| MAY 2006 |

$3.95

# MONMOUTH health & life

## A VEGGIE GARDEN HOW-TO

## a bistro reborn– CASK 591

## DECKS AND PATIOS A 5-STEP PLAN

## best bets

- discount couture in shrewsbury
- marimba-fest in ocean grove
- guinness and ghosts in red bank

## *The Sopranos* Steven Van Zandt rock star, rebel, radio guru

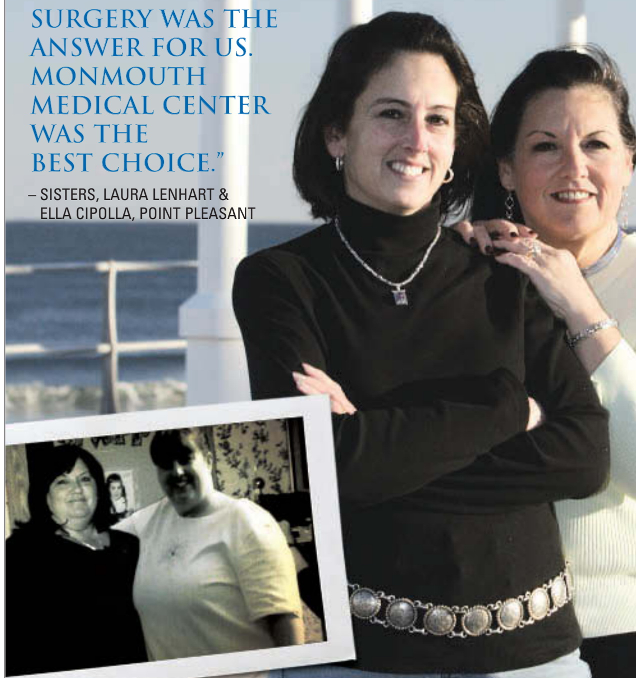
## health link

- revolution in cancer surgery
- new test for AD/HD
- saving newborn preemies

PRSRT STD
U.S. POSTAGE
PAID
MAILED FROM
ZIP CODE 61764
PERMIT NO. 110

THE GOOD LIVING MAGAZINE *from* MONMOUTH MEDICAL CENTER
An affiliate of the Saint Barnabas Health Care System

SAINT BARNABAS HEALTH CARE SYSTEM



"HAVING GASTRIC BYPASS SURGERY WAS THE ANSWER FOR US. MONMOUTH MEDICAL CENTER WAS THE BEST CHOICE."

– SISTERS, LAURA LENHART & ELLA CIPOLLA, POINT PLEASANT

**MINIMALLY INVASIVE BARIATRIC SURGERY AT MONMOUTH MEDICAL CENTER.**

When sisters Laura Lenhart and Ella Cipolla decided that their weight was robbing them of energy and good health, they turned to Monmouth Medical Center's bariatric surgery program. Under the direction of Dr. Frank Borao, a renowned expert on minimally invasive bariatric surgery, the sisters each had laparoscopic gastric bypass and lost a total of 230 pounds in just one year, greatly improving their health, and their quality of life.

The Bariatric Surgery Program at Monmouth Medical Center is the region's most comprehensive and most advanced, with laproscopic procedures that reduce risk and shorten recovery time. Our multidisciplinary team includes experienced surgeons, a registered nurse, dietitian, and psychologist. And we provide outstanding support before and after the procedure, including monthly support groups, and five-year follow-up of all patients to ensure the highest level of care.

To learn more about the Bariatric Surgery Program at Monmouth Medical Center, please call (732) 923-6070.

**www.saintbarnabas.com**

*Teaching. Treating. Leading.*

# NOTEWORTHY ACCOLADES

As you'll read in a special report in this issue's Health Link, Monmouth Medical Center continually searches for ways to improve quality—and to measure our success. The article on page 41 features a look at initiatives in critical care and neonatal intensive care, as well as the effectiveness of a Rapid Response Team—an innovation designed to maintain a hospitalized patient's stable condition.

Most recently, Monmouth celebrated another successful College of American Pathologists (CAP) inspection—the gold standard in pathology and laboratory appraisal. Over the years, Monmouth has established itself as the region's leader in laboratory analysis, and the CAP accreditation places our laboratory among a select group of 6,000 facilities in the United States.

Additionally, the Jacqueline M. Wilentz Comprehensive Breast Center's unblemished record for meeting all national standards for mammography quality has now reached 11 consecutive years. The center, opened in 1994, has passed the annual Food and Drug Administration inspection without a single violation each year since the federal program took effect in 1995. When images are precise, it leads to more accurate interpretation and diagnosis. For women who undergo regular mammograms, this sophistication helps us detect breast cancer at its earlier stage.

Further illustrating our commitment to excellence is the fact HealthGrades—the nation's premier independent health care quality company—named Monmouth Medical Center among the top 5 percent of U.S. hospitals for overall clinical quality performance. Monmouth also received its highest rating for treatment of heart attack, heart failure and stroke; pulmonary and OB services; and total hip replacement.

These accomplishments reflect the ethos that Monmouth Medical Center has worked so hard to fashion. But the feat I am most proud of, because it is truly exemplary of teamwork, is the recognition we received from Press Ganey, the health care industry's leading independent surveyor of patient satisfaction. In an acclaimed assessment of select hospitals nationwide, Monmouth was named "Distinguished Academic Center," among an elite group of the nation's nine leading teaching hospitals. We have an enviable record of superior care and service—and our recognition by Press Ganey speaks volumes about these efforts.

Sincerely,

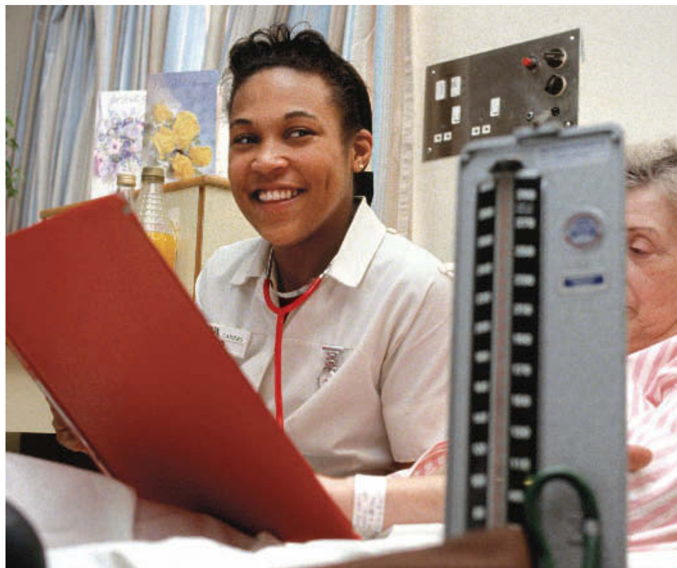
Frank J. Vozos, M.D., FACS
Executive Director
Monmouth Medical Center

FUTUREOFCARE

## GOING THE EXTRA MILE

*Monmouth Medical Center constantly searches for ways to improve quality—and prove it*

How does a hospital show its commitment to the best possible quality of care? Doing so takes more than meeting regulatory requirements and hiring the finest doctors, nurses and other professionals. It takes making quality innovations—and measuring the results.



As a university-level research facility (the main clinical campus for Philadelphia's Drexel University College of Medicine), Monmouth Medical Center has long had notable advantages in providing—and demonstrating—quality. But there's always room to improve, so Monmouth also embraces specific initiatives to assure optimal clinical excellence and patient safety. Here's what it's doing in three areas:

### THE INTENSIVE CARE UNIT

In intensive care, patients are critically ill—and more vulnerable to germs. When it comes to blood infections among ICU patients with central line catheters, the Centers for Disease Control and Prevention set 4 per 1,000 patient-days as the maximum acceptable level. Last year, Monmouth did better than that. It had 0.

No hospital can promise perfection, but under the leadership of George C. Davis, M.D., medical director of the ICU, and nurse Maureen Bowe, clinical director of critical care, Monmouth has been one of the pioneers of a collaborative effort by the New Jersey Hospital Association to improve both patient care and safety in ICUs. "We're looking to change the culture of institutions, to make us all more safety-conscious," says Bowe.

Ideas for doing that are welcome from all quarters. It was a pharmacy student and a primary care nurse who suggested a special eye-shaped warning that is now placed outside rooms and on charts when two patients on a floor share a surname, a possible cause of mix-ups. Certain abbreviations are banned—such as "u" for units, because it's too easy for "10 u" to look like "100," a mistake that could mean giving a patient 10 times the appropriate dose. And the computerized Pyxis station that dispenses medication gives staffers special alerts for certain products—a prompt to check heart rate, for example, for the heart medicine Digoxin, which can be dangerous if given when the heart rate is too low.

"To reduce the incidence of pneumonia and other infections for patients on ventilators," says Dr. Davis, "we've made a number of changes. We scrutinize the use of antibiotics—and the length of time patients are on them—so we don't overmedicate and promote resistant organisms. We use intravenous insulin to control the blood-sugar levels of all patients under stress, even though we once thought those levels didn't matter for nondiabetics. Our nurses follow a bundle of proven 'best practices'—such as elevating the patient's bed at a 30-degree angle. We

JANINE WIEDEL PHOTOLIBRARY/ALAMY

insist that everyone wash their hands for 15 seconds before entering every room, and provide alcohol hand gel near every room to make it easier. And we have daily rounds for residents each weekday at 9 a.m."

The effort is clearly working. While the CDC's benchmark for ventilator-acquired pneumonia per thousand patient-days was 5.4 last year, Monmouth came in at 0.9—a dramatic drop from the previous year. And the daily rounds, begun two years ago, have proved especially helpful.

Just think of the busiest place you've ever worked, and how hard it was to get people together or get messages to them right away. "Morning rounds bring all the disciplines together, and that's a big help in improving care, cutting costs and discharging people from the ICU as soon as they are stabilized," says Bowe. "What the respiratory therapist decides, for example, can affect what the nutritionist recommends, and a prompt adjustment of nutrition can help the nurse see to it that there's no skin breakdown.

"We've always been a multidisciplinary team," adds Bowe, "but these rounds make our collaboration more immediate. They raise the bar for everyone."

**Advanced technology and little things like hand-washing contribute to Monmouth ICU's strong showing in reducing infections.**

## THE RAPID RESPONSE TEAM

Monmouth is one of a small minority of U.S. hospitals that have instituted the Rapid Response Team, an innovation advanced by the nonprofit, Cambridge, Massachusetts-based Institute for Healthcare Improvement. "When a patient is rapidly deteriorating, most hospitals respond by calling the treating physician—who may or may not be on site—for instructions," explains Dennis Farrell, Monmouth's performance improvement coordinator. "And if the patient's condition deteriorates to the point that heartbeat or breathing stops, they'll call a 'code blue' to save the patient's life. But studies reveal that patients show certain signs as much as 12 hours before a code blue—or an emergency transfer to the intensive care unit." Early responses to those warning signs, says Farrell, can prevent many of those crises and save lives.

That's what a Rapid Response Team does. It includes a physician, a respiratory therapist and a nurse with special training in critical care. Plenty of doctors are on hand on weekdays, but on evenings, nights and weekends, these teams augment regular staff and are always ready to be at the bedside in minutes to do what's needed to restore a patient's condition.

TOP: BANANASTOCK/ALAMY; BOTTOM: BANANASTOCK/ALAMY

The team will come running in response to any of six signs that have proved to be harbingers of trouble:

- breathing that's too fast or slow (more than 28 breaths a minute, or less than 8)
- a heart rate that's too fast or slow (more than 125 beats a minute, or less than 40)
- blood pressure that's too high or low (a systolic reading, the top number, that is higher than 170 or less than 90)
- a pulse oximeter rate showing less than 90 percent oxygen saturation in the blood
- a sudden change in level of consciousness—for example, a patient suddenly becoming disoriented or confused, or
- a general appearance that, even without these concrete signs, makes an experienced nurse worry.

"The Rapid Response Team is not a requirement we must meet," says Patricia Zweier, director of nursing performance improvement. "It's something we do because we feel it's going to make a difference."

And does it? The program debuted just last year, but already there's evidence of improvement. Code blues, which averaged 8.5 per month before the program, were down for the last quarter of 2005, Zweier reports, and in December there were just two.

**Rapid Response Teams, introduced just last year, have already reduced "code blues" at Monmouth.**

## THE NEONATAL UNIT

Nowhere in the hospital are the stakes higher than in the Neonatal Intensive Care Unit (NICU), where infants born prematurely or in distress are cared for. Here, success can mean 80 or 90 years of happy and productive living that almost didn't happen.

About 80 percent of the babies in the unit progress normally despite their prematurity, reports Carlos Alemany, M.D., the NICU's medical director. For the other 20 percent, doctors have a fight on their hands, both to assure survival and to avoid lifelong complications.

Even small changes in the care given these babies can make a life-or-death difference. But treating 500 infants a year doesn't provide a large enough sample to provide valid statistical lessons about what works best. So Monmouth belongs to the Vermont Oxford Network, a consortium of more than 400 NICUs in the U.S. and Europe, which creates a larger data pool that informs improvements to care on an ongoing basis.

Monmouth's was the first NICU in the state, the first at a community teaching hospital in the nation and the first Level III NICU in the region. "It's consistently in the top 10 percent of hospitals in avoiding complications such as severe retinopathy, which can cause blindness, and intraventricular hemorrhage, which can produce cerebral palsy," says Dr. Alemany. The medical center's survival statistics for early preemies are also strong. It saves 50 percent of babies born at 23 weeks (the national average is 20 percent to 40 percent); 70 percent to 90 percent of those born at 24 weeks (versus an average of 50 percent) and more than 95 percent of those born at 25 weeks (where the average is 70 percent to 75 percent).

But you don't rest on laurels in a field like this one. Much remains unknown about the long-term effects of neonatal interventions, and Monmouth doctors are working to discover just what babies need. For example, how can one neutralize the harmful effects of an artificial environment on the development of babies' brains? And how should a respirator be set to make an infant work just hard enough but not too hard? To help make these calls, the hospital participates in a training initiative called NIDCAP (for Newborn Individualized Developmental Care and Assessment Program), which studies infants closely.

"Let's say the carbon dioxide count on a baby's ventilator is too high," says Dr. Alemany. "So we make a change and get a better number. But do we also look to see if the patient is crying or struggling against the machine? Are we actually providing comfort?"

Indeed, relieving pain is another current push in the NICU. "Babies do feel pain," the doctor says, "and they can't tell us about it." Monmouth is committed to this quality improvement—for empathy's sake, and for another reason too. "What is coming out in the literature," says Dr. Alemany, "is that babies who get better pain relief have better outcomes." M

**The Neonatal Intensive Care Unit has high rates of survival for preemies, and it's attentive to its tiny patients' comfort too.**

BOTTOM: IMAGESTOPSHOP/ALAMY

CAREFORKIDS

## NEW HOPE FOR KIDS WHO CAN'T PAY ATTENTION

*Today there's a test to determine whether they have AD/HD or one of its imitators*

© LWA-DANN TARDIF/ZEFA/CORBIS

Try as you might, you can't make your son finish his homework. The view out the window beckons, and he keeps breaking his pencil point and playing with the cat. Every two minutes he's up and running around. You're fit to be tied.

He may have attention-deficit/hyperactivity disorder (AD/HD), a neurobehavioral condition that, according to the Centers for Disease Control and Prevention, affects 4.4 million Americans 4 to 17 years old. In 2003, the agency says, 7.8 percent of school-age children in the U.S. were reported by their parents to have an AD/HD diagnosis.

Traditionally, AD/HD has been diagnosed with teacher questionnaires rating how regularly inattention or hyperactivity gets in the way of learning. They were only accurate about half the time, according to Richard Reutter, M.D., a developmental and behavioral pediatrician at Monmouth Medical Center. Now, he says, "there's an objective test that is highly sensitive and highly specific for AD/HD." It's called a quantitative electroencephalogram (QEEG), and in it electrodes are hooked up to the subject's head to measure brain-wave activity. More than 90 percent of persons with AD/HD have been found to have an atypical brain-wave pattern in which slow theta waves predominate over faster beta waves—a pattern that can be corrected with medication. The QEEG test for AD/HD is gaining wider acceptance and has been recognized by the American Academy

### To learn more about AD/HD . . .

Consult these sources:

- **Attention Deficit Information Network Inc.** 475 Hillside Avenue, Needham, MA 02194-1200; 781-455-9895; www.addinfonetwork.com
- **National Resource Center on AD/HD,** a program of Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD); 1-800-233-4050; www.help4adhd.org

of Pediatrics. FDA approval is expected soon.

Precise diagnosis is important, because the AD/HD label has been applied incorrectly, warns Dr. Reutter. "In 2002," he says, "a large Mayo Clinic study found that at least 50 percent of those diagnosed with AD/HD didn't really have it, but had another condition causing AD/HD-like symptoms."

Conditions that can mimic AD/HD include dyslexia, depression, anxiety, central auditory processing disorders (trouble filtering out background noise and focusing on hearing what's important) and Asperger's syndrome, a kind of autism marked by difficulty in responding to social cues.

AD/HD itself is divided into three main types. In one, inattention is the dominant feature, making kids seem like daydreamers. In a second kind—relatively rare—hyperactivity and impulsive behavior are more salient characteristics, while in the most frequently occurring variety the two traits are combined in varying degrees.

The QEEG test takes about an hour, with results available about 48 hours later. Its cost is now covered by most (but not all) insurance companies, says Dr. Reutter. He routinely uses it to diagnose AD/HD, and also to monitor response to medications, which should bring brain-wave activity closer to the typical pattern.

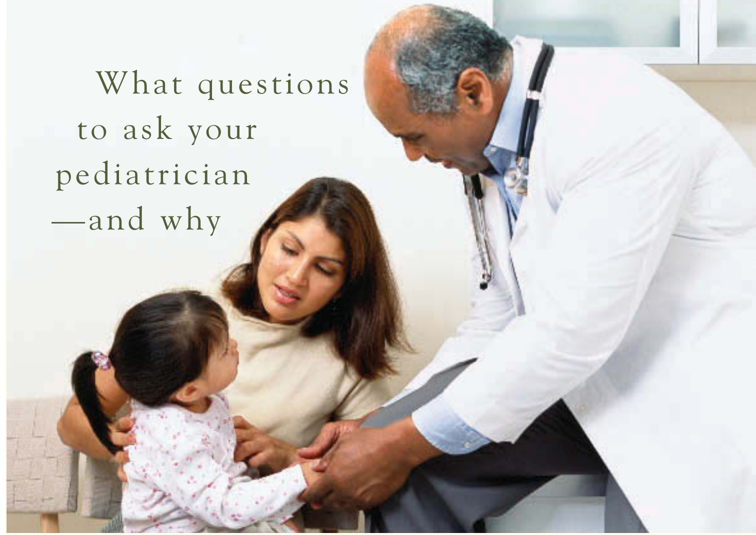
"The long-term benefits of accurate diagnosis and treatment using QEEG are enormous," says Dr. Reutter. M

## AD/HD isn't just for kids

**Do you have difficulties with attention, organization, mood control and follow-through? Years ago, doctors thought attention-deficit/hyperactivity disorder didn't exist in adults, but they've learned better—and so have many parents who've sought treatment for their children. For some, getting a fix on Johnny's problems has brought an instructive look in the mirror too.**

**"AD/HD is a mental health problem that is often overlooked in adults," says the American Academy of Family Physicians (AAFP), adding that the condition "may be inherited." Of course, jitteriness and distraction can have many causes, the AAFP points out. Depression, anxiety, thyroid or hormone problems, substance abuse, lead exposure or the side effects of prescription drugs or herbal medicines could be responsible. One quick check is to recall whether your symptoms have been lifelong, as AD/HD doesn't suddenly occur in adulthood.**

**If you're diagnosed with AD/HD as an adult, your physician may prescribe a stimulant or antidepressant and suggest certain lifestyle changes. Then there's the piggyback effect. Decades of grappling with AD/HD symptoms without knowing their cause can lead to low self-esteem and other issues, and a support group, counseling or psychotherapy may help.**



## What questions to ask your pediatrician—and why

❑ **Does my child have attention-deficit/hyperactivity disorder (AD/HD)?** The doctor may order a quantitative electroencephalogram (QEEG) test. He or she may also inquire in detail about your child's conduct in recent months and whether difficulty paying attention, concentrating or sitting still—or a pattern of impulsive acts or statements—has occurred often enough to be disruptive.

❑ **Does he or she need medication?** Not all AD/HD kids do. But many are treated with methylphenidate (trade name Ritalin), or mixed amphetamine salts (Adderall) and norepinephrine. These medications raise the levels of a neurotransmitter in the brain called dopamine when kids perform certain routine functions. In effect, the medication makes the tasks more interesting, and distraction less likely. Medication also improves reaction time. For children whose hyperactivity is a dominant feature, stimulant medication is sometimes used with a drug called clonidine (Catapres). But AD/HD medications may also cause some kids to lose weight, temporarily grow more slowly or have trouble falling asleep, and much is unknown about their long-term effects. You and your doctor should weigh the pros and cons of medication carefully.

❑ **How can I guide my child at home?** Behavior management techniques may reduce the amount of medication needed. Some relief may come with simple steps like:

- not letting your child get overtired or overstimulated
- setting and enforcing limits on activities
- rewarding good behavior and school performance
- assigning specific locations for possessions at home

❑ **What adjustments are needed at school?** Your child's teachers should be your partners in planning to meet his or her educational needs. The child may benefit from special services—or accommodations, such as a seat at the front of the class.

❑ **Should the child see an eye doctor?** AD/HD is often accompanied by a physical eye problem called convergence insufficiency, which makes it hard to keep both eyes focused on a near target, and so to read. Fortunately, this condition responds to simple eye exercises.

To find out more about the treatment of attention-deficit/hyperactivity disorder at Monmouth Medical Center, call 732-923-7250.

TOP: PHOTODISC; BOTTOM: RON CHAPPLE/JUPITERIMAGES

SURGICALSTRIDES

## A NEW WEAPON AGAINST A DEADLY CANCER

*Recovery is quicker when esophageal tumors are removed laparoscopically*

A 70-year-old woman is cancer-free today thanks to minimally invasive surgery done recently at Monmouth Medical Center. And she is able to eat without pain once again.

The operation, a laparoscopic esophagectomy (LE), was performed by laparoscopic surgeon Frank J. Borao, M.D., and thoracic surgeon Anthony J. Squillaro, M.D., who removed a large tumor from the woman's esophagus.

The procedure was introduced at Monmouth just last year, and the center remains the only facility in Monmouth and Ocean counties to offer it. LE marks a new technical pinnacle for the institution's Minimally Invasive Surgery Section, established in 2000 under Dr. Borao's direction. It is technically challenging, but it's much easier on the patient than doing it the traditional way, which—because of the extent of the esophagus, or foodpipe—often requires large incisions in the abdomen, chest or neck.

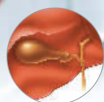
Like other laparoscopic surgeries, LE is done with a very small telescope introduced into the body (through "pinhole" incisions) and tiny tools manipulated with the guidance of video monitors. "We don't actually put our hands inside the patient," explains Dr. Borao.

Laparoscopic surgery was pioneered by gynecologists in the 1970s and has spread across the operative disciplines; the approach is now routinely employed, for example, in gallbladder procedures. (See the timeline, "Laparoscopic Surgery at Monmouth: a Heritage of Firsts," below.) But only in the last few years has it been applied to removing the esophagus—and only, so far, in a few specialty centers across the country.

TOP: STOCKBYTE PLATINUM/ ALAMY; BOTTOM LEFT: © SINGH/CUSTOM MEDICAL STOCK PHOTO

### Laparoscopic surgery at Monmouth: a heritage of firsts

**For more than a decade and a half, Monmouth Medical Center has been in the forefront of surgery's rapid advance, as the embrace of new laparoscopic techniques using much smaller incisions has made operations less invasive, recovery times faster and complications fewer. Here are a few milestones:**



**1990**

**A team of Monmouth surgeons becomes the first in New Jersey to perform a laparoscopic cholecystectomy—the minimally invasive removal of the gallbladder.**

**1994**

**General, vascular and orthopaedic surgeons at Monmouth do the New York/New Jersey area's first spinal fusion surgery, a less-invasive alternative to traditional surgery for degenerative disc disease.**

## Heartburn daily? See your doctor

**You may be able to cut your odds of someday needing esophageal surgery. Consult your physician if you're regularly experiencing heartburn for a long time, because you may be at risk for Barrett's esophagus, in which protracted contact with acid changes the nature of the cells lining the esophagus. While not itself malignant, Barrett's esophagus sharply increases your risk of developing esophageal cancer.**

**Your doctor may suggest medications to reduce acid and/or heightened monitoring of the esophagus for possible cancer. Other tips to try include:**

- **avoiding or limiting greasy or fatty foods**
- **cutting down on caffeine and alcohol**
- **letting at least three hours go by after dinner before you retire, to lessen the chance of acid reflux**

**To find out more about minimally invasive surgery at Monmouth Medical Center, call 732-389-1331.**

Cancer of the esophagus is on the rise, with about 14,500 new cases diagnosed in the U.S. annually. "This surgery may offer a cure for patients whose cancer has not spread beyond the esophagus," says Dr. Borao. "Unfortunately, most patients with this kind of cancer are diagnosed quite late." For them, LE is a palliative rather than a curative procedure, but it can still make an enormous difference by relieving symptoms such as the inability to eat and difficulty swallowing.

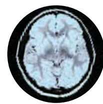
LE can't be used on every patient with esophageal cancer, Dr. Borao explains. For unusually large, bulky tumors, it may be necessary to employ traditional open surgery instead. "If we set out to do LE and a problem arises, we can always convert to an open procedure," he says.

But the laparoscopic approach has important advantages. For most patients, it makes possible a shorter hospital stay, a quicker recovery, reduced need for post-operative narcotics and a decreased likelihood of complications—such as infections and the formation of hernias—which are a major concern in traditional esophageal surgery. *M*

TOP: DEBORAH JAFFE/GETTYIMAGES; BOTTOM LEFT: © ARTICULATE GRAPHICS/CUSTOM MEDICAL STOCK PHOTO

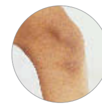
**1996**

**Michael A. Goldfarb, M.D., chief of surgery, and Saad A. Saad, M.D., chief of pediatric surgery, introduce a procedure that uses a bronchoscope, a device that looks inside the windpipe, to make a second incision unnecessary in children's hernia surgery.**



**2000**

**Neurosurgeons Jonathan Lustgarten, M.D., and David Estin, M.D., make Monmouth the first hospital in the tri-state area to introduce endoscopic surgery that removes pituitary tumors and tumors from the base of the brain without incisions.**



**2002**

**Frank J. Borao, M.D., performs the state's first laparoscopic sural nerve harvest, taking a nerve from one patient's leg that is then used in a nerve reconstruction procedure in another patient's arm by plastic surgeon Andrew Elkwood, M.D.**

SKINDEEP

## SHAVING HINTS FOR HEALTHY SKIN

*A 5-point checklist for avoiding trouble as you wield the blade*

Shaving isn't rocket science, but it can affect the health of the skin, your body's largest and most visible organ. Experts say faulty shaving tools or methods can cause skin irritations, especially if your skin is thin, dry or extra-sensitive. So answer these five questions to be sure you're looking out for your skin as you shave:

❑ **1. Do you press a warm cloth on your skin before shaving?** Experts recommend this, or shaving after a warm bath or shower, in order to soften the hair and prepare it to be cut.

❑ **2. Do you apply a shaving cream, lotion or gel before shaving to lubricate the skin?** "Hairs become softer and easier to cut once they've absorbed moisture," explains Forrest Resnikoff, M.D., a dermatologist at Monmouth Medical Center. Lubrication stimulates the erector pilli muscle, pushing hairs up so they're ready for the blade. It also triggers the release of softening oils from within the skin.

❑ **3. Do you use a clean, sharp razor?** If you're prone to skin irritations, an electric razor may be a good choice. "And if you use disposable razors," says Dr. Resnikoff, "discard each one after about four days. As they dull they're more likely to cut the skin, and they can collect bacteria." Also, replace blades regularly in a safety razor.

❑ **4. Do you shave in the direction of hair growth rather than against it?** Use long, smooth movements and avoid repeated strokes in the same area.

❑ **5. Do you follow up by rinsing your skin afterward with warm water?** This is recommended, and so is the use of a gentle skin lotion after your shave. Avoid after-shave preparations that contain alcohol, says Dr. Resnikoff; they can dry the skin, and "there's no need to sting yourself without benefit."

Sometimes women shaving their thighs develop a problem called falliculitis, which is marked by tiny pus-filled bumps. An antibacterial soap such as Hibiclens may clear up this condition, says the doctor.

If skin irritation persists, see your dermatologist. He or she may be able to prescribe a topical steroid cream that will help. *M*

### The nuisance of razor bumps

**African-American men are especially susceptible to pseudofolliculitis barbae, or razor bumps, but it can affect any racial group, says dermatologist Forrest Resnikoff, M.D., of Monmouth Medical Center. Razor bumps occur when hairs curl and grow back into the skin after a close shave. To prevent them, wait a minute after applying shaving cream to let the hairs soften. Lift up hairs that begin to in-grow with an alcohol-cleansed needle or tweezers (do not pluck) just before shaving. Or try chemical depilatories (wash your face twice with soap and water afterward) or laser hair removal. Still, says the doctor, "for some men the best advice is to grow a beard."**

**If you need help in locating a dermatologist, please call 1-888-SBHS-123.**

TOP: BENNO DE WILDE/GETTY IMAGES; BOTTOM: ANDRE CEZAR/ALAMY

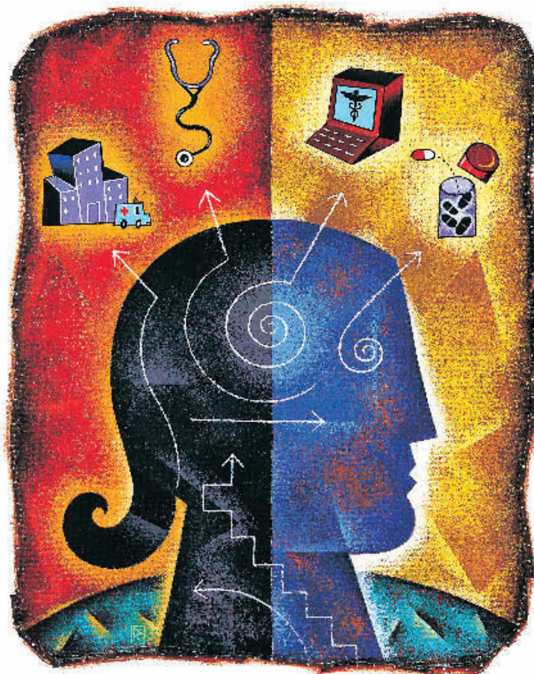
# KNOW YOUR COVERAGE

## 4 QUESTIONS TO HELP YOU GET THE RIGHT TREATMENT WITHOUT BUSTING THE BUDGET

Health insurance has changed. It's both more costly and more complex than it used to be. And that puts new responsibilities on you, the consumer.

"People need to be more knowledgeable today about their insurance and what it covers," says Kathleen Hauck, employee benefits coordinator at Monmouth Medical Center.

With health care costs and therefore premiums rising fast, employers who once provided insurance as a fully paid benefit are asking workers to pay a share. (One study says just 28 percent of employees had fully paid plans in 2003, down from 35 percent in 1998.) But insurers still want your company's business, and your company still wants to keep your loyalty. So they slice and dice coverage in various ways to offer you different options. Fortunately, four key questions can help you decide among those options and get the most bang for your health care buck:



1\. WHAT SERVICES WILL YOU USE MOST? If you are offered a choice of plans, read the brochures and ask questions of your company's insurance broker before you sign up for one. Consider your family's medical needs. Are your doctors listed in the provider networks? (The online version is more reliable than a printed book, because such lists change fast.) If you have young children, you may value an HMO's provision for well visits and immunizations—and its low copayments, which can make it easy to pop into the pediatrician's office. But remember that HMOs cut costs by limiting your access to doctors. If you're past 50 or have a chronic condition or a favored specialist, a PPO (preferred-provider organization) or POS (point-of-service) plan with a wider specialist network—or better out-of-network benefits—may be preferable.

2\. WHAT DOES YOUR PLAN REQUIRE? Once you've chosen a plan, avoid headaches by following its rules for things like precertification for hospital services. "Read your summary plan description so you'll know what's covered and what to do," says Hauck. As savvy as we've grown about managed care, many of us still don't do that.

And remember that there are different coverage plans—and provider networks—within each insurance brand. It's not enough to ask if a doctor "takes Oxford"; check your insurance card to see if you mean Oxford's "Liberty Plan Classic," its "Freedom Plan" or another variant.

3\. WHAT WILL YOU SPEND THIS YEAR? If your employer offers a flexible-spending account, says Hauck, go for it. Such accounts let you pay out-of-pocket medical and dental expenses with pre-tax dollars deducted regularly from your paycheck, lowering your tax bill. Included are the cost of over-the-counter medicines, as well as copayments and your share of medical bills. Your job is to estimate your likely medical expenses for the year ahead. Be conservative, because you'll forfeit any funds left over at year's end. "Some people are afraid of this use-it-or-lose-it feature," says Hauck, "but they're missing out on a good way to ease the pocketbook squeeze of rising copays."

4\. DO YOU HAVE SPECIAL NEEDS? Even in the computer age, it can help to ask a person for what you need. Your doctor may sign up with a new network at your request (especially if your employer has clout in your area). Or your company may agree to offer flexible-spending accounts. You can even explain your situation to a rep at your insurer's toll-free number. They're not big on making exceptions to the rules, but they may suggest a solution you haven't thought of. Call early, though; don't wait until there's a dispute. M

HEIDI YOUNGER

by Timothy Kelley

# MEMORY'S PLEA

## A PAINFUL PAST CAN BE THE OCCASION FOR A GENEROUS PRESENT

When Joel Opatut's children asked about the indelible number on his arm, he told them it was a telephone number.

"They went for it!" he happily declares. And so did his grandchildren, years later.

Opatut, 82, a Polish-born Holocaust survivor, feels no special need to share old woes with the young.

"Why should the tears go into their plate of soup?" he says, with one of the old-country images that make his still-accented speech a picturesque delight.

Still, each of us must make peace with our own history. And when it serves a purpose, this businessman and philanthropist isn't afraid to look back.

Opatut was 15 when German tanks rolled into Poland as World War II began. He and his three brothers, valued as potential laborers, were sent to concentration camps—and survived. His parents and two sisters were less fortunate. In 1943, they were among a group of villagers who were taken out and shot.

When Allied troops approached, Opatut was led by retreating Germans on a forced march. "It was raining," he says. "Pouring, with buckets." The group took shelter overnight in a barn, and at dawn one of the Jews opened the barn door. "He didn't see any Gestapo around, so he said, 'I think we're free.'" Opatut's group was found by a unit of African-American GIs from Patton's Third Army, and they were a revelation. "We'd never seen black people before," he says.

He tells these stories freely, and he also recalls a more recent sentimental journey that was all about the past. A decade ago, he took his children to visit the exact spot alongside a highway where he'd met his wife Frances. He and one of his brothers had noticed two girls sitting on a bench and had stolen—he admits—two bicycles to give them a ride. "We had a double wedding," he says. Fifty years later, the bench was still there.

Opatut came to America in 1949 with Frances, his son Abe, his brothers and their families. He worked at menial jobs because he spoke no English. But the next year he and his brothers made a down payment on a chicken farm in Freehold. "The chickens understood our language," he quips.

Evidently they did. By the time his firm, Colonial Foods Inc., went public in 1971, it had 5 million chickens and produced more than 18 million eggs a week. He also branched out into real estate investments that proved lucrative.

Opatut, who lives in West Long Branch and Bal Harbour, Florida, never remarried after Frances' death in 1977. But he enjoys time with his three adult children—besides Abe there are daughters Arlene and Toby—and seven grandchildren. And he shares the fruits of his success in ways that honor his story. At Monmouth Medical Center, where doctors' persistence saved him from an almost-fatal heart attack 25 years ago, he has helped fund the Joel Opatut Cardiopulmonary Rehabilitation Center. He gives to United Jewish Appeal, which sponsored his arrival in the U.S. And two years ago he went back to Poland. With the help of his grandson Peter and the mayor of his hometown, he arranged for the refurbishment of the long-neglected Jewish cemetery there as a memorial gesture to those who perished. Opatut recently screened a video of the cemetery's dedication ceremony, he says, and "the floor was wet. Everybody was crying—including me."

Still, it was a positive answer to the past. "Now," he says, "my conscience doesn't bother me so much." M

HEATHER SOLIMINE

# WHAT'S Happening AT MONMOUTH MEDICAL CENTER

THE CENTER FOR KIDS & FAMILY OFFERS A HOST OF PROGRAMS THIS SEASON

## CHILDBIRTH PREPARATION/PARENTING

Programs are held at Monmouth Medical Center, 300 Second Avenue, Long Branch. To register, call 732-923-6990.

**One-Day Preparation for Childbirth** **April 23, May 21,** 9 a.m.–4:30 p.m. $179/couple (includes breakfast and lunch).

**Two-Day Preparation for Childbirth** (two-session program) **May 6 and 13, June 3 and 10,** 9 a.m.–1 p.m. $150/couple (includes continental breakfast).

**Preparation for Childbirth** (five-session program) **May 23, 30, June 6, 13 and 20; July 11, 18, 25, August 1 and 8,** 7:30–9:30 p.m. $125/couple.

**Marvelous Multiples** (five-session program) **May 10, 17, 24, 31 and June 7,** 7–9 p.m. For those expecting twins, triplets or more. $125/couple.

**Eisenberg Family Center Tours** **April 30, May 7, 21, June 4,** 1:30 p.m. Free. (No children under 14 years old.)

**Baby Fair** **June 15,** 7–9 p.m. Free. For parents-to-be and those considering a family, featuring the Eisenberg Family Center tours, refreshments, gifts. (No children under 14.)

**Make Room for Baby** **April 22, May 13,** 10–11 a.m. For siblings ages 3 to 5. $40/family.

**Becoming a Big Brother/Big Sister** **May 20,** 10–11:30 a.m. For siblings age 6 and older. $40/family.

**Childbirth Update/VBAC** **May 3,** 7:30–9:30 p.m. Refresher program including information on vaginal birth after cesarean. $40/couple.

**Baby Care Basics** (five-session program) **April 22 and 29,** noon–2 p.m.; **May 11 and 18,** 7:30–9:30 p.m., $80/couple.

**Breastfeeding Today** **May 4,** 7–9:30 p.m. $50/couple.

**Cesarean Birth Education** **April 19, June 14,** 7:30–9:30 p.m., $40/couple.

**Grandparents Program** **May 15,** 7–9 p.m. $30/person, $40/couple.

**Parenting Young Children Through S.T.E.P.** (five-session program) **May 31, June 7, 14, 21 and 28,** 7–9 p.m. Systematic Training for Effective Parenting from infancy to age 6. $75/person or $100/couple.

**Understanding Your Baby's Behavior** **May 9,** 10–11:30 a.m., $40/couple.

## JUST FOR KIDS (Also see sibling programs above.)

**Safe Sitter** (one-session program) **April 29, June 24,** 9 a.m.–4 p.m. For 11- to 13-year-olds on responsible, creative and attentive babysitting. Monmouth Medical Center. Call 1-888-SBHS-123. $50/person. (Snack provided; bring bag lunch.)

## GENERAL HEALTH

**Monmouth Medical Center Health and Fitness Expo at the NJ Marathon Weekend** **April 28,** 3–7 p.m.; **April 29,** 9 a.m.–7 p.m., Ocean Place Resort & Spa, Long Branch. For registration and information call 732-578-1771.

**Stress-Free Workshop** **May 9,** "Meditation for Inner Calm," 7–9 p.m., Monmouth Medical Center. Call 1-888-SBHS-123. $10/person/session.

The following three programs will be held 10 a.m.–2 p.m. at Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown: **"To Your Health" Showcase** **May 10, June 14, July 12; Blood Pressure Screening** **May 10, June 14, July 12; Cholesterol Screening** **May 10.**

**Hypnosis for Weight Loss** **May 11,** 7–9 p.m., Monmouth Medical Center. Registration required. Call 1-888-SBHS-123. $35/person.

**Hypnosis to Stop Smoking** **June 8,** 7–9 p.m., Monmouth Medical Center. Registration required. Call 1-888-SBHS-123. $35/person.

## SENIOR HEALTH

**Lyme Disease** **April 19,** 1–3 p.m., Mutahir A. Abidi, M.D., rheumatology. SCAN.*

**Is the Medicare Prescription Drug Program Right for You?** **April 21,** 10–11:30 a.m.; **May 9,** 10–11:30 a.m., presented by the Saint Barnabas Health Care System and Aetna Medicare, Monmouth Medical Center. Registration is required. Call 1-888-SBHS-123.

**Diabetes Update** **April 26,** 1–3 p.m., Bernard Shagan, M.D., endocrinology and internal medicine. SCAN.*

**Count Your Calcium** **May 3,** 1–3 p.m. SCAN.*

**Blood Pressure Screening** **May 10, June 14, July 12,** 10:30–11:30 a.m. Long Branch Senior Center (age 60 and over—membership required), 85 Second Avenue.

**Communication Skills for Stressful Situations** **May 12,** 9:30 a.m. Marlboro Township Recreation Senior Program, Community Center, 1996 Recreation Way. Membership and registration required. Call 732-617-0100.

**Incontinence** **May 16,** 11–11:45 a.m., Daniel L. Kim, M.D., urogynecology. Howell Senior Center (age 60 and over), 251 Preventorium Road. Registration and free membership required. Call 732-938-4500, ext. 2554.

**Living Wills and Organ Donation** **May 17,** 1–3 p.m. SCAN.*

**Stress-Free Energy Booster** **May 24,** 1–3 p.m. SCAN.*

**Dementia** **May 31,** 10–11 a.m. Jessica L. Israel, M.D., internal medicine. Senior Health Day at Marlboro Township Recreation Senior Program, Community Center, 1996 Recreation Way. Membership and registration required. 732-617-0100.

**Arthritis and Osteoarthritis** **May 31,** 1:15–2:15 p.m., Mutahir A. Abidi, M.D., rheumatology. Senior Health Day at Marlboro Township Recreation Senior Program, Community Center, 1996 Recreation Way. Membership and registration required. Call 732-617-0100.

**Hypertension** **June 9,** 9:30 a.m. Gautam J. Desai, M.D., internal medicine. Marlboro Township Recreation Senior Program, Community Center, 1996 Recreation Way. Membership and registration required. Call 732-617-0100.

*SCAN Learning Center (Senior Citizens Activities Network, for those 50 and over) is located at Monmouth Mall, Eatontown. To register for programs, call 732-542-1326. SCAN membership is not required.