Jim Collins, author of the best seller, *Good to Great*, states that “good is the enemy of great, and that is one of the key reasons why we have so little that becomes great.”

He further states that the principle reason why there are so few great institutions is that it is simply too easy to settle for good ones. Surely, American healthcare is not immune from complacency. Many believe that it has become what is known in the business world as a “mature enterprise”: increasingly risk-averse, at times self satisfied and unduly expensive.

Collins further asks in his book “can a good company become great and if so, how?”

Using tough benchmarks, Collins and his research team identified a set of elite companies that made the leap to great results and sustained those results for at least 15 years! After the leap to greatness, the good to great companies created cumulative stock returns that beat the general stock market by an average of seven times in 15 years.

Surely most people would agree that our world today has become tougher, more competitive and less forgiving of wasted resources and squandered opportunities. This book caused quite a stir when it was first published seven years ago. Since we live in a time of dramatic change, one could question if the principles in the book apply in the new economy of today.

Yes, the world is changing and will continue to do so. However, that does not mean that we should stop the search for timeless principles. To use an example, practices in engineering continually evolve and change, while the laws of physics remain relatively fixed. What Collins and his team were looking for are called timeless principles, the enduring physics of great organizations, that would remain true and relevant no matter how the world changes.

While a specific application may change (engineering), certain immutable laws of organized human performance (physics) will endure. That good is the enemy of great is not just a business problem. It is a human problem. If we have cracked the code on the question of good to great, we should have something of value for any organization. More to follow on this vital concept in future issues!

*Michael R. O’Leary, MD,
Interim CEO and Director of Laboratories*
Diagnostic Information

Medicare laws dictate that clinicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare may deny payment for a test even though the physician believed it was appropriate if the test did not meet Medicare’s definition of medical necessity. National Coverage Determinations (NCD’s) and Local Coverage Determinations (LCD’s) list specific CPT codes for covered tests, as well as the Medicare-approved ICD-9 codes (diagnosis codes) for those laboratory tests that are reasonable and necessary for the diagnosis or treatment of the ICD-9 codes provided by the ordering clinician. ICD-9 codes supporting medical necessity must be included on the laboratory requisition. The diagnosis must be present for the procedure to be paid and there must be documentation within the patient’s medical record.

Providing our laboratory with accurate and essential diagnostic information is critical to the efficient operation of our laboratory. Without appropriate diagnostic documentation, the laboratory is not reimbursed for the tests performed. Additionally, diagnostic information can determine whether or not an ABN should be signed. Clients of Laboratory Alliance may provide either an ICD-9 code or a written diagnosis in the space provided on our requisitions. Providing diagnostic information when ordering a test not only helps the laboratory operate efficiently and receive payment for its services, it eliminates the time and expense the physician office may incur when responding to requests from the laboratory.

National Coverage Determinations (NCD’s) and Local Coverage Determinations (LCD’s)

National Coverage Determination (NCD) is a national policy statement for a diagnostic laboratory test. It indicates which diagnoses, signs, or symptoms are payable for specific tests. Information concerning the appropriate diagnosis codes for NCD-covered tests can be found at www.cms.hhs.gov/MCD. The following is a list of the tests covered under a NCD:

- AFP
- CBC
- CA 15-3
- CA 19-9
- CA 27.29
- CA 125
- CEA
- Collagen Crosslinks (N-Telopeptide)
- Culture, Urine
- Digoxin
- GGT
- Glucose Testing
- HCO, Quantitative
- Hemoglobin A1C
- HIV Testing, Diagnosis
- HIV Prognosis, including Monitoring
- Iron Studies:
  - Ferritin
  - Iron
  - IBC
  - Transferrin
- Lipid Testing (Lipid Profile, including Cholesterol)
- Occult Blood
- PSA, Monitor
- PT
- PTT
- Thyroid Testing:
  - T4
  - Free T4
  - TSH
- Thyroid Hormone (T3 or T4) Uptake or THBR

Local Coverage Determination (LCD)

An LCD is a local policy statement by the local Medicare carrier or fiscal intermediary that indicates which diagnoses, signs, or symptoms are payable for specific tests. Information concerning the appropriate diagnosis codes and the Medicare fees for LCD-covered tests can be found at www.umd.nycpic.com/lcd.html. The following is a list of tests covered by an LCD:

- Allergy (Rast Test)
- B-Type Natriuretic Peptide (BNP)
- Calcium, Ionized
- CRP, High Sensitivity
- Erythrocyte Sedimentation Rate (ESR)
- Flow Cytometry
- Helicobacter Pylori Tests
- Hepatitis Tests (Hepatitis B Surface Antigen, Hepatitis B Core Antibody, Hepatitis B Surface Antibody, Hepatitis C Antibody)
- Immunocytometry
- Magnesium
- Prostatic Acid Phosphatase (PAP)
- PTH
- Troponin

When ordering a test that does not meet NCD or LCD guidelines, an Advanced Beneficiary Notice (ABN) should be obtained from the patient. The purpose of the ABN is to give the patient advance notice that Medicare may not pay for the test ordered. When payment is denied as not medically necessary, Laboratory Alliance can only bill the patient if we have received a valid ABN.

Reflex Testing

Reflex testing is testing that is performed as a result of initial test results. The reflexively ordered test is used to further identify significant diagnostic information required for appropriate patient care. A list of the reflex tests that are performed by Laboratory Alliance, when appropriate, is found in our Directory of Services as well as on the back of our test requisitions.

Panels

Organ or disease panels will only be billed and reimbursed when all test components are medically necessary. If only some components are medically necessary, or if the physician wishes to order other tests not included in the panel, those tests should be ordered individually. A list of tests included in the American Medical Association acceptable panels is printed on our requisitions and is found in our Directory of Services. The Medicare reimbursement for these tests can be found at http://www.umd.nycpic.com/umd.html. Medicaid reimbursement will usually be equal to, or less than, the Medicare reimbursement.

Clinical Consultation Services

Appropriate test usage and test ordering may be discussed with either Michael R. O’Leary, MD, Interim Chief Executive Officer and Director of Laboratories, or Jayne L. Healey, MD, Assistant Director of Laboratories. They may be reached by contacting our Customer Service Department at (315) 461-3008.
February MASH Camp for Middle School Students

Community General Hospital will host its annual MASH Camp Feb. 19-20 for area middle school students. “Medical Academy of Science and Health” is a two-day experience that exposes the students to a variety of health care careers by involving them in tasks in a hospital setting.

The full-day camp is divided into various experiences which each last about an hour. Students gain insight on careers in the laboratory, physical therapy, EKG/respiratory, pharmacy, orthopedics, emergency department and nursing. Rural Metro also makes a presentation. The laboratory involvement is headed by Maria Dillon, Laboratory Manager of the RRL at CGH. Maria has participated since the program’s inception five years ago as a representative of Laboratory Alliance.

For an application or for more information, contact Community General Hospital's Patient/Staff Education Coordinator Margaret Chase at 492-5416 or by e-mail to margaretcchase@cgh.org.

The camp is coordinated by the Central New York Area Health Education (CNYAHEC).

Welcome to Our New Clients

Joseph Novek, DPM
Fayetteville, N.Y.

Oneida Healthcare Center
Oneida, N.Y.

Samuel B. Rameas, MD
Camillus, N.Y.

Volunteer Opportunities Abound at Francis House

If you are interested in doing something that makes you feel good while doing good for others, here is a volunteer opportunity to consider. Francis House on Michaels Avenue in Syracuse is always in need of volunteers to do almost anything – including light housekeeping, cooking, food planning, grocery shopping, snow blowing or shoveling, gardening or serving as a greeter, to name a few.

To volunteer, or to learn more, contact Volunteer Coordinator Rea Carver at 475-5422 or by e-mail at rcarver@francishouseny.org.

~ Always Ready to Assist You ~

Our Customer Service Representatives and Account Representatives are always ready to assist our clients and our staff. Our Call Center staff receive, on average, 1,500 phone calls per week. All calls are answered on average, in 21 seconds. They are most frequently asked to:

• Look up laboratory results and fax them;
• Provide the location of one of our 13 Patient Service Centers;
• Schedule a pickup of specimens by one of our couriers;
• Provide the specimen collection requirements for a laboratory test.

Our Account Representatives make face-to-face visits to an average of 225 client locations per month. When they are not on the road, they too handle numerous inquiries from our many customers.

Customer Service Representatives (CSR) and Account Representatives (AR), left to right, include CSR Linda Ball, CSR Leanne Nervina, CSR Erin Mauro, AR Melissa Frizzi, CSR Tamika Rippany, AR Jean-Paul L’Orange, CSR Linda Bondy and CSR Dawn Bradshaw. Absent: CSR Linda Brittell.

Warm temperatures in early January helped in the progress of an entrance-way construction project at our Operation’s Center. The enclosure was built around the employee entrance located on the back of the building. The Operations Center is located in Electronics Park in Liverpool.
An Interview with Mitchell Brodey, MD
Community General Hospital Infection Control
Subject: Anal Rectal Cytology

By Janet Miller, Cytopathology Manager and Ann Marie Derecola, Program Director

In October 2007, Dr. Mitchell Brodey’s office contacted our Cytology Department with its first request for anal rectal cytology (ARC). Recently, Program Director Ann Marie Derecola and Cytology Manager Janet Miller met with Dr. Brodey to discuss the importance and clinical indications for this test.

Ann Marie: What has prompted the increased need for ARC testing?
Dr. Brodey: The New York State Department of Health has identified the anal pap as a quality care indicator. Literature reports the incidence of anal carcinoma as 35/100,000 for men with male sex partners and 70/100,000 for men positive for HIV.

In my practice, I had two patients earlier this year with metastatic anal cancer and three other patients with anal carcinoma. This appears to be a higher incidence than that represented in the literature. Actually, the incidence of anal carcinoma in women is higher than in men.

Although the current literature has conflicting evidence regarding the value of cytology testing for anal carcinoma and the development of disease, this test is one that can be performed for earlier diagnosis of disease.

Janet: How are you collecting the specimens?
Dr. Brodey: I am using a cytology brush to obtain the sample – inserting the brush approximately two inches into the anal canal and applying pressure to collect the cells. The brush is then swished in the cytology fixative to release the captured cells. Lubricant should not be used because it obscures the cells in the specimen.

Ann Marie: How frequently will you order this test on patients?
Dr. Brodey: The guidelines recommend testing HIV positive men once a year and every three years for men that are HIV negative. Women with condyloma of the vulva, abnormal Paps or cancer of the vulva should be tested.

Affected men and women are now benefiting from the available HIV drug cocktails. There is a decreased incidence of Kaposi’s sarcoma and lymphoma in HIV positive patients and we are now seeing diseases that take longer to develop, such as anal cancer.

Janet: Where are you referring your patients that have abnormal cytology on their ARC test?
Dr. Brodey: There is a nurse practitioner in Rochester who performs high resolution anoscopy and biopsies to follow-up on abnormal cytology results. For those patients with suspicious or positive cytology reports, I am referring them to colorectal doctors for confirmation and treatment. Patients who have carcinoma may be treated with surgery, radiation, and/or chemotheraphy, depending on the stage of their disease.

Anal Paps should be the standard of care to screen for anal carcinoma. Some clinicians may not want to collect these specimens because the collection process it is up close and personal. Even if rectal exams are performed the anus is not visualized. We need to offer the high resolution anoscopy locally. It is not difficult to do. Women could be screened by their gynecologists. This is a cancer. We can diagnose it and treat it earlier.

Authors note: Although there are cases of anal carcinoma in the general population, cytology screening is only indicated for high risk groups. Human Papilloma Virus (HPV) testing is not recommended on the anal specimens.

The following patient populations should be tested based on guidelines used by Palefsky, et al. at the University of California at San Francisco.

1. HIV negative men with a history of receptive anal intercourse or anal warts.
2. HIV positive men with a history of receptive anal intercourse or anal warts. Some clinicians screen with greater frequency, those patients with CD4 counts that are less than 500/mm.
3. HIV negative women with a history of anal warts, high grade squamous intraepithelial lesions/carcinoma, or vulvar squamous intraepithelial lesion (SIL)/carcinoma.
4. HIV positive women. Some clinicians screen with greater frequency those women with CD4 counts that are less than 500/mm.
5. Consider screening organ transplant patients who are taking chronic immunosuppressive agents.

Effective Oct. 29, 2007, Laboratory Alliance of Central New York introduced an FDA-approved multiplexed flow immunoassay for evaluating human antibody response to Epstein - Barr virus (EBV) infection. The new bead-based methodology combines multiple antigens in a single reagent, obviating the need for a panel of assays. This state-of-the-art approach offers the potential for reduced cost, turnaround time and sample volume. Although there is no “gold standard” for diagnosis of EBV infection, comparison with conventional enzyme immunoassay (EIA) shows excellent overall concordance.

Historically, EBV serology was performed via indirect fluorescent antibody (IFA) testing. This 1980’s methodology yielded antibody titers, reported as the highest dilution with detectable positivity (e.g. 1:320). Within the last decade, IFA was replaced by enzyme-linked immunosorbent assay (ELISA) and EIA-based testing. Results of these assays are reported as antibody indices, as compared to known standards. Although reported as numerical values, indices are interpretable only as positive or negative in comparison to assay-specific reference ranges. Antibody indices are not titers and are not intended to be used quantitatively. Above the positive cutoff, detection quickly becomes nonlinear, and numerical values are not meaningful. The only instance in which numerical results can be accurately compared is with paired acute and convalescent sera assayed simultaneously in a single batch analysis. This is rarely done.

Similarly, results of the current multiplexed bead assay are reported qualitatively (“positive” or “negative). By reviewing the pattern of antibody responses, the status of EBV infection can be surmised. Briefly, anti-VCA (viral capsid antigen) IgM and IgG antibodies rise rapidly during acute infectious mononucleosis. Anti-VCA IgM disappears over approximately four weeks, and anti-VCA IgG persists for life. Anti-EA-D (D component of the early antigen) IgG antibody rises transiently during acute infection and becomes undetectable after approximately 3-6 months. Anti-NA-1 (nuclear antigen) IgG appears approximately 3 months after initial infection and typically persists for life. The summary table below provides a useful reference for serological classification.

Correlation of EBV serology patterns with results of the latex-agglutination heterophile antibody assay (Monospot) may be helpful. This test is often, but not always, positive in the setting of acute infection. Children under 5 years of age often do not make heterophile antibodies in response to acute EBV infection. The Monospot assay is unreliable in this age group.

Any serological pattern not identified in the table below should be considered inconclusive.

For more information, please consult our website www.laboratoryalliance.com, or contact Chemistry Manager Cheryl Haskins at (315) 410-7014.

### Technology Corner

**We have added this test to our menu of tests performed:**
- Rapid Group B Strep by PCR

**Test ordering algorithms have been added to our web pages for:**
- Syphilis Testing
- Group B Strep Testing from Vaginal/Rectal Samples

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**Table: EBV Serological Status**

<table>
<thead>
<tr>
<th>EBV Serological Status</th>
<th>NA-1 IgG</th>
<th>VCA IgG</th>
<th>EA-D IgG</th>
<th>VCA IgM</th>
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<td><strong>Late Acute Infection</strong></td>
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<td>Pos (+)</td>
<td>Pos (+)</td>
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<td><strong>Convalescence</strong></td>
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* Heterophile antibody positive.
** Heterophile antibody negative.
Paving the Path to Business Continuity Maturity

By Gina Potenza, CBCP, M.S.
Information Systems Manager, Business Systems

Deployment of a hardcopy Business Continuity Plan (BCP) is only the first step in ensuring resiliency of a business. On an annual basis it’s important to plan ways to help mature the Business Continuity Program. So what exactly is the maturity target our company is shooting for? What is the evolutionary path we should follow to get there?

Our target for business continuity centers on having a measurably high degree of BCP competency. At this level, our program would encompass the full scope of the business and would be able to keep pace with any level of change within the organization. Complex business strategies would be formulated and successfully tested and there would be tight integration with our internal change control methods. These continuous process improvement initiatives would keep us in a high state of preparedness.

The road taken to reach this level of maturity is certainly not easy and by no means can we expect to achieve this degree of synergy when a plan and its program are still so new within an organization. Our commitment must be continuous. It’s better to plan and achieve something small and continue to build on it every year rather than try to get the perfect BCP all at once. Any good business continuity planner will tell you that their plan is a dynamic entity due to the three realities we face with business continuity:

1. BCP is not going way. Its acceptance into a business should grow every year.
2. The program must be sustainable. This means there will always be opportunities to improve on what we have.
3. Things need to happen. When they do, we can begin to see a shift to added value and increased cost effectiveness. These realities provide a platform for planners to create annual program goals and objectives that help align plans with upcoming business changes, as well as help programs continue to evolve to a higher level of maturity.

This year’s BCP program objectives are designed to lead Lab Alliance down this path of growth and maturity. To begin with, our BCP initiatives will seek to evolve from project to process. Because our BCP program is fairly new, it was expected that we developed and implemented it as a project. This was a logical method since it allowed for detailed planning and tracking of our progress. It’s now time to transition from the ad-hoc project to a sustainable, cost-effective and value-added process. With this in mind annual goals and objectives have been developed with long-term impacts in mind.

Here are some of the program initiatives we will be focusing on this year:

- Adoption of the structure and methods defined in the Incident Command System — This system allows Laboratory Alliance to utilize a response and management tool used not only by emergency responders but by hospitals to effectively prepare and respond to various types of disasters.
- Annual update to our Hazard Vulnerability Analysis. (Threat Assessment) — Changes in our environment and business are perfect reasons to keep this assessment up to date.
- Annual update to our Business Impact Studies — Once again, changes in our business need to be reflected and planned for and cannot be understood in the context of business continuity planning unless they are evaluated using this method.
- Pandemic Planning — The assumptions for businesses surrounding a pandemic event provide a deep foundation for drafting a specific plan that addresses the longevity of the threat, the high percentage of absenteeism and the impact to employees.
- Succession Planning — Although we could assume that succession will take care of itself in an emergency, we leave our business vulnerable to time lost, opportunities missed and decreased business value. This, too, is a dynamic and continually evolving process.

These are just a few highlights of this year’s initiatives. Our plate is definitely full in 2008 but it’s the “nutrition” needed to build our BCP into a more mature and sustainable process. For those involved, continued on page 7

Elmcrest Students Learn About Microbiology

Linda Stallcup, Microbiologist at our Operations Center, recently shared her knowledge of microbiology with sixth graders from Elmcrest Elementary School in Liverpool. Pictured with Linda are (left) Sierra Greason and (below) Rebecca DiMartino (left) and Brittany Hart (center). Prior to Linda’s visit, the students cultured specimens taken from various locations in the school. In an effort to get the students excited about microbiology, Linda provided a hands-on learning experience by first demonstrating and then overseeing the students as they performed Gram Stains on their specimens. The following day, Linda met the parent of a student to whom she presented. “The parent informed me that her child was so excited about the presentation. Her child spoke of the experience frequently,” said Linda.
New Employees
Please welcome our new employees:

At our Operations Center
Robert Brewer, Courier
Charles Foster, Courier
Lou Christino, Courier
Kevin Davis, Laboratory Office Assistant
Wayne Nowakowski, Courier
Elizabeth Poulette, Histotechnician
Donald Stone, Laboratory Office Assistant
Jacqueline Zimphen, Laboratory Office Assistant

At our Operations Center

At our Rapid Response Laboratory at Community General Hospital
Erin McDonald, PSC Receptionist

At our Rapid Response Laboratory at St. Joseph’s Hospital Health Center
Amanda Baronowski, Laboratory Office Assistant
Stephanie Coglitore, Technical Processing Assistant
Ted Hile, Laboratory Office Assistant
Danielle Jantzi, Medical Technologist
Renee Strazzere, Laboratory Office Assistant

First CHAMP Award
The first recipient of the CHAMP award was announced at the employee holiday party on Jan. 5. Laboratory Alliance was pleased to award this professional recognition to David J. Mineo, Senior Analyst in the Information Systems (IS) Department. Multiple nominations were submitted to the Employee Recognition Committee for Dave.

Dave joined Laboratory Alliance in 1999 and has worked in the IS Department since April 2002. He began his IT career as a computer programmer in 1982.

Prior to joining Laboratory Alliance, Dave worked six years as a medical technologist in the Air Force and 11 years with Quest Diagnostics in Williamsville, N.Y., and MDS Laboratories in Poughkeepsie, N.Y.

He attended Syracuse University’s Center for Business Information Technologies in the Microsoft Systems Engineer Program. He is a Microsoft Certified Systems Administrator.

As a Senior Information Systems Associate, Dave is responsible for many of the network applications including e-mail and anti-virus software.

The Employee Recognition Committee thanks everyone who participated in the recognition program. The committee is now accepting nominations for the next Laboratory Alliance CHAMP.

Congratulations
To Chris Galloway, Processing Assistant at the Operations Center in Chemistry, and his wife Casey on the birth of their baby girl Kylee Jane, born Nov. 16.

Community Outreach
Representatives from Laboratory Alliance continue to promote all laboratory professions and spread awareness about clinical laboratory science.

Future school career fairs include:
Bellevue Middle School Academy – Jan. 31
Nottingham High School – March 7
Beard Middle School – April 3
Henniger High School – April 3

Employee Anniversaries

December
5 Years
Debra Shannon
Virginia Stannard
Mary Ellen Milczarski

January
5 Years
Jaime Dejesus
Deborah Thielking

10 Years
Maureen Conklin
Margaret Thompson
Iris Holiday
Diane King
Jeou Kwan
Russ Rawling
Rebecca Reynolds

February
10 Years
Karen Barella
William Bourg
Mary K. Clancy
Nancy Crossett
Cheryl Haskins
Janet Miller
George Panarisi
Rita Sabino
Daniel Sheehan

Paving the Path to Business Continuity Maturity
Continued from page 6
it’s a task that requires strong leadership and guidance, proactive employee awareness programs, appropriate program structure, coordination between departments and functions, incorporation into business initiatives and processes, pre-defined metrics to measure state of preparedness, adequate resources and even partnerships with external agencies.

Good things happened as we rolled out the Business Continuity Program last year. Teams were trained and more engaged and supportive of the program, testing proved more effective and productive and there was a sense of confidence that the documented plan was of value to our company. There is now a sense of commitment to BCP throughout the organization. Where do we go from here? Rather, I should say: Watch us grow from here!
Calendar of Events

Saturday, Feb. 2
39th Annual Heart Ball to benefit the American Heart Association, Oncenter. Laboratory Alliance is a corporate sponsor.

Tuesday, Feb. 5
Syracuse Auto Dealers Association (SADA) Charity Preview to benefit 13 area not-for-profits, Oncenter Complex. Laboratory Alliance is a corporate sponsor.

Thursday, March 20
Syracuse Chamber Business Show, Cargill Exhibit Center, New York State Fairgrounds, 9 a.m.-6 p.m. Laboratory Alliance will be one of the many exhibitors.

Saturday, March 29-Tuesday, April 1
CLMA Annual Meeting, “ThinkLab,” Atlanta, Ga. Laboratory Alliance will be a presenter.

Friday, April 25
Men Who Cook to benefit the Mental Health Association of Onondaga County, Hotel Syracuse, 5:30 p.m. Laboratory Alliance is a corporate sponsor.

Looking for Convenience?
When your healthcare provider orders laboratory tests visit a Laboratory Alliance Patient Service Center in your neighborhood.

- Baldwinsville
- Camillus
- Cazenovia
- Cicero
- East Syracuse
- Fayetteville
- Liverpool
- North Syracuse
- Pulaski
- Syracuse (4 sites)

Courteous, professional staff • No waiting • Plenty of parking close to the entrances • Most medical insurance plans accepted
Visit us online for addresses and map locations.

Thank You for Your Sympathy
The senior management of Laboratory Alliance is deeply grateful to all current and past employees, their families, our friends and many business associates who reached out in sympathy to us and the family of Frank Kearns, following his sudden death on December 1, 2007.
In addition, Francis House on Michaels Avenue in Syracuse is most appreciative for all the donations made in Frank’s memory.

Laboratory Alliance offers the SurePath® Pap test.

- Increases the detection of abnormal/precancerous cells
- Reduces unsatisfactory results
- Provides greater clarity for diagnosis
- Lowers the incidence of inconvenient repeat testing
- Screens for HPV infection on the same specimen if requested

“For all these reasons, I asked my doctor to send my Pap test to Laboratory Alliance. Ask your doctor about this type of screening for the early detection of cervical cancer.”

To learn more, visit us at www.laboratoryalliance.com