Governor McKee signs legislation to support sale of Roger Williams Medical Center and Our Lady of Fatima Hospital

PROVIDENCE — Governor **DAN McKEE** recently signed legislation to support the sale of Roger Williams Medical Center and Our Lady of Fatima Hospital by creating an $18-million fund to assist potential buyer Centurion in closing the transaction, contingent upon Centurion securing outside financing.

"Keeping Fatima and Roger Williams open is my top priority—for both the communities these hospitals serve and the dedicated professionals who care for their patients," said Governor Dan McKee. "My team has worked closely with the Attorney General's Office and the General Assembly, and we will continue to work together to assure the long-term viability of these critical hospitals."

"A potential closure of Fatima and Roger Williams hospitals is a catastrophic scenario for the people of Rhode Island and our fragile healthcare system. Not only would it affect the patients of the two hospitals, but the ripple effect would be devastating for Rhode Island's other hospitals and the patients they serve. Thankfully, with urgent recognition of this serious problem, our state government came together swiftly to ensure the sale of Fatima and Roger Williams hospitals proceeds," said Representative **SCOTT A. SLATER** (D-Dist. 10, Providence), Vice Chairman of the House Finance Committee.

"Tens of thousands of Rhode Islanders rely on Fatima and Roger Williams for medical care. For those patients, for the stability of our entire health system, and for our state's well-being now and in the years to come, we absolutely must find a secure and sustainable path forward for these safety-net hospitals. The legislation being signed today—which is fiscally responsible and limited in scope, while creating a critical backstop that will protect Rhode Islanders—represents a critical piece of that puzzle. On behalf of the Senate, I am grateful for the outstanding efforts of all the parties involved and the overwhelming support from the General Assembly," said Senator **LOUIS P. DiPALMA** (D-Dist. 12, Middletown, Little Compton, Newport, Tiverton), Chairman, Senate Committee on Finance.

This legislation dedicates $18 million from the state's supplemental rainy-day fund to support Centurion's acquisition of the hospitals, and includes several safeguards to support the acquisition while protecting taxpayers. No state funds will be used unless the Rhode Island Health and Educational Building Corporation issues the bonds needed to purchase the hospitals. The $18-million appropriation will not be given directly to Centurion even if the sale moves forward. Instead, the funds will be placed in a backup reserve account and can be used only if Centurion is unable to make its bond payments and only after its primary reserve has been fully exhausted. The bond issuance is expected to total about $80 million; the state's financial exposure is capped at $18 million.

"I am thankful to the General Assembly and Governor McKee for the passage and signing of this legislation, which is fundamentally about securing stability for patients, staff and the communities that rely on these hospitals every day," said Rhode Island Executive Office of Health and Human Services Secretary **RICHARD CHAREST**. "This legislation gives Centurion the opportunity to finalize the sale of these hospitals, to preserve care, and to protect our state's broader health care system."

"Roger Williams Medical Center and Our Lady of Fatima Hospital are critical safety-net hospitals. These facilities need to stay open for the patients they serve, and for the healthcare system in Rhode Island overall," said Director of Health **JERRY LARKIN, MD**. "The passage and signing of this legislation represents an important step in that direction. We are very grateful to the Governor and the General Assembly for their leadership and action on this critical issue." ❖

Sen. Whitehouse reintroduces the Prior Authorization Relief Act to more quickly deliver care to patients

Washington, DC — U.S. Senator **SHELDON WHITEHOUSE** (D-RI) reintroduced the Prior Authorization Relief Act on Feb. 3, 2026, This legislation to cut the administrative burdens associated with prior authorizations, a tool requiring healthcare providers to secure approval from health insurance plans before delivering medicines and services for a patient, resulting in faster care for patients. The bill eliminates prior authorizations from providers in value-based payment models.

"Americans are rightfully fed up with healthcare bureaucracy, and one of the many reasons is payment warfare by prior authorization," said Whitehouse, a senior member of the Senate Finance Committee. "Providers in value-based programs have every incentive to avoid unnecessary medical care, so these prior authorization requirements simply delay treatment and drive up overhead costs. My legislation aims to cut red tape and make it faster, easier, and cheaper to deliver high-quality care to patients."

Over 53 million prior authorization requests were submitted to Medicare Advantage health insurance plans in 2024. This can lead to increased administrative red-tape for healthcare providers and potential harm for patients.

Senator Whitehouse's Prior Authorization Relief Act would require the Centers for Medicare and Medicaid Services (CMS) to perform an audit across prior approvals required in Medicare Advantage insurance plans for medicines and services and ensure CMS standardizes prior authorization requirements across those medicines and services identified through the Agency's audit.

"Prior authorization continues to be a significant barrier to care faced by Medicare Advantage enrollees, and additional oversight and accountability are desperately needed," said **DAVID LIPSCHUTZ**, Co-Director of the Center for Medicare Advocacy. "Standardizing prior authorization requirements would be an important step forward towards achieving such accountability." ❖

New finding for glioblastoma treatment from Brown University Health

PROVIDENCE — In a groundbreaking study, researchers from Brown University Health have identified a factor that may help improve treatment for glioblastoma, a very aggressive and very common form of adult brain cancer. The findings were published in *Cell Reports*, and they reveal how differences among cells within a single tumor influence the cancer's response to chemotherapy. This promising new therapy might increase the odds of a favorable outcome for patients.

Glioblastoma is extremely difficult to treat because no two cells within the tumor behave exactly alike. Even within the same tumor, some cells respond to treatment while others do not, allowing the cancer to continue to grow. Scientists have long known that tumors are composed of diverse cells, but the biology behind these differences, and their impact on treatment, have remained unknown.

"Traditionally, researchers have focused on the overall behavior of a tumor by studying the average response across all the individual cells, using differences between the cells to interpret the average," said senior author **CLARK CHEN, MD, PhD**, Professor and Director of the Brain Tumor Program, Department of Neurosurgery at Brown University Health. "Our study fundamentally flipped that approach. Rather than focusing on the average response, we focused on the differences between individual cells within the same tumor, and what we found could change how we treat glioblastoma."

Chen's team discovered that a small molecule called miR-181d acts like a master switch that helps control how much of a DNA-repair protein called MGMT (short for methyl-guanine methyl transferase) each glioblastoma cell produces. When glioblastoma tumors are treated with chemotherapy, levels of miR-181d drop. This drop amplifies the differences among individual cells within the tumor, thereby allowing more cells to make more MGMT and survive treatment. The research team found that administering miR-181d into the tumor can reduce this effect, making the cancer cells behave more uniformly, and importantly, more likely to respond to chemotherapy.

"This is an exciting step forward," commented **GATIKRUSHNA SINGH**, Assistant Professor of Neurosurgery, University of Minnesota and one of the study's key collaborators. "Scientifically, it helps explain why tumors maintain so much internal variability. Clinically, it opens the door to gene-therapy strategies that could be truly game-changing for many glioblastoma patients."

The discovery has already led to the development of a new potential therapy aimed at improving patients' responses to chemotherapy by stabilizing miR-181d levels within the tumor.

This study was a collaborative effort involving scientists from Brown University Health, the University of Minnesota, VisiCELL Medical Inc., Stanford University, and Johns Hopkins University. ❖

Promising new prostate cancer trials treat first patients at The Miriam Hospital

PROVIDENCE — The Miriam Hospital has treated the first patients worldwide in two new clinical trials testing groundbreaking therapies for prostate cancer, affording local patients cutting-edge treatments years before they may be available elsewhere.

The two studies are part of Brown University Health's Early Phase Clinical Trial (Phase I) Program, led by **BENEDITO CARNEIRO, MD**, Director of Clinical Research and Cancer Drug Development and Associate Director of the Division of Hematology/Oncology and Co-Leader of the Cancer Therapeutics Program at the Legorreta Cancer Center at Brown University.

"The Early Phase Clinical Trial Program at Brown University Health and Legorreta Cancer Center is essential to making this kind of progress possible," said Dr. Carneiro "Our program allows us to safely bring the most innovative cancer therapies to patients early and close to their home, while advancing research that can change how prostate cancer is treated worldwide."

Both studies are centered on treatments designed to precisely target prostate cancer cells while minimizing damage to healthy tissue. One trial is testing a new type of immunotherapy that helps the body's immune system recognize and attack prostate cancer. It works by guiding immune cells directly to cancer cells that carry a protein commonly found in prostate cancer. The second trial is evaluating a targeted drug delivery approach that sends a cancer-killing medicine directly to prostate cancer cells. This strategy is designed to limit side effects by concentrating treatment where it is needed and sparing healthy cells. These studies are sponsored by AstraZeneca.

The Miriam Hospital's prostate cancer team, including medical oncologists, urologists, and radiation oncologists are also participating in several other clinical trials for patients with newly diagnosed and advanced prostate cancer. "These trials reflect the very best of what The Miriam Hospital stands for, innovation, collaboration, and a deep commitment to our patients," said **MARIA DUCHARME, DNP, RN**, President, The Miriam Hospital and Chief Quality Executive, Brown University Health. "By bringing first-in-the-world clinical research to our community, we are giving patients access to highly advanced care close to home and helping shape the future of prostate cancer treatment." ❖

RIDOH travel-related measles advisory

Measles transmission in the U.S. continues to increase. A large measles outbreak is currently impacting a region of South Carolina and smaller outbreaks are occurring in Arizona, Utah, and Florida, among others. Travel to areas with active measles transmission increases during school and higher education breaks in February, March, and April; the Rhode Island Department of Health (RIDOH) reminds clinicians to be vigilant for potential measles cases.

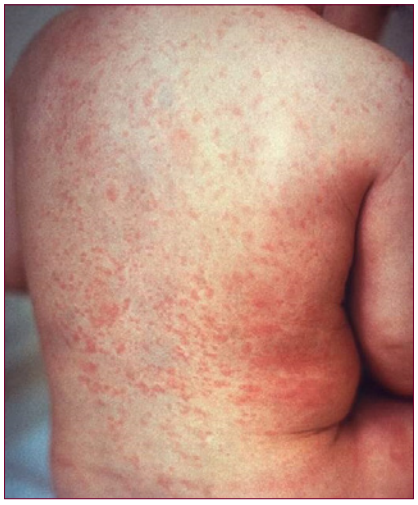
RIDOH is sharing the following guidance for identifying, reporting, and testing suspected measles cases. RIDOH also urges clinicians to review MMR vaccination records and strongly encourage MMR vaccination for patients who may not be up to date on MMR vaccination.

RIDOH request the following actions:

- Report all suspected cases of measles to RIDOH immediately at the time of initial clinical suspicion by calling 401-222-2577 (Monday–Friday, 8:30 am–4:30 pm) or 401-276-8046 after hours.
- Collect specimens for measles testing in patients presenting with febrile rash illness, clinically compatible measles symptoms, and epidemiological risk factors, such as travel or exposure to travelers.
- Ensure all patients are up to date on MMR vaccine. Refer to this resource for tips on having vaccine conversations and addressing concerns about the MMR vaccine.
- Review strategies for preventing measles transmission.

Measles cases have been increasing rapidly in the U.S. since early 2025 with large, extended outbreaks. Delayed recognition of measles can increase the risk of transmission. The clinical presentation of measles in adults and children is an acute, viral illness characterized by fever followed by a generalized, maculopapular rash. Additional symptoms may include cough, conjunctivitis and coryza. Koplik spots, blue-white spots on the buccal mucosa, are occasionally seen.

The rash usually starts on the face, proceeds down the body, and may include the palms and soles. The rash, which lasts for several days, fades in order of appearance. Patients are considered infectious 4 days before and 4 days after rash onset. Measles can be severe. Complications include diarrhea, otitis media, pneumonia, hepatitis, and encephalitis.



Requested Actions:

1. Report all suspected cases of measles immediately (24 hours a day) to RIDOH at 401-222-2577 Monday–Friday 8:30 am–4:30 pm or 401-276-8046 after hours, at the time of initial clinical suspicion. Don't wait for laboratory confirmation to report.

- Review the clinical features of measles.
- Maintain a high index of suspicion for measles in people with compatible febrile rash illness.

2. Collect specimens in patients presenting with febrile rash illness, clinically compatible symptoms, and clinically compatible measles symptoms, and epidemiological risk factors, such as travel or exposure to traveler.

- Contact RIDOH for assistance with submitting specimens to the Rhode Island State Health Laboratories (RISHL) for testing. Follow CDC's testing recommendations and collect a nasopharyngeal swab for reverse transcription polymerase chain reaction (RT-PCR), as well as a serum specimen for serology from all patients with clinical features compatible with measles.
- RISHL cannot accept throat swabs at this time. Please only collect a nasopharyngeal swab and a blood specimen for RISHL submissions.

Please follow these specimen transport instructions:

- **Refrigerated**: Transport and deliver to the laboratory within 72 hours of collection at 2–8°C in a cooler able to maintain specimen temperature. A plug-in electric cooler is recommended, however a cooler packed with excess frozen gel packs is acceptable as long as the transport temperature is maintained at 2–8°C.
- **Frozen**: If specimen previously frozen, it must be transported on frozen gel packs in insulated shipper.
- RISHL specimen collection guidance for Measles PCR can be found here.

3. Ensure all patients are up to date on MMR vaccine. As of February 5, 2026, CDC reported 95% of current measles cases in the U.S. were unvaccinated or had an unknown vaccination status.

Measles is almost entirely preventable through vaccination. The MMR (measles, mumps, and rubella) vaccine remains the best protection against measles. MMR vaccines are safe and highly effective, with 2 doses being 97% effective against measles (1 dose is 93% effective). When more than 95% of people in a community are vaccinated (coverage >95%) most people are protected through community immunity (herd immunity).

Vaccination coverage among U.S. kinder-gartners has decreased over time, but Rhode Island has a very good MMR vaccination rate. Approximately 97% of Rhode Island kindergartners have completed the MMR series, above the national average of 92.5%.

Rhode Island's measles immunization recommendations and requirements are as follows:

Pediatric Patients

Children should receive a first dose of MMR between 12 and 15 months of age, and a second dose between 4 and 6 years of age. Two doses of MMR are required for entry into kindergarten and all subsequent grades. For adolescents and older students, two doses of MMR are also required for entry into colleges and universities in Rhode Island. Learn more.

- For additional support**:** Healthcare professionals can run a KIDSNET Missing Immunization Report to assess patients who may be missing doses of MMR. The report will also highlight MMR doses that may need to be repeated due to timing between doses. Consider nurse-only visits to get patients in faster. If you need technical assistance or access to the Rhode Island Child and Adult Immunization Registry (RICAIR), please reach out to DOH.KIDSNET@health.ri.gov.

Adults

Adults who have not been vaccinated against measles, those who have only received one dose of MMR, or those who are not sure of their immune status can still be vaccinated.

Adults may contact their healthcare professionals to find out whether they were vaccinated against measles. Adults who were not vaccinated against measles and who do not have evidence of immunity against the disease may be advised to get at least one dose of MMR. There is no harm in giving MMR to a person who may already be immune to one or more of the vaccine viruses. Pregnant women should not receive any live virus vaccine during pregnancy, including MMR.

Travelers

- International travel: Anyone traveling internationally should be fully vaccinated before traveling. It is very important that infants 6 to 11 months old get one dose of MMR before international travel. Then they should get one more doses after their first birthday in accordance with the standard schedule. Children 12 months and older need two doses separated by at least 28 days, and teenagers and adults who do not have evidence of immunity against measles need two doses separated by at least 28 days.
- Domestic travel: Given current U.S. measles cases, people traveling to U.S. locations with active measles outbreaks should ensure they are fully vaccinated, following the immunization guidance stated above.

Vaccination and immunity for healthcare workers

MMR is required for all healthcare workers in certain facilities. A list of these facilities can be found at: https://health.ri.gov/immunization/information/healthcare-workers. These facilities should ensure:

- All newly hired healthcare workers in these facilities must have received two doses of MMR, show laboratory evidence of immunity, or show laboratory confirmation of disease.
- For current healthcare workers in these facilities born before 1957 who lack laboratory evidence of measles immunity or laboratory confirmation of disease, two doses of MMR vaccine are recommended. These individuals will be required to be vaccinated during outbreaks.

4. Prepare for measles cases:

- Review infection control plans for assessing patients who may have measles or who may have been exposed.
- Screen for fever with rash at the point of entry into a healthcare facility and place symptomatic individuals in airborne isolation immediately. Don't allow patients with suspect measles to remain in waiting rooms. If a negative pressure room isn't available, place the patient in an exam room with a closed door, and don't use that room for at least 2 hours after the patient has left.
- Healthcare workers should adhere to standard and airborne precautions when evaluating suspect cases, regardless of their vaccination status.
- All healthcare workers should have documented evidence of immunity to measles. ❖

New regulation for medical practice groups

NEWPORT — Effective January 28, 2026, per a new regulation, medical practice groups in Rhode Island are required to submit a Notice of Material Change to the Office of the Attorney General before completing certain transactions, including, among other things, mergers or affiliations that result in a group of eight or more clinicians, transactions involving hospitals or health systems, arrangements involving management services organizations, and transactions involving private equity or other significant investors.

This will give the Attorney General advance notice of transactions that could impact access to care, market competition, or the delivery of healthcare services in Rhode Island. The notice must generally be submitted at least 60 days in advance of the effective date of a covered transaction.

The Attorney General encourages practices to carefully review these materials and to consult legal counsel if any transaction that might fall within the scope of this requirement is under consideration. RIMS will continue to monitor implementation of the regulation and share updates or clarifications as they become available.

For more about this regulation, please see:

The Notice of Material Change Form, which outlines what information must be submitted; and

The Attorney General's press release, which summarizes the intent and scope of the new regulation. ❖

PACT Act event held by VA Providence in Woonsocket

WOONSOCKET—The VA Providence Healthcare System, partnering with the Veterans Benefits Administration, Veterans Inc, and the Elks Lodge Veterans Committee, hosted a successful PACT Act outreach event on January 25th.

The event took place at the Woonsocket Elks Lodge and provided Veterans with crucial information and support regarding enrollment, benefits, and resources.

Event attendees were able to connect directly with VA Providence's enrollment team and representatives from key organizations dedicated to serving Veterans.

"The turnout today was incredible, and it's a testament to the commitment of our community to ensuring Veterans receive the care and benefits they've earned," said **LAWRENCE CONNELL**, Director of the VA Providence Healthcare System. "By bringing these services directly to Veterans, we're making it easier for them to access the support they need."

The PACT Act, expands healthcare eligibility and benefits for Veterans exposed to burn pits and other toxic substances, remains a vital topic for Veterans seeking to understand their options.

To learn more about the PACT Act or future events, please visit https://www.va.gov/providence-health-care/events. ❖

New blood markers identified that may detect early pancreatic cancer

PHILADELPHIA — National Institutes of Health (NIH)-supported investigators developed a blood test to find pancreatic ductal adenocarcinoma. The new test could improve survival rates from pancreatic cancer, one of the deadliest forms of cancer which tends to be diagnosed at late stages when therapy is less likely to be effective. The findings were published in *Clinical Cancer Research*.

Approximately one in 10 pancreatic cancer patients survive more than 5 years from diagnosis. When the cancer is found and treated at an earlier stage, experts expect that survival would improve.

Researchers at the University of Pennsylvania Perelman School of Medicine, PA, and Mayo Clinic, Rochester, MN, used a phased approach to testing biomarkers in the blood collected from patients with pancreatic cancer and similar patients without the malignancy. They included two blood biomarkers previously explored for use in this way, carbohydrate antigen 19-9 (CA19-9), which is used to monitor treatment response in patients with pancreatic cancer, and thrombospondin 2 (THBS2), another previously used marker but neither worked well as a screening tool.

In analyzing banked blood samples, the team found two novel biomarker proteins that were elevated in the blood of early-stage pancreatic cancer patients compared with healthy volunteers, aminopeptidase N (ANPEP) and polymeric immunoglobin receptor (PIGR).

When they combined ANPEP and PIGR with CA19-9 and THBS2 the four-marker panel successfully identified pancreatic cancer cases from non-cases 91.9% of the time for all stages combined at a false positive rate of 5% in non-cases. Similarly, for early-stage (stage I/II) cancer, the four-marker test identified 87.5% of cases.

"By adding ANPEP and PIGR to the existing markers, we've significantly improved our ability to detect this cancer when it's most treatable," said the study's lead investigator, **KENNETH ZARET, PhD**, University of Pennsylvania's Perelman School of Medicine. "Our retrospective study findings warrant further testing in larger populations, particularly in people before they show symptoms," Zaret said. "Such 'prediagnostic' studies would help determine if the test could be used as a screening tool for people at high risk of developing the disease based on family history, genetic screening results or personal history of pancreatic cysts or pancreatitis."

The study was supported by NIH grants U01CA210138, P50CA102701, S10 OD023586-01, P30 DK020579, UL1 TR002345, P30CA091842, and U01CA210138. ❖

New Middletown location for Brown Health Medical Group Primary Care

MIDDLETOWN — Brown University Health Medical Group Primary Care has opened a new site in Middletown, at 99 East Main Road, Suite 19A. A ribbon-cutting ceremony was held at the ~15,000-square-foot facility on Feb. 11, with Brown University Health leaders, Middletown clinicians, and staff in attendance. The space features on-site lab services, specialty space, updated amenities, and room for expansion.

"The opening of our Middletown location represents more than a new address—it marks a major investment and commitment to the future of primary care for this community," said **EDWARD McGOOKIN, MD**, Chief of Primary Care, Brown Health Medical Group Primary Care. "In a region where access to primary care has long been limited, this new site meets community need by expanding access to high-quality coordinated care in the region."

The Middletown care team looks forward to expanding access with the addition of new clinicians to the practice later this year. They also aim to reconnect with two key patient groups: individuals on Brown Health Primary Care's current waitlist and patients who were displaced during earlier provider transitions. ❖