**Greater California Pathology Infrastructure Call Minutes**

Thursday 8/02/2018

11:00am – 12:00pm Eastern

Attendees: Scott Riddle, Mignon Dryden, Marta Induni, Peggy Adamo, Marina Matatova, Paul Fearn, Serban Negoita, Alyssa Wang

**Goal of meeting:** See if NCI can clarify any registry questions about SEER Pathology Survey; see if registry will be able to pull specific data numbers for meeting follow-up questions; see where NCI would want to invest in for the future based on registry feasibility and technical nuances; discuss more at the SEER\*DMS F2F meeting on pain points and how can SEER help

* Review and refine registry infrastructure schematic (tools, transfer mechanisms, pathology processing systems)
  1. GrCA informatics diagram
     1. **All reports go through CCR before arrives to GrCA registry (need to update diagram to reflect this?)**
     2. Lab/hospital 🡪 Path reports go to California Cancer Registry, which handles all processing 🡪 AIM Transmed 🡪 Eureka 🡪 then goes to Greater California registry
     3. Lab/hospital 🡪 Path reports go to California Cancer Registry, which handles all processing 🡪 **sFTP** 🡪 Mirth 🡪 Eureka 🡪 then goes to Greater California registry
     4. Lab/hospital 🡪 Path reports go to California Cancer Registry, which handles all processing 🡪 PHINMS 🡪 EMARC Plus 🡪 Eureka 🡪 then goes to Greater California registry
  2. Other
     1. California Cancer Registry has own Transmed, so does Los Angeles; Greater Bay may have Transmed but GrCA registry is not sure
     2. Some sFTPs are handled in-house for non-HL7s; for PDFs and spreadsheets
        1. Use may change due to California legislation (January 1, 2019, law effective to retire sFTP and direct connection routes; no onsite visits will take place after the effective date; all hospitals and labs must send information electronically; smaller labs have the option to manually enter the information in)
     3. GrCA can access certain CCR servers for individual pathology reports; if they do this, they manually enter information into EUREKA
        1. One way to get into casefinding system is e-path 🡪 flows into EUREKA, queued up for review and coding
        2. Other way is manual review with same workflow; review and if deemed reportable, then manually type info into casefinding system
        3. Casefinding system is part of EUREKA
           1. ‘Add on’ part of EUREKA queries physicians who get sent a notification to review cases—when physician enters info, that gets sent back into EUREKA
           2. Prevents paper from being needed to be mailed back and forth from physicians; electronic way to get this follow-back information
           3. This ‘Add on’ program is available to all California registries; Greater Bay and Los Angeles registries are late to adopt as GrCA registry was first to adopt
     4. GrCA also goes onsite to review paper pathology reports and bring back copies to scan in; tested bringing iPad and taking photo of paper path report
* Infrastructure Questions:
  1. Were there any specific reasons for choosing the individual pathology routes at your registry? (e.g. certain labs had certain technical requirements)
     1. CCR develops the methods for getting path reports in
     2. CCR push timeline when CCR took over pathology technical infrastructure?
        1. GrCA and CCR were ‘together’ at one point in same offices; 5 years after state contract came up for registry versus operations that caused GrCA and CCR to split (based on who won the contracts)
  2. Who reaches out to the labs at your registry or do the labs reach out to you?
     1. GrCA traditionally didn’t have AIM licenses
     2. When GrCA was together with CCR, they shared
     3. Now, GrCA has one from 6 months ago for large Pathlogic lab to identify cases in their system; otherwise, GrCA didn’t have AIM license for several years
        1. Pathlogic has since moved to spreadsheet to identify usable cases
     4. When Mignon finds someone who is interested, she hands them over to CCR for technical specifications
     5. During 2016 and 2017, Serban said a report showed that were funds available? Installations started in 2017 based on report? Are any installations in progress?
        1. Mignon not aware there have been any AIM funds since she has been with registry 4 years ago
        2. UC Irvine (which GrCA had worked with previously?) had license but lost it; they appealed and worked toward getting installed properly, getting fees going
        3. Scott said AIM is great for filtering and getting info you need; if by January 1, 2019, registry doesn’t have license, will need to send cases to CCR for processing
     6. Other
        1. Would more people go through PHINMS versus MIRTH? This decision is for CCR to determine; not up to facility to decide
        2. Sandy Johns from CDC is willing to work with any path lab willing to go down PHINMS and EMARC route; doesn’t have to be national labs
        3. For HL7, most facilities will send to CCR and CCR will determine what to do with it
        4. **Question from NCI:** EMARC installed in lab/facility? **Answer:** Cannot be installed in lab/facility because one has to sign up to be a registry to download it; lab would also have to dedicate more staff to cancer reporting
  3. Are there any labs or hospitals that use multiple routes to send you pathology reports? (e.g. Hospital A sends data by sftp and through AIM). If so, can you provide the background to this setup.
     1. **GrCA Answer:** No, it is enough work for them to do it one way
  4. Are there are restrictions in potentially changing from one pathology route to another? Are you currently considering any additional pathology routes or processes?
     1. NCI would need to discuss it with both CCR and GrCA
     2. As long as info is transmitted in the same way (e.g., AIM), there are probably not going to be any issues; but CCR does everything for GrCA so need to include them in the conversation; there are also standards for what type of file CCR is willing to accept; there is a test site that one can use to test for quality control also
     3. CR developing secure portal to receive files from these entities (e.g., PHINMS) as well
  5. Are there any preferred pathology routes at your registry (in terms of efficiency or cost)?
     1. The three routes showed in the diagram are used; unlikely that CCR would use another route

1. Pathology processing questions
   1. How many Total Pathology Reports were received in 2017 (calendar year)? Total count of path reports from all routes (EUREKA and sFTP to individual labs, etc.)
      1. Electronic: Scott Riddle has this info
      2. Manual: Kyle Ziegler has this info
      3. **Greater California will compile those numbers and send it to NCI as soon as possible**
      4. **Marta Induni said that non-reportables (~30%) will go up when electronic files are dumped by facilities in order to comply with the law; Scott estimates that 65-70% nonreportable unlike Marta’s estimated 30%; since there is no LIS filtering from these facilities**
   2. Of the total pathology reports in question #1, how many of the reports are:
      1. **Greater California will compile those numbers and send it to NCI as soon as possible**
   3. As of today, how many cases are identified through pathology reports at your registry (%)
      1. **Greater California will compile those numbers and send it to NCI as soon as possible**
      2. **Scott asked a question to clarify:** Hospitals report and GrCA compares information it has to decide what to follow back on; with new law, GrCA expects to know about a case before it comes in; does it depend on how GrCA has already identified case- whether matched up report with case already or if not yet received path report?
      3. **NCI response:** NCI is looking at type of reporting source; without a lab report, registry would miss a case
   4. As of today, what is the proportion of histologically confirmed consolidated cases for which there is at least one pathology report.
      1. **Greater California will compile those numbers and send it to NCI as soon as possible**
      2. E.g., how many CTCs do you have for 2017; out of this number, how many have at least one pathology report?
      3. **Scott clarification question:** pathology report in the GrCA system or report that hospital noted that is part of their record? **Answer:** Pathology reports in the GrCA registry system that they would be able to cross-reference
2. Review post-call questions (if time allows)
   1. **Answers for some of these questions are at CCR, but Mignon has some answers that she will pass on to NCI**
   2. For Questions #4 and #5, NCI asking for information on proportion/counts
      1. Clarifying description: If AIM disappears tomorrow, what cases will not have a pathology anymore because the report was in AIM, etc.