

WORKING P A P E R

Evaluation of the Arkansas Tobacco Settlement Program

Program Advancement in 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 an 0.828-percent share of the payments being made to participating states over the next 25 years. Arkansas is unique in the commitment made by both elected officials and the general public 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, specifies that the Arkansas tobacco funds are to support 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 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 the 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 second report from the RAND evaluation. The report updates the information and assessments provided in our first biennial report submitted to the ATSC in 2004. Using the evaluation methods described in Chapter 1 and Appendix A, the evaluation is 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?

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 funded programs—for program initiation, short-term, and long-term actions. In the 2004 evaluation report, we reported our conclusion that the ADH Tobacco Prevention and Cessation Program, College of Public Health, Delta AHEC, Arkansas Aging Initiative, and the Arkansas Biosciences Institute had achieved their initiation goals and short-term goals.

At the same time, we reported that the Medicaid expansion program had not achieved its initiation goal, and both the Medicaid program and the MHI had not achieved their short-term goals. As of this second report, the Medicaid program still has not achieved its initiation goal because the CMS continues to refuse approval of the AR-Adults expansion program. In addition, the three operational Medicaid expansion programs continued to under-spend, although the enrollments and spending on enrollee's health care services in these programs have grown since FY2003. Therefore, we again conclude that the Medicaid program has not yet met its short-term goal of increasing participation in the expanded programs. Our finding this year is based solely on the continued low activity levels in the three operational programs, because we recognize that the AR-Adults program is not likely to obtain CMS approval.

The Minority Health Initiative has progressed since last year in accomplishing its short-term goals. Soon after completion of our 2004 report, the MHI released a list of priority health problems for African Americans; however, similar priorities for other minority populations in the state are not yet addressed explicitly in the list. We conclude now that the MHI has met this short-term goal for the African American population by establishing its initial priority list, although we encourage it to update its list to encompass issues for other minority populations. We also note that growth in enrollments in MHI programs has been slow.

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

Assessing Program Progress on Long-Term Goals

The Initiated Act specifies long-term goals for the programs supported by the Tobacco Settlement funds. These goals target “ultimate” outcomes for the improvement of the health and well-being of Arkansans, which are expected to take years to be accomplished. In addition, the stated goals do not have measurable endpoints that can be used to determine the extent to which programs have achieved them.

In this year's evaluation work, RAND has worked with the programs to establish measures that can be used to assess progress toward these goals. Two sets of measures have been developed: long-term programmatic goals that define the programs' vision for their future scope of activities, and outcome measures for assessing the effects of the programs on the most salient outcomes for each program. The program goals for each program are presented in Chapters 3 through 9, and the outcome measures are presented in Chapters 10 and 11. These measures for each program are brought together for ease of reference in Appendix E.

We encourage the ATSC to formally approve the programs' long-term goals, and to monitor their progress toward those goals. The monitoring should be a two-step process, starting with tracking how well programs are moving toward their operational goals, and then assessing how much effect this progress is having on their outcome measures. If those levels of operation are not affecting outcomes, then the long-term goals may have to be revised to target stronger interventions to ultimately affect outcomes.

Summary of Program Performance

Overall, the seven Tobacco Settlement programs have continued to refine and grow their program activities during the most recent year. In doing so, the programs have made a number of changes in their activities in response to the program-specific recommendations we presented in our 2004 evaluation report. In Chapters 3 through 9, we present updates on their activities, trends on their process indicators, and responses to our recommendations, and we also offer updated recommendations for future program actions based on our assessments of their current programming status.

A limited number of policy issues relative to the programs were identified in this year's evaluation. These issues are discussed below under "Policy Issues and Recommendations".

PROGRAM EFFECTS ON OUTCOMES

An important part of any evaluation the examination of 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 non-smoking outcomes.

Program Effects on Smoking Outcomes

In last year's report we emphasized that it was too early to expect to be able to detect an impact of the Tobacco Settlement programs on smoking outcomes for a number of reasons. With every passing year, we are more likely to be able to measure an effect of the programs. With most of the programs first reaching full operation in 2002, we do not expect to be able to detect a significant impact on adult smoking prevalence until 2006 when we will have access to data for smoking behavior in 2005. This expectation is based on the experience in other states that have implemented comprehensive smoking control programs.

In spite of these limitations, we are beginning to detect an impact of tobacco control programming in vulnerable populations such as youth and pregnant women. The effects addressed here are changes in overall smoking behavior across the state's population, which are influenced collectively by the actions taken by various programs to affect this outcome, including tobacco taxes, smoke-free environment laws, the Tobacco Settlement programs, and other unidentified factors.

- Two groups of young people are smoking less since the start of the Tobacco Settlement programs than would be expected based on pre-programming trends:
 - Young adults, age 18 to 25
 - Pregnant teenagers
- Tobacco Settlement programming has successfully reduced smoking among all pregnant women.

- There has been dramatically improved compliance with laws prohibiting sales of tobacco products to minors.
- Arkansas has avoided the increase in adult smoking since 2000 that has occurred, on average, in its surrounding states. Arkansas has increased cigarette taxes and tobacco control spending over this period, while on average, the other states have not.
- Cigarette sales in Arkansas continue to decline, although the rate of decline has not accelerated since the beginning of the Tobacco Settlement programming.
- Our analysis of smoking prevalence in the Delta region shows no program impact. In fact, pregnant women in the Delta are smoking more since the beginning of Tobacco Settlement programming.
- Our analysis of the variation in smoking by county does not yet provide evidence that people who live in areas where the ADH focused their activity are less likely to smoke.

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.* Although teen pregnancies have been decreasing throughout the state since 1995, we do not find any evidence that Delta AHEC programming accelerated this trend in the Delta.
- *Medicaid Benefits for Pregnant Women.* We continue to find evidence 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.
- *Other Medicaid Expanded Benefits.* In our analysis reported in the 2004 evaluation report, we found no clear effects 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. Increased payments to hospitals for Medicaid inpatient stays have not affected hospitalization use by recipients. We are assessing the effects of ARSeniors on avoidable hospitalizations, but we will have expect that a measurable effect will not be found for several years. We will update these analyses in future reports.
- *Arkansas Aging Initiative.* Timely and appropriate outpatient care should reduce the likelihood of hospitalizations for ambulatory care sensitive conditions. We have analyzed baseline avoidable-hospitalization rates for the areas served by the COAs, and we will continue to monitor these rates in future years when sufficient time has passed that we can reasonably expect to find an impact from their activities.

PROGRAM RESPONSES TO COMMON THEMES AND ISSUES

Some common themes and issues emerged from the first evaluation cycle that apply across the programs. For those issues, we offered recommendations in the 2004 evaluation report for actions to strengthen the programs in the future. We are monitoring the progress of the programs

in carrying out these recommendations. We summarize the recommendations here, highlighting activities undertaken by the programs for each recommendation.

Collaboration and Coordination Across Programs

Collaborative activities among the programs should 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.

Recommendation. We encourage the programs to pursue opportunities for collaboration as their work continues.

Responses: The amount of cross-program collaboration has grown during the past year. The programs collaboration most actively thus far have been the ADH, COPH, Delta AHEC, MHI, and AAI. Examples of their collaborative activities are listed in Chapter 12. The ABI and the Medicaid expansion programs are not engaged in joint activities with other programs. Both programs differ substantially from the others, which are more oriented to public health and community education programs.

Governance Leadership and Strategic Direction

The diversity of the programs is reflected in the wide variety of governing bodies they have. The governing bodies should play active roles in guiding the future strategic direction for the programs, and they also provide important links to the environment so the program hears the views of its stakeholders and has access to vital resources it needs. Records of governance decisions and actions should be made publicly available to document their program oversight.

Recommendation. 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 the program is accountable for quality performance.

Recommendation. 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.

Responses: These recommendations are most relevant for the ADH, Delta AHEC, AAI, MHI, and ABI, all of which have some form of board, commission, or advisory groups. The COPH and Medicaid expansion programs do not have designated boards or advisory groups; we suggest they consider forming advisory groups as vehicles for eliciting community input, developing strategy on pertinent issues, and identifying potential funding opportunities.

- ADH – The Tobacco Cessation Advisory Board was created as mandated in the Initiated Act to provide oversight for the tobacco prevention and cessation program. This board is reported to be providing strong policy guidance to the program.
- ABI - The ABI board meets regularly and is reported to be closely informed on the ABI activities. The Board and staff also work to ensure they are updating and listening to the ABI advisory boards. The ABI board membership is fixed by the Initiated Act, but the advisory committee members brings a breadth of additional expertise to the program.

- AAI – The advisory boards of the regional Centers on Aging are providing the COAs with community input and access to funding opportunities. Strengthening the roles of these boards has not been a priority item for attention this year. The COAs are mixed in how they use and work with their advisory boards.
- Delta AHEC – Although its business direction derives from the UAMS AHEC system, the Delta AHEC has formed advisory boards at each of its three sites. The Helena board has been actively involved in the planning for the new AHEC building.
- MHI – A number of physicians currently serve as Commissioners for the AMHC. It is not clear whether the Commission has members with public health expertise. Two Commission seats have remained unfilled since the current executive director was hired (these are government appointments).

Monitoring and Quality Improvement

As of the end of FY2004, few of the programs had internal mechanisms for regular monitoring and providing feedback on the program's progress. Such a monitoring process, when well implemented, enables programs to perform regular quality improvement and can help the programs fulfill their external accountability to legislators and other state policy makers.

Recommendation. To monitor and improve quality and to assess program effects on health outcomes, the funded programs should have in place an ongoing quality monitoring process that has valid measures of performance, regular data collection on the measures, corrective actions to address problems, and regular reporting of data to management. The internal performance indicators and corrective actions should change over time to bring about ongoing, incremental improvements in the program operation.

Responses: The information provided by the programs on their quality improvement activities reflects the relative newness of the programs and the early status of some of their quality efforts. Three of the programs – the Delta AHEC, AAI, and MHI – currently are in the stages of establishing data systems and defining standards for performance.

The ADH has a program-wide evaluation mechanism in place that has been providing it with information for quality monitoring in the TPEP program. During this past year, the ADH has been standardize the performance and monitoring requirements for all the organizations with which it is contracting. All evaluation information collected is reported regularly to the Tobacco Cessation Advisory Board.

The COPH and ABI report that they have well-established quality management systems. The COPH has a quality improvement process because it is required for accreditation. The ABI research has been built upon already existing research programs within the participating institutions. Each university is monitoring its research activities, with reports submitted to the ABI central office.

The Medicaid expansion program does not have an active quality improvement process at this time. Such a process could be useful for ensuring the quality of the enrollment process, which could yield increased enrollments and recipients who are more informed about the programs and they benefits available to them.

Financial Management

In the 2004 evaluation report, our analysis of the spending of the Tobacco Settlement funds identified issues in two areas: budgeting for the appropriation process and the program financial management and accounting systems and capabilities.

The appropriation 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 initial spending constraints experienced by the programs were perpetuated in the FY 2004-05 biennial appropriations because the program leaders were reluctant to make substantial changes that might risk opening up the entire package to funding changes or reductions.

Recommendation. For the upcoming appropriations process, 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. In addition, the programs should restructure the budgets they submit to the state for the next appropriations process so that allocations of spending across line items reflects actual program needs and are consistent with the appropriations definitions.

Responses: The programs that were having the greatest problem with poorly allocated appropriations were the AAI, COPH, Delta AHEC, and the UAMS portion of the ABI, all of which are part of the UAMS system. 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 FY2006-07 biennial appropriations, the programs modified their line item allocations as needed.

Financial management and accounting. Several of the programs are lacking in 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 and use this information to guide program management.

Recommendation. 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). Within this system, the programs should ensure they have:

- Personnel with the relevant qualifications to perform accounting or bookkeeping functions,
- Separate accounts for each key program component;
- Monthly monitoring of program spending along with reporting of financial statements and explanations of variations from budget to the program governing body.

Responses: From a structural perspective, all of the programs are supported by well established financial systems, although multiple systems are involved. Operationally, few programs are using these accounting resources for proactive monitoring and reporting of financial data by program management and governance. In RAND's most recent analysis of program spending, we were able to obtain the needed data from the programs much more easily

than we could last year. However, for the programs with multiple components (ABI and the AAI), we still had to go to the individual components for their financial data, rather than being able to obtain it from the leadership of the overall program. We would be able to get the needed information from the program leads if the individual components were submitting regular financial statements to them. Other programs with multiple program components (e.g., Delta AHEC, MHI, and possibly COPH) do not yet appear to be establishing separate accounts for individual components.

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. As the programs move forward, it will be important for the Commission to hold them to uniformly high standards of performance and results.

Recommendation. 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 governing body involvement, progress in achieving goals, quality improvement activities, cross-program collaboration, and actions taken in response to evaluation recommendations.

Recommendation. 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.

Recommendation. 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 in sufficient detail 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.)

Recommendation. 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.

Recommendation. 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.

Recommendation. 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.

Commission response: The ATSC has changed the format for 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 they also are being asked to provide this information in their presentations at Commission meetings.

The ATSC office is working to develop a financial reporting format that can provide uniformity in reporting across programs. Work is proceeding carefully in this process to ensure that the format developed is useful and feasible for all the programs. It plans to begin require reporting of program financial performance after establishing the format and procedures.

The technical support function is being developed as an integral part of the ATSC strategic plan that currently is being updated and revised. The State Department of Volunteerism has been identified as a resource to draw upon as the ATSC moves forward to support technical development work by the programs. A portion of the ATSC budget is being protected to fund these activities. Also as part of its strategic planning process, the ATSC is developing plans for guidance to programs on strengthening the roles of their governing or advisory boards.

POLICY ISSUES AND RECOMMENDATIONS

As stated in the 2004 evaluation report, we reiterate here that 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 another year 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.

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 establish long-term goals, and trends in impacts on relevant outcomes.

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

Tobacco Prevention and Cessation Program

Both inadequate tobacco control policy by the State and erosion of financial resources for the ADH tobacco prevention and cessation program are weakening the ability of this otherwise well-designed and managed program to affect smoking behaviors by Arkansans. Our outcome evaluation is starting to detect reductions in smoking rates among some population groups, but these gains may not be sustained if support for this programming continues to erode. Other key components of a comprehensive tobacco-control program are legislation that bans smoking in public areas and increased taxes on tobacco products. Arkansas has increased tobacco taxes but has not been able to enact meaningful 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 for tobacco prevention and cessation activities to a level that complies with the percentage share stated in the Initiated Act.

Recommendation: The General Assembly and State administration are encouraged to increase other financial resources for tobacco control programming, which should be

designed to complement the ADH programming so that existing shortfalls in CDC-recommended levels of funding for individual program components can be alleviated.

Recommendation: The State should enact additional legislation that bans smoking in public places, which would reinforce the actions already being taken by the ADH and other organizations to achieve and maintain behavior changes for Arkansans and to reduce smoking rates.

Minority Health Initiative

The MHI is uniquely positioned to address directly the health needs and priorities of the minority populations in the state. It has made progress in both programming growth and financial reporting during FY2005, and it is spending more of its available funds than it had in the previous biennium. However, issues of declining enrollments, quality problems, and extremely high unit costs have been identified for the MHI Hypertension initiative. These issues appear to be related to the structure of the contract with the Community Health Centers of Arkansas, with little accountability or financial consequences for low enrollments or inadequate clinical performance.

Recommendation. The AMHC should strengthen the MHI programming, with technical support as appropriate by the ATSC, so that its funding resources are used for cost effective programming for the health needs of minority populations.

Recommendation. As stated last year, if the MHC continues to under-spend its Tobacco Settlement funding through FY 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.

Recommendation. If the MHI Hypertension initiative cannot achieve appropriate service volumes, quality and costs, then alternative service delivery organizations and contracting mechanisms should be considered to replace its current contract with the community health centers.

Medicaid Expansion

The intent of the Initiated Act was to use the funds to provide insurance coverage for individuals not otherwise eligible for Medicaid. The under-spending of the Tobacco Settlement funds for this program has two consequences for the state: absence of insurance coverage for people in poverty, and loss of federal funds through the Federal Medicaid matching of three dollars for every State dollar spent on health care services. The Medicaid program could reinforce the growth of enrollments and service delivery in the expansion programs by investing some of the unspent Medicaid Expansion Program funding in more extensive enrollment outreach and other activities to expand enrollments in the three existing expansion programs. Although these administrative costs have Federal match at a lower 1:1 ratio, the enrollments they generate will lead to medical care expenditures that receive the full 3:1 Federal match.

Recommendation: A portion of the appropriation for the Medicaid Expansion Program 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: The unspent Medicaid expansion funds should be put to work within the Medicaid program to cover health care services for people in need who do not meet the standard Medicaid financial requirements, to ensure that Arkansans are obtaining needed care and that the state retains the large leveraging of funds available through Federal Medicaid matches. This could be through emphasis on growth of the existing expansions or adding other Medicaid expansion options.

ATSC Management of Program Progress

During the first years of the Tobacco Settlement program, the RAND evaluation team assessed the progress of the funded programs in the startup and early operation of their activities, and we worked with the programs to establish goals and measures for monitoring their continued operation and growth. The evaluation team believes it is time now to begin to shift the role of monitoring the programs' activities away from the external evaluator into the hands of the ATSC by the end of FY2006. RAND has a responsibility to assist and support the ATSC in integrating this evaluation function into its ongoing operation. RAND will continue to serve as an objective observer of program performance reports and data on the programs' process indicators, while shifting the emphasis of its evaluation to focus more on analysis of program effects on outcomes, which requires the modeling and statistical expertise that we can best provide.

Recommendation. The ATSC should continue to work toward establishing a complete reporting package through which the funded programs provide it with performance information on both their program activities and spending, which it should use for monitoring program performance on a regular basis. This package should include quarterly reports that contain the items specified in our 2004 evaluation report, as well as quarterly financial statements, quarterly data that extend trends in the process indicators of service activity, and annual reports on progress toward long-term goals.

DISCUSSION

The Arkansas General Assembly and Tobacco Settlement Commission have much to be proud of in the investment made in the seven programs supported by the Tobacco Settlement funds. These 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 as the funded programs continue to learn and adjust to achieve full program effectiveness. To do justice to the health-related services, education, and research these programs are now delivering, they should be given the continued support and time they need to fulfill their mission of helping to significantly improve the health of Arkansans.

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 in the Initiated Act to dedicate the Tobacco Settlement funds to support health-related programming.