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Annual Report 2003–2004

A message from the Director

This year, the Ontario Breast Screening Program (OBSP) achieved a key milestone in its aim to provide high quality breast screening services to more women in Ontario – the affiliation of the Program's 100th site! A celebration was held at the 100th site, the North York General Hospital – Branson Division. OBSP's extensive network of breast screening sites served over 200,000 women in Ontario in 2003/2004.

While the OBSP provides a programmatic approach to breast screening, to ensure the best outcomes possible for women, recruitment of the population of the women aged 50-69 to the program remains a challenge. The OBSP's goal is to achieve a 70% participation rate by the year 2010. In addition, in 2003, "Targeting Cancer: an action plan for cancer prevention and detection" was released jointly by Cancer Care Ontario and the Canadian Cancer Society – Ontario Division. Targets in the plan include achievement of 90% participation of Ontario women aged 50-69 in organized breast screening by the year 2020. So, while the Program has been steadily growing, to the current rate of 24%, there is still much to be accomplished.

Moving into the near future, I anticipate further growth in the number of affiliated sites, and number of breast screening clients. As OBSP works together with the newly created integrated cancer programs in the regions, there will, no doubt, be new ideas, opportunities and approaches identified to move the program forward. OBSP staff at provincial office and the regional hubs look forward to another productive year of expansion of quality breast screening with all of the Program's partners.

Verna Mai, MD, MHSc, FRCPC

Director, Preventive Oncology, Cancer Care Ontario

Program Components

Comprehensiveness

OBSP screening is available to all women in the Province who are between the ages of 50 and 74. The OBSP will screen older women on request. Women are not eligible if they have had breast cancer or breast augmentation, or if they currently have symptoms of breast disease requiring diagnostic work-up.

Screening Modalities Include:

- 1 Two-view mammography with staff and equipment that meets the OBSP's standards, as well as those of the Canadian Association of Radiologists (CAR) Mammography Accreditation Program.
- 2 Clinical breast examination at most locations by a specially educated nurse examiner.
- 3 Information on breast self-examination.

Continuum of Service

It is important that screening be linked to a continuum of service that includes multidisciplinary assessment. An OBSP assessment centre functions on site in Hamilton and other OBSP sites have formed linkages with assessment centres.

Flexibility

The OBSP is flexible in its program components. For example, clinical breast examination is encouraged as a program component, but is not mandatory. A site that cannot provide this service is still welcome to affiliate provided it can meet the Program's mammography standards.

Our Goal

To achieve a 70% participation rate in Ontario women aged 50-69 by the year 2010.

Organized delivery

Recruitment, recall and follow-up.

The OBSP reaches out to all women in its target group. In order to do so, different models are used to address barriers of distance, language and other problems. For example, key materials are translated, special outreach programs promote the OBSP, shuttle buses and a mobile coach serve outlying areas and OBSP staff work with family physicians to encourage them to refer directly, or assist in generating letters of invitation.

A computer system facilitates the recall of eligible clients on an annual or biennial basis.

Quality assurance and quality control.

Quality standards for program delivery are carefully monitored by the OBSP. The nurse examiners performing clinical breast examination are initially trained and then undergo an annual practice review. The OBSP strives to achieve the best quality mammograms possible. The radiologists undergo an annual outcome review and the mammography technologists have an annual film review. The OBSP physics consultants monitor the mammography and film processing equipment.

Evaluation

Screening is closely linked to assessment so that the outcomes of screening can be readily monitored. Data are collected and evaluated related to demographics, health practices, risk factors, referral rates, cancer detection rates, assessment procedures, interval cancers and retention of clients in the Program.

Provincial Overview

The Ontario Breast Screening Program (OBSP) has been in operation since 1990. It meets Canadian and International standards for the early detection of small invasive cancers. The Program has achieved high levels of patient satisfaction and is strongly supported by many family doctors. It has established screening sites that are accessible to almost all women in Ontario.

The OBSP offers eligible women two-view mammography, clinical breast examination at most locations by a specially educated nurse examiner, information on breast self-examination and automatic client recall. Both the woman and her physician are informed of screening results and when screening abnormalities are detected, suggestions for further assessment are provided to the primary care or referring physician.

Screening centres also facilitate appointments for diagnostic imaging upon physician request and obtain follow-up information on reported abnormalities. Most women are re-invited every two years; however, some women are asked to return in one year.

As of the end of March 2004, there were 100 sites across the Province. This includes 91 affiliate sites and 9 regional hubs to ensure women have access to this service Province wide. (See list of regional hubs and affiliated sites, pages 6–10.)

The mobile coach in Northwestern Ontario provides screening as well as diagnostic mammography and clinical breast examination to women who live in communities without mammography facilities and who would not normally be eligible for OBSP.

A well run screening program must be able to ensure that patients have access to timely and accurate diagnostic assessment when they are screen-positive. Since 1991, the OBSP has operated an integrated comprehensive assessment program at its Hamilton Centre. Evaluation shows that this clinic can deliver assessment faster than the “usual care” approach at other centres, with substantially fewer surgical biopsies in women with benign lesions. This supports the development of linkages between the OBSP and assessment facilities to serve the needs of all women with suspected breast abnormalities. In addition to the site in Hamilton, 17 assessment affiliates have been established. (See list of assessment affiliates, pages 6–10.)

Congratulations to the new screening and assessment sites that joined during the 2003/2004 fiscal year. They are listed below in order of affiliation:

New Screening Affiliates

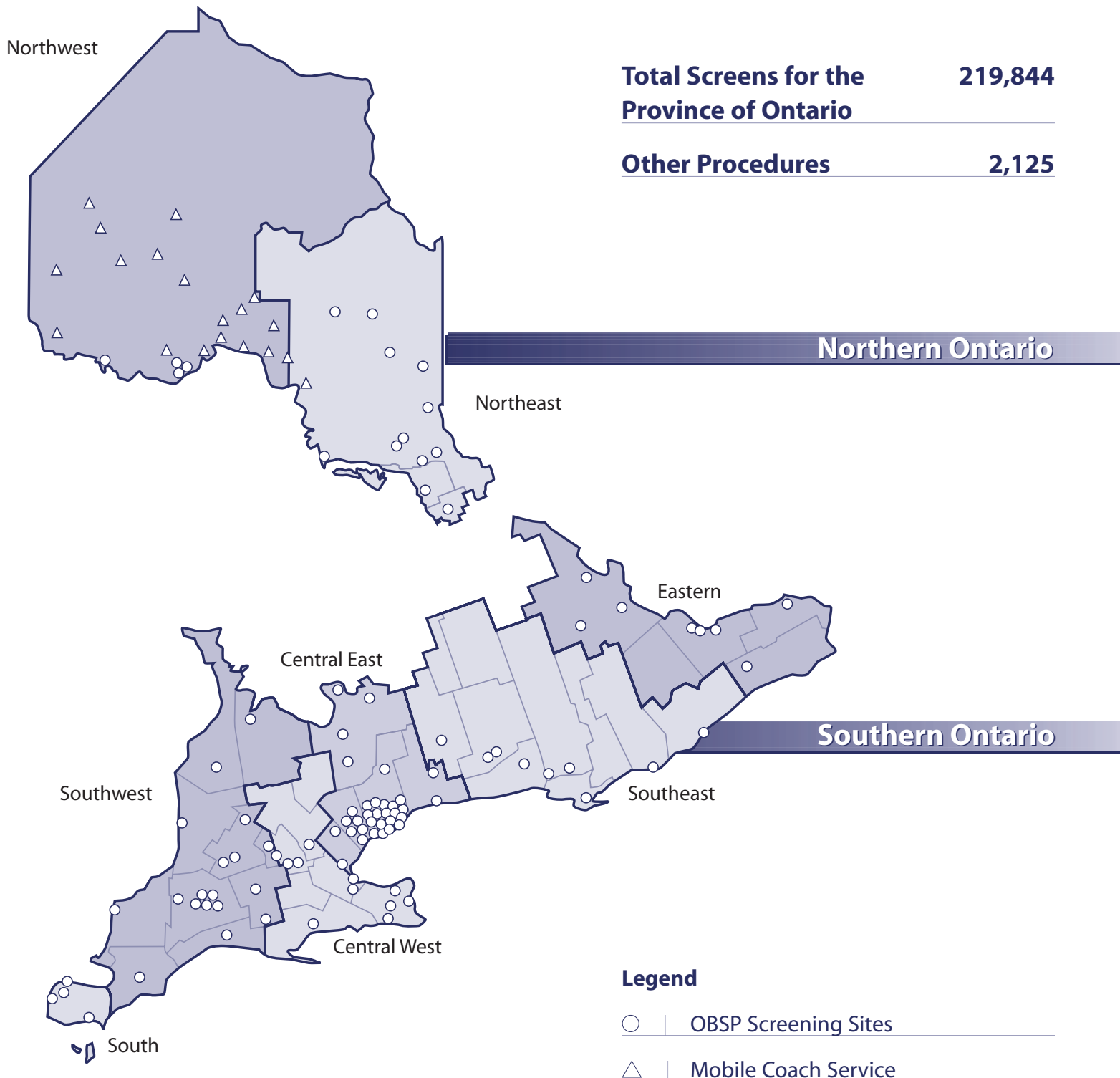
- Tillsonburg District Memorial Hospital
- The Medical Centre, Peterborough
- Ontario Medical Imaging, Richmond Hill
- Humber River Regional Hospital, Church Street
- North York General Hospital -Branson Division
- Niagara Health System–Port Colborne General Hospital

New Assessment Affiliates

- Grey Bruce Regional Health Care, Owen Sound
- Windsor Regional Hospital, Metropolitan Campus
- St. Joseph's Healthcare, Hamilton
- Winchester District Memorial Hospital

OBSP Screening Sites & Areas Served by the OBSP Mobile Coach

As of March 31, 2004

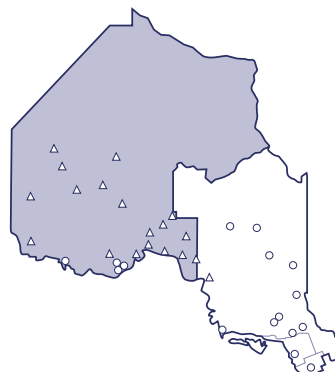


Regional Statistics – OBSP Hubs and Affiliates

April 1, 2003 to March 31, 2004

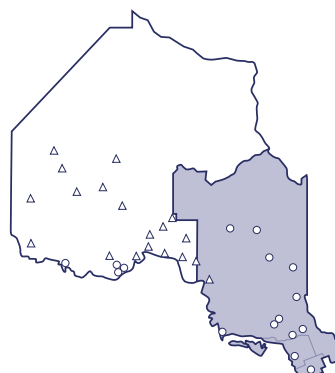
Northwest Region

Administrative Base		Number of Screens
Thunder Bay	➤ Mobile coach serves Northwest Region.	5,561
Affiliates		
Fort Frances	➤ Riverside Breast Screening and Education Clinic	468
Thunder Bay	➤ Thunder Bay Medical Centre Diagnostics	865
	➤ CML HealthCare – Port Arthur Clinic	626
Total		7,520
	➤ Mobile Coach Diagnostic Procedures	413



Northeast Region

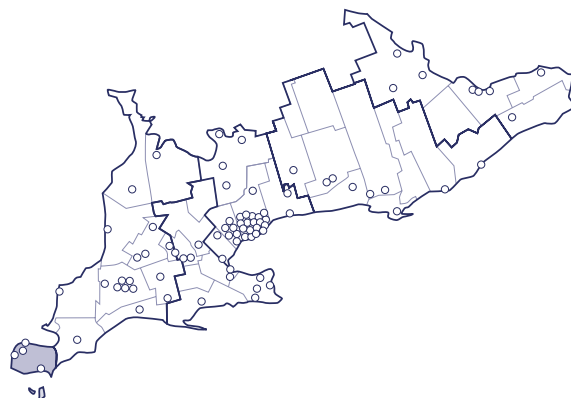
Hub		Number of Screens
Sudbury	➤ Sudbury OBSP Centre	7,532
Affiliates		
Bracebridge	➤ South Muskoka Memorial Hospital	632
Hearst	➤ Hôpital Notre Dame	228
Kapuskasing	➤ Sensenbrenner Hospital	590
Kirkland Lake	➤ Kirkland and District Hospital	493
New Liskeard	➤ Temiskaming Hospital	622
North Bay	➤ North Bay General Hospital	3,083
Parry Sound	➤ West Parry Sound Health Centre	939
Sault Ste. Marie	➤ Group Health Centre	5,117
Sturgeon Falls	➤ West Nipissing General Hospital	578
Sudbury	➤ CML HealthCare – Sudbury	454
	➤ Sudbury Regional Breast Health Program *	
Timmins	➤ Timmins and District Hospital	1,530
Total		21,798



Note | * Provides breast assessment only | * * Provides both breast assessment and screening

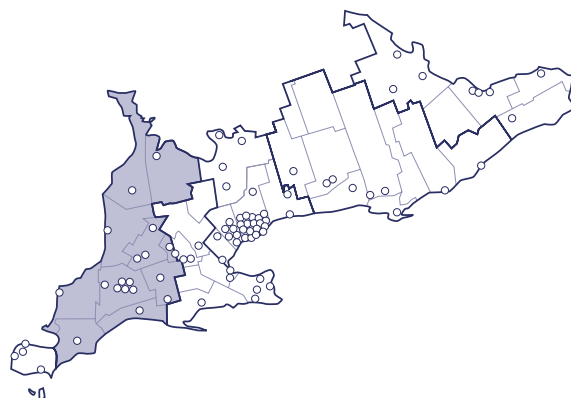
South Region

Hub		Number of Screens
Windsor	➤ Windsor OBSP Centre	5552
Affiliates		
Chatham	➤ The Chatham Kent Health Alliance	3,406
Leamington	➤ Leamington District Memorial Hospital	510
Windsor	➤ CML HealthCare – Windsor	287
	➤ Windsor Regional Hospital ** – Metropolitan Campus	1,176
Total		10,931



Southwest Region

Hub		Number of Screens
London	➤ London OBSP Centre	7,719
Affiliate		
Goderich	➤ Alexandra Marine and General Hospital	1,000
Kitchener	➤ Grand River Hospital	1,849
	➤ RDS Victoria/Kitchener Ultrasound, Mammography & X-Ray	1,354
Listowel	➤ Listowel Memorial Hospital **	1,283
London	➤ CML HealthCare – London	951
	➤ London Health Sciences Centre	619
	➤ London X-Ray Associates	1,173
	➤ St. Joseph's Health Care **	965
Owen Sound	➤ Grey Bruce Health Services **	4,026
St. Thomas	➤ St. Thomas-Elgin General Hospital	1,278
Sarnia	➤ Bluewater Health – Mitton Site	2,830
Stratford	➤ Jenny Trout Centre, Ultrasound and Mammography Associates of Stratford	1,176
	➤ Stratford General Hospital	842
Strathroy	➤ Strathroy Middlesex General Hospital	978
Tilsonburg	➤ Tilsonburg District Memorial Hospital	516
Walkerton	➤ South Bruce Grey Health Centre	719
Woodstock	➤ Woodstock General Hospital	1,228
Total		30,506



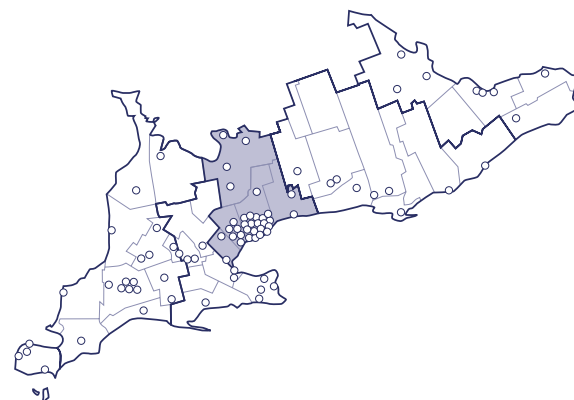
Note | * Provides breast assessment only | ** Provides both breast assessment and screening

Regional Statistics – OBSP Hubs and Affiliates

April 1, 2003 to March 31, 2004

Central East Region

Hubs		Number of Screens
Toronto	➤ North York OBSP Centre	5,759
	➤ Scarborough OBSP Centre	5,057
Affiliates		
Alliston	➤ Stevenson Memorial Hospital	1,676
Barrie	➤ The Royal Victoria Hospital	6,781
Brampton	➤ Wm. Osler Health Centre,	5,273
	Brampton Memorial Hospital Campus	
	➤ CML HealthCare – Brampton	509
Etobicoke	➤ Wm. Osler Health Centre,	1,915
	Etobicoke Hospital Campus	
Georgetown	➤ Wm. Osler Health Centre,	1,162
	Georgetown Hospital Campus	
Markham	➤ Markham Mammography Clinic Inc.	3,681
Midland	➤ Ontario Medical Imaging – Huronia	839
Mississauga	➤ Credit Valley Diagnostic Centre	869
	➤ Credit Valley Imaging Associates	1,194
	➤ CML HealthCare – King X-Ray and Ultrasound	1,149
	➤ Dixie X-Ray Breast Imaging Centre	1,281
Newmarket	➤ Southlake Regional Health Centre	2,933
Orillia	➤ Ontario Medical Imaging	1,656
Oshawa	➤ Oshawa Clinic Imaging Centre	1,610
Richmond Hill	➤ Ontario Medical Imaging	720
Toronto	➤ Dixie X-Ray Ltd. **	5,357
	➤ CML HealthCare – Fairview	1,621
	➤ CML HealthCare – Lawrence	897
	➤ Edward Street Radiology Associates – Main	4,525
	➤ Edward Street Radiology Associates – Yonge	3,474
	➤ North York General Hospital – Branson Division	291
	➤ Quality Medical Imaging – Bloor	960
	➤ Quality Medical Imaging – Spadina	1,207
	➤ Quantum Medical Imaging Services Inc.	2,736
	➤ St. Michael's Hospital Health Centre **	2,769
	➤ Sunnybrook & Women's College Health Sciences Centre, Women's College Hospital Campus	3,578
	➤ Victoria Park Mammography	4,193
Unionville	➤ CML HealthCare – Unionville	642
Weston	➤ Humber River Regional Hospital, Church Street	616



Total 76,930

Central West Region

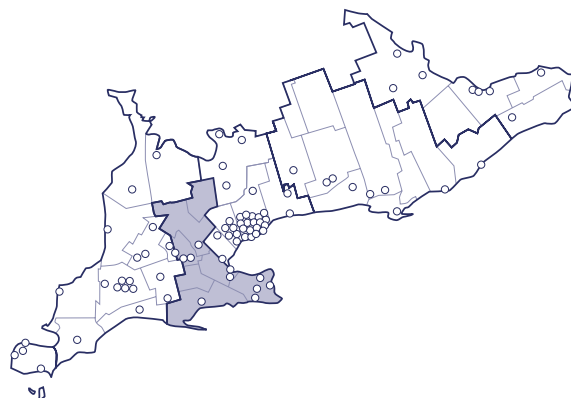
Hub		Number of Screens
Hamilton	➤ Hamilton OBSP Centre **	11,467

Affiliates

Burlington	➤ Burlington Ultrasound and Radiology	3,084
Cambridge	➤ Cambridge Memorial Hospital	2,203
	➤ RDS Diagnostics Ltd.	547
Guelph	➤ Guelph Imaging Centre	1,030
Hamilton	➤ St. Joseph's Healthcare Hamilton, Centre for Ambulatory Health Services **	2,097
Niagara Falls	➤ NHS – Greater Niagara General Hospital **	3,527
Port Colborne	➤ NHS – Port Colborne General Hospital	193
St. Catharines	➤ NHS – St. Catharines General Hospital **	3,531
Simcoe	➤ Norfolk General Hospital	457
Welland	➤ NHS – Welland County General Hospital **	2,367

Total 30,503

Hamilton Centre	Assessments	1,196
	Recalls	516



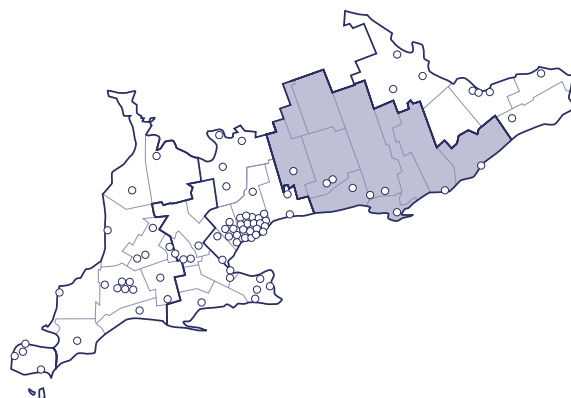
Southeast Region

Hub		Number of Screens
Kingston	➤ Kingston OBSP Centre	7,761

Affiliates

Belleville	➤ Quinte Healthcare – Belleville General Hospital	1,769
Brockville	➤ Brockville General Hospital	1,620
Campbellford	➤ Campbellford Memorial Hospital	662
Kingston	➤ Hôtel Dieu Hospital *	
Peterborough	➤ The Medical Centre	373
	➤ Peterborough Regional Health Centre, Rogers Street Site	2,447
Picton	➤ Quinte Healthcare – Prince Edward County Memorial Hospital	178
Port Perry	➤ Port Perry Imaging **	1,965
Trenton	➤ Quinte Healthcare – Trenton Memorial Hospital	1,360
Victoria County	➤ Ross Memorial Hospital (Lindsay)	1,649

Total 19,784



Note | * Provides breast assessment only | * * Provides both breast assessment and screening

Regional Statistics – OBSP Hubs and Affiliates

April 1, 2003 to March 31, 2004

Eastern Region

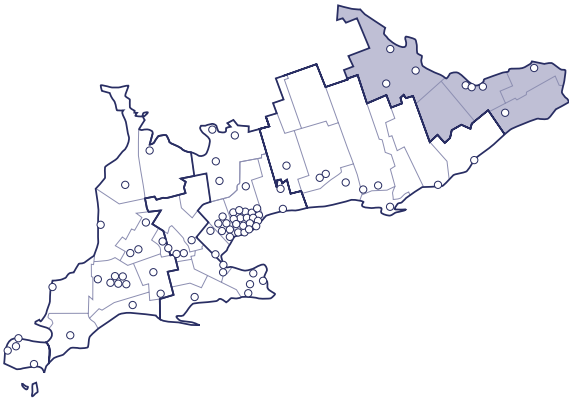
Hub

Ottawa	➤ Ottawa OBSP Centre	13,851
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Affiliates

Barry's Bay	➤ St. Francis Memorial Hospital	536
Hawkesbury	➤ Hawkesbury and District General Hospital	1,429
Ottawa	➤ Merivale Medical Imaging	693
	➤ Montfort Hospital	951
	➤ Ottawa Regional Women's Breast Health Centre *	
Pembroke	➤ Pembroke General Hospital Inc. **	2,235
Renfrew	➤ Renfrew Victoria Hospital **	1,547
Winchester	➤ Winchester District Memorial Hospital **	630

Total		21,872
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Note | * Provides breast assessment only | * * Provides both breast assessment and screening

Breast Assessment

The success of screening is very dependent on the quality of the follow-up of screen-detected abnormalities – that is, the quality and timeliness of the breast assessment process used to reach a final diagnosis. Breast assessment involves the expertise of a team of health professionals working in collaboration to perform diagnostic breast imaging, biopsies, obtain surgical consultation and pathology expertise. Targets have been developed by the Canadian Breast Cancer Screening Initiative[†] of 90% of cases resolved within 5 weeks from time of abnormal screen where there is no open biopsy, and 90% of cases resolved within 7 weeks where there is an open biopsy for women age 50–69. The proportion of OBSP abnormal breast screens diagnosed within the recommended time intervals was 79.8% for screens without a diagnostic open biopsy and 39.5% for women with a diagnostic open biopsy.

The establishment of multidisciplinary, comprehensive breast assessment affiliates to which OBSP clients can be referred has been an initiative of the OBSP over the last several years. Based on the work of the Ontario Breast Assessment Collaborative Group criteria have been established for these affiliations which include:

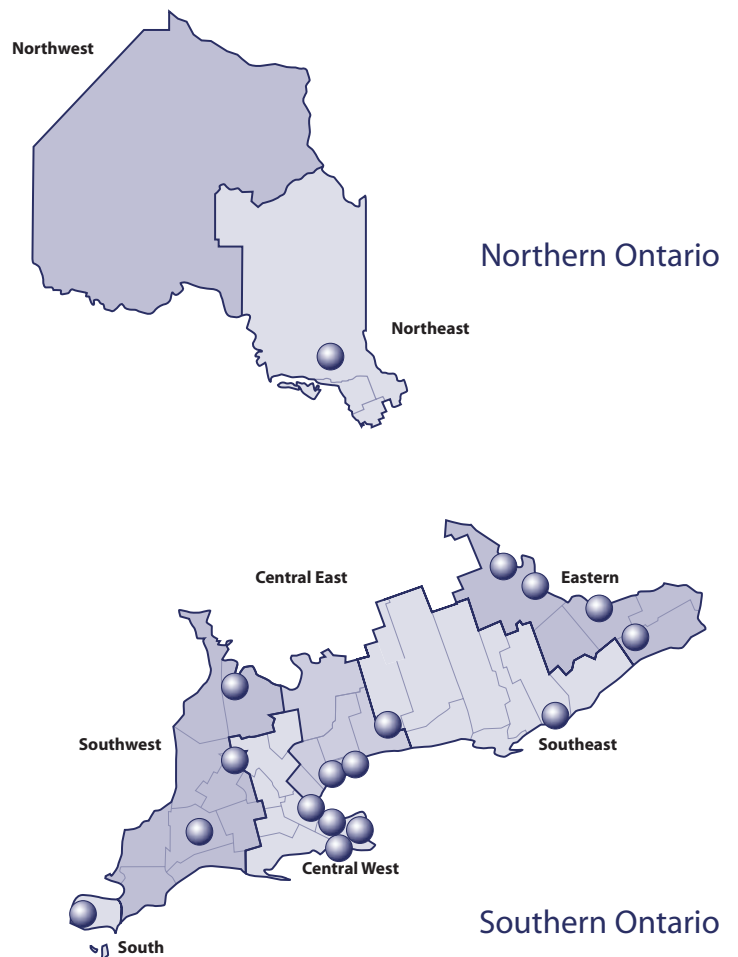
- The integration of family physicians into the breast assessment process
- Achievement of CAR Accreditation for mammography equipment
- The availability of radiologists with breast imaging expertise
- The availability of ultrasound facilities and core biopsies
- The availability of breast pathology expertise
- A designated patient navigator who will coordinate the investigations involved in the diagnosis of the abnormality
- A detailed care map for the coordination of services and expected timelines
- Mechanisms for ongoing evaluation and quality improvement
- Agreement to report the results of assessment according to set standards
- Agreement to achieve set timelines, such as providing the client's definitive diagnosis to her primary care provider within 2 weeks of completing the assessment process.

Note:

- † Report of the Working Group on the Integration of Screening and Diagnosis for the Canadian Breast Cancer Screening Initiative (2000).

A breast assessment facility can either perform all the services required for breast work-up or may establish pathways with other facilities to provide the additional services necessary.

During 2003/04, the OBSP established four new assessment affiliates: Grey Bruce Regional Health Care – Owen Sound, Windsor Regional Hospital – Metropolitan Campus, St. Joseph's Healthcare – Hamilton and Winchester District Memorial Hospital; bringing the total number of assessment affiliates to 17. While the assessment initiative is directed toward women screened through the OBSP, eventually all women will benefit from a quality driven and standardized approach to care. The OBSP is working with many other Ontario facilities interested in becoming breast assessment affiliates.



The Benefits of Organized Screening

Organized screening is a key factor in reducing breast cancer deaths and offers clear advantages to women, physicians, and screening facilities.

Organized screening at the OBSP benefits women

- **The OBSP makes screening easily accessible:** Women with or without a family physician can be screened through the OBSP. Women can book their own appointments, receive their results directly, and are reminded by letter when they're due for their next screen.
- **With the OBSP, all women are closely monitored:** All abnormal screens are followed through to diagnosis — and OBSP staff are available to answer questions and offer support to women as they go through the assessment process.
- **The OBSP ensures quality:** All our screening facilities are accredited by the Canadian Association of Radiologists' Mammography Accreditation Program (CAR-MAP), and our rigorous quality-control measures mean women receive excellent mammograms and clinical breast exams.

“Being part of the OBSP means being part of a high-profile program that does something special for the women in the community. Women recognize the name, and they're happy after the first visit to be part of the program. We've had clients drop in with cards for the staff, to tell them that their good care and information made the whole screening process that much more pleasant. A lot of the women in our community don't have a family physician or have difficulty getting to see their doctor. With the OBSP, that's not a problem. Women appreciate that.”

*Bonnie Sipos,
Regional Technical Director of Diagnostics,
Niagara Health System*

Partnering with the OBSP benefits family physicians

- **The OBSP supports busy family physicians** by booking women for breast screening, automatically recalling them, providing clinical breast examinations (optional), automatically referring women for diagnostic tests (with their physicians' authorization), and referring women back to their family doctors for additional health care needs.
- **The OBSP gives physicians peace of mind:** Physicians know that at the OBSP, their patients have regular mammography and are recalled for screening at appropriate intervals. The OBSP completes a breast cancer risk assessment for each client to determine if annual or biennial screening is appropriate. Automatic yearly screening will be provided for those who are eligible. If a woman needs breast assessment, OBSP staff will monitor her clinical pathway through to diagnosis. The OBSP's high quality-assurance standards, including mandatory CAR-MAP accreditation and measuring performance with national evaluation indicators, ensure that patients receive excellent care.
- By referring their patients to the OBSP, **physicians indirectly participate in an ongoing body of research on best practices in breast screening.** The OBSP's research arm also provides physicians with valuable, comprehensive, and reliable data on their own practices and community health needs.

“The OBSP has raised the bar in terms of quality care. Because all OBSP sites are accredited through CAR-MAP, women — and their family physicians — have the peace of mind that comes from knowing that they're getting the best care possible.”

*Dr. Daniel Slipacoff,
Radiologist and President,
Dixie X-Ray Ltd., Toronto*

Affiliating with the OBSP benefits screening facilities

- **The OBSP helps screening facilities obtain CAR-MAP accreditation**, and provides ongoing support, advice, and quality-control measures to help facilities maintain excellent service.
- **The OBSP raises the bar on quality by providing comprehensive feedback** on all aspects of a facility's performance. Technologists, for example, undergo annual film reviews, while radiologists receive reports on their recall, positive predictive value, cancer detection, and interval cancer rates. Province-wide data allows staff and facilities to see how they compare, identify areas for enhancement, and set goals for improvement.
- The OBSP's **province-wide, integrated client management system** provides an information structure that governs virtually every aspect of the program: it registers clients and recalls them at regular intervals, generates letters, eliminates duplication, and ensures that all women are monitored through screening and assessment processes. To ensure the most effective use of the system, the OBSP provides training and ongoing technical support for the system.
- **Affiliating with the OBSP makes good business sense:** A very high percentage (85% in 1997/98) of women in the program become repeat screening clients, and doctors who refer to the OBSP often also refer patients for other screening and diagnostic services. As well, remuneration for screening is higher through the OBSP than it is through the OHIP system.
- **OBSP Screening Affiliates have access to OBSP Breast Assessment Affiliates for abnormal screens.** The OBSP network provides clients with expedited access to assessment. As well, OBSP assessment affiliates provide navigators or coordinators to guide and support women through the assessment process to diagnosis.

“Regular feedback from the OBSP lets our technologists, nurse examiners, and radiologists see how they're doing, and provides them with incentive to constantly improve their skills. Being involved with the OBSP has definitely increased our screening numbers. It opens the door for a lot of women.”

*Valerie Skalecki,
Manager, Group Health Centre,
Sault Ste. Marie*

Organized breast cancer screening benefits everyone — now and in the future

- Organized screening programs save lives by finding breast cancer early, when it's more easily treated. Organized screening also provides researchers with valuable information about best practices for detecting cancer. And that means we can constantly improve. Being part of an organized screening program helps save women's lives now — while helping safeguard the future health of their daughters and granddaughters.

How screening facilities can become OBSP screening affiliates

- **If you already have CAR mammography accreditation**, contact the OBSP to fill out an Application for Affiliation form and request an orientation binder.
- **If you do not yet have CAR mammography accreditation** and would like assistance obtaining it, contact the OBSP Provincial Office to complete the Application for Assistance with CAR-MAP in Preparing for Affiliation form.

Forms and more information are available online at: www.cancercare.on.ca/prevention_102.htm, or by contacting the OBSP Provincial Office at (416) 971-9800 ext.1104.

Program Results 1990–2002

Recruitment and Compliance

Program results are presented by calendar years. Outcome statistics have not been included for 2003 as not all women referred for assessment in 2003 have completed follow up.

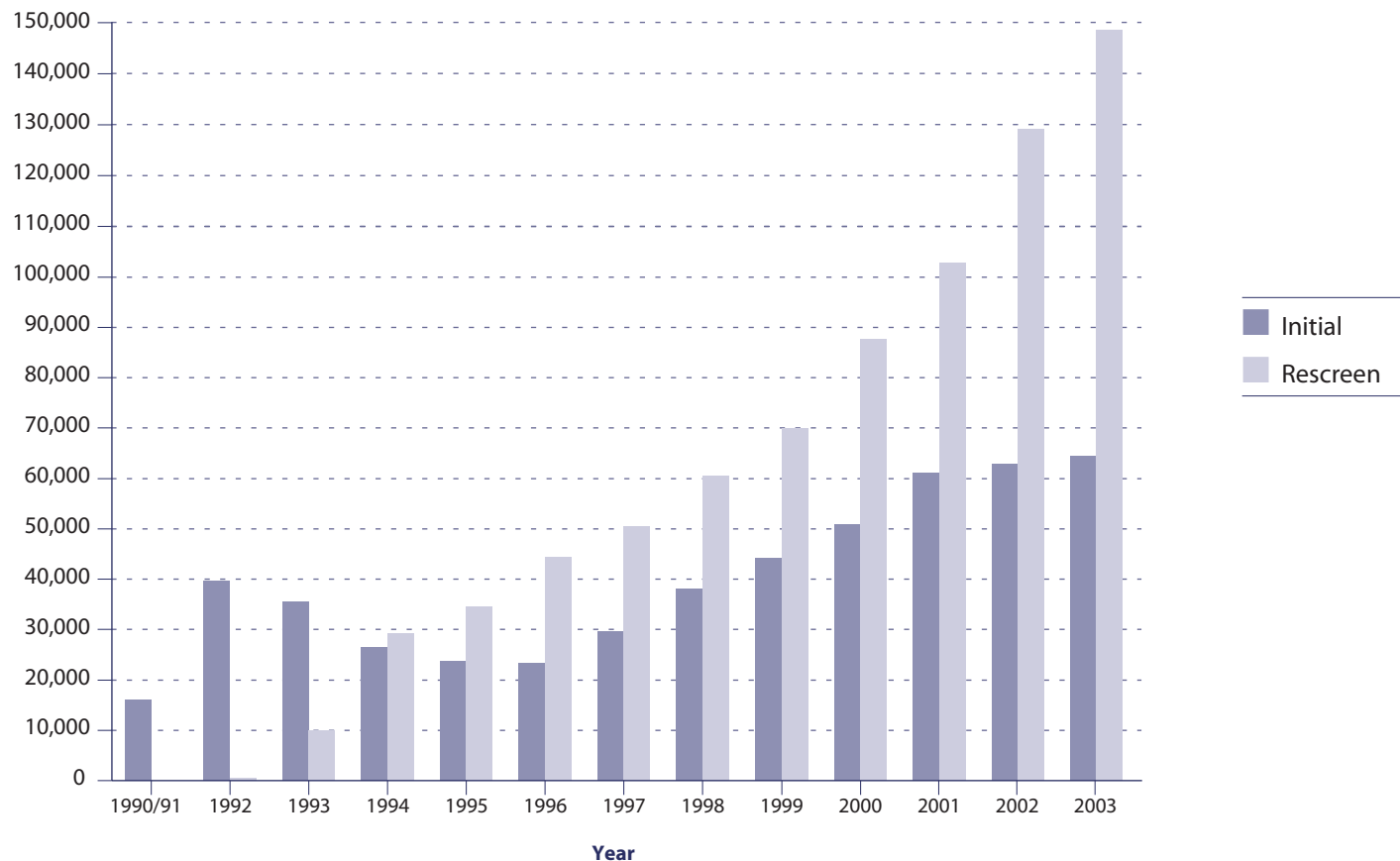
Number of Screens

From the time of its first screen in July 1990 until December 31, 2003, the Ontario Breast Screening Program has provided 1,282,595 screens to 514,867 Ontario women over the age of 50. Less than half (40.1%) of all client visits were initial screens (that is, women having their first screen at OBSP) and the remainder (59.9%) were women returning for a subsequent program screen. Since its first complete year in 1990/91, the annual number of screens has increased substantially from 15,970 in 1990 to 211,945 in 2003 (Figure 1).

During the early years of the Program, as each of the ten regional hubs and the mobile van began operation across the Province, the number of initial screens increased from 15,970 in 1990/91 to 39,734 in 1992. Starting in 1993, the initial screens declined continuously to 23,251 in 1996 and then began to increase again to 63,639 in 2003 with the opening of affiliate centres. In contrast, the number of rescreens has increased consistently from 562 in 1992 to 148,306 in 2003.

Figure 1 Number of Screens in OBSP, by Year, 1990 – 2003

Number of Screens

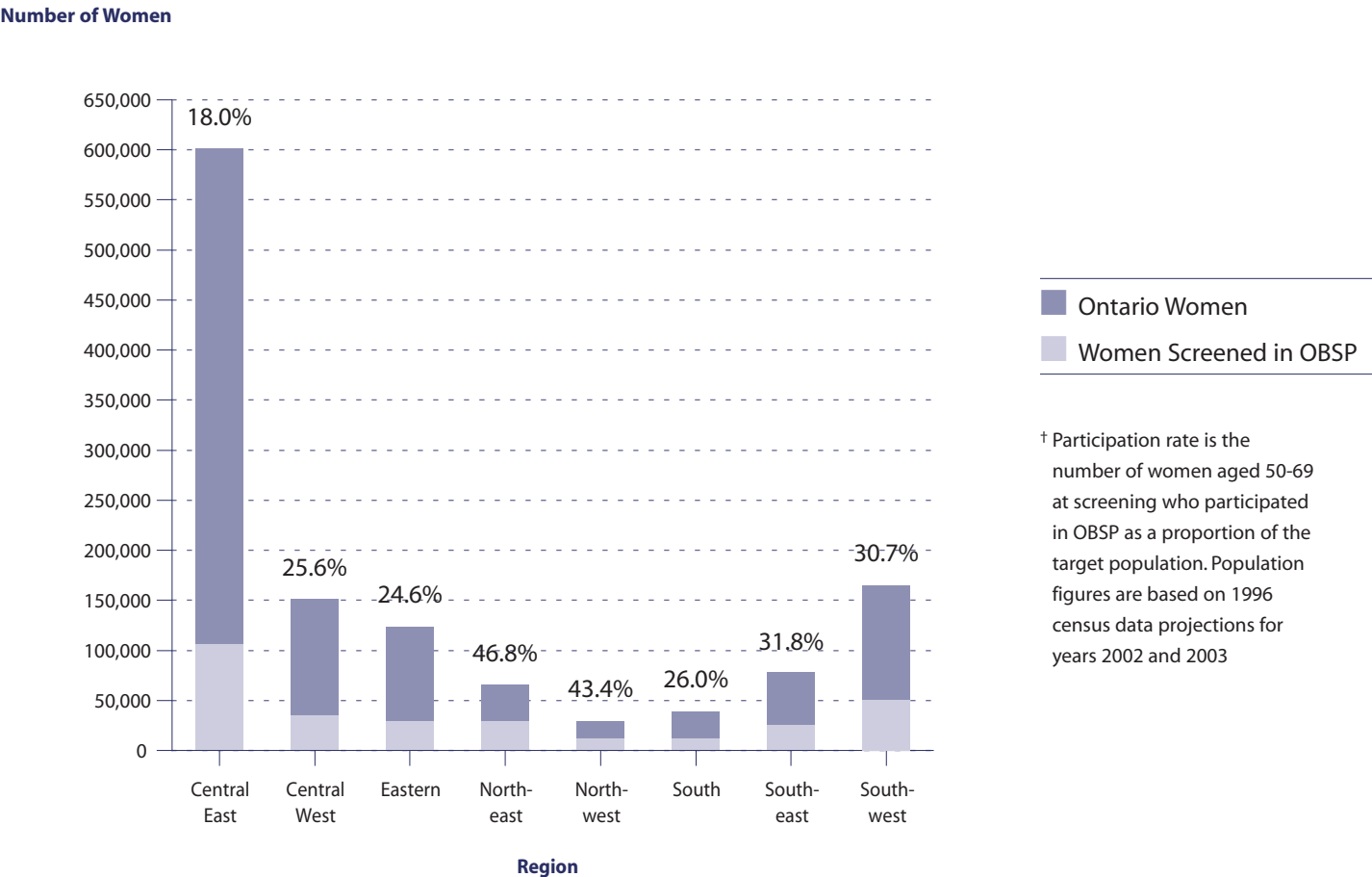


OBSP Participation Rate in Ontario Women Aged 50-69

The goal of the Ontario Breast Screening Program is to screen 70% of women aged 50 to 69. Figure 2 shows the participation rates for women 50 to 69 years of age by region. Between 2002 and 2003, 302,196 women aged 50 to 69 were screened by the OBSP, yielding a participation rate of 24.4% of all women 50 to 69 years of age in Ontario.

Participation rates range from a high of 46.8% in the Northeast region to a low of 18.0% in the Central East region. It is anticipated that continued program expansion will improve overall recruitment as well as increased coverage across the Province.

Figure 2 OBSP Participation Rate[†] in Ontario Women Aged 50-69 by Region, 2002 and 2003



Recruitment and Compliance

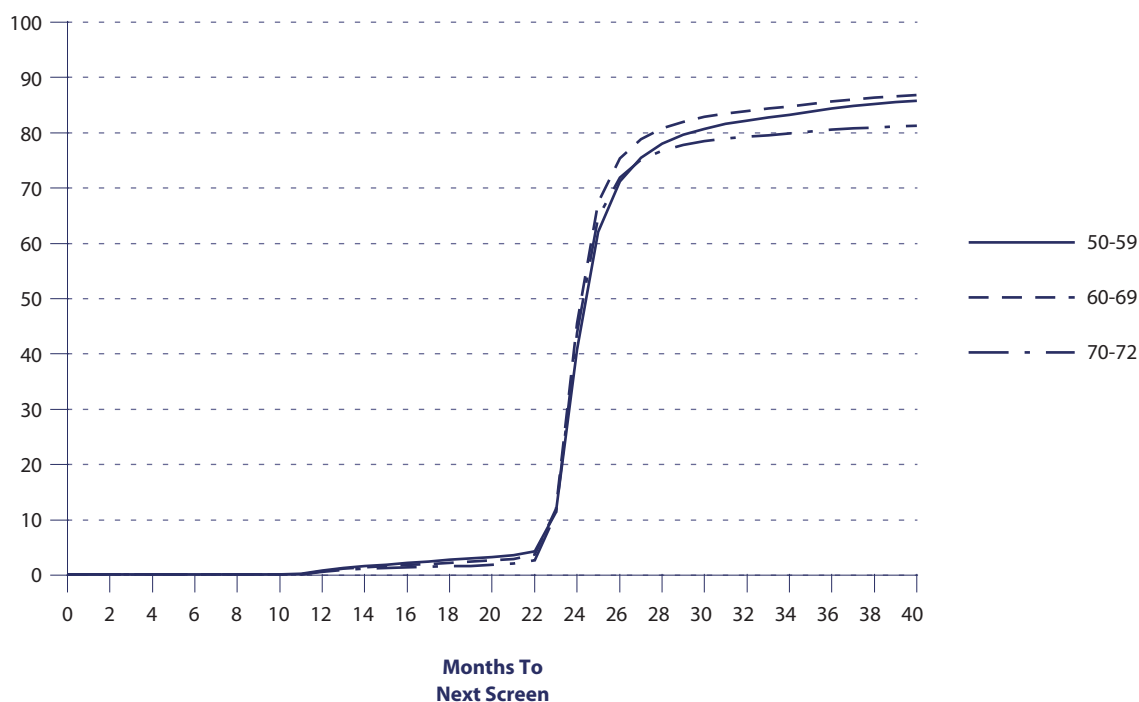
Compliance to Rescreening

Figure 3 shows the percentage of women who returned for rescreening by age group for women aged 50-72[†] who last attended the OBSP between 1999 and 2000 and who had a rescreening recommendation of 2 years. Recall letters were sent to targeted women two months before their next screening visit to remind them to return for screening.

Overall, 86.1% of women returned for at least one rescreen at OBSP and 81.2% returned within 6 months of their recommended screening date. These percentages were highest for women 50 to 69 years of age (86.5% for ever returned; 81.5% return within 6 months) and lowest for women 70-72 years of age (81.3% for ever returned; 78.3% return within 6 months).

Figure 3 Compliance to Rescreening by Age Group at OBSP, 1999 – 2000

Cumulative Percent Rescreened



Note:

† Women excluded are those who have breast cancer, those who received a one-year or annual recall, as well as those aged 73 or 74 years as they are not recalled due to their age.

OBSP Participant Profile

During the screening visit, some risk factor and clinical information is obtained during a personal interview with the nurse examiner or technologist. Mammographic breast density is indicated by the radiologist when recording their findings from the mammogram. Some of the results of the information collected for women aged 50-74 are shown in Table 1.

Having a first degree relative with breast cancer and having high mammographic breast density are important risk factors for developing breast cancer. Being 30 years

of age or older at first full-term pregnancy and never having had children (nulliparity) are associated with modest elevations in risk. Estrogen replacement therapy slightly increases the risk.

Of the OBSP women screened in 2002, 16.1% had a family history of breast cancer, 8.7% had high mammographic breast density, 10.4% had their first birth at 30 years of age or older, 11.3% were nulliparous, and 35.8% were currently on estrogen replacement therapy.

Table 1 OBSP Participation Profile by Age Group, 2002

	Age at Exam (%)			Total(%)
	50-59	60-69	70-74	50-74
Number of women	94,811	68,581	22,301	185,693
Family history of breast cancer [†]				
Yes	14.4	17.1	20.0	16.1
No	85.6	82.9	80.0	83.9
Mammographic breast density [‡]				
≥ 75%	11.3	6.5	4.8	8.7
< 75%	88.7	93.5	95.2	91.3
# unknown	8	19	7	34
Age at first birth (including still-born)				
≥ 30	12.1	8.2	10.4	10.4
< 30	87.9	91.8	89.6	89.6
# unknown	230	167	60	457
Number of children (including still-born)				
None	13.1	9.5	9.6	11.3
≥ 1	86.9	90.5	90.4	88.7
# unknown	118	75	22	215
Current estrogen use				
Yes	38.8	35.6	24.0	35.8
No	61.2	64.4	76.0	64.2
# unknown	1,167	868	265	2,300

Notes:

† Family history of breast cancer includes breast cancer in first-degree relatives (mother, sister, daughter, father, brother, son).

‡ The proportion of connective tissue and epithelial tissue as opposed to fat.

Screening Results

Screening Outcome Summary

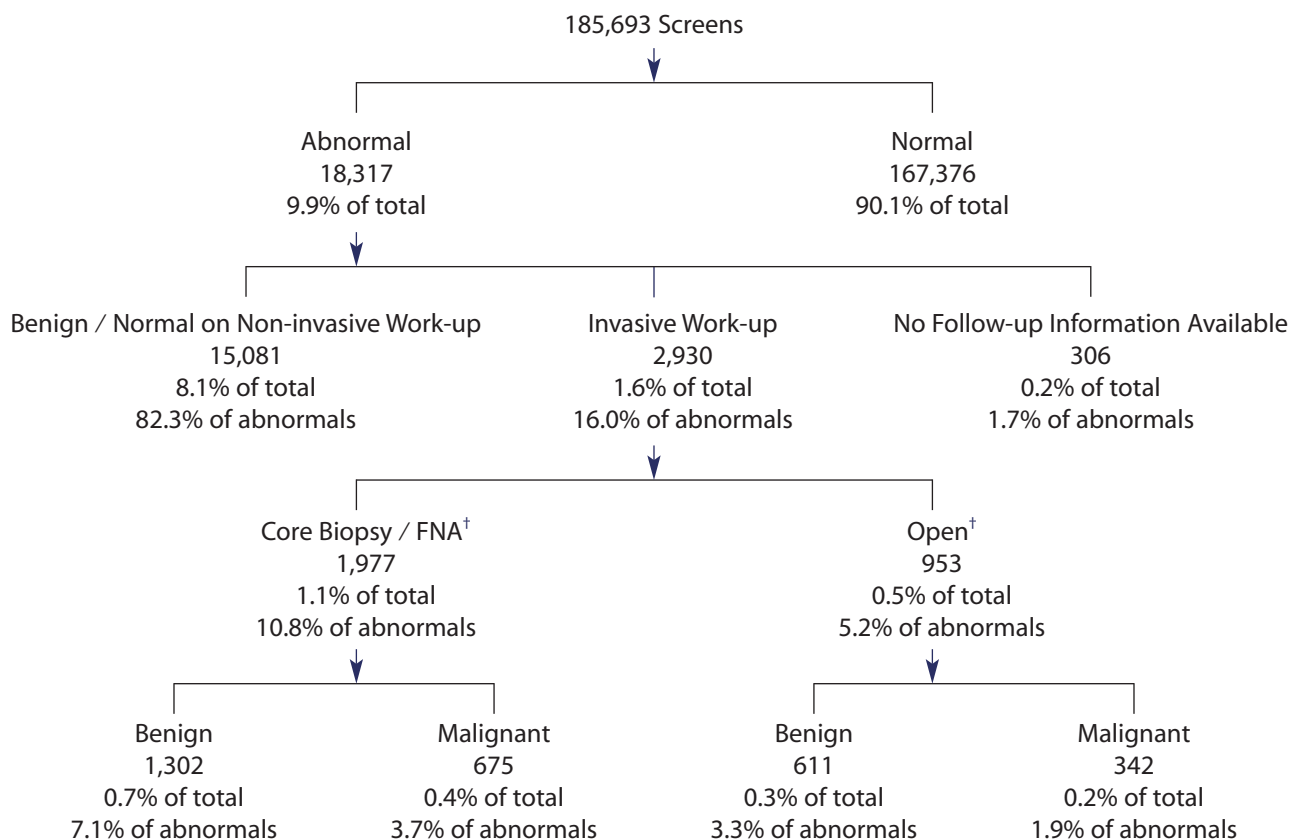
Figure 4 depicts a summary of the outcomes during 2002 for initial screens and rescreens combined for women aged 50-74. Overall, about 9.9% were referred for assessment and 1,017 cancers were detected (cancer detection rate of 5.5 per 1,000 screens and positive predictive value of 5.6 cancers per 100 referrals). The majority of women referred (82.3%) had non-invasive work-up, 16.0% had invasive work-up and 1.7% had no follow-up information. The majority of women with a benign final result (88.7%) were diagnosed without a biopsy, 7.7% were diagnosed by a fine needle aspiration and/or core biopsy and 3.6% were diagnosed by an open biopsy. The majority of women with breast cancer (66.4%) were diagnosed by fine needle aspiration and/or core biopsy and 33.6% were diagnosed by an open biopsy.

Outcome Indicators

Table 2 provides information about outcome indicators by age group for 2002. Of the 185,693 screens performed on women aged 50-74, 18,317 (9.9%) had an abnormal result and 1,017 breast cancers were diagnosed (5.5 per 1,000 screens and 5.6 per 100 referrals). Referral rates decreased slightly with age from 13.4% in women 50-59 to 11.2% in women 70-74 years of age for initial screens and from 8.8% in women 50-59 to 8.1% in women 60-69 and 70-74 years of age for rescreens. The invasive cancer detection rates increased with age from 4.2 to 6.4 per 1,000 for initial screens and from 3.5 to 7.3 per 1,000 for rescreens in women 50-59 and 70-74 years of age, respectively.

For initial screens, the in-situ cancer detection rate (per 1,000 screens) increased slightly with age from

Figure 4 Screening Outcome Summary of OBSP Screens, 2002



Note:

† Biopsy which resulted in a final diagnosis

0.7 in women 50-59 to 1.1 in women 60-69 years of age and then declined to 0.5 in women 70-74 years of age. For rescreens, the in-situ cancer detection rate (per 1,000 screens) remained stable in women 50-59 and 60-69 years of age at 0.8 and increased slightly to 0.9 in women aged 70-74 years.

Consistent with higher cancer detection rate, the positive predictive value (the number of women detected with breast cancer per 100 referrals) was highest for women aged 70-74 for rescreens (10.2% for women aged 70-74 years versus 4.9% for women aged 50-59 years) and highest for women aged 60-69 and 70-74 for initial screens (6.1% for women aged 60-69 and 70-74 years versus 3.7% for women aged 50-59 years). In contrast, the benign to

malignant surgical biopsy ratio (ratio of women with a benign diagnosis versus a malignant diagnosis following a surgical biopsy) was highest for women aged 50-59 (0.81:1) and lowest for women aged 70-74 (0.40:1), with higher values indicating lower quality of pre-surgical assessment. The percentage of OBSP abnormal screens without an open biopsy diagnosed within the recommended interval increased slightly with age (from 76.2% to 77.1% in women aged 50-59 and 70-74 years, respectively). The proportion of OBSP abnormal screens with an open biopsy diagnosed within the recommended interval increased from 35.2% in women aged 50-59 to 39.1% in women 60-69 years of age and then declined slightly to 38.0% in women aged 70-74 years.

Table 2 Outcome Indicator by Age Group, OBSP, 2002

Outcome Indicator	Age at Exam			Total
	50-59	60-69	70-74	50-74
Number of screens n (%)				
Initial	41,078 (67.5)	15,705 (25.8)	4,083 (6.7)	60,866
Rescreen	53,733 (43.0)	52,876 (42.4)	18,218 (14.6)	124,827
Number of cancers n (%)				
Initial	203 (58.8)	114 (33.0)	28 (8.1)	345
Rescreen	230 (34.2)	292 (43.5)	150 (22.3)	672
Referral rate (%)				
Initial	13.4	11.9	11.2	12.9
Rescreen	8.8	8.1	8.1	8.4
Invasive cancer detection rate (per 1000)				
Initial	4.2	6.2	6.4	4.9
Rescreen	3.5	4.7	7.3	4.6
In-situ cancer detection rate (per 1000)				
Initial	0.7	1.1	0.5	0.8
Rescreen	0.8	0.8	0.9	0.8
Positive predictive value (%)				
Initial	3.7	6.1	6.1	4.4
Rescreen	4.9	6.8	10.2	6.4
Benign to malignant surgical biopsy ratio				
All Screens	0.81:1	0.48:1	0.40:1	0.61:1
Diagnostic Interval [†] (%)				
Within 5 weeks without an open biopsy	76.2	76.4	77.1	76.4
Within 7 weeks with an open biopsy	35.2	39.1	38.0	36.9

Note:

[†] Diagnostic interval was stratified according to women with and without an open diagnostic biopsy (ie, open biopsy which resulted in a final diagnosis).

Screening Results

Diagnostic Investigation

Table 3 summarises the diagnostic procedures for 17,963 (98.1%) of the women aged 50-74 who had abnormal screening result for 2002. Procedures undertaken after the date of diagnosis were excluded. The most common diagnostic procedures were ultrasound (64.5% of referred women), followed by a diagnostic mammogram (62.1%),

a family physician visit (16.4%) and a consultation with a surgeon (15.0%). Furthermore, 3.5% underwent a fine needle aspiration, 9.4% underwent a core biopsy and 5.3% underwent an open biopsy.

Table 3 **Diagnostic Procedures Received by OBSP Participants with Abnormal Screens, by Age Group, 2002**

	Age at Exam			Total
Procedure [†] (% assessed)	50-59	60-69	70-74	50-74
Physician visit	15.1	17.8	18.4	16.4
Surgical consultation	14.7	14.9	16.9	15.0
Diagnostic mammogram	62.2	62.2	61.7	62.1
Ultrasound	66.4	63.0	59.6	64.5
Fine needle aspiration	3.3	3.4	4.4	3.5
Core biopsy	8.8	9.8	11.3	9.4
Open biopsy	5.0	5.4	6.8	5.3
Number assessed	10,010	6,048	1,905	17,963

Note:

† Percentages and numbers are based on women with diagnostic assessment information available. Women receiving more than one procedure are included in more than one grouping. Procedures after date of diagnosis have been excluded.

Histologic Features of Screen Detected Breast Cancers

Table 4 summarises the histologic features of screen detected breast cancers by age group. For 2002, 1,017 women were diagnosed with breast cancer, 85.1% were invasive and 14.9% were in-situ. Of the invasive tumours the majority (85.9%) were infiltrating ductal carcinoma.

Tumour size, nodal status and stage are important indicators in assessing program success, as they provide an indication of whether a reduction in mortality is possible. Established Canadian standards specify that at least 25% of screen detected breast cancers should be less than or equal

to 10 mm in diameter and less than 30% of screen detected cancers should have lymph node metastases. Of the invasive tumours with known size, 36.6% were less than or equal to 10 mm and of the invasive tumours with known nodal status, 20.9% had lymph node metastases. Staging data also indicate that breast cancers are being detected at an early stage with about 74.0% of the tumours with known stage being stage 0 (in-situ) or stage I (tumour size of 2 cm or less with no regional lymph node involvement) and 23.9% being stage II (larger tumour size and/or regional lymph node involvement). Only 2.1% were stage III or stage IV (presence of distant metastasis).

Table 4 **Histologic Features of Screen Detected Breast Cancers in OBSP, by Age Group, 2002**

Outcome Indicator	Age at Exam No. (%)			Total No. (%)
	50-59	60-69	70-74	
Type of cancer				
In-situ	74 (17.1)	59 (14.5)	19 (10.7)	152 (14.9)
Invasive	359 (82.9)	347 (85.5)	159 (89.3)	865 (85.1)
Tumour size (invasive only), mm				
≤ 5	42 (11.8)	21 (6.0)	12 (7.5)	75 (8.7)
6-10	83 (23.2)	110 (31.7)	48 (30.2)	241 (27.9)
11-15	91 (25.5)	92 (26.5)	41 (25.8)	224 (26.0)
16-20	64 (17.9)	70 (20.2)	29 (18.2)	163 (18.9)
>20	77 (21.6)	54 (15.6)	29 (18.2)	160 (18.5)
# unknown	2	0	0	2
Nodal status (invasive only)				
Negative	261 (77.0)	251 (78.0)	116 (87.2)	628 (79.1)
Positive	78 (23.0)	71 (22.2)	17 (12.8)	166 (20.9)
# unknown	20	25	26	71
Histologic grouping (invasive only)				
Infiltrating ductal carcinoma	314 (87.5)	296 (85.3)	133 (83.6)	743 (85.9)
Infiltrating lobular carcinoma	21 (5.8)	24 (6.9)	14 (8.8)	59 (6.8)
Tubular	15 (4.2)	12 (3.5)	6 (3.8)	33 (3.8)
Mucinous	6 (1.7)	12 (3.5)	6 (3.8)	24 (2.8)
Other [†]	3 (0.8)	3 (0.9)	0 (0.0)	6 (0.7)
TNM staging [‡]				
0 (in-situ)	74 (17.8)	59 (15.5)	19 (11.4)	152 (15.8)
I	225 (54.0)	223 (58.5)	113 (68.1)	561 (58.3)
II	105 (25.2)	94 (24.7)	31 (18.7)	230 (23.9)
III-IV	12 (2.9)	5 (1.3)	3 (1.8)	20 (2.1)
# unknown	17	25	12	54

Notes:

[†] Other includes metaplastic.

[‡] TNM staging for invasive tumours less than or equal to 2 cm was determined by assuming nodal status negative (N0) whenever nodes were not examined and there was no distant metastasis (M0).

Screening Results

Comparison of OBSP Outcome Indicators to Canadian Standards

Table 5 depicts the OBSP screening outcomes for women referred by mammography, compared with Canadian standards. Recently, national standards for Canada have been developed which combine elements of Canadian programs and address Canada's population health context. The Canadian standards were established for asymptomatic women screened by mammography between the ages of 50 and 69 years with no prior diagnosis of breast cancer.

Overall, OBSP meets Canadian standards for the majority of outcome indicators measured.

Participation rate is anticipated to increase with the opening of new screening affiliates. Time to diagnosis and benign to malignant surgical biopsy ratio are expected to improve where comprehensive, high quality, multidisciplinary assessment is integrated with screening.

Table 5 Outcome Indicators in OBSP compared to Canadian Standards, Ages 50-69, 2002

Outcome Indicator	Total Mammography	Canadian Standard
Participation Rate [†] (%)		
All screens	24.4	≥ 70
Retention rate [‡] (%)		
All screens	81.5	≥ 75
Referral Rate (%)		
Initial	10.5	< 10
Rescreen	6.3	< 5
Invasive Cancer Detection Rate (per 1000)		
Initial	4.5	> 5
Rescreen	3.8	> 3
Positive Predictive Value (%)		
Initial	5.1	≥ 5
Rescreen	7.4	≥ 6
Benign to Malignant Surgical Biopsy Ratio		
All screens	0.54:1	≤ 2:1
Tumour Size ≤ 10mm (%)		
All screens	37.4	>25
Node Positive (%)		
All screens	21.8	< 30
Diagnostic Interval [§] (%)		
Within 5 weeks without a diagnostic open biopsy	79.8	≥ 90
Within 7 weeks with a diagnostic open biopsy	39.5	≥ 90
Post Screen Detected Invasive Cancer Rate (per 10,000 person years) *		
Within 12 months	5.1	< 6
Within 24 months	9.4	< 12

Notes:

[†] Data for 2002 and 2003 screen years were used.

[‡] Percentage of women who last attended the OBSP in 1999 or 2000 with a two year screening recommendation who were rescreened within 30 months (ie, up to 6 months after the recommended interval) of their previous screen.

[§] The Canadian standard includes any open biopsy. In contrast, the OBSP diagnostic screening interval indicator includes only open biopsies performed within the date of diagnosis

* Data for 1996 and 1997 screen years were used. Both modalities of referral were considered.

Appendix 1 – Breast Screening Program Performance Measures

As of February 2002

Indicator	Definition	Target [†] (age 50-69)
1 Participation Rate	Percentage of women who have a screening mammogram (calculated biennially) as a proportion of the eligible population	≥70 %of the eligible population
2 Retention Rate	The estimated percentage of women who are rescreened within 30 months of their previous screen	≥ 75% rescreened within 30 months
3 Abnormal Call Rate (%)	Percentage of women screened who are referred for further testing because of abnormalities found with a program screen	< 10 (initial screen) < 5 (rescreens)
4 Invasive Cancer Detection Rate	Number of women detected with invasive cancer during a screening episode per 1,000 women screened	> 5 per 1,000 on initial screen > 3 per 1,000 on rescreens
5 In Situ Cancer Detection Rate	Number of women detected with ductal carcinoma in situ cancer (rather than invasive cancer) during a screening episode per 1,000 women screened	Surveillance and monitoring purposes only
6 Diagnostic Interval	Total duration from abnormal screen to resolution of abnormal screen	≥ 90% within 5 weeks if no open biopsy ≥ 90% within 7 weeks if open biopsy
7 Positive Predictive Value	Proportion of abnormal cases with completed follow-up found to have breast cancer (invasive or in situ) after diagnostic workup	≥ 5% (initial screen) ≥ 6% (rescreen)
8 Benign to Malignant Open Biopsy Ratio	Among open biopsies, the ratio of number of benign cases to the number of malignant cancer cases	≤ 2:1 open (initial and rescreen combined)
9 Invasive Cancer Tumour Size	Percentage of invasive cancers with tumour size of <10 mm in greatest diameter as determined by the best available evidence: 1) pathological, 2) radiological, 3) clinical	> 25% < 10 mm
10 Positive Lymph Nodes in Cases of Invasive Cancer	Proportion of invasive cancers in which the cancer has invaded the lymph nodes	< 30% node positive
11 Post-screen Detected Invasive Cancer Rate	Number of women with a diagnosis of invasive breast cancer after a negative screening episode per 10,000 person-years at risk, within 12 AND 24 months of the screen date.	< 6 per 10,000 person-years (within 12 months) < 12 per 10,000 person-years (within 24 months)

Note:

† Canadian targets obtained by consensus and based on evidence supported by literature

Reference:

Health Canada. *Quality Determinants of Organized Breast Screening Programs in Canada*.

Ottawa: Minister of Public Works and Government Services Canada, 2003. Page 68. www.healthcanada.ca

Appendix 2 – OBSP Staff Directory

As of March 31, 2004

Provincial Office / Cancer Care Ontario

620 University Avenue, 11th Floor
Toronto, Ontario M5G 2L7

Tel 416 971-9800 **Fax** 416 217-1255

Director, Preventive Oncology

Dr. Verna Mai

Tel 416 217-1252 **Fax** 416 217-1243

Provincial Manager

Bob Knight

Tel 416 217-1231 **Fax** 416 217-1255

Radiologist-in-Chief

Dr. Rene Shumak

Tel 416 971-9800 ext 1138 **Fax** 416 971-6888

Physics Consultant

Dr. Martin Yaffe

Physics Consulting Group

Sunnybrook and Women's College

Health Sciences Centre Imaging Research, Rm S-657 2075

Bayview Avenue, Toronto ON M4N 3M5

Tel 416 480-5702 **Fax** 416 480-5714

Provincial Health Promotion Coordinator

Lorna Dobi

Tel 416 971-9800 ext 1126 **Fax** 416 971-6888

Provincial MRT Coordinator

Erin Jones

OBSP London

339 Talbot Street, London ON N6A 2R5

Tel 519 432-6016 ext 219 **Fax** 519 432-0271

Consultant Pathologist

Dr. Frances O'Malley

Mount Sinai Hospital

600 University Avenue, 6th Floor

Toronto ON M5G 1X5

Tel 416 586-4548 **Fax** 416 586-8628

Appendix 3 – Regional Centres

As of March 31, 2004

Central East Region

10 Milner Business Court, Suite 204
Scarborough, Ontario M1B 3C6
Tel 416 298-1453 Fax 416 298-7470

Regional Administrator	Susan Fekete
Medical Coordinator	vacant
Radiology Coordinators	Dr. Eve Fishell Dr. Rene Shumak

Central West Region

Sir William Osler Health Institute
565 Sanatorium Road, Suite 207
Hamilton, Ontario L9C 7N4
Tel 905 389-0300 Fax 905 389-5278

Regional Administrator	Teresa McPhail
Medical Coordinator	vacant
Radiology Coordinator	Dr. Slobodan Franic

Eastern Region

Hampton Park Plaza
1419 Carling Avenue, Suite 214 (2nd Floor)
Ottawa, Ontario K1Z 7L6
Tel 613 728-6508 Fax 613 728-6333

Regional Administrator	Suzie Joannis
Medical Coordinator	Dr. Vincent Young
Radiology Coordinator	Dr. Gérard Collin

Northeast Region

4 Walford Road
Sudbury, Ontario P3E 2H4
Tel 705 675-2294 Fax 705 675-2637

Regional Administrator	Carolyn Jackson
Medical Coordinator	Dr. Amanda Hey
Radiology Coordinator	Dr. Rick Sloan

Northwest Region

68 North Algoma Street
Thunder Bay, Ontario P7A 4Z3
Tel 807 343-1690 Fax 807 345-6602

Acting Regional Administrator	Alison McMullen
Medical Coordinator	vacant
Radiology Coordinator	Dr. Donald Henderson

South Region

1275 Walker Road, Unit 10
Windsor, Ontario N8Y 4X9
Tel 519 253-1179 Fax 519 253-0734

Regional Administrator	Lynn Chappell
Medical Coordinator	Dr. John Shaw
Radiology Coordinator	Dr. Winston Ramsewak

Southwest Region

339 Talbot Street
London, Ontario N6A 2R5
Tel 519 432-6016 Fax 519 432-0271

Regional Administrator	Lynn Chappell
Medical Coordinator	Dr. Paul Ferner
Radiology Coordinators	Dr. Keith Sparrow

Southeast Region

786 Blackburn Mews
Kingston, Ontario K7P 2N7
Tel 613 384-4284 Fax 613 384-8645

Regional Administrator	Brenda Bass
Medical Coordinator	Dr. Diane Pross
Radiology Coordinator	Dr. Doris Jabs

Appendix 4 – OBSP Committees

As of March 31, 2004

OBSP Strategic Management Committee

Association of Local Public Health Agencies

Maureen Harmer

Breast Cancer Action

Joan Sirrs

Canadian Breast Cancer Foundation, Ontario Chapter

Sharon Wood

Canadian Cancer Society, Ontario Division

Patti Payne

Cancer Care Ontario

Dr. Verna Mai, (Chair)

Director, Preventive Oncology

Wendy Bell

Northwestern Regional Cancer Program

Raylene Godel

Preventive Oncology Committee of the Board

Ontario Association of Radiologists

Dr. George Loughheed

Dr. Viviane Messaad

Dr. Giuseppe Tarulli

Ontario Breast Screening Program

Lynn Chappell

Regional Administrator

Dr. Diane Pross /Dr. Paul Ferner

Medical Coordinator (alternate)

Bob Knight

Provincial Manager

Dr. Rene Shumak

Radiologist-in-Chief

Ontario College of Family Physicians

Dr. Jamie Meuser

Ontario Medical Association

Dr. Margaret Collins

Patient/Survivor Representatives

Ann Grant

Triena Huneault

Heather Lyons

The purpose of the OBSP Strategic Management Committee is to provide overall guidance to the Director of Screening Programs at Cancer Care Ontario on the strategic management of the OBSP. Specific responsibilities of the Committee include:

- To set the direction of the Program in order to deliver a quality assured breast screening program across the province.
- To develop and direct program policies in accordance with the mandate of Cancer Care Ontario and the delivery of CCO programs at the regional level.
- To evaluate the monitored outcomes of the Program with a view to continuous improvement in the quality and efficiency of breast cancer screening in the province.

The Committee meets quarterly and is chaired by the Director, Preventive Oncology at Cancer Care Ontario. Membership includes: One Representative from each of Canadian Breast Cancer Foundation, Canadian Cancer Society (Ontario Division), Ontario Medical Association, Ontario College of Family Physicians, CCO Preventive Oncology Board, Public Health; two representatives of the regional cancer programs; three representatives from the Ontario Association of Radiologists; four patient/survivor representatives; and one representative of each of OBSP medical staff, radiologists and administration.

Appendix 4 – OBSP Committees

As of March 31, 2004

Research Committee

Cancer Care Ontario

Dr. Anna Chiarelli
Scientist, Screening Unit

Dr. Verna Mai
Director, Preventive Oncology

Dr. Larry Paszat
Director, Preventive Oncology Program TSRCC

Ontario Breast Screening Program

Brenda Bass
Regional Administrator

Dr. Gérard Collin
Radiology Coordinator

Dr. Frances O'Malley
Consultant Pathologist

Dr. Rene Shumak
Radiologist-in-Chief

Dr. Martin Yaffe
Physics Consultant

Nada Malek
Research Clerk

Ontario Cancer Institute

Dr. Norman Boyd
Head, Division of Epidemiology and Statistics (Chair)

Patient/Survivor Representatives

Heather Resnick

The purpose of the OBSP Research Committee is to provide overall guidance and advice to the OBSP on research activities involving Program data or clients. Specifically, the Committee develops and reviews key research policies and protocols, ensures that there is a standardized review of proposals, identifies research and Program evaluation priorities, monitors the progress of research projects and monitors and/or approves all manuscripts or reports prior to submission.

The Committee is chaired by the Head of the Division of Epidemiology and Statistics, Ontario Cancer Institute. Its membership includes the Director, Preventive Oncology, three regional OBSP representatives, the Radiologist-in-Chief of the OBSP, Scientist(s) for the Screening Unit, faculty members of the University of Toronto and community representatives.

The Committee meets quarterly or as often as necessary to review research proposals and policies, to monitor the progress of research projects and to identify research priority areas for the OBSP. The Committee is also available to provide guidance in the preparation of proposals and/or manuscripts pertaining to OBSP research projects.

Appendix 4 – OBSP Committees

As of March 31, 2004

Ontario Breast Assessment Collaborative Group

Cancer Care Ontario

Dr. Verna Mai (Chair)

Dr. Margaret Fitch

Canadian Association of Pathologists

Dr. Frances O'Malley

Canadian Breast Cancer Foundation, Ontario Chapter

Sharon Wood, Executive Director

Canadian Cancer Society, Ontario Division

Patricia Payne, Manager, Program Development

Canadian Surgical Society of Oncology

Dr. Douglas Mirsky

College of Physicians and Surgeons of Ontario

Dr. Daniel Klass

Institute for Clinical Evaluative Sciences

vacant

Ontario Association of General Surgeons

Dr. Robert Mackenzie (Advisory to Group)

Ontario Association of Medical Radiation Technologists

Ms. Carolyn Caughell

Ontario Association of Pathologists

Dr. Leela Elavathil

Ontario Association of Radiologists

vacant

Ontario Breast Screening Program

Bob Knight, Provincial Manager

Dr. Rene Shumak, Radiologist-in-Chief

Ontario College of Family Physicians

Dr. Ruth Heisey

Ontario Hospital Association

Dr. Elizabeth Carlton

Ontario Medical Association

Dr. Margaret Collins

Ontario Medical Association – Section on Rural Practices

Dr. Ian Shiozaki

Ontario Public Health Association

Judith Cousins

Community Breast Assessment Development

Dr. Diane Pross, Kingston

Carole Mayer, Sudbury

Jane Warner, Kingston

Dr. David Williams, Thunder Bay

Patient/Survivor Representative

Heather Campeau

The Ontario Breast Assessment Collaborative Group (OBACG) identifies and brings together providers and consumers involved in breast assessment. This is in order that their roles can be understood as well as their perceptions on the gaps in service provision and opportunities for improvements. Specific goals and objectives of the OBACG include:

- To act as a forum for discussion of models and components of breast assessment needed in Ontario in order to provide equal access, quality of service and minimize duplication.
- To ensure communication and be a source of information about breast assessment to professional groups, consumer groups as well to CCO committees provincially and regionally.
- To set and advocate for the acceptance of breast assessment standards.
- To monitor and evaluate quality indicators of the breast assessment process.

The OBACG meets quarterly and is chaired by the Director, Preventive Oncology at Cancer Care Ontario.