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 on the state of the things.

Essentially looking back at what we have accomplished, but also looking ahead for the next year.

OK, I think everybody knows who I am.

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.
and I think the other point is of course we’re in this state of anticipation,
but mixed in with a little bit of I would say. 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 maybe 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 or whatever it is, why do we do this? It is to deliver care to our patients and we are in academic system.
which means we’re teaching organization. It’s part of our tripartite mission and that means how to educate the next generation, whether it’s trainees or nursing. How do we take resources and improve our patient care? But it can’t be done in silo, especially as we look at the Cancer Center in the distributed nature, not only at the sites. But off the constituencies, how many folks are involved there? Roughly 300 members of the Yale Cancer Center. And then if you look at the number of
people we look at our nursing or staff.
It's 2000 people, so that's a lot of people,
many departments, many sites,
it's great to see it,
but then the day today can
sometimes feel sometimes difficult,
sometimes fabulous,
but it all means that we have
to work together.
And this is just one quote from Helen Keller.
In talking about,
it means that we have to learn
to work with each other.
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, this is our vision statement. I think sometimes these are put 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 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 enter enter or in New Haven. And how do you conceptualize and deliver all of this transformative transformational care? It’s easy to save,
00:05:50.558 --> 00:05:53.180 and I’m talking about in a PowerPoint.
NOTE Confidence: 0.754928194
00:05:53.180 --> 00:05:55.286 But then it’s the teams that put it together,
NOTE Confidence: 0.754928194
00:05:55.290 --> 00:05:57.740 and those teams include our nursing or
NOTE Confidence: 0.754928194
00:05:57.740 --> 00:06:00.268 residents or staff or clinical trial list,
NOTE Confidence: 0.754928194
00:06:00.270 --> 00:06:00.878 our leadership,
NOTE Confidence: 0.754928194
00:06:00.878 --> 00:06:01.486 or administrators.
NOTE Confidence: 0.754928194
00:06:01.486 --> 00:06:03.828 And then I think you get the soup
NOTE Confidence: 0.754928194
00:06:03.828 --> 00:06:05.220 of what we’re trying to do.
NOTE Confidence: 0.754928194
00:06:05.220 --> 00:06:06.470 We’re trying to make magic
NOTE Confidence: 0.754928194
00:06:06.470 --> 00:06:07.720 each and every day and
NOTE Confidence: 0.872470029375
00:06:07.780 --> 00:06:10.070 improve the lives of our patient. Next slide.
NOTE Confidence: 0.898601058181818
00:06:12.090 --> 00:06:14.520 OK, so when we look at this idea of
NOTE Confidence: 0.898601058181818
00:06:14.520 --> 00:06:16.700 what does the clinical care and of
NOTE Confidence: 0.898601058181818
00:06:16.700 --> 00:06:19.480 course we then use our SMILLOW standards.
NOTE Confidence: 0.898601058181818
00:06:19.480 --> 00:06:22.018 The goals we would say is we want to
NOTE Confidence: 0.898601058181818
00:06:22.018 --> 00:06:24.290 deliver care that’s easily accessible.
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, 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 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 re establishing 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
00:08:53.117 --> 00:08:55.800 clinics moved and then some came back.
NOTE Confidence: 0.853748399
00:08:55.800 --> 00:08:57.440 There’s still some disruptions,
NOTE Confidence: 0.853748399
00:08:57.440 --> 00:08:59.140 but in the midst of it, we continue
NOTE Confidence: 0.853748399
00:08:59.140 --> 00:09:01.485 to train our nurses and our teams.
NOTE Confidence: 0.853748399
00:09:01.490 --> 00:09:04.486 We’ve continued to work on improving things,
NOTE Confidence: 0.853748399
00:09:04.490 --> 00:09:07.395 whether it’s through this lean task project,
NOTE Confidence: 0.853748399
00:09:07.400 --> 00:09:09.700 for improving scheduling for infusions,
NOTE Confidence: 0.853748399
00:09:09.700 --> 00:09:12.060 launching patient experience forms,
NOTE Confidence: 0.853748399
00:09:12.060 --> 00:09:13.830 improving residency training,
NOTE Confidence: 0.853748399
00:09:13.830 --> 00:09:15.204 resident centered care,
NOTE Confidence: 0.853748399
00:09:15.204 --> 00:09:17.036 training for our teams,
NOTE Confidence: 0.853748399
00:09:17.040 --> 00:09:18.027 and then at the end of it,
NOTE Confidence: 0.853748399
00:09:18.030 --> 00:09:19.749 I think we have to think about how do
NOTE Confidence: 0.853748399
00:09:19.749 --> 00:09:21.469 we improve the patient experience.
NOTE Confidence: 0.853748399
00:09:21.470 --> 00:09:23.030 As you see this each team,
NOTE Confidence: 0.853748399
00:09:23.030 --> 00:09:24.670 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 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
been having a national conversation
and that will be seen in the cancer domain so you can see.
That they’re focusing on culture engagement,
and I this is looking inward,
but also outward.
We’re going to have to do both,
and this is the part that this team is also looking next slide.
So this just acknowledges,
I think,
the the all the arrows all it sees is all the stuff you all felt it.
It was hard work.
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.
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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. 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,
the early signal shows that.

Having a dedicated team does improve things like length of stay in early discharge, so again it’s a positive signal.

It’s something will continue to learn from and as Eric comes on this will be something for us to discuss and see how this relates to how we deliver our care, but also think about how does it impact our training experience?

Are we thinking about all those facets and training the next generation?

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.
whose are ambulatory officer on with these 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. 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.

OK, so some more data. 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 just add more data.

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,

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of course,

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as we all know is you get busy busy

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people keep getting busier 'cause

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your patients continue they continue

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to follow us and you can see that

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that growth is exponential because

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those patients stay with us and

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I think this is an opportunity of working.

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How do we use telehealth in this population?

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How do we think as teams

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around our follow up visits?

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Is that always done the same way?

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Are there smarter ways of doing

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this as we look ahead next slide?

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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 is 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. 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
person and that’s what we see here
that the telehealth is declining.
I think 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. Until Yelp. I think there are opportunities similar to what I mentioned around. The follow up visits and I’m not. 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 as holistically.
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 division over almost about two years ago and obviously focused on 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 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
The classical theme is an area of huge growth and need partly reflects Connecticut as a state with an aging state population that many of our sites are inundated with benign heme. It’s either an opportunity or a stressor. It certainly is a lot of demand, but how do we use it for our research? I think those are some things that I know. The heme group is thinking with Bob Boehner and others also want to point out Marcus motion on the left. Some of you may not have met him he is our inaugural director of CMC.
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 then for 2022 for this coming year. 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. 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 this 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, 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
last week for GI Surgical Oncology.

How do we offer more advanced robotic cancer surgery?

A lot of patients want to seek that out and

so often those are the entries and we need to be really tactical on how we think about that for our patients.

They look here rather than going to New York. The last division is palliative care led by Jeff Capel,

So they look here rather than going to New York. The last division is palliative care led by Jeff Capel,

and they were able to get two Milbank grants,

one to look at providing care,

standardized care for palliative care services, and the Cancer Center.
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.

If you’ve been attending all of this, clearly are our clinical trials increased or dramatically?

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 thoracics 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.

the other one as I mentioned.
00:28:23.970 --> 00:28:24.870 is this genevier
00:28:24.934 --> 00:28:28.024 fund. As you know we got a $5 million
00:28:30.154 --> 00:28:32.973 grant gift from Lewis and depression
00:28:32.973 --> 00:28:34.695 appear earlier in the year and we just
00:28:34.695 --> 00:28:36.570 announced the three leaders Jennifer
00:28:36.570 --> 00:28:39.062 Antonio Morrow as a clinical director,
00:28:39.062 --> 00:28:41.369 Ranjit Bindra’s or scientific director
00:28:41.370 --> 00:28:43.580 and thinking about destination program.
00:28:43.580 --> 00:28:46.124 And also as we launch our
00:28:46.124 --> 00:28:48.809 neurosciences tower at SRC next slide.
00:28:48.810 --> 00:28:50.650 Now, why you know the how of what
00:28:50.650 --> 00:28:52.587 we do and what does it result?
00:28:52.590 --> 00:28:53.850 And if you look at it again,
00:28:53.850 --> 00:28:55.866 back to this network and how do we make
NOTE Confidence: 0.806033240909091
it academic and how do we think about it?

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. Next slide.

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 carlist centers that came together by consolidation of a
lot 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? 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?

What do we do?

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.

And this is all the recruitments we’ve

seen this over in Renee’s weekly

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and in my monthly town halls 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 does has been developing treatments. Or press resistant. Treatment resistant prostate cancers using pro tech modality which I
NOTE Confidence: 0.9342354
00:32:38.467 --> 00:32:40.637 know you've heard a lot from Joe
NOTE Confidence: 0.9342354
00:32:40.709 --> 00:32:42.816 Kim and Dan Patrick and Roy and
NOTE Confidence: 0.9342354
00:32:42.816 --> 00:32:44.656 others in the other recruits.
NOTE Confidence: 0.9342354
00:32:44.656 --> 00:32:46.960 Here to point out these continuous
NOTE Confidence: 0.9342354
00:32:47.033 --> 00:32:49.379 Dr Krishnamurthy who also just joined
NOTE Confidence: 0.9342354
00:32:49.379 --> 00:32:51.957 us recently as Chief of Pediatric
NOTE Confidence: 0.9342354
00:32:51.957 --> 00:32:55.076 Oncology from memory and he brings an
NOTE Confidence: 0.9342354
00:32:55.076 --> 00:32:59.529 expert in BMT and really excited to have him.
NOTE Confidence: 0.9342354
00:32:59.530 --> 00:33:01.287 You can see the rest both Tomahawk,
NOTE Confidence: 0.9342354
00:33:01.290 --> 00:33:03.610 the world who has done the world’s first.
NOTE Confidence: 0.9342354
00:33:03.610 --> 00:33:05.460 This nation’s first face transplant,
NOTE Confidence: 0.9342354
00:33:05.460 --> 00:33:06.468 but it’s, uh,
NOTE Confidence: 0.9342354
00:33:06.468 --> 00:33:07.476 his daytime job?
NOTE Confidence: 0.9342354
00:33:07.480 --> 00:33:09.364 Is cancer reconstructive services
NOTE Confidence: 0.9342354
00:33:09.364 --> 00:33:10.777 is also here,
NOTE Confidence: 0.9342354

65
from Brigham and I mentioned Dr Mandel, who’s here from the Ohio State and leading probably one of the world’s or nations, exported spinal oncology and recruited from neurosurgery.

OK, so switching gears to some of our research mission. I spent a lot of time on the Clinical mission on switching gears to our research mission and as we know, we are a comprehensive Cancer Center which means we’re supported by a CCSG grant.

And we have 300 full-time members of the grant needs a lot of work to manage it, and that work is done by Bob Garofalo,
who has been leading the CCSD. Granted all of the administrative workload for us since 2015. He let us through a renewal. Bob is stepping down and add captain, who you all know will be taken over as associate Director for Research Affairs on January 1st for the next year. You can see their goals to continue to improve infrastructure, operational efficiency, and. Help leader re submission next slide. OK, this kind of graph speaks to itself. I think nice steady growth over grant funding.
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 thinks about how do you mentor new investigators and ultimately, how do we improve the number of teen science awards? That are going across our cancer centers. One of the successes is this, which is the Doral trial? Which was led by Boy Herbs and the correlative work for this by done by Katy Perry. And this is for EGFR mutated non small cell lung cancer. 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 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. 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
excitement over pants.

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Support on this next slide.

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OK, so talking about our associate director, Doctor Mark Lemon runs the associate director of basic science research.

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The Cancer Biology Institute is on the West campus.

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He’s been able to recruit six members who were really in fostering research.

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The goal here is to foster basic science and bring it to a translational end.

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And you can see the Doctor Lemon’s goals for the next year to help foster continued part of this translational research.

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And how do you work across the other
associate directors in data science

and which I know is an area that Doctor Lemon is really focused on. Because as we know that genomics is becoming part and parcel of our lights.

Next OK, so the next program dot Roy Herbst, also runs the translation and clinical research as the Associate Cancer Center director, and here they focused very successfully. Used the tier team science mechanism and also are fostering this too, for leading to spores NPO ones I know. He would be very excited and as I might to mention that the diversity
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.
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 is how do we also increase URM recruitment to set clinical trials?

And one of the ways pad is thinking about is decentralizing clinical trials, bringing them closer.

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. 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 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. 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 the fair and you
can see some of her team from our health fairs and really had a nagging feeling in. Really got some information at this health fair. Came to see Alice Andrew Santino actually had ovarian cancer was treated by our team and kind of tells you. That this is these fairs and I also have a teaching responsibility to our community. And this in this case we had, you know, an early patients diagnosis and helped this patient next. OK, and and then this is part of back doors at NCI.
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 on Smilow Connect and. In future obviously that as you see it, 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. 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. Think Dan is de Mayo is one of the most understated and thoughtful people, and I pushed him in so much of the research and helping me in all of.
00:46:08.468 --> 00:46:10.826 this and has been an incredible help
NOTE Confidence: 0.84100243625
00:46:10.826 --> 00:46:12.856 as our deputy director Margaret,
NOTE Confidence: 0.84100243625
00:46:12.860 --> 00:46:13.787 as I mentioned,
NOTE Confidence: 0.84100243625
00:46:13.787 --> 00:46:16.308 just came on and was doing two jobs
NOTE Confidence: 0.84100243625
00:46:16.308 --> 00:46:18.283 and then I pushed her for a lot of
NOTE Confidence: 0.84100243625
00:46:18.283 --> 00:46:19.976 things and she never let it on even
NOTE Confidence: 0.84100243625
00:46:19.976 --> 00:46:21.520 though she was new to our role.
NOTE Confidence: 0.84100243625
00:46:21.520 --> 00:46:23.038 Obviously there are many other folks.
NOTE Confidence: 0.84100243625
00:46:23.040 --> 00:46:24.120 I can’t mention them all.
NOTE Confidence: 0.84100243625
00:46:24.120 --> 00:46:24.734 I do.
NOTE Confidence: 0.84100243625
00:46:24.734 --> 00:46:26.576 One acknowledge Brian Smith and Tisha
NOTE Confidence: 0.84100243625
00:46:26.576 --> 00:46:29.036 Johnson for all the help and the CTO office,
NOTE Confidence: 0.84100243625
00:46:29.040 --> 00:46:31.112 what they did and what Nancy and
NOTE Confidence: 0.84100243625
00:46:31.112 --> 00:46:33.016 Dan Brown and and Keith Church
NOTE Confidence: 0.84100243625
00:46:33.016 --> 00:46:35.221 will have done as we have think,
NOTE Confidence: 0.84100243625
00:46:35.230 --> 00:46:38.254 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 might chiefs who took on many,

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, I look forward to working with Eric over the next few months to transition. 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 you all can think about what you do and how that helps us eaten every day. We are one academic cancer health
system we have to think about.

Why do we all come here?

Whether it’s the nurses, the staff.

The environment that everyone comes with a calling.

You think this was very clear when I was here during the pandemic and I saw our environmental health services and there was an empty hospital.

But nursing working in units, but quiet that everybody has a calling health care is hard, but it comes from the heart and we all want to think about why
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. I think to do this well, 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, 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 a 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. 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. Just want to say thank you for your incredible service over these past many months. So I can only imagine what has
been involved in running the
complexities of the Cancer Center and.
And the department,
and I think that 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.

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NA TO this is Lori.

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I have to echo Cabman and.

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Since I got here a little over three years ago,

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you were one of the first people that I came to see and the collaboration that you have had with us and cancer from day one has just.

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uh, amazing.

NOTE Confidence: 0.804922945

It’s just been fabulous and

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there’s a part of me that has to apologize a little bit for.

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Trying to get you over here to serve as our interim ’cause

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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
00:52:27.079 --> 00:52:28.665 and thank you from all of us.
NOTE Confidence: 0.84461802
00:52:29.340 --> 00:52:30.150 Thank you, Lori.
NOTE Confidence: 0.842037362352941
00:52:41.370 --> 00:52:43.114 Quiet group, I’m going to give a minute
NOTE Confidence: 0.842037362352941
00:52:43.114 --> 00:52:45.309 or so if someone wants to ask a question.
NOTE Confidence: 0.842037362352941
00:52:45.310 --> 00:52:48.300 It’s alright Roy. Go ahead. I knew
NOTE Confidence: 0.855434557142857
00:52:48.310 --> 00:52:50.798 it’s so thank you. It’s been and will
NOTE Confidence: 0.855434557142857
00:52:50.798 --> 00:52:52.810 continue to work a lot together.
NOTE Confidence: 0.855434557142857
00:52:52.810 --> 00:52:54.316 Great working with you and especially
NOTE Confidence: 0.855434557142857
00:52:54.316 --> 00:52:56.039 as we’ve had to work through
NOTE Confidence: 0.855434557142857
00:52:56.039 --> 00:52:57.367 the clinical trials together.
NOTE Confidence: 0.855434557142857
00:52:57.370 --> 00:52:58.348 It’s just been.
NOTE Confidence: 0.855434557142857
00:52:58.348 --> 00:53:00.304 Your leadership has been just enormous.
NOTE Confidence: 0.855434557142857
00:53:00.310 --> 00:53:01.882 I’ll ask now that you’ve seen
NOTE Confidence: 0.855434557142857
00:53:01.882 --> 00:53:02.668 the Cancer Center.
NOTE Confidence: 0.855434557142857
00:53:02.670 --> 00:53:06.440 And as you go back to be chief of surgery,
NOTE Confidence: 0.855434557142857
00:53:06.440 --> 00:53:08.960 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.

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.

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 as distributed until we came and then some of the folks like Nina and others were incredible champions of taking breast care.
But I think there’s opportunity for us in even. Sites like water, Ferd 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 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.
00:56:44.426 --> 00:56:46.650 I want to give people two minutes back.
NOTE Confidence: 0.922286833333333

00:56:46.650 --> 00:56:49.222 I hope everyone had lunch, but thank you all.
NOTE Confidence: 0.922286833333333

00:56:49.222 --> 00:56:50.787 You are an amazing group.
NOTE Confidence: 0.922286833333333

00:56:50.790 --> 00:56:52.330 We are very large.
NOTE Confidence: 0.922286833333333

00:56:52.330 --> 00:56:55.010 We are strong and I want you to
NOTE Confidence: 0.922286833333333

00:56:55.010 --> 00:56:57.215 acknowledge yourself and I want to thank
NOTE Confidence: 0.922286833333333

00:56:57.215 --> 00:56:59.695 each and everyone of you for making this.
NOTE Confidence: 0.922286833333333

00:56:59.700 --> 00:57:01.770 You know for coming through the
NOTE Confidence: 0.922286833333333

00:57:01.770 --> 00:57:03.150 pandemic and containing growth.
NOTE Confidence: 0.922286833333333

00:57:03.150 --> 00:57:04.305 Thank you everybody.
NOTE Confidence: 0.922286833333333

00:57:04.305 --> 00:57:07.000 Have a great rest of the day.