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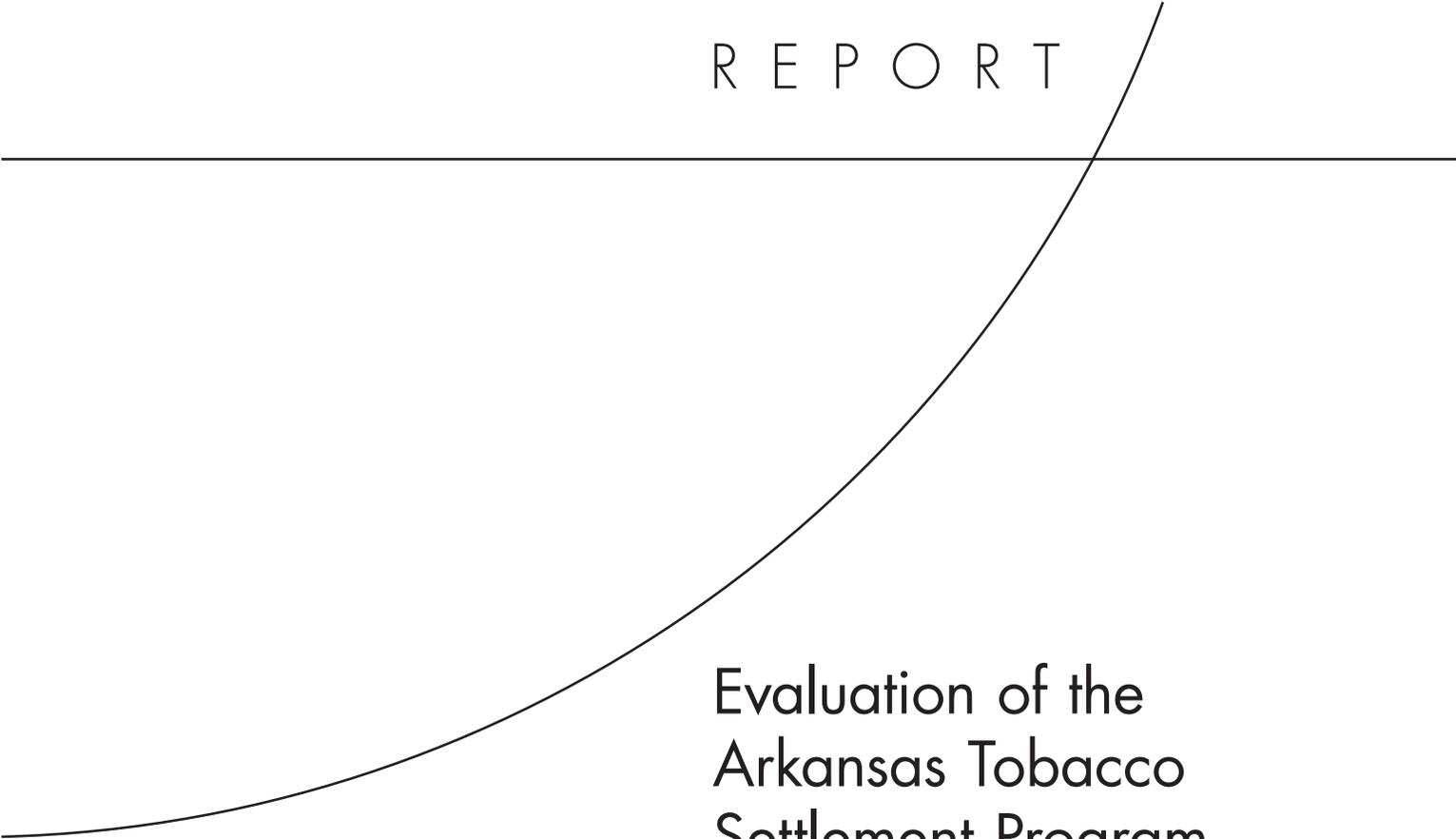
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R E P O R T



Evaluation of the Arkansas Tobacco Settlement Program

Progress During 2004 and 2005

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Summary

The Master Settlement Agreement (MSA), the historic agreement that ended years of legal battles between the states and the major tobacco companies, was signed on November 23, 1998. Under the terms of the MSA, Arkansas has a 0.828 percent share of the payments made to participating states over the next 25 years. Arkansas is unique in the commitment made to invest its share of the Tobacco Settlement funds in health-related programs. The Arkansas Tobacco Settlement Proceeds Act of 2000 (referred to hereafter as the Initiated Act), a referendum passed by the voters in the November 2000 election, established the Arkansas Tobacco Settlement Commission (ATSC) to oversee the spending of MSA monies on seven health-related programs:

- Tobacco Prevention and Education Program (TPEP)
- College of Public Health (COPH)
- Delta Area Health Education Center (Delta AHEC)
- Arkansas Aging Initiative (AAI)
- Minority Health Initiative (MHI)
- Arkansas Biosciences Institute (ABI)
- Medicaid Expansion Programs (MEP)

The Initiated Act was explicitly aimed at the general health of Arkansans, not just at the consequences of tobacco use. Only one of these programs, TPEP, is completely dedicated to smoking prevention and cessation; it does, however, receive about 30 percent of Arkansas' MSA funds. Some programs primarily serve short-term health-related needs of disadvantaged Arkansas residents (AAI, Delta AHEC, MEP, MHI); others are long-term investments in the public health and health research knowledge infrastructure (ABI, COPH). Table S.1 shows the legislative appropriations and actual funding for support of these programs.

Table S.1
Appropriations and Funding for the Programs Supported by the Tobacco Settlement Funds and the Tobacco Settlement Commission

Funded Program	FY2004		FY2005		FY2006		FY2007	
	Appropriation	Funding	Appropriation	Funding	Appropriation	Funding	Appropriation	Funding ^a
Tobacco Settlement Commission	\$2,417	\$1,226	\$2,429	\$454	\$638	\$969	\$641	TBD
Tobacco Use Prevention and Education	18,979	17,401	19,022	\$15,070	17,451	15,097	15,179	13,729
AR Bioscience Institute	15,765	12,555	15,765	10,873	15,765	10,892	15,765	9,906
Medicaid Expansion ^b	20,064	16,410	20,087	14,211	27,554	14,237	13,833	12,947
College of Public Health	3,487	2,871	3,487	2,487	3,486	2,491	3,486	2,265
Delta AHEC	2,324	1,914	2,324	1,658	2,324	1,661	2,324	1,510
AR Aging Initiative	2,324	1,914	2,324	1,658	2,324	1,661	2,324	1,510
Minority Health Initiative	2,012	2,001	2,016	1,733	1,967	1,736	1,972	1,579
Total for programs	64,955	55,067	65,026	47,689	70,872	47,774	54,884	43,446

SOURCE: Arkansas Tobacco Settlement Commission.

a. Funding amounts for FY2007 are projected; actual amounts were provided on July 1, 2006, after the date this report was completed.

b. Amounts for the Medicaid Expansion represent only the Tobacco Settlement funding; these amounts are matched by federal funding according to cost sharing provisions of the Arkansas Medicaid program, which also are reflected in its total appropriations.

As part of its evaluation function, the ATSC contracted with the RAND Corporation to perform a comprehensive evaluation of the progress of the programs in fulfilling their missions, as well as their effects on smoking and other health-related outcomes. This report, the second in RAND's series of evaluations, addresses the following research questions:

- Have the programs achieved the goals that were set for them for the past two years?
- How did the programs respond to the recommendations made in earlier evaluations?
- How do actual costs for new activities compare to the budget; what are sources of any variances?
- How do the programs function with regard to the major program management process functions of governance, strategic decisionmaking, monitoring, quality improvement, financial management, and contracting?
- What effects do the programs have on improving the health of Arkansans in terms of smoking behavior, health outcomes related to tobacco use, and other health outcomes the programs address?

The answers to these questions serve to generate recommendations for how the programs, the ATSC, and other Arkansas agencies might better fulfill the aims of the Initiated Act.

SUMMARY OF PERFORMANCE THROUGH FISCAL YEAR 2006

Overall, the seven Tobacco Settlement programs have continued to refine and grow their program activities. In Chapters 3 through 9, we present assessments of each program's progress. Here, we summarize results across programs, signaling observed problems.

Achievement of Initiation and Short-Term Goals Specified by the Act

The Initiated Act stated basic goals to be achieved by the funded programs through the use of the Tobacco Settlement funds. It also defined indicators of performance for each of the programs—for program initiation, short-term, and long-term actions. In the 2004 evaluation report, we reported that MEP and MHI had not achieved the planned goals.

MEP had not achieved its initiation goals because the AR-Adults expansion program had not been approved by the federal Centers for Medicare and Medicaid Services (CMS). Additionally, MEP was underspending on two of the other three expansion programs. In the past two years, the AR-Adults expansion program has been approved and is starting up. However, underspending is still occurring for other programs within MEP.

MHI had not yet prepared a list of priority health problems for minority populations nor put together the biographical database that the act specified. Since then, MHI has released a list of priority health problems for African Americans; however, it has not provided a list for other minority populations in Arkansas, nor has it assembled the biographical database.

Program Progress on Self-generated Short-term Goals

RAND worked with each of the programs to specify short-term actions to be accomplished during FY2006. These are reported in detail in the respective evaluations of the

seven programs (Chapters 3 through 9) and summarized here. This year, four programs—TPEP, COPH, Delta AHEC, and ABI—have met all of their goals and subgoals, while three programs have not. AAI fell short on the goal of putting together a database of funding opportunities. MHI did not submit an application for survey funding, increase enrollment in the Hypertension Initiative, or expand the Eating and Moving for Life Initiative. MEP did not achieve desired utilization of benefits in the AR-Seniors program or increase enrollment in that program.

ASSESSMENT OF PROGRAM MANAGEMENT PROCESSES

For the 2006 evaluation cycle, we introduced a management and governance process evaluation component, based on a questionnaire sent to all of the funded programs in advance of the in-depth interviews conducted in April 2006. The template for this form is Appendix C of this document. With this form, we requested information regarding four critical aspects of each program of the ATSC.

Our orientation for using this questionnaire is that, after four years of funding, the overall structures of the programs are largely in place, and our attention should turn to how the programs are functioning (i.e., process evaluation). While direct assessment of desired outcome measures is becoming more and more relevant, there is still a need for the major part of the evaluation to look at whether the processes necessary to promote successful outcomes are in place. Our examination covered information regarding the process of the four following components of program functioning:

- Governance leadership and strategic direction
- Monitoring and quality improvement
- Financial management
- Contract management

For each of these four components, we asked for each component in turn what the program had in place to administer the component, and then how well the processes in place were doing.

Governance Leadership and Strategic Direction

The diversity of the programs is reflected in their wide variety of governing bodies. Now that the start-up period is over, the governing bodies should play active roles in guiding the future strategic direction for the programs. These bodies also provide an important vehicle for linking a program to its environment so the program hears the views of its stakeholders and has access to vital resources. We asked each program to specify what governing and advisory boards it has and to rate the degree of involvement of these boards in performing oversight, monitoring program performance, and providing an interface with communities. These ratings are provided in the individual chapter reports of the programs and are summarized in Table S.2.

**Table S.2
Governance and Advisory Boards**

Program	Governing Board	Advisory Boards
TPEP	None	TPEP Advisory Board. Mostly advises on community needs and interactions
COPH	University of Arkansas Board of Trustees (from a distance)	None
Delta AHEC	University of Arkansas Board of Trustees (from a distance)	Advisory boards at each site mostly advise on community interfaces
AAI	University of Arkansas Board of Trustees (from a distance)	Reynolds Institute Community Advisory Board and boards at each regional Center on Aging advise, with considerable variation on degree of involvement
MHI	Arkansas Minority Health Commission exercises considerable oversight	Medical Advisory Board for the Hypertension Initiative, which is only minimally involved
ABI	ABI Governing Board of ex-officio appointees exercises considerable oversight	Scientific and Advisory Committees concern themselves with goals and priorities and monitor quality
MEP	None	None

The natural differences among governance patterns make simple generalization among all the programs difficult. None of the programs has much board involvement in fundraising; as budgets tighten, this could be an area where assistance could be helpful. Given the crucial role of raising funds beyond MSA amounts, boards could and perhaps should take on a greater (and often traditional) role in raising funds. Those programs that are several levels down in the organizational hierarchy from their official oversight organs can find themselves at the mercy of policies that have nothing to do with themselves, without recourse to effective intervention. Those programs that do not have advisory groups should consider forming some groups as vehicles for eliciting community input, developing strategy on pertinent issues, and identifying potential funding opportunities.

Monitoring and Quality Improvement

As of the end of FY2004, few of the programs had internal accountability mechanisms for regular monitoring and providing feedback on their progress; or, where mechanisms were in place, they relied on local program staff, who often did not have sufficient training or resources

to fully comply. Such a monitoring process, when well implemented, enables programs to perform regular quality improvement and assess how well each program component is meeting its goals. This capability also can help the programs fulfill their external accountability for performance to legislators and other state policymakers. Table S.3 summarizes the quality management processes by program.

Table S.3
Quality Management

Program	Formal Quality Management Process	Monitoring capability
TPEP	Occasional external evaluations	Data collection and evaluation mechanisms in place to monitor work of contractors and grantees
COPH	Formal process in place since inception	Monitoring in place to support quality management
Delta AHEC	No overall formal process. Process for Diabetes Clinic	Some monitoring capability, but could be improved
AAI	No overall formal process. Informal tracking of activities for each Center on Aging	Little monitoring capability
MHI	No overall formal process. Process in place for Hypertension Initiative but not for others	Little monitoring capability, even for Hypertension Initiative
ABI	Formal process in place since inception	Monitoring in place to support quality management
MEP	No formal process	Monitoring capability for service delivery. Could benefit from monitoring consumers' experience

The information provided by the programs on their quality improvement activities is uneven and reflects the tradition of quality within the type of agency running the program. The more purely academic programs (COPH, ABI) have mature processes; line agencies within departments (TPEP, MEP, Delta AHEC) have no formal processes but have reporting requirements that could be the basis of processes; and specialized agencies (AAI, MHI, ATSC itself) would benefit from establishing official quality improvement regimes.

Financial Management

Our earlier evaluations showed that several of the programs have been lacking in some aspect of the accounting and bookkeeping skills needed for effective financial management. We recommended in these instances a local automated accounting system, along with additional training and support to strengthen staff ability to document spending accurately and to use this information to guide program management. Table S.4 summarizes the results of this year’s assessment.

Table S.4
Financial Management

Program	Global System in Place	Program Capability for Components
TPEP	The state financial management system	Monitors program components, subcontracts, and grants through separate accounts. Staff qualified
COPH	The UAMS financial system	Monitors program components, but not separately. Staff qualified
Delta AHEC	The UAMS AHEC financial system	Monitors program components, but not separately. Staff qualified
AAI	The UAMS AHEC financial system	Components centrally monitored. Staff qualified
MHI	The state financial management system	Components not fully monitored. Staff not fully qualified
ABI	Each of the member universities has its own financial system	Program components self-monitored (as per Initiated Act). Staff qualified
MEP	The state financial management system	Monitors program components through separate accounts. Staff qualified

Contract Management

We asked each of the programs to provide information about how they manage contracts for services. Only TPEP and MHI have contracts. Both contract for expertise, while TPEP also issues subgrants for service delivery, and MHI contracts for treatment initiatives. TPEP has monthly financial tracking, monitors the quality of performance of contractees, and regularly compares contractee spending to reported activities. By contrast, MHI has monthly financial

tracking only for the Hypertension Initiative, with annual financial tracking for other contracts. There is some monitoring of quality of performance, and there is no comparison of spending to activity.

PROGRAM EFFECTS ON OUTCOMES

An important part of any evaluation is examining the extent to which the programs being evaluated are having effects on the outcomes of interest. We assessed both effects on smoking outcomes and other program effects on nonsmoking outcomes.

Program Effects on Smoking Outcomes

Our analysis of smoking behavior in Arkansas provides evidence of the continued effectiveness of the Tobacco Settlement programs (primarily TPEP) on smoking outcomes, especially for the most vulnerable populations, such as young people and pregnant women. Smoking prevalence measures are largely taken from the Arkansas Division of Health Youth Tobacco Survey, the national Behavioral Risk Factor Surveillance System survey of adults, and the Arkansas Adult Tobacco Survey. Our main findings regarding smoking outcomes are summarized as follows:

- Smoking has decreased substantially among middle school and high school students since programming began.
- Tobacco Settlement programming has reduced smoking among young people, compared with what would be expected based on pre-program trends.
 - Young adults ages 18 to 25, are smoking less than previously.
 - Pregnant teenagers are smoking less than previously.
 - Pregnant women ages 20 to 29 are smoking less than previously.
- The dramatic improvement in compliance with laws prohibiting sales of tobacco products to minors has continued and has been verified by federal auditors.
- Adult smoking prevalence declined in 2005, following a slight increase in 2004, but we cannot yet confirm that this recent decline is a real effect.
- Our analysis of the variation in smoking by county does not provide evidence that people who live in areas where the TPEP activity was focused are less likely to smoke.
- There have been improvements in the rates of a variety of diseases that are affected in the short term by smoking and by secondhand smoke. The evidence is strongest in the cases of strokes and acute myocardial infarctions (heart attacks).

As in past years, our analysis of smoking rates for young adults, pregnant adults, and pregnant teenagers shows conclusively that these groups are smoking less than would be expected if there had been a continuation of the trends in rates that preceded the Tobacco Settlement programming. However, we did not observe definitive evidence of reduced adult smoking.

Program Effects on Nonsmoking Outcomes

Highlights of our findings regarding effects of the Tobacco Settlement programs that have a direct impact on health outcomes other than smoking are as follows:

- *Delta AHEC Teen Pregnancy Programming.* The Delta AHEC has made progress on collecting participant data, including satisfaction and health outcomes information. However, progress has been slow on the management and analysis of these data. We encourage the program to direct additional resources toward ensuring that data are collected and stored in a manner that lends itself to analyses that can be used to monitor program progress and evaluate participant outcomes.
- *Minority Health Initiative.* The MHI has data on outcomes for two out of three counties for its hypertension program participants, but no data for its Eating and Moving for Life initiative. RAND analysis demonstrates a possible effect of the hypertension program on blood pressure. MHI should improve its data collection in both programs and improve its data analysis capabilities.
- *Arkansas Aging Initiative.* There is some evidence that the Centers on Aging have reinforced the decline in avoidable hospitalizations in the counties where they are located. AAI data collection and analysis initiatives are making some progress toward providing useful evaluation of their programs.
- *Medicaid Benefits for Pregnant Women.* We continue to find that the expansion of benefits for pregnant women has led to increased prenatal care. We find **no** evidence that the expansion has reduced smoking among pregnant women or increased birth weights of their babies. Both of these effects would have been expected from increased care for pregnant women.
- *Expanded Medicaid Hospital Benefit.* We find some evidence that one component of the expanded hospital benefits is associated with increased access to hospital care for conditions requiring very short stays. The other component that reimburses for hospital days 21 through 24 appears to be reducing the amount of unreimbursed care rather than increasing the amount of care.
- *Expanded Medicaid Seniors Benefit.* There is weak evidence that the AR-Seniors program has accelerated the decline in avoidable hospitalizations among the elderly. We will monitor this incipient trend in future years.

For the two academic programs, COPH and ABI, we did not look at direct impact on health outcomes but instead used more traditional academic outcome measures.

- *College of Public Health.* The COPH's number of high-quality scholarly publications has increased substantially. Independent reviews of two of its leading projects confirm that the COPH is making major contributions toward the health of Arkansans.
- *Arkansas Biosciences Institute.* The ABI's publication of research findings in top-quality scholarly journals has increased dramatically over the past three years. Its research is being disseminated in respected journals in a wide variety of scientific subjects. Independent reviews of two recommended projects provide detailed

verification that the major ABI projects are making significant contributions in their field.

COMMON THEMES ACROSS PROGRAMS

Our analysis identified two common themes across programs meriting attention: collaborative activities among the programs and the matching of appropriations and funding. We summarize here the discussion of these themes in Chapter 12.

Collaboration and Coordination across Programs

Collaborative activities among the programs strengthen their ability to serve the goals of the Initiated Act, to use the Tobacco Settlement funds efficiently, and to enhance needed health services for Arkansans. Different programs have different bases of expertise and can address common populations and common problems more effectively if they collaborate. Some programs have been working together since early in the program, and others have gradually increased their collaboration. Still, there is room for even more effort in this regard.

Appropriations Process and Fund Allocations

During the initial budgeting and appropriations process, several programs had appropriation allocations across expense classifications that did not fully match their operational needs. The program leaders were reluctant to make substantial changes to the fund allocations in the second biennial appropriations because doing so brought the risk of opening up the entire package to funding changes or reductions. Thus, the spending constraints experienced by the programs in the first two fiscal years were perpetuated in the FY2004–2005 biennial appropriations, which hindered several programs from using their funding effectively. We therefore recommended that the state should provide the programs with clear definitions of the appropriation line items as well as guidance for the budgeting process, so that programs understand clearly how they can use funds in each line item to support their activities.

The programs that were having the greatest problem with poorly allocated appropriations were the four programs that are part of the University of Arkansas for Medical Sciences (UAMS) system: AAI, COPH, Delta AHEC, and the UAMS portion of the ABI. UAMS submitted a proposal for reallocation of the FY2005 budgeted line items for these programs to the Peer Review Committee of the General Assembly, which approved the reallocation. For the FY2006–2007 biennial appropriations, which were completed in April 2005, the programs modified their line item allocations as needed. This step should help ensure that future program appropriations do not place artificial constraints on the programs' ability to spend according to operational needs.

TOBACCO SETTLEMENT COMMISSION

Although the primary focus of RAND's evaluation activities is on the funded programs, we have also examined the Arkansas Tobacco Settlement Commission itself. The ATSC is directed by the Initiated Act to conduct monitoring and evaluation of the funded programs "to ensure optimal impact on improving the health of Arkansans and fiscal stewardship of the

Tobacco Settlement” and “to justify continued support based upon the state’s performance-based budgeting initiative.”

ATSC Monitoring and Evaluating Activities

The Initiated Act directs the ATSC to develop measurable performance indicators to monitor programmatic functions that are state-specific and situation-specific and to support performance-based assessment for government accountability. In its second Biennial Report, submitted on August 1, 2004, the ATSC referenced, included as an attachment, and responded to RAND’s first evaluation report covering 2002–2004 (Farley et al., 2005a). We summarize here the actions taken by the ATSC in response to each of our recommendations.

- *Quarterly Reports.* The commission should modify the content of the regular quarterly reports from the programs to require routine reports on their progress in addressing the issues identified in this evaluation. In response, the ATSC has changed the format of the quarterly reports submitted by the programs to incorporate the provisions listed in the recommendation. The programs are now submitting this information to the ATSC regularly, and the programs also are being asked to provide this information in their presentations at commission meetings.
- *Financial Reporting.* The commission should work with the state finance office and the funded programs to ensure that the programs are correcting the inadequacies of the accounting and financial management processes that this evaluation has identified. In response, the ATSC office is working to develop a financial reporting format that can provide uniformity in reporting across programs. In addition, the ATSC office has been monitoring actions by the programs to correct problems with inaccurate allocation of funds across appropriations line items. Now, all programs submit financial reports to the ATSC each quarter.
- *Technical Support.* The commission should earmark a modest portion of the Tobacco Settlement funds (\$150,000 to \$200,000 each year) to establish a mechanism that makes technical support available to the funded programs. This support should be targeted to help the programs correct some of the issues identified in this evaluation. The ATSC responded by developing this function as an integral part of the ATSC strategic plan. A portion of the ATSC budget was reserved to fund these activities. However, because of ceilings in the appropriations for the commission, it has been unable to purchase technical support in any significant quantity. The commission intends to request an increase in appropriation in order to implement these activities.
- *Expectations for Governing Bodies.* The commission should establish expectations for the performance of the governing bodies of the funded programs with respect to providing policy and strategic guidance for their programs, as well as monitoring program performance. The commission has not yet responded to this recommendation but is considering what to do, given the diversity of boards, commissions, and advisory groups among the various programs.
- *Enhancing Outcome Evaluations.* As the programs mature further, and more longitudinal information becomes available on outcomes, the commission should ensure that outcome evaluation work continues to document the extent of those effects. Meanwhile, the

commission should interpret early outcome information with caution to ensure that conclusions regarding the programs' effectiveness are grounded on sufficient data. In response, the ATSC has emphasized to legislators that it will take time to begin to see outcomes.

Community Grants

According to the Initiated Act, if the deposits into the Arkansas Tobacco Settlement Commission Fund exceed the amount necessary to pay its expenses, then the ATSC may make grants, within its appropriation limits, to support community activities. In FY2004, the ATSC awarded its first set of 16 grants under this provision for a total of \$353,678 in grants to community organizations. In the second round of community grants, awarded in FY2005, the ATSC funded 22 grants for a total of \$487,522, with amounts ranging from \$8,000 to \$24,998. The ATSC established a requirement of quarterly reporting for the community grants, including both provision of information on progress, challenges, and successes in implementing the funded activity and reporting on grant expenditures.

Because the ATSC chose to use some of its available funds for technical support to the seven funded programs, it did not award new community grants for FY2006. Instead, it identified two existing awardees and renewed their grants.

RECOMMENDATIONS

Finally, we present our recommendation for the ATSC and for each program separately. Elaboration of the recommendations is provided in Chapter 12 for the policy issues that overarch the programs and in Chapters 3 through 9 for the individual programs.

Overall Recommendation Regarding Continued Program Funding

We again recommend this year that Tobacco Settlement funding continue to be provided to the seven funded programs. At the same time, performance expectations for the programs should be maintained actively through regular monitoring of trends in their process indicators, progress toward the newly established long-term goals, and trends in impacts on relevant outcomes. As stated in the 2004 evaluation report, we believe the programs supported by the Tobacco Settlement funds provide an effective mix of services and other resources that respond directly to many of Arkansas' priority health issues. With additional years of operation, the programs have achieved their initiation and short-term goals defined in the Initiated Act, with but one exception. The programs' impacts on health needs also can be expected to grow as they continue to evolve and increasingly leverage the Tobacco Settlement funds to attract other resources.

Overarching Policy and ATSC Recommendations

- **Aggressively seek funding to supplement the Tobacco Settlement funds.** To the extent that funding cannot be maintained, potential revisions to the funding allocations of Tobacco Settlement funds should be considered.

- **Leverage Tobacco Settlement funds.** Especially given the anticipated funding crunch, there is a need to rethink the direct service delivery components of programs that have them, and either justify the contribution of these components to people beyond the direct recipients, or eliminate these components.
- **Develop data collection and analysis plans and dedicate resources for implementing these plans.** The ATSC should provide funds for the training of program staff to accomplish these goals. These funds should be appropriated in the next General Assembly appropriations cycle.
- **Intensify the collaboration among the seven Tobacco Settlement programs.** This is most beneficial where programs experience challenges that can benefit from expertise that other programs possess.
- **Install formal quality improvement processes in each program.** Each program and the ATSC itself should have a documented formal quality management program as well as a complete reporting package through which the funded programs provide the ATSC with performance information on both their program activities and spending.

Tobacco Prevention and Education Program

- **Raise funding levels for the nine components of a comprehensive statewide tobacco control strategy to the minimums recommended by the Centers for Disease Control and Prevention (CDC) for Arkansas.** The funding share for tobacco prevention and cessation activities should be at least the percentage share stated for such activities stated in the Initiated Act.
- **Change the process TPEP uses to budget its funds to be in line with the other Tobacco Settlement programs.** Because the legislature funded an Arkansas Rainy Day Fund by shifting the first year of funds out of TPEP, budgeting is more complicated for TPEP than for the other programs receiving Tobacco Settlement funding.
- **Provide evaluation technical assistance for subcontractors and grantees.**
- **Evaluate the statewide media campaign** both in terms of output (public service announcements and community events) and focus, given that a statewide workplace smoking ban went into effect in July 2006.
- **Strengthen communication between TPEP staff and the TPEP Advisory Committee.** The TPEP Advisory Committee has a great deal of expertise that is not being fully utilized.

College of Public Health

- **Continue efforts to meet the new accreditation requirements by December 2007.** Such efforts include expanding full-time faculty for doctoral and master's programs, recruiting students for the new doctoral programs, and obtaining funding to support the additional salaries.

Delta Area Health Education Center

- **Continue to increase resources to conduct program evaluation activities.** Evaluation should be built into future programs and processes.

Arkansas Aging Initiative

- **Make fundraising across all regions one of its highest priorities,** identifying and pursuing funding opportunities through the state and federal governments, foundations, and the private sector. It may be some time before the local Community Advisory Committees are capable of the level of fundraising necessary to guarantee the long-term sustainability of the local Centers on Aging.
- **Ensure that each Center on Aging (COA) establishes and maintains a formal quality improvement process.** Systematic performance monitoring of the COAs is necessary and can be facilitated by the uniform database for tracking activities at the local level.

Minority Health Initiative

- **Improve the financial and quality management activities for all activities.** Most MHI activities continue to lack proper oversight and quality management.
- **Improve the program's capacity to carry out program activities funded by the Act and performance-monitoring activities.** The program needs to build or buy capacity to monitor both its internally funded and contracted activities.
- **Continue efforts to develop a database and design it in consideration of quality improvement processes.** The Initiating Act's mandate to create a database that includes biographical data, screening data, costs, and outcome has yet to be implemented.
- **Continue to study racial and ethnic health disparities and prioritize needs.** Prioritized needs for minorities other than African Americans have not yet been established.
- **Continue strategies to reach target populations** (i.e., minority Arkansans) across the state. MHI needs to know what part of the population its awareness efforts are reaching and if there are ways to increase health education dissemination.
- **Reassess MHI (as opposed to the normal annual cycle of assessment).** If, at that time, performance has not improved to the point where there is confidence that full functionality of the program can be achieved in a reasonable amount of time, then the MHI programming should be redistributed to other programs within the Tobacco Settlement framework. MHI is uniquely positioned to address directly the health needs and priorities of the state's minority populations. It has made some real progress in programming growth and financial reporting during FY2005, and it is spending more of its available funds than it had in the previous biennium. However, as discussed in Chapter 7, issues of declining enrollments, quality problems, and extremely high unit costs have been identified. While MHI has improved slightly on all fronts in the past year, it is still not functioning adequately. We are reluctant to repeat recommendations that have not

been fully followed in the past. At the same time, the inherent value of much of the MHI programming and the important role filled by the Arkansas Minority Health Commission (AMHC) make us reluctant to recommend closing the program or moving it elsewhere. We therefore have adopted a compromise recommendation.

Arkansas Biosciences Institute

- **Be prepared to accommodate potentially severe cuts in funding.** ABI needs to continue to obtain grant funding at a level that can support the infrastructure that has been established at the different universities.

Medicaid Expansion Programs

- **Allocate funds to educate newly enrolled and current enrollees on a regular basis in the Pregnant Women’s Expansion program and in the AR-Seniors program** regarding the services they are eligible to receive.
- **Initiate an outreach campaign to inform both potential enrollees and providers about the availability of the Medicaid Expansion Programs.** Enrollment trends for the Pregnant Women’s Expansion have exceeded expectations but still lag behind projections. More troubling is that income-eligible elderly individuals are overlooked for enrollment in the AR-Seniors program because they are not applying for Qualified Medicare Beneficiary status.
- **Intensify efforts to meet spending targets for the expansions they support.** While the Medicaid programs are to be applauded for their intense effort in bringing the four expansion program on board, they should ensure that all four programs spend the funds available.

DISCUSSION

The Arkansas General Assembly and Tobacco Settlement Commission continue to have much to be proud of in the investment made in the seven programs supported by the Tobacco Settlement funds. COPH and ABI are particularly to be acknowledged for their contributions to improving the public health skills of Arkansans and increasing the national and global visibility of Arkansas as a locus of research applied to improving the health of the population. All programs continue to make substantial progress in expanding and strengthening the infrastructure to support the health status and health care needs of Arkansas residents. We have begun to observe effects on smoking outcomes, and with time, we believe the prospects are good for the programs to achieve observable impacts on other health-related outcomes over the next few years.

Arkansas has been unique among the states in being responsive to the basic intent of the Master Settlement Agreement by investing its funds in health-related programs with a focus on reducing smoking rates. We encourage state policymakers to reaffirm this original commitment in the Initiated Act to dedicate the Tobacco Settlement funds to support health-related programming. To do justice to the health-related services, education, and research these programs are now delivering, they must have the continued support and time they need to fulfill

their mission of helping Arkansas to significantly improve the health of its residents. In addition, they must take the actions needed to ensure that issues identified in this evaluation are addressed to reinforce the effectiveness of Arkansas' investment in the health of its residents.