physician Production at Brown

- Brown University has about the same percentage of graduates who enter primary care (18%) as peer private institutions, below the national average of 35% but higher than highly research-intensive universities such as Johns Hopkins, which has only 5% of graduates entering primary care.
- Approximately 10 medical students at Brown University annually enroll in the Primary Care-Population Medicine Program, a dual degree program that awards both an MD degree and a Master of Science.
- Brown was established as a primary care training program in 1972.

Rhode Island Residents Applying to Medical School (2024-2025)

- 110 applicants — 53 matriculants (9th best rate nationally)
- The number of applicants ranked 43rd when controlling for state population
- 32.2% of RI residents who matriculate, matriculate in-state -- only Maryland and New Hampshire have a lower percentage

Instate Matriculants for New England Medical Schools

School	Percent of Students	Number of Students
University of Connecticut	81.3%	91
University of Massachusetts	62.6%	147
Tufts	27.7%	56
University of Vermont	25.8%	32
Boston U-Chobanian Avedisian	20.7%	29
Harvard	13.9%	23
Brown	13.2%	19
Quinnipiac-Netter	11.6%	11
Dartmouth-Geisel	4.2%	4
Yale	1.0%	1

UME and GME

	Rhode Island	Ranking	US
Retention			
% physicians retained in-state from UME, 2020	12.6%	44	39.7%
% physicians retained in-state from public UME, 2020	--	--	43.7%
% physicians retained in-state from GME, 2020	30.9%	47	45.1%
% of physicians in-state from UME and GE Combined (2020)	49.3%	44	69.7%

- While nationally, retention in the state for medical students is 39.7% and even higher for public medical schools (43.7%), the retention rate in Rhode Island is much lower at 12.6%.

Primary Care Residency Output

Program	Discipline	Program Length	# New Trainees Per Year AY2023-2024	Total Resident Enrollment – All Years AY2023-2024	# of Graduates AY2022-2023	# of Graduates from AY2022-2023	# of Graduates from AY2022-2023
Brown Categorical Internal Medicine Residency Program (Lifespan-RIH/TVIH)	Internal Medicine	3	29	87	29	0	0%
Brown General Internal Medicine	General Internal Medicine	3	10	30	10	5	50%
Roger Williams Internal Medicine Residency Program	Internal Medicine	3	18	48	18	2	11%
Hasbro Children's Hospital Pediatric Residency	Pediatrics	3	16	49	16	5	31%
Brown Family Medicine Residency	Family Medicine	3	16	48	16	15	94%
Kent Hospital Internal Medicine Residency	Internal Medicine	3	13	38	13	2	15%
Brown Pediatric-Internal Medicine	Internal Medicine-Pediatrics	4	4	16	4	2	50%
Total			106	316	106	31	29%

- 29% of Residents Enter Primary Care Residencies in RI
- 14% of residents remain to practice in RI after completing residency.

In-State Physician Production

- Among all medical school matriculants nationally, 60% attend a school in their home state.
- On average, the 20 private MD schools accepted 13.9% of their students from their respective home states.
- Brown aligns with the average of top-tier private medical schools, with 13.2% of its matriculants coming from Rhode Island.
- Brown University's in-state enrollment rate is nearly identical to peer institutions such as Penn, Johns Hopkins University, the University of Chicago, Duke University, and Harvard University. This analysis indicates that Brown's percentage of in-state students is consistent with that of other top-tier private medical schools.
- Among private medical schools with the lowest percentages of in-state students, Yale University admitted just 1% from Connecticut, George Washington University accepted 2.4% from Washington, D.C., and Dartmouth College enrolled 4.2% from New Hampshire.

Allopathic vs. Osteopathic

Allopathic vs. Osteopathic

- The curriculum is almost identical.
- Accreditation is similar: consolidation considered
- Business models are often different:
 - Allopathic Schools utilize the academic model:
 - Teaching, medical practice, and research
 - Development of family practice plans expands the quantity and quality of healthcare in the region
 - Emphasis on research significantly expands the economic impact of medical school in the region
 - Osteopathic Business Model: Strong Net Income
 - Minimal supervision and cost for clinical training
 - Minimal impact on regional healthcare
 - Lesser regional economic impact
 - The budget is based mainly on tuition

Models for Medical Expansion

Branch Campus of Existing Medical School

- Partnership between an established medical school and an independent university or hospital to offer medical education
- Designed to address physician shortages by training students in areas that can't support an independent medical school
- Operates under the administration/accreditation of the primary medical school
- Degrees awarded by the primary institution

Example:

- Maine Track, Tufts University offers a 3-year program at the Maine Medical Center in Portland.

Models for Medical Education Expansion

Partnership Medical School

- A partnership between one or more universities or hospitals to offer medical education.
- A formal agreement exists between local universities for operations and faculty appointments.
- Partner universities provide classroom facilities and pre-clinical training.

Examples:

- Medical College of Georgia and University of Georgia
- University of Arizona and Arizona State University
- UNT Health Science Center and Texas Christian University

Models for Medical Education Expansion

Independent Medical School

- Either University (majority) or hospital-based (i.e., Geisinger, Kaiser)
- Public, Private, or For Profit (only two MD schools)
- Must hold accreditation (MD – LCME or DO- COCA)
- Is fully responsible for all aspects of the program
- Most rely on independent hospital partners – only a few own and operate hospitals.

Reimbursement Rates and Recent Actions

Barriers to Primary Care: Increasing Medicare & Medicaid Reimbursement Rates

Rhode Island's Historically Low Reimbursement Rates

- Medicaid physician fees in RI are only 38% of Medicare's rates, the lowest among all states.
- This is dramatically lower than the national average of ~72%.
- Hospitals receive 15–20% lower Medicaid payments per patient than Massachusetts and Connecticut.

Lower reimbursement has led to provider shortages and financial strain.

- Low rates made attracting and retaining doctors difficult, especially for Medicaid patients.
- Higher rates in neighboring states have led to a “brain drain” due to better pay crossing state lines.
- Rhode Island hospitals serve 74% of government-insured patients, making them more vulnerable to federal cuts.

Rhode Island's Commitment to Increasing Medicare & Medicaid Reimbursement Rates

Recent Medicaid Rate Increases (Effective Oct. 1, 2024)

- The largest Medicaid reimbursement increase in RI's history covers nearly all provider types.
- Aims to align payments closer to regional norms after years of stagnation.
- Tied to a 3.3% annual increase based on CMS indexes to account for inflation.

State Initiatives to Address Disparities

- Expanded Medicaid managed care payments: \$333.8 million in state-directed hospital payments planned for FY 2026.
- Increased funding aims to narrow the gap between Medicaid and private insurance reimbursements.

Recent Action in Rhode Island to Address Physician Shortages

Medical School Student Debt Relief

2024 legislative wins for Primary Care:

- Two legislative initiatives were passed to help address Rhode Island's shortage of primary care providers. It has been incorporated into the 2025 state budget bill.
- The bills provide funding to enable primary care practices to serve as clinical training sites and would defray student loan payments for people beginning their career as primary care physicians, nurse practitioners, or physician assistants in return for a commitment to practice in Rhode Island.
- Both bills are part of the HEALTH initiative (Holistic Enhancement and Access Legislation for Total Health) to improve health care access and affordability in Rhode Island.

Questions Still Remaining...

Vision for the new medical school

- Where will clinical training take place?
- How to attract RI Students?

Financial Realities

- Capital Costs
- Start-up Costs
- Tuition and revenue
- Ongoing Support

Moving Forward

- Timetable
- Funding
- How to advocate for a public Medical School in today's environment?

Open Discussion

Overview of Allopathic Medical Schools vs. Osteopathic Medical Schools

Focus Area	DO – Osteopathic	MD – Allopathic
General Foundational Components	<ul style="list-style-type: none"> 4-year college degree required prior to medical school with general prerequisite courses 4-year medical school program <ul style="list-style-type: none"> Other than DO medical students learning osteopathic manipulative medicine (OMM)* a form of hands-on care used to diagnose, treat and prevent illness or injury and is taught only at DO schools*, the medical training for MDs and DOs is indistinguishable. Approximately 40,000 osteopathic medical students are enrolled for the 2024-25 academic year. (American Osteopathic Association) Total enrollment for M.D. students stands at 100,000, an increase of 1.8% from 2024-25. Enrollment has been increasing for a decade. (Association of American Medical Colleges) 	<p></p>
Accrediting Body	<ul style="list-style-type: none"> The American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) is the only accrediting body for pre-doctoral osteopathic medical education. A feasibility study must be prepared and submitted by the Chief Executive Officer and the Dean of the applicant COM in order for a COM to be evaluated for Pre-accreditation status. The financial pro forma portion of the Feasibility Study must be conducted by a nationally recognized accounting firm/management firm. Must include letter of comment from the respective state osteopathic association. 	<ul style="list-style-type: none"> To achieve and maintain accreditation, a medical education program leading to the MD degree in the United States and Canada must meet The Liaison Committee on Medical Education (LCME) accreditation standards. LCME standards and elements are, to a large extent, non-prescriptive. The non-prescriptive nature of LCME standards may be the underlying explanation for the commonly heard aphorism that, “If you have seen one medical school, you have seen one medical school.” If no entity already approved to award academic degrees in the State of New York, that authority has to be achieved before any dealings with LCME.
Administration	<ul style="list-style-type: none"> Adequate staff support, including but not limited to, the appointment of a Chief Executive Officer, a dean/chief academic officer, and a chief financial officer It is expected that a dean, as the Chief Academic Officer of the COM, will be hired at least 6 months prior to the submission of the Feasibility Study in the development of the COM and will provide the guidance and direction in the development of the COM 	<ul style="list-style-type: none"> The dean of a medical school has sufficient access to the university president or other institutional official charged with final responsibility for the medical education program and to other institutional officials in order to fulfill his or her responsibilities; there is a clear definition of the dean’s authority and responsibility for the medical education program. The dean has the power to select and deselect faculty who teach medical students.

Focus Area	DO – Osteopathic	MD – Allopathic
	<p>through all steps of the pre-accreditation process and beyond through Provisional accreditation and into Accreditation.</p> <ul style="list-style-type: none"> The Chief Academic Officer must have an earned D.O. degree from a COCA-accredited COM, have AOA board certification, and be employed in the development of the applicant COM on a full-time basis. 	<ul style="list-style-type: none"> The position of Dean of Medicine requires a medical degree and clinical experience in addition to a record of teaching and research that will qualify for rank of full professor with tenure in one of the school's departments. The Vice Dean for Academic Affairs functions as the chief academic officer of the School of Medicine. The Vice Dean oversees the appointment, promotion and development of the faculty of the school and stimulates and supports the development of the most effective curriculum in undergraduate medical education necessary to prepare students to enter any field of post-graduate training upon graduation. The Associate Dean for Clinical Affairs oversees the clinical operations of the School of Medicine. The Associate Dean works with the Dean and the clinical department chairs to establish a thriving practice plan in an academic medical center setting.
Finances	<ul style="list-style-type: none"> All funds described immediately above must be available for not less than four years of instruction (i.e., graduation of first class) Minimum segregated, unencumbered reserve fund escrowed until the graduation of the first class. This fund must not be borrowed or pledged and must be 100% wholly owned assets of the COM or parent institution. The fund must be equal to the greater of the two: <ul style="list-style-type: none"> \$12,500,000 or Tuition multiplied by number of students multiplied by four years Applicant must also secure a minimum operating reserve fund equal to one-quarter of the amount of the minimum segregated, unencumbered reserve 	<ul style="list-style-type: none"> The present and anticipated financial resources of a medical school are derived from diverse sources and are adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals. Much of university support derives from fundraising, endowment income, and grant funding. LCME requires demonstrating long-term (10-15yrs) financial stability. The LCME does not view favorably institutions that are solely, or largely, dependent on tuition to fund their operating costs. (no more than 50% of operating budget can be tuition).

Focus Area	DO – Osteopathic	MD – Allopathic
	<p>fund. This fund also cannot be borrowed or pledged and must be 100% wholly owned by the COM or its parent institution.</p>	
Faculty Overview	<ul style="list-style-type: none"> • Composition of the faculty, 80 percent full time (paid either by the University or the Health System) and 20 percent voluntary (could be largely community preceptors). 	
Faculty	<ul style="list-style-type: none"> • The COM must have sufficient and appropriately trained faculty, supplemented by part-time and adjunct faculty. • Prior to being granted Provisional accreditation status: Faculty must be hired consistent with the initial hiring plan and pro forma submitted to the COCA. • Faculty must include osteopathic physicians, basic scientists, and other qualified faculty to carry out the COM’s mission and objectives. • COMs are highly encouraged to have osteopathic physicians as the chairs of all clinical departments and divisions in their COMs. This will ensure expression of osteopathic tenets throughout the curriculum and adequate mentoring opportunities for the students. 	<ul style="list-style-type: none"> • The faculty staffing plan requires that at least half of the first-year (M-1) teaching faculty be on board by that Preliminary Accreditation visit and that the faculty members have had substantial input into developing the curriculum. Must provide the total number of full-time, part-time, and volunteer faculty in the basic science and clinical departments for each listed academic year. • While the LCME does not give a minimum number of basic faculty required, it has generally acknowledged that schools with 2 full-time basic science faculty in each discipline (Anatomy, Histology, Biochemistry, Microbiology, Physiology, Pharmacology, Pathology) as sufficient. To satisfy the LCME’s principle of 2 faculty members per discipline, the School of Medicine will need approximately 14 (7*2). These full-time basic science faculty must be appointed 100% to the School of Medicine. • If the MD-granting medical school’s basic science faculty are not full-time members of their school, the proposed school will explain the way basic sciences are shared, however, the model will be scrutinized by LCME reviewers with concerns about faculty “ownership” of the curriculum. The LCME will have questions about the model, particularly whether there is central control of the curriculum.

Focus Area	DO – Osteopathic	MD – Allopathic
Curriculum	<ul style="list-style-type: none"> Osteopathic medical schools tend to have a stronger focus on primary care medicine than MD schools. Few programs offer DO/PhD degrees Observations and hands-on opportunities for OMM can be provided in a college setting, primary care office, student clinic, or hospital setting. Prior to being granted Provisional accreditation status: The first- and second-year curricula must be fully developed. 	<ul style="list-style-type: none"> A comprehensive evidence-based medicine curriculum developed to extend longitudinally from pre-clerkship training throughout clinical experiences. Many programs also offer MD/PhD and MD/MPH degrees and other dual degree programs. (i.e., potential opportunities for special focus areas and or joint degrees with engineering, MBA's, law, etc.) The faculty of a medical school define its medical education program objectives in outcome-based terms that allow the assessment of medical students' progress. The faculty of a medical school are responsible for the detailed development, design, and implementation of all components of the medical education program.
Clerkship Training	<ul style="list-style-type: none"> Prior to being granted Provisional accreditation status: A COM must outline clinical placements for 3rd and 4th year undergraduate medical education students (clerkship) in sufficient detail. Developing COMs must secure written agreements with clinical providers and/or preceptors to provide the clinical education component of the clerkship programs. COM leadership may choose to offer payment or adjunct faculty status to clinical preceptors (clinical faculty providing the education to 3rd and 4th year medical students). Must utilize the Osteopathic Postdoctoral Training Institution (OPTI) partners to offer clerkship opportunities. 	<ul style="list-style-type: none"> In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the medical school's faculty, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Each medical student in a medical education program participates in one or more required clinical experiences conducted in a health care setting in which he or she works with resident physicians currently enrolled in an accredited program of graduate medical education. A medical school ensures that supervision of medical student learning experiences is provided throughout required clerkships by members of the school's faculty.
Research	<ul style="list-style-type: none"> Overall, osteopathic medical schools have more modest research programs compared to MD schools. 	<ul style="list-style-type: none"> The MD educational pathway includes more opportunities in research and specialty training, since

Focus Area	DO – Osteopathic	MD – Allopathic
Post-doctoral (GME)	<ul style="list-style-type: none"> • However, recently, an increasing emphasis on biomedical research at several of the osteopathic colleges has expanded opportunities for DOs interested in pursuing careers in medical research. • The COM must make contributions to the advancement of knowledge and the development of osteopathic medicine through scientific research. This effort may include, but may not be limited to, the conduct of and resulting publication in peer-reviewed journals of “bench” research, clinical trials, patient care research, medical educational research, and health services research. The faculty adequacy model must demonstrate adequate faculty time for research efforts. • Graduates go on to residencies in any specialty of medicine; there are more than 500 osteopathic residency programs, but graduates can also enter the NRMIP. • Because of the philosophy of osteopathic medicine, DO programs tend to produce physicians who go on to practice in primary care. Today, 60% of practicing DO physicians work in Family Medicine, Internal Medicine, Pediatrics and Obstetrics and Gynecology. • Demonstrate educational planning and noted progress in generating graduate medical education opportunities using a retrospective GME Feasibility Report, incorporating the metrics in the GME Accountability Report that demonstrates the expected placement in GME, including OGME, for their prospective class. 	<p>allopathic medical schools have more funding and resources available in these areas. They are also more likely to have a hospital connected to their medical school campus.</p> <ul style="list-style-type: none"> • Faculty Research Start-up and Continued Research Faculty Support could average around \$10M over 11 years.
Single ACGME accreditation	<ul style="list-style-type: none"> • Graduates enter the National Residency Match Program (NRMP) and go on to residencies in any specialty of medicine 	<ul style="list-style-type: none"> • Graduates enter the National Residency Match Program (NRMP) and go on to residencies in any specialty of medicine

Focus Area	DO – Osteopathic	MD – Allopathic
	<ul style="list-style-type: none"> Starting in July 2015, over five years, the AOA, AACOM, and the ACGME are working to create a single, unified accreditation system for graduate medical education programs in the United States. This will ensure that all physicians trained in the U.S. will have the same graduate medical education accreditation, and as of June 30, 2020, the AOA will cease its accreditation functions. 	

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A
COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE
WORKFORCE RELATED TO EDUCATING AND RETAINING
PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Friday, May 30, 2025
TIME: 2:30 PM
PLACE: Senate Lounge - State House

AGENDA:

- I. Welcome
- II. Feasibility Study Update and Presentation:
 - Paul Umbach and Ha Pham – Tripp Umbach
- I. Q&A
- II. Adjournment

There will be no public testimony at this meeting.

COMMISSION INFORMATION

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

TELEVISION AND LIVESTREAMING

The meeting may be televised by Capitol Television on Cox Communications, channels 15 and 61 for high definition; i3 Broadband (formerly Full Channel) on 15; and Verizon, on channel 34. Senate committee hearings may also air on Channel 75 for Cox Subscribers. Livestreaming is available at <https://capitolvri.cablecast.tv/>

POSTED: TUESDAY, MAY 27, 2025, 4:57 P.M.

Concept Paper Overview

Establishing a Public MD-Granting School at the University of Rhode Island

May 23, 2025

Overview

The University of Rhode Island (URI) is uniquely positioned to address Rhode Island's critical shortage of primary care physicians by developing a public, MD-granting medical education program. With over 300 additional primary care providers needed statewide, and nearly half of the current physicians nearing retirement, the situation has reached a tipping point. Unlike most states, Rhode Island lacks a public MD medical school, and Brown University's medical graduates primarily pursue specialties rather than primary care. URI offers a strong foundation for a new school of medicine through its existing pharmacy, nursing, and health sciences programs, which provide infrastructure, interprofessional education opportunities, and established clinical partnerships. As an R1 research institution, URI has an opportunity to attract high-caliber faculty and students. The proposed program would emphasize primary care and community-based training, with strong integration across health disciplines. This approach, favored over other models such as a public DO school or regional campus, would help retain more graduates in-state, particularly through incentives like loan forgiveness. The school would also generate economic growth, research activity, and healthcare access improvements. With strong stakeholder support and backing from the state government, URI is strategically positioned to lead a transformative effort to expand the physician workforce and improve healthcare equity across Rhode Island.

Demonstrated Need

Rhode Island is experiencing a growing shortage of primary care physicians, a challenge that significantly threatens residents' access to timely and comprehensive healthcare. As of 2024, estimates suggest that between 200,000 and 400,000 adults in the state do not have adequate access to primary care services, indicating a shortage of approximately 133 to 266 clinicians based on standard patient-to-provider ratios.¹

¹ [Rhode Island General Assembly, 2024](#)

On April 29th, 2025, Governor Dan McKee and state health leaders introduced a new initiative to strengthen Rhode Island’s weakened primary care system at a news conference. The initiative proposes measures like grant support for clinics and increased payment rates from major commercial insurers. At the conference, it was announced that Rhode Island requires 300 additional primary care providers to meet current demand.² This gap is driven by several factors, including an aging physician workforce, increasing rates of burnout due to administrative burdens, and the relatively low financial incentives in primary care compared to specialty fields.³

The impact of this shortage is already evident in the healthcare system. Patients frequently encounter long wait times—sometimes several months—for primary care appointments, and many are forced to seek care across state lines.⁴ Emergency departments have become overburdened as individuals turn to them for routine care, typically managed in outpatient settings.⁵

This erosion of access has also led to a decline in trust between patients and healthcare providers, especially as maintaining continuity of care becomes increasingly difficult. In response, the state has launched several initiatives, including the Primary Care Training Sites Program, which provides grants to support future workforce development and policy strategies aimed at expanding clinic capacity and improving provider reimbursement rates.⁶ Despite these efforts, substantial investment and coordination will be necessary to close the primary care gap and ensure sustainable access to essential services across Rhode Island.

In 2023, Rhode Island had 4,199 physicians (all specialties), of which 327 were family medicine/general practice physicians.⁷ Projections suggest that Rhode Island requires approximately 300 additional physicians to meet its healthcare demands effectively.⁸ Moreover, the state’s physician workforce is aging rapidly, with 44% of active physicians aged 55 and older, suggesting that a substantial number are within a decade of retirement.⁹

Rhode Island is one of only two states without a public MD-granting medical school, making the University of Rhode Island (URI) well-positioned to address this pressing need. Brown University, currently the sole MD-granting institution in the state, predominantly produces specialists rather than primary care providers. Of 106 graduates from primary care residencies in Rhode Island in academic year 2002–2023, only 15 (14%) planned to provide primary care in Rhode Island, demonstrating a critical leakage in the state’s healthcare workforce pipeline.¹⁰

Capability of URI

The University of Rhode Island possesses substantial foundational assets, including established programs in pharmacy, nursing, health sciences, and biomedical research, which ensure a strong foundation for developing a new medical school. These programs offer existing infrastructure such as simulation labs, research facilities, and experienced administrative teams, which can be shared to reduce startup costs and streamline operations. The programs also create valuable

² Rhode Island Current, 2025

³ Office of the Health Insurance Commissioner, 2023

⁴ Rhode Island PBS, 2024

⁵ Kaiser Family Foundation Health News, 2024

⁶ Healthcare Innovation Group, 2024

⁷ Association of American Medical Colleges

⁸ Rhode Island Current, 2025

⁹ Robert Graham Center

¹⁰ Primary Care Access for All: A Roadmap for Addressing the Primary Care Crisis in Rhode Island

opportunities for interprofessional education, allowing medical students to train alongside future nurses, pharmacists, and allied health professionals in team-based care environments that reflect real-world clinical settings, fostering collaboration, patient outcomes, and alignment with accreditation requirements.

Additionally, existing clinical partnerships and rotation sites developed for nursing and pharmacy students can accelerate the development of clinical training placements for medical students. These programs also help establish academic pipelines, encouraging students from related fields to pursue medical education through pre-med tracks and early assurance programs. Complementary health education programs strengthen the institution's credibility, positioning URI for a more successful and sustainable school of medicine (SOM).

The recent classification of URI as an R1 research institution significantly enhances its capacity to attract top-tier faculty, research funding, and high-caliber students. Existing community partnerships and relationships with local hospitals and health systems provide a strong platform for clinical training and community-based healthcare initiatives.

Regional stakeholders strongly support establishing a community-focused allopathic medical school program emphasizing primary care while preparing students for careers in all specialties. Such an approach would integrate interdisciplinary education with existing pharmacy and nursing programs at URI, offering extensive clinical training partnerships with community health centers and hospitals. Longitudinal primary care clerkships and affordability initiatives would further incentivize Rhode Island and regional students to remain in the state after training.

While critical challenges remain, such as securing sustainable funding, expanding clinical training capacities, and managing potential resistance from existing institutions, the long-term benefits of addressing Rhode Island's physician shortage outweigh these hurdles. URI's strong alignment with healthcare partners and support from state government initiatives position the university strategically to overcome these barriers and establish a transformative medical education program that serves the state's future healthcare needs.

Economic Development

Establishing a public medical school at URI would yield substantial economic benefits, including job creation, research funding opportunities, and advancing Rhode Island's biomedical sector. A URI medical school could dramatically increase the proportion of physicians trained and retained within the state by fostering local education and retention incentives, such as loan forgiveness and tuition reimbursement. This strategy would directly improve healthcare access, particularly in underserved regions. Typically, the annual operations of a public medical school in the early years of development have an economic impact of approximately \$150 million and supports approximately 1,000 jobs directly and indirectly.¹¹ Each physician trained at the medical school who completes residency and remains in the community have an annual \$2.2 million economic impact and supports 15 jobs directly and indirectly.¹²

¹¹ Figures subject to change after final analysis. Tripp Umbach data.

¹² Tripp Umbach data.

Stakeholders identified promising opportunities for a diverse financial strategy combining state appropriations, philanthropic contributions, and public-private partnerships. Rhode Island's recent legislative commitment (i.e., HEALTH Initiative) to increasing Medicaid reimbursements and funding for clinical training sites demonstrates the state's readiness and ability to support significant investments in healthcare infrastructure.¹³

Recommended Model

URI should develop a public MD-granting medical education program in partnership with hospitals, health systems, and community clinics throughout Rhode Island. The program will complement Brown University's Alpert School of Medicine, focusing on community education, research, and clinical care. It will also be firmly integrated with the university's nursing, pharmacy, public health, and other health-related programs. Tripp Umbach deemed this model to be superior when compared to a private medical school or a regional campus of an existing institution in neighboring states.

In general, community-based medical schools identified below have multiple health care training partners, which include community health clinics located throughout their service region. These public medical schools are more likely than large medical centers to produce students who enter primary care specialties, participate in community-based research and service initiatives. Most importantly, they are more likely to remain in practice in community settings.

Community-Based Medical Schools:

- | | |
|--|---|
| 1. Central Michigan University College of Medicine (COM) | 14. University of California, Riverside SOM |
| 2. Charles E. Schmidt College of Medicine at Florida Atlantic University | 15. University of Central Florida COM |
| 3. CUNY SOM | 16. University of Hawaii, John A. Burns SOM |
| 4. East Tennessee State University James H. Quillen COM | 17. University of Houston Tilman J. Fertitta Family COM |
| 5. Eastern Virginia Medical School | 18. University of Nevada, Reno SOM |
| 6. Florida International University Herbert Wertheim COM | 19. University of North Dakota SOM and Health Sciences |
| 7. Florida State University COM | 20. University of South Carolina SOM Columbia |
| 8. Marshall University Joan C. Edwards SOM | 21. University of South Dakota, Sanford SOM |
| 9. Michigan State University College of Human Medicine | 22. University of Texas at Austin Dell Medical School |
| 10. Northeast Ohio Medical University | 23. University of Texas Rio Grande Valley SOM |
| 11. Southern Illinois University SOM | 24. Virginia Tech Carilion SOM |
| 12. Texas Tech University Health Sciences Center Paul L. Foster SOM | 25. Washington State University Elson S. Floyd COM |
| 13. Texas Tech University Health Sciences Center SOM | 26. Wright State University Boonshoft SOM |

¹³ [State of Rhode Island General Assembly, 2024](#)

Vision for the Proposed Medical School

The vision for establishing a new public medical school reflects a strategic and mission-driven response to the state’s growing healthcare needs and workforce shortages. This initiative outlines a comprehensive plan to enhance clinical training opportunities, attract Rhode Island students into medicine, and ensure long-term financial sustainability. With a focus on community partnerships, state and cross-border collaborations, and a commitment to improving access to care in underserved areas, the proposed SOM emphasizes both the academic and economic benefits of a public medical school.

Questions Still Remain

The following discussion addresses outstanding questions and considerations for advancing the development of a public medical school, from securing clinical training sites to attracting local students and establishing sustainable financial and legislative support for the proposed SOM.

1. *Where will clinical training take place?*
 - URI must secure partnerships with a broad array of health care providers throughout Rhode Island. Organizations interviewed shared an interest in creating a relationship with a public medical institution. These institutions can serve as anchor institutions for clerkships, residencies, and potentially faculty recruitment.
 - Leverage community hospitals and Federally Qualified Health Centers (FQHCs) across the state to fulfill rural and primary care training requirements (i.e., Thundermist Health Center)
 - Establish Graduate Medical Education (GME) affiliation agreements with hospitals in eastern Connecticut and southeastern Massachusetts to expand access to specialty care training while minimizing the impact on in-state capacity.
 - Tripp Umbach believes that there is sufficient training capacity in Rhode Island for a medical school class of 100 students. The following table lists current teaching and non-teaching hospitals as well as their academic affiliations. It is most common for a hospital with an academic affiliation to take medical students from multiple schools.

Teaching Hospitals			Non-Teaching Hospitals		
Hospital	Bed Size	Residency Sponsor	Hospital	Bed Size	Location
Rhode Island Hospital	719	Brown University	Our Lady of Fatima Hospital	312	North Providence
Kent Hospital	359	Independent	Landmark Medical Center	214	Woonsocket
Meriam Hospital	247	Brown University	Westerly Hospital	129	Westerly
Roger Williams Hospital	220	Boston University	Newport Hospital	125	Newport
Women’s & Infants	137	Brown University	South County Hospital	100	South Kingstown
Hasbro Children’s	63	Brown University			

2. How to attract students from Rhode Island?

To attract and retain Rhode Island students, the proposed medical school should implement a multi-faceted, mission-driven recruitment strategy. A key component is the establishment of guaranteed admission pathways, such as BS/MD programs or early assurance options, designed for high-achieving Rhode Island undergraduates and high school students. These pathways provide clear, structured opportunities for local students to pursue medical education without the uncertainty associated with traditional application routes. Additionally, the school should emphasize a strong commitment to training physicians who will serve within the state, particularly in rural and underserved communities. This mission focus can be woven into admissions criteria, curricular design, and outreach initiatives. Tuition incentives and service-based commitments, such as offering in-state tuition or student loan repayment for graduates who practice in Rhode Island post-residency, can further incentivize students to remain in-state, helping to build a locally rooted physician workforce.

3. What are the financial realities and estimated capital/start-up costs?

The development of a new academic and simulation building is a critical component of establishing a medical school at the University of Rhode Island, with estimated capital costs totaling approximately \$125 million. This projection is based on recent benchmarks from comparable institutions, such as the University of Central Florida, the University of Nevada, Las Vegas (UNLV), and the University of Texas Rio Grande Valley (UTRGV), all of which have constructed facilities similar to those supporting modern medical education.

To manage costs and maximize efficiency, URI may consider co-locating the new school with existing health science infrastructure or implementing a phased construction plan that aligns facility expansion with projected enrollment growth. This approach would allow for strategic scaling of resources while maintaining financial sustainability during the initial stages of development.

The start-up costs for launching the new medical school, excluding construction, are projected to be approximately \$90 million. These funds will support essential early-stage activities, including curriculum development, accreditation preparation, recruitment of founding faculty and administrative leaders, and marketing efforts to build visibility and attract applicants. A private lead donor will be instrumental in generating momentum and credibility for the campaign, catalyzing broader philanthropic support. In addition to private contributions, state appropriations and philanthropic gifts will play a crucial role in funding these foundational efforts, ensuring the school is well-positioned for a successful launch and long-term impact.

Tuition and Revenue

The proposed medical school should anticipate setting tuition at approximately \$50,000 annually, based on Tripp Umbach's recommendation, aligning it with rates at other public medical schools and maintaining competitiveness for in-state and regional applicants. Similar to most public medical schools, tuition revenue alone will not suffice to cover the institution's full operating costs. To ensure long-term financial sustainability and quality programs, the proposed medical school will need \$20 million in annual state operating revenue. This funding must be supplemented by clinical revenue generated through partnerships with health systems, as well as ongoing philanthropic contributions to support scholarships, faculty development, and programmatic innovation.

To ensure the long-term financial sustainability of the new medical school, URI must secure a recurring state budget line item for operational support, with a recommended annual appropriation of \$25 million. This funding stream will be critical for maintaining core academic functions, supporting faculty, and delivering high-quality medical education. Additionally, URI should establish a dedicated medical school foundation to cultivate long-term philanthropic support and build an endowment that provides financial stability and flexibility over time. Additionally, by leveraging clinical faculty from partner health systems, the school can reduce the overhead of full-time salaried faculty; thereby lowering personnel costs while still ensuring students receive high-quality, hands-on clinical instruction.

4. *What is the proposed timetable?*

- Year 1-2: Planning, community engagement, and accreditation preparation.
- Year 3: Submit application to LCME, hire a founding dean, and a leadership team.
- Year 4: Conditional accreditation and student recruitment.
- Year 5: First class matriculates.
- Year 9+: Graduate first cohort.

5. *Funding (Over 10-year period)¹⁴*

- **\$225 million total**
 - Seed funding from the community and university foundations (\$20 million)
 - Lead/Private donor (\$40 million)
 - State start-up (\$30 million)
 - Annual ongoing state support (\$25 million*)
 - Seek initial legislative appropriation for feasibility and design (\$50 million*)
 - Secure matching private funds or health system commitments (\$60 million*)

6. *How do we advocate for a Public Medical School?*

Advocating for a public medical school in today's environment requires a strategic approach that highlights both the risks of inaction and the wide-ranging benefits of investment. A key argument should focus on the economic consequences of not establishing a public medical school, including lost opportunities

*One-time donation.

¹⁴ Financial figures submit to change after final analysis.

for job creation, research funding, and long-term economic growth. Additionally, proponents must emphasize the role a public medical school can play in advancing health equity and addressing critical physician shortages, particularly in underserved communities. The school should be positioned as an integral component of statewide efforts to strengthen the healthcare workforce, support the retention of local talent, and align with broader economic development goals. To succeed, advocacy efforts must bring together a diverse coalition of stakeholders, including leadership from the University of Rhode Island, state legislators, local hospitals, community health centers, and economic development organizations, all unified around a shared vision for improving health outcomes and economic resilience across the state.

Conclusion

Establishing a public, MD-granting, community-based SOM at URI presents an exceptional opportunity to address Rhode Island's critical shortage of primary care physicians, enhance healthcare access, promote economic development, and increase in-state physician retention. The combination of existing university capabilities, statewide needs, and strategic economic incentives offers a compelling rationale for advancing this pivotal initiative.

Additional Details To Be Included in the Feasibility Study

1. Define a curriculum model emphasizing interdisciplinary training and primary care clerkships.
2. Evaluate the number of potential applicants, including retention rates for URI medical graduates.
3. Examine potential synergies with existing institutions, particularly those at Brown University.
4. Develop a timeline for establishing and accrediting the new medical school, including milestones and key decision points.
5. Identify key indicators to measure the medical school's impact on healthcare outcomes, economic development, and physician workforce retention.

New U.S. Public Medical Schools (Established Post-2000)

The table below lists 15 public medical schools in the U.S. founded (or first class admitted) since 2000, with their inaugural class year and size, current enrollment, and details on state funding for start-up, annual operations, capital, and private donations for facilities:

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
Recommendation for URI							
Median Data							
Florida International U. Herbert Wertheim COM (Miami, FL)	2009	43	480 total (120 per class)	\$34,186	Authorized 2006; received non-recurring start-up appropriations (\$5.2M in FY2007-08, \$6.2M in 2008-09) additional \$7.1M in FY2009-2010 for inaugural year.	Annual state operating support \$20.3M by year 10 (planned to reach \$20M/year when fully enrolled).	\$64M for facilities construction including \$20M Public Education Capital Layout (PECO) funds for a research building and \$20M state-matched to \$20M private donations.
U. of Central Florida College of Medicine (Orlando, FL)	2009	41	480 total (120 per class)	\$41,570	The state provided \$18.6M in start-up funds over 2007–2009. The local community raised \$6.5M for full scholarships for charter-class students.	State annual recurring support \$20.8M by full enrollment (Year 10)	\$82M for new facilities, including \$30M in community/private funds matched by \$30M state funds, plus \$22M from state PECO bonds.
Florida Atlantic U. Charles E. Schmidt COM (Boca Raton, FL)	2011	64	313 total (78 per class)	\$33,220	Authorized 2010; Florida provided new funding (\$10M in FY2010-11) to launch the independent FAU medical program.	State annual recurring support \$20M by mid-2010 (e.g., \$20.7M in FAU's 2014-15 Education and General Budget for the medical school)	\$50M state appropriation (2010) for new medical building matched by FAU and donors. \$139M new six-story medical school facility opened in 2012
Univ. of Nevada, Las Vegas (UNLV) Kirk Kerkorian SOM (Las Vegas, NV)	2017	60	240 total (60 per class)	\$32,903	Nevada's 2015 Legislature appropriated \$26.7M for start-up operating costs for hiring faculty and curriculum to launch the SOM in 2017.	State general-fund support \$19.6M in FY2016-17, rising to \$30.2M by FY2018-19 as class size grew. Public funding will ultimately cover 18% of the school's total budget at full size.	\$25M state capital appropriation in 2017 for a new medical school building, contingent on a private \$25M match. Total project \$125M; an anonymous donor provided \$25M
Univ. of Arizona College of	2007	24	400 total (100 per class)	\$42,590	Established in 2007 in partnership with ASU and the City of Phoenix. State support	Continue as a state-funded UA medical college (now separate from UA Tucson).	The \$135M Health Sciences Education Building on the Phoenix Biomedical Campus was

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
Medicine – Phoenix (Phoenix, AZ)					included operating funds via UA; City donated the downtown Phoenix Union High School site and funded its \$30M renovation.	Receives annual state appropriations through UA; class size approved to increase to 100, reflecting ongoing state investment.	funded by state appropriations and city bonds (for UA/ASU). Phoenix provided land and facilities (via city bond projects), enabling a whole 4-year campus.
Washington State Univ. Elson S. Floyd College of Medicine (Spokane, WA)	2017	60	240 total (60 per class)	\$43,842	Authorized by WA Legislature in 2015 (ending UW's exclusivity). State provided \$2.5M initial planning funds (2015) and \$10.0 M in the 2017–19 biennium to support the first 60 students.	Annual state funding \$10M–\$11M per biennium for each new class added (\$10M to support 60 first year students and 60 second year students in 2017–19). By complete 4-year enrollment, ongoing state support is \$24M/year.	Utilized existing WSU-Spokane health campus facilities. The state had previously invested \$70M in a Biomedical Sciences building in Spokane in anticipation of expanding medical education. In 2019, WSU began planning a new building to double enrollment (seeking state capital funds).
University of Texas at Austin Dell Medical School (Austin, TX)	2016	50	200 total (50 per class)	\$24,525	UT System Regents committed \$25M/year plus \$40M over eight years for start-up (faculty recruitment). In 2012, Travis County voters approved a property tax (Central Health) providing \$35M/year to support the new medical school.	Ongoing support includes the \$25M annual UT System funding. (Dell Medical also benefits from local tax revenue \$35M/yr and external grants.) The Texas Legislature formally authorized the school in 2019 but provides no large direct appropriation (Dell Medical seeks state formula funding parity).	\$50M naming gift from the Michael & Susan Dell Foundation for facilities. UT Regents approved the construction of three new medical campus buildings in 2013, which were funded via UT bonds and philanthropy. The main Health Learning Building opened in 2016.
University of Texas Rio Grande Valley School of Medicine (Edinburg/Harlingen, TX)	2016	55	210 total (55 per class)	\$24,970	Founded with UT System support during the creation of UTRGV. UT Regents approved \$54M for a new medical school building in Edinburg and \$10M for a simulation hospital in Harlingen. Initial operating funds were covered by UT System and reallocated regional campus funds (no separate state line-item at launch).	Now receives state formula funding as part of UTRGV. The Texas Legislature began appropriating support for the medical school in general appropriations by the 2010s. (e.g., \$71.4M for UTRGV's health programs in FY2020- 21, including the medical school). Continued UT System backing as needed.	\$54M state PUF-funded Medical Education Building in Edinburg. Harlingen's existing Regional Academic Health Center was transferred from UTMB for clinical training. Additional state capital funds provided for expanding research and clinic facilities across the Valley (ongoing).

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
University of Houston Tilman J. Fertitta College of Medicine (Houston, TX)	2020	30	120 total (30 per class)	\$27,726	Authorized by the Texas Legislature in 2019. The start-up funding plan is called for \$120M over 10 years (combining state appropriations, philanthropy, and intellectual property revenue). An initial \$20M in state funds was secured to launch the college, alongside significant donations (e.g., a \$3M anonymous gift to cover inaugural class tuition).	Seeks \$10M+ annually in state support as it grows (Texas provided an initial special-item appropriation in 2019, then formula funding as part of UH). The UH System aimed for \$40M in state, \$40M in donor, and \$40M in other funding over the decade. As of 2023, state funding is included in UH's base budget for 120 medical students.	The new medical school building was funded by UH bonds and philanthropy (Tilman Fertitta's \$50M naming gift). The college aims to raise capital and endowment funds privately; the state did not directly fund construction. (Local partner HCA will provide clinical training facilities.)
Texas Tech Univ. HSC El Paso – Paul L. Foster SOM (El Paso, TX)	2009	40 (charter class)	400 total (100 per class)	\$26,183	Established as a four-year TTUHSC regional campus in 2009. Texas Legislature invested over \$60M from 2007–2009 to build and open the El Paso (including new faculty hires and operations). Achieved separate accreditation status in 2013.	Receives recurring state appropriations via TTUHSC El Paso – e.g., \$53M/year by 2020. Funded under the Texas formula for medical education and exceptional item support for border health.	\$90M in capital funding for the medical campus (state tuition revenue bonds and appropriations in 2006–2008). Included a new Medical Education Building (\$40M) and Research building (\$50M) adjacent to the University Medical Center of El Paso. Additional \$32M state funds 2015 for a new Medical Sciences building.
Central Michigan University College of Medicine (Mt. Pleasant, MI)	2013	64	400 total (100 per class)	\$41,788	Michigan provided \$12.5M in one-time funds to assist start-up, and CMU raised operational funds internally and via local healthcare partners to admit the first class in 2013.	Receives state support through CMU's base appropriation. CMU's clinical revenues supplement annual medical education funding. (Michigan has no separate line-item for the COM; CMU covers costs via tuition and state university funds.)	The state's \$25M in capital outlay helped build CMU's medical education building. CMU bonds and local hospital contributions covered the \$30M+ in construction.
Oakland Univ. William Beaumont	2011	50	500 total (125 per class)	\$59,096	Launched as a partnership between Oakland University (public) and Beaumont Health	Beaumont's clinical funding and tuition sustain OUWB's operations; it is	\$28M joint investment by Beaumont and Oakland U. to renovate and equip a medical

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
School of Medicine (Rochester, MI)					(private). Beaumont provided substantial start-up funding (>\$10 M) and facilities. Michigan's Higher Ed budget did not initially increase for OUWB, so the school operated on Beaumont support and tuition in the early years.	not separately line-funded by the state (state support to Oakland Univ. is general). OUWB matriculates 125 students/annually with stable financing from its health system partnership.	school building and new anatomy labs. Beaumont also invested in a new research and education center on its hospital campus to support the school.
Cooper Medical School of Rowan U. (Camden, NJ)	2012	50	400 total (100 per class)	\$49,349	2009 executive order merging Rowan and Cooper Health. New Jersey provided start-up appropriations (\$30M over 2010–2012) to hire faculty and attain LCME accreditation. Cooper Health System contributed operating funds before first enrollment.	Receives annual state support through Rowan's appropriation. As of 2015, class size reached four whole cohorts, and state operating support for CMSRU was folded into Rowan's base (Rowan's overall state funding increased after UMDNJ reorganization in 2013 to support its two medical schools).	The \$139M new Medical Education Building opened 2012. Funded by a combination of New Jersey state capital bonds and Cooper/Rowan contributions.
Virginia Tech Carilion School of Medicine (Roanoke, VA)	2010	42	168 total (42 per class)	\$65,739	Opened in 2010 as a public-private partnership (Virginia Tech & Carilion Clinic). Carilion Clinic invested \$100M+ to cover startup and operating costs (the model had no new state funds at launch). VTCSON became an official college of VT, enabling some state support via VT.	Now part of Virginia Tech, it receives state general funds indirectly, but the medical education program still relies heavily on Carilion's clinical revenue and philanthropy. The relatively small class size helps keep ongoing state funding needs modest.	Carilion financed the original medical school building on its Roanoke campus. Virginia's state government provided \$59M for the adjoining Fralin Biomedical Research Institute but no upfront capital for the medical school itself. Expansion plans in 2023 sought state funds for a new education building to double class size.
Carle Illinois College of Medicine (Urbana Champaign, IL)	2018	32	128 total (32 per class)	\$53,766	Established in 2018 as a no-state-funds venture: \$100M pledge from Carle Health System (over 10 years) covers start-up costs. UIUC is committed to no new state appropriations – additional funding comes from	Continues operating without dedicated state funding. Supported by Carle's ongoing contributions, tuition, and external grants. (The college is part of UIUC but outside the regular state	The college renovated existing UIUC facilities. A donor-funded renovation of Everitt Lab (\$10M) created state-of-the-art medical classrooms and labs. Future expansion may seek state capital funds, but no state funds were used.

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
					donor gifts, research grants, and clinical revenue.	budget for medical education)	

Table 1: Annual In-State Tuition for New Public Medical Schools

Medical School	In-State Tuition (2024–2025)
Carle Illinois College of Medicine (University of Illinois Urbana-Champaign)	\$57,525
Central Michigan University (CMU) College of Medicine	\$46,325
Cooper Medical School of Rowan University (CMSRU)	\$49,349
Florida Atlantic University (FAU) Charles E. Schmidt College of Medicine	\$34,186
Florida International University (FIU) Herbert Wertheim College of Medicine	\$41,570
Florida State University (FSU) College of Medicine	\$32,903
Oakland University William Beaumont (OUWB) School of Medicine	\$59,096
Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso)	\$26,183
University of Arizona College of Medicine – Phoenix	\$42,590
University of Central Florida (UCF) College of Medicine	\$33,220
University of Houston Tilman J. Fertitta Family College of Medicine	\$27,726
University of Texas at Austin Dell Medical School	\$24,525
University of Texas Rio Grande Valley (UTRGV) School of Medicine	\$24,970
Virginia Tech Carilion School of Medicine (VTCOM)	\$65,739
Washington State University Elson S. Floyd College of Medicine	\$43,842

Source: [Shermassian Academic Consulting](#)

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Thursday, October 9, 2025

TIME: 5:00 PM

PLACE: Senate Lounge – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Public Comment
- I. Adjournment

There will be public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.



RHODE ISLAND SENATE

SPECIAL LEGISLATIVE COMMISSIONS – PRIMARY CARE WORKFORCE

Morgan DiMaio, Policy Analyst

SIGN-UP TO DELIVER TESTIMONY TO THE COMMISSION

Date: 10/9/2025

Time of Meeting:

5:00 PM

Meeting Location:

Senate Lounge

NAME	ORGANIZATION REPRESENTING
Gregg Amore ✓	R.I. Secretary of State ✓
Patrick Crowley ✓	AFL-CIO ✓
Matthew Roman ✓	Therapist ✓
ROBERT E. Craun Jr. Treasurer James P. Craun Jr. ✓	General Treasurer's Office ✓
NITIN STRANGE MD ✓	SELF Noncommitted
MERRILL THOMAS ✓	PROVIDENCE COMMUNITY HEALTH CENTER ✓
John M'Leane ✓	SELF/citizen ✓
Emily Green ✓	self/citizen USMS Pawest ✓
George Zanyeh ✓	CITY OF PAWTUCKET John Shaw ✓
Jeremy Coughlin ✓	Fuerza Laboral - Central Falls
Lisa Menard-Manlove MD ✓	self (Woodman Health)
Jenna Iannuccilli MD ✓	self - Landmark URI ✓
Nadine Himmelfarb MD ✓	RIMS/RIACEP Pres
James G. Griffin MD ✓	RI Society of Physicians & Surgeons
JOHN WELCH ✓	BS W&E TWO MED SCHOOLS FOR PRIMARY CARE

NO TESTIMONY WAS GIVEN ON THIS ITEM AT THIS MEETING

1 G. Allard ✓



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Chief of Primary Care

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To the Primary Care Workforce / URI Medical School Study Commission
Rhode Island General Assembly
October 7, 2025

Chairperson and Members of the Commission,

Thank you for the opportunity to provide testimony on the state of primary care in Rhode Island and the urgent need for strategic investment and reform. Based on my experience as Chief of Primary Care at Brown Health Medical Group, I offer this testimony.

Key Messages:

1. Primary care is central to improving population health and reducing healthcare costs.
2. Payment reform and policy changes are essential to drive transformation in care delivery.
3. Workforce challenges and chronic underinvestment threaten the sustainability of primary care.

Primary care is the foundation of a high-performing health system. It is the first point of contact between patients and the healthcare delivery system, providing continuity of care, emphasizing prevention, and coordinating services across specialties. Communities with robust primary care systems experience lower mortality rates, improved chronic disease management, fewer emergency department visits, and higher patient satisfaction rates. In pediatrics, primary care is especially critical. It supports early and sustained developmental screening and surveillance, behavioral health, immunizations, and the prevention of lifelong chronic conditions.

According to the 2025 Commonwealth Fund report, Rhode Island ranks fourth nationally in health system performance, a testament to our commitment to innovation and value-based care.

Despite these successes, we face significant challenges. Nationally, we are experiencing an underinvestment in primary care, with only 5 cents of every healthcare dollar spent on primary care. A shrinking physician workforce marked by early retirements and a poor replacement rate for existing primary care physicians with newly trained clinicians. Inadequate GME funding for primary care further challenges the ability to meet the primary care needs of our population. EHR systems burden clinicians and require more time for patient preparation and task completion, reducing patient access.

Establishing a new state university medical school in Rhode Island offers several potential benefits, including expanding access to medical education and addressing the state's physician workforce needs. However, it also presents significant challenges, particularly given the state's already limited clinical training capacity, which currently serves students from Brown University's Warren Alpert Medical School and five other university programs for nurse practitioners and physician assistants. Importantly, opening a new medical school does not inherently guarantee that more graduates will enter primary care, one of the stated goals of the initiative. There are alternative, potentially more cost-effective strategies to strengthen the primary care pipeline, such as expanding loan repayment and scholarship programs tied to

primary care service, increasing the number of primary care residency slots, supporting community-based training sites, and enhancing mentorship and career development pathways for students interested in primary care. Any proposal for a new medical school must be carefully weighed against these options and the realities of Rhode Island's healthcare training infrastructure.

To secure the future of primary care in Rhode Island and nationally, we must:

1. Double the investment in primary care to 10% of healthcare spending.
2. Double the number of medical graduates entering primary care through GME reform and community-based training.
3. Double the number of Rhode Islanders FQHCs serve, requiring workforce expansion and infrastructure support.

Primary care is a common good. Its decline is not inevitable—it is a policy choice. We must act decisively to reverse underinvestment, support our workforce, and ensure access to care for all Rhode Islanders. We must move away from fee-for-service toward prospective, value-based payment models. Additionally, we need to support team-based care and integrated behavioral health in our primary care settings. We can enhance our IT systems and leverage AI to reduce administrative burdens. There is a tremendous opportunity to improve collaboration between primary and specialty care. We must engage with our community-based organizations and address social drivers of health.

I urge this Commission to prioritize primary care in its recommendations to the General Assembly. The health of our communities—and the sustainability of our healthcare system—depend on it.

Thank you for your attention and your commitment to this vital issue.

Respectfully submitted,



Edward McGookin, MD, MHCDS, FAAP
Chief of Primary Care
Brown University Health – *Brown Health Medical Group Primary Care*
15 LaSalle Square, Providence, RI, 02903
Office: 401.606.9470 | Cell: 401.363.2015 | Fax: 401.453.3258
brownhealth.org/primarycare



State of Rhode Island
Office of the General Treasurer

James A. Diossa
General Treasurer

9 October 2025

The Honorable Pam Lauria
Co-Chair, Special Legislative Commission

Marc B. Parlange
President, University of Rhode Island
Co-Chair, Special Legislative Commission

RE: *Concerning the Establishment of a State Medical School at the University of Rhode Island*

Co-Chairs Lauria and Parlange:

I write in strong support of continued efforts to establish a state medical school, housed at the University of Rhode Island. Earlier this week, this Commission released an Independent Feasibility Study that confirmed Rhode Island has “[a] clear and growing need for physicians, especially in primary care and underserved areas.” *Independent Feasibility Study into a Medical School at the University of Rhode Island*, Tripp Umbach, at *17 (September 2025) (hereinafter referred to as the “Feasibility Study”). Across our state – and particularly in communities of color – Rhode Islanders are finding it increasingly difficult to find a doctor for a checkup or treatment. We must take decisive action to ensure healthcare remains accessible and affordable irrespective of demographic or socioeconomic status and that begins with efforts to attract and retain those that provide care.

A state medical school will help accomplish that goal by training a new generation of physicians that have roots in Rhode Island. Studies routinely show that college and post-graduate students are more likely to seek employment opportunities in the state or region where they studied, particularly where there is economic opportunity. See, e.g., *Politics for Place: How to Make Sustainable Investments in Communities*, W.E. Upjohn Institute for Employment Research (March 2024). The likelihood further increases when the student is born and raised in that state or region. And if we can retain students that are grounded in Rhode Island – that were raised here and look like our friends, family, and neighbors – they will be more effective providers because they *understand* our communities.

But as the Feasibility Study recognized, the state must create “targeted incentive programs that strengthen recruitment and retention.” *Feasibility Study*, at *24. While a state medical school will

certainly increase the likelihood that doctors pursue training opportunities and employment in Rhode Island, “[s]uch programs are essential” to reduce “the risk of losing talent to other regions.” *Id.* Absent such incentives, students may be drawn to higher salaries in neighboring states.

If you have any further questions, please do not hesitate to reach out to me directly or to my Director of Policy and Intergovernmental Affairs, Robert Craven, Jr., at Robert.CravenJr@treasury.ri.gov.

Respectfully,

A handwritten signature in black ink, appearing to be 'J. Diossa', enclosed within a circular scribble.

James A. Diossa
General Treasurer



**DONALD R. GREBIEN
MAYOR**



**Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906**

September 30, 2025

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Mayor Donald Grebien from the City of Pawtucket, and I write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services. This is insufficient and unsustainable for the health of our residents and the economic vitality of the entire state.

I constantly hear about the challenges residents face in finding primary care physicians within Pawtucket and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

While the state of Rhode Island has pursued several primary care-related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare, and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improvement of the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Donald R. Grebien
Mayor
City of Pawtucket



September 24, 2025

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

My name is Margaret Holland McDuff, CEO of Family Service of Rhode Island, and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I frequently hear about the challenges residents face in finding primary care physicians throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead. As a close collaborator with primary care practices, we at Family Service of Rhode Island see firsthand the shortage and how it affects the care of the clients that we serve.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for considering investing in a public medical school at the University of Rhode Island.

Sincerely,

A handwritten signature in black ink that reads 'Margaret Holland McDuff'.

Margaret Holland McDuff
CEO
Family Service of Rhode Island

RHODE ISLAND COALITION FOR ELDER JUSTICE

Working Together for a Safe and Just Elder Community



Education | Advocacy | Empowerment

Rhode Island Coalition for Elder Justice
140 Warwick Neck Ave
Warwick, RI 02889
ricoalitionforelderjustice@gmail.com

October 1, 2025

Rhode Island Senate
RI Primary Care Provider Workforce and Education Commission
Senate Finance Committee
82 Smith Street
Providence, RI 02906

Re: Letter of Support for Establishing a Public Medical School at URI

Dear Chairperson Lauria and Members of the Commission,

On behalf of the Rhode Island Coalition for Elder Justice, I am writing in strong support of the state's investment in a public medical school at the University of Rhode Island.

The primary care crisis in Rhode Island has reached a critical point. The state requires approximately 300 additional primary care providers to meet current needs, while nearly half of our practicing physicians are nearing retirement. Current estimates suggest that between 200,000 and 400,000 Rhode Islanders do not have reliable access to primary care services.

Our Coalition frequently hears from older adults and caregivers who struggle to secure primary care. Long wait times—often lasting several months—force residents to either seek care in neighboring Massachusetts or rely on emergency departments for issues that should be managed in primary care settings.

This shortage disproportionately affects older adults, many of whom live with multiple chronic conditions that require regular monitoring and timely intervention. Delayed access to primary care can lead to worsening health outcomes, unnecessary hospitalizations, unable to refill medications and increased vulnerability to neglect. For the population we serve, the absence of reliable primary care is not just an inconvenience—it can mean the difference between independence at home and premature institutionalization.

While the state has taken important steps through workforce development grants and other initiatives, these alone will not close the growing gap. The University of Rhode Island is uniquely positioned to be part of the solution. As the state's flagship public research university, URI already houses nationally recognized programs in pharmacy, nursing, health sciences, and biomedical research, supported by strong clinical partnerships and existing infrastructure.

A public medical school at URI would not only address the shortage of primary care physicians, but also:

- Create good-paying jobs and strengthen the healthcare workforce pipeline,
- Advance Rhode Island's biomedical sector, and
- Improve health outcomes and quality of life for residents across the state.

For these reasons, we urge the Commission and the Senate Finance Committee to support investment in establishing a public medical school at the University of Rhode Island.

Thank you for your consideration of this important opportunity to safeguard Rhode Island's health system for current and future generations.

Sincerely,

Robin Ashley Covington, MPA
The Rhode Island Coalition for Elder Justice

The Coalition is a partnership among victim service agencies, senior service agencies, community groups, advocacy groups, law enforcement and state departments. Its purpose is to create an effective community coordinated response to the abuse of older adults. The Coalition is a statewide effort inclusive of adults aged 50 and older (who may also be disabled).



**Senior Agenda Coalition
of Rhode Island**

A Beacon for RI's Older Adults & Adults with Disabilities

To: Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
From: SACRI - Senior Agenda Coalition of RI
Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island
Date: 10-9-2025

Dear Chairperson, Lauria and honorable members of the Commission,

On behalf of SACRI, we write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

As Executive Director of a statewide older adult advocacy coalition, I, our board, and members often hear of the challenges older adults face in finding primary care physicians. From New Shoreham to Woonsocket older adults are being displaced from primary care and the next steps are usually laborious, web driven and unfriendly to our older population. And even when a PCP is secured, the wait times are untenable. This unfortunately leads to folks in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

The SACRI Office phone often gets voicemails from people seeking assistance in finding care, and we do our best to make appropriate referrals and connections for older adults and their families seeking help.

- The numbers reside here in the [RI Healthy Aging Report](#)- We urge you to review it.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. Many of these issues, and bills SACRI has vigorously supported in the Legislative process. We find the University of Rhode Island is well-positioned to address the pressing need and contribute to solving the

primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for considering investing in a public medical school at the University of Rhode Island.

Sincerely,

Carol Anne Costa, on behalf of SACRI

Chairpersons and Members of the Committee,

My name is Tatiana Baena, and I am submitting this testimony in strong support of the proposal to create a public medical school at the University of Rhode Island.

I come to you wearing several hats. As an At-Large Councilwoman in Central Falls, I represent a city made up of working-class families, many of whom are immigrants, essential workers, and people of color. Access to timely, quality, and culturally responsive health care is one of the most pressing issues we face, and it's not just about coverage. It's about having enough providers who understand our communities, speak our languages, and stay in Rhode Island long enough to make an impact.

Just this week, I hosted a Community Conversation on Health Care where dozens of residents came to ask questions about navigating their coverage, finding providers, and understanding how federal policy shifts will impact them. A common theme was how difficult it is to find doctors, especially primary care providers and specialists, who are available, accessible, and trustworthy. Some families are waiting months for appointments. Others are forgoing care entirely.

As a mother, I understand this challenge on a deeply personal level. When your child is sick, access is not optional, it's urgent. And when you live in a city like Central Falls, which has some of the highest poverty rates in the state, every barrier to care is a risk to someone's health and well-being.

As the founder of Better Perspective Consulting, I work with nonprofits, schools, and small businesses across the state, many of whom are doing their best to fill the gaps in care through outreach, case management, and wraparound support. But no amount of community programming can replace the systemic need for more trained, mission-driven medical professionals right here in Rhode Island.

And as a proud alumna of the University of Rhode Island, I know firsthand how powerful public higher education can be. Like many URI grads, I chose to stay here in Rhode Island to give back to the communities that shaped me. A public medical school would offer that same opportunity to a new generation of future doctors, especially local students of color, who are deeply committed to serving in-state, but may not have the resources or access to pursue a medical degree elsewhere.

A public medical school at URI is timely and strategic. It creates a pipeline for local students, aligns with our economic and public health needs, and sends a clear message that Rhode Island is serious about solving the provider shortage by investing in talent that reflects and understands our communities.

Even if I am unable to testify in person, I wanted to make sure my voice, and the voices of my constituents are represented in this conversation. I urge you to support this proposal and help Rhode Island take a meaningful step toward a healthier, more equitable future.

Sincerely,
Tatiana Baena

"THE MISSION OF CENTRAL FALLS HIGH SCHOOL

is to cultivate academic, social and civic responsibility within the school community, as we prepare students for participation in a global society."



Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street. Providence, RI 02906

October 9, 2025

Re: Testimony in Support of Establishing a Public Medical School at the University of RI

Dear Chairperson Lauria and members of the Commission,

I am Dr. David Upegui from North Providence and I am writing in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island. Below please find a description of my reasoning for supporting this endeavor.

The Primary Care Workforce Crisis: An Urgent Problem

The health of our residents and the economic vitality of the entire state are currently undermined by an insufficient and unsustainable primary care workforce.

- The primary care crisis has reached a point of no return: a minimum of **300 additional primary care providers are needed statewide.**
- Almost half of the current physicians in RI are close to retirement age, guaranteeing the crisis will worsen.
- Recent figures suggest that between **200,000 and 400,000 adults** in the state do not have access to primary care services.
- The consequences are clear: long wait times (lasting several months) force Rhode Islanders to seek care in Massachusetts or in emergency departments.

Evidence of Local Talent: The Central Falls Pipeline

As a graduate and now teacher at Central Falls High School, I can attest to the immense potential of our local students to succeed in challenging healthcare careers. Investing in a local medical school capitalizes on the talent we are already developing.

- **Dr. David Hernandez:** I taught Dr. Hernandez when he was 16. He went on to medical school and last year completed his residency at Yale University, where he won the prestigious teaching residency award.
- **Gregorio Benitez:** He is currently completing an MD/PhD program at the University of Michigan.

Dr. David Upegui, Science Teacher
24 Summer Street, Central Falls, RI 02863
Ph: 401-727-7710 Email: upeguid@cfschools.net

These former students are powerful evidence that our students *can* succeed in medicine when given the opportunity.

The Compelling Reason for a URI Medical School: If local students are able to attend medical school in their home state, they can receive the critical support of their families, communities, and schools.

- **Retention:** Students educated locally are statistically far more likely to stay local after graduation, which is the most direct path to **alleviating the current shortage of medical professionals in our state.**
- **Role Models:** These local graduates will serve as powerful role models to the current generation of younger students.

URI as the Necessary Solution

While Rhode Island has pursued related policies like grants for workforce development, these alone cannot close the primary care gap. The University of Rhode Island is uniquely positioned to address this pressing need:

- As the state's public flagship research university, URI already has established programs in pharmacy, nursing, healthcare, and biomedical research.
- URI possesses existing infrastructure, world-class faculty, and strong clinical partnerships.

State investment in a public medical school at URI would result in job creation, accelerate the state's biomedical sector, and immediately improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island. If you have any questions about this letter and its content, please do not hesitate to contact me: upeguid@cfschools.net | upeguid@brown.edu, or by telephone at 401-727-7710.

Sincerely,



David Upegui, PhD
Science Teacher / Adjunct Lecturer in Education (Brown U.)
PAEMST 2019 (2017 cohort)



WOOD RIVER HEALTH
Caring for Our Community Since 1976

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairpersons Lauria and Parlange:

I am writing in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island. As the CEO of a federally qualified health center in a rural area, we acutely experience the shortage of primary care providers.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I frequently hear about the challenges residents face in finding primary care physicians throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

The reduction in the workforce has caused a large number of patients from other practices to seek care with us. The wait times to onboard a new patient are increasing and can be up to 6 months. Waiting 6-12 months for a primary care appointment or routine care causes harm to patients – preventable conditions are not detected and chronic disease burden increases. Additionally, patients with acute needs will have no choice but to seek care in an Emergency Department, often for conditions that can be treated in an ambulatory care setting. This adds cost to the system and puts strain on understaffed hospitals. To accommodate patient demand, we increased our provider panels and adjust daily schedules to create more appointments. This increased burden accelerates the burnout already experienced by our staff.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

As part of the decision to create a Medical School at URI, it is important to also consider the necessary clinical rotations for students, as well as the required residency training post-graduation. Family and Internal

Medicine providers, including FQHCs, will need support and investment to precept students for their respective rotations. Additionally, without family medicine and internal medicine residencies in Rhode Island, graduates will need to leave the state to obtain their training. I urge the committee to keep that in mind when reviewing and discussing the feasibility study.

Thank you for considering investing in a public medical school at the University of Rhode Island.

Sincerely,



Alison L. Croke
President & CEO



The Substance Use and
Mental Health Leadership Council of RI

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear; Chairperson and members of the Commission,

My Name is John J. Tassoni, Jr. , President / CEO of The Substance Use and Mental Health Leadership Council of RI and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I frequently hear about the challenges residents face in finding primary care physicians throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for considering investing in a public medical school at the University of Rhode Island.

Sincerely,


John J. Tassoni, Jr.
President / CEO

15 Messenger Drive, Warwick, RI 02888 | Phone: 401.521.5759
www.sumhlc.org

September 26, 2025

**Primary Care Provider Workforce
and Education Commission
Rhode Island State Senate
82 Smith Street
Providence, RI 02906**

Re: Letter in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

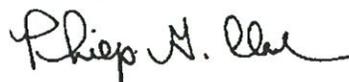
As a professor of gerontology and health sciences at URI, I am writing to express my strong support for investment in a public medical school at the University of Rhode Island. I am the Director of the Rhode Island Geriatric Education Center (RIGEC) at URI, funded by the Health Resources and Services Administration (HRSA), the federal agency responsible for healthcare workforce development. RIGEC is a consortium of academic, clinical, and community-based partners providing interprofessional geriatrics education and training to prepare healthcare and human service professionals, faculty, students, and caregivers to better meet the physical, functional, and psychosocial needs of older adults.

In September 2024, I made a presentation to a meeting of the RI House Special Legislative Commission to Study and Provide Recommendations for Services and Programs for Older Adult Rhode Islanders. During the meeting, the chair of the Commission commented on how the development of a medical school at URI would positively impact health care for older adults; it reinforced the important connection between geriatrics and primary care being made by our state government. Now in 2025, Rhode Island has become a "super aging" state, with 20% of its population 65+. Moreover, it currently ranks 4th in the US with the percentage of its population aged 85+; these older adults are often those most in need of health care to meet their multiple chronic and complex health problems.

A medical school at URI would provide an innovative and exciting opportunity to link primary care and geriatrics within an interprofessional teamwork model. RIGEC has extensive relationships with primary care provider networks across the state and is collaborating with our partners to provide Age-Friendly training to these providers. Age-Friendly care is based on a model developed by the Institute for Healthcare Improvement (IHI) and the Hartford Foundation that emphasizes the core areas required for high quality geriatric care.

In short and in summary, the development of a medical school at URI would build on the University's already established health professions programs to promote much needed interprofessional education in geriatric care. The result will be better health-related outcomes and lives for our state's rapidly growing population of older adults.

Sincerely,



Phillip G. Clark, ScD
Professor and Director

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Emily Drennan from Pawtucket and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within the surrounding area and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead. It is becoming commonplace to postpone or skip annual checkups as the amount of work it takes to just schedule an appointment can be overwhelming. It feels like Rhode Islanders are being forced to accept that primary care is not something that can be guaranteed for all and we cannot allow this to continue.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Judy Whitehead from Bellingham, MA and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island. Although I live in Massachusetts, I have been working in healthcare in the state of Rhode Island for over 35 years.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead. It was astonishing to learn that more than 25,000 patients had to find new PCP's when Anchor Medical Associates closed earlier this summer. My sister was one of those affected. She has had extensive medical issues the past few years and it was crucial that she have a PCP to provide prior authorizations for ongoing medical testing and care. This only added to her burden and caused unneeded stress and anxiety. This can be preventable for future patients and the establishment of a public medical school is one important solution.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Judy Whitehead, PACE-RI

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Liz Boucher from Cranston and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within Cranston and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

I was a long-time patient of Anchor Medical, and their abrupt closure left me scrambling to find a new primary care practitioner. I had very little choice and had to select a PCP simply because they were accepting new patients. In fact, my new primary care provider is a PA, not a physician, because I could not find a physician. As a 54-year-old woman, I am concerned that an increased need for my personal medical care as I age is in direct negative correlation with available providers.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Liz Boucher
Cranston, RI

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Melissa Simonian from North Providence and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

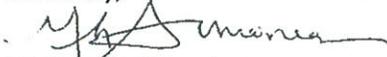
The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead. I experienced this in my own family when an elderly aunt's physician retired it took six months to find a new PCP and only one year later, that person moved out of state.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,



Melissa A. Simonian

PACE Organization of Rhode Island

10 Tripps Ln.

Riverside, RI 02915

**Personal Citizen's Comments to the Rhode Island State Senate Supporting the
Establishment of a Medical School at the University of Rhode Island**

Submitted to: The Honorable Members of the Rhode Island State Senate

Date: 09 October, 2025

Subject: Support for the Development of a Primary Care-Focused Medical School at the University of Rhode Island

Dear Honorable Senators and General Assembly of Rhode Island:

Thank you for this opportunity to address you today on a matter that will profoundly impact the health and future of our great state. I stand before you as a citizen, Ph. D graduate of URI and a clinical scientist who believes that Rhode Island has a unique opportunity to address one of our most pressing healthcare challenges while positioning our state as a national leader in medical education.

Executive Summary

Rhode Island faces a critical healthcare workforce shortage, primarily of primary care physicians, which threatens the health and economic vitality of our state. I respectfully urge the State Senate to support the establishment of a primary care-focused Medical School at the University of Rhode Island (URI) as a strategic solution that will address immediate healthcare needs state-wide, while positioning Rhode Island as a national leader in innovative medical education and community-based healthcare delivery.

The Healthcare Crisis Demands Immediate Action

Rhode Island currently faces a severe primary care physician shortage, requiring approximately 300 additional primary care doctors to adequately serve our population. Currently the national average is only approximately 22% of recent Medical School graduates go into primary or family care. This shortage has created cascading effects throughout our healthcare system: extended wait times for essential medical services, overwhelmed emergency departments managing non-emergency cases due, and inadequate access to preventive care that could prevent costly health crises. The current regulations implemented in the HR-1 bill passed by both arms of congress will exacerbate the healthcare of many of our citizens.

The timing for this initiative is particularly necessary and perhaps advantageous given recent federal policy changes, including HR-1 provisions that create new opportunities for federal funding tied to provider capacity and service to underserved populations. RI must position itself to capitalize on these opportunities.

Strategic Vision: Building on Proven Strengths

URI already possesses a strong healthcare education foundation through its established College of Nursing and College of Pharmacy. The proposed Medical School would complete this healthcare education ecosystem, creating an integrated approach that addresses our state's specific community needs rather than only pursuing generic medical education.

Proposed Medical School would be designed from the ground up to inspire and train primary care & family physicians—the doctors our communities desperately need.

This strategic precision represents a significant departure from traditional Medical Schools where students often drift toward high-paying specialties. By focusing specifically on primary care training, family practices and community-based services, URI can influence career pathways from the beginning, as research demonstrates that students in primary care-focused environments are three times more likely to choose primary care careers and remain in their training communities.

The URI Collaborative Model: Innovation in Action

The proposed Medical School would implement an interprofessional education model where medical, nursing, and pharmacy students train together from day one. This approach, supported by physician-educators who could maintain active clinical practices while teaching, would create seamless integration between education and community care. Picture interprofessional teams working together in community clinical settings, breaking down the silos that too often fragment patient care. Could this synergy of programs replace programs like the SMART Clinics throughout the state? SMART Clinic is the program that is being withdrawn from the Providence Community Health Centers due to lack of Primary Care Physicians and inadequate Medicaid reimbursements.

The Medical School faculty could be structured as practicing physician-educators, maintaining active clinical practices while teaching the next generation of doctors. This dual role ensures our students learn from faculty who are actively engaged in patient care, bringing real-world experience directly into the classroom and clinical rotations in the community. In addition, as was done in Oregon expand the Medical School community base to include the Medicaid School Base Services (SBS) statewide. In addition, the Teaching Health Center Graduate Medical Education (THCGME) Program provides residency programs grants to reduce costs. These grants support the work of building a program, developing training curriculum, recruiting clinical faculty, retooling workflow to integrate residents, and getting accredited.

Residency programs could be set up with all of the local hospitals such as South County Hospital or Westerly Hospital as well as various local clinics that are Federally Qualified (ex. Providence Community Health Centers (PCHC), Thundermist Health Center, Wood River Health Services) . An example of a local clinical with residency program is the Wright Center in NE Pennsylvania as a Federally Qualified Health Center (FQHC). PCHC has a Nurse Practitioner and Primary Care Optometry Residency programs

Clinical rotations and residencies would occur in community settings, potentially replacing withdrawn SMART clinical services (Providence) and ensuring that students develop strong connections to RI communities. This community integration strategy serves both educational and service delivery objectives.

Innovative Programs and State Partnership Opportunities

The Medical School would position RI to participate in and lead several innovative healthcare initiatives:

Medicaid Program Enhancement:

- Medicaid School-Based Services (SBS) expansion
- Teaching Health Center Graduate Medical Education (THCGME) Program participation
- 1915(c) Medicaid Home- and Community-Based Services
- Community level support for Medicaid participants to ensure proper eligibility and re-enlistment

State Agency Collaboration: Following successful models at the University of Massachusetts Medical School and Ohio State University, the proposed URI Medical School would serve as more than a teaching center. It would help RI expand primary care services, strengthen Medicaid applications to ensure eligibility for federal matching funds, support innovative payment models, attract Graduate Medical Education financing, and develop comprehensive managed care plans to maximize pharmacy benefit access. For example, Mass. Medical School developed a program (<https://forhealthconsulting.umassmed.edu/products/>) that helps state government agencies, nonprofits, and managed care organizations to meet today's health care challenges — and are prepared for what's to come. Their public university–state agency model offers state agencies a unique approach to improving health care outcomes while controlling costs. Ohio' Medical Schools have a Government Resource Center (GRC) and a Medicaid Technical Assistance and Policy Program (medtapp) that leverages the state's Medical Schools to objectives to improve health care to the state citizens.

Most importantly, the program established in RI under the URI Medical School would demonstrate cost savings through improved primary care outcomes, reducing reliance on expensive emergency services while improving health outcomes for RI residents.

Substantial Economic Impact and Long-Term Strategic Advantage

The economic benefits of this initiative represent a transformational investment in RI's future prosperity. While the Medical School would generate an estimated \$50 million in direct annual economic impact and create hundreds of high-paying jobs immediately, the long-term economic advantages are even more compelling.

Sustainable Economic Growth Through Healthcare Infrastructure: Each primary care physician trained represents approximately \$2.4 million in career economic impact to the state, but this figure understates the broader economic multiplier effects. A robust primary care workforce attracts businesses, supports population growth, and reduces the long-term healthcare cost burden on state resources. Companies increasingly consider healthcare infrastructure when making location decisions, and a strong primary care foundation makes RI more competitive for business attraction and retention.

Generational Wealth Creation: Unlike traditional economic development initiatives that may have limited lifespans, healthcare education creates self-sustaining economic growth. Physicians trained in RI who remain in the state become economic anchors, establishing practices, employing staff, purchasing homes, and contributing to local economies for 30–40-year careers. The compound economic impact of training just 25 physicians annually would generate over \$2 billion in career economic activity over a generation.

Additional incentives such as loan forgiveness to graduates who remain in the area can be effective. When we combine this with Rhode Island's quality of life and sense of community, we create powerful incentives for graduates to build their practices right here in our state.

Healthcare Cost Avoidance and System Efficiency: The long-term economic advantage extends beyond direct job creation to substantial cost avoidance. Improved primary care access reduces expensive emergency department utilization, prevents costly complications from unmanaged chronic conditions, and enables early intervention that saves both lives and healthcare dollars. These savings compound annually, creating a virtuous cycle of improved health outcomes and reduced healthcare spending.

The state level Medicaid strategic benefits amplify these economic advantages:

- Graduate Medical Education support eligibility providing potential federal funding
- Protection and potential expansion of Federal Medical Assistance Percentage (currently 57.5%)
- Enhanced primary care capacity for Medicaid beneficiaries reducing state healthcare costs
 - Increased preventions and early intervention in chronic conditions
 - Reduced emergency clinical use
 - Primary care coordination of overall care increases efficiency by reducing duplicate testing, reducing unnecessary referrals, and readmissions etc.
- Demonstrated cost savings through improved primary care outcomes versus emergency services utilization
- Positioning RI to capture emerging federal funding opportunities in community-based healthcare delivery

Community-Based Healthcare Delivery Model

The Medical School would create multiple service touchpoints throughout RI communities through faculty practices, respite care programs linked to the College of Nursing, and clinical services at local clinics serving Medicaid and uninsured citizens. This model addresses workforce shortages through both immediate patient care via faculty practices and long-term training of new providers.

The program would provide crucial support to Medicaid beneficiaries through health assessments and eligibility documentation assistance while ensuring adherence to federal mandates and serving vulnerable populations throughout the state.

Addressing Implementation Concerns

Financial feasibility concerns are mitigated by the substantial infrastructure already existing at URI and the expertise available in current healthcare programs. The Medical School's physical facility requirements may be phased over several years, allowing for measured, sustainable development. The demand for this program is both documented and urgent, as evidenced by our current healthcare workforce shortage and the documented need for 200 additional primary care physicians in RI.

National Leadership and Innovation

This initiative would position RI as a national leader, demonstrating how smaller states can achieve outsized impact through strategic collaboration. The seamless pipeline from education to community care represents an innovation showcase that aligns with new federal healthcare regulations favoring community-based academic programs. Our physician-faculty practicing in the community, nursing students training alongside primary care residents serving homebound patients, and pharmacy students understanding real-world medication management—this creates a seamless pipeline from medical education to community care. RI has the opportunity to show that a smaller state can punch above its weight by being smarter, more focused, and more collaborative than larger competitors.

RI has the opportunity to become a model for other states facing similar challenges, proving that strategic investment in healthcare education can yield both immediate and long-term benefits for communities.

Community Health Impact

The program would serve critical target populations including seniors needing personalized primary care, children requiring strong preventive care foundations, working families needing accessible and affordable healthcare, and elderly and disadvantaged populations through enhanced federal-funded services.

Call to Action

The central question before the RI State Senate and General Assembly is not whether our state needs more primary care physicians – that need is clearly documented and urgent. The question is whether RI will seize this transformative opportunity to address our healthcare crisis while positioning our state as a national leader in innovative healthcare education and delivery.

The foundation exists at URI, the need is documented, and the economic benefits are substantial. Federal funding opportunities through various Medicaid programs and waivers could provide support for this initiative. The comprehensive approach addresses immediate healthcare needs while building long-term capacity for RI communities.

Vision for Rhode Island's Future

RI can be place where innovation meets compassion through collaborative healthcare solutions. The URI Medical School represents more than an educational institution – it represents RI's commitment to ensuring that all citizens have access to high-quality, community-based primary care.

The research and development potential through university-state agency partnerships, combined with the comprehensive approach to addressing both immediate needs and long-term capacity building, makes this initiative a sound investment in Rhode Island's future.

Conclusion

I respectfully urge the Rhode Island State Senate to support the development of a primary care-focused Medical School at the University of Rhode Island. This initiative represents a strategic,

evidence-based solution to our healthcare workforce crisis that will generate substantial economic benefits while improving health outcomes for all Rhode Island residents.

The time for action is now. Rhode Island has the opportunity to lead the nation in innovative healthcare education and delivery. I ask for your support in making this vision a reality for the benefit of all Rhode Island communities.

Prepared by John McLane, Ph.D.
4 Montrose Ct
Westerly RI 02891

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Morgan Dimaio

From: JANET AUSTIN <nitsuanaj@verizon.net>
Sent: Saturday, September 20, 2025 8:15 PM
To: Morgan Dimaio
Subject: URI Medical School
Attachments: text.txt

URI Medical School

I was pleased to see that URI is considering opening a medical school. Finally.

I believe RI is the only state that has neither a state medical school nor an agreement with another state, so that state residents students can benefit from residency preference. My husband is retired from Brown, as a 40 year medical professor, and he often advised RI students to move to Texas, become a resident for 1 year, then apply to one of their medical schools. How many future RI doctors have we lost?

As an example, our own daughter, born and raised in RI, graduated from URI in 2010, with excellent grades, Phi Beta Kappa. She applied to 22 medical schools including some less popular ones in far flung states. She was not interviewed at Brown even though her dad was a tenured full professor in the medical school. She could not apply to UMass, as they were not accepting out of state applications that year. She was rejected at Oklahoma even though her grades and MCAT scores were far above their average accepted student....but she was not a resident.

At the last minute she was accepted from the waiting list, in the charter class at a brand new medical school in Michigan. (Oakland University William Beaumont). She met a Michigander and stayed on, as a primary care doctor. I just visited to meet their second baby, and clearly they have no intention of moving to RI.

I'm certain that, had she been accepted at a RI medical school, she would now be a primary care provider in RI. As would hundreds of other RI students who had to leave the state for medical school.

I'm sure this is not news to you, but I wanted to share an example, in case it helps. I also recommend looking into Oakland University William Beaumont as an example of a new medical school that focuses on primary care.

Thanks,

Janet Austin, Warwick, RI
FOR

Morgan Dimaio

From: john newenglandsyrup.com <john@newenglandsyrup.com>
Sent: Wednesday, October 8, 2025 12:01 PM
To: Morgan Dimaio
Subject: Testimony on URI Medical School

All too often, when the government considers health care, they only consider the financial aspects of health care. There is a lot more to it than just the financial part. There is a serious shortage of health care providers , not just in RI, but all across the country. All the money in the world won't provide for health care if there are no doctors and nurses to provide the care. I support the proposed new medical school at the university of Rhode Island.

John Marchant
President,
Scituate Health Alliance
john@newenglandsyrup.com
401-243-3790

Morgan Dimaio

From: Rebecca Clark <nwptrn@yahoo.com>
Sent: Wednesday, October 8, 2025 3:12 PM
To: Morgan Dimaio
Subject: Re: public hearing on establishing a College of Medicine at URI

To Whom It May Concern,

As a RI resident, and a member of the medical community of Newport, RI (I am a Registered Nurse of 35 years), I would like to lend my support to the establishment of a College of Medicine at URI. In this environment, it's a travesty that the community has such a difficult time accessing health care. This can ONLY be a very good asset to RI.

Thank you.

Rebecca Clark-Homer, RN, BSN
165 Ellery Ave.
Middletown, RI 02842
401-855-1580

TESTIMONY IN SUPPORT OF A PUBLIC MEDICAL SCHOOL AT URI

My name is Dr. Susan Killenberg. I completed my training in psychiatry at Brown University in 1996, and I continue to work in RI, currently as the Chief Psychiatrist at the RI Office of Disability Determination in Providence.

I want to express my strong support for funding and opening a public Medical School at URI to address the shortage of Primary Care Providers (PCPs) in our state. Due to the shortage of mental health providers nationwide, Primary Care Providers often act on the front line in the treatment of mental health conditions for their patients. With the shortage of PCPs in RI, not only are physical health conditions left untreated, but mental health conditions are left untreated as well.

In my job at the Disability Determination Office, I commonly see people applying for disability who have treatable mental health conditions; however, they are unable to obtain the mental health care they need to thrive. When their conditions are not treated, they often feel overwhelmed and unable to work. As a result, they apply for social security disability benefits. This is an unfortunate cycle, but it is the natural consequence of illness that goes untreated.

I urge you to support the opening of a public medical school in RI to expand our PCP workforce. Not only will this improve the physical health of our residents, but it will also improve the mental health of Rhode Islanders. In this way, a healthier population will drive a healthier workforce and economy. Investing in a medical school equals an investment in the health of our population and the health of our job force and economy.

Thank you.

Susan Killenberg, MD

Little Compton, RI

October 9, 2025

**Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906**

October 9, 2025

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Carol Levitt, MD, from Scituate and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Having a public medical school at the University of Rhode Island would provide the opportunity for our Rhode Island kids to become physicians who have roots in our communities and are likely to stay here and care for their families and friends and strengthen the economic and social fabric of our state. The state of Florida has documented the positive impact of state medical schools on the development and retention of physicians. 41% of doctors who did their residencies in Florida remained in Florida to practice. 75% of doctors who went to medical school in Florida and stayed to do their residencies in Florida stayed in Florida. In Florida, 80-90% of students in the state medical schools are Florida residents. Using those data, with a projected inaugural class size of 50 students matriculating in the fall of 2029 at the public medical school at The University of Rhode Island, we could welcome about 30 new physicians a year to live in Rhode Island and care for the people of Rhode Island. The plan is to increase to 100 students a year by the fall of 2033. That means over 60 new physicians per year.

Thank you for your time and the opportunity to testify in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,
Carol Levitt, MD

**Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906**

October 9, 2025

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson, Lauria and members of the Commission,

I am Amanda Tiburcio, from East Providence, RI and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services. In East Providence, RI there are 488 primary care physicians for a population of 47,961. This is insufficient and unsustainable for the health of our residents and economic vitality of the entire state.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Amanda Tiburcio
45 Main St. apt. 36, Wareham, MA, 02571
PACE Organization of RI

Morgan Dimaio

From: Susan Wilhelmina <edsis1@gmail.com>
Sent: Wednesday, October 8, 2025 4:35 PM
To: Morgan Dimaio
Subject: URI Medical School proposal and Feasibility study

To whom it may concern:

The 2025 Tripp Umbach URI medical school feasibility study is a comprehensive consideration of the need, financial viability, and evolving healthcare and financial impacts of such a development for Rhode Island.

I would like to emphasize that the failure of current healthcare results from a culture of *market* objectives over patient health outcomes that has proliferated over decades.

Conceptually, insurance is an admirable, commendable idea: pooling resources as a community, in order to provide support in times of individual need. It requires expertise in actuarial vigilance and balance, focused on the greater good for both community and individual stakeholders. The reality more often is instead pure profit-motivation on the part of administrative middle meddlers masquerading as “health insurance,” and primarily concerned with stockholder gain, over and above fair-share. They pass their inefficiencies on to patient consumers and/or apply for write-offs from taxpayer-funded regulatory allowances.

The dominance of health science specialization, minus comprehensive considerations, fails by leaving the total human patient out of the equation. One may begin with a family doctor, but soon likely has a cast of specialists, and revolving rosters of hospitalists— none of whom consult with one another. Once a series of plateau-and-decline hospitalizations cannot cure or improve, a succession of clinics and therapists—in-patient and out— follows.

Patient/consumers have been sold on the idea that an expensive lifelong battery of testing-and-worrying, and a pill for this / a procedure for that, is preventative wellness. The relaxation of regulation that allowed direct to consumer advertisement was a huge boost, not to the health of those consumers, but to Big Pharma and to their legal teams. Sadly governance is preoccupied with following the money— and being on the receiving end, while containing allocation.

A responsible health and wellness education should be integrated into K-12 curriculum, certainly not left to advertisers. Internet and AI influence must be addressed in order to support collaboration between patient and doctor, and to eliminate bad actors.

Thank you for viable solution-based engagement with this issue.

Susan

Sent from my iPhone
edsis1@gmail.com

Written testimony in support of the establishment of a College of Medicine at the University of Rhode Island

When I was newly postpartum, my husband and I discovered that our primary care doctor was moving healthcare groups, from an office walking distance from our house in Newport to Tiverton. We agonized over the decision for a good couple of weeks – would we roll the proverbial dice with a different care provider on the island, or would we follow him to a different health group, trusting that he could provide the same level of care we were currently receiving? We ultimately made the decision to follow him off-island – a decision we know we were in a fortunate position to be able to make – because of the attentive, personalized care my husband and I received from him. That’s not to say the decision hasn’t come without its challenges – a 30-45 minute commute for primary care when you are not feeling well is no small feat, as my husband and I have discovered in the intervening years.

We are not the only ones on the island who face this predicament. Most of the primary care practices on Aquidneck Island have long wait lists, forcing many Newport County residents to either cross their fingers and hope that they get an appointment with a local provider before a health issue rears its ugly head or travel significant distances to find an available primary care provider. For those in our communities without reliable access to private transportation, the situation is much more dire. Those without the ability to see a primary care physician at least once a year face well-documented, long-term health risks, including higher instances of depression and substance abuse in addition to higher overall rates of mortality. Without early preventative care and diagnosis, individuals then must turn to already overloaded urgent care centers and emergency departments for treatment.

Healthcare isn’t accessible if it’s not local, and currently there is not enough local primary care to go around on Aquidneck Island. That is why I strongly support the creation of a College of Medicine at the University of Rhode Island with a focus on primary care. As the state’s public university, URI is in a unique position to house a College of Medicine, fostering the great minds of this state and, importantly, retaining them through partnerships with some of the best hospitals in the area, including Newport Hospital, Newport County’s only hospital. In addition to examining the current Medicaid and private insurance reimbursement rates, I urge the state to not only help establish and support a College of Medicine at URI, but to help fund scholarships for students who agree to stay in Rhode Island to practice primary care.

Not only would the creation of this school mean the continued longevity of healthcare infrastructure in the state and the creation of new jobs – each physician who completes residency supporting approximately 15 jobs and creating an economic impact of \$2.2

million – but it will mean healthier individuals who can continue to work, raise families, and give back to their communities because they don't have to worry about negative health outcomes. The creation of this medical school will not only help keep medical talent in Rhode Island long-term, but may even attract new talent to the state, as recent rankings conducted by the Wall Street Journal place URI as the number 1 public university in New England, the 9th best public flagship university in the country, and the 76th best overall university in the U.S. Additionally, if URI offers a 7-year BS/MD program, there is an even better chance of attracting high-performing students seeking to increase their impact in a shorter amount of time, lessen their student loan burden, and potentially extend undergraduate scholarships to their first year of medical schooling, while providing our state with the primary care doctors we so desperately need. At a time where there is a lot of uncertainty in the world, investing in a College of Medicine is a step towards securing a healthier, better, and more sustainable future for our state, and I do hope that you will consider playing a part in what is sure to become a proud legacy for Rhode Island.

—

Cassie Voll

Newport, Rhode Island

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson, Lauria and members of the Commission,

I am Melissa Zinz from Ledyard, CT and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

- I have an elderly Aunt and Uncle who lost their primary care physician due to Anchor Medial Associates closing due to lack of physicians in the area. My Aunt is in good health, but my uncle has several health problems, and not being able to find a PCP has put a lot of stress on them. This shouldn't be an issue that they need to worry about in their late 70's.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Melissa Zinz
227 Haley Rd
Ledyard, CT 06399

I work at Pace Organization of Rhode Island.

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Samuel Zwetchkenbaum, DDS, MPH, from Providence and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island. While I do work for the RI Department of Health, I write this as a private citizen and dentist in RI.

I recognize the importance of a medical school in RI and truly hope it happens. I wish to add that if a medical school is considered, **now is the opportune time to consider a dental school as well.**

Just as there is a crisis in primary care access, the same crisis exists in dental access. The dentist-to-population ratio in RI is well below the national average. While the number of dentists is equivalent to what we had in the early 1970's, people are keeping their teeth, so there is much more work needed. The dentist workforce is aging. All this means it is hard to get a dental appointment, and few practices participate in Medicaid.

As a combined medical-dental school, there are efficiencies, because the first two years are very similar. True, you'd need to add a lab for dentists to learn some basic techniques of carving teeth in wax, setting denture teeth, etc., but in many ways, the training is similar in the beginning.

For third and fourth years, you'd need to create a dental clinic and also develop rotations for students at health centers. But this clinic is sorely needed because it can be a patient care resource for people across the state of Rhode Island for both basic and specialty care.

I encourage you to look at newly developed combined medical-dental schools, for example Kansas City University (KCU)'s new school in Joplin, MO, which has both a dental school and medical school. It strives to be holistic and teach students the importance of interprofessional education. Dr. Marc Hahn, President and CEO of KCU, is a born and bred Rhode Islander and would be happy to provide guidance.

Thank you for considering investing in a public medical school **AND dental school** at the University of Rhode Island.

Sincerely,



Samuel Zwetchkenbaum, DDS, MPH

**Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906**

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Rosemarie Bolger of Cranston and I write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

I have a friend who could not secure an appointment with a primary care doctor for 2 years. She has several medical conditions, and this left her without treatment and medications needed to help her. It left her in chronic pain and limited her ability to do many things she was used to doing such as caring for her grandson, the ability to sew and crochet and many things around the house.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy,

nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Rosemarie Bolger
62 Magnolia St
Cranston, RI 02910

Also, an employee at PACE-RI

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Corissa Bernier from North Scituate, RI and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead; The wait lists - that are thousands of people long - created in order to be seen by a physician or advanced practice provider hopefully within the next 12 months; The burn-out by our healthcare providers being pushed to extreme panel sizes that only allows for 15 minute visits at best to get to know the whole person's history; the physicians that are relocating out of state because of better pay. It's a mess and we need to do something about it – NOW.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. It is only a short-term strategy and puts a band-aid on the long-term problem. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Corissa S. Bernier
59 Highland Terrace
North Scituate, RI 02857
Chief Financial Officer – PACE Rhode Island
URI Graduate '00 and '06
Former Board member of the Scituate Health Alliance

Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Tom Boucher from Cranston and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our city and throughout the state. I also have a personal story related to this challenge.

Six months ago, I received a letter informing me that my terrific primary care doctor was leaving after 20 years to go practice in Massachusetts. I asked him about it and he said it was because he would be paid more and have less administrative burden. One week before he was set to leave, I found a very concerning lump. I called his office and they arranged for me to come in the next day. After his evaluation, he said his team would book me an ultrasound so the lump could be assessed. Three weeks later (the earliest appointment I could get), I had the scan and was told someone would be in touch with the results. While I saw the outcome in the online portal my primary care group uses, no one has called or emailed me in the three weeks since the scan to explain what the results mean. I was told I have an appointment with my new PCP who is 65 years old (and likely close to retirement) in four months. I expect I will need to reach out soon so I can avoid falling through the cracks.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,

Tom Boucher
53 Welfare Ave
Cranston, RI 02910



Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

Dear Chairperson Lauria and members of the Commission,

I am Maryellen Girard from Richmond and write in support of the state of Rhode Island investing in a public medical school at the University of Rhode Island.

The primary care crisis has reached a point of no return - 300 additional primary care providers are needed statewide, while almost half of the current physicians are close to retirement age. Recent figures suggest that between 200,000 and 400,000 adults in the state do not have access to primary care services.

I constantly hear about the challenges residents face in finding primary care physicians within our town/city and throughout the state. Long wait times - lasting several months - for primary care appointments result in Rhode Islanders seeking care in Massachusetts or in emergency departments instead.

- As my role as Chief of Growth for PACE-RI, I often hear from older adults in the community that practices are not accepting new patients and those who do have wait times of over one year.

While the state of Rhode Island has pursued several primary care related policies and initiatives, such as grants to support workforce development, this alone will not address the primary care gap. The University of Rhode Island is well-positioned to address the pressing need and contribute to solving the primary care crisis in the state. As the state's public flagship research university, URI has established programs in pharmacy, nursing, healthcare and biomedical research; existing infrastructure; world-class faculty; and strong clinical partnerships. State investment in a public medical school at URI would result in job creation, acceleration of the state's biomedical sector, and improve the quality of life for current and future Rhode Islanders.

Thank you for your time and the opportunity to speak in favor of investing in a public medical school at the University of Rhode Island.

Sincerely,



Maryellen Girard

PACE-RI

10 Tripps Lane

Riverside, RI 02915



**Rhode Island Senate RI Primary Care Provider Workforce and Education Commission
82 Smith Street
Providence, RI 02906**

Re: Testimony in Support of Establishing a Public Medical School at the University of Rhode Island

October 9, 2025,

Dear Chairpersons Lauria and Parlange:

As President and CEO of Providence Community Health Centers since 2001, I have seen firsthand the increasing challenges that health care organizations have in recruiting and retaining primary care providers. The impact on access to health care has been significant; we currently have a waiting list of approximately 4,000 people waiting to be seen by a primary care provider.

Those of us dedicated to making our communities healthier places to live are strongly in favor of the state investing in a public medical school at the University of Rhode Island.

Without further intervention, the future of primary care in our state is bleak. Rhode Island currently has a shortage of 300 primary care providers with almost half of those currently practicing close to retirement age. Estimates are that anywhere between 25% and 50% of Rhode Islanders don't have access to primary care services. This creates a strain on the entire system. By default, many of these patients end up in hospital emergency rooms that must triage and treat people who are sicker than they would be if they had regular access to primary care. This is both inhumane and inefficient.

As Rhode Island's largest community health center, Providence Community Health Centers cares for more than 85,000 patients. On a daily basis, we see what lack of access can do to a patient's physical and mental well-being.

A public medical school could be a major part of the solution. Statistics from the Association of American Medical Colleges show that more than 50% of new doctors stay in the state where they completed residency training to practice medicine. In our state, that percentage is even higher. At a time when we are nearing a critical shortage of providers, this would provide an incredible boost.

There are, of course, other necessary steps -- including improved reimbursement rates and more robust loan forgiveness program -- to ensure Rhode Island is competitive when it comes to attracting and retaining primary care providers. The establishment of a public medical school at the University of Rhode Island would stand as a foundational action to help us address this challenge.

Just this month, URI was rated the best public university in New England for the second year in a row by The Wall Street Journal. The commitment to quality is there on an overall level and URI is already recognized for excellence in a number of programs like biomedical research, pharmacy, and nursing.

On behalf of our 500 employees and the 85,000 people in our care, I strongly endorse a public medical school at the University of Rhode Island. Thank you.

Sincerely,



Merrill Thomas
President & CEO
Providence Community Health Centers

N.S. Damle MD MS MACP

180 Cedar Hill Drive

Jamestown RI 02835

401 932-2277

nsdamle07@gmail.com

Testimony

Rhode Island Senate Commission

Medical School at University of Rhode Island

October 9, 2025

Members of the Commission:

Thank you for the opportunity to address the primary care crisis and physician training in Rhode Island. I am speaking as an individual physician.

I am not taking a position for or against the formation of a medical school at the University of Rhode Island (URI) but am here to present considerations for the commission as you study this initiative as a potential partial solution to access for primary care in the state.

I am a board certified internal medicine/primary care physician in private practice in Wakefield Rhode Island for the past 37 years. I am on clinical faculty at the Alpert Medical School of Brown University and chair of its Clinical Faculty Advisory Committee, past president of the Rhode Island Medical Society and past president of the American College of Physicians (the largest specialty organization in the U.S.).

My partner and I formed our practice in Wakefield in 1988 and have grown over the years to the present nine providers. We have four physicians and five nurse practitioners who care for 15000 patients in primarily Washington County.

As we speak we have three retiring physicians and have no prospects to fill those positions. In fact we have not added a physician in internal medicine or family medicine in over ten years. Difficulties in recruitment is not new and is true for most practice groups and hospital systems. Medical students and post graduate trainees are not choosing primary care specialties at a pace to keep up with local or national demand.

As an internal medicine and primary care physician I welcome the commission's efforts to solve the primary care crisis in Rhode Island. I would like to briefly outline some data, observations and solutions.

As you are aware training to become a physician takes years of hard work and dedication. It starts in college and even in high school as young adults sort out their interests and motivation. Admission to medical school is competitive and the curriculum is challenging. Following four years of medical school, are several years of post -graduate training in a specialty and for some advanced training in subspecialties. The debt on graduation from medical school is on average 200000 dollars per student.

My understanding is that this commission's task is to look for solutions to the primary care crisis, in particular the prospect of opening of a second medical school in the state at the University of Rhode Island. I would like to offer some observations and recommendations to the commission:

1. There is little evidence nationally that more medical schools lead to more primary care physicians. Only about 30% of a class will do internal medicine, pediatrics or family medicine. In internal medicine the vast majority will go on to subspecialize and not practice primary care.
2. New York University has a tuition free medical school with no impact on students entering the primary care specialties.
3. Kaiser and Quinnipiac medical schools with an emphasis on primary care have not shown any increase in the number of students entering primary care.
4. A small minority of graduates of the Alpert Medical School at Brown University stay in the state and an even fewer number train in primary specialties.
5. Logically, one would think that a state medical school with a majority of in state students would lead to more in state trainees and practicing physicians in primary care. Unfortunately this may not be the case.
6. Loan repayment programs are helpful but must be robust, as they are in our neighboring states of Massachusetts and Connecticut. In these states there are programs that forgive 150000 to 200000 dollars in medical school loans with commitments to stay in the state. We would need funding and a commitment from students to stay in Rhode Island after graduating University of Rhode Island.
7. There are multiple post graduate training opportunities in the neighboring states and around the country. Students are free agents. Importantly, it is not the medical school location as much as the post graduate training (specialty and subspecialty) that determines where physicians will practice.
8. The time line as you are aware from inception to graduation from a medical school can be 5-6 years, several hundred million dollars and up to 10 years before there is a return on investment with practicing primary care physicians serving Rhode Island residents.
9. Importantly, we have a fixed number of spaces in the state for training graduates of medical schools in all specialties and subspecialties that is based on federal funding for post graduate programs. At present the major training hospitals (Brown Health) in Rhode Island are committed to the Warren Alpert Medical School of Brown University as their primary academic affiliate.

10. In addition to a medical school the state will need to develop post graduate training programs in primary care and many other specialties. University of Rhode Island medical students will need places to train and if they are not available in state they will go elsewhere. The formation of a medical school has to be in tandem with excellent post graduate training opportunities within the state.
11. In contrast to the formation of a medical school, investment in the development of post graduate training programs in the state for primary care specialties of internal medicine, family medicine and pediatrics would be more cost effective and a shorter time line of three years to produce practicing primary care physicians for the state.

Having said all of this, the solution to the primary care crisis in Rhode island and nationally is not primarily more medical schools but creating incentives for medical students and post graduate trainees to enter primary care. The fundamental problem is reimbursement to the primary care specialties of internal medicine, family medicine and pediatrics. This has been an issue for decades and now has reached an access crisis nationally and in Rhode Island.

Medical students and trainees weigh many factors in their decision to choose a specialty but with significant debt and a career long income gap, understandably few will choose primary care. The income gap between primary care and other specialties is not small but a magnitude of 4-5 times earnings. Further, there is a state differential of 20-30% between our state and Connecticut and Massachusetts.

We need significant reimbursement reform and not in 5-10 percent increments. The state legislature has the means to pressure health plans to change their payment structure and provide relief from administrative burdens that is a leading cause of physician burnout. Without fundamental reform and equity between states there can be no meaningful transformation of primary care in Rhode Island.

I am speaking as an individual primary care internal medicine physician who has practiced for over 35 years and have witnessed the slow march to the present healthcare crisis for our Rhode Island residents.

The time to act is now and cannot wait 6-10 years. I submit that the commission should look carefully at the various elements of medical training as I have outlined and seek payment reform that will create a robust primary care workforce and consequentially provide access to patients, increase the quality and decrease the cost of healthcare. This is the best return on investment for Rhode Islanders.

I thank you for your time and hard work on this critical issue for the health of our residents. I am happy to participate in further discussions on this critical topic.

Nitin S. Damle MD MS MACP

Arches Medical

Clinical Assistant Professor of Medicine

Alpert Medical School of Brown University

Past President Rhode Island Medical Society

Past President American College of Physicians

Morgan Dimaio

From: Beach Gal <beachgal124@aol.com>
Sent: Thursday, October 9, 2025 3:46 PM
To: Morgan Dimaio
Subject: State Medical school

I am writing to support the creation of a Rhode Island State medical school. There is a severe physician shortage in Rhode Island and I think this could help . I would suggest a financial incentive to prospective students similar to other programs that would count years of practice in the state as credits to their tuition to encourage prospective students to establish their practice here.

Thank you ,
Mary Schultz
37 Grandview Avenue
Lincoln, RI
Sent from my iPhone

Morgan Dimaio

From: klmschultz@aol.com
Sent: Thursday, October 9, 2025 3:26 PM
To: Morgan Dimaio
Subject: URI Medical School

I am a retired nurse who worked 20 years at Rhode Island Hospital and I believe that the state desperately needs a public medical school. While Brown is a good school, they don't produce enough primary care doctors who will practice in Rhode Island. For this we need our own state-supported medical school with a tuition forgiveness plan for doctors who practice primary care in our state.

Lynn Schultz RN
37 Grandview Ave.
Lincoln, RI 02865
klmschultz@aol.com

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Thursday, October 30, 2025

TIME: 5:00 PM

PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Paul Umbach and Ha Pham – Tripp Umbach (Via Webex)
- III. Q&A
- IV. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERSITY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, November 18, 2025
TIME: 4:00 PM
PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Discussion & Review of draft Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, January 13, 2025

TIME: Rise of the Senate

PLACE: Room 313 – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Discussion & Review of draft Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

Suggested Conclusions and Recommendations from the Following Commission Members: Christopher Koller, Marie Ganim, Elena Nicolella, Michael Fine

The Charge:

“The purpose of said commission shall be to make a comprehensive study of Rhode Island’s healthcare workforce related to educating and retaining primary care physicians and establishing a state medical school at the University of Rhode Island.”

Given the charge we recommend including the following in the Conclusions and Recommendation sections of the report.

Conclusions

The importance of primary care:

1. High quality primary care is “the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationship.” (NASEM report).
2. Populations with better access to high quality primary care have better prevention, diagnosis and treatment of chronic conditions, fewer acute ER visits and hospital admissions, fewer health-related disparities and longer lifespans. (all sorts of evidence to support).
3. Primary care is best delivered in interdisciplinary teams.
4. Primary care access can be measured as people reporting a usual source of care, number of primary care clinicians, or appointment availability.

The state of primary care in Rhode Island:

5. Access to and use of high-quality primary care is getting worse in RI, as it is across country.
6. We do not, however, have a reliable measure of the extent to which Rhode Islanders in each Rhode Island community have and use high-quality primary care.

The role of medical education and a new medical school in improving access to high quality primary care in Rhode Island

7. Increasing the supply of primary care clinicians in RI is a sure way to improve access and will depend on producing more and retaining more of them. Educating more primary care clinicians in state is an important element of increasing supply.
8. Educating more clinicians is a necessary but not sufficient for increasing supply. Clinicians stay where they train. A RI plan to produce more primary care clinicians must have residency strategies that incent training more primary care clinicians and training them in community settings like community health centers. Medicaid and Medicare pay for these programs, although some larger employers are in effect training their own advanced practice providers.

Establishing a Medical School at the University of Rhode Island

9. Based on lessons from other public medical schools, Rhode Island has the clinical and administrative capacity to establish a medical school at the University of Rhode Island. The following are key requirements and elements to do so
 - i. (summary of Tripp Umbach study key points)

Recommendations

RI needs a strategic, deliberate and accountable approach, using public policy levers (statutory, budgeting, regulatory and purchasing) to create a primary care-oriented delivery system in RI - one with an explicit preference and priority for primary care and where all Rlrs report having access to a usual source of care.

1. RI should **proceed with a URI medical school** focused on primary care, ensuring early confirmation of the capacity for providing the required inpatient and ambulatory clinical experiences for the proposed medical school class size *(Include funding recommendations in current report.)*
2. Legislative appropriations to support the medical school must be attached to accountability for URI medical school to produce skilled, committed primary care clinicians, adhering to evidence of what works elsewhere:.

- a. For example, the URI Medical School should have a Community Advisory Board to ensure the focus on community-based primary care is maintained.
 - b. Based on evidence from other medical schools with a high percentage of primary care graduates, the legislature should direct URI to issue annual public reports regarding its performance on the following characteristics:
 - Admissions policies selecting for PC-oriented students
 - Community-based training (LICs, continuity clinics)
 - Strong, well-supported primary care departments and faculty
 - Required robust primary care clerkships
 - Lower tuition and targeted financial incentives
 - Rural/underserved training programs and tracks
 - Explicit primary-care mission
3. To improve primary care access, policy makers must also pay attention to advanced practitioner programs. Rhode Island should use this opportunity at URI to lead the nation in developing **interprofessional training opportunities** for primary care teams, including NPs, pharmacists, Physician Assistants and BH clinicians, in collaboration with existing professional schools and clinical practices in the state.
4. Educating more clinicians is necessary but not sufficient for increasing supply. Clinicians stay where they train. RI must have a concrete plan to produce more primary care clinicians through a **residency (i.e., postgraduate training) strategy** that incentivizes training more primary care clinicians and training them in community settings like Community Health Centers. Medicaid and Medicare funding is available to help pay for these programs. State investment, such as the funds provided to support the Thundermist Family Medicine Residency Program, must continue and expand.
5. RI should expand and enhance the current **State Health Professional Loan Repayment Program** and develop a **Health Professional Primary Care Scholarship** program that includes an obligation to practice primary care for at least five years. We should also take this opportunity to review the effectiveness of all programs aimed at reducing the healthcare education debt, including the Wavemaker Fellowship Program. Specific targeted retention incentives, such as professional development stipends, should be evaluated to ensure data supports their implementation.

6. EOHHS should be given direction and resources to **measure and oversee** our primary care workforce production, supply and retention. This should include regular data collection, measurement, reporting and recommendations to increase production, retention and accessibility of skilled primary care clinicians.

7. In addition to a medical school and robust residency programs, RI must continue to focus on other proven strategies to improve retaining primary care clinicians: appropriate payment for primary care, lowering administrative burdens for clinicians and commitments to improving public health and lowering uninsured rates. We should establish a **Primary Care Commission** that ensures we maintain focus on achieving a primary-care oriented system of care. The first task of this Commission should be to review evidence and develop a residency strategy to produce and retain skilled and committed primary care clinicians, and public policy to support the strategy.

**SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY
OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING
AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE
MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND**

NOTICE OF MEETING

DATE: Tuesday, January 27, 2026

TIME: 5:15 PM

PLACE: Senate Lounge – Rhode Island State House

AGENDA

- I. Welcome & Introductions
- II. Consideration of Commission Report
- III. Adjournment

There will be no public testimony at this meeting.

Please contact Morgan DiMaio in the Senate Policy Office (mdimaio@rilegislature.gov) for any questions regarding this meeting.

SENATOR
V. SUSAN SOSNOWSKI
District 37

680 Glen Rock Road
West Kingston, Rhode Island 02892

Room 112
Rhode Island State House
Providence, Rhode Island 02903

RESIDENCE: 401-783-7704
OFFICE: 401-276-5581
FAX: 401-222-2967

sen-sosnowski@rilegislature.gov

State of Rhode Island



Senate Chamber

CHAIRPERSON
Committee on
Environment & Agriculture

VICE-CHAIR
Committee on Commerce

Committee on Finance

Dear Senator Lauria and President Parlange:

As our distinguished panel concludes its work, I write in enthusiastic support of its final report and recommendations, which include proceeding with plans to create a medical school at the University of Rhode Island.

I am privileged to represent the URI community in the Rhode Island Senate, and I was deeply honored to sponsor the 2024 Senate resolution that created the special legislative commission. It has also been a great honor to serve alongside you both, and so many other dedicated civic leaders and medical professionals, as a member of the commission.

While I am unable to be in attendance for today's meeting due to a family medical situation, I want to express my gratitude for the outstanding work done by every member of the commission over the last year-plus, as well as my profound enthusiasm for the proposed medical school.

URI has been rightfully recognized as the top public university in New England for multiple years. The addition of an MD-granting medical school will only enhance its strength and standing, in our region and beyond. As the report and its findings outline, URI is extremely well-suited to add a medical school, and the benefits – for our communities, our health care system, and our economy – would extend across our state for years to come.

The Senate continues to be a leading voice in addressing the serious health care challenges facing Rhode Island, especially our primary care workforce shortage. I want to express my gratitude to President Lawson and our leadership team for making this issue a top priority. Senator Lauria and President Parlange, I also want to specifically thank you for your exemplary leadership of this important panel's work.

Sincerely,

A handwritten signature in black ink that reads "V. Susan Sosnowski". The signature is written in a cursive style with a large initial "V".

Senator V. Susan Sosnowski

SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND

COMMISSION QUORUM ROLL CALL

Meeting Date: January 27, 2026

Commission called to order at: 5:20pm .

Meeting Time: 5:15pm

Commission adjourned/recessed at: 5:32pm .

COMMISSION MEMBER	Party	PRESENT	ABSENT
SENATOR PAMELA LAURIA <i>CHAIRPERSON</i>	<i>Democrat</i>	X	
MARC PARLANGE <i>CHAIRPERSON</i>	<i>N/A</i>	X	
SENATOR ALANA DIMARIO	<i>Democrat</i>	X	
SENATOR V. SUSAN SOSNOWSKI	<i>Democrat</i>		X
SENATOR THOMAS PAOLINO	<i>Republican</i>	X	
REPRESENTATIVE SUSAN DONOVAN	<i>Democrat</i>	X	
REPRESENTATIVE BAGINKSI	<i>Democrat</i>		X
MAYOR MARIA RIVERA	<i>N/A</i>		X
STACI FISCHER	<i>N/A</i>	X	
KERRY LAPLANTE	<i>N/A</i>	X	
DANNY WILLIS	<i>N/A</i>	X	
PATRICK VIVIER	<i>N/A</i>	X	
BARBARA WOLFE	<i>N/A</i>	X	
MARGO COOK	<i>N/A</i>		X

Minimum Number of Members Present to Constitute a Quorum

11

ATTENDANCE TOTALS

15

PRESENT

5

ABSENT

SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND

COMMISSION QUORUM ROLL CALL

Meeting Date: January 27, 2026

Commission called to order at: _____.

Meeting Time: 5:15pm

Commission adjourned/recessed at: _____.

COMMISSION MEMBER	Party	PRESENT	ABSENT
ARMAND SABITONI	N/A	_____	X _____
THOMAS RYAN	N/A	_____	X _____
ELENA NICOLELLA	N/A	X _____	_____
STACY PATERNO	N/A	X _____	_____
CHRISTOPHER KOLLER	N/A	X _____	_____
MARIE GANIM	N/A	X _____	_____
MICHAEL FINE	N/A	X _____	_____

Minimum Number of Members Present to Constitute a Quorum

11

ATTENDANCE TOTALS	
15 PRESENT	5 ABSENT

SPECIAL LEGISLATIVE COMMISSION TO MAKE A COMPREHENSIVE STUDY OF RHODE ISLAND'S HEALTHCARE WORKFORCE RELATED TO EDUCATING AND RETAINING PRIMARY CARE PHYSICIANS AND ESTABLISHING A STATE MEDICAL SCHOOL AT THE UNIVERISTY OF RHODE ISLAND

COMMISSION ACTION ROLL CALL

Meeting Date: 1/27/2026

FINAL REPORT

Sponsor: N/A

URI DRAFT REPORT

MOTION / ACTION TAKEN ON REPORT

Motion made by Sen. DiMario, seconded by Senator(s) Sen. Paolino for:

- Passage
 Passage in Concurrence
 Passage as Amended
 Passage as Sub _____
 Continue
 Hold for Further Study
 Committee Heard
 Indefinitely Postpone

VOTE OF THE COMMISSION

COMMISSION MEMBER	Party	YEA	NAY	ABSENT	ABSTAIN
ARMAND SABITONI	N/A	_____	_____	X	_____
THOMAS RYAN	N/A	_____	_____	X	_____
ELENA NICOLELLA	N/A	X	_____	_____	_____
STACY PATERNO	N/A	X	_____	_____	_____
CHRISTOPHER KOLLER	N/A	X	_____	_____	_____
MARIE GANIM	N/A	X	_____	_____	_____
MICHAEL FINE	N/A	X	_____	_____	_____

VOTE RESULTS

15
YEA

0
NAY

5
ABSENT

0
ABSTAIN

Addendum 4

**Tripp Umbach: Independent Feasibility Study – University of Rhode Island –
School of Medicine**

Tripp Umbach

Turning Ideas Into Action

University of Rhode Island

Independent Feasibility Study into a
Medical School at the University of Rhode Island

September 2025

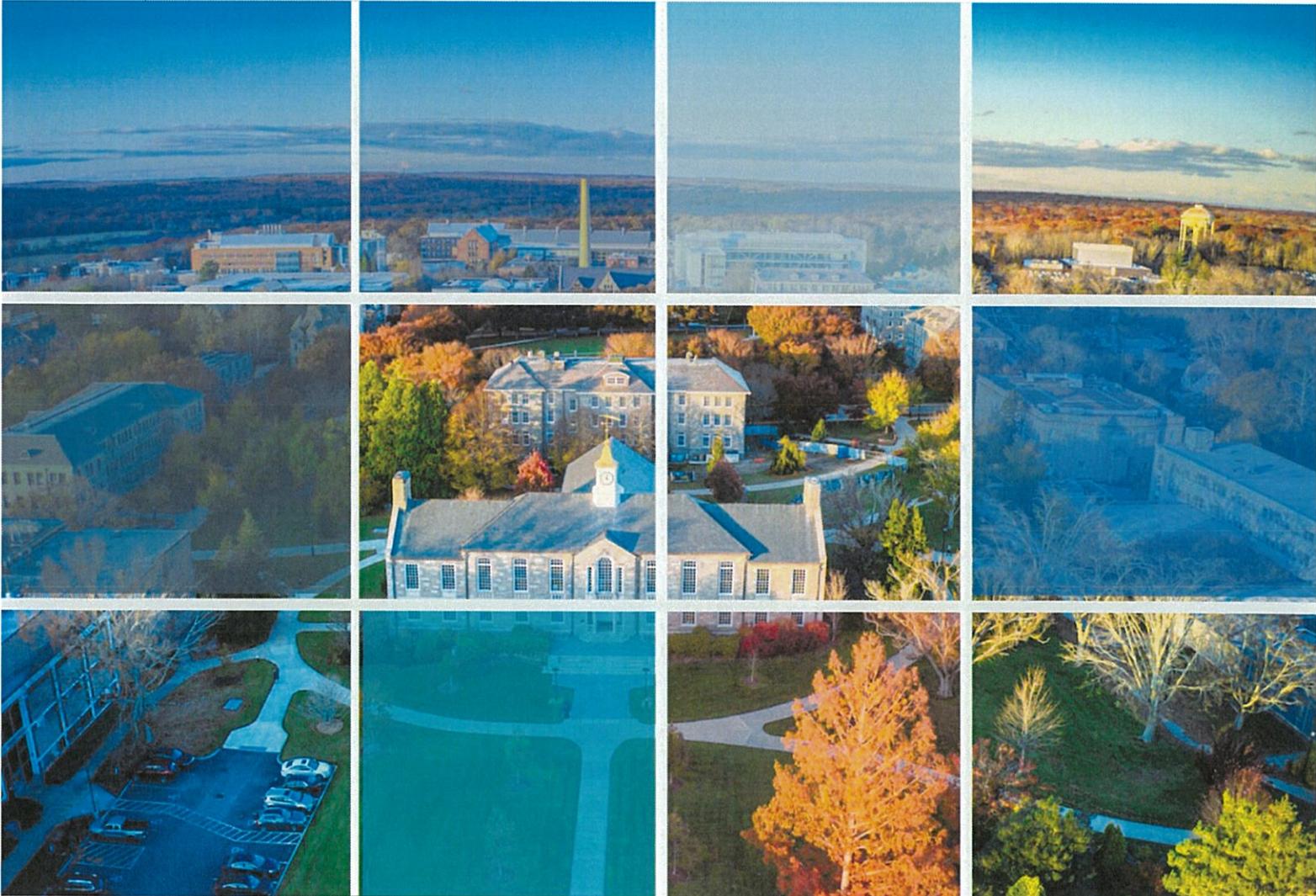


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Vision for a Public Medical School

Rhode Island is facing an acute shortage of physicians, particularly in primary care, as the state grapples with one of the lowest physician-to-population ratios in New England. The physician workforce is approaching retirement age, and the pipeline of new doctors is insufficient to meet current and future demand. The absence of a public School of Medicine (SOM) exacerbates this challenge, as it limits in-state opportunities for medical education and training. Most medical graduates trained in Rhode Island leave the state to pursue residency and practice elsewhere, restricting access to care in Rhode Island's communities, particularly in underserved areas.

To address this crisis, Tripp Umbach recommends establishing a public, M.D.-granting medical education program at the University of Rhode Island. Leveraging the University of Rhode Island's strong foundation in pharmacy, nursing, and health sciences, along with its research infrastructure and established clinical partnerships, a new school of medicine would expand access to care, strengthen the healthcare workforce, and retain more physicians in Rhode Island. This initiative represents a transformative opportunity to improve health outcomes, foster economic growth, and ensure that Rhode Islanders have timely access to comprehensive, high-quality healthcare.

The vision extends beyond medical education to building a statewide pipeline of future physicians, beginning with K-12 engagement and extending through expanded residency programs into practice. By cultivating local talent and expanding residency training, Rhode Island can improve physician retention and address longstanding inequities in healthcare access, particularly in underserved communities. Achieving this will require a broad coalition of URI leadership, policymakers, hospitals, community health centers, and economic development partners to work together in aligning their strategies, funding, and legislation.

Executive Summary

Tripp Umbach believes the University of Rhode Island (URI) is well-positioned to respond to Rhode Island's pressing shortage of primary care physicians by establishing a public, M.D. School of Medicine. Unlike most states, Rhode Island does not have a public medical school. As a result, Brown University's (Brown) graduates, who are primarily from outside the state, typically practice outside of Rhode Island. While Brown University has served for more than 50 years as an anchor of physician workforce development, with approximately 60 percent of Rhode Island physicians having some affiliation with the university, a public School of Medicine is needed to provide greater access for Rhode Islanders to complete medical school and residency training at a lower-cost institution.

URI has a robust academic and research foundation for a new school of medicine, anchored by its existing pharmacy, nursing, and health sciences programs, which offer infrastructure, interprofessional learning, and clinical partnerships. As a Carnegie R1 research institution, URI can attract top-tier faculty to leverage the School of Medicine to grow existing research programs. Most importantly, a new public medical education program centered on primary care and community-based training would encourage graduates to remain in the state, particularly with supportive incentives such as loan forgiveness and scholarships for Rhode Islanders. Developing robust graduate medical education (GME) concurrently with the School of Medicine is a crucial strategy for expanding the physician workforce.¹ Adding additional residency training sites where graduates from the URI School of Medicine can complete their training will maximize the state's return on investment. Therefore, graduate medical education development must be a high priority during the school's early development and beyond.

Beyond meeting the urgent demand for more doctors, a new School of Medicine at the University of Rhode Island would serve as a catalyst for economic development, expand the state's research capacity, and improve healthcare access. With strong support from stakeholders and state leaders, URI is strategically positioned to lead this transformative initiative for Rhode Island's healthcare future. The case for a public School of Medicine rests not only on the benefits of investment but also on the costs of inaction, poor health outcomes, missed research funding, and diminished long-term economic growth that other regions are already capturing.

A new URI School of Medicine, if highly integrated with hospitals, community-based clinics, and residency programs statewide, would directly address physician shortages and health inequities, particularly in those communities currently underserved in primary care, while increasing the retention of local talent. As a cornerstone of Rhode Island's healthcare and economic development strategy, it has the potential to build workforce capacity, increase per capita incomes, accelerate research, and expand access to care. Again, achieving this vision will require a broad coalition, comprising URI leadership, policymakers, hospitals, community health centers, and economic development organizations, united by a shared commitment to improving health outcomes and driving statewide prosperity.

¹ Graduate medical education refers to the residency and fellowship training that physicians complete after medical school, which prepares them for independent practice and is a critical factor influencing where they eventually work.

Rhode Island Needs A Public School of Medicine

Rhode Island faces profound demographic and healthcare challenges that underscore the urgent need for a new public School of Medicine to serve its residents. Although the state's population is growing modestly, its demographic profile is undergoing a dramatic shift. Seniors now represent the fastest-growing share of residents, and Rhode Island has both the highest percentage of residents over age 85 in New England and one of the highest disability rates in the nation.² One in four Rhode Islanders is already age 60 or older, and this group is living longer with multiple chronic health conditions, from hypertension and high cholesterol to complex comorbidities requiring continuous care.^{3,4} Older adults need and consume more healthcare services than any other population segment, and their growing numbers are placing unprecedented pressure on hospitals, clinics, and primary care providers across the state. Compounding these trends, older Rhode Islanders face rising economic vulnerability, with more living below the poverty line, relying on food assistance, or working beyond retirement age. Together, these dynamics create urgent demand for more physicians, particularly those trained in geriatrics, chronic disease management, and primary care.

At the same time, the state is experiencing a deepening physician shortage that is evident in vulnerable communities and those underserved in primary care. Nationally, the United States is already short thousands of primary care physicians, and projections indicate the deficit could reach up to 48,000 by 2034.⁵ Rhode Island will require more than 300 additional primary care providers, while nearly half of its current physicians are approaching retirement, underscoring the urgency of action.⁶

The state reflects these troubling national trends, with a net loss of primary care physicians, an aging workforce nearing retirement, and low retention of new doctors. Between 2011 and 2017, Rhode Island's two-family medicine residency programs graduated 87 physicians, but fewer than half (44%) remained in the state to practice. Although some losses were offset by the in-migration of family physicians trained elsewhere, overall capacity continues to lag demand. Feedback from physicians and stakeholders consistently underscores a workforce stretched to its limits, leaving many patients struggling to access timely primary care.⁷

As a result, many Rhode Islanders, particularly those in rural areas, low-income communities, and among populations of color, struggle to access timely, preventive, and coordinated care. Federal data confirm that only 72 percent of primary care needs are currently being met across the state's Health Professional Shortage Areas (HPSAs), with shortages concentrated in the northern and southern regions.⁸ Patients in these communities often face long waits, extended travel distances, or resort to emergency departments for non-urgent needs, which increases costs and worsens health outcomes.

² [Point 32 Health Foundation](#)

³ [Healthy Aging Data Report; Rhode Island, 2025](#)

⁴ [Ibid.](#)

⁵ [Rhode Island Health Care System Planning; 2024 Foundational Report](#)

⁶ [Rhode Island Current News Outlet](#)

⁷ [Rhode Island Health Care System Planning; 2024 Foundational Report](#)

⁸ [Designated Health Professional Shortage Areas Statistics, Second Quarter of Fiscal Year 2025 Designated HPSA Quarterly Summary. Bureau of Health Workforce Health Resources and Services Administration. U.S. Department of Health & Human Services.](#)

This combination of demographic pressures and physician shortages has transformed a workforce challenge into a statewide healthcare crisis. Without sustained investment in physician education, recruitment, and retention, Rhode Island will be unable to meet the needs of its aging and increasingly complex population. Establishing a new public School of Medicine at the University of Rhode Island represents a strategic and mission-driven response to the evolving needs of the state. A public School of Medicine would expand the physician pipeline, strengthen training capacity in partnership with hospitals and community health centers, and help retain more graduates to practice locally and help ensure that Rhode Islanders, including seniors, have access to appropriate and timely primary care. By prioritizing primary care and training physicians to serve underserved communities, a URI School of Medicine would not only address current shortages but also lay the foundation for a healthier, more equitable future.

University of Rhode Island Capabilities

The University of Rhode Island demonstrates strong and comprehensive capabilities in the health sciences, providing a solid foundation for the development of a School of Medicine. The institution maintains an extensive portfolio of undergraduate, graduate, and professional programs across the health sciences, nursing, pharmacy, and related fields of science and technology. Within the College of Health Sciences, students pursue bachelor's degrees in fields such as psychology, public health, clinical neuroscience, communicative disorders, dietetics, kinesiology, and human development, supported by graduate offerings in nutrition, speech-language pathology, counseling, and psychology. URI also awards doctoral degrees in behavioral sciences, health sciences, psychology, nutrition and food science, and the Doctor of Physical Therapy, reflecting its ability to train health professionals and researchers at the highest levels of expertise.

Complementing these programs, the URI College of Nursing offers a robust continuum, ranging from the BSN and RN-to-BSN pathways to graduate-level training, including a Master of Science in Nursing, the Doctor of Nursing Practice, and a PhD in Nursing. Pharmacy is another area of distinction, anchored by the PharmD program and supported by bachelor's, master's, and PhD degrees in pharmaceutical sciences, medicinal chemistry, and related specialties. Interdisciplinary strengths in biomedical engineering, biotechnology, marine biology, chemistry, medical laboratory sciences, and neuroscience broaden URI's academic base, linking health education to science, research, and innovation. The addition of an M.D. program will strengthen all of these programs and research areas.

Degree conferral data from the university underscore the depth and scale of URI's health-related training pipeline. Between 2020 and 2024, the Health Sciences consistently produced the most significant number of total URI graduates, with annual totals ranging from 789 to 929. Psychology, public health, kinesiology, and human development were among the leading contributors, with steady growth also observed in clinical neuroscience, nutrition, and speech-language pathology. The College of Nursing conferred between 300 and 404 degrees annually, with traditional BSN output strengthening over this period. Pharmacy maintained stability, conferring 173–210 degrees per year, led by the PharmD program, which consistently produced over 100 graduates annually. Together, these data highlight URI's ability to train large cohorts of students across the health professions with established clinical partners throughout Rhode Island, a prerequisite for building the workforce and academic infrastructure needed for a School of Medicine.

Research capacity further strengthens URI's position. From 2016 to 2024, research expenditures rose from \$97.9 million to \$137.5 million in 2024. Most of this growth has been fueled by federal funding, which increased from \$61.6 million in 2016 to more than \$111.5 million in 2024. This trajectory reflects URI's ability to secure competitive federal grants, particularly in the health and biomedical fields, while institutional funds and other sources have provided additional, though more variable, support. The steady rise in federally sponsored research demonstrates both scholarly strength and the infrastructure necessary to support clinical, translational, and basic science research, all essential components of a School of Medicine.

It is worth noting that Federal research funding was significantly disrupted in 2025, with notable indirect cost rate caps and program terminations exceeding \$40 million impacting URI, particularly in environmental and international projects. Tripp Umbach's feasibility study indicates that building a URI public School of Medicine would span roughly five years to launch and would have a scaled research enterprise in the mid-2030s. While Tripp Umbach believes funding conditions will improve in future decades, projections for federal research support in the 2030s are uncertain. However, the historical growth of NIH funding provides some assurance that a new School of Medicine will be able to participate in new Federal funding streams.

Taken together, URI's broad and growing academic programs, its steady pipeline of health sciences graduates, and the university's research base all point to significant institutional capacity. These assets not only prepare URI to educate physicians but also position the university to integrate medical education into its existing ecosystem of health professions, science, and research programs, thereby addressing Rhode Island's workforce needs and expanding its role in academic medicine.

Tripp Umbach compared URI with the most recent public universities that have launched a new medical school over the past decade.⁹ We found that URI has a solid institutional foundation for developing a new public medical school when compared with other public universities that have recently launched M.D. programs. As a Carnegie R1 institution, URI has experienced significant growth in research expenditures, reaching approximately \$144 million in FY23, placing it ahead of several peers, such as the University of Nevada, Las Vegas (UNLV) and the University of Central Florida, when they opened their medical schools. It is well-established that Colleges of Pharmacy and Health Sciences provide a strong academic foundation, giving URI a deeper health sciences base than many of the newer medical schools had when they launched.

Financially, URI's endowment has surpassed \$200 million, which is modest compared to larger peers such as Washington State University (Washington State) or the University of Houston, but is larger than the endowment at the University of Texas Rio Grande Valley and the University of Texas, Tyler (UT Tyler).

From a governance standpoint, URI functions as a stand-alone flagship rather than part of a larger university system, similar to those in Texas and Florida. This structure can provide nimbleness in

⁹ Tripp Umbach evaluated the following public institutions that opened a medical school within the past decade: UT Tyler 2023, University of Houston 2020, UNLV 2017, Washington State 2017, UT Austin 2016, and UT Rio Grande 2016.

decision-making, but it lacks the pooled capital and system-wide political strength that accelerated the launch of schools in Texas, which benefited from the University of Texas System’s resources and advocacy. Furthermore, the Texas A&M system has recently approved a new medical school at Tarleton State, a much smaller institution compared to URI. Similar institutions to URI, such as UNLV and the University of Houston, relied heavily on private donors, including a named donor and significant state matching funds.

Taken together, URI’s profile places it in the middle tier of recent public founding institutions: stronger in research productivity and academic depth than many, but smaller in financial capacity and without the system-level backing of others. With strategic commitments from the state and philanthropy, Tripp Umbach believes that URI’s platform is sufficiently strong to support the successful launch and long-term sustainability of a public medical school.

A Transformational School of Medicine for Rhode Island

Tripp Umbach, based on experience developing 20 new public medical programs over the past 30 years, believes that the University of Rhode Island can build a transformational School of Medicine that directly addresses the health needs of Rhode Islanders and contributes to a more prosperous Rhode Island. Rather than replicating traditional private medical school models with a focus on subspecialty care, URI can design an M.D. program that emphasizes community-based training grounded in population health improvement and health equity, directly helping to ensure that all Rhode Islanders can access the primary care services they need.

A central feature of the proposed University of Rhode Island School of Medicine will be a technology-driven approach to primary care, preparing future physicians to lead in a rapidly evolving healthcare environment. Students will be trained in telemedicine, artificial intelligence, assisted diagnostics, and wearable health technologies, equipping them to deliver efficient, patient-centered care in both traditional and virtual settings. The curriculum will integrate predictive analytics and population health tools, enabling learners to leverage big data to identify disease trends, assess patient risk, and design targeted community interventions. Additionally, hands-on training in remote patient monitoring and home-based care will ensure graduates are skilled in using digital health platforms to deliver proactive, preventative treatment. By integrating these innovations into the medical education model, URI’s School of Medicine will cultivate a physician workforce capable of meeting the healthcare needs of Rhode Islanders while establishing a new standard for modern, technology-enabled primary care.

URI’s proposed curriculum is envisioned in three integrated phases that reflect both the best national practices and Rhode Island’s pressing workforce needs. Phase I, spanning the first 15–18 months, would utilize case-driven, systems-based learning blocks that incorporate health equity, epidemiology, and interprofessional training within URI’s Nursing, Pharmacy, and Health Sciences programs. From the outset, students would work in teams on simulations of chronic disease management, behavioral health integration, and medication safety. Phase II would replace the outdated “rotation carousel” with longitudinal integrated clerkships based in Federally Qualified Health Centers (FQHCs) and community hospitals throughout the state.

Each student would follow a patient panel across family medicine, internal medicine, pediatrics, women’s health, behavioral health, and surgery for 9–12 months, supplemented by short, high-intensity clinical “bursts” in tertiary care. Phase III would emphasize advanced clinical responsibility alongside quality improvement, health equity, and population health projects linked to Rhode Island’s Health Equity Zones and statewide primary care stabilization priorities. Capstone scholarly work would connect students to clinical and translational research platforms. This curriculum not only educates excellent physicians but also prepares them to practice where Rhode Island needs them most, namely, in community-based, primary care-driven environments.

Applicant Supply

Tripp Umbach believes that demand for medical education is strong enough to support a public M.D. program at URI with an ultimate class size of 100 students. In the most recent admissions cycle, 102 Rhode Island residents applied to U.S. M.D. programs. Only 16 matriculated in-state at Brown University, 37 enrolled elsewhere, and nearly 50 did not secure an M.D. seat, clear evidence of unmet local demand.¹⁰ It is worth noting that only a handful of students matriculating at Brown completed high school in Rhode Island, as most Rhode Island medical students achieved in-state status while attending Brown University as undergraduate or graduate students.

New and expanding schools routinely draw thousands of applications annually, and Tripp Umbach believes that URI can expect similar results. For example, Wake Forest University’s new Charlotte campus drew more than 12,800 applications for just 49 inaugural seats. The Alice L. Walton School of Medicine in Arkansas received over 2,000 applications for 48 available seats. Other programs show the same trend: Charles R. Drew University’s first class of 60 students was chosen from nearly 1,000 applicants; the California University of Science and Medicine received more than 2,400 applications for 64 inaugural seats and later over 5,000 annually as its program grew; FIU’s Herbert Wertheim College of Medicine drew 3,247 applicants for its 43 inaugural seats and now sees over 6,000 annually.¹¹

Taken together, these examples suggest that even a modest inaugural class of 50 students at URI could realistically expect 2,000 applicants in its first year. The precise number would depend on factors such as branding, mission, and marketing. Still, the evidence is clear: demand for a new School of Medicine is robust, and a URI program designed around primary care, community health, and public service would likely draw thousands of applicants each cycle from Rhode Island and neighboring states.

The real opportunity lies in attracting and retaining Rhode Islanders who choose a public School of Medicine option and remain in the state for residency training. Evidence shows that while 57% of physicians nationally practice where they complete residency, the rate rises above 68% when both medical school and residency are completed in-state.¹² Today, Rhode Island retains only about 14% of its

¹⁰ [Association of American Medical Colleges](#)

¹¹ [Association of American Medical Colleges](#)

¹² [Association of American Medical Colleges](#)

medical graduates.¹³ A URI M.D. program, coupled with expanded GME positions, could elevate long-term retention into the 60% range, thereby transforming the state's workforce pipeline.¹⁴

Collaborations with Existing Institutions

Brown and Lifespan have recently strengthened their alignment as Brown University Health, anchoring the state's tertiary and specialty care. URI should complement this training footprint by expanding community-based training capacity, developing clerkships in ambulatory and FQHC settings, and co-creating complementary statewide clerkship training to prevent site conflicts. Collaboration with Brown's GME programs is essential to expand family medicine, internal medicine, psychiatry, OB-GYN, and select hospital-based residencies. On the research front, URI can leverage existing collaborations with the Brown Innovation and Research Collaborative for Health (BIRCH) to align medical student scholarly work with neuroscience, public health, and translational science initiatives.

By embracing a mission-driven, community-anchored model, URI can expand medical education in Rhode Island without limiting the size and scope of the existing private medical school. A public M.D. program designed around primary care, equity, and local workforce retention would not only address unmet demand but also strengthen statewide health outcomes, expand residency training, and amplify existing partnerships with Brown University and the hospital systems. Through purposeful collaboration with Brown and the State of Rhode Island, URI can help secure a healthier future for Rhode Island, one in which more physicians are trained, retained, and inspired to serve the communities where they are most needed.

Financial Summary

Tripp Umbach recommends a financial model for a new public School of Medicine at the University of Rhode Island that meets accreditation standards rooted in the experience of nearly every newer M.D. program in the United States over the past 30 years. Tripp Umbach recommends an initial launch investment of approximately \$175 million, supported through a phased strategy of early philanthropic gifts, institutional contributions, and long-term public commitments. While start-up deficits are anticipated for any new medical school, they are offset over time by tuition revenue, clinical partnerships, research growth, and operational efficiencies. The model assumes \$20 million in initial state support and an annual state investment of \$22.5 million beginning in 2029 when the first students arrive and continuing in the future to sustain operations at full maturity with 100 students per class. It is important to remember that the funds are in addition to appropriations provided to URI for other programs. Also, the funds are allocated for the medical education program and do not include support for GME, loan repayment programs, or other incentives.

To place this amount into context, the U.S. average for annual state support per medical student is \$275,000, with Connecticut being \$189,565 and Massachusetts at \$97,975; therefore, Rhode Island's \$52,250 per student request within the feasibility study is approximately half as much per student as in

¹³ [Association of American Medical Colleges](#)

¹⁴ Tripp Umbach estimates based on AAMC data.

Massachusetts, almost four times less than in Connecticut, and nearly five times less than the U.S. average.

Total revenues by the URI School of Medicine are projected to increase from \$28.7 million in 2029 to more than \$77.0 million by 2037, while expenses are expected to rise from \$22.9 million to over \$61.0 million during the same period. Assuming \$175 million in start-up funding can be secured within three planning years, financial stability is achieved by the third year of operation, with consistent surpluses reaching \$16 million by 2037, thereby ensuring the long-term viability required by the accreditor.

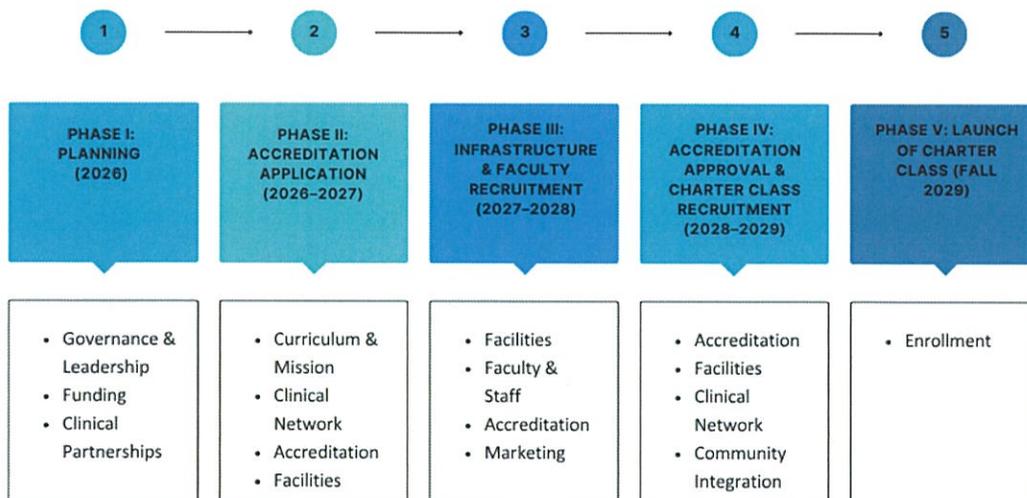
Economic Impact

The proposed University of Rhode Island School of Medicine represents both a healthcare necessity and an economic catalyst for the state. Tripp Umbach projects that once fully operational, the school will generate \$196 million in annual economic activity from its operational spending, support approximately 1,335 jobs, and contribute \$4.5 million in annual state and local tax revenues. Beyond economic growth, the School of Medicine will enhance URI's competitiveness for federal and private research funding, thereby reinforcing the university's R1 research status. The URI School of Medicine will also serve as a partner to the state and local government in tackling public health disparities, rural healthcare access, and population health. Framing the School of Medicine around both its health and economic benefits will help build a broad coalition of policymakers, business leaders, and healthcare partners committed to sustaining support. Just as important, advocacy must highlight the risks of inaction, including worsening physician shortages, more Rhode Islanders lacking the health care services they need, heavier reliance on out-of-state providers, and the continued loss of local talent and research funding to peer regions.

Implementation Roadmap

Tripp Umbach recommends that the University of Rhode Island follow a roadmap designed to launch the state's first public School of Medicine as early as 2029 but no later than 2030. This phased strategy aligns governance, funding, accreditation, and partnership development to ensure the school is mission-driven, financially sustainable, and fully prepared to address Rhode Island's physician workforce needs. By building capacity step-by-step, URI will establish the institutional foundation, foster statewide partnerships, and secure the necessary financial commitments for long-term success.

Implementation Roadmap



Phase I: Planning and Financial Support (2026). The initial phase will establish governance and leadership structures, secure funding commitments, and initiate the development of clinical partnerships. A School of Medicine Steering Committee, supported by advisory boards, will guide the process, while a dedicated Liaison Committee on Medical Education (LCME) readiness task force will prepare the accreditation application. After the special legislative commission submits its findings and recommendations to the RI Senate in early 2026 to proceed with planning, URI's leadership will advance through various university and state approvals to offer the M.D. degree.¹⁵ A founding dean, selected through a national search, will be appointed by mid-2026, allowing a full three years for the dean to secure preliminary accreditation through the Liaison Committee on Medical Education required to admit the first 50 students.

On the financial side, URI will pursue the state support necessary to enable the launch and sustained success of a School of Medicine, including \$20 million in state start-up funds, \$22.5 million in recurring annual state support starting when the school enrolls its first students in 2029. At the same time, URI will engage hospitals and community health centers to establish anchor training sites and secure public-private partnerships across Rhode Island.

Phase II: Accreditation Application (2026–2027). With leadership in place, the founding dean and faculty will design a community-based, primary care-focused curriculum and establish new academic pipelines, such as BS/M.D. and early assurance programs. Formal agreements with hospitals and federally qualified health centers will expand the clinical training network, and partnerships will be

¹⁵ A special legislative commission will submit to the RI Senate by January 2, 2026, a comprehensive study of Rhode Island's healthcare workforce related to educating and retaining primary care physicians and establishing a state medical school at the University of Rhode Island.

developed to grow in-state residency opportunities. Accreditation milestones will include submission of the LCME “Applicant” status in 2026, followed by a self-study and attainment of “Candidate” status in 2027. Faculty recruitment and facilities planning will also begin during this phase.

Phase III: Infrastructure & Faculty Recruitment (2027–2028). This phase will focus on constructing and expanding academic and simulation facilities, as well as hiring department chairs, faculty, and core staff. URI will submit its LCME “Pre-Accreditation” application in late 2027 and host its first site visit in 2028. At the same time, URI will launch a marketing and admissions campaign, focusing on recruiting and providing scholarships to Rhode Island students committed to serving in underserved communities, supported by a loan forgiveness program.

Phase IV: Accreditation Approval & Charter Class Recruitment (2028–2029). By fall 2028, URI will seek LCME “Preliminary Accreditation,” paving the way for student recruitment. Admissions will open for an inaugural class of 50 students, supported by new academic and simulation facilities. Clinical clerkships will be operationalized across hospitals and community health centers, and partnerships with residency programs will ensure alignment between medical education and GME opportunities. Concurrently, URI will launch faculty research initiatives and statewide community health programs to deepen its role as a partner in addressing Rhode Island’s healthcare needs.

Phase V: Launch of Charter Class (Fall 2029). URI will welcome its first 50 M.D. students into a mission-driven, community-based curriculum emphasizing primary care and service to underserved populations with unmet primary care needs in Rhode Island. The school will also position itself as both a healthcare and economic engine, generating hundreds of millions of dollars in economic impact and billions in long-term social benefits. Beyond the inaugural class, URI will be guided by a strategic plan to continue to plan for the expansion of class size, research, and residency programs into the 2030s, ensuring a durable pipeline of physicians for Rhode Island.

Consultant Recommendations

To ensure that the proposed University of Rhode Island School of Medicine is both feasible and transformative for the state, Tripp Umbach developed a series of strategic recommendations that address Rhode Island's urgent physician workforce needs while positioning URI as a future national leader in community-based public medical education. These recommendations focus on building a mission-driven program that prioritizes primary care and underserved populations, creating a distributed clinical training network across the state, securing diversified and sustainable funding, strengthening local talent pipelines with retention incentives, and framing the school as both a healthcare and economic engine.

Build a Mission-Driven, Community-Based Medical Education Model

Tripp Umbach recommends that URI move forward with the development of a public M.D.-granting School of Medicine, opening in 2029. URI's School of Medicine will differentiate itself by aligning its mission with Rhode Island's most pressing workforce needs, such as primary care, community health, and equitable access. This requires a distributed model of medical education, including large tertiary hospitals, community hospitals, and health centers. URI should integrate its existing academic strengths, pharmacy, nursing, public health, and allied health sciences into interprofessional team-based training. A central feature of the proposed University of Rhode Island School of Medicine will be a technology-driven approach to primary care, preparing future physicians to lead in a rapidly evolving healthcare environment.

The curriculum should embed longitudinal primary care clerkships in FQHCs, rural clinics, and hospitals across the state, reflecting Rhode Island's unique demographics. Admissions policies should prioritize in-state candidates, people from communities underserved in primary care, and applicants committed to practicing in primary care and underserved communities. By aligning student selection, curriculum, and financial incentives with this mission, URI can directly address the fact that fewer than 15% of residency graduates currently remain in Rhode Island to practice, and even fewer to practice in primary care.¹⁶ The URI School of Medicine will thereby provide Rhode Island with a distinct complement to Brown University's research-focused private medical school.

By aligning student selection, curriculum, and financial incentives with this mission, URI can directly address the fact that fewer than 15% of residency graduates currently remain in Rhode Island to practice, and even fewer to practice in primary care.¹⁶ The URI School of Medicine will thereby provide Rhode Island with a distinct complement to Brown University's research-focused private medical school.

Establish a Comprehensive Clinical Training Network

Securing broad clinical partnerships statewide is the most immediate and vital step for implementation, as URI must negotiate binding clerkship agreements with large tertiary and smaller community hospitals, as well as FQHCs. Based on Tripp Umbach's assessment, Rhode Island has sufficient training capacity to support an annual M.D. class size of approximately 100 students, if placements are diversified across the state and various specialty rotations can be developed for URI students at Brown

¹⁶ [Association of American Medical Colleges](#)

University Health facilities. Early and sustained partnership building will be essential to ensuring clinical training relationships, critical to achieving LCME accreditation timelines, are met.

To support the full spectrum of specialties, GME affiliations must be established with a wide range of facilities, including Kent County Memorial, Our Lady of Fatima Hospital, Landmark Medical Center, South County Hospital in Wakefield, and Westerly Hospitals. URI should also adopt shared faculty models with hospital partners to reduce start-up costs while ensuring quality teaching and clinical supervision. This distributed network will enable URI to place students across a range of urban, suburban, and rural sites, thereby relieving pressure on Brown University Health, which has a clinical training relationship with Brown's private medical school.

Secure, Robust, Diversified, and Sustainable Funding

Tripp Umbach's feasibility study documents the need for approximately \$175 million in start-up funding over the early program development. Initially, a total of \$62.5 million must be raised by URI to advance the project. To accomplish this, URI must develop a diversified funding strategy that extends beyond its current resources to ensure long-term sustainability.

Tripp Umbach recommends the following funding sources:

1. \$30 million in seed funding over the next two years to be raised by the URI Foundation,
2. \$20 million in seed funding from the state of Rhode Island, and
3. \$50 million in endowment to be raised from private donations over the next 10 years to provide support for scholarships and ongoing operations.
4. \$75 million in private funds over a three-year period starting in 2026, to cover start-up costs. This amount can be reduced if the state can provide general obligation bonds to cover \$62.5 million in anticipated facilities costs. Under this scenario, \$37.5 million will be needed from a named donor.
5. \$22.5 million is needed annually beginning in 2029, when the first class is expected to arrive. Additional state funding will be required for GME and educational incentives, such as loan forgiveness and scholarships, to retain graduates in the state.
6. After start-up, URI will also need to leverage public-private partnerships with health systems, generating shared revenue through clinical practice plans and research grants. Other new medical schools have secured significant resources from health system partners, including Meridian Health System (Hackensack, NJ), Carle Health System (Urbana-Champaign, IL), HCA (Nashville, TN), and Meritus Health (Hagerstown, MD).

Tripp Umbach's pro forma represents the ideal situation where funds are secured and facilities are in place before the first students arrive. While the LCME prefers to see all funding and facilities in place, there are many examples of institutions that were able to accommodate their first class in temporary facilities on campus and without a fully funded endowment. However, the LCME recommends that a portion of a university's endowment or foundation be allocated to support the medical school.

A detailed business plan is needed in early 2026 to move the project forward, including hiring a founding dean and securing the required resources. Any delay in 2026 can result in the first class not arriving until 2030.

Create Local Talent Pipelines and Retention Incentives

To ensure Rhode Island derives long-term benefit from URI's investment, the school must prioritize recruitment and retention of local students. A "grow your own" model should begin with partnerships with Rhode Island high schools, expanding STEM pipeline programs, and developing early assurance tracks for URI undergraduates. Admissions policies should favor Rhode Islanders and applicants committed to practicing locally, particularly in primary care.

Financial incentives must be tied to service commitments, including in-state tuition guarantees, loan forgiveness, and repayment programs for graduates who practice primary care in Rhode Island for a minimum of five years following the completion of their residency. Funding for these incentives is in addition to \$20 million in seed funding and \$22.5 million in annual state support recommended in the feasibility study. Such incentives will counteract the debt burden that is a major driver of physician out-migration. URI should also collaborate with state and hospital partners to expand fellowship training opportunities in psychiatry, cardiology, gastroenterology, and surgical subspecialties, ensuring graduates have viable pathways to complete advanced training without leaving the state. With 44% of Rhode Island's physician workforce nearing retirement age, retaining homegrown talent and incentivizing physicians to remain in primary care are critical to closing workforce gaps.

Overview

In January 2025, the University of Rhode Island, in partnership with the Rhode Island State Senate, commissioned Tripp Umbach to conduct an independent feasibility study focusing on establishing the state's first public School of Medicine at the University of Rhode Island. Tripp Umbach was selected for its national reputation and extensive experience, having guided more than 40 new medical school developments and completed over 2,000 consulting engagements for universities, health systems, and governments since 1990. The findings of this report represent the professional opinions of Tripp Umbach, informed by extensive experience, primary and secondary research, stakeholder input, and assumptions and conditions outlined within the study.

The study, overseen by a special legislative Senate commission co-chaired by Senator Pamela J. Lauria and URI President Marc Parlange, assessed physician workforce shortages, healthcare access challenges, and opportunities to strengthen medical education and research in Rhode Island. Tripp Umbach employed a structured methodology that combined demographic and workforce projections with community engagement and financial modeling to inform its analysis. Key areas of analysis included models for medical education delivery, clinical training capacity, URI's institutional readiness, and long-term financial sustainability. The study also measured broader economic and social impacts, including job creation, research growth, and improved access to healthcare across the state.

The analysis highlights the unique opportunity for URI to establish a public School of Medicine that directly addresses the state's critical physician workforce shortages, supports economic development, and strengthens healthcare access in underserved in primary care areas.

Key Evaluation Criteria

Tripp Umbach's feasibility analysis for establishing a public M.D.-granting School of Medicine is anchored in five core evaluation criteria outlined below. The study focuses on Rhode Island, with additional environmental scanning conducted to assess needs throughout the state. The following requirements are used to determine whether the study area possesses the foundational elements required to successfully launch and sustain a long-term, high-quality medical education program.

- **Physician Shortage** – A clear and growing need for physicians, especially in primary care and underserved areas, is a core justification for establishing a new School of Medicine. Tripp Umbach evaluated workforce trends, provider ratios, and projected demand to determine whether regional shortages align with broader challenges to healthcare access.
- **Evaluation of Medical School Models** – Identifying a viable pathway for expanding medical education in the region required careful consideration of multiple delivery approaches. Tripp Umbach evaluated both allopathic (M.D.) and osteopathic (D.O.) models, weighing their alignment with Rhode Island's healthcare needs and URI's institutional strengths. Tripp Umbach also evaluated the benefits and constraints of establishing a regional campus with public and private medical schools in neighboring states.

- **Institutional Readiness/Capacity** – Strong academic and research institutions are essential for a successful medical school. This includes sufficient infrastructure, educational leadership, faculty strength, and the ability to integrate the new program without compromising existing offerings.
- **Clinical Training Interest** – A strong foundation of clinical training sites is vital for both undergraduate medical education and residency programs. Tripp Umbach evaluated the availability, accessibility, and quality of training opportunities across hospitals, clinics, and community health providers to ensure students can gain diverse, hands-on experiences in real-world healthcare settings.
- **Community and Stakeholder Support** – Broad support from local health systems, local government agencies, academic institutions, and philanthropic partners is critical for long-term success. Tripp Umbach analysis considered the depth of engagement and alignment with community health priorities and workforce development goals.

Key Findings

Rhode Island stands at a pivotal moment in shaping the future of its healthcare system, as demographic shifts, workforce shortages, and rising demand for care converge to create both challenges and opportunities. The state's aging population, coupled with a growing physician gap, particularly in underserved communities, underscores the urgent need for innovative solutions to expand access and strengthen primary care.

Stakeholders across the healthcare landscape recognize that recruitment and retention strategies alone are not enough; Rhode Island requires a bold, sustainable approach to medical education. The feasibility study finds that a public M.D. program at the University of Rhode Island offers the most viable model, supported by committed clinical partners, the potential to expand GME infrastructure, and a clear pathway to long-term physician retention and improved access to primary care services for Rhode Islanders. Notably, financial analysis demonstrates that the School of Medicine is not only achievable but will deliver a strong return on investment for Rhode Island taxpayers, while positioning URI as a driver of healthcare, education, and economic growth across the state and beyond.

1. Changing demographics require more healthcare access

Rhode Island's population is growing modestly, but its demographic profile is changing rapidly. The most significant shift is the sharp rise in the elderly population, with seniors now representing the fastest-growing share of residents. This population requires and consumes the most healthcare services. This combination of overall growth and a rapidly aging population has far-reaching implications for the labor force, healthcare, education, and housing. It underscores the urgent need for strategic planning and investment, particularly in healthcare workforce development. Establishing a public medical school at URI directly aligns with these demographic realities, helping to address physician shortages and strengthening the state's capacity to care for an aging and increasingly complex population.

At the same time, the state's healthcare system faces mounting pressures. A growing and aging population is driving up demand for medical services, yet Rhode Island struggles with a shortage of physicians. As communities expand and residents live longer, the gap between patient needs and available providers has widened. The aging population is the primary driver of this demand, underscoring the importance of developing strategies to strengthen and sustain the physician workforce.

Rhode Island is home to more than 1.1 million residents, with one in four aged 60 or older as of 2023.^{17,18} Compared with other New England states, Rhode Island reports the highest prevalence of chronic health conditions, including high cholesterol, hypertension, and multiple chronic diseases.¹⁹ Seniors need and consume more healthcare services than any other age group, and their rapid growth has already put a strain on the state's healthcare system. This trend will continue to influence how care is delivered and resourced in the years ahead.

¹⁷ [Data USA](#)

¹⁸ [Healthy Aging Data Report; Highlights from 2025.](#)

¹⁹ [Ibid.](#)

The passage of the Patient Protection and Affordable Care Act (ACA) further increased physician demand by expanding access to insurance and enabling more residents, particularly seniors, who already have the highest per-capita healthcare consumption, to seek care. An aging population presents not only financial challenges but also an increased need for physicians trained in geriatrics and the management of chronic diseases. As older adults require more care, the demand for providers who serve this population is expected to continue rising.

Another distinctive factor is Rhode Island's higher-than-average proportion of residents with disabilities, 13.0% compared to 12.0% nationally.²⁰ This demographic reality places additional demands on the healthcare system, requiring tailored services, specialized providers, and greater attention to and investment in accessibility. Addressing these needs is not only a matter of equity but also essential for the overall health and well-being of Rhode Islanders. Expanding the physician workforce to serve both an aging and disabled population is vital for building a healthier, more prosperous Rhode Island.²¹

Rhode Island also has the highest percentage of residents aged 85 and older in New England and the third-highest in the nation.²² Compounding this trend, the economic stability of older adults has declined, even before the COVID-19 pandemic. From 2016 to recent years, the share of residents age 65+ living below the poverty line rose from 8.6% to 9.5%, food benefit participation among adults age 60+ increased from 11.9% to 15%, and workforce participation among adults age 65+ climbed from 16.3% to 21.9%.²³ These indicators reveal growing financial vulnerability among Rhode Island's older population.

Together, these dynamics, population growth, an aging demographic, expanded insurance coverage, and higher disability rates are creating unprecedented pressures on Rhode Island's healthcare system. To respond effectively, state policymakers should pursue strategies to strengthen the primary care workforce. Key steps include physician reimbursement reform, targeted funding for primary care GME, and debt relief programs for medical students.²⁴ Such efforts are essential to ensuring Rhode Island can meet the healthcare needs of its residents now and in the future.

2. The Growing Physician Gap in Rhode Island

The United States is confronting a worsening shortage of primary care physicians, driven by an aging workforce, early retirements fueled by burnout, and the lasting effects of the COVID-19 pandemic. Federal estimates from October 2024 indicate that more than 13,000 additional primary care physicians would have been required to eliminate Health Professional Shortage Area (HPSA) designations nationwide.²⁵ Looking ahead, the Association of American Medical Colleges projects that by 2034 the deficit could reach between 17,800 and 48,000 primary care physicians, highlighting the urgency of expanding medical education pipelines and retention strategies to meet growing healthcare demands.²⁶

²⁰ [Rhode Island Office of Healthy Aging](#)

²¹ [Rhode Island 2030 Strategic Plan](#)

²² [Point 32 Health Foundation](#)

²³ [Ibid.](#)

²⁴ [Robert Graham Center; Projecting Primary Care Physician Workforce 2010-2030](#)

²⁵ [Rhode Island Health Care System Planning; 2024 Foundational Report](#)

²⁶ [Ibid.](#)

The pipeline of new physicians entering primary care is not keeping pace with national needs, as fewer graduates are choosing this pathway. Since 2011, the share of U.S.-trained M.D. graduates matching into primary care residencies has steadily declined, signaling a troubling trend. Nationally, from 2012 to 2020, only about one in five physicians who completed residency were still practicing primary care two years after completing their residency.²⁷ Geographic variation also persists, as in 2020, states such as Alaska and Maine saw higher proportions of new physicians entering primary care, while other regions struggled to recruit and retain providers in this critical field.²⁸

Workforce shortages are limiting access to primary care across the United States, with underserved communities experiencing the most significant strain. Increasingly, Americans lack an ongoing relationship with a primary care provider. Between 2012 and 2021, the share of adults without a usual source of care rose from 24.4% to 28.7%, while the percentage of children without an established source of care grew from 9.4% to 13.6%. These trends highlight the widening gap in access to consistent, preventive care.²⁹

By 2045, Rhode Island will require an estimated 4,100 to 4,600 practicing physicians to maintain access to care and meet the needs of an aging population.³⁰ Recent data highlight the growing strain on Rhode Island's primary care workforce. In 2019, the state experienced a net loss of 14 primary care physicians per 100,000 residents. Projections indicate a deficit of nearly 100 primary care providers by 2030. The problem is compounded by an aging workforce, with 44% of family physicians already over age 55 as of 2018 and approaching retirement. Retention of new doctors is a challenge. Between 2011 and 2017, Rhode Island's two-family medicine residency programs graduated 87 physicians, but fewer than half (44%) remained in the state to practice. Although some losses were offset by the in-migration of family physicians trained elsewhere, overall capacity continues to lag demand. Feedback from physicians and stakeholders consistently highlights a workforce that is stretched to its limits, leaving many patients struggling to access timely primary care.³¹

Unfortunately, Rhode Island's physician shortage has evolved into a workforce crisis, leading to significant health consequences throughout the state. In communities where access to primary and specialty care is limited, residents face higher risks of delayed diagnoses, unmanaged chronic conditions, and preventable hospitalizations.

Without consistent access to physicians, individuals are less likely to receive timely screenings, coordinated treatment, and follow-up care, all of which are essential to maintaining long-term health and preventing disease progression. This shortage is particularly pronounced in rural and vulnerable communities. In the U.S., in 2022, there were nearly 3 times as many active physicians per 100,000 population in urban areas as in rural areas (286 vs. 98 per 100,000 population, respectively), illustrating severe provider scarcity in these areas.³² Additionally, in 2022, access to primary care varied across

²⁷ [Rhode Island Health Care System Planning; 2024 Foundational Report.](#)

²⁸ [Ibid.](#)

²⁹ [Ibid.](#)

³⁰ [Rhode Island Office Attorney General; Statewide Health Care Capacity Assessment](#)

³¹ [Ibid.](#)

³² [Association of American Medical Colleges](#)

demographic groups. Nearly one-quarter of Hispanic adults (24%), 13% of Black adults, 19% of adults in the lowest income bracket, and 21% of adults without a high school degree reported not having a usual source of care, compared with 8% of White adults, 6% of adults in the highest income category, and 9% of those with some post-secondary education.³³

Rhode Island is confronting a deepening physician shortage, particularly in its communities that are already underserved by primary care and the existing healthcare infrastructure, transforming a workforce challenge into a pressing statewide emergency. According to the latest federal data, only 72% of primary care needs are currently being met across the state’s HPSA, necessitating as many as 13 additional physicians to eliminate existing designations.³⁴ Rural areas fare even worse. This shortage is compounded by low physician retention, as fewer than half of medical residents trained in Rhode Island choose to practice in-state, making it difficult to sustain and grow the local physician workforce and address the rising needs for primary care services across the state.³⁵ These dynamics underscore an urgent need for targeted strategies, primarily through education, recruitment, and retention initiatives, to ensure equitable access to healthcare across Rhode Island, particularly for its most vulnerable communities.³⁶

Table 1 shows that Rhode Island has 13 primary-care HPSA designations, resulting in the need for additional practitioners to remove the HPSA designation label. Rhode Island demonstrates a high need for primary-care physicians as measured by the number of counties in the state that are full or partial HPSAs. According to the latest federal data, only 72% of primary care needs are currently being met across the state’s HPSA, necessitating as many as 13 additional physicians to eliminate existing designations.

Table 1: Designated Health Professional Shortage Areas 2024³⁷

Maine	Number of Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Primary Care	13	137,033	72.13%	13
Mental Care	12	394,307	58.09%	11

Map 1 illustrates the primary care shortage throughout Rhode Island. According to Map 1, Health Professional Shortage Areas are primarily located in the northern and southern regions of Rhode Island.

³³ [Rhode Island Health Care System Planning; 2024 Foundational Report](#)

³⁴ [Designated Health Professional Shortage Areas Statistics, Second Quarter of Fiscal Year 2025 Designated HPSA Quarterly Summary. Bureau of Health Workforce Health Resources and Services Administration. U.S. Department of Health & Human Services.](#)

³⁵ [American Medical Association](#)

³⁶ Vulnerable populations are groups of individuals who experience greater barriers to accessing healthcare, higher exposure to health risks, and reduced capacity to achieve optimal health outcomes due to factors such as low income, advanced age, racial or ethnic minority status, rural residence, limited English proficiency, disability, or chronic health conditions.

³⁷ [Designated Health Professional Shortage Areas-2024](#)

(A darker HPSA shade indicates a more severe shortage of primary care physicians. As depicted on the map, the HPSAs in Rhode Island are primarily located in the northern and southern parts of the state.

Map 1: Health Professional Shortage Areas in Rhode Island ³⁸



Source: [data.HRSA.gov](https://data.hrsa.gov), January 2025.

As a result, many residents face long travel distances, limited appointment availability, and transportation barriers, often leading them to delay care or resort to emergency departments for non-urgent needs, which drives up costs and worsens healthcare outcomes for both individuals and communities.

Preventive care and early intervention, the foundation of better health outcomes, are significantly compromised in regions with limited physician coverage. Vulnerable populations, including low-income families, older adults, and Medicaid recipients, are especially at risk as inconsistent access to care fuels disparities and contributes to fragmented, poorly coordinated treatment. Over time, these gaps deepen inequities and place increasing strain on Rhode Island’s already stretched healthcare system.

Meeting this challenge will require focused and sustained investment in building and retaining the state’s physician workforce. Expanding training opportunities, strengthening recruitment, and developing incentive programs, particularly in primary care and underserved areas, are essential to ensure that every Rhode Islander has access to the care they need. By closing the physician gap, Rhode Island can improve health outcomes, reduce disparities, and create a stronger, more equitable healthcare system for its communities.

³⁸ [Data.HRSA.gov](https://data.hrsa.gov), January 2025.

3. Physician Recruitment and Retention Programs are Essential

A key strategy to address Rhode Island’s physician shortage is the creation of targeted incentive programs that strengthen recruitment and retention. Such programs are essential to maintaining stability across hospitals and health systems by keeping experienced physicians in the state and reducing the risk of losing talent to other regions. They also help attract providers to underserved areas by offering financial support, loan forgiveness, or other benefits, ensuring that vulnerable communities have access to consistent, high-quality care. Beyond filling immediate gaps, incentive programs foster a more diverse healthcare workforce and reduce disparities in access and outcomes. By prioritizing these initiatives, Rhode Island can build a stronger and more sustainable physician workforce, thereby improving healthcare delivery statewide.

Rhode Island has taken significant steps to strengthen its physician workforce through a range of recruitment and retention programs aimed at addressing primary care shortages. In 2025, the state launched a \$5 million Primary Care Grants Program, followed by an additional \$6.7 million in awards to 85 practices, providing up to \$300,000 per site to help recruit and retain physicians, nurse practitioners, and physician assistants, particularly in practices serving Medicaid patients.³⁹ The state also operates the Health Professional Loan Repayment Program (HPLRP), which offers loan forgiveness to healthcare providers who commit to working in areas of healthcare shortage. Historically, 91% of participants have remained practicing or licensed in Rhode Island.⁴⁰ To further encourage retention, the General Assembly recently expanded the Wavemaker Fellowship to primary care, offering tax credits of up to \$6,000 annually for four years to newly graduated providers who stay in the state.⁴¹ Additionally, the Rhode Island Department of Health introduced Primary Care Training Site Grants of up to \$90,000 per year to practices hosting physician assistant, nurse practitioner, and residency training, to boost in-state training capacity by 50%.⁴²

Additional efforts nationally to secure and increase the number of primary care physicians can be cited at Hackensack Meridian School of Medicine in Nutley, N.J., which launched a Primary Care Scholars Program in 2024 to address physician shortages and student debt. The program offers a 50% tuition scholarship, a \$7,500 relocation stipend, and a \$2,500 monthly living allowance, with full tuition forgiveness if graduates complete their residency and practice in Hackensack for the same number of funded years. Starting with five students, it expanded to 10 in 2025–26 and plans 15 next year. The initiative is designed as a cost-effective way to build a sustainable pipeline of primary care physicians while strengthening long-term retention.⁴³

Hackensack’s SOM initiative was directly inspired by a pioneering effort at Geisinger, which introduced a similar scholarship-for-service model several years earlier. The Abigail Geisinger Scholars Program, launched in 2019 at the Geisinger Commonwealth School of Medicine in Pennsylvania, was designed to directly address physician shortages in primary care by tying financial support to service commitments.

³⁹ [The State of Rhode Island](#)

⁴⁰ [De Beaumont Foundation](#)

⁴¹ [State of Rhode Island General Assembly](#)

⁴² [Rhode Island Department of Health](#)

⁴³ [Becker’s Clinical Leadership](#)

Under this model, students receive full tuition coverage and living assistance throughout their medical school education. In return, they commit to pursuing a primary care specialty and agree to work within the Geisinger Health System for a minimum of four years following the completion of their residency.⁴⁴ By alleviating the financial burden of medical education, the program creates a debt-free pathway into primary care, ensuring that Geisinger develops a stable and loyal pipeline of physicians to serve its communities. The path has inspired other healthcare systems to adopt similar models as cost-effective strategies for strengthening their physician workforces.

The establishment of a public medical school at the University of Rhode Island would amplify the impact of these state-led recruitment and retention initiatives by creating a direct, local pipeline of physicians trained to meet Rhode Island's healthcare needs. Funding from the state is even more crucial in combating recent federal limits on graduate education loans, which could deter interest in attending medical school.

By embedding medical education within the state, URI could align admissions policies, curriculum design, and clinical training with the goals of existing programs such as the Health Professional Loan Repayment Program and the Wavemaker Fellowship, ensuring graduates are both incentivized and prepared to remain in Rhode Island. Furthermore, the URI School of Medicine could serve as a key partner for Primary Care Grants and Training Site Grants by expanding the number of practices that can host medical students and residents, thereby directly strengthening retention pathways.

4. A Public M.D. School of Medicine at the University of Rhode Island Emerges as the Most Viable Medical Education Model⁴⁵

The University of Rhode Island possesses strong and comprehensive capabilities in the health sciences, providing a robust foundation for establishing a medical school. URI offers extensive undergraduate, graduate, and doctoral programs across health sciences, nursing, pharmacy, and related fields, producing large cohorts of health professionals annually. Between 2020 and 2024, the College of Health Sciences consistently graduated between 789 and 929 students per year. The Nursing program conferred 300–404 degrees annually, while the Pharmacy program maintained 173–210 degrees, led by the PharmD program. These outputs underscore URI's ability to sustain a broad pipeline of health workers. Research capacity is further enhanced, as total research expenditures increased from \$97.9 million in 2016 to \$144 million in 2023, with federal funding more than doubling over the period, reflecting the scholarly strength in health and biomedical sciences. Together, URI's training pipeline, research growth, and interdisciplinary programs position the university to launch a medical school that advances workforce development, healthcare access, and academic medicine in Rhode Island.

Both pathways were carefully assessed, considering Rhode Island's healthcare needs, URI's institutional strengths, and the state's position within the broader landscape of medical education. While a D.O. program would expand access to medical education, our assessment found that an M.D.-granting school would provide the most significant impact by addressing physician shortages, aligning with URI's R1 research designation, and maximizing opportunities for funding, clinical partnerships, and graduate

⁴⁴ [Geisinger Health System](#)

⁴⁵ Information in key finding #4 was supplied by the University of Rhode Island.

medical education development. In addition, an allopathic pathway best aligns with the university’s strengths in teaching and medical practice, allowing for the integration of future family practice plans that expand both the quantity and quality of healthcare statewide. Placing a stronger emphasis on research will significantly enhance URI’s economic impact while positioning the school as a driver of innovation and regional growth.

The M.D. model provides a strong complement to Brown University’s private medical school by enabling URI to establish a mission-driven, community-based program focused on primary care, population health, and retaining graduates in Rhode Island. Unlike Brown, URI can offer a more accessible and affordable pathway into medical education, addressing barriers created by Brown’s high tuition costs and limited acceptance rate.

Brown University’s Warren Alpert Medical School attracts most of its students from outside Rhode Island, with only about 13 percent of matriculants coming from within the state. This enrollment pattern has significant implications for workforce retention. Data show that of those who enter primary care residency programs in Rhode Island, only about 14 percent remain to practice locally. Only 30 percent of residency and fellowship program graduates from Brown’s residency and fellowship programs stay in the state.⁴⁶ Despite these positive outcomes for a subset of trainees, the broader pattern holds that most Brown medical graduates eventually leave Rhode Island to practice elsewhere. Therefore, Tripp Umbach evaluated the distinct advantages/disadvantages of both degrees for a public medical school to assist stakeholders in selecting the optimal path forward.

Table 2: Overview of Medical School Models

Allopathic (M.D.)	Osteopathic (D.O.)
Advantages	
<ul style="list-style-type: none"> • The M.D. degree carries the strongest prestige and visibility worldwide, enhancing URI’s profile and competitiveness. • Alignment of URI’s R1 Research Status supports growth in biomedical research, NIH funding, and interdisciplinary collaboration across pharmacy, nursing, and health sciences. • The output of an M.D. workforce directly addresses Rhode Island’s critical physician shortages, especially in primary care and underserved communities. • A public M.D. program with in-state admissions focuses and service incentives increases the likelihood that graduates will stay and practice in Rhode Island. • Strengthens relationships with hospitals, community health centers, and health systems across the state. 	<ul style="list-style-type: none"> • D.O. programs are recognized for producing higher proportions of graduates in primary care, directly addressing workforce shortages. • Emphasizes whole-person care, preventive health, and patient-centered practice, aligning with community health needs. • Osteopathic medicine is one of the fastest-growing fields in the U.S., with rising student interest and expanding recognition. • D.O. schools have been developed with leaner infrastructure compared to M.D. programs, which could reduce initial costs. • Strong emphasis on distributed clinical education, which may align well with Rhode Island’s network of community hospitals and clinics. • Could position URI as the first public university in New England to host a D.O.

⁴⁶ [Association of American Medical Colleges](#)

Allopathic (M.D.)	Osteopathic (D.O.)
<ul style="list-style-type: none"> Generates hundreds of millions in annual economic activity, creates thousands of jobs, and expands the tax base. Attracts significant state investment, private gifts, and health system partnerships, building a diversified and sustainable financial base. Provides a complementary alternative to Brown’s private, research-focused model by emphasizing community-based, mission-driven medical education. Creates opportunities for Rhode Islanders to pursue affordable medical education in-state, strengthening local healthcare capacity. 	<p>school, offering a unique identity in the regional education landscape.</p> <ul style="list-style-type: none"> Provides an alternative pathway into medicine for Rhode Island students who may not otherwise pursue an M.D., helping expand the overall physician pipeline.
Disadvantages	
<ul style="list-style-type: none"> Requires significant upfront investment for facilities, faculty, and infrastructure. The LCME accreditation pathway is lengthy and complex, requiring early evidence of robust clinical and financial capacity. Brown University already has an established footprint in Rhode Island hospitals, creating potential competition for clerkship placements. Developing an M.D. school may take longer than a D.O. program due to stricter accreditation and infrastructure standards Stakeholders aligned with Brown or other institutions may push back against a second medical school in the state. An M.D. program often has higher tuition, which could deter applicants or increase graduate debt without sufficient scholarship support. Even with a public school, retention of physicians’ post-residency is not guaranteed unless paired with strong pipeline and incentive programs. Launching a medical school could divert resources, leadership attention, and state appropriations from other URI programs and priorities. 	<ul style="list-style-type: none"> A D.O. degree, while increasingly accepted in the U.S., has less international prestige and mobility compared to the M.D. degree. D.O. programs generally emphasize teaching and primary care over high-level biomedical research, limiting alignment with URI’s research mission and funding opportunities. A D.O. program may attract less philanthropic interest and fewer large-scale research grants than an M.D. program. Growth of D.O. schools nationally may saturate the market, making it harder for URI to stand out. COCA (Commission on Osteopathic College Accreditation) may have more flexibility than LCME; it still requires a robust clinical and faculty network that could be difficult to secure in Rhode Island. Some patients, policymakers, and international institutions remain less familiar with osteopathic medicine, potentially creating barriers. A D.O. program may not offer a clear distinction from other new D.O. schools nationally, whereas an M.D. program in Rhode Island would be unique.

The recommended community-based medical school model is designed to train future physicians within the real-world settings where they are most needed, rather than relying solely on large academic medical centers. This approach emphasizes partnerships with a distributed network of hospitals,

community health centers, FQHCs, and rural clinics to provide diverse clinical training experiences. Students learn in small, team-oriented environments that prioritize primary care, population health, and service to communities underserved in primary care. By embedding learners directly into community settings, the model fosters strong connections between medical education and local health needs, ensuring that training is both relevant and responsive to these needs. Additionally, the model supports interprofessional collaboration by integrating medical students with nursing, pharmacy, public health, and allied health trainees, preparing graduates to work in coordinated care teams. Community-based medical schools not only expand access to medical education but also improve physician retention in the regions where they are trained, strengthen healthcare systems, and contribute to local economic and workforce development.

A public M.D. program represents a clear and strategic pathway for the University of Rhode Island to address the state's most pressing healthcare and economic challenges. As the only public flagship and R1 research institution in Rhode Island, URI is uniquely positioned to lead this effort by leveraging its established strengths in pharmacy, nursing, and health sciences and building a mission-driven, community-based model of medical education. An M.D. school not only carries the highest level of national and international recognition, but it also maximizes opportunities for state investment, federal research funding, and philanthropic support. Most importantly, it provides a sustainable solution to Rhode Island's physician shortages, ensuring that more locally trained physicians remain in the state to practice. Establishing a public M.D. school at URI is not just an academic expansion; it is an essential investment in the future health, economic vitality, and resilience of Rhode Island and its communities.

5. Clinical partners are committed to engaging with the University of Rhode Island

The development of a public M.D. program at URI will be driven by strategic partnerships with Rhode Island's hospitals, health systems, and community clinics. Every healthcare organization interviewed by Tripp Umbach expressed an interest in working with the new medical school by providing training opportunities and working with the school to develop or expand residency positions. The program will complement Brown University's Alpert School of Medicine, focusing on community education, research, and clinical care. The community-based education model ensures students receive a high-quality, consistent, and integrated clinical education from the onset. The existing strengths of URI's College of Pharmacy, College of Nursing, and School of Public Health, as well as other health-related programs, serve as critical anchors, ensuring the success of the proposed School of Medicine and providing a strong foundation for interprofessional training and collaboration. It also provides a platform for shared strategic planning, faculty development, and expansion of GME and research, making it the most efficient and impactful model for the region. Tripp Umbach deemed this model to be superior when compared to a private medical school or a regional campus of an existing institution in neighboring states.

In general, the community-based medical schools identified below have multiple healthcare training partners, including community health clinics located throughout their service regions. These public medical schools are more likely than large medical centers to produce students who enter primary care specialties and participate in community-based research and service initiatives. Most importantly, more are likely to remain in practice in community settings.

Community-Based Medical Schools:

1. Central Michigan University College of Medicine (COM)
2. Charles E. Schmidt College of Medicine at Florida Atlantic University
3. East Tennessee State University James H. Quillen COM
4. Eastern Virginia Medical School
5. Florida International University Herbert Wertheim COM
6. Florida State University COM
7. Marshall University Joan C. Edwards SOM
8. Michigan State University College of Human Medicine
9. Northeast Ohio Medical University
10. Southern Illinois University SOM
11. Texas Tech University Health Sciences Center Paul L. Foster SOM
12. Texas Tech University Health Sciences Center SOM
13. The City University of New York (CUNY) SOM
14. University of California, Riverside SOM
15. University of Central Florida COM
16. University of Hawaii, John A. Burns SOM
17. University of Houston Tilman J. Fertitta Family COM
18. University of Nevada, Reno SOM
19. University of North Dakota SOM and Health Sciences
20. University of South Carolina SOM Columbia
21. University of South Dakota Sanford SOM
22. University of Texas at Austin Dell Medical School
23. University of Texas Rio Grande Valley SOM
24. Virginia Tech Carilion SOM
25. Washington State University Elson S. Floyd COM
26. Wright State University Boonshoft SOM

R1 research universities predominantly anchor these medical schools. They go beyond addressing physician shortages to stimulating demand for housing, services, and local businesses. Based on input from community stakeholders, affordable housing for medical students is a key focus area for URI's medical school planning efforts.

Additionally, the presence of a medical education hub could foster a supportive environment for healthcare-related start-ups or biotechnology firms. Together, these elements would promote economic activity and job creation across education, healthcare, technology, and service sectors, strengthening the region's healthcare capacity while establishing a pipeline for innovation and talent development. The opening of the school of medicine will likely enhance URI's positioning. Additionally, a new medical school at URI would serve as both a cornerstone of Rhode Island's healthcare system and a catalyst for broader economic and innovation-driven growth.

6. Expanding Graduate Medical Education Infrastructure Positions URI's School of Medicine for Long-Term Physician Retention

Graduate medical education refers to the residency and fellowship training that physicians complete after medical school, which prepares them for independent practice and is a critical factor influencing where they eventually work. National data show that 57.1% of physicians remain in the state where they completed their residency, underscoring GME's central role in shaping the physician workforce and addressing local shortages.⁴⁷ In contrast, only 44.9% of people who complete GME in Rhode Island remain.⁴⁸ Rhode Island continues to face persistent challenges in retaining physicians trained in-state, particularly after they complete their residency. High out-migration underscores the need for GME infrastructure that provides both training and root establishment. Without formalized paths to practice locally, even students trained in Rhode Island often leave, further exacerbating provider shortages, especially in primary care and underserved regions. These gaps highlight that Rhode Island's lack of robust GME infrastructure is a significant barrier to establishing a stable, long-term physician workforce. Expanding residency programs not only builds a pipeline of locally trained physicians but also strengthens healthcare delivery, supports underserved communities, and generates economic benefits for host states and institutions.

Establishing local GME infrastructure is critical to physician retention. By building GME programs within Rhode Island, where graduates train and ultimately settle, URI is investing in a proven strategy to anchor medical professionals within the state and counteract longstanding retention challenges.

Local residency programs also offer strategic benefits to hospitals and communities. Teaching hospitals report that once residency programs are established, physician recruitment becomes easier, retention improves, and the quality of applicants increases, often resulting in reduced recruitment costs and enabling hospitals to bridge staffing gaps more efficiently.⁴⁹ Additionally, integrating residents into care teams enhances outcomes. Hospitals with GME programs experience faster patient throughput, lower risk-adjusted mortality rates, and higher patient satisfaction, creating a virtuous cycle of improved healthcare delivery and enhanced institutional reputation.⁵⁰ Developing GME capacity aligns with projected needs, as national estimates warn of a physician shortfall of up to 124,000 by 2034, with significantly larger gaps likely in underserved and rural areas.⁵¹

Expanding GME infrastructure at the University of Rhode Island would not only improve physician retention but also strengthen the state's healthcare and economic ecosystem. Residency programs are potent drivers of hospital performance, with teaching hospitals demonstrating improved patient outcomes, enhanced care coordination, and stronger recruitment pipelines.⁵² GME expansion supports URI's R1 research status by integrating graduate medical trainees into clinical research and practice plans, fostering innovation, and attracting additional federal and philanthropic funding. By embedding

⁴⁷ [Association of American Medical Colleges](#)

⁴⁸ [American Medical Association](#)

⁴⁹ [California Hospital Association](#)

⁵⁰ [Ibid.](#)

⁵¹ [Association of American Medical Colleges](#)

⁵² [California Hospital Association](#)

residents in community hospitals, FQHCs, and rural clinics, URI could address care gaps while simultaneously fueling the state’s economy through job creation and research growth. In this way, expanded GME capacity serves as both a workforce solution and a catalyst for Rhode Island’s long-term healthcare and economic development.

GME infrastructure is one of the most powerful levers for ensuring physician retention, as physicians often stay in the location where they train. Residency programs strengthen hospital recruitment and expand training capacity in underserved specialty areas. Locally trained doctors are more likely to practice in the state long term. For Rhode Island, where retention rates are low and shortages acute, building URI’s GME infrastructure is essential for achieving sustainable improvements in workforce stability and healthcare access.

Numerous hospitals and health systems offer strong potential for local clinical partnerships and collaborations throughout the state. Table 4 identifies these institutions, including hospitals and medical centers that could support clerkship and residency training opportunities for URI’s medical students. The development of the University of Rhode Island’s proposed public School of Medicine presents a chance to expand clerkship and residency opportunities across a diverse network of teaching hospitals statewide. Rhode Island already has a foundation of institutions engaged in medical education, including Kent Hospital, Landmark Medical Center, Newport Hospital, Rhode Island Hospital, Roger Williams Medical Center, The Miriam Hospital, Women & Infants Hospital, and the Providence VA Medical Center, all of which currently host clerkships and/or residency programs. Collectively, these hospitals represent over 1,000 teaching beds and span urban, suburban, and community-based settings, ensuring students and residents gain exposure to a wide range of patient populations and clinical environments.

The University of Rhode Island’s School of Medicine can build on this infrastructure by formalizing statewide partnerships, diversifying training sites to include community hospitals and health centers and expanding GME capacity in critical shortage areas such as primary care, geriatrics, and behavioral health. By leveraging existing clinical assets and creating new clerkship and residency placements, URI will be well-positioned to train physicians who are more likely to remain in Rhode Island, thereby directly strengthening the state's healthcare workforce and improving access to care across the state.

Table 4: Hospitals with Clerkships and Residencies

Hospital Name	Staffed Beds	City	County	Teaching Hospital	Residency
Kent Hospital	343	Warwick	Kent County	X	X
Landmark Medical Center	131	Woonsocket	Providence County	X	X
Newport Hospital	109	Newport	Newport County	X	--
Providence VA Medical Center	73	Providence	Providence County	X	--
Rhode Island Hospital	706	Providence	Providence County	X	X
Roger Williams Medical Center	160	Providence	Providence County	X	X

Hospital Name	Staffed Beds	City	County	Teaching Hospital	Residency
The Miriam Hospital	247	Providence	Providence County	X	X
Women & Infants Hospital	247	Providence	Providence County	X	X
Our Lady of Fatima Hospital	312	North Providence	Providence County	--	--
South County Health	79	Wakefield	Washington County	--	--
The Westerly Hospital	88	Westerly	Washington County	--	--

Source: Robert Graham Center; GME for Teaching Hospitals

7. The School of Medicine is financially viable and will provide a strong return on investment (ROI) to Rhode Island Taxpayers

Financial Analysis

The financial analysis conducted by Tripp Umbach demonstrates that the proposed University of Rhode Island School of Medicine is financially viable, provided that an initial investment of \$175.0 million in private and institutional funds is secured. The State of Rhode Island commits to an appropriation of \$20 million in start-up funding and an annual appropriation of \$22.5 million once the school is operational, in addition to funding for tuition, loan forgiveness, and retention incentives. The pro forma is built on a phased strategy that balances early philanthropic and institutional support with long-term tuition, research, clinical, and practice revenues. Tuition is recommended to begin at \$50,000 annually, increasing to \$63,338 by 2037, consistent with peer public medical schools and ensuring affordability for in-state and regional students.

While tuition revenue is projected to grow from \$2.5 million in the first year of enrollment (2029) to more than \$24 million by Year 9, diversified revenue streams, including philanthropy, endowment growth, and clinical partnerships, are essential to cover operating costs. Expenses, led by faculty and staff salaries, benefits, facilities, and student services, are expected to grow in parallel, from \$22.9 million in 2029 to \$61 million by 2037. It is essential to note that new medical schools typically increase their research expenses in line with available research funds. The cost for researchers is embedded in the salaries, with the assumption that 30% of the time for basic science faculty will be spent on research activities. Importantly, while modest deficits are expected in the earliest operational years, revenues begin to exceed expenses by Year 5, with surpluses expanding to nearly \$16 million annually by 2037.

These surpluses will allow the School of Medicine not only to sustain high-quality academic and clinical programs but also to reinvest in research, innovation, and scholarship support. The inclusion of a scholarship endowment, projected to grow to \$3.7 million annually by 2037, and state-supported tuition and loan forgiveness programs, will enhance affordability for local students and strengthen URI's mission to train physicians who remain in Rhode Island. Taken together, these projections demonstrate

a clear pathway from early start-up investment to long-term financial sustainability, positioning the URI School of Medicine as both an academic and economic anchor for the state.

Economic Impact

Tripp Umbach's national studies estimate that medical schools and teaching hospitals generate more than \$600 billion annually in the U.S. economy. Academic medicine is a powerful driver at the national, statewide, and local levels, stimulating employment, investment, and innovation. The establishment of an independent M.D.-granting School of Medicine at the University of Rhode Island will likewise bring substantial economic expansion to the state's economy, while attracting further economic development through expanded health science programs, clinical and research partnerships with hospitals, and private-sector investment in healthcare-related business development.

The University of Rhode Island's School of Medicine is expected to generate significant direct and indirect economic benefits, achieving an annual return on investment of \$8.70 for every dollar invested in the program at maturity. This measure is based solely on the operations of the School of Medicine and its economic impact on the state of Rhode Island. Expanded benefits related to research growth, new company formations, and the effect of new physicians significantly expand the ROI. Direct benefits will result from spending on capital improvements, ongoing operations, the hiring of new faculty and staff, and student spending in surrounding communities. Indirect benefits will flow from these expenditures as they circulate through the state's economy, creating a multiplier effect that contributes to Rhode Island's overall economic growth.

The inaugural class of 50 students is anticipated to enroll by the fall of 2029, with the school reaching full maturity with 100 students by 2033. Beyond its direct economic impact, the school's graduates will strengthen Rhode Island's physician workforce, particularly in primary care, thereby contributing to cost savings in healthcare delivery for communities across the state.

Annual impacts will include direct, indirect, and induced effects from operations, employment, student spending, visitor activity, and physician workforce contributions. Tripp Umbach's projections are based on conservative assumptions, meaning actual impacts could be greater once the school is fully operational. Not included in this analysis are additional economic benefits tied to more patients staying in-state for care, patients being attracted to Rhode Island due to expanded services, or the growth of medical education at affiliated hospitals.

Economic contributions will scale with the school's growth. By 2030, annual operations are expected to generate \$88 million in impact, support 655 jobs, and contribute \$2 million in tax revenues. By 2035, the impact is projected at \$147 million annually, supporting 910 jobs and generating \$3.5 million in state and local revenues. By 2040, the total annual impact is expected to reach \$196 million, supporting 1,335 jobs and generating \$4.5 million in revenues.

The long-term contribution of URI physician graduates will be even more transformative. According to the American Medical Association, physicians nationwide generate \$2.3 trillion in direct and indirect economic output. Each physician supports an average of \$3.2 million in economic impact, 17 jobs, and \$126,129 in state and local tax revenues. Based on these benchmarks, by 2035, each graduating class of 100 new physicians, with 60 newly graduated physicians who remain in Rhode Island to practice after

residency, will generate an estimated \$160 million annually in economic activity, support 850 jobs, and generate \$6.3 million in state and local taxes. In addition, \$90 million in cost savings to the healthcare delivery system is attributed to an estimated 25 primary care physicians who remain in Rhode Island and practice annually.

Over time, these impacts will grow dramatically, as by 2045, after 10 classes of medical students complete their residencies and remain in Rhode Island (assuming a 60% retention rate), the total economic impact of practicing physicians is expected to exceed \$1.1 billion annually. This projection reflects both the state’s stable population base and the increased demand for healthcare services as a large portion of the current physician workforce approaches retirement. Against this backdrop, the University of Rhode Island’s School of Medicine is poised to have a dramatic and measurable impact.

Over the next two decades, the school is projected to produce more than 500 physicians who will complete their residency training and choose to practice in the state. The medical school and the additional physicians are expected to support over \$10 billion in economic impact, create more than 5,000 total jobs, and generate \$63 million in total state and local taxes. In sum, the school will contribute to increasing household incomes and drive economic growth, thereby contributing to a more prosperous Rhode Island.

Return on Investment (ROI)

By 2045, the University of Rhode Island’s new medical school will generate a transformative return on the state’s \$22.5 million annual investment (not including \$20 million in start-up), when these payments begin as students enter the first class in 2029.

Over the next 20 years (2026-2045), the state is expected to invest a total of at least \$382.5 million in supporting Rhode Island students at the URI public medical school. This investment is expected to result in 564 new URI physicians practicing in Rhode Island, with 169 of them specializing in primary care, by 2045. Therefore, every \$1 invested by Rhode Island taxpayers in the new medical school will generate nearly \$30 in economic activity, tax revenue, and healthcare cost savings for the state.

Table 5: ROI in 2035 and 2045

Metric	Economic, Fiscal Impact, & Cost Savings Impacts 2035	ROI 2035 ⁵³	Economic, Fiscal Impact, & Cost Savings Impacts 2045	ROI 2045 ⁵⁴
Total Economic impact of the URI SOM and 564 physicians in practice	\$982.5 million	\$1: \$7.28	\$10.7 billion	\$1: \$28.03
Total State Taxes Generated by URI SOM and new Drs.	\$22.1 million	\$1: \$0.17	\$155.1 million	\$1: \$0.41

⁵³ Based on \$135 million in total investment by the state of Rhode Island.

⁵⁴ Based on \$382.5 million in total investment by the state of Rhode Island.

Metric	Economic, Fiscal Impact, & Cost Savings Impacts 2035	ROI 2035 ⁵³	Economic, Fiscal Impact, & Cost Savings Impacts 2045	ROI 2045 ⁵⁴
Healthcare Cost Savings to the State over the 20 years	\$-	\$-	\$575.3 million	\$1 \$1.50
Total	\$1.0 billion	\$1: \$7.45	\$11.5 billion	\$1: \$29.94

Note: \$0 state investment until students arrive in 2009

While this number alone will not fully close the projected physician gap, it represents a full 15 percent of the total workforce Rhode Island is expected to need by 2045. These locally trained physicians will not only expand the supply of healthcare providers but also improve retention, as graduates with strong regional ties are significantly more likely to practice in the communities where they receive their training. The addition of 500 physicians over twenty years will therefore make a meaningful contribution to Rhode Island’s long-term physician workforce capacity, strengthening the healthcare system and ensuring more residents have access to high-quality care close to home.

Expanding medical education through the University of Rhode Island’s School of Medicine will also bring broader societal benefits. The school will help address pressing workforce needs by producing more doctors with regional connections, stimulate the development of a healthcare innovation economy through research and commercialization, and improve health outcomes for Rhode Island residents by aligning physician training with community health needs.

Economic Impact of Graduate Medical Education

Graduate medical education programs affiliated with the school will further magnify these benefits. Each resident physician in training generates approximately \$450,000 in annual economic impact, as funding for residency training primarily comes from outside sources and represents new dollars entering the state’s economy. Residency programs strengthen hospitals financially, improve access to care, and enhance clinical quality. Expanding residency positions in Rhode Island, particularly in primary care and specialties with shortages, such as pediatrics, psychiatry, and general internal medicine, will be crucial to meeting the state’s healthcare needs.

The benefits of residency programs are far-reaching. They increase physician recruitment, save hospitals approximately \$5 million annually in uncompensated care, and reduce recruitment costs by an average of \$100,000 per physician. Hospitals with residency programs offer a broader range of services, have higher quality scores, and experience lower utilization of emergency departments, thanks to resident-staffed outpatient clinics. Residents who remain in the community after training bring an intimate knowledge of Rhode Island’s healthcare landscape, ensuring continuity of care and strong community ties.

The establishment of an independent M.D.-granting School of Medicine at the University of Rhode Island represents a transformative opportunity for the state’s economy, workforce, and healthcare

system. With conservative projections indicating nearly \$1.5 billion in cumulative economic impact within the first decade, the project offers significant long-term returns for Rhode Island residents, hospitals, businesses, and policymakers.

Conclusion and a Path Forward

Tripp Umbach's feasibility analysis demonstrates that establishing a public, M.D.-granting School of Medicine at the University of Rhode Island is both viable and necessary to meet the state's pressing healthcare needs. By enhancing workforce development and postsecondary education and increasing per capita personal income, a medical school will help build a more prosperous Rhode Island. A new school of medicine would not only expand physician training capacity but also create a pathway for Rhode Island students to enter the field of medicine and remain in-state as practicing physicians. A public School of Medicine at the University of Rhode Island represents an unprecedented opportunity to address physician shortages, retain local talent, and strengthen the state's healthcare and economic future. With coordinated leadership and commitment from the university, the state, and the community, URI can achieve this vision and matriculate its first class of future Rhode Island physicians within the next four years.

By embedding community partnerships, rural and underserved training experiences, and expanded graduate medical education through collaborations with Rhode Island healthcare organizations, URI can launch a truly transformational program that strengthens the healthcare system while advancing economic development.

Rhode Island hospitals, community health centers, and regional partners in Massachusetts and Connecticut have the capacity and interest to host clinical clerkships and residencies. URI can attract local students by offering B.S./M.D. pathways, early assurance programs, tuition incentives, and service-based loan repayment tied to in-state practice. Financially, the model is achievable with an estimated \$175 million in private and state contributions for start-up and facilities, as well as ongoing state support of approximately \$22.5 million (not including \$20 million in start-up funds), with separate state funding for tuition and loan forgiveness retention programs. A new School of Medicine at URI is projected to contribute more than \$196 million annually to the state's economy, while creating high-paying jobs in healthcare and higher education. These investments align with successful benchmarks from other public medical schools launched over the last two decades and can be scaled strategically through phased construction and clinical faculty partnerships.

This report offers strategies to address the physician shortage by developing a program that produces 100 graduates annually. It emphasizes the importance of securing commitments from Rhode Island's healthcare organizations, finalizing a sustainable business plan, and investing in medical education facilities. This approach aims to produce a steady pipeline of physicians prepared for residency programs, improve healthcare quality by encouraging graduates to remain in the state, and stimulate economic growth across Rhode Island, benefiting the community and its residents.

The timeline for implementation is realistic and achievable within a four-year period. With planning and accreditation preparation in the first two years, leadership recruitment and LCME application submission in year three, and student recruitment in year four, URI can welcome its inaugural medical class by year four. A multi-year funding strategy anchored by private philanthropy, state appropriations, and matching gifts will provide the resources needed for launch and long-term stability.

Over the next two decades, the school is projected to produce approximately 500 physicians who complete their residency training and choose to remain in the state to practice. These approximately 500 additional physicians will support a \$1.1 billion economic impact, resulting in 5,000 total jobs and \$63 million in total state and local taxes.

Without action, Rhode Island risks falling further behind in physician supply, workforce retention, and healthcare access, especially in primary care and underserved areas. Rooted in a deep partnership between URI, the State of Rhode Island, healthcare organizations, and private donors, URI can create a School of Medicine that is not only financially sustainable but also mission-driven, community-centered, and aligned with statewide health equity and economic development goals.



Appendices

**Tripp
Umbach**
Turning Ideas Into Action

Appendix A: Project Overview

Project Facilitation

In January 2025, the University of Rhode Island engaged Tripp Umbach to conduct a feasibility study regarding the establishment of a new medical school in Rhode Island. The study examined the state's capacity to support expanded medical education and provided strategic recommendations based on healthcare needs, physician workforce gaps, and community priorities. As part of this process, Tripp Umbach analyzed market conditions, reviewed demographic and workforce data, and gathered feedback from key stakeholders to evaluate the viability of developing a medical school at URI.

Throughout the project, Tripp Umbach monitored progress, reviewed data as it was developed, and provided feedback on the report structure. Tripp Umbach valued the interactive collaboration and incorporated suggestions and additions to the analysis as needed. Regular conference calls were held to ensure ongoing communication, engagement, and alignment on deliverables.

Feasibility Analysis

To evaluate the need and feasibility of establishing a medical education program in Kingston, Rhode Island, Tripp Umbach collected, updated, and analyzed both primary and secondary data through several approaches. More than 30 targeted stakeholder interviews were completed with senior academic leaders, health science program directors, affiliated hospital administrators, community health leaders, and local and state officials to gather insights on curriculum requirements, student recruitment, faculty needs, clinical training capacity, community health priorities, funding opportunities, residency expansion, and potential partnerships. An environmental scan assessed demographic trends, population health data, and physician workforce needs across Rhode Island and the region, while also inventorying teaching hospitals, training sites, residency programs, research institutes, and reviewing other regional medical school development plans. In addition, a review of recent community health needs assessments completed by regional health systems and public health organizations provided context on local health priorities within the framework of federal healthcare reform and population health initiatives. Lastly, Tripp Umbach developed a 10-year financial model for the proposed medical school, including preliminary estimates of revenues, expenses, faculty and staff needs, start-up and operating costs, escrow requirements, and capital investments.

Economic Impact Analysis

Tripp Umbach will conduct an economic impact analysis to assess the benefits a URI medical school could generate for the state. The analysis will examine:

- **Construction Impacts:** Direct effects of campus development, including spending on labor, materials, and services, and the resulting economic ripple effects.
- **Operational Impacts:** Ongoing benefits once the school is established, including job creation for faculty, researchers, and staff, as well as indirect and induced impacts on local businesses, property values, tax revenues, and community investment.

- **Long-Term and Social Impacts:** The role of the school in attracting healthcare professionals, researchers, and students; expanding the healthcare workforce; advancing research; and improving public health outcomes through education, outreach, and community engagement.

Planning Session/Meeting and Final Feasibility Analysis Report

Before finalizing the report, Tripp Umbach facilitated an in-person planning meeting with URI to present findings from the interviews, environmental scan, financial modeling, and community needs assessment. Input from URI was incorporated into the recommended program and financial model.

Tripp Umbach prepared an independent report with detailed findings and recommendations. The report also presented the rationale, financial model, and economic benefits. The report will provide URI with a framework to continue to build stakeholder support among higher education, healthcare providers, physicians, government leaders, and community representatives.

B. Community Stakeholder Findings

Tripp Umbach extends sincere appreciation to the key stakeholders who generously shared their time, insights, and experiences during the interview process. Their thoughtful input was invaluable in shaping the depth and quality of this study, ensuring that the findings reflect the perspectives and priorities of those most closely connected to medical education in Rhode Island. Key stakeholders are listed in alphabetical order by last name.

Amy Albert, Director, Workforce Development at Rhode Island Free Clinic
Meredith Armstrong, Director of the Center for Career and Experiential Education
Representative Jacquelyn Baginski (District 17, Cranston)
Abby Benson, Vice President for Administration and Finance
Margo Cook, Chairwoman, University of Rhode Island Board of Trustees
Susana Conklin, Chief of Staff, Providence Community Health Centers
Alison Croke, President & CEO, Wood River Health
Representative Susan R. Donovan (District 69, Bristol, Portsmouth)
Senator Alana M. DiMario (District 36, Narragansett, North Kingstown, New Shoreham)
Ashley Foley, Director, Pre-Health Professions, Center for Career and Experiential Education
Dr. Michael Fine, Author, Organizer, and Speaker on Health Care and Democracy
Dr. Staci Fischer, Transplant Infectious Disease Specialist and Graduate Medical Education Leader
John Fernandez, President and CEO, Brown University Health - Lifespan
Dr. Marie Ganim, Former RI Health Insurance Commissioner, Adjunct Faculty Member, Brown University, and Northeastern University
Christopher F. Koller, President, Milbank Memorial Fund
Joan Kwiatkowski, CEO, PACE Rhode Island
Senator Pamela J. Lauria (District 32, Barrington, Bristol, East Providence)
Kerry LaPlante, Dean of the College of Pharmacy at the University of Rhode Island
Elena Nicolella, President and CEO, Rhode Island Health Center Association
Christina Paxson, President, Brown University
Stacy Paterno, Executive Vice President, Rhode Island Medical Society
Marc Parlange, President and Co-Chair of the Commission, University of Rhode Island
Aaron Robinson, President and CEO, South County Health

Matt Roman, COO Thundermist Health Center
Mayor Maria Rivera, Central Falls, Rhode Island
Armand Sabitoni, Vice Chair, URI Board of Trustees
Representative K. Joseph Shekarchi, House Speaker
Office of Representative K. Joseph Shekarchi, Lynne Urbani
Office of Representative K. Joseph Shekarchi, Henry Kinch
Merrill Thomas, President and CEO, Providence Community Health Centers
Danny Willis, Dean of the College of Nursing at the University of Rhode Island
Michael Wagner, President and CEO, Care New England
Patrick Vivier, Dean of the College of Health Sciences at the University of Rhode Island
Office of Senate President Dominick J. Ruggiero, Michael DeAngelis, Chief of Staff
Office of Senate President Dominick J. Ruggiero, Joe Masino, Deputy Chief of Staff
Senator V. Susan Sosnowski (District 37, South Kingstown)
Barbara E. Wolfe, Provost, University of Rhode Island

Key Findings from Stakeholder Interviews

In early spring 2025, Tripp Umbach conducted interviews with 35 healthcare and community leaders across Rhode Island to gauge support for establishing a medical school at the University of Rhode Island. Stakeholders represented a broad cross-section of the region, including healthcare, higher education, local government, economic development, and public health. Their feedback revealed strong and diverse support for a new medical school, emphasizing the critical need to expand the healthcare workforce, the potential for economic and community growth, the challenges of funding and political considerations, and the importance of building strategic partnerships to ensure long-term sustainability.

Rhode Island Faces Critical Physician Workforce Shortages

Across nearly every interview, stakeholders underscored that Rhode Island is experiencing significant physician shortages in both primary care and high-need specialties. Primary care shortages were described as “at a crisis point,” with patients waiting months for appointments. Behavioral health and psychiatry were repeatedly highlighted as urgent gaps, particularly in communities disproportionately affected by substance use disorders and mental health challenges. Women’s health, geriatrics, and rural primary care were also cited as areas of greatest vulnerability. Stakeholders warned that without intervention, shortages will intensify as the physician workforce ages and the state’s population health needs grow. Several interviewees emphasized that Rhode Island consistently loses medical graduates to other states for residency training—a pipeline issue that undermines the state’s ability to retain physicians.

A URI medical school should be designed to target the state’s most urgent workforce gaps, with admissions, curriculum, and clinical training focused on primary care, behavioral health, women’s health, and community-based practice. Building strong retention strategies, through GME expansion and service incentives, will be critical to ensure graduates remain in Rhode Island.

University of Rhode Island is Well-Positioned to Lead in Medical Education

Stakeholders consistently pointed to the University of Rhode Island’s strengths in nursing, pharmacy, biomedical sciences, and public health as an unmatched foundation for a new medical education program. URI’s established reputation for health sciences, combined with its role as the state’s flagship public institution, positions it to develop an interprofessional education model that integrates across disciplines. URI offers accessibility and affordability that could help diversify the physician pipeline by attracting first-generation and underrepresented students who may not otherwise pursue medical education. As one stakeholder noted, “If URI doesn’t lead this, no one else in Rhode Island will.”

URI has a unique opportunity to serve as a public-access medical school with a mission of equity and service. Leadership should leverage URI’s interprofessional strengths to design a program that differentiates itself from private models, while appealing to funders and policymakers interested in expanding opportunity and addressing disparities.

Expansion of Graduate Medical Education is Essential

Nearly all interviewees emphasized that any new medical school must be paired with a deliberate expansion of residency programs in Rhode Island. Without adequate graduate medical education capacity, graduates would be forced to leave the state, continuing the cycle of physician loss. Hospital executives and community health leaders expressed interest in collaborating with URI to expand GME but cautioned that significant investments and policy support would be required. Several stakeholders cited opportunities to align new residencies with community-based care and underserved populations, thereby strengthening the connection between medical education and Rhode Island’s public health needs.

It was recommended that URI should prioritize early planning for residency expansion in partnership with hospital systems, community health centers, and state policymakers. Securing funding for new residency slots and aligning GME with community-based care will be essential for long-term workforce retention and impact.

Medical Education Expansion Must Address Community Health Gaps

Stakeholders expressed strong support for a URI medical school that prioritizes health equity, access, and community-based training. Several emphasized that Rhode Island’s most pressing health needs exist among Medicaid populations, rural communities, and historically underserved groups. Interviewees stressed that URI’s medical education model should embed students in community health centers, FQHCs, and safety-net hospitals, preparing them to serve where the need is greatest. One participant summarized: “If a new medical school doesn’t address our disparities, it’s not worth building.”

The medical school should adopt a mission-driven curriculum that emphasizes social determinants of health, community engagement, and population health management. Strategic partnerships with

safety-net providers and FQHCs should be built into the core of the program to ensure alignment with Rhode Island's equity goals.

University of Rhode Island Medical School Could Drive Economic Growth and Innovation

It was viewed that the development of a medical school at URI would be a potential economic engine for Rhode Island. Anticipated benefits included attracting federal and philanthropic research funding, creating new high-skilled jobs, expanding healthcare services, and boosting the state's competitiveness in higher education and biomedical research. Some stakeholders linked the initiative to the state's ability to retain talent, arguing that Rhode Island loses many of its brightest students to medical schools and jobs in other states. By serving as both an academic and economic hub, URI's program could foster broader community development while meeting healthcare needs.

URI should highlight the dual return on investment of a medical school by addressing healthcare workforce needs while catalyzing economic development. Building an economic impact case can strengthen legislative, philanthropic, and community support for the initiative.

Political and Competitive Dynamics Must Be Managed Strategically

Stakeholders highlighted that the current legislative environment could offer opportunities to advance a new medical school if its mission is clearly defined and aligned with Rhode Island's needs. They emphasized that strong collaboration among state leaders, higher education institutions, and healthcare partners would be essential to building broad-based support and ensuring the school contributes meaningfully to the state's workforce and community health priorities. At the same time, interviewees emphasized that a URI program would serve a distinct mission as a public alternative, accessible to a broader cross-section of students and designed around Rhode Island's workforce and community needs. To succeed, stakeholders advised URI to build broad-based political support, cultivate strong partnerships within the healthcare system, and clearly articulate its unique mission and role within the state's higher education and healthcare ecosystem.

URI will need to differentiate its mission and proactively build coalitions with healthcare providers, community leaders, and policymakers. Clear communication of URI's role as a public, equity-focused, and workforce-driven institution will be key to navigating competitive and political challenges.

Appendix C: Rhode Island Environmental Scan

The environmental scan below provides a comprehensive context to evaluate the viability, sustainability, and alignment of the potential expansion of a medical education program based on regional needs. By examining demographic trends, physician workforce projections, and community health indicators, the scan ensures that the proposed medical school is responsive to the realities of population health and the state's long-term demand for providers. It also assesses the capacity of local hospitals, clinics, and community health centers to serve as clinical training sites, a factor essential to accreditation and student success. In addition, an environmental scan reviews the higher education and medical education landscape across the region, helping to identify potential overlaps, gaps, and opportunities for collaboration. The environmental scan evaluates external influences such as economic conditions, public policy priorities, and regulatory environments that could shape the success of the initiative. Taken together, these insights provide decision-makers with a clear, evidence-based picture of the opportunities and challenges, allowing them to make informed choices about the feasibility and strategic direction of a new medical school.

Regional Environmental Scan

The focus areas for the feasibility study encompassed the following counties: Bristol, Kent, Newport, Providence, and Washington.

Rhode Island Population Data

Rhode Island covers 1,033.9 square miles of land and 511.1 square miles of water area. It is the 50th largest state by area. Rhode Island is divided into five counties but has no county governments. The state is divided into 39 municipalities, which handle all local government affairs.¹ Providence is the largest city by population, followed by Warwick and Cranston.² The University of Rhode Island is the state's largest. The main campus of the University of Rhode Island is located in Kingston, Washington County.³

Rhode Island has a 2023 population of 1,095,371 people, a slight increase from the 2022 population of 1,094,250. Based on the 2023 data from the U.S. Census Bureau, an estimated 69.1% of the state's population is White, 5.0% is African American/Black, 3.4% is Asian, 0.2% is Native American or Alaska Native, 0.1% is Native Hawaiian or Other Pacific Islander, 0.8% is Some Other Race, 4.4% are Multiple Race and 17.1% is of Hispanic or Latino origin.⁴

According to the Economic Research Service, Rhode Island residents' average per capita income in 2023 totaled \$67,562.⁵

The ERS reports that the poverty rate statewide in Rhode Island is 11.4%. The unemployment rate is 3.0% in Rhode Island compared to 3.2% in 2022. A total of 10.5% of the population has not completed

¹ [RI.gov](https://www.rhodeisland.gov/)

² [World Population Review](https://www.worldpopulationreview.com/countries/rhode-island/).

³ [Data USA. Rhode Island. 2023](https://data.usa.gov/rhode-island/)

⁴ [U.S. Census Bureau, American Community Survey. 2023](https://www.census.gov/data/tables/2023/acs/american-community-survey.html)

⁵ [Rural Health Information Hub](https://www.rhodeshield.org/health-information-hub/)

high school, while 26.5% of the population obtained a high school diploma or equivalent (USDA-ERS, 2023).⁶

Demographics

- The 2023 population estimate for Rhode Island totaled 1.1 million, of which 93.2% are citizens. This rate is lower than the national average of 93.4%.⁷

Race⁸

- In 2023, Rhode Island had 10.8 times more White (non-Hispanic) residents (756k) than any other race or ethnicity. There were 69,800 Other (Hispanic) and 69,200 Multiracial (Hispanic) residents, the second- and third-most common ethnic groups.
- 17.1% (188,000) of the state’s population is Hispanic in 2023, an increase from 1.89% (25,900) in 2022.
- As of 2023, 15.1% of Rhode Island residents (165,000) were born outside of the United States; the national average is 13.5%. In 2022, the percentage of foreign-born citizens in Rhode Island was 14.7% (161,000), indicating an increase in the rate.
- The most common non-English language is Spanish (135,886 households), followed by Portuguese (29,134 households), and Haitian Creole (9,259 households).

Table 6: Race

2023	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Kingston	83.2%	5.4%	2.8%	0.3%	0.1%	2.3%	6.0%
Bristol County	90.4%	1.1%	2.3%	0.0%	0.0%	1.2%	5.0%
Kent County	86.6%	2.1%	3.0%	0.1%	0.1%	1.9%	6.3%
Newport County	84.9%	3.8%	1.7%	0.2%	0.0%	2.3%	7.0%
Providence County	62.1%	8.3%	4.2%	0.6%	0.1%	10.8%	13.9%
Washington County	90.4%	1.3%	2.2%	0.3%	0.0%	0.9%	4.8%
Rhode Island	72.3%	5.8%	3.5%	0.4%	0.1%	7.1%	10.7%
United States	63.4%	12.4%	5.8%	0.9%	0.2%	6.6%	10.7%

Source: [U.S. Census Bureau, ACS](#)

⁶ [USDA Economic Research Service; Rhode Island](#)

⁷ [Data USA](#)

⁸ Ibid.

Age

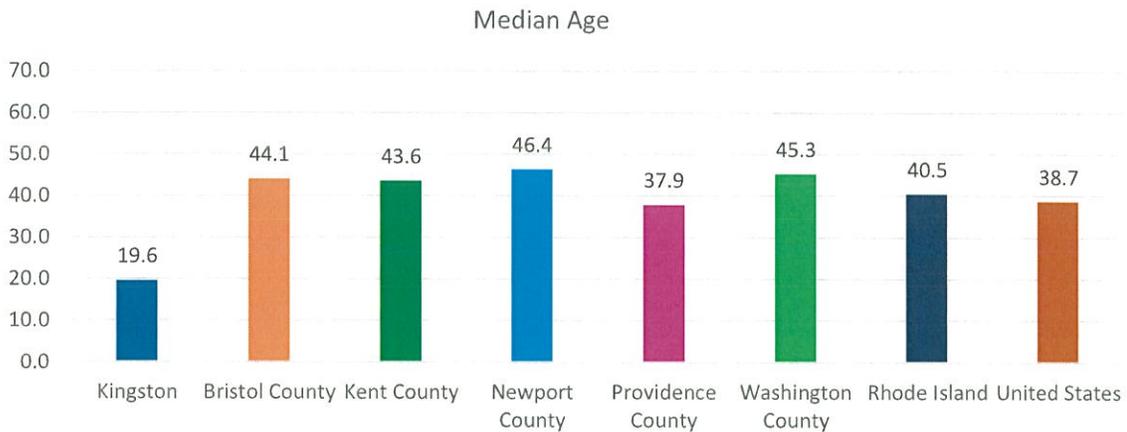
In 2023, the median age of all people in Rhode Island was 40.5. Newport County has the most aging population within the study area, with a median age of 46.4, higher than the state and national (38.7) medians. Providence County had the youngest population with a median age of 37.9.

Table 7: Age

County	Median Age
Kingston	19.6
Bristol County	44.1
Kent County	43.6
Newport County	46.4
Providence County	37.9
Washington County	45.3
Rhode Island	40.5
United States	38.7

Source: [U.S. Census Bureau. ACS 5-Year Estimate](#)

Figure 1: Median Age



Source: [U.S. Census Bureau. ACS 5-Year Estimate. 2023.](#)

Population

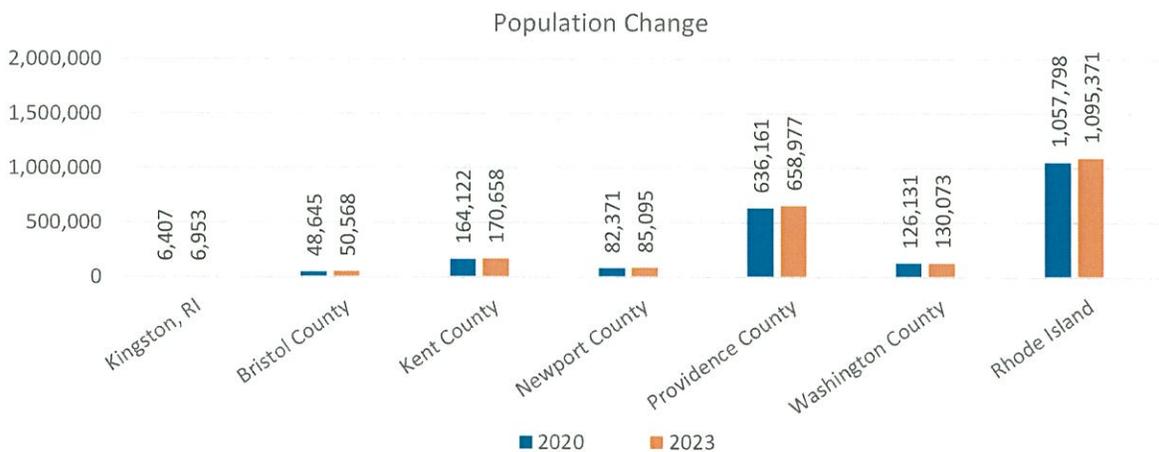
Rhode Island has experienced an overall population increase since 2020. The highest growth rate has occurred in Bristol and Kent counties, with 4.0%. The city of Kingston, though relatively small in population, had the highest rate of increase within the study areas, with 8.5%.⁹ From 2020 to 2023, Rhode Island had more residents under the age of 18 than those 65 and older.

Table 8: Demographics of Rhode Island

2023	Population, 2023 estimate	Population, 2020 estimate	Population, % change	Persons < 5 years, 2023	Persons <18 years, 2023	Persons 65+, 2023
Kingston	6,953	6,407	8.5%	56	495	272
Bristol County	50,568	48,645	4.0%	1,813	9,163	10,351
Kent County	170,658	164,122	4.0%	7,870	31,235	33,989
Newport County	85,095	82,371	3.3%	3,407	13,899	20,779
Providence County	658,977	636,161	3.6%	36,064	133,818	105,399
Washington County	130,073	126,131	3.1%	4,659	20,365	29,403
Rhode Island	1,095,371	1,057,798	3.6%	58,813	208,480	199,921
United States	332,387,540	326,569,308	1.8%	18,939,899	73,645,238	55,970,047

Source: [U.S. Census Bureau. ACS 5-Year Estimate](#)

Figure 2: Population Change, Rhode Island



Source: [U.S. Census Bureau. ACS 5-Year Estimate. 2023.](#)

⁹ [U.S. Census Bureau. ACS 5-Year Estimate. 2023.](#)

Income and Poverty

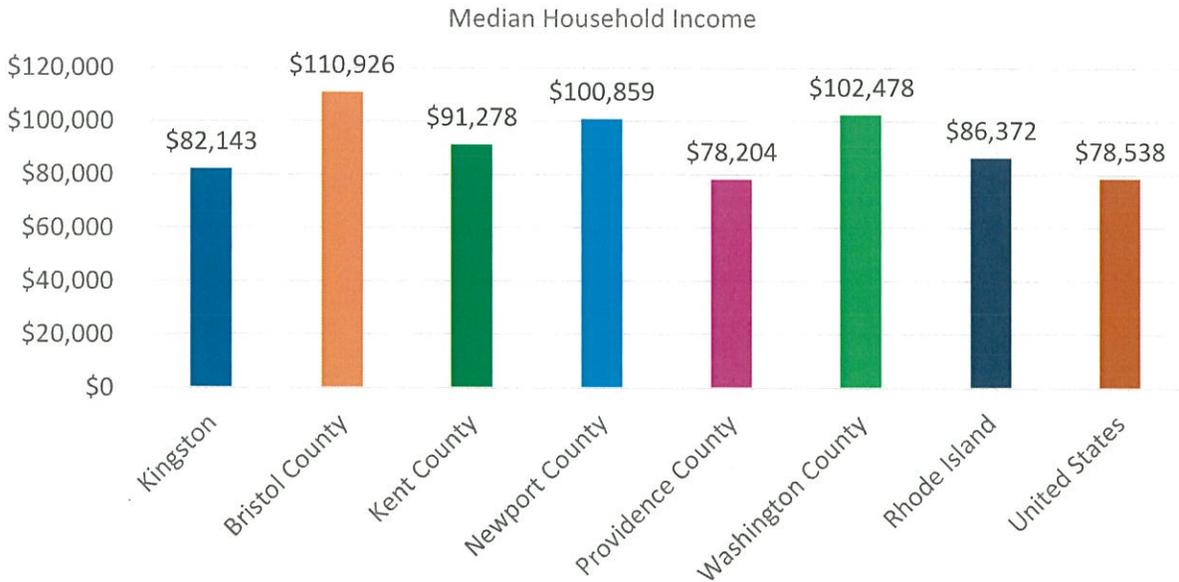
In 2023, households in Rhode Island earned a median annual income of \$86,372, more than the median annual income of \$78,538 across the United States. This is in comparison to a median income of \$81,370 in 2022.

Table 9: Income

2023	Total Households	Average Household Income	Median Household Income
Kingston	652	\$110,533	\$82,143
Bristol County	19,420	\$148,308	\$110,926
Kent County	72,743	\$115,863	\$91,278
Newport County	36,186	\$139,007	\$100,859
Providence County	256,505	\$101,714	\$78,204
Washington County	52,048	\$130,358	\$102,478
Rhode Island	436,902	\$112,642	\$86,372
United States	127,482,865	\$110,491	\$78,538

Source: [U.S. Census Bureau. ACS 5-Year Estimate](#)

Figure 3: Income



Source: [U.S. Census Bureau. ACS 5-Year Estimate. 2023](#)

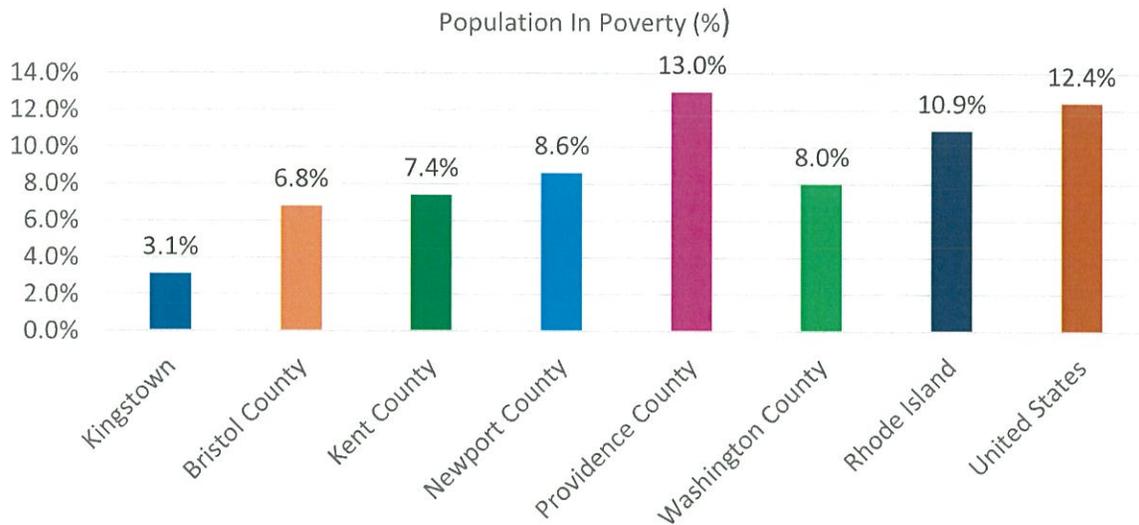
In 2023, 10.9% of the population for whom poverty status is determined in Rhode Island (approximately 114,890 of the 1.05 million people) lived below the poverty line, which is less than the national average of 12.4%. The largest impoverished demographic is those aged under 18, with 13.3%, followed by those aged 18 to 34, with 12.9%. A higher percentage of females were determined to be below the poverty line compared to males, with 12.0% and 9.7% respectively.¹⁰

Table 10: Population in Poverty

2023	Total Population	Population in Poverty	Population in Poverty (Percentage)
Kingston	1,804	56	3.1%
Bristol County	47,001	3,189	6.8%
Kent County	169,107	12,500	7.4%
Newport County	81,547	7,027	8.6%
Providence County	631,780	82,273	13.0%
Washington County	124,063	9,901	8.0%
Rhode Island	1,053,498	114,890	10.9%

Source: U.S. Census Bureau. ACS 5-Year Estimate

Figure 4: Population in Poverty, Rhode Island¹¹



Source: [U.S. Census Bureau. ACS 5-Year Estimate. 2023.](#)

¹⁰[U.S. Census Bureau, ACS 5-Year Estimate. 2023.](#)

¹¹ Ibid.

In 2023, the Native Hawaiian or Pacific Islander population had the highest proportion of those living in households with income below the federal poverty level at 28.9%, followed by Some Other Race at 23.3% and Black or African American (18.0%).¹²

Table 11: Race and Poverty

2023	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Kingston	2.3%	77.8%	No Data	0.0%	No Data	100.0%	No Data
Bristol County	6.7%	13.0%	0.0%	2.5%	0.0%	10.9%	7.3%
Kent County	6.9%	4.2%	14.5%	2.7%	9.2%	27.5%	10.7%
Newport County	7.3%	21.4%	17.9%	1.3%	0.0%	16.3%	17.0%
Providence County	9.3%	17.9%	17.0%	11.6%	36.4%	23.4%	18.2%
Washington County	6.8%	52.6%	10.75%	25.2%	0.0%	22.8%	8.6%
Rhode Island	8.2%	18.0%	16.6%	10.7%	28.9%	23.3%	16.7%
United States	9.9%	21.3%	21.8%	9.9%	17.2%	18.2%	14.7%

Source: U.S. Census Bureau, ACS 5-Year Estimate

Employment

In December 2024, there were 559,156 people employed in Rhode Island. This represents an increase in employment when compared to 556,000 people in December 2023.

Table 12: Employment¹³

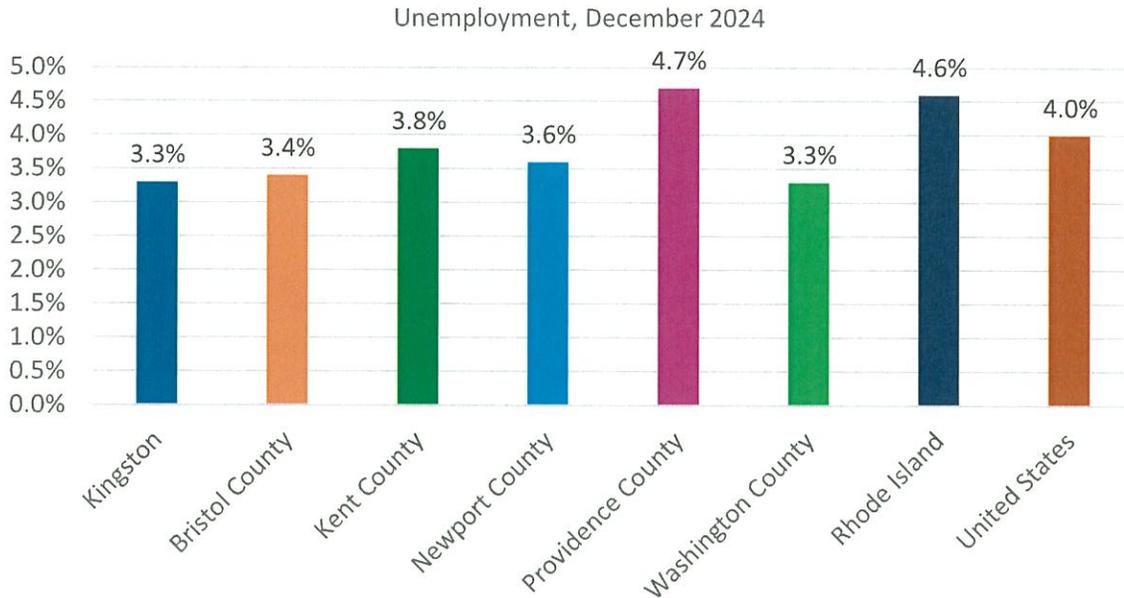
December 2024	Labor Force	Number Employed	Number Unemployed	Unemployment
Kingston	17,082	16,523	559	3.3%
Bristol County	27,123	26,190	933	3.4%
Kent County	95,816	92,177	3,639	3.8%
Newport County	46,080	44,441	1,639	3.6%
Providence County	343,366	327,214	16,152	4.7%
Washington County	71,523	69,136	2,387	3.3%
Rhode Island	583,902	559,156	24,746	4.6%
United States	168,164,000	161,456,000	6,708,000	4.0%

Source: [Rhode Island Department of Labor and Transportation-Local Area Unemployment Statistics. 2023-2024.](#)

¹² U.S. Census Bureau, ACS 5-Year Estimate. 2023.

¹³ [DLT- State of Rhode Island Department of Labor and Training. Local Area Unemployment Statistics. 2023-2024. PDF](#)

Figure 5: Rhode Island Unemployment Rate, 2024



Source: [Rhode Island Department of Labor and Transportation-Local Area Unemployment Statistics, 2023-2024.](#)

According to the U.S. Bureau of Labor Statistics, Rhode Island had an unemployment rate of 4.5% in November and December of 2024, as shown in Table 8. The Education and Health industry had the highest number of employees at 113,200 people, followed by the Trade, Transportation, and Utilities industry (78,400) and the Professional and Business Services industry (70,100).

Table 13: Rhode Island Economy at a Glance

	Nov 2024	Dec2024
Labor Force Data (number of people in 1000s, and seasonally adjusted)	Rhode Island	
Civilian Labor Force	591.4	591.4
Employment	564.6	564.7
Unemployment	26.8	26.8
Unemployment Rate %	4.5	4.5
Nonfarm Wage and Salary Employment		
Total Nonfarm	514.4	514.5
Mining and Logging	0.2	0.2
Construction	22.6	22.6
Manufacturing	39.7	40.0
Trade, Transportation, and Utilities	78.4	79.0
Information	5.5	5.5

	Nov 2024	Dec2024
Financial Activities	35.1	35.1
Professional & Business Services	70.1	69.4
Education & Health Services	113.2	112.6
Leisure & Hospitality	60.9	61.4
Other Services	22.2	22.2
Government	66.5	66.5

Source: [U.S. Bureau of Labor Statistics. Geographical Information. 2024](#)

Education

In 2022, universities in Rhode Island awarded 22,005 degrees. Table 9 reveals that the student population of Rhode Island consisted of more women (44,165) than men (31,787).

Table 14: Number of Degrees and Student Population by Gender

2022	Student Population		
	Degrees	Male	Female
Kingston	4,664	7,314	10,159
Bristol County	1,283	2,400	2,549
Kent County	2,999	5,887	8,271
Newport County	859	984	1,971
Providence County	12,200	15,202	21,215
Washington County	4,664	7,314	10,519
Rhode Island	22,005	31,787	44,165
United States	5,415,716	8,064,307	11,141,400

Source: [Data USA](#)

Most students graduating from universities in Rhode Island are White (13,033 and 63.1%), followed by Hispanic or Latino (2,721 and 13.2%), Black or African American (1,583 and 7.66%), and Unknown (1,394 and 6.74%).

The largest universities in Rhode Island by number of degrees awarded are the University of Rhode Island (4,664 and 21.2%), Brown University (3,506 and 15.9%), and the Community College of Rhode Island (2,161 and 9.82%).

Table 15: University Degrees Awarded

2022	The Largest Universities by Number of Degrees Awarded
Kingston	University of Rhode Island (4,664 and 100%)

2022	The Largest Universities by Number of Degrees Awarded
Bristol County	Roger Williams University (1,130 and 88.1%) and Roger Williams University School of Law (153 and 11.9%).
Kent County	Community College of Rhode Island (2,161 and 72.1%), New England Institute of Technology (838 and 27.9%).
Newport County	Salve Regina University (793 and 92.3%) and IYRS School of Technology and Trade (66 and 7.68%).
Providence County	Brown University (3,506 and 28.7%), Rhode Island College (1,614 and 13.2%) and Johnson & Wales University-Providence (1,577 and 12.9%).
Washington County	University of Rhode Island (4,664 and 100%)
Rhode Island	University of Rhode Island (4,664 and 21.2%), Brown University (3,506 and 15.9%), and Community College of Rhode Island (2,161 and 9.82%).
United States	Western Governors University (43,908 and 0.811%), Ivy Tech Community College (31,118 and 0.575%) and Grand Canyon University (29,319 and 0.541%).

Source: [Data USA](#)

The most popular degree majors awarded in Rhode Island are General Studies (1,080 and 4.91%), General Business Administration and Management (4.78%), and Registered Nursing (919 and 4.18%).

In 2022, White students were the most common race/ethnicity group awarded degrees at institutions. These 13,03 degrees mean that there were 4.79 times more degrees awarded to White students than the next closest race/ethnicity group, Hispanic or Latino, with 2,721 degrees awarded.

Table 16: Popular Majors

2022	Popular majors
Kingston	Registered Nursing (290 and 6.22%), General Psychology (230 and 4.93%), and General Business Administration and Management (207 and 4.44%).
Bristol County	Law (150 and 11.7%), Criminal Justice-Law Enforcement Administration (113 and 8.81%), and Paralegal (76 and 5.92%).
Kent County	General Studies (1,078 and 35.8%), Registered Nursing (364 and 12.1%), and General Business (3112 and 3.73%)
Newport County	General Business Administration and Management (115 and 13.4%), Registered Nursing (114 and 13.3%), and Criminal Justice-Law Enforcement Administration (113 and 13.2%).
Providence County	General Business Administration and Management (623 and 5.11%), Truck, Bus & Commercial Vehicle Operator and Instruction (607 and 4.98%), and General Finance (471 and 3.86%).
Washington County	Registered Nursing (290 and 6.22%), General Psychology (230 and 4.93%), and General Business Administration and Management (207 and 4.44%)
Rhode Island	General Studies (1,080 and 4.91%), General Business Administration and Management (1,051 and 4.78%), and Registered Nursing (919 and 4.18%).

2022	Popular majors
United States	Liberal Arts and Sciences (354,866 and 6.55%), General Business Administration and Management (343,412 and 6.34%), and Registered Nursing (262,974 and 4.86%).

Source: [Data USA](#)

Table 17 below displays the public high school enrollment rate (9-12 grades) for Rhode Island.

Table 17: High School Enrollment Rate, Rhode Island 2023

Location	Number
Bristol County	1,989
Kent County	6,024
Newport County	2,490
Providence County	24,502
Washington County	4,365
Rhode Island	44,262

Source: [Rhode Island Public School Enrollment. Kids Count Factbook](#)

The tables below indicate counties in Rhode Island and their rate of educational attainment. Table 13 shows the population aged 18-24 without a high school diploma. Kent County had the highest rate with 12.4%, followed by Providence County with 10.6%, and Washington with 7.5%. Bristol County had the lowest rate at 3.3%.

Table 14 reveals the counties with populations that (located in Rhode Island) earned a degree higher than a high school diploma and those with bachelor's degrees. The city of Kingston has the highest rate of the population with a high school diploma at 100% and those with a bachelor's degree or higher at 82%. Bristol, Newport, and Washington counties have 50% or higher populations that have earned a bachelor's degree or higher.

Table 18: 18- to 24-Year-Olds Without a High School Diploma, Rhode Island 2023

	Percent	Metro/Non-metro
Kingston	1.8%	Metro
Bristol County	3.3%	Metro
Kent County	12.4%	Metro
Newport County	6.4%	Metro
Providence County	10.6%	Metro
Washington County	7.5%	Metro

	Percent	Metro/Non-metro
Rhode Island	9.6%	Metro
United States	11.6%	

Source: [U.S. Census Bureau. ACS 5-Year Estimate](#)

Table 19: Education in Rhode Island, 2023

2023	High School Graduate or Higher, age 25+	Bachelor's Degree or Higher, age 25+
Kingston	100.0%	82.0%
Bristol County	93.5%	51.8%
Kent County	92.8%	34.3%
Newport County	95.3%	53.0%
Providence County	86.3%	32.3%
Washington County	95.3%	50.5%
Rhode Island	89.5%	37.3%
United States	89.4%	35.0%

Source: [U.S. Census Bureau. ACS 5-Year Estimate](#)

Health

Primary care physicians in Rhode Island see an average of 993 patients per year. This represents a decrease of 0.101% from the previous year (994 patients).¹⁴

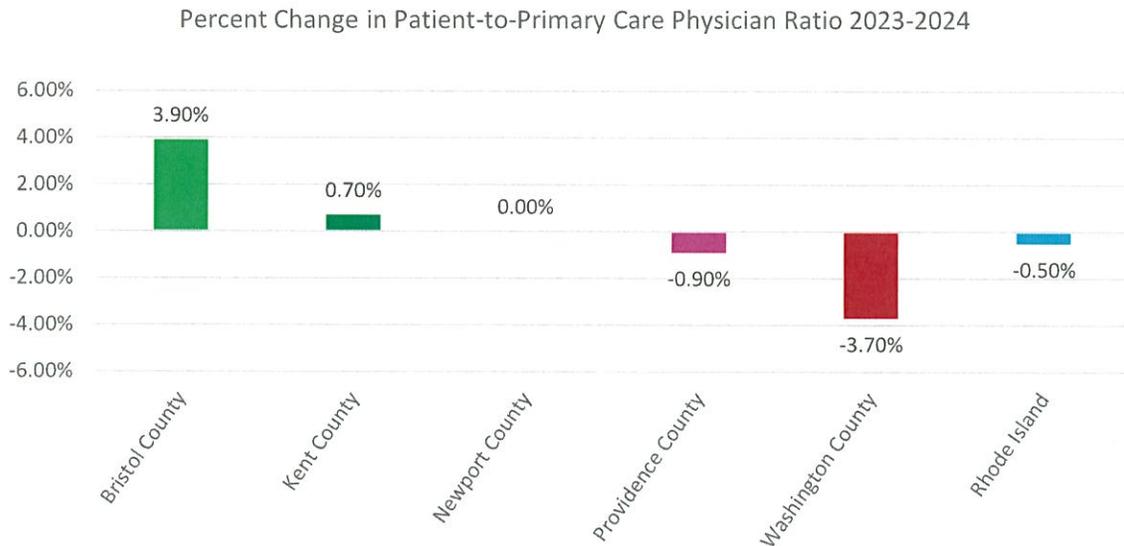
Table 20: Primary Care Physicians

2024 Reported Year	Primary Care Physicians 2023	Primary Care Physicians 2024	% Change in Patient-to-Primary Care Physician Ratio 2023-2024
Bristol County	98	102	3.9%
Kent County	143	144	0.7%
Newport County	71	71	0.0%
Providence County	642	636	-0.9%
Washington County	111	107	-3.7%
Rhode Island	1,065	1,060	-0.5%

Source: [County Health Rankings & Roadmaps](#)

¹⁴ [Data USA](#)

Figure 6: Patient-to-Primary Care Physician Ratio



Source: [County Health Rankings & Roadmaps](#)

Mental health providers in Rhode Island see an average of 221 patients per year. This represents a 1.34% decrease from the previous year (224 patients).¹⁵

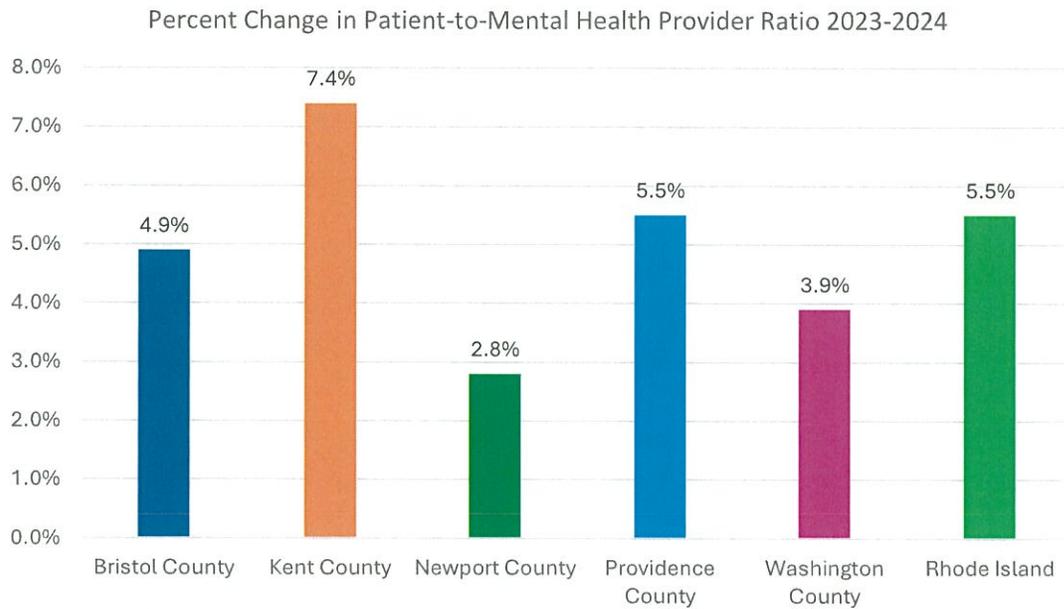
Table 21: Mental Health Providers

2024 Reported Year	Mental Health Providers 2023	Mental Health Providers 2024	% Change in Patient-to-Mental Health Provider Ratio 2023-2024
Bristol County	116	122	4.9%
Kent County	634	685	7.4%
Newport County	317	326	2.8%
Providence County	3,445	3,647	5.5%
Washington County	447	465	3.9%
Rhode Island	4,961	5,247	5.5%

Source: [County Health Rankings & Roadmaps](#)

¹⁵ [Data USA](#)

Figure 7: Patient-to-Mental Health Provider Ratio¹⁶



Source: [County Health Rankings & Roadmaps](#)

Health Risks

The table below shows the percentage of adults who have diabetes and obesity within the study area.

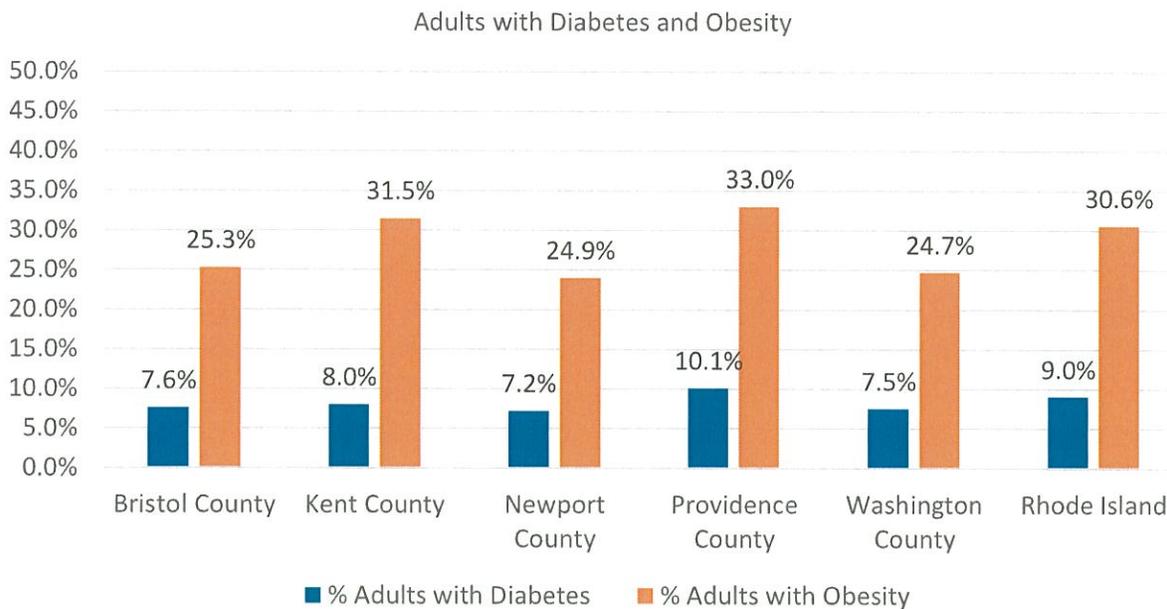
Table 22: Adults with Chronic Conditions

2023	% Adults with Diabetes	% Adults with Obesity
Bristol County	7.6	25.3
Kent County	8.0	31.5
Newport County	7.2	24.9
Providence County	10.1	33.0
Washington County	7.5	24.7
Rhode Island	9.0	30.6

Source: [Data USA](#)

¹⁶ [County Health Rankings & Roadmaps.2024.](#)

Figure 8: Adults with Chronic Conditions



Source: [Data USA 2023](#)

Health Overview ¹⁷

- Overall, 5% of Rhode Island’s population under age 65 did not have health insurance in 2023.
- In 2023, the ratio of population to primary care physicians in Rhode Island reached 990:1.
- In 2023, the number of hospital discharges for ambulatory-care-sensitive conditions per 100,000 Medicare enrollees totaled 2,677.

Challenges in Rhode Island ¹⁸

- High prevalence of excessive drinking.
- High prevalence of physical inactivity.
- Low numbers of dental care providers per 100,000.

Strengths in Rhode Island ¹⁹

- High childhood immunization rates.
- Low homicide rate.

¹⁷ [County Health Rankings & Roadmaps](#)

¹⁸ [America’s Health Rankings](#)

¹⁹ [Ibid](#)

- High per capita public health funding.

Highlights in Rhode Island²⁰

- Drug deaths increased 147% from 15.7 to 38.8 deaths per 100,000 population from 2010 to 2022.
- Chronic kidney disease increased from 2.3% to 3.7% of adults, representing a 61% rise, from 2016 to 2023.
- Smoking rates decreased by 53% from 20.0% to 9.5% among adults between 2011 and 2023.
- Food insecurity decreased 33% from 14.4% to 9.7% of households from 2011-2013 to 2021-2023.

County Health Rankings²¹

Health is influenced by every aspect of how and where we live. Access to secure and affordable housing, safe neighborhoods, good-paying jobs, and quality early childhood education are important factors that can put people on a path to a healthier life. However, access to these opportunities often varies based on where you live, your race, or the circumstances into which you were born. Data show persistent barriers to opportunity for people with lower incomes and communities of color across the United States. Differences in health factors emerge from unfair policies and practices at many levels over many decades.

Medical education programs anchored in communities have great potential to address the present and future needs of physicians who care for the region. Maintaining strong ties to the community improves clinical outcomes. Strong community partnerships through medical education will become increasingly critical as hospitals take on greater responsibility for health outcomes.

The table below shows the health rankings of counties within the study area.

Table 23: 2023 County Health Rankings Within the Study Area of Rhode Island²²

	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Bristol County	1	1	2	1	2	1	2	3
Kent County	4	4	4	4	4	3	4	2
Newport County	2	2	1	2	1	2	3	1
Providence County	5	5	5	5	5	5	5	5

²⁰ [Ibid](#)

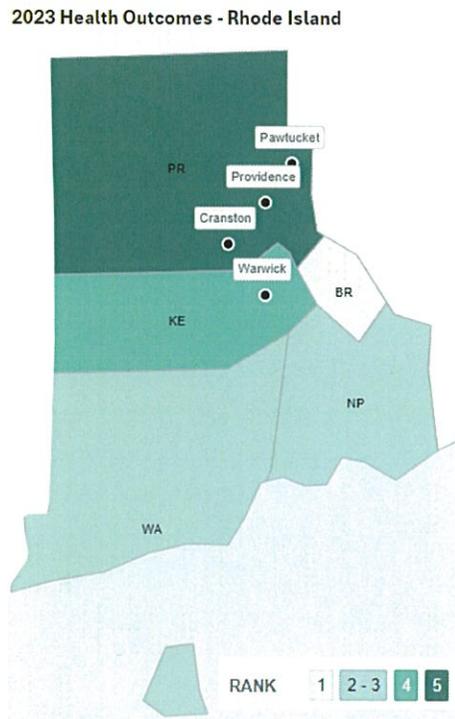
²¹ [County Health Rankings & Roadmaps](#)

²² [Country Health Rankings and Roadmaps](#)

	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Washington County	3	3	3	3	3	4	1	4

Source: [County Health Rankings & Roadmaps](#)

Map 1: 2023 Health Outcomes – Rhode Island ²³



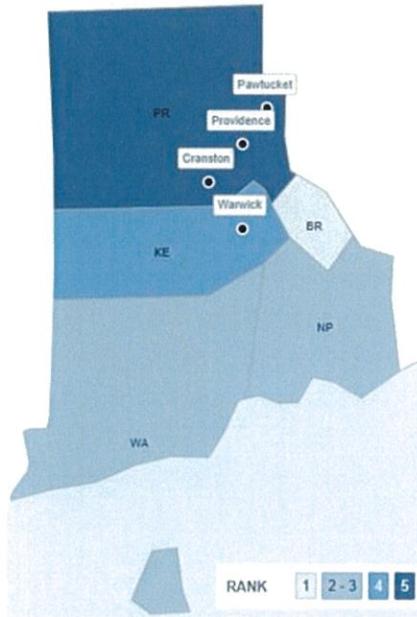
Source: [County Health Rankings & Roadmaps](#)

Health Outcomes reveal how long people live on average within a community and how much physical and mental health people experience in a community while they are alive. Bristol County ranks first of the five counties for Health Outcomes, followed by Newport and Washington.

²³ [County Health Rankings & Roadmaps](#)

Map 2: 2023 Health Factors – Rhode Island ²⁴

2023 Health Factors - Rhode Island



Source: [County Health Rankings & Roadmaps](#)

Health Factors represent those things that can improve the lives of people and help them live longer and healthier. They are indicators of the future health of our communities. Bristol ranked first of the five counties, followed by Newport and Washington.

A state demonstrates a high need for primary-care physicians as measured by the number of counties in the state that are full or partial HPSAs. Table 19 shows that Rhode Island has 13 primary-care HPSA designations, resulting in the need for an additional 13 practitioners to remove the HPSA designation label as of December 2024.

Map 3 illustrates the primary care shortage throughout Rhode Island. A darker HPSA shade indicates a more severe shortage of primary care physicians. The HPSAs in Rhode Island are primarily located in the northern and southern parts of the state.

Table 24: Designated Health Professional Shortage Areas-2024²⁵

Maine	Number of Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Primary Care	13	137,033	72.13%	13

²⁴ [County Health Rankings & Roadmaps.](#)

²⁵ [Designated Health Professional Shortage Areas-2024](#)

Maine	Number of Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Dental Care	13	140,340	35.72%	23
Mental Care	12	394,307	58.09%	11

According to Map 3, Health Professional Shortage Areas are located mostly in the northern and southern areas of Rhode Island.

Map 3: Health Professional Shortage Areas in Rhode Island ²⁶



Source: [data.HRSA.gov](https://data.hrsa.gov), January 2025.

²⁶ [Data.HRSA.gov](https://data.hrsa.gov), January 2025.

Map 4: Rhode Island Rural Healthcare Facilities-2024

Rhode Island Rural Healthcare Facilities



*Sites according to data.HRSA.gov (October 2024), showing only locations outside of [U.S. Census Bureau Urban Areas](https://www.census.gov/urban-areas) with a population of 50,000 or more

Source: Rural Health Information Hub. 2024

Clinical Landscape in Rhode Island

Table 25 lists the hospitals and medical centers, totaling more than 2,429 beds in Rhode Island. These sites offer students opportunities to obtain clerkships and residency training. Clinical partnership opportunities exist at FQHCs, physician offices, community centers, nursing homes, and clinics.

Table 25: Non-Federal, Short-Term, Acute-Care Hospitals

Hospital Name	City	Staffed Beds	Total Discharges	Patient Days	Gross Patient Revenue (\$000)
Kent Hospital	Warwick	343	10,910	58,014	\$1,067,379
Landmark Medical Center	Woonsocket	131	6,107	24,148	\$721,392
Newport Hospital	Newport	109	4,079	16,723	\$403,106
Our Lady of Fatima Hospital	North Providence	312	3,753	14,185	\$567,249
Rhode Island Hospital	Providence	706	28,885	184,939	\$4,451,836
Roger Williams Medical Center	Providence	160	6,260	25,998	\$610,298
South County Health	Wakefield	79	5,167	19,446	\$716,286
The Miriam Hospital	Providence	247	16,383	71,635	\$1,832,916
The Westerly Hospital	Westerly	95	3,077	13,842	\$470,415

Hospital Name	City	Staffed Beds	Total Discharges	Patient Days	Gross Patient Revenue (\$000)
Women & Infants Hospital	Providence	247	10,222	68,572	\$1,066,347
Providence VA Medical Center	Providence	0	0	0	\$0
TOTAL		2,429	94,843	497,502	\$11,907,224

Source: [American Hospital Directory](#)

Table 26: Federally Qualified Health Centers and Look-Alikes in Rhode Island

Facility Name	Address	City	State	Zip	County
Blackstone Valley Community Healthcare	39 East Ave	Pawtucket	RI	02860-4003	Providence County
Comprehensive Community Action Inc.	311 Doric Ave, Ste 1	Cranston	RI	02910-2903	Providence County
Northwest Community Health Care	36 Bridge Way	Pascoag	RI	02859-3131	Providence County
East Bay Community Action Program	19 Broadway	Newport	RI	02840-2937	Newport County
The Providence Community Health Centers Inc.	375 Allens Ave	Providence	RI	02905-5010	Providence County
Tri-County Community Action Agency	1126 Hartford Ave	Johnston	RI	02919-7109	Providence County
Thundermist Health Center	171 Service Ave	Warwick	RI	02886-1014	Kent County
Wood River Health Services Inc.	823 Main St	Hope Valley	RI	02832-1920	Washington County

Source: [Health Resources & Services Administration](#)

Table 27: ACGME and AOA Family Medicine Residency Programs in Rhode Island

Institution Name	Program Name	Program City
Thundermist Health Center of Woonsocket	Thundermist Health Center of Woonsocket	Woonsocket
Rhode Island Hospital/Brown University Health	Rhode Island Hospital/Brown University Health	Providence
Women and Infants Hospital of Rhode Island	Women and Infants Hospital of Rhode Island	Providence
Roger Williams Medical Center	Roger Williams Medical Center	Providence
Butler Hospital	Butler Hospital	Providence

Institution Name	Program Name	Program City
Kent Hospital	Kent Hospital/Brown University Program	Warwick/Pawtucket

Source: [Accreditation Council for Graduate Medical Education](#)

Table 28: Nursing Homes in Rhode Island

Facility	Address	Phone (401)	No. of Beds	Medicare	Medicaid	County
Crestwood Nursing & Rehabilitation Center	568 Child Street, Warren	245-1574	76	Y	Y	Bristol
Grace Barker Nursing Home	54 Barker Avenue, Warren	245-9100	86	Y	Y	Bristol
Rhode Island Veterans Home	480 Metacom Avenue, Bristol	253-8000	192	N	N	Bristol
The Dawn Hill Home for Rehabilitation & Healthcare	One Dawn Hill Road, Bristol	253-2300	133	Y	Y	Bristol
Silver Creek Rehab & Healthcare Center	7 Creek Lane, Bristol	253-3000	128	Y	Y	Bristol
Warren Skilled Nursing & Rehabilitation	642 Metacom Avenue, Warren	245-2860	63	Y	Y	Bristol
Alpine Nursing Home	557 Weaver Hill Road, Coventry	397-5001	60	Y	Y	Kent
Avalon Nursing Home	57 Stokes Street, Warwick	738-1200	31	Y	Y	Kent
Brentwood Nursing Home	4000 Post Road, Warwick	884-8020	96	Y	Y	Kent
Respiratory and Rehabilitation Center of RI	10 Woodland Drive, Coventry	826-2000	210	Y	Y	Kent
Greenwood Center	1139 Main Avenue, Warwick	739-6600	130	Y	Y	Kent
Kent Regency Center	660 Commonwealth Avenue, Warwick	739-4241	153	Y	Y	Kent
Riverview Healthcare Community	546 Main Street, Coventry	821-6837	190	Y	Y	Kent
Saint Elizabeth Home East Greenwich	1 Saint Elizabeth Way, East Greenwich	471-6060	168	Y	Y	Kent

Facility	Address	Phone (401)	No. of Beds	Medicare	Medicaid	County
Sunny View Nursing Home	83 Corona Street, Warwick	737-9193	57	Y	Y	Kent
West Shore Health Center	109 West Shore Road, Warwick	739-9440	145	Y	Y	Kent
West View Nursing and Rehabilitation Center	239 Legris Avenue West Warwick	828-9000	120	Y	Y	Kent
Royal Middletown Nursing & Rehabilitation Center	193 Forest Avenue, Middletown	847-2777	50	Y	Y	Newport
Grand Islander Center	333 Green End Avenue, Middletown	849-7100	146	Y	Y	Newport
Heatherwood Nursing & Subacute Center	398 Bellevue Avenue, Newport	849-6600	114	Y	Y	Newport
John Clarke Retirement Centre	600 Valley Road, Middletown	846-0743	60	Y	Y	Newport
St. Clare Home	309 Spring Street, Newport	849-3204	50	Y	Y	Newport
Village House Nursing & Rehabilitation Center	70 Harrison Avenue, Newport	849-5222	95	Y	Y	Newport
Bannister Center for Rehabilitation & Healthcare	135 Dodge Street, Providence	521-9600	161	Y	Y	Providence
Bayberry Commons	181 Davis Drive, Pascoag	568-0600	110	Y	Y	Providence
Berkshire Place	455 Douglas Ave, Providence	553-8600	220	Y	Y	Providence
Bethany Home of Rhode Island	111 South Angell Street, Providence	831-2870	33	Y	Y	Providence
Briarcliffe Manor	49 Old Pocasset Road, Johnston	944-2450	122	Y	Y	Providence
Cedar Crest Nursing Centre	125 Scituate Avenue, Cranston	944-8500	156	Y	Y	Providence
Cherry Hill Manor	2 Cherry Hill Road, Johnston	231-3102	172	Y	Y	Providence
Stillwater Assisted Living and Skilled Nursing Community	20 Austin Avenue, Greenville	949-3880	80	Y	Y	Providence
Cra-Mar Meadows	575 Seven Mile Road, Cranston	828-5010	41	Y	Y	Providence

Facility	Address	Phone (401)	No. of Beds	Medicare	Medicaid	County
Eastgate Nursing & Rehabilitation Center	198 Waterman Avenue, East Providence	431-2087	68	Y	Y	Providence
Elmhurst Rehabilitation and Healthcare Center	50 Maude Street, Providence	456-2600	206	Y	Y	Providence
Elmwood Nursing and Rehabilitation Center	225 Elmwood Avenue, Providence	272-0600	70	Y	Y	Providence
Evergreen House Health Center	1 Evergreen Drive, East Providence	438-3250	160	Y	Y	Providence
Friendly Home	303 Rhodes Avenue, Woonsocket	769-7220	126	Y	Y	Providence
Golden Crest Nursing Centre	100 Smithfield Road, Providence	353-1710	152	Y	Y	Providence
Grandview Center	100 Chambers Street, Cumberland	724-7500	72	Y	Y	Providence
Greenville Skilled Nursing & Rehabilitation	735 Putnam Pike, Greenville	949-1200	131	Y	Y	Providence
Harris Health Care Center-North	60 Eben Brown Lane, Central Falls	722-6000	32	Y	Y	Providence
Harris Health Center	833 Broadway, East Providence	434-7404	31	Y	Y	Providence
Hattie Ide Chaffee Home	200 Wampanoag Trail, Riverside	434-1520	69	Y	Y	Providence
Hebert Nursing Home	180 Log Road, Smithfield	231-7016	133	Y	Y	Providence
Heritage Hills Nursing & Rehabilitation Center	80 Douglas Pike, Smithfield	231-2700	100	Y	Y	Providence
Holiday Retirement Home	30 Sayles Hill Road, Manville	765-1440	170	Y	Y	Providence
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road, Providence	353-6300	210	Y	Y	Providence
Jeanne Jugan Residence	964 Main Street, Pawtucket	723-4314	49	Y	Y	Providence
Mansion Nursing and Rehabilitation Center	104 Clay Street, Central Falls	722-0830	62	Y	Y	Providence
Morgan Health Center	80 Morgan Avenue, Johnston	944-7800	120	Y	Y	Providence

Facility	Address	Phone (401)	No. of Beds	Medicare	Medicaid	County
Mount St Rita Health Centre	15 Sumner Brown Road, Cumberland	333-6352	98	Y	Y	Providence
Oak Hill Health and Rehabilitation Center	544 Pleasant Street, Pawtucket	725-8888	129	Y	Y	Providence
Oakland Grove Health Care Center	560 Cumberland Hill Road, Woonsocket	769-0800	178	Y	Y	Providence
Orchard View Manor	135 Tripps Lane, East Providence	438-2250	166	Y	Y	Providence
Overlook Nursing & Rehabilitation Center	14 Rock Avenue, Pascoag	568-2549	100	Y	Y	Providence
Pawtucket Falls Healthcare Center	70 Gill Avenue, Pawtucket	722-7900	154	Y	Y	Providence
Crystal Lake Rehabilitation and Care Center	999 South Main Street, Pascoag	568-3091	71	Y	Y	Providence
Scandinavian Home	1811 Broad Street, Cranston	461-1433	24	Y	Y	Providence
St Antoine Residence	10 Rhodes Avenue, North Smithfield	767-3500	180	Y	Y	Providence
Steere House Nursing and Rehabilitation Center	100 Borden Street, Providence	454-7970	120	Y	Y	Providence
Summit Commons Rehabilitation and Health Care Center	99 Hillside Avenue, Providence	574-4800	165	Y	Y	Providence
Tockwotton on the Waterfront	500 Waterfront Drive, East Providence	272-5280	52	Y	Y	Providence
Trinity Health & Rehabilitation Center	4 St Joseph Street, Woonsocket	765-5844	185	Y	Y	Providence
Waterview Villa Rehabilitation and Health Care Center	1275 South Broadway, East Providence	438-7020	132	Y	Y	Providence
Woonsocket Health Centre	262 Poplar Street, Woonsocket	765-2100	150	Y	Y	Providence
Apple Rehab Clipper	161 Post Road, Westerly	322-8081	60	Y	Y	Washington
Elderwood Of Scallop Shell at Wakefield	55 Scallop Shell Way, Peace Dale	789-3006	80	Y	Y	Washington

Facility	Address	Phone (401)	No. of Beds	Medicare	Medicaid	County
Kingston Center For Rehabilitation and Health Care	415 Gardner Road, West Kingston	295-8520	55	Y	Y	Washington
Roberts Health Centre	25 Roberts Way, North Kingstown	294-3587	66	Y	Y	Washington
Bayview Rehabilitation and Healthcare Center at Scalabrini	860 North Quidnessett Road, North Kingstown	884-1802	120	Y	Y	Washington
South County Nursing and Rehabilitation Center	740 Oak Hill Road, North Kingstown	294-4105	120	Y	Y	Washington

Source: [Rhode Island Department of Health](#)

Table 29 presents application data for U.S. M.D.-granting medical schools in the Northeast region (Connecticut, Massachusetts, New York, Rhode Island, and Vermont) for the 2024–2025 academic year.

Tufts University (MA) received the highest number of applications (14,248), with only 7.5% from in-state students and 58.4% from women. In contrast, CUNY (NY) shows 100% in-state applicants because of its unique admissions structure. Overall, most schools had a significantly larger share of out-of-state applicants, and across nearly all schools, women represented a higher share of applicants than men.

Table 29: U.S. M.D.-Granting Schools 2024-2025 Academic Year

Applications by School		Applications ¹	Applications			
			by In State Status		by Gender ²	
			In State	Out of State	Men	Women
State	Medical School		%	%	%	%
CT	Connecticut	4,626	10.1	89.9	40.7	58.5
	Quinnipiac-Netter	7,341	4.8	95.2	42.9	56.5
	Yale	6,597	3.3	96.7	46.5	52.4
MA	BU-Chobanian Avedisian	10,680	8.4	91.6	40.4	58.6
	Harvard	7,890	8.1	91.9	46.1	52.7
	Massachusetts-Chan	4,903	21.3	78.7	39.9	59.2
	Tufts	14,248	7.5	92.5	40.8	58.4
NY	Albany	12,973	15.9	84.1	42.2	57.2
	Buffalo-Jacobs	5,828	36.8	63.2	42.7	56.4
	CUNY	57	100.0	0.0	42.1	57.9
	Columbia-Vagelos	7,291	15.0	85.0	44.4	54.5

Applications by School		Applications ¹	Applications			
			by In State Status		by Gender ²	
State	Medical School		In State	Out of State	Men	Women
		%	%	%	%	
	Cornell-Weill	7,345	17.0	83.0	45.4	53.5
	Einstein	8,896	19.8	80.2	45.1	53.9
	Mount Sinai-Icahn	8,890	16.4	83.6	43.6	55.3
	NYU Long Island-Grossman	4,370	26.2	73.8	38.1	61.1
	NYU-Grossman	8,271	13.8	86.2	41.4	57.4
	New York Medical	9,075	22.5	77.5	42.3	57.0
	Renaissance Stony Brook	5,303	38.6	61.4	43.0	56.1
	Rochester	5,925	22.1	77.9	45.8	53.2
	SUNY Downstate	6,596	37.9	62.1	39.2	60.0
	SUNY Upstate-Norton	6,635	33.9	66.1	41.0	58.3
	Zucker Hofstra Northwell	4,790	32.0	68.0	43.5	55.6
RI	Brown-Alpert	8,315	1.1	98.9	42.7	56.3
VT	Vermont-Larner	9,301	0.8	99.2	42.6	56.6

Source: [AAMC, 2024 FACTS: Applicants and Matriculants Data](#)

The table below shows applications and matriculants for U.S. M.D.-granting medical schools in the 2024–2025 academic year across Connecticut, Massachusetts, New York, Rhode Island, and Vermont. Tufts University received the highest number of applications (14,248) and enrolled 202 students, with the majority coming from out of state (72.3%) and women comprising 64.4% of the class. Meanwhile, CUNY enrolled 57 students, all from in-state. In general, most schools enrolled a majority of out-of-state students, and women represented a larger share of matriculants at many institutions.

Table 30: U.S. M.D.-Granting Schools 2024-2025 Academic Year

Applications by School		Applications ¹	Matriculants	Matriculants			
				by In State Status		by Gender ²	
State	Medical School			In State	Out of State	Men	Women
		%	%	%	%		
CT	Connecticut	4,626	112	81.3	18.8	42.9	57.1
	Quinnipiac-Netter	7,341	95	11.6	88.4	42.1	57.9
	Yale	6,597	104	1.0	99.0	48.1	51.9
MA	BU-Chobanian Avedisian	10,680	140	20.7	79.3	38.6	59.3

Applications by School		Applications ¹	Matriculants	Matriculants			
				by In State Status		by Gender ²	
				In State	Out of State	Men	Women
State	Medical School			%	%	%	%
	Harvard	7,890	165	13.9	86.1	38.2	60.6
	Massachusetts-Chan	4,903	235	62.6	37.4	28.1	70.2
	Tufts	14,248	202	27.7	72.3	35.1	64.4
NY	Albany	12,973	140	35.0	65.0	49.3	50.0
	Buffalo-Jacobs	5,828	181	87.8	12.2	47.5	51.4
	CUNY	57	57	100.0	0.0	42.1	57.9
	Columbia-Vagelos	7,291	138	14.5	85.5	47.1	52.2
	Cornell-Weill	7,345	106	24.5	75.5	39.6	56.6
	Einstein	8,896	165	44.2	55.8	37.0	63.0
	Mount Sinai-Icahn	8,890	119	26.9	73.1	51.3	48.7
	NYU Long Island-Grossman	4,370	24	66.7	33.3	37.5	62.5
	NYU-Grossman	8,271	104	11.5	88.5	51.0	49.0
	New York Medical	9,075	219	46.1	53.9	45.2	54.3
	Renaissance Stony Brook	5,303	136	75.0	25.0	44.9	54.4
	Rochester	5,925	102	27.5	72.5	46.1	52.0
	SUNY Downstate	6,596	201	85.1	14.9	41.8	57.2
	SUNY Upstate-Norton	6,635	172	80.8	19.2	43.0	56.4
	Zucker Hofstra Northwell	4,790	99	64.6	35.4	43.4	56.6
RI	Brown-Alpert	8,315	144	13.2	86.8	43.1	55.6
VT	Vermont-Larner	9,301	124	25.8	74.2	46.0	50.8

Source: [AAMC, 2024 FACTS: Applicants and Matriculants Data](#)

Appendix D: Budget Summary

The pro forma for the University of Rhode Island's proposed medical school outlines projected revenues, expenses, and financial performance over 11 years (2026–2037). The plan begins with three planning years and then transitions into operational years once the first medical school class is admitted in 2029. The table reflects both the startup investment required and the long-term sustainability of the school once fully established.

Revenue during the early years is driven primarily by significant philanthropic and institutional commitments. This includes \$20 million from the state of Rhode Island and \$17.5 million from URI in seed funding in 2026, \$50 million naming donor gift, and \$25 million in matching funds from private partners in 2027. Endowment contributions of \$50 million and additional investments of \$12.5 million begin in 2027, bringing the total private investment to \$137.5 million. Beginning in 2029, state allocations of \$22.5 million annually provide consistent baseline support.

Tuition revenue begins once students are enrolled in 2029, starting at \$2.5 million and growing steadily to more than \$24.4 million annually by 2037. Additional revenue streams, such as philanthropy, research grants, clinical practice plan income, and research contracts, scale upward in later years, diversifying and strengthening the financial position of the medical school.

On the expense side, salaries and fringe benefits represent the largest cost category, ramping up as administrative staff, faculty, and student support services are added. Faculty costs increase substantially as more cohorts of students enter the program, with total salaries and benefits growing from about \$15.0 million in 2029 to more than \$36.6 million annually by 2037. Other expenses include operating costs, IT, simulation centers, and building-related expenditures. A significant one-time capital expense of \$31.3 million is recognized in 2027 and 2028 to prepare facilities for instruction. Overall expenses grow from approximately \$22.9 million in the first operational year to more than \$61.0 million annually by 2037.

Financial performance reflects expected deficits in the startup years because of high upfront investment. Losses occur in certain years (notably 2028), as tuition revenue has not yet matured, and expenses remain high. However, beginning in 2029, the school transitions into sustained positive operating margins, generating profits between \$5.8 million and \$16.0 million annually.

The URI medical school pro forma demonstrates a well-structured financial pathway from initial investment to long-term stability. Upfront funding commitments from donors, private partners, and the state are critical to cover startup costs and early operating deficits. Once tuition revenues stabilize and research and clinical programs expand, the school is projected to operate at a substantial surplus, allowing for reinvestment in its academic, research, and community missions while ensuring long-term viability.

**The University of Rhode Island Pro Forma
Budget Summary**

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
Revenue												
Tuition	\$-	\$-	\$-	\$2,500,000	\$5,047,000	\$9,017,650	\$13,167,360	\$16,319,878	\$19,591,732	\$21,612,347	\$23,736,566	\$24,448,663
Research grants	\$-	\$-	\$-	\$-	\$-	\$2,000,000	\$2,500,000	\$3,135,000	\$3,906,250	\$4,882,813	\$6,103,516	\$7,629,395
Clinical	\$-	\$-	\$-	\$-	\$-	\$1,000,000	\$1,350,000	\$1,822,500	\$2,460,375	\$3,321,506	\$4,484,033	\$6,053,445
Practice Plan	\$-	\$-	\$-	\$-	\$-	\$1,000,000	\$540,000	\$729,000	\$984,150	\$1,328,603	\$1,793,613	\$2,421,378
Research Contracts	\$-	\$-	\$-	\$-	\$-	\$1,200,000	\$1,560,000	\$2,028,000	\$2,636,400	\$3,427,320	\$4,455,516	\$5,792,171
Endowment	\$50,000,000	\$50,000,000	\$50,000,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000	\$2,500,000
Private Funds	\$-	\$25,000,000	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-
Naming Donor	\$-	\$50,000,000	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-
Seed Funding (University Foundation)	\$17,500,000	\$12,500,000										
State Allocation	\$20,000,000	\$-	\$-	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000	\$22,500,000
Business Plan												
Philanthropy	\$-	\$1,000,000	\$1,250,000	\$1,562,500	\$1,953,125	\$2,441,406	\$3,051,758	\$3,814,697	\$4,768,372	\$5,960,464	\$7,450,581	\$9,313,226
Other Revenue	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-
Subtotal Revenue	\$37,500,000	\$138,500,000	\$1,250,000	\$29,062,500	\$32,000,125	\$41,659,056	\$47,169,118	\$52,839,075	\$59,347,278	\$65,533,052	\$73,023,825	\$80,658,277
Scholarship Contra Revenue (assumed 15% of Tuition)	\$-	\$-	\$-	\$375,000	\$757,050	\$1,352,648	\$1,975,104	\$2,447,982	\$2,938,760	\$3,241,852	\$3,560,485	\$3,667,299
Total Revenue less Scholarship	\$37,500,000	\$138,500,000	\$1,250,000	\$28,687,500	\$31,243,075	\$40,306,409	\$45,194,014	\$50,391,093	\$56,408,519	\$62,291,200	\$69,463,340	\$76,990,977

**The University of Rhode Island Pro Forma
Budget Summary**

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
Expenses												
Salaries and Fringe												
Administrative	\$-	\$3,415,537	\$3,415,537	\$3,582,873	\$3,865,623	\$3,865,623	\$3,865,623	\$3,865,623	\$3,865,623	\$3,865,623	\$3,865,623	\$3,865,623
Academic Affairs	\$-	\$1,995,504	\$2,571,008	\$3,110,508	\$3,735,903	\$4,421,653	\$4,628,906	\$4,605,700	\$4,637,876	\$4,642,564	\$4,647,392	\$4,652,366
Student Services	\$-	\$604,722	\$1,657,945	\$1,917,945	\$2,054,445	\$2,054,445	\$2,054,445	\$2,054,445	\$2,054,445	\$2,054,445	\$2,054,445	\$2,054,445
MS1 and MS2 Faculty	\$-	\$2,186,409	\$2,186,409	\$4,112,818	\$4,788,194	\$7,052,291	\$7,052,291	\$7,052,291	\$7,052,291	\$7,052,291	\$7,052,291	\$7,052,291
MS3 and MS4 Faculty	\$-	\$763,853	\$763,853	\$2,337,233	\$4,170,688	\$9,738,932	\$9,738,932	\$13,184,346	\$13,184,346	\$17,019,759	\$17,019,759	\$17,957,988
Institut. Support Eliminated*	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$968,500
Total Salaries and Fringe	\$-	\$8,966,025	\$10,594,752	\$15,061,376	\$18,614,852	\$27,132,943	\$27,340,196	\$30,762,403	\$30,794,580	\$34,634,681	\$34,639,509	\$36,551,212
Other Expenses												
Operating Expenses	\$-	\$5,857,000	\$2,072,650	\$3,497,845	\$3,163,093	\$6,927,177	\$12,693,500	\$13,333,785	\$14,299,939	\$17,154,235	\$17,910,011	\$18,179,492
IT Expenses	\$-	\$813,340	\$1,904,015	\$2,143,280	\$2,273,958	\$2,591,600	\$2,627,519	\$2,867,493	\$3,011,340	\$3,222,212	\$3,324,510	\$3,604,723
Simulation Expenses	\$-	\$2,650,000	\$571,400	\$909,240	\$1,105,002	\$1,166,552	\$1,228,880	\$1,281,549	\$1,335,126	\$1,378,182	\$1,422,792	\$1,457,031
Building Expenses	\$-	\$31,250,000	\$31,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000	\$1,250,000
Total Other Expenses	\$-	\$40,570,340	\$35,798,065	\$7,800,365	\$7,792,052	\$11,935,329	\$17,799,899	\$18,732,827	\$19,896,406	\$23,004,629	\$23,907,312	\$24,491,246
TOTAL EXPENSES (Salaries and Fringe + Other)	\$-	\$49,536,365	\$46,392,816	\$22,861,741	\$26,406,905	\$39,068,272	\$45,140,095	\$49,495,231	\$50,690,986	\$57,639,310	\$58,546,822	\$61,042,458
Total Revenue Expenses	\$37,500,000	\$88,963,635	\$45,142,816	\$5,825,759	\$4,836,170	\$1,238,137	\$53,919	\$895,863	\$5,717,533	\$4,651,890	\$10,916,518	\$15,948,519
Running Profit (Loss)		\$126,463,635	\$81,320,819	\$87,146,578	\$91,982,748	\$93,220,885	\$93,274,804	\$94,170,667	\$99,888,200	\$104,540,090	\$115,456,608	\$131,405,127

* Institutional Support Eliminated in Year 9 (picked up by school)

The University of Rhode Island Pro Forma Enrollment and Revenue

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
MS1				50	50	75	75	100	100	100	100	100
MS2					48	48	72	72	96	96	96	96
MS3						47	47	71	71	95	95	95
MS4							47	47	71	71	95	95
Total Students	0	0	0	50	98	170	241	290	338	362	386	386
ANNUAL TUITION (3% annual increase)												
MS1		\$-	\$-	\$50,000.00	\$51,500.00	\$53,045.00	\$54,636.35	\$56,275.44	\$57,963.70	\$59,702.61	\$61,493.69	\$63,338.50
MS2		\$-	\$-	\$-	\$51,500.00	\$53,045.00	\$54,636.35	\$56,275.44	\$57,963.70	\$59,702.61	\$61,493.69	\$63,338.50
MS3		\$-	\$-	\$-	\$-	\$53,045.00	\$54,636.35	\$56,275.44	\$57,963.70	\$59,702.61	\$61,493.69	\$63,338.50
MS4		\$-	\$-	\$-	\$-	\$-	\$54,636.35	\$56,275.44	\$57,963.70	\$59,702.61	\$61,493.69	\$63,338.50
ANTICIPATED TUITION REVENUE												
	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
MS1	\$	\$	\$	\$2,500,000.00	\$2,575,000.00	\$3,978,375.00	\$4,097,726.25	\$5,627,544.05	\$5,796,370.37	\$5,970,261.48	\$6,149,369.33	\$6,333,850.41
MS2	\$	\$	\$	\$	\$2,472,000.00	\$2,546,160.00	\$3,933,817.20	\$4,051,831.72	\$5,564,515.56	\$5,731,451.02	\$5,903,394.55	\$6,080,496.39
MS3	\$	\$	\$	\$	\$	\$2,493,115.00	\$2,567,908.45	\$3,995,556.28	\$4,115,422.96	\$5,671,748.41	\$5,841,900.86	\$6,017,157.89
MS4	\$	\$	\$	\$	\$	\$	\$2,567,908.45	\$2,644,945.70	\$4,115,422.96	\$4,238,885.65	\$5,841,900.86	\$6,017,157.89
Total Tuition Revenue	\$	\$	\$	\$2,500,000.00	\$5,047,000.00	\$9,017,650.00	\$13,167,360.35	\$16,319,877.75	\$19,591,731.86	\$21,612,346.57	\$23,736,565.60	\$24,448,662.57
ANTICIPATED OTHER REVENUE (built as a placeholder for future revenue streams)												
Research grants (Assumed no growth through provisional accreditation, then 25% annually)						\$2,000,000.00	\$2,500,000.00	\$3,125,000.00	\$3,906,250.00	\$4,882,812.50	\$6,103,515.63	\$7,629,394.53
Clinical Revenue (Assume 35% growth annually after provisional accreditation)						\$1,000,000.00	\$1,350,000.00	\$1,822,500.00	\$2,460,375.00	\$3,321,506.25	\$4,484,033.44	\$6,053,445.14
Practice Plan (Assume 40% of Annual Clinical Revenue)						\$1,000,000.00	\$540,000.00	\$729,000.00	\$984,150.00	\$1,328,602.50	\$1,793,613.38	\$2,421,378.06
Research contracts (Assumed 30% yey growth)						\$1,200,000.00	\$1,560,000.00	\$2,028,000.00	\$2,636,400.00	\$3,427,320.00	\$4,455,516.00	\$5,793,170.80

The University of Rhode Island Pro Forma Enrollment and Revenue												
	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
Seed Funding (Community and University Foundation)		\$12,500,000.00	\$12,500,000.00									
Endowment				\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00	\$2,500,000.00
Matching private funds		\$25,000,000.00	\$25,000,000.00									
Naming Donor		\$50,000,000.00										
State Allocation				\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00	\$22,500,000.00
Legislative Appropriation for Business Plan												
Philanthropy		\$1,000,000.00	\$1,250,000.00	\$1,562,500.00	\$1,953,125.00	\$2,441,406.25	\$3,051,757.81	\$3,814,697.27	\$4,768,371.58	\$5,960,464.48	\$7,450,580.60	\$9,313,225.75
Other Revenue												
Total Revenue	\$	\$88,500,000.00	\$38,750,000.00	\$29,062,500.00	\$32,000,125.00	\$41,659,056.25	\$47,169,118.16	\$52,839,075.01	\$59,347,278.44	\$65,533,052.29	\$73,023,824.64	\$80,658,276.85

The University of Rhode Island Pro Forma
Salaries and Fringe
(Planning Years through Year 3)

Roles	Salary*	Fringe **	School Cost=1 Instt. Cost=0	Current Year		Planning Year 1		Planning Year 2		Year 1		Year 2		Year 3	
				FTE	2026	FTE	2027	FTE	2028	FTE	2029	FTE	2030	FTE	2031
					\$		\$		\$		\$		\$		\$
Administrative															
Dean	\$910,583.00	30.00%	1	0.00	\$	1,183,757.90	1.00	1,183,757.90	1.00	1,183,757.90	1.00	1,183,757.90	1.00	1,183,757.90	1.00
Project Manager	\$100,000.00	30.00%	1	0.00	\$	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00
Admin Support for Dean	\$85,000.00	30.00%	1	0.00	\$	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00
Designated Institutional Official (DIO)	350,000.00	30.00%	1	0.00	\$	\$227,500.00	0.50	\$227,500.00	0.50	\$227,500.00	0.50	\$227,500.00	0.50	\$227,500.00	0.50
Admin Support - GME	\$85,000.00	30.00%	1	0.00	\$	\$55,250.00	0.50	\$55,250.00	0.50	\$55,250.00	0.50	\$55,250.00	0.50	\$55,250.00	0.50
Director of Development	\$130,000.00	30.00%	1	0.00	\$	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00
Admin Support for Development	\$70,000.00	30.00%	1	0.00	\$	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Assoc. Dean of Operations and Administration	\$430,533.00	30.00%	1	0.00	\$	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00
Director of Finance/Budget	\$187,440.00	30.00%	1	0.00	\$	\$121,836.00	0.50	\$121,836.00	0.50	\$121,836.00	0.50	\$121,836.00	0.50	\$121,836.00	0.50
HR/Employee Relations Mgr	\$120,000.00	30.00%	1	0.00	\$	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00
Admin Support - Finance	\$70,000.00	30.00%	1	0.00	\$	\$45,500.00	0.50	\$45,500.00	0.50	\$45,500.00	0.50	\$45,500.00	0.50	\$45,500.00	0.50
Admin Support - HR	\$70,000.00	30.00%	1	0.00	\$	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Director of Accreditation and CQI	175,000.00	30.00%	1	0.00	\$	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00
Admin Support - Accreditation	\$70,000.00	30.00%	1	0.00	\$	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Director of Communications	\$120,000.00	30.00%	1	0.00	\$	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00
Subtotal Administrative					\$	3,415,536.80	13.00	\$3,415,536.80	13.00	\$3,582,872.80	14.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00
Academic Affairs															
Director of Institutional Assessment and Data Analyst	\$110,000.00	30.00%	1	0.00	\$	\$71,500.00	0.50	\$71,500.00	0.50	\$71,500.00	0.50	\$71,500.00	0.50	\$71,500.00	0.50
Director of Licensing and Credentialing	\$95,000.00	30.00%	1	0.00	\$	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00
Assoc Dean for Faculty Affairs	\$294,503.00	30.00%	1	0.00	\$	\$191,426.95	0.50	\$191,426.95	0.50	\$191,426.95	0.50	\$191,426.95	0.50	\$191,426.95	0.50
Admin Faculty Affairs	\$70,000.00	30.00%	1	0.00	\$	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Assoc. Dean for Curricular Affairs	\$350,000.00	30.00%	1	0.00	\$	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00
Admin Support - Assoc Dean for Curricular Affairs	\$70,000.00	30.00%	1	0.00	\$	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Asst. Dean for Pre-Clerkship Curriculum	\$298,000.00	30.00%	1	0.00	\$	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00
Curriculum Coordinator - Year 1	\$80,000.00	30.00%	1	0.00	\$	\$26,000.00	0.25	\$26,000.00	0.25	\$26,000.00	0.25	\$26,000.00	0.25	\$26,000.00	0.25

**The University of Rhode Island Pro Forma
Salaries and Fringe
(Planning Years through Year 3)**

Curriculum Coordinator - Year 2	\$80,000.00	30.00%	1	0.00	\$	0.25	\$26,000.00	0.25	\$26,000.00	0.50	\$52,000.00	0.75	\$78,000.00	1.00	\$104,000.00
Curriculum Coordinator - Assessment	\$80,000.00	30.00%	1	0.00	\$	0.25	\$26,000.00	0.25	\$26,000.00	0.50	\$52,000.00	0.75	\$78,000.00	1.00	\$104,000.00
Director of Case Development	\$150,000.00	30.00%	1	0.00	\$	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00
Asst. Dean for Clerkship Curriculum	\$319,894.00	30.00%	1	0.00	\$	0.00	\$	0.50	\$207,931.10	0.50	\$207,931.10	1.00	\$415,862.20	1.00	\$415,862.20
Curriculum Coordinator 1-Year 3	\$70,000.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.50	\$45,500.00	1.00	\$91,000.00
Curriculum Coordinator 1-Year 4	\$70,000.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.50	\$45,500.00
Director of Evaluation and Assessment	\$125,000.00	30.00%	1	0.00	\$	0.50	\$81,250.00	0.50	\$81,250.00	0.50	\$81,250.00	1.00	\$162,500.00	1.00	\$162,500.00
Educational Technologist	\$125,000.00	30.00%	1	0.00	\$	0.50	\$81,250.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00
Director of Clinical Skills and Simulation	\$250,000.00	30.00%	1	0.00	\$	0.25	\$81,250.00	0.50	\$162,500.00	1.00	\$325,000.00	1.00	\$325,000.00	1.00	\$325,000.00
SP Trainer and Coordinator	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.75	\$82,875.00	1.00	\$110,500.00
SP and Simulation Coordinator	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.75	\$82,875.00	1.00	\$110,500.00
Admin. Support - Clinical Skills & Simulation	\$70,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$22,750.00	0.50	\$45,500.00	0.50	\$45,500.00	1.00	\$91,000.00
Chair Admin Support and Clerkship Coordinator - Surgery	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Ob/Gyn	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Internal Medicine	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Yr4 Electives	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Pediatrics	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Family Medicine	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Emergency Medicine	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Chair Admin Support and Clerkship Coordinator - Psychiatry	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$27,625.00	0.50	\$55,250.00	0.50	\$55,250.00	1.00	\$110,500.00
Subtotal Academic Affairs					\$	8.50	\$1,995,503.90	12.75	\$2,571,008.05	16.75	\$3,110,508.05	20.25	\$3,735,902.63	26.75	\$4,421,652.63

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Clerkship Director - Surgery	\$500,232.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$162,575.40	0.50	\$325,150.80	1.00	\$650,301.60
Surgery Faculty	\$500,232.00	30.00%	1	0.00	\$	0.25	\$162,575.40	0.25	\$162,575.40	0.25	\$162,575.40	0.50	\$325,150.80	1.00	\$650,301.60
Surgery Chair	\$625,290.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$203,219.25	0.50	\$406,438.50	1.00	\$812,877.00
Clerkship Director-Ob/Gyn	\$367,717.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$119,508.03	0.25	\$119,508.03	1.00	\$478,032.10
Ob/Gyn Faculty	\$367,717.00	30.00%	1	0.00	\$	0.25	\$119,508.03	0.25	\$119,508.03	0.25	\$119,508.03	0.50	\$239,016.05	1.00	\$478,032.10
Ob/Gyn Chair	\$459,646.25	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$149,385.03	0.50	\$298,770.06	1.00	\$597,540.13
Clerkship Director-Internal Medicine	\$288,686.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$93,822.95	0.25	\$93,822.95	1.00	\$375,291.80
Internal Medicine Faculty	\$288,686.00	30.00%	1	0.00	\$	0.25	\$93,822.95	0.25	\$93,822.95	0.25	\$93,822.95	0.50	\$187,645.90	1.00	\$375,291.80
Internal Medicine Chair	\$360,857.50	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$117,278.69	0.50	\$234,557.38	1.00	\$469,114.75
Clerkship Director-Psychiatry	\$285,020.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$92,631.50	0.25	\$92,631.50	1.00	\$370,526.00
Psychiatry Faculty	\$285,020.00	30.00%	1	0.00	\$	0.25	\$92,631.50	0.25	\$92,631.50	0.25	\$92,631.50	0.50	\$185,263.00	1.00	\$370,526.00
Psychiatry Chair	\$360,857.50	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$117,278.69	0.50	\$234,557.38	1.00	\$469,114.75
Clerkship Director-Pediatrics	\$287,600.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$93,470.00	0.25	\$93,470.00	1.00	\$373,880.00
Pediatric Faculty	\$287,600.00	30.00%	1	0.00	\$	0.25	\$93,470.00	0.25	\$93,470.00	0.25	\$93,470.00	0.50	\$186,940.00	1.00	\$373,880.00
Pediatric Chair	\$359,500.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$116,837.50	0.50	\$233,675.00	1.00	\$467,350.00
Clerkship Director - Family Medicine	\$259,760.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$84,422.00	0.25	\$84,422.00	1.00	\$337,688.00
Family Medicine Faculty	\$259,760.00	30.00%	1	0.00	\$	0.25	\$84,422.00	0.25	\$84,422.00	0.25	\$84,422.00	0.50	\$168,844.00	1.00	\$337,688.00
Family Medicine Chair	\$324,700.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$105,527.50	0.50	\$211,055.00	1.00	\$422,110.00
Clerkship Director - Emergency Medicine	\$361,302.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.25	\$117,423.15	0.25	\$117,423.15	1.00	\$469,692.60
Emergency Medicine Faculty	\$361,303.00	30.00%	1	0.00	\$	0.25	\$117,423.48	0.25	\$117,423.48	0.25	\$117,423.48	0.50	\$234,846.95	1.00	\$469,693.90
Elective Director(s)	\$300,000.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.00	\$-	0.25	\$97,500.00	1.00	\$390,000.00
Subtotal MS3 and MS4 Faculty					\$	1.75	\$763,853.35	1.75	\$763,853.35	5.00	\$2,337,233.03	8.75	\$4,170,688.44	21.00	\$9,738,932.13
Potential Areas for Institutional Support															
Director of Information Technology	\$150,000.00	30.00%	1	0.00	\$	0.50	\$97,500.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00
Instructional Designer	\$125,000.00	30.00%	1	0.00	\$	0.50	\$81,250.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00
Informational Technologist 2	\$85,000.00	30.00%	1	0.00	\$	0.50	\$55,250.00	1.00	\$110,500.00	0.50	\$55,250.00	1.00	\$110,500.00	1.00	\$110,500.00

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(Planning Years through Year 3)**

Informational Technologist 3	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.50	\$	1.00	\$55,250.00	1.00	\$110,500.00
Informational Technologist 4	\$85,000.00	30.00%	1	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.00	\$	0.00	\$
Librarian	\$120,000.00	30.00%	1	0.00	\$	0.50	\$78,000.00	0.75	\$117,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00
Financial Aid Officer	\$90,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$29,250.00	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00
Counselor (Wellness and Mental Health)	\$100,000.00	30.00%	1	0.00	\$	0.00	\$	0.25	\$32,500.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00
Subtotal Institutional Support				0.0	\$	2.0	\$312,000.00	4.3	\$646,750.00	5.5	\$815,750.00	6.5	\$926,250.00	7.0	\$981,500.00		
5% annual salary increase					\$				\$463,901.26		\$562,075.09		\$793,856.31		\$977,055.11		
Total Personnel Costs					\$		\$9,278,025.25		\$11,241,501.70		\$15,877,126.28		\$19,541,102.26		\$28,114,442.85		
					Total FTE	37.25		50.75		70.75		83.50		111.75			

Continued below to years 4-9....

The University of Rhode Island Pro Forma
Salary and Fringe
(Year 4 through Year 9)

Roles	Salary*	Fringe **	School Cost=1	Year 4		Year 5		Year 6		Year 7		Year 8		Year 9	
				2032	FTE	2033	FTE	2034	FTE	2035	FTE	2036	FTE	2037	
Administrative															
Dean	\$910,583.00	30.00%	1.00	\$1,183,757.90	1.00	\$1,183,757.90	1.00	\$1,183,757.90	1.00	\$1,183,757.90	1.00	\$1,183,757.90	1.00	\$1,183,757.90	1.00
Project Manager	\$100,000.00	30.00%	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00
Admin Support for Dean	\$85,000.00	30.00%	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00
Designated Institutional Official (DIO)	\$350,000.00	30.00%	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00
Admin Support - GME	\$85,000.00	30.00%	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00
Director of Development	\$130,000.00	30.00%	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00	\$169,000.00	1.00
Admin Support for Development	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Assoc. Dean of Operations and Administration	\$430,533.00	30.00%	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00	\$559,692.90	1.00
Director of Finance/Budget	\$187,440.00	30.00%	1.00	\$243,672.00	1.00	\$243,672.00	1.00	\$243,672.00	1.00	\$243,672.00	1.00	\$243,672.00	1.00	\$243,672.00	1.00
HR/Employee Relations Mgr.	\$120,000.00	30.00%	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00
Admin Support - Finance	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Admin Support - HR	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Director of Accreditation and CQI	\$175,000.00	30.00%	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00	\$227,500.00	1.00
Admin Support - Accreditation	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Director of Communications	\$120,000.00	30.00%	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00
Subtotal Administrative			15.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00	\$3,865,622.80	15.00
Academic Affairs															
Dir. of Institutional Assess. & Data Analyst	\$110,000.00	30.00%	1.00	\$147,290.00	1.00	\$151,708.70	1.00	\$156,259.96	1.00	\$160,947.76	1.00	\$165,776.19	1.00	\$170,749.48	1.00
Director of Licensing and Credentialing	\$95,000.00	30.00%	1.00	\$123,500.00	1.00	\$123,500.00	1.00	\$123,500.00	1.00	\$123,500.00	1.00	\$123,500.00	1.00	\$123,500.00	1.00
Assoc Dean for Faculty Affairs	\$294,503.00	30.00%	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00	\$382,853.90	1.00
Admin Faculty Affairs	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Assoc. Dean for Curricular Affairs	\$350,000.00	30.00%	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00	\$455,000.00	1.00
Admin Support - Assoc Dean for Curricular Affairs	\$70,000.00	30.00%	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00	\$91,000.00	1.00
Asst. Dean for Pre-Clerkship Curriculum	\$298,000.00	30.00%	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00	\$387,400.00	1.00
Curriculum Coordinator - Year 1	\$80,000.00	30.00%	1.00	\$104,000.00	1.00	\$104,000.00	1.00	\$104,000.00	1.00	\$104,000.00	1.00	\$104,000.00	1.00	\$104,000.00	1.00

The University of Rhode Island Pro Forma Salary and Fringe (Year 4 through Year 9)														
Potential Areas for Institutional Support														
Director of Information Technology	\$150,000.00	30.00%	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00	1.00	\$195,000.00
Instructional Designer	\$125,000.00	30.00%	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00	1.00	\$162,500.00
Informational Technologist 2	\$85,000.00	30.00%	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00
Informational Technologist 3	\$85,000.00	30.00%	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00
Informational Technologist 4	\$85,000.00	30.00%	0.50	\$55,250.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00	1.00	\$110,500.00
Librarian	\$120,000.00	30.00%	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00	1.00	\$156,000.00
Financial Aid Officer	\$90,000.00	30.00%	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00	1.00	\$117,000.00
Counselor (Wellness and Mental Health)	\$100,000.00	30.00%	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00	1.00	\$130,000.00
Subtotal Institutional Support			7.5	\$1,036,750.00	8.0	\$1,092,000.00								
5% annual salary increase				\$1,405,722.14		\$1,418,847.32		\$1,592,720.17		\$1,594,328.98		\$1,786,334.04		\$1,786,575.47
Total Personnel Costs			113.50	\$28,376,946.33	121.75	\$31,854,403.43	122.00	\$31,886,579.69	131.00	\$35,726,680.88	131.00	\$35,731,509.32	133.00	\$36,674,712.10

The University of Rhode Island Pro Forma
Operating Expenses

	Planning Year 1	Planning Year 2	Planning Year 3	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037
MS1	0	0	0	50	50	75	75	100	100	100	100	100
MS2	0	0	0	0	48	48	72	72	96	96	96	96
MS3	0	0	0	0	0	47	47	71	71	95	95	95
MS4	0	0	0	0	0	0	47	47	71	71	95	95
Total Students	0	0	0	50	98	170	241	290	338	362	386	386
School Cost = Institutional Cost = 0	Planning Year 1 2026-2027	Planning Year 2 2027-2028	Planning Year 3 2028-2029	Year 1 2029-2030	Year 2 2030-2031	Year 3 2031-2032	Year 4 2032-2033	Year 5 2033-2034	Year 6 2034-2035	Year 7 2035-2036	Year 8 2036-2037	Year 9 2037-2038
Students Research Projects (SZK annually per student)	\$-	\$-	\$-	\$100,000.00	\$196,000.00	\$340,000.00	\$482,000.00	\$580,000.00	\$676,000.00	\$724,000.00	\$772,000.00	\$772,000.00
Purchase Cases*		\$50,000.00	\$52,500.00	\$55,125.00	\$57,881.25	\$60,775.31	\$63,814.08	\$67,004.78	\$70,355.02	\$73,872.77	\$77,566.41	\$81,444.73
National Board of Medical Examiners Examinations (built in 5% annual increase)												
NBME CAS Annual Subscription	1		\$1,700.00	\$1,785.00	\$1,874.25	\$1,967.96	\$2,066.36	\$2,169.68	\$2,278.16	\$2,392.07	\$2,511.67	\$2,637.26
NBME CAS 15 exams per MS1 @ \$ 48 each + 10 makeup/remediation exams	1	\$-	\$-	\$38,304.00	\$40,219.20	\$42,230.16	\$44,341.67	\$46,558.75	\$48,886.69	\$51,331.02	\$53,897.57	\$56,592.45
NBME CAS 15 exams per MS2 @ \$ 48 each + 10 makeup/remediation exams	1	\$-	\$-		\$36,792.00	\$38,631.60	\$40,563.18	\$42,591.34	\$44,720.91	\$46,956.95	\$49,304.80	\$51,770.04
NBME CBSEs 4 exams per MS2 @ \$ 57 each	1	\$-	\$-		\$6,344.10	\$6,661.31	\$6,994.37	\$7,344.09	\$7,711.29	\$8,096.86	\$8,501.70	\$8,926.79
NBME CBSA 2 vouchers per MS2 @ \$60 each	1	\$-	\$-		\$6,678.00	\$7,011.90	\$7,362.50	\$7,730.62	\$8,117.15	\$8,523.01	\$8,949.16	\$9,396.62
NBME 7 clerkship exams per MS3 @ \$ 51 each + 50 makeup/remediation exams	1	\$-	\$-			\$20,295.45	\$21,310.22	\$22,375.73	\$23,494.52	\$24,669.25	\$25,902.71	\$27,197.84

The University of Rhode Island Pro Forma
IT Expenses

			Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
			MS1	0	0	0	50	75	75	100	100	100	100	100
			MS2	0	0	0	0	48	72	72	96	96	96	96
			MS3	0	0	0	0	47	47	71	71	95	95	95
			MS4	0	0	0	0	0	47	47	71	71	95	95
			Total Students	0	0	0	50	170	241	290	338	362	386	386
			School Cost = 1				Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
			Institut. Cost = 0				2029-2030	2030-2031	2031-2032	2032-2033	2033-2034	2034-2035	2035-2036	2036-2037
Software (annual increase 5%)														
Canvas	32,000			\$32,000.00	\$33,600.00	\$35,280.00	\$37,044.00	\$38,896.20	\$40,841.01	\$42,883.06	\$45,027.21	\$47,278.57	\$49,642.50	\$52,124.63
Learning Space	275,000			\$275,000.00	\$288,750.00	\$303,187.50	\$318,346.88	\$334,264.22	\$350,977.43	\$368,526.30	\$386,952.62	\$406,300.25	\$426,615.26	\$447,946.02
Echo360	15,000			\$15,000.00	\$15,750.00	\$16,537.50	\$17,364.38	\$18,232.59	\$19,144.22	\$20,101.43	\$21,106.51	\$22,161.83	\$23,269.92	\$24,433.42
LCMS+	\$110,000.00			\$110,000.00	\$115,500.00	\$121,275.00	\$127,338.75	\$133,705.69	\$140,390.97	\$147,410.52	\$154,781.05	\$162,520.10	\$170,646.10	\$179,178.41
Poll Everywhere	\$5,500.00			\$5,500.00	\$5,775.00	\$6,063.75	\$6,366.94	\$6,685.28	\$7,019.55	\$7,370.53	\$7,739.05	\$8,126.00	\$8,532.31	\$8,958.92
Aquifer*	\$60,000.00			\$60,000.00	\$63,000.00	\$66,150.00	\$69,457.50	\$72,930.38	\$76,576.89	\$80,405.74	\$84,426.03	\$88,647.33	\$93,079.69	\$97,733.68
Pathoma (\$120 per MS1)		\$120.00	1	\$-	\$-	\$6,000.00	\$6,300.00	\$9,922.50	\$10,418.63	\$14,586.08	\$15,315.38	\$16,081.15	\$16,885.21	\$17,729.47
Procedures Consult Online Modules	\$4,300.00			\$4,300.00	\$4,515.00	\$4,740.75	\$4,977.79	\$5,226.68	\$5,488.01	\$5,762.41	\$6,050.53	\$6,353.06	\$6,670.71	\$7,004.25
Biolumida	\$22,000.00			\$22,000.00	\$23,100.00	\$24,255.00	\$25,467.75	\$26,741.14	\$28,078.19	\$29,482.10	\$30,956.21	\$32,504.02	\$34,129.22	\$35,835.68
Primal Pictures	\$21,000.00			\$21,000.00	\$22,050.00	\$23,152.50	\$24,310.13	\$25,525.63	\$26,801.91	\$28,142.01	\$29,549.11	\$31,026.56	\$32,577.89	\$34,206.79
Sketchy Medical (MS1 & MS2)		\$150.00	1	\$-	\$-	\$7,875.00	\$15,435.00	\$20,341.13	\$25,525.63	\$31,360.06	\$37,522.68	\$39,398.81	\$41,368.75	\$43,437.19
eAnatomy	\$3,190.00			\$3,190.00	\$3,349.50	\$3,516.98	\$3,692.82	\$3,877.46	\$4,071.34	\$4,274.91	\$4,488.65	\$4,713.08	\$4,948.74	\$5,196.17
Uworld Step 1 - 6 month (\$500 per MS2)		\$500.00	1	\$-	\$-	\$-	\$24,000.00	\$25,200.00	\$39,690.00	\$36,000.00	\$48,000.00	\$48,000.00	\$48,000.00	\$48,000.00
Uworld Step 2 CK - 12 months (\$500 per MS3)		\$500.00	1	\$-	\$-	\$-	\$-	\$23,500.00	\$24,675.00	\$39,138.75	\$41,095.69	\$57,736.55	\$60,623.37	\$63,654.54

The University of Rhode Island Pro Forma
IT Expenses

				Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
Clinical Science Mastery Series (\$195 per MS3)	\$195.00		1	\$-	\$-	\$-	\$-	\$-	\$9,165.00	\$9,623.25	\$14,537.25	\$16,027.32	\$22,517.25	\$23,643.12	\$24,825.27
Acland Academy Video	\$6,000.00		1	\$6,000.00	\$6,000.00	\$6,300.00	\$6,615.00	\$6,945.75	\$7,293.04	\$7,657.69	\$8,040.57	\$8,442.60	\$8,864.73	\$9,307.97	\$9,773.37
Scholar RX (\$385 per MS1 and MS2)	\$385.00		1	\$-	\$-	\$-	\$19,250.00	\$37,730.00	\$52,208.89	\$65,515.79	\$69,531.00	\$91,722.10	\$96,308.21	\$101,123.62	\$106,179.80
VisualDx Basic	\$7,500.00		1	\$7,500.00	\$7,500.00	\$7,875.00	\$8,268.75	\$8,682.19	\$9,116.30	\$9,572.11	\$10,050.72	\$10,553.25	\$11,080.92	\$11,634.96	\$12,216.71
Rush Review	\$3,000.00		1	\$3,000.00	\$3,000.00	\$3,150.00	\$3,307.50	\$3,472.88	\$3,646.52	\$3,828.84	\$4,020.29	\$4,221.30	\$4,432.37	\$4,653.98	\$4,886.68
Complete Anatomy (\$100 per MS1 and MS2)	\$1,000.00		1	\$-	\$-	\$-	\$5,000.00	\$9,800.00	\$12,300.00	\$14,700.00	\$17,200.00	\$19,600.00	\$19,600.00	\$19,600.00	\$19,600.00
Banner (or other SES)	\$1,000,000.00		1	\$-	\$-	\$1,000,000.00	\$1,050,000.00	\$1,102,500.00	\$1,157,625.00	\$1,215,506.25	\$1,276,281.56	\$1,340,095.64	\$1,407,100.42	\$1,477,455.44	\$1,551,328.22
Clinical Evaluation System (LCMS+ module)	\$35,000.00		1	\$-	\$-	\$35,000.00	\$36,750.00	\$38,587.50	\$40,516.88	\$42,542.72	\$44,669.85	\$46,903.35	\$49,248.51	\$51,710.94	\$54,296.49
ID creation software	\$15,000.00		1	\$-	\$-	\$50,000.00	\$52,500.00	\$55,125.00	\$57,881.25	\$60,775.31	\$63,814.08	\$67,004.78	\$70,355.02	\$73,872.77	\$77,566.41
All of E (Emedley)	\$50,000.00		1	\$-	\$-	\$50,000.00	\$52,500.00	\$55,125.00	\$57,881.25	\$60,775.31	\$63,814.08	\$67,004.78	\$70,355.02	\$73,872.77	\$77,566.41
Digital Microscopy Software	\$35,000.00		1	\$-	\$-	\$35,000.00	\$36,750.00	\$38,587.50	\$40,516.88	\$42,542.72	\$44,669.85	\$46,903.35	\$49,248.51	\$51,710.94	\$54,296.49
E-text books (\$500 per student)	\$20,000.00		1	\$-	\$-	\$-	\$25,000.00	\$51,450.00	\$89,250.00	\$126,525.00	\$152,250.00	\$177,450.00	\$190,050.00	\$202,650.00	\$202,650.00
Subtotal for Software				\$-	\$564,490.00	\$1,762,714.50	\$1,913,975.23	\$2,088,107.74	\$2,282,449.89	\$2,459,263.78	\$2,624,323.15	\$2,808,939.18	\$2,970,008.28	\$3,118,226.20	\$3,260,625.01
Hardware															
iPads, apple care and keyboard cases for all MS1	\$1,500.00		1	\$	\$	\$	\$75,000.00	\$75,000.00	\$112,500.00	\$112,500.00	\$150,000.00	\$150,000.00	\$150,000.00	\$150,000.00	\$150,000.00
Computer equipment purchase**	\$4,000.00		1	\$131,000.00	\$131,000.00	\$72,000.00	\$80,000.00	\$51,000.00	\$113,000.00	\$7,000.00	\$33,000.00	\$1,000.00	\$36,000.00	\$	\$100,000.00
Technology replacement 35% of annual				\$45,850.00	\$45,850.00	\$25,200.00	\$28,000.00	\$17,850.00	\$39,550.00	\$2,450.00	\$11,550.00	\$350.00	\$12,600.00	\$	\$35,000.00

The University of Rhode Island Pro Forma

IT Expenses

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
equipment cost)												
Camera and ID printer		\$ 30,000.00										
Subtotal for Hardware	\$	\$206,850.00	\$97,200.00	\$183,000.00	\$143,850.00	\$265,050.00	\$121,950.00	\$194,550.00	\$151,350.00	\$198,600.00	\$150,000.00	\$285,000.00
Stipends for 4 Student IT support leads (ZMS1 and ZMS2)				\$ 40,000.00	\$ 42,000.00	\$44,100.00	\$46,305.00	\$ 48,620.25	\$ 51,051.26	\$53,603.83	\$56,284.02	\$59,098.22
Total IT Expenses		\$813,340.00	\$1,904,014.50	\$2,143,280.23	\$2,273,957.74	\$2,591,599.89	\$2,627,518.78	\$2,867,493.40	\$3,011,340.44	\$3,222,212.11	\$3,324,510.22	\$3,604,723.23

*(MedU Virtual Patient Cases/Modules)

** (Laptops, docking stations, monitors, iPads, keyboards, mice, printers, cases and apple care for all colleagues.

The University of Rhode Island Pro Forma Simulation Expenses

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
MS1	0	0	0	50	50	75	75	100	100	100	100	100
MS2	0	0	0	0	48	48	72	72	96	96	96	96
MS3	0	0	0	0	0	47	47	71	71	95	95	95
MS4	0	0	0	0	0	0	47	47	71	71	95	95
Total Students	0	0	0	50	98	170	241	290	338	362	386	386
School Cost = 1	Planning Year 1	Planning Year 2	Planning Year 3	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Institut. Cost = 0	2026-2027	2027-2028	2028-2029	2029-2030	2030-2031	2031-2032	2032-2033	2033-2034	2034-2035	2035-2036	2036-2037	2037-2038
Standardized Patients*												
MS1 (3 CPX exams per year, 22 SPs * 24 hours per month * 11 months * \$30 per hour)				\$174,240.00	\$182,952.00	\$192,099.60	\$201,704.58	\$211,789.81	\$222,379.30	\$233,498.26	\$245,173.18	\$257,431.84
MS2 SP training (22 SPs * 40 hours per year * \$30 per hour)			\$26,400.00	\$27,720.00	\$29,106.00	\$30,561.30	\$32,089.37	\$33,693.83	\$35,378.52	\$37,147.45	\$39,004.82	\$40,955.06
MS2 (2 CPX exams per year, 22 SPs * 24 hours per month * 7 months * \$30 per hour)				\$110,880.00	\$116,424.00	\$122,245.20	\$128,357.46	\$134,775.33	\$141,514.10	\$148,589.80	\$156,019.29	\$163,820.26
MS2 SP training (22 SPs * 40 hours per year * \$30 per hour)				\$26,400.00	\$7,720.00	\$29,106.00	\$30,561.30	\$32,089.37	\$33,693.83	\$35,378.52	\$37,147.45	\$39,004.82
MS3 (6 CPX per year, 30 SPs * 120 hours * \$30 per hour)					\$108,000.00	\$113,400.00	\$119,070.00	\$125,023.50	\$131,274.68	\$137,838.41	\$144,730.33	\$151,966.85
MS3 SP training (30 SPs * 40 hours * \$30 per hour)					\$46,800.00	\$49,140.00	\$51,597.00	\$54,176.85	\$56,885.69	\$59,729.98	\$62,716.48	\$65,852.30
Simulation Clinic SPs												
SP Supplies (\$200 per student - drapes, gowns, tongue blades)				\$10,000.00	\$19,600.00	\$34,000.00	\$48,200.00	\$58,000.00	\$67,600.00	\$72,400.00	\$77,200.00	\$77,200.00
Simulation Supplies (\$300 per student - skin, blood, etc)				\$15,000.00	\$29,400.00	\$51,000.00	\$72,300.00	\$87,000.00	\$101,400.00	\$108,600.00	\$115,800.00	\$115,800.00
Subtotal Standardized Patient Expenses	\$	\$	\$ 26,400.00	\$364,240.00	\$560,002.00	\$621,552.10	\$683,879.71	\$736,548.69	\$790,126.12	\$833,182.43	\$877,791.55	\$912,031.13
Simulation Software		\$250,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00
Additional XR/VR/AR Technology (HoloLens)		\$250,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00
AI Technology		\$150,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00	\$45,000.00
Task Trainers												
Obstetric Trainers												
Multivenous Access Arm Kits												
Arterial Puncture Wrists												
Central Venous Cannula Simulators												
Adult Lumbar Puncture												
Pediatric Lumbar Puncture												
Adult Epidural Trainer												
Little Anne CPR Trainers												

The University of Rhode Island Pro Forma
Simulation Expenses

	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
Adult Airway Trainers												
C-Section Trainer												
FLS Boxes												
FES Trainer												
Knot Trainers												
Female Pelvic Trainers												
Male Pelvic Trainers												
Breast Exam Trainer												
NG Tube and Trach Care												
Female Catheter Trainer												
Male Catheter Trainer												
Male Rectal Trainer												
Mannikins		\$1,500,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00	\$300,000.00
2 Harveys												
Gaumard - Premie HAL												
Gaumard - Baby Newborn												
Gaumard - Child, 5 years												
CAE - Adult & Child HPS												
CAE - Lucina Female/Birthing												
Gaumard - Victoria Female/Birthing												
CAE - Apollo Adult Male												
Laerdal - SimMan3C												
Laerdal - SimBaby 3 month												
Ultrasound Equipment, Mannikins, and Machines		\$250,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00
Lower Arm Tissue Inserts for IV & Arterial Lines												
Gen II PICC with IV Access Trainer												
Midcapular Thoracentesis Ultrasound Training Model												
Parcentesis Ultrasound Training Model												
Combination IUP Ectopic Pregnancy Transvaginal Model												
Multi Vessel Ultrasound Training Block Model												
Scrotal Ultrasound Phantom												
Knee Phantom												
Multi Vessel IV block												
Branched Vessel IV Block												

The University of Rhode Island Pro Forma Simulation Expenses												
	Planning Year 1 2026	Planning Year 2 2027	Planning Year 3 2028	Year 1 2029	Year 2 2030	Year 3 2031	Year 4 2032	Year 5 2033	Year 6 2034	Year 7 2035	Year 8 2036	Year 9 2037
CAE Vimedix Ultrasound Simulator												
Phillips Sparg												
Phillips Lumify												
GE Venue Go												
TOTAL SIMULATION EXPENSES	\$	\$2,650,000.00	\$571,400.00	\$909,240.00	\$1,105,002.00	\$1,166,552.10	\$1,228,879.71	\$1,281,548.69	\$1,335,126.12	\$1,378,182.43	\$1,422,791.55	\$1,457,031.13

The University of Rhode Island Pro Forma Building Expenses												
	Planning Year 1 2026-2027	Planning Year 2 2027-2028	Planning Year 3 2028-2029	Year 1 2029-2030	Year 2 2030-2031	Year 3 2031-2032	Year 4 2032-2033	Year 5 2033-2034	Year 6 2034-2035	Year 7 2035-2036	Year 8 2036-2037	Year 9 2037-2038
MS1	0	0	0	50	50	75	75	100	100	100	100	100
MS2	0	0	0	0	48	48	72	72	96	96	96	96
MS3	0	0	0	0	0	47	47	71	71	95	95	95
MS4	0	0	0	0	0	0	47	47	71	71	95	95
Total Students	0	0	0	50	98	170	241	290	338	362	386	386
School Cost = 1												
Institutional Cost = 0												
Medical Education Building		\$31,250,000.00	\$31,250,000.00									
Maintenance (1% of building value)				\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00
TOTAL BUILDING EXPENSES	\$	\$31,250,000.00	\$31,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00	\$1,250,000.00

*Assumed annual increase of 5% for IT associated costs

Appendix G: Health Professions Schools of Matriculated URI Graduates (2017-2023)

Data obtained from URI demonstrates that between 2017 and 2023, URI students demonstrated strong pre-med outcomes, with graduates matriculating into more than 40 different medical schools nationwide. In total, at least 58 URI graduates entered M.D. programs, including highly competitive institutions such as Brown University-Alpert (22), University of Connecticut (5), Quinnipiac University-Netter (4), Drexel University (3), and New York Medical College (3). During the same period, at least 27 URI graduates pursued D.O. programs, led by the University of New England (13), with additional concentrations at the New York Institute of Technology College of Osteopathic Medicine (3) and Philadelphia College of Osteopathic Medicine (3). These results highlight URI's success in preparing students for medical school while also underscoring that many must leave Rhode Island to pursue their degrees. Establishing a public medical school at URI would provide an in-state option, allowing the university to retain more of its talented graduates and strengthen the physician workforce for Rhode Island.

If more than one matriculant, the total number is noted in parentheses.

Doctor of Medicine (M.D.) Programs	Doctor of Osteopathic Medicine (D.O.) Programs
Brown University-Alpert (22)	Alabama College of Osteopathic Medicine
Cooper Medical School of Rowan University	Idaho College of Osteopathic Medicine
Dartmouth-Geisel (2)	Lake Erie College of Osteopathic Medicine-Seton Hill (2)
Drexel University (3)	Lake Erie College of Osteopathic Medicine-Bradenton
Geisinger Commonwealth Medical College	Liberty University
Hackensack-Meridian College of Medicine	Lincoln Memorial University-DeBusk
Howard University	Marian University (2)
Johns Hopkins University	NY Institute of Technology College of Osteopathic Medicine (3)
Loyola University-Stritch	Nova Southeastern University
New York Medical College (3)	Ohio University-Heritage
New York University-Grossman	Pacific Northwest University
Ohio State University	Philadelphia College of Osteopathic Medicine (3)
Pennsylvania State University	Philadelphia College of Osteopathic Medicine-South Georgia
Quinnipiac University-Netter (4)	Rocky Vista University College of Osteopathic Medicine-Utah
Rutgers University-Robert Wood Johnson	Rowan University
Tufts University	Touro University
Tulane University	University of New England (13)
University of Massachusetts-Chan (2)	Western University-Pomona

Doctor of Medicine (M.D.) Programs	Doctor of Osteopathic Medicine (D.O.) Programs
University at Buffalo-Jacobs	
University of Cincinnati	
University of Connecticut (5)	
University of Maryland (2)	
University of Miami-Miller	
University of Vermont-Larner (4)	
Washington University – St. Louis	

Admitted University of Rhode Island Graduates' GPAs and Test Scores

(For the 2017-2023 application cycles)

Doctor of Medicine (MD) Programs

	Cumulative GPA	BCPM GPA	TOTAL MCAT
AVERAGE	3.76	3.72	511
25th PERCENTILE	3.68	3.61	508
MEDIAN	3.81	3.80	511
75th PERCENTILE	3.91	3.93	515
NATIONAL AVERAGES (2022)	3.73	3.66	512

Doctor of Osteopathic Medicine (DO) Programs

	Cumulative GPA	BCPM GPA	TOTAL MCAT
AVERAGE	3.68	3.62	504
25th PERCENTILE	3.53	3.50	502
MEDIAN	3.72	3.64	504
75th PERCENTILE	3.82	3.76	507
NATIONAL AVERAGES (2020)	3.67	3.65	505

Admission Rates 2017-2023

Includes applicants who applied more than once

Admitted	110
Rejected	21
Percent admitted	84%

Appendix E: Economic Impact Methods and Notes

Tripp Umbach has conducted over 500 economic impact studies for academic institutions and large healthcare systems, including all 154 U.S. medical schools and more than 400 teaching hospitals – encompassing both allopathic and osteopathic institutions.

IMPLAN Methodology

The economic impact of the proposed medical school at the University of Rhode Island was estimated using IMPLAN (IMPact Analysis for PLANning), an econometric modeling system developed by applied economists at the University of Minnesota and the U.S. Forest Service. The IMPLAN modeling system has been in use since 1979 and is used by more than 500 private consulting firms, university research centers, and government agencies. The IMPLAN modeling system combines the U.S. Bureau of Economic Analysis' input-output Benchmarks with other data to construct quantitative models of trade flow relationships between businesses and between businesses and final consumers. From this data, one can examine the effects of a change in one or several economic activities to predict its effect on a specific state, regional, or local economy (impact analysis). The IMPLAN input-output accounts capture all monetary market transactions for consumption in each period. The IMPLAN input-output accounts are based on industry survey data collected periodically by the U.S. Bureau of Economic Analysis (U.S. BEA) and follow a balanced account format recommended by the United Nations.

IMPLAN's Regional Economic Accounts and the Social Accounting Matrices were used to construct state- and regional-level multipliers, which describe the economy's response to a change in demand or production caused by anticipated activities and expenditures. Each industry that produces goods or services generates demand for other goods and services. This demand is multiplied through a particular economy until it dissipates through "leakage" to economies outside the specified area. IMPLAN models discern and calculate leakage from local, regional, and state economic areas based on workforce configuration, the inputs required by specific types of businesses, and the availability of both inputs in the economic area. Consequently, economic impacts that accrue to other regions or states because of a change in demand are not counted as impacts within the economic area.

The model accounts for substitution and displacement effects by deflating industry-specific multipliers to levels well below those recommended by the BEA. In addition, multipliers are applied only to personal disposable income to obtain a more realistic estimate of the multiplier effects of increased demand. Importantly, IMPLAN's Regional Economic Accounts exclude imports to an economic area, so the calculation of economic impacts identifies only those impacts specific to the economic impact area. IMPLAN calculates this distinction by applying Regional Purchase Coefficients (RPC) to predict regional purchases based on an economic area's particular characteristics. The RPC represents the proportion of goods and services purchased regionally under normal circumstances based on the area's economic characteristics described in terms of actual trade flows.

Employment Definitions

IMPLAN analysis measures jobs/positions (part-time or full-time), not full-time equivalents (FTEs). Full-time and part-time employees impact the economy and support additional indirect and induced employment. Employment data for this was provided as an output of all individuals who receive a paycheck at a sample of 14 osteopathic branch campuses. This includes all full-time and part-time employed faculty, staff, and students.

State and Local Tax Impact Definition

State and local tax impacts generated in future years are based on actual taxes generated by established branch campuses (i.e., payroll, property, sales, unemployment, income, and any other taxes paid to the state). Any federal taxes paid by the proposed campus are not included in the state and local tax impacts (i.e., FICA payments).

Visitor Definitions

Impact analysis looks to quantify the impact of attracting “fresh” dollars to a region. Therefore, when including visitor spending in the impact analysis of a medical school, the analysis will include only those visitors coming to a region from outside of the said region. Visitors to events who also live in the region would have spent their dollars in that region otherwise; therefore, this dollar was not attracted to the region because of the organization being analyzed. For this project, the impact analysis looked at impacts on the state of Rhode Island. Visitors to the proposed campus were counted only if they were from outside the region being analyzed.

FAQs Regarding Economic Impact Assessment

What is the economic impact?

Economic impact begins when an organization spends money. Economic impact studies measure the direct economic impact of an organization’s spending plus additional indirect spending resulting from direct spending. The economic impact has nothing to do with dollars collected by institutions, their profitability, or their sustainability, since all operating organizations have a positive economic impact when they spend money and attract spending from outside sources.

Direct economic impact measures the dollars generated within a geographic region because of the presence of an institution. This includes spending on goods and services with vendors within the region, the spending of its employees and visitors, and the economic impact generated by businesses within the region that benefit from the institution's spending. It is important to remember that not all dollars spent by an institution stay in the geographic region of study. Dollars spent outside the region in the form of purchases from out-of-area vendors are not included in an institution’s economic impact on the region.

The total economic impact includes the “multiplier” of spending from companies that do business with an institution. Support businesses may include lodging establishments, restaurants, construction firms, vendors, and temporary agencies. Spending multipliers attempt to estimate the ripple effect in the economy where the spending occurs. For example, spending by an institution with local vendors

provides these vendors with additional dollars that they re-spend in the local economy, causing a “multiplier effect.”

What is the multiplier effect?

Multipliers are a numeric way of describing the secondary impacts stemming from an organization’s operations. For example, an employment multiplier of 1.8 would suggest that for every 10 employees hired in the given industry, eight additional jobs would be created in other industries, such that 18 total jobs would be added to the given economic region. The multipliers used in this study range from 1.8 to 2.0. The Multiplier Model is derived mathematically using the input-output model and Social Accounting formats. The Social Accounting System provides the framework for the predictive Multiplier Model used in economic impact studies. Purchases for final use drive the model. Industries that produce goods and services for consumer consumption must purchase products, raw materials, and services from other companies to create their product. These vendors must also procure goods and services. This cycle continues until all the money is leaked from the region’s economy. Three effects are measured with a multiplier: the direct, the indirect, and the induced effects. The direct effect is the known or predicted change in the local economy to be studied. The indirect effect is the business-to-business transactions required to satisfy the direct effect. Finally, the induced effect is derived from local spending on goods and services by people working to satisfy the direct and indirect effects.

What methodology was used in this study?

IMPLAN (IMpact analysis for PLANning) data and software. Using classic input-output analysis in combination with regional-specific Social Accounting Matrices and Multiplier Models, IMPLAN provides a highly accurate and adaptable model for its users. The IMPLAN database contains county, state, ZIP code, and federal economic statistics specialized by region and not estimated from national averages. It can measure a regional or local economy’s effect on a change or event in its activity.

What is employment impact?

Employment impact measures the direct employment (employees, staff, faculty, administration) plus additional employment created in the economy because of an institution’s operations.

Indirect and induced employment impact refers to other regional employees whose jobs exist because of an institution’s economic impact. In other words, jobs related to the population — city services (police, fire, EMS, etc.), employees at hotels and restaurants, clerks at retail establishments, and residents employed by vendors used by the institution.

What is the difference between direct and indirect taxes?

Direct tax dollars include sales taxes and net corporate income taxes paid directly by the institution to the state. In contrast, indirect taxes include taxes paid to by vendors the state for doing business with an institution and or individuals.

Is this a one-time impact, or does the impact repeat each year?

The results presented in this economic impact study are generated annually. The economic impact in future years can be either higher or lower based on number of employees, students, capital expansion, increases in external research, and state appropriations.

Appendix F: Consultant Qualifications

Tripp Umbach is recognized nationally as the leading consulting firm in academic medicine and the development of new medical schools. Over its history, Tripp Umbach has consulted with more than half of all US medical schools, as well as international universities, to advance medical education, improve healthcare access, and strengthen local economies. This track record demonstrates the firm's capacity to deliver actionable, data-driven, and community-responsive solutions for universities and states seeking to establish new medical schools.

Over the past three decades, the firm has guided the creation, expansion, and accreditation of more medical schools than any other consulting organization in the United States. Specifically, Tripp Umbach has provided feasibility, planning, and implementation services for 50 new or expanding medical schools through projects in more than 100 regions. The firm's expertise spans a wide range of models, including traditional stand-alone institutions, health system-driven schools, multi-regional partnerships, and the transition of existing regional campuses into independent programs.

Beyond medical education, Tripp Umbach is a national leader in Graduate Medical Education consulting, helping communities and health systems expand residency and fellowship training to complement undergraduate medical education. This dual expertise in both UME and GME enables the firm to design comprehensive physician workforce pipelines tailored to the needs of states and regions.

Tripp Umbach also brings unmatched experience in economic impact analysis for academic medicine. Since 1995, the firm has conducted national economic impact studies for the Association of American Medical Colleges, measuring the contributions of all U.S. medical schools and more than 400 teaching hospitals. This unique capability ensures that Tripp Umbach's feasibility assessments integrate not only academic and accreditation considerations but also the economic and social return on investment for host states and communities.

