Next Steps:

1. See what metrics are feasible within Georgia
   1. Talk with Linda regarding metrics, run by Kevin
2. Marina to send out post call questions
   1. Questions 1, 2, 3, 🡪 looking at labs using routes, please provide names if possible
   2. Questions 4,5 🡪 work internally with Linda to flush analytical questions
3. Adjust routes per notes (see below)
4. Okay to highlight Georgia in face-to-face

Notes:

* Hospital labs go directly to AIM (majority), other go to sFTP
  + If >500 reported 🡪 AIM, if smaller 🡪 sFTP.
* Question: What facilities go through PHINMS?
  + No hospital/lab
  + Large commercial labs (ex. Labcorp, Quest)
* Question: Any other products in AIM?
  + Monitor is used for counts, not importing data 🡪 really just an administrative tool
  + AIM has a component that will go to the billing system where epath is installed to get demographic information and attaches to HL7 to send in.
    - The pure purpose of this component is to link to billing.
    - Component is part of the installation package on the hospital end.
* Notes on paths
  + Simplified:
    - 1 Route = State 🡪 PHINMS 🡪 Transmed or DMS (autoloader)
    - 2 Routes = sFTP with Paper PDF or HL7
    - 1 Route = AIM 🡪 Directly to register
      * Still, transmed server receives from the hospitals/labs and goes to autoloader
    - 1 Route = Excel/faxes to registry, manually extracted to DMS
  + Route with PHINMS
    - Some go to AIM, some go straight to DMS
      * Question: What is the differentiation?
        + Early labs go to AIM, and later files can be supported by DMS
* Paper Pathology through sFTP as well (PDF of a pathology report)
  + Screened against DB
  + Only abstract the missing ones
  + Store paper files by facilities by month of submission.
  + Question: What application is used for this?
    - Historically was Abstract Plus, now directly in DMS.
  + VERY SMALL PROPORTION
* AIM Software Installed at the Lab, just a way to transmit data.
  + To weed out the non-reportable
    - Does give some false positives.
  + Vendor reports in DMS to get a count 🡪 IMS should have
* Question: why is filtering done at the hospital?
  + Filtering reports in Transmed vs. Hospital Server
  + For reports that come from PHINMS, transmed can do the filtering.
    - Only reportable will make it from hospital to AIM.
  + Filtering at hospital
    - Legally, hospital not supposed to transmit report for non-cancer patients.
    - The AIM server transmits reports to central registry AND hospital registry
      * A main selling point for AIM is the hospital filtering.
        + They then check a subset to make sure filtering well.
* Question: What is secure webmail?
  + Georgia HIN System
  + Called Georgia direct. Goes from the Lab to Georgia Direct (email service) to registry
  + Secure email; needs authorization to have an account
  + Can send medical records to others with the account – includes protected data.
  + Labs/Hospitals 🡪 Secure Email 🡪 Downloaded (majority PDF, some HL7) 🡪 goes into folders, divided by facilities, ultimately goes to Autoloader.
    - 1 or 2 facilities sending HL7 through that process.
    - Hard because they come in as batches.
* Demographic Information Challenges
  + HL7 that are sent in from outside AIM often don’t have demographics. Have to send in that info, often by Fax.
  + Information is then added to an excel file and the spreadsheet gets added to folders by facility.
  + AIM uses the component to get into billing system for demographic information (see above).
* Information related to Review Pathology Processing Questions data received from 2015
  + The number of non-electronic pathology reports is not true, it is only what is currently in DMS
    - This doesn’t include a sizable number of paper reports.
    - Don’t have time/resources, may screen for them based on facilities that you think are underreporting.
  + The original report that was given in survey may provide a more accurate estimate of the percent of paper reports (approaching upwards of 90%).
  + Important to look at the proportion of non-reportable among specific routes.
    - Question: Do you think it’s a significant difference among different routes?
      * Don’t know if they have a way to answer. Only way to do it right not is to have someone manually screen.
      * So right now, IMS helps them to bring all the screening in.
      * Don’t have a good indication, because some in the database could be non-reportable and they don’t have the capacity to screen.
  + Relating to question 5
    - Referring to Path only case
    - 95% of path reports are AIM 🡪 where vendor wasn’t blank.
    - Small proportion of total identified non-AIM
      * Although a valuable resource.
    - Number stated: 21,000
      * How many AIM? How many non-AIM?
    - Hard to quantify.
  + Relating to question 6
    - Trying to identify facilities that generally do not have a pathology report.
    - Note: not going to biopsy a late stage, etc. 🡪 however question asks specifically for histologically confirmed cases, which means there should be a biopsy.
      * Should have a biopsy if all pathology is attached to CTC but it’s not – often attached to the person.
      * IMS note: hard to match because didn’t code.
      * IMS question: Difference between epath and epath GA in vendor? PHINMS messages through system may have GA attached to it.
* 55% of CFO cases are from AIM path
* IMS question: epath and Georgia: right to include path report and HL7 or just HL7?
  + Always wand path report and HL7 together.

Other notes:

* Pathgroup (?) moving away from AIM
* Question: what lab sends through different routes? Diamond lab (not sure if that’s what it is called).