

MONMOUTH

health & life

THAT'S AMORE
MOONSTRUCK IN
ASBURY PARK

saratoga springs eternal

DOGGONE GOOD:
SUITE LIVING
FOR CANINES

psst! we've
got a secret . . .
and we're telling

STAY
WELL

- what to do about that aching back
- a new way to target tumors
- control your child's asthma

PERFECT PIEROGIES
IN BRADLEY BEACH

THE MEASURE OF A LIFE

HE DIDN'T GET A CHANCE TO GROW UP, BUT HE WAS ABLE TO GIVE

We'd all like to think that when we're gone, we'll have left something positive behind. Michael Gerard Puharic left a charity called Michael's Feat.

He lived just three days, and he knew only the struggle of a tiny body against forces too big to beat. But his short life touched other lives, say his parents, Adam and Dana Puharic of Aberdeen. The charity is their way of remembering.

It's also a way of helping other families with seriously ill infants. If you have a sick baby, say the Puharics, you don't think about razors, toothbrushes or even bassinets. You think about your baby. So their registered charity provides these small necessities one might forget.

In spring 2000, when Dana was five months pregnant, the Puharics learned from a sonogram that their first-born would have a chromosomal defect called Trisomy 13, which affects 1 in 5,000 live births and almost always proves fatal within the first year.

"There were decisions to make," Dana recalls.

"I drew strength from Dana," says her husband. "She never wavered in her desire to meet this baby, whatever was going to happen."

Doctors had warned the Puharics that their child might be underweight, but when he was born on July 29, he was 7 pounds, 8 ounces. "He was a ruddy, chubby-cheeked little boy," says Adam. "Yes, he had a cleft palate, but he was so beautiful. It was amazing. He had my toes. He had my earlobes."

The couple wanted to spend every possible moment with Michael, and doctors and nurses at Monmouth Medical Center's neonatal intensive care unit worked to oblige. "Their support, compassion and friendship were incredible," says Dana. The nurses



Adam and Dana Puharic share a laugh with Grace (LEFT) and Grant.

and doctors also gathered needed items such as clothing, a car seat and something for the baby to sleep in, so that the Puharics could take their son home.

"Words can't say how appreciative we were," says Dana. "We had a wonderful time bonding with him. But of course he was very sick, and I guess he wasn't meant to be here on earth with us."

Michael died at home on August 1, 2000.

Condolence calls poured in. When a friend asked what the Puharics were doing in lieu of flowers, it "sent a shock wave through my brain," says Adam—and triggered an idea. He and Dana decided to celebrate Michael's life as well as mourn his death—because, as they saw, his life had brought many good things. "We'd been treated with incredible compassion, generosity and humanity by strangers and friends alike," says Adam. "To forget that would be unworthy of Michael's time on earth."

"The impact Michael had in such a short time on so many people allowed Adam and me to ask, 'What can we do for other families in our situation?'" says Dana. And that's how Michael's Feat was born.

Already the charity (www.michaelsfeat.org; 732-239-7887) has donated more than \$25,000 worth of needed items and pocket money to families with sick babies. The Puharics would like it to grow "slowly but smartly" to become national in scope, making sure the huge majority of funds taken in always goes to recipients, not to administration.

Today the Puharics treasure their two healthy children—Grace, 19 months; and Grant, 5 months—and also the things they learned from the baby boy who has been the catalyst for so much giving.

"The key here," says Adam, "is that you don't measure the value of a life by its length." ☺

CAREFORKIDS

BATTLING ASTHMA, A DISEASE ON THE RISE

If your child has this breathing disorder, make a treatment plan—and stick with it

What's the leading chronic childhood disease in the U.S. and the most frequent reason children are hospitalized? It's asthma. The Environmental Protection Agency reports that in 2001, about 9 percent of the nation's children—that's 6.3 million—were asthma sufferers. In recent decades the proportion of American children diagnosed with asthma has doubled—and the experts aren't sure why.

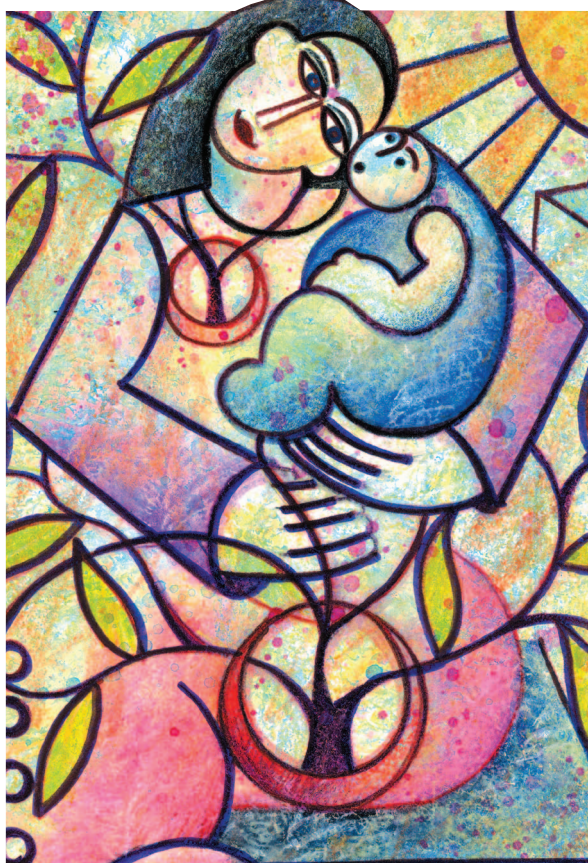
To explore this and other questions about asthma, *Monmouth Health & Life* spoke with Robert L. Zanni, M.D., chief of pediatric pulmonology at Monmouth Medical Center.

MH&L: Why is asthma on the increase?

Dr. ZANNI: There are several theories. One is simply that we're diagnosing more cases because we're better at diagnosis. Another is that children are exposed to more viral infections earlier, in pre-school, day care centers and the like. A third is air pollution.

MH&L: What signs show a child may have asthma?

Dr. ZANNI: A cough that lasts for weeks or months, which you've assumed was a cold, could be asthma—or something else. A child who gets a wheeze with every cold may have asthma. And during a severe asthmatic attack a child may have trouble breathing.



MH&L: When would a family come to you rather than to their regular pediatrician?

Dr. ZANNI: Sometimes the diagnosis of asthma isn't clear-cut, and a general pediatrician will refer a family to me for evaluation and pulmonary function tests. In less severe cases I may simply help the pediatrician and the family get treatment on track, while in tougher ones I may work with them on an ongoing basis.

MH&L: What happens once asthma is diagnosed?

Dr. ZANNI: We place a child into one of four categories: mild intermittent, mild persistent, moderate persistent or severe persistent. For each one there's a treatment plan offered by the National Institutes of

Health. In all three "persistent" categories, the child needs to take medicines on a regular basis to control the underlying inflammation in the lungs—even if he or she is feeling fine. That's sometimes hard for kids to understand. Children in these categories shouldn't rely only on the rescue medications that help them overcome attacks, because the more you use the rescue medicines, the less effective they become. So more and more inflammation builds up, and you're headed for trouble. Remember: *chronic inflammation* is what asth-

CARE FOR KIDS



BATTLING ASTHMA, A DISEASE ON THE RISE *continued*

ma is all about.

MH&L: What medicines treat inflammation?

DR. ZANNI: There is a category of drugs called inhaled corticosteroids, which mimic the action of a hormone made in the adrenal gland that reduces inflammation. There's also a new class of anti-inflammatory medicines known as leukotriene modifiers, which are taken by mouth. They block the activity of a chemical called leukotriene that is involved in airway inflammation.

MH&L: What are the rescue medications?

DR. ZANNI: Also called relievers or bronchodilators, they are taken to open airways and ease

breathing when the child is having an attack. They include short-acting beta-agonists such as albuterol, which can be taken by inhaler or by aerosol spray.

MH&L: What role is played in asthma by allergens, substances children are allergic to?

DR. ZANNI: A large one. Some infants and toddlers have asthma that seems to be primarily triggered by viruses. They tend to get better as they get older. But

in most people with chronic asthma, problems are triggered by allergies. Usually, part of my evaluation of a child is to determine if allergy testing is required.

MH&L: What clues point to an allergy test?

DR. ZANNI: When I take a history, I listen particularly to what seasons of the year children have prob-

lems. I'm also attuned to anything in the environment that may be suspicious. Lately, for example, we've seen problems in older schools where mold is present.

MH&L: So what is the child's own role in all this?

DR. ZANNI: It's important that the child be an active and knowledgeable participant in the treatment plan. We ask kids to use a device called a peak-flow monitor at regular intervals to check how well the lungs are functioning. Readings are keyed to color-coded zones that resemble a stoplight, with a green zone meaning things are under control, a yellow one suggesting caution and a red one warning of trouble. There is an action plan for each zone.

MH&L: Should a child with well-managed asthma ever have to be hospitalized?

DR. ZANNI: Nothing is absolute, but generally we should be able to keep a child out of the hospital. That's our goal. *o*

Resources on childhood asthma

Check out these groups and their websites to find out more:

- **American Lung Association, 800-586-4872 (a number that reaches your local lung association) or www.lungusa.org/asthma/ascpedfac99.html**
- **National Institutes of Allergy and Infectious Disease (NIH) 301-496-5717 or www.niaid.nih.gov/newsroom/focuson/asthma01/basics.htm#why**
- **National Heart, Lung and Blood Institute (NIH) 301-592-8573 or www.nhlbi.nih.gov/health/public/lung/index.htm**
- **Asthma and Allergy Foundation of America, 800-727-8462 or www.aafa.org/templ/display.cfm?id=2&sub=25**
- **American Academy of Allergy, Asthma and Immunology, 800-822-2762 or www.aaaai.org**



personal take

From around the world come tips from recent research on asthma:

- A study in Denmark showed that if you **encase pillows and mattresses in polyurethane**, you may reduce an asthmatic child's need for anti-inflammatory medications.
- Scientists in India found that boosting levels of antioxidants in the blood may ease asthma symptoms. Antioxidants include vitamins C and E; to get more in your system, **eat more fruits, nuts and vegetables.**
- If you still smoke, **step outside to light up if you have an infant.** Researchers in Australia say smoking in the same room increases your baby's risk of hospitalization for respiratory ills. (Better tip: Quit!)
- Kids with asthma have different views than their parents on how well their condition is controlled, say researchers in Britain. In their study, parents focused on avoiding acute attacks, while youngsters stressed how visible their asthma was to peers. Authors say that supports the idea that parents must **involve asthmatic children in their own care.** And a British company called E-San is testing a software program that may soon use mobile phones to remind kids to do their peak-flow monitoring. When results are input in a pocket PC, it would e-mail their doctors if data suggested an imminent attack.



THE VOLUNTEER SPIRIT

At Monmouth Medical Center, adults and teens share a knack for giving back

Helping others, says Marge Mistysyn, is a way to help yourself. The Monmouth Beach resident is eloquent about the joys of being a volunteer helper at Monmouth Medical Center. And why not? She's a volunteer herself, and she's also the one people call (at 732-923-6670) to sign up to volunteer.

"I send out application forms when people call in offering to help," she explains. "Then I mail letters to their references and handle the paperwork."

Mistysyn, 76, says that when her husband died in 1992, "I didn't know where to turn, what to do." Pitching in at the center gave her a new focus. "I'm very, very happy volunteering. Without it, I'd probably still be sitting on the couch crying. I like to say it saved my life."

She's one of nearly 400 helpers who donate their time and energy to the medical center's work. "Our volunteers assist, enhance and support the patients and staff," says Louise Shivers, Monmouth's volunteer coordinator. "Their work falls into three basic categories: patient comfort, clerical duties and reception." They include both adults and teenagers, with adults in the majority except during the summer. There's a minimum age of 14, and as for the upper limit, well, one man who delivers newspapers and supplies turned 90 last December.

"He does a lot of running around," says Shivers. "He's become legally blind, but fortunately he knows this place like the back of his hand."

At the young end of the spectrum, Shivers remembers a high school freshman, a boy who signed up to volunteer on the orthopedic ward, which has a satellite physical therapy unit attached. "He delivered



Louise Shivers (TOP) marshals the enthusiasm of busy volunteers like **Phyllis Zuckerman (LEFT)**, **George Tamburino** and **Marge Mistysyn**.

flowers and water, made beds and pushed wheelchairs. The unit loved him and he loved them. He stayed for all four years of high school and fell in love with the field. Now he's at Northeastern University, studying to be a physical therapist."

Volunteers must commit to at least four hours a week. They are accepted after an interview and a background check. Then there's a four-hour general orientation to the hospital as a

whole, and another orientation in their unit when they're assigned. Each day they sign in at Shivers's office before going to their unit. Teenagers wear red shirts; adult men and women wear blue blazers and pink coats, respectively.

"Sometimes I think I'm helping myself more than I'm helping the hospital," confides Phyllis Zuckerman, 72, a Long Branch resident who for many years kept the books for the picture framing shop she ran with her husband. She works every Tuesday from 9 a.m. to 1 p.m., making beds, walking patients to the bathroom, running errands for the nurses and doing similar chores. "I love it," she says. "When I'm doing it, I don't realize I'm an old lady."

For Doris Alexander, the hospital environment is a carry-over from her career as supervisor of a histopathology laboratory. For the past eight-and-a-half years—these days, for six hours on Mondays—she's been helping with photocopies and other clerical work in Monmouth's Medical Education Department. "I feel as though I'm contributing something," she says.

So does George Tamburino, 67, who puts in five to seven hours each Thursday, delivering two community weekly newspapers to more than 300 recipients around the hospital. "It's a sign of gratitude, I guess," he says. "My mom was treated here once, and she received excellent care." ☺

EASING PAIN

YOUR ACHING BACK

Can exercise—ouch!—combat this almost universal problem?

Back pain yields pride of place only to the common cold as the most common medical complaint. Eighty percent of us will experience serious back pain at some point in our lives.

“Most low back pain has a structural cause,” says Gordon D. Donald, M.D., a spinal specialist and orthopedic surgeon at Monmouth Medical Center (MMC). “Treatment relies on either correcting or compensating for a painful deficiency of structural support.”

Some backaches are due to muscle strain or an injury to the surrounding ligaments, which is known as a sprain. Or back muscles may contract involuntarily—go into spasm—in response to muscle strain or a sprain, causing additional pain.

Less commonly, back pain stems from damage to a disk, a unit of cushiony material between the vertebrae in the spinal column. A disk may become prolapsed or herniated (a “slipped disk”), meaning that the softer material at the center of the disk bulges outward through a weak point in the harder outer layer. This can put pressure on the nerves of the spine.

“The key to back pain treatment is the right diagnosis,” says Cary Glastein, M.D., an orthopedic spine surgeon at MMC. “It’s a good idea to see a spinal specialist, and an MRI [magnetic resonance imaging] scan often can be helpful.”

Surgery to relieve back pain is becoming more effective (see “Back Surgery Leaps Forward,” page 45). But surgery is *not* required for the vast majority of back pain sufferers, says Dr. Glastein, who does several hundred back and neck operations a year.

Many doctors now agree that the best treatment for most back problems is exercise. True, exer-



When to see your doctor

See your physician if back pain:

- is recurrent or chronic
- is severe or keeps you from your normal activities
- lasts more than three or four days
- is accompanied by fever or weight loss
- comes with numbness, leg weakness or bladder-control problems

cise may be the last thing you want to think about when your back hurts. But back pain is commonly associated with weak back and stomach muscles, and exercises that increase muscle strength also tend to decrease back pain in the long run.

“Initially, when you hurt your back, rest is appropriate,” says Dr. Glastein. “But muscles protect the ligaments, cartilage and bones of your skeletal system. Once you’re feeling a little better, you should build those muscles up with exercise.”

Ideally, it’s wise to combine stretching and strengthening exercises with an aerobic activity such as walking or swimming. Your best bet is to embark on an individualized exercise program developed by a knowledgeable professional, such as your doctor or a physical therapist. *o//*



Bring your back back

Try these proven tips to help you recover from backache:

- Take a nonsteroidal anti-inflammatory drug such as ibuprofen for pain relief. If the pain is severe, your doctor may recommend a prescription medication.
- Maintain as many of your ordinary activities as your pain will allow. In a recent study, patients who followed this advice recovered more quickly than those who rested in bed.

- If the pain is severe enough to put you in bed, rest there should be limited to two to three days. Anything longer will slow your recovery.

- Apply an ice pack for five to 10 minutes at a time for the first 48 hours. After that, use moist heat.

BACK SURGERY LEAPS FORWARD

How a tool shaped like a sextant helps surgeons ease lumbar pain

It started with a crunch. On February 28, 2002, Tracey Covington, 31, of Bradley Beach was taking inventory on the job as a Home Depot sales associate.

“As I was lifting something,” she recalls, “I felt a crunch in my lower back and felt paralyzed for 10 or 15 minutes.” The pain sent her home. Next day came a visit to the emergency room, then a weekend “screaming in pain,” a course of physical therapy and then, finally, relief—through an operation at Monmouth Medical Center that was a first for the area.

Degeneration of the soft, cartilaginous disks in between vertebrae in the spine can cause such pain, says Jonathan Lustgarten, M.D., the neurosurgeon who did the procedure. “We try first to get patients feeling better with physical therapy, anti-inflammatory medications and exercise,” he says.

These treatments didn’t work for Covington, but because her deterioration was limited to a single disk, she was a good candidate for spinal interbody fusion, in which a disk is replaced by bony matter that helps the two adjoining vertebrae fuse together. In one such fusion procedure, a neurosur-



Pioneer? Tracey Covington, shown with Dr. Lustgarten, is just glad to be feeling better.

geon removes the problem disk and in its place puts a combined “allograft” and “autograft.” The allograft is a piece of bone from a cadaver that has been machined and processed for this use. The autograft is a bone of the patient’s that is “harvested” through an incision in the patient’s front. The bony combination ultimately fuses and stabilizes the spine.

Spinal fusion often requires inserting a mechanism made of rods and screws that locks the bony combination in position so it can fuse. The patient must be turned over and incisions made up and down the patient’s back to implant this mechanism. Usually those incisions are from six to eight inches long and require that muscles be stripped away from the spine. But in the new sextant rod insertion system, the long incisions and muscle stripping are unnecessary. A device that resembles an old-time sextant used for navigation enables the screws and rods to be tunneled through muscle via several tiny incisions and placed in the spine.

Last November 26, Dr. Lustgarten performed the procedure on Covington, making her probably the first patient in central New Jersey to benefit from the new system, which means a shorter hospital stay, faster recovery and less pain.

Covington isn’t ready to turn handsprings yet, but feels much better. “Dr. Lustgarten really lets you understand what’s going on inside of you,” she says. ☺



CONQUERING CANCER

MINIMIZE THE RISK TO YOUR LUNGS

To protect yourself, avoid cigarette smoking—yours or others’

No lethal malady was ever so firmly identified with a behavior as lung cancer is with smoking. Yesterday’s nonchalant puffing by stars on the screen and stolen drags by teens trying to be cool are now known for what they were: flirtations with a killer.

But knowledge sometimes isn’t enough, says David J. Sharon, M.D., medical director of the Leon Hess Cancer Center at Monmouth Medical Center and co-chair of a lung cancer research group for the Cancer Institute of New Jersey.

“There’s a lot of denial,” says Dr. Sharon. “People believe it will happen to other people, but not to them.”

The American Cancer Society estimates that lung cancer kills at least 89,200 men and 65,700 women in the U.S. each year. That makes it the leading cause of cancer deaths. It’s true that treatments are improving (see “Beating the Odds,” page 47), but



those who smoke are still, as Dr. Sharon says, “playing with a loaded gun.”

Besides smoking, lung cancer can be caused by exposure to radon and asbestos—and to other people’s smoke. Lung cancer has no symptoms in its early stages. Later on, it may cause a worsening “smoker’s cough,” coughing up blood, chest pain, shortness of breath, wheezing, loss of appetite and/or weight and repeated bouts of pneumonia, bronchitis or hoarseness. If you notice these symptoms, see your doctor. The earlier lung cancer is detected, the more effective treatment can be. *oM*

fast facts



Cutting through the smoky haze

- Is it wasted breath to lecture teens about smoking? Not necessarily. Researchers tracked 711 young smokers for five years, starting in their senior year of high school. Those whose parents disapproved of their smoking were less likely to remain smokers in early adulthood.
- Quit-smoking telephone “help” lines actually do help smokers kick the habit. A year-long study found that people who had access to such phone counseling were twice as likely to quit as those who didn’t. The “quitlines” are available in 33 states. (In New Jersey, dial 1-866-NJSTOPS from 8 a.m. to 8 p.m. Monday through Friday or from 11 a.m. to 5 p.m. on Saturday.)
- Don’t fall for the notion that snuff, a nicotine-containing tobacco product placed between lip and gum, can help get smokers unhooked. Often, suggests a report recently published in the *American Journal of Preventive Medicine*, it leads right back to the ashtray instead. ‘Snuff said.

personal takes



If at first you don’t succeed . . . Don’t let embarrassment or self-reproach heighten your risk of lung cancer. Cigarette smoking is addictive. If you’ve tried and failed 100 times to kick the habit, don’t despair. Know you’re not alone and make try number 101 a winner. To stay clean-lunged once you’ve quit, the National Cancer Institute suggests you be aware of activities that once automatically called for a smoke. How many of these common “triggers” apply to you?

- drinking morning coffee • having an evening cocktail
- finishing a meal • working under pressure
- feeling blue • talking on the phone
- driving a car • watching TV • playing cards
- watching someone else smoke

Whatever your own smoking triggers were, take a deep breath at those moments and remind yourself that your habits have changed—for the healthier!

CONQUERING CANCER

BEATING THE ODDS

An experimental treatment helped one lung-cancer patient

An exception to the rule. That's what you'd call Samuel Mark, 69, a Jackson resident and semi-retired engineering consultant. He was treated recently for cancer of the lung, but he never smoked.

Is he, perhaps, a victim of the bum luck that plagued baseball's Brooklyn Dodgers, a team he joined briefly in 1954 before an injury sidelined him?

He has another theory: second-hand smoke. "I was around smokers my whole life," he reports.

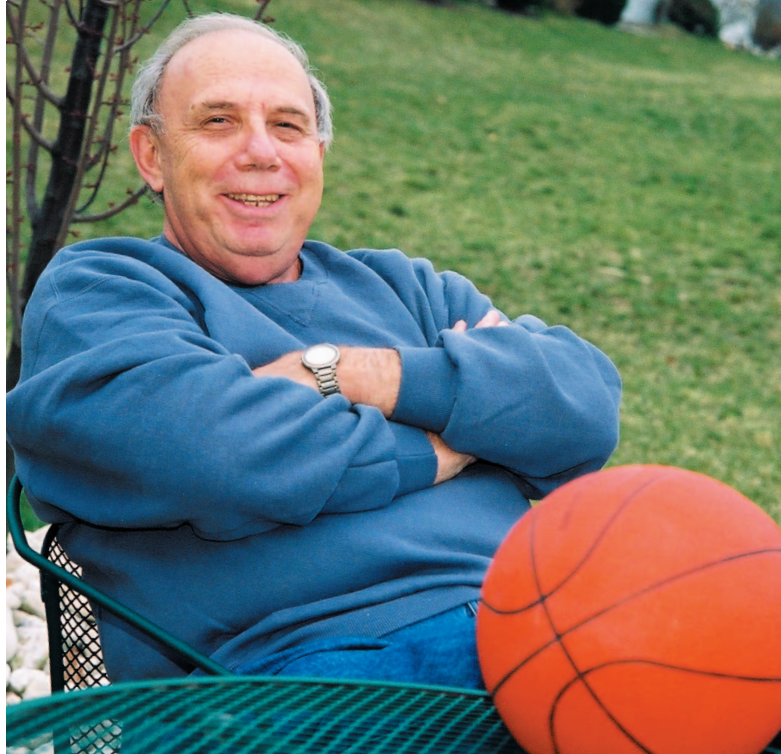
Whatever the origins of his cancer, Mark is glad that fortune was kinder when it came to treatment. Late last year, when the 3.5-centimeter tumor in his lung was treated, he became one of the first few central New Jersey residents to undergo extracranial stereotactic radioablation—intense, focused radiation in high doses on a site outside the brain.

"In stereotactic radioablation, imaging systems allow a tumor to be visualized in a three-dimensional reconstruction," says Smitha Gollamudi, M.D., chair of radiation oncology at Monmouth Medical Center. "Then those images are downloaded into a computer planning system that lets us target the tumor with a highly accurate beam so that the high-dose region of the radiation is delivered right to the tumor." The beams are so focused, she adds, that nearby tissue sustains little damage.

The technology, also known as stereotactic radiosurgery, has been around for about 15 years. But until recently it was only used for brain tumors. Mark's operation was part of an experimental study. As one might imagine, the recipient of such precise, high-dose beams must remain still. Monmouth solves that problem by encasing patients in a full-body frame that immobilizes the chest.

"They put you in a plastic molded wrap and they pump all the air out so you're actually mummified, up to the neck, for about five minutes," says Mark. "It's uncomfortable, but not actually painful."

For Mark, the treatment came after a cancer in the thyroid that originally announced itself with coughing spells on a trip to Europe. His thyroid was removed. Next came surgery to extract malignant cells from both sides of the neck, then conventional



radiation and finally the experimental treatment.

"Mr. Mark was a candidate for this procedure because the lesion in his lung was in a critical area that he could not undergo surgery for," says Adam Raben, M.D., who performed the stereotactic radioablation. "It threatened to block off his right lung."

Now Mark's tumor has "regressed" to just 2.5 centimeters and may no longer pose a danger.

"IT HASN'T SLOWED ME DOWN AT ALL," SAYS SAMUEL MARK OF HIS LUNG CANCER TREATMENT. HE'S EVEN CHALLENGED HIS DOCTOR TO A ONE-ON-ONE ON THE BASKETBALL COURT.

"Sometimes they just stabilize, become scar tissue and never grow again," says Dr. Raben. "I think his prognosis right now is quite good."

The news is also good for the experiment. "We've had absolutely no side effects related to treatment, and a majority of the tumors have been stabilized or have gone away," he adds.

"I think this technique will become a standard treatment alternative for patients with lung cancers or other malignancies outside the brain, where a very high dose of treatment can be given safely," says Dr. Raben. And because the treatment is concentrated, he adds, "it may be a more convenient alternative for patients having to undergo prolonged radiation."

Asked if he would recommend the procedure, Mark gives a hearty assent. "There's no pain involved, and it hasn't slowed me down at all." Besides his usual golf, he says, he is playing basketball—and has challenged Dr. Raben to a game. *M*



WHERE TO GO TO GET YOUR LIFE BACK

CHOOSING AN INPATIENT REHABILITATION FACILITY?

START BY ASKING THESE 9 QUESTIONS.

Some of them can't wait to get back to running marathons. Others would be delighted if they could lift a teacup. Patients in rehabilitation vary widely in condition, but they all have an injury or illness that limits their ability to do things the rest of us take for granted. And they're working to win their lives back.

It's important to choose the right facility if you or a relative need rehab services, says Padma Adusumilli, M.D. She is a board-certified physiatrist—a physician who has passed a special test in the field of physical medicine and rehabilitation—and medical director of the year-old Rehabilitation Hospital of Tinton Falls. That 60-bed, 47,000-square-foot facility is operated as a joint venture by Birmingham, Ala.-based HealthSouth and Monmouth Medical Center.

Ask these nine questions about each facility:

1. **IS IT ACCREDITED?** To earn and maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations, a hospital must undergo an on-site quality survey at least every three years.
2. **WHAT LEVEL OF FACILITY IS IT?** The Tinton Falls hospital is the only freestanding acute rehab hospital in Monmouth County. That means it provides daily physician visits and intensive rehabilitation services (physical, occupational and speech therapies) for three hours or more, seven days a week.
3. **WHAT MEDICAL EXPERTISE IS AVAILABLE?** At Tinton Falls, physiatrists are the attending physicians, and an internal medicine consultant also sees patients as required, but at least two to three times each week.

4. **IS 24-HOUR NURSING SERVICE PROVIDED?**

5. **WHAT IS THE FACILITY'S EXPERIENCE IN HANDLING CASES SIMILAR TO YOURS?**

6. **WHAT SERVICES ARE OFFERED?** Besides the basic therapies, is therapeutic recreation available? Does the facility, like Tinton Falls, have respiratory therapists, case managers, dietitians and neuropsychologists? Is education included in the treatment plan? Ask, too, if support groups are offered.

7. **IS FOLLOW-UP OUTPATIENT CARE AVAILABLE?** Consider your future outpatient needs—and geographic convenience—when selecting a facility for your rehab hospital stay. At Tinton Falls, many of the same therapists work with both inpatients and outpatients, and a van transports patients as needed.

8. **WHAT IS THE HOSPITAL'S PATIENT SATISFACTION RATE?** These rates are based on surveys processed by an independent agency. "The national average is 89 percent," says Dr. Adusumilli. "In its first year, Tinton Falls scored 96.5 percent."

9. **WHAT IS THE COMMUNITY DISCHARGE RATE?** Rehab patients' goal is to go home, not to a nursing home, and this is the percentage of patients who achieve that goal. Tinton Falls' community discharge rate of 85 percent is considered a strong one.

After asking these questions, visit the facilities you're considering, talk to the doctors and nurses and talk with patients whose condition is similar to yours.

Knowing you've chosen the right rehab facility can give you peace of mind on the comeback trail. *ll*