What I would like to do this morning is talk a little bit about where the Cancer Center and Smilow are at the moment, give you a little update.

For those who are more on the clinical side, you'll hear a little overview of what happened in terms of our overview of the Cancer Center and of our recent CCSG Cancer Center Support Grant.

For those of you more on the research side, I'm going to talk a little bit about where we are clinically.

There might be like a little bit of vision sprinkled in here and there.
I'm gonna try not to offend large groups of people or individuals. I can assure you that there are individuals who I have not mentioned in the slides who I probably should have. And I apologize to you up front and you know, just doing my best.

This is our mission to reduce the burden of cancer in Connecticut and beyond through transformative science and community partnership, all as one big entity.
ensuring Health Equity and exceptional care for all.

So there's not too much to argue with that.

And to go a little further, in my mind, we strive to provide truly outstanding multidisciplinary care across the state through our network to all residents to conduct clinical trials to develop better cancer therapy, since where we are today is simply not good enough to integrate our care and clinical trials with basic translational and population science research to enhance population health. And by that I'm really referring
to the fact that I think that in addition to treating cancer, we should be paying attention to the population, particularly the population of Connecticut, which for the cancer centers, our catchment area in terms of issues like prevention.

We should be educating people about cancer. We should just be paying attention to those who are not necessarily our patients yet or perhaps ever. And of course, we want to educate and train the next generation of researchers and clinicians. I can’t say how important that is.
I don’t speak a great deal in this talk about our fellowship program or other fellowship programs and residencies within the institution, but the training of people is really critical. So the Cancer Center has 309 members, it contains 6 research programs shown here. There are actually 7 shared resources. There’s now 8 because we had one that was just newly approved or well, not officially yet. We have $95.7 million in Cancer Research funding annually. We’d like that number to go up and something in excess of 100 would
be nice within the next year.
And we have a lot of publications, including a lot of publications in high impact journals.
I’ll just mention that this year we took a much more stringent view of how we defined cancer related publications. The total number actually fell compared to past years because we were very specific about what counted as a Cancer Research publication after I arrived here and in preparation for the Cancer Center for grant, but sort of for general purposes beyond that, we did convene a fairly large group of people to develop a strategic plan.
And the themes of that plan are shown on this slide. Research, discovery and innovation, access and care, cancer burden, our own culture, equity and inclusion and education, training and career development. And we'll touch on some of these later. We also as part of the Cancer Center Core grant and beyond that for our own purposes had to identify priority cancers. This doesn’t mean the cancers not included on this list are that we don’t care about or that
we won’t do research there or that

we’ll turn patients away never.

But these four were the cancers that

we identified as priority cancers.

And they were identified as

priority cancers either because,

number one, they’re very common,

which is true for three of these

#2 there are problems in terms

of disparities in the state.

And that is true of each of these.

It’s probably true for all cancer,

but it’s particularly true for each of these.

And finally,

we also wanted to focus on

cancers where we had expertise or
wanted to build the expertise.

So this was quite carefully thought through.

We also did something that is a little bit unusual.

I think in these Cancer Center core grants is that we also identified 4 cross cutting themes.

And those themes were early onset cancer, meaning early age of onset defined practically as people who are diagnosed with cancer under the age of 50.

In my mind, 50s getting a little old.

But in many tumor types,
that’s the definition that is used.

And as people probably know,

there has been a great deal in

the press as a result of what has

happened clinically in terms of the

increasing incidence of certain

cancers in young individuals,

most notably colon cancer.

I will tell you for that,

for the past 25 years,

everyone has said to me yearly there’s

so much breast cancer in young women.

It’s increasing, it’s increasing.

The truth is it has increased

a very tiny amount.

But it, you know,
it’s very different from the colon cancer story, where in fact incidence of colon cancer in people under the age of 50 has really gone up very substantially over the course of the past 20 years. So we also are focusing on brain metastases, which I think are an increasing problem as our treatments get better for disease outside of the brain. And often times disease from the brain seems to be more resistant for lots of different reasons, obesity and metabolism. And as people probably know,
being overweight or obese is associated with an increase of incidence and in some cases an increase in mortality for 13 different tumor types. And finally, of course, the ubiquitous problem of tobacco use, which has gotten a little bit better throughout our country and in Connecticut over the past couple of decades. But it’s still a major problem and a problem that is particularly relevant to underrepresented groups. And while we’re touching on disparities, I’ll just embarrass Tracy for a minute, who’s sitting here in the 3rd row.
We have launched an initiative focused on cancer disparities, particularly in Connecticut. As many of you may know, the statistics are really quite alarming. For instance, if you’re a 20 year old woman in the United States who happens to be black, you have twice the chance of being dead from breast cancer by the time you’re 50. That’s the most dramatic of the statistics that I know, but it’s true really across the board and in all cancer types. Race is a major issue.
being Hispanic or Latinay may make the course of treatment more challenging because people have trouble coming in, accessing treatment.

But in some cases in breast cancer is one of them. Mortality is actually not compromised at all for reasons we don’t fully understand.

But we recruited Tracy Battaglia, who had a long career, well, not that long because she’s still in the middle of her career, but Tracy who had been at Boston Medical Center at Boston University for an extended period of time, lots of experience focusing on.
00:09:21.895 --> 00:09:24.800 ways to diminish disparities, largely through patient navigation.

Tracy joined us on February 26th and we’re all really happy that that happened. We also gave out some internal grants this past year totaling $500,000. That money came from a donor who specifically wanted to focus on this area and some of the topics are shown here and you’re going to hear more and more about this over the course of the next couple of years. We also have a new initiative focused on early onset cancers and that’s just getting off the ground and Beta Giri
and Nancy Borselman are leading this.

The idea is that we really want a statewide program across our entire network that focuses on younger individuals both to optimize care and perhaps even more importantly to try to understand what it is that these younger individuals face in terms of getting treatment and why some of them are developing cancer.

So there will be a large research cohort that is established and then an opportunity to ask hypothesis driven questions within the within that context. And we’re excited about that.
good for everything because we will help these younger individuals, we will learn from them for the health, we will probably bring more younger individuals into the system and it’s just the right thing to do. Our research programs in the Cancer Center are shown here as well as the various leaders. It’s, there’s no particular reason why some have 3 leaders and some have two. It’s, it’s, it’s not that we felt that the ones that have three that the people
are somehow insufficient or inadequate, but it has just evolved this way in general. And most programs across the country, they’re anywhere from 2 to 3 leaders. And it’s possible than the programs that have two that we will add people. In my mind leading a, one of the research programs in the Cancer Center is, is, is something like a 10 year job. And I think it’s important to remember that all of these positions are positions where we should have some turnover. And we’ve had some turnover over the past few years. And I think it’s really important
00:12:09.264 --> 00:12:11.570 in terms of keeping the intellectual activity within the program very fresh.

00:12:17.440 --> 00:12:20.490 I want to talk for a couple of minutes about what I would call the transformation of the clinical research operation in early 22, which actually coincided with my arrival.

00:12:23.935 --> 00:12:27.265 The clinical trials office was not in great shape and I think we don’t need to say a lot more other than accrual had fallen, protocol activation time was high.

00:12:30.840 --> 00:12:33.984 The clinical trials office was not in great shape and I think we don’t need to say a lot more other than accrual had fallen, protocol activation time was high.

00:12:37.158 --> 00:12:40.039 for other reasons before I was even here.

00:12:47.452 --> 00:12:51.305 system partially because of the great resignation associated with COVID and and for other reasons before I was even here.

00:12:54.651 --> 00:12:57.240 I recruited Ian Krop,
who joined us a month after I arrived, who then promptly recruited Alyssa Gateman as the Executive Director.

And under their leadership, the CTO was totally reorganized, staffing was stabilized.

Protocol activation times have dramatically declined.

So more work to do for sure.

Many more protocols were open, investigator initiated trials were prioritized and accrual has increased, not as much as we would like, but it’s going up.

And this is the accrual on interventional treatment trials.
And what you can see is that it Nader in 2022 at just over 500 and the projected number for fiscal year 24 which ends on June 30th is just over 700. But we really should be at 1000 within a year or two. And this shows the proportion of patients who are recruited to interventional trials in New Haven versus at our external sites throughout the state. And I think we have room for improvement in both. As people know, one of the major changes that we have instituted in the network is that we’re
really focusing on sub specialized care.

And the more sub specialized we get,

I think naturally the more people will go on,

on trials at sites around the state

because it’s really specialists who

ultimately know the disease well and,

tend to be that much more committed

to enrolling people in trials.

And, you know,

we appreciate all the efforts

that have been put into this by

people throughout the network.

And we’re also, I should add,

trying to make sure that that,

doctors throughout the network

have the necessary time both to
00:14:58.750 --> 00:15:00.725 be specialists and attend tumor
00:15:00.725 --> 00:15:03.079 boards and and do all of that,
00:15:03.080 --> 00:15:05.640 but then also to enroll people in trials,
00:15:05.640 --> 00:15:07.865 which takes longer than just
00:15:07.865 --> 00:15:09.200 doing standard care.
00:15:09.200 --> 00:15:11.156 We have done reasonably well from
00:15:11.156 --> 00:15:12.460 the standpoint of recruiting
00:15:12.522 --> 00:15:13.839 under represented groups.
00:15:13.840 --> 00:15:15.520 We want to do better.
00:15:15.520 --> 00:15:18.760 We are the proportion of patients
00:15:18.760 --> 00:15:22.170 who are largely Black and and Latin
00:15:22.170 --> 00:15:26.016 A who are recruited to trials in our
00:15:26.016 --> 00:15:29.012 system actually is sort of on par
00:15:29.012 --> 00:15:33.552 with the state population as a whole.
00:15:33.552 --> 00:15:36.718 But again, we can do much, much better.
I want to touch on DEI. We recruited a new DEI leader in the Cancer Center, Faye Rogers, after a national search. And that national search LED us back home. And Faye, of course, is an associate professor in radiation oncology, has done a great deal related to DEI throughout the School of Medicine and has just really done a great job over the past year. And she has recruited an assistant director, Iris Selfie, who actually also is the DEI representative for hematology and oncology.
within the Department of Medicine.

There are ongoing monthly meetings of the DEI Council.

I’m sure if there’s anyone here who’s interested in the DEI council, please contact Faye.

And in the fall, we had about 60 people together for a whole day for anti racism training.

And it was remarkably both interesting and I think effective and eye opening.

And it’s gonna be repeated at least once, probably more than once with a broader audience.

Community outreach and engagement
00:17:02.468 --> 00:17:03.959 is critically important.
NOTE Confidence: 0.95806975
00:17:03.960 --> 00:17:05.240 It's critically important for
NOTE Confidence: 0.95806975
00:17:05.240 --> 00:17:06.840 the Cancer Center Core Grant,
NOTE Confidence: 0.95806975
00:17:06.840 --> 00:17:09.878 but it's important for all of us.
NOTE Confidence: 0.95806975
00:17:09.880 --> 00:17:12.205 Our community outreach and engagement
NOTE Confidence: 0.95806975
00:17:12.205 --> 00:17:15.018 component of the of the grant
NOTE Confidence: 0.95806975
00:17:15.018 --> 00:17:17.436 is led by Marcella Nunes Smith.
NOTE Confidence: 0.95806975
00:17:17.440 --> 00:17:20.163 But let me just sort of take
NOTE Confidence: 0.95806975
00:17:20.163 --> 00:17:22.360 a step beyond the grant.
NOTE Confidence: 0.95806975
00:17:22.360 --> 00:17:27.274 We really need to embrace the community.
NOTE Confidence: 0.95806975
00:17:27.280 --> 00:17:28.392 And by the community,
NOTE Confidence: 0.95806975
00:17:28.392 --> 00:17:31.119 I mean not just the New Haven community,
NOTE Confidence: 0.95806975
00:17:31.120 --> 00:17:33.260 but the statewide community.
NOTE Confidence: 0.95806975
00:17:33.260 --> 00:17:38.287 It is remarkable to me that we live in a
NOTE Confidence: 0.95806975
00:17:38.287 --> 00:17:41.440 city that is a majority minority city,
NOTE Confidence: 0.95806975
00:17:41.440 --> 00:17:44.278 that there's inadequate care that is,
that is available to people in our own city. And some of that is about lack of knowledge. Some of it is about being uncomfortable with all of us. And I truly believe we can make that better by reaching out and spending time in, in the community. And there are many opportunities to do that. And we’re going to be tapping more and more of you to, to get involved. And finally, we’re, we’re coming to the end about the issues related to the Cancer Center and, and the recent grant we put in.
But of course, Cancer Research, education, training and coordination, which in the world of CCS GS is called Surtek, which is led by Harriet, has the oversight over education and training essentially for everyone. And they’ve done really a great job. But the goal is, is to start with students in high school and college and to continue efforts to support training all the way through post doctoral fellows and, and actually faculty. So thank goodness the CCSG is done. I thought it might kill me.
It didn’t, thankfully. And we did reasonably well, actually quite well. And it’s because we have a truly amazing team. We have a great team of deputy directors and associate directors and countless others, all the program leaders and, you know, all of the people who work in administration. And it was really a huge team effort that I think really paid off. And it paid off not only because ultimately we’ll get a adequate or much better than adequate,
so we’re going to get a good score,
I believe.
But it paid off because it really
brought us all together and helped
us all learn much more about
which is really critical.
And with that in mind,
I just want to put in a little
plug for membership. In the YCC.
There are a variety of criteria
for membership.
And in truth,
if anyone doesn’t meet those criteria,
there are clinical
memberships as well.
And so we really want to get everyone involved. And finally, before leaving this whole area, we did have our conclave, which I guess for the past 10 or 12 years has been the annual meeting where awards are given. I will confess that I personally hate the name. You know, we're not trying to run a papal selection in secrecy. If you actually look up conclave, it talks about choosing the Pope. It also talks about meetings in general that
are basically held in private dark rooms.

And that’s not really what Conclave is about.

And so next year look for a new name.

But I just want to congratulate all of these people who received awards.

So let’s talk about sort of the clinical end of the world.

And 1st, I think it’s important for everyone to realize that there’s been a real change over the past couple of years. And this is not a change because of my arrival. It’s something that’s been bubbling up through the organizations for a lot longer. And that is that there is a real

integrated and desire for alignment
between Yale New Haven Health System and Yale School of Medicine. And at the risk of sharing too much, I will say that I think there were problems for many years in the past. And in my own view, there’s plenty of guilt to go around or blame to go around, I think on the health system side for many years. And, and I’m, I’m actually remembering back to when I was a resident just a decade or two ago, but certainly at that time,
and I think more recently, the health system didn’t necessarily appreciate that having Yale physicians, having an academic Medical Center feeding into a health system was particularly valuable. And it was hard for people to distinguish a community Dr. not that they didn’t practice great medicine and not they weren’t valuable, but it was they didn’t really see any benefit from having academic physicians. And in truth, on the school side, which I think endlessly frustrated
for years, there were plenty of clinicians who thought that being a clinician was seeing two patients every three days. And you know, in many, many ways, and this actually now dates back to when I was a resident, clinical medicine wasn’t part of an integral and it wasn’t a critical element in the School of Medicine for many, many years. And, and all of these things have changed. And what has led to this view that alignment is so critical is that I think everybody realizes that we can...
just be so much better if we work together.

So that’s what’s going on.

In truth, as Lori Pickens points out repeatedly in Smilo, in the Cancer Center, we’ve been much more aligned for a long time. And I think that’s true, but it’s gone further. So as part of this alignment, I was appointed as president of Smilo. Lori continued in her very critical role in Smilo and was appointed the Chief Administrative Officer for YCC. So both of us have roles on both sides of the street and I somehow managed to convince Lori to move...
00:24:08.112 --> 00:24:09.997 to the office across from me,

00:24:10.000 --> 00:24:14.520 which actually enhances communication hugely.

00:24:17.080 --> 00:24:20.368 We have an increasing number of

00:24:20.368 --> 00:24:22.012 administrative positions where

00:24:22.012 --> 00:24:23.916 people work at the moment still

00:24:23.916 --> 00:24:25.111 for either the healthcare system

00:24:25.111 --> 00:24:26.398 or the School of Medicine,

00:24:26.400 --> 00:24:28.455 but their responsibilities on what

00:24:28.455 --> 00:24:31.552 I will continue to refer to as both

00:24:31.552 --> 00:24:33.799 sides of the street for the moment,

00:24:33.800 --> 00:24:36.720 probably not the best way of doing it in.

00:24:36.720 --> 00:24:38.160 In terms of philanthropy,

00:24:38.160 --> 00:24:40.988 we have a new assistant vice president

00:24:40.988 --> 00:24:43.241 for cancer philanthropy who was hired

00:24:43.241 --> 00:24:45.670 by the school but who now overseas
fundraising in both YCC and Smilo.

And in my own view,

we have left millions of dollars on the table from generous donors because we just didn’t do it right and in a coordinated fashion.

And Sue, for those of you who have not met her is great and it’s somebody I worked with in from 2000, 4 to 2009 or 10 at Dana Farber.

And totally by luck,

she called me up and was just wanted to chat the day we opened up this position.

And it turned out she had just left the job and it was great.

And the overall goals are to eliminate
duplicate processes and to have seamless interactions and we have to do that. So where are we in terms of clinical trends? And you know this looks at all sorts of different types of events of care, infusion surgery cases, radiation oncology treatments, what have you. This is all good. And you know,
This is the kind of growth that one would like to see in a healthy organization.

Double digit growth is pretty hard to deal with.

This kind of growth is something that we can deal with focusing down on Med onc and hematology.

In terms of hematology, you can see that there's a mix of both classical heme, which all of us for a while were perplexed.

But the truth is this is an area that is growing hugely.

Alfred has done a great job as the
champion of classical hematology And it’s, it’s a huge growth area.
I used to think that it was because in primary care nobody knew anything about how to work up anemia any longer, and that the world has just changed in the minute someone sees a value with the Red Star, they say call hematologist. But I think that it’s also very much part of the fact that with our more complicated medical treatments, there are just way more hematologic problems and acute hematologic problems than was the case many years ago.
And they are really busy and you can see the very large solid tumor volume we have. And in terms of this just shows a little snapshot of new patient visits across a variety of different areas.

These are the four sort of biggest solid tumor areas and you can see that there is continued growth. I want to point out that we’re all over Connecticut for the most part. I mean we’re, we don’t have a huge presence up in the northeast corner in Windham County and Tolland County, but we, we are obviously distributed very well across the shoreline and up towards Waterbury and increasingly towards Hartford.
And assuming that everything moves forward with the Prospect acquisition, we will have a stronger presence in Waterbury as well as Manchester right outside of Hartford. And at the moment we see about 50% of patients who were diagnosed with cancer in Connecticut. I think that in truth that percentage should be much higher and it’s going to be higher by continuing to raise the profile of care here and its sites around the state. And again, having disease specialized care at
each and every one of our sites is really something that’s going to be critical. So in my mind, what we’re doing is developing A statewide academic oncology program that provides sub specialized state-of-the-art multidisciplinary care enhanced by the most important forward-looking trials. Do you want to take this moment to emphasize that cancer is a team sport and that it is? It’s not so much true in leukemia and lymphoma where medical oncologists do most of the work, but in all of the solid tumors,
it is a partnership between the surgeon and the radiation oncologist and the medical oncologist. And although there’s this tendency, I think for structural reasons to think of the Cancer Center as more about medical oncology, because in truth, the medical oncology and hematology actually sit in the Cancer Center. From a financial standpoint, I am. And the Cancer Center as a whole is every bit as much focused on the surgeons and radiation oncologists as
we are on the medical oncologists.

And I can add to that, you know, pathologists and,

I will confess that I have gone back and forth about how we name the, the, the each of the individual programs and what's the center of excellence and what's what’s the clinical research team and what have you.

And I've gone back and forth on this, but I think this is pretty final and I, I guess I'm presenting it here.

And if you have any major problems, you can tell me later.

But I think within each and every one of our diseases,
we have essentially a large center of excellence with a director or several co-directors. I think within that we have a clinical program that focuses on clinical growth, clinical performance, clinical pathways, everything you can imagine. There’s a translational research team with a lead that’s trying to bring together the translational researchers and then a very critical clinical research team. And in some cases, leadership may be in multiple places the same person, and in others,
it may be a different name in every place.

And I think what’s important is to make sure that we have leaders who are, who both have the time and the interest to tackle each of these areas.

And of course, the centers of excellence are not the academic home of the faculty. The academic home for the faculty continues to remain in the departments.

The academic home for the faculty continues to remain in the departments. There was nothing written on the errors. This was my animation to remember how important radiation oncology and surgery are.

Oh, yeah, oh, that’s right.
So as you know we have divided up into divisions based on disease. And I just want to point out that in hematology, I’m residing is now the chief of malignant hematology or he malignancies as I usually call it. Alfred for now over a year has been the chief in, and Alfred for for now over a year has been the chief in, and Alfred is working very closely together and I think very well. And I just want to point out that this picture of Alfred must be at least 15 years old. He’s not here.
So it’s it, it doesn’t have the same effect.

Oh, he is so Alfred, I, you know, I just couldn’t resist. He does look. He he, he, he looks good. But I saw that picture and I said like, you know, is that his bar mitzvah picture?

So, and these are the faculty and before I was talking about the faculty in the Cancer Center. There are 151 faculty in the Cancer Center and you can see how they’re distributed.
I hate to talk about funds flow, but I think there are people who remain very interested in this. So in the Cancer Center, the medical oncologist, hematologist, neuro oncologist and palliative care physicians. In the old days, meaning more than a year ago, the hospital backed the salaries of all clinicians. Anybody who did more than 20% clinical
work had their salary essentially covered by the hospital if they didn’t have other sorts of funding. In the new era, your Cancer Center director is provided with funds based on RVUS, and I have to make it all work. The model provides for some protected time for some people who are actively engaged in unfunded research, particularly clinical trials. It’s a model that I dare say is a little more generous than some people have. And it is because everyone in the system, in both the school and in the healthcare system,
recognize that it takes time to develop
clinical trials and that cancer care
can’t be done without clinical trials.
And I think the most important
message is don’t worry,
'cause I’m worrying for all of you and I’m
not trying to be paternalistic about that.
But I really,
I will tell you,
there are departments where people
are really panicked about this.
There is no reason to panic and
I do want everyone to who is
within these areas to pay attention
and to do their best to
maximize their generation of RV us.

But I don’t want anyone to feel tortured that they’re supposed to, you know,

suddenly as a result of funds flow,

see 10 extra patients a week.

Just just make sure that you’re that we’re getting paid for what you do and take good care of people.

The pay, you know, where all of the fund, you know, so it used to be that,

that the system, the healthcare
system used to just fund the salaries.

Now they fund the payments that come that support the idea. Here is a much tighter collaboration.

We’ve had a lot of recruits in 2023 and 2024. What happened?

Oh, I hit the wrong one. And we have more recruits coming.

We have two recruits to the Center for Molecular and Cellular Oncology and that’s Sarah and Corleen on either end of the top.

We have recruits in the solid tumors and in the malignacies.

And I’ll just point out someone who
none of you know who’s Raghav Sundar, who’s actually coming from Singapore that Pam recruited and will be here in the next couple of months.

So my friend for many years, Hal Burstein used to always talk about the lightning rounds where he went through things very quickly.

So these are my lightning announcements about the lightning rounds where he went through things very quickly.

We have an ongoing search for chief of Neuro oncology.

We’re looking for many classical hematologists and Alfred’s taking the lead on that because they are hugely understaffed.
We have a soon to be launched search for a senior clinician scientist to lead cellular therapies as soon to be launched, search for a lymphoma leader that Amar is going to champion. We're going to expand the development office. We have an ongoing recruitment of a new biostatistical leader. Our present leader has been great, but hasn’t had the time to be full. Time in the Cancer Center and we we have the search ongoing for that. We’re going to be hiring at least two to three physician scientists, probably one in the area of breast cancer.
There are three spores that are in planning stages.

We have an ongoing search for an SVP of patient care services and much more.

I want to call out some people for special thanks and, or some groups.

You know, none of us could do everything we do on the clinical side without the nurses and both the nurses that staff the clinics and the nurses that staff the infusion rooms and the inpatient units and of course the APPS. And we have a lot of APPS and we need them.

We couldn’t do what we do without the administrative professionals of all types, from the most senior people.
to the most junior people, both in Smilo and the YCC. We couldn’t do it without the social workers and the pharmacists and of course our patients and their families and the clinical trials staff and the clinical trials participants and the students, residents, fellows and postdocs and many others. And let me just mention that we couldn’t do this with a the, the team of people who take care of the OR oversee the operations in Smilo like Kevin and Sarah and, at the moment Tracy and so many others.
We are in the news. Just want to point this out.

Many of you may have seen the billboards and, if you haven’t, I thought I would show you this slide and this is my last slide.

And you know, it’s often said that culture eats strategy for breakfast. And the question is what?

What’s culture about? So I actually did a little Google search last night and I found many different definitions of what constitutes a positive culture. And I picked out the.
Adjectives, the characteristics that I thought were most important and I decided not to try to rank them or to try to pick the top five, although I probably could pick the top five, but just list them. So trust, transparency, equity, emotional intelligence, respect. Next one I think is actually pretty important support for and confidence in risk taking and innovation, a sense of purpose and then the three CS cooperation, caring and competence.
And you know, this is really what I hope we can all strive for because it really is true that it is having the right culture that allows us to do so much better work, whether it’s work in the laboratory, work in the wet laboratory, dry laboratory, clinical trials, and of course in the care of the people who need our care. So, you know, it’s something we should all really think about. And thanks. I deliberately left 1520 minutes so that there would be time for questions.
Thanks.

There are questions. You just have to eat bagels.

Yes, I know like many of us, you were spending a lot of time thinking about Wellness for our clinicians and teams. It’s an ongoing addition to funds flow. It’s another worry on your mind. Maybe you could share some of your thoughts. We’re all here to help. So I think funds flow actually helps with it in the sense that I think, it’s important to be in control of our own destiny and we can...
be very clear about expectations with funds flow and we have the ability to protect time for some people. But you know, it goes way beyond that. And you know, the one thing that has been shown repeatedly in efforts to enhance clinician well-being, and I don’t think we should focus just on physicians here. What doesn’t work are things like massages. And you can give a gift certificate for a massage and I think somebody feels better for about 15 minutes. And, and that this has been shown across the country,
but we have to focus on ways that on all of the things that make clinicians frustrated.

And so the systems in that presently exist that just drive everyone mad, like some of which we have control over, some of which we don’t insurance approvals and writing notes and endless clicks and this, that and the other.

And you know, it’s, it’s a slow process, but we can get there.

I will tell people and you should feel good about this.

Although I had a conversation with
Sarah about this and she’s not convinced that she’s going to buy in, but I am absolutely convinced that within the next two years, you’re going to be able to walk into a room and talk to a patient and a note will be generated. And personally, Sarah thinks that she that it won’t be as good as her note. But sorry to embarrass you, but but I think that that’s a huge step forward for a lot of us and we’ll make things better. And we just have to keep focusing on this.
I think the other thing though, is it really helps, you know, to have the right culture. And you know, as you all know, I also believe that having the right kinds of relationships with for the clinicians, with the people we take care of, and I will extend this now to the researchers, having the right kind of relationship with the people you work with every day and, you know, everyone around us really makes our lives better.
So, Roy, do you like your picture? I do, you know, I've yet to see it, but I, I need a picture from my mother so you can send. Would you want me? Do you want me to e-mail her this slide? That would be great. It's Passover. Well, Eric, that was a great talk. So I wanted to ask, you know, a question forward thinking the future of oncology and how we're going to cure cancer. So I'm struck by, you know, we're at Yale and I think our advantage is,
you know, an amazing university.

We're actually #4 right now in Blue Ridge funding,

which is looking at all the medical schools.

We've got so much going on in every area.

So finishing up your ASCO presidency with everything you've seen,

what are a couple of areas where we could take the science of Yale and really be the leaders, you know,

something new and an exciting technology and,

and can we all get together and, and make that happen?

Well, you know, I think it's, it is a challenging problem, but I,
you know, I really believe that by, sometimes form helps function. And I think that by setting up programs such that clinicians and scientists are talking to each other, you can take it that, you know, you can take a step forward. And, you know, the Cancer Center is meant to be a highly translational entity. So, you know, there’s a lot of great science at Yale and we need to start or we need to. We don’t need to start. It’s well started. As you know, we need to increase what’s going on.
And of course, we all know that there are certain cancers that are a particular challenge where we really haven’t made that much progress. And I’m going to take one where it’s not like that, you know, breast cancer, you know, we’ll probably be at the point in 10 years where we can say, you know, the vast, vast, vast, you know, 98% of people will will be cured or will not have to die from the disease if they have treatment available to them. We’re nowhere nearly there in terms of
pancreatic cancer and glioblastoma.

And, you know, we have to sort of redouble our efforts there. Thanks.

There’s somehow I miss the fact that Yang was had like taken that role of passing around the microphone. Thanks so much.

Yeah, no, I know. I know. It’s good.

Hi. Thank you. Eric, I was curious, I know within your the first slides that the patient experience was really embedded in your priorities. And I just wondered if you could speak a little more specifically to that and what you think are the priorities that we should be
expecting and focusing on for the whole enterprise should be in that area. You know, I don’t, I, I, I will say, I don’t think we do badly in general from a patient experience standpoint. I think when people come, they do feel that they’re cared for. But, you know, in my mind, we need to make it from the minute somebody calls until they no longer need us. And so people from day one need to feel like they get, you know, they need two things. They need great care, great care in terms of technical expertise,
but they also need people who care about them. And, you know, in my mind, that’s having the right partnerships between clinicians and, and patients. I think it’s something that is comes out of both the right kind of systems and the right culture. And, you know, there are a number of cancer centers where there are great doctors and I think pretty bad culture. And you can tell because of what patients say about their experience there. And then there are places where the culture is right or better and
where there's a real focus on making sure that the patient is cared for.
And that's what we have to just keep striving for.
I will tell you that, you know, we're not there yet as a whole system, and we're not there even in the Cancer Center by any means. But we need to fix our access problem across the whole system. You know, when you call up and you get an appointment with a rheumatologist and you get... you know, an appointment,
you call in March and you get an appointment in September. Like that doesn’t work.
So, you know, we need to be available, we need to care, we need to have expert care.
And finally, we, we all need to take care of each other, which is a part of, you know,
like Roy’s pushed for this, I’ve pushed for this. Part of the reason we want more and more people back at work, not 100% of the time, but most of the time. And, and working a little less from home is it’s really hard to do the culture thing from a distance.
You know, I think that and that now I'm just sort of going off, but I think that, you know, it's much easier to have sort of contentious on the one hand, contentious, on the other hand, unproductive interactions by Zoom and, and in person it works better. And the follow up question is, And the follow up question is, oh, change gears. But thank you for the, the other answer. And I agree, I think access is, is really critical. But changing gears, I, you referred a couple minutes ago.
to the AI revolution that’s coming.
And I’ve been hearing a little bit about bridge and this technology of,
you know, forming our notes while we’re in the room.
I wondered if you could speak to that and what we know might be coming there.
I, I, I saw and I think it’ll be great.
I have been to three retreats in the past three months that focused
entirely on AI and how AI is going to affect everything that we do, I think is still an unknown. I think from an administrative standpoint, like with notes, it can be very, very helpful. I think there are a lot of people who have many concerns by patients calling up and interacting with a, you know, chat box and not even realizing that’s what they’re interacting with. And I think there are feelings that in those situations, patients need to be informed what they’re dealing with.
00:52:19.640 --> 00:52:21.476 You know, the other of course,
NOTE Confidence: 0.94904448
00:52:21.480 --> 00:52:23.960 big areas are how can,
NOTE Confidence: 0.94904448
00:52:23.960 --> 00:52:27.480 how can AI help us with decision making?
NOTE Confidence: 0.94904448
00:52:27.480 --> 00:52:29.080 You know, in my mind,
NOTE Confidence: 0.94904448
00:52:29.080 --> 00:52:30.712 really good clinicians,
NOTE Confidence: 0.94904448
00:52:30.712 --> 00:52:31.800 you know,
NOTE Confidence: 0.94904448
00:52:31.800 --> 00:52:35.620 can bring together lots of different
NOTE Confidence: 0.94904448
00:52:35.620 --> 00:52:37.800 data from many different sources
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00:52:37.875 --> 00:52:40.157 to make a decision with a patient.
NOTE Confidence: 0.94904448
00:52:40.160 --> 00:52:42.080 But the truth is there’s so
NOTE Confidence: 0.94904448
00:52:42.080 --> 00:52:43.636 much information out there that
NOTE Confidence: 0.94904448
00:52:43.636 --> 00:52:45.553 none of us can do it as well as
NOTE Confidence: 0.94904448
00:52:45.619 --> 00:52:47.279 we can with some assistance.
NOTE Confidence: 0.446000455
00:52:50.600 --> 00:52:53.400 OK who? Amar? OK,
NOTE Confidence: 0.785768258888889
00:52:53.680 --> 00:52:54.940 Yeah, yeah. Thanks, Eric.
NOTE Confidence: 0.785768258888889
00:52:54.940 --> 00:52:57.240 Sorry I couldn’t be in, in person.
And so great vision.

I think I would.

I was wondering whether you could speak more to your thoughts about how the efforts in clinical research with the new model will be incorporated without transactional components. I'm particularly worried about the junior faculty who are hoping to be clinical trialists and all the like huge amount of work that goes into its and early phase clinical trials. And as you know, getting grant funding for this generally has not been easy.
00:53:27.675 --> 00:53:28.385 So how, 
NOTE Confidence: 0.785768258888889
00:53:28.385 --> 00:53:30.710 how do we maintain that academic 
NOTE Confidence: 0.785768258888889
00:53:30.710 --> 00:53:33.460 interest in clinical trials without 
NOTE Confidence: 0.785768258888889
00:53:33.460 --> 00:53:36.000 having these junior faculty shift 
NOTE Confidence: 0.785768258888889
00:53:36.000 --> 00:53:38.452 to RVU generation and without 
NOTE Confidence: 0.785768258888889
00:53:38.452 --> 00:53:40.476 compromising the academic mission? 
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00:53:40.480 --> 00:53:42.920 I 
NOTE Confidence: 0.797133706
00:53:42.920 --> 00:53:45.398 think it’s a great question, Amir. 
NOTE Confidence: 0.797133706
00:53:45.398 --> 00:53:47.459 So in much the same way that 
NOTE Confidence: 0.797133706
00:53:47.459 --> 00:53:49.754 for somebody in who’s going 
NOTE Confidence: 0.797133706
00:53:49.760 --> 00:54:00.800 you can’t say, well, 
NOTE Confidence: 0.797133706
00:54:00.800 --> 00:54:07.988 three days, 
NOTE Confidence: 0.797133706
00:54:07.988 --> 00:54:11.340 you know, three days, 
NOTE Confidence: 0.797133706
00:54:11.340 --> 00:54:13.740 three days a week you’re in clinic 
NOTE Confidence: 0.797133706
00:54:13.740 --> 00:54:25.960 and then if you get a grant,
you can have protected time in the laboratory that doesn’t work on the clinical research and either and particularly early in people’s careers, they need protected time. I mean, we recognize that for laboratory investigators, it is true for clinical investigators as well. And through a variety of mechanisms and funds flow, we have the flexibility to do that. That doesn’t mean that people can work one day a week and spend the rest of the time,
you know,

doing whatever they want to be doing.

And they have to ultimately demonstrate productivity because we all have to be accountable.

But we will be able to protect people’s time. And if we can’t, we will lose a generation of people.

So I’m certainly committed to that.

You’re going to be part of the conversation about how exactly we’re going to implement that.

Hi. I just wanted to ask a question going on that, but not related to the clinician, but more related to the timing.
from when you have an IIT presented to the time it indeed opens. It takes about a year or so or more sometimes. So and also for activation of clinical trials, you have seen that that’s also something that takes a while. So how are we going to think ahead to try to make that a little shorter? So it’s not that lengthy. Well, thankfully I have two great colleagues in Ian and Alyssa, and I let them think about that whole activation piece because I know that they’re thinking about...
it far better than I ever could.

And they have, they have really made significant strides there.

There’s more work to be done, and some of it has to do with working in a large matrix system and not having full control over this, but they’re slowly chiseling away at that.

In terms of the IIT, you know, a lot of the time is really spent perfecting the idea. And I think with the right mentorship, we can do that more quickly. You know, a year seems sort of OK to me. Six months would be better.
And I think 6 months is about as good as you can get in terms of having an idea, putting it all together and then getting it through. But I think that’s ultimately the goal. So I want to thank everyone. I will try to do this again in about another year. I, I just want to say that, you know, we really want to make this place great. It’s it is great, but we want to make it greater. And, and I think that we’re sort of on the cusp of, of really a very different way of,
of working together.

And I think that we are going to be far more productive both research wise and clinically than we ever have been. And that's sort of an arrogant thing to say for somebody who's been here for two years. But I, I, I really do believe there's just such unbelievable potential here that and, and such a spirit of wanting it to be better and working together that I, you know, just gonna keep our, our, our eyes focused on what's really important. So come talk anytime.