May 12, 2026

Faculty Meeting

Topics for today

- Faculty annual review process is open in Workday (Hannah)
- APC biosketch reminder (Hannah)
- APC/APO credentialing reminder for BI/MAH (Hannah)
- OFD Announcement (Jane)
- Announcement (Irene)
- ACGME accreditation (James)
- Incentive Comp (James)
- Faculty presentation (Jenn)
- Faculty presentation (Manny)

Clinical Faculty Recognition Event

May 14th, 5:00-6:30PM in Dana 1620

Join us to celebrate the contributions of DFCI clinical faculty:
Recognize the recipients of the 2026 Clinical Faculty Awards and those promoted on the Institute Titles pathway in 2025.
DFCI President and CEO Ben Ebert to give closing remarks.

Clinical Mentoring award
Jennifer Snaman
Senior Physician/Psychologist
Erik Fromme
Stephanie Tung
Institute Physician/Psychologist
Kate Lally

DFCI OFD Announcements – May 2026

Announcing the Faculty Council

Nomination deadline: May 18th, 2026

The Faculty Council represents the Dana-Farber faculty:
- Aligns and consolidates the work of the CFC/CWF/FIC
- Provides a forum to discuss issues impacting faculty professional development
- Serves as a conduit for sharing key faculty interests with executive and faculty leadership

We encourage interested faculty to submit a nomination (self-nominations welcome) to serve on the Council.

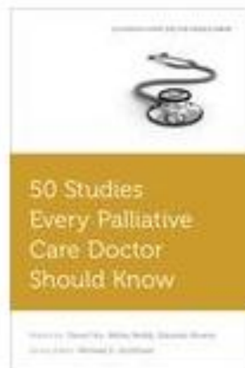
Research Faculty Opportunities	***Clinical Faculty Opportunities***
New Investigator Scientific Symposium	**2026 Clinical Faculty Recognition Event**
May 19th, 2026 @ MIT Endicott House	May 14th, 2026, 5-6:30pm, Dana 1620

Dana-Farber Cancer Institute | Office for Faculty Development

Top PC journal articles for medical students

please email Irene at irene_yeh@dfci.harvard.edu
with your favorite articles to share

Top 25 Studies in Hospice and Palliative Care (#HPMtop25)



50 Studies Every Palliative Care Doctor Should Know

Classic articles (from Block Rounds)

- Groves- Taking Care of the Hateful Patient
- Lazare- Shame and Humiliation in the Medical Encounter
- Balint- The Doctor, His Patient, and the Illness
- Erikson- Eight Ages of Man (book chapter)
- Kleinman- Culture, Illness & Care

ACGME accreditation

- 6 Fellow Positions

Supportive Oncology

Faculty Incentive Program

Academic Year 2027 · July 1, 2026 – June 30, 2027

$329,000	≥20% SO effort	3
Total Bonus Pool	Eligibility	Program Components

PROGRAM COMPONENTS

How Points Are Earned

Clinical Productivity

40%

Metric

- Clinical encounters above divisional threshold

How counted

- Encounter totals converted to points via divisional threshold

Period

- Full academic year (Jul 2026 – Jun 2027)

Academic Scholarship

40%

Papers (prev. calendar year)

- 2 pts — First or last author
- 1 pt — Other authorship

Grants (externally funded)

- 4 pts — Principal Investigator
- 2 pts — Co-Investigator

Scope

- Jan 1 – Dec 30, 2026
- Peer-reviewed only

Engagement Goals

20%

Format

- Two SMART professional goals set during annual review with division chief

Focus areas

- Mentorship
- Education
- Program development
- QI

Note

- Papers & grants excluded from engagement goals

Points self-reported by faculty in the AY27 Workday annual evaluation form prior to annual review meeting

Compliance Requirements and Bonus Calculation

Citizenship Requirements

Must complete by their respective deadlines:

- ✓ All compliance requirements (e.g., Healthstream)
- ✓ Submitted re-credentialing materials
- ✓ Completed annual review materials
- ✓ Fulfilled occupational health requirements

Missed Deadline Penalties

1 deadline missed	**–25% reduction**
2 deadlines missed	**–50% reduction**
3+ deadlines missed	**No bonus paid**

Bonus Calculation & Payment

$329,000

Total AY27 Bonus Pool

Point Value Formula

Value per point = $329,000 ÷ Total points earned by all faculty

Each faculty member's bonus = their point total × point value

Key Dates

Program year: July 1, 2026 – June 30, 2027

Academic products window: Jan 1 – Dec 30, 2026

Bonus paid by: September 30, 2027

Eligibility: SO effort ≥20%; faculty in their first year with the department are not eligible

Jennifer Snaman, MD MS; PACT Clinician Investigator

Work

Clinical

- PACT (25%)
- Pedi neuro-oncology (15%)

Research

- Early parental bereavement
- Communication and decision-making in AYAs
- Co-lead PCAR Lab

Education

- Communication training
- Intersection of pediatric oncology and palliative care

Mentoring

- Clinical PACT Fellows
- SO Research Fellows
- PHO Fellows

Palliative Care and Resilience (PCAR) Lab

https://labs.dana-farber.org/pcar/

- PCAR
  - PCAR PIs
    - Danielle DeCourcey
    - Jenn Snaman
    - Joyce Yi-Frazier
    - Abby Rosenberg
    - Angela Feraco
    - Affiliated PIs
      - Sarah McCarthy
  - Operations
    - Liam Comiskey
      - RA/CRCs
    - Courtney Junkins
      - Coaches, per diem
  - Methods
    - Qualitative
      - Manan Nayack, PhD
    - Biostats
      - Emanuele Mazzola, PhD
      - Li Chen, MS

Mentees, trainees ~20

PACT: Interprofessional clinicians

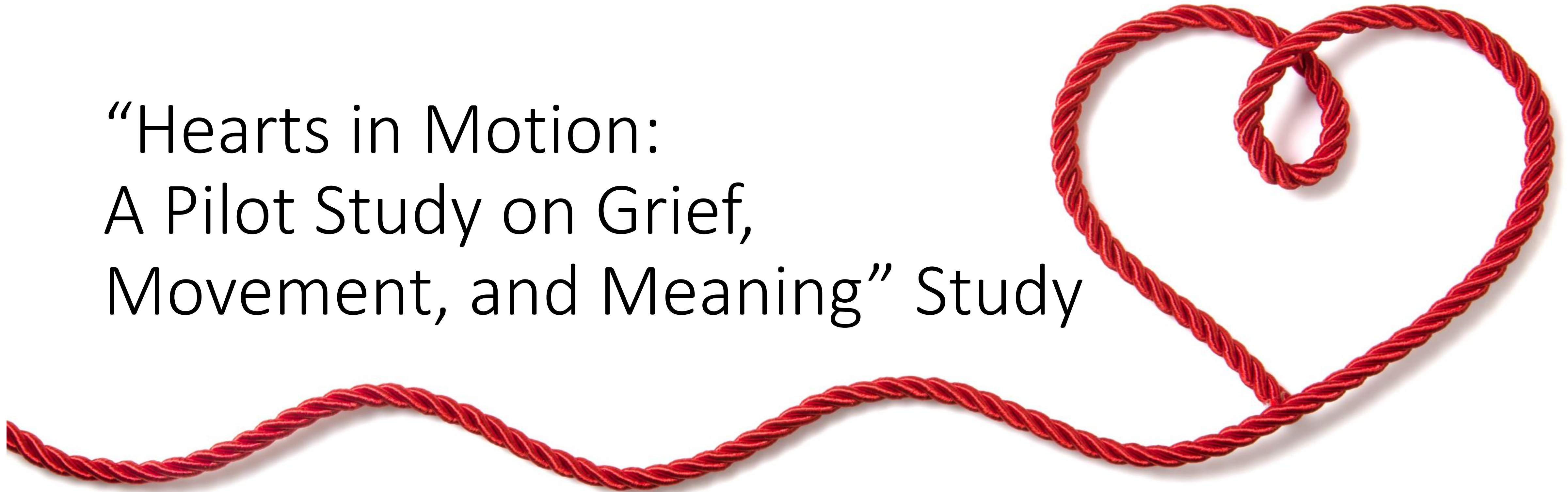
Carlie Hankard, Tiffany Pena

Research team admin support

Collaborating Research Groups

Passion (Project)

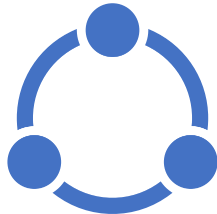
“Hearts in Motion:
A Pilot Study on Grief,
Movement, and Meaning” Study



E-Motion, Inc. is a non-profit organization on a mission to ensure community is a right for all of us. We provide programming for grieving individuals and grief literacy training for organizations, communities and teams. We do this through the power of movement, community, and ritual.

the Movement Community experience

The Movement Community is a 9-week, in-person experience for people who have experienced a life-disrupting loss. Each group includes 10–20 grievers and is guided by a trained E-Motion facilitator. Together, your group will set a shared distance goal—like walking or running a 10K—and follow a weekly movement plan to help you get there.

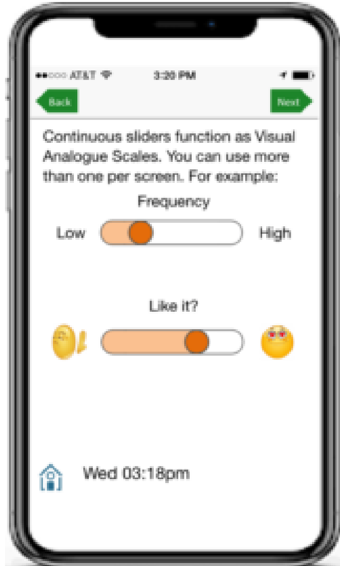


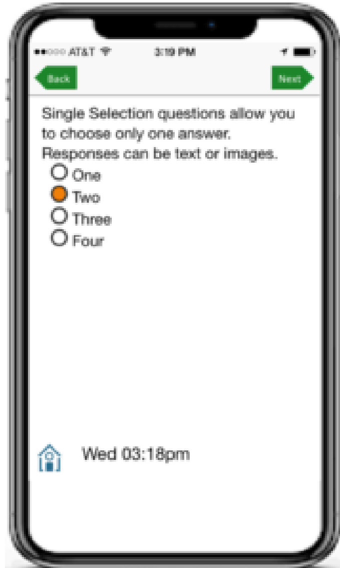
Weekly in-person group movement gathering

Weekly emails from facilitators

Distance goal completion

Dynamic Data & AI-Driven Personalized Baselining





Trigger survey when the average of the 10 most recent samples is at the 10th percentile or above.

Disable triggers between the hours of 9 PM and 7 AM .

Use the Last 10000 samples to establish baseline.

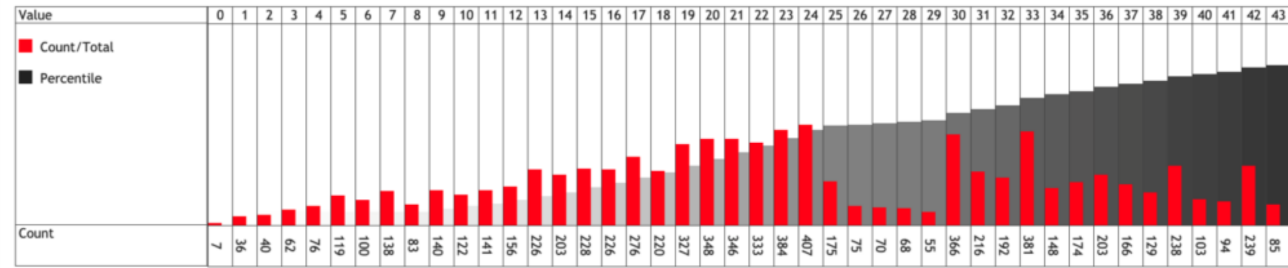
Minimum time between notifications is 15 minutes.

Average value to None .

Round values to the nearest None .

Set Trigger | Delete Trigger | Show Data | Show Daily Avgs

Data from through



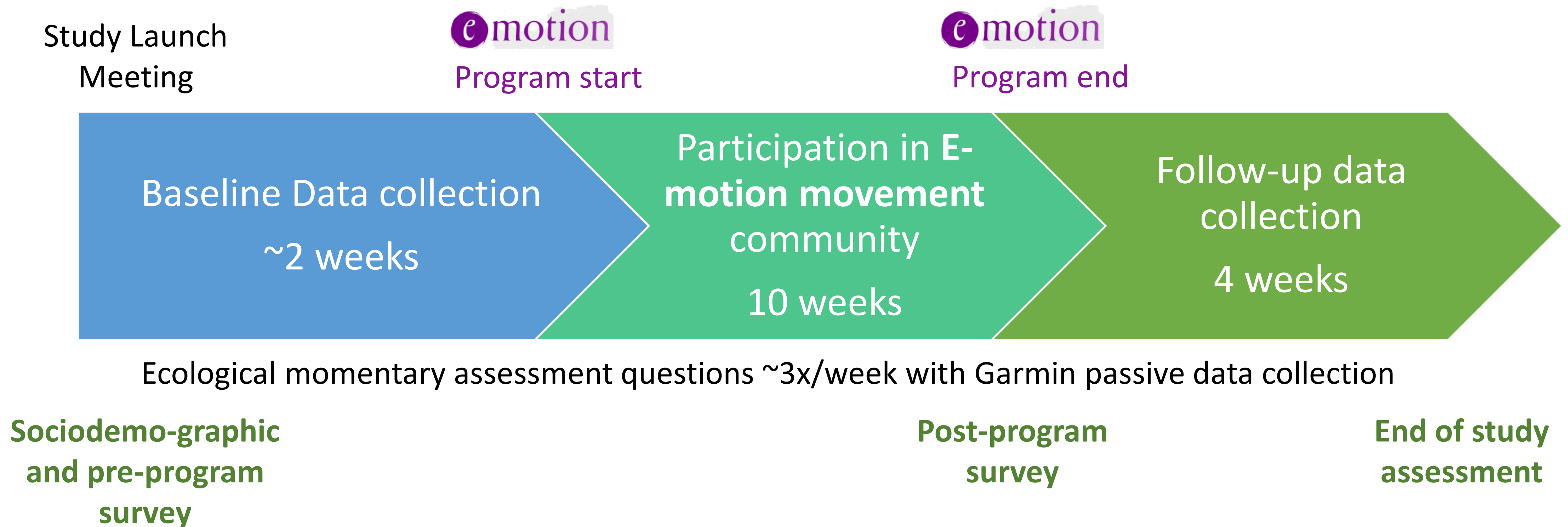
Sample Count	# Vals	Min Val	Max Val	Avg Val	Min Count	Max Count	Avg Count
10000	96	0	95	30.95	1	407	104.17

Value	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Count	7	36	40	62	76	119	100	138	83	140	122	141	156	226	203	228	226	276	220	327	348	346

Value	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43
Count	333	384	407	175	75	70	68	55	366	216	192	381	148	174	203	166	129	238	103	94	239	85

Study Aims

Examine the feasibility, engagement, and explore psychosocial outcomes of a movement-focused grief support model using wearable devices and EMA in N~25 bereaved parents



Data Collection

Data	Source	Details	Baseline	E-Motion	Follow-up
Sociodemo-graphics	Ilumivu app	<10 questions	X		
Grief and psychosocial outcomes, supports	REDCap	~100 questions	X		
Mood, sleep, connection, grief, etc.	Ilumivu app	Single item or brief surveys	X	X	X
HR, sleep, HRV, steps, stress	Garmin device	Continuous monitoring	X	X	X
Grief and psychosocial outcomes, supports	REDCap	~100 questions			X
Acceptability (intervention and E-motion)	Post-survey and interview	Validated questions			X
Feedback on program	Semi-structured interview				X

Hearts in Motion

Currently enrolling
Data collection to begin mid March
Much more (data) to come!!

Special thanks to:

- Sarah McCarthy, PhD
- Becky Aures, MD
- Our amazing research team
  Elizabeth Jin, Briana Tirabassi

Thank you!!
Please reach out:
Jennifer_snaman@dfci.Harvard.edu

SO Faculty Meeting Presentation

MANUEL FANARJIAN, MD

2026 MAY 12

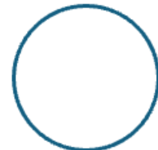
Agenda

Path to DFCI (2 min)

Projects & Demos (8 min)

Q&A (5 min)

Path to DFCI



2024

Palliative Care | Clinical Informatics
Current role

2023

HPM Fellowship
Harvard Interprofessional Palliative Care Fellowship

2021

Digital Health HumanFirst
Led clinical product development at a digital health startup through acquisition by large CRO

2020

Harvard HealthTech
Non-ACGME fellowship in biodesign: health tech design & implementation

2017

Internal Medicine
Residency training in Internal Medicine

2013

Medical School
University of North Carolina SOM

2010

Medical Device
Worked in the CV arm of a large medical device company

2006

Biomedical Engineering
Undergrad degree in BME; focus on medical devices, biosensors

Operational Focus:

- Thoughtful integration of software into clinical workflows
- Institutional architecture for testing, validation, deployment and monitoring of clinical AI
- Operationalization of informatics interventions with demonstrated research efficacy

Ongoing projects to highlight the above:

- Nōta: new patient intake application
- HealthVision
- LLM-enabled patient distress screening

New Patient Intake (Nōta)

The Problem

Gathering, organizing and reviewing historical medical records for new patients in MedOnc clinics is onerous and fraught w/ error

The Solution

A custom-built application that connects with Epic to automatically recognize, organize and summarize medical records for new pts

Status

Pilots complete in Merrimack Valley and NOC. Expansion to BOC, IPC, BCH STAT and TOP is either ongoing or starting soon.

Collaborators (thank you!)

Several across regional campuses and Longwood

Dana-Farber Cancer Institute

New Pat Intake App Service

In Progress

Generate summary

Records | Files | Appointments | **Review Summary**

Search records

All | Labs/Path | Imaging | Notes | Filters

| Imaging
Left ultrasound-guided core breast biopsy

| Path
BREAST PATHOLOGY

| Imaging
MAM BIOPSY CLIP PROCEDURE (RADIOLOGY USE ONLY)

| Imaging
MAMMOGRAM ADDITIONAL VIEW TOMOSYNTHESIS LEFT

| Imaging
SCREENING MAMMOGRAM

| Imaging
MAMMOGRAM ADDITIONAL VIEW TOMOSYNTHESIS RIGHT

| Imaging
SCREENING MAMMOGRAM

| Imaging
FOCUSED Left BREAST ULTRASOUND

| Imaging
SCREENING MAMMOGRAM

| Path
PATHOLOGY REPORT Surgical Pathology Report

Summary

05/07/2026; BOC MD Default

Prompt version: v.3
Created Date: 05/07/2026 7:15 AM

Show/Hide sources

Patient Overview & Cancer Treatment History

-year-old woman with a new diagnosis of left breast invasive ductal carcinoma (IDC), screen-detected on mammography. Diagnostic imaging on identified a 1.3 cm hypoechoic mass at 7:00, 7 cm from the nipple, BI-RADS 4. Ultrasound-guided core biopsy on confirmed invasive ductal carcinoma, well differentiated (Scarff-Bloom-Richardson grade I/III) with associated intermediate-grade, cribriform DCIS and no lymphovascular invasion. Receptor testing showed ER positive and PR positive with HER2 IHC 2+; HER2 was NEGATIVE by ISH (HER2:CEP17 ratio 1.2). Ki-67 proliferation index is 1%. A radiology addendum deemed the pathology concordant and recommended surgical consultation. She is scheduled for medical oncology on and surgical oncology on . Source Source Source Source Source

Personal background and social history (residence, family supports, employment, hobbies, and sources of strength) are not documented in the provided records. Additional history will be important for treatment planning and support needs at upcoming visits.

- **Name (DOB):**
- **Diagnosis (Date of Diagnosis):** Left breast invasive ductal carcinoma, well differentiated; pathology signed Source Source
- **Staging:** Not documented. No nodal assessment or metastatic staging reported.
- **Details of Pathology Report:**
  - Site: Left breast, 7 o'clock, 7 cm from nipple; ultrasound-guided core biopsy (specimen collected Source
  - Histology: Invasive ductal carcinoma, well differentiated (Scarff-Bloom-Richardson grade I/III) Source
  - Size in biopsy: At least 0.8 cm; DCIS present, intermediate nuclear grade, cribriform; LVI absent Source Source Source
  - Ki-67: 1% Source
  - Noted lesion size on imaging/procedure worksheet: 1.3 cm; mass ill-defined Source
- **Genetic Mutations / Receptor Expression:**
  - Estrogen Receptor: "Diffusely (>95%) strongly positive" Source
  - Progesterone Receptor: "Positive (50%) weak staining" Source
  - HER-2/neu: "2+/Indeterminate"; ISH addendum: "NEGATIVE for HER2 amplification by ISH: HER2 : CEP17 ratio 1.2" Source Source

Cancer Treatment Summary:

100% 2 / 27

Outside Information

BREAST PATHOLOGY

Specimen: Tissue

Component 9 d ago

Final Diagnosis

```
A. LEFT BREAST, 7 O'CLOCK, 7 CM FROM NIPPLE, ULTRASOUND-GUIDED CORE
BIOPSY:
INVASIVE DUCTAL CARCINOMA, well differentiated (Scarff-Bloom-
Richardson grade I/III).
Number of cores involved: Multiple.
Tumor measures at least 0.8 cm in this biopsy.
Ductal Carcinoma in Situ: present, intermediate nuclear grade,
cribriform.
Lymphovascular invasion: absent.

 has reviewed this case and agrees with the above
diagnosis.
 is notified about the diagnosis via secure message.

RESULTS OF IMMUNOHISTOCHEMICAL STUDIES
Test: Result
Estrogen Receptor:            Diffusely (>95%) strongly positive
Progesterone Receptor:        Positive (50%) weak staining
HER-2/neu:                              2+/Indeterminate
Ki67 Proliferation Index 1%
Immunostain p63 highlights myoepithelial cells in DCIS.

Notes: Because the HER-2/neu stain result is 2+, analysis for gene
amplification will be done by in situ hybridization, results of which
will be reported in an addendum.

ER: Internal control of normal breast tissue is positive.

Appropriate positive and negative control tissues were reviewed for
all of the reagents.

Time in formalin: 14.5 hours.

Scoring for ER, PR and HER2 is detailed in the CAP/ASCO Breast
Biomarker Reporting guidelines at https://www.cap.org/protocols-and-
guidelines/cancer-reporting-tools/cancer-protocol-templates#protocols
Scores for HER-2 overexpression in breast carcinoma range from 0 to
3+, as detailed in 2018 ASCO/CAP Guidelines (Wolff et al, Arch Pathol
Lab Med 2018; 142:1364-1382).
All antibodies are produced by Ventana Medical Systems, Tucson, AZ,
Clones: ER: SP1, PR: 1E2, HER2: 4B5 (rabbit) and are employed using
the DAB technique. All tests are cleared or approved by the FDA.
Electronically signed by
```

v1.9.0

HealthVision

The Problem

Pertinent information is often buried in unstructured clinical notes (e.g., SIC) or drowning in a sea of EHR noise. ***Needles in a haystack***

The Solution

LLM-generated clinical summaries crafted around specific use-cases: SIC documentation, outpatient intervisit summaries

Status

BRIDGE-SIC pilot completed early this year, preparing to support larger RCT over the coming months. SO Intervisit summary pilot also nearing the starting line

Collaborators (thank you!)

Kelly(!), Kate, Caroline, Yvan, Shannon, Lannie, Charmaine, Meg

HealthVision Encounters

Search all patients

Encounters

Goals of Care

Print

HEALTH

Spotlight

AI Assistant

HISTORY

Conditions

Visits

Goals of care

Summary

is a patient with metastatic pancreatic tail adenocarcinoma who has demonstrated a clear and evolving understanding of his illness throughout his care. Initially focused on recovering from surgical resection and managing his ileostomy, his understanding deepened significantly after the discovery of peritoneal metastasis during his ileostomy reversal in early 2026. He has engaged openly with his oncology team regarding his limited systemic therapy options given prior treatment exposure and residual peripheral neuropathy. He has expressed a strong preference for prioritizing quality of life over aggressive chemotherapy, though he ultimately elected to pursue gemcitabine and nab-paclitaxel for palliative purposes. He carries significant psychosocial burden, including anxiety about his prognosis and deep concern for his wife, who has advancing Alzheimer's disease. He has proactively engaged in estate planning and is preparing for future care transitions for both himself and his wife.

's primary goals have consistently centered on improving his quality of life, with ileostomy reversal representing a major milestone toward that end. He has expressed hope that symptom management will improve with new medications and that he can regain strength between treatment cycles. His main worries include cancer progression, treatment side effects, and his wife's ability to manage daily affairs if he becomes incapacitated. He has found support through palliative care, counseling services, and his family, including his sister and son who serve as designated trustees. The healthcare team has provided prognostic counseling, discussed limited treatment options, and recommended ongoing palliative care support for symptom management and coping. Follow-up plans include continued oncology visits, symptom monitoring, and psychosocial support to help navigate the challenges of his advancing illness.

Serious illness conversations

Patient illness understanding

Note by

We discussed that he has limited systemic therapy options given his prior exposure history. There are no clinical trials currently available for him. His therapeutic options include gemcitabine and nab-paclitaxel readministration or 5-FU and Onivyde. After discussion, he elected to pursue gemcitabine and nab-paclitaxel. We discussed the purpose and prognosis of the treatment of pancreatic cancer. Again, we discussed that he has limited systemic therapy options given his neoadjuvant treatment course. He is very interested in trialing therapy for palliative purposes.

View full note ↗

rcinoma has progressed to the peritoneum, that prior treatments have not been
t information online (increasing his anxiety), and has not yet discussed life expectancy
or palliative purposes."We discussed the purpose and prognosis of the treatment of
b-paclitaxel." "The discovery of metastasis has caused significant emotional distress and
airs. He has not discussed life expectancy with his oncology team but has sought

otherapy, preferring quality of life over treatment given side effects (dislike of 5-FU pump,
ocus on his quality of life and feels that the risks associated with chemotherapy outweigh

with residual cancer after surgery; he was discouraged, with significantly decreased
is."He is discouraged, reports his mental health has been negatively impacted due to the
oing pain. He reports significantly decreased quality of life due to ostomy, especially
near future."

Documented prognosis

- [2026]Metastatic pancreatic tail adenocarcinoma to the peritoneum (KRAS G12V, ATM Y370fs); prognosis guarded with limited systemic therapy options given prior treatment history — patient elected to pursue gemcitabine/nab-paclitaxel for palliative purposes.

Supportive Oncology Collaborative (SOC) Referral Assessment

Patient Info:

Cancer Status: Follicular lymphoma with transformation to diffuse large B-cell lymphoma (DLBCL). Most recent imaging shows progressive disease with Deauville 5 on PET/CT including multistation nodal progression above/below diaphragm, pleural nodules, osseous lesions, and airway/esophageal compression with refractory progression; initiated Polatuzumab/Bendamustine/Rituximab (

SOC Evaluation warranted: Yes
Given refractory, progressive DLBCL with substantial symptom burden (pain, nausea), documented anxiety and care coordination difficulties, and significant social/logistical stressors (transportation, caregiver reliability, finances), a comprehensive psychosocial evaluation and stepped-care support are warranted. Although oncology social work and nurse navigators are involved, ongoing distress is evident (medication confusion, appointment refusal, housing/utility concerns), and the patient is transitioning care locally—an SOC team can optimize coping, behavioral strategies, and align palliative support with active treatment

Severity of suffering: Moderate

Nature of suffering:

- Physical: Recurrent nausea/poor appetite, hypotension requiring IV fluids, thrush, and cancer-related pain up to 7–9/10; active disease causing airway/esophageal compression
- Psychological/emotional: Anxiety noted on problem list; hesitancy transitioning to a new local oncologist and use of coping (moaning) during visits; medication confusion causing worry (allopurinol) .
- Social-relational/logistical: Intermittent caregiver availability, transportation barriers requiring cab vouchers, and financial/utility concerns; one episode of appointment refusal requiring a wellness check .
- Existential/spiritual: Requested prayer/blessing and was connected with spiritual care .

Protective factors:

- Family support identified and engagement with social work, nurse navigator, pharmacy, and resource specialists; lives with daughter and granddaughter in Maine .
- Many symptoms are actively managed by oncology (antiemetics, analgesics, prophylaxis, hydration) with palliative care noted in the problem list and ongoing care transitions planned to a local oncologist

LLM-enabled distress screening

The Problems

1. It's hard to know if the patients most in need of psychosocial support are being referred to the SOC organically
2. It's cumbersome to manually triage those who are referred

Our Approach

Evaluating whether LLM review of 6 months of clinical encounters can identify patients with a high degree of untreated suffering

Status

LLM-generated summaries for 50 patients are undergoing manual review and evaluation by PC/Psych MDs. ETA 4 weeks

Collaborators (thank you!)

- PC: Kate, Charlotta, Caroline, Kelly, Alexis
- Psych: Carrie Wu, Stephanie Tung, Steve Conway, Tim Steinhoff

Q&A

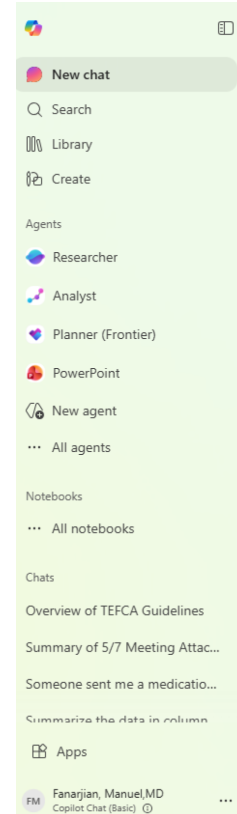
THANKS FOR YOUR TIME!

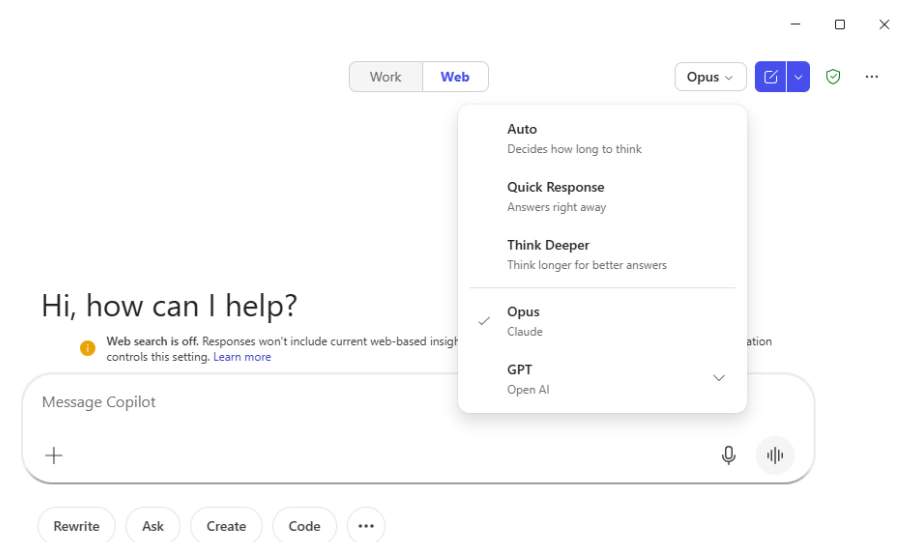
2026 MAY 12

Discussion: Claude by Anthropic

Helpful information from Manny Fanarjian:

- While we work on an enterprise BAA with Anthropic, the best way to access a version of Claude safe for DFCI work is:
- Request a Microsoft 365 Copilot license with this form
- Once approved, in the Copilot app, change the model toggle in the top-right corner from 'Auto' to 'Claude'. See screenshot.





Next meeting: July 23, 2026, 12:00 PM

DFCISOProfessionalDevelopment@dfci.harvard.edu