Notes for Los Angeles Pathology Infrastructure Call

Next Steps

* Los Angeles meetings and next steps discussed
  + Can LA look into the database and see the proportion of cases without a pathology report and then see how many of the reports are electronic vs. manual.
  + They do have a report server so they can produce some reports.
    - Monthly the 3 California registries have CCR reports call to request reports, so can request for other California registries as well.
    - However, Los Angeles processes epath a little differently than other regions
      * More and larger volume.
  + LA to send full list of alternatives they send out, and the link to CCR portal (lab facing info)
* Marina to send post-call questions
* From Los Angeles: Dennis, Diane and Andrea
* History of Los Angeles Registry
  + Started with freestanding registry run by University of Southern California.
  + They would send staff to the labs in the county, and take photocopies of all cancer files.
  + This was somewhat invasive because finding cancer files means going through all files.
  + After 1995, with UCLA, started sending path reports every month through FTP and they could then screen.
* Notes:
  + In January, whole state will be on epath.
  + CA has an epath work group to make things consistent.
  + In terms of reaching out to labs, Dennis contacted them all. They had an agreement with AIM not to reach out.
  + Reasons for choosing pathology routes: price; FTP was free, then moved to AIM.
  + Question: pathology routes that are not functioning effectively?
    - Not trouble with existing epath installations
    - Challenge: volume of false positive paths.
    - Would rather cast a wide net, and then have to sift through, because cases are used for other studies as well.
    - As of now, they are manually coding 100% of the path reports
      * High labor costs.
  + Path reports in 2017 – Completely on Eureka
    - 371,576 path reports delivered to Eureka.
    - However, between 40-60% are false positives depending on the facilities.
  + Question: Are there restrictions in potentially changing from one pathology route to another?
    - No restriction, CCR has provided a list of approved alternatives, so must be one of these.
    - No contracts in place.
  + Non-electronic pathology reports
    - With law change, will be irrelevant 6 months from now.
  + When looking at cases and reports, consolidated cases will be considered as one unit of observation.
* Routes
  + State Database is Eureka, end point is Eureka
  + All 3 CA registries share the Eureka system
  + Everything stays at the state level
    - DOH DB Processing system via Eureka
  + CSP Server
    - Local box housed at computing center
    - Just a path machine (only set up that way because historical)
  + It is cheaper to redirect from their server to Eureka than all hospitals to Eureka.
  + They do not touch locally, do all work on Eureka.
  + EMARC Plus is included
    - Goes straight to Eureka.
  + They believe they use PHINMS for transport.
* Currently, these routes represent 78% of the path reports
  + 22% not HL7 electronic. They are scanned and then put into Eureka a different way.
  + They will not be handled manually starting next year, but they aren’t yet sure how they will be handled.
  + Denominator of these percentages: Of the total pathology reports that they get.
* Summary of routes:
  + 1. Through AIM
  + 2. For out of state goes to PHINMS 🡪 EMARC Plus
* Challenge
  + Remaining facilities that are not epath are low volume
  + Cost in overhead disproportionate to number of cases
  + Low volume, Low IT Support, High staff turnover.
* Question: is there a direct feed into AIM?
  + Can use Quest Diagnostic to log in 🡪 Download preselected file 🡪 Manually download to Eureka.
* How to use epath?
  + Reports to lab/hospital 🡪 AIM 🡪 Eureka Statewide 🡪 CSP access on production base, specific work queue 🡪 Registrar reviews epath for reportable terminology (these are deidentified) 🡪 If non-reportable, hit discard 🡪 If it is reportable, will hit identify 🡪 Positive Case Identification 🡪 Has the patient’s personal information.
  + Once someone hits the identify button the system will prompt the case to go back to the facility and then you have the patient identifier to start building case.
    - Includes site, histology, laterology
  + Near real-time reporting
  + It is not until a facility provides an abstract that the case is pushed forward - otherwise, it sits in a queue.
    - Link all paths that need to be reported
    - There is a 6-month window to find the non-reporting party in order to get the full path report.
* Question: Do you create cases based on path report only?
  + No – need hospital to provide abstract or the case remains in suspense.
* Question: Do you ever get 2+ hospitals for same case?
  + Yes, it is possible, especially if someone goes first to a community hospital.
  + That’s why consolidation is important. If they are the same or similar, will consolidate.
  + Consolidation 🡪 reviews pathology and abstract reports.
* New in California
  + CCR to conduct outreach to facilities who do not have path labs.
  + This is the first step for path lab to register that they exist and intend to/to not report the cases.
  + CCR accepts the following as alternative methods:
    - Web service site
    - sFTP
    - Direct data entry into web portal
    - (Missed one)
* Possible New Reporting Options
  + Concern:
    - Not getting traction
    - One thing needed is to design for small volume labs/facilities – “mom and pop shops”
    - How to get reports into Eureka, and how to really do the case findings, when they don’t have CTA, and the staff aren’t that qualified to even know what to send in
      * Staff may miss cases, and case finding is difficult, so the question is how to facilitate this.
  + Wondering if a tech company can create a tool for case finding and transmission with little user involvement.
  + What about: AIM has developed an alternative process
    - They can go into a small facility, and regardless of what format the paths are, they can set up a way to employ a selection tool that Transmed uses and transmit path reports to the local server.
      * This can be 1 server serving multiple installations.
      * Still concerned with these places being able to identify reportable cases.
  + Plan to audit these facilities to see if they’re doing a good job identifying cases.
  + Future expectation
    - Every licensed lab will have a copy of the pathology report.
  + Question: Current AIM not scalable for small facilities. Why?
    - Primarily cost
    - Facilities also don’t have much IT support, and the work often needs to be done with onsite IT support.
  + Alternative
    - Transmit information from report to central location and then screen in the central location
      * Important to have a common format, so that all reports land in the server and are standardized.
* Question: do you have a list of licensed pathology labs?
  + Yes, the California Cancer Registry has a list of path labs they believe exist
  + 66 completed questionnaires from labs.
  + Labs include hospital and free-standing locations.
* Question: do you think AIM needs to do more regarding false positives or should another system be improved?
  + AIM needs to do better or develop a product or second function to refine results at a second step.
    - Needs to fine tune the product
    - However, need to keep in mind that facilities have facility-specific issues.