



THE SANDRA & MALCOLM BERMAN
CANCER INSTITUTE

2016 ANNUAL REPORT

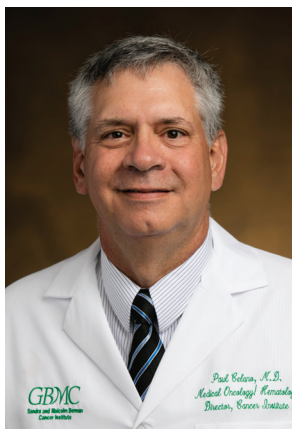
We're
BUILDING
FOR *your*
FUTURE



LETTER FROM THE MEDICAL DIRECTOR

GBMC

**THE SANDRA & MALCOLM
BERMAN CANCER INSTITUTE**



Paul Celano, MD FACP

FRIENDS,

It has been my honor and privilege to assume the leadership of the Sandra and Malcolm Berman Cancer Institute at the Greater Baltimore Medical Center. Our program has been nationally recognized to provide the most compassionate and highest quality care to our patients who are fighting cancer. This past year has been an exciting time for the oncology program at GBMC. We continue to build on our successes from the past and to work toward enriching our services to better care for our patients affected by cancer into the future.

Since the retirement of my friend and mentor Dr. Gary I Cohen, we have added several new key personnel to the cancer program. Medical Oncology has been fortunate to bring on two medical oncologists Rina Patel, MD, and Ari Elman, MD, a new nurse practitioner Melissa Wolf, CRNP, and two new oncology practice nurses, Susan Simeon, RN, and Bonnie Pesacov, RN, AOCN. Radiation Oncology has added Kruti Patel, MD. Karen Pitman, MD, FACS, Otolaryngologist/Head and Neck Surgeon, is now the Medical Director of the Milton J. Dance Center, Jr. along with another Head and Neck Surgeon Ryan Sobel, MD. In addition to our other cancer team members, these providers will enhance our goal of clinical excellence and leadership.

In this era of health care reform, the Berman Cancer Institute is committed to providing the best quality care and value to our patients. The entire GBMC Healthcare system is about to complete a conversion to the EPIC medical information system. This information technology system will greatly increase communication and improve care within GBMC as well as with other medical institutions. We have also established a new pharmacy sub-committee to better assess the value of the plethora of new oncology agents. Clinical pathways are being established to ensure that state-of-the-art care will be provided in the most efficient manner. Finally, plans are underway to establish an Oncology Medical Home to better coordinate cancer care from diagnosis through survivorship.

Our nationally awarded cancer research program continues to grow and expand options for our patients. GBMC is a member of the Eastern Cooperative Oncology Group (ECOG-ACRIN) through Johns Hopkins. We are a principle site for the National Cancer Institute's NRG Cooperative Group as well as several industry-sponsored clinical trials. This allows GBMC to offer a robust array of clinical research trials including the latest in molecularly targeted therapies and immunotherapies. For instance, our cancer patients take advantage of the Molecular Analysis for Therapy Choice trial, known as NCI-MATCH is a phase II precision medicine trial that seeks to determine whether matching certain drugs or drug combinations in adults whose tumors have specific gene abnormalities will effectively treat their cancer, regardless of their cancer type.

GBMC has had excellent multidisciplinary clinical oncology programs in head and neck cancers, breast cancer and gynecological malignancies. We are in the process of developing programs in gastrointestinal cancers, genitourinary, and pulmonary cancers. Please be on the lookout for upcoming patient and medical provider educational offerings. In addition, we will be expanding our cancer survivorship and palliative care services. The Berman Cancer Institute at GBMC is also building a specific program that will address the special needs of elderly patients with cancer. All of these efforts will utilize and integrate the fabulous talents available within the GBMC healthcare system and will result in significant improvement in patient care and satisfaction.

I am very proud of the past accomplishments and commitment of the GBMC cancer program. I am very excited about providing the absolute best in cancer services to our patients and community into the future.

Paul Celano, MD

Paul Celano, MD FACP



BREAST CENTER

Knowledge is Power in Understanding Breast Cancer Risk Assessments

FEATURED PROGRAM



WHY IS A RISK ASSESSMENT IMPORTANT?

The care of breast disease is a rapidly changing field with new and important discoveries and treatment options emerging frequently. Genetic cancer risk assessment has become a medical standard of care option for persons with a personal or family history of cancer suggestive of an increased cancer risk. The greatest experience and application of genetic testing at this time is seen in the evaluation of hereditary breast cancer. Identifying genetic

risk factors enables women to choose among risk reducing interventions such as healthier life style choices, chemoprevention and prophylactic surgery (removal of breasts and /or ovaries).

Sara Fogarty, DO, Breast Surgeon and Associate Director at the Sandra & Malcolm Berman Comprehensive Breast Care Center at GBMC states, “There are many ways we are able to estimate a patient’s risk, detect abnormalities early and treat this disease successfully.” “A risk assessment enables women to understand the likelihood of getting breast cancer and leads to a discussion about interventions to reduce this risk.”



WHAT TO EXPECT

During a risk assessment, the physician inquires about a number of standard personal health details like age, menopausal status, use of hormone replacement therapy (HRT) and parity (which refers to the number of children a woman has borne). He or she will also measure the patient’s body mass index (BMI) and take a family history of first- and second-degree relatives with breast or ovarian cancer, including their ages at the time of diagnosis. The physician uses a computer model to assess the data and can discuss results with the patient during the same visit. The results of the assessment allow the physician to determine when it’s appropriate to begin mammograms for screening, whether the patient is eligible for more extensive MRI screening or genetic testing.

THE BOTTOM LINE

Although patients cannot control some risk factors like family history or age, they can take action on others. Measures that have the most impact on reducing risk include maintaining a healthy weight through diet and exercise, minimizing alcohol use, and minimizing exposures to estrogen. “Breast cancer risk assessments are often the beginning of a conversation between the patient and physician about what the patient can control in order to minimize her risk.” notes Dr. Fogarty. “This is an important first step towards prevention.”

“People should keep in mind that modern medicine has many tools available to estimate a patient’s risk, detect abnormalities early and treat the disease successfully.”

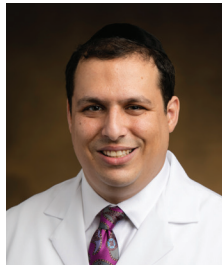
— SARA FOGARTY, DO



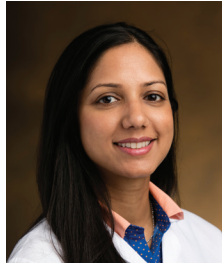
NEW PHYSICIANS

“We continue to build on our successes from the past and to work toward enriching our services to better care for our patients affected by cancer into the future.”

— PAUL CELANO, MD FACP
CHIEF OF THE DIVISION OF
MEDICAL ONCOLOGY, GBMC



ARI H. ELMAN, MD, has joined GBMC as a medical oncologist in the Sandra & Malcolm Berman Cancer Institute. Dr. Elman received his medical degree from the University of Maryland School of Medicine and completed his residency in Internal Medicine at Temple University Hospital in Philadelphia, Pennsylvania. He previously worked at Lankenau Medical Center in Wynnewood, Pennsylvania, where he served as chief resident and as an academic hospitalist. Dr. Elman had his fellowship training in Hematology and Oncology at the University of Maryland Marlene and Stewart Greenebaum Cancer Center in Baltimore, Maryland, and is board-certified in Medical Oncology.



RINA KHATRI PATEL, MD, recently joined GBMC as a medical oncologist in the Sandra & Malcolm Berman Cancer Institute. Dr. Patel earned her medical degree from Case Western Reserve University School of Medicine in Cleveland, Ohio. She completed her residency in Internal Medicine at The Johns Hopkins Hospital in Baltimore, Maryland with the Osler Medical Residency Program, followed by a fellowship in Medical Oncology and Hematology, also at The Johns Hopkins Hospital. Board-certified in Medical Oncology, Dr. Patel is a member of the American Society of Hematology and the American Society of Clinical Oncology.

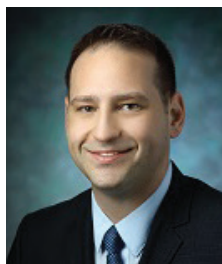


KRUTI PATEL, MD, recently joined GBMC as a radiation oncologist. Dr. Patel earned her medical degree from Stony Brook University School of Medicine in Stony Brook, New York in 2010 and completed her internship in Internal Medicine at Abington Memorial Hospital in Abington, Pennsylvania. She went on to finish her residency training in Radiation Oncology at the University of Maryland Medical Center in Baltimore, where she served as Chief Resident from 2013 to 2014. Dr. Patel is board-certified in Radiation Oncology.



KAREN T. PITMAN, MD, FACS, has been named Medical Director of the Milton J. Dance Jr. Head & Neck Center and Johns Hopkins Head & Neck Surgery located at GBMC. She also serves as co-director of the Johns Hopkins Voice Center located at GBMC.

Board-certified in Otolaryngology-Head and Neck Surgery, Dr. Pitman earned her medical degree from Uniformed Services University of the Health Sciences in Bethesda, Maryland, and completed her residency in Otolaryngology at Naval Medical Center in Portsmouth, Virginia. She went on to complete a fellowship in Head and Neck Oncologic and Cranial Base Surgery at the University of Pittsburgh School of Medicine, Department of Otolaryngology. Dr. Pitman has extensive academic experience and has held multiple military and government positions. Most recently, she served as Interim Chief of Surgical Oncology and head and neck surgeon in the Division of Surgical Oncology at Banner MD Anderson Cancer Center in Arizona.



RYAN H. SOBEL, MD, recently joined GBMC as a head and neck surgeon. He earned his medical degree from the Drexel University College of Medicine and completed his fellowship at Johns Hopkins Hospital for Advanced Training in Head and Neck Oncologic Surgery. Dr. Sobel is also fellowship-trained in TransOral Robotic Surgery (TORS) and minimally invasive surgical approaches in head and neck surgery. He previously served as Director, Head & Neck Surgical Oncology at Inova Dwight and Martha Schar Cancer Institute in Virginia.

NEW SERVICES



◀ LINEAR ACCELERATOR

A new linear accelerator, the Elekta Versa HD is now being used to treat patients. With 3D conformal radiation therapy and Intensity Modulated Radiation Therapy, the treatment volume conforms to the shape of the cancer tumor or region using advanced treatment planning software. This conformal treatment reduces the amount of radiation to surrounding normal tissue and organs and increases the amount of radiation to the target volume. 3D conformal radiation therapy is given by directing high-energy photons beams to the cancer tumor.

Intraoperative Radiation Therapy (IORT) ▶ A New Frontier in Treating Early Stage Breast Cancer

Breast cancer is a diagnosis that one in eight women will receive during her lifetime. It can be a scary and overwhelming experience, filled with doctors' appointments, treatment plan discussions and important decisions to be made. For women whose cancer requires radiation in addition to surgery, treatment itself becomes a time commitment, as they visit the hospital daily over a period of weeks for therapy. GBMC is pleased to offer a new approach to radiation for certain patients. Through intra-operative radiation therapy (IORT), eligible breast cancer patients can receive their entire course of radiation in one session during the lumpectomy surgery. After the breast surgeon removes the lump, a radiation oncologist uses a special device to radiate the area where the tumor used to be. Then the surgeon completes the procedure by closing the site.

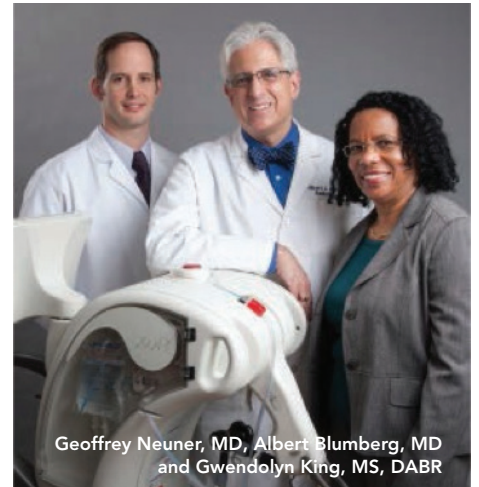
In addition to the convenience of consolidating weeks of radiation treatment into one session, initial findings show that the recovery time is comparable to that of undergoing lumpectomy alone. The risk of cancer recurrence is also similar between IORT and external radiation therapy. "In a select group of women, IORT offers the chance to have a single radiation dose at the time of surgery," explains Lauren Schnaper, MD, Director of the Sandra & Malcolm Berman Comprehensive Breast Care Center at GBMC.

"It is an attractive alternative to repeated whole breast radiation treatments over an extended period of time. Not everyone is eligible

for this type of procedure. The tumor must be a certain size and have favorable behavioral characteristics. IORT is not recommended for young women or those with ductal carcinoma in situ." Albert Blumberg, MD, radiation oncologist at GBMC, elaborates:

"The tumor itself should be deep enough in the breast to allow one centimeter between skin surface and the balloon surface of the radiation device. Ideal candidates are 60 or older, although those in their 50s could be considered if other criteria are met." There appear to be fewer side effects with IORT as well. Since the treatment occurs under the skin and within the breast tissue itself, skin damage and irritation is reduced. With the highly concentrated dose of radiation being precisely directed to the lumpectomy cavity, other surrounding healthy issues and organs, including the lungs, heart and ribs, receive reduced radiation exposure. "This technology is helping women to receive treatment quickly so they can get on with their lives," says Dr. Blumberg.

"We're proud to be able to offer it as an option in their cancer care."



Geoffrey Neuner, MD, Albert Blumberg, MD and Gwendolyn King, MS, DABR



◀ BOUTIQUE

The Boutique Salon and Wellness Center moved from the main hospital to Physician's Pavilion West. The Boutique specializes in services, clothing and accessories to meet the individual needs of women diagnosed with cancer as well as those with alopecia or skin care needs resulting from scars burns or laser treatments. The Boutique offers wigs, scarves, and hats for hair loss, products for skin care and over-all image consultation. A unique selection of clothing, accessories and gifts is always available in the Boutique.



SERVICES

SUPPORT SERVICES

Boutique Salon & Wellness Center
Chemotherapy Educational Sessions
Pet Therapy
Financial Counseling
Financial Support for Eligible Patients
Genetic Counseling
High-Risk Breast Cancer Screening Program
Lymphedema Rehabilitation Services
Music Therapy
Nutrition Counseling
Oncology Certified Nurses
Ostomy Care
Ostomy Support Group
Pain Management
Palliative Care Program
Psychosocial Support for Patients and Families
Survivorship Program
Cancer Registry
Transportation Assistance
Hepatobiliary
Intracranial

MEDICAL ONCOLOGY & HEMATOLOGY

Chemotherapy, including biotherapy
Infusion Center
Inpatient Unit
Leukemia, Lymphoma-Hodgkin's and non-Hodgkin's Lymphoma, Multiple Myeloma and Myelodysplastic Syndrome
Management of Red Cell, White Cell, Leukocyte and Platelet Disorders
Targeted Therapies

SURGICAL ONCOLOGY

Breast
General
GI/Coleorectal
GYN
Head & Neck
Thoracic
Urological

RADIATION ONCOLOGY

Breast HDR Brachytherapy
CT Simulator
Electron Therapy
High Dose Rate (HDR) Brachytherapy
IGRT
IMRT
IORT
Prostate Brachytherapy
Rapid Arc
Respiratory Gating
Stereotactic Ablative Radiotherapy
Stereotactic Radiosurgery (SRS)

SPIRITUAL CARE

Advance Directive Counseling
Caregivers Support Group
Chapel
Spiritual Support Team
Spiritual/Religious Resources

COMMUNITY PARTICIPATION

Cancer Coalition: Baltimore County/Health Departments
American Cancer Society

- Look Good, Feel Better
- Relay For Life

Komen MD
The Red Devils
Hopewell Cancer Support
Zaching Against Cancer
Ulman Cancer Fund for Young Adults
Leukemia & Lymphoma Society
Cancerve
Lunch Cancer Alliance

COMMUNITY OUTREACH

Community Cancer Education
Maryland Cancer Control Plan Steering Committee
Screenings for Prostate, Skin, Oral
Baltimore County Public School System

CLINICAL TRIALS

Breast
Gastrointestinal
Genitourinary
Gynecologic
Head and Neck
Leukemia/Lymphoma/Myeloma
Lung
Melanoma & Skin



Berman Cancer Institute physicians from a variety of disciplines are selected annually as best by their peers for the *Baltimore Magazine's* "Top Doctors" issue.

Providing Cancer Patients with Current and Future State-of-the-Art Care

CLINICAL TRIALS

Clinical trials are a critical, yet often underutilized, component of enhancing cancer diagnosis and treatment options for patients worldwide.

Recognizing this importance, GBMC HealthCare has been participating in clinical trials since 1990, and currently offers more than 50 trials for treatment, diagnosis, side effects and prevention of cancer for a variety of disease sites including breast, colorectal, gynecologic, head and neck, blood, lung, skin, pancreatic and prostate, as well as studies pertaining to weight loss and quality of life.

“Clinical trials are vital to our patients because they give them access to not only current, but also future, state-of-the-art cancer treatments,” says Paul Celano, MD, Division Head of Medical Oncology at GBMC. “The clinical trials program assures our patients that GBMC oncology physicians are committed to providing the very latest care innovations, while helping to advance cancer care.”

All GBMC clinical trials are conducted on campus but are often sponsored or funded by the National Cancer Institute (NCI) or pharmaceutical companies. GBMC’s clinical trials program is a partner in the Johns Hopkins Clinical Research Network (JHCRN), enabling GBMC patients access to open studies offered through Johns Hopkins as well. GBMC is also registered as an independent research site with NRG Oncology through the National Surgical Adjuvant Breast and Bowel Project (NSABP), Radiation Therapy Oncology Group (RTOG) and the Gynecologic Oncology Group (GOG), allowing GBMC to actively participate in ongoing national studies. Additionally, the organization’s oncology physicians serve on several national committees that help to create and administer clinical trials such as the National Institutes of Health, Eastern Cooperative Oncology Group, NSABP and the GOG, among others.

“Many different types of clinical trials exist, and not all of them focus on advanced-stage disease. Some trials treat early stages of the disease, track suspicious nodules and more,” says Madhu Chaudhry, MD, medical oncologist at the Sandra & Malcolm Berman Cancer Institute. “The lengths of the trials vary greatly. Some patients can be on active treatment for months or even years, then remain in follow-up with the study for up to 20 years.” GBMC has enrolled more than 2,000 patients in clinical trials since the inception of the program, and more than 400 patients are currently in the follow-up phase. Noteworthy achievements of GBMC’s program include involvement in major phase III trials involving treatment modalities that have already shown promising results amongst smaller groups of people. Several of these have led to changes in standard cancer treatments and drug approvals, the main example being NSAPB-B31. During this breast cancer trial, which incorporated a two-arm phase III randomized study, all of the patients involved received standard adjuvant chemotherapy and half also received Herceptin®.



Madhu Chaudhry, MD, and Paul Celano, MD

“GBMC oncology physicians are committed to providing the very latest care innovations, while helping to advance cancer care.”

— PAUL CELANO, MD

The difference between the two groups was so significant that the trial led to the approval of Herceptin as a medication for certain types of breast cancer.

“We are not an academic institution, but we are very successful in enrolling patients in important phase III trials,” says Dr. Chaudhry. “We also offer studies that enable patients to receive cancer medications that are not yet available. We believe that the state-of-the-art treatment for cancer is participation in a clinical trial, if available. Patients report that they feel better in helping other patients in the future as well as improving cancer care.”

The clinical trials research team pre-screens all new patients and notifies physicians if a patient meets clinical trial eligibility criteria. Physicians interested in available clinical trials for their patients may visit www.gbmc.org/clinicaltrials for more information about current studies.

PHYSICIAN ANNUAL STUDY

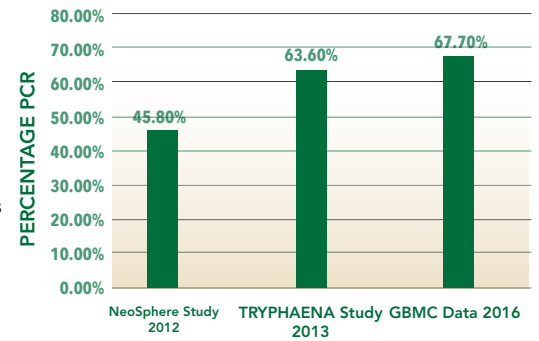
EVALUATION OF PATHOLOGIC RESPONSE IN HER-2 POSITIVE PATIENTS RECEIVING NEOADJUVANT TRASTUZUMAB/PERTUZUMAB

Annual study 2015 (Standard 6.1)
UPDATE 11/10/2016:

Pertuzumab is a HER-2/neu receptor antagonist indicated for treatment of patients with HER-2/positive, locally advanced or inflammatory breast cancer (tumor size > 2cm or node positive based on axillary biopsy). Studies have shown that patients treated with pertuzumab in combination with trastuzumab show an improved efficacy in breast cancer therapy. A multicenter phase 2 study (NeoSphere) published in *Lancet* in 2012 showed an improved pathologic response at time of definitive surgery. Patients who received pertuzumab and trastuzumab in the neoadjuvant

setting in combination with docetaxel had a 45.8% pathologic complete response rate as compared to those given trastuzumab and docetaxel alone (29%). A second trial (Tryphaena study published in *Annals of Oncology*, 2013), showed complete pathologic response rates as high as 63.6% in patients treated with 6 cycles of docetaxel, carboplatin, Herceptin and Perjeta (TCH +P). Evaluation of our data from 2013 to present, 21/31 patients who received neoadjuvant chemotherapy with trastuzumab and pertuzumab showed a complete pathologic response (67.7%).

PATHOLOGIC COMPLETE RESPONSE RATES IN PATIENTS RECEIVING NEOADJUVANT HERCEPTIN/PERJETA



CANCER REGISTRY DATA

GBMC 2015 CANCER SITES

PRIMARY CANCER SITE CANCER SITE	ANALYTIC CASES*	NON-ANALYTIC CASES**	ALL 2015 CASES
HEAD AND NECK			
ORAL CAVITY	56	5	61
PHARYNX	35	3	38
SALIVARY GLAND	11	2	13
LARYNX	24	5	29
NASAL CAVITY/SINUS	9	1	10
OTHER	3	0	3
DIGESTIVE SYSTEM			
ESOPHAGUS	10	2	12
STOMACH	27	4	31
COLON/RECTOSIGMOID	105	7	112
RECTUM	29	4	33
ANUS/ANAL CANAL	14	1	15
LIVER	6	0	6
PANCREAS	38	4	42
OTHER	24	0	24
RESPIRATORY SYSTEM			
LUNG/BRONCHUS	147	6	153
OTHER	2	0	2
BLOOD & BONE MARROW			
LEUKEMIA	24	6	30
MULTIPLE MYELOMA	24	3	27
OTHER	31	4	35
BONE			
CONNECT/SOFT TISSUE	6	2	8
SKIN			
MELANOMA	35	4	39
OTHER	10	3	13
BREAST			
	391	18	409
FEMALE GENITAL			
CERVIX UTERI	35	7	42
CORPUS UTERI	91	4	95
OVARY	27	4	31
VULVA	23	1	24
OTHER	4	2	6
MALE GENITAL			
PROSTATE	105	24	129
TESTIS	4	0	4
OTHER	0	0	0
URINARY SYSTEM			
BLADDER	29	5	34
KIDNEY/RENAL	69	4	73
OTHER	1	0	1
BRAIN & CNS			
BRAIN (BENIGN)	7	0	7
BRAIN (MALIGNANT)	6	0	6
OTHER	0	0	0
ENDOCRINE			
THYROID	74	4	78
OTHER	2	0	2
LYMPHATIC SYSTEM			
HODGKIN'S DISEASE	12	1	13
NON-HODGKIN'S	66	8	74
UNKNOWN PRIMARY	22	0	22
OTHER/ILL-DEFINED	0	0	0
TOTALS	1639	148	1787

* Analytic Cases: Patients either diagnosed or diagnosed and/or received a portion of first course treatment at GBMC.
** Non-Analytic Cases: Patients received first course treatment elsewhere and presented to GBMC with recurrence or progression.

BREAST CANCER SURVIVAL RATES

GBMC 5 YEAR BREAST CANCER SURVIVAL RATES
DIAGNOSED 2009 — OBSERVED

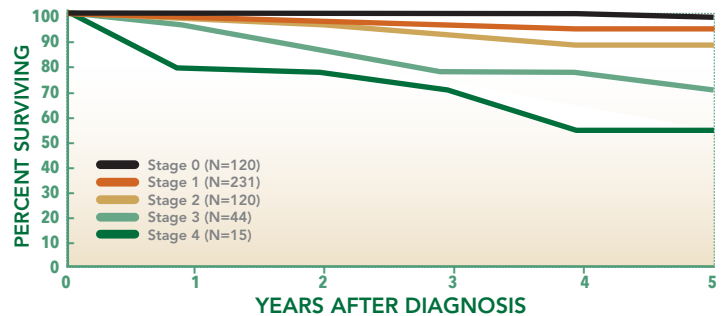


TABLE 8: FIVE-YEAR RELATIVE SURVIVAL RATES*
BY STAGE AT DIAGNOSIS, US, 2005-2011

	ALL STAGES	LOCAL	REGIONAL	DISTANT
BREAST (FEMALE)	89	99	85	26
COLON & RECTUM	65	90	71	13
ESOPHAGUS	18	40	22	4
KIDNEY †	73	92	65	12
LARYNX	61	76	45	35
LIVER ‡	17	31	11	3
LUNG & BRONCHUS	17	55	27	4
MELANOMA OF THE SKIN	92	98	63	17
ORAL CAVITY & PHARYNX	63	83	62	38
OVARY	46	92	73	28
PANCREAS	7	27	11	2
PROSTATE	99	>99	>99	28
STOMACH	29	64	30	5
TESTIS	95	99	96	74
THYROID	98	>99	98	54
URINARY BLADDER §	77	70	34	5
UTERINE CERVIX	68	92	57	17
UTERINE CORPUS	82	95	68	17

*Rates are adjusted for normal life expectancy and are based on cases diagnosed in the SEER 18 areas from 2005-2011, all followed through 2012. †Includes renal pelvis. ‡Includes intrahepatic bile duct. §Rate for in situ cases is 96%.

Local: an invasive malignant cancer confined entirely to the organ of origin. Regional: a malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. Distant: a malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Source: Howlader N, Noone AM, Krapcho M., et al. SEER Cancer Statistics Review, 1975-2012, National Cancer Institute, Bethesda, MD.

http://seer.cancer.gov/csr/1975_2012/, based on November 2014 SEER data submission, posted to the SEER website April 2015. American Cancer Society, Inc., Surveillance Research, 2016

PURPOSE

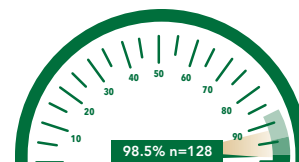
To promote and facilitate high-quality patient care through adherence to clinical quality of cancer care measures by providing accurate, real-time clinical data to the cancer team.

The Rapid Quality Reporting System (RQRS):

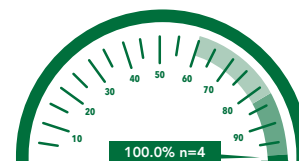
- Allows expedited data entry of a critical subset of items specifically relevant to anticipated standard of care treatments.
- Enables accredited cancer programs to report data on patients concurrently.
- Shows cancer programs up-to-date concordance rates relative to the state, other similar programs, and all CoC accredited programs across the country.
- Provides the hospitals timely notification of treatment expectations.

By participating in RQRS, your cancer program can:

- Improve patient care with access to real clinical time performance rates.
- Evaluate historical performance to compare with current practice.
- Use the information in RQRS to develop real clinical time interventions to enhance the quality of care in your cancer program.
- Monitor and prevent patients from experiencing a delay in treatment or catch patients who are at risk of “slipping through the cracks.”
- Compare performance rates in your cancer program with other participating cancer programs.
- Encourage timely and accurate collection of adjuvant treatment informations.



Tamoxifen or third-generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for woman with AJCC T1cN0M0, or stage IB - III hormone receptor positive breast cancers



Radiation therapy is considered or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women >= 4 positive regional lymph nodes

MASTR Gauge Desc | 2016 National Cancer Data Base | Generated on Sept. 15, 2016

CP3R MEASURES

SITE & MEASURE	COE EXPECTED EXPECTED EPR*	GBMC EPR*	MEASURE DESCRIPTION
BREAST - HT	90%	97.86%	(NQF #0220) Tamoxifen or third-generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor positive breast cancer.
BREAST - BCSRT	90%	93.16%	(NQF #219) Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.
BREAST - NBX	80%	97.86%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer.
COLON - 12 RLN	85%	88.76%	(NQF #0225) At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

**EPR - Estimated Performance Rates*

INTRODUCTION

The success of the Commission on Cancer’s (CoC) Cancer Program Practice Profile Reports (CP3R) have demonstrated that improvements in data quality and patient care are possible when the entire cancer committee supports system-level enhancements to ensure complete and precise documentation.

COE QUALITY OF PATIENT CARE REPORTS

The CP3R (v3) provides feedback to our programs to:

- Improve the quality of data across several disease sites;
- Foster pre-emptive awareness to the importance of charting and coding accuracy;
- Improve clinical management and coordination of patient care in the multidisciplinary setting.

Each year, cancer committees are required to review the quality of patient care using the CP3R to evaluate care within and across disciplines, to discuss successful processes, and to evaluate how processes can be improved to promote evidenced-based practice. The cancer committee is expected to address performance rates that fall below specific thresholds established by the CoC.



COMMUNITY INVOLVEMENT

TOBACCO AWARENESS IN THE SCHOOL-AGE POPULATION



Presentation given to 6th grade assembly at Cockeysville Middle School March 16, 2016.

Karen Ulmer, RN, and Laura Schein

Presented by: Karen Ulmer, MS, RN, CORLN, Otolaryngology Nurse Specialist, The Milton J. Dance, Jr. Head & Neck Center and Laura Schein, BS, Community Outreach Coordinator, Oncology Support Services

In the U.S., tobacco use is responsible for — one in five deaths annually. For every person who dies from a tobacco-related illness, 20 more people suffer with at least one serious tobacco-related illness. Of the roughly 416,000 kids who become new smokers each year, almost 1/3 will die of a tobacco-related illness.

Among adults in the U.S. who smoke, — 91% tried their first cigarette, and 77% became daily smokers, before the age of 20. Each day, 4,000 U.S. adolescents aged 12-17 try their first cigarette.

Early education regarding the risks associated with tobacco use, and avoiding that initial experience, is key to protecting our youth from the dangers of tobacco.



COMMUNITY OUTREACH 2015 ANNUAL REPORT

- Screened 18 men for prostate cancer; three were advised to seek further follow up for high PSA, excluding those with BPH. No prostate cancers were reported.
- Screened 50 participants for skin cancer; 11 were advised to seek follow up, and those same 11 were recommended biopsies.
- Screened eight participants for oral cancer; two were advised to seek follow up with a dentist, primary care physician, ENT, or an oral surgeon. There were no suspicious cancer findings.
- Voice screening examinations for 13 participants, with three referred and no suspected cancers.
- The Lung Cancer Early Diagnosis CT Program utilizes high-resolution, spiral, non-contrast CT scans. One screening was held with 16 high-risk individuals; there were 10 equivocal findings. No one was referred to their primary care physician for non-pulmonary findings.
- Supported several outreach activities and health fairs including those at Oakcrest, T. Rowe Price, and Loyola University; also, Relay For Life Baltimore County-Towson, Light The Night for the Leukemia & Lymphoma Society, and the Senior Expo.
- Continued to provide oncology support programs/services including Look Good Feel Better (62), head & neck patient and family support group (223). Also offered Tasty Tuesday's nutritional education series (58). The Caregiver Celebration provided support and activities for roughly 30 people. The Annual Survivorship Celebration had over 300 attendees.

SUPPORTED NUMEROUS OUTREACH ACTIVITIES, HEALTH FAIRS, AND COMMUNITY EVENTS:

- North Baltimore County Relay For Life Kick-off: January 31
- MD School For the Blind Employee Health Fair: March 17
- Loyola College Health Fair: April 14
- HopeWell Cancer Support Reach Out And Run: April 19
- Medical Mutual: April 29
- Towsontown Festival: May 3
- Melanoma Monday: May 4
- McCormick Health Fair: May 11
- T. Rowe Price Health Fair: May 12
- GBMC Employee Health Fair: May 14
- Komen MD Breast Cancer Consortium: May 28
- WBCM Health Fair: June 2
- Relay For Life North Baltimore County-Towson: June 13 (Raised \$3,200 as a team!)
- Annual Survivorship Celebration: June 14
- Father's Day 5K & Wellness Fair: June 21
- GBMC-Hopkins Gynecological Survivor Symposium: September 19
- GBMC Legacy Chase: September 26
- Senior Expo: October 28-29
- Cancer Caregiver Event: November 5-6
- Leukemia & Lymphoma Society Light The Night: November 14

Submitted by: Laura Schein, Community Outreach Coordinator

CANCER COMMITTEE

Paul Celano, MD (Medical Director/Committee Chair)
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Sara Fogarty, DO (Breast Center)	Michael Stein, CMPE (Exec Director/Ca Program Admin)
Connie Herbold (Cancer Center)	Vanessa Stinson, CTR (Cancer Registry)
Alan Kimmel, MD (Ctr for Rehabilitation)	

COMMITTEES



Our patient-focused cancer conferences put the patient at the center of treatment options available.

MULTIDISCIPLINARY CONFERENCES

Our patient-focused cancer conferences put the patient at the center of treatment options available. Each patient presented at the cancer conference has a team of experts who collaborate, all in one room, to design and deliver the most comprehensive recommendations tailored to each individual patient. Team members include medical oncologists, surgical oncologists, radiation oncologists, pathologists, radiology, clinical trials, and genetics counselors, all dedicated to develop the best treatment plan for each individual patient, utilizing the NCCN guidelines.

- Breast
- GYN
- Head & Neck
- Medical Oncology
- Palliative Care
- Radiation Oncology
- Rehabilitation/Lymphedema
- Psychosocial Rounds
- Thoracic
- Urology

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