It's All About Our Connections

By George Popp, Chief Information Officer

Interfaces are critical to the success of our business. The continual evolution of technology, as well as frequent software upgrades, forces our information technology (IT) professionals to stay current. We installed our first Laboratory Information System in 1998-99, allowing connectivity to our affiliated hospitals. A dozen years later our commitment to leading-edge technology has resulted in our ability to provide a connection to just about any health care system. And, with the passage of the American Recovery and Reinvestment Act in 2009, the need for connectivity became a necessity overnight.

We've Come a Long Way

Our early interfaces to affiliated hospitals allowed the receipt of patient demographic information and laboratory test orders via Laboratory Alliance’s centralized computer systems at our Electronics Business Park location and dissemination of lab results and billing information back to the hospitals. We implemented a custom point-to-point interface to our reference lab and, in the early 2000s, our first Electronic Medical Record (EMR) interface.

In 2005, we took a dramatic step forward by purchasing an interface engine. Now, single orders and test results could be manipulated to connect to or from multiple sources, such as hospitals and EMRs. This interface engine continues to serve as a critical piece in the development and support of almost all interfaces to and from Laboratory Alliance.

Today, having completed about 50 interfaces to various EMR’s, physician office laboratory information systems and hospital information systems, we have observed that even though these interfaces are built on a “standardized” format – called Health Level 7 (HL7) – in reality, each vendor can interpret the standard differently. The first time we interface to a particular EMR, we have to make adjustments on Laboratory Alliance’s interface engine so that the data fields appear correctly in that EMR or in our Lab Information System.

A Standardized System for All

In 2009, in response to Congress’ passage of the American Recovery and Reinvestment Act (ARRA), hospitals and physician practices started gearing up for the portions of the Act that affect health care – specifically the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act contains incentives related to health care information technology in general and the specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

The use of this technology can improve patient care and lower health care costs nationwide by facilitating communication, coordination and collaboration among healthcare providers. However, fewer than 20 percent of physicians currently utilize complete EHRs.

The federal government is offering financial incentives to stimulate adoption of this technology. The law authorizes Medicare and Medicaid reimbursement incentives for eligible professionals and hospitals that meet milestones along the road to becoming “meaningful users” of EHR technology.

Part of the ARRA/HITECH Act defines the requirements necessary for hospitals and practices to receive financial incentives. Meaningful Use will be implemented in three stages, with only phase one defined to date. A hospital or practice EMR/EHR must meet the progressively stronger language in each phase to receive financial compensation.

EMRs must be approved by the Certification Commission for Health Information Technology (CCHIT) or another federally approved agency to meet Meaningful Use guidelines. Laboratory test ordering and result reporting help to meet the Meaningful Use guidelines. Practices that don't meet these requirements by specified dates may lose reimbursement from federal programs. With more than 350 EMR/EHR systems nationwide, Laboratory Alliance is a leader in providing connectivity to our affiliated hospitals and providers.
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EHR systems available nationally, many vendors are scrambling to prepare their products to meet the Meaningful Use requirements.

The Recipe for Success

Typically, an implementation for an orders and results interface for an EMR product that is new to us takes 6-12 weeks. The schedule includes: setting up the electronic connectivity, initial communication testing, coordinating the test compendium and physician databases, basic functionality testing, complete validation testing and, finally, LIVE. For subsequent customers implementing that same EMR, the process can take significantly less time.

It is important to note that each interface is not self-sustaining. As new tests become available and old tests become obsolete, updates to the interface are necessary. For example, changes in practitioners or additions of insurance carriers require maintenance. If either the practice or Laboratory Alliance updates its software, a validation process needs to take place to confirm the data is flowing as designed. Lastly, ongoing support is required as connections can drop and other glitches can occur.

Everyone Wins

When the implementation process is complete, the end result is an interface that is a win-win for everyone. Laboratory Alliance wins by receiving accurate and comprehensive patient demographics, insurance and diagnosis coding information as well as the electronic order. The office wins by eliminating manual entry of paper lab requisitions and receiving electronic lab results, real time or near real time, directly to its EMR system. The patient wins because medical decisions based on lab results can be made quickly.

The State of Laboratory EMR Interfaces Today

About 50 percent of the EMR interfaces that are productional (live) or in development today only offer a results interface to the EMR. Some currently have or are planning to offer a “demographics bridge,” the capability to pass patient demographic and insurance data to Laboratory Alliance, but only about 50 percent of these offer a lab orders interface. This lab orders interface is critical for meeting Meaningful Use requirements in the future.

Laboratory Alliance works closely with the Regional Health Information Organization (RHIO), HealtheConnections. We are now interfaced to pass laboratory results from our three owners’ hospitals and will soon be adding the outreach (physician’s office, nursing home, etc.) laboratory testing. The RHIO offers a centralized source for a practitioner to have access not only to lab results, but all patient health care information in a secure manner provided the patient has given consent.

Combining these relatively new electronic EMR interfaces with our Web-based lab results inquiry product, Laboratory Alliance is making every effort to provide the technology to meet the needs of our customers. We anticipate that during the next few years we will be very busy connecting to many of our clients as they upgrade or install their new laboratory systems and/or EMR’s.

Summary of Terms

ARRA: The American Recovery and Reinvestment Act of 2009 – a federal economic stimulus package. ARRA is also commonly called the Stimulus Act. It was passed to promote consumer spending, investment and create jobs. Many areas of the economy are touched by this Act.

EHR: An Electronic Health Record system is an EMR and more. EHR’s are designed to reach beyond the office where the patient was seen, connecting with other offices to provide a complete “health” record of the patient.

EMR: Electronic Medical Record – a digital version of the paper records in an office. The data in an EMR primarily is a self-contained system that does not significantly interface with other systems.

HITECH ACT: The Health Information Technology for Economic and Clinical Health Act is part of the ARRA. It contains specific provisions for financial incentives as well new security requirements related to electronic Protected Health Information (e-PHI).

Meaningful Use: Part of the ARRA/HITECH Act that defines the requirements necessary for hospitals and practices to receive financial incentives. Meaningful Use will be implemented in three stages with only phase one defined to date. A hospital or practice EMR/EHR must meet the progressively stronger language in each phase to receive financial compensation. After a period of time, an entity can be penalized for failure to achieve these milestones by decreased Medicare and/or Medicaid reimbursement.

RHIO: Regional Health Information Organization – a multi-stakeholder entity whose role is to provide electronic integration and information exchange through health information technology. In the Central New York area, the RHIO is HealtheConnections.

Mobile Laboratory Visits Syracuse

One of our vendors, bioMérieux, brought their Odyssey Mobile laboratory display to our Operations Center on June 20. The visit enabled our employees and staff from other labs and hospitals to see their equipment and new technology.

To learn more about bioMérieux, visit their website at www.biomerieux-usa.com/odyssey.
Laboratory Alliance Recognized for Commitment to Learning

Laboratory Alliance was recognized at the fourth annual CNY BEST Learning and Performance Awards presented by the Central New York Chapter of the American Society for Training & Development (CNY ASTD) at an awards ceremony on June 9.

The awards recognize excellence in learning and performance practices in the region. The program honors organizations, internships, consultants and individuals who have linked learning to strategic growth or success through a demonstrated commitment to helping employees enhance their skills and continued learning.

Laboratory Alliance received the Internship Special Commendation, recognizing its contributions to interns’ learning progress or success while linking the organization’s strategic growth or success. Laboratory Alliance was acknowledged for its College While You Work internship program. In collaboration with Broome Community College, college biology and chemistry graduates are provided technical training while working at Laboratory Alliance with daily online study time and hands-on laboratory experience.

Laboratory Alliance Recognized for Commitment to Learning

Elsie Wilson, left, medical technologist, Microbiology Department, and Marcia Degilio, technical supervisor, Microbiology Department, attended the Clinical Virology Symposium in Daytona Beach, Fla., and presented a poster on Herpes Simplex Virus research performed at Laboratory Alliance.

Welcome to our New Clients

Advanced Care Pharmacy
East Syracuse, N.Y.

American Medwell
Chittenango, N.Y.
Dewitt, N.Y.
LaFayette, N.Y.

Cardinal Health NPS
Syracuse, N.Y.

Center for Medical Weight Loss
Baldwinsville, N.Y.

PrimeCare Medical Consultants
Central Square, N.Y.

Technology Corner

The following new tests and test methods have been added to the menu of tests performed by Laboratory Alliance:

• Methylmalonic Acid
• Klebsiella oxytoca Reflex Test
New Test to Diagnose Epidemic and Non-Epidemic *Clostridium difficile* Infections

By Paul A. Granato, Ph.D., Director of Microbiology

*Clostridium difficile* was first discovered as a cause of antibiotic-associated diarrhea (AAD) in 1977. Currently, *C. difficile* is now recognized as the leading cause of hospital-associated or nosocomial diarrhea accounting for at least 25% of such infections and an estimated 3 million cases of diarrhea and colitis annually in the United States. The mortality rate associated with this disease is 1% to 2.5%.

The virulence of *C. difficile* is associated with its ability to produce an enterotoxin, called toxin A, and a cytotoxin, called toxin B. Early diagnosis and prompt aggressive treatment are critical in managing *C. difficile* AAD and colitis. A polymerase chain reaction (PCR) assay that screens for the presence of toxin B, which our Microbiology Department has been using since August 2009, is the most sensitive and reliable test for establishing the laboratory diagnosis of *C. difficile* diarrheal infection.

Outbreak of Shiga Toxin-Producing *Escherichia coli* Infections in Germany

By Paul A. Granato, Ph.D., Director of Microbiology

The Centers for Disease Control (CDC) has been monitoring a large outbreak of diarrheal disease in Germany that was caused by a rare serotype of Shiga toxin-producing *Escherichia coli* (STEC), *E. coli* O104:H4, that was first detected in mid-May. As of June 12, 2011, thousands of individuals in Germany acquired the STEC diarrheal illness with 3,604 patients developing hemolytic uremic syndrome (HUS), a type of kidney failure that is associated with STEC infections. Twenty eight of these 3,604 patients died as a result of developing HUS. In addition, another 12 patients with STEC diarrhea also died but they did not develop HUS.

In the United States, one confirmed and four suspected cases of STEC O104:H4 infections have been documented. No deaths have been reported in these four patients but each one had a history of recent travel to Germany. The CDC has recommended that any person who has recently traveled to Germany and has signs or symptoms of STEC infection, or HUS, should seek medical care and let the medical provider know about the outbreak of STEC infections in Germany and the importance of being tested for STEC infection.

The serotype of STEC that is causing this illness, O104:H7, is rare and has never been reported in the United States previously. Originally, cucumbers imported from Spain were thought to be the food source responsible for this outbreak of disease. However, subsequent epidemiologic investigations have shown that contaminated bean sprouts grown on an organic farm in northern Germany were the likely source of this food-borne outbreak.

In 2005, a new strain of *C. difficile* was described in North America and Europe that was associated with causing severe, epidemic diarrheal disease and colitis. This new strain, which was characterized by molecular analysis as *C. difficile* 027/NAP1/BI, caused much more serious disease with markedly higher mortality rates. Genetic analysis of this epidemic strain showed that it was a strain of *C. difficile* that had a mutation in the regulatory gene that controls the expression of both the toxin A gene (tcdA) and the toxin B gene (tcdB) whereby excess amounts of these toxins (up to 25 to 30 times the normal amounts) are produced. This new mutant strain also produces a significantly higher number of *C. difficile* spores that may contribute to a higher incidence of patient relapse following treatment and/or increased rates of nosocomial infection. In addition, the epidemic strain is also resistant to the fluoroquinolone group of antibiotics whereas the non-epidemic strain is susceptible to these antibiotics. Because it can cause much more serious disease, the new mutant strain of *C. difficile* 027/NAP1/BI is often called the hypervirulent or epidemic strain or simply the NAP1 strain.

Previously, there were no commercially available laboratory tests to detect the presence of the NAP1 strain of *C. difficile* in stool specimens. Recently, a new PCR test was approved by the FDA for detecting both the non-epidemic (wild-type) and epidemic (mutant) strains of *C. difficile* in stool specimens. Laboratory Alliance’s Microbiology Department is pleased to announce that it has replaced its previously used PCR *C. difficile* test with this new gene amplification assay. The sensitivity of this upgraded PCR assay is identical to our previously used method (>98%) but has the advantage of detecting the epidemic strain of *C. difficile*, which can cause much more serious disease.

The recommended treatment for *C. difficile* AAD and/or colitis has been metronidazole or vancomycin but relapses of infection may approach 20 to 25%. Recently, a new antibiotic, fidaxomicin (Dificid®), has been approved for use in treating *C. difficile* infection but it is costly being at least twice as expensive as vancomycin. Fidaxomicin has been reported (N. Engl. J. Med. 2011. 364:422-431) to be comparable in treatment efficacy to vancomycin but has the advantage of having a 50% lower rate of recurrence (13% vs. 24%) when infection is caused by the non-epidemic strain of *C. difficile*. However, fidaxomicin relapse rates are higher than vancomycin when infections are caused by the epidemic or hypervirulent strains of *C. difficile*. This information alone serves to emphasize the importance and value for performing the upgraded PCR assay that Laboratory Alliance has recently implemented as a routine test service. The availability of this upgraded service to detect *C. difficile* infections and to distinguish disease caused by epidemic and non-epidemic strains should have a decidedly favorable impact on therapeutic management and patient outcomes.
Klebsiella oxytoca - A New Bacterial Cause of Antibiotic-Associated Hemorrhagic Colitis*

By Paul A. Granato, Ph.D., Director of Microbiology

The genus Klebsiella (family Enterobacteriaceae), of which K. pneumoniae and K. oxytoca are the two most commonly isolated species, consists of gram-negative, non-motile, encapsulated rods. As opportunistic pathogens, Klebsiella spp. can cause a variety of illnesses including pneumonia, urinary tract and soft tissue infections, sepsis, meningitis, liver abscess, and gastrointestinal disease in the immunocompromised patient or those with underlying conditions. Current studies strongly suggest that Klebsiella, and in particular K. oxytoca, may also be associated with a variety of gastrointestinal syndromes that include antibiotic-associated hemorrhagic colitis (AAHC).

The role of K. oxytoca as a definitive cause of AAHC was proven with the fulfillment of Koch’s postulates in 2006 using a highly methodical approach that provided conclusive evidence that K. oxytoca causes AAHC. The scientific report (N.E.J.M. 2006. 355:2418-2426) combined a prospective patient study with stool culture, in vitro cytotoxin assays, histopathology studies, and a newly developed animal model for AAHC to establish K. oxytoca as a cause of AAHC.

Current knowledge of K. oxytoca AAHC

The use of antibiotics frequently results in diarrhea. Antibiotic-associated diarrhea results from the direct toxic effects of the antibiotic or the disruption of normal gut microflora and overgrowth of less favorable or pathogenic organisms that cause diarrhea. This change in intestinal flora can lead to decreased colonic carbohydrate metabolism and bile acids that exacerbate symptoms. Antibiotic-associated diarrhea occurs in up to 30% of patients receiving antibiotics and can develop anywhere from a few hours after beginning therapy to 8 weeks after treatment cessation. The disease is significant when patients experience 3 or more loose or watery stools per day. Risk factors for antibiotic-associated diarrhea include advanced age (over 65 years old), immunosuppression, and hospitalization.

AAHC is a distinct form of antibiotic-associated diarrhea caused by K. oxytoca. For unknown reasons, K. oxytoca AAHC has been associated with the concurrent use of non-steroidal anti-inflammatory drugs. The disease is marked by the clinical absence of C. difficile, lack of pseudomembrane formation, and hematochezia. Colonoscopic examination often reveals segmental hemorrhagic colitis, involving the transverse and ascending colon with rectal sparing. Mucosal bowel abnormalities include erythema, edema, ulcerations, purpura, diffusely hyperemic mucosa with submucosal hemorrhage, and fibrinopurulent damage. Histopathologic studies of biopsy specimens have indicated acute inflammation, ischemic damage of the tissue, and submucosal hemorrhage. Laboratory values often reveal marked leukocytosis and elevated C-reactive protein. In the majority of AAHC cases, the disease is self-limiting, and spontaneous resolution of symptoms occurs in a matter of days after cessation of the offending antibiotic. Treatment strategies have also included use of alternative antibiotics. Probiotics may have some benefits, but more research is still needed for patient safety, as bacteremia from probiotic agents is a potential complication for immunocompromised patients.

Characteristics Distinguishing K. oxytoca from C. difficile Gastrointestinal Disease

C. difficile is identified as the cause of antibiotic-associated colitis in the majority of cases, but other bacteria can cause infection when patients are C. difficile negative. Klebsiella should be considered in the differential diagnosis, and several characteristics can alert physicians in recognizing colitis caused by K. oxytoca rather than C. difficile. Key contrasting differences defining K. oxytoca colitis are the absence of pseudomembrane formation and the presence of bloody diarrhea. Furthermore, K. oxytoca colitis is most commonly associated with the use of β-lactams, whereas C. difficile disease occurs following the use of β-lactams, clindamycin, cephalosporins, and fluoroquinolones. Although β-lactams antibiotics have been implicated as an important factor in the development of AAHC, other antibiotic classes that cause a major reduction of bowel flora can also trigger K. oxytoca infection. Resolution of symptoms caused by C. difficile usually requires treatment with metronidazole or vancomycin, whereas withdrawal of antibiotics is recommended for K. oxytoca AAHC. K. oxytoca is also not known to cause complications routinely found with C. difficile disease, such as death, toxic megacolon, intestinal perforation and shock. Unlike the NAP1/027 (BI/NAP1) outbreak clone of C. difficile, clonal prevalence or outbreaks of K. oxytoca specifically causing AAHC have not been described.

Laboratory Identification of Klebsiella oxytoca AAHC

Physicians may suspect K. oxytoca AAHC if the patient is C. difficile negative, has been on antibiotic therapy, has symptoms including diarrhea with hematochezia, and colonoscopic findings indicate segmental hemorrhagic colitis. K. oxytoca can be cultured from the stool, colonic biopsy specimens, or intraluminal fluid from patients with antibiotic-associated diarrhea. Biopsy specimens and intraluminal fluid appear to be similarly sensitive for detection of K. oxytoca. It has been reported that K. oxytoca can be isolated in nearly pure culture from the feces of patients suffering from antibiotic-associated colitis. However, pure or heavy cultures from any patient with hemorrhagic colitis should still be reported to the physician, because K. oxytoca is also a rare cause of severe infectious colitis without a history of antibiotic use.

Currently, there is no available test for the laboratory diagnosis of K. oxytoca AAHC. However, the Laboratory Alliance's Microbiology Department is actively developing a culture-based method for the recovery of this organism from diarrheal stool specimens. Once this test has been validated by our laboratory, a technical bulletin will be distributed announcing the availability of this test.

*This article was adapted from publication authored by N.M. Green et. al. that appeared in Clinical Microbiology Newsletter, 2009. 31:111-116.
Symptoms of STEC infection include severe stomach cramps, diarrhea (which is sometimes bloody), and vomiting. If there is fever, it is usually low grade. The disease is usually self-limited with most people getting better within five to seven days without medical intervention. However, some patients go on to develop HUS, usually about a week after the diarrhea starts. The classic triad of findings in HUS is acute renal damage, microangiopathic hemolytic anemia (evidence of schistocytes and helmet cells on peripheral blood smear), and thrombocytopenia.

It is not recommended to give antibiotics to patients with suspected STEC infections until complete diagnostic testing can be performed and STEC infection is ruled out. Some studies have shown that administering antibiotics to patients with STEC infections might increase their risk of developing HUS. However, clinical decision making must be tailored to each individual patient. There may be indications for antibiotic use in patients with severe intestinal inflammation, if bowel perforation is a concern. Of note, isolates of STEC O104:H4 from patients in Germany have demonstrated resistance to multiple antibiotics.

STEC O104:H7 causes a diarrheal disease identical to that caused by E. coli O157:H7. Both of these E. coli serotypes cause diarrhea and HUS based upon their ability to produce either or both of two toxins, called Shiga-like toxin 1 and Shiga-like toxin 2. Strains of E. coli that produce Shiga-like toxin 2 have a much higher incidence of causing HUS. A special feature of the outbreak STEC O104:H4 in Germany is that it appears to produce excessive amounts of Shiga-like toxin 2, thereby causing more serious disease in humans and its associated higher incidence of HUS.

The only method commercially available for the detection of STEC in stool specimens is an enzyme immunoassay (EIA) that screens for the presence of Shiga-like toxins 1 and 2 in stool specimens. Since 2004, our Microbiology Department has tested routinely all stool specimens submitted for “Enteric Bacterial Culture” for the presence of STEC by using an EIA methodology. Other enteric bacteria also tested for routinely are Salmonella, Campylobacter, and Shigella. If the stool specimen is “positive” for the presence of STEC, another type of EIA test is performed to determine if Shiga-like toxin 1 and/or Shiga-like toxin 2 is present in the specimen. This information is extremely important because it alerts the physician that a patient infected with STEC that produces Shiga-like toxin 2 may have a higher risk of developing HUS and that the use of antibiotic therapy is usually contraindicated.
New Employees

Please welcome our new employees

**At our Corporate Offices**
- Sari Reikes – Finance Controller

**At our Operations Center**
- Stephen Champlin, Jr. – Phlebotomist
- George Gerges – Histotechnician
- Sarah Kane – Phlebotomist
- Sonja Lamphere – Histotechnician
- Stacy McClendon – Phlebotomist
- Claudia Melidona – Histotech Assistant
- Stephanie Prell – Patient Service Center Receptionist
- Keith Rando – Medical Laboratory Technician
- Eric Roberts – Phlebotomist
- Bridget Sovocool – Laboratory Office Assistant
- Meghan Sovocool – Laboratory Office Assistant

**At our Rapid Response Laboratory at Crouse Hospital**
- Nikki Zingaro – Medical Technologist

**At our Rapid Response Laboratory at St. Joseph’s Hospital**
- Kristina Abalos – Chemistry Technical Supervisor
- Ruslan Ali-Zade – Medical Technologist
- Pamela Archibald – Laboratory Office Assistant
- Amber Edwards – Laboratory Office Assistant
- Amanda Farnham – Medical Technologist
- Malik Kabir – Laboratory Office Assistant
- Nicole Larca – Laboratory Office Assistant
- Laura McNamara – Medical Technologist
- Nicole Morales – Laboratory Office Assistant
- Johnathan O’Kelley – Laboratory Office Assistant
- Suzanne Swierczek – Laboratory Office Assistant

**At our Rapid Response Laboratory at Upstate University Hospital at Community General**
- Thomas Matthews – Medical Technologist
- Rita Romano – RRL Manager

Employee Anniversaries

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<tr>
<th>Monthly Anniversaries</th>
<th>Years</th>
<th>Employees</th>
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| June, 5 years         | Beth Conway  
Kimberly Johnson  
Kathleen Males  
Samuel Martino Jr.  
Andrew Paton  
Dana Simpson  
Susan Walker | 5 years | Beth Conway  
Kimberly Johnson  
Kathleen Males  
Samuel Martino Jr.  
Andrew Paton  
Dana Simpson  
Susan Walker |
| July, 5 years         | Daniel Epstein  
Jillian Kimball  
Erika Nicholson  
Nadine Riche | 5 years | Daniel Epstein  
Jillian Kimball  
Erika Nicholson  
Nadine Riche |
| July, 10 years        | Michelle Kelley  
William McCarthy  
Jocelyn McManamay  
Tamika Ripply | 10 years | Michelle Kelley  
William McCarthy  
Jocelyn McManamay  
Tamika Ripply |
| August, 10 years      | Kelly Kranz | 10 years | Kelly Kranz |

Another Great Employee Turnout at the Chase Corporate Challenge

Many of our employees participated in the Chase Corporate Challenge on a beautiful June evening. Once again, Kelly Kranz created a great t-shirt design that incorporates the contest theme, Greener Tomorrow, and both logos, Chase and Laboratory Alliance.

These June 5-year anniversaries were mistakenly listed in our Spring issue of LabLines as having March anniversaries.
Wednesday, Sept. 7  Auburn Memorial Hospital 15th Annual Golf Classic, Skaneateles Country Club. Laboratory Alliance is a corporate sponsor

Friday, Sept. 16  35th annual Tribute Evening to benefit Crouse Hospital Foundation, The Oncenter. Laboratory Alliance is a corporate sponsor

Friday, Sept. 16  September Song to benefit Hospice of Central New York, Traditions at the Links. Laboratory Alliance is a corporate sponsor

Monday, Sept. 19  St. Joseph’s Hospital Foundation 19th Annual Golf Classic, Turning Stone Resort. Laboratory Alliance is a corporate sponsor

Wednesday, Oct. 12  “There’s No Place Like Home” event to benefit Francis House, NYS Fairgrounds. Laboratory Alliance is a corporate sponsor

Friday, Oct. 28  Fall Harvest Gala to benefit the Community General Foundation, Holiday Inn Convention Center. Laboratory Alliance is a corporate sponsor