**Iowa Pathology Infrastructure Call Minutes**

Monday 8/6/2018

4:00pm – 5:00pm Eastern

Attendees: Kathleen McKeen, Bobbie Jo Matt, Gary Hulett, Marina Matatova, Paul Fearn, Alyssa Wang

**Background:** The SEER pathology survey aimed to understand the current landscape for SEER\*DMS registries – what are current technologies used by registries to process pathologies? Knowing this information can inform our understanding and future investments.

**Minutes:**

Review and refine registry infrastructure schematic

* E-path reports: come in through Transmed or CAS receiver (incoming folder) 🡪 folder is scoured regularly and then dumped into secure processing folder 🡪 once a week, info is tokenized and placed into relational database to generate feedback to field staff personnel (for in-house registry pathology reports) and back to hospitals, such as Unity Point (an 11-hospital system, the largest hospital network in Iowa)
  1. Unity Point does not use the AIM product; IA registry is the clearinghouse for distributing information in a timely manner
  2. IA registry services 46 locations, not including those entities (including out-of-state laboratories) they feedback into as a courtesy
  3. Autoloader is not a feature offered in the current version of SEER\*DMS currently
  4. They load information in through SEER\*DMS Gooey(sp?), but there is no way of automating that load
  5. Other than small number of reports from out-of-state labs, e-path are imported into the system manually and then processed through SEER\*DMS
  6. Bulk are stopped at relational databases; Rod has person who goes and distributes those lists; but those records are not being placed into SEER\*DMS
  7. Whole system was set up to do casefinding and for RRSS studies initially; that’s why records were not placed into SEER\*DMS
* **NCI Question:** Does your registry receive paper-based reports? **Answer:** We receive paper reports (less than 100) from some labs, but this number has been going down because of labs closing. The paper reports come into office, IA staff enters data into SEER\*DMS, the paper record gets imaged, and the image is attached to SEER\*DMS record. Tennessee is paper.
* **NCI Question:** Tell me more about the relational database.
  1. Flat monolithic text
  2. Codifiable fields that is only a portion of what the registry wants to know, e.g., SSN, first name, last name, demographic information, etiology of case, file name, physician information
     1. This information was broken down to create a textual table and later externalized into XML file
     2. If new text rule field added, IA registry can point it as a proper column to keep that information
     3. Raw data file is kept in case they want to mine for certain information
  3. When report comes into relational database, system asks “Do I know about this person?”
     1. Staff checks the file and asks, “Is this the same file?”
     2. If it’s an augmented file, they note that and treat it as additional information they need to capture; they add that additional case data text as new row
     3. If it’s a completely separate issue for the same patient (e.g., new tumor), it is given a new row
* **NCI Question:** Is processing of HL7s done before they hit the relational database? **Answer:** No, to maintain a pristine copy of the record
* **NCI Question:** What are examples of when your registry would manually bring in reports through SEER\*DMS Gooey(sp?)? **Answer:** We separate if out-of-state (OOS) national lab (e.g., Dianon),
* **Registry’s use of AIM**
  1. AIM just came out with AI update
     1. IA has a policy to always create an image of the system prior to an update and vet the application using a parallel test system
     2. After applying the policies, they test the update
     3. IA encountered socket issues after applying the AI
     4. They stop the update and check for affected files; they restore the original pristine image
     5. Then they run mTP and let queues from hospitals run
     6. Last, they test/apply the update all over again
  2. AIM troubleshooting complaint
     1. When AIM is troubleshooting issues for a registry, they will be on the computer together, but then the AIM representative might go answer a phone for another customer and be away for 10 minutes or so, leaving the registry on the line waiting
* Gary has a viewer that they can look up information by person and the registry can see if they have an e-path out there; this is outside of SEER\*DMS; this can create a PDF that is not an HL7
  1. These PDFs could be brought into SEER\*DMS as an attachment, but this viewer is just used to gather information
  2. Used when an abstract is confusing or has conflicting text, registry may go to the eViewer and pick one report or the other
  3. IA registry does follow-back in SEER\*DMS

Review post-call questions

* Dr. Plass is a pathologist from the university in the state and has contacts across the state; now, Gary and Rod are making these contacts due to their work with AIM; some of these contacts are hard to deal with (for example, one contact effort has been taking 2 years)
* **Registry question:** On processing pathology question, for the total pathology reports, what do you mean? IA registry numbers get inflated because not all of them get abstracted. (More than reports come it, so IA estimated ~85,000 path report and 79 paper reports total, but IA reports probably 61,000.) Do you want IA to filter this number down? **Answer:** We want to get a sense of the volume you’re receiving? What is the e-path versus paper/non-e-path? How many are reportable and how many are not?
* **NCI question:** How do you filter out a nonreportable case? **Answer:** Long answer for the registry to answer; what do we consider duplicates?

**Next Steps:** Iowa registry will send Marina more information about how they filter out nonreportable cases; Marina will pass this information onto Serban.

Marina will see if we can schedule another 30 minute call for clarification and to get Serban to provide his input as well.