**Seattle Pathology Infrastructure Call Agenda**

Monday 8/20/2018

4:00pm – 5:00pm Eastern

**Seattle Responses to Infrastructure Questions - 8/20/2018**

| **Question** | **Response** |
| --- | --- |
| 1) Were there any specific reasons for choosing the individual pathology routes at your registry? (e.g. certain labs had certain technical requirements) | * 1992 first lab went paperless (and it was the largest lab in the region). * Took what they could give us and all were originally set up as monthly submissions manually run and transmitted by the labs. * Labs allowed us to do the case selection at CSS. * We do have to delete negative path on a schedule. Currently, we keep 5 years worth. In January 2018, we are scheduled to delete specimen year 2014. |
| 2) Who reaches out to the labs at your registry or do the labs reach out to you? | * Some derm offices and GI clinics contact either the state registry or us. Chris Poon responds to each. * Hospital registrars sometimes tell us about changes in path lab reporting (not so often anymore) * **Missing Path Tracker Application** to identify holes in reporting of current facilities and potential new labs.   + Derm offices   + GI clinics   + Urology   + Hematopoietic   + Military (VA, DoD)   + NPCR-AERRO -- missing path reports   + Non-SEER region path labs (Salem, OR, UCSF) * Challenge: non-CSS region labs buying labs or obtaining CSS-region clients.   + InCyte |
| 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)  a) If so, can you provide the background to this setup | * Most use a single route * Polyclinic - exception   + Cellnetix   + Derm separate because their dermatopathologists are documenting their professional interpretation in Epic. They don’t get interpreted at Cellnetix. |
| 4) Are there are restrictions in potentially changing from one pathology route to another? | * Opens up the question of who are you and why are you receiving 100% of the path? * Hospital and lab systems have become larger organizations; therefore, getting administrative approval for an IT project is much harder. * Monetary cost for a lab for setting up an "interface."   + Valley Medical - Covered under their "Migration" to EPIC. Smoothest transition to HL7 ever for us.   + InCyte - Trying to get a cost estimate from them for an AIM installation. In an informal conversation about interfaces in general, we learned costs vary from as little as $500 to $5,000. |
| 5) Are you currently considering any additional pathology routes or processes? | * Considering more use of NexGen Connect (formerly MIRTH Connect) for the transmission process when any of our remaining "monthlies" need to change their current process of submitting to us. (Usually due to an LIS change at the lab.) * Working on obtaining radiology imaging reports |
| 6) Are there any preferred pathology routes at your registry (in terms of efficiency or cost)? | * Preferences   + CSS does the report selection here   + Daily submission |
| Obstacles | * NPCR-AERRO epath   + Routed to WSCR first   + WSCR does a geographic selection for CSS   + Sporadic receipt   + InCyte - Receiving only 1/3rd of past submission prior to Eastside Path (Bellevue) purchase (500 declared reportable versus 1,500 declared reportable). |

**Seattle Responses to Pathology Processing Questions - 8/27/2018**

1. How may total pathology reports received in 2017? 960,708 (Missing 10,000 electronic reports from one large health care system that stopped reporting mid-year)
2. Of the total pathology reports in question #1, how many were:
   1. Electronic: 959,479
   2. Non-Electronic: 1,229 plus whatever was shredded as non-reportable
3. Of the total pathology reports in question #1, how many of the reports are:
   1. Reportable: 97,144
   2. Non-Reportable: 863,564. Seattle does the case selection in-house. Labs reporting electronically send 100% path to us for us to do the selection.
4. Of the pathology reports that were part of reportable cases in #3a, how many were
   1. Electronic: 95,511
   2. Non-Electronic: 1,229
5. As of today, how may total cases are identified through pathology reports at your registry (%): **See narrative on next page**.
6. As of today, what is the proportion of histologically confirmed cases (CTCs) for which there is at least one pathology report? Table 1 shows the portion of histologically confirmed cases with at least one linked pathology report.

**Table 1: Histologically Confirmed Cases by Dx Year with Linked Path**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Dx Year** | **Linked Path** | **No Linked Path\*** | **% Linked Path** | **% No Linked Path** |
| 2010 | 23,984 | 1,326 | 94.8% | 5.2% |
| 2011 | 24,519 | 1,365 | 94.7% | 5.3% |
| 2012 | 23,963 | 1,560 | 93.9% | 6.1% |
| 2013 | 24,614 | 1,522 | 94.2% | 5.8% |
| 2014 | 25,667 | 1,351 | 95.0% | 5.0% |
| 2015 | 26,187 | 1,289 | 95.3% | 4.7% |
| 2016 | 27,336 | 1,215 | 95.7% | 4.3% |
| 2017 | 27,589 | 1,137 | 96.0% | 4.0% |

\*The types of CTCs under No Linked Path include the following:

* Scanned path reports that are linked to the patient set at Seattle and not the CTC
* Veterans Administration and Department of Defense only cases (no e-path being transmitted)
* Heme, colorectal, melanoma and prostate cases where biopsies are performed in physician offices with slides being read outside our geographic region.

After checking the number of “no linked path” reports as part of this write-up response, we wondered whether we may have overstated the histologic confirmation on these cases. For example, a preliminary look at diagnosis year 2017 reveals 460 CTCs with a scanned path report attached to the patient set and 90 CTCs reported by VA or DoD (for which we have no path report), leaving 587 CTCs for Dx Year 2017 with no linked path. This number seems too high a volume of biopsies being read outside our geographic area. We know these particular sites have a percentage of slides read in other parts of the country, but we suspect a couple other issues may also be going on - incomplete reporting by labs currently submitting data to us and coding errors in the diagnostic confirmation field.

Annually, Seattle reviews CTCs where diagnostic confirmation is 6 - 9 to see if we should have updated diagnostic confirmation when linking new pathology reports. To date, we have not done a review looking at diagnostic confirmation 1-5 but the CTC is lacking a linked path report. Completing this response has prompted us to decide to add this as an annual quality control review.

**Issues to Consider if Active Casefinding from Pathology Reports is Eliminated or Selectively Reduced**

Seattle has always performed 100% active casefinding from pathology reports. Since 1987, Seattle has had rapid case identification with the majority of histologically confirmed tumors being reflected in our database by four to six months after diagnosis regardless of whether we had received the corresponding abstracts from hospital registrars. As of 2018, histologically confirmed tumors are now reflected in the database within one to six weeks from diagnosis.

Seattle's viewpoint on quality control efforts is that if you have missed the case, then you have missed all the data items. Therefore, our priority was to incorporate quality control on incidence-level decisions whenever possible. In 1987, the biggest bang for our programming dollar was to begin automating our casefinding processes. We started with disease index files (ICD-9 and now ICD-10 coding) and folded in e-path as we transitioned to receiving nearly 100% of the region's pathology reports electronically.

Other central registries perform casefinding audits on portions of a diagnosis year for some of their reporting facilities each year. In fact, SEER used to perform casefinding audits on the SEER registries, selecting certain source months and selecting small, medium, and large facilities. Although we no longer have the level of effort statistics from a 1998 SEER quality control review, we recall that it seemed to be more labor intensive performing the quality control review on the nine selected facilities than our staff normally expended on all the facilities using our electronic programs.

During Seattle's Path Survey call on August 20, 2018, Serban asked if we could identify the percentage of histologically confirmed cases with linked path, specifically with reporting source 3 (Laboratory Only). Table 2 provides that information; however, we have some caveats to explain.

**Table 2: Histologically Confirmed Cases by Dx Year with Linked Path by Reporting Source**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dx Year** | **rs1** | **rs2** | **rs3** | **rs4** | **rs5** | **rs6** | **rs7** | **rs8** | **Total** |
| **2010** | 90.9% | 0.6% | 7.9% | 0.3% | 0.0% | 0.1% | 0.0% | 0.3% | 100.0% |
| **2011** | 90.5% | 0.7% | 8.4% | 0.2% | 0.0% | 0.1% | 0.0% | 0.2% | 100.0% |
| **2012** | 91.6% | 0.4% | 7.7% | 0.1% | 0.0% | 0.1% | 0.0% | 0.1% | 100.0% |
| **2013** | 90.8% | 0.4% | 8.5% | 0.2% | 0.0% | 0.0% | 0.0% | 0.1% | 100.0% |
| **2014** | 91.7% | 0.4% | 7.4% | 0.3% | 0.0% | 0.1% | 0.0% | 0.2% | 100.0% |
| **2015** | 90.3% | 0.7% | 8.0% | 0.7% | 0.0% | 0.1% | 0.0% | 0.3% | 100.0% |
| **2016** | 86.8% | 0.8% | 11.1% | 0.8% | 0.0% | 0.1% | 0.0% | 0.5% | 100.0% |
| **2017** | 80.5% | 0.5% | 17.7% | 0.7% | 0.0% | 0.0% | 0.0% | 0.6% | 100.0% |

Table 2 shows a high of **17.7%** of reporting source 3 (Laboratory Only) cases. Some hospitals have yet to complete diagnosis year 2017. However, as of August 27, 2018, the percentage of Laboratory Only cases for diagnosis year 2018 is 60% because we are determining whether pathology reports represent incidence cases as those reports arrive at the central registry; we cannot wait for hospitals to report their abstracts if SEER’s expectation is for us to have rapid incidence reporting. The combination of the CoC relaxing its abstract timeliness requirements and standard setters delayed release of materials to vendors and registrars outlining the latest data collection requirements had a severely negative impact on the timeliness of hospital abstract reporting.

As we discussed on the teleconference, for the purpose of achieving rapid incidence reporting, we would consider the percentage of cases to be reported as Laboratory Only to be nearly 100%. A pathology report is the casefinding source by which the majority of cases are initiated in our registry. However, CSS does identify the clinically confirmed cases using our non-path source, which typically occurs within 60 days of admission to a reporting facility in our region. These cases have a reporting source of 1, 3 or 8.

During our teleconference, we were not clear as to the reason you focused on Reporting Source 3 cases being the only cases likely to be missed if we didn’t have electronic pathology reporting. The majority of cases with reporting sources of 4, 5, 6 and 8 would not be in our database unless we received pathology reports. CSS uses the pathology report as the document to initiate followback to physician offices, nursing homes, coroners, surgery centers and other outpatient facilities to obtain additional information on these cases.

We also wondered if SEER is considering switching from laboratories reporting e-path directly to central registries to somehow obtaining the e-path via hospital registries as a means of containing the cost of e-path reporting. Seattle casts a very wide net using our internally developed word list to perform casefinding with path reports. We previously tried two attempts for pathology laboratories to perform the report selection for us (in parallel with our normal receipt of 100% of the path), it resulted in 15% to 20% underreporting. They had difficulty accurately identifying which pathology reports contained a potentially reportable disease process in spite of being given our list of terms to aid in the report selection. Labs also struggled to parse the reports based on geographic residency of the patient and/or reporting physician.

We have significant concerns should SEER direct us to outsource to hospital registrars the submission of e-path from hospitals to central registries via a yet-to-be-determined mechanism.

1. Delays in the timeliness of receipt of the e-path will occur. Several hospital registries in our region are losing their staff and are unable to meet six month reporting, let alone the 1-6 week reporting Seattle needs for our rapid incidence reporting. Also, the delay in the release of the 2018 abstracting software will result in a reporting delay from hospitals to the central registry given that most will need to re-review the medical records for any 2018 cases they partially completed using pre-2018 software.
2. Likely gaps in reporting for affiliated but non-hospital physician offices are likely. Hospital registrars are not required to abstract Class 43 (path only) cases by the CoC. The likelihood that they will casefind non-hospital path properly is small.
3. Increase in under-reporting multiple primaries will result. Many of the mistakes we see in our hospital registrars' reporting has to do with their application of the multiple primary rules. It is our opinion that central registry consolidation staff members achieve a higher level of understanding of the multiple primary rules due to the higher volume of cases that central registry staff must process. In addition, for Seattle, we send our staff through the SEER\*Educate multiple primary exercises twice year
4. Dependence on hospital registry software vendors such as C/Net and Oncolog regarding their implementation of case selection will result in regional underreporting of incidence cases. Seattle considers a past or present mention of reportability worth investigating. Some central registries have narrowed their casefinding net by not looking in the clinical history of a path report for a reportable term. We think many hospital registries would also not choose not to look at clinical **history only** path reports as a means of saving their staff time because those will like not result in reporting an analytic case for the hospital registry.
5. Loss of review of slides (ROS) pathology reports from the labs providing the review will occur. For example, the UW Pathology provides a large review of slides service for our region. Most of those patients will choose to have their cancer treated at a facility closer to their home; therefore, these cases are not analytic (Class 43) for the UW cancer registry. In theory, we should receive the originating pathology report from the originating path lab. However, previous audits of the review of slide pathology reports show that we do not always receive the corresponding original pathology report. This is our primary mechanism used to identify new reporting facilities with a slide reading/pathology report generating capability located in our region and labs outside our region that perform slide prep and reading services for clinicians in our geographic region. Our casefinding supervisor contacts those new facilities. For known pathology labs and physician offices located in our region, we follow-back to determine why we did not receive the originating path report. For labs and physician offices located outside of our region, we notify the Washington State Cancer Registry (WSCR). To date, WSCR not been successful in helping us close the holes on that group of missing pathology reports.

Leading our casefinding efforts with path reports enable us to selectively target disease index casefinding efforts to sites with typically higher volumes of clinical diagnostic confirmation and to sites with observed incidence rates lower than expected volumes for the current year when compared to historical trends. The disease index produces too many false positive medical record reviews. By targeting our review to a subset of disease index codes for sites we suspect are under-reported from pathology, we reduced the volume of unnecessary medical record reviews by 7,000 last year.

For Seattle to continue to meet Lynne's goal of RAPID incidence reporting (incidence reporting within six weeks), we need to lead with receiving and processing pathology reports.