**Kentucky Pathology Infrastructure Call Minutes**

Wednesday 8/8/2018

9:00am – 10:00am Eastern

Attendees: Tonya Brandenburg, Stephanie Carmack, Frances Ross, Paul Fearn, Alyssa Wang

**Action Items:**

* There is **AIM ISIS Registrar** attached to the repository that helps KCR monitor what is coming in (Need to modify Marina’s schematic)
* Put Tonya in the radiation oncology workgroup or the E-rez coordinator may join it
* **KY to send a written response to each of these questions to Marina**
* **Marina will also send KY follow-up questions**

**Minutes:**

* Review and refine registry infrastructure schematic
  1. KCR will likely be live in SEER\*DMS at the end of the year
     1. When on SEER\*DMS, KCR hopes to have something like this: Lab/hospital submit data via PHINMS 🡪 In-house processing system 🡪 input data into registry local file system 🡪 autoloader folder 🡪 SEER\*DMS
  2. Current method:
     1. When path reports get through the process, someone manually abstracts into local database, which has NAACCR abstracts; NAACCR abstracts feeds into central registry
        1. **Specific route 1**: Information from lab/hospital goes to repository if not abstract yet to be turned into NAACCR abstract before going to a local DB
        2. **Specific route 2**: If the information is already a NAACCR abstracted, it doesn’t need to be abstracted and goes straight into the local facility DB hosted at KCR that can hold NAACCR abstract (individual DBs per facility)
        3. KCR provides path reports for hospitals, so they have that abstract
        4. KCR has 54 labs/facilities, but KCR has more than 54 DBs because some labs may break off into 3 separate facilities, etc.
        5. KCR can mark abstracts to know who they belong to for sorting
  3. Use of AIM vs. PHINMS
     1. AIM Transmed server is the primary one. PHINMS is used minimally (less than 1%), and 1 or 2 main national labs use PHINMS to send information to KCR
  4. AIM Transmed servers
     1. AIM Transmed servers are set up at the lab hospital side
     2. Lab/hospital send data in and KCR receives information in their repository
  5. Looking at volume coming in
     1. There is **AIM ISIS Registrar** attached to the repository that helps KCR monitor what is coming in
     2. Need to modify Marina’s schematic
  6. Paper paths
     1. Received from dermatologists around the state, mailed in
     2. Hospital abstractors abstract from them
     3. Some straggler labs also send
     4. KCR receives about 1,000 paper paths a year
     5. After abstracting, abstracts go to the local DBs by facility
  7. Other routes missing on schematic?
     1. No
* Pathology Processing Questions

**5) As of today, how many total cases are identified through pathology reports at your registry (%)**

* + 1. Clarification question: KCR doesn’t know how to answer this
       1. Intent is to understand if any cases are identified solely through a pathology report – is this something that KCR currently does?
       2. KCR does have some path-only cases
       3. Stephanie masses path reports from a year behind; Stephanie makes a list of missed-case list if those look reportable to the hospital
          1. KCR does an audit of all path reports on a delayed basis to make sure they come in from a best source
          2. If no other information from that facility, they go ahead and report from a path-only method
       4. KCR is finding that almost everything that comes through is reportable (probably 3:1 ratio or 10-25% are probably not reportable)
       5. Thus, this question only wants registries to identify path-only numbers; trying to see what is reportable or not
       6. **NCI Question:** For abstracts from reporting facilities, are there ever any false positives from those submitted abstracts? **Answer:** It happens occasionally; during record consolidation, KCR might find record was so ambiguous; Very rare

**6) As of today, what is the proportion of histologically confirmed cases (CTCs) for which there is at least one pathology report.**

* + 1. Clarification question: KCR doesn’t know how to answer this
       1. KCR doesn’t think they can figure this out
       2. When KCR routes path report to hospital, hospital can link path report to abstract; KCR encourages this, but it is optional for the hospital. KCR is working to make it happen for all of them, similar to how SEER\*DMS creates a record attached to a patient set
          1. This option has been available for only a couple of years
          2. KY will write a narrative on this and send it back to Marina
       3. **NCI Question:** For the cases, those are only created for someone reportable; has someone created a case that turned out to not be reportable? **Answer:** Rare but could happen; bladder cases for example
       4. **NCI Question:** Case created for which no path report or abstract from a facility, can cases be created without either one of those things? **Answer:** KCR will start getting some E-rez/radiology reports, but hospital would also probably send a NAACCR abstract also

**NCI question:** Radiation oncology workgroup for diagnostic radiology to assess what is available across the registries for this type of data. **Answer:** Put Tonya in the radiation oncology workgroup or the E-rez coordinator may join it

* Diagnostic radiology would be useful for casefinding
* E-reg coordinator for monitoring for reportability

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