So good afternoon, everybody.
Welcome to the Grand rounds for Can't steal Cancer Center in Smilow Cancer Hospital today.
As you know, it's really a reflection from the director essentially looking back at what we have accomplished, but also looking ahead for the next year. At this point I've been serving as
your interim Cancer Center director

since March 1st and really has been a

privilege and a pleasure to get to know

this wonderful Community in more detail.

Over the past few months next.

Slide and I think the other point is of

course we’re in this state of anticipation,

but mixed in with a little

Also you know what’s coming,

and I think everyone seen and met with Eric.

And if you haven’t,

I know you’re in for a treat.

He was in our network committee meeting

this morning and a wonderful human

being and just couldn’t be more excited
that we’ve been able to recruit Eric, who as you know, is a former Yale alumni and will be joining us February 1st. 

But as. 

He has learned has been already a part and parcel of our community. As soon as you sign the job, you start to become involved, so we’ve been really excited to have Eric be a part of our community. Next slide.

OK, so as we talk about sort of our Cancer Center and in Renee, you put the I guess, the. 

Can be code.
I think it’s helpful for maybe my perspective and maybe for those of you who are new and some of you may be who’ve been here for awhile. It’s helpful to look at how fast we have grown, and I think sometimes when you’re in the midst of it, you forget how much we have done so you know just a little history. We started the Yale Cancer Center as a comprehensive Cancer Center. It’s 2010 when the Smilow Cancer Hospital was built, and then the network was launched only 2012.
So it’s really recent.

And then if you see the Cancer Biology Institute open on best Campus in 2015 or phase one unit in 2016 and then in 2018 as Doctor Fuchs was here, Charlie were here.

We went through our renewal and had an outstanding score along with what is fabulous is to see an increase in our research funding and then as you look today in 2021 in between bipan through EMR in the midst of a pandemic.

But I think it’s helpful to look from our perspective of where we are in the red starts.
For those of you who are aware or care centers and those are scattered around the state of Connecticut. B are fortunate that we're the only academic institution in the state of Connecticut. And then what many people would love to see as a distributed delivery system, which is here. As you can see it exists through Connecticut and also through Rhode Island, as are cited. Best really, this is something that’s unique and it’s built up very much in the last few years.
I think it’s growing pains and in some of the stuff that is ongoing now that you feel.

But as Eric comes on as Doctor Brian comes on, I hope all of you will think around. How do we connect all of this pieces together?

And if you go to the next slide, Renee think the way we think about it is we want to build an academic health system. If you put our. Or signage, whether we call it by nature or Yale whatever it is, why do we do this? It is to deliver care to our patients and we are in academic system,
00:03:49.000 --> 00:03:50.850 which means we’re teaching organization.
NOTE Confidence: 0.754928194
00:03:50.850 --> 00:03:53.466 It’s part of our tripartite mission and that
NOTE Confidence: 0.754928194
00:03:53.466 --> 00:03:56.239 means how to educate the next generation,
NOTE Confidence: 0.754928194
00:03:56.240 --> 00:03:58.490 whether it’s trainees or nursing
NOTE Confidence: 0.754928194
00:03:58.490 --> 00:04:00.290 or the next generation.
NOTE Confidence: 0.754928194
00:04:00.290 --> 00:04:02.162 How do we take resources and
NOTE Confidence: 0.754928194
00:04:02.162 --> 00:04:03.410 improve our patient care?
NOTE Confidence: 0.754928194
00:04:03.410 --> 00:04:04.887 But it can’t be done in silo,
NOTE Confidence: 0.754928194
00:04:04.890 --> 00:04:06.698 and especially as we look at the Cancer
NOTE Confidence: 0.754928194
00:04:06.698 --> 00:04:08.260 Center in the distributed nature,
NOTE Confidence: 0.754928194
00:04:08.260 --> 00:04:10.170 not only at the sites.
NOTE Confidence: 0.754928194
00:04:10.170 --> 00:04:11.502 But off the constituencies,
NOTE Confidence: 0.754928194
00:04:11.502 --> 00:04:13.500 how many folks are involved there?
NOTE Confidence: 0.754928194
00:04:13.500 --> 00:04:15.725 Roughly 300 members of the
NOTE Confidence: 0.754928194
00:04:15.725 --> 00:04:17.060 Yale Cancer Center.
NOTE Confidence: 0.754928194
00:04:17.060 --> 00:04:18.860 And then if you look at the number of
00:04:18.860 --> 00:04:20.554 people we look at our nursing or staff.

00:04:20.560 --> 00:04:23.467 It’s 2000 people, so that’s a lot of people,

00:04:23.470 --> 00:04:25.710 many departments, many sites,

00:04:25.710 --> 00:04:27.950 and that talks about.

00:04:27.950 --> 00:04:28.781 It’s great.

00:04:28.781 --> 00:04:30.166 It’s great to see it,

00:04:30.170 --> 00:04:32.546 but then the day today can

00:04:32.546 --> 00:04:34.130 sometimes feel sometimes difficult,

00:04:34.130 --> 00:04:34.728 sometimes feel sometimes difficult,

00:04:34.728 --> 00:04:36.821 but it all means that we have

00:04:36.821 --> 00:04:37.989 to work together.

00:04:37.990 --> 00:04:40.717 And this is just one quote from Helen Keller.

00:04:40.720 --> 00:04:41.404 In talking about,

00:04:41.404 --> 00:04:43.000 it means that we have to learn

00:04:43.056 --> 00:04:44.196 to work with each other.

NOTE Confidence: 0.754928194
Think about how we do great and where we have opportunities and that I think is probably more telling today as we look in 18 months into a pandemic, that some things work wonderfully. But some things we know are health systems could do so much better next slide. So if this is important also in terms of thinking about what we do and why we do it, is this is our vision statement. I think sometimes these are put in on websites, but I want to think about how we deliver. Care is as health care teams. We deliver care one patient at a time,
not in the abstract. It’s one patient at a time. What it and its each and every interaction. So when we talk about the tripartite mission research, education. Clinical innovation and then increasingly at community.

it becomes very real in the patient interactions. Whether it happens at best early or in New Haven. And how do you conceptualize and deliver all of this transformative transformational care? It’s easy to save,
and I’m talking about in a PowerPoint. But then it’s the teams that put it together, and those teams include our nursing or residents or staff or clinical trial list, our leadership, or administrators. And then I think you get the soup of what we’re trying to do. We’re trying to make magic each and every day and improve the lives of our patient. Next slide.
So that means when we want the patient appointment, it’s available to us as how you would want your family treated. I think the standards we hold for ourselves is that care is good in that can be defined as that it has good opinions or pathology, radiology, imaging those things. Matter, as it’s been shown time and time again also means the clear delivery for a patient standpoint. Is multidisciplinary that the patient can see all the parts the specialists they need in a more
streamlined rate rather than going in serial one after the other. That’s not very patient centric, and of course we can use care pathways. We then need to focus about how to be improved care, but I think the other part and I want all of you to sort of take the you know as we think about this clearly, there’s what we do today. But part of the mandate for academic health systems is how do we improve the care for tomorrow? And that means how do we take the, you know, the research, the quality to improve care,
and I think you’ve seen that in the town halls that push that all of the teams come together to talk about, learn about each other. Whether it’s how do our nursing teams interact and how do we deliver care? Or how is all this basic science related to something very granular? Like how do we deliver care to our patients sitting in? Front office, so this is the hard part, it’s its. It’s why we’re here, but it’s also where we have to flex our muscles and work together next.
Now as we look back in the year, it's been probably very much. I think sometimes we need to take a pause and breath and say how much have we done. We've done a lot and the fearless team you see on your left is our two leaders on our day-to-day clinical operations came Slusser, chief nursing Officer and Kevin Billingsley, who is our CMO and both of them have taken us on a lot. Whether it was through the pandemic and all the changes that happened and then how we regrouped and delivered care back. Again,
and how we continue to do it.

Of course I want to acknowledge that this year we went through magnet and that is really reflects the work of our nursing team and all the great work we do.

I think as we look around all the teams and how this has been done, a lot of the stuff beyond reestablishing care and I will say it’s not all reestablishes where we expected.

I think our bar has changed as we come back with all the changes of you know last year we moved from North Pavilion to SRC and
clinics moved and then some came back.
There’s still some disruptions, but in the midst of it, we continue to train our nurses and our teams.
We’ve continued to work on improving things, whether it’s through this lean task project, for improving scheduling for infusions, launching patient experience forms, improving residency training, resident centered care, training for our teams, and then at the end of it, I think we have to think about how do we improve the patient experience. As you see this each team, and I’m not going to go through all of this,
but each team. Has put in their goals for the next year. It is important for us to look back, acknowledge the hard work of each and every team, but also look ahead and say what do we want to do for the next year. And as you can see, they are obviously focused on many things. Certainly focusing on what is up front and centrals. How do we improve our recruitment and retention strategy? I think this is a nationwide but not phenomenal.
It is most acute for health care as we’re seeing that our teams that have worked through them. Pandemic we’re seeing changes, so we need to think about how do we retain our best people. But there are other things. How do we improve care? How do we look at quality and morbidity and mortality conference? How do we look at our patient experience with our press Gainey, and enhance that and this team you will see across is how do we think the Black Lives Matter engaged? All of the communities and we have
00:10:21.318 --> 00:10:22.855 been having a national conversation

00:10:22.855 --> 00:10:25.137 and that will be seen in the cancer domain so you can see.

00:10:25.137 --> 00:10:26.776 That they’re focusing on culture engagement,

00:10:28.780 --> 00:10:31.240 and I this is looking inward,

00:10:31.240 --> 00:10:32.044 but also outward.

00:10:32.044 --> 00:10:33.920 We’re going to have to do both,

00:10:33.920 --> 00:10:36.648 and this is the part that that this team is also looking next slide.

00:10:36.648 --> 00:10:39.264 It was hard work.

00:10:39.264 --> 00:10:41.438 I think we can now smile and
00:10:51.413 --> 00:10:52.597 say it was great.
NOTE Confidence: 0.853748399
00:10:52.600 --> 00:10:54.973 I will still remember when we reopened
NOTE Confidence: 0.853748399
00:10:54.973 --> 00:10:56.841 the inner North pavilion floors
NOTE Confidence: 0.853748399
00:10:56.841 --> 00:10:59.193 and how much excitement there was.
NOTE Confidence: 0.853748399
00:10:59.200 --> 00:11:00.736 Unhappiness with our teams.
NOTE Confidence: 0.853748399
00:11:00.736 --> 00:11:04.139 But this kind of the chaos of this arrows
NOTE Confidence: 0.853748399
00:11:04.139 --> 00:11:06.890 reflect all the hard work you all did.
NOTE Confidence: 0.853748399
00:11:06.890 --> 00:11:08.318 I want to thank you all.
NOTE Confidence: 0.853748399
00:11:08.320 --> 00:11:10.010 I want you to acknowledge.
NOTE Confidence: 0.853748399
00:11:10.010 --> 00:11:11.425 Each and everyone of yourselves
NOTE Confidence: 0.853748399
00:11:11.425 --> 00:11:13.160 and Pat resolve on the back.
NOTE Confidence: 0.853748399
00:11:13.160 --> 00:11:14.344 It was hard work.
NOTE Confidence: 0.853748399
00:11:14.344 --> 00:11:16.940 Perhaps we never felt like we had a pause,
NOTE Confidence: 0.853748399
00:11:16.940 --> 00:11:18.686 because as soon as we moved,
NOTE Confidence: 0.853748399
00:11:18.690 --> 00:11:20.294 the work continued coming
NOTE Confidence: 0.853748399
00:11:20.294 --> 00:11:21.497 and continues coming.
We're busier than ever, but I do think it's important for us to say we did it. We have that core and us, and as we look ahead, we have that ability in this next slide. However, things are not pristine and I want to be honest that it's things are still in flux. I've talked about the labor challenges. I think we are busy. If you don’t see that, look at RED. It’s always busy. Always about 60 to 80 patients waiting to be admitted and that.
00:11:51.218 --> 00:11:53.031 means that are some of her places
NOTE Confidence: 0.897425928333333
00:11:53.031 --> 00:11:54.760 are not where we expect that.
NOTE Confidence: 0.897425928333333
00:11:54.760 --> 00:11:56.489 I’m not going to go through and
NOTE Confidence: 0.897425928333333
00:11:56.489 --> 00:11:58.109 reiterate all of the clinics that
NOTE Confidence: 0.897425928333333
00:11:58.109 --> 00:12:00.020 are probably still not where you all
NOTE Confidence: 0.897425928333333
00:12:00.079 --> 00:12:02.126 thought and perhaps some of that will
NOTE Confidence: 0.897425928333333
00:12:02.126 --> 00:12:04.300 mean that we may change overtime.
NOTE Confidence: 0.897425928333333
00:12:04.300 --> 00:12:05.780 That’s not a good or a bad thing.
NOTE Confidence: 0.897425928333333
00:12:05.780 --> 00:12:07.178 It’s how we look at it.
NOTE Confidence: 0.897425928333333
00:12:07.180 --> 00:12:08.374 I always see the glass is
NOTE Confidence: 0.897425928333333
00:12:08.374 --> 00:12:09.679 not half empty or half full.
NOTE Confidence: 0.897425928333333
00:12:09.680 --> 00:12:11.269 It’s waiting for us to be filled
NOTE Confidence: 0.897425928333333
00:12:11.269 --> 00:12:13.138 with all the colors we want to see
NOTE Confidence: 0.897425928333333
00:12:13.138 --> 00:12:14.680 and the flavors we want to put.
NOTE Confidence: 0.897425928333333
00:12:14.680 --> 00:12:16.024 And that’s what I want you
NOTE Confidence: 0.897425928333333
00:12:16.024 --> 00:12:16.920 to think about now.
It does mean that spaces get type tight.

We have to acknowledge that it’s sometimes hard.

It means that programmatic growth sometimes doesn’t seem obvious or sometimes can be difficult.

But I can guarantee you there’s ingenuity and creativity in all of you.

Whether it’s the nursing team.

Whether it’s the trainees or whether it’s the physicians, every one of us has that capacity and that skill set.

Next slide.

OK,
so some of the other stuff besides talking about the pandemic, which I think we’ve spent a lot of time, is some of the good stuff that happened while we were just so busy catching our breath on doing routine care so often in crisis. Sometimes the best minds and best solutions are born and the hospital program was launched over the past year by Doctor Carrier Edelson along with Doctor Jensen Morris who haven’t. If you haven’t met, she runs our hospitals program, and although it’s only been launched for a few short months,

00:13:14.840 --> 00:13:16.845 Having a dedicated team does

00:13:16.845 --> 00:13:18.449 improve things like length

00:13:18.449 --> 00:13:20.580 of stay in early discharge,

00:13:20.580 --> 00:13:22.656 so again it’s a positive signal.

00:13:22.660 --> 00:13:24.145 It’s something will continue to

00:13:24.145 --> 00:13:26.230 learn from and as Eric comes on

00:13:26.230 --> 00:13:28.120 this will be something for us to

00:13:28.120 --> 00:13:29.710 discuss and see how this relates

00:13:29.710 --> 00:13:31.292 to how we deliver our care,

00:13:31.292 --> 00:13:33.476 but also think about how does it

00:13:33.476 --> 00:13:35.440 impact our training experience?

00:13:35.440 --> 00:13:37.393 Are we thinking about all those facets

00:13:37.393 --> 00:13:39.099 and training the next generation?

00:13:39.100 --> 00:13:41.809 But I think early on really remarkable
success or working across different programs and across our institution. Next slide. And other things are this next day initiative. I think if it’s someone in your family, if you have a cancer diagnosis, we would all say we want to be seen as soon as we hear about it. So this is an initiative launched by Sarah McCallion, launched by Sarah McCallion,
whose are ambulatory officer on with Chomsky and the data shows that this has launched in several locations. I’m not going to name them on lot in southern Connecticut. Along with other areas and what has shown is that we are able to do this for things like Breast Cancer Care. About 15% of people are being seen by the next day and also we’re seeing about 10% of people being seen in the next day. So there’s a huge patient demand for this and offering this is something that we need to start doing, but the dynamics of it become hard
because it does mean it puts stressors on the frontlines team to think about how do we work more intelligently around this rather than just making art? Please go longer next slide. And then the patient experience, which is critical around how we think as you know, Terra Sam presents a lot of this and she’s helped by her director of patient experience, Michelle Kelby, Albert and some of the experiences that they have really done is the patient experience forums. We’ve talked about those and then we formed the P fact.
These patient and family advisory councils for patients educate us on what are the missing things that we may never hear about or think about. And I think those are important dialogues because partly we live. They say we do it in a community. Some of that community is us as human beings, but we live in a community. I'm currently sitting in New Haven. Some of your sitting in Torrington or water for door investor Lior Greenwich. So what does that community think about us?
And this is, I think, thinking how? How do we make these abstract notions very much local and important to our patients who live within that community?

Next slide.

In terms of thinking about new patient volumes, this is helpful. We had a lot of growth you can see up till 2017 I think. Think somethings plateaued down and as we look in twenty 2021 I think some things for us to look and pause and say there are...
areas where we need to focus on.

Again, this is just more thinking about and as we think of our strategic framework and I know many of us spend a lot of time thinking about it next. And what are the worker views? Associated with their work. That's how one way of how we measure work. There many other ways, but this is how we measure one of our domains of the work and it just shows the data over the past few years. Next slide and then of course,
even though we shared the new patient data, of course, as we all know is you get busy busy people keep getting busier 'cause your patients continue they continue to follow us and you can see that growth is exponential because those patients stay with us and I think this is an opportunity of working. How do we use telehealth in this population? How do we think as teams around our follow up visits? Is that always done the same way? Are there smarter ways of doing this as we look ahead next slide? And then just I want to make a point.
This is a complicated slide. Going this is monthly starting in October on the X axis, going all the way to October 2021, and what you can see is in blue in person visits the the light blue color or whatever we call it is video and then that orangish color is telephone visits. We all know that telehealth took off as the pandemic happened. We all know that telehealth took off as the pandemic happened. So you can see that although for cancer patients still need their infusion and need to. Visit us so we continue to do
a lot of inpatient visit there

as you know my other hat is.

I'm the head of the Yale medicine practice plan.

If you look telehealth across our health system, it was up to 30-40%.

But here was about 20% back in last year and this is the rest

of the trend is not a typical we see that as things opened up, patients wanted to see us more in

phone as you all know, was not reimbursed.

Is is there's some reimbursement,
so we encourage video,

but as we look ahead I don’t think you should have banned.

I think there are opportunities similar to what I mentioned around.

The follow up visits and I’m not.

I’m what I mentioned early on as we look at our care centers and they’re distributed.

And if you’re thinking of an academic health system,

not everyone has that expertise.

We look at, you know,

in every domain and how do we bring the specialist?
Can we use telehealth as a tactical way rather than everyone going to visit that patient to bring that specialist to remote sites? Again, this is not the answer is not today, but those conversations are happening. Delivering that will require some nuances as we pilot them out and think about it. I know certainly in surgery I’ve seen some nice areas and in Waterbury with thoracic doing this and I think there’s opportunity for us to think and use it across holistically.

Next slide.
OK, the now, although we are very distributed, there are four divisions that are part of the yield Cancer Center and I think it’s important to think about what they do, ‘cause they’re full time in the Cancer Center. So going Herbst runs the division of Medical Oncology, and although it’s one of our largest division with about 80 people, clearly lot of work and I’m not going to be able to acknowledge it. Some of the key highlights as
they have multiple spores.

They’re also trying to get faculty development and recruitment as we continue to be busy.

Lots of drug approvals you can see in head, neck, lung and bladder cancer and I have to say this team has worked really well on faculty, staff and Wellness during the pandemic for next year they continue to. Think about faculty recruitment and development goals.

Also, how do we bring that academic piece in the system is fellows come out and they want a much more different practice then perhaps in the past and
they’re looking at putting in a fourth score application in breast cancer.

Next slide.

Looking at division of Hematology led by the Stephanie Helene,

who as you know took over the tripartite mission as I mentioned,

but also as I know Stephanie also think about how do we disseminate innovation throughout the world,

’cause the research here is phenomenal.

Now if you move to the next slide, I think what needs to happen is
and what Doctor Helene is very much focused on is how do we bring that depth into all the programs? Because lymphoma is very different from leukemia and that the in especially as we think of the scientific innovations in this. This kind of tells you about how diverse this team is, how large this team is, a couple points to make out point out here the yellow boxes show all the new team members they have and they are some of them are in here. Some of them are in the health system. One point to point out is that
00:21:06.101 --> 00:21:08.459 the classical theme is an area of.
00:21:08.460 --> 00:21:11.016 Huge growth and need partly reflects
00:21:11.016 --> 00:21:13.938 Connecticut as a state with an aging
00:21:13.938 --> 00:21:16.230 state population that many of our
00:21:16.230 --> 00:21:18.927 sites are inundated with benign heme,
00:21:18.930 --> 00:21:21.639 it’s either an opportunity or a stressor.
00:21:21.640 --> 00:21:23.893 It certainly is a lot of demand,
00:21:23.893 --> 00:21:26.440 but how do we use it for our research,
00:21:26.440 --> 00:21:28.348 I think those are some things that I know.
00:21:28.350 --> 00:21:28.842 I know,
00:21:28.842 --> 00:21:30.564 the heme group is thinking with Bob
00:21:30.564 --> 00:21:32.076 Boehner and others also want to
00:21:32.076 --> 00:21:33.770 point out Marcus motion on the left.
00:21:33.770 --> 00:21:36.451 Some of you may not have met him is
00:21:36.451 --> 00:21:39.048 he is our inaugural director of CMC.

43
Dr. Mission joined us last summer from City of Hope, an accomplished Howard Hughes investigator, whose goal is to bring the physician scientist. How do we train them? And he’s been able to recruit three people in his group. So really excited about how that comes across and then you can see how Stephanie’s thinking about the network and all of the pieces. I think this group will continue to get bigger over the next year, as Doctor Weiner joins us. Next slide.
They had the shanavia brain tumor front. You saw the announcement earlier this week. They also had a U 19 grant with Antonio Amaro and Ranchi and drawn launching the therapeutic network. They’re continuing to do a lot of clinical trials and their goals are to kind of optimize their inpatient services as well as launch a PO1 in the future and then I know that they have also a recruitment needs in this group. Next slide. Alright, so therapeutic radiology or...
radiation oncology as well is the department led by Doctor Glaser, one of the top five programs in the country. Clearly very much definitely invested in building teams, translational science or what we mean by taking signs from the bench to the bedside. We have to acknowledge that they had the mosaic cyber attack and how this team worked tirelessly to make sure that no one’s no patients treatment was interrupted, and I think that’s a. Fabulous achievement in addition, Lynn Wilson has now stepped in as our new Deputy CMO for therapeutic.
radiology is the idea of a Cancer Center and being matrix that we need the connection so really want to welcome Lynn informally and on this in role and then for the next year. I think all of us have heard the proton center that will be in in the Central Connecticut domain that started construction. They’re working on building a spinal. Oncology program with neurosurgery and Woody Mendel. Dr Mendel just joined us and they’re also looking at a spore grant in DNA repair. And of course, the team.
If you’ve already heard continued recruitment back to the theme of the academic health System, Surgical services is broad. There are many department Dr. Goshen is our deputy CMO for surgical services working across the six Department of Surgery. Again, I’m not going to name the multiple recruitments, but they’re here and the health system thing what has happened and this is. It kind of exciting is that we have been able to standardize some of the
treatment delivery across the health system, especially in breast and some of the more structural works. I think looking ahead, this is about part of the theme of academic health system. How do we make sure that patients have access to surgical services in the health system? Doesn’t make a lot of sense for surgeons to be going to these sites, but how do we think about that? That is an opportunity because when we look at Smilow services, we are about 50% of the state.
yet we look at surgical services
across the six surgical department
that’s not congruent.
We are only about 30% of the state,
so there’s an opportunity to
grow our surgical services.
There’s a lot of destination programs that
are being developed with multiple teams,
are being developed with multiple teams,
and you can see all those things.
We also need to think about
how patients come to us,
not only for trials but also
novel treatment offerings.
We’ve started the Hipec program
with Alina Ratner and then.
Our Division I just did a case
00:25:21.366 --> 00:25:23.519 last week for GI Surgical Oncology.
00:25:23.520 --> 00:25:25.350 How do we offer more advanced robotic cancer surgery?
00:25:25.350 --> 00:25:27.754 A lot of patients want to seek that out and
00:25:27.754 --> 00:25:28.390 so often those are the entries and we need to be really tactical on how we think about that for our patients.
00:25:28.448 --> 00:25:30.224 so often those are the entries and we
00:25:30.224 --> 00:25:32.177 need to be really tactical on how we think about that for our patients.
00:25:32.177 --> 00:25:35.715 to New York. The last division is palliative care led by Jeff Capel,
00:25:35.715 --> 00:25:37.862 standardized care for palliative care services, and the Cancer Center.
00:25:37.862 --> 00:25:39.830 and they were able to get two Milbank grants, and they were able to get two Milbank grants,
Also a dashboard. Development she general so is focused on developing a system right palliative care program and you can see her goals, which is to continue to build the ambulatory network for palliative care services. Because there is a huge need for how we think about that for our patients. And then with the pandemic we had a.
Shut down and now we are enrolling, but slowly as we have seen the labor disruption. This is what I want to stress. Here is what we are feeling is nationwide. If I look at all the Cancer Center director listservs, what we are seeing is every other center. So what I although it doesn’t make the hard work easier, it just to recognize that what we are facing is something that the rest of the country is facing. I think part of the pieces that we’re also doing in terms of.
Thinking about is how do we deliver care in our darts or the Centers for Cancer care or vehicles for taking this tripartite mission and making it one patient at a time? And these are the cares the cancer care teams. Now some of them have been launched next slide formally, into thinking about all of the domains. So now thinking about the clinical teams, the research, the quality, the clinical trials, and this is Roy herbs in the long dream, which you can see it's. Truly multidisciplinary and you
can see in the box all the services that go in delivering care services and also all the sites that have thoracic services.

Cancer services in both Trumbull and Greenwich. Next slide.

Similarly, Pam Kunz launched the Center for Gastrointestinal Cancers, and this is a large just in terms of thinking about GI cancers and has matrix with as a relationship with the digestive service line and you can see all the leaders and all
the different specialty programs.  

Huge complex undertaking.  

I want to congratulate this team and working so inclusively across the entire system. Next slide.  

And then the breast team just launched. As you know, Doctor Lustberg joined us recently from the Ohio State and has already been busy at work and has been building an inclusive team for breast cancer, which as you know, is distributed throughout our care sites. Next slide.  

OK, the other one as I mentioned.
This genevier fund. As you know we got a $5 million grant gift from Lewis and depression appear earlier in the year and we just announced the three leaders Jennifer Moliterno as a clinical director, Antonio Morrow as a clinical trials and Ranjit Bindra’s or scientific director. And also as we launch our neurosciences tower at SRC next slide. Now, why you know the how of what we do and what does it result? And if you look at it again, back to this network and how do we make
It's still relatively young as our integrated system, but we treat roughly 50% of our patients diagnosed in this state, and I think the part which I've mentioned that patients want to be seen especially for you know their day-to-day needs within closer to home. They may want to come for their complicated surgery here, but for the day today. I think thinking from a patient perspective, they want that care closer to home.
and so they have 16 locations across Connecticut and Rhode Island next slide.

So this is a great story. I love stories because I think stories stick with us more than you know, a bunch of factoids and dashboards. So Captain Simon is serves in the public health service and was diagnosed with multiple myeloma and was treated by Jason. How this? Atwater Ford and he needed a stem cell transplant and Jason contact it's two seropian who brought him here and he had his transplant and peace and was taken care of by the team and NP7.
And then he’s gone back to water Ford to get the rest of secure. I mean, that seems that’s the kind I mean. We want more of this. It’s not easy, but then it happens. It’s like the right thing to do because you know, he got the majority of his care closer to home, but when he needed the complicated stuff, he came here to New Haven. OK, so the other part of our care centers just some facts which I think it’s always are good to know if you think about why NHH and Yale School of Medicine 8% of our people across our
School of Medicine and the hospital come for access to clinical trials. That’s not just in cancer, but if you look in cancer, 25% of patients are in clinical trials. That’s a pretty petty in our care sites and then care centers deliver 40% of our cancer care. So I think you get the idea that a lot of patients are patients. Are being treated on these care centers, but how do we improve upon as the next generation is we think about the evolution of the karst centers that came together by consolidation of a
l of services. I mentioned already.

How do we provide advanced services?

Whether it’s therapeutic radiology,

Whether it’s palliative care

or surgical services,

how do we use telehealth more strategically?

And I think also what we need to

do is how do we highlight what is

the strength of an academic system?

Why is a good pathology?

Diagnosis the right diagnosis

and right staging important.

It has an impact if you don’t

stage a person right the right time

you can’t go back and fix it.

So I think this is something we need
to do when we talk to our patients and our app work to highlight what is the value of an academic health system. Yes, clearly we want to have easy access but also what do we? That’s a differentiator from, say, the others in the market is something that really needs to be something that our patients. And our referring physicians and teams understand next slide. Right, this is all the recruitments we’ve seen this over in in Renee’s weekly
and in my monthly town halls and over the past year.

But someone, some folks to point out is Doctor Isaac Kim who just joined us in October as the chair of Urology. Doctor Kim is a physician scientist. He joined us from Rutgers where he led the division of Urology and Clinical. He’s an expert and robotic prostate, so bringing that destination, clinical expertise and research he has been developing treatments. Or press resistant.

Treatment resistant prostate cancers using pro tech modality which I
00:32:38.467 --> 00:32:40.637 know you've heard a lot from Joe
00:32:40.709 --> 00:32:42.816 Kim and Dan Patrick and Roy and
00:32:42.816 --> 00:32:44.656 others in the other recruits.
00:32:44.656 --> 00:32:46.960 Here to point out these continuous
00:32:47.033 --> 00:32:49.379 Dr Krishnamurthy who also just joined
00:32:49.379 --> 00:32:51.957 us recently as Chief of Pediatric
00:32:51.957 --> 00:32:55.076 Oncology from memory and he brings an
00:32:55.076 --> 00:32:59.529 expert in BMT and really excited to have him.
00:32:59.530 --> 00:33:01.287 You can see the rest both Tomahawk,
00:33:01.290 --> 00:33:03.610 the world who has done the world’s first.
00:33:03.610 --> 00:33:05.460 This nation’s first face transplant,
00:33:05.460 --> 00:33:06.468 but it’s, uh,
00:33:06.468 --> 00:33:07.476 his daytime job?
00:33:07.480 --> 00:33:09.364 Is cancer reconstructive services
00:33:09.364 --> 00:33:10.777 is also here,
00:33:10.780 --> 00:33:13.657 from Brigham and I mentioned Dr Mandel,
NOTE Confidence: 0.9342354
00:33:13.660 --> 00:33:15.502 who’s here from the Ohio State
NOTE Confidence: 0.9342354
00:33:15.502 --> 00:33:16.730 and leading probably one
NOTE Confidence: 0.821288381333333
00:33:16.788 --> 00:33:18.238 of the world's or nations,
NOTE Confidence: 0.821288381333333
00:33:18.240 --> 00:33:20.028 exported spinal oncology and
NOTE Confidence: 0.821288381333333
00:33:20.028 --> 00:33:21.369 recruited from neurosurgery.
NOTE Confidence: 0.926715635
00:33:23.850 --> 00:33:25.365 OK, so switching gears to
NOTE Confidence: 0.926715635
00:33:25.365 --> 00:33:26.880 some of our research mission.
NOTE Confidence: 0.926715635
00:33:26.880 --> 00:33:28.976 I spent a lot of time on the.
NOTE Confidence: 0.926715635
00:33:28.980 --> 00:33:31.002 Clinical mission on switching gears to
NOTE Confidence: 0.926715635
00:33:31.002 --> 00:33:32.998 our research mission and as we know,
NOTE Confidence: 0.926715635
00:33:33.000 --> 00:33:36.003 we are a comprehensive Cancer Center which
NOTE Confidence: 0.926715635
00:33:36.003 --> 00:33:38.429 means we’re supported by a CCSG grant.
NOTE Confidence: 0.9122745
00:33:41.940 --> 00:33:44.333 And we have 300 full-time members of the
NOTE Confidence: 0.9122745
00:33:44.333 --> 00:33:46.879 grant needs a lot of work to manage it,
NOTE Confidence: 0.9122745
00:33:46.880 --> 00:33:49.360 and that work is done by Bob Garofalo,
NOTE Confidence: 0.9122745
00:33:49.360 --> 00:33:51.580 who has been leading the CCSD.
NOTE Confidence: 0.9122745
00:33:51.580 --> 00:33:53.380 Granted all of the administrative
NOTE Confidence: 0.9122745
00:33:53.380 --> 00:33:55.254 workload for us since 2015.
NOTE Confidence: 0.9122745
00:33:55.254 --> 00:33:57.858 He let us through a renewal.
NOTE Confidence: 0.9122745
00:33:57.860 --> 00:34:00.450 Bob is stepping down and add captain,
NOTE Confidence: 0.9122745
00:34:00.450 --> 00:34:03.267 who you all know will be taken over as
NOTE Confidence: 0.9122745
00:34:03.267 --> 00:34:05.322 associate Director for Research Affairs
NOTE Confidence: 0.9122745
00:34:05.322 --> 00:34:07.396 on January 1st for the next year.
NOTE Confidence: 0.9122745
00:34:07.400 --> 00:34:09.104 You can see their goals to
NOTE Confidence: 0.9122745
00:34:09.104 --> 00:34:10.240 continue to improve infrastructure,
NOTE Confidence: 0.9122745
00:34:10.240 --> 00:34:12.016 operational efficiency, and.
NOTE Confidence: 0.9122745
00:34:12.016 --> 00:34:15.568 Help leader re submission next slide.
NOTE Confidence: 0.9122745
00:34:15.570 --> 00:34:18.330 OK, this kind of graph speaks to itself.
NOTE Confidence: 0.9122745
00:34:18.330 --> 00:34:20.430 I think nice steady growth
NOTE Confidence: 0.9122745
00:34:20.430 --> 00:34:21.690 over grant funding.
NOTE Confidence: 0.9122745

67
Important point to point out is our NIH NCI funding or cancer specific funding has increased.

We also had these research programs. I’m not going to talk about them, but I think just to see out that these six research program represents our efforts for framework for engaging all of our Members in high impact science. So again, it’s team work, similar to what we said on the clinical side in each program is often led by either by multiple leaders that bring complementary experience. And also, I think what the goal is to have synergy between them.
And then in each of these programs, one of the successes is this, which is the Doral trial? That were led by Boy Herbs and the correlative work for this was done by Katy Perry. Anything the Kaplan Meier for the folks who could see it is.
You can see when you’re treated with this new drug was merited, which is an EGFR receptor. You can see the improvement in survival from placebo from 61% to 97%. I think that graph speaks for itself and that this is a great trial in improving outcomes for our stage two and three eight patients. What this highlights is how the clinical team and the translational teams and all the teams are working together and how we what we do here, then changes clinical management across the country next slide.
Lots and lots of awards.
I think we can probably can’t cover them all, but some few ones to think about as highlight or obviously.
Two people who got inducted into the National Academy of Science, doctor Liping Chen and Scott Miller were inducted, which is one of the highest honors in the country, along with National Academy of Medicine doctor Marcella Nunez Smith. You can see Pankun Scott, woman oncologists at the year and that led to a lot of national
00:36:31.550 --> 00:36:33.410 excitement over pants.
NOTE Confidence: 0.938774228
00:36:35.490 --> 00:36:38.160 Support on this next slide.
NOTE Confidence: 0.938774228
00:36:38.160 --> 00:36:40.638 OK, so talking about our associate director,
NOTE Confidence: 0.938774228
00:36:40.640 --> 00:36:44.064 Doctor Mark Lemon runs the is the associate
director of basic science research.
NOTE Confidence: 0.938774228
00:36:44.064 --> 00:36:46.798 And as as I mentioned,
NOTE Confidence: 0.938774228
00:36:46.800 --> 00:36:49.712 the Cancer Biology Institute
NOTE Confidence: 0.938774228
00:36:49.712 --> 00:36:51.044 is on the West campus.
NOTE Confidence: 0.938774228
00:36:51.044 --> 00:36:56.699 He’s been able to recruit six members
who were really in fostering research.
NOTE Confidence: 0.938774228
00:36:56.700 --> 00:36:58.916 The goal here is to foster basic science
NOTE Confidence: 0.938774228
00:36:58.916 --> 00:37:01.082 and bring it to a translational end.
NOTE Confidence: 0.938774228
00:37:01.082 --> 00:37:04.138 And you can see the Doctor Lemons goals
NOTE Confidence: 0.938774228
00:37:04.138 --> 00:37:07.446 for the next year to help Foster continued
NOTE Confidence: 0.938774228
00:37:07.446 --> 00:37:10.579 part of this translational research.
NOTE Confidence: 0.938774228
00:37:10.580 --> 00:37:12.668 And how do you work across the other
00:37:12.670 --> 00:37:14.295 associate directors in data science

00:37:14.295 --> 00:37:16.914 and which I know is an area that

00:37:16.914 --> 00:37:18.768 Doctor Lemon is really focused on.

00:37:18.770 --> 00:37:21.395 Because as we know that genomics is

00:37:21.395 --> 00:37:24.088 becoming part and parcel of our lights.

00:37:24.090 --> 00:37:29.096 Next OK, so the next program dot Roy Herbst,

00:37:29.100 --> 00:37:30.208 also runs the translation

00:37:30.208 --> 00:37:31.593 and clinical research as the

00:37:31.593 --> 00:37:32.910 Associate Cancer Center director,

00:37:32.910 --> 00:37:35.580 and here they focused very successfully.

00:37:35.580 --> 00:37:39.108 Used the tier team science mechanism

00:37:39.110 --> 00:37:40.610 and also are fostering this too,

00:37:40.610 --> 00:37:43.520 for leading to spores NPO ones I know.

00:37:43.520 --> 00:37:45.680 He would be very excited and as I

00:37:45.754 --> 00:37:47.890 might to mention that the diversity

NOTE Confidence: 0.938774228
training both in a T32 program as well as the BMS diversity program which is led by Nabi Fast for next year. Of course I think.

We would all agree that improving optimizing the CTO office is critical along with submitting at least one news for grant next slide. These are all the drug approvals that have led from Yale LED studies. Kind of highlighting our continued success in this arena, except.

And then for the C2, I think many of you’ve seen this slide, but as part of improved optimizing and acknowledging our distributed system,
we’ve announced two more medical directors, Stacy Stein and Neil Fishback, along with Stephanie. Hillary, who runs the labs. Alyssa Gateman is our interim director for the C2 office and Margaret Gil. Shannon came on full time as part of the Cancer Center as their new deputy director. And then I think you’ve all heard that urine is helping us to see how do we do? Things more in optimized way without improving our infrastructure excellent. And then these centers, I think, are also important bridges that
think about our darks and how do we then continue to engage in this.

Once we called matrix and how do we recruit new people and have them be successful? So I mentioned Cancer Biology Institute as one example.

We will also mention CMCO Marcus missions program. He just recruited David Braman was going to focus on renal cancers and you can see all the copper program.

It’s very successful and I want to point out by CIO which.

It’s launched as a bridge was launched as a bridge program several years ago, and as between the Cancer Center
and Immunobiology, Marcus was appointed as the full time director recently this year.

Next slide.

So our 84 population and then the sports, which I think you can see the data for itself, how much funding they bring in the leaders of these three scores. And I think you’ve heard that there’s goals to at least put one or two new sports for the upcoming year next week. So Melinda Irvine runs. Are is the associate director for population science and the
goal here is how do you improve?

Think about our research and focusing on our catchment area and her goals for the next year to see.

How do we take our genomic signs and connected.

We are all connected by Epic, so how do you use this data science and leverage or electronic health record?

With our research to be more sort of, you know cloud would be make call cloud analytics is something that everybody is thinking along with as you saw Mark.

Simon is also thinking about that, and then of course, foster collaborations next.
And a pet Larussa runs the experimental therapeutics program.

Of course, this is focused on how do we take our faculty and position science and do investigator initiated trials? Think things to think about. Sometimes it’s hard to get here, and this is where clinical trials or geography helps us in that those...
trials are available to our patients. Except.

And then if you think about our catchment area, our catchment is the state of Connecticut in 97% of our cases come from the state of Connecticut. Now it’s important to note that Connecticut is in the highest second highest quintile in the country for cancer incidence and 5% higher than the US average, in particular Hispanic or Latino population is a 20% percent higher cancer rate and that gives us, as we think about our different sites.
How do we think about our research and will be improved care and then of course in New Haven.

We know we have higher rates of smoking and obesity which are also cancer risk factors explained.

Now, one of the ways to improve is how do you address the needs. This is one example by Andrea Silber, who has the owner trial, which is goal is to improve minority enrollment in clinical trials. This is and breast cancer. And how do we offer that to our communities?
In our local community. In addition, these trials are supported not only by the CCSG or the NCI grant, but also by foundational funding by BMS, Genentech, etc. In terms of trying to improve care to our communities. Next site, but this is like I love this story. So Maryland Barber was having some symptoms and she kind of went to her primary care even was, you know had her levels checked in, including her CEO on 25 all normal she went to a health fair and you
00:42:25.814 --> 00:42:27.788 can see some of her team from
00:42:27.788 --> 00:42:29.820 our health fairs and really had
00:42:29.820 --> 00:42:31.245 a nagging feeling in in.
00:42:31.250 --> 00:42:32.338 Really got some information
00:42:32.338 --> 00:42:33.426 at this health fair.
00:42:33.430 --> 00:42:36.088 Came to see Alice Andrew Santino
00:42:36.088 --> 00:42:38.619 actually had ovarian cancer was treated
00:42:38.619 --> 00:42:41.339 by our team and kind of tells you.
00:42:41.340 --> 00:42:44.330 That this is these fairs and I also have a
00:42:44.401 --> 00:42:47.316 teaching responsibility to our community.
00:42:47.320 --> 00:42:49.574 And this in this case we had,
00:42:49.580 --> 00:42:51.932 you know, an early patients diagnosis
00:42:51.932 --> 00:42:53.890 and helped this patient next.
00:42:56.090 --> 00:42:57.825 OK, and and then this is
00:42:57.825 --> 00:42:59.590 part of back doors at NCI.
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Grant that community outreach and engagement is a critical part of our mission. As in as a comprehensive Cancer Center and Marcella Nunez Smith leads this. Our community outreach and engagement program with the goal to reduce or eliminate disparities in our catchment area and the goal here is to use data or dashboards to then understand the burden and then use it to outreach back to the communities to then improve. Here, I think increasingly then, as once you understand what the problems are. Also, how do you ask the right questions? And how do you develop your research around that?
Is something that I know more as Marcelo steps away from our White House duties is looking to develop further next slide. And then last but not least, Barbara Burtness was appointed as a new interim. Again, I mentioned this earlier on in our talk that this is going to be an area that’s important to us and Barbara is a huge champion of this. Having done this work locally, both in swimming and the Deans committees and nationally for E. COG already since starting,
she’s been doing a lot of training and implicit bias for trainees. For physicians, a lot of communication initiatives. As you’ve been seeing that there’s a climate survey going on. Then of course we want to eventually get a permanent lady for this role next time. And she’s already launched A DE Council. It’s obviously highly inclusive and diverse. and this committee I know will continue to look at all of our parts and to see how can we think about all these issues.
And in equity, HealthEquity next slide.

And then Harry Cougar runs our education and training. She’s the associate director for that.

Their program is looking at how do you use metrics to improve and optimize training outcomes and also how do we look at the entire pipeline of students and trainings and optimize their research experience? Because this is why they come to us.

Some of the other things to highlight here is the cancer student interest group that has launched, including initiative for MD PHD’s.
You can see the other training

for APR ends for residents,

something of pride to us,

or 25% of our class is URM this year.

And of course,

the fellowship will be expanding from 8

to 10 trainings which also looking ahead.

Next slide,

so I want to take a moment.

First of all,

I want to thank you know I couldn’t

have done this all of the months,

have done this all of the months,

and although I’m going to be your Cancer

Center director for the next few months,

I may not have many more opportunities

with the holiday season.
I want to take a moment to acknowledge the people who were silent, but helping me every minute. Lori Pickens, who as you know, is our Senior VP, is phenomenal. She has always figured out ways to make my life easier and. I pushed him in so much of the research and helping me in all of
this and has been an incredible help

as our deputy director Margaret,

just came on and was doing two jobs

and then I pushed her for a lot of

though she was new to our role.

Obviously there are many other folks.

I can’t mention them all.

I do.

One acknowledge Brian Smith and Tisha

Johnson for all the help and the CTO office,

what they did and what Nancy and

Dan Brown and and Keith Church

will have done as we have think,

thought about the C2 and all the.
Things about what a contemporary clinical trials office looks like. Think I want some of the surgeons, may be an unlikely. It’s known they’re probably all in the operating room, but I also want to acknowledge my department they did lose my attention and that’s my faculty. Might chiefs who took on many, many other roles for being wonderful citizens. I do love this Cancer Center bell, so look forward to giving my cheeks and my faculty my time and attention.
So I want to thank all of the folks we’ve been really incredible partners, and then I want to end on a note. As we look ahead next slide, please. Of what you know, we’ve already been working together on recruitments etc, so I think you is. He has a big job but he is obviously very experienced and he has a lot of support, but I want to think come back to how We are one academic cancer health
00:47:37.408 --> 00:47:39.070 system we have to think about.

00:47:39.070 --> 00:47:40.246 Why do we all come here?

00:47:40.250 --> 00:47:41.910 Whether it’s the nurses,

00:47:41.910 --> 00:47:42.740 the staff.

00:47:42.740 --> 00:47:44.220 The environment that everyone

00:47:44.220 --> 00:47:45.700 comes with a calling.

00:47:45.700 --> 00:47:47.499 You think this was very clear when

00:47:47.499 --> 00:47:50.130 I was here during the pandemic and I

00:47:50.130 --> 00:47:51.930 saw our environmental health services

00:47:51.990 --> 00:47:55.760 and there was an empty hospital.

00:47:55.760 --> 00:47:57.600 But nursing working in units,

00:47:57.600 --> 00:47:59.860 a calling health care is hard,

00:47:59.860 --> 00:48:01.645 but it comes from the heart and

00:48:01.645 --> 00:48:03.470 we all want to think about why

NOTE Confidence: 0.84100243625
we came to do this job.

It’s important to acknowledge that there is a lot of heart in doing this work. It’s not just all dashboards and data and planning. Of course we need to have what I call connectivity or collaboration. I gave you some examples, but there are times when it doesn’t work right and there are times when it works beautifully. It is something we were going to continue to evolve and learn to work across and how we connect,
whether it’s in the research arena, in the clinical arena, in quality, safety, whatever we do, but we have to do it more nimbly, so we do not make it so hard for each and everyone of us. And then how does it lead to a community? Some of it is internal to us on how we think about us, because all of these seeds lead to appropriate engagement. Why we are happy at work and not happy haha, but why we feel satisfied with their jobs? So community building is all within us. It has to be local at the end of the
day it can’t come from 8 zoom meeting.  
It is sometimes sitting and having lunch together.  
It’s shared in the hallway with a smile.  
How we greet each other.  
But that community has to come from all of us,  
whether I see the DeLuca Awards  
and I saw all the nursing teams hanging out with each other.  
That’s community.  
And then we also have to think increasingly as the conversation is happening on and whether  
receive vaccine rollouts or others.  
How important health equity is
in how outcomes are seen,
we may do the best science,
but at the end of the day that has
to be done in the where we live and
that’s our patience and they may
have social determinants of health that may.
Make the best treatments.
If they can’t access them,
it’s irrelevant,
so that is also a community.
I want you to think about.
So with the next few months I will be here.
I will be engaged and but I will
also work with Eric.
I look forward to welcoming him
and having a smooth transition.

I want to thank you all for giving me the privilege of being your leader and with that I hope I leave a few minutes for question and answers. So thank you so much.

So we can open for questions and it is zoom. So we can open for questions and it is zoom. It’s not a webinar for once, so it’s OK to raise your hand and ask a question or put it in the chat. I’m going to leave leadoff.

Kevin Billingsley here. Kevin Billingsley here. Just want to say thank you for your incredible service over these past many months. So I can only imagine what has
I have been involved in running the complexities of the Cancer Center and the department, and I think although we have had, we still have challenges in front of us. I think all of us are really excited for the future, and we see the growth and we see the opportunity. And I think it’s a very bright time for our organization. Thank you Kevin for highlighting because I think if you didn’t sense it from my excitement, I think we are. We have a fabulous institution and the
best is yet to come and be a great people.
NOTE Confidence: 0.804922945

NA TO this is Lori.
NOTE Confidence: 0.804922945

I have to echo Cabman and.
NOTE Confidence: 0.804922945

Since I got here a little
NOTE Confidence: 0.804922945

you were one of the first people that
NOTE Confidence: 0.804922945

I came to see and the collaboration
NOTE Confidence: 0.804922945

that you have had with us and
NOTE Confidence: 0.804922945

cancer from day one has been just.
NOTE Confidence: 0.804922945

Uh, amazing.
NOTE Confidence: 0.804922945

It’s just been fabulous and
NOTE Confidence: 0.804922945

there’s a part of me that has
NOTE Confidence: 0.804922945

to apologize a little bit for.
NOTE Confidence: 0.804922945

Trying to get you over here to
NOTE Confidence: 0.804922945

serve as our interim ’cause
NOTE Confidence: 0.804922945

it’s a part of me that feels
guilty at this point as well,
but you have just really stepped
into this and just been an
incredible partner for all of us,
and I probably didn’t realize quite
how much you would be taking on,
but I just want to thank you from
the bottom of my heart because your
partnership has always been so valuable
and having you here over the last.
I don’t know what 6 to 8
months working with us like.
This has just come.
It’s just been terrific and
and really thank you for me
and thank you from all of us.

Thank you, Lori.

Quiet group, I’m going to give a minute

It’s alright Roy. Go ahead. I knew

Great working with you and especially

continue to work a lot together.

Great working with you and especially

as we’ve had to work through

the clinical trials together.

It’s just been.

Your leadership has been just enormous.

I’ll ask now that you’ve seen

the Cancer Center.

And as you go back to be chief of surgery,

which it sounds like it’s a pretty big job.
What have you learned?

How can we build better multi modality clinics?

So one of the things that we really want, I think to increase our care.

Our reputation is to really be seeing patients with tumor boards and multimodality way across the system.

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You know, really in good question. I think as.

First of all, thank you for all the hard work you’ve done.
I think I put surgeon

hours with you every day,

so thank you for hand bearing with me.

I've had a chance to visit

some of the care centers.

Unfortunately I didn’t have a chance
to visit each and everyone of them,

but I think what struck me is how
connected the patients were for their
local community and how incredible the
service and and the team work was.

Think at least my department wasn’t
distributed until we came and
then some of the folks like Nina
Horowitz and others were incredible
champions of taking breast care.
But I think there’s opportunity for us in even. Sites like water, Ferdi and Torrington.

I think the part that we have to figure out is how do we make it not so difficult because it’s not efficient for us to put everybody in the clinic at the same time, so I think some of the pieces will be and I kind of put the telehealth piece to me. That is an opportunity around thinking for the specialty cares for some of the care like breast cancer. We may want to think about.
should breast cancer.

All of the services be available at every site.

And again this is work.

I know Liz is star Herbert is thinking about with the rest of the teams and the Jeremy and and and others but.

This is the pieces that we have to think about on the part.

Sometimes our teams are multiple employment models.

It doesn’t mean it’s good or bad, we just have to think tactically around.

If imaging is not yield.
medicine but someone else, how do we make sure we’re still working as a team and thinking on these systems? The last piece I’m going to tell in this is an opinion, so please, but I do think. That there’s still a lot of education that’s needed on the importance of multidisciplinary management, not into our patients who are. Ultimately it’s their health and not to the physicians, but to our patients. And our primary care doctors, especially in southern Connecticut,
where there’s a lot of people whose first thought is to go to New York, and in my mind that should never happen. If you were a patient in Connecticut, and you have Yale Cancer Center in your background. They should know all of us, but I can tell you there are many times they don’t know all of us and they call me and I answered these phones and I’m like. Well, here’s the world’s best expert in XYZ, but they are not aware so that education is upon all of us. Every interaction is an educational opportunity and that is what we have
to do to educate our communities on what we bring in language that they can understand. And it’s easy to explain. So again, that’s what I mean by a distributed health system to explain what is whether it’s therapeutic importance of giving I MRT radiation, or whether it’s proton or whether it’s complicated clinical trials or complicated surgery. But there’s a huge opportunity and and obviously we will be working with your teams to sort of make that happen. Alright, it’s 1258.
I want to give people two minutes back.

I hope everyone had lunch, but thank you all.

You are an amazing group.

We are very large.

We are strong and I want you to acknowledge yourself and I want to thank each and everyone of you for making this.

You know for coming through the pandemic and containing growth.

Thank you everybody.

Have a great rest of the day.