Major Issues

Department of Public Institutions

Prepared for

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I. INTRODUCTION

The purpose of this document is to present a broad brush picture of the Department of Public Institutions at a given point in time. It will be organized in a manner which mirrors the organization itself, treating each operating unit within the Department individually by summarizing the major policy and/or operational issues which are presently extant with respect to that particular unit. The idea is not so much to portray everything that is happening at the Department ... for that would indeed require volumes ... but rather to give the reader a "feel" for the organization, its immediate past and expected future, as well as some of the key personalities involved in its management.

This information will be summarized for the Department as a whole (including Central Office), Mental Health, Mental Retardation, Alcoholism and Drug Abuse, Services for the Visually Impaired, and Veterans' Nursing Homes. Certain of the areas (such as Mental Health and Mental Retardation) will include treatment of both facilities and community programs.

II. DEPARTMENT OF PUBLIC INSTITUTIONS/CENTRAL OFFICE

The major issues at the level of the overall Department include a need to strengthen Departmental management through a reorganization of management functions and strengthened management capabilities, the need to establish an active planning capability to set in place a policy foundation to guide operational decisions, and a need to conduct operations in a more organized and systematic fashion.

Historically, the Department of Public Institutions has operated in an extremely decentralized manner. Virtually every facility and each of the program divisions, in effect, operated as a department unto itself. It has not been uncommon for DPI's operating units to appear before the Legislature advocating positions diametrically opposed to those of either the Department and/or the Governor. Accordingly, the Department has not been organized in such a way that central administrative authority can be efficiently exercised, nor has there been any real management strength developed at the organization's core.

When I arrived here, for example, I had over two dozen people reporting directly to me as the Director of Institutions ... which in effect meant that most of them operated without much supervision. Further, one could only count three or four individuals (and not all of them able, by a long way) who could be considered to constitute the top management.

A position of Deputy Director for Finance and Administration was created, the position of Director of Medical Services ... which had been vacant for years ... was filled, and certain individuals from within the existing management ranks were identified as being competent and given added responsibilities. Finally, the table of organization was streamlined, though it still has perhaps too many people reporting directly to the Director.

We have also began to ask the operating units to do things in a more consistent and uniform manner. Not surprisingly, this has been passively resisted to a degree by many of the incumbent unit managers, but persistent efforts on the part of the Department's leadership together

with some turnover in the management ranks has helped to facilitate a transition to a new way of doing things. Also helpful has been the fact that the managers of the Department have for the first time begun receiving annual performance evaluations based on the achievement of previously established personal objectives.

In order to strengthen planning, an underutilized planning coordinator was given a new title and authority to go with it, to put in place a set of policies to guide planning throughout the Department. Most recently, as a result of the Arthur Andersen study, we have consolidated the planning functions in Central Office into an Office of Planning and Policy Development, which will function as an extension of the executive office of the Director of Institutions.

The result of this increased emphasis and attention given to planning has been the development of an integrated mission statement for the Department and a set of planning goals to form the basis for the development of strategic objectives at the operating unit level.

In addition to strategic planning, the development of statewide systems plans for the areas of mental health, mental retardation, and alcoholism and drug abuse is a statutory responsibility, which the Department for the past several years has observed more in the breach, than in fact. We have, however, published a State Mental Health System Plan, followed by a Mental Health Strategic Plan, earlier this year and expect by the end of the present calendar year we will have published system plans for mental retardation and for alcoholism and drug abuse.

If they are well done, the importance and value of these documents cannot be overestimated. A discussion of the impact and implementation of the State Mental Health Plan will follow later in this paper, but suffice it to say here that we are attempting to get away from what has been the past practice of spending millions of dollars annually on these programs with absolutely no notion of what it is, in a strategic sense, we are trying accomplish.

Key individuals involved in the top management of the Department at Central Office include Dale Johnson, Deputy Director for Finance and Administration, Dr. Henry Smith, Director of Medical Services, Dr. William Ford, Deputy Director, Dr. Peter G. Beeson, Director of Planning, Marian Layman, Director of Personnel, Arlyss Brown, General Counsel, Jeanne Heier, the Director's secretary and personal assistant, and Jose Soto, Executive Assistant to the Director of Institutions. A general idea of the major responsibilities of each of these folks can be obtained by referring to the table of organization included elsewhere in this briefing document.

The Central Office budget program contains three major components -- the Director's Office, Administrative Services, and Data and Evaluation. The Director's Office budget totals $624,367 and provides for 16 Full Time Equivalent (FTE) positions. The major functions included in the Administrative Services Division are Engineering, Budget and Grants Management, Accounting and Purchasing, Word Processing, and Financial Responsibility. The Engineering Subdivision includes seven staff that provide centralized architectural and engineering services to the nine DPI capital facilities. The Budget and Grants Management Subdivision

includes six positions. The Accounting and Purchasing Subdivision establishes and monitors agency systems for payroll, vendor payments, purchasing, inventory control, and cost reporting and includes 6.4 FTEs. The Department's Word Processing Center includes four positions and serves all staff located at Central Office. The Financial Responsibility Subdivision contains 24 positions responsible for billing and collecting all payments from third parties for the cost of patient care at BSDC and the three regional centers. Patient account offices are located on each campus and serve as the initial point of billings and collections. The total budget for the Administrative Services Division is $1,396,707.

The primary purpose of Data and Evaluation Services is the design and implementation of management information systems for Central Office and facility management. The total budget for this Division is $238,003 and provides for 6.5 positions. This section works in close cooperation with DAS Central Data Processing.

III. MENTAL HEALTH

The three regional centers, located in Lincoln, Norfolk, and Hastings, are, of course, the State's public psychiatric hospitals. While they have existed since the early days of statehood, they have undergone a period of paradigmatic change over the past couple of decades attendant to a social/medical movement generally referred to as deinstitutionalization. Whereas these three hospitals once accounted for a total population of close to 6,000 individuals, their present day patient census comes closer to 600.

The past twenty years have also seen costs go from roughly $15.00 per patient day to the present total of approximately $125.00. This is, as one might expect, indicative of the fact that the institutions provide a vastly different, and more intense, type of service than they did even two decades ago.

Historically, each of the three regional centers has operated completely independent of the others, and with a considerable degree of autonomy from the Department itself. Interestingly, they have never developed any conceptual notion of why it is they exist other than to "give good patient care" (a rallying cry for virtually every hospital in existence). Accordingly, the institutions, as we find them today, pretty much accept anyone who shows up on their doorstep with a legitimate reason to be there, and provide whatever service the attending physician thinks appropriate in that particular instance. The crux of all of this is that these institutions are to a very large degree local or area social service agencies. Adams, Lancaster, and Madison Counties, for example, account for 16% of Nebraska's population but for 44% of persons admitted to regional centers under the Emergency Protective Custody provisions of the statutes.

If the management of the regional centers have not attended to the larger issues surrounding their continued existence, it is in one way somewhat hard to fault them. The fact is that these people are on a daily basis faced with operational imperatives (such as the water from the showers in the LRC Male Security Building running down the walls on the outside of the building) which tend to make it difficult for them to lift their vision to more global issues. That difficulty notwithstanding, this lack

of strategic vision must effectively be addressed. It is, after all, pretty difficult to deal with and obtain funding to remedy physical facility problems unless and until the role and mission for the facility has been established, as well as the need for it to be there in the first place.

The recently completed State Mental Health System Plan attempts to address this need by spelling out an appropriate role and mission for the regional centers, which is intended to undergird the establishment of a strategic plan for each of these institutions. Essentially, the system plan attempts to address the appropriate niche for a public psychiatric hospital, whereas the regional centers have tended to operate as just one more health care institution, with no particular attention to what the policy dynamic of public ownership really means.

The position of the System Plan is that the public mental health care sector, including the regional centers, should concentrate on doing those things which the private sector is unable or patently unwilling to undertake. In the case of institutional care, it seems obvious that community hospitals have established a solid track record in the provision of short-term acute care, but because of the economics involved can never be expected to be a major force in the provision of longer term inpatient care. Accordingly, the System Plan outlines for the regional centers an increasing role in the provision of extended inpatient and structured supportive long-term care.

Presently we are working with the management of the three regional centers to direct and assist the development of strategic plans outlining

objectives for the systematic achievement of this overall policy initiative.

Key actors in the administration of the regional centers are Dr. Klaus Hartmann, Superintendent of the Lincoln Regional Center, Lloyd Jenson, Chief Executive Officer of the Hastings Regional Center, and Allen McElravy, Chief Executive Officer of the Norfolk Regional Center. Of the group, Jenson and Hartmann are roughly equal in tenure, though Jenson is almost 30 years older than Hartmann and quite close to retirement. McElravy has only been at Norfolk for a couple of years, and while he is occasionally somewhat difficult to supervise, he has done a very workmanlike job of straightening out what was an administrative nightmare at the time of his appointment.

The total budget for the three mental health regional centers is $29.2 million. This has been allocated to provide $10.8 million for the Hastings Regional Center, $11.7 million for the Lincoln Regional Center, and $6.7 million for the Norfolk Regional Center. This appropriation will provide for the following number of staff positions at the three regional centers: Hastings Regional Center - 500 FTE; Norfolk Regional Center - 285 FTE; Lincoln Regional Center - 513 FTE. During 1984-85 the general fund provides 63 percent of the support for the regional centers, cash fund 30 percent, and federal funds 7 percent.

No one is sure exactly why (although there are some pretty educated guesses), but public psychiatric hospitals in Nebraska and elsewhere are presently under significantly increasing pressures to provide additional inpatient care. I have seen a quite noticeable increase in the service

demands upon the three regional centers in my 14 months in office. When I came here, all three hospitals would rarely be at capacity, although Lincoln was operating that way much of the time. Today, all three hospitals are quite often full, with persons waiting for admission.

One has to be extremely careful in bringing additional beds into the system, as such beds will almost inevitably be filled simply by virtue of their existence. At the same time, I do believe that within the next couple of years we will need to add at least a very modest amount of additional capacity to the system, and the most appropriate place to do this seems to be at Norfolk. We can, at that location, open up an additional ward (34 beds) for no more than the cost of remodeling the area and employing the additional staff. The last place (or at least the most expensive place) to add beds would be at Lincoln, where significant capital expenditures would be required for extensive remodeling and rehabilitation of existing unused space.

One factor which could change this situation would be if we would transfer the CCS/MR Unit (a 21-bed facility for individuals who are both mentally retarded and mentally ill) from Lincoln to the Beatrice State Developmental Center. Such a transfer is called for in the Plan of Implementation adopted pursuant to the Horacek class action suit, and if it were actually accomplished, those additional beds could be utilized for psychiatric patients. Of course, accomplishing the transfer would require a certain amount of capital expenditure at BSDC in order to accommodate the additional patient load. For whatever it is worth, it is our judgment here that transferring the unit to Beatrice makes programmatic sense.

The Community Mental Health Program consists of 13 community mental health clinics (operating additional numbers of satellite clinics) through the six mental health regions. Just why we need six regions for 13 clinics is something of a mystery, but at any rate, we have them.

The community mental health clinics were originally envisioned by the Department as being the "other half" of the deinstitutionalization movement. In other words, those persons who were being "warehoused" at the regional centers would be supported in community living by various services made available through the community mental health centers. Somewhere along the line that original idea has become quite blurred, and the centers for the past decade or so have pursued a course which could generally be described as attempting to make the community mentally healthy. None of what the centers do in this regard ... stress management clinics, marriage counseling, etc. ... can be described as bad, and most certainly adds to community life. At the same time, they are certainly not operating as part of a state mental health system providing services with state general fund dollars on a priority basis to those individuals who are the most seriously mentally disabled.

This is exactly the type of role and mission which is outlined for them by the State Mental Health System Plan. Specifically, we are asking the centers to begin to prioritize the development of new and enhanced services to the chronically mentally ill, which services constitute a fairly direct alternative to institutionalization. In line with this policy we have, for the first time, required that for the coming fiscal year the centers earmark approximately 8% of their allocation for the provision of such new or enhanced services.

Unfortunately, that amount of money, even including some redirection of present effort, is not going to come anywhere near getting the job done if we are to interdict the revolving door process which characterizes the lives of the vast bulk-of our State's chronically mentally ill citizens.

Even though it amounts to comparing apples to oranges, it is interesting to look at the community mental health program against the context of community-based services for the mentally retarded. This Department appropriates something in excess of $20 million annually for CBMR services on behalf of some 2,200 clients. In addition, there are Title XX Social Service dollars and other public monies going into these various programs.

Conversely, we estimate there are some 8,000 Nebraskans who are chronically mentally ill, only half of whom are in the system at any given moment, and the FY85 appropriation for that program is approximately $6 million. Also interesting to note is that from FY 1979 through 1984, state general funds for CBMR have increased by an amount of 128%, while state general funding of community mental health programs has increased 17%.

Of course, these figures of and by themselves are valueless, but when taken together with the service deficits identified in the Mental Health System Plan, they do take on a certain significance and indicate that if Nebraska is indeed to ever "drop the other shoe" on the deinstitutionalization of the mentally ill, we are going to have to spend some money, in addition to providing planning and policy leadership, along with administrative controls, for the community mental health programs.

The Office of Community Mental Health programs operates as a section within the Mental Health Division, although as an interim measure, the director of that office reports to me during this period while the program is in significant transition. The Office has suffered from a notable lack of direction, if not actual mismanagement, for the past several years, but we believe the appointment of Jim Wiley to the position of Director will do much to remedy that situation. Jim has recently done a nice job of moving into his new responsibilities, and I consider him to be a very positive addition to our management group.

The general fund operating budget of $253,184 for the Office of Community Mental Health provides for a staff of 7 FTE. The state aid appropriation for community-based mental health programs is $5,070,551 of general funds. In addition, the federal block grant funds total $919,732.

IV. MENTAL RETARDATION

The Department of Public Institutions has certain responsibilities for the provision of services to persons who are mentally retarded, both in institutional and community settings. The key locus of these responsibilities, as they respect community-based mental retardation services (CBMR) is the Office of Mental Retardation, which constitutes a program division within Central Office. Institutional care is provided at the Beatrice State Developmental Center.

With respect to CBMR services, the Department faces a certain dichotomy in that the state aid appropriation for these services is made to the Department in behalf of the six mental retardation regions, but the

Department, pursuant to the statutes, as interpreted by the Nebraska Attorney General, lacks the authority to direct the expenditure of these monies.

Legislation introduced and sponsored by the Department during the past session of the Nebraska Unicameral would have changed this situation. The bill, LB 720, would have given the Department the authority to prescribe a core of basic MR services and to have required their provision on a uniform basis across the state by the mental retardation regions. The bill was opposed by the regions and the Association for Retarded Citizens (NebARC) but nevertheless managed to be advanced to General File. A set of compromise amendments agreed to by the Department and the regions would have somewhat proscribed the administrative authority spelled out in the legislation and clarified that individuals who qualify for CBMR services in Nebraska are entitled to receive them. Nevertheless, LB 720 died on General File when the Legislature adjourned sine die.

With the demise of the legislation, it was determined that the Department's most feasible future course of action with respect to CBMR services (given the political clout of the regions) would be to explore what administrative options are available to provide administrative leadership for the program under the present statute. Accordingly, three major responsibilities have been identified as clearly expressed in the present law, and we are in the process of developing the means and procedures of implementing those responsibilities.

The responsibilities referred to include statewide planning, promulgation and enforcement of standards regarding quality assurance, and budget analysis and recommendation. With respect to statewide planning, the Office of Mental Retardation presently is in the process of developing a State Mental Retardation System Plan, which will be quite similar in format to the Mental Health Plan adopted earlier this year. Essentially, that plan will spell out the basic service model which should be available across Nebraska and also define the role and responsibility of various levels of public and private organizations in the provision of these services. This will be the first state MR plan which the Department has published in recent memory.

With respect to quality assurance, we are in the process of updating our regulations and upon their completion, will begin an annual survey of each region to determine that they are providing services consistent with the standards promulgated by the Department. The present statute clearly makes this function the responsibility of the Department and authorizes DPI to withhold funding if standards are not met.

Regarding cost analysis and budget recommendation, the present law requires the Department of Public Institutions to receive the annual budget requests of the MR regions, to analyze the requests and to make a budget recommendation to the Governor and the Appropriations Committee of the Legislature. The law also provides that "the final budget for each region shall be set by the Legislature." Subsequent to the budget having been approved by the Legislature, the Department's role is strictly limited to distributing the appropriated funds to the regions, in 12 equal payments during the fiscal year. Historically, the Department's

review of these budget requests has been limited to examining the reasonableness of line item expenditures (are travel costs excessive?) and/or simply adding a flat continuation percentage to the historic costs.

The result has been that neither DPI nor the Legislature really has had anything to measure the budget requests against, and the appropriation to the regions is essentially a product of the lobbying and political maneuvering of the regions and NebARC. An example of the effectiveness of the MR lobbying in this regard came during the last session, when this constituency garnered 44 votes to override a gubernatorial veto of an expansion of the CBMR appropriation beyond that recommended by DPI.

In order to progress from this present situation, the Department has retained the firm of Touche Ross to develop a cost model to be used in analyzing and making recommendations concerning the CBMR budget requests. The final product of the Touche Ross study (which begins this week and will be completed in mid-August) will be a methodology which will define the projected average cost of providing the basic core of MR services described in the State Plan to the eligible clients in a given region. Even utilizing this analysis methodology, the final regional appropriation will be set by the Legislature and considerably subject to political influences. At least, however, the Governor and the Legislature will for the first time have something against which to measure and assess both the present costs and the budget requests for the CBMR programs.

The Director of the Office of Mental Retardation is David Evans. Dave is a Michigan native and came to the position some 2½ years ago with a very solid professional background in MR services. This background and a high level of personal commitment to persons with mental retardation notwithstanding, Dave has shown some deficits as a manager. He is, however, working on these, and I believe that with continued encouragement can overcome them and play an important role in the management of his own division and the Department as well.

His staff, unfortunately, is largely made up of individuals who are undistinguished either by competence or commitment to the Department. Just about all of these people have come out of the regions, and chiefly see their function ... and that of OMR ... as providing support and assistance to the regions in whatever they want to do, as opposed to OMR being a State planning and regulatory body. Dave understands, however, that this situation must be addressed and will in the months ahead be working closely with staff to improve their effectiveness.

The total general fund appropriation for state aid to community-based mental retardation is $21,048,373 for 1984-85. The Title XX appropriation from the Department of Social Services provides for $4.9 million of federal funds. This appropriation is by region, as specified by the Legislature in the appropriation bill. The operating budget for the Office of Mental Retardation provides for seven staff and a total of $266, 542.

The Beatrice State Developmental Center (BSDC) has changed greatly over the past several years, chiefly attendant to a plan of correction for a

Medicaid compliance waiver, and conditions spelled out in the Plan of Implementation agreed to as a part of the consent decree in the Horacek class action suit. BSDC has gone through a significant capital improvement program which will see completion late this year ... well in advance of the April 16, 1985, deadline for compliance with the Title XIX waiver. The reduced population on that campus has been moved into rehabilitated and modernized facilities, and those being vacated will be closed down and eventually razed.

Our planning has been directed at achieving a target population next April of 432 residents. However, because the Legislature did not approve our request for funds to place 30 present residents in community programs, it has been necessary to revise this planning to project a target population of 458.

We have within the last few months seen increasing pressures for new admissions to BSDC, and in order to hit the target population planned for, it is necessary for us to resist these pressures wherever possible. In addition, we are committed, under the Plan of Implementation, to divert BSDC admissions into community programs, unless the cognizant region certifies that services are unavailable for that particular individual.

As the BSDC population has increased over the past few years, the staff has gone through a series of reductions geared to this workload decrease. Part of the folk wisdom of state government is that as these staff reductions have occurred, they have come disproportionately from the worker ranks and have not affected administrative and support personnel

to the same extent. A look at the numbers involved, however, fails to confirm this assertion. If one is willing to accept that the ratio of support and administrative, to direct care staff was correct at the beginning of the period of cutbacks, then it remains correct today, as the same ratio has more-or-less been maintained over this period.

The present management of DPI, however, is not willing to accept this assumption (that the original ratios were appropriate) and feels that BSDC has profited (or suffered) from somewhat of an excess of administrative and support positions. Accordingly, we have during the fiscal year beginning July 1, 1984, targeted some 35 FTEs on that campus for elimination and will utilize these as direct care positions in the Veterans' Nursing Homes and the Norfolk Regional Center. Fortunately, most of these positions can be eliminated through attrition, obviating the necessity of employee layoffs but still working toward one of our announced goals of prioritizing expenditures for direct patient care and client services within the DPI budget.

The superintendent of BSDC is Dr. Hugh Sage. Hugh has a PhD in educational psychology and is working on a master's in public administration from UNO. Of all of our facility managers, he is the best and appears to have the greatest personal and professional investment in the managerial process.

When I came to this position, there seemed to be a distinct employee morale problem at the BSDC campus, as well as in the Department in general. Of all of our managers, Hugh has probably done the best job of opening up additional avenues of communication with employees as well as

placing additional emphasis on recognizing their performance and contribution. Accordingly, there has been a noticeable improvement in this situation at BSDC, as well as in the Department.

The total budget for the Beatrice State Developmental Center during 1984-85 is $17,483,659. This consists of $7,111,921 general funds, $2,665,637 cash funds, and $7,706,101 federal funds. The average FTE during 1984 will be 872.9.

V. ALCOHOLISM AND DRUG ABUSE

The history and development of DPI's Division on Alcoholism and Drug Abuse would make a fascinating subject for a doctoral dissertation in organizational theory/human dynamics. If nothing else, it shows how the skill and imagination of one individual can impact the social and political life of an individual state.

Nothing much was happening with the alcoholism program until the mid-70's when Bill Ford assumed the directorship of the division. Bill translated his vision of a network of community-based alcoholism care and treatment services into a state plan which he sold to the Nebraska Unicameral to the tune of $4 million. This effort, combined with the decriminalization of public intoxication, and a DPI administration which was willing to let Bill do pretty much what he pleased, really put the show on the road.

In addition to funding programs on a statewide basis (primarily through the six mental health regions), the Nebraska Division on Alcoholism and

Drug Abuse (as it preferred to be accorded) trained and certified alcoholism counselors, supported a prevention center through a contract with the University of Nebraska, provided traineeships for doctoral candidates in clinical psychology, published its own newsletter and pursued its own legislative goals independent of, and frequently in conflict with, the administration of both the Department and the incumbent state administration. As reflective of that era as anything might be, perhaps, is the Division's letterhead which resembled none other in Nebraska state government and which prominently displayed the name of the division and Bill as its director, while acknowledging in microscopically small print, DPI as its parent organization.

In all of this, Ford was the godfather. He rewarded the favored with grants, jobs, and consultation assignments (according to legend) and by the same token was not above withholding same from those outside the fold.

All of this was held together pretty well by Bill's brilliance and personal magnetism until 1980, when he lobbied for and was accorded a newly created position of Deputy Director of the Department. His successor was an individual by the name of Jim Bailey, and as so often happens in an organization developed around the cult of one individual's personality, the Division under Bailey's leadership (or lack thereof) fell into considerable disarray. Bailey, who is an affable individual but certainly not a skilled administrator, resigned shortly after the change in leadership at DPI, and Dr. Cecilia Willis was recruited to the position of Division Director.

Cece Willis is a very capable, hardworking and loyal individual and over the past ten months has managed, by and large, to straighten out the administration of the Division. At the same time, there are a number of anomalies concerning the alcoholism and drug abuse programs which continue to beg for resolution.

The need to plan strategically for the future of alcoholism and drug abuse services in Nebraska was emphasized during the past session of the Nebraska Legislature, which seriously considered increasing the tax on alcholic beverages and dropping an additional $1 million, or so, into the Division's state aid appropriation. Certainly, if the alcoholism and drug abuse program is to be significantly expanded (and it has not been shown, in my mind at least, that this sort of expansion is warranted), we ought to have a more cohesive statewide understanding of what services are needed, and should be provided by whom and to whom. We hope and intend to resolve many if not most of these issues with the completion of a State Plan for Alcoholism and Drug Abuse (the first since Ford's original version) by the end of the present calendar year.

The Alcoholism and Drug Abuse Division appropriation provides for a total staffing of 12.5 positions. The operating budget for the Division includes $227,654 general funds and $208,971 federal funds. The federal fund is that portion of the block grant that may be allocated for administration of the program. The state aid appropriation provides for $3,815,822 of general funds and $1,300,00 of federal block grant funds.

VI. SERVICES FOR THE VISUALLY IMPAIRED

Of the various operating units, the Services for the Visually Impaired (SVI) probably occupies the least amount of the Department's administrative time and attention. This Division works with visually impaired clients on a statewide basis to teach them cane travel as well as vocational and personal living skills, all designed to enable them to function independently in society.

There has been occasional criticism of the program as being built around one conceptual model which appears designed to not just make a blind person independent, but perhaps fiercely so. One of the recent controversies, for example, concerned the use of leader dogs for the blind, which SVI does not advocate, feeling that it only substitutes one form of dependence for another. (Besides, dogs shed hair, bark at the moon, and drink from mudpuddles.) While SVI claims that they inform their clients of leader dogs as an alternative to cane travel, I tend to feel they tend to provide such information rather grudgingly, and not very consistently.

The essence of this same type of philosophical dispute has also characterized the politics of who is appointed to the SVI Advisory Committee. Of the two chief national organizations of the blind ... The National Council for the Blind and The National Federation of the Blind ... the Federation is much more militant and the one with which both the leadership and staff of SVI tend to align themselves. Under the former decentralized management of DPI, the Advisory Committee tended to operate more-or-less as an independent commission, and these two organizations

have waged some rather pitched battles (or at least the Federation has) over the "representativeness" of seats on the Committee. Additionally, it must be admitted that the situation has not been helped of late by a certain amount of delay which has occurred in getting appointments made to the Committee.

The major issue involving SVI since my coming to this position has been getting the organization moved to more habitable and suitable quarters, from its former space in the old Children's Orthopedic Hospital. Originally, SVI and its supporters wanted the State to purchase the former Stephenson's School Supply Building on "O" Street. When that request was denied, plans were drawn to lease the space, but after considerable time and effort it was determined to be unsuitable. Subsequently, suitable space was located and renovated in the former Bethesda Hospital on South 48th Street. SVI recently completed their move to these new quarters and appear to be well located and satisfactory in them.

The Director of the Services for the Visually Impaired is himself a fascinating study. Jim Nyman is Canadian by birth, lost his sight as a youngster in a blasting cap accident, and has determinedly pursued a life style seemingly designed to demonstrate that blindness is an inconvenience but not a handicap. In addition to Dr. Nyman's educational and professional accomplishments, he is a competitive runner, having completed several marathons.

He is a skillful manager who seems to inspire the trust and confidence of his staff, who share his vision of himself as not just a public

administrator, but an advocate for the needs of blind persons. Unfortunately, there are those (including many in this Department) who see Jim as arrogant, rude, and uncooperative, and he does indeed to have a tendency to be somewhat abrasive. However, on balance Jim seems to welcome the additional support he has received from stronger, more centralized DPI management, as well as to chafe under the additional supervision which is an unevitable result of that process. So, while we can expect to continue to have occasional problems with both Jim and SVI, it is by and large a sound program filling an important need in our society.

The majority of the Services for the Visually Impaired programs are funded by federal vocational rehabilitation funds that require a match of 20% state general funds. The total number of positions available to the Services for the Visually Impaired is 50. The operating budget to provide administration and direct services totals $1,381,446. and the amount of funds for aid to visually impaired persons is $275,000.

VII. THE VETERANS' NURSING HOMES

The two major issues involving the Nebraska Veterans' Homes are where they should be administratively housed and what their future should look like. Periodically, the Nebraska Veterans Council (an alliance of all of the various veterans' organizations) makes noises about moving the Homes from DPI's administration and placing them in Veterans Affairs. I personally have no great problem with that, but have previously been given to understand that Governor Kerrey opposes it, for what I consider to be pretty sound managerial reasons.

Presently, our Department furnishes a number of support services for the Veterans' Homes which would have to be replicated, were they placed in Veterans Affairs. In addition, placing the Homes under Veterans Affairs' control would mean that they would indeed be facilities operated for veterans by veterans with virtually no exercise of independent managerial oversight. There was an interim legislative study resolution proposed on this topic (I believe with the support of Jake Gonzales), but it was not introduced in the Legislature.

The future of the Veterans' Homes is to me a much larger and thornier issue. Nebraska makes a commitment to these facilities which appears to be far in excess of that undertaken by other states. For example, the operating budget for the Homes is presently some $14 million, supporting 922 beds and involving 647 FTE positions in facilities at Grand Island, Scottsbluff, Norfolk, and Omaha. Massachusetts, by comparison, has two such facilities with an annual budget of $18.7 million, 822 FTE positions and 875 beds.

What this seems to suggest is that, although the subject is sure to be political dynamite, Nebraska ... in view of the WW II veterans' age cohort, which rapidly approaches senior citizen status ... may need to legislatively address how and to what extent the state is to provide discrete housing and nursing care to veterans and veterans' dependents. We are presently examining that issues, along with projecting future service demands, and hope to have a comprehensive report on the subject available later this summer.

The 1984-85 budget for the Nebraska Veterans' Homes includes $5,141,456 of general funds and $9,496,518 of cash funds. The cash funds consist of per diem payments by the Veterans Administration as well as payments from members according to their personal resources. The total number of staff available at each facility during 1984-85 is: Grand Island - 384.5 FTE; Norfolk - 102.5 FTE; Scottsbluff 40.5 FTE; and Omaha - 135.5 FTE.

VIII. SUMMARY

The election of Governor Bob Kerrey and the accompanying change in state administration came at an almost provident time for the Department of Public Institutions. In 1982 the Department was in the process of winding down a fractious and ofttimes bitter class action law suit concerning the care and treatment of persons with mental retardation, as well as freeing itself from the controls and directives which had, over the past two decades, come to the organization as a result of the receipt of categorical federal grant funds.

In addition, there had not existed since the early 1970's strong central Departmental management with a rather clear notion of what the organization's future should look like. Accordingly, DPI had for more than a decade been allowed to drift along, receiving its most significant direction and mandates from sources external to the Department.

For the present, then, the Department finds itself in the midst of what amounts to a managerial renaissance. Challenged by an able and effective Governor, the Department is attempting simultaneously to strengthen its

internal management and organizational efficiency, while assessing its programmatic universe and charting a clear and strategic course for the future. The initial results of this effort are encouraging, both from the standpoint of the early achievements of the initiative, and the caliber of individuals whom top management has been able to recruit to the challenge.

For the months and years immediately ahead, DPI's major task will be to foster and continue this sense of excitement and achievement in order to sustain and put permanently in place those long-range policies and actions which will appropriately and effectively guide the Department through the balance of this century.