

CAREConnections

Information and Inspiration for Caregivers

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Dear Caregiver,

Returning home from a hospital stay can result in unexpected challenges for many seniors—and for their family caregivers. According to studies, one in five Medicare patients are readmitted to a hospital within thirty days after discharge, and that means a poorer prognosis for recovery, increased stress for the patient and caregiver, and, of course, greater health care costs.

As a family caregiver, you can help your loved one make a successful transition from hospital to home—or to wherever they transition—by being a well-educated member of the discharge planning team. After all, you know the patient better than anyone else, and you have important things to say about their post-hospital recovery and about your duties as the family caregiver.

This issue is specifically about the transition from hospital to home and helping your loved one make it safely and successfully—while also considering your own needs. Learning more about the process can help ensure that your loved one comes home and *stays* home.

The Editors



Avoiding a Hospital Readmission

by Adena Kling, MSW, LCSW

Seventy one-year old Mr. James (pseudonym) was admitted to the hospital for a fall he had at home after he had become disoriented and confused. He had multiple bruises on the left side of his body, and his blood pressure and diabetes were out of control. He had been down on the floor for twelve hours before being discovered by his family. After five days in the hospital, he was ready to be discharged with a list of new medications for controlling his blood pressure and diabetes. Prior to discharge, he had been instructed by his nurse regarding how and when to take his new medications, and told to follow up with his primary care provider as soon as possible. The discharge planner had

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VISIT WITH A CAREGIVER

Evelyn (Evi) Bassoff is a Boulder psychotherapist and author of numerous books and articles drawn from her practice and life experience. Some of that experience includes caring for her husband after his hospitalization and surgery.

Care Connections: Evi, I know that your husband, Bruce, had some serious shoulder surgery about six months ago. In this issue, we're looking at what happens when someone is discharged from the hospital. What kind of guidance did you and Bruce receive that prepared you for bringing him home after surgery?

Evi: The most valuable help came from an acquaintance whose husband had recently undergone a similar procedure. Without her help, we would have been up a creek. Her advice was more detailed than anything given to us by the doctor's office. For instance, after shoulder surgery, an ice machine is used to reduce swelling, and she recounted how cold her husband had become on the ice machine and suggested we gather gloves and warm clothes including a woolen cap to be ready for that. Also, since Bruce's right shoulder would be immobilized, she suggested slit-

ting several large T-shirts and sewing on Velcro as fasteners so that the shirts could be put on and taken off without hurting his shoulder. It was like getting a kid ready for camp.

The most important advice she gave us was to fight to keep Bruce in the hospital overnight even though the surgery was designated as an outpatient procedure. If you have to, "fake a faint" if the hospital wants him to leave before he's ready, she added. That wasn't necessary because Bruce's doctor was totally understanding when, before the operation, Bruce told him that we were worried sick that I, weighing in at 110 pounds and not yet recovered from my own neck injury, might not be able to get him home safely or take proper care of him during the first post-surgery night. Staying in the hospital until the next day proved to be a godsend. The hospital nurses were able to calibrate his pain medication, get him stabilized, treat his wound, and show me how to get him in and out of his sling. If we had gone home right away, we would have been off to a very bad start. It would have been a disaster waiting to happen.

CC: I understand you also did some online research.

Evi: Yes. I discovered that the patient can't sleep in a bed for several weeks and would need a recliner with a chair lift. Bruce used the recliner I purchased online day and night for months. Another acquaintance told us that the chair's controls should be on the non-surgery side; she knew this from experience because her husband had to ask for her help every time he wanted to change position. The buttons were on his surgery side, which was immobile.

CC: Bruce required a lot of care at first. How did you manage with your job?

Evi: I took two and a half weeks off to devote to home care. To my surprise, being a caregiver 24/7 turned out to be a positive experience. I did some fancy cooking and even learned to bake a green tomato pie. We tried to do something really nice together every day. When the sidewalks weren't icy and he could get out of the house, we'd take walks or go to the movies. You know the saying, "Don't wait for the storm to end. Learn to dance in the rain." Bruce needed my help

with everything for many weeks, and he was generous with his gratitude. Because of his appreciation, I never felt resentful or taken advantage of. Quite the opposite, I felt very much loved. I also gained a new respect for him because he showed so much courage during his painful ordeal. We both felt the experience brought us even closer.

CC: It sounds like a new kind of honeymoon.

Evi: Maybe, but the heavy duty care lasted only a few weeks. Then I went back to work and back to my own life. It got harder. Bruce still needed a lot of help, but now I was shuttling back and forth between him, work, and everyday obligations. I was exhausted, and Bruce was getting sick and tired of his dependence on me, especially of my having to give him rides. The only time during the many months of recovery that we had fights was when we were in the car, and I was doing the driving while he grumbled in the passenger seat. We were both ready to resume life as we used to live it but were still tethered in this way.

CC: Were you prepared in any way for the emotional aftermath of surgery?

Evi: Not in any formal way, but as a psychotherapist I wasn't surprised at how our relationship evolved during his recovery. Lots of mutual support, appreciation, and honesty about how we were both affected. The professionals we saw, doctors and PTs, encouraged us by saying, "Bruce, you're doing well. Everything in your recovery is normal." Those reassuring words were markers of progress and hope.

CC: Do you have any advice for someone whose family member is scheduled for surgery or other non-emergency hospitalization?

Evi: Seek advice from people who have experienced something similar and accept any help offered. My friends brought food, one friend helped sew Velcro on the T-shirts, and someone else brought a chair for the shower. Push hard for your family member to stay in the hospital until you're confident you can both manage at home. Caregiving does take an emotional and physical toll, so please remember to take care of yourself too.

CC: Thanks, Evi, for your experience and your wisdom.





Avoiding a Hospital Readmission

(continued from page 1)

also followed up with his family to make sure he had someone who could monitor him at home.

Three days later Mr. James was back in the hospital with altered mental status. Apparently, he had been taking his newly prescribed blood pressure medication along with his old one which resulted in a toxic medication effect and extreme confusion and disorientation. This second hospitalization was much longer than the first as stabilizing him was much more difficult. Of course, everyone was asking the obvious questions: what happened and how could this have been prevented? Did Mr. James understand the instructions he had received from the nurse prior to discharge? Was his family on board with what needed to happen for his follow-up care?

This type of scenario occurs regularly. The result is not only a bad outcome for the patient but also increased health care costs from easily avoidable re-hospitalizations. According to statistics from the Centers for Medicaid and Medicare Services (CMS):

- 19-20% of Medicare beneficiaries discharged from an inpatient facility are readmitted within 30 days.
- 34% of patients are readmitted within 90 days.
- Over 50% of those re-hospitalized within 30 days of a medical discharge did not follow up or see their primary care provider.
- Less than 50% of patients can list all of their medications and common side effects from those medications.
- Less than 50% of discharged patients can identify their diagnosis.
- Many of them had no outpatient MD appointment follow up.

- Many patients have difficulty obtaining transportation to medical appointments.
- And many of them are experiencing financial constraints that result in limited health care access to follow-up appointments and/or prescription medications.

In addition, a 2009 *New England Journal of Medicine* study of Medicare beneficiaries found that the cost of unplanned re-hospitalization was \$17.4 billion, highlighting the importance of improving transitions of care to decrease the potential for hospital readmissions.

Transitions of care (TOC) is an important process that starts from the time the patient is admitted to an inpatient facility and does not wait until discharge to begin aftercare planning. The goal of a good TOC program is to provide patients with the tools and support they will need to promote knowledge and self-management of their medical conditions and better prepare them for their transition from hospital to home. By communicating important and relevant information about a patient's diagnosis, medications, and discharge/aftercare treatment plan to patients, families, caregivers, and community providers, the hospital readmissions can be greatly reduced.

Families and caregivers should be aware that they are to be partners in the "transition from hospital to home" process and should feel empowered to ask the health care provider questions to ensure that the transition home is a safe one. The following are important and necessary aspects to look for during a loved one's hospital admission:

- The patient has a written discharge plan and understands his/her diagnosis, medications, and side effects.
- Outpatient appointments are either already made or can be made as soon as possible once a patient is discharged.

- All outpatient providers have received important information regarding the patient's condition and aftercare plan and that "coordination of care" is an active and ongoing process.
- Families and caregivers are "in the loop" and are aware of all discharge/aftercare plans.
- Families and caregivers understand "red flags" which could signal deterioration in the patient's condition and know how to respond.
- Patients, families, and caregivers should all have input into the health care goals for managing the patient's illness and have a say in service preferences for meeting those goals.

Having a beloved family member in the hospital is never easy, but hopefully by following these important guidelines and partnering with health care providers, a safe and healthy discharge can be obtained and a difficult readmission can be avoided.

Adena Kling, MSW, LCSW, is a Medical Social Worker at Longmont United Hospital.

Shifting to a Lower Gear

by Emily Cooper



When your care recipient is in the hospital, whether for a planned procedure or after an emergency, you switch into crisis mode. Your loved one's needs are front and center, and everything else necessarily takes a back seat. You spend hours in the hospital room, keeping your loved one company and supplementing the care provided by the hospital staff, and you grab food and sleep in a catch-as-catch-can way. Between your duties at the hospital, you run home to feed the pets, walk the dog, check the mail, make a few phone calls, take a quick shower, and juggle everything else that absolutely must get done. And you also may try to keep up with work, child care, or other pressing commitments. Whew!

You're totally focused on your loved one, as you need to be, and by the time he or she is ready to be discharged from the hospital, you may find that you're exhausted. (Because, honestly, you probably were pretty darn busy caring for your loved one *before* the hospitalization too.) But your responsibilities aren't over. Once your loved one is home, you're back to being the primary caregiver again, and there are likely to be some additional care needs because of the crisis, at least for a while. You're probably asking yourself how you can possibly continue at this breakneck pace.

The answer is ... you *can't* keep going at the high speed that was required while your loved one was in the hospital. As soon as the crisis is over, it's important to switch from *crisis* mode to *long-term care* mode. We all can go on hyper-drive for a brief period when we have to, but at some point we must downshift to a more sustainable pace. Remember the fable about the tortoise and the hare? A hare-like pace works fine for a short-term crisis like a hospitalization, but the tortoise's pace helps us last for the long run. Slow and steady wins the race, especially if the race is a marathon that may go on for months or years.



When you and your loved one have been through a crisis, and you've had to let a lot of your daily self-care slide, it's important to regroup and get back to your healthier habits (or *start* them if you haven't before). That means



finding time, hopefully every day, to attend to your own needs—including decent sleep, nutritious food, exercise, health care, and time away from caregiving. And if your loved one has extra care needs for a while (or for the long-term), don't hesitate to ask family and friends to contribute in a bigger way. Many different people have an interest in your loved one's health, so let them help as they can. *Every* thing you take off your own list means a little more time and greater well-being for you. *Strength for Caring.com* suggests the following ways that friends or family can help during and after a hospitalization:

- Help prepare the home for the patient's return (move furniture, make repairs, install grab bars, etc.)
- Visit the patient in the hospital
- Take flowers, cards, and gifts home from the hospital
- Pick up the mail and newspapers
- Water flowers outside
- Mow grass
- Shovel snow/salt the walk
- Let the dog out
- Feed the pets
- Prepare and deliver a meal
- Do grocery shopping (or provide respite care while the caregiver shops)
- Pick up prescriptions
- Help with laundry
- Take children on an outing
- Care for children while you take the patient to therapy
- Bring work from the office

You and your loved one have made it through another crisis, so congratulate yourself and sit down, have a cup of tea, and *breathe*. Take the opportunity to slow down a little while you can.

Emily Cooper is Editor of Care Connections and the Information and Assistance Specialist – Caregiver Programs for Boulder County Area Agency on Aging.

From Hospital to Home

Bringing your loved one home after he or she is discharged from the hospital can be overwhelming. There are so many things to think about and do. It's important that you understand the discharge process, that you think clearly about what's ahead, and that you ask needed questions and get them answered before making that trip back home. Doing so can help ensure that your loved one makes a successful transition from hospital to home and that you're prepared to manage the care that will be required.

Compared to ten years ago, hospital patients are discharged home in a shorter period of time. Acute hospitalizations rarely last more than three to five days, after which patients are moved elsewhere: to a rehabilitation facility, a nursing home, a transitional care unit—or home. The process of transitioning a patient from the hospital to another care location is called *discharge planning*.

Medicare defines discharge planning as “a process used to decide what a patient needs for a smooth move from one level of care to another.” Being discharged does not mean that a patient is fully recovered. It only means that the hospital's clinical staff and the insurance company have determined that the patient is “medically stable” and no longer requires hospital-level care.

Many people help plan a hospital discharge, and they are often referred to as a “team.” The team may include a doctor who authorizes the discharge, a nurse or social worker who coordinates the discharge and makes sure everything happens smoothly, and the family caregiver, who knows the patient best.

The “discharge planner” (usually the nurse or social worker) is responsible for making sure that the plan for the patient's discharge is, according to Medicare, “safe and adequate.” This means that the patient should be going to a place that does not present immediate



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danger to his health and well-being, and that realistic plans have been made for appropriate follow-up care. Medicare does not specifically define “safe” and “adequate,” so the discharge planner—and the family caregiver—must interpret what it means in the individual patient’s case.

While hospitals are supposed to ensure that patients understand their recovery needs, often the responsibility is left to the patient or family caregiver to ask questions and get answers about post-discharge needs and issues. As soon as possible after your loved one’s admission to the hospital, ask to meet with the nurse or social worker designated as the discharge planner in order to talk about discharge. There are a lot of details to work out and the sooner the better.

Tell the discharge planner that you are the family caregiver and discuss with them:

- How much time you can devote to being a caregiver
- Whether you will provide all or some of the needed care
- Whether you can continue to work at your job or must take time off?
- Whether you have any health problems or other limitations
- Whether you have other commitments, such as child care
- All your other questions and concerns about being a caregiver

Taking your loved one home, rather than transitioning her to a rehabilitation facility or elsewhere, may be the best option, but it must make sense for your loved one *and* you. You need to feel comfortable, capable, and confident with what is expected of you before your loved one leaves the hospital. If you cannot be available to provide full-time care to your loved one after the discharge, say so—clearly and consistently. A discharge plan based on faulty assumptions or incorrect information will not work.

If your loved one comes home, you will likely do certain tasks as part of your care. It is important that you know how to do these tasks safely and properly, so learn as much as possible while your loved one is still in the hospital. You can watch hospital staff as they do these tasks and ask them to watch as you try the tasks yourself. Learn what you can and ask whom to call if you have questions at home. If you’re afraid of doing certain tasks or uncomfortable helping with things such as bathing, toileting, or changing adult diapers, speak up. The hospital team needs to know what tasks you can and cannot do so they can help you plan for any needed help.

Your loved one may have unrealistic expectations about what he can do on his own. Ask a nurse or doctor to evaluate him and then to explain to you and to him what will and will not be possible. The in-hospital assessment can determine Medicare or insurance eligibility for home care services such as visiting nurses and home care aides. Find out what follow-up care will be paid for by insurance and what your loved one or you will have to pay out of pocket. In order to justify coverage, you may have to make the case that the care your loved one needs is “medically necessary.”

If you feel that your loved one is not physically ready to be discharged, ask about the thresholds she had to meet for discharge and request a re-examination by the doctor. If you do not agree with the hospital’s discharge plan, you have the right to appeal the decision. The hospital must let you know how to appeal and must explain what will happen. If you want to look at other choices than those presented to you by the discharge planner (for instance, a different nursing home for rehab), you may have to do some research on your own. It’s time to be persistent; don’t sign anything you don’t understand or agree with.

(continued on page 10)



COMMUNITY RESOURCES

This column provides information about coming events and classes, helpful services, and other resources of special interest to family caregivers in Boulder County. (See “Information and Assistance in Boulder County” on the back page for ways to learn more about local resources.)

Medicare Basics Classes, for anyone wanting to learn more about benefits, costs, and choices under Medicare, are provided monthly by Medicare Counselors with Boulder County Area Agency on Aging. Classes are on Thursday, July 5, and Thursday, August 2, both 2:00 – 4:00 p.m., at East Boulder Senior Center, 5660 Sioux Drive, in Boulder (call 303-441-1546 to register); Monday, July 16, and Monday, August 20, both 10:00 a.m. – noon, and Tuesday, July 3, 5:30 – 7:30 p.m., at Longmont Senior Center, 910 Longs Peak Avenue, in Longmont (call 303-651-8411 to register); and Friday, August 24, 1:30 – 3:30 p.m., at Lafayette Senior Center, 103 S. Iowa Avenue, in Lafayette (call 303-665-9052 to register). Classes are free, but donations are appreciated. **Find My Best Plan: Using Medicare.gov to Compare Drug and Advantage Plans**, sessions in a computer lab setting that help you compare and choose the Medicare drug and health plans best suited to your needs, are on Wednesday, July 11, and Wednesday, August 15, 10:00 a.m. – noon, at Boulder County Courthouse East Wing – Basement Computer Lab, 2025 14th Street, in Boulder (call 303-441-1546 to register); and Tuesday, July 24, and Tuesday, August 28, 8:00 – 9:45 a.m., at Longmont Public Library – Adult Computer Lab, 409 4th Avenue, in Longmont (call 303-651-8411 to register). Classes are open to anyone with PC/Internet experience and are free; donations welcome.

Boulder County Area Agency on Aging offers **Powerful Tools for Caregivers**, a 15-hour course (meets once a week for 2 ½ hours) that gives family caregivers the tools to ensure they take care of themselves while caring for older loved ones, on Wednesdays, July 11 – August 15, 1:30 – 4:00 p.m., in Lafayette, and on Wednesdays, October 10 – November 14, 1:30 – 4:00 p.m., in Boulder; and the **National Caregiver Training Program**, a 21-hour course (meets once a week for 3 hours) that helps family caregivers acquire the skills needed to provide safe, confident home care for frail older loved ones, on Thursdays, October 4 – November 15, 1:30 – 4:30 p.m., in Boulder. Both courses are open to Boulder County residents caring for a relative, partner, or friend who is 60 or over, or of any age if the person has dementia. There is no charge, but donations are appreciated. Financial assistance for respite care during class periods is available. To register or for more information, email InfoCaregiver@bouldercounty.org or call 303-678-6116.

Longmont Senior Services presents the **Maintain Your Brain Series**, with John Dean, Speech and Language Pathologist, Outpatient Manager of Life Care Center of Longmont, and director of the Parkinson’s Team at Summit Rehab. It starts with **Maintain Your Brain!**, a free lecture about the causes of different types of memory loss and techniques for improving memory and problem solving abilities, on Wednesday, July 11, 1:00 – 2:30 p.m.; and continues with a nine-week series that includes **Part 1: Initial Session**, a screening with cognitive and memory tests to assess individual needs and establish baselines, on Thursday, July 12, 1:00

– 3:00 p.m.; and **Part 2: Classes**, weekly classes with functional memory and problem solving activities and cognitively challenging puzzles and game activities to improve mental function, on Wednesdays, July 18 – September 5, 1:00 – 2:00 p.m.; all at Longmont Senior Center, 910 Longs Peak Avenue, Longmont. There is a \$40 charge for Longmont residents (\$50 for non-residents) for Parts 1 and 2. Pre-registration is required; call 303-651-8411. The series is particularly recommended for persons with Parkinson’s disease and their caregivers.

The **3rd Annual Boulder County Senior Law Day**, a morning of educational seminars, presented by attorneys and other local experts, on important issues facing seniors and their family caregivers, is on Saturday, August 11, 8:00 a.m. – 1:00 p.m. (7:15 a.m. check-in and continental breakfast), at The Plaza Hotel Conference Center, 1850 Industrial Circle, in Longmont. Keynote speech, “Maintaining an Active Mind,” is by Mary Ann Keatley, PhD, Brain Fitness, and seminar topics include Advance Medical Directives, Geriatric Care Managers, Hard Conversations with Your Kids, Local Housing Options, Memory Loss, Resources for Staying in Your Home, and others. Register, by August 6, by calling 303-441-1685 or at www.seniorlawday.org (click on Boulder County for online registration and complete seminar descriptions). There is no registration fee.

The Alzheimer’s Association Colorado Chapter offers **The Savvy Caregiver**, a 6-week course (meets once a week for 2 hours) that helps family caregivers acquire the specific skills needed to care for a loved one with Alzheimer’s disease or another dementia, on Tuesdays, September 4

– October 9, 6:00 – 8:00 p.m., at Longmont Senior Center, 910 Longs Peak Avenue, in Longmont. It’s recommended that participants take an overview class (i.e., The Basics: Memory Loss, Dementia, and Alzheimer’s) before enrolling. Pre-registration is required, at www.alz.org/co. A donation of \$25 is suggested.

If your care recipient is a veteran, he or she may qualify for **veterans’ benefits** such as service-connected disability, non-service connected disability pension, or health care. Widows/widowers of veterans may also qualify for benefits which could include assistance for home health care, assisted living, or nursing home placement. To learn more, contact a Boulder County Veteran’s Services Officer: Karen Townsend, 303-776-8502, in Longmont, or Michael Holliday, 303-441-3890, in Boulder.

CareConnect (formerly RSVP) now offers the **YardBusters Program**, which matches volunteers who love to work outdoors with seniors and adults with disabilities who need assistance managing their yard and removing fall safety hazards. To sign up for assistance, call Aaron at 303-443-1933, ext. 413 or visit www.careconnectbc.org.

For a list of **Caregiver Support Groups** that meet in Boulder County, email InfoCaregiver@bouldercounty.org or call 303-678-6116.

To share information about a resource or coming event for family caregivers, email InfoCaregiver@bouldercounty.org or call 303-678-6116. The deadline for the September/October issue is July 26.





If your loved one is discharged to home, and he is eligible for home care services, find out what the home care agency provides and what you must get on your own. Ask:

- Will we need a hospital bed, shower chair, commode, oxygen supply, or other equipment? If so, where do we get these items?
- What supplies do we need? Where do we get them?
- Will insurance pay for the equipment and supplies?
- Is the home ready for providing care? (Is there room for a hospital bed or other large equipment? Has it been fall-proofed?)

Your loved one may have new medications to take after the hospitalization. Be sure to ask:

- What new meds will she take? For how long? What are they for?
- Should they be taken with meals or at certain times of the day?
- Do they have side effects?
- Can they be taken with the meds that were taken prior to admission?
- Do we get these new meds from the pharmacy or from the hospital?
- Will insurance pay for them? Are there generic alternatives?

You're likely to have a lot questions during the first days that your loved one is at home. Get phone numbers for people on the hospital team, as well as for any home care agency involved with the care. Make sure you know:

- Are there any symptoms that should be reported right away? Who should I call and what should I do?
- Are there limits or restrictions on what my loved one can do?
- Is it safe for my loved one to be left alone?
- Are there foods she can or cannot eat?

Your loved one probably will be required to have a follow-up visit with a physician sometime after the hospitalization. Ask:

- Does my loved one have a follow-up appointment outside the home?
- Who is it with?
- What is the reason for the appointment?
- Date, time, and location?

Yes, lots to do. But careful attention to the process and to every detail during the discharge planning will be worth the effort.

Parts of this article were drawn from Hospital to Home: Plan for a Smooth Transition, a publication of Administration on Aging - Eldercare Locator and United Hospital Fund.

**“Home is the place that goes where you go,
yet it welcomes you upon your return.**

Like a dog overjoyed at the door.

**We’ve missed you is what you hear,
no matter how long you’ve been gone.”**

— L. Frank Baum, *The Wizard of Oz*

HELP US BE MORE GREEN ~ AND SAVE SOME GREEN!

We need to cut costs, not trees. Please help us conserve our precious natural and financial resources by receiving *Care Connections* electronically rather than as a paper copy. Just email InfoCaregiver@bouldercounty.org with your name, email address, and postal address. Your information will not be shared with other institutions. Thanks for your help!



Helpful Post-Hospitalization Resources

Meal Delivery

Free five-day delivery of meals for persons just released from the hospital
Project Homecoming, Meals on Wheels
303-441-3908

Medical Equipment Loans

Medical equipment loan closets at service organizations and senior centers
www.BoulderCountyHelp.org (Select Seniors & People with Disabilities, then Service Directory, then Health and Medical, then Assistive Technology/Loan Closets)

Grocery Shopping and Delivery

Volunteer shopping and delivery of groceries to homebound seniors
Carry-Out Caravan, RSVP/CareConnect
303-443-1933 (Boulder, Lafayette, Louisville, Superior, Erie)
303-772-2262 (Longmont)

Grab Bar Installation

Volunteer handyman services for minor home repairs/adaptations
Fix-It Program, RSVP/CareConnect
303-443-1933

Home Health Care Agencies

Wide range of health and social services provided in-home
www.BoulderCountyHelp.org (Select Seniors and People with Disabilities, then Service Directory, then In Home Health Care)

Medicare Counseling

Assistance with Medicare/Medigap billing problems

Medicare Counselors, Boulder County Area Agency on Aging
303-441-1546

Family Caregiver Training

Training in the hands-on skills of caregiving
National Caregiver Training Program, Boulder County Area Agency on Aging
See “Community Resources,” page 8.

More Information about Discharge Planning / Hospital to Home Transition

www.nextstepincare.org
www.n4a.org/pdf/HospitaltoHome.pdf

For information on other community resources, visit www.BoulderCountyHelp.org or call your local Resource Specialist (phone numbers on back page).



WANTED: CAREGIVERS WITH SOMETHING TO SAY!

In honor of National Family Caregivers Month, the November/December issue of *Care Connections* will be devoted to the writing of family caregivers like you. Have you written about your caregiving experience—or would you like to try? Please share your words with our readers. Professional writing experience is *not* required! Submissions are due September 20. Email to InfoCaregiver@bouldercounty.org or mail to *Care Connections*, Boulder County Area Agency on Aging, P. O. Box 471, Boulder, CO 80306. Submissions cannot be returned. For more information, call 303-678-6116. *Thank you*

CARE Connections
Boulder County Area Agency on Aging
P. O. Box 471
Boulder, CO 80306



INFORMATION AND ASSISTANCE IN BOULDER COUNTY

Within Boulder County, there are several key ways to access information and assistance about resources and services for older adults and their family caregivers:

- Check out **Network of Care for Seniors and People with Disabilities**, a comprehensive online service directory, at www.BoulderCountyHelp.org.
- Call the **CONNECT! Information and Assistance Line**, at 303-441-1617, and Boulder County Area Agency on Aging staff will respond to your message.
- Call the **Resource Specialist** in your community (numbers below). Services vary by community but include identifying needs, finding solutions, exploring options, and providing in-depth assistance.

Allenspark area	303-747-2592
City of Boulder	303-441-4388 (bilingüe: 303-441-3918)
City of Lafayette	303-665-9052, ext. 3
City of Longmont	303-651-8716 (bilingüe)
City of Louisville	303-335-4919
Lyons area	303-823-9016
Nederland area	303-258-3068
Niwot area	303-652-3850

