The goal of this document is to outline the integration plan that will guide the combination of Care New England and Lifespan, and the relationship between the combined entity and Brown University as their academic partner. The document is intended to be summary-level and is subject to refinement, pending input from community stakeholders, including payors, patient advocacy groups, existing Care New England and Lifespan boards, and others.

Context and Overview of Benefits

Lifespan (LS) and Care New England (CNE) have proposed forming a single entity, the Rhode Island Academic Healthcare System (RIAHCS),[1] that will establish a robust academic affiliation with Brown University (Brown and fundamentally improve how healthcare is delivered in Rhode Island (RI). The need for this combination is driven by several factors, including increasing demand for healthcare services, the need to reduce inequities in access and outcomes, the limitations of operating as separate entities, and other market and financial forces.

The need for healthcare services is growing. As a percent of its total population, RI has more seniors (65+) than the nation overall,[2] and because seniors utilize 2.5x more healthcare services than those in the next nearest age group,[3] the demands on the state's healthcare system are high and expected to increase as the senior demographic continues to age. Another patient group that places additional demands on the state's healthcare system are those with chronic disease. Of all adults in RI, 10.4% have diabetes, 6.1% have cardiovascular disease, and 30% are obese,[4] and treating these individuals requires a broader range of services, including specialized care and coordination programs.

Furthermore, disadvantaged communities throughout RI continue to experience subpar healthcare access and quality. For example, Black and Latino residents are more likely to face financial barriers to receiving care than their White counterparts,[5] and Black infants have a mortality rate that is nearly 4x higher than that of White infants.[6]

These challenges compel LS and CNE to do more to serve the community. However, the ability of LS and CNE to make meaningful change as individual entities is limited because they face material threats to their long-term sustainability and effectiveness:

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[1] RIAHCS is used for ease of reference in this document and is not intended to suggest it will be the official system name

[2] US Census Bureau (2019)

[3] Healthcare Cost and Utilization Project "Trends in Hospital Inpatient Stays by Age and Payer, 2000-2015" (2018, Statistical Brief #235)

[4] Kaiser Family Foundation "State Health Facts" (2017-2019)

[5] KFF "Adults Who Report Not Seeing a Doctor in the Past 12 Months Because of Cost by Race/Ethnicity" (2019)

[6] Rhode Island Department of Health "RIH Issue Brief: Perinatal and Infant Health" (2020)

a. [redacted]

b. [redacted]

[redacted]

c.

d.

LS and CNE have worked to address these trends (a through d) on their own through various strategies and initiatives, but the aforementioned problems persist. The best way for the parties to meet the growing needs of the state and region is by integrating. To that end, the parties have developed this clinical integration blueprint to achieve the following goals:

- **Coordinate and Standardize Care to Reduce Waste**
- **Increase Access to Lower-Cost Care and Accelerate the Transition to Value-Based Payment Models**
- **Improve Quality and Decrease Disparities in Healthcare Outcomes**
- **Transform RI into a Hub for Life Sciences Research and Innovation**
- **Nurture the Local Healthcare Workforce**

To achieve these goals, LS, CNE, and Brown have identified several initiatives to pursue within the first several years of the combination. These initiatives, which are detailed in the following sections, are interdependent and, in aggregate, will result in a fundamentally new way of delivering healthcare in RI. By bringing together their complementary services, LS and CNE will offer, under one system, a comprehensive range of specialty and primary care services across the state. This will allow the combined system to coordinate care more effectively and build destination programs around women's health, cancer, psychiatry/behavioral health, cardiac care, and other areas of existing expertise. Additionally, RIAHCS will work with public and private payors, providers, and community organizations to develop programs and make investments that better meet the state's needs around health disparities, unnecessary utilization, and rising costs. Moreover, as a single entity, RIAHCS will be able to collaborate more effectively with Brown and other local partners to advance research, reduce health disparities, invest in community programs, and transform RI into a destination for health science development and innovation.

The initiatives identified to achieve these goals require CNE and LS to operate in a way that would not be possible absent a combination. For example, there are initiatives that involve redirecting patients from LS facilities to CNE facilities and vice versa or co-investing in uniform electronic medical record (EMR) systems, programs, facilities, and other technology that neither system would have an incentive and/or ability to do without being financially integrated and thus able to benefit from the efficiencies gained. Ultimately, the value is not in any one initiative but in the aggregate interplay of these mutually reinforcing initiatives.

The potential benefits of this combination to patients, payors, and the broader community are transformative. By coming together, LS and CNE, in conjunction with their academic affiliation with Brown, can help the state avoid the uncertainties that come without a robust, full-service RI-based academic healthcare system (underserved communities, fragmented care, migration of services to MA and Connecticut, and undercapitalized research and clinical programs) while managing healthcare cost growth, improving the quality of care, increasing access to the appropriate care settings in the communities it serves, reducing disparities, and transforming RI into a world-class hub of research and innovation.

Coordinate and Standardize Care to Reduce Waste

The initiatives outlined below involve realigning clinical functions to ensure all patients, especially those from disadvantaged communities, get the appropriate level of care at the right time and the right place to avoid unnecessary utilization including lab tests, imaging, ED visits, and more. These initiatives also involve reorganizing programs and facilities so RIAHCS uses its resources more effectively to promote equitable, high-quality care across the state.

1. **Unify the Operating Model for Each Clinical Program.** [redacted]

2. **Optimize System-Wide Inpatient Capacity.** [redacted]

[redacted]

[redacted]

3. **Invest in a Unified Set of Information Technology.** [redacted]

[redacted]

[redacted]

Below are key milestones in the path to implement this initiative, to be overseen by the Chief Information Officer and appropriate parties from Brown, to be determined.

4. **Address Unmet Psychiatric/Behavioral Health Needs.** Through CNE's Butler Hospital (Butler), which serves adult and adolescent patients, and The Providence Center, as well as LS' Bradley Hospital (Bradley), which serves pediatric patients, and Gateway Healthcare, RIAHCS will offer for the first time a full complement of inpatient and outpatient psychiatric/behavioral health services for adults, children, and adolescents. RIAHCS has identified three initiatives to knit these programs together and address unmet needs related to crisis, inpatient, and outpatient care. These initiatives will be overseen by the psychiatry/behavioral health service line leaders.

Psych Initiative #1: Crisis Care - Build a Brief Stay Unit at Butler.

Psych Initiative #2: Inpatient Care - Centralize Appropriate Inpatient Care at Butler.

Psych Initiative #3: Outpatient Care - Embed Psychiatric / Behavioral Health into Other Clinical Services.

5. **Transform WIH Into a Comprehensive Women's Hospital.** Healthcare for women is particularly fractured in RI. While CNE operates the only women's hospital in the state, it is focused largely on obstetrical, gynecology and breast cancer care. Meanwhile, RIH treats complex surgical and medical cases requiring other specialists (e.g., urology, cardiology, etc.). Thus, care for women is spread across two systems, is inconvenient for patients, and leads to suboptimal coordination, which, as explained in the opening section, drives overutilization and rising healthcare costs. Furthermore, there are persistent differences in maternal health outcomes across race and other social factors. For example, in RI, Black, Hispanic, and Asian women are more likely to receive delayed prenatal care (after the first trimester) than White women,[27] and the rate of preterm birth rate among Black women in RI is 40% higher than that experienced by other women.[28]

   RIAHCS will have the combined range of expertise needed to transform WIH from a largely obstetric and breast/gynecologic cancer-focused hospital into a comprehensive women's hospital that supports a range of specialties. This transformation will involve several components. [redacted].

[redacted]

[27] RI Department of Health "RI Issue Brief: Preconception, Pregnancy, and Postpartum Health" (2020)
[28] March of Dimes "State Report Card: RI" (2020)

6. **Establish RI's First Comprehensive Cancer Center.** The LS Cancer Institute is the premier cancer provider in the state, and combined with CNE's existing expertise in breast, gynecologic, and other oncologic sub-specialties, RIAHCS will be able to provide the full spectrum of cancer care within RI and extend preventive care to all communities, especially those that have historically been underserved. Furthermore, with Brown as an academic partner, RIAHCS can advance cancer research and improve access to advanced treatments in development. Below are key milestones in the path to implement this initiative, to be overseen by the oncology service line leads in collaboration with the Dean of Brown's Warren Alpert School of Medicine.

Increase Access to Lower-Cost Care and Accelerate the Transition to Value-Based Payment Models

These initiatives involve transitioning care from higher-cost to lower-cost settings, as well as investing in ways to help the community more easily access preventative care to avoid more costly interventions in the future. These initiatives also entail RIAHCS working more closely with payors to develop payment models that incentivize healthcare value and working with community organizations to address social determinants of health.

7. **Work with Payors to Develop Innovative Payment Models and Lower Costs.** As a combined health system, RIAHCS will be positioned to accept the financial responsibility for a larger number of covered lives, including the vast majority of covered Medicaid lives. This creates an opportunity to pursue innovative payment models with governmental and commercial payors that can lead to cost reductions and quality

improvements for consumers and payors. [redacted]

[redacted]

[redacted]

8. **Redirect Appropriate Cases from RIH's HOPD to CNE's ASC.** The combined entity can help stem the growth in healthcare costs by moving care to ambulatory surgery centers (ASC)s, which offer significant cost advantages to traditional hospitals or hospital

[30] CMS "Next Generation ACO Model Financial and Quality Results" (2018)

outpatient departments (HOPDs).[31]

9. **Assess Need and Build One to Two Ambulatory Care Centers Throughout the State.** RIAHCS will expand access to lower-cost ambulatory care by building one to two multidisciplinary ambulatory care centers throughout the state, focusing on currently underserved areas.

Improve Quality and Decrease Disparities in Healthcare Outcomes

These initiatives involve developing system-wide set of standards, protocols, and infrastructure to uphold the Institute of Medicine's six aims of quality, which dictate that care should be safe, effective, patient-centered, timely, efficient, and equitable.

10. **Redesign Quality Infrastructure and Publicly Set/Monitor Quality and Cost Goals.** In the spirit of its commitment to quality and transparency and in direct response to a request from BCBSRI, RIAHCS will work with payors to establish quality, patient experience, and cost goals and publicly report on their performance. Defining the specific goals that are most impactful will require working more closely with payors and other experts (e.g., Brown School of Public Health, RI Quality Institute), but example system-wide goals include:

    a. CMS Overall Quality ranking of four stars or higher
    b. better than the national average in overall and major service line rates of readmission, hospital-acquired conditions, morbidity, and mortality
    c. better than peer performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures
    d. eliminate differences in patient quality and satisfaction outcomes by race, ethnicity, gender, and other social factors

[redacted]

[redacted]

[redacted]

11. **Expand Services at CNE's Express Care Center in the Pawtucket/Central Falls Area.** Pawtucket and Central Falls lack the care settings necessary to treat lower-acuity medical events, so many people in these communities rely on EDs to get care that could otherwise be provided in other settings at lower cost. CNE's Express Care Center in Pawtucket provides services to the community but is not licensed as an urgent care center and lacks the breadth of services needed to help people avoid unnecessary ED visits. With LS' expertise operating urgent care sites, RIAHCS will expand the services at its Express Care Center, offering a fuller set of primary, behavioral health, and urgent care offerings to a previously underserved area. Below are key milestones in the path to implement this initiative, to be overseen by the Chief Operating Officer.

[redacted]

12. **Invest in Population Health Infrastructure and Addressing the Social Determinants of Health.** As RIAHCS moves more towards value-based care models, the system becomes more able (and incentivized) to invest in technologies, capabilities, and programs that improve population health and address the social factors that affect health outcomes. Thus, CNE and LS have initially committed $10 million over three years to address social determinants of health, including lack of affordable housing, food insecurity, insufficient transportation to/from medical appointments, social isolation, and unemployment. As one entity, RIAHCS can more effectively ensure programs and resources are developed and deployed in ways that will help overcome these barriers while also partnering with Brown and other community organizations to advance these efforts. Below are key milestones in the path to implement this initiative, to be overseen by the Chief Health Equity Officer and the Director of Population Health.

[redacted]

[redacted]

[redacted]

Transform RI into a Hub for Life Sciences Research and Innovation

With Brown, RIAHCS has an opportunity to cultivate partnerships with outside academic, industry, and community partners to make RI an attractive destination for life sciences research and development, as well as make cutting edge therapies more available to Rhode Islanders.

13. **Transform RI into a Life Sciences Research and Innovation Hub**. RIAHCS and Brown will have several attributes that biotechnology entrepreneurs and manufacturers would find compelling: a unified research administration and access to a comprehensive clinical database over a range of conditions. This is an improvement over the current situation in which clinical data and processes to submit grants, manage clinical trials, and conduct translational research are fragmented across three separate entities. On top of that, RIAHCS and Brown will offer clinicians spanning a broad array of medical specialties, world-class scientists and researchers affiliated with an internationally renowned university, a comprehensive database of clinical outcomes data over a range of conditions, and new graduates eager to get involved in start-up opportunities. Moreover, all these attributes are available in a state with a lower cost of doing business and cost of living than other states in the northeast. With these features, RIAHCS and Brown can serve as catalysts to grow research and innovation across the state, which will not only help Rhode Islanders access cutting edge therapies more quickly and easily but also help bolster the state economy and increase RI's ability to secure funds for largescale research

programs. To do this, Brown, LS, and CNE have outlined the following plan to streamline their research operations and invest in broader research development. Below are key milestones in the path to implement this initiative, to be overseen by the RIAHCS Co-CEOs, President of Brown, and the Dean of the Warren Alpert Medical School.

[redacted]

[redacted]

[redacted]

Nurture the Local Healthcare Workforce

As a single entity working with Brown, RIAHCS is better positioned to develop training programs and career pathways to enrich the existing workforce, attract a new generation of healthcare professionals, and foster a workforce that reflects the racial and ethnic background of the people it serves.

14. **Expand and Enrich the Healthcare Workforce in RI.** As described above, RI faces significant healthcare workforce shortages that limit the ability to meet patient needs and support impactful research. As an integrated entity, RIAHCS will work more closely with Brown to develop new programs that attract physicians and public health

professionals to the area and train the next generation of healthcare workers that reflect the diversity of the patients it serves. Also, compared to LS and CNE as single systems, RIAHCS can more effectively recruit and retain staff by developing career pathways that allow employees to enjoy different professional experiences over the course of their career, including opportunities to work in different clinical areas (e.g., adult, pediatric) and care settings (e.g., academic medical center, community hospital). Below are key milestones in the path to implement this initiative, to be overseen by the Chief Human Resources Officer and Chief Diversity Officer.

[redacted]

[redacted]

Enablers

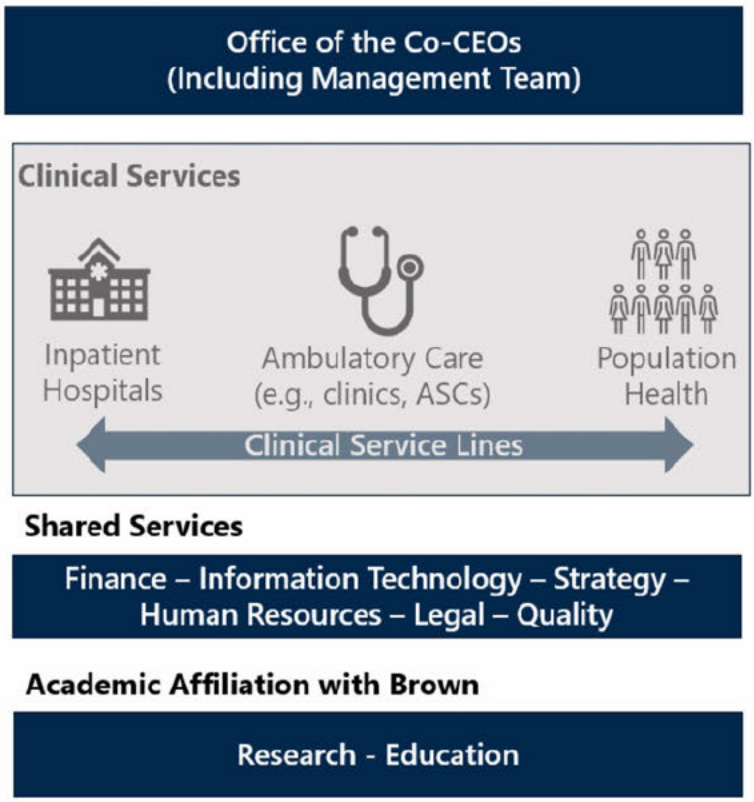
RIAHCS and Brown are committed to the initiatives identified above and the goals of: (a) coordinating and standardizing care to reduce waste, (b) increasing access to lower-cost care and accelerating the transition to value-based payment models, (c) improving quality and decreasing disparities in healthcare outcomes, (d) transforming RI into a hub for life sciences research and innovation, and (e) nurturing the local healthcare workforce. To enable these initiatives and ensure they are implemented in a timely manner, RIAHCS and Brown have made the following commitments.

[redacted]

[redacted]

b. Provide Capital to Develop Clinical, Research, and Community Programs. Many of the initiatives above will require significant capital investments, and the parties will work to assess the full scope of the funds needed over the coming months. These proposed capital commitments will be shared with LS and CNE's existing board members to expedite the approval process. Regardless, RIAHCS is committed to investing more than historical levels (approximately $100M per year, combined). [redacted]). Separately, Brown has committed at least $125M to support initiatives related to the transformation of healthcare delivery and research.

Figure 1. Illustrative Depiction of Initial RIAHCS Structure



Conclusion and Next Steps

The initiatives identified above are all in the service of fundamentally improving and transforming how healthcare is delivered in RI. As a combined system, RIAHCS will have the efficiencies of scope and scale needed to confront the salient operational, social, and economic challenges that currently limit the equitable and ubiquitous provision of high-quality, lower cost health care. In addition to providing higher-value care, the combined system will be more sustainable in the long run and better positioned to pursue long-term growth in the northeast corridor. Furthermore, with Brown as an integrated academic partner, RIAHCS can enhance quality and research overall and serve as a catalyst for the development of a robust research and innovation hub in the area that will attract health industry entrepreneurs, providers, researchers, and manufactures to the state and enhance RI's economy and social capital for many decades to come.

Over the coming months, LS and CNE, working closely with Brown, will share this plan with representatives from RI patient advocacy groups, payors, providers, public sector agencies, academic institutions, and businesses. [redacted] For each of the final priority initiatives, the parties will develop a comprehensive integration plan that includes a detailed workplan and timeline; estimated improvements in access, quality, cost, and equity; and projected capital needs. [redacted]

Appendix

[redacted]

Appendix B. Other Initiatives for RIAHCS to Develop

To further overall system goals and to bolster the initiatives already defined above, RIAHCS identified additional initiatives to develop further in the future:

[redacted]

[34] Audited financial statements (FY19, FY20, FY21 YTD June 2021); Industry medians from Moody's (2021 based on 2020 data)

[redacted]

[redacted]

[redacted]

Table 1. Participants in the Integration Planning Process

Role / Subject Matter Focus	LS Representatives	CNE Representatives
Senior Leadership (met weekly)	Dr. Tim Babineau, CEO	Dr. James Fanale, CEO
Broader Leadership Oversight	Dr. Tim Babineau Paul Adler Todd Conklin Mark Hasbrouck David Kirshner Mamie Wakefield Dr. Ken Wood	Dr. James Fanale Robert Haffey Joe Iannoni Dr. Raymond Powrie Gail Robbins Ashley Taylor
Academics / Research	Michael Henderson Dr. Bharat Ramratnam Dr. Ken Wood	Sue Elmore Gail Robbins
Cardiovascular	Janine Larimore Dr. Athena Poppas	Dr. Paari Gopalakrishnan Dr. Raymond Powrie
Emergency Medicine	Dr. Megan Ranney Dr. Jay Schurr	Dr. Laura Forman Dr. Ashley Lauria, MD
Geriatrics/ Chronic Disease	Cathy Duquette Dr. Ken Wood	Ruth Scott Dr. Ana Tuya-Fulton
Imaging and Testing	Dr. John Cronan Jonathan Pine	Dr. Paari Gopalakrishnan
IT	Cedric Priebe	Joseph Iannoni Phil Kahn
Neurosciences	Dr. Karen Furie Dr. Ziya Gokaslan	Dr. Paari Gopalakrishnan Dr. Arshad Iqual
Oncology	Susan Korber Donna O'Brien Dr. David Wazer	Dr. Paul DiSilvestro Dr. Paari Gopalakrishnan Dr. Raymond Powrie
Pediatrics/ Neonatology	Dr. Phyllis Dennery Tracey Wallace	Dr. Robert Insoft Shannon Sullivan
Psychiatry/ Behavioral Health	James Florio Dr. Henry Sachs Dr. Jody Underwood	Jennifer Healy Mary Marran Dr. James Sullivan
Quality Systems	Cathy Duquette Michael Henderson Dr. Ken Wood	Dr. James E. Fanale Robin Neale Dr. Raymond Powrie

Role / Subject Matter Focus	LS Representatives	CNE Representatives
Standardization, Integration, and Coordination	Todd Conklin Cathy Duquette Crista Durand Dr. Louis Rice Dr. Ken Wood	Dr. James E. Fanale Robert Haffey Dr. Raymond Powrie
Value Based Care, Population Health, and Other Payor Innovation	David Balasco Carrie Bridges David Kirschner Dr. Alan Kurose Dr. Steven Lampert Daniel Moynihan	Dr. James E. Fanale Alyscia Grant Matthew Harvey John Minichiello
Women's Health	Meagan Hunt Dr. Margaret Miller	Dr. Robert Insoft Shannon Sullivan Dr. Methodius G. Tuuli
Workforce	Lisa Abbott	AJ Avila
Other	Nick Dominic (facilities) Christie Rath (supply chain)	Kathy Peirce (home health)