

Nebraska Department of Health & Human Services
State Unit on Aging
2008 - 2011 Plan for Aging Services

*“To promote the dignity, independence and freedom of
choice for older Nebraskans”*

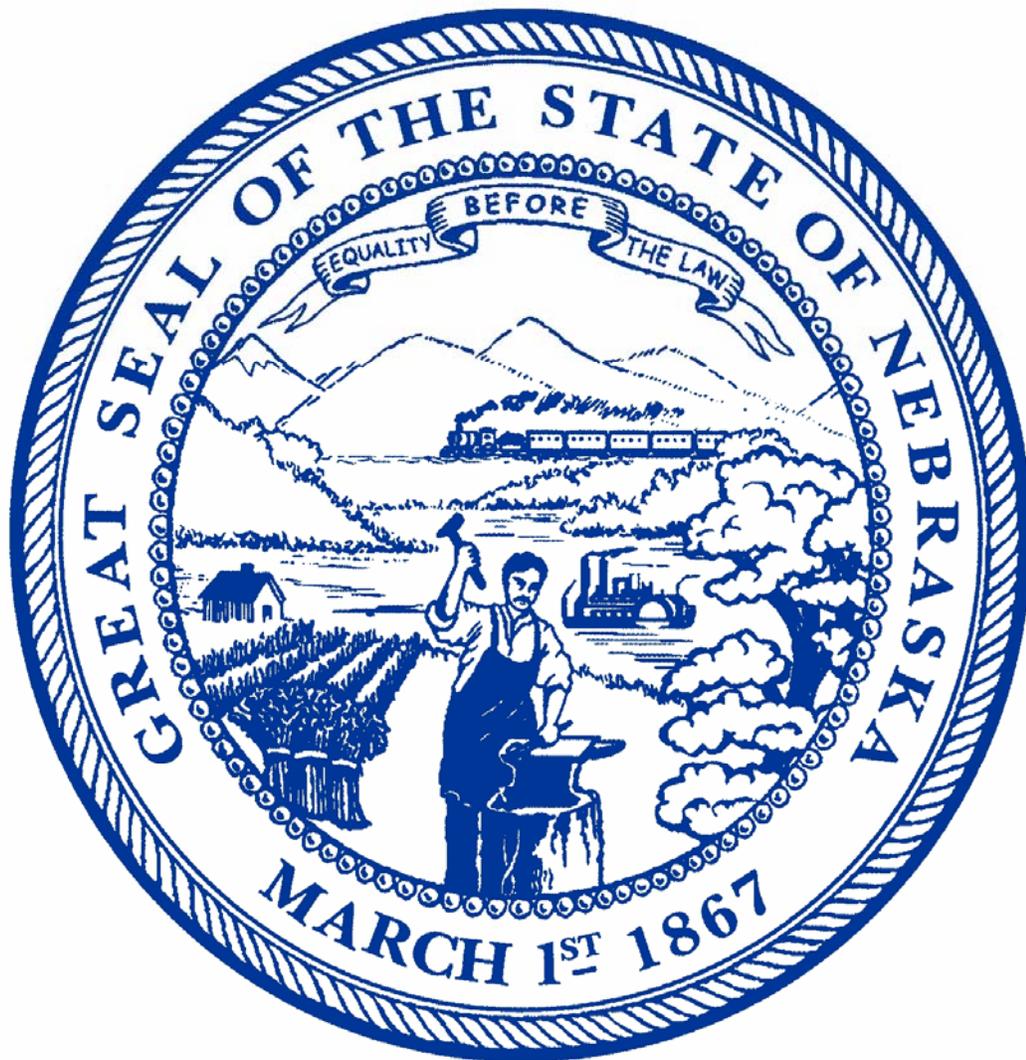


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This document prepared by the Nebraska State Unit on Aging. Special thanks to Dr. Christopher Kelley, Ph.D. from the University of Nebraska Omaha.

Verification of Intent

Hereby submitted is the Plan for Aging Services for the State of Nebraska for the period October 1, 2007 through September 30, 2011. It includes all assurances and plans to be implemented by the Nebraska Department of Health and Human Services – State Unit on Aging under the provisions of the Older Americans Act, as amended, during the period stated. The Department of Health and Human Services – State Unit on Aging has been designated the authority to develop and administer the State Plan for Aging Services in accordance with all requirements of the Act, and is primarily responsible for the coordination of all state activities related to the purposes of the Act, i.e., the development of a comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as an effective and visible advocate for older persons in the state.

I hereby approve this State Plan for Aging Services and submit it to the U.S. Assistant Secretary for Aging for approval.

7-24-07

(Date)

(Signed)

Dave Heineman

Governor

State of Nebraska

This plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the U.S. Assistant Secretary for Aging. The Nebraska Department of Health and Human Services, in accordance with the Older Americans Act as amended in 2006, and its implementing regulation, adheres to the assurances listed in Appendix C.

7/23/07

(Date)

(Signed)

Guinevere W. Channoff

Director

Division of Medicaid and Long Term Care

Department of Health and Human Services

PURPOSE OF THE STATE PLAN ON AGING

In order to plan for the ongoing and future needs of older adults in Nebraska and to meet the requirements of Section 307 of the Older Americans Act (OAA), the Nebraska Department of Health & Human Services State Unit on Aging has prepared a State Plan for submission to the federal Administration on Aging (AoA). Nebraska has opted to present a Four-Year State Plan for the period October 1, 2007 through September 30, 2011.

The State is required by Older Americans Act regulations to:

- Develop a State Plan for submission to the Assistant Secretary on Aging;
- Administer the State Plan in accordance with Title III of the OAA, as amended;
- Be responsible for planning, policy development, administration, coordination, priority setting and evaluation of all state activities related to the objectives of the OAA;
- Serve as an effective and visible advocate for older individuals by reviewing, commenting on and recommending appropriate action for all State plans, budgets and policies which may impact older Nebraskans; and,
- Provide technical assistance and training to any agency, organization, association or individual representing the needs and interests of older individuals.

This plan reflects the Nebraska Department of Health & Human Services mission, “Helping people live better lives through effective health and human services.” The State Unit on Aging’s mission is to “promote the dignity, independence, and freedom of choice for older Nebraskans.” The State Plan incorporates the mission and goals into the body of the plan and includes comments received during the public hearing.



Overview of Nebraska's Implementation of the Older Americans Act

The mission of the State Unit on Aging is "to promote the dignity, independence and freedom of choice for older Nebraskans." To accomplish this, the state unit performs a variety of advocacy, planning, research, education, coordination, public information, monitoring and evaluating functions. It collaborates with public and private service providers to ensure the presence of a comprehensive and coordinated community-based services system that will assist individuals to live in a setting that they choose that best meets their needs and to continue to be a contributing member of their community.

The Older Americans Act of 1965 and last amended in 2006 provides the framework for developing a comprehensive and coordinated system of aging services in the United States. As provided in the Act, the Administration on Aging designates a State Unit on Aging in each state. That State Unit on Aging is responsible for developing and administering a state plan on aging.

The State Unit on Aging was created in 1997 and prior to that, the State Unit on Aging was designated as the Nebraska Department on Aging Services from 1982 to 1997 and the Nebraska Commission on Aging from 1971 to 1982.

The State Unit on Aging has a 12 member Advisory Committee appointed by the governor. The committee advises the State Unit on Aging on the needs of older Nebraskans and reviews the policies and budgets. A list of committee members is included in Appendix D.

Nebraska's aging network includes eight Area Agencies on Aging designated by the State. These agencies were originally formed under the Nebraska Intergovernmental Cooperation Act. The agencies are governed either by a board comprised of local elected county/city officials or their designees or by an instrumentality of local government.

The eight agencies serve Nebraska's older citizens in each of the state's 93 counties. The area agency offices are located in Beatrice, Hastings, Kearney, Lincoln, Norfolk, North Platte, Omaha, and Scottsbluff. A map showing the regions served by each agency is included in this plan (see page 6).

The State Unit on Aging grants state and federal funds to the area agencies to support local programs and services. The State Unit on Aging administers Title III and Title VII of the Older Americans Act and the Nebraska Community Aging Services Act. These funding sources allow the area agencies to provide a variety of aging services throughout their Planning and Service Area.

The State Unit on Aging, utilizing state funds, administers the Nebraska Care Management Program. This program is operated through all eight Area Agencies on Aging and assists older persons who need long term care to identify and access services that support independent living.

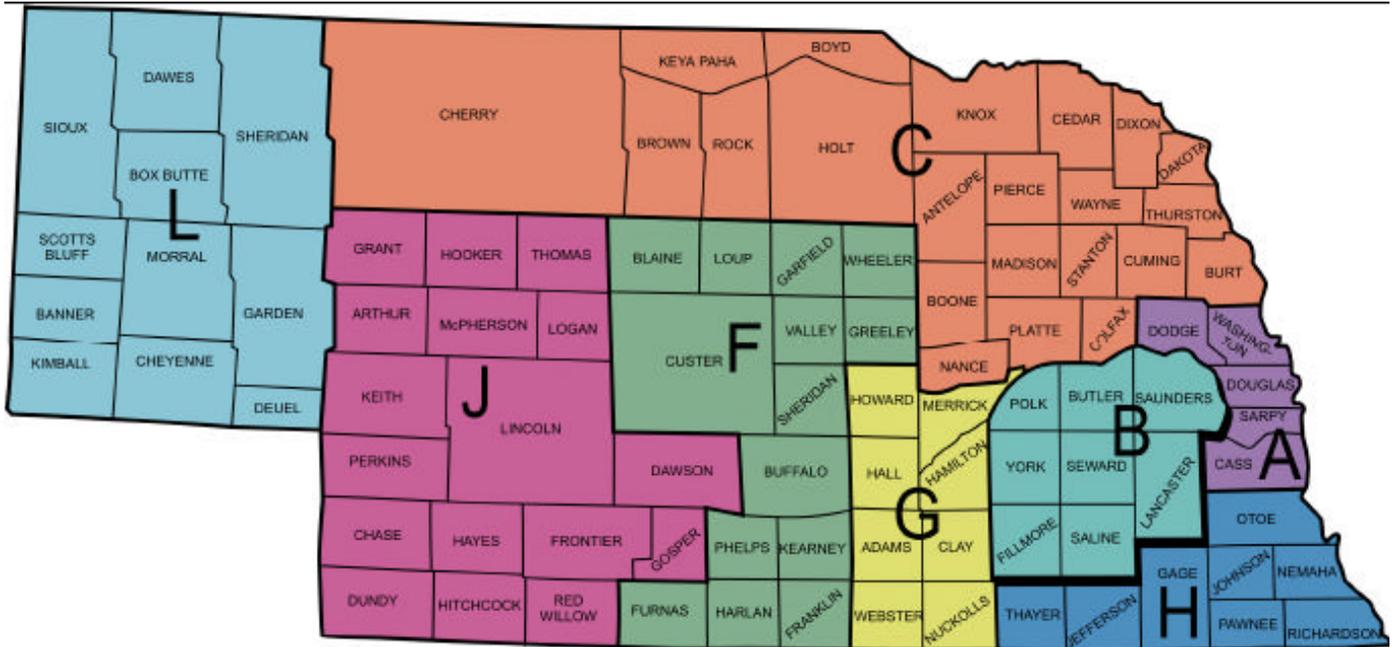
Under a contract managed by the State Unit on Aging, the Area Agencies on Aging provide pre-admission screening services for the Nebraska Senior Care Options Medicaid Program. Area Agency on Aging staff determines whether Medicaid eligible applicants for nursing facility care require that type of care. The Area Agencies on Aging also provide service coordination for persons over the age of 65 who are enrolled in the Aged and Disabled Medicaid Waiver Program.

Elder Rights services are provided by and coordinated through the State Unit on Aging. The Office of the State Long-Term Ombudsman serves as an advocate for long-term care facility residents by accepting, investigating, and resolving complaints. The program also advocates for changes at a system level that will benefit long-term care facility residents. The Legal Services Program assists the Area Agencies on Aging in developing and enhancing legal assistance programs. The state unit also coordinates activities with other agencies that are designed to provide insurance counseling and which are intended to prevent abuse, neglect, or exploitation of older persons.

The State Unit on Aging administers the state portion of the Senior Community Service Employment Program. This employment program provides training opportunities to older workers. The state positions are awarded to the Eastern Nebraska Office on Aging, the Lincoln Area Agency on Aging and Experience Works. Our administration responsibilities include development of the State Coordination Plan, equitable distribution of training positions and coordination of advocacy in behalf of older worker issues.



Nebraska Area Agencies on Aging



A. Eastern Nebraska Office on Aging

Beverly Griffith, Director
 4223 Center Street
 Omaha, NE 68105
 402-444-6444

G. Midland Area Agency on Aging

Dianne Fowler, Director
 305 N. Hastings, Room 202
 Hastings, NE 68902
 402-463-4565

B. Lincoln Area Agency on Aging

June Pederson, Director
 1005 O Street
 Lincoln, NE 68508
 402-441-7022

H. Blue Rivers Area Agency on Aging

Larry Ossowski, Director
 1901 Court Street
 Beatrice, NE 68310
 402-223-1352

C. Northeast Nebraska Area Agency on Aging

Connie Cooper, Director
 119 Norfolk Avenue
 Norfolk, NE 68702
 402-370-3454

J. West Central Nebraska Area Agency on Aging

Linda Foreman, Director
 115 N. Vine
 North Platte, NE 69101
 308-535-8195

F. South Central Nebraska Area Agency on Aging

Rod Horsley, Director
 4623 2nd Avenue, Suite 4
 Kearney, NE 68847
 308-234-1851

L. Aging Office of Western Nebraska

Victor Walker, Director
 1517 Broadway, Suite 122
 Scottsbluff, NE 69361
 308-635-0851

Demographics of Nebraska's Aging Services Recipients

The Nebraska State Unit on Aging works with an aging network, which includes Nebraska's eight Area Agencies on Aging and the service providers that they use to provide a wide range of aging services. Many of these are core services as defined by the National Aging Program Information System (NAPIS). This overview includes a summary profile of older Nebraskans, a description of the purpose of the service, and the outcome that the service addresses. The data reflected below is derived from NAMIS (Nebraska Aging Management Information System). The data does not include the number of people served by the Long Term Care Ombudsman, Senior Care Options, Aged and Disabled Medicaid Waiver, and Nebraska SMP Program.

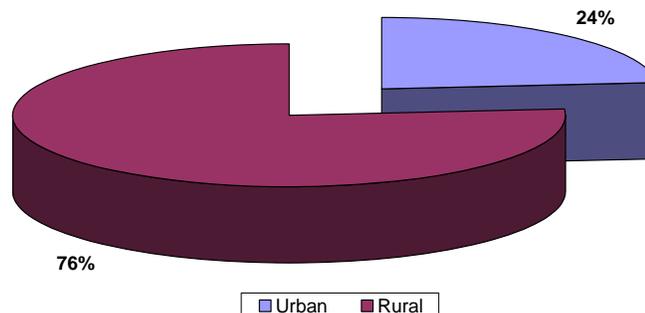
2006 Unduplicated Nebraska Aging Network Clients

During 2006 the Area Agencies on Aging in Nebraska served 31,615 older adults. This represents 12.2% of the 60+ population in the state.

Rural Clients

Of the total clients served more than 23,212 (76%) lived in rural areas.

Unduplicated Aging Clients Categorized by Area

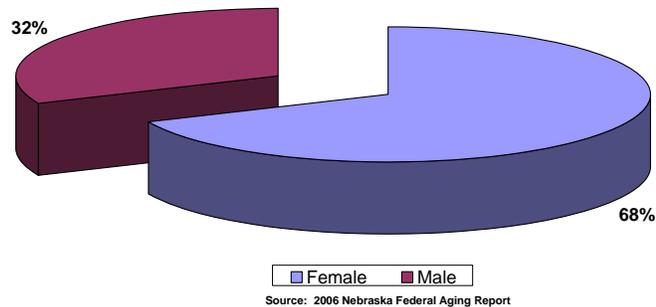


Source: 2006 Nebraska Federal Aging Report

Client Gender

Growth in the female client population is consistent with national trends. The male and female client populations both experienced small increases in the past year. The female population continues to be more than 2/3 of the male population.

Unduplicated Aging Clients Categorized by Gender

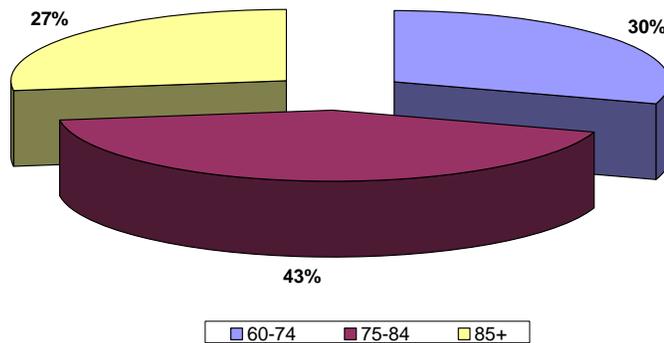


Source: 2006 Nebraska Federal Aging Report

2006 Client Age

Of those clients served in 2006, 70% were age 75 and over. The 85+ population, while small in number are among the heaviest users of aging services.

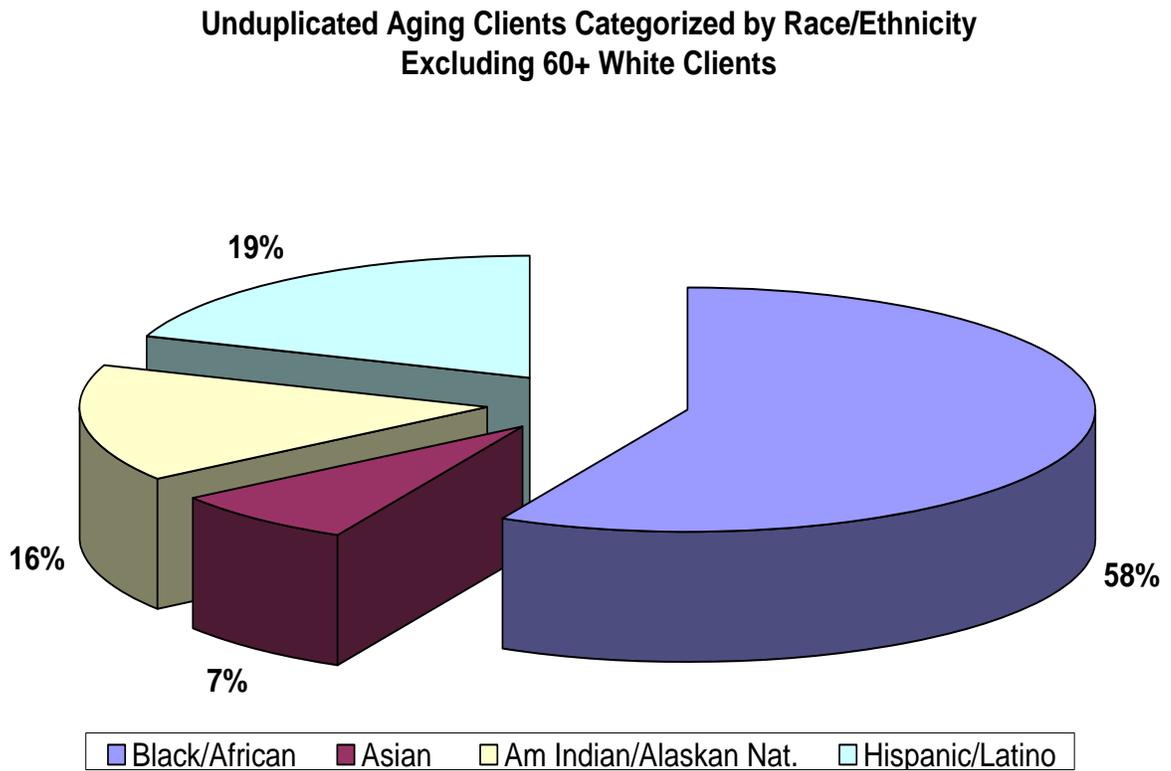
Unduplicated Aging Clients Categorized by Age



Source: 2006 Nebraska Federal Aging Report

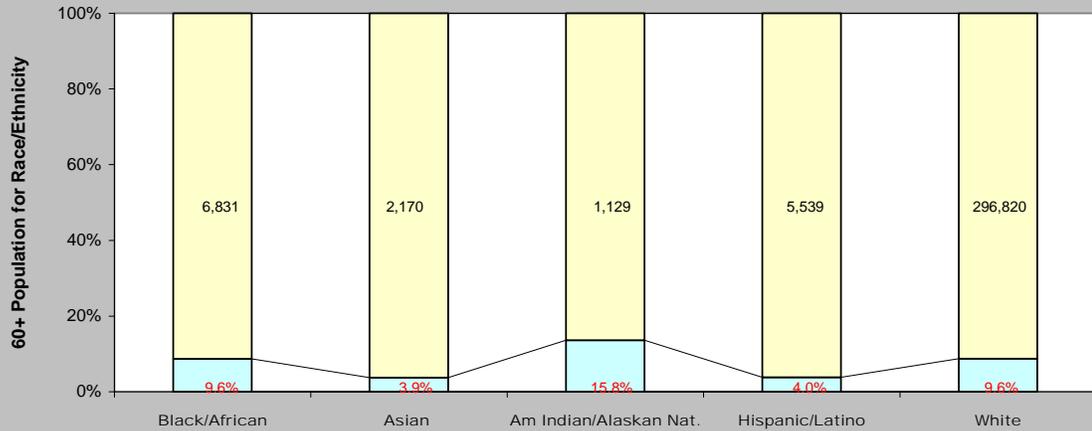
Client Race

84% of clients age 65 or older were non-Hispanic white, 8% were non-Hispanic black, 2% were non-Hispanic Asian and Pacific Islander, and less than 1% was non-Hispanic American Indian and Alaska Native. Hispanic persons made up 6% of the older client population.



Source: 2006 Nebraska Federal Aging Report

Aging Clients Categorized by Percent of Total 60+ Population for each Race/Ethnicity Group in NE



Source: 2006 Nebraska Annual Report and Bureau of the Census 2005

From the 2006 Nebraska Annual Report, of the total 60+ population from each race/ethnicity grouping, the following percentages are receiving aging services: 9.6% Black/African American, 3.9% Asian, 15.8% American Indian/Alaskan Native, 4.0% Hispanic/Latino, and 9.6% White.

Living Arrangement

.030% of all non-institutionalized older Nebraskans lived alone in 2006. This represents 41% of older women and 18% of older men. The proportion living alone increased with advanced age. Among women aged 75 and over, for example, half (49.4%) lived alone.

Client Nutrition Risk Assessment

Of the 25,508 older adults screened for nutrition risk in 2006, 54.5% scored at moderate to high nutritional risk. From those screenings, 22.4% indicated having food insecurity.

Care Management Clients

During 2006 the Care Management Program provided clients with 43,142 hours of service. 7,012 Care Management clients were served during the same period.

Profile of Nebraska Aging Services

For information on units of service provided in 2006 see appendix C.

The State Unit on Aging oversees the following programs and services that are provided by the Area Agencies on Aging, unless otherwise noted in the service description.

In-Home Services provide direct assistance in performing activities of daily living or instrumental activities of daily living to persons who need long-term care. They enhance the safety of people who choose home as the setting in which to receive long-term care services.

The goal of in-home services is to enhance a person's ability to live where he/she wants to live by helping that person overcome barriers that threaten independent living. In-home services include Personal Care, Homemaker, Chore, Emergency Response System, Durable Medical Equipment and Respite Care.

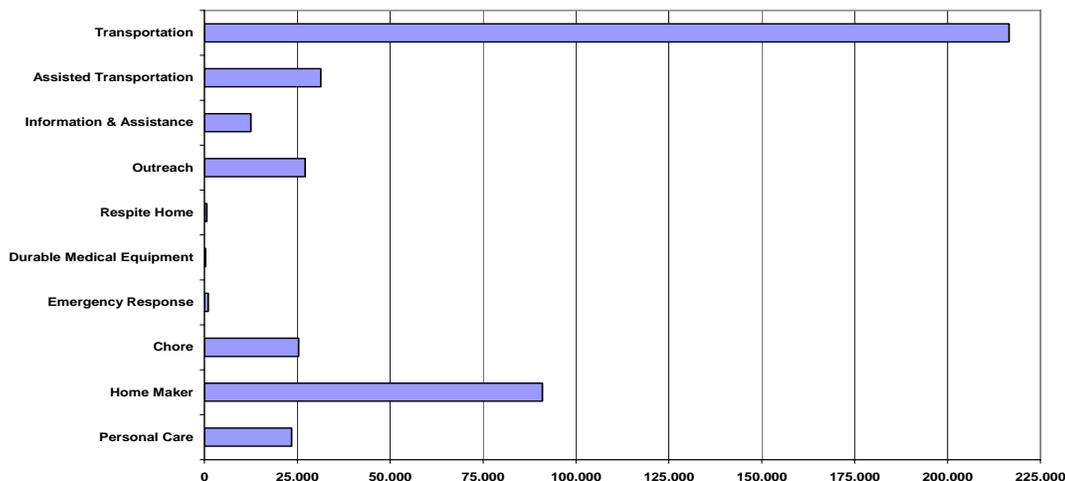
In-home services help older Nebraskans live in situations that meet their needs and support independence by maintaining a safe environment, assisting in meal preparation or other homemaking tasks and providing assistance with bathing, dressing and other activities of daily living that are essential to independent living.

These services also contribute to a sense of health, well being, good nutrition, and security. Services like Respite, along with other in-home services, help caregivers effectively carry out, balance, and sustain their caregiving roles over time.

Access Services encourage and assist older individuals to use the facilities and services available to them. There are two distinct types of access services: physical and informational. Physical access services help people move from one location to another to get goods or services. Informational access services help people get services by increasing their awareness of services and encouraging them to use the services. Access services include Transportation, Assisted Transportation, Information & Assistance and Outreach.

Access services help Older Nebraskans participate in, and contribute to, the political, economic and cultural life of their communities. They also assist people to understand the value of and learn how to obtain aging services.

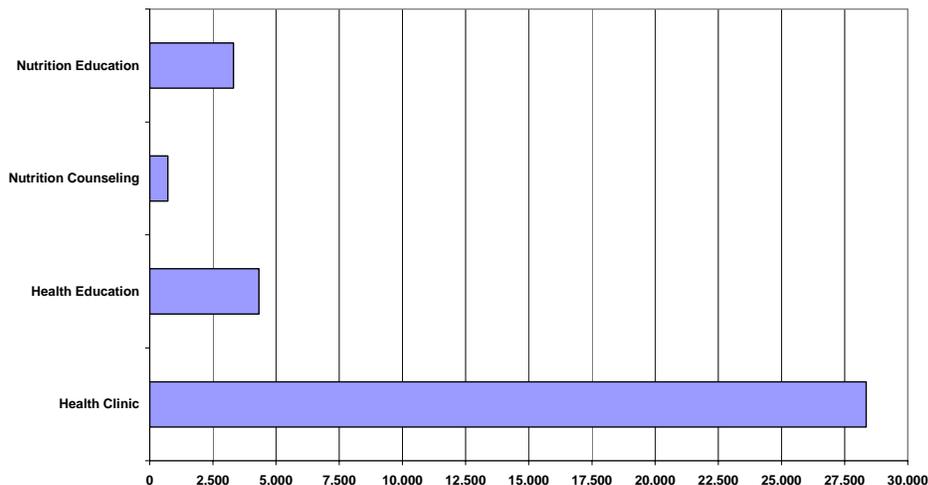
**2006 Access & In-Home Aging Units of Service
Excluding III-E Caregiver Service Units**



Source: 2006 Nebraska Federal Aging Report

Health Promotion/Disease Prevention evidence-based programming is provided through the aging network to help older adults live healthier more active lives. Low-cost interventions at the community level include areas such as fall prevention, physical activity, chronic disease self-management, and nutrition. Seniors benefit from these programs by making behavioral changes that have proven effective in reducing the risk of disease and disability among the elderly.

2006 Health Promotion Units of Service



Source: 2006 Nebraska Federal Aging Report

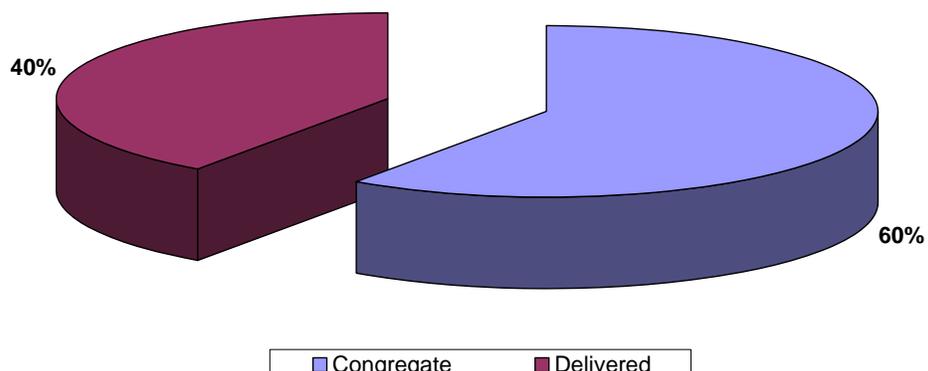
Nutrition services help older adults who would otherwise lack access to adequate amounts and quality of food to receive the meals they need to stay healthy and decrease their risk of disability. The Older Americans Act Nutrition Program provides congregate and home-delivered meals to persons 60 years of age and older and their spouses.

Meals served under the program must provide at least one-third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, as well as the Dietary Guidelines for Americans, issued by the Secretaries of Departments of Health and Human Services and Agriculture.

The Nutrition Program also provides a wide range of other related services through the aging network's service providers. Programs such as nutrition screening, assessment, education, and counseling are available to help older participants meet their health and nutrition needs. These programs also include special health assessments for such diseases as hypertension and diabetes. Through additional services, older participants learn to shop, plan, and prepare nutritious meals that are economical and enhance their health and well-being. The congregate meal programs provide older people with positive social contacts with other seniors at the group meal sites.

In addition to providing nutrition and nutrition-related services, the Nutrition Program provides an important link to other needed supportive in-home and community-based services such as homemaker-home health aide services, transportation, physical activity programs, and even home repair and home modification programs.

2006 Aging Systems Congregate & Home Delivered Meals Provided



Source: 2006 Nebraska Federal Aging Report

Counseling Services are designed to provide information and advice for older individuals in regard to public and private insurance, public benefits, lifestyle changes, legal matters and other appropriate matters. Included in counseling services are Legal Assistance, Financial Counseling, Volunteer Placement, Case Management, Employment Program, Ombudsman and Mental Health Counseling.

Financial Counseling services include public benefits information and tax assistance. This service is designed to assist an older individual to obtain financial services and benefits.

Volunteer Placement services help older individuals who are seeking volunteer opportunities in an aging-sponsored volunteer role to be placed in an appropriate situation.

Case Management services help older adults reside in living situations that meet their needs and support independence. Services begin with an assessment to determine needs.

Employment Placement is offered in some areas to assist an older individual (55 and over) to find paid employment. This is important to the general well being of older citizens.

Mental Health Counseling services provide counseling to an individual by a licensed mental health professional which is intended to address a diagnosed mental health condition.

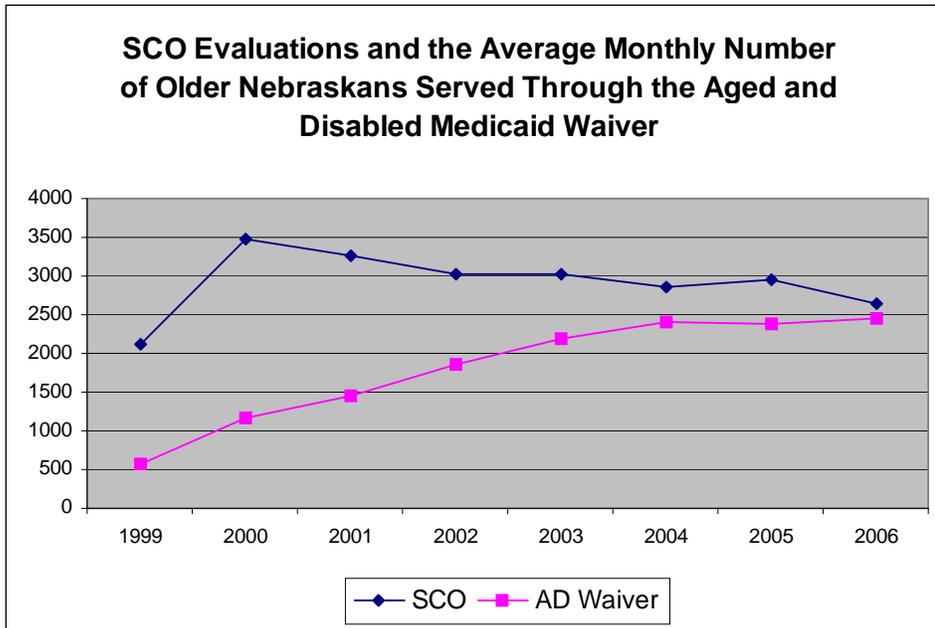
CHOICES (Choosing Home or In-Community Elder Services) encompasses three programs providing case management related services whether an individual is on Medicaid or private pay, in-home, or seeking Medicaid payment for nursing facility care. The three programs that make up CHOICES are Care Management, Senior Care Options and the Aged and Disabled Medicaid Waiver program.

These programs are coordinated to provide continuity for client care as individuals transition through the long-term care continuum of services. CHOICES allows for the individual to be served without disruption or delay as individuals' long-term care needs change. CHOICES focuses on helping older individuals stay independent in their own homes as long as possible by using home and community based services. When in-home options are exhausted, recommendations are made to the client and family as to what steps should be taken for the well-being of the

older individual. CHOICES programs are available statewide and are operated through the eight Area Agencies on Aging.

Senior Care Options is a nursing facility preadmission screening program for Medicaid eligible individuals, sixty-five years of age and above, to prevent premature institutionalization. Senior Care Options is required by state law and is funded through Medicaid. The program involves the completion of a state approved evaluation for eligible individuals referred to the program when Medicaid payment is being sought for nursing facility services to determine whether those individuals meets nursing facility level of care. As a component of the evaluation process Senior Care Options also provides education to individuals and their families about alternatives to institutionalized care while emphasizing client choice. The State Unit on Aging is responsible for the program, including managing the program regulations as well as the Medicaid funded contracts with the Area Agencies on Aging. The contracts with the Area Agencies on Aging are for the operation of the program, to include qualified Area Agency on Aging staff conducting the evaluations.

Aged and Disabled Medicaid Waiver Program is a comprehensive home and community based services program that utilizes a self-directed services approach for individuals meeting nursing facility level of care. The program includes services coordination and resource development to provide client needs assessment, care planning, provider recruitment and approval, service authorization, and the monitoring of services and service payments for older persons receiving Home and Community Based Services through the Aged and Disabled Waiver. The Aged and Disabled Waiver Program is a Medicaid program. The State Unit on Aging manages the contracts with the Area Agencies on Aging for services coordination and resource development.



Care Management assists people who need long-term care to continue to live at home. The service begins with a comprehensive assessment of a client to determine needs. Care managers and clients develop a care plan, and mutually decide on the services needed for implementation. These services help older adults reside in living situations that meet their needs and support independence. In many cases, the services helps caregivers effectively carry out, balance and sustain their caregiving roles over time.

The Nebraska Care Management Program was created via legislative mandate in 1987 and resulted in the establishment of a statewide system of care management unit through the Area Agencies on Aging. Care managers assist older persons with functional disabilities and their families select and obtain a variety of services that allow them to remain in a residence of their choosing.

One of the unique features of the Nebraska Care Management Program is a cost sharing mechanism. Clients who have incomes between 150% of poverty and 300% of poverty are asked to pay a portion of the cost of the service. Persons who have incomes above 300% of poverty are asked to pay the full fee for services provided. Most of the clients served by the Care Management Program are just above the income eligibility guidelines for Medicaid, so client fees do not account for a great proportion of the program's revenue.

There is maintenance of effort requirement contained in the Care Management Services Act. The act requires the Area Agencies on Aging that used state funds for care management prior to the passage of the act maintain that level of financial support for care management services. Four of the eight Area Agencies on Aging have maintenance of effort requirement. Currently all eight Area Agencies on Aging provide care management services.

National Family Caregiver Support Program focuses on the informal caregiver who is providing necessary care to a family member who is sixty years of age or older and experiences deficits in at least two activities of daily living and/or has a cognitive impairment that inhibits the client's ability to function independently. Activities of daily living include the accepted criteria for bathing, dressing, toileting, mobility (including transferring), continence, eating and cognitive impairment.

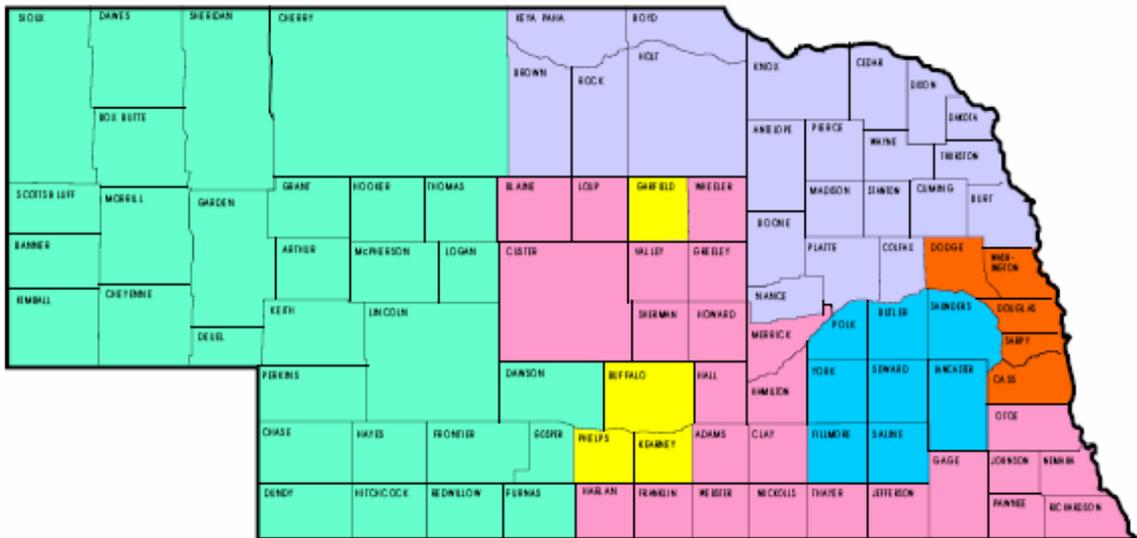
The focus of this program is to provide services that allow the caregiver to continue in his/her role. The caregiver can receive support in the form of information, care management education, training, respite either in-home or institutional, (personal care, homemaker and chore can be approved if ancillary to provide respite), durable medical equipment if it assists the caregiver, minor home modifications, support groups and home delivered meals. A service can be approved if it allows the caregiver to successfully maintain his/her caregiving role.

Another aspect of the National Family Caregiver Support Program is support for grandparents or relative caregivers who are the primary caregivers for a grandchild who is eighteen years of age or younger. The grandparent or relative has to be at least sixty years of age or older, live with the child, be the primary caregiver for that child and have a legal or informal relationship.



Nebraska Long Term Care (LTC) Ombudsman Program

The Nebraska LTC Ombudsman Program was established by federal mandate (Older Americans Act) and State statute (Nebraska LTC Ombudsman Act). The Program is coordinated by the State LTC Ombudsman and encompasses both Regional and Local LTC Ombudsman Programs, located at five of the Area Agencies on Aging. Each Program serves specific areas of the state and ensures that the Ombudsman services are available to residents of every nursing home and assisted living facility in Nebraska.



Regional Ombudsman Program (Western Nebraska)

Regional Ombudsman Program (Central and Southern Nebraska)

Local Ombudsman Program (Lincoln Area Agency on Aging)

Local Ombudsman Program (Eastern Nebraska Office on Aging)

Local Ombudsman Program (Northeast Nebraska Office on Aging)

Local Ombudsman Program (South Central Nebraska Office on Aging)

Ombudsman staff and state-certified volunteers advocate for the rights of residents of long-term care facilities and work to improve their care and quality of life through an emphasis on empowerment, education, problem-solving and conflict resolution. Anyone can bring a resident complaint or concern to the attention of the Ombudsman, however, the Ombudsman's goal is to seek to resolve the complaint or concern to the satisfaction of the resident. Ombudsman volunteers, called Ombudsman Advocates, must meet the program requirements, including 20 hours of initial training, before being assigned to work with residents of a specific long-term care facility.

The services provided by Nebraska's Long Term Care Ombudsman Program include:

Education – to inform residents, families, facility staff and others about a variety of issues related to aging, long-term care and residents' rights.

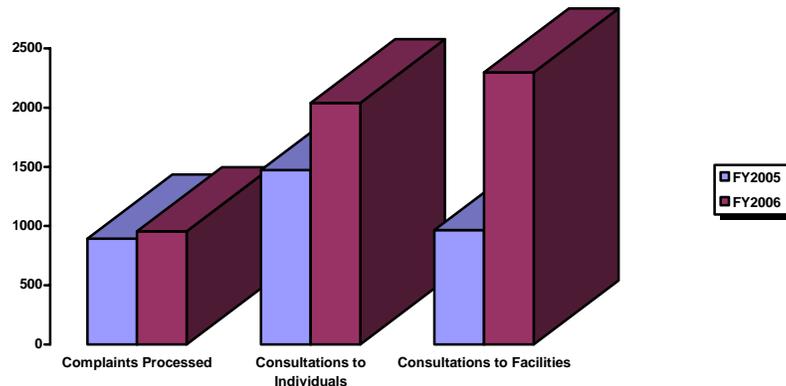
Information and Referral – to empower individuals in resolving their complaints.

Consultation – to make recommendations for protecting the rights of residents and improving their care and quality of life.

Individual Advocacy – to facilitate the resolution of complaints and to protect the rights of residents.

Systems Advocacy – to identify significant concerns and problematic trends and to advocate for systemic changes that will benefit current and future residents of long-term care facilities.

Nebraska LTC Ombudsman Program Services



Source: Ombudsmanager

Nebraska SMP

The Nebraska SMP Project, formerly the Nebraska ECHO Project, is a statewide project funded by an Administration on Aging grant and coordinated by Nebraska's Long Term Care Ombudsman Program. The SMP is composed of staff and volunteers who provide education and advocacy for Nebraskans on how to identify, report and prevent Medicare or Medicaid fraud, error and waste.

During the last 6 months of FY2006, the Nebraska SMP provided 160 community education events reaching over 15,000 people and 55 media events. 143 complaints of possible fraud were received by Nebraska's SMP and were referred or resolved, resulting in over \$28,000 of documented savings to beneficiaries. A website with information on the Nebraska SMP was also



developed during FY2006 at www.hhss.ne.gov/smp.

The expertise and resources of the Nebraska SMP Steering Committee assists SMP staff and volunteers in their education and advocacy efforts. Members include representatives from the Area Agencies on Aging (AAA), Long Term Care Ombudsman Program (LTCOP), Senior Health Insurance Information Program (SHIIP), CIMRO Nebraska (Quality Improvement Organization), Integriguard (Program Safeguard Contractor), Medicare Contractors, Medicaid, advocacy (e.g. AARP Nebraska) and provider organizations (e.g. Nebraska Health Care Association).

Legal Assistance

Legal Assistance is the provision of legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney. This assistance is a one on one contact between a service provider and elderly client. Information on relevant issues is also presented to the participants at a congregate meal site or senior center in a group setting.

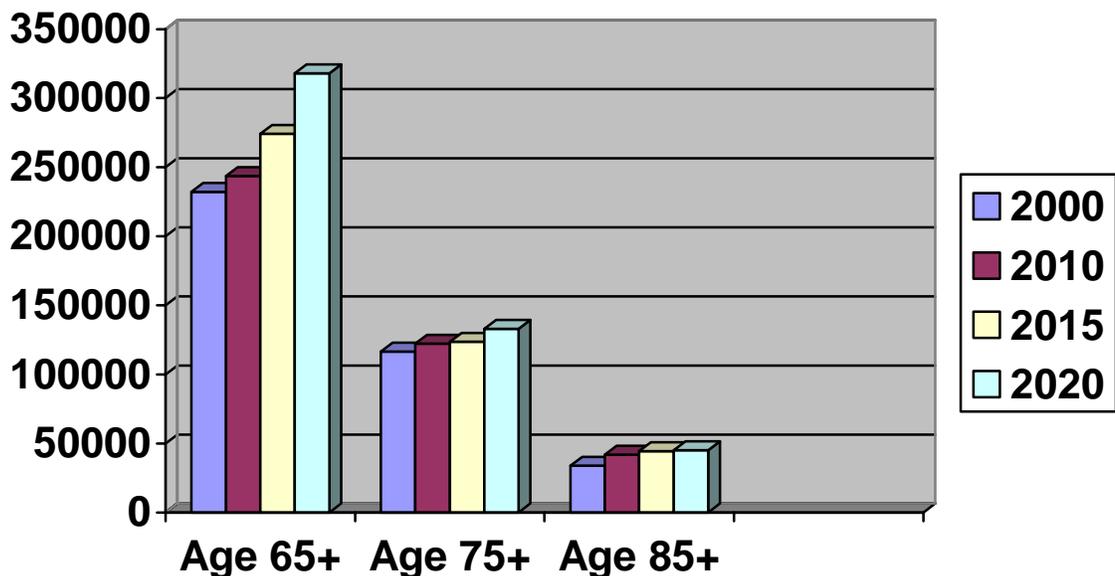


Changing Profile of Nebraska's Aging Population

From the U.S. Census Bureau population projections released in 1996, we can anticipate a moderate increase in Nebraska's elderly population until about 2010, a rapid increase for the next 20 years to 2030, and then a return to a moderate increase between 2030 and 2050. Similar projections prepared by the Social Security Administration (SSA) support these figures (SSA, 1995). In the early period, the elderly population is expected to increase by 17 percent. In the next period, 2010 to 2030, the population aged 65 and over is expected to grow by 75 percent. The period of 2030 to 2050 growth rate has a projected increase of 14 percent which would include the number of elderly to increase as well.

The growth in the number of the oldest old (aged 85 and over) is of greater public concern. During 1995 to 2010, this population is expected to grow by 56 percent, as compared with 13 percent for the population aged 65 to 84. This means that a larger share of the elderly will be over age 85. In subsequent decades, especially between 2030 and 2050, the 85-and-over age group will grow sharply as the baby-boom cohorts age.

Changing Population of Nebraska's Aging Population



Source: Centers for Public Affairs Research University of Nebraska Jerry Deichert

The anticipation of the increasing numbers of Nebraska's aging population during the next 10 years will affect how services are delivered, including to those individuals with low incomes, the minority population, and those residing in the rural areas, as well as those with limited English proficiency. Those individuals 85 and older will be expected to have a greater need for supportive services.

The State Unit on Aging will work with the Area Agencies on Aging and other community partnerships to meet the needs of the changing population of older individuals using the following methods:

- Empower Older Nebraskans to make a healthy and safe choice of where they live.
- Assist older Nebraskans in accessing home and community based services, which enable them to delay entry into nursing homes and live in an environment of their choice through case management activities.
- Assist older Nebraskans in learning about long-term care options when seeking assistance with or planning for additional needs.
- Encourage Nebraskans to plan ahead for their future long term care needs, as an avenue for maintaining optimal independence and autonomy, including choice and control over where, how and from whom they receive long term care services.
- Assist Nebraskans in maintaining their independence and autonomy and empower them to be knowledgeable of and to exercise their rights, including the right to live in the least restrictive environment possible
- Promote health and prevent disease via evidence based Health Prevention Disease Prevention (HPDP) programs.
- Address the nutritional well-being for older Nebraskans served through the Aged and Disabled Waiver and Care Management Programs.
- Encourage Nebraskans to engage in preventative health activities and effectively manage chronic illness, as an avenue for decreasing or delaying the likelihood of needing long-term care and services in the future.
- Assist long-term care facility residents in receiving quality care and experiencing the highest quality of life.

More information on the above methods and the planned strategies to achieve these methods can be found in the Goals, Objectives and Strategies section of this plan which starts on page 23.

Goals, Objectives, Strategies and Measures

Goal #1 - Older Nebraskans are independent, autonomous and have the right to participate in their communities and live in the environment of their choice.

Objective 1.1 - Empower Older Nebraskans to make a healthy and safe choice of where they live.

Strategies:

- Train Care Management and other gatekeepers to screen for nutrition risk and identify the need for referral to food and nutrition services.
- Provide food and nutrition choices in home delivered meals including special diets, texture modification, hot-frozen meal choices and daily or weekly deliveries.
- Collaborate with hospitals and nursing homes to ensure that food and nutrition choices are provided in discharge planning as part of comprehensive nutrition services.
- Continue to identify and build aging network partnerships.

Measurements:

- Maintenance or improvement of Nutrition Risk Assessment scores at reassessment by 2%.
- By the end of FY 2009, consumers who received congregate or home delivered meals will rate the services as very good or excellent at least 75% of the time.
- Reduce the number of individuals reporting food insecurity by 2%.

Objective 1.2- Assist older Nebraskans in accessing home and community based services, which enable them to delay entry into nursing homes and live in an environment of their choice through case management activities.

Strategies:

- Provide case management activities through the Care Management program.
- Continue Medicaid funded contracts with the Area Agencies on Aging for Aged and Disabled Medicaid Waiver services coordination.

Measurements:

- Incrementally increase, through expansion of the Aged and Disabled Medicaid Waiver program as Medicaid nursing facility expenditures decrease, the number of Older Nebraskans served by the Aged and Disabled Medicaid Waiver program through the aging network.

Objective 1.3 - Assist older Nebraskans in learning about long-term care options when seeking assistance with or planning for additional needs.

Strategies:

- Provide long-term care options education for Medicaid eligible older Nebraskans seeking nursing facility admission through continued Medicaid funded contracts with the Area Agencies on Aging for the Senior Care Options (SCO) program.
- Provide long-term care options education for Nebraskans and their families through aging network services.
- Explore options, through Medicaid reform, for preadmission screening for non-Medicaid eligible residents pursuing nursing facilities admission as an avenue to provide information about other long-term care options prior to resources and income being spent down.

Objective 1.4 - Encourage Nebraskans to plan ahead for their future long term care needs, as an avenue for maintaining optimal independence and autonomy, including choice and control over where, how and from whom they receive long term care services.

Strategies:

- Increase public awareness of the need to plan for future long term care needs through Nebraska's "Own Your Future" Long Term Care Planning Campaign by continuing to solicit opportunities for media coverage, disseminate written materials, provide community education, enhance Nebraska's long term care planning website and partner with other agencies and organizations.

Measurements:

- Number of "Own Your Future" Tool Kits ordered by Nebraskans and number of Nebraska's long-term care planning website hits.

Objective 1.5 - Assist Nebraskans in maintaining their independence and autonomy and empower them to be knowledgeable of and to exercise their rights, including the right to live in the least restrictive environment possible.

Strategies:

- Provide education and advocacy regarding the rights of residents of long-term care facilities, through the services of the Nebraska Long Term Care Ombudsman Program, to current and potential residents, their families and friends, caregivers and the general public.

Measurements:

- Number of consultations to individuals and facilities, number of community education sessions, number of facility staff training sessions and number of Resident and Family Council meetings attended.

Objective 1.6 - Recognize and promote the contribution of older workers in our economy.

Strategies:

- Publicize older worker contribution through recognition events such as Nebraska's Most Outstanding Older Worker and the Governor's Proclamation of Older Worker Week.
- Provide state leadership with groups such as Nebraska's Older Worker Council and our state's Senior Community Services Employment Program (SCSEP).
- Provide management support to our sub-grantees to assure accomplishment of the SCSEP program performance goals.

Measurements:

- Number of program participants finding employment.
- Retention rates of those finding employment.
- Services levels (number of persons served).
- Satisfaction with the program through surveys of program participants, host agency training sites, and employers.

Goal #2 - Older Nebraskan's have the right to health and well-being.

Objective 2.1 - Promote health and prevent disease via evidence based Health Prevention Disease Prevention (HPDP) programs.

Strategies:

- Offer nutrition screening, nutrition education, and nutrition counseling.
- Provide evidence based HPDP nutrition and physical activity programs.
- Partner with HPDP programs to increase accessibility.
- Review and design policies to ensure that health promotion and disease prevention are priorities.
- Activity search for potential HPDP RFP opportunities.
- Assist the aging network in developing outcome based measures that are appropriate for measuring health and prevention services.

Measurements:

- Increase the number of senior centers offering evidence-based programs by 5%.
- By the end of FY 09, 50% of older adults, who participate in evidence-based programming, will demonstrate increased strength, range of motion, flexibility, endurance, aerobic fitness, or balance.
- By the end of FY 09, consumers who received evidence-based programming will rate the services as very good or excellent at 75% of the time.

Objective 2.2 - Address the nutritional well-being for older Nebraskans served through the Aged and Disabled Waiver and Care Management Programs.

Strategies:

- Provide nutrition risk screening to persons receiving case management services and offer nutritional counseling services to those identified at nutritional risk.

Objective 2.3 - Encourage Nebraskans to engage in preventative health activities and effectively manage chronic illness, as an avenue for decreasing or delaying the likelihood of needing long term care and services in the future.

Strategies:

- Provide information to Nebraskans through Nebraska’s “Own Your Future” Long Term Care Campaign, encouraging healthy choices and increasing awareness of future benefits.

Measurements:

- Number of “Own Your Future” kits ordered by Nebraskans and number of Nebraska’s long term care planning website hits.

Objective 2.4 - Assist long-term care facility residents in receiving quality care and experiencing the highest quality of life.

Strategies:

- Provide information on residents’ rights, through the Nebraska Long Term Care Ombudsman Program, to current and potential consumers of long-term care services, their families, and caregivers, including a residents’ right to quality care and quality of life.
- Provide advocacy services, through the Nebraska Long Term Care Ombudsman Program, to empower and assist in the resolution of long-term care facility residents; concerns and complaints.
- Continue to develop partnerships between the Nebraska Long Term Care Ombudsman Program and other agencies and organizations, in order to improve the overall quality of long-term care.

Measurements:

- Number of consultations to individuals and facilities, number of community education sessions, number of facility staff training sessions and number of Resident and Family Council meetings attended.
- Number of complaints received and the number of complaints resolved.

Goal #3 - Older Nebraskans have their rights protected and are free from abuse, neglect and financial exploitation.

Objective 3.1 - Increase awareness of and protect the rights of case management clients, including their right to be free from abuse, neglect, and financial exploitation.

Strategies:

- Continue to educate older Nebraskans receiving case management services about their rights and abuse, neglect or and financial exploitation, to include the collaboration with and referral to other aging network services.

Objective 3.2 - Increase awareness of and protect the rights of long-term care facility residents, including their right to be free from abuse, neglect, and financial exploitation.

Strategies:

- Provide education to long term care facility residents, their families and friends, facility staff and the general public on residents' rights and assist in the protection of these rights through the Nebraska Long Term Care Ombudsman Program.
- Provide advocacy services to protect the rights of long-term care facility residents, and empower and assist in the resolution of their concerns through the Nebraska Long Term Care Ombudsman Program.

Measurements:

- Number of consultations to individuals and facilities, number of community education sessions, number of facility staff training sessions and number of Resident and Family council meetings attended.
- Number of complaints received and number of complaints resolved.

Objective 3.3 - Increase awareness of and protect the rights of all older Nebraskans, including their right to be free from abuse, neglect, and financial exploitation.

Strategies:

- Provide education and systemic advocacy on behalf of older Nebraskans through the Nebraska Elder Rights Coalition, including the identification

of key elder rights issues and the development, and implementation of resolution strategies and the efficient utilization of scarce resources.

Objective 3.4 - Provide legal services that will provide education about rights and representation in instances in which a person needs assistance in exercising rights.

Strategies:

- Fund and assure the provision of legal services that provide education about rights and representation in instances in which a person needs assistance in exercising rights.

Measurements:

- Number of cases closed. Percentage of cases, focusing on target population issues. Percentage breakdown of services types. Number of active cases over time. Monetary impact on clients.



Goal #4 - Older Nebraskans and their families are empowered to make informed decisions and have the knowledge to access services.

Objective 4.1 - Delay institutionalization in high risk and non-Medicaid individuals.

Strategies:

- Create an Advisory Committee to assist with establishment, planning, implementation, and marketing of an Aging & Disability Resource Center.
- Identify high-risk groups for targeting prevention initiatives and activities.
- Continue to identify and build aging network partnerships.
- Develop aging network best practices models.
- Heighten awareness about food and nutrition services through:
 - printed material
 - web base information
 - inform about what nutrition services Medicare and Medicaid will cover with regards to monetary assistance
 - include 2-3 key nutrition questions on the uniform I&R assessment
 - ID food assistance program, e.g., Food Stamp Program, SFMNP, CSFP
 - inform about possible private pay options for food and nutrition services.

Measurements:

- Maintenance or improvement of Health Days CDC core questions at reassessment by 2%.
- Maintenance or improvement of Nutrition Risk Assessment scores at reassessment by 2%.
- Maintenance or improvement of ADL scores at reassessment by 2%.
- Number of unduplicated count of participants receiving meal services will increase by 2%.

Objective 4.2 - Provide streamlined access to health and long term care related information and services through easily accessible avenues for Nebraskans.

Strategies:

- Promote the Area Agencies on Aging, Nebraska Referral and Resource System website, and the answers4families.org website as avenues for Nebraskans to obtain information about services.
- Provide a streamlined approach for Nebraskans in meeting their needs through utilizing the CHOICES program to provide case management services through the Area Agencies on Aging regardless of whether individuals receive Medicaid, maintain in their home or assisted living, or pursue nursing facility placement.
- Provide information regarding long-term care and planning resources written materials, presentations, and Nebraska's Long Term Care Planning website, produced by Nebraska's "Own Your Future" Long Term Care Planning Campaign.
- Provide information regarding long-term care facility care and services, residents' rights and abuse, neglect and financial exploitation through the services of the Nebraska Long Term Care Ombudsman Program.
- Provide education regarding how to identify report and prevent possible Medicare and Medicaid fraud, error and waste through the services of the Nebraska SMP project.

Measurements:

- Number of "Own Your Future" Tool Kits ordered by Nebraskans and number of Nebraska's Long Term Care Planning website hits.
- Number of Ombudsman consultations to individuals and facilities, number of community education sessions, number of facility staff training sessions and number of Resident and Family Council meetings attended.
- Number of SMP community outreach sessions, number of group education sessions, number of one-to-one counseling sessions, number of individuals reached, and number of media events.

Goal #5 - Maintain accurate data on all programs servicing older Nebraskans.

Objective 5.1 - Capture complete and accurate data for programs and services provided through the aging network for data analysis and funding purposes.

Strategies:

- Area Agencies on Aging will enter data in required information management systems and monitor the data for accuracy and completeness.
- State Unit on Aging staff will conduct ongoing monitoring of data in information management systems utilized for aging network services.
- State Unit on Aging staff will monitor data input by Area Agencies on Aging at least each quarter.
- State Unit on Aging will prepare reports for each Area Agency on Aging on data input compared to previous fiscal year and current area plan and ask each Agency to respond to significant differences.
- Each Area Agency on Aging will appoint one staff member to be responsible for internal monitoring of data and data entry into reporting and monitoring application.
- State Unit on Aging will conduct periodic meeting of Area Agency on Aging staff responsible for internal data and data entry monitoring to discuss problems, best practices, and determine training needs.



Community Listening Sessions

The State Unit on Aging conducted site visits to senior centers in each of Nebraska's eight Area Agency on Aging planning and services areas in 2006-2007. The short-term goal of the State Unit on Aging was to evaluate services provided under the Older Americans Act for completion of Nebraska's 2007 State Plan. The long-term goal was to identify potential locations for an Aging & Disability Resource Center. The eight communities visited were Bellevue, Geneva, Gothenburg, Hebron, Holdrege, O'Neill, St. Paul, and Scottsbluff. The sites chosen by the State Unit on Aging, with consultation with the local Area Agencies on Aging, were communities with senior centers that offer comprehensive services (nutrition, transportation, information & assistance, etc.). In addition, the State Unit on Aging strove to select sites located at a distance from the local Area Agency on Aging, communities in which strong and sustainable services for seniors had been developed on a grass-roots basis.

On each of these eight site visits, State Unit on Aging officials conducted listening sessions of approximately one hour in length with two groups of individuals to assess the adequacy of current programs and services for older adults and to identify unmet needs. The first listening session was held with community leaders; which included elected officials, health care professionals, long-term care administrators, and providers of home and community-based services (including local clergy). In addition, at least one person currently providing care to a family member was present. In each city, approximately eight to fifteen community leaders participated in these discussions. The second listening session was conducted at the senior center itself at lunchtime. At these sessions, the majority of participants in the discussion were regular clients of the senior center. At each site, the center manager was present, as well as at least one board member of the senior center. Across the eight sites, an average of 25 senior center clients took part in these sessions.

The questions asked by State Unit on Aging officials during these listening sessions were based on Administration on Aging guidelines found in the 2006 State Plan instructions. The State Unit on Aging's intent was to determine whether the goals and objectives of this State Plan were being met, from the perspective of local communities, and where emphasis for the next State Plan should be placed. Across the Eight Area Agencies on Aging planning and service areas, three common themes emerged. First, transportation services, particularly to and from health care facilities during the evening and on weekends, were often in short supply. Second, the information and assistance that is available to seniors, in vital

areas such as caregiver support and reporting elder abuse, is often unclear, even among regular participants in other Older Americans Act programs. Third, while improvements to preventive health care in these eight communities have taken place, programs in education, screening and prevention are not reaching many citizens who would benefit.



Medicaid Long Term Care Reform

(The following contains excerpts from the Nebraska Medicaid Reform Plan, December 2005)

Medicaid reform, mandated by the Nebraska Legislature under LB 709 (2005), required “fundamental reform” of the state’s Medicaid program, a significant rewriting of Medicaid-related statutes and the preparation of a Medicaid reform plan.

More than 200,000 persons are currently eligible to receive Medicaid benefits in Nebraska each month. Total Nebraska Medicaid expenditures now exceed \$1.4 billion annually. The rate of growth in Medicaid expenditures continues to exceed the growth in General Fund revenues, which can be attributed to many causes, including demographic and economic factors, personal lifestyle choices, the structure of Medicaid as a public assistance entitlement and health care system factors, particularly prescription drugs and long term care. In Nebraska, the elderly and individuals with disabilities comprise twenty-three and three-tenths percent of the Medicaid population and represent sixty-seven and two-tenths percent of Medicaid expenditures.

The greatest increases in Nebraska Medicaid expenditures are in the categories of prescribed drugs and long-term care. Prescribed drugs, including over-the-counter medications increased almost \$114 million from SFY00 to SFY05, or 89.1%. Expenditures for nursing facility services increased \$29.2 million, or 11.6%. Expenditures for home and community-based waiver services (HCBS) increased 120.8% from SFY00 to SFY05, reflecting the expanded availability of HCBS, which has resulted in less expensive, less restrictive community services for many elderly and persons with disabilities.

Long-term care services, including home and community based services (HCBS), nursing facility services, and intermediate care facilities for the mentally retarded (ICF/MRs), accounted for more than one-third of Nebraska Medicaid expenditures in SFY05. Between SFY00 and SFY05 there was a shift in the locus of long-term care services, from more intensive nursing facility services to less expensive, generally less intensive, assisted living or home and community-based services.

Expenditures on nursing facilities increased 11.6% from SFY00 to SFY05, for an average increase of only 2.2% a year. At the same time, expenditures for assisted living services increased from \$4.8 million to \$23.9 million, an average annual increase of 37.6%. Expenditures for other home and community-based waiver services increased from \$71.3 million in SFY00 to \$145.1 million in SFY05. For

FY 2006 Nebraska Medicaid payments to vendors totaled \$1,430,907,617, of which 20.7% went to nursing facilities while only 12.7% went towards waiver services (Aged and Disabled and Developmental Disabilities waivers combined). In Nebraska, the aged population accounts for 54% (9,918 unduplicated individuals) of the total average monthly number of Medicaid recipients served by long-term care services.

In Nebraska, the process for developing a Medicaid reform plan began with internal HHSS work groups, who had approximately three months to generate ideas, perform research, and prepare draft recommendations. This was followed by public meetings, Medicaid Reform Advisory Council hearings, and the final report. Since then, each strategy identified in the report was assigned to a chairperson and small committee within HHSS. Representatives of the State Unit on Aging were and are actively involved in working on several specific strategies identified in Nebraska's Medicaid Reform Plan, including those that focused on long-term care.

Nebraska Long-Term Care Medicaid Reform Strategies:

1) Nebraska's Home and Community Based Waiver has been renewed by CMS and approved for additional slots. The most recent Aged & Disabled Waiver renewal increased by 213 slots over the previous renewal. Waiver slots are projected to expand incrementally to meet the projected growth in the segments of the population expected to need long-term care services. The current renewal runs through July 31, 2011, but may be amended if warranted.

SUA Involvement: SUA staff manages the A & D Waiver contracts with the Area Agencies on Aging for services coordination. SUA staff monitors the slots available to the Area Agencies on Aging and coordinate with the Medicaid and Long Term Care Division to allocate additional available slots based on need.

2) HHSS has appointed a Rural Long-Term Care Reform Advisory Committee.

The Rural Long-Term Care Reform Advisory Committee began work in 2006. Its goal is to recommend strategies to change Nebraska's rural long-term care system from one that relies on institutional care to one that serves consumers in non-institutional settings. The committee met August 30, 2006 to review pertinent data. The committee met again November 14, 2006 to discuss barriers to serving persons in the community and February 28, 2007 to discuss solutions to the gaps and barriers.

SUA Involvement: Representatives of Nebraska’s State Unit on Aging participated in the work group formed to address the rural long-term care system. SUA staff also continues to serve in a resource role for the advisory committee and attend advisory committee meetings.

3) A Long-Term Care Partnership program is being implemented. HHSS and the Nebraska Department of Insurance are collaborating on establishment of a long-term care partnership program in which persons who use benefits from qualified insurance policies to cover their long-term care expenses are allowed to protect an equivalent amount of assets for Medicaid eligibility and estate recovery purposes. The program's intent is to create incentives for private financing of long-term care and to provide an appropriate mechanism for sheltering assets. A Nebraska Medicaid state plan amendment to obtain federal approval of this program was submitted to CMS September 25, 2006. The Department of Insurance, through the National Association of Insurance Commissioners (NAIC), is working to establish procedures to identify insurance policies that meet partnership requirements, to create reciprocity for these policies among states, to develop LTC policy exchange provisions, and to ensure that insurance sales agents receive appropriate training.

SUA Involvement: A representative of Nebraska’s State Unit on Aging serves as Chair of the Long-Term Care Planning Campaign (Own Your Future) workgroup, which continues to stay informed on the progress of Nebraska’s Long-Term Care Partnership program’s implementation and will assist in the dissemination of this information via Campaign materials, website and community education efforts.

4) A Long-Term Care Planning Awareness Campaign is being implemented. Nebraska was selected to participate in the national “Own Your Future” (OYF) Long-Term Care Planning Campaign. Nebraska HHSS, together with the Governor’s Office and other partners, developed and is currently implementing Nebraska’s OYF campaign, an education, and outreach effort designed to promote long-term care planning. The OYF campaign is also an important part of Nebraska’s Medicaid Reform efforts, emphasizing personal responsibility and supporting consumer choice. In November 2006, a letter from Governor Heineman was mailed to approximately 230,000 Nebraska households with residents between the ages of 45-65, promoting awareness of future long-term care needs and encouraging Nebraskans to order an OYF Tool Kit. As of March 2007, Nebraskans had ordered over 14,500 Kits. The Tool Kit and Nebraska Insert provide information on how to begin planning for future long-term care needs by engaging in preventive health activities, modifying home environments and

utilizing assistive technology, considering advance directives and other legal possibilities, exploring financial planning and insurance options, learning more about community resources and talking with family members and friends about future plans. The Tool Kit also has information on Nebraska's Long-Term Care Planning website, www.answers4families.org/ltcplanning. As of March 2007, Nebraska's website had received over 7,000 hits.

SUA Involvement: A representative of Nebraska's State Unit on Aging serves as Chair of the workgroup responsible for the development and continued implementation of this public awareness campaign.

5) Nebraskans are being informed of alternatives to nursing home care.

Nebraska's Area Agencies on Aging (AAA) assist non-Medicaid eligible individuals to make informed choices concerning appropriate and cost-effective long-term care services. Through the AAA Care Management programs, staff provide assessments of an individual's needs and identify resources and programs available to meet those needs in the least restrictive and most cost-efficient setting and manner. Care Managers can also arrange for home and community-based services and provide regular monitoring, as well as identify potential funding sources for those individuals with a limited ability to pay.

SUA Involvement: Representatives of Nebraska's State Unit on Aging chair and serve on the workgroup responsible for the identification of additional strategies to increase public awareness of lower cost home and community-based long-term care services.

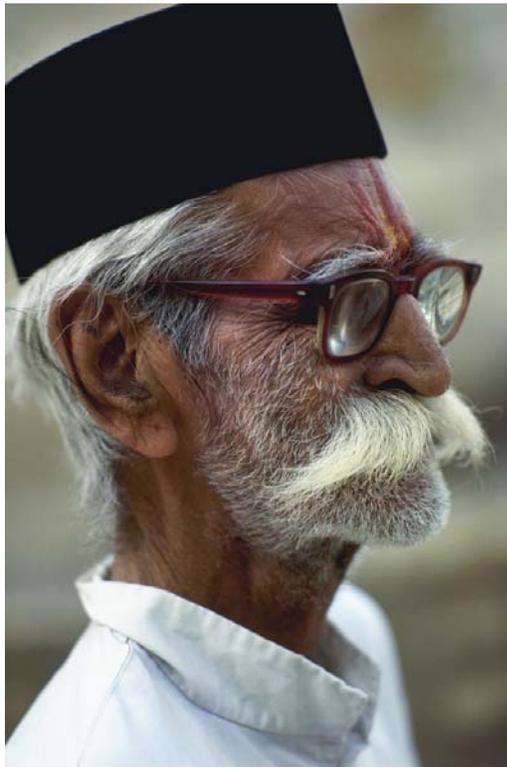
6) Money Follows the Person. Nebraska's Health and Human Service System was informed in January 2007 that it was awarded a Money Follows the Person (MFP) grant. The MFP program will be administered by HHSS' Home and Community-Based Services Division (HCBS).

SUA Involvement: SUA representatives have asked to partner in the establishment and implementation of Nebraska's MFP program. SUA representatives will be involved in the development and implementation of the MFP Operational Protocol. SUA representatives are also in a unique position to help identify nursing facility residents as potential candidates for transitioning from institutional to home settings.

Deficit Reduction Act

The federal Deficit Reduction Act of 2005 made a number of changes to the federal law governing Medicaid eligibility and benefits. The law included some new requirements, which states were required to implement, for individuals who are Medicaid eligible, including citizenship documentation, treatment of income and assets, and asset transfers. The law also allowed states to develop long-term care partnership programs, as described above.

SUA Involvement: A representative of Nebraska's State Unit on Aging assisted in the dissemination of Medicaid Eligibility Documentation Consumer and Advocate Tip Sheets, which were produced by a Nebraska consumer advocacy organization and approved by Nebraska HHSS for distribution. Tip Sheets were produced and disseminated to relevant service agencies, including Nebraska's Area Agencies on Aging for distribution to consumers. In addition, Nebraska's Elder Rights Coalition, coordinated by a representative of Nebraska's State Unit on Aging, also monitored and provided input on behalf of older Nebraskans regarding Nebraska's development of DRA regulations on asset transfers.



Medicare Modernization Act

The Nebraska State Unit on Aging has been and will continue to be actively involved in providing education on the Medicare Modernization Act (MMA) and in providing assistance to older Nebraskans to help them avail themselves of the benefits available under the MMA, including the prescription drug benefit and prevention services.

The Nebraska SMP Project Director represents the State Unit on Aging on the Core Planning Group of Nebraska's Medicare Prescription Drug Coalition, which includes representatives from the Nebraska Senior Health Insurance Information Program (SHIIP), AARP Nebraska, Nebraska Area Agency on Aging Association, Nebraska Medicaid, Social Security Administration, University of Nebraska, and Nebraska Health Care Association. During the past three years, the Coalition has provided extensive statewide education regarding the implementation and continued development of the Medicare Part D Prescription Drug Program, including web-based trainings, satellite and teleconferences, media events, dissemination of written materials, community education, and enrollment events and development of a consumer website.

The Nebraska Medicare Prescription Drug Coalition also provided one-to-one assistance to older Nebraskans, providing them with information on Part D plans and helping with their enrollment in the plan of their choice. The Coalition held education and enrollment events across the state reaching thousands of beneficiaries, particularly targeting rural and geographically isolated residents. Nebraska's Coalition also helped develop and maintain various Local Medicare Drug Coalitions across the state, providing information and technical assistance to help them educate older adults in their communities and assist with enrollment.

In addition to the efforts of Nebraska's statewide and local coalitions, education and assistance for older adults was provided through the outstanding efforts of the staff and volunteers of Nebraska's SHIIP. Nebraska's SHIIP is a program of the Nebraska Department of Insurance, but contracts with six of Nebraska's eight Area Agencies on Aging to operate Local SHIIPs. Each Area Agency on Aging also provided information and assistance for older adults regarding Part D, answering questions, sponsoring enrollment events, making relevant referrals, correcting errors, resolving problems and advocating on behalf of the beneficiary with pharmacies, Part D plans, Social Security and Medicare.

Finally, the Nebraska SMP received numerous reports from Nebraska beneficiaries of fraud schemes and other consumer protection issues associated with the implementation of Part D. The SMP staff and volunteers worked to resolve these concerns and educate Nebraskans, through community education, outreach, media events, website information, web-based, satellite training events, and dissemination of written materials.

Nebraska's Medicare Drug Coalition and its members plan to continue providing education and assistance for older Nebraskans regarding Medicare Part D, through the Coalition's website, training for Aging Network professionals and community education, media and enrollment events for beneficiaries.

In addition, Nebraska's aging network, together with Nebraska's SHIIP, will continue to provide education for Nebraskans on other aspect of the MMA, including information on Medicare's coverage of prevention services and promotion of the "MyMedicare" website as a resource for beneficiaries and their families and caregivers. This education will include statewide dissemination of written materials, website information, community education, and media events. Examples of educational efforts are upcoming presentations on "My Health, My Medicare" at the 2007 Nebraska Ombudsman & SMP Volunteer Conference and the 2008 Nebraska Governor's Conference on Aging.

The Nebraska SMP, through Nebraska's Long Term Care Ombudsman Program and Nebraska's AAAs, and in partnership with Nebraska SHIIP and AARP Nebraska and other relevant agencies and organizations will continue to provide statewide education for Nebraskans on how to identify, report and prevent Medicare and Medicaid fraud, error and waste. The Nebraska SMP will continue to be an active partner of both the Nebraska Medicare Drug Coalition and the Nebraska Medicare Coalition (sponsored and coordinated by Nebraska SHIIP), working together to provide Medicare information and assistance to Nebraskans in the most effective, comprehensive and efficient way possible.

Emergency Preparedness Plan

Information obtained from the State of Nebraska Emergency Operations Plan

The primary responsibility for the safety and welfare of the residents of the State of Nebraska and its political subdivisions rests with the respective governments. To fulfill this responsibility, various government entities must individually, and where possible, jointly implement procedures to insure that proper emergency actions are taken in a timely manner to provide support and assistance to the population affected.

It is the policy of the State of Nebraska to initially respond to the effects of a disaster with local and state resources, quasi-public resources and those available from the Federal government without the declaration of a Major Disaster.

Local governments are responsible for emergency planning to ensure that the best possible use is made of all existing resources for disaster response and recovery efforts. In order to ascertain whether planning has been adequate, local government will have a jurisdiction-wide, progressive and comprehensive training and exercise program covering direction and control coordination, and functional areas. The evaluation process will determine the need; assign the responsibility and timeline for changes to local emergency plans.

When a disaster occurs, local government must take immediate and effective actions to alleviate suffering and protect life and property. It is the responsibility of local government to develop capabilities that will provide for emergency operations during disasters. Local government is responsible for the development of an organization with a well-trained emergency staff and for providing relief and recovery assistance to the limits of their capability.

The Nebraska Emergency Management Act of 1996 as amended outlines the organization of State government with respect to preparing for and operating under disaster conditions.

The Governor holds the supreme executive power in the State, and has the responsibility to meet the dangers to the State and its people caused by disasters. In the event of a disaster beyond local control, the Governor may assume direct operational control and may issue proclamations and make, amend, and rescind orders, rules, and regulations to carry out the Nebraska Emergency Management Act. State agency heads will be directed by the Governor to utilize facilities of the State to the maximum extent practicable.

Various agencies within State government have Emergency Support Functions (ESF's) in addition to normal responsibilities. State agencies may be requested or required to be involved in disaster related activities. State statutes mandate specific agencies to perform an active role in emergency response or support. The responsibility to develop and maintain necessary procedures to meet emergency responsibilities rests with each agency.

As part of the Nebraska Department of Health & Human Services, the State Unit on Aging Administrator's task assignments include, but are not limited to the following.

- Collect facts and make studies of conditions and problems pertaining to the general welfare of the elderly in the state.
- Serve as central agency and advisory department for information on the elderly between federal, state, local government agencies, and private organizations.
- Coordinate and cooperate with government agencies of all levels in administering and supervising programs and services designed for the elderly.
- Evaluate the effects of disaster on the elderly and make reports and recommendations to the Governor on activities needed to promote the general welfare of the aging.

A primary responsibility at all levels of government is to insure that all possible measures are taken to protect the citizens in the advent of potential or actual disaster. In addition to normal emergency services, there are two major areas for government action.

1. Warning and Emergency Public Information: Warning the public is accomplished through a combination of methods depending on the specific situation. Methods include sirens (outdoor warning), radio, television, and the cable television system utilizing multilingual personnel where necessary. Media based warnings may include the nature and duration of the threat and may provide information or advice on the proper actions to take.
2. Evacuation: When time permits or when continued presence in the vicinity of a hazard effect poses a threat to the life and safety of the citizens affected, an evacuation may be ordered.

Each department, agency or organization with responsibilities under the Plan, are also responsible for insuring that its personnel are adequately trained and capable of carrying out their required tasks. This includes staff of the State Unit on Aging and the Area Agencies on Aging.

Each agency will assess training needs and insure that formal emergency management training programs are made available to personnel involved in disaster response.

Training and exercises will be consistent with the State's and agencies five year Homeland Security Exercise Plan.

As part of the Nebraska Health & Human Services System, the State Unit on Aging falls under the Nebraska Pandemic Influenza Prevention and Control Guidelines, a copy of this plan is included in this document as Appendix D. The State Unit on Aging Administrator will continue to include staff as part of the Bioterrorism Preparedness and Response Planning Team.

Each Area Agency on Aging shall have on file and submit a copy to the State Unit on Aging, a current plan for the services to the elder during disasters, including, but not limited to, tornado (high winds), chemical, nuclear, flood, and blizzards. As part of the plan for services to the elderly during disasters, a copy of the Pandemic Flu Plan, showing how each Area Agency on Aging will recognize the different disaster response strategies to an infectious disease occurrence vs. a response to a natural disaster. Importance will be shown to ensure that the Pandemic Flu Plan addresses issues such as communication, assessment, surveillance, staff training, and the coordination of resources. The plan shall show the coordination with Civil Defense and Red Cross and its pyramid alert system, including notification of the disaster coordinator.



Transportation Coordination

The State Unit on Aging and Nebraska's Aging network has long recognized the importance of access services. Transportation was one of the first services developed with the original Older Americans Act funding. Our eight Area Agencies on Aging helped develop most of Nebraska's Rural Public Transit Systems. Many of these systems still operate from the local senior center. However, as Federal Public Transit funds became available, these public transit systems applied for operational and vehicle replacement assistance. Currently, only a modest amount of Older Americans Act funds are used for transportation services in our State.

Preparations for the White House Conference on Aging and our community forums have shown the importance of transportation services to our service population. Transportation needs highlighted include:

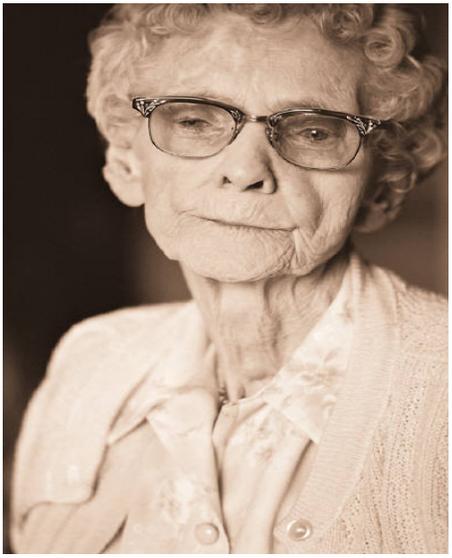
1. need for transportation during public transit off-hours (evening and weekend),
2. increased support for medical transportation, and
3. need for escorts by transit systems.

The State Unit on Aging maintains its involvement with the State Department of Roads regarding transportation issues. This involvement includes serving on the Governor's Transportation Coordination Initiative. This group's goals are similar to the President's United We Ride campaign. Significant activities and direction include:

1. A statewide survey of Rural Public Transportation was completed in 2005. Another survey focused upon resources within Nebraska that provide transportation services (completed in March 2007). These surveys are the necessary preparation to develop a plan of service coordination.
2. Promotion of transportation coordination will focus on the experience of two cities (Kearney and Grand Island). Both are medium-sized Nebraska cities. Each city serves as a regional center for shopping and medical services. Nebraska's Best Practice model of coordinated transportation resides in Kearney. Currently, the City of Kearney has developed a brokered transportation system. Their R.Y.D.E (Reach Your Destination Early) is the result of years of local discussion. Kearney's system's success has encouraged the neighboring City of Grand Island to move along a similar

path. The success of Kearney and Grand Island will be the examples the Governor's Workgroup expect to build upon in developing more coordinated transportation systems in Nebraska.

The State Unit on Aging discussed with potential partners the degree of interest in a closer examination of transportation needs of seniors and available transportation options. Positive interests lead to the development of our proposal to develop a Senior Mobility Coalition. This idea was submitted as a grant to the National Center on Senior Transportation.



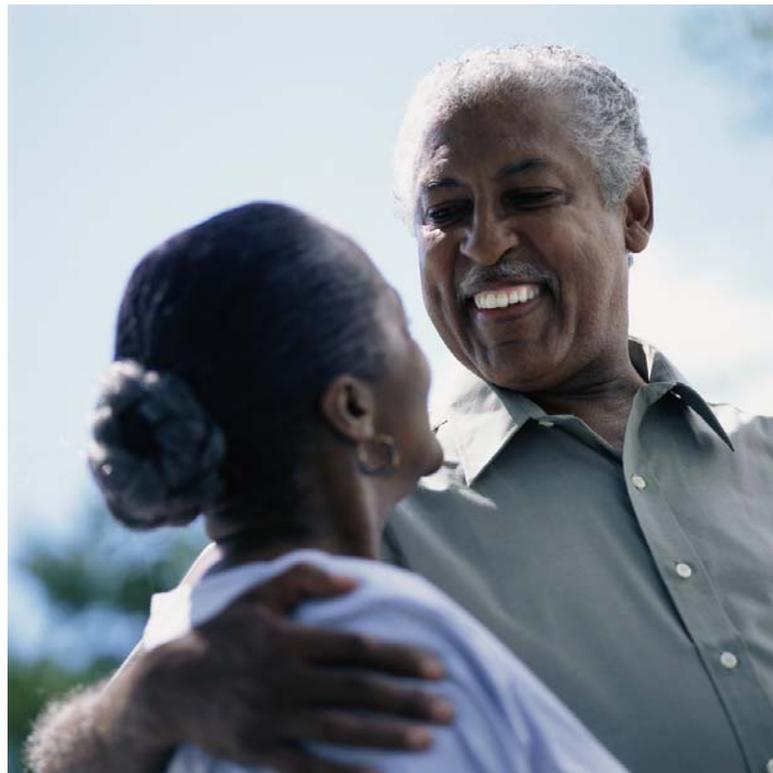
Nebraska's Significant Activities

- **The Alzheimer's Grant Project** - Nebraska is in the seventh year of their Alzheimer's Disease Demonstration Grant to the States. The grant provides consumer directed services to the caregivers of individuals experiencing Alzheimer's disease. This project was selected to be one of the Choices for Independence Champions featured on the Administration on Aging's website during Older Americans month. Partners in this project have been the Eastern Nebraska Office on Aging, Midlands Alzheimer's Association, University of Nebraska-Omaha Gerontology Program, Catholic Charities and Very Special Arts.
- **The Seniors Farmers' Market Program** - In collaboration with the Department of Agriculture, this program provides older adults who are income and age eligible, coupons, which can be used to purchase fresh produce at local Farmers' Markets across the state. In FY06, the program was able to serve over 6,919 older adults.
- **Arthritis Self Help Management** - A partnership with the Nebraska Arthritis Program, the Nebraska Chapter of the Arthritis Foundation, and the State Unit on Aging, was created to provide training for individuals in the Aging Network to become leaders in the Arthritis Foundation Exercise Program and the Arthritis Foundation Self Help Program. These programs are currently being offered through select senior centers across the state.
- **Diabetic Retinopathy** - Funded through a Healthy Vision grant, the State Unit on Aging collaborated with the State Diabetes program to heighten awareness about the importance of eye care for older adults with diabetes and strengthen the knowledge base for older adults as well as health educators on the principles of good diabetes management.
- **Nebraska Caregiver Coalition** - The State Unit on Aging was a founding member of the Nebraska Caregiver Coalition, which includes twenty-two member organizations. Recently the Coalition was one of twenty nation-wide selected to participate in the project "Building Sustainable Care giving Coalitions" which will provide training and funding over the next year.
- **Governor's Conference on Aging** - The 22nd Governor's Conference on Aging was held in Kearney, Nebraska at the Holiday Inn Conference Center. There were 35 sessions providing information on health & wellness, finances, Medicare Part D, cultural diversity, as well as many other interesting presentations. Governor Heineman and his wife, Sally Ganem, attended the conference. Over 260 people, consisting of Older

Nebraskans and professional staff that work with older adults, attended the conference.

- **Nebraska Elder Rights Coalition** - The Elder Rights Specialist in the State Unit on Aging facilitated the development of the Nebraska Elder Rights Coalition, in order to identify issues of concern to older adults and discuss possible strategies to address or resolve them. The Coalition is composed of representatives from the State Unit on Aging, the Area Agencies on Aging, Legal Service organizations, advocacy organizations, the academic community, and others. Priority issues were identified as the provision of legal services to older Nebraskans and the protection of vulnerable adults from financial exploitation.
- **6th Annual Ombudsman and SMP Volunteer Conference** - During FY 06, the Ombudsman Program held a statewide conference for volunteers providing training on healthcare fraud, aging, and advocacy issues and recognizing 78 volunteers for their outstanding efforts on behalf of older Nebraskans and those residing in long-term care facilities.
- **“Own Your Future” Long Term Care Planning Campaign** - As part of Nebraska’s Medicaid Reform efforts, the State Long Term Care Ombudsman chaired a workgroup that facilitated Nebraska’s selection as one of six states participating in the U.S. Department of Health & Human Services “Own Your Future” Campaign, which encourages personal responsibility in planning for future long-term care needs and provides consumers with useful resources, including Nebraska’s Long Term Care Planning website www.answers4families.org/lcplanning. As of April 2007, over 14,500 Nebraskans had ordered the “Own Your Future” Tool Kit and Nebraska’s website had over 7,200 hits.
- **Nebraska Medicare Prescription Drug Coalition** - The Nebraska Ombudsman Program is a core member of the Coalition, which includes representatives from public and private agencies and organizations. During FY 06, Ombudsman staff and volunteers actively participated in a statewide effort to increase public awareness of the Medicare Prescription Drug Program and, through Nebraska SMP educational materials, of Part D related scams. This included dissemination of written information, web casts and satellite conferencing, education and enrollment sessions and a website www.answers4families.org/medicare/coalition.html.
- **Remaking Nebraska Medicine** - During FY 06, Nebraska’s Ombudsman Program was a core member of the planning team for Nebraska’s “Remaking American Medicine” educational effort, which included production of a Nebraska Public Television special as an

adjunct to the national series, radio spots and a website with consumer information and resources at http://netnebraska.org/television/news/ne_connects/index_remaking_ne_rx.html.



Additional Provisions & Requirements

Financing the Services

Nebraska is not submitting any changes to its intrastate funding formula previously approved. We are including a copy of our current allocation plan for the Area Agencies on Aging. The Federal funding for Nebraska has basically remained flat for several years. We are not anticipating the funding will be different for the next four years. However, the plan will be amended if significant changes are made regarding the funds Nebraska receives.

Area Agencies on Aging are required to budget a minimum 15% of their Title III B dollars for Access Services as well as 15% for In-Home Services. The requirement for Legal Services under this title is 2%. The area agencies are monitored to ensure that the amounts budgeted are actually expended for these mandatory programs.

Intrastate Funding Formula

The State Unit on Aging grants State & Federal funds to the Area Agencies on Aging to support local programs and services. The State Unit on Aging administers Title III, Title VII Older Americans Act Funds, as well as funds from the Nebraska Community Aging Services Act and Care Management Funds.

Funding is allocated to the Area Agencies on Aging through an Intrastate Funding Formula that is developed in accordance with guidelines issued by the United States Assistant Secretary for Aging for the Administration on Aging. The funding formula cannot be changed without a public hearing and input from the Area Agencies on Aging.

Formula is weighted to emphasize low-income persons 60 years, older, elderly 75+, and elderly minorities 60+.

Each Area Agency on Aging receives a base that is 1/8 of the first \$2,104,440. The balance up to \$4,975,038 is weighted as follows:

60+ population = 60%
60+ poverty = 20%
60+ minority = 20%

Total funds that exceed \$4,975,038 are weighted as follows:

60+ population = 50%

75+ population = 25%

60+ poverty = 25%

CASA funds are distributed on 75+ populations in each PSA.

The Aging Network in Nebraska provides services to 60+ minority and poverty persons at levels greater than their proportion in the total populations. This indicates that the current Intrastate Funding Formula distributes funds in an equitable manner.

Different sources of Funding under Title III of the Older Americans Act include:

- Title III-B-Supportive Services
- Minimum of 15% of all allocation must be used for Access Services.
- Minimum of 15% of allocation must be used for In-Home Services.
- Minimum of 2% of allocation must be used for Legal Services.
- Title III-C-1-Congregate Meal Programs
- Title III-C-2-Home Delivered Meal Programs
- Title III-D-Preventative Health
- Title III-E-Family Caregivers Support
- Title VII- Ombudsman & Elder Abuse

Interstate Funding Formula Numerical Statement

The State Unit on Aging distributes State Community Aging Services Act (CASA) and Federal Administration on Aging (AoA), and Title III funds using the following formula:

Note: Except for the “base” computation (Part A-1), all percentages are applied to each area agency’s Planning and Service Area population category which bears the same ratio to that total categorical population of the state.

Part A

Title III-B, III-C(1), III-C(2), III-D, III-E, Federal Funds and State match.

A-1. Initial allocation of Title III-B up to \$1,921,424; Title III-C(1) up to \$2,414,224; Title III-C(2) up to \$473,650; Title III-D up to \$37,190; and Title III-E \$128,550. (Total \$4,975,038)

Base	42.30%
60+ Population	34.62%

60+ Poverty	11.54%
60+ Minority	11.54%

A-2. Additional Allocation above \$4,975,038.

60+ Population	50.00%
75+ Population	25.00%
60+ Poverty	25.00%

Part B

The Nebraska Community Aging Services Act (CASA) non-discretionary State Funds.

B-1. Initial allocation of CASA at \$494,295:

BRAAA	\$ 44,515
ENOA	\$ 76,865
LAAA	\$ 58,644
MAAA	\$ 64,563
SCNAAA	\$ 24,825
AOWN	\$ 36,131
NENAAA	\$114,873
WCNAAA	\$ 73,879

B-2. Additional allocation of CASA above \$494,295:

60+ Population	50.00%
75+ Population	25.00%
60+ Poverty	25.00%

Note:

1. Any Area Agency on Aging (AAA) may request carryover generated under Part “A” which does not exceed 10% of Part “A” funds allocated by formula to that AAA. The State Unit on Aging will recapture all non-obligated funds annually and award the requested (10%) funds under the following years approved plan.
2. Any carryover which exceeds 10% of Part “A” for that AAA will be recaptured by the State Unit on Aging and distributed at its discretion.

Note: Each fiscal year, the State Unit on Aging spends an amount equal to not less than 105% of the amount expended for such services (including amounts expended under Title V and Title VII) in fiscal year 1978 to provide services to older individuals who reside in Nebraska’s rural areas.

NEBRASKA HEALTH & HUMAN SERVICES-DIVISION ON AGING SERVICES							NDOA-2007	-PI-09	
RESERVATION TABLE AND PRIORITY SERVICE MINIMUMS							June 1, 2007		
FOR THE YEAR ENDING JUNE 30, 2008									
AREA AGENCY	TITLE III-B	TITLE III-C(1)	TITLE III-C(2)	TITLE III-D	TITLE III-E	CASA	TOTAL RESERVATION TABLE	CARE MANAGEMENT	CARE MGMT CASA BASE
BLUE RIVERS	\$185,378	\$227,146	\$86,243	\$4,833	\$88,086	\$287,101	\$878,787	\$141,567	\$0
EASTERN	593,668	726,139	315,550	8,506	352,315	1,074,836	\$3,071,014	577,399	28,645
LINCOLN AREA	317,885	388,653	174,012	3,661	197,657	663,596	\$1,745,464	318,480	19,000
MIDLAND	208,750	255,678	100,360	4,868	104,978	337,670	\$1,012,304	161,208	0
SOUTH CENTRAL	190,794	233,762	89,369	4,867	91,740	285,960	\$896,492	144,935	40,000
WESTERN (AOWN)	199,058	244,036	88,645	5,891	87,518	256,108	\$881,256	163,313	0
NORTHEAST	299,597	366,214	166,393	3,026	190,553	604,218	\$1,630,001	295,637	33,271
WEST CENTRAL	201,870	247,372	93,428	5,348	95,053	280,250	\$923,321	132,743	0
TOTAL	\$2,197,000	\$2,689,000	\$1,114,000	\$41,000	\$1,207,900	\$3,789,739	\$11,038,639	\$1,935,282	\$120,916
PRIORITY SERVICE MINIMUMS									
	ACCESS	IN-HOME	LEGAL						
			SERVICES						
	15%	15%	2%						
BLUE RIVERS	27,807	27,807	3,708						
EASTERN	89,050	89,050	11,873		NOTES				
LINCOLN AREA	47,683	47,683	6,358						
MIDLAND	31,313	31,313	4,175						
SOUTH CENTRAL	28,619	28,619	3,816						
WESTERN (AOWN)	29,859	29,859	3,981						
NORTHEAST	44,940	44,940	5,992						
WEST CENTRAL	30,281	30,281	4,037						

Serving Low-Income Minority and Older Nebraskans with Limited English Proficiency

The State Unit on Aging estimates that there were 1,883 low-income minority and older Nebraskans with limited English proficiency who received services in 2005. These are the most current figures available for providing services to these older individuals.

The methods used to satisfy the service needs of the low-income minority and individuals with limited English proficiency are as follows:

- Senior Centers are located in urban neighborhoods; the larger communities are where the concentration of low-income minority and older Nebraskans with Limited English Proficiency reside.
- The Area Agencies on Aging work with community organizations to increase awareness of available aging support services. Service intensity is higher for minority and limited English proficiency populations than the general population.
- Collaboration with minority neighborhood groups to develop local resource directories will be a continuing process. The directories will be developed in both English and Spanish.
- The Area Agencies on Aging serving Nebraska's two largest communities will hire staff to increase their outreach to specific minority populations. Contracts with community organizations that serve low-income neighborhoods will continue. Staff of the Area Agencies on Aging will be placed at community organizations serving minority and limited English proficiency populations.

The State Unit on Aging requires the Area Agencies on Aging to implement additional methods and activities to provide and/or increase outreach, information and assistance and other Title III services that are not now available to the Native American tribes in their Planning & Service Area. The initiative will help ensure that Native American's who are 60+ receive services, programs and benefits funded through Title III of the Older American's Act. The State Unit on Aging will work with the Area Agencies on Aging to determine methods that can be best utilized to increase access to Title III services for Native Americans who are 60+ and their spouses. Non-Indians living on the reservations currently receiving meals at the Title VI site are reimbursed for the meals by the Title III program.

Services in Rural Nebraska

The state of Nebraska is considered a rural state, with 93 counties in which 90 of these counties are in the rural area. Six of the eight Area Agencies on Aging provide services entirely to these rural areas. The other two Area Agencies provide services to both the urban and rural areas. The State Unit on Aging estimates that of the 36,000 clients who received services in FY 06 nearly 2/3 resided in rural Nebraska.

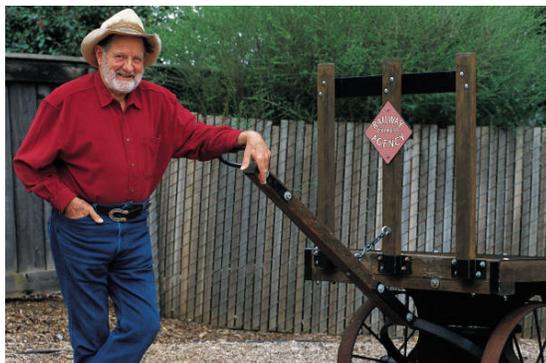
Two-hundred and five of the two-hundred and forty nine senior centers are located in Nebraska's rural counties. These senior centers provide a focal point for aging services in rural areas across Nebraska.

Nebraska's Care Management Program has provided a means of addressing the need for the coordination of long-term care in rural communities. Care Management is a service that assists individuals who live in these rural areas to organize the community's service resources so they may remain in their homes and delay premature entry into nursing homes.

The Nebraska Department of Health & Human Services State Unit on Aging will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

The projected amount of cost for services for FY 08 - FY 11 utilizing Title III funding are as follows, noting this information is based on funding available from Federal, State and Local funds:

FY 08	\$ 11,038,639
FY 09	\$ 11,204,218
FY 10	\$ 11,540,034
FY 11	\$ 11,711,513



Mental Health

At the State level, in coordination and collaboration with the Nebraska Division of Behavioral Health, the Nebraska State Unit on Aging plans to continue efforts to increase public awareness of mental illness and its impact on older Nebraskans, remove barriers to mental illness diagnosis and treatment and coordinate mental health services, including screenings. In addition, the State Unit on Aging will continue to work in partnership with Behavioral Health to identify systemic problems and concerns regarding mental illness in older adults and to identify solutions and preventative strategies.

For example, the State Long Term Care Ombudsman serves on the newly formed Behavioral Health multidisciplinary workgroup to address concerns regarding long-term care facilities and services for residents with a mental illness diagnosis. The Ombudsman also serves on the Region V Behavioral Health Advisory Committee. A representative of the State Unit on Aging also serves on the Nebraska All-Disasters Mental Health Committee, to continue to develop plans for meeting the mental health needs of Nebraskans, in the event of a disaster. The Ombudsman is also a member of an Advisory Committee to Nebraska Advocacy Services, the identified state advocacy agency for persons with disabilities. The two programs work together to advocate for and on behalf of individuals with disabilities, including mental illnesses, who reside in long-term care facilities, helping to ensure their rights are protected and their needs are met.

The State Unit on Aging received an Alzheimer's Demonstration grant from the Administration on Aging for fiscal year 2007 in order to develop a demonstration program that included a series of four mental health seminars, consisting of four sessions each at four different Adult Day Care sites in the Omaha metropolitan area. These sessions were designed to provide information and support for caregivers on various topics, including stress, family conflict, end-of-life planning, and caregiver resources. The State Unit on Aging has submitted a proposal to the Administration on Aging for an Alzheimer's Demonstration grant for fiscal year 2008 in order to develop a program to support individuals with early onset Alzheimer's disease and their caregivers. The proposed program would again include mental health support for both the individuals and their caregivers, as well as information on legal and financial planning.

At the local level, Nebraska Area Agencies on Aging plan to continue to coordinate services with their Regional Behavioral Health Systems, as well as local behavioral health service providers, working to ensure the mental health needs of

older Nebraskans are met and concerns are addressed. This includes access to services (e.g. transportation), information, assistance, and outreach. On an individual basis, Medicaid Service Coordinators and Care Managers work together with local Behavioral Health providers to provide mental health services for their clientele. As another example, the Lincoln Area Agency on Aging operates the Harvest Project in conjunction with two behavioral health providers, working to meet the needs of low-income and homeless older adults with mental health and/or substance abuse problems. Nebraska's Area Agencies on Aging also provide cross-training opportunities, so that AAA staff are familiar with the programs and services offered by the Behavioral Health regions and mental health providers and these individuals are also familiar with the programs and services offered by the AAAs.

A recent meeting involving representatives of both Behavioral Health and the Ombudsman Program served to launch plans for on-going collaboration between the two programs at the Local level, especially the development of cooperative efforts with Nebraska Behavioral Health Regions' Emergency Services and Consumer Services programs. Ombudsman staff and volunteers continue to work with the increasing numbers of individuals residing in long-term care facilities who have mental health needs.



Volunteers

The Nebraska State Unit on Aging and the Nebraska Area Agencies on Aging will continue to make use of qualified and trained volunteers to assist in the provision of direct services to older Nebraskans. In addition, the State Unit on Aging and the Area Agencies on Aging will continue to partner with other relevant agencies and organizations to help in the recruitment of volunteers, including AARP Nebraska, local service clubs and Volunteer Service Clearinghouses, as well as agencies and organizations with experience in providing training, placement and stipends for volunteers.

The Senior Corps supports significant volunteer initiatives throughout Nebraska. These programs focus on schoolchildren (Foster Grandparents), frail homebound adults (Senior Companion) and a broad variety of community organizations serving the elderly (Retired Senior Volunteer Program). The Senior Corps supports a large number of volunteers through training, appropriate placement and stipends (for low-income volunteers). The success of their Senior Companion programs led to the establishment of a modest State initiative a few years ago. Today the State program serves 17 communities (not covered by the Senior Corps). This program supports both stipend and non-stipend volunteers. The Senior Corps model has been the foundation of our State initiative.

On the State level, the Ombudsman program plans to continue to partner with AARP Nebraska to recruit volunteers for the Ombudsman and SMP programs. Currently, approximately 90% of the volunteers with these programs were recruited through an AARP Nebraska membership mailing. The Nebraska SMP also partners with Nebraska SHIP, sharing volunteers, providing cross-training for staff and volunteers of each program, facilitating volunteer participation in joint educational and media events and encouraging appropriate referrals between programs. This approach allows for maximum usage of limited resources, in order to provide the highest quality, most cost-effective services for Nebraska's Medicare beneficiaries.

The State Unit on Aging also partners with the Alzheimer's Association on a variety of projects, including the most recent Alzheimer's Demonstration Grant project. This project included training for Alzheimer's Association volunteers on the provision of peer support for caregivers. The Alzheimer's Association has a large volunteer network and an extensive experience in all aspects of volunteer training and coordination.

Aging & Disability Resource Center

The Aging and Disability Resource Center (ADRC) Grant Program, a cooperative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), was developed to assist states in their efforts to create a single, coordinated system of information and access for all persons seeking long term support to minimize confusion, enhance individual choice, and support informed decision-making.

Since 2003, 43 states have received ADRC initiative grants. The Nebraska State Unit on Aging will continue to research information regarding the possibility of applying for an ADRC grant once the request for proposals become available.

The Community Listening Sessions held in conjunction with the annual Area Agency on Aging monitoring visits was to locate potential sites for an ADRC. The sites chosen were located at a distance from the Area Agencies on Aging in communities with strong and sustainable services for seniors.

The vision the State Unit on Aging has for long-term care services in Nebraska are:

- Affordable choices and options that promote independence and dignity for individuals
- Consumer control and meaningful involvement in the design and delivery of the programs and services that affect their lives
- Information that empowers people to make informed decisions
- Easy access to a range of health, long term care and environmental supports
- Support for family caregivers
- Assurances that people are getting the highest quality care available

Information regarding applying for an ADRC grant will continue to be monitored, as the Nebraska State Unit on Aging intends to apply for and make the ADRC a reality in Nebraska.

Listing of State Plan Assurances and Required Activities Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the Area Agency on Aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the Area Agency on Aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each Area Agency on Aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the Area Agency on Aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the Area Agency on Aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the Area Agency on Aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the Area Agency on Aging, for providing services to low-income minority individuals, older individuals with

limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each Area Agency on Aging shall--

- (I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
- (II) describe the methods used to satisfy the service needs of such minority older individuals; and
- (III) provide information on the extent to which the Area Agency on Aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each Area Agency on Aging shall provide assurances that the Area Agency on Aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

- (I) older individuals residing in rural areas;
- (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV) older individuals with severe disabilities;
- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the Area Agency on Aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each Area Agency on Aging shall provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the Area Agency on Aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each Area Agency on Aging shall provide assurances that the Area Agency on Aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each Area Agency on Aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the Area Agency on Aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each Area Agency on Aging shall provide assurances that the Area Agency on Aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each Area Agency on Aging shall provide assurances that the Area Agency on Aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each Area Agency on Aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each Area Agency on Aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each Area Agency on Aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each Area Agency on Aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the Area Agency on Aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an Area Agency on Aging, or in the designation of the head of any subdivision of the State agency or of an Area Agency on Aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an Area Agency on Aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that Area Agencies on Aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the Area Agency on Aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that Area Agencies on Aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any Area Agency on Aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

- (A) public education to identify and prevent abuse of older individuals;
- (B) receipt of reports of abuse of older individuals;
- (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the Area Agency on Aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the Area Agency on Aging, or available to such Area Agency on Aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that Area Agencies on Aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an Area Agency on Aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that Area Agencies on Aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

**Sec. 308, PLANNING, COORDINATION, EVALUATION,
AND ADMINISTRATION OF STATE PLANS**

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

**Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as
numbered in statute)**

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, Area Agencies on Aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with Area Agencies on Aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

- (ii) receipt of reports of elder abuse;
 - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
 - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
- (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
- (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
- (i) if all parties to such complaint consent in writing to the release of such information;
 - (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
 - (iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

- (1)(A) The State Agency requires each Area Agency on Aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
- (B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any Area Agency on Aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an Area Agency on Aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

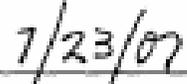
(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an Area Agency on Aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the Area Agency on Aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or Area Agency on Aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or Area Agency on Aging.


Signature and Title of Authorized Official


Date

ATTACHMENT B

STATE PLAN PROVISIONS AND INFORMATION REQUIREMENTS

The following provisions and information requirements are listed in the indicated sections of the Older Americans Act, as amended in 2006. State Plans may address the provisions and information requirements in a format determined by each State.

Section I. State Plan Information Requirements

Information required by Sections 102, 305, 307 and 705 that must be provided in the State Plan:

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))

The term “in-home services” includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

See pages 11-17

Section 305(a)(2)(E)

provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

See pages 54-55

Section 306(a)(17)

Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

See pages 42-44

Section 307(a)

(2) The plan shall provide that the State agency will:

(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306

(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (*Note: those categories are access, in-home, and legal assistance*).

See pages 77-78

Section 307(a)(3)

The plan shall:

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); (*Note: the “statement and demonstration” are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area*)

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

See pages 50-55

Section 307(a)(8) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

See pages 16-17 & 77-78

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

See page 55

Section 307(a)(21)

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title (*title III*), if applicable, and specify the ways in which the State agency intends to implement the activities .

See page 54

Section 307(a)(28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State’s statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

- (i) the projected change in the number of older individuals in the State;
- (ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
- (iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
- (iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

See pages 21-22

Section 307(a)(29)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

See pages 42-44 & 110-154

Section 307(a)(30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency

preparedness plans, including the State Public Health Emergency Preparedness and Response Plan. *See pages 42-44 & 110-154*

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social

service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

See pages 107-109

Direct Delivery Service Waiver Criteria

Area Agencies wanting to provide direct delivery of service must complete the Direct Delivery of Service form. The form must include state-developed criteria for evidence that will support a direct service waiver request. Services that do not require a waiver include Information Assistance, Care Management, Outreach and Ombudsman. Criteria for evidence that will support a direct service waiver request are as follows:

1. Assure an Adequate Supply of Services

Criteria that will support a direct service waiver request to assure an adequate supply of services includes the following:

- A. Public notice with required language in a newspaper in the planning and service area and at least one of the following in each county in the planning and service area:
 - 1) Press releases provided to the official county newspaper;
 - 2) Evidence of public notice given at a county board meeting;
 - 3) Minutes of a county human service coordinating organization in which notice of the need for service providers is given; or
 - 4) Direct notification via the mail to potential providers in the area.

2. Services Related to the Area Agency on Aging's Administrative Function

Services that fall into this category should include; Education and Training, Public Information, General Information and Publication.

- A. A written description, with supporting documentation if available, of how the services is related to the agency's administrative function and how that function would be affected by contracting the services.

3. Provide Services of Comparable Quality More Economically

Criteria that will support a direct service waiver request to provide services of comparable quality more economically include the following:

- A. A determination in writing by the AAA comparing the quality of the service currently being provided by the AAA and the service proposed by provider submitting a written proposal to the AAA showing the proposed services are of lesser quality, or
- B. A determination in writing by the governing board of the AAA comparing the efficiency of the service currently being provided by the AAA and the

service proposed by provider submitting a written proposal to the AAA showing the proposed services provider is less efficient.

In addition to providing justification for providing services directly based upon efficiency or effectiveness, the waiver request must include:

1. documentation that a public hearing occurred;
2. evidence that all interested parties within the area had been notified of and provided an opportunity to testify at the public hearing; and
3. a record of the notification process; and
4. if the waiver request is ongoing from year to year, documentation that potential service providers in the area have been notified, either directly via the mail or by issuing a Request for Proposals at least once every four years. (This will not be required for FY-07, but will be required for the FY-08 plans.)

The State Unit on Aging reviews each direct service waiver request for compliance. If compliance has been met, the State Unit on Aging provides public notice for the intent to grant a waiver for direct delivery of service.

Six of Nebraska's eight area agencies on aging received a direct service waiver for Access services, two of the eight area agencies on aging received a direct service waiver for Legal services and three of the eight area agencies on aging received a direct service waiver for In-home services for FY 08.

The minimum funds from Title III-B that can be budgeted for direct service waivers are:

Access Services	15%
In-home Services	15%
Legal Services	2%

DEFINITIONS, ACRONYMS AND ABBREVIATIONS USED IN THE NEBRASKA AGING NETWORK

AAA: Area Agency on Aging.

AARP: American Association of Retired Persons.

Access services: Services associated with access to services such as information and assistance, transportation, outreach, and case management.

Activities: Actions taken in support of an outcome.

Activities of Daily Living: (ADL's): Basic activities essential to living independently, such as eating, walking, the ability to transfer oneself from one place to another, bathing, and toileting.

Adult Protective Services: The Nebraska Adult Protective Services Act was enacted to help remedy abusive situations. The Adult Protective Services (APS) Program of the Nebraska Department of Health & Human Services enforces the Act.

Advocacy/Representation: Representing and actively promoting the interests of another.

Aged and Disabled Medicaid Waiver: See **Waiver, Aged and Disabled**.

Ageing Network: A highly complex and differentiated system of federal, state, and local agencies, organizations, and institutions responsible for serving and representing the needs of older persons.

Administration on Aging (AoA): The principal federal agency responsible for programs authorized under the Older Americans Act of 1965.

Area Agency on Aging (AAA): Public or private agencies responsible for developing and administering a comprehensive and coordinated system of services to meet the needs of older people in a specific geographic area. Nebraska has eight (8) Area Agencies on Aging created by interlocal agreements:

- ↪ Aging Office of Western Nebraska (AOWN), located in Scottsbluff
- ↪ Blue Rivers Area Agency on Aging (BRAAA), located in Beatrice
- ↪ Eastern Nebraska Office on Aging (ENOA), located in Omaha
- ↪ Lincoln Area Agency on Aging (LAAA), located in Lincoln
- ↪ Midland Area Agency on Aging (MAAA), located in Hastings
- ↪ Northeast Nebraska Area Agency on Aging (NENAAA), located in Norfolk
- ↪ South Central Nebraska Area Agency on Aging (SCNAAA), located in Kearney

↪ West Central Nebraska Area Agency on Aging (WCNAAA), located in North Platte

Assistive Technology: A program operated through the Nebraska Department of Education that provides technology and home modification information and services.

Benefits Counseling: Program which provides information and counseling to older Nebraskans regarding Medicare, Medicaid, and health insurance. Provided in Nebraska by the Department of Insurance through its Nebraska Insurance Counseling & Assistance (NICA) program.

Centers for Medicare & Medicaid Services: (CMS): Formerly known as the Health Care Financing Administration (HCFA). It is the federal agency that provides health care funding and regulates the provision of health care. Also administers the Medicare program and is the primary federal agency administering Medicaid programs.

CHOICES (Choosing Home or In Community Elder Services): A combination of three programs (Aged and Disabled Waiver, Care Management, and Senior Care Options) which work together to assure that older Nebraskans receive the right services at the right time through case management, assessment, and planning.

Community Aging Services Act (CASA): Nebraska statutes passed on July 17, 1982 which created the Nebraska Department on Aging, which is now the Nebraska State Unit on Aging.

CONNECT (Coordinating Options in Nebraska's Network Through Effective Communications and Technology): An automated client tracking system used by a number of HHSS programs, including the Aged and Disabled Waiver. Senior Care Options will also eventually use CONNECT.

DRI: Dietary Reference Intake (as established by the Food & Nutrition Board of the Institute of Medicine, National Academy of Sciences), include daily nutrient recommendations for healthy Americans based on age and gender.

Focal Point: A facility established to encourage the maximum collocation and coordination of services for older individuals. Usually housed in a senior center.

FY: Fiscal Year. The state fiscal year begins July 1; the federal fiscal year begins October 1. Most other governmental units, such as cities and counties, also have their own FYs.

Greatest Economic Need: Those elderly participants whose needs are the result of income levels at or below the poverty threshold established by the U.S. Bureau of the Census.

Greatest Social Need: Those elderly participants whose needs are associated with non-economic factors, including physical and mental disabilities, language barriers, cultural or social isolation caused by racial or ethnic status, which restrict an individual's ability to perform normal tasks or threatens one's capacity to live independently.

Food Insecurity: Limited or uncertain access to nutritious, safe foods necessary to lead a healthy lifestyle.

HHS: The U.S. Department of Health and Human Services.

DHHS: Nebraska Department of Health and Human Services

HUD: U.S. Department of Housing and Urban Development.

In Home Services: Services designed to assist older persons to be able to stay in their own homes. These services include such things as handyman, chore, personal care, and homemaker.

Instrumental Activities of Daily Living (IADL's): Tasks requiring the completing of a series of actions in sequence, such as using the telephone, shopping for groceries, preparing meals, doing housework, managing medications, and managing money.

Interlocal Agreements: Agreements authorized by state statute which permit local governmental units to make the most efficient use of their powers by enabling them to cooperate with other local governmental units on a basis of mutual advantage to provide services.

Intrastate Funding Formula: A legally required, state-determined algorithm which governs the distribution of Older Americans Act funds to Area Agencies on Aging in the state of Nebraska. The algorithm helps to insure that funds are distributed equitably and are targeted to areas and groups in greatest need.

Legal Assistance: Provision of legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.

Long-Term Care: The range of formal and informal services provided to individuals who have lost or are otherwise lacking some capacity for self-sufficiency and who are expected to need on-going support for an extended period of time.

Long-Term Care Ombudsman Program: A program operated by the Nebraska State Unit on Aging to represent the needs and interest of present and potential long-term care facility residents.

Medicare: A federal health insurance for people 65 or older, people with permanent kidney failure, and certain disabled people under 65. It is administered

by the Centers for Medicare & Medicaid Services (CMS, formerly known as HCFA) of the U.S. Department of Health and Human Services (HHS). The Social Security Administration, also a part of HHS, provides information about the program and handles enrollment.

Medicaid: A medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 and is often referred to as “Title XIX.” It is a joint Federal—State program that reimburses providers for covered services to eligible persons. HHS and CMS administer it.

NASC: The Nebraska Association of Senior Centers.

NASUA: National Association of State Units on Aging

National Aging Program Information System (NAPIS): A reporting system containing statistical information about services funded by the Older Americans Act and used to prepare quarterly reports submitted to the Administration on Aging by the Nebraska State Unit on Aging.

Nebraska Aging Management Information System (NAMIS): An automated reporting system that collects statistical information about services funded by the Older Americans Act and used to prepare the annual State Program Report (SPR) submitted to the Administration on Aging by the Nebraska State Unit on Aging.

Nebraska Care Management Program: A program operated through the Area Agencies on Aging which assists frail, older individuals to remain in their own home for as long as possible. It provides a client assessment, care plan development, implementation and follow-up.

Senior Health Insurance Information Program (SHIIP): Agency that provides information and counseling to older Nebraskans regarding Medicare, Medicaid, and health insurance.

Needs Assessment: A systematic process of determining which services are necessary in order to maintain individuals in their homes.

Nutrition Services Incentive Program (NSIP): Formerly known as USDA. A federal program which provides funding, cash or cash and commodity allocation to a State Agency on Aging or to a Tribal organization based on the number of meals actually served in the previous year in relationship to the total meals actually served by all States or Tribes in the previous year. Formerly known as USDA.

Older Americans Act (OAA): Federal statute first passed in 1965 which provides older Americans (generally, Americans aged 60 and over) opportunities for full participation in the benefits of our society.

Outcome-Based Planning: A process in which desired results are identified and activities planned to achieve those results.

Outcomes: The result of actions taken by the aging network to improve the well being of older persons and improve the efficiency or effectiveness of the operation of the aging network.

Outreach: Activity by an agency or organization designed to identify potential clients and encourage their use of existing services and benefits.

Performance Measures: The means to determine whether services are meeting predetermined results. The focus is upon efficiency, quality and effectiveness.

Poverty Level: Household income level defined by the U.S. Bureau of the Census as the threshold for determining poverty as established by the Bureau.

Pre-admission Screening: See **Senior Care Options**.

RDA: Recommended Dietary Allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences.

Respite: A program that offers a caregiver (of an older person) time off on a regularly scheduled or by-request basis. This type of care, which is often companionship, can be offered in the older person's home, in the home of the respite worker or in a community or in a community (or Senior Center). It can be paid or unpaid.

Rural: All territory not defined as urban (see **Urban**).

Senior Care Options (SCO): Nebraska's pre-admission screening program for Medicaid-eligible persons aged 65 and older which determines the need for nursing facility care and offers alternative services.

Senior Center: A community facility for the organization and provision of a broad spectrum of services for older persons, including, but not limited to: health, social, meals, educational, and recreational services.

Service Provider: An entity that is awarded a subgrant or contract from an Area Agency on Aging to provide services under the area plan.

Social Service Block Grant: a part of the Social Security Act formerly known as Title XX which provides block grant funds to the Nebraska Health and Human Services System (HHSS) to provide services to low-income people. Such services as chore, meals, homemaker, day care, and transportation can be provided by HHSS. Nebraska designs its own mix of services within the state.

SSI: Supplemental Security Income.

State Program Reports (SPR): A report containing statistical information about long-term care ombudsman program services submitted annually to the Administration on Aging by the Nebraska State Unit on Aging.

SUA: The Nebraska State Unit on Aging.

Supplemental Security Income: A federal program operated by the Social Security Administration that provides a small monetary supplement to low-income people.

Target Population: Those most frail and vulnerable individuals aged 60 and older for whom one or more of the following is true:

- ↪ reside in rural areas;
- ↪ have the greatest economic or social needs;
- ↪ are low-income minorities;
- ↪ have severe disabilities;
- ↪ have limited English-speaking ability; or
- ↪ have Alzheimer's Disease or a related disorder or are the caregivers of such individuals.

Title III-B (Supportive Services and Senior Centers): A part of the Older American Act of 1965 (as amended) under which Area Agencies on Aging, senior center, or other service provider can provide a variety of services to older people. This title does not include the meal program.

Title III-C1 (Congregate Nutrition Services): A part of the Older Americans Act of 1965 (as amended) under which Area Agencies on Aging, senior centers, or other service providers can serve meals to older persons in a group setting.

Title III-C2 (Home Delivered Nutrition Services): A part of the Older Americans Act under which Area Agencies on Aging, senior centers, or other service providers can serve meals to an older person in their own home.

Title III-D (Disease Prevention and Health Promotion Services): A part of the Older Americans Act under which Area Agencies on Aging, senior centers, or other service providers can provide disease prevention and health promotion services.

Title III-E (National Family Caregiver Support Program): A part of the Older Americans Act under which Area Agencies on Aging, senior centers, or other service providers can provide supportive services to caregivers of older adults.

Title V (Community Service Employment for Older Americans): A part of the Older Americans Act under which Area Agencies on Aging can assist older workers.

Title VII: (Allotments for Vulnerable Elder Rights Protection Activities): A part of the Older Americans Act under which state units on aging and Area Agencies on Aging can provide information and advocacy services for vulnerable

older persons. Includes the Long-Term Care Ombudsman, Legal Assistance, Outreach, and Benefits Counseling programs.

Urban: Areas that meet at least one of following sets of criteria:

- A central place and its adjacent densely-populated territories with a combined minimum population of 50,000; or
- A census designated place such as a city or town with 20,000 or more inhabitants.

Volunteer Ombudsman Advocate Program: Volunteer advocates who are certified by the State Unit on Aging as a part of the Long-Term Care Ombudsman Program. Volunteers advocate for the rights of residents in long-term care facilities, investigating concerns related to their quality of life and quality of care. The program is operated through Area Agencies on Aging.

Waiver, Aged and Disabled: A home and community-based Medicaid-funded program for eligible persons of all ages whose care needs match those of people in nursing facilities. The individual works with a services coordinator to develop a safe and cost-effective Plan of Services and Supports which includes one or more waiver services such as adult day health service, assisted living, home care chore, home-delivered meals, home modifications, nutrition counseling, and transportation.



Public Hearing for FY 08-11 State Plan for Nebraska State Unit on Aging

A public hearing was held in Kearney, Nebraska on June 28, 2007. Members of the State Unit on Aging Advisory Committee were present as were members of the State Unit on Aging staff. Kearney was chosen for the location of the public hearing due to the fact that is in the center of the State and might encourage more participation.

A sign in sheet and copies of Public Notices printed in local newspapers are included on the following pages.

AFFIDAVIT OF PUBLICATION

State of Nebraska }
LANCASTER COUNTY, } ss.

PUBLIC NOTICE
NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES -
STATE UNIT ON AGING
STATE PLAN FOR
AGING SERVICES HEARING
The Nebraska Department of Health & Human Services - State Unit on Aging NOTICE IS hereby given that the State Unit on Aging will hold a hearing on the proposed four-year state plan for aging services on June 28, 2007, commencing at 1:00 p.m., at the Remado Inn, 301 2nd Avenue, Kearney, Nebraska.
THE PURPOSE of the hearing is to take testimony and evidence concerning the proposed state plan for aging services. The plan will be effective from October 1, 2007 to September 30, 2011.
COPIES OF THE PROPOSED STATE PLAN ARE AVAILABLE FOR PUBLIC EXAMINATION AT THE OFFICE OF THE Nebraska Department of Health & Human Services - State Unit on Aging, 301 Centennial Mall South, Lincoln, Nebraska.
All interested people are invited to attend and testify at the hearing. Interested persons may also submit written comments prior to the hearing, which will be made part of the hearing record at the time of the hearing.
Dated at Lincoln, Nebraska, this 23rd day of June, 2007.
Joann Weis, Administrator, Nebraska Department of Health & Human Services - State Unit on Aging.
#4511424 1x June 23

The undersigned, being first duly sworn, deposes and says that she/he is a Clerk of the Lincoln Journal Star, legal newspaper printed, published and having a general circulation in the County of Lancaster and State of Nebraska, and that the attached printed notice was published in said newspaper one successive time(s) the first insertion having been on the 23RD day of June A.D., 2007 ~~and thereafter on~~ _____, 20____ and that said newspaper is the legal newspaper under the statutes of the State of Nebraska. The above facts are within my personal knowledge and are further verified by my personal inspection of each notice in each of said issues.

Jill White
Subscribed in my presence and sworn to before me this _____ day of June 30, 2007
Jenna Marie Lindberg Notary Public
Printer's Fee, \$ _____ 4511424

Lines 36 Times 1 Amount \$ 18.51

AFFIDAVIT of PUBLICATION

The State of Nebraska }
The County of Buffalo } ss.

Lori Guthard being first duly sworn says that she is Advertising Manager of The KEARNEY HUB, a daily newspaper printed in whole and published in its entirety at its office maintained in Kearney, in said county and of general circulation therein and been published for more than 52 weeks in said county prior to the first publication of the annexed notice and has a bonafide circulation of more than 300 copies, and that the notice, a true copy of which is hereto annexed, was published in said paper as follows:

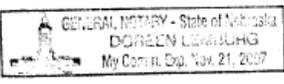
the first publication being on the 23 day of June
2007 and subsequent publication(s) on the
.....day of....., 2007
.....day of....., 2007
.....day of....., 2007
.....day of....., 2007
.....day of....., 2007

Lori Guthard

Subscribed in my presence and sworn to before me this

26 day of June, 2007

Doreen Lemburg
Notary Public.



Public Notice
Nebraska Department of Health and Human Services State Unit on Aging State Plan for Aging Services Hearing
The Nebraska Department of Health & Human Services - State Unit on Aging NOTICE IS hereby given that the State Unit on Aging will hold a hearing on the proposed four year state plan for aging services on June 28, 2007, commencing at 1:00 p.m., at the Ramada Inn, 301 2nd Avenue, Kearney, Nebraska.
THE PURPOSE of the hearing is to take testimony and evidence concerning the proposed state plan for aging services. The plan will be effective from October 1, 2007 to September 30, 2011.
COPIES OF THE PROPOSED STATE PLAN ARE AVAILABLE FOR PUBLIC EXAMINATION AT THE OFFICE OF THE Nebraska Department of Health & Human Services - State Unit on Aging, 301 Centennial Mall South, Lincoln, Nebraska.
All interested people are invited to attend and testify at the hearing. Interested persons may also submit written comments prior to the hearing, which will be made part of the hearing record at the time of the hearing.
Dated at Lincoln, Nebraska, this 23rd day of June, 2007.
Joann Weis, Administrator,
Nebraska Department of Health & Human Services - State Unit on Aging,
Je23,t1

Public Notice

Nebraska Department of Health and Human Services
STATE UNIT ON AGING
State Plan for Aging
Services Hearing

The Nebraska Department of Health and Human Services - STATE UNIT ON AGING, hereby gives notice that the State Unit on Aging will hold a hearing on the proposed four year state plan for aging services on June 20, 2007, commencing at 1:00 p.m. at the Seneca Inn, 500 2nd Avenue, Kearney, Nebraska.

THE PURPOSE of the hearing is to take testimony and evidence concerning the proposed state plan for aging services. The plan will be effective from October 1, 2007 to September 30, 2011.

COPIES OF THE PROPOSED STATE PLAN ARE AVAILABLE FOR PUBLIC EXAMINATION AT THE OFFICE OF THE Nebraska Department of Health and Human Services - State Unit on Aging, 501 Centennial Mall South, Lincoln, Nebraska.

All interested people are invited to attend and testify at the hearing. Interested persons may also submit written comments prior to the hearing, which will be made part of the hearing record at the time of the hearing.

Dated at Lincoln, Nebraska, this 20th day of June, 2007.

Jason Wells, Administrator
Nebraska Department of Health & Human Services - State Unit on Aging

Proof of publication

AFFIDAVIT

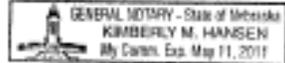
State of Nebraska, County of Douglas, ss:

Joyce Sawatzki, being duly sworn, deposes and says that he/she is an employee of The Omaha World-Herald, a legal daily newspaper printed and published in the county of Douglas and State of Nebraska, and of general circulation in the Counties of Douglas, and Sarpy and State of Nebraska, and that the attached printed notice was published in the said newspaper on the 23 day of June 2007, and that said newspaper is a legal newspaper under the statutes of the State of Nebraska. The above facts are within my personal knowledge. The Omaha World-Herald has an average circulation of 188,248 Daily and 235,161 Sunday, in 2007.

(Signed) Joyce Sawatzki Title: Account Executive

Subscribed in my presence and sworn to before me this 25th day of June, 2007.

Kimberly M. Hansen
Notary Public



Printer's Fee \$ _____
Affidavit _____
Paid By _____

Public Hearing June 28, 2007 Kearney, Nebraska
 Nebraska Department of Health & Human Services
 State Unit on Aging
 FY 2008-2011 State Plan for Aging Services

Name	Address
Penny Clark	Lincoln, NE
Cindy Kadavy	HHS Lincoln, NE
Chris Kelly	Lincoln, NE
Arthur Embrey	Holtville, NE
Robert B. Bayless	2107th St
Louis Allgayer	Elwood, NE
Clare Schmidt RYN	Grand Island, NE
JUDITH LEAFDALE	HARRISBURG, NE
Kenneth H. Niedan	Box 489, Hushey, NE 68143
Jeanne Weiss	Lincoln, NE
Quinn McLaughlin	Lincoln, NE
Janice Blue	Beatrice, NE
George J. Wagner	Hushey, NE
Shirley Hughes	Beatrice, NE

**DHHS- State Unit on Aging
Advisory Committee Meeting
June 28, 2007
Ramada Inn
Kearney, NE**

Present: Rod Hughes, Rodale Emken, Judith Leafdale, Clare Schmidt, Lou Allgayer, Ken Niedan

Absent: Kathy Strokebrand, Nancy Hanson, Wayne Garrison, Gerald Davenport, Joanne Lofton, Floyd Vrtiska,

Staff: Joann Weis, Penny Clark, Brooke Lind-Olson, Cindy Kadavy, Janice Price

Guests: Vivianne Chaumont, Medicaid and Long-Term Care Director
Chris Kelly, University of NE-Gerontology

Ken Niedan, Chairperson: Called the meeting to order and took roll.

Joann Weis: State plan goes to Kansas City August 1, and then to Washington D.C. to be approved.

Penny Clark: Talked about Sam Smith from the Kansas City Regional Aging Office visited the last week of June and looked over the State plan. He gave a few suggestions such as: the plan needs addresses and emails of the Area Agencies on Aging. In the projected numbers for changing demographics need to take out the “abouts” and “estimated” phrasing. The CHOICES portion of the plan needs to be explained more in-depth, and explain the Senior Care Options better. Need to say how we are going to achieve the goals and how. The State Unit on Aging should get a lot of credit for working hard on the plan, as well as Chris Kelly from the University of NE. The State plan is not usually looked at other than every four years. From now on it will be looked at once a year.

The emergency preparedness portion was discussed in depth. The pandemic flu insert was required by the Administration on Aging (AOA). This is a very important topic. A state-wide transportation coalition was discussed and has become a national issue. The reservation table needs the funding formula added.

The Department of Health and Human Services has a revamped website.

There is a new director at the Midland Area Agency on Aging; Diane Fowler.

Clare Schmidt: The plan was very well done, and would like to include more about Adult Day Care.

Rodale Emken: Talked about the emergency preparedness plans and used the Holdrege Ice storms as an example of their importance.

Rod Hughes: Discussed the flooding up by Norfolk and how they needed an emergency plan in place.

Vivanne Chaumont: Introduced herself as the new Director for Medicaid and Long-Term Care, and explained a little about the redevelopment.

Janice Price: The Caregiver Coalition grant that was received in 2004 formed 22 agencies statewide. We were chosen as 1 out of 20 coalitions to attend the training in Chicago.

The AAA's monitoring sessions are all finished. Community Listening sessions were held at each site, with the potential of piloting an Aging and Disability Resource Center.

Possibility that will be receiving an Alzheimer's grant to identify early on-set, and should find out soon if received it or not.

Penny Clark: The Governor's conference on Aging is to be held May 14 & 15, 2008 in Kearney, NE at either the Ramada or the Holiday Inn. The theme will be "Plan Today, Enjoy Tomorrow".

Cindy Kadavy: The May 2007 volunteer conference has 85 people attend. Some of the main topics were the aging population in correctional facilities, how prisons were not built with aging in mind, and the possibility of medical parole. Statistically 2% of the American population is incarcerated, which is about 6 million people, so the cost is astronomical. The CMS system and fraud issues were touched on. Dementia was also spoken about.

The Elder Rights Coalition is applying for a grant to expand elder legal services in the NE. We have a hot-line now, but want to expand the hours it operates.

Joann Weis: A new organizational chart for the Department of Health and Human Services will be out soon. Vivianne Chaumont keeps everyone updated very well with all the changes. There will be budget reductions and six new directors.

The next Advisory Committee meeting will be held in the Fall of 2007 in either September or October in Kearney, NE.

Rodale Emken: Motioned to approve the State 4 Yr. Plan.

Clare Schmidt: Seconded the approval of the State 4 Yr. Plan.

The motion was approved unanimously.

Meeting Adjourned.

Taxonomy Service Composite for FY 06

Information from Nebraska Aging Management Information System (NAMIS)

	Service	Units of Service
1.	Personal Care (Hour)	23,867
2	Homemaker (Hour)	93,864
3	Chore (Hour)	26,150
4	Home Delivered Meals (Meal)	907,276
5	Adult Day Care/Health (Hour)	5,755
6	Case Management (Hour)	51,242
7	Congregate Meals (Meal)	1,347,698
8	Nutrition Counseling (Session per Participant)	798
9	Assisted Transportation (1-Way Trip)	31,324
10	Transportation (1-Way Trip)	139,665
11	Legal Assistance (Hour)	3,367
12	Nutrition Education (Session per Participant)	12,471
13	Information & Assistance (Contact)	32,346
14	Outreach (Contact)	32,788
15	Health Education (Session)	17,463
16	Emergency Response System (Client-Month)	11,168
17	Employment Placement (Placement)	307
18	Financial Counseling (Contact)	8,025
19	Health Clinic (Contact)	48,739
22	Durable Medical Equipment (Contact)	692
23	Mental Health Counseling (Contact)	0
26	Respite-Home (Hour)	10,311
29	Volunteerism (Hour)	156,864
30	Home Health Aide (Visit)	0
33	Senior Care Options (Screening)	2,646
34	Medicaid Waiver CM (Client-Month)	2,460
35	Supportive Services (Hour)	168,624
36	Ombudsman/Volunteers (Contact)	5,293
37	Information Services (Activity) III-E	1,269
38	Access Assistance (Contact) III-E	11,827
39	Counseling (Session) III-E	1,689
40	Respite Care (Hour) III-E	11,954
41	Supplemental Services III-E	4,477

NEBRASKA AGING NETWORK SERVICE DEFINITIONS AND UNITS OF SERVICE

The unit for the service immediately follows the name of the service. When the unit is an hour, the State Unit on Aging requests that area agencies measure in quarter hour increments (every 15 minutes). If an Area Agency on Aging decides not to use quarter hour increments, they must use the current unit of service hourly measurement of; less than 30 minutes is 0 hours and more than 30 minutes 1 hour.

CLUSTER 1 – REGISTERED SERVICES:

1. PERSONAL CARE (1 HOUR) – Personal assistance, stand-by assistance, supervision or cues for a person with an ADL impairment.

This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up, is reported under I&A.

Activities of Daily Living (ADL) are eating, dressing, bathing, toileting, and transferring in and out of bed;

Personal assistance would be to actually assist someone with an ADL; Stand-by assistance would mean standing next to someone ready to help while someone is doing an ADL; Supervision would mean to provide instruction and assistance as needed while someone is doing an ADL; Cues would mean to give a prompt or reminder about doing or how to do the ADL;

This service is not respite;

This service is not adult day care;

This service does not include administering medication or medical treatments.

2. HOMEMAKER (1 HOUR) – Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework for a person with an IADL impairment.

This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up, is reported under I&A.

Instrumental Activities of Daily Living (IADL) are preparing meals, shopping for personal items, using the telephone, doing light housework.

The activity of managing money is limited to what is necessary to shop for personal items or prepare meals. Light housework would most often be “inside” work and includes things like dusting, vacuuming, general pick-up, making beds, clearing counter and dish washing, cleaning bathroom, the basic routing cleaning.

3. CHORE (1 HOUR) – Assistance such as heavy housework, yard work or sidewalk maintenance for a person with an IADL impairment.
This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up is reported under I&A.
Instrumental Activities of Daily Living (IADL) are heavy housework, yard work, or sidewalk maintenance.
Heavy housework would be things like cleaning when the furniture is moved, “spring cleaning” needed because client has not been able to maintain routine cleaning, and washing windows.
Chore is typically work that involves something “outside”. Things like carrying out garbage or doing yard work like mowing, trimming, etc.
Includes sidewalk maintenance like snow removal, repairing cracks, etc.
Chore also includes minor repairs and maintenance like painting, minor plumbing, banister placement, changing furnace filters, etc. Services that do not require a trained service specialist.

4. HOME DELIVERED MEALS (1 MEAL) – A meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act and State/Local laws. As noted in Section IIA, meals provided to individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals figure. Certain Title III E funded home delivered meals may also be included; see the definition of NSIP meals below.

What is an NSIP Home-Delivered meal? A Nutrition Services Incentive Program (NSIP) Meal is a meal served in compliance with all the requirements of the Older Americans Act, which means at a minimum that:

- 1) It has been served to a participant who is eligible under the Older Americans Act and has not been means-tested for participation.
- 2) It is compliant with the nutrition requirements.

3) It is served by an eligible agency.

4) It is served to an individual who has an opportunity to contribute.

Meal counts include all Older Americans Act eligible meals including those served to persons under age 60 where authorized by the Older Americans Act. NSIP meals also include home delivered meals provided as Supplemental Services under the National Family Caregiver Support Program (Title III E) to persons aged 60 and over who are either care recipients (as well as their spouses of any age) or caregivers.

5. ADULT DAY CARE/ADULT DAY HEALTH (1 HOUR) – Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health.

Key part of definition is that this is a supervised group setting.

6. CASE MANAGEMENT (1 HOUR) – Assistance in the form of access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

To be considered Case Management there must be a comprehensive assessment document completed.

End of CLUSTER 1

CLUSTER 2 – PERSONS SERVED, UNITS OF SERVICE

7. CONGREGATE MEALS (1 MEAL) – A meal provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and State/Local laws. Meals provided to individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals.

What is an NSIP Congregate meal? A Nutrition Services Incentive Program (NSIP) Meals is a meal served in compliance with all the requirements of the Older Americans Act, which means at a minimum:

- 1) It has been served to a participant who is eligible under the Older Americans Act and has not been means-tested for participation.
- 2) It is compliant with the nutrition requirements.
- 3) It is served by an eligible agency.
- 4) It is served to an individual who has an opportunity to contribute.

Meal counts include all Older Americans Act eligible meals including those served to persons under age 60 where authorized by the Older Americans Act.

8. NUTRITION COUNSELING (1 SESSION PER PARTICIPANT) – Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietician, and addresses the options and methods for improving nutrition status.

Key is “individualized”.

Health Professional by Nebraska law and policy is a Registered Dietitian or licensed Medical Nutrition Therapist (effective September, 1996 with a grandfather clause) by the American Dietitian Association (ADA) or State of Nebraska.

9. ASSISTED TRANSPORTATION (1 ONE WAY TRIP) – Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up, is reported under I&A.

Assistance is needed by the person, not just providing the transportation. Remember that each one-way trip is counted as a unit of service.

End of CLUSTER 2

CLUSTER 3 – UNITS OF SERVICE

10. TRANSPORTATION (1 ONE-WAY TRIP) – Transportation from one location to another does not include any other activity.

This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up, is reported under I&A.

Remember that each one-way trip is counted as a unit of service.

11. LEGAL ASSISTANCE (1 HOUR) – Legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.

Must be reported under Group Services in NAMIS II.

Must be an individual, one-on-one contact between a service provider and an elderly client.

12. NUTRITION EDUCATION (1 SESSION PER PARTICIPANT) - A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants and care givers in a group or individual setting overseen by a dietitian or individual or comparable expertise.

13. INFORMATION AND ASSISTANCE (1 CONTACT) – A service that:

- a. Provides individuals with information on services available within the communities;
- b. Links individuals to the services and opportunities that are available within the communities;
- c. To the maximum extent practicable, establishes adequate follow-up procedures.

Internet web site “hits” are to be counted only if information is requested and supplied.

Note that this service specifies adequate follow-up procedures. These could include that following instructions from a client for “no follow-up” is deemed adequate follow-up by the agency.

Must be an individual, one-on-one contact between a service provider and an elderly client.

Do not count an activity that involves a contact with several elderly clients or potential clients (group services). (AoA-PI-96-01)

14. OUTREACH (1 CONTACT) - Intervention with individuals initiated by and agency or organization for the purpose of identifying potential clients (or their caregivers) and encouraging their use of existing services and benefits. NOTE: The service units for information and assistance and for outreach are individual, one-on-one contacts between a service provider and an elderly client or caregiver. An activity that involves contact with multiple current or potential clients or caregivers (e.g., publications, publicity campaigns, and other mass media activities) should not be counted as a unit of service. Such services might be termed public information and reported on the public information category.

Must be an individual, one-on-one contact between a service provider and an elderly client.

Do not count an activity that involves a contact with several elderly clients or potential clients (group services). (AoA-PI-96-01)

Circulation of a publication is not outreach.

End of CLUSTER 3

CLUSTER 4 - OTHER SERVICES PROFILE

For each service listed in this CLUSTER there must be a service purpose/mission identified from a list of six possibilities:

- a. Services which address functional limitations;
- b. Services which maintain health;
- c. Services which protect elder rights;
- d. Services which promote socialization/participation;
- e. Services which assure access and coordination;
- f. Services which support other goals and purposes.

15. HEALTH EDUCATION (1 SESSION) - Any other related education that does not fall under "Nutrition Education" or "Education/Training". Also includes mental health.

Each session will be counted (not individuals in the group). These are non-individual sessions (must be group setting). Will include legal presentations at senior centers.

Purpose/Mission: B - Services which maintain health.

16. EMERGENCY RESPONSE SYSTEM (CLIENT MONTH) - Direct action to make available emergency response system for persons who are frail or at risk of loss of independence and who can benefit from the security provided

by such a system. System must be formal emergency response system (example; lifelines).

Formal Emergency Response System. Must be “electronic notification system.” Client count is per month - this service would be a duplicate count from month to month.

Purpose/Mission: B - Services which maintain health.

17.EMPLOYMENT PLACEMENT (1 PLACEMENT) - Placement of an older individual (55 and older) who is seeking paid employment in a job.

Purpose/Mission: F - Services which support other goals/outcomes.

18.FINANCIAL COUNSELING (1 CONTACT) - Provision of information and presentation of options on a one-to-one basis designed to assist an older individual to obtain financial services and benefits. Service includes public benefits counseling and tax assistance counseling.

One-to-one is the key. One contact may be one person contacted several times to resolve an issue.

Purpose/Mission: E - Services which assure access and coordination.

19.HEALTH CLINIC (1 CONTACT) - Services provided by licensed health care professionals that are designed to identify, prevent or treat a physical or mental health problem. Service must include individualized health intervention provided by a health professional (example: blood pressure, hearing screening, etc.).

This is non-home setting and individualized. This would include health fairs if individualized services were provided by a licensed health care professional. Includes mental health diagnosis or screening.

Purpose/Mission: B - Services which maintain health.

20.RESERVED

21.RESERVED

22.DURABLE MEDICAL EQUIPMENT (1 CONTACT) - The provision of goods to an individual at no cost or at a reduced cost which will directly support the health and independence of the individual with an assessed need.

Goods are adaptive devices or assistive technology to be used by an individual. One contact is a delivery of “goods” (as previously defined).

Purpose/Mission: A - Services which address functional limitations.

23. MENTAL HEALTH COUNSELING (1 CONTACT) - Counseling provided to an individual by a licensed mental health professional, which is intended to address a diagnosed mental health condition.

Purpose/Mission: B - Services which maintain health.

24. RESERVED

25. RESERVED

26. RESPITE-HOME (1 HOUR) - Respite care services offer temporary, substitute supports for older persons in their home or in the home of a primary caregiver in order to provide a brief period of relief or rest for family members or other caregivers.

This service is reported only if it is paid with AAA funds or is provided by volunteers utilized by Contractors paid with AAA funds. Brokering, situations in which a client is referred to a provider and the Center Director/Staff or Contractor/Staff and only provides follow-up is reported under I&A.

Respite care as defined here is a service that provides supervision on a temporary basis to relieve caregiver from that role on a temporary basis. It does not involve the provision of personal care or home health care. If services provided are personal care, home health aide or another appropriate service then assign the service to that category. If none of the other service definitions are appropriate and care is provided in the home this is the appropriate category.

Purpose/Mission: B - Services which maintain health.

27. RESERVED

28. RESERVED

29. VOLUNTEERISM (1 HOUR) - Services or support provided on behalf of an older person by an unpaid individual. Only those services or support provided directly by an Area Agency on Aging or pursuant to a contract with an Area Agency on Aging shall be included.

Purpose/Mission: D - Services which promote socialization/participation.

30. HOME HEALTH AIDE (1 VISIT) - Administration of medication or medical treatment by a certified Home Health Aide or a licensed health professional.

Purpose/Mission: B - Services which maintain health.

31.RESERVED

32.RESERVED

33.SENIOR CARE OPTIONS SCREENING (1 PERSON SCREENED) -
Evaluation of a person age 65 or older for Medicaid coverage of Nursing
Facility care.

Purpose/Mission: E - Services, which assure access and coordination.

34.MEDICAID WAIVER (1 CLIENT/MONTH) - Assessment, authorization
and coordination of services to a person who is enrolled in the Medicaid
Aged and Disabled Home and Community Based Service Waiver.

Purpose/Mission: A - Services which address functional limitations.

35.SUPPORTIVE SERVICES (1 HOUR) - Provision of a broad spectrum of
services (including the provision of health, social and educational services
and provision of facilities for recreational, general information,
interpretation/translation, public information, publication, etc.) for older
persons.

Purpose/Mission: F - Services which support other goals/outcomes.

36.OMBUDSMAN/VOLUNTEER (1 CONTACT) - Includes cases
(investigation and resolution of complaints that are made by and on behalf of
residents of nursing homes and assisted living facilities) and consultations
provided to individuals and facilities (data taken from Ombudsman report).

Total number of CONTACTS = Total number of CASES + Total number of
CONSULTATIONS to Facilities + Total number of CONSULTATIONS to
Individuals (data taken from Ombudsman report).

End of CLUSTER 4

Title III-E Services to Caregivers

37.INFORMATION SERVICES (1 ACTIVITY_ - A service for caregivers
that provides the public and individuals with information on resources and
services available to the individuals within their communities. (NOTE:
Service units for information services are for activities directed to large
audiences of current or potential caregivers such as disseminating
publications, conducting media campaigns, and other similar activities.)

38. ACCESS ASSISTANCE (1 CONTACT) - A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. (NOTE: Information and assistance to caregivers is an access service, i.e., a service that:

- a) provides individuals with information on services available within the communities;
- b) links individuals to the services and opportunities that are available within the communities;
- c) to the maximum extent practicable, establishes adequate follow-up procedures.

Internet web site “hits” are to be counted only if information is requested and supplied.

This service includes information and Assistance for caregivers as well as Care Management services for caregivers.

39. COUNSELING (1 SESSION PER INDIVIDUAL) - Counseling to individual caregivers to assist them in making decisions and solving problems related to their caregiver roles. Counseling may be provided to caregivers in several different settings, such as counseling to individuals, support groups, and caregiver training (of individual caregivers and families), but the unit of service remains 1 session per individual.

40. RESPITE CARE (1 HOUR) - Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care includes:

- 1) In-home respite (personal care, homemaker, and other in-home respite).
- 2) Respite provided by attendance of the care recipient at a senior center or other non-residential program.
- 3) Institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and
- 4) for Grandparents caring for children (i.e., summer camps).

If the specific service units purchased via a direct payment (cash or voucher) can be tracked or estimated, report those service unit hours. If not, a unit of service in a direct payment is one payment.

41.SUPPLEMENTAL SERVICES (1 UNIT OF ACTIVITY) - Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies.



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State Plan Provisions from Section 705(a)(7)

Many of the following provisions are addressed in state law and regulations. Nebraska state regulations are in the Nebraska Administrative Code. Regulations regarding the provision of aging services are found in Title 15 of the Code. The following will consist of a reference to the appropriate title and chapter of the Nebraska Administrative Code (NAC), references to other documents, and as necessary, a short narrative. All provisions in statute, regulations, and other documents can be seen at www.dhhs.ne.gov/reg/t15.htm.

Provisions addressing the right and opportunity of Area Agencies on Aging and service providers to a public hearing upon request can be found at 15 NAC, Chapter 1, section 001.02 and sections 002.05 - 002.05J.

Nebraska regulations place the responsibility for determining the extent to which public and private programs and resources address and meet the needs of older Nebraskans upon the eight Area Agencies on Aging, which provide the bulk of the services. Each Area Agency on Aging determines the need in its own manner, but all are required to conduct public hearings and solicit the opinions and guidance of the public.

As part of the information and assistance programs, Nebraska's Area Agencies on Aging provide information and/or referral services to older Nebraskans on pensions and other benefit programs including their rights to such benefits. The State Unit on Aging includes this in the Area Plan Review process and periodically monitors the Area Agencies on Aging's performance via onsite visits and review of reports and data.

Nebraska funds vulnerable elder rights protection activities exclusively through Title VII and always has, so there is no possibility that pre-existing funds are being supplanted.

Any agency, including an Area Agency on Aging, may apply and be designated as a local long-term care ombudsman program. This can be viewed in 15 NAC, Chapter 3, section 3-003.

All representatives of the Office of the State Long-Term Care Ombudsman, care managers, and health care providers are mandatory reporters under the Nebraska Adult Protective Services Act, and are required to file reports and cooperate with Adult Protective Services to the extent allowed by law. In an opinion dated June

11, 1996, the Nebraska Attorney General's Office concluded that representatives of the Nebraska Office of the State Long-Term Care Ombudsman, would not be required to reveal the identity of specific clients, but may be required to provide general information that does not identify specific clients.

Elder Abuse Prevention Funds

The State Unit on Aging currently has several programs that help prevent the abuse, neglect and financial exploitation of vulnerable adults.

The State Long-Term Care Ombudsman Program - Nebraska law mandates that ombudsman and ombudsman advocates investigate and seek to resolve only those complaints that do not fall under the jurisdiction of the state Adult Protective Services Act. In the process of advocating for residents of long term care facilities and working to protect their rights, resolve complaints and improve the quality of care and the quality of life they receive, the long-term care ombudsman program helps prevent the abuse, neglect and financial exploitation of vulnerable adults.

The Nebraska SMP - The funding received for the Nebraska SMP allows the long-term care ombudsman program to provide education, advocacy and technical assistance to beneficiaries and their care givers, in order to identify, report and prevent Medicare and Medicaid waste, fraud and error.

Elder Abuse Prevention Special Projects - Elder abuse prevention funds are awarded to Nebraska through Title VII to provide grants to agencies, groups, individuals and organizations for specific elder abuse prevention activities. Each entity is required to submit a proposal with a description of how the specific activity will address the prevention of elder abuse, as well as a budget. The maximum amount allowed for any proposal is \$5,000 and the activity must be a specific activity, rather than on-going funding for a staff position.

Projects that have received funding include the following:

- purchasing of elder abuse prevention videos for the State Unit on Aging library;
- funding for Adult Protective Services, Ombudsman and Area Agency on Aging staff to attend workshops and conferences on elder abuse;
- funding for presenting a workshop/conference on elder abuse for the general public; and
- funding for the production of written materials on elder abuse prevention issues for public distribution.

- Nebraska Elder Rights Coalition - The Elder Rights Specialist in the State Unit on Aging facilitated the development of the Nebraska Elder Rights Coalition, in order to identify issues of concern to older adults and discuss possible strategies to address or resolve them. The Coalition is composed of representatives from the State Unit on Aging, the Area Agencies on Aging, Legal Service organizations, advocacy organizations, the academic community, and others. Priority issues were identified as the provision of legal services to older Nebraskans and the protection of vulnerable adults from financial exploitation.



Nebraska Pandemic Influenza Prevention and Control Guidelines

Please note: This is an “evergreen” document and is constantly being revised to be consistent with national directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in influenza surveillance and viral technology occur.

Nebraska Pandemic Influenza Guidelines Page 1 Revised 2/21/2006

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Acknowledgments

The Nebraska Health and Human Services System appreciates contributions from members of the Governor's *Pandemic Influenza Advisory Committee*, in the development of these Guidelines.

The Pandemic Influenza Advisory Committee Members were appointed by Governor Johanns to serve a one year commitment from March 2005 until March 2006. They include the following:

Nebraska Governor's Pandemic Influenza Advisory Committee

CHAIR – Deputy Chief Medical Officer – Nebraska Health and Human Services System, Lincoln, NE

Nebraska Hospital Association, Lincoln, NE

Public Health Association of Nebraska, Lincoln, NE

Nebraska State Senator, Lincoln, NE

Two (2) US Senators or Legislative Health Aides, Washington, DC

Three (3) US Congressman or Legislative Health Aides, Washington, DC

Nebraska Pharmacist's Association, Lincoln, NE

Voices for Children, Omaha, NE

Interchurch Ministries of Nebraska, Lincoln, NE

University of Nebraska Public Policy Center, Lincoln, NE

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Superintendent of Schools, Henderson, NE

Nebraska Sheriffs Association, West Point, NE

Independent Counseling Services, Ainsworth, NE

Omaha Tribe of Nebraska, Macy, NE

Bethel Baptist Church, Omaha, NE

Nebraska Minority Public Health Association, Lincoln, NE

Nebraska Association of County Officials, Yutan, NE

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Nebraska Emergency Management Agency, Lincoln, NE
South Heartland District Health Department, Hastings, NE
Nebraska Health Care Association, Lincoln, NE
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Definition of Terms and Acronyms

ACIP - Advisory Committee on Immunization Practices; the nationally recognized group of public health and private medical experts who advise the U.S. Department of Health and Human Services on immunization practices

Antigenic Drift - A gradual change in the influenza virus, over time, resulting in higher than normal morbidity

Antigenic Shift - A significant, abrupt change in the influenza virus

CDC - The Centers for Disease Control and Prevention

DCHD - Douglas County Health Department

ED - Emergency Department

EMS - Emergency Medical Services

HAN - Health Alert Network

ICP - Infection Control Practitioner

ILI - Influenza-Like Illness

IM Group - Influenza Management Group; a core public health group, designated by the NE HHSS Chief Medical Officer, that coordinates and oversees pandemic prevention and control activities across Nebraska

LLCHD - Lincoln-Lancaster County Health Department

NE HHSS- Nebraska Health and Human Services System, Department of Services

NE HHSS R&L - Nebraska Health and Human Services System, Department of Regulation and Licensure

NE HHSS - Nebraska Health and Human Services System

NE SEOP - Nebraska State Emergency Operations Plan

NEDSS - National Electronic Disease Surveillance System

NEMA - Nebraska Emergency Management Agency

NETSS - National Electronic Telecommunications System for Surveillance

NPHL - Nebraska Public Health Laboratory

NSP - Nebraska State Patrol

NOVEL VIRUS - A new influenza virus, resulting from a viral antigenic shift

PANDEMIC - World wide epidemic, caused by a novel virus

PHAN - Public Health Association of Nebraska

VACMAN - VACCine MANagement System. A vaccine purchasing and distribution database management system used by government-funded state and territorial immunization projects.

VAERS - Vaccine Adverse Event Reporting System; a national system that tracks adverse events following vaccinations

VPAG - Vaccine Priority Advisory Group; an advisory group to HHSS that will identify priority populations for vaccination and receipt of antiviral medications

Nebraska Pandemic Influenza Prevention and Control Guidelines

Introduction

Influenza viruses are unique in their ability to cause sudden infection in all age groups on a global scale. The infamous “Spanish flu” of 1918-19 was responsible for more than 20 million deaths worldwide, primarily among young adults. Mortality rates associated with the more recent pandemics of 1957 and 1968 were reduced, in part, by antibiotic therapy for secondary bacterial infections and more aggressive supportive care. However, both of these later pandemics were associated with high rates of morbidity and social disruption.

The Nebraska Department of Health and Human Services System (NEHHSS) in cooperation with the *Governor’s Pandemic Influenza Committee*, and public, private, federal, state and local partners, has developed the Nebraska Pandemic Influenza Prevention and Control Guidelines to outline strategies by which pandemic influenza-related morbidity, mortality, and social disruption may be reduced. The Guidelines should be read and understood prior to an influenza pandemic. This is a dynamic document that will be updated to reflect new developments in the understanding of the influenza virus, its spread, treatment and prevention.

The guidelines address:

1. Coordination and management of resources and responsibilities;
2. Surveillance activities, designed to detect and monitor influenza activity;
3. Vaccine and antiviral medication distribution and delivery; and
4. Communications and public information.

Influenza Outbreaks and Impact

Yearly influenza epidemics

Influenza is an infection of the respiratory tract caused by the influenza virus and is spread by coughing and sneezing. The time period between exposure and illness is usually one to three days and the onset of symptoms is sudden. Typical symptoms include fever, cough, sore throat, runny or stuffy nose, as well as headache, muscle aches and often, extreme fatigue. Most people who get influenza recover completely in one to two weeks, but some people develop serious and potentially life-threatening medical complications, such as pneumonia.

In an average year, influenza is associated with more than 20,000 deaths nationwide and more than 100,000 hospitalizations. Because influenza is not a reportable disease, and health care providers don’t always test for influenza, these numbers cannot be accurately estimated for the State of Nebraska. Flu-related complications can occur at any age; however, the elderly and people with chronic health problems are much more likely to develop serious complications.

Seasonal influenza occurs every year for several reasons. First, influenza vaccine is a “killed” virus vaccine and is effective for only a short period of time (3-6 months). Second, many people do not receive the influenza vaccine. Third, and most importantly, people are susceptible to influenza virus infection throughout life because influenza viruses continually change. A person infected with influenza virus develops antibodies against the “current” virus. As the virus changes, the person’s “older” antibodies no longer recognize the “new” virus. When the viral changes are minor, the “older” antibodies can provide some limited protection. When the changes are significant, the “older” antibodies provide little if any protection.

Risk of pandemic influenza

Gradual change in the virus, over time, is called an antigenic drift. A drift will cause greater than normal morbidity and mortality, resulting in significant disruptions to communities and health care systems, such as higher numbers of absenteeism, shortages of influenza vaccines and antiviral medications and higher rates of pneumonia and pneumonia-related deaths.

Rarely, a significant, abrupt viral change occurs, known as an antigenic shift. When a shift occurs, large numbers of people, and sometimes the entire population, have no antibody protection against the new virus. If the new, novel virus is easily spread, it has the ability to cause sudden infection in all age groups on a global scale, resulting in a worldwide epidemic, called a pandemic. During the Twentieth Century, pandemics occurred in 1918, 1957 and 1968.

Since its development more than 50 years ago, influenza vaccination has been the cornerstone of influenza prevention and control. Every year, between 70 and 80 million doses of vaccine are manufactured and administered in the United States. Pandemic influenza is a unique public health emergency and, in spite of ongoing improvements in the manufacturing and delivery of vaccines, it will present a number of challenges.

The entire population will have little or no immunity and therefore, the targeted populations will expand far beyond the usual “high risk” groups. The Centers for Disease Control and Prevention (CDC) estimates that, in the United States alone, up to 200 million people will be infected, 50 million people will require outpatient care; two million people will be hospitalized, and between 100,000 and 500,000 persons will die. The “warning period”, preceding spread of the pandemic strain in the U.S., is likely to be relatively short, so vaccine will have to be manufactured, distributed and administered as quickly as possible.

A severe or moderate vaccine shortage is likely, especially early in the pandemic; it is possible that when a pandemic begins, no vaccine will be available.

When vaccine becomes available, it will arrive over an extended period of time. A two-dose schedule is likely because a pandemic strain will be new to the population (as opposed to the yearly strains, to which many people may have some immunity).

Outbreaks are expected to occur simultaneously throughout much of the U.S., preventing relocation of human and material resources. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.

Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel who provide other essential community services. The effect of pandemic influenza on individual communities will be relatively prolonged, lasting six to eight weeks with repetitive cycles that could phase in over 18 months, compared to the minutes, hours, and days observed in most other natural disasters.

Planning Assumptions

Morbidity, Mortality, and Healthcare Utilization Projections

PandemicFlu.gov

Based on extrapolation from past pandemics in the United States, the U.S. Department of Health and Human Services (US DHHS) has estimated the number of people who may become ill and require various levels of health care. The estimates are based on a 30% attack rate (percentage of the population that becomes ill) and an assumption that 50% of people with illness will seek care.

Table 1 is reproduced from the PandemicFlu.gov website (<http://pandemicflu.gov/plan/pandplan.html>).

The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between more and less severe scenarios. Planning should include the more severe scenario.

Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, the elderly, pregnant women, and persons with chronic medical conditions.

Table 1. Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios (U.S.A.)

Characteristic	Moderate (1958/68-like)	Percentage of illness	Severe (1918-like)	Percentage of illness
Total population (U.S.)	300,000,000		300,000,000	
Illness (30% attack rate)	90,000,000		90,000,000	
Outpatient medical care	45,000,000	50.0%	45,000,000	50.0%
Hospitalization	865,000	0.96%	9,900,000	11.00%
ICU care	128,750	0.14%	1,485,000	1.65%
Mechanical ventilation	64,875	0.07%	745,500	0.83%
Deaths	209,000	0.23%	1,903,000	2.11%

*Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.

The percentages used for the national estimates were applied directly to the Nebraska population to estimate the impact on Nebraska (Table 2). This method is limited by the fact that the population profile of Nebraska is not exactly the same as for the entire country. However because of the many uncertainties and assumptions that factor into these estimates, they will provide a sense of what could possibly happen during a pandemic. These are not meant to attempt to predict what will happen. Rather, they are intended to be taken into consideration by pandemic influenza planners.

Table 2. Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios (Nebraska)

Characteristic	Moderate (1958/68-like)	Percentage of illness	Severe(1918-like)	Percentage of illness
Total population (NE)	1,711,263		1,711,263	
Illness (30% attack rate)	513,379		513,379	
Outpatient medical care	256,689	50.00%	256,690	50.00%
Hospitalization	4,928	0.96%	56,472	11.00%
ICU care	719	0.14%	8,471	1.65%
Mechanical ventilation	359	0.07%	4,261	0.83%
Deaths	1,181	0.23%	10,832	2.11%

*Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.

CDC FluAid

The CDC has developed a model (“FluAid”) for predicting estimates of the impact of deaths, hospitalizations, and outpatient visits due to pandemic influenza.¹

The model was used to assist state and local planners to develop estimates of morbidity and mortality from pandemic influenza. The model is based on data from the pandemic of 1968.

The estimates for Nebraska are presented as a range because of the uncertainties of the assumptions used in the model. Many factors, such as severity of disease and communicability, will be dependent upon the characteristics of the virus that emerges as a pandemic virus. It is impossible to accurately predict these factors. These numbers are intended to provide a range of possible estimates and to reflect the degree of uncertainty that is inherent in these projections.

It is important to remember that during an actual pandemic, high risk populations, influenza death rates, and outpatient/hospitalization rates could vary significantly from the rates and percentages assumed in these projections. These estimates are intended to assist healthcare and public health planners in planning for surge capacity requirements.

FluAid Assumptions

- An attack rate of 30% was used to be consistent with the DHHS model above. Attack rate is defined as the percentage of the population that becomes clinically ill.
- The lower number presented reflects the “most likely” scenario as calculated using the FluAid model of the 1968 pandemic. The higher number simply multiplies these estimates by six to reflect a severe pandemic.

¹ Meltzer MI, Shoemaker HA, Kohnanski M, Crosby R, 2000. FluAid 2.0: A manual to aid state and local-level public health officials plan, prepare and practice for the next influenza pandemic (Beta test version). Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (Available at <http://www2.cdc.gov/od/fluaid>, accessed February 7, 2006)

This factor is mentioned by the Trust for America’s Health 2as the possible severity of a pandemic similar to 1918.)

- The model takes into consideration differences in people of different ages, as well as those at “high-risk” due to pre-existing medical conditions. Individuals at “high-risk” are those who have a pre-existing medical condition such as asthma, diabetes mellitus, and cardiovascular disease, as defined by the National Advisory Committee on Immunization Practices, which makes them more susceptible to having secondary complications and adverse health outcomes.
- The 2000 U.S. Census was used for population estimates. The default population distribution in FluAid for Nebraska is based on 1999 estimates from the U.S. Census. The actual population in 2000 was substituted for the default 1999 estimates.

- The default percentages of high-risk individuals in each age group were retained. These estimates are based on national data.³
- A pandemic can be expected to occur in waves, with waves possibly lasting many weeks. These estimates cover a time period of approximately 8 weeks. Table 3 shows the estimated number of Nebraskans who would be considered to be at high risk for complications due to influenza because of a health condition based on this model.

Table 3. Estimated Population at High Risk³ for Complications by Age Group

Age Group	NE population (2000 U.S. Census)	Percentage of Population at High Risk ²	Estimated high risk population
0 – 18	450,062	6.4%	28,803
19 – 64	1,028,469	14.4%	148,099
65+	232,732	40.0%	93,093
Total	1,711,263		269,995

Projected outpatient visits are shown in Table 4. The chart shows, for example, that in a severe pandemic scenario, 200,000 individuals in the 0-18 year age group might seek outpatient care over eight weeks.

² Trust for America’s Health. June 2005. “A Killer Flu?” Available at <http://healthyamericans.org/reports/flu/Flu2005.pdf> Accessed February 13, 2006

³ High-risk percentages are based on the Advisory Committee on Immunization Practices definition of groups at high-risk for complication of influenza infection. Meltzer MI, Cox NJ, Fukuda K. Modeling the Economic Impact of Pandemic Influenza in the United States: Implications for Setting Priorities for Intervention. Background Paper, April 30, 1999 Available at: http://www.cdc.gov/ncidod/EID/vol5no5/melt_back.htm

Table 4. Projected Outpatient Visits

Age Groups (years)	Number of Outpatient Visits	
	1968-like Pandemic (pandemic)	FluAid Default Severe (assumed to be similar to less severe)
0 – 18	79,855	79,855
19 – 64	158,710	158,710
65+	36,132	36,132
Total	274,697	274,697

Groups at high-risk for complications of influenza infection were considered as a factor in the projections. Table 5 outlines the number of projected hospitalizations by age group and pandemic severity. It is important to note that during an actual pandemic, both hospitalization rates and the percentage of the population at high-risk for influenza complications could vary significantly from the rates and percentages used to develop these projections.

Table 5. Projected Hospitalizations

Age Groups (years)	Number of Hospitalizations	
	1968-like Pandemic FluAid	Default Severe (6 times 1968) Six times
0 – 18	252	1,512
19 – 64	3,802	22,812
65+	2,035	12,210
Total	6,089	36,534

Estimates of possible deaths are shown in Table 6. During an actual pandemic, both influenza death rates and the high-risk populations could vary significantly from the rates and percentages assumed in the projections.

Table 6. Projected Deaths (numbers not rounded)

Age Groups (years)	Number of Deaths	
	1968-like Pandemic FluAid	Default Severe (6 times 1968) Six times
0 – 18	14	84
19 – 64	644	3,864
65+	763	4,578
Total	1,421	8,526

Federal, State, and Local Response

A strong, coordinated effort among federal, state, local, public and private entities will be essential to deal with the challenges presented by pandemic influenza. The following assumptions guide Nebraska's response to a pandemic event.

National Level Response

The Federal government has primary responsibility for coordination of activities on a national level and assumes responsibility for:

1. Vaccine research and development;
2. Coordinating national and international surveillance;
3. Assessing and potentially enhancing vaccine and antiviral capacity and coordinating public-sector procurement;
4. Devising a suitable liability program for vaccine manufacturers and persons administering the vaccine;
5. Developing a national "clearinghouse" for vaccine availability information, vaccine distribution and redistribution;
6. Developing a national adverse events surveillance system;
7. Developing a national information database/exchange/clearinghouse on the Internet;
8. Developing "generic" guidelines and/or "information templates" that can be modified and/or adapted as needed at the State and local levels, including:
9. Fact sheets on influenza, the influenza vaccine, and antiviral agents.
10. Strategies and guidelines for interacting with the media and communicating effectively with public health, medical communities and the general public.
11. Guidelines for triage and treatment of influenza patients in outpatient, inpatient and non-traditional medical care settings.
12. Guidelines for setting up and operating mass vaccination programs.
13. Guidelines for distribution and use of antiviral agents.
14. The Federal government is currently pursuing mechanisms by which influenza vaccine can be made available more rapidly and in much larger quantities prior to and during the next pandemic.
15. Liability protection for vaccine manufacturers and persons who administer influenza vaccine will likely be made available through Congressional legislation.
16. Although antiviral agents are available that can theoretically be used for both treatment and prophylaxis during the next pandemic, these agents will likely be available only for limited distribution.
17. Resources can be expected from the national level for plan implementation.

State Level

The State of Nebraska Health and Human Services will be the lead state agency and coordinate statewide surveillance, response and control activities. Those activities include:

1. Distribution of limited antiviral medications or vaccines according to recommendations from HHS/CDC, the Governor's Pandemic Advisory Committee and the Pandemic Expert Panel, the IM group.
2. Activation of mass vaccination clinics as indicated by developing surveillance and epidemiology.
3. Administration of vaccine supplies in accordance with federal guidelines and state recommendations;
4. Activation of local pandemic response plans and support of local public health departments in activation of plans and establishing interventions.
5. Communication to and support of healthcare and public health partners throughout the state for purposes of developing local pandemic response plans,
6. Communications to and support of development of pandemic plans for communities and businesses,
7. Continuous, detailed and comprehensive communication with Nebraska Citizens.

Local Level

Local and district public health departments will be the lead local agency. Local health departments will work in coordination with local and county emergency managers to activate local pandemic influenza plans as directed by and in coordination with state public health officials.

Local and district public health departments will work collaboratively with State public health officials to:

1. Complete pandemic response plans for the local or district health department
2. Ensure provision of surveillance and control activities at the local level,
3. Provide surveillance and case management activities to track and manage pandemic influenza outbreaks,
4. Provide Isolation and quarantine activities as needed and directed by epidemiology,
5. Support local volunteer services, emergency response and health care resource management,
6. Manage local vaccination centers when vaccine or anti-viral medications become available,

Local public health officials, local emergency management directors and the community (i.e. hospitals and medical clinics, community action agencies, schools and employers) will:

1. Develop plans for individual businesses and community agencies
2. Encourage development of pandemic response plans for families and other elements of the social infrastructure
3. Develop local plans for suspension of civic events and application of isolation and quarantine measures
4. Assume local responsibilities to the extent possible and appropriate,
5. Maintain local critical infrastructure to assure continued communication, transportation and delivery of essential services and goods,
6. Establish local business and community policies to minimize disease transmission,
7. Care for ill and dead, and
8. Take steps to minimize social disruption.

Coordination and management

Key Collaborative Agencies

Lead State Agency and Sections

Nebraska Health and Human Services System, Department of Regulation and Licensure, Bioterrorism Preparedness and Response Section; Public Health Assurance, Disease Surveillance Section

Additional Key State Government Support Agencies and Programs

- NE HHSS R&L Office of Public Health (Coordination with local health districts)
- NE HHSS R&L Office of Public Health Communications and Legislative Services Department of Regulation and Licensure (Risk communication)
- Nebraska Public Health Laboratory (NPHL)
- NE HHSS R&L Emergency Medical Services Program
- NE HHSS Department of Finance and Support, Credentialing
- NE HHSS R&L Legal Services
- NE HHSS Department of Services, Information Systems and Technology
- NE HHSS Department of Services, Immunization Program
- NE Department of Administrative Services
- NE Department of Agriculture
- NE Department of Natural Resources
- NE Department of Environmental Quality
- Nebraska Emergency Management Agency (NEMA)

Key Federal Support Agencies

- Health and Human Services (HHS)
- Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA)
- Federal Emergency Management Agency (FEMA)

Other Key Support Departments, Agencies and Organizations*

- Local and County Emergency Management Directors
- Public Health Association of Nebraska
- Local public health departments
- Community Action Agencies
- Nebraska Hospital Association
- Nebraska Medical Association
- Nebraska Pharmacists Association
- The Nebraska Medical Center
- University of Nebraska Medical Center
- University of Nebraska, Lincoln Veterinary Lab
- Creighton University Medical Center
- Association of State and Territorial Health Officers

Operations Philosophy

The resources available to handle a severe influenza season or pandemic influenza event will vary considerably across the state. It is the responsibility of the lead agencies to make the best possible use of existing state, local, public, private and volunteer resources.

Each local government is under the jurisdiction of and served by the Nebraska Emergency Management Agency (NEMA) and participates with a local emergency management organization that has either a full-time director or deputy director. Nebraska's counties are served by twenty local public health departments. All local health departments are working with community partners to develop, implement and exercise coordinated community emergency response plans that include plans specific to the identification, response, control and recovery activities related to pandemic influenza. All local health departments have identified mass dispensing sites and key personnel necessary to set up and run the sites. That information is located in local and state data bases and is updated on an ongoing basis. Local and regional response plans are required to be linked to other regional and state response plans to ensure coordination of efforts and maximize use of limited resources. Nebraska is a partner state with the ten-state Mid-America Alliance

(MAA). Collaborative and sharing agreements are being developed and expanded with all states bordering Nebraska.

NE HHSS and NEMA must work closely with the federal government, local public health officials and local emergency management directors to identify resources, determine the areas' service delivery capacities, identify gaps in service delivery, secure and provide the additional resources necessary to address the area threats. State and local public health officials, local emergency management directors and communities work in a coordinated, organized manner when dealing with the serious issues presented by an influenza pandemic.

The Nebraska Emergency Management Act grants the Governor authority to provide state-level support to local governments in times of extreme emergency or disaster. The Nebraska State Emergency Operations Plan describes how State Government responds to occurrences of disasters and emergencies throughout the State. Pandemic planning requires special emphasis on certain functions not specifically addressed in the Nebraska State Emergency Operations Plan (NE SEOP). The Nebraska Pandemic Influenza Prevention and Control Guidelines is an appendix to the NE SEOP and provide specific guidance related to pandemic influenza. An official emergency does not have to be declared for any or all of the Nebraska Influenza Prevention and Control Guidelines to be implemented by NE HHSS.

Governor's Pandemic Influenza Advisory Committee

The Governor appointed a *Pandemic Influenza Advisory Committee* to advise NE HHSS and the Governor on the identification of priority groups, distribution and allocation of vaccine supplies and antiviral agents, and creation of the Nebraska Pandemic Influenza Prevention and Control Guidelines. Specific advice was requested to assist in preparations for workplace, schools, and communities.

Key stakeholders on the Pandemic Influenza Advisory Committee include:

- State and Local Public Health, including state legal counsel.
- Public and private health sector, specifically including behavioral health
- Medical ethicists
- Emergency Response
- Law enforcement
- State and county officials
- Clergy
- Public School representatives

Pandemic Response	Key Decisions for Advisory Committee
Vaccine	<ul style="list-style-type: none"> • Identify key priority groups for vaccine (i.e. health care providers, community infrastructure, high risk groups, anyone involved in culling influenza-infected animals). • Identify assumptions (such as various levels of vaccine availability, phases of pandemic).
Antiviral therapy and prophylaxis	<ul style="list-style-type: none"> • Suggest guidelines for use of limited antiviral supplies. • Recommend alternate use of adamantanes vs. neuraminidase inhibitors depending on the epidemiology of the disease. • Suggest prioritization guidelines for both prophylaxis and treatment. ? • Advise HHSS on purchase and use of antiviral and vaccine stockpiles.
Actions to decrease spread of a pandemic	<ul style="list-style-type: none"> • Recommend guidelines for isolation and quarantine. • Recommend how and when the Governor or local agent should restrict public gatherings and closing of schools.

Influenza Management Group (IM Group)

When CDC identifies an influenza shift or emergence of a “novel” virus, the NE HHSS Director will designate an Influenza Management Group (IM Group) to coordinate and oversee prevention and control activities as recommended by the Governor’s committee and CDC, including the identification and assignment of specific state and local tasks.

A. The Influenza Management Group will be convened by the Director of NEHHSS and may include any of the following. Situations and disease epidemiology will direct the composition of the IMG, and it may change as a pandemic season progresses.

1. NE HHSS

a. HHSS Director or Chief Medical Officer or designee, serving as Chair

b. State Medical Epidemiologist;

c. BT Medical Epidemiologist

d. BT Surveillance Coordinator

e. Health Surveillance Coordinator

f. Public Health Laboratory Director or Designee

g. Safety/Emergency Response Coordinator

h. Immunization Program Coordinator or Designee

i. Public Information Officer

2. Douglas County Health Department (DCHD) Surveillance Chief

3. Lincoln-Lancaster County Health Department (LLCHD) Communicable Disease Chief

4. Representative(s) of additional local health department;

5. Representatives of additional public and private agencies and organizations will be added to the IM Group as necessary to ensure working relationships with health, medical, pharmacy and community partners.

B. The IM Group's responsibilities will include, but not necessarily be limited to:

1. Ongoing assessment of the pandemic, including projections of case numbers and likely patterns of disease transmission across the state;

2. Oversight of pandemic-related control activities and coordination of activities with local and regional resources;

3. Ongoing determination of the areas' service delivery capacities and identification of needs and gaps;

4. Ongoing identification, prioritization and distribution of available federal, state and local resources (See Appendix ; B. Pandemic Response Checklist) (*note: Checklist will include list of things to consider and include space to add local information; i.e. potential clinic sites; local & regional public service providers, including emergency responders, law enforcement, public services; area hospitals and medical providers; manpower needs/numbers and location of personnel; medical supplies – items, numbers available, sources; acute beds – locations, availability; population estimates; available inventories may not be listed, but sources of up-to-date information can be recorded*);

5. Securing and providing additional resources to prevent or control the pandemic.

6. Ongoing communications regarding the pandemic and associated activities with appropriate state, local and federal officials; including the HHSS Chief Medical Officer, members of the HHSS Policy Cabinet, the Governor's Office, the NE Emergency Management Agency and CDC.

7. Communication with public and private health care providers and the public regarding the situation and recommendations. (See VII. COMMUNICATIONS)

C. Oversight

1. NE HHSS staff will be responsible for coordination and oversight of statewide activities.

2. Local health departments will be responsible for coordination and oversight of activities in their jurisdictions.

D. The IM Group will meet as frequently as necessary to assure effective coordination and oversight of pandemic response activities, including timely and appropriate communications.

E. Nebraska Chief Medical Officer may change the membership of the IM Group as indicated by the ongoing epidemiology of the disease.

Surveillance

Overview

The Nebraska Pandemic Influenza Prevention and Control Guidelines address the basic elements that are critical to Nebraska's pandemic response. One of the most important elements is the Laboratory and Disease-Based Surveillance System.

Surveillance is the cornerstone of planning for the next influenza pandemic.

Influenza viruses' antigenic properties constantly change. Therefore, both virology surveillance, in which influenza viruses are isolated for antigenic and genetic analysis, and disease surveillance, in which the epidemiological features and clinical impact of new variants are assessed, should be viewed as equally critical for pandemic preparedness.

NE HHSS will coordinate surveillance activities with local health departments. NE HHSS will gather and maintain statewide surveillance data, working collaboratively with local health departments.

Key surveillance components for influenza and influenza-like illness (ILI) include:

- Sentinel Physicians - The NE HHSS will coordinate pandemic surveillance activities through the use of influenza sentinel physicians at 8 to 10 sentinel sites. Sentinel physicians are selected across the state at a proportion of one per 250,000 population. Specimens submitted to the Nebraska Public Health Laboratory (NPHL) will be tested to determine the presence and/or type of influenza virus.
- Laboratory Resources - There are several licensed laboratories in Nebraska, including NPHL, that perform virology at some level (see Attachment 1). **These laboratories are capable of isolating an influenza virus** in cell culture from nasopharyngeal and pharyngeal swabs and will be enlisted to evaluate cultures during a pandemic.
- Reporting – Electronic Laboratory reporting between the NPHL, NE HHSS and CDC occurs weekly using available and approved CDC and state information and communication systems. The National Electronic Telecommunications System for Surveillance (NETSS) is currently utilized to transmit notifiable disease information from county health offices to Lincoln and the CDC Epidemiology Program Office. Some laboratories are reporting directly to NE HHSS NEDSS system using automated electronic reporting systems. Still others fax or send paper laboratory reports. Significant efforts are in place in Nebraska to encourage electronic laboratory reporting consistent with national guidelines and anticipated national electronic health record standards.
- Hospital Reporting – Local health departments contact hospitals in their districts on a regular basis (at least weekly) to determine the number of patients admitted with influenza like illness (ILI). Each local health department will send these

reports to NE HHSS to be put into a data base. This will help determine the rate of increase/decrease of ILI admissions.

Current Influenza Surveillance

Sentinel physicians call in influenza data weekly to the CDC Influenza Branch, and the Nebraska data are entered on a designated website weekly so it may be viewed as desired. Positive influenza culture specimen results, which are collected from Nebraska influenza sentinel physicians early in the season and during peak periods of influenza activity, are transmitted from NPHL each week to the CDC Influenza Branch located in Atlanta. These results are also collected by the Nebraska NEDSS program.

State and Territorial Epidemiologist's Report

The State and Territorial Epidemiologist's Report consists of a weekly report from each state epidemiologist (or their designee) of the overall level of influenza activity in the state. This system provides the only state level influenza data that CDC makes publicly available and these data are widely used by the media, the public, and public health officials. All 50 states, New York City, and Washington DC, report the level of influenza activity for their state/city to CDC each week between October and mid-May. Disease activity is classified into one of five categories based on specific definitions (see Table 2.)

Table 5: Influenza Activity Levels

Activity Level	ILI activity*/Outbreaks		Laboratory data
No activity	Low	And	No lab confirmed cases†
Sporadic cases	Not increased	And	Isolated lab-confirmed
		-- OR --	
	Not increased	And	Lab confirmed outbreak in one institution‡
Local	Increased ILI in 1 region**; ILI activity in other regions is with not increased		Recent (within the past 3 weeks) lab evidence of influenza in region increased ILI
	2 or more institutional outbreaks (ILI or lab confirmed) in 1 region; with the ILI activity in other regions is greater than not increased	-- OR -- And	Recent (within the past 3 weeks) lab evidence of influenza in region outbreaks; virus activity is no sporadic in other regions
Regional (doesn't apply to states with ≤4 regions) lab	Increased ILI in ≥2 but less than half of the regions	And	Recent (within the past 3 weeks) confirmed influenza in the affected regions
	Institutional outbreaks (ILI or lab lab confirmed) in ≥2 & less than half of the regions	-- OR -- And	Recent (within the past 3 weeks) confirmed influenza in the affected regions
Widespread lab	Increased ILI and/or institutional outbreaks (ILI or lab confirmed) in at least half of the regions	And	Recent (within the past 3 weeks) confirmed influenza in the state

* ILI activity is assessed using a variety of data sources including sentinel providers, school/workplace absenteeism, and other syndromic surveillance systems that monitor influenza-like illness.

† Lab confirmed case = case confirmed by rapid diagnostic test, antigen detection, culture, or PCR. Care should be given when relying on results of point of care rapid diagnostic test kits during times when influenza is not circulating widely. The sensitivity and specificity of these tests vary and the predictive value positive may be low outside the time of peak influenza activity. Therefore, a state may wish to obtain laboratory confirmation of influenza by testing methods other than point of care rapid tests for reporting the first laboratory confirmed case of influenza of the season.

‡ Institution includes nursing home, hospital, prison, school, etc.

**Region: population under surveillance in a defined geographical subdivision of a state. A region could be comprised of 1 or more counties and would be based on each state's specific circumstances. Depending on the size of the state, the number of regions could range from 2 to approximately 12. The definition of regions would be left to the state but existing state health districts could be used in many states. Allowing states to define regions would avoid somewhat arbitrary county lines and allow states to make divisions that make sense based on geographic population clusters. Focusing on regions larger than counties would also improve the likelihood that data needed for estimating activity would be available.

Current surveillance activities include:

1. Voluntary reporting of laboratory-confirmed influenza;
2. Voluntary submission of influenza isolates to the NPHL for strain sub-typing;
3. Voluntary reporting of ILI outbreaks in long-term care facilities;
4. Voluntary reporting of ILI admissions to hospitals;
5. Voluntary reporting of ILI outbreaks in schools;
6. Voluntary reporting of school absenteeism;
7. A voluntary, state network of sentinel physicians reporting the number of patients presenting with ILI and the total number of patient visits by age group each week;
8. Investigations of unexplained deaths in Nebraska.

Enhanced Influenza Surveillance

The following enhanced surveillance system will be used in Nebraska to detect and characterize circulating strains of influenza virus and generate epidemiological information. This information will be used to guide the actions of public health officials before, during, and after a pandemic of influenza. The NE HHSS Disease Surveillance Section will maintain and continue to enhance and refine the existing influenza surveillance infrastructure of the NE HHSS.

During the inter-pandemic period:

1. Provide epidemiological information during the annual influenza season; and
2. Monitor antigenic changes in circulating viruses in order to provide information for the formulation of vaccine for the subsequent season.

During a potential or actual pandemic:

1. Provide epidemiological information regarding the presence of pandemic strains and the magnitude of influenza illness in the state of Nebraska.
2. Utilize epidemiological information to guide the actions of public health officials in Nebraska.

Sentinel Sites in Nebraska – Core Functions

1. Laboratory Component: The sentinel sites submit throat swab specimens from 2 –3 patients with influenza-like illness (ILI) to the Nebraska Public Health Laboratory (NPHL) for influenza testing, at each of the following stages during the influenza season:
 - a. At the beginning of the season (usually late October or November), when ILI first presents at a health care facility;
 - b. Midway through the season (usually late December and January); and
 - c. Toward the end of the season (usually March or early April).

2. Morbidity Reporting Component: The sentinel sites report influenza morbidity data directly to the CDC via telephone or fax on a weekly basis from the second week in October through the last week of May. The weekly transmission consists of:

- a. The number of patients seen for ILI during a given week in each of four age categories: 0–4 years; 5–24 years; 25–64 years; and > 65 years; and
- b. The total number of patients seen for any reason at the sentinel site during that week.

3. Reports of ILI above Baseline

The CDC compiles morbidity data submitted by the sentinel sites and provides weekly reports on the percent of visits that are due to ILI on the national, regional and state level. This percent is compared to a baseline of 0–3%. The weekly reports also include morbidity as assessed by state and territorial epidemiologists as “sporadic”, “regional” or “widespread”. These reports are available from a CDC site on the Internet.

B. Enhanced Surveillance at Sentinel Sites

a. When enhanced surveillance is needed, the NE Disease Surveillance Section enlists the assistance of sentinel sites and other health care facilities to rapidly identify any possible importation of a specific influenza virus. The current sentinel surveillance system will be expanded and diversified as determined to be necessary, in order to ensure that surveillance provides population-based information.

b. Select sites that will also allow identification of influenza in specific subpopulations (e.g., high- risk groups, hospital and emergency rooms, children, and healthy adults).

1. A designated staff person will contact sites on a regular basis to ensure they are both reporting ILI and submitting specimens for testing appropriately.

2. Improve the timeliness and viability of the viral specimens collected and submitted for isolation:

a. Specimen collection kits will be sent from the NPHL to sites at the beginning of the season (and as needed) via an overnight mail delivery service, and will be submitted via regular mail on Monday through Wednesday for free testing.

b. Increase the number of viable specimens submitted for arrival on Thursday and Friday by use of a free overnight mail delivery service.

c. Specimen collection kits will be rapidly deployed to sites on an as-needed basis via courier or an overnight mail delivery service to facilitate diagnosis and outbreak control.

3. Reporting of virology isolates will differentiate specimens submitted by sentinel and non-sentinel physicians.

4. Historical laboratory morbidity data in Nebraska will be reviewed and baselines/thresholds determined.

C. Laboratory Testing for Influenza

1. The NPHL provides viral isolation (for typing and sub-typing) and serologic testing for influenza on specimens submitted by both sentinel and non-sentinel sites. The NPHL tests hundreds of influenza specimens annually. Approximately three hospitals in Nebraska routinely isolate influenza virus and send isolates to the NPHL for subtyping.

a. Increase laboratory capacity for surveillance of influenza during the season (October through March) and for the differential diagnostic testing of other respiratory pathogens that also cause ILI (e.g., adenovirus, respiratory syncytial virus (RSV), parainfluenza virus types 1-3, *Legionella* species and *M. pneumoniae*) will be expanded.

b. The influenza-responsible epidemiologist will actively solicit submission of clinical specimens from the expanded number of sentinel sites at regular intervals throughout the influenza season (October through March).

c. The influenza-responsible epidemiologist will actively solicit the submission of secondary isolates, and the results of any rapid testing being done, at regular intervals from all work-based populations, those likely to travel or who have international visitors, particularly from Asia.

d. Laboratory staff will perform rapid influenza antigen testing for influenza A and B on select specimens to facilitate outbreak investigation and control, as well as to limit the spread of imported influenza.

1) The number of clinical specimens tested for influenza will increase by 10%.

e. All positive specimens will be subtyped for surveillance and diagnostic purposes.

1) The number of secondary isolates confirmed and subtyped from other laboratories will increase by 10%.

f. Laboratory staff will perform differential diagnostic testing for other respiratory pathogens.

g. The NPHL will provide weekly cumulative reports of submissions for viral isolation. The Influenza Surveillance Coordinator will maintain two databases that will have the following information:

1) The number of specimens submitted, whether by sentinel or non-sentinel sites;

2) Positive cultures and virus types and subtypes; and

3) Demographic and epidemiological information on each positive case.

D. Investigation of Clusters

NE HHS R&L Disease Surveillance Section staff will coordinate efforts with local health department staff to investigate reported clusters of ILI at long-term care facilities and other institutions in their assigned geographical areas.

E. Investigation of Non-Season Influenza Cases

The NE Influenza Surveillance Coordinator will work with local health departments to investigate any cases of influenza that occur outside of the regular influenza season.

F. Deaths from Influenza and Pneumonia

Two cities in Nebraska report weekly to CDC on deaths from pneumonia and influenza, which is reported in the MMWR. These cities are Omaha and Lincoln.

G. Syndromic Surveillance

NE HHSS will use the Health Alert Network for communications between providers and HHSS for rapid identification and response to ILI and ILI clusters in conjunction with other laboratory and clinical indicators. The online survey tool, or other adjunct technologies can be used for providers and other public health partners to report cases and hospital status.

H. Develop a system for year-round surveillance of influenza.

1. A subset (25%) of regular sentinel sites will be selected to submit specimens during the 'inter-season' (April through September). Selection criteria for these sites will include patient populations likely to travel or have visitors from other countries, particularly Asia and the Southern Hemisphere; staff willing to collect and submit specimens; capacity to perform rapid influenza screening test and geographic/population diversity.

a. Epidemiology staff will actively solicit submission of specimens from patients at these sites with a high likelihood of importing influenza into Nebraska. Selection criteria for patients will include meeting the case definition for ILI, and some epidemiological indicators (e.g., recent travel or visitors from Asia, the Southern Hemisphere, Alaska, cruises or other setting identified as having outbreaks of influenza).

2. Isolates will be reported to CDC via National Respiratory and Enteric Virus Surveillance System (NRVESS).

3. Demographics on cases will be reported electronically to the Epidemiology Section of the Influenza Branch at CDC electronically or by telephone.

4. The NPHL Virus Isolation Laboratory has cross-trained staff to ensure adequate personnel for influenza viral testing.

5. During influenza season or an outbreak, local health departments survey hospitals in their district weekly for ILI admissions and send the information to NE HHSS

6. NE HHSS is exploring additional surveillance systems to enhance existing influenza surveillance. These include hospital admission data, hospital discharge data, HMO influenza data and ambulance diversions

7. NE HHSS exploring contingency plans for enhancing State and local virology and disease-based surveillance systems in the event of a novel virus alert or

pandemic alert. These enhancements might include surveillance of severe respiratory illness and unexplained deaths at local hospitals; surveillance at clinics catering to international travelers; and surveillance of persons traveling from geographic areas in which the novel strains have been isolated.

8. NE HHSS will maintain a list of Influenza Coordinators and Immunization Program Coordinators for the six states bordering Nebraska and will update this list annually.

9. NE HHSS is enhancing electronic and telecommunications capability with local communities, neighboring states and CDC through the Nebraska Health Alert Network.

10. The NE HHSS Disease Surveillance Section will ask the influenza sentinel surveillance sites to submit two specimens a month for the duration of the pandemic.

11. The NE HHSS Disease Surveillance Section, in collaboration with CDC, local health officials, clinicians and academicians, and using protocols developed the CDC, will implement and pilot-test final modifications in enhanced surveillance system, which may include:

- a. Documentation of outbreaks of influenza in different population groups;
- b. Determination of age-specific attack rates, morbidity and mortality;
- c. Description of unusual clinical syndromes (as well as risk factors for those syndromes and appropriate treatment);
- d. Description of unusual pathologic features associated with fatal cases;
- e. Efficacy studies of vaccination or chemoprophylaxis;
- f. Monitoring of ability of hospitals and outpatient clinics to cope with increased patient loads;
- g. Assessment of the effectiveness of control measures such as school and business closings.

12. Assess the medical, social and economic impact of the pandemic.

Surveillance Activities by Stages of Pandemic Influenza

The goal of pandemic surveillance is to describe the epidemiology of pandemic influenza in Nebraska. This information will assist in developing preventive action recommendations, allocating medical resources, and responding to public questions and concerns. Influenza activity can be described by stage, as follows:

Table 6: Pandemic Influenza Phases and Levels

Phase	Level	Definition
0 yearly Inter- pandemic Phase people,	0	Epidemic influenza viruses circulate in human populations causing outbreaks; no evidence that a novel influenza virus has infected humans
	1	Novel Virus Alert: Identification of a novel influenza virus in a person
	2	Confirmation that the novel influenza virus has infected two or more people,
	3	but the ability of the virus to spread rapidly person-to-person and cause Pandemic Alert: Confirmation of person-to-person spread in the general population with at least one outbreak lasting for more than 2 weeks in one country
1		Confirmation that the novel influenza virus is causing several outbreaks in one country and has spread to other countries, with consistent disease patterns indicating serious morbidity and mortality is likely in one segment of the population
2		Outbreaks and epidemics are occurring in multiple countries and spreading across the world
3		End of the first wave of the pandemic
4		Confirmation of the second or later wave caused by the same novel virus strain
5		Confirmation that the pandemic has ended

Pre-pandemic (on-going planning)

1. National and international surveillance

In the United States, international influenza surveillance activities are coordinated by the World Health Organization (WHO), in collaboration with the Center for Influenza Reference and Research at the CDC. National surveillance is coordinated by CDC, with state and local health departments assuming primary responsibility for carrying out virology, morbidity, and mortality surveillance components.

Current U.S. surveillance activities include:

- a. Approximately 70 laboratories which report the number and type of influenza viruses isolated each week, and send representative and unusual viral specimens to CDC for comparative antigenic and genetic analysis;
- b. State and territorial epidemiologists report the level of influenza activity in their State each week as “widespread,” “regional,” “sporadic” or “no activity”;
- c. A voluntary, national network of sentinel physicians report the number of patients presenting with influenza-like illness (ILI) and the total number of patient visits by age group each week;
- d. Vital Statistics Offices of 122 U.S. cities report, on a weekly basis, the percentage of total deaths caused by influenza and pneumonia;
- e. A variety of other sources which spontaneously report influenza.

Novel Virus Alert

1. International identification

Continue influenza surveillance as during the Pre-pandemic Stage.

2. North American identification

a. Notify laboratory directors, infection control practitioners (ICPs), physicians, emergency rooms, and urgent care centers; request that patients presenting with ILI submit a specimen for viral culture, especially those with a recent travel history to region where the pandemic strain of influenza is circulating or persons with unusually severe symptoms.

b. A split specimen should be obtained. One specimen should be submitted to the usual laboratory provider for testing (i.e., identifying influenza A or B) and one specimen should be submitted directly to the NPHL for novel virus testing.

c. Specimens will be tested by the NPHL for the following reasons:

1) NPHL is currently the only Nebraska laboratory capable of subtyping influenza isolates, providing faster turn-around time for subtyping;

2) Antigens used in testing for the novel virus will likely only be available at state public health laboratories

3) Specimens may require testing at CDC; fertilized eggs may be required to grow the virus; and

4) Rapid molecular subtyping methods are available; currently the CDC has supplied specific real-time PCR protocols for influenza subtyping to the NPHL.

d. NEMA, NSP and others will coordinate assistance for specimen transport, as appropriate.

Pandemic Alert

1. International circulation

Once pandemic influenza has been identified circulating internationally, the goal of pandemic alert surveillance is to identify the novel influenza virus circulating in Nebraska. The NE HHSS Disease Surveillance Section will initiate enhanced surveillance including:

a. Notify laboratory directors, ICPs, physicians, emergency rooms, and urgent care centers; request that patients presenting with ILI symptoms submit a specimen for viral culture, especially those with a recent travel history to regions where the pandemic strain of influenza is circulating or persons with unusually severe symptoms.

b. A split specimen should be obtained. One specimen should be submitted to the usual laboratory provider for testing (i.e., influenza A or B) and one specimen

should be submitted directly to the NPHL for novel virus testing. Specimens will be tested by the NPHL for the following reasons:

- 1) NPHL is currently the only Nebraska laboratory capable of subtyping influenza isolates, providing faster turn-around time for subtyping;
 - 2) Antigens used in testing for the novel virus will likely only be available at state public health laboratories;
 - 3) Specimens may require testing at CDC; fertilized eggs may be required to grow the virus;
 - 4) Rapid molecular subtyping methods are available; currently the CDC has supplied specific real-time PCR protocols for influenza subtyping to the NPHL
- c. NEMA, NSP and others will coordinate assistance for specimen transport, as appropriate.

2. North America circulation

a. Notify laboratory directors, ICPs, physicians, emergency rooms, and urgent care centers; request that patients presenting with ILI submit a specimen for viral culture, especially those with a recent travel history to region where the pandemic strain of influenza is circulating or persons with unusually severe symptoms.

b. A split specimen should be obtained. One specimen should be submitted to the usual laboratory provider for testing (i.e., influenza A or B) and one specimen should be submitted directly to the NPHL for novel virus testing. Specimens will be tested by the NPHL for the following reasons:

- 1) NPHL is currently the only Nebraska laboratory capable of strain typing influenza isolates, providing faster turn-around time for strain typing;
- 2) Antigens used in testing for the novel virus will likely only be available at state public health laboratories;
- 3) Specimens may require testing at CDC; and fertilized eggs may be required to grow the virus.
- 4) Rapid molecular subtyping methods are available; currently the CDC has supplied specific real-time PCR protocols for influenza subtyping to the NPHL

Pandemic Imminent

1. International circulation

a. Notify ICPs, physicians, emergency rooms, and urgent care centers; request that patients presenting with ILI symptoms submit a specimen for viral culture, especially those with a recent travel history to regions where the pandemic strain of influenza is circulating or persons with unusually severe symptoms.

b. A split specimen should be obtained. One specimen should be submitted to the usual laboratory provider for testing (i.e., influenza A or B) and one specimen

should be submitted directly to the NPHL for novel virus testing. Specimens will be tested by the NPHL for the following reasons:

- 1) NPHL is currently the only Nebraska laboratory capable of subtyping influenza isolates, providing faster turn-around time for subtyping;
 - 2) Antigens used in testing for the novel virus will likely only be available at state public health laboratories;
 - 3) Specimens may require testing at CDC; fertilized eggs may be required to grow the virus.
 - 4) Rapid molecular subtyping methods are available; currently the CDC has supplied specific real-time PCR protocols for influenza subtyping to the NPHL.
- c. NEMA will coordinate assistance for specimen transport, as appropriate.

2. North America circulation

a. Nebraska surveillance of pandemic influenza will rely primarily on sentinel physician sites. The number of sentinel sites may be increased to better describe pandemic influenza activity. Sentinel sites will be distributed throughout the state to represent the population distribution of Nebraska. NE HHSS will request that providers obtain and submit a specimen for viral culture and a Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form from a proportion of patients (i.e., 1:10) presenting with ILI.

b. The Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form will collect the following:

- 1) Demographics
- 2) Date of birth
- 3) Symptoms
- 4) Symptom onset date
- 5) Specimen collection
- 6) Vaccination history
- 7) Severity of illness
- 8) Travel history

Pandemic (first wave)

1. Nebraska's surveillance of pandemic influenza will rely primarily on sentinel physician sites. Sentinel sites will be distributed throughout the state to represent the population distribution of the state. NHHSS will request that providers obtain and submit a specimen for viral culture and a Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form from a proportion of patients (i.e., 1:10) presenting with ILI.

2. The Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form will collect the following information:

- a. Demographics
- b. Date of birth
- c. Symptoms
- d. Symptom onset date
- e. Specimen collection
- f. Vaccination history
- g. Severity of illness
- h. Travel history

Second Wave

1. Nebraska's surveillance of pandemic influenza will rely primarily on sentinel physician sites. Sentinel sites will be distributed throughout the state to represent the population distribution of the state. NHHSS will request that providers obtain and submit a specimen for viral culture and a Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form from a proportion of patients (i.e., 1:10) presenting with ILI.

2. The Pandemic Influenza-like Illness Enhanced Disease Report Card and Laboratory Submission Form will collect the following information:

- a. Demographics
- b. Date of birth
- c. Symptoms
- d. Symptom onset date
- e. Specimen collection
- f. Vaccination history
- g. Severity of illness
- h. Travel history

B. Pandemic over (Recovery)

The goals of "pandemic over" surveillance are to provide a detailed retrospective characterization of the pandemic and to evaluate the efficacy of protective action recommendations and emergency management strategies. These surveillance activities may include:

- 1. Review death certificates statewide for pneumonia and influenza deaths.
- 2. Review hospital admissions for ILI.
- 3. Conduct retrospective studies of vaccine efficacy.
- 4. Conduct validation studies of influenza illness reporting.
- 5. Conduct retrospective studies of protective action recommendations.

Vaccine Allocation

Vaccine Priority Advisory Group

It is assumed that influenza vaccine containing the novel strain of virus will be available for administration. Antiviral medications will also provide some protection and may be distributed when vaccine is unavailable or in short supply (See VI. VACCINE AND ANTIVIRAL MEDICATION). In a pandemic situation, it will be essential that there is an equitable distribution of vaccine and antiviral medications to priority groups regardless of income or access to care. The Governor has appointed a *Pandemic Influenza Advisory Committee* to advise NE HHSS regarding prevention and control activities in the work place and community, and to identify priority populations for vaccine and antiviral medications, based on:

- Federal guidelines and published research,
- Availability of vaccine and antiviral medications,
- Morbidity and mortality data (international, national, state and local).

The Immunization Management Group will communicate regularly with the Governor's committee and the rank order of the priority groups may be modified as resources and morbidity change.

The Governor's Pandemic Flu Committee is broadly based including representatives from the public and private health care sector, special populations, employers, ethicists, and others as deemed appropriate. The members acknowledge that their decisions center around potentially conflicting values and that a key question to address is, "What are we intending to prevent?" (i.e. death, serious illness, overall burden of illness, economic and productivity loss).

Special attention will be paid to educating the medical community and general public about influenza prevention, treatment, and control, priority vaccination groups, including the rationale for the rank order and how the decisions were made. A critical focus of public communication is on prevention measures people can take to protect themselves, their families and their community until influenza vaccine is available or the pandemic has ended.

Vaccine and Antiviral Medications

Purchase of Vaccine

Pandemic influenza will pose a number of challenges for vaccine delivery. Private providers and public health officials will have to work together to immunize persons across the state. In all likelihood, CDC will nationalize the vaccine

distribution; federal authorities will purchase and distribute the vaccine to the states. The states will then manage distribution to their residents. It is anticipated that the vast majority of vaccine will be distributed through the public health sector, administered in public locations and through mass clinics, according to the Priority Group list. If private medical providers are able to purchase vaccine, they will be encouraged to do so and to prioritize its administration to populations as defined by the Governor's committee.

NE HHSS will purchase influenza vaccine through the CDC or multi-state purchasing agreements, as appropriate. Additionally, NE HHSS will receive and distribute federally purchased vaccines, as available. If the vaccine is delivered directly from the manufacturers, it will be recorded electronically into VACMAN from the manufacturers to the central office and processed through the State Immunization Information System (SIIS).

Storage and Delivery of Vaccines and Supplies

Vaccine will be stored in secured facilities that have back-up power sources. For security reasons locations will not be made public. HHSS has identified locations for local and regional storage of vaccine and antiviral inventories, HHSS and NEMA in cooperation with SNS plans have identified facilities to store vaccination-related supplies and inventories for further distribution across the state. As needed, HHSS will also identify and form contractual agreements with warehouses or similar facilities in Lincoln and regional sites. Supplies will most likely include syringes, coolers and reusable "cold packs", consent forms, providers' informational packets (i.e. information of vaccine storage, administration, usage and adverse reaction reporting forms), educational literature and other materials needed to conduct mass vaccinations. If possible, HHSS will have vaccine and supplies shipped directly to regional storage sites. Department staff, NSP, National Guard resources and potentially commercial carriers will be used to deliver vaccine and supplies to local communities.

Use of Antiviral Agents

The antiviral agents, amantadine and rimantadine, interfere with the replication of type A influenza viruses. Many studies have shown the drugs to be 70%-90% effective in preventing illnesses caused by a wide variety of naturally occurring strains; it is unclear if similar levels of efficacy can be achieved with pandemic strains. Amantadine and rimantadine can reduce the severity and duration of signs and symptoms of influenza A illness when administered within 48 hours of illness onset. Because of their "generic" usefulness against all known influenza A viruses,

amantadine and rimantadine may play an important role in prevention and treatment in a pandemic, especially when sufficient supplies of vaccine are not available. Oseltamivir has been shown to be very effective however expense and availability may limit its use. These issues will continue to be resolved as the Federal recommendation become clearer and the strategic ordering for stockpiles is accomplished. Other issues associated with widespread use of these antiviral medications:

- Quantities will be limited;
- Priorities have not been established regarding target groups and use of limited supplies for chemoprophylaxis versus therapy.
- Widespread use of amantadine and rimantadine may lead to emergence of drug-resistant viral strains.

The potential for adverse drug reactions associated with amantadine, and to a lesser extent rimantadine, and potential adverse interactions with other drugs have raised concerns about safety and liability in a scenario of large scale distribution and use. Until these issues can be resolved at the national level, priority planning activities for allocation and distribution of antiviral agents should be relatively limited. In the event that antiviral use is determined to be a feasible part of a pandemic strategy, the IM Group and VPAG will determine how use of such medication can best be integrated into the State's Guidelines and strategies.

Provision of Vaccine

Pandemic influenza will require administration of vaccine to a large number of people in a fairly short time.

1. General Coordination and Oversight

a. The State will work with the local Emergency Management Directors in counties other than Lancaster and Douglas to coordinate and oversee vaccination activities including:

1) Mass clinic activities, and

2) Vaccinating or ensuring the vaccination of targeted staff and/or residents in large agencies or institutions.

a) Agencies include government and law enforcement; public safety/service personnel (i.e. key government officials, NE State Patrol, police, fire fighters, emergency medical responders, utility workers, public health employees).

b) Institutions include state and local correctional facilities; hospitals; long-term care facilities; developmental centers; HHSS regional centers; colleges and universities.

- c) The State will vaccinate or ensure the vaccination of staff and students at the University of Nebraska – Lincoln and staff and inmates at the Nebraska Correctional Facilities in Lincoln and Omaha.
- b. Local health departments have developed and are exercising mass administration plans and will oversee vaccination activities in their respective counties, including:
- 1) Mass clinic activities, and
 - 2) Vaccinating or ensuring the vaccination of targeted staff and/or residents in large agencies or institutions located in their counties, with the exception of those listed above as being the State’s responsibility.
- a) Agencies include government and law enforcement; public safety/service personnel (i.e. key government officials, police, fire fighters, emergency medical responders, utility workers, public health employees)
- b) Institutions include local correctional facilities; hospitals; long-term care facilities; colleges and universities, except as specified above, under the State’s responsibilities.

2. Mass Clinics

The vast majority of vaccine will be administered in mass public clinics. Many Nebraska communities are already familiar with the concept of mass clinics because of the state’s public childhood immunization clinic network that has been in place for over 25 years. The established policies and procedures, currently followed in the public childhood immunization clinics, will be used as the template for mass influenza clinic operations. These policies and procedures address:

- Clinic flow;
- Staff training and responsibilities;
- Patient education/informed consent;
- Vaccine storage, preparation and administration;
- Standing physician orders related to vaccine administration and emergency protocol;
- Vaccine accountability;
- Patient record keeping;
- Reporting usage; and
- Monitoring/reporting adverse events.

a. Clinic Staff:

The State and local communities will need to make personnel available to staff the mass clinics. Depending on availability, ‘alternate’ vaccine providers, such as health profession students and trained lay people may be utilized. Volunteer recruitment and training plans may need modifications for the special circumstances of a pandemic. For example, orientation or training activities may need to be more focused (i.e. task specific versus

providing a broader overview of clinic activities). Non-essential activities, as defined by the community, may need to be canceled or rescheduled and personnel diverted into vaccine administration and record keeping. The disruption of normal services could last for a significant period of time (4-8-weeks). Available personnel, including administrators, could be used for registration and data entry, if they are not certified to provide immunizations. Community volunteers can also be recruited. Vaccine teams will staff the clinics. A team will consist of one person to register and hand out educational materials, one person to draw up vaccine in single dose syringes, one licensed health care provider to administer the vaccine and one person to enter data and complete any other paper work. It is estimated that one team will be able to administer 50 doses per hour, with a maximum of 400 doses per day.

b. Clinic Sites:

Local health departments have identified public clinic sites. Sites include locations where large numbers of target populations are likely to be present (i.e. senior citizen centers); other possible locations include armories, schools, churches, civic auditoriums and other facilities that are conveniently located and able to handle large scale clinic operations.

c. Transportation:

Transportation to and from clinics may be an issue for some communities. Cooperative agreements may be needed with public transportation providers to ensure target populations are able to get to public clinic sites. Volunteers may be recruited to provide transportation. The National Guard also has the personnel, expertise and equipment to assist in transporting large numbers of persons, if necessary.

d. Other Requirements:

Local health departments are also addressing security needs, the needs of special populations, stockpiles of clinic supplies, coordination with emergency response and the health care communities, in their plans.

Tracking and Assessment of Vaccine Utilization

The State will track vaccine inventories, distribution to sites and demographics of persons immunized. Continued assessment of this information will be used to monitor equitable and appropriate distribution of vaccine to high morbidity areas and target populations. The State will enlist the assistance of local health departments and public immunization clinic personnel to assist in tracking vaccine use.

Ideally, the vaccine administration database will track adverse reactions and provide a reminder/recall system for second dose administration. The national

VAERS (Vaccine Adverse Event Reporting System) system is already in place for reporting adverse vaccine-associated events and will be used in a pandemic situation.

A printed vaccine information sheet will be prepared with information relating to the vaccine and its contraindications, expected benefits, risks, side effects, and treatment measures. The authorization portion of this form will be in a tear-off format and will include a section for the patient's name and certain vital information. The State, DCHD, LLCHD or other providers will retain the signed consent portion, and the vaccine recipient will keep the informational/cautionary portion. This form will be prepared in other languages, as appropriate (e.g., Spanish).

Electronic recording and transfer of data from the local to state level should be used whenever possible. When this is not technically feasible, a written protocol regarding vaccine distribution should be in place which specifies responsible sending and receiving parties, information to be shared routinely and mode of transmission of information.

The feasibility of tracking doses given in the private sector, should that happen, is uncertain; however, private sector administration data would help provide a more complete picture of vaccination coverage.

Tracking and utilization databases will be key components, when conducting post-pandemic evaluation of disease prevention efforts.

1. NE HHSS responsibilities:

a. Coordinate the distribution of all vaccine coming into Nebraska through CDC and/or from pharmaceutical companies;

b. Work with local health departments and health care providers to track vaccine availability and monitor distribution.

c. If "VACMAN" is not available, the State will track vaccine distribution as follows:

1) For each shipment received from the state and each shipment out to a public clinic site, the log will record:

a) Date received or redistributed;

b) Manufacturer;

c) Lot number and expiration date;

d) Quantity of vaccine received or redistributed;

e) Local clinic site receiving vaccine.

2) A separate entry will be used with each shipment received or redistributed; each date of activity; each manufacturer; each lot number and/or each site receiving vaccine.

d. Receive and assess vaccine utilization reports from local mass clinics in all counties except Douglas and Lancaster;

- 1) Work with local public health to roster records on individuals receiving vaccine in mass clinics.
- 2) If electronic or software programs are not available to track vaccine distribution or maintain rosters records on individuals vaccinated, a paper system will be used, documenting the same information.
2. Local health department responsibilities:
 - a. Coordinate vaccine distribution and monitor utilization in their respective counties; except as indicated above, under the State's responsibilities;
 - b. Forward distribution and utilization reports to the State for inclusion in state-wide analyses;
 - c. Maintain roster records on individuals receiving vaccine in mass clinics. The vaccine information statement could be modified to include a section for the patient's name and certain vital information.
 - d. If electronic or software programs are not available to track vaccine distribution or maintain rosters records on individuals vaccinated, a paper system will be used, documenting the same information.
2. Non-public sites
 - a. Records on individuals vaccinated by non-health department agencies will be archived at the institution or agency that administered the vaccine.
3. Regional and local distribution
 - a. Regional and local sites will track any further distribution to local public clinics.
 - b. For each shipment received from the state and each shipment out to a public clinic site, the log will record:
 - 1) Date received or redistributed;
 - 2) Manufacturer;
 - 3) Lot number and expiration date;
 - 4) Quantity of vaccine received or redistributed;
 - 5) Local clinic site receiving vaccine.
 - c. A separate entry will be used with each shipment received or redistributed; each date of activity; each manufacturer; each lot number and/or each site receiving vaccine.

Communications

The availability and dissemination of timely, accurate and appropriate information among public health officials, medical care providers, the media and the general public will be one of the most important facets of the pandemic response. NE HHSS will work in partnership with the CDC, local health departments and professional organizations and agencies to ensure the availability of accurate

information and the dissemination of that information to professionals and the general public before, during and after a pandemic flu emergency.

A. Development and Dissemination of Information

1. NE HHSS Communications and Legislative Services Division has a crisis and emergency risk communication (CERC) plan that outlines the responsibilities and activities of the communications staff during public health emergencies. HHSS CERC plan is available to the local health departments through a secure web site.

a. In order to keep information consistent, HHSS Communications and Legislative Services Division will oversee communications with the media.

b. To raise awareness and help educate the public health and medical communities and the general public, HHSS will share responsibilities across programs, agencies and organizations. Some examples of education include: advance preparation for pandemic flu; caring for the ill at home; proper self-care practices.

2. Publications and Guidance Information

The following are currently being developed at a national level and will be provided to states. A team of NE HHSS professionals (including health care providers and other medical professionals, public information officers, and behavioral health specialists) will review the documents and distribute them as appropriate to the local health departments through the secure web site.

a. Generic “fact sheets” (i.e. “Questions and Answers”) on influenza, vaccine and antiviral agents;

b. General prevention messages, including “do’s and don’ts” for the general public;

c. Training modules (Web-based, video, printed, etc.)

d. “Canned” presentations, slide sets, videos and documentaries;

e. Strategies and guidelines for interacting and communicating effectively with the media, public health and medical providers, and the general public.

f. Guidelines for triage and treatment of influenza patients in outpatient, inpatient and non-traditional health care settings;

g. Guidelines for setting up and operating mass clinics;

h. Guidelines for the distribution and use of antiviral medications;

i. Guidelines for the use and potential effectiveness (or non-effectiveness) of “traditional” (“generic”) disease control measures, such as the use of masks and other hygienic barriers, as well as strategies to curtail community transmission, such as the cancellation of large community events and temporary closure of schools and large, “non-essential” businesses. (It should be noted that the value of these measures is largely uncertain at this time.)

3. Public Health Network and Medical Community

a. The NE HHSS website, the HAN system, and collaborative partners (i.e. NE Hospital Assoc., NE Medical Association, and Public Health Association of NE)

will be used to disseminate information to a variety of appropriate public health and medical providers.

b. The HAN will be used for rapid dissemination of information whenever possible.

c. Videoconferencing will be used when needed to disseminate information to public health and medical providers.

d. In the event of pandemic flu, public health and the medical community will receive, at a minimum:

1) Appropriate medical information and updates (i.e. vaccine administration recommendations, contraindications and adverse events associated with influenza activities and other information/updates published in the MMWR);

2) Information on surveillance activities including diagnosing disease and laboratory confirmation;

3) The locations of outbreaks and predicted spread;

4) Information on priority/targeted populations, vaccine availability and clinic locations;

5) Updates on appropriate and current control activities.

e. Media: The NE HHSS Communications and Legislative Services Division maintain a database of media statewide and some from surrounding states. This data base that includes newspapers, television and radio stations, is currently used to communicate information to Nebraskans and will be used in the event of a pandemic emergency. Through news releases, news conferences, the HHSS web site, etc., the media will receive and be able to distribute to the general public regular updates regarding the event that include:

1) Appropriate contact information;

2) Principles of risk communication to the affected population that explains and informs the public in simple terms about the risk;

3) Emergency courses of action (i.e. vaccine administration recommendations including contra-indications and adverse affects, the locations of outbreaks and predicted spread, vaccine availability, clinic locations, etc.);

4) A commitment to continued communications; and

5) Notice of where the public can get more information.

HHSS Office Coverage

In May of 2005 a new 24/7/365 number was activated. That number is staffed by health care professionals at the NE Poison Control Center. This number is available for health professionals and public health partners.

Information on outbreaks usually comes via telephone, e-mail or fax to NE HHSS R&L Environmental or Disease Surveillance. Normal business hours are Monday

through Friday, 8 a.m. to 5 p.m. During non-business hours, callers are directed by voice recording to leave a message or call the Nebraska State Security Office. The Security office has been provided a list of personnel and numbers for staffs' pagers, cell telephones and home telephones. DCHD and LLCHD have business hours, 8 p.m. until 4:30 p.m., Monday through Friday, and have established protocol for after-hour emergencies.

Training

A. This plan and the resources identified in the plan will be utilized to train public health and emergency services staff throughout Nebraska concerning influenza pandemic preparedness and response.

B. NE HHSS will work in partnership with PHAN, local health departments and professional organizations and agencies to train professionals and volunteers who will be participating with NE HHSS in responding to a pandemic.

C. NE HHSS will collaborate with the NE Center for Biopreparedness Education to identify training needs and provide education for public and private health care professionals regarding influenza, mass response, incident command, and other identified topics.

HHSS Plan in Action www.hhss.ne.gov/pandemic

This is an example of how our state pandemic flu plan would work if there's human-to-human transmission of a new deadly virus. The responses here are based on the given scenarios. In real life, things could happen very differently. It could be worse, it could be better. We won't know until it happens.

What happens in Nebraska if...

The United States has a confirmed case of pandemic flu (human-to-human transmission).

Response:

- Issue state public health alert.
- Ramp up surveillance (data from doctor's offices, hospitals, schools, labs and travel histories).
- Activate the Health Alert Network and send message telling all Nebraska healthcare providers, health departments and hospitals what signs and symptoms to watch out for and to report anything suspicious.
- Work with the media to get preparedness and personal protection messages out to Nebraskans.
- Activate HHSS pandemic flu hotline and special web pages.

- Tell Nebraskans to watch their children and family members for signs and symptoms of pandemic flu. If they think that they or a family member might have pandemic flu, they should call their healthcare provider.
- Pull together government pandemic flu groups along with healthcare providers, businesses and schools to discuss situation and decide next steps. Identify who will receive vaccine and antivirals, if available.
- Survey pharmacies to see how much antiviral medication is on hand.
- If vaccine is available, begin vaccinating Nebraskans.

Pandemic flu outbreaks are in surrounding states.

Response:

- Surveillance is on-going.
- Limit activities to those considered essential (i.e. school, grocery shopping, medical visits, work).
- Discuss closing public activities (i.e. athletic events, concerts).
- Continue to work with media to get preparedness and protection information to Nebraskans.
- Monitor illnesses and deaths in other states and nationally.

Nebraska has one confirmed case of pandemic flu.

Response:

- Person with pandemic flu would be hospitalized, isolated and receive antiviral medication.
- Governor declares public health emergency.
- Continue discussions about public closures.
- Work closely with medical community to identify new cases and spread of disease.
- Voluntary quarantine for people exposed.
- Encourage members of the business community to activate pandemic plans.
- Keep Nebraskans informed of new developments through the media and HHS website, continue personal preparedness/protection messages.

Nebraska has several cases of pandemic flu.

Response:

- Work with local health departments to contain outbreaks.
- Issue voluntary restrictions on activities and travel.
- Recommend school and business closures.
- Recommend people work from home and stay home.

- Request federal stockpile of medical equipment and medicine.

Nebraska has a large amount of sick people and numerous deaths.

This is the point where government resources and the hospitals would be strained or overwhelmed...that is why planning and partnership is crucial at a local level. This is where Nebraskans would need to take care of each other in their own communities.

For more information on the Nebraska Pandemic Flu Plan, visit www.hhss.ne.gov/puh/epi/flu/pandemic/docs/State-Plan.pdf.

Organizational Structure Nebraska Department of Health & Human Services

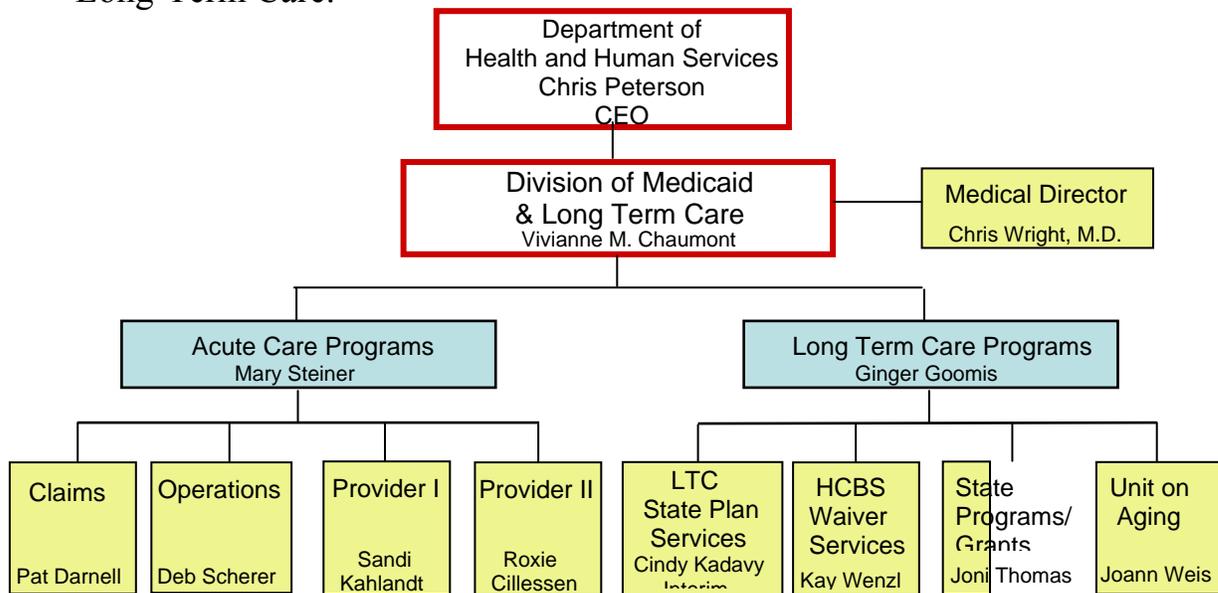
On March 15, 2007, Governor Dave Heineman signed into law Legislative Bill 296, which merged the three agencies of the Health and Human Services System into one Department of Health and Human Services. The change became effective July 1, 2007.

The organizational structure of the Department of Health and Human Services includes a Chief Executive Officer who is appointed by the Governor and subject to confirmation by a majority vote of the members of the Legislature.

The department has six divisions: Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long-Term Care, Public Health, and Veterans' Homes.

The directors of the divisions are also appointed by the Governor and subject to confirmation by a majority vote of the members of the Legislature. The division directors report to the CEO.

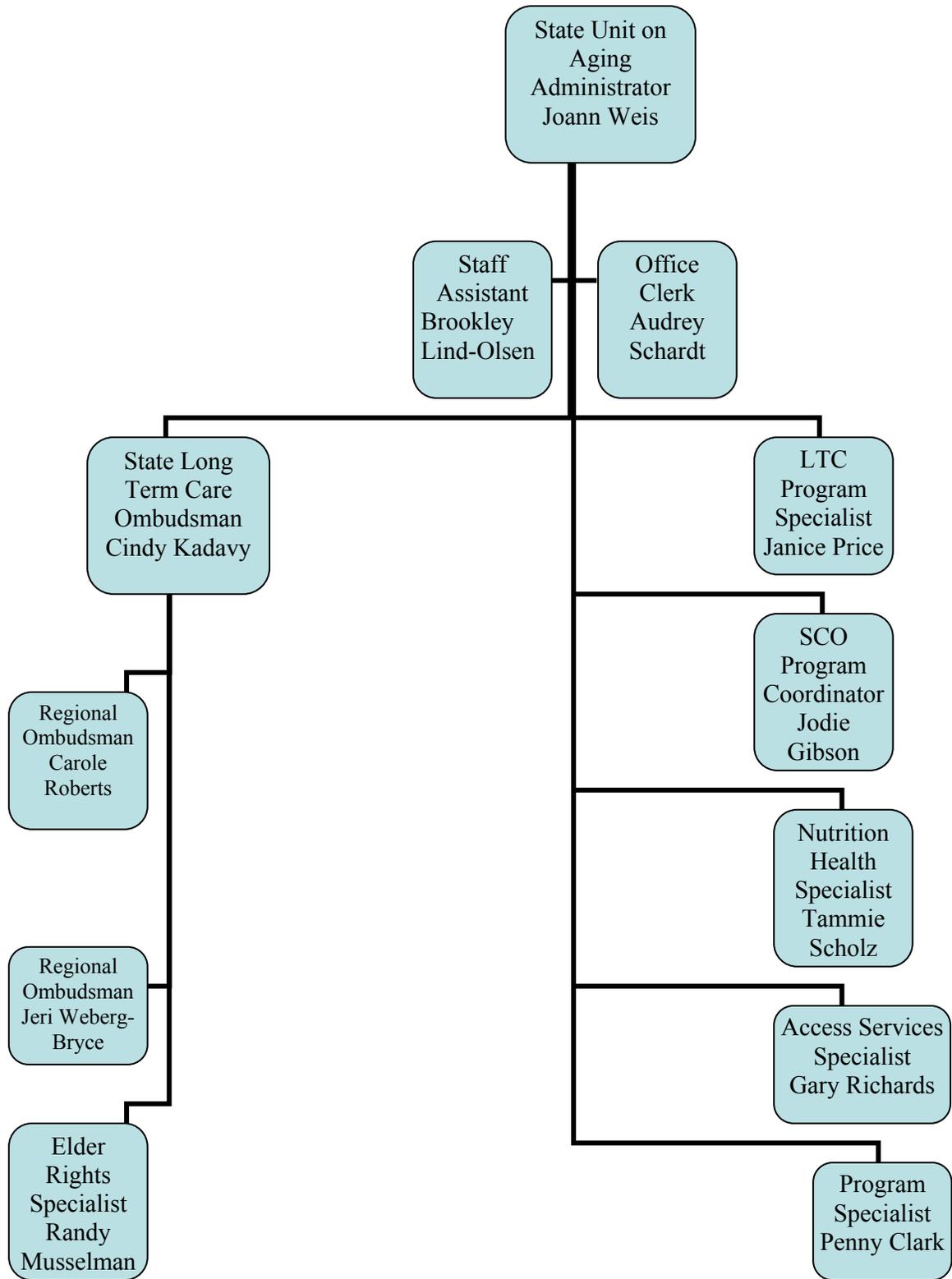
The Nebraska State Unit on Aging falls under the Division of Medicaid and Long-Term Care.



Gubernatorial Appointees
 Director Appointees

Updated 7/6/2007

State Unit on Aging Organizational Chart



A new website design was part of the restructuring of the Department of Health & Human Services. The new website gives users an easier navigation through the system. As part of this new design, the State Unit on Aging pages have also been updated.

The State Unit on Aging will continue to update the website and as the system allows intends to add an active calendar. The goal is to allow users to complete a questionnaire that will after giving some general information, inform them of what services they might qualify for, and direct them to the appropriate agencies.

The following are screen shots of the new Department of Health & Human Services State Unit on Aging website pages. To access more of the website visit www.dhhs.ne.gov.

The screenshot shows the homepage of the Nebraska Department of Health & Human Services. At the top, there is a navigation bar with the following categories: BEHAVIORAL HEALTH, CHILDREN & FAMILY SERVICES, DEVELOPMENTAL DISABILITIES, MEDICAID & LONG TERM CARE, PUBLIC HEALTH, and VETERANS' HOMES. Below this is a search bar with a "Search" button. A large question mark is displayed in the center of the page. To the left, there is a vertical menu with various links such as "Home", "About DHHS", "A-Z Topics", "Birth Certificates & Vital Records", "Children & Families", "Disabilities", "Disasters & Emergencies", "Diseases", "Environmental Health", "Financial Assistance", "Grants & Loans", "Health, Safety & Wellness", "Licensing & Registrations", "Medicaid & Medicare", "Mental & Behavioral Health", "Rules & Regulations", "Seniors & Aging", "Special Populations", and "Statistics & Reports". In the center, there is a "How Do I.." section with a "Please Select One" dropdown menu and a "GO!" button. Below this, a message states: "On July 1, 2007 our Website address changed. Please update your bookmarks. WELCOME to DHHS from the CEO". A "NEWSROOM" section follows, with two entries: "July 6, 2007 Health Alert Issued for Iron Horse Trail Lake; Alert Continues for Fremont Lake #20" and "July 3, 2007 Another Case of West Nile Virus Reported". A "HOT TOPICS" section lists: "Rebirth of an Agency", "Pregnancy Related Depression", "Sister Study on Breast Cancer", and "Extensively Drug-Resistant Tuberculosis - CDC Link". On the right side, there are sections for "Alerts" (Health Alert Network), "Online Services" (Birth Certificate, License Renewal, Job Application), "Forms", "Translate Site" (with flags for Spanish, French, German, Chinese, and Russian), and "Powered by SYSTRAN". At the bottom right, there is a "GET SMART Know When Antibiotics Work" logo and a "Own Your Future" banner.

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Search

Division of Medicaid & Long Term Care

The Division of Medicaid and Long Term Care encompasses the Medicaid Program, Home and Community Services for Aging and Persons with Disabilities and the State Unit on Aging.

- [Medicaid Program](#)
- [Home and Community Services](#)
- [Long-Term Care](#)
- [State Unit on Aging](#)

Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. Medicaid provides health care for more than one in every ten Nebraskans.

Additionally, the Division administers non-institutional home and community-based services for individuals qualified for Medicaid waivers, the aged, adults and children with disabilities and infants and toddlers with special needs.

The Division also administers the Adult Protective Services Program for the prevention, correction or discontinuance of abuse, neglect or exploitation of a vulnerable adult, using the least restrictive alternative and promoting self care and



**Vivianne Chaumont,
Director**

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Search

State Unit on Aging

"To Promote the Dignity, Independence, & Freedom of Choice for Older Nebraskans"

The Aging Network in Nebraska is made up of individuals and organizations in the public and private sectors. Funded by the Older Americans Act, the Nebraska Community Aging Services Act and the Nebraska Department of Health & Human Services, the State Unit on Aging has broad responsibilities for addressing the concerns of older Nebraskans.

- [Aging Services & Resources](#)
- [Area Agencies on Aging](#) 
- [Useful Links](#)
- [Contact the State Unit on Aging](#)

The State Unit on Aging grants state and federal funds to the eight Area Agencies on Aging in Nebraska to support local programs and services.

With the assistance of local individuals and advisory groups, each Area Agency on Aging determines needs and develops a plan to provide an appropriate array of services for its aging population.

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State Unit on Aging

Services & Resources

 [Nebraska Area Agencies on Aging](#)

[Income Support](#)

[Home & Community Services](#)

[Insurance Programs](#)

[Adult Protective Services](#)

[Long Term Care Ombudsman Program](#)

[Aging Advisory Committee](#)

[Nebraska SMP \(Medicare/Medicaid Fraud & Waste\)](#)

[Community Action Program](#)

[Nutrition Programs](#)

[Elder Rights Program](#)

[Reverse Mortgage](#)

[Employment](#)

 [Selecting a Nursing Home](#)

[Homestead Tax Exemption](#)

 [Senior Centers](#)

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Planning Ahead for Future Long-Term Care Needs

Governor Heineman and the Nebraska Health and Human Services System encourage Nebraskans to begin now to plan for their future long-term care needs, by initiating family conversations, making improvements in health and management of chronic disease, learning more about community resources, considering home modification and assistive technology and exploring legal and financial options. Research indicates that planning ahead allows individuals more control over their future choices.

Own Your Future



Nebraska's Long-Term Care Planning Resources

To learn more about Nebraska's Own Your Future Long-Term Care Planning Awareness Campaign and a variety of long-term care and planning resources, visit www.answers4families.org/lcplanning or call Answers 4 Families at 800-746-8420.