Long-term care (LTC) is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot **care** for themselves for **long** periods of time

"Long-term care" means helping people of any age with their medical needs or daily activities over a long period of time. Long-term care can be provided at home, in the community, or in various types of facilities. When you look for long-term care, it is important to remember that quality varies from one place or caregiver to another. It is also important to think about long-term care before a crisis occurs. Making long-term care decisions can be hard even when planned well in advance.

Types of Long-Term Care

Home care can be given in your own home by family members, friends, volunteers, and/or paid professionals. This type of care can range from help with shopping to nursing care. Some short-term, skilled home care (provided by a nurse or therapist) is covered by Medicare and is called "home health care." Another type of care that can be given at home is hospice care for terminally ill people.

Community services are support services that can include adult day care, meal programs, senior centers, transportation, and other services. These can help people who are cared for at home-and their families. For example, adult day care services provide a variety of health, social, and related support services in a protective setting during the day. This can help adults with impairments-such as Alzheimer's disease-continue to live in the community. And it can give family or friend caregivers a needed "break."

Independent Living Communities:. A number of these facilities offer help with meals and tasks such as housekeeping, shopping, and laundry. Residents generally live in their own apartments.

Assisted living provides 24-hour supervision, assistance, meals, and health care services in a home-like setting. Services include help with eating, bathing, dressing, toileting, taking medicine, transportation, laundry, and housekeeping. Social and recreational activities also are provided.

Nursing homes offer care to people who cannot be cared for at home or in the community. They provide skilled nursing care, rehabilitation services, meals, activities, help with daily living, and supervision. Many nursing homes also offer temporary or periodic care. This can be instead of hospital care, after hospital care, or to give family or friend caregivers some time off ("respite care").

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How Will I Pay for these Services?

Long-term care can be very expensive. In general, health plans and programs do not routinely cover long-term care at home or in nursing homes

- **Medicare** is the Federal health insurance program for people age 65 and older and for some disabled younger people. Medicare generally does not pay for long-term help with daily activities. Medicare pays for very limited skilled nursing home care after a hospital stay. If you need skilled care in your home for the treatment of an illness or injury, and you meet certain conditions, Medicare will pay for some of the costs of nursing care, home health aide services, and different types of therapy.
- **Medicaid** is a Federal-State program that pays for health services and long-term care for low- income people of any age. The exact rules for who is covered vary by State. Medicaid covers nursing home care for people who are eligible. In some States, Medicaid also pays for some home and community services.
- **Private Insurance**. Medicare beneficiaries may supplement their policy with insurance purchased from private organizations. Most of these policies, often called Medigap insurance, will help pay for some skilled care, but only when that care is covered by Medicare. Medigap is not long-term care insurance. Commercial insurers offer private policies called long-term care insurance. These policies may cover services such as care at home, in adult day care, in assisted living facilities, and in nursing homes. But plans vary widely. If you have such a policy, ask your insurer what it covers. If you think you may need long-term care insurance, start shopping while you are relatively young and healthy, and shop carefully.
- **Personal Resources**. You may need to use resources such as savings or life insurance to pay for long-term care. Most people who enter nursing homes begin by paying out of their own pockets. As their personal resources are spent, many people who stay in nursing homes for a long time eventually become eligible for Medicaid.

Resources:

Expanded In-home Services for the Elderly (EISEP)

- EISEP services include non-medical in-home services such as housekeeping, personal care, respite, case management, and related services (such as emergency response systems).
- EISEP services support and supplement informal care provided by clients' families.
- Clients are required to share the cost of services, based on income. These costs are determined by a sliding scale and range from no-cost to full-cost

Who is eligible?

EISEP assists older people (aged 60 and older) who need help with everyday activities to take care of themselves (such as dressing, bathing, personal care, shopping, and cooking), want to remain at home, and are not eligible for Medicaid.

The EISEP Program receives State and local funding. In addition, EISEP clients are required to cost share according to a sliding scale reflecting their income and the cost of the services they receive

How do I find EISEP services?

EISEP case managers help older people and their families to decide what help is needed and to arrange for those services. Services may include non-medical in-home services, case management, non-institutional respite, ancillary services, and other community services. EISEP supports and supplements the care provided by families and friends

Consumer Directed Personal Assistance Program (CDPAP)

- This Medicaid program provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services.
- Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse.
- Recipients have flexibility and freedom in choosing their caregivers.
- The consumer or the person acting on the consumer's behalf (such as the parent of a disabled or chronically ill child) assumes full responsibility for hiring, training, supervising, and – if need be – terminating the employment of persons providing the services.

How do I find the Consumer Directed Personal Assistance Program?

Before a person can receive services, his or her doctor must send a completed Physician's Order for Services to the local social services district, which then completes a social and nursing assessment. A nurse assessor then determines whether the recipient can appropriately participate in CDPAP, and recommends the amount, frequency and duration of services.

Requirements of CDPAP

Recipients must be able and willing to make informed choices regarding the management of the services they receive, or have a legal guardian or designated relative or other adult able and willing to help make informed choices.

The consumer or designee must also be responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services; and keep payroll records.

NHTD

The Nursing Home Transition and Diversion (NHTD) Medicaid Waiver is a Home and Community Based Services (HCBS) program, administered by the New York State Department of Health (DOH) through contractual agreements with Regional Resource Development Centers (RRDC)

The NHTD waiver uses Medicaid funding to provide supports and services to assist individuals with disabilities and seniors toward successful inclusion in the community. Waiver participants may come from a nursing facility or other institution (transition), or choose to participate in the waiver to prevent institutionalization (diversion).

Waiver services may be considered when informal supports, local, State and federally funded services and Medicaid State Plan services are not sufficient to assure the health and welfare of the individual in the community, or when waiver services are a more efficient use of Medicaid funds.

Philosophy of the NHTD Waiver

The NHTD Medicaid waiver was developed based on the philosophy that individuals with disabilities and/or seniors have the same rights as others. This includes the right to be in control of their lives, encounter and manage risks and learn from their experiences. This is balanced with the waiver program's responsibility to assure the waiver participants' health and welfare.

Waiver services are provided based on the participant's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in cooperation with providers to develop a Service Plan. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful productive activities. Waiver participant satisfaction is a significant measure of success of the NHTD waiver.

TBI

- For individuals with Traumatic Brain Injury (HCBS/TBI)
- One component of a comprehensive strategy developed by the NYS Department of Health to prevent unnecessary entrances into nursing homes and to help individuals leave nursing homes to live in the community
- Provides 11 Medicaid-funded services needed to assist participants to live in community-based settings and achieve maximum independence; services are used in combination with existing Medicaid services
- Participants may be eligible for rent subsidies and housing supports and limited one-time payment for furniture and household supplies.
- Each recipient must be given the choice of living in the community or in a nursing facility, and – if choosing the community – a living arrangement that can meet his or her needs.

Who is eligible?

An individual who is:

- diagnosed with TBI or a related condition,
- eligible for nursing facility level of care,
- enrolled in the Medicaid program, and
- between 18 and 64 years of age, and injured after the age of 18.

Palliative Care

Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Palliative care treats people suffering from serious and chronic illnesses such as cancer, cardiac disease such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's, Parkinson's, Amyotrophic Lateral Sclerosis (ALS) and many more.

Palliative care focuses on symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression. It also helps you gain the strength to carry on with daily life. It improves your ability to tolerate medical treatments. And it helps you have more control over your care by improving your understanding of your choices for treatment.

A Partnership of Patient, Specialists and Family

Palliative care is a team approach to care. The core team includes doctor, nurse and social work palliative care specialists. Massage therapists, pharmacists, nutritionists, chaplains and others may also be part of the team.

The team spends as much time as necessary with you and your family. They become a partner with you, your family and your other doctors. They support you and your family every step of the way, not only by controlling your symptoms, but also by helping you to understand your treatment options and goals.

Talking to Your Doctor

If you or a loved one has been diagnosed with a serious illness, you may benefit from palliative care. Speak to your doctor and ask for it. Bring the handout with you!

Aid and Attendance

Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses. It is paid in *addition* to a veteran's basic pension. The benefit may not be paid without eligibility to a VA basic pension. Aid and Attendance is for applicants who need financial help for in–home care, to pay for an assisted living facility or a nursing home. It is a non–service connected disability benefit, meaning the disability does not have to be a result of service. You cannot receive non–service and service–connected compensation at the same time. Aid and Attendance benefits are paid to those applicants who:

- Are eligible for a VA pension
- Meet service requirements
- Meet certain disability requirements
- Meet income and asset limitations

Who is Eligible for Veterans Affairs Basic Pension and Aid and Attendance?

A pension is a benefit that the VA pays to wartime veterans who have limited or no income and who are at least 65 years old or, if under 65, are permanently or completely disabled. There are also "Death Pensions," which are needs based for a surviving spouse of a deceased wartime veteran who has not remarried.

What are the Service Requirements for Aid and Attendance?

A veteran or the veteran's surviving spouse may be eligible if the veteran:

- Was discharged from a branch of the United States Armed Forces under conditions that were not dishonorable **AND**
- Served at least one day (did not have to be served in combat) during the following wartime periods and had 90 days of continuous military service:
- Veterans, spouses of veterans or surviving spouses can be eligible for Aid and Attendance benefits if they meet the following disability requirements:

- The aid of another person is needed in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, toileting, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment; or
- The claimant is bedridden, in that his/her disability or disabilities require that he/she remain in bed apart from any prescribed course of convalescence or treatment; or
- The claimant is in a nursing home due to mental or physical incapacity; or

The claimant is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

PACE

PACE (Program of All-inclusive Care for the Elderly) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

With PACE, the focus is on you — you have a team of health care professionals working with you and your family to make sure you get the coordinated care you need. Your team is experienced in caring for people like you. Usually they care for a small number of people, so they really get to know you.

When you enroll in PACE, you may be required to use a PACE-preferred doctor. These doctors are best suited to help you make health care decisions.

How does PACE work?

PACE organizations provide care and services in the home, the community, and the PACE center. They have contracts with many specialists and other providers in the community to make sure that you get the care you need. Many PACE participants get most of their care from staff employed by the PACE organization in the PACE center. PACE centers meet state and federal safety requirements.

Who can get PACE?

You can have either Medicare or Medicaid, or both, to join PACE. PACE is only available in some states that offer PACE under Medicaid. To qualify for PACE, you must:

- Be 55 or older
- Live in the service area of a PACE organization
- Need a nursing home-level of care (as certified by your state)
- Be able to live safely in the community with help from PACE

Note

You can leave a PACE program at any time.

What does PACE cover?

PACE provides all the care and services covered by Medicare and Medicaid if authorized by your health care team. If your health care team decides you need care and services that Medicare and Medicaid doesn't cover, PACE may still cover them.

Here are some of the services PACE covers:

- Adult day primary care (including doctor and recreational therapy nursing services)
- Dentistry
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Medical specialty services
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Physical therapy
- Prescription drugs

Note

If you join a PACE program, you'll get your Part D-covered drugs and all other necessary medication from the PACE program. You don't need to join a separate Medicare Prescription Drug Plan. If you do, you'll be disenrolled from your PACE health and prescription drug benefits.

- Preventive care
- Social services, including caregiver training, support groups, and respite care
- Social work counseling
- Transportation to the PACE center for activities or medical appointments, if medically necessary. You may also be able to get transportation to some medical appointments in the community.