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.

At this point I’ve been serving as
00:00:35.198 --> 00:00:37.091 your interim Cancer Center director
NOTE Confidence: 0.92371523
00:00:37.091 --> 00:00:40.005 since March 1st and really has been a
NOTE Confidence: 0.92371523
00:00:40.005 --> 00:00:43.030 privilege and a pleasure to get to know
NOTE Confidence: 0.92371523
00:00:43.030 --> 00:00:45.472 this wonderful Community in more detail.
NOTE Confidence: 0.92371523
00:00:45.480 --> 00:00:48.690 Over the past few months next.
NOTE Confidence: 0.92371523
00:00:48.690 --> 00:00:51.237 Slide and I think the other point is of
NOTE Confidence: 0.92371523
00:00:51.237 --> 00:00:53.798 course we’re in this state of anticipation,
NOTE Confidence: 0.92371523
00:00:53.800 --> 00:00:55.480 but mixed in with a little
NOTE Confidence: 0.92371523
00:00:55.480 --> 00:00:57.039 bit of I would say.
NOTE Confidence: 0.92371523
00:00:57.039 --> 00:00:58.704 Also you know what’s coming,
NOTE Confidence: 0.92371523
00:00:58.710 --> 00:01:02.373 and I think everyone seen and met with Eric.
NOTE Confidence: 0.92371523
00:01:02.380 --> 00:01:03.076 And if you haven’t,
NOTE Confidence: 0.92371523
00:01:03.076 --> 00:01:04.420 I know you’re in for a treat.
NOTE Confidence: 0.92371523
00:01:04.420 --> 00:01:06.611 He was in our network committee meeting
NOTE Confidence: 0.92371523
00:01:06.611 --> 00:01:08.572 this morning and a wonderful human
NOTE Confidence: 0.92371523
00:01:08.572 --> 00:01:10.805 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. 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.
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 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,

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 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 be 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.

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.
Think about how we do great and where we have opportunities and 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 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 enter enter or in New Haven.

And how do you conceptualize and deliver all of this transformative 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.

OK, so when we look at this idea of what does the clinical care and of course we then use our SMILLOW standards. The goals we would say is we want to 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, 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 it’s. 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 re establishing care and I will say it’s not all. I think our bar has changed as we come back with all the changes.

Last year we moved from North Pavilion to SRC.
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
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.
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 --> 00:12:10.679 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.
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. And that’s the right intent. Do you know? We need to think about our patients, how we would want to be treated and they want to be seen next day. 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?

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. And then we delivered this tripartite mission. 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 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 I 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 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 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

think phone as you all know, was not reimbursed.

Is is there’s some reimbursement,
00:18:10.230 --> 00:18:11.322 so we encourage video,
00:18:11.322 --> 00:18:13.385 but as we look ahead I don’t
00:18:13.385 --> 00:18:15.160 think you should have banned.
00:18:15.160 --> 00:18:15.986 Until Yelp.
00:18:15.986 --> 00:18:18.051 I think there are opportunities
00:18:18.051 --> 00:18:20.689 similar to what I mentioned around.
00:18:20.690 --> 00:18:22.594 The follow up visits and I’m not.
00:18:22.600 --> 00:18:25.327 I’m what I mentioned early on as we look
00:18:25.327 --> 00:18:28.587 at our care centers and they’re distributed.
00:18:28.590 --> 00:18:30.000 And if you’re thinking of
00:18:30.000 --> 00:18:31.128 an academic health system,
00:18:31.130 --> 00:18:33.380 not everyone has that expertise.
00:18:33.380 --> 00:18:34.440 We look at, you know,
00:18:34.440 --> 00:18:36.282 in every domain and how do
00:18:36.282 --> 00:18:37.510 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.

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 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. 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 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
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 is 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? 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.
00:22:13.100 --> 00:22:15.424 They had the shanavia brain tumor front.

00:22:15.430 --> 00:22:17.586 You saw the announcement earlier this week.

00:22:17.590 --> 00:22:20.630 They also had a U 19 grant with Antonio Amaro and Ranchi and drawn

00:22:20.630 --> 00:22:23.795 launching the therapeutic network.

00:22:23.795 --> 00:22:26.115 They’re continuing to do a lot of clinical trials and

00:22:26.120 --> 00:22:28.700 then for 2022 for this coming year.

00:22:30.510 --> 00:22:32.430 Their goals are to kind of optimize their inpatient services as well as

00:22:32.430 --> 00:22:35.517 launch a PO1 in the future and then.

00:22:35.517 --> 00:22:37.750 I know that they have also a recruitment needs in this group.

00:22:40.020 --> 00:22:42.057 Alright, Next slide. Alright,
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.
00:23:55.800 --> 00:23:57.390 If you’ve already heard continued
NOTE Confidence: 0.846467799166667
00:23:57.390 --> 00:23:58.980 recruitment back to the theme
NOTE Confidence: 0.846467799166667
00:23:59.034 --> 00:24:00.549 of the academic health System,
NOTE Confidence: 0.846467799166667
00:24:00.550 --> 00:24:01.730 Surgical services is broad.
NOTE Confidence: 0.846467799166667
00:24:01.730 --> 00:24:02.615 There are many,
NOTE Confidence: 0.846467799166667
00:24:02.620 --> 00:24:03.841 many department Dr.
NOTE Confidence: 0.846467799166667
00:24:03.841 --> 00:24:06.283 Goshen is our deputy CMO for
NOTE Confidence: 0.846467799166667
00:24:06.283 --> 00:24:08.209 surgical services working across
NOTE Confidence: 0.846467799166667
00:24:08.209 --> 00:24:10.619 the six Department of Surgery.
NOTE Confidence: 0.846467799166667
00:24:10.620 --> 00:24:10.917 Again,
NOTE Confidence: 0.846467799166667
00:24:10.917 --> 00:24:12.699 I’m not going to name the
NOTE Confidence: 0.846467799166667
00:24:12.699 --> 00:24:13.293 multiple recruitments,
NOTE Confidence: 0.846467799166667
00:24:13.300 --> 00:24:15.722 but they’re here and the health system
NOTE Confidence: 0.846467799166667
00:24:15.722 --> 00:24:18.200 thing what has happened and this is.
NOTE Confidence: 0.846467799166667
00:24:18.200 --> 00:24:20.120 It kind of exciting is that we have
NOTE Confidence: 0.846467799166667
00:24:20.120 --> 00:24:22.337 been able to standardize some of the
00:24:22.337 --> 00:24:24.450 treatment delivery across the health system,

00:24:24.450 --> 00:24:26.480 especially in breast and some

00:24:26.480 --> 00:24:28.510 of the more structural works.

00:24:28.510 --> 00:24:29.470 I think looking ahead,

00:24:29.470 --> 00:24:31.286 this is about part of the theme

00:24:31.286 --> 00:24:32.566 of academic health system.

00:24:32.570 --> 00:24:35.705 How do we make sure that patients

00:24:35.705 --> 00:24:37.730 have access to surgical services

00:24:37.730 --> 00:24:39.350 in the health system?

00:24:39.350 --> 00:24:40.862 Doesn’t make a lot of sense for

00:24:40.862 --> 00:24:42.550 surgeons to be going to these sites,

00:24:42.550 --> 00:24:44.188 but how do we think about that?

00:24:44.190 --> 00:24:46.395 That is an opportunity because

00:24:46.395 --> 00:24:48.886 when we look at smilow services.

00:24:48.886 --> 00:24:51.225 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,
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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 --> 00:25:26.265 A lot of patients want to seek that out and need to be really tactical on how we think about that for our patients.

00:25:27.754 --> 00:25:28.390 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, 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, so what we are seeing is every other center. 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.

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

55
the different specialty programs.

Huge complex undertaking.

I want to congratulate this team

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.

Next slide.

the other one as I mentioned
00:28:23.970 --> 00:28:24.870 is this genevier
NOTE Confidence: 0.877241247333333

00:28:24.934 --> 00:28:28.024 fund. As you know we got a $5 million
NOTE Confidence: 0.806033240909091

00:28:28.030 --> 00:28:30.154 grant gift from Lewis and depression
NOTE Confidence: 0.806033240909091

00:28:30.154 --> 00:28:32.973 appear earlier in the year and we just
NOTE Confidence: 0.806033240909091

00:28:32.973 --> 00:28:34.695 announced the three leaders Jennifer
NOTE Confidence: 0.806033240909091

00:28:34.695 --> 00:28:36.570 Moliterno as a clinical director,
NOTE Confidence: 0.806033240909091

00:28:36.570 --> 00:28:39.062 Antonio Morrow as a clinical trials and
NOTE Confidence: 0.806033240909091

00:28:39.062 --> 00:28:41.369 Ranjit Bindra’s or scientific director
NOTE Confidence: 0.806033240909091

00:28:41.370 --> 00:28:43.580 and thinking about destination program.
NOTE Confidence: 0.806033240909091

00:28:43.580 --> 00:28:46.124 And also as we launch our
NOTE Confidence: 0.806033240909091

00:28:46.124 --> 00:28:48.809 neurosciences tower at SRC next slide.
NOTE Confidence: 0.806033240909091

00:28:48.810 --> 00:28:50.650 Now, why you know the how of what
NOTE Confidence: 0.806033240909091

00:28:50.650 --> 00:28:52.587 we do and what does it result?
NOTE Confidence: 0.806033240909091

00:28:52.590 --> 00:28:53.850 And if you look at it again,
NOTE Confidence: 0.806033240909091

00:28:53.850 --> 00:28:55.866 back to this network and how do we make
NOTE Confidence: 0.806033240909091
00:28:58.173 it academic and how do we think about it?
NOTE Confidence: 0.806033240909091
00:29:00.172 It's still relatively young
NOTE Confidence: 0.806033240909091
00:29:02.164 as our integrated system,
NOTE Confidence: 0.806033240909091
00:29:04.594 but we treat roughly 50% of our
NOTE Confidence: 0.806033240909091
00:29:06.329 patients diagnosed in this state,
NOTE Confidence: 0.806033240909091
00:29:08.472 and I think the part which I've
NOTE Confidence: 0.806033240909091
00:29:10.388 mentioned that patients want to be
NOTE Confidence: 0.806033240909091
00:29:12.260 seen especially for you know their
NOTE Confidence: 0.806033240909091
00:29:14.189 day-to-day needs within closer to home.
NOTE Confidence: 0.806033240909091
00:29:16.234 They may want to come for their
NOTE Confidence: 0.806033240909091
00:29:17.110 complicated surgery here,
NOTE Confidence: 0.806033240909091
00:29:18.830 but for the day today.
NOTE Confidence: 0.806033240909091
00:29:20.916 I think thinking from a patient perspective,
NOTE Confidence: 0.806033240909091
00:29:22.705 they want that care closer to home.
NOTE Confidence: 0.806033240909091
00:29:25.054 So the goal is to get that
NOTE Confidence: 0.806033240909091
00:29:26.400 center within 30 minutes,
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.

Captain Simon served 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
00:30:34.325 --> 00:30:36.520 School of Medicine and the hospital

00:30:36.520 --> 00:30:38.698 come for access to clinical trials.

00:30:38.700 --> 00:30:40.610 That’s not just in cancer,

00:30:40.610 --> 00:30:42.908 but if you look in cancer,

00:30:42.910 --> 00:30:44.625 25% of patients are in clinical trials.

00:30:44.630 --> 00:30:46.796 That’s a pretty petty in our

00:30:46.796 --> 00:30:49.226 care sites and then care centers

00:30:49.226 --> 00:30:50.810 deliver 40% of our cancer care.

00:30:50.810 --> 00:30:52.284 So I think you get the idea that

00:30:52.284 --> 00:30:53.526 a lot of patients are patients.

00:30:53.530 --> 00:30:55.539 Are being treated on these care centers,

00:30:55.540 --> 00:30:57.868 but how do we improve upon as the

00:30:57.868 --> 00:31:00.117 next generation is we think about the

00:31:00.117 --> 00:31:02.120 evolution of the karcist centers that

00:31:02.120 --> 00:31:04.148 came together by consolidation of a

NOTE Confidence: 0.9342354
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? 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 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 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
00:33:01.287 --> 00:33:03.610 You can see the rest both Tomahawk,
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
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 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 was done by Katy Perry. Which was led by Boy Herbs and the correlative work for this was 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. But also says that how I think. 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
NOTE Confidence: 0.938774228
00:36:44.064 --> 00:36:46.798 director of basic science research.
NOTE Confidence: 0.938774228
00:36:46.800 --> 00:36:49.712 And as as I mentioned,
NOTE Confidence: 0.938774228
00:36:49.712 --> 00:36:51.044 the Cancer Biology Institute
NOTE Confidence: 0.938774228
00:36:51.044 --> 00:36:52.779 is on the West campus.
NOTE Confidence: 0.938774228
00:36:52.780 --> 00:36:54.691 He’s been able to recruit six members
NOTE Confidence: 0.938774228
00:36:54.691 --> 00:36:56.699 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
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.
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
00:39:29.478 --> 00:39:30.554 and Immunobiology,

NOTE Confidence: 0.938774228

00:39:30.560 --> 00:39:32.821 and Marcus was appointed as the full
time director recently this year.

NOTE Confidence: 0.938774228

00:39:32.821 --> 00:39:34.399 Next slide.

NOTE Confidence: 0.938774228

00:39:34.400 --> 00:39:36.200 So our 84 population and then the sports,

NOTE Confidence: 0.938774228

00:39:36.200 --> 00:39:39.016 which I think you can see the
data for itself,

NOTE Confidence: 0.8895491875

00:39:39.020 --> 00:39:41.281 how much funding they bring in the

NOTE Confidence: 0.8895491875

00:39:41.281 --> 00:39:42.250 leaders of these three scores.

NOTE Confidence: 0.8895491875

00:39:42.250 --> 00:39:43.867 And I think you’ve heard that there’s

NOTE Confidence: 0.8895491875

00:39:43.867 --> 00:39:45.200 goals to at least put one or two new

NOTE Confidence: 0.8895491875

00:39:45.200 --> 00:39:46.796 for population science and the

NOTE Confidence: 0.8895491875

00:39:46.796 --> 00:39:48.877 So Melinda Irvine runs.

NOTE Confidence: 0.793062029523809

00:39:52.600 --> 00:39:53.768 Are is the associate director

NOTE Confidence: 0.793062029523809

00:39:53.768 --> 00:39:55.228 for population science and the

NOTE Confidence: 0.793062029523809

00:39:55.228 --> 00:39:56.598 Next slide.

NOTE Confidence: 0.793062029523809

00:39:56.598 --> 00:39:58.877 sports for the upcoming year next week.

NOTE Confidence: 0.793062029523809

00:39:58.877 --> 00:39:59.519
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, 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 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. 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
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, an early patients diagnosis you know, and helped this patient next.

OK, 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 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. 80 for diversity, equity and inclusion. 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. Really has never made it that even if I called her on a weekend. Never blinked. 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
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, 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
We have to think about why 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. 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, 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 questions 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.

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 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

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you were one of the first people that

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I came to see and the collaboration

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that you have had with us and

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cancer from day one has been just.

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Uh, amazing.

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It’s just been fabulous and

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there’s a part of me that has

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to apologize a little bit for.

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Trying to get you over here to

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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
ingcredible 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 or so if someone wants to ask a question.

It’s alright Roy. Go ahead. I knew it’s been and will 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.

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 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. Well, here’s the world’s best expert in XYZ, and they call me and I answered these phones and I’m like. Well, here’s the world’s best expert in XYZ, and they call me and I answered these phones and I’m like. Every interaction is an educational opportunity and that is what we have.
to do is 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.