



Community Cancer Program 2019 Annual Report



STATISTICAL DATA FROM 2018

CANCER COMMITTEE UPDATE

A letter from the Chairman of the Cancer Committee

The 4th Earl of Chesterfield—or perhaps it was a French painter in the days of Louis XIV—wrote to his son, “Whatever is worth doing at all, is worth doing well.” Likely you thought this trenchant piece of advice is just something your parents told you to encourage excellence in your schoolwork, or at least to avoid a sloppy result from doing your chores begrudgingly and carelessly. But this is wisdom. Who wants less than the best results from the things that we do? Who is willing to settle for second? Why not strive for the top prize, the brass ring, the gold medal? Nowhere is this more applicable than in medicine, and within the broad scope of medical practice particularly the care of people with cancer, when so much is on the line.



CalvertHealth has established itself firmly in the front ranks of hospital excellence in the state of Maryland. Our quality scores are second to none. The diligent hard work and dedication to providing quality medical care and ensuring patient safety that characterize the health system as a whole are abundantly evident within our Oncology Service.

At the end of last year, the American College of Surgeons Commission on Cancer (CoC) awarded CalvertHealth accreditation with commendation, providing official national recognition of our commitment to quality cancer care. Commission representatives were notably impressed by studies conducted by a team headed up by Dr. Arati Patel; the findings of one study have been adopted by the CoC as a best practice.

This year we are about to initiate a cooperative study with an outside organization to ensure that our patients with multiple myeloma, a challenging and complex bone marrow cancer, the management of which is undergoing rapid evolution, receive treatment according to the best, most contemporary information available. The several multidisciplinary cancer management conferences that occur several times a month bring together cohesive, integrated teams of caregivers that can assess patient care from complimentary perspectives and produce consensus plans for treatment of the cancers affecting individual persons with attention to individual needs.

In our ongoing efforts to communicate with increasing effectiveness to and with our community, we have produced a new website for our Oncology Service. This year you will have the opportunity not just to learn from a wide variety of published articles on cancer subjects but to participate in this process by submitting questions of general interest, such that you will help us pay attention to the matters that are on your mind. And so we will form a partnership, steering the care of persons with cancer forward into the second century of CalvertHealth.

A handwritten signature in black ink, appearing to read "K. Abbott".

Kenneth Abbott, MD
Medical Oncologist
Chairman, Cancer Committee

CalvertHealth 2019 Cancer Committee

The members meet regularly to review and evaluate the quality and direction of the overall cancer program, and make recommendations for improvement.

Kenneth Abbott, MD
Medical Oncologist
Cancer Committee Chair

Bilal Ahmed, MD
Medical Oncologist

Ervind Bhogte, MD
General Surgeon

Sandra Cassell-Corbin, CRNP
Clinical Research Coordinator

Mary Golway, RN
Community Outreach Coordinator

Nicole Hedderich, MHA, BSN, RN, CPHQ
Clinical Quality Improvement
Coordinator

Brianna McKenzie, RHIT, CTR
Certified Tumor Registrar
Cancer Conference Coordinator

Stacey Newman, LSWC
Social Worker
Psychosocial Services Coordinator

Richard Mapp
Cancer Registry Quality Coordinator

David Sacks, LCSW-C
Palliative Care Representative

Glenn Selman, MD
Diagnostic Radiologist

Kathleen Settle, MD
Radiation Oncologist

Christine Shipley, RN, OCN, MSN
Oncology Nurse

Kasia Sweeney
Cancer Program Administrator

Theodore Tsangaris, MD
Cancer Liaison Physician

Nancy Ulanowicz, MD
Pathologist

STATISTICAL SUMMARY of CANCER CASES at CALVERTHEALTH MEDICAL CENTER

Calendar Year 2018 Statistics (January 1-December 31, 2018)

Patient Demographics

Data from the American Cancer Society's Facts and Figures for 2018 estimated that there would be over 1,735,350 new cancer cases in 2019, some 33,810 diagnosed in Maryland.

In 2018, there were 208 new cancer cases accessioned at CalvertHealth. Of the 208 new cancer cases, 195 were analytical cases and 13 were non-analytical cases. Analytic cases are those diagnosed at our hospital, or we received all or part of their initial course of treatment here. Non-analytical were seen to recurrent or progressive diseases.

Medicare was the primary insurance coverage for 49% of the patients, followed by private insurance at 37%, non-insured at 4% and all others (including Medicaid and insurance not specified) at 10%.

Sex distribution shows 39% male and 61% female. Race distribution included: 88% White, 11% Black, .5% Filipino and .5% Other Asian.

Top 5 Sites:

Figure 4 (opposite page) summarizes the top five primary sites for 2018, which includes breast (73 cases), lung (15 cases), urinary bladder (15 cases), prostate (11 cases) and colon (11 cases).

Figure 1: 2018 Analytic vs Non-Analytic Data

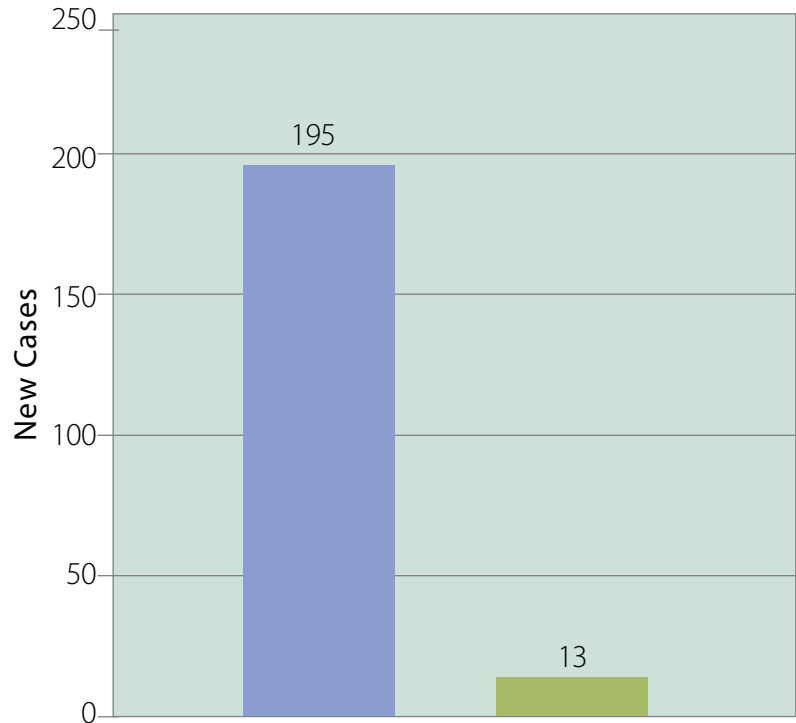
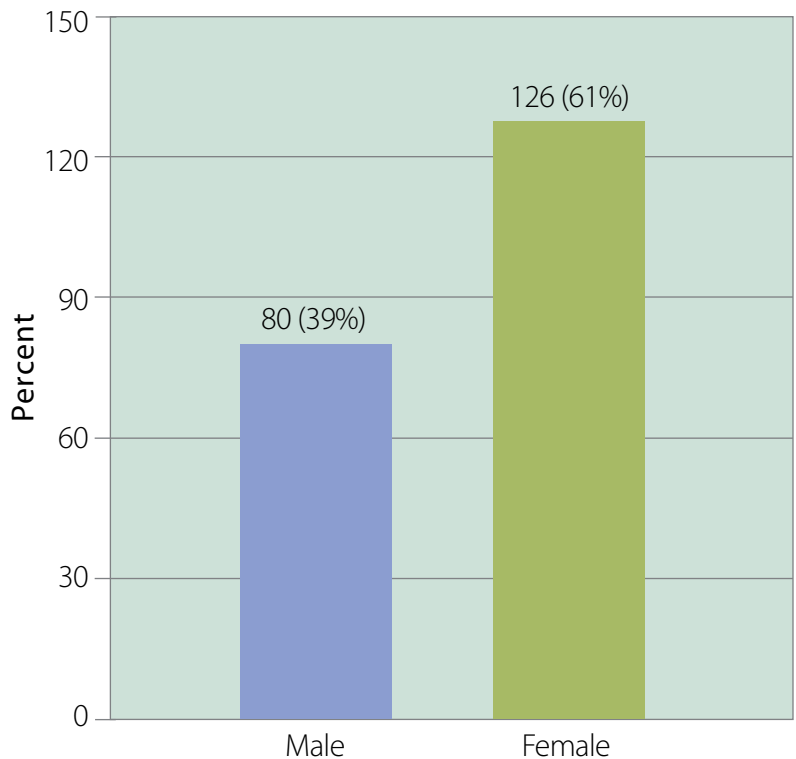


Figure 2: 2018 Gender Distribution at CHMC





**Commission
on Cancer®**
ACCREDITED PROGRAM

CalvertHealth Cancer Care Earns Accreditation with Commendation

In 2019, CalvertHealth Medical Center's oncology program was granted a three-year accreditation with commendation by the American College of Surgeons Commission on Cancer (CoC). This is the highest level of accreditation that can be awarded. Earning this distinction demonstrates our commitment to providing high-quality, patient-centered care. To earn CoC accreditation, a cancer program must meet or exceed 46 quality care standards and undergo a rigorous onsite survey every three years. This accreditation is recognized by the National Cancer Institute, Centers for Medicare and Medicaid Services, The Joint Commission and the American Cancer Society. When cancer patients choose to seek care at a CoC-accredited cancer center, they can be assured they are gaining access to the most-up-to-date, comprehensive, cancer care – from outreach and screening to diagnosis, treatment and survivorship.

Figure 3: 2018 Race Distribution

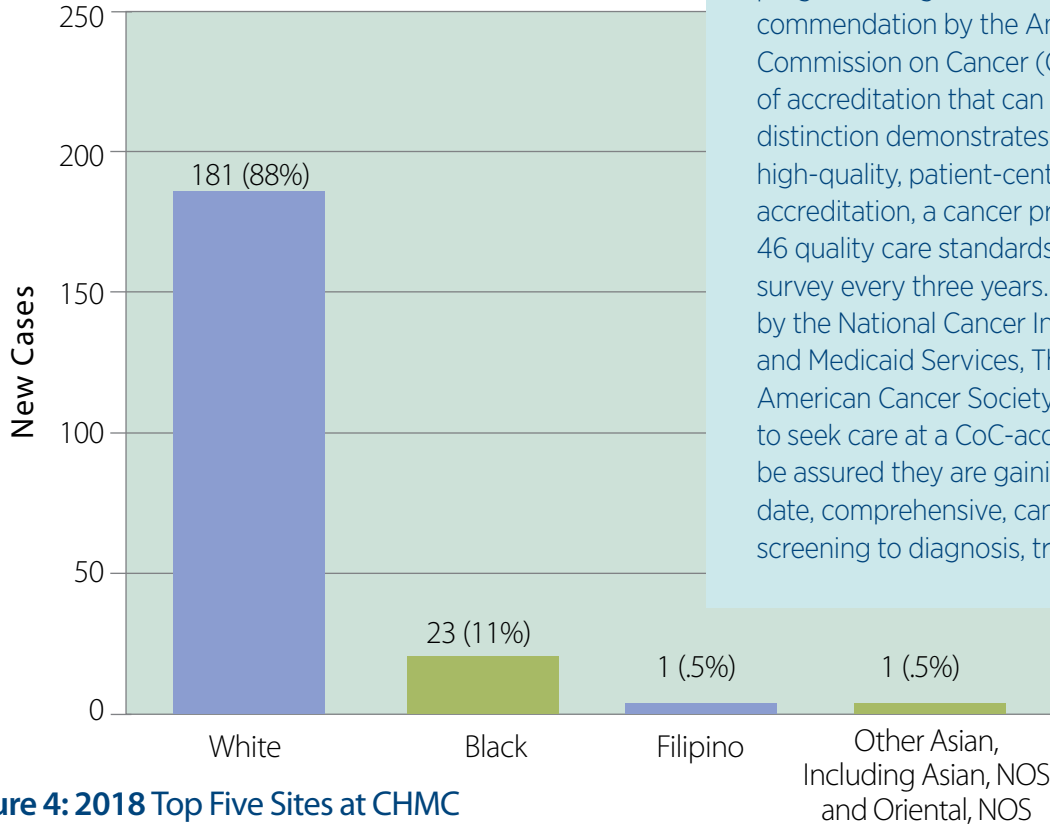
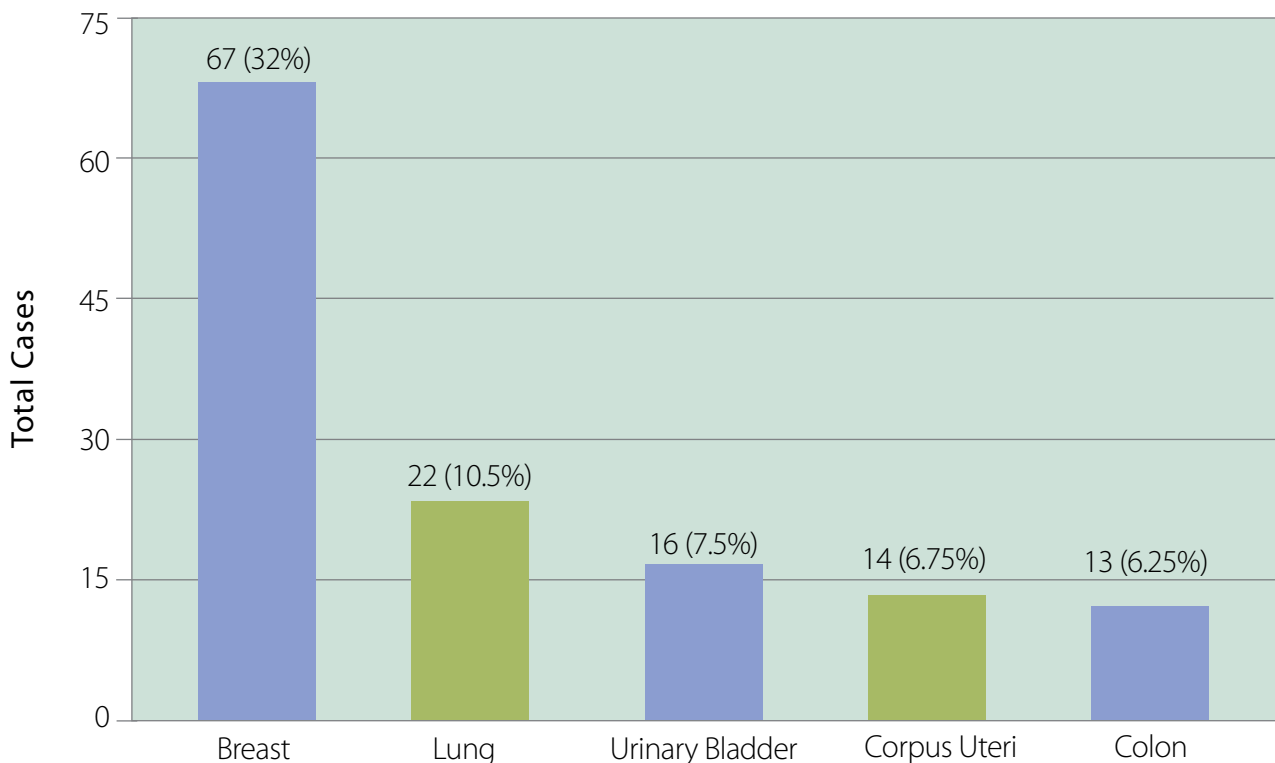


Figure 4: 2018 Top Five Sites at CHMC



STATISTICAL SUMMARY of CANCER CASES at CALVERTHEALTH MEDICAL CENTER

Calendar Year 2018 Statistics (January 1-December 31, 2018)

Summary of Body System and Sex Report

DISEASE SITE	MALES	FEMALES	TOTAL
TOTALS	69 (100.00%)	123 (100.00%)	192 (100.00%)
Lip / Oral Cavity / Pharynx	1 (1.45 %)	1 (0.81 %)	2 (1.04 %)
Esophagus	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Stomach	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Small Intestine	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Colon	6 (8.70 %)	5 (4.07 %)	11 (5.73 %)
Rectum	2 (2.90 %)	0 (0.00 %)	2 (1.04 %)
Anus	0 (0.00 %)	2 (1.63 %)	2 (1.04 %)
Liver	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Pancreas	6 (8.70 %)	3 (2.44 %)	9 (4.69 %)
Other Digestive Organ	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Larynx	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Lung	7 (10.14 %)	8 (6.50 %)	15 (7.81 %)
Other Respiratory	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Bones and Joints	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Soft Tissue	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Melanoma - Skin	3 (4.35 %)	4 (3.25 %)	7 (3.65 %)
Kaposi Sarcoma	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Mycosis Fungoides	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Other Skin	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Breast - Female	0 (0.00 %)	73 (59.35 %)	73 (38.02 %)
Breast - Male	3 (4.35 %)	0 (0.00 %)	3 (1.56 %)
Cervix	0 (0.00 %)	2 (1.63 %)	2 (1.04 %)
Corpus Uteri	0 (0.00 %)	11 (8.94 %)	11 (5.73 %)
Ovary	0 (0.00 %)	1 (0.81 %)	1 (0.52 %)
Other Female Genital	0 (0.00 %)	3 (2.44 %)	3 (1.56 %)
Prostate	11 (15.94 %)	0 (0.00 %)	11 (5.73 %)
Other Male Genital	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Urinary Bladder	11 (15.94 %)	4 (3.25 %)	15 (7.81 %)
Kidney	0 (0.00 %)	1 (0.81 %)	1 (0.52 %)
Other Urinary	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)
Eye and Orbit	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Brain and Nervous System	0 (0.00 %)	2 (1.63 %)	2 (1.04 %)
Thyroid	0 (0.00 %)	1 (0.81 %)	1 (0.52 %)
Other Endocrine System	0 (0.00 %)	0 (0.00 %)	0 (0.00 %)
Non-Hodgkin Lymphoma	4 (5.80 %)	2 (1.63 %)	6 (3.13 %)
Multiple Myeloma	3 (4.35 %)	0 (0.00 %)	3 (1.56 %)
Other Hematopoietic	5 (7.25 %)	0 (0.00 %)	5 (2.60 %)
Unknown Sites	1 (1.45 %)	0 (0.00 %)	1 (0.52 %)

Exclusions: All non-analytic cases and patients diagnosed at Calvert who received treatment at another facility.

Cancer Program Quality Study 1: Early Identification of Neutropenic Fever

IDENTIFIED PROBLEM/ISSUE:

Administration of antibiotic therapy within 2 hours of arrival for patients presenting to CalvertHealth Medical Center (CHMC) Emergency Department (ED) with Neutropenic Fever. Eligible patients are those who have a cancer diagnosis and recent chemotherapy with Absolute Neutrophil Count (ANC) less than or equal to 1000 cells/mcL, temperature greater than or equal to 38.3° C (101° F); or a temperature greater than or equal to 38.0 C (100.4° F) lasting at least an hour. *Delay in administration can cause progression to sepsis.*

STUDY METHODOLOGY/CRITERIA FOR EVALUATION:

Plan-Do-Check-Act methodology was used to evaluate patients >18 years of age who presented to the ED between CY2015-CY2017 with a diagnosis of neutropenic fever. Guidelines established by the Infectious Disease Society of America (IDSA) were chosen as the standard of care for evaluation of the neutropenic patient population. Neutropenic fever was defined as patients with a cancer diagnosis and recent chemotherapy (30 Days) with ANC less than or equal to 1000 cells/mcL and a temperature greater than or equal to 38.3C (100.4F) lasting at least one hour.

COMPARISON WITH NATIONAL BENCHMARKS OR GUIDELINES:

IDSA (*Infectious Disease Society of America*) guidelines were used to compare CHMC performance against evidence-based practice.

SUMMARY OF FINDINGS:

A review of data provided found that in CY15, 6 patients met the criteria to activate the neutropenic fever protocol and of these 6 patients, 3 (50%) received antibiotics within two hours of arrival at Emergency Department. In 2016, 4 patients met the criteria to activate the neutropenic fever protocol *and of these 4 patients*, 1 (25%) received antibiotics within the required two hours of arrival at Emergency Department. Finally, in 2017, 3 patients met the criteria to activate the neutropenic fever protocol and of those 3 patients, all 3 (100%) received antibiotics within two hours of ED arrival. In total during the period of study 13 patients met the criteria to activate the neutropenic protocol and of these 13, 7 (54%) received antibiotics within the required two hours of arrival at the Emergency Department.

DATE	CHEMOTHERAPY

DESIGN CORRECTIVE ACTION PLAN BASED ON EVALUATION OF DATA:

Patient chemotherapy ID wallet cards were developed with the oncology nursing staff (*pictured above*). Patients receiving chemotherapy now receive a wallet card at the patient's nurse education visit in the Hematology/Oncology office. The patient is educated to present the chemo ID card to the registration staff at the ED if/when the patient requires emergent care. After a short trial on the process for patient education and dissemination, the chemo ID wallet cards were implemented at CalvertHealth to assist Emergency department (ED) staff and providers in better identifying patients who may be at risk for chemotherapy induced neutropenia and/or infections that require quick intervention. In addition, an in-patient admission neutropenic order set and ED neutropenic order set were developed using evidence-based treatment guidelines and implemented at CalvertHealth. Last but not least, in an effort to better standardize the identification of those presenting with neutropenic fever to CalvertHealth, an educational presentation by one of our oncologists was presented to the CalvertHealth ED physician group on neutropenic fever and other chemotherapy and immune therapy related complications that may be encountered within the emergency department. The ED nurses received education by the ED nurse educator and the registration staff were included in the education process.

Dates Reported To Medical Staff/Administration: 11/5/2018

Dates Reported To Cancer Committee: 9/13/2018; 12/13/2018

2019 FOLLOW UP/OUTCOMES:

In 2019, we reviewed our processes to ensure adherence to the protocols that were established. Data was collected showing an improvement from 54% of eligible patients treated within 2 hours to 83% of eligible patients treated within 2 hours. The denominators are small so the committee agreed to continued monitoring and ongoing educational for ED providers and nursing staff.



Cancer Program Quality Study 2: Minimizing Time to Diagnosis for Lung Cancer Patients Undergoing Lung Biopsy Procedures

IDENTIFIED PROBLEM/ISSUE:

Lung cancer is the leading cause of cancer related deaths worldwide in part related to the advanced stages of presentation and the aggressive nature of the disease. Early detection and timely diagnosis directly impacts improvements in survival and prognosis. Delays in diagnosis can result in progression of disease, worsening of patient related symptoms and most importantly can lead to delays in cancer related treatments. Furthermore, this type of delay in care is associated with significant physical and emotional distress for the patient and family. At our institution, we have developed a thoracic oncology program and meet regularly for multidisciplinary tumor board discussions on diagnostic testing and comprehensive treatment planning. It became apparent that in certain circumstances, we were unable to establish a malignant diagnosis in a timely manner. This knowledge lead us to review all of our consecutive diagnostic thoracic procedures and the corresponding pathologic specimens obtained over a one year time period. We recognized that when the initial pathologic review of a thoracic specimen was non-diagnostic, there was a need for additional diagnostic procedures. This resulted in a delay in diagnosis and a missed opportunity for our medical team to initiate therapy in a timely manner. A careful analysis of possible explanations for this error in diagnosis, has lead us to implement several remedies to address these issues.

STUDY METHODOLOGY/CRITERIA FOR EVALUATION:

Plan-Do-Check-Act methodology was used to evaluate cases for CY2017 who underwent a lung biopsy. A retrospective review of all consecutive lung specimens collected at CalvertHealth including information regarding the manner in which the specimen was obtained (*i.e. CT guided vs. Bronchoscopy*) and the proceduralist obtaining the specimen. Classification of malignant versus non-malignant was also analyzed.

COMPARISON WITH NATIONAL BENCHMARKS OR GUIDELINES:

The National Cancer Institute (NCI) at the National Institutes of Health guidelines state as a best practice a physician receiving pathology reports from the pathologist should occur within 10 days of the biopsy or surgery. **CalvertHealth utilized the NCI guideline to ensure that pathology reports are received and reviewed from pathologist within 7-10 days following a biopsy or surgery.** This does not include additive molecular and ancillary testing.



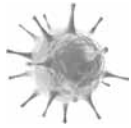
This Quality Study was named a Top 20 entry for the Maryland Patient Center's 2020 Minogue Award for Patient Safety Innovation.

SUMMARY OF FINDINGS:

During the calendar year of 2017, there were 67 diagnostic thoracic procedures performed at CalvertHealth by 3 separate proceduralists (A,B,C). Proceduralist A, performed a total of 34 diagnostic bronchoscopies, 25 with lavage and 9 with lavage and additional needle biopsy. CT guided biopsies were performed by Provider B and Provider C who performed 25 procedures, 8 with lavage and additional needle biopsy respectively. The focus of our analysis was on our diagnostic capabilities with regard to cancer, therefore we excluded all biopsies in which malignancy was not suspected pre-operatively (*31 cases excluded from the sample*). In addition, we excluded an additional 20 cases where there was a positive identification of malignancy at the time of the initial diagnostic procedure. The average time to confirmation of diagnosis in this group of 20 patients was 3 days. The standard of care, as established by the National Cancer Institute from the time of diagnostic procedure to finalized pathology results is 7-10 days. That left a sample size of 16 cases where malignancy was suspected pre-operatively however, the initial specimen was negative for malignant cells. In 7 of these cases, a diagnosis of cancer was ultimately made following a subsequent invasive diagnostic thoracic procedure. The average time to confirmation of diagnosis in this group of 7 patients was unfortunately 3 months. We were able to demonstrate that a non-diagnostic first invasive lung procedure resulted in the need for additional invasive testing and a delay in rendering a diagnosis of malignancy.

DESIGN CORRECTIVE ACTION PLAN BASED ON EVALUATION OF DATA:

We performed a comprehensive retrospective review of the 7 procedures that were associated with a delay in diagnosis, and analyzed the cases according to pre-pathologic evaluation and post-pathologic evaluation as possible



Members of the multidisciplinary thoracic team at Calvert meet regularly to actively collaborate on treatment planning.

explanations for the non-diagnostic results. For example, location of the tumor, type of procedure, expertise of the proceduralist, patient comfort during procedure, tissue necrosis, adequacy of specimen collection, appropriate preservation of the specimen and time interval to the pathology lab can all impact the ability to identify malignant cells in the specimen. Examples of post pathologic issues impacting diagnosis include expertise of the pathologist, specimen processing and handling, specialty testing involved, and communication of the pathologist with the proceduralists. Five of the 7 cases were performed by proceduralist A, using bronchoscopy assisted lavage, with 3 of these procedures also including bronchoscopy-obtained needle biopsy. In all of these cases, inadequate sampling was identified as the primary cause of negative biopsy results. Proceduralist A reviewed the entire process with the manufacturer of bronchoscopy equipment, the nursing team and the pathology department. It was determined that the saline preservative that was being used by this proceduralist resulted in a degradation of the malignant cells within 16 hours, which was the time interval between specimen retrieval and pathology review. Following communication between the pathologist and proceduralist, the preservative was switched from saline to formalin and procedure check lists were developed to ensure consistency of the procedure(s) and materials. **To date, proceduralist A has indicated significant improvements in the diagnostic capabilities of the bronchoscopy procedures.**

There were two cases of a non-diagnostic result following CT-guided thoracic biopsies for proceduralist B and C. Our multidisciplinary team reviewed these two cases and determined that the procedure performed by proceduralist C was associated with inadequate tissue sampling at the time of the initial

diagnostic procedure. **Going forward, the pathologist and proceduralist C have agreed to work directly together at the time of invasive thoracic biopsies to verify adequate sampling.**

The explanation for the non-diagnostic result for the procedure performed by proceduralist B was likely location and size of malignancy.

DATES REPORTED TO MEDICAL STAFF/ADMINISTRATION:
11/5/2018

DATES REPORTED TO CANCER COMMITTEE: 9/13/2018;
12/13/2018

2019 FOLLOW UP/OUTCOMES:

In 2019 we reviewed additional data to evaluate improvements in our performance as a result of improvements in response to the 2018 study. During the calendar year of 2018, there were 39 diagnostic thoracic procures performed on 32 patients at CalvertHealth by the same three procerduralists identified in the previous study. We excluded the 15 patients in which malignancy was not suspected pre-operatively. Once again, we focused our analysis on the seventeen patients in the study in whom malignancy was positively identified.

Fourteen of the 17 individuals had malignancy confirmed at the time of their initial diagnostic procedure. The average time to confirmation of malignancy diagnosis in this group of patients who underwent a single diagnostic procedure was 2.5 days. The standard of care, as established by the National Cancer Institute from time of diagnostic procedure to finalized pathology result is 7-10 days. For the same group of 20 patients in CY2017 study, this interval was also very low at 3 days.

For three individuals, the initial specimen was negative for malignant cells and therefore a second invasive diagnostic thoracic procedure was necessary to make a definitive diagnosis. The average time to confirmation of a malignant diagnosis in these patients was 30 days.

Compared with our data from CY2017, we have been able to expedite performing additional diagnostic procedures with our current multidisciplinary approach, improving from 3 months to 30 days. In addition, we have also had improvements in minimizing the need for second procedure CY2017 26% vs CY2018 18%.

Based on the above results, we have demonstrated an improvement in our multidisciplinary approach at CalvertHealth resulting in timely and comprehensive diagnosis of thoracic malignancies, with continued enhanced communication amongst our team.

BREAST IMAGING: Beyond the Basics



Dr. Baker consults regularly with renowned breast surgeon, Dr. Theodore Tsangaris, director of CalvertHealth's oncology program to ensure coordination of care and positive patient outcomes.

Why Breast Imaging Specialists and 3D Mammography Are So Important

In fall 2019, the CalvertHealth Sheldon E. Goldberg Center for Breast Care was pleased to welcome **Drs. Chandra Baker** and **Bora Lee**, dedicated breast imagers from Johns Hopkins, to its multidisciplinary team. Dr. Baker specializes in women's imaging including mammography, breast ultrasound, breast MRI and image-guided biopsy and Dr. Lee has a special interest in minimally invasive procedures including image-guided biopsy.

Dr. Baker, who works closely with the medical center's cancer program, also serves as medical director for CalvertHealth's breast imaging program. "Dr. Baker's expertise and her commitment to women's health are impressive," said Kasia Sweeney, who oversees oncology services at CalvertHealth Medical Center. "We're delighted she chose to join the team at our breast center. She has sophisticated skills informed by more than a decade of radiology experience."

Since opening in 2010, the CalvertHealth Sheldon E. Goldberg Center for Breast Care has changed the landscape of how breast care is provided in Southern Maryland. The center brings together in one convenient location a multidisciplinary team of breast health experts with an experienced navigator backed by the latest breast-imaging technology like lower-dose 3D mammography – designed to detect even the most subtle signs of early cancer.

Dr. Baker sat down for a one-on-one interview to talk about CalvertHealth's breast imaging program, its technological capabilities, screening guidelines and other breast imaging topics.

Q *Why is breast imaging important?* If we could only rely on clinical symptoms to make a diagnosis of breast cancer, we would rarely find lesions in the earliest stages when we have the best chance to cure the disease. The purpose of screening mammography is to try to find breast cancers early, when they are smaller and thus easier to treat successfully. (CMIC is designated as a "Breast Imaging Center of Excellence" by the American College of Radiology.)

Q *Why should women choose to come here?* Calvert performs full-service breast care. That means whether you have benign or malignant breast disease, you can receive all of your care locally. Calvert is large enough to play that role while ensuring patients receive personalized care.

Q *What are the benefits of a 3D mammogram?* A 3D mammogram compared to traditional full-field digital mammography (2D) is like comparing a chest X-ray to a chest CT. Because it essentially takes image slices through the breast, you see much more detail. (CMIC added 3D mammography in 2013.)

Q *What are the advantages of an image-guided biopsy vs. a surgical biopsy?* Image-guided biopsies are generally pretty easy. They are done with local

anesthesia (lidocaine injection) only. You are completely awake and the procedure usually takes no more than 30 minutes. The pathology results are usually available within a few days. If the patient requires surgery, then planning can be done so that only one trip is made to the operating room. If the patient goes to surgery for a biopsy just to get the diagnosis, she may find herself having to return to the operating room for a more definitive surgery if needed after diagnosis.

Q How is breast MRI beneficial? Breast MRI is extraordinarily sensitive and it can pick up early tiny cancers; however, this means it often will pick up benign lesions as well. It is generally reserved for determining the extent of disease in someone who has been diagnosed with breast cancer or response to chemotherapy, for screening along with mammography in very high-risk patients and for evaluating breast implants. (The dedicated women's suite at CMIC features a state-of-the-art PET/CT scanner, digital mammography and breast MRI as well as 3D mammography, breast ultrasound and stereotactic biopsy.)

CalvertHealth Welcomes Two New Breast Imaging Specialists

Chandra N. Baker, MD

"With breast imaging we get to interact with the person connected to the images we interpret," said board-certified diagnostic radiologist Dr. Chandra Baker, who specializes in breast imaging. "This makes what we do so much more fulfilling." A fellowship-trained breast imager, Dr. Baker has been in practice for 10 years. She went on to add, "Giving good news is easy but those times when it's not I want my patients to know they are not alone and I want them to leave me feeling hopeful." Before coming to Calvert, Dr. Baker was an Assistant Professor for Radiology at The Johns Hopkins School of Medicine for two years. Prior to that, she was a partner in a private practice in North Carolina. Dr. Baker graduated from Georgetown University School of Medicine and went on to complete her residency at MedStar Georgetown University Medical Center and a fellowship in interventional radiology at the University of Pennsylvania and a fellowship in breast imaging at George Washington University. When it comes to patient care, she said: "I live by the golden rule. Treat others the way you would like to be treated. Period."



Bora Lee, MD

The CalvertHealth Sheldon E. Goldberg Center for Breast Care is pleased to welcome Dr. Bora Lee, a fellowship-trained breast imager from Johns Hopkins to its multidisciplinary team. Dr. Lee, who is board certified in diagnostic radiology, has practiced exclusively in breast imaging for nine years. Dr. Lee sees patients in the Calvert Medical Imaging Center (CMIC) and works closely with the medical center's cancer program. She has a special interest in minimally invasive procedures including image-guided biopsy. Before coming to Calvert, Dr. Lee was an Assistant Professor for Radiology at The Johns Hopkins School of Medicine for four years where she was actively involved in patient quality and safety. Dr. Lee graduated from the University of Virginia School of Medicine in 2005 and went on to complete her residency there in 2010 and a fellowship in breast imaging at the University of California Los Angeles in 2011. When it comes to patient care, she said: "To me, every patient is a VIP."



SELF-CARE SATURDAY

On November 9, 2019, CalvertHealth held a Women's Health Brunch & Learn offering opportunities to receive a screening mammogram, skin cancer screening, DEXA bone density screening, clinical breast exam, blood pressure screening and lots of education and informational materials regarding the importance of regular screenings and self-care. Forty-seven women attended the event; 30 received skin cancer screenings (12 were scheduled for follow-up); three women received mammograms at the event and an additional 12 schedule a mammogram for a future date; and six clinical breast exams were performed, one was referred for a mammogram/ultrasound.

2019 WOMEN'S HEALTH *Brunch & Learn*

Scan the QR Code with the camera feature of your mobile phone or device to see a detailed report of screening outcomes.



IMPORTANT RELATED SERVICES

FOR MORE
INFORMATION
ABOUT
CANCER
SUPPORT GROUPS
CALL
410.535.8722

Warning Signs of Cancer

- C** Change in bowel or bladder habits
- A** A sore that does not heal
- U** Unusual bleeding or discharge
- T** Thickening or lumps in breast or elsewhere
- I** Indigestion or difficulty in swallowing
- O** Obvious change in wart or mole
- N** Nagging cough or hoarseness

CALVERTHEALTH MEDICAL CENTER

Breast Cancer Support Group.....	410.414.4516
Breast Care Navigator.....	410.414.4516
Case Management	410.535.8235
Center for Breast Care at CMH	410.414.4700
Community Wellness.....	410.535.8233
Dietitian	410.535.8276
Gynecologic Oncology Center at CMH.....	410.535.8272
Infusion Therapy Center.....	410.535.8276
Maryland Relay Service.....	1.800.735.2258
Medical Records.....	410.535.8275
Oncology Social Worker	410.414.4730
Pastoral Care	410.535.8249
PHYSICIAN REFERRAL	1.888.906.8773
Radiology Department.....	410.535.8320
Tumor Registry	410.414.4658

OUTSIDE SERVICES

Calvert County Health Department Colorectal Cancer Screenings	410.535.5400 x 348
Calvert County Health Department Breast and Cervical Screenings.....	410.535.5400 x 350
Calvert Hospice.....	410.535.0892
Chesapeake Potomac Regional Cancer Center	
<i>Charlotte Hall Radiation Oncology Center</i>	301.884.2508
<i>Waldorf Radiation Oncology Center</i>	301.705.5802

This facility is accredited by The Joint Commission on Accreditation of Healthcare Organizations. If you would like to report a concern about the quality of care you received here, you can contact The Joint Commission at **1.800.994.6610**.

CalvertHealth Medical Center does not discriminate with regard to patient admissions, room assignment, patient services or employment on the basis of race, color, national origin, age, gender identification, religion, disability or sexual orientation.

El Centro Médico de CalvertHealth no discrimina con respecto a admisiones de pacientes, asignaciones de habitaciones, servicios al paciente o empleo sobre la base de raza, color, origen nacional, religión, discapacidad, edad, sexo, incapacidad, identificación de género o sexual orientación.

Trung tâm Y tế CalvertHealth không phân biệt đối xử về việc nhập viện của bệnh nhân, phân công tại phòng, dịch vụ bệnh nhân hoặc việc làm dựa trên chủng tộc, màu da, nguồn gốc quốc gia, tôn giáo, khuyết tật, tuổi, giới tính, khuyết tật, nhận dạng giới tính hay khuynh hướng tình dục.

ADDITIONAL INFORMATION

American Cancer Society

Mid-Atlantic Division, Inc.
1041 Route 3 North, A-1
Gambrills, MD 21054
www.cancer.org

Cancer Research and Prevention Foundation

1600 Duke Street
Suite 110
Alexandria, VA 22314
www.preventcancer.org



100 Hospital Road, Prince Frederick, MD 20678
CalvertHealthMedicine.org

For questions about physician referral, class registration or support groups, call:

Physician Referral Line: 888.906.8773
Maryland Relay Service: 800.735.2258