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Executive Summary

The Pan-Canadian Cervical Screening Network (PCCSN) is a strategic initiative of the Canadian Partnership Against Cancer (the Partnership). The PCCSN serves as a national forum to discuss and take action on matters related to cervical cancer screening programs and their integration with HPV testing and vaccination initiatives.

On November 13, 2013, the PCCSN hosted a Cervical Cancer Screening Targets Workshop in Toronto, Ontario with approximately 50 participants from across Canada. Attending were PCCSN member representatives and individual experts from national and provincial cancer care organizations, provincial cervical cancer screening programs, pathologists, gynaecologists, colposcopists, family physicians, biostatisticians and epidemiologists.

The purpose of the workshop was to begin the process of establishing cervical cancer screening targets in Canada. This workshop also provided participants with an opportunity to network, share information, collaborate and become aligned regarding quality standards in Canadian cervical cancer screening.

In 2009, the Screening Performance Indicators Working Group, under the guidance of the Public Health Agency of Canada’s Steering Committee for the Cervical Cancer Prevention and Control Network, developed 12 performance indicators for cervical cancer screening programs. The purpose of these indicators was to monitor cervical screening progress in the areas of coverage, cytology performance, system capacity, follow-up, and outcomes. The Pan-Canadian Cervical Screening Network then collaborated with Canadian cervical cancer screening programs to develop standardized reporting definitions for the 12 indicators followed by the production of a report that provided information on cervical cancer screening across Canada.

Before developing targets, a comprehensive national and international scan of data, targets, and relevant literature was conducted by the Partnership. Based on a review of this environmental scan, six indicators with proposed targets were presented to the workshop for discussion.

Based on workshop findings, the following six targets and considerations were agreed upon:

**Participation**

The recommended target is ≥ 80 percent for women aged 21 to 69 should be screened within the recommended screening interval plus six months (i.e. 3 years plus 6 months). There was strong interest in developing action plans to improve participation in order to meet this target.

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Specimen Adequacy
The recommended target is 0.5 to ≤ 2 percent of tests should be reported as unsatisfactory. Criteria for specimen adequacy need to be further defined. There was also a desire to develop action plans to achieve this target including providing feedback to clinicians.

Cytology Turnaround Time
The recommended target is 90 percent of Pap tests should be reported within 14 calendar days (or 10 working days). Reducing the turnaround time to provide women with a cytology outcome as quickly as possible was felt to be important when setting this target. Developing action plans regarding the notification of results was viewed as necessary and important.

Time to Colposcopy
The recommended target for time to colposcopy is 90 percent of women with a high-grade Pap test result should have a colposcopy examination within six weeks from the Pap test report date or four weeks from the colposcopy referral date. It was agreed the target should strongly reflect the importance of reducing the time to diagnosis thereby reducing anxiety for women as much as possible.

Establishing different targets for high- and low-grade cytology was also discussed. Similarly, participants suggested establishing a target to capture compliance with attendance at colposcopy. Overall, participants felt there was a need to develop action plans for this indicator and target.

Cytology Histology Agreement
The recommended target is ≥ 65 percent of high-grade Pap tests (HSIL+) with histological work-up should have a pre-cancerous or an invasive cancer histological outcome. It was recommended that both ASC-H and HSIL+ be tracked but, at this time, a target should only be set for HSIL+. This target will require monitoring and amendment once the HPV cohort reaches screening age.

Cancer Incidence
While there was agreement that a target should be established, participants concluded that additional information is required before it is set. It was suggested this target should include an associated time frame. Similarly, the impact of immunization will need to be factored into the target setting.

Overall, participants felt it was important to establish targets for the six identified indicators. These targets have been developed based on the findings of a comprehensive national and international environmental scan in collaboration with experts from across the country. The targets chosen are aspirational, yet achievable. There is a willingness among those present to develop action plans to realize these targets and to enhance overall quality improvements in cancer control.
Introduction

The Pan-Canadian Cervical Screening Network (PCCSN) is a strategic initiative of the Canadian Partnership Against Cancer (the Partnership). The PCCSN serves as a national forum to discuss and take action on matters related to cervical cancer screening programs and their integration with HPV testing and vaccination initiatives.

On November 13, 2013, the PCCSN hosted a Cervical Cancer Screening Targets Workshop in Toronto, Ontario with approximately 50 participants from across Canada. Attending were PCCSN member representatives and individual experts from national and provincial cancer care organizations and provincial cervical cancer screening programs, pathologists, gynaecologists, colposcopists, family physicians, biostatisticians, and epidemiologists.

The purpose of the workshop was to begin the process of establishing cervical cancer screening targets in Canada. This workshop also provided participants with an opportunity to network, share information, collaborate and become aligned regarding quality standards in Canadian cervical cancer screening. This report provides an account of the workshop and its outcomes.
Workshop Overview and Presentations

Dr. Meg McLachlin, Chair, PCCSN, welcomed participants and provided an overview of the workshop and the desired outcomes. Dr. McLachlin encouraged participants to engage in frank and open dialogue throughout the day with the aim of coming to consensus on the establishment of national targets for cervical cancer screening in Canada.

SETTING NATIONAL CERVICAL CANCER SCREENING TARGETS

Dr. Heather Bryant
Vice President, Cancer Control
Canadian Partnership Against Cancer

Dr. Heather Bryant provided an overview of establishing targets within the context of Canada’s National Cancer Control Strategy. Dr. Bryant highlighted the value of establishing indicators in screening programs as they enable measurement of progress and identify gaps. Similarly, establishing national targets serves as a motivation for change and as a means for programs to strive toward shared goals.

Using the Hospital Model adopted from Heenan et al., 2010, Dr. Bryant made a distinction between “big dots” (i.e. national outcome indicators) and “little dots” (i.e. clinical and corporate quality and process indicators). She noted the focus of the workshop was on the big to medium size dots and building consensus regarding national drivers and indicators. The indicators selected require sufficient evidence to demonstrate that the big dots are being realized. She encouraged participants to take a holistic approach in setting targets for cervical cancer screening, taking into consideration both scientific-based evidence and data as well as the patient’s perspective.

Workshop participants were tasked with setting pan-Canadian cervical cancer screening targets. Dr. Bryant acknowledged this is a complex task as those working at developing targets are located across the country. However, participants bring with them a great depth and breadth of experience relating to cervical cancer prevention, detection and treatment as well as screening and target setting in general. Dr. Bryant encouraged participants to focus their efforts on selecting a small but meaningful set of targets that are aspirational, yet achievable.
RAISING THE BAR WITH TARGETS

Mr. Rami Rahal
Director, System Performance Cancer Control
Canadian Partnership Against Cancer

Mr. Rami Rahal provided participants with the rationale behind target setting and explained the difference between aspirational, policy and technical targets.

Mr. Rahal demonstrated the significance of setting targets by referencing the 1998 Public Service Agreements (PSA) in the United Kingdom. The establishment of meaningful targets in the PSA led to system performance improvements. These improvements were achieved because the following factors were present:

- The targets selected were precise and short-term (5-10 years) versus long-term and general
- Progresses were measured at the local level, not just the national level
- Clinicians were engaged in the design and implementation of targets
- Organizations were given increased financing, information, and managerial capacity to respond to challenging targets
- Concrete incentives were attached to the targets

Consistent with the PSA findings, the following actions were identified as success factors in target setting within Canada:

- Selecting performance domains that are relevant to administrators, clinicians, and the public/patients
- Developing evidence- and consensus-based targets in collaboration with key stakeholders
- Providing funding and other incentives to move performance to the target levels (i.e. wait times)
- Measuring and reporting progress at set intervals

The Partnership is currently working with its partners to introduce system performance targets. These targets will help identify the magnitude and direction of performance improvement opportunities. Future indicator results will be assessed against the targets. This will allow for the evaluation of performance improvement initiatives that may be implemented at the local or national levels.
In 2008, Ireland’s national cervical screening program, CervicalCheck, was established. CervicalCheck provides women between the ages of 25 and 60 with free access to cervical smear tests. Women between the ages of 25 and 44 are screened every three years. Women aged 45 and older are screened every five years after two normal smear test results three years apart.

CervicalCheck identified its quality assurance indicators and established its targets using a collaborative process. A Quality Assurance Committee was formed with representation from each aspect of the cervical cancer screening processes (program administration, primary care, cytopathology, colposcopy, and histopathology). Each of these stakeholder groups identified their respective indicators and targets. This information was presented to an international panel of experts in the area of cervical cancer screening for review and approval. The Committee subsequently published a document entitled *Guidelines for Quality Assurance in Cervical Cancer Screening*.

This document was prescriptive in nature and provided a significant degree of qualitative direction in terms of how to implement screening. Now that the program is established, the next iteration of this document is in progress and will provide broader and higher level guidelines.
Dr. Flannelly shared the targets that CervicalCheck has established and their progress to date. A summary is as follows:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TARGET</th>
<th>FACTORS &amp; CONSIDERATIONS</th>
</tr>
</thead>
</table>
| PARTICIPATION                    | > 80%                                                                 | • Fifth year participation was 73.7%  
• Women 50-60 years of age are less likely to be screened than women 25-40 years of age  
• Concerted efforts are being devoted to the younger cohort (25-29) to foster trust and compliance |
| LABORATORY TURNAROUND TIME       | Results communicated within 2 weeks of sample at laboratory          | • For 2010-11, 95% of women were notified within the target time frame  
• Smear tests initially had to be sent to laboratories in the United States, which had a negative impact on this target  
• Training program was established  
• Repatriation of 50 percent of the cytology testing has occurred |
| WAIT TIMES FOR RESULTS TO WOMEN  | 90% within 4 weeks                                                    | • Sustained improvements have been achieved over time  
• Started at 40% in year 1 and is now at 75%  
• Target reached in last quarter of year 4  
• Target is reviewed monthly |
| CYTOPATHOLOGY UNSATISFACTORY REPORTING RATES | < 2% | • Low-grade reporting is higher than anticipated requiring more repeat smears |
| TIME TO COLPOSCOPY               | > 90% offered colposcopy appointment within 8 weeks of referral     | • Challenges with new referral capacity  
• Accommodating an additional 16,500 women  
• Colposcopy services contracted to deliver quality assured colposcopy |
| COLPOSCOPY DEFAULT RATE          | < 15%                                                                | • Default rate is currently 9.4% |
| BIOPSY RATE                      | > 95%                                                                | • A biopsy should be performed in the presence of an atypical transformation zone and a smear test which suggest underlying CIN  
• Biopsy rate for 2011 - 12 was 88% |
| HISTOPATHOLOGY RATE              | > 95%                                                                | • Biopsy specimens should be suitable for histological diagnosis  
• The histopathology rate for 2011 - 12 was 98.7% |
| COMPLIANCE BETWEEN COLPOSCOPIC IMPRESSION OF HIGH GRADE DISEASE AND HISTOLOGICALLY PROVEN HIGH- GRADE CIN | > 65% | • Compliance between colposcopic impression of high- grade disease and histologically proven high-grade CIN was 75.3% in 2011 - 12  
• All colposcopists are certified  
• All colposcopy services are required to have a monthly multi-disciplinary team meeting |
| TREATMENT AT COLPOSCOPY (UNDER LOCAL ANAESTHETIC) | > 80% | • In 2011 - 12, 94% of women had treatment under local anaesthetic as opposed to general anaesthetic |

In addition to the above, targets have been set to reduce cervical cancer incidence by 35 percent and mortality by 50 percent by 2018.

Dr. Flannelly concluded her presentation by emphasizing the value of measuring and reporting targets at the local level and maintaining a patient-centred focus.
Dr. Verna Mai provided examples of setting targets in breast and colorectal cancer screening in Canada.

**Breast Cancer Screening**

The Breast Cancer Screening Network has developed a comprehensive set of targets and indicators and has recently published the third edition of *Guidelines for Monitoring Breast Cancer Screening Performance*\(^4\). Thirteen indicators and targets have been established that meet the following criteria:

- Data for the indicator are regularly available
- Data available for the indicator are of high quality
- Meaningful targets have been defined on an evidentiary basis
- Indicators and targets are useful for national comparison
- Monitoring on a regular basis is valuable
- Each indicator is widely accepted for use in program evaluation

The Network periodically reviews the indicators and targets based on program performance reports.

**Colorectal Cancer Screening**

A Targets and Quality Indicators Workshop was held in 2011 for screening program experts and representatives to build consensus on attainable targets and timelines for core quality indicators. This process led to the identification of six targets. The first round of screening results for provincial programs compared to the targets has recently been published.\(^5\)

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Target Setting

Process Description
The remainder of the day focused on setting targets for cervical cancer screening quality indicators. Dr. Kathleen Decker, Chair, Cervical Cancer Screening Monitoring & Evaluation Working Group, PCCSN, provided an overview of the 12 cervical screening indicators currently measured in Canada. These performance indicators, based on the indicators developed by the Screening Performance Indicators Working Group under the guidance of the Public Health Agency of Canada’s Steering Committee for the Cervical Cancer Prevention and Control Network, include the following:

1. Participation rate  
2. Retention rate  
3. Specimen adequacy  
4. Screening test results  
5. Cytology turnaround time  
6. Time to colposcopy  
7. Histological investigation  
8. Cytology histology agreement  
9. Pre-cancer incidence rate  
10. Cancer incidence rate  
11. Cancers diagnosed at Stage 1  
12. Screening history in cases of invasive cancer

The result of a national and international environmental scan that was conducted to identify potential indicator targets was also provided.

The scan resulted in the identification of the following six indicators for which targets potentially could be set, based on targets used elsewhere and available data within Canada:

1. Participation rate  
2. Specimen adequacy  
3. Cytology turnaround time  
4. Time to colposcopy  
5. Cytology histology agreement  
6. Cancer incidence rate

For each of these six quality indicators, Dr. Decker provided an overview of the indicator including the definition developed by the Monitoring and Evaluation Working Group, the evidence from the environmental scan including targets used by other jurisdictions, a review of the data provided by the provinces used to measure each indicator and the proposed target for discussion. The proposed target was developed by the Partnership...
after reviewing the environmental scan and available evidence. Participants worked in pre-assigned groups to answer the following three questions:
1. Is there agreement that a target is needed?
2. What is a reasonable target for Canada?
3. Are there other considerations?

After the discussion of each target, the small groups were given an opportunity to share their responses with the larger group and to engage in further discussion. At the end of the day, participants reviewed the highlights captured during the large group discussions and were again encouraged to provide additional input. The remainder of this report details the key themes and findings of this process.

**PARTICIPATION RATE**

Participation rate was defined as the:

*Percentage of eligible women in the target population who had at least one Pap test in a three-year period.*

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBERTA</td>
<td>80%</td>
</tr>
<tr>
<td>BRITISH COLUMBIA</td>
<td>70%</td>
</tr>
<tr>
<td>SASKATCHEWAN</td>
<td>70%</td>
</tr>
<tr>
<td>IRELAND</td>
<td>80%</td>
</tr>
<tr>
<td>NEW ZEALAND</td>
<td>80%</td>
</tr>
</tbody>
</table>

An 80 percent target for participation was presented for consideration

**Is there agreement that a target is needed?**
Participants agreed that a target was required.

**What is a reasonable target for Canada?**

≥ 80 percent of women 21 - 69 years of age should be screened within the recommended screening interval plus six months.

**Are there other considerations?**
- Although alternative targets were suggested including 90 percent, 100 percent, or better than current rate, 80 percent was agreed to be achievable and aspirational.
- The time frame for the target should include three years plus six months to allow for delays in scheduling an appointment for a Pap test.
• It was recommended that the indicator definition be changed to screening test (instead of Pap test) to reflect the change in technology and use of HPV testing.
• Adjusting for hysterectomy is important because it provides a more accurate rate, particularly for women over 40 years of age. Hysterectomy adjustment should occur whenever possible.
• HPV immunization rates/targets are important to consider when setting this target.
• A core age range for the target (e.g., 30 - 69 years) was discussed, but it was agreed that the target should include all women included in screening guidelines (21 - 69 years of age).

**SPECIMEN ADEQUACY**
Specimen adequacy was defined as the:

*Percentage of test results that are reported to be unsatisfactory in a 12-month period.*

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOVA SCOTIA</td>
<td>0.5% - 1.7%</td>
</tr>
<tr>
<td>AUSTRALIA</td>
<td>0.5% - 5.0%</td>
</tr>
<tr>
<td>IRELAND</td>
<td>≤ 2.0%</td>
</tr>
<tr>
<td>NEW ZEALAND (CONVENTIONAL CYTOLOGY)</td>
<td>1.0% - 8.0%</td>
</tr>
<tr>
<td>NEW ZEALAND (LIQUID BASED CYTOLOGY)</td>
<td>1.0% - 5.0%</td>
</tr>
</tbody>
</table>

A target of ≤ 2 percent for specimen adequacy was presented for consideration.

Is there agreement that a target is needed?
Participants agreed that a target was required.

What is a reasonable target for Canada?
0.5 to ≤ 2.0 percent of tests should be reported as unsatisfactory.

Are there other considerations?
• Participants considered 0.5 to ≤ 2 percent to be an appropriate target.
• The definition of specimen adequacy is important and should be consistent. The Canadian Society of Cytopathology definition should be followed.
• Specimen adequacy may vary with the population and technology used; this should be taken into consideration when interpreting the indicator.
• The reasons for inadequacy should also be monitored.
CYTOLOGY TURNAROUND TIME

Cytology turnaround time was defined as the:

*Median number of calendar days from the date the specimen is taken to the date the finished report is issued over a 12-month period.*

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOVA SCOTIA</td>
<td>≤ 20 days</td>
</tr>
<tr>
<td>BRITISH COLUMBIA</td>
<td>20 days</td>
</tr>
<tr>
<td>IRELAND</td>
<td>≤ 10 days</td>
</tr>
<tr>
<td>NEW ZEALAND</td>
<td>≤ 7 days</td>
</tr>
</tbody>
</table>

A target of ≤ 10 days for cytology turnaround was presented for consideration.

Is there agreement that a target is needed?

Participants agreed that a target was required.

What is a reasonable target for Canada?

90 percent of Pap tests should be reported within 14 calendar days (or 10 working days).

Are there other considerations?

- The definition of cytology turnaround time (date the test was taken, date the test was reported) was discussed.
- Women’s needs (i.e. the need to be informed of the test results as soon as possible) are an important consideration in setting this target.
- However, the workshop participants also discussed the possible unintended negative consequences of too short a turnaround time.
- The notification of results to women is an important aspect of this indicator and will require action plans by the provinces and territories.
- It was recommended that the percentage of tests within a specified time period be reported instead of a median. The suggested target was re-defined based on this recommendation.
- In the future, it may be useful to consider different turnaround times for abnormal and normal Pap tests.
TIME TO COLPOSCOPY

Time to colposcopy was defined as the:
*Percentage of women with a high-grade Pap test result (AGC/ASC-H/HSIL+) who had a follow-up colposcopy examination 3, 6, 9, 12 months subsequent to the index Pap test.*

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA</td>
<td>6 weeks ASC-H or AGC</td>
</tr>
<tr>
<td>SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA</td>
<td>4 weeks HSIL</td>
</tr>
<tr>
<td>IRELAND</td>
<td>&gt; 90% within 4 weeks</td>
</tr>
<tr>
<td>UNITED KINGDOM</td>
<td>&gt; 90% within 4 weeks</td>
</tr>
</tbody>
</table>

A target of 90 percent ≤ 3 months for time to colposcopy was presented for consideration.

Is there agreement that a target is needed?
Participants agreed that a target was required.

What is a reasonable target for Canada?
90 percent of women with a high-grade Pap test result should have a colposcopy examination within six weeks from the Pap test report date or four weeks from the colposcopy referral date.

Are there other considerations?
- The discussion for this indicator focused on the importance of the woman’s perspective and the need to reduce the time to diagnosis as much as possible to minimize anxiety.
- In order to improve compliance with this target in the future, it was recommended that screening programs and colposcopy providers develop discharge protocols to return women to routine screening, thereby reducing the overall time to diagnosis.
- This may be particularly important as HPV testing is expected to increase demand for colposcopy and possibly increase wait times.
- Workshop participants discussed setting two targets – one for high-grade and one for low-grade Pap test results, but it was felt that high-grade Pap test results were a priority at this time.
- As future indicators are discussed, it was suggested that compliance with colposcopy or default rate be measured within a specified time frame.
CYTOLOGY HISTOLOGY AGREEMENT

Cytology histology agreement was defined as the:
*Percentage of high-grade Pap tests (HSIL+) with histological work-up found to have a pre-cancerous lesion or an invasive cancer in a 12-month period.*

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRELAND, UNITED KINGDOM, AUSTRALIA AND NEW ZEALAND</td>
<td>≥ 65%</td>
</tr>
</tbody>
</table>

A target of ≥ 65 percent for cytology histology agreement was presented for consideration.

Is there agreement that a target is needed?
Participants agreed that a target was required.

What is a reasonable target for Canada?
≥ 65 percent of high-grade Pap tests (HSIL+ cytology result) should have a pre-cancerous or an invasive cancer histological outcome.

Are there other considerations?
• Divergent views were expressed with respect to what should be included in the target:
  ◦ Include HSIL+ and ASC-H
  ◦ Separate HSIL+, ASC-H and LSIL
  ◦ Focus on HSIL+ and monitor ASC-H
• It was decided to focus on HSIL+ at this time.
• The reasons for a lack of agreement should be further examined as there are many.
• If only HSIL+ is considered, it was suggested the target should be higher (e.g., ≥ 80%); however, the group agreed that ≥ 65 percent was appropriate at this time.
• The target may need to be amended (lowered) when the HPV vaccine cohort enters the screening population because of declines in PPV due to lower prevalence.
• The suggested revisions to the target should be included in the current indicator definition/calculation document.
• Finally, the terminology used for histology should be up to date and consistent across the country.
CANCER INCIDENCE RATE

Cytology histology agreement was defined as the:

Age-standardized incidence rate per 100,000 women of invasive cervical cancer diagnosed in a year.

The following current targets were presented:

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>CURRENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW ZEALAND</td>
<td>7.5 per 100,000</td>
</tr>
</tbody>
</table>

A target of ≤ 7.5 per 100,000 for cancer incidence rate was presented for consideration.

Is there agreement that a target is needed?
Participants agreed that a target was required.

What is a reasonable target for Canada?
To be determined as additional information is required before a target can be set.

Are there other considerations?
- A target was not set at this time because the group felt that more information is required about international target definitions and the impact of HPV immunization.
- In order to provide more information about a potential target, the Cancer Risk Management Model (CRMM) platform developed by the Partnership will be used to model the expected incidence rate based on various participation and immunization rates.
- A timeline for achieving a cancer incidence rate target should also be provided.
- It may be useful to provide a target by age and histology.
Dr. McLachlin summarized the highlights and workshop themes and thanked participants for their input.

The PCCSN has created an opportunity for leaders in cervical cancer to work together to set national targets. Workshop participants shared their experiences and views with each other in a productive and positive manner. The information will be sent back to all workshop participants for review. The following action items were put forward as next steps:

- Use the Cancer Risk Management Model platform to refine a target for cancer incidence.
- The Cervical Cancer Monitoring & Evaluation Working Group will synthesize the information gathered and refine the national targets for inclusion in the next Monitoring & Evaluation Results Report.
- The Cervical Cancer Monitoring & Evaluation Working Group will use the feedback from the meeting to consider the development of new indicators.
- The PCCSN will develop action plans regarding these targets initially focusing on initiatives to improve participation.

When finalized, the report will be widely circulated and will remain a topic of discussion for the PCCSN.
## Appendix A

### PARTICIPANT LIST

<table>
<thead>
<tr>
<th>PROVINCE/TERRITORY</th>
<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
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Fax: 506-453-5522  
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## APPENDICES

### APPENDIX A

**PARTICIPANT LIST**

<table>
<thead>
<tr>
<th>PROVINCE/TERRITORY</th>
<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTHWEST TERRITORIES</td>
<td>Heather Hannah Territorial Epidemiologist Epidemiology &amp; Disease Registries Population Health Department of Health and Social Services Government of the Northwest Territories</td>
<td>Department of Health and Social Services Government of the Northwest Territories Box 1320, Yellowknife, NT X1A 2L9 Tel: 867-920-3241 Email: <a href="mailto:heather_hannah@gov.nt.ca">heather_hannah@gov.nt.ca</a></td>
</tr>
<tr>
<td>NOVA SCOTIA</td>
<td>Rob Grimshaw Medical Director, Cervical Cancer Prevention Program Cancer Care Nova Scotia</td>
<td>QEII Health Sciences Centre, VG Site 5th Floor, Room 5004, Dickson Bldg. 5820 University Avenue, Halifax, NS B3H 1V7 Tel: 902-473-2366 Email: <a href="mailto:doctor@grimshaw.com">doctor@grimshaw.com</a></td>
</tr>
<tr>
<td>NOVA SCOTIA</td>
<td>Erika Nicholson Director Screening Programs Cancer Care Nova Scotia</td>
<td>Cancer Care Nova Scotia 1276 South Park Street, 5th Floor Halifax, NS B3H 2Y9 Tel: 902-473-7437 Fax: 902-473-4425 Email: <a href="mailto:erika.nicholson@ccns.nshealth.ca">erika.nicholson@ccns.nshealth.ca</a></td>
</tr>
<tr>
<td>ONTARIO</td>
<td>Joan Murphy Clinical Lead Ontario Cervical Screening Program</td>
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</tr>
<tr>
<td>ONTARIO</td>
<td>Jessica Moffatt Senior Policy Lead Prevention and Cancer Control Cancer Care Ontario</td>
<td>Cancer Care Ontario 505 University Ave. Toronto, ON M5G 1X3 Tel: 416-971-9800 ext. 2386 Email: <a href="mailto:Jessica.moffatt@cancercare.on.ca">Jessica.moffatt@cancercare.on.ca</a></td>
</tr>
<tr>
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</tr>
<tr>
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<td>Queen Elizabeth Hospital Tel: 902-894-2316 Email: <a href="mailto:kamead@ihis.org">kamead@ihis.org</a></td>
</tr>
<tr>
<td>PRINCE EDWARD ISLAND</td>
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<td>Health PEI Four Neighbourhoods Health Centre 152 St. Peters Road Charlottetown, PEI C1A 5P8 Tel: 902-368-5901 or 1-888-561-2233 Email: <a href="mailto:mdelaney@ihis.org">mdelaney@ihis.org</a></td>
</tr>
<tr>
<td>SASKATCHEWAN</td>
<td>Wanda Fiessel Provincial Manager Saskatchewan Prevention Program for Cervical Cancer</td>
<td>Saskatchewan Cancer Agency 400-2631-28th Avenue Regina, SK S4S 6X3 Tel: 306-359-5857 Email: <a href="mailto:wanda.fiessel@saskcancer.ca">wanda.fiessel@saskcancer.ca</a></td>
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</table>
## Appendix A (continued)

### PARTICIPANT LIST

<table>
<thead>
<tr>
<th>PARTNER ORGANIZATIONS</th>
<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
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<tbody>
<tr>
<td>CANADIAN CANCER SOCIETY</td>
<td>Robert Nuttall&lt;br&gt;Acting Director&lt;br&gt;Cancer Control Policy&lt;br&gt;Canadian Cancer Society</td>
<td>Canadian Cancer Society&lt;br&gt;55 St. Clair Avenue West, Suite 300&lt;br&gt;Toronto, ON M4V 2Y7&lt;br&gt;Tel: 416-934-5336&lt;br&gt;Fax: 416 961-4189&lt;br&gt;Email: <a href="mailto:Robert.Nuttall@cancer.ca">Robert.Nuttall@cancer.ca</a></td>
</tr>
<tr>
<td>SOCIETY OF CANADIAN COLPOSCOPISTS</td>
<td>Monique Bertrand&lt;br&gt;Head, Division of Gynecologic Oncology</td>
<td>London Health Sciences Centre&lt;br&gt;London Regional Cancer Program&lt;br&gt;800 Commissioners Road East&lt;br&gt;PO Box 5010, London, ON A1B 4J6&lt;br&gt;Tel: 519-685-8500 ext. 55643&lt;br&gt;Email: <a href="mailto:monique.bertrand@lhsc.on.ca">monique.bertrand@lhsc.on.ca</a></td>
</tr>
<tr>
<td>SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA</td>
<td>Jennifer Blake&lt;br&gt;CEO, Society of Obstetricians and Gynaecologists of Canada</td>
<td>Society of Obstetricians and Gynaecologists of Canada&lt;br&gt;780 Echo Drive&lt;br&gt;Ottawa, ON K1S 5R7&lt;br&gt;Tel: 613-730-4192 ext. 224&lt;br&gt;Fax: 613-730-4314&lt;br&gt;Email: <a href="mailto:jblake@sogc.com">jblake@sogc.com</a></td>
</tr>
<tr>
<td>THE COLLEGE OF FAMILY PHYSICIANS OF CANADA</td>
<td>James A. Dickinson&lt;br&gt;Professor of Family Medicine and Community Health Sciences&lt;br&gt;University of Calgary</td>
<td>Department of Family Medicine&lt;br&gt;G012, Health Sciences Centre&lt;br&gt;3330 Hospital Drive NW&lt;br&gt;Calgary, AB T2N 4N1&lt;br&gt;Tel: 403-210-9228&lt;br&gt;Fax: 403-270-4329&lt;br&gt;Email: <a href="mailto:dinkinsj@ucalgary.ca">dinkinsj@ucalgary.ca</a></td>
</tr>
<tr>
<td>CANADIAN SOCIETY OF CYTOPATHOLOGY</td>
<td>Janine Benoit&lt;br&gt;Pathologist&lt;br&gt;Chair, Canadian Society of Cytopathology</td>
<td>Saskatoon City Hospital&lt;br&gt;701 Queen Street&lt;br&gt;Saskatoon, SK S7K 0M7&lt;br&gt;Tel: 306-655-8205&lt;br&gt;Email: <a href="mailto:Janine.benoit@saskatoonhealthregion.ca">Janine.benoit@saskatoonhealthregion.ca</a></td>
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## Appendix A (continued)

### PARTICIPANT LIST

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<tr>
<th>INVITED GUESTS</th>
<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
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</table>
| INTERNATIONAL KEYNOTE SPEAKER | Grainne Flannelly  
Clinical Director, CervicalCheck  
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## APPENDICES

### Appendix A (continued)

## PARTICIPANT LIST

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<tr>
<th>OTHER</th>
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</table>
| GUEST | **Gregory Doyle**  
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<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
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Joint Cancer Screening Committee | Email: diane.major@hotmail.com |
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# APPENDICES

## PARTICIPANT LIST

<table>
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<tr>
<th>REGERTS</th>
<th>NAME AND AFFILIATION</th>
<th>CONTACT INFORMATION</th>
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<tr>
<td><strong>ALBERTA</strong></td>
<td><strong>Nora Johnston</strong>&lt;br&gt;Acting Executive Director&lt;br&gt;Wellness Branch&lt;br&gt;Family and Population Health Division&lt;br&gt;Alberta Health</td>
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</tr>
<tr>
<td><strong>QUÉBEC</strong></td>
<td><strong>Jean Latreille</strong>&lt;br&gt;Directeur&lt;br&gt;Direction de la lutte contre le cancer&lt;br&gt;Ministère de la santé et des services sociaux</td>
<td>Ministère de la santé et des services sociaux&lt;br&gt;1075 Chemin Ste-Foy&lt;br&gt;7e étage&lt;br&gt;Québec, QC G1S 2M1&lt;br&gt;Email: <a href="mailto:jean.latreille@msss.gouv.qc.ca">jean.latreille@msss.gouv.qc.ca</a></td>
</tr>
<tr>
<td><strong>QUÉBEC</strong></td>
<td><strong>Carole Belanger</strong>&lt;br&gt;Cadre Conseil&lt;br&gt;Direction québécoise du Cancer&lt;br&gt;Ministère de la santé et des services sociaux</td>
<td>Ministère de la santé et des services sociaux&lt;br&gt;1075 Chemin Ste-Foy, Bureau 712&lt;br&gt;Québec, QC G1S 2M1&lt;br&gt;Tel: 418-266-2376&lt;br&gt;Fax: 418-266-5862&lt;br&gt;Email: <a href="mailto:carole.belanger@msss.gouv.qc.ca">carole.belanger@msss.gouv.qc.ca</a></td>
</tr>
<tr>
<td><strong>SASKATCHEWAN</strong></td>
<td><strong>Sunita Toffan</strong>&lt;br&gt;Central Support, Acute and Emergency Services Branch&lt;br&gt;Saskatchewan Ministry of Health</td>
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</tr>
<tr>
<td><strong>PUBLIC HEALTH AGENCY OF CANADA</strong></td>
<td><strong>Karen Grimsrud</strong>&lt;br&gt;Senior Medical Advisor&lt;br&gt;Centre for Chronic Disease Prevention&lt;br&gt;Public Health Agency of Canada</td>
<td>Public Health Agency of Canada/Agence de la santé publique du Canada&lt;br&gt;9th Floor, Address Locator 6809A&lt;br&gt;785 Carling Avenue&lt;br&gt;Ottawa, ON K1A 0K9&lt;br&gt;Tel: 613-957-1329&lt;br&gt;Email: <a href="mailto:karen.grimsrud@phac-aspc.gc.ca">karen.grimsrud@phac-aspc.gc.ca</a></td>
</tr>
</tbody>
</table>
Appendix B

WORKSHOP AGENDA

PAN-CANADIAN CERVICAL CANCER SCREENING TARGETS WORKSHOP AND NETWORK MEETING
November 13, 2013 – Agenda
Hyatt Regency Toronto Hotel
Toronto, ON
Meeting Room - Regency A-B

Attendees:
Pan-Canadian Cervical Cancer Screening Network
Cervical Cancer Screening, Monitoring & Evaluation Working Group
Invited individual experts in the area of cervical cancer screening targets/target setting/data analysis

Keynote Speaker:
Dr. Grainne Flannelly, Clinical Director, CervicalCheck, National Cervical Screening Programme, Ireland

Meeting Objectives:
• In-person networking and collaboration promoting alignment of quality standards in cervical cancer screening across the country
• Beginning to build consensus and setting cervical cancer screening targets for Canada
## WORKSHOP AGENDA

### DAY 1 – WORKSHOP

Breakfast  8:00 - 8:30 in Regency A B

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<tr>
<td>Welcome and Call to Order</td>
<td>Meg McLachlin</td>
<td>8:30 – 8:35</td>
</tr>
<tr>
<td>• Welcome to Members and Guests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Approval of Agenda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting National Cervical Cancer Screening Targets</td>
<td>Heather Bryant</td>
<td>8:35 – 8:45</td>
</tr>
<tr>
<td>• Brief overview of the importance and significance of targets in Canada’s national cancer control strategy</td>
<td></td>
<td></td>
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<tr>
<td>Raising the Bar with Targets</td>
<td>Rami Rahal</td>
<td>8:45 – 9:05</td>
</tr>
<tr>
<td>• Practical examples of targets that have enhanced overall quality improvements in cancer control</td>
<td></td>
<td></td>
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<tr>
<td>International Keynote Speaker</td>
<td>Grainne Flannelly</td>
<td>9:05 – 10:05</td>
</tr>
<tr>
<td>• Implementing a Quality Assured Cervical Screening Programme in Ireland - The CervicalCheck Story</td>
<td></td>
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</tr>
<tr>
<td>• Discussion</td>
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<tr>
<td>Break 10:05 – 10:25</td>
<td></td>
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<tr>
<td>Setting Targets for Cancer Screening in Canada</td>
<td>Verna Mai</td>
<td>10:25 – 10:35</td>
</tr>
<tr>
<td>• Examples in Breast and Colorectal Cancer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction and Overview of Target-setting discussion and process/Broad overview of evidence</td>
<td>Kathleen Decker</td>
<td>10:35 – 10:50</td>
</tr>
<tr>
<td>Presentation of evidence; Proposed national targets; Table discussions and feedback presentations for the following cervical cancer screening quality indicators: 1. Participation 2. Specimen Adequacy</td>
<td>Kathleen Decker</td>
<td>10:50 – 12:15</td>
</tr>
<tr>
<td>Lunch 12:15 – 13:15</td>
<td></td>
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<tr>
<td>Presentation of evidence; Proposed national targets; Table discussions and feedback presentations for the following cervical cancer screening quality indicators: (continued) 3. Cytology Turnaround Time 4. Time to Colposcopy</td>
<td>Kathleen Decker</td>
<td>13:15 – 14:45</td>
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<tr>
<td>Break 14:45 – 15:05</td>
<td></td>
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<tr>
<td>Presentation of evidence; Proposed national targets; Table discussions and feedback presentations for the following cervical cancer screening quality indicators: (continued) 5. Cytology Histology Agreement 6. Cancer Incidence</td>
<td>Kathleen Decker</td>
<td>15:05 – 15:45</td>
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<tr>
<td>Final Feedback</td>
<td>Meg McLachlin</td>
<td>15:45 – 16:45</td>
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<tr>
<td>Review by table of all comments and opportunity for final additional feedback (5 mins for each indicator)</td>
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<tr>
<td>Wrap Up and Next Steps</td>
<td>Kathleen Decker</td>
<td>16:45 – 17:00</td>
</tr>
<tr>
<td>Review of final comments on each indicator</td>
<td></td>
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</tr>
<tr>
<td>Next Steps</td>
<td>Meg McLachlin</td>
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<tr>
<td>Adjournment – 17:00</td>
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