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TECHNICAL  
R E P O R T

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Evaluation of the  
Arkansas Tobacco  
Settlement Program

Progress from Program  
Inception to 2004

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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, the participating states will receive more than \$206 billion in payments from the tobacco companies over the next 25 years. Arkansas has an 0.828-percent share of these payments, which it has been receiving since the agreement was finalized.

Arkansas is unique in the commitment that has been made by both elected officials and the general public to invest its share of the Tobacco Settlement funds in health-related programs. Under terms of the Arkansas Tobacco Settlement Proceeds Act of 2000, which was a referendum passed by the voters in the November 2000 election, the Arkansas tobacco funds are supporting seven health-related programs:

- Arkansas Department of Health (ADH) Tobacco Prevention and Cessation
- Medicaid Expansion Programs
- Research and Health Education (Arkansas Biosciences Institute [ABI])
- Targeted State Needs Programs – the College of Public Health (COPH), the Delta Area Health Education Center (AHEC), the Arkansas Aging Initiative (AAI), and the Minority Health Initiative (MHI).

Only one of these programs is completely dedicated to smoking prevention and cessation. Some programs are serving short-term health-related needs of Arkansas residents; others are long-term investments in the public health and health research infrastructure.

The Tobacco Settlement Proceeds Act of 2000 (referred to hereafter as the Initiated Act) also created the Arkansas Tobacco Settlement Commission (ATSC) and gave it the responsibility for monitoring and evaluating the performance of the funded programs. As part of its evaluation function, the ATSC contracted with the RAND Corporation to serve as an external evaluator. RAND was charged with performing a comprehensive evaluation of the progress of the programs in fulfilling their missions, as well as the programs' effects on smoking and other health-related outcomes. This report is the first biennial report from our evaluation.

The evaluation methods are described in Chapter 1 and Appendix A. The evaluation was designed to address the following four research questions:

- Have the funded programs developed and implemented their programming as specified in the Tobacco Settlement Proceeds Act of 2000?
- What factors are contributing to the programs' implementation successes or challenges?
- How do actual costs for new activities compare to the budget; what are sources of any variances?
- What effects do the funded programs have on improving the health of Arkansans?

This report presents the results of RAND's evaluation of the start-up and early operation of the funded programs. Therefore, this first evaluation cycle focused on addressing the first three evaluation questions. In addition, baseline data on key outcomes were analyzed to identify

trends in the outcomes before the programs were introduced and any early impacts that might be detected. Subsequent evaluation steps will focus increasingly on assessing the outcomes.

## **SUMMARY OF PERFORMANCE THROUGH FISCAL YEAR 2004**

### **Achievement of Short-Term Goals**

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 funding programs—for program initiation, short-term, and long-term actions.

Given our evaluation results, we conclude that, with a few exceptions, the programs achieved their initiation goals and their short-term goals. The programs that met their goals were the ADH Tobacco Prevention and Cessation Program, College of Public Health, Delta AHEC, Arkansas Aging Initiative, and the Arkansas Biosciences Institute. We observed substantial variations in the start-up times for the programs, which are reflected in the quarterly spending trends reported in the chapters for the individual programs. We note that these variations are driven largely by differences in the degree to which programs were building upon existing efforts. Those that were starting entirely new programs (e.g., Arkansas State University within ABI, College of Public Health) had a longer lag in operational growth during the first year than those that already had program foundations in place.

One of the performance exceptions we identified is the Medicaid Expansion Programs. This program was not able to implement one of its four Medicaid benefit expansions, and it has spent only a small fraction of its Tobacco Settlement appropriations. The failure to implement the AR-Adult program, which would provide new Medicaid benefits to adults less than 65 years of age, was due to refusal by the Centers for Medicare and Medicaid Services (CMS) to approve the benefit expansion, despite the best efforts of the Medicaid program staff. The three expansion programs that were implemented spent much less than planned due to a combination of low enrollments and under-use of covered benefits by enrollees, in part because of inadequate outreach and communication to eligible individuals about the benefits available to them.

The other performance exception is the Minority Health Initiative. Operated by the Arkansas Minority Health Commission, MHI met only part of its short-term goals by being initiated within 12 months of available appropriation and funding. However, a change in management leadership resulted in slow early progress in implementing its program components, and the pace of growth continued to be slow through the following two years. This slow pace is reflected in weak trends for screenings and service activities performed by the program, as well as in under-spending of the Tobacco Settlement funds. In addition, the program did not meet its short-term goal of establishing a list of priority health problems and planned interventions for the minority populations.

We believe that both the Medicaid Expansion Programs and the Minority Health Initiative are important components of a strategy to address the priority health needs of Arkansans. Therefore, it will be important to strengthen the programs so that they can make effective use of the resources made available by the Tobacco Settlement funding for serving those needs.

## Summary of Program Performance

We present here summary assessments of the performance of each of the programs with Tobacco Settlement funding. Recommendations for program improvements are presented at the end of the evaluation chapter for each program (Chapters 3 through 9).

**Tobacco Prevention and Cessation Program.** The Arkansas Department of Health has successfully met all of the planning requirements set out in the Initiated Act. These requirements include starting the program within six months of available appropriation and funding, as well as establishing the local tobacco prevention initiatives (community coalitions). The programs and coalitions funded by the ADH reached full operation in a timely manner, and in general they are progressing on schedule.

Several legislative actions have diverted some of the funds slated for tobacco prevention and cessation to other health concerns, with the result that the ADH program is under the minimum-spending levels recommended by the Centers for Disease Control and Prevention (CDC) for a comprehensive statewide tobacco control strategy. Reductions in funding for direct tobacco control activities can be expected to lead to weaker impacts on smoking rates. The ADH program could be reinforced by legislation that established a statewide ban on smoking in public establishments or increased the price of tobacco, measures that have been shown to be effective in other states.

**College of Public Health (COPH).** The COPH has worked effectively to meet its goals for its educational program, and it has met the requirements of the Act. It has done an impressive job in establishing a public health educational institution in the two years since receiving the tobacco funds. It has become a crucial part of the University of Arkansas for Medical Sciences (UAMS) system and a valuable resource to the surrounding communities. Strengths include its strong community focus, the emphasis on training the public health workforce, and the diversity of the student body. In addition, COPH is expanding its faculty, continuing to develop the curriculum, and providing opportunities for students in all of its programs.

**Delta Area Health Education Center (AHEC).** The Delta AHEC has successfully established three locations to serve residents in the seven Delta counties, and program activity continued to increase since it began operation, thus meeting the short-term goal stated in the Act. However, it will take time to build the still-larger resources and program volume required to reach many of the Delta residents. The AHEC's health professional training also has progressed steadily, despite barriers that have limited its ability thus far to establish a medical residency program (e.g., inadequate medical specialty depth in the community). The Delta AHEC has the potential to make small improvements in the health of the area population, but a more comprehensive approach will be needed to address a myriad of challenges in the Delta and greatly improve health outcomes for the region's residents.

**Arkansas Aging Initiative (AAI).** The Arkansas Aging Initiative has done an excellent job in establishing seven Centers on Aging (COA) and, in most regions, senior health clinics, which are serving the health needs of older Arkansans. The COAs have been able to create strong ties to their local communities, which will serve them well both in terms of continued support and for potential collaboration to increase outreach into the community. The Reynolds Center on Aging still is working to get some COAs fully operational. In some regions, the challenge has been to find a local hospital to be a viable partner in establishing a senior health

clinic. In others regions, the challenge has been to tease apart the roles of the COA and the AHEC and to find ways for them to work together effectively.

**Minority Health Initiative (MHI).** The Arkansas Minority Health Commission (AMHC) was previously formed to identify the health needs of minorities, address disparities in health care, and advocate for policy changes in the provision of health education and care. The Tobacco Settlement Proceeds Act expanded the AMHC's roles by specifying that the AMHC initiate health screenings and treatment interventions. Progress of the MHI to date indicates that the AMHC has struggled with its new screening and treatment focus. The number of minorities screened and treated thus far in its programs remains low compared to the funds available as a result of the Act. Consequently, a substantial portion of the MHI Tobacco Settlement funds was not put to work on needed services, and MHI funds were returned to the State at the end of the first biennium.

**Arkansas Biosciences Institute (ABI).** The ABI and its member institutions have made substantial progress in establishing a research program that addresses the five research areas specified in the Initiated Act. Results of the research are beginning to be disseminated to the scientific community through the ABI fall symposium, scholarly publications, lectures and seminars, and contacts with the media. In addition, ABI has used the Tobacco Settlement funds to establish several core facilities available to all participating institutions. These facilities have created new research efficiencies in the state. ABI has successfully leveraged the Tobacco Settlement funds to bring in extramural funding at an average ratio of 2.8 extramural dollars for each Tobacco Settlement dollar spent on targeted research programs.

**Medicaid Expansion.** The Medicaid Expansion Programs have grown steadily, building on existing staffing and information systems. However, enrollments are much lower than expected and enrollees are not informed of what services are covered by the expansion programs. As a result, this program is spending a small percentage of the Tobacco Settlement funds allocated for it. There is a need for better education and outreach so that the general population can be informed about the available programs. In addition, enrolled populations need to be educated better about their Medicaid benefits. The AR-Adults program remains elusive, with refusal by the federal government to approve it, in part because the federal government's priorities have shifted in the past two years to reduce the government's spending on Medicaid.

## **PROGRAM EFFECTS ON OUTCOMES**

An important part of any evaluation is the step of examining the extent to which the programs being evaluated are having effects on the outcomes of interest. Using the long-term goals defined in the Act for each program, we developed outcome measures in consultation with the programs' staff and the Tobacco Settlement Commission. The programs are still too new, and available data from many surveys and other sources are too imprecise to detect an effect so soon after program initiation. When we report that there is no evidence of a program effect, that does not mean there are no effects; it means that it is too early to tell. Future analyses with additional data will be able to make finer distinctions between positive effects and no effects. For example, in view of the experiences of other State smoking cessation programs, we estimate that effects on smoking behaviors should be observable in data for 2005, given that the ADH program became fully operational in 2002 (U.S. Department of Health and Human Services (DHHS), Chapter 7, 2000).



## Overall Effects on Smoking Trends

Changes in overall smoking behavior across the state's population are the collective effects of the various actions taken to affect smoking, including tobacco taxes, the Tobacco Settlement programs, other interventions, and other unidentified factors:

- Given the limited amount of time and the limited amount of survey data, we have not yet detected a change in the adult smoking rate since implementation of the Tobacco Settlement programs.
- Cigarette sales continued a downward trend that had begun before the recent tax increases and the start of the Tobacco Settlement programs. This trend could mean that smokers are smoking less now, on average, or it could reflect increased transporting into Arkansas of cigarettes purchased out of state in response to the tax increases.
- The limited evidence we could develop with available data suggests that smoking rates by youth began to decline in 1999 and continued declining through 2003, with no change in trend as the Tobacco Settlement programs began operation. Our analysis of these rates was hampered by the recent low response rate in the 2003 survey of youth (Youth Risk Behavior Surveillance System [YRBSS]).
- Other sources of data suggest that the Tobacco Settlement programs have begun to have a positive effect on smoking behavior in Arkansas:
  - The percentage of pregnant women who reported that they smoked in 2003 was less than expected from baseline trends of smoking prevalence.
  - The percentage of smokers among both young adults (aged 18 to 25) and teen mothers (aged 11 to 18) declined below the baseline trend of declining rates in 2003.

## Program-Specific Effects on Smoking Outcomes

Geographically specific analyses were performed to attempt to identify more-local effects on smoking behaviors that could be attributed to tobacco prevention and cessation activities by ADH and other funded programs:

- *ADH Tobacco Prevention and Cessation.* ADH activity has been distributed throughout the state, with some areas receiving substantially more services than others. At this point, it is too early to tell whether areas with greater ADH activity are experiencing greater decreases in smoking than areas with less ADH activity.
- *Services to the Delta Region.* Smoking rates in the Delta region had been increasing during the baseline period before the Tobacco Settlement programs began, but they have decreased following program initiation. We do not have evidence that allows us to attribute this success to any particular program, so we tentatively conclude that it is due to the combined efforts of several programs with tobacco prevention and cessation activities in that region. Those programs include the Delta AHEC, the Minority Health Initiative, the ADH, and a new Center on Aging.

## Program Effects on Non-Smoking 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 downward trend in teen pregnancy has accelerated in the Delta since Tobacco Settlement funding began. However, the downward trend also has accelerated elsewhere in the state, suggesting that factors other than Delta AHEC programming may be at work.
- *Medicaid Benefits for Pregnant Women.* We find strong evidence that the percentage of women who received prenatal care has increased with the expansion of Medicaid benefits for pregnant women. We could find no evidence, however, that this increase of prenatal care translated into reductions of low-weight births.
- *Other Medicaid Expanded Benefits.* No clear effects were found for the expansion of Medicaid hospital payments or the ARSeniors program, which provides Medicaid coverage for individuals aged 65 years or older who previously did not qualify financially for Medicaid. The increased payments to hospitals for each Medicaid inpatient stay have not affected the amount of hospitalization used by Medicaid recipients. It is too early to detect effects of ARSeniors on health status of seniors, as measured by avoidable hospitalizations; this analysis will be continued as more data are collected.
- *Arkansas Aging Initiative.* The seven new Centers on Aging (COA) went into operation at differing times between 2001 and 2003, and only four COAs were active in 2002 or earlier. The avoidable-hospitalization analysis we performed provides baseline information on rates of these events in the areas served by the COAs, but it is premature to find any effects of their services on reduction in avoidable hospitalizations.

## COMMON THEMES AND ISSUES

Although the experiences and lessons from each of the funded programs are unique, reflecting the diverse nature of the programs, some common themes and issues have emerged from this evaluation cycle that apply across the programs. We present these issues here, along with recommendations for actions to strengthen the programs in the future. As the evaluation proceeds, we will monitor progress in carrying out these recommendations and the program-specific recommendations delineated at the end of each process evaluation chapter.

### Collaboration and Coordination Across Programs

Some programs already were working together, and we identified other opportunities for additional collaborative programming. Collaborative activities among the programs would strengthen their ability to serve the goals of the Act, to use the Tobacco Settlement funds efficiently, and to enhance needed health services for Arkansans.

**Recommendations.** We encourage the programs to pursue opportunities for collaboration as their work continues. Some examples that could be pursued include the following:

- Delta AHEC, MHI, and COPH working together for training and recruitment of health professionals for the Delta region.
- Partnering of the Delta AHEC and MHI in delivering education and other health-related services to residents of the Delta region.

- Coordination of the tobacco prevention and cessation program offered by the Delta AHEC and the ADH tobacco programming in the Delta region, to make optimal use of their combined resources.
- Within the ADH program, collaboration between the local community coalitions and other ADH programs to increase their effects on smoking behaviors in the local areas served, including merchant inspections conducted by the Tobacco Control Board and the media messages of the tobacco prevention and cessation media campaign (called SOS).
- Coordination of services provided by the MHI and the minority program that is part of the ADH tobacco prevention and treatment program.
- Collaboration between the COPH and the regional Centers on Aging, with their AHEC partners, to establish training programs for health care managers in the AHEC regions.
- Partnering between the COPH faculty and graduate students and other programs (e.g., Delta AHEC, MHI) to improve health education programming and quality improvement efforts.

### **Governance Leadership and Strategic Direction**

Throughout our process evaluation, we found that the programs tended to focus on the priority of getting their programs operational and starting service delivery. There was substantial variation across programs in the extent to which their governing bodies were engaged in the process or guided priorities and strategy. Now that the start-up period is over and the programs are more mature, the governing bodies should play active roles in guiding the future strategic direction for the programs. They 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 the vital resources it needs.

The diversity of the programs is reflected in the wide variety of governing bodies they have. Regardless of the nature of a program's governing or advisory body, these boards should be bringing added value to the programs as "arm's length" observers and guides. The role of these bodies is especially important for those programs that are bringing together disparate organizations to collaborate on a program's activities. Obvious examples are the ABI Board and the advisory boards of the Centers on Aging. Regardless of their structures, all the funded programs are accountable to the public, and it is appropriate for records of governance decisions and actions to be made publicly available to document the governing bodies' policy oversight of the programs.

***Recommendation.*** We offer the following recommendations for program governance:

- The governing boards or advisory boards of the funded programs should work with program management in defining a clear direction for the program, and should perform a constructive oversight function to ensure that the program is accountable for quality performance.
- Individuals who can provide expertise on the goals defined for the program by the Initiated Act should be included in the membership of the program governing boards or advisory boards. For example, under the MHI, the AMHC now is expected to deliver effective health interventions in minority communities, in addition to its original

advocacy role, but the composition of the Commission has not been changed to reflect this expanded mission.

## **Monitoring and Quality Improvement**

Several of the programs experienced difficulties in collecting data on the process indicators used in the evaluation, reflecting the fact that few of the programs have internal accountability mechanisms for regular monitoring and providing feedback on the program's progress. Where mechanisms were in place, they relied on local program staff, who often do not have sufficient training or resources to fully comply. Such a monitoring process, when well implemented, is essential for performing regular quality improvement and for assessing 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.

***Recommendations.*** We offer the following recommendations for actions the programs should take to monitor and improve quality and to assess the programs' effects on health outcomes:

- Drawing upon the basic principles of continuous quality improvement methods, the funded programs should have in place an ongoing quality monitoring process that has the following key elements:
  - a set of valid internal indicators that represent key performance aspects of the program
  - the collection of data as an integral part of program operation, including data on program enrollments, demographic characteristics of enrollees, service encounters, feedback from enrollees through surveys or other data collection, and outcomes
  - corrective actions to address problems and strengthen service delivery, taken in response to the issues identified in the monitoring process
  - regular analysis and reporting of performance data to the program management and oversight board and committees.
- The internal performance indicators and corrective actions should change over time to bring about ongoing, incremental improvements in the program operation.
- The long-term goals for the programs specified in the Act, which are aimed at public accountability for achieving selected key program milestones, should be revised periodically to establish more appropriate and measurable goals that address the key effects the programs should be achieving.
- Sufficient resources should be allocated to build capacity at the program and community levels to ensure that the programs can comply with these recommendations, including investments by programs in staff training and technical support from the Tobacco Settlement Commission.

## **Financial Management**

For most programs, our analysis of the spending of the Tobacco Settlement funds was complicated by a diversity of problems, ranging from an inability to extract data from the State finance system, to incomplete or inaccurate records maintained in programs' local accounting systems. The notable exception was the ADH Tobacco Prevention and Cessation program,

which has a well-structured set of accounts that delineates spending for each of its program components and provides usable information for the program management on a regular basis. We have identified issues in two areas: budgeting for the appropriation process and the program financial management and accounting. Presented here is a summary of issues and recommendations for each area.

**The appropriation process and fund allocations.** The first appropriations for the Tobacco Settlement programs (for fiscal years [FYs] 2002 and 2003) allocated the funds to specific budget line items based on budgets developed by the programs and submitted to the State. The appropriations legislation prohibited spending in excess of the appropriated amount for each budget item without the approval of the Legislative Council.

During the initial budgeting process for the programs, several programs had appropriation allocations across expense classifications that did not fully match the operational needs of some of the programs. Issues contributing to this outcome were the newness of the programs, inadequate information on the definitions of the line items in the appropriations, and the short time the programs were given to develop and submit budgets to the State. The problems with the appropriations can be observed in the spending adjustments and inconsistencies in reported spending that we found in our spending analysis. We also heard frequent reports by program staff working with the State financial system that they have developed techniques for working around constraints in the appropriations.

The program leaders were reluctant to make substantial changes to the fund allocations in the second biennial appropriations for fear of opening up the entire package to funding changes or reductions. This reluctance reflected their perceptions that continued program funding was at serious risk, because they saw legislators looking for ways to shift the Tobacco Settlement funds away from support of their programs to supporting other financial needs of the state. As a result of this inaction, the spending constraints experienced by the programs in the first two fiscal years were perpetuated in the FY 2004-05 appropriations, hindering several programs from using their funding effectively. These constraints have also led to intense discomfort on the part of program staff regarding the accounting practices they have applied to be able to use the available funds.

**Recommendations.** We offer the following recommendations:

- The State should use the upcoming appropriations process to enable the programs to start afresh with budgets that accurately reflect their actual operating expenses by line item. 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 should restructure the budgets they submit to the State for the next appropriations process so that allocations of spending across line items reflect actual program needs and are consistent with the appropriations definitions.

**Financial management and accounting.** Some of the programs have the needed financial staff in place, but several programs are lacking some aspect of the accounting and bookkeeping skills needed for effective financial management. Additional training and support should be provided to the programs, as needed, to strengthen their ability to document their spending accurately and to use this information to guide program management.

**Recommendations.** We offer the following recommendations for actions to be taken:

- Every program should have in place a *local* automated accounting system that it uses to record expenditures as they occur and to report spending to its governance and management on a monthly basis. This system would provide the detailed financial information needed for program management that is not provided by the larger systems within which many of the programs operate (e.g., the State or UAMS financial systems).
- The personnel who perform the accounting function in each program should have the relevant qualifications, including training in bookkeeping or accounting and in the program's accounting system. Programs whose personnel lack these qualifications should train existing personnel as needed or should hire qualified personnel.
- Within the programs' local accounting systems, separate accounts should be set up for each key program component so that the program can budget for and monitor spending by component.
- The management of the programs should monitor program spending on a monthly basis, using financial statements and support documentation. Financial statements should be reported to the program governing body at every meeting, and variations from the budget should be identified and explained.
- The staff responsible for the program financial function should be given formal training on use of the relevant external accounting system to which their programs report expenditures (e.g., State system, UAMS system).

### **Monitoring by the Tobacco Settlement Commission**

The Tobacco Settlement Commission has an important role in ensuring the effective use of the financial resources that the Tobacco Settlement has provided to Arkansas. The Commission can use the information and recommendations in this report to help guide its future activities as it continues to oversee the programs' performance and to provide support for programs to correct identified shortcomings. As the programs move forward, it will be important for the Commission to hold them to uniformly high standards of performance and results.

**Recommendations.** We offer here our recommendations for Commission actions:

- 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. Issues to be addressed include the following:
  1. involvement of the programs' governing body (or advisory boards) in guiding program strategy and priorities
  2. specific progress of the programs in achieving the goals and objectives of their strategic plans
  3. actions being undertaken for continuous quality improvement and progress in improving services
  4. actions being taken for collaboration and coordination among programs to strengthen programming

5. the specific issues identified in the recommendations at the end of each program's chapter in this report.
- 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.
  - To ensure that program spending is being monitored regularly, the Commission should require the programs to submit quarterly financial statements of budgeted versus actual spending. The financial statements should be sufficiently detailed to enable the Commission to identify variances from budget, and explanations of variances should be provided. (These reports could be the same as those submitted to the programs' governing boards.)
  - 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 helping the programs correct some of the issues identified in this evaluation. The support could include, for example, support for data collection for performance measures, needs assessments, budgeting, or grant writing, as well as for short-term needs of programs for specific skills or knowledge that they do not have from their staff. As one of the funded programs, the COPH would be one appropriate resource to provide such technical support.
  - 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.
  - As the programs mature further, and as 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.

## **ARE THE GOALS IN THE ACT THE CORRECT GOALS?**

An important role of this evaluation is to step back and look at the larger picture, to review how well the scope of services provided by the seven funded programs responds to the current state health priorities. To examine this question, we drew largely upon data generated by the Tobacco Settlement programs themselves, as they performed needs assessments and developed information on other health care issues in the state. We identify a number of priority health needs for Arkansans, and we assess the extent to which the Tobacco Settlement programs address those priority needs.

### **Top Health Priorities for Arkansas**

We have identified the following issues and health priorities for the state:

- Arkansas has a higher death rate than the rest of the country.
- Heart diseases and cancer are the top two killers in Arkansas, as well as for the country.

- Hypertension is a serious risk factor for heart disease, with disproportionate prevalence in minority populations.
- Obesity, smoking, and physical inactivity are the most important preventable contributors to morbidity and mortality in general, as well as to heart disease, cancer, and stroke.
- Rates of both infant mortality and low birth weight in Arkansas are substantially higher than those for the entire United States, and the rates are higher for births to African American women in Arkansas than for white women.
- The elderly population represents a larger percentage of the total population in Arkansas than in the country.
- The most important health problems reported by older adults are arthritis, high blood pressure, and heart trouble.
- The most important health needs reported by older adults are affordable prescription medications, affordable health care, and affordable health insurance.
- Arkansas has shortages of health care practitioners in the rural areas of the state.
- Many rural hospitals have converted to critical access hospitals, taking advantage of special Medicare payment policies to preserve rural hospital capacity.
- There are substantial differences between African Americans and whites in Arkansas in health status and mortality rates.
- African Americans report that they are suspicious of the health care system, expressing distrust of physicians, insurers, hospitals, and pharmaceutical companies based on experiences in obtaining health care.
- Many minorities report that they have experienced discrimination from health care providers in the form of assumptions about their background and understanding based on language or color.
- Estimated rates of uninsurance in Arkansas are very similar to those for the country.
- Arkansans aged 19 to 64 years have the highest rates of lack of insurance coverage.

## **RECOMMENDATIONS REGARDING PROGRAM FUNDING**

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. In addition, the College of Public Health and the Arkansas Biosciences Institute are building educational and research infrastructure that will make long-term contributions to the state's health needs. The programs, with but two exceptions, have achieved their initiation and short-term goals, and each program is making valuable contributions to addressing the health priorities for the state. As the programs continue to grow and mature, and as they further leverage the Tobacco Settlement funds to attract other resources, their impacts on health needs also can be expected to increase.

***Overall Recommendation Regarding Continued Program Funding.*** We recommend that the Tobacco Settlement funding continue to be provided to the seven programs that receive these funds. At the same time, the performance expectations for the programs during the next two years should focus on achievement of the outcomes relevant to each program.



In addition to this overall recommendation, we offer the following suggestions regarding possible funding adjustments and related issues for some programs, for consideration by the Commission, Governor, and General Assembly in their policy deliberations.

### **Minority Health Initiative**

This program is uniquely positioned to address directly the health needs and priorities of the minority populations in the state. Because of the importance of its role, the MHI should be given every opportunity to fulfill its mandate under the Act. However, the unspent MHI funds represent services that have not been made available to minority populations with health needs.

**Recommendation:** The Commission should work with the Minority Health Commission to help strengthen its MHI programming, set priorities for actions, and fully apply its funding resources to programming for the health needs of minority populations. If the MHC continues to under-spend its Tobacco Settlement funding through fiscal year 2005, then its funding share should be reduced to the level it is spending and the unused resources should be applied to other programming that addresses the health needs of minorities.

### **Tobacco Prevention and Cessation Program**

The ADH Tobacco Prevention and Cessation Program is funded at levels below the CDC recommendations as a result of legislation that redirected some of its funding to other public health activities. This reduced funding impedes the program's ability to affect smoking behaviors. In addition, its share of the total Tobacco Settlement dollars now is smaller than what the Initiated Act had designated for tobacco prevention and cessation activities. Other key components of a comprehensive tobacco control program that would reinforce the Arkansas initiative are legislation that increases taxes on tobacco products and that bans smoking in public areas. Arkansas has increased tobacco taxes but currently does not have statewide bans on smoking in public places.

**Recommendation:** The funding share for the ADH Tobacco Prevention and Cessation Program should be increased to return its funding level for tobacco prevention and cessation activities to levels that comply with the CDC recommendations.

**Recommendation:** The State should move forward with legislation to ban smoking in public places, with a goal of expanding the scope of the ban over time, which would reinforce the actions already being taken by the ADH and other organizations to achieve and maintain behavior changes for Arkansans and reduction in smoking rates.

Three general options might be used to bring funding for the ADH Tobacco Prevention and Cessation Program up to the minimum levels recommended by the CDC: (1) obtaining additional funding external to the Tobacco Settlement funds, (2) returning the funds originally designated for the ADH program to the program, or (3) shifting funding among the Tobacco Settlement programs. The most constructive of these options is to obtain additional external funding to bolster the total amount spent on tobacco prevention and cessation activities. The other options of returning funds previously taken from the ADH program or shifting funds from other Tobacco Settlement programs would negatively affect other programs that are serving the state's health needs. In addition, the third option would require changing the funding share provisions stated in the Initiated Act.

Several tobacco prevention and cessation actions recently have begun in the state, and the additional financial resources they are applying will help bring Arkansas closer to compliance with the CDC minimum funding guidelines. One of these actions is the new coverage by the Arkansas State Medicaid program for smoking-cessation drugs and professional consultation services, effective October 1, 2004, at an estimated cost of \$3 million annually. The other is the action by the Arkansas State Employees' and Public School Teachers' plan to add tobacco prevention and cessation services as a covered benefit for its 128,000 enrollees, funded by the Employee Benefits Division.

As the State considers alternatives for increasing financial resources for tobacco programming, it should track existing and planned funding for each of the nine program components for which the CDC recommends minimum funding levels (see Table 3.10). Current funding levels fall short of the CDC recommendations for five of the program components, and, ideally, any new external funding should be applied to help strengthen the financial support across the nine components.

### **Medicaid Expansion**

The under-spending of the Tobacco Settlement funds for this program has two consequences for the state. The first is the absence of insurance coverage for the people in poverty who these expanded benefits were intended to reach, with its concomitant effects on health status and outcomes. The second is loss of federal funds that the State obtains through the matching of three dollars of federal Medicaid funding for every State dollar spent on health care services. Some of the funds not spent on the expansion programs indeed are being used through the Rainy Day Fund to cover Medicaid shortfalls. However, the intent of the Initiated Act was to use the funds to provide insurance coverage for individuals not otherwise eligible for Medicaid. We offer some options here to better fulfill that intent:

***Recommendation:*** A portion of the appropriation for the Medicaid Expansion Programs should be budgeted and used to support community outreach on the expanded benefits and education of enrollees on the health care benefits available to them.

***Recommendation:*** Consider applying some of the unspent funding for the Medicaid Expansion Programs to establish another Medicaid expansion that would provide coverage for evidence-based, preventive health and treatment services for obesity and inactivity.

***Recommendation:*** Evaluate the feasibility and value of establishing a 20-percent Medicaid bonus payment for physicians providing primary care services to residents of rural health professional shortage areas in the state, again using some of the unspent Medicaid Expansion Programs funding.

### **DISCUSSION**

The Arkansas General Assembly, Tobacco Settlement Commission, and people of Arkansas have much to be proud of in the investment made in the seven programs supported by the Tobacco Settlement funds. These programs in general have made substantial progress in expanding and strengthening the infrastructure to support the health status and health care needs of Arkansas residents. It is still too early to assess the effects of the funded programs on these outcomes. Yet we believe their prospects are good for achieving observable impacts over the

next few years, if they are given the time and support they need to learn and adjust to achieve full program effectiveness.

Arkansas has been unique among the states in being responsive to the basic intent of the Master Tobacco Settlement by investing its funds in health-related programs with a focus on reducing smoking rates. We encourage the State policymakers to reaffirm this original commitment 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, the programs must be given the continued support and time they need to fulfill their goals. In addition, actions should be taken to ensure that issues identified in this evaluation are addressed to reinforce the effectiveness of Arkansas' investment and enhance its ability to achieve improvements in the health of its residents.