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Cooper Heart Institute Racks Up Impressive List of Recent Firsts

The Cooper Heart Institute, under the direction of Perry J. Weinstock, MD, Head of the Division of Cardiovascular Disease, has recently added more clinical firsts to its already-impressive roster of achievements – testament not only to the cutting-edge cardiac expertise that resides here but also to the commitment Cooper has made to the infrastructure that supports it.

"A first-rate cardiac program requires a lot of resources," says Michael Rosenbloom, MD, Co-Director of the Cooper Heart Institute and Head of the Division of Cardiothoracic Surgery, citing instrumentation, technology, specialized cardiac anesthesia and critical care, and support personnel. "And the hospital has gone all-in to provide them."

This commitment has put the Cooper Heart Institute on the proverbial map as the region's most comprehensive cardiac program, earning national recognition for its quality outcomes and attracting outstanding clinical talent.

As a result, a growing number of companies are partnering with Cooper on clinical trials that are helping to transform the practice of cardiac care – and offering hope to previously untreatable patient populations through innovative devices and surgical techniques like transcatheter aortic valve replacement (TAVR) – an area in which Cooper excels.

"We're also known for our close relationship between cardiac surgery and cardiology," Dr. Rosenbloom notes. "Everyone here realizes that working together not only serves patients best but it's also the way to achieve our goal of getting new technology as soon as it's available. Industry recognizes us for this collaboration, and it's a real plus."

In the past few months alone, Cooper Heart Institute has racked up an array of notable firsts – both within and outside clinical trials:

Percutaneous Intervention for Mitral Valve Regurgitation

Cooper is one of only two sites in New Jersey participating in the COAPT Trial, a national clinical trial designed to study the safety and effectiveness of Abbott Vascular's MitraClip® device in heart failure patients who have functional mitral regurgitation and are considered extremely high-risk for surgery (MitraClip currently is FDA-approved only for use in patients with degenerative mitral valve disease who are not surgical candidates).

"Cooper was selected as a study site because of our extensive experience in structural heart disease," notes Sajjad A. Sabir, MD, Co-Director of the Structeral

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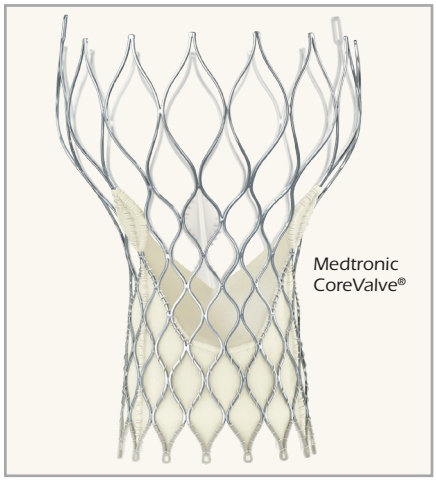

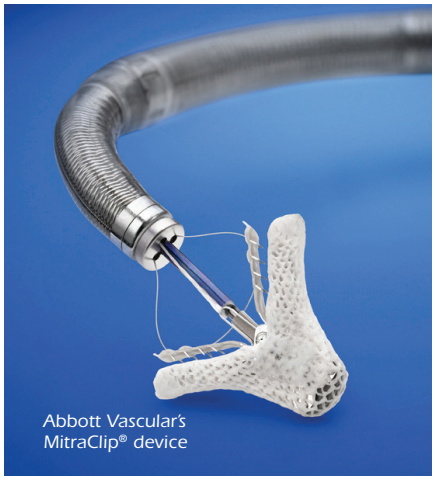

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University Health Care

Heart Disease Program in Cooper's Division of Cardiovascular Disease. "We're excited about this because there are a lot of patients with mitral valve regurgitation who have no other treatment option."

Medtronic CoreValve®: New Option for Inoperable Aortic Stenosis Patients

Good Friday was a very good day for two Cooper patients who were the first in South Jersey to undergo implantation of the Medtronic CoreValve®, used to treat severe aortic stenosis in patients ineligible for open-heart surgery.

"The Edwards SAPIEN valve was initially FDA-approved for this extreme-risk patient population and Cooper was the first in New Jersey to offer it to patients; now it's also commercially available for high-risk patients who are candidates for either surgery or TAVR," explains Dr. Sabir. "The CoreValve is currently only for those patients who are at extreme risk for surgery, and we are the first and only institution in South Jersey to offer this new technology to our patients."

Cryoablation for Treating Atrial Fibrillation (AF)

Radiofrequency (RF) ablation is the standard treatment for paroxysmal AF when medications don't work; however, its success rate is only about 70 percent, and approximately one-third of patients treated require more than one procedure. The RF energy is delivered one point at a time around the pulmonary veins via a catheter tip, so there can be gaps, and it's time-consuming.

In 2012, the FDA approved another type of ablative therapy for AF, cryoablation (freezing). This treatment is also delivered via a catheter, but this technique uses a balloon that inflates within the heart, outside the origin of the pulmonary veins. "It's more homogeneous and the entire vein can be isolated in just a few minutes," says Andrea M. Russo, MD, Director of Electrophysiology and Arrhythmia Services, who performed the first procedure at Cooper earlier this year.

Certain patients may be better candidates for one form of therapy than another. In any case, both modalities are now available for patient care at Cooper.

"So we have an option for patients based on their anatomy and the type of atrial fibrillation they have," Dr. Russo adds, noting that Cooper is the only facility in South Jersey to offer cryoablation. She's hopeful this technology will reduce the recurrence rate and says, "The preliminary evidence is looking positive."

Edwards TRANSFORM Trial: Faster, Safer Aortic Valve Replacement

Cooper is the only study site in the state for TRANSFORM, the first US clinical trial of a rapid deployment system for surgical aortic valve replacement procedures. The Edwards Lifesciences INTUITY valve system, which consists of a bovine pericardial heart valve and novel balloon-expandable frame, is designed to facilitate small-incision surgery and rapid valve deployment with the goal of enabling faster procedures.

"This new valve system enables us to cut up to an hour off the operation because it doesn't require the 15 to 18 pairs of sutures that other valves do," says Dr. Rosenbloom, who is the principal investigator. "As a result, patients spend less time on bypass which means less risk and fewer complications," he says. "It's very exciting."

Valve-In-Valve Procedure: Replacing Failing Tissue Valves Without Surgery

In January, an 82-year-old female patient at Cooper underwent New Jersey's first valve-in-valve procedure to replace her failing, surgically implanted bioprosthetic aortic valve with a transcatheter valve – without open-heart surgery. Using transcatheter techniques, the new valve was placed inside the old surgically implanted valve and expanded by inflating a balloon, pushing the old valve out of the way.

"The entire procedure took less than an hour, the patient went home in less than 48 hours, and she is feeling dramatically better," says Interventional Cardiologist Georges I. Kaddissi, MD, of Cardiovascular Associates of the Delaware Valley. "This procedure is a life-saving option for select patients with failed tissue valves who are not candidates for another open-heart surgery."

A New Solution for Central Sleep Apnea

Central sleep apnea, a type of sleep-disordered breathing, is associated with a higher rate of ventricular arrhythmias. The Cooper Heart Institute is participating in a safety and efficacy study to evaluate the Respicardia® **rem**ede® System, an implantable medical device designed to improve cardiovascular health by restoring a more normal breathing pattern during sleep.

Clinical Cardiologist John A. Andriulli, DO, Director of Cooper's Arrhythmia Device Program, and the cath lab team performed the first **rem**ede® System implantation on January 30, 2014.

Absorb™ Bio-Absorbable Stent

Cooper also participated in a national trial to evaluate the benefits of a first-of-its-kind drug-eluting bioresorbable vascular scaffold for the treatment of coronary artery disease (ABSORB III). Abbott's Absorb™ device works by restoring blood flow to the heart like a metallic stent, but then dissolves into the body, leaving behind a treated vessel that may resume more natural function and movement.

Interventional Cardiologist Andrew P. Zinn, MD, of Cardiovascular Associates of the Delaware Valley, inserted the first Absorb device into a patient earlier this year.

"Our relationship with industry builds on itself," Dr. Rosenbloom says. "As we do well in clinical trials, it attracts more companies looking to launch their products."

As a result, Cooper is able to offer more solutions to more patients – evidenced by the spate of recent firsts outlined here.

"There's very little we can't do," he adds. "We can take the highest-risk cases and do well – and routine cases do even better." ■

For Structural Heart Program information and additional information on any of the groundbreaking procedures and other comprehensive heart treatment programs call 856.296.6516. Call 856.342.2034 for all other inquiries, or go online to CooperHealth.org/heart.

The Cooper Breathing Center: South Jersey's Only Comprehensive Resource for Diagnosing Dyspnea

Shortness of breath can be a symptom of myriad conditions, and identifying the underlying cause isn't always clear-cut. To aid in this process and speed the time to treatment, the Cooper Breathing Center offers a one-stop multidisciplinary resource for accurate, timely diagnosis and treatment planning.

"We're the only comprehensive center in South Jersey focused on why someone has shortness of breath," says the Center's Director Melvin R. Pratter, MD, FCCP, FACP. He heads a team of six pulmonologists who utilize today's most advanced diagnostic modalities including cardiopulmonary exercise testing, bronchoscopy and other interventional pulmonary procedures, and a state-of-the-art sleep lab – all conveniently located on site.

In fact, Dr. Pratter and his colleagues have set the standard in how to diagnose a patient who presents with shortness of breath, publishing two research studies that show a systematic algorithmic approach is the most efficient – and ensures the most appropriate utilization of resources.

"Our approach emphasizes using the minimum number of carefully selected tests, moving from the simplest to the more complex," he explains. "If the patient can be diagnosed with simple analysis, no further tests are needed. If not, it's a systematic progression, with more complicated, invasive tests used only if preliminary testing indicates they're required.

"As a result of this focused approach, we make diagnoses in 99 percent of cases with fewer tests," he adds.

Another strength of the Center is its close collaboration with other Cooper specialists.

Melvin R. Pratter, MD, FCCP, FACP, Director of the Cooper Breathing Center (center), with Jonathan E. Kass, MD, and Ramya Lotano, MD, two members of the Cooper Breathing Center pulmonary team.

"Even though we're all pulmonologists, we don't approach a diagnosis strictly from that point of view," Dr. Pratter notes. "We really take a holistic approach.

"In many cases, shortness of breath might indicate a heart problem or something else outside the lungs," he continues. "So instead of doing what most pulmonologists do – an exhaustive workup in their own specialty then, when nothing is found, referring the patient to another specialist for yet more tests – our evaluation isn't complete until we have a diagnosis.

"The most common causes of shortness of breath relate to the lungs and heart, so we work closely with cardiologists and radiologists [on imaging studies]," he says. "But if other tests or expertise are needed, we have it all here at Cooper, and we're used to doing this together."

In fact, he notes, it's not uncommon for there to be more than one underlying cause of a patient's shortness of breath – underscoring the advantage of Cooper's multidisciplinary collaborative approach to diagnosis.

"We do a lot of communicating in person, by phone and by sharing records," Dr. Pratter says. "Everything one specialist is doing is transparent and available to everyone involved."

In addition to lung diseases such as COPD, asthma, asbestosis and cancer, and heart and vascular disease, other underlying causes of shortness of breath may include obesity, allergies, anxiety, airway obstruction, disorders affecting breathing nerves and muscles, disorders of the blood and metabolism, restriction of chest volume due to such conditions as scoliosis, and certain medications.

When the reason for a patient's dyspnea is not clear-cut, Dr. Pratter urges physicians to refer to the Cooper Breathing Center.

"We have both clinical and research capabilities here," he says. "We have enormous experience doing this. And patients can be seen the same week they call." ■

High Risk Lung Cancer Screening

Lung cancer is the number one cause of cancer death in the US, but until recently there has been no reliable way to detect lung cancer in its earliest, most treatable stages. Today, based on the findings of landmark National Lung Screening Trial (NLST) and other randomized studies, the U.S. Preventive Services Task Force now recommends annual screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke, or have quit within the past 15 years.

MD Anderson Cancer Center at Cooper has offered a High Risk Lung Cancer Screening program following the NLST criteria since 2012. Our team of lung cancer experts has developed a comprehensive program to detect and treat lung cancer, monitor lung nodules and educate high risk individuals on the steps they can take to reduce their risk of developing lung cancer.

To refer a patient to the MD Anderson Cooper High Risk Lung Cancer Screening Program call **856.342.2141.**

For more information or to make a referral, please call 856.342.2406.
The Cooper Breathing Center is located in Voorhees at 900 Centennial Boulevard, Building 1.

Oral-Maxillofacial and Facial Trauma Surgery at Cooper: Comprehensive Expertise to Restore Form and Function

In 2012, Jolanta Yeasky, then 58, slipped and hit her chin, breaking her lower jaw in two places. The surgeon who performed emergency surgery at her local hospital stabilized the fracture using a metal plate and 18 screws.

Brian M. Smith, DMD
Division Head, Oral and Maxillofacial Surgery

Her repaired jaw, however, was only about half-inch wide. As a result, Yeasky could no longer wear her lower dentures, leaving her unable to eat anything but soft foods while she waited for her jaw to heal.

When Yeasky learned she'd need additional surgery before she could be fitted for new dentures – and that her insurance "didn't work" with the surgeon who'd initially repaired her jaw – she began looking for a new provider. Her search led her to Cooper University Health Care's respected Division of Oral and Maxillofacial Surgery/ Facial Trauma Surgery and Brian M. Smith, DMD, Division Head of Oral and Maxillofacial Surgery.

"The emergency surgery had restored the outline of Ms. Yeasky's jaw but not its function, since it was so small," Dr. Smith relates. Plus, her jaw had never fully healed, and it had shifted to one side.

"Our goal is always to restore form and function," he continues. "If you have one without the other, you're not really going to get the result you want, as Ms. Yeasky's initial outcome demonstrated."

In addition, he says, facial trauma isn't treated only during the acute phase. "There's a long-term aspect to it because it often involves temporomandibular joint (TMJ) dysfunction, loss of teeth and cosmetic issues," Dr. Smith says, noting that effective treatment requires an integrated, holistic approach. Cooper is South Jersey's only academic institution with the depth and breadth of oral-maxillofacial expertise to provide this comprehensive range of services (see sidebar), attracting patients from across the US.

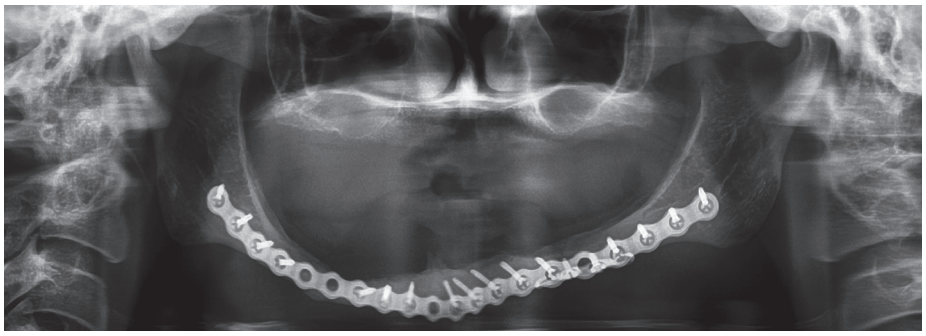
In Yeasky's case, on January 30, 2014, Dr. Smith placed the frame of the cadaver mandible on the outside of her lower jaw, grafted bone taken from her iliac crest to the cadaver mandible, then injected bone growth factor between the two. The result: her jaw is now three inches wide – and symmetrical.

"I am healing and I definitely see a big difference," she says. "I look at my X-rays and it's amazing. And I'm not in pain."

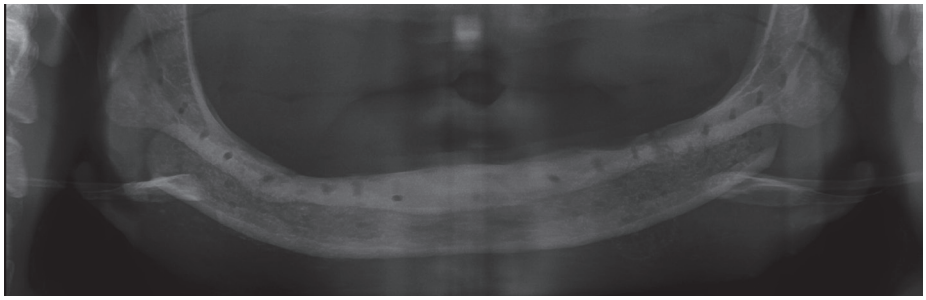
A nurse herself, Yeasky gives high marks to Dr. Smith and the entire team of surgeons, dentists and nurses who have cared for her at Cooper. "I've never had such a great experience," she says.

It will take six to nine months for the bone of her lower jaw to be strong enough for dental implants, for which Yeasky will undergo surgery in the fall. She will get upper implants sooner.

"The first thing I'll do when I get my new teeth top and bottom is eat salad," Yeasky adds. "Then I'll go back and show Dr. Smith my smile." ■



Post traumatic atrophic resorbed mandible.



Regrown mandible after grafting and growth factors.

Cooper's Division of Oral and Maxillofacial Surgery has outpatient facilities in Voorhees and Washington Township. To refer a patient or schedule an initial appointment, please call 856.270.4100.

Extensive Oral and Maxillofacial Procedures Available at Cooper

With a team of four oral/maxillofacial and facial cosmetic surgeons led by one of the nation's foremost experts in diagnosing and treating facial pain disorders, Cooper offers an exceptional level of advanced expertise in diagnosing and treating the conditions that affect the function and aesthetics of the mouth, teeth, jaws and face. Our capabilities include:

- Craniofacial reconstruction
- Orthognathic (corrective jaw) reconstructive surgery
- Management of tumors and pathology of the jaw and facial complex
- Distraction osteogenesis
- TMJ laser arthroscopy
- Zygomaticus implants
- Immediate-loading dental implants
- Mini and traditional dental implants
- Implant-anchored dentures
- Ride preservation/augmentation
- Bone grafting
- Gingival reconstruction and soft-tissue grafting
- Wisdom teeth extraction
- Surgical intervention for obstructive sleep apnea

Botox® for Preventing Chronic Migraine: Clinical Practice Results Exceeding Those of Initial Studies

Botox® — the renowned wrinkle smoother — is proving its value as a headache soother. FDA-approved in 2010 for treating chronic migraines in adults, Botox (onabotulinumtoxinA) is offering new hope for the estimated 14 million Americans who suffer from chronic migraine[1] – and for whom all other treatment options have failed.

"Chronic migraine is defined as debilitating headaches that have gone on for at least three months, occurring at least 15 days per month, and lasting four or more hours each of those days," explains Cooper Neurological Institute neurologist Larisa Syrow, MD.

"A certain percentage of patients have intractable migraines," she continues. "They're feeling hopeless and so are their physicians, since they've tried so many treatments and nothing is helping. Botox gives them a really good chance for improvement."

The FDA's approval of Botox for use in treating chronic migraine was based on results from two studies that reported patients treated with it experienced a major decrease in the frequency of headache days.

"These original reports, however, don't sound as impressive as the results I'm seeing in practice," Dr. Syrow says. "Many patients experience a radical improvement in the frequency and severity of their migraines."

Larisa Syrow, MD
Attending Neurologist
Assistant Professor of Neurology

Treatment — administered every 12 weeks — entails a total of 31 injections into muscles in several areas in the forehead, the sides and back of the head, neck and shoulders, producing a partial and temporary "denervation" that decreases pain signals to the brain.

"Botox prevents the vesicle where acetylcholine is stored from binding to the membrane where the neurotransmitter can be released," Dr. Syrow explains. "This blocks the release of acetylcholine by the neuron, effectively weakening the muscle for up to three months."

She also notes that Botox has fewer side effects and contraindications than other medications prescribed to treat chronic migraine. The most common side effects – as with any injection – include a chance of localized bleeding, infection or soreness at the injection site. There also is a small possibility of asymmetric forehead and other temporary cosmetic effects. More serious side effects are extremely rare. Pregnancy is the only significant contraindication for this preventive treatment.

Importantly, most insurers cover Botox treatment when it's documented that the patient meets the criteria for chronic migraine and that multiple other treatment modalities have failed.

"While Botox is relatively expensive — insurers are covering it because the alternatives, such as going to the emergency room or taking tons of medications, are no less expensive," Dr. Syrow notes. "And if it helps patients prevent their migraines, it's a small price to pay."

If you have a patient with intractable chronic migraine headaches who has exhausted other treatment options, you are encouraged to refer him or her (the majority of migraine sufferers are women) to Dr. Syrow for evaluation.

"I'm not just the procedure lady," she stresses. "I'll do a comprehensive evaluation and if I don't think Botox is the right approach, I won't administer it. Sometimes it's not a matter of medications at all but lifestyle modifications, such as diet and stress management. I'll talk about these options with the patient, if appropriate.

> "Botox prevents the vesicle where acetylcholine is stored from binding to the membrane where the neurotransmitter can be released. This blocks the release of acetylcholine by the neuron, effectively weakening the muscle for up to three months."

"But if Botox injections are indicated, we can provide them," she continues. "If nothing else has worked, it's well worth trying. It's important for patients — and their doctors — to know that there's hope." ■

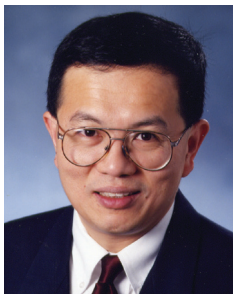
1Source: www.migraineresearchfoundation.org

For more information or to refer a patient, please call Cooper Neurological Institute at 856.342.2445.

Cell-Free Fetal DNA: New Technology for Non-Invasive Prenatal Testing

Genetic Counseling an Integral Component

A newer, non-invasive test that analyzes fetal DNA circulating in a pregnant woman's blood is proving more accurate in screening for trisomy 21 (Down syndrome) and other chromosomal abnormalities than the standard two-part sequential screen or maternal serum quad screen.



Tuan A. Dinh, MD

Meena Khandelwal, MD

With a simple blood draw from an expectant mother, the cell-free fetal DNA test (cfDNA) provides higher sensitivity and specificity as well as a significantly lower false-positive rate than traditional testing. In fact, according to a joint committee opinion issued by the American Congress of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine, several large-scale validation studies have demonstrated detection rates for fetal trisomy 13 (Patau syndrome), trisomy 18 (Edwards syndrome), and trisomy 21 of greater than 98 percent with very low false-positive rates (less than 0.5 percent compared to 3.5 percent for the sequential screen and 5 percent for the quad screen).

These findings led the committee to conclude that cell-free fetal DNA appears to be the most effective screening test for aneuploidy in high-risk women, leading a growing number of insurers to cover the test in these cases. It is not currently recommended for routine screening in low-risk women due to a lack of long-term outcome and cost-effectiveness data in this population.

"The high-risk population is defined as women who meet one or more of these criteria," explains Cooper OB/GYN faculty member Tuan A. Dinh, MD. "They are 35 and older at delivery, have had a prior pregnancy with a chromosomal abnormality, their fetal ultrasound findings indicate an increased risk of trisomy, or they have had a sequential or quad screen that is positive for trisomy."

Dr. Dinh and colleague Meena Khandelwal, MD, agree that the cfDNA test offers numerous other advantages over existing technology.

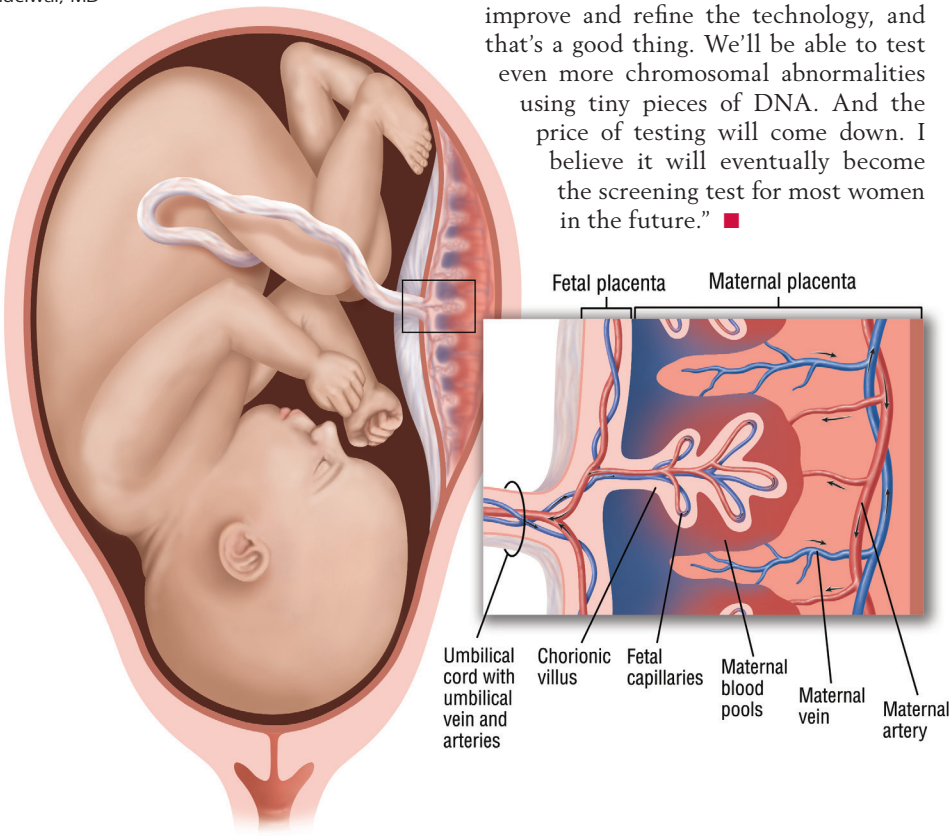
"It's a single, simple, non-invasive test that can be performed as early as 10 weeks into a pregnancy," says Dr. Khandelwal, noting that the sequential screen requires two patient visits and final results may not be available for 16 or 17 weeks into the pregnancy. The cfDNA test also can reveal the fetus' gender.

Further, she notes, some of the cfDNA tests now available can, through deletion assays, also detect anomalies of the sex chromosomes such as Turner's syndrome (XO syndrome), Klinefelter's syndrome (XXY syndrome), Triple X syndrome (XXX syndrome).

Drs. Khandelwal and Dinh stress, however, that cfDNA remains a screening test, and that additional, more invasive diagnostic testing – such as amniocentesis or chorionic villus sampling (CVS) – must be done before taking action to terminate a pregnancy.

"Because cfDNA testing is done only for high-risk women, here at Cooper we always recommend they undergo genetic counseling to understand their options as well as what this test can and cannot screen for," Dr. Khandelwal says. "Patients must understand the whole picture before choosing this test, and they must be counseled well – something that general obstetrician-gynecologists may not have the time or training to do.

"This test holds a lot of promise," she adds. "Companies are competing to improve and refine the technology, and that's a good thing. We'll be able to test even more chromosomal abnormalities using tiny pieces of DNA. And the price of testing will come down. I believe it will eventually become the screening test for most women in the future." ■



For more information about cell-free fetal DNA testing at Cooper, please contact the Cooper University Health Care Department of Obstetrics and Gynecology at 856.342.2065.

Cooper Center for Population Health, Positioning for the Future of Health Care

Staff of Cooper University Health Care in May 2011 marked a turning point for the growing institution. With 30 years of government, education, private sector and entrepreneurial experience, Louis S. Bezich, Chief of Staff of Cooper University Health Care, is charged with bringing a fresh, but seasoned, eye to an industry under fire for crippling the economy with its lack of accountability and runaway costs.

The creation of the Cooper Center for Population Health is among Bezich's first initiatives. The purpose is to explore the best practices to reduce health care costs without cutting or rationing service.

"The rising cost of health care is unsustainable, so providers around the country are doing this one way or another. Our goal is to get Cooper out front. To enhance our reputation for efficient, collaborative patient-centered care," says Bezich, who is also Executive Director of the Center for Population Health.

Population Health is a synonym for the kind of "high touch," patient-centered system that has long been known as accountable care. It is not the same as public health, which is a government-driven system that strives to keep safeguards in place to keep society healthy.

While public health may fund the creation of a life-saving vaccine, "Population Health makes sure people actually get the shots," says Anthony J. Mazzarelli, MD, Cooper's Senior Vice President and Chief Medical Officer.

Organizationally, the Center is an umbrella that oversees and test drives all innovation with regard to accountable care within the Cooper system. It is a think tank where some of the best ideas in the country are vetted for their applicability to South Jersey. Stephanie M. Watkins, DO, recently joined the team as Physician Advisor to educate Cooper's doctors and staff about the need for a seismic shift in the delivery of health care and to solicit their support and recommendations. Dr. Watkins serves as a coach and team builder.

Louis S. Bezich

Anthony J. Mazzarelli, MD

Rather than a place or a classroom, Dr. Mazzarelli calls the Center for Population Health a "strategy."

"Since the beginning of time, we've been in the sick business. When you're sick you come to the hospital. We operate on volume. Therefore, hospitals have zero incentive to keep people healthy. Economics and the federal Accountable Care Act tell us this funding formula has to change. The center will help lead the way," states Mazzarelli.

Why would a hospital that thrives on volume seek to reduce it? First, under health care reform, the federal government is offering financial incentives to hospitals that reduce volumes and penalties to those that don't.

Similar carrots and sticks are also in place in the contractual relationships between hospitals and insurance companies. Secondly, hospitals must strive to maximize their competitiveness against a future in which people need them less.

"Population Health is an indictment of the old system or our ongoing system of care," notes Mazzarelli. adding that "while we are able to provide extraordinary medical care such as saving lives in traumatic incidents, the real challenge is making sure patients take the necessary steps to stay out of the hospital, that they take their medications and keep their primary care appointments."

Cooper has an extraordinary opportunity to influence change by educating students at the Cooper Medical School of Rowan University. Appropriate training is already in place. The challenge, however, is reinventing a system for established doctors and other providers.

One of the key components of Population Health is anchoring patients to a medical home generally located in a primary care physician's office. Another is to focus on the highest users of health care, those with chronic or multiple conditions — also known as hot spots or frequent flyers — who need regular monitoring, from nutrition counseling to home visits, and to keep them out of the hospital. Under the direction of John F. Robertson, Jr., MD, Cooper is piloting a program, the Cooper Employee Centered Medical Home, with a slice of its 9,100 covered employees and their families to manage their care.

And, by taking 20 percent equity in AmeriHealth New Jersey — the first venture of its kind in New Jersey — Cooper is collaborating with an entity that stresses wellness, instead of sickness.

"Insurance companies win when people stay healthy. As a hospital, we can learn from them," says Mazzarelli. ■

The Employee Centered Medical Home (ECMH) is a new program launched by the Center for Population Health. High-utilizers of health care services within Cooper's insured ("covered") lives are invited to join the ECMH with a goal of reducing costs and improving outcomes and patient satisfaction.

Cooper University Health Care

3 Executive Campus, Suite 240-B
Cherry Hill, NJ 08002

INDICIA

Cooper Transfer Center

One Point of Contact for Specialized Patient Care

855.CUH.XFER (855.284.9337) • Fax: 855.632.6663

24 hours a day/7 days a week • CooperHealth.org/Transfer

Coordination of all transportation logistics by ground or air.

For more information about the **Cooper Transfer Center**, contact Ryan Miller, RN, Director of Patient Logistics, at 856.968.7931.

For more information: ***SJMedicalReport.com***

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