

# **Arkansas Tobacco Settlement Commission**

## **Meeting Minutes**

**Wednesday, June 21, 2006**

**Cox Conference Room**

**1:30 p.m. to 4:00 p.m.**

Type of Meeting: Special Meeting

Chairperson: Bill B. Lefler

Board Members Present:

Gen. (Ret.) Bill B. Lefler, DDS, FACP, Chairman

John Ahlen, Ph.D.

Omar Atiq, M.D.

Paul Halverson, DrPH

Joni Jones (designee for John Selig)

Karen Wheeler, Ph.D. (designee for Linda Beene, Ed.D.)

Board Members Absent:

Anthony Fletcher, M.D.

Dee Cox (designee for Ken James, Ed. D.)

Staff Present:

Chiquita Munir

Karen Elrod

Invited Guests:

Beck Hall, Delta AHEC

Leslie Humphries, ABI

Dr. Larry Cornett, ABI

Lynda Lehing, TPEP

Joni Jones, DHHS

Suzanne McCarthy, ACHI

Warren Readnour, AG's Office

Dr. Jennifer Dillaha, DHHS

Mike Stormes, DF&A

Tracy Gatlin, AMHC

Dr. Claudia Beverly, COA

Janet Hopper, UAMS

Jim Raczynski, COPH

Willa Sanders, COPH

Nell Smith, Democrat/Gazette

Robin McAtee, COA

### **I. Call to order**

**General Bill Lefler**

General Lefler called the meeting to order at 1:40 p.m. He welcomed observers, public, and the press. The ATSC has received the resignation of Dr. Ryan Buffalo, a letter has been sent to the Speaker of the House requesting appointment for his vacancy. Today's agenda has been shifted around a bit; Mike Stormes from the Department of Finance and Administration will discuss the MSA payments that have been received by the State of Arkansas.

## **II. 2006-07 MSA Payment Distribution**

**Mike Stormes**

Mike Stormes handed out a chart that explained the tobacco funds received under the Master Settlement Agreement. This chart showed where we have been and where we are going. When the initiated act was drafted it was set up in a way that would allow us to know by the beginning of each fiscal year (July 1 of each year) the amount budgeted for the coming fiscal year. Payments received by June 30 will be the funds available for the agencies to budget the next fiscal year. We ask agencies to prepare their budgets by May of the current FY, in April of the current FY I send out an estimate; these estimates are sometimes low as to not set up expectations.

### **Questions**

General Lefler- How much is the \$100 million dollars originally set aside for the Healthy Century Trust Fund worth now?

Mike Stormes -It is close to \$113 million dollars.

General Lefler- The purpose of the \$100 million dollars is what?

Mike Stormes- The intent was to maintain the programs in the event the MSA funding decreases (because of decreased tobacco sales). According to Initiated Act 1, and it would take a 2/3 vote, the legislature could amend the Healthy Century Trust Fund and spend that money as they choose (there are some specifications as to how they can spend it).

Chiquita Munir-Can you confirm that programs cannot make an early draw down on MSA funds once the April 15 payment comes in.

Mike Stormes -The law is very specific, monies cannot be drawn early, the monies are collected and then they are made available the next fiscal year.

Jennifer Dillaha –Please explain how the TPPS is different than the other programs.

Mike Stormes-DHHS amended initiated act 1 to provide for a onetime transfer of funds from the TPPS to cover the initial costs of the Medicaid waiver program. TPPS is now funded each FY with a loan from the budget stabilization trust fund. The loan is then repaid with the income from that particular FY.

Lynda Lehing- When will the FY07 appropriations in funding show up in the master settlement?

Mike Stormes- You may not have access to it until July 1. You will know what those amounts are because you have filed you FY07 annual operations plan.

John Ahlen- With this kind of history now can you maintain any type of estimate now more than one year at a time.

Mike Stormes- With the litigation going on, there is not a good way to estimate future MSA payments.

No other questions.

**State of Arkansas**  
**Tobacco Funds Received under the Master Settlement Agreement**  
Funds are available for Programs in the Fiscal Year following the Fiscal Year Received

| Fiscal<br>Year<br>Received | Fiscal<br>Year<br>Budgeted |     | Before Debt Service |               | After Debt Service |              |
|----------------------------|----------------------------|-----|---------------------|---------------|--------------------|--------------|
|                            |                            |     | Estimate            | Actual        | Estimate           | Actual       |
| 2001                       | 2002                       | (1) | \$122,095,111       | \$122,095,110 | \$22,095,111       | \$22,095,110 |
| 2002                       | 2003                       |     | \$55,801,847        | \$62,180,505  | \$50,801,847       | \$57,180,505 |
| 2003                       | 2004                       |     | \$57,997,749        | \$60,067,457  | \$52,997,749       | \$55,067,457 |
| 2004                       | 2005                       |     | \$51,474,278        | \$52,688,976  | \$46,474,278       | \$47,688,976 |
| 2005                       | 2006                       |     | \$51,019,461        | \$52,774,224  | \$46,019,461       | \$47,774,224 |
| 2006                       | 2007                       | (2) | \$43,600,000        | \$48,446,985  | \$38,600,000       | \$43,446,985 |

(1) The initial settlement payment was reduced by \$100 million to fund the corpus of the Healthy Century Trust Fund. Beginning with the 2003 fiscal year, \$5 million each year is transferred for Debt Service on Bonds.

(2) The estimate for FY07 provided to agencies on April 10, 2006 assumed payments might suffer up to a 20% reduction Actual is Year-To-Date, additional payments may be received before June 30, 2006.

**III. Approval of minutes from last meeting**

**General Lefler**

Minutes of the April 26, 2006 meeting were reviewed by Commissioners.

General Lefler entertains a motion to vote.

Motion to Approve: Dr. Atiq

Seconded by: Dr. Halverson

Minutes from April 26, 2006 meeting were unanimously approved.

**IV. Financial Update**

**Chiquita Munir**

Chiquita Munir updated the commission on the budget. The Commission has year to date spent \$446,000 total for operating expenses and for RAND payments. We have a balance in our budget of \$140,000 dollars of which \$111,000 was allocated for tobacco settlement grants, but because of limitations with our budget for travel it is in our best interest not to fund grants in excess of what we have already have committed to.

No questions

General Lefler entertains a motion to vote to accept the budget.

Motion to Approve: Dr. Ahlen

Seconded by: Dr. Atiq

Budget was unanimously approved.

## V. Disputed MSA Payments Update

Chiquita Munir

There were several questions at the last meeting about MSA payment reductions and why we received those reductions. I will attempt to address those questions on behalf of Teresa Marks the assistant attorney general who handles tobacco issues; she was unable to attend this meeting.

### *Overview of MSA*

- The State of Arkansas receives annual payments of .8280661% of the total amount paid by Participating Manufacturers (PMs)
- The state will receive payments “in perpetuity”
- Each yearly payment will include all relevant calculations and adjustments

46 states (and five other jurisdictions) entered into a Master Settlement Agreement for which Arkansas receives .8% of the share of the total amount paid by Participating manufacturers. The state will receive payments “in perpetuity” meaning for as long as this agreement is in effect or another agreement goes into effect making the current agreement no longer valid. Each year, payments will include all relevant calculations and adjustments.

Our state is unique in how it is one of the few states that is using its money for healthcare. The MSA agreement states that the settling states will receive payments every April 15 2000 and thereafter through perpetuity.

### *Calculations and Adjustments*

- Responsibility for calculations and adjustments conferred to an “Independent Auditor”
- *PriceWaterhouseCoopers* was “selected by agreement of the Original Participating Manufacturers and Attorneys General of the Settling States who are members of the NAAG executive committee”

Because of the complexity of the MSA payment calculations and adjustments the MSA conferred responsibility over to an Independent Auditor. The terms of the MSA states that this Independent Auditor should be a major, nationally recognized, certified accounting firm selected by agreement of the Original Participating Manufacturers and the AG’s who were also members of the NAAG executive committee. Price Waterhouse Coopers was the firm selected to handle calculations and adjustments.

### *Calculations and Adjustments*

- Base Payment
- Inflation Adjustment
- Volume Adjustment
- Previously Settled States’ Reduction
- Non-Settling States’ Adjustment
- Non-Participating Manufacturer (NPM) Adjustment
- Miscalculated/Disputed Payments Offset
- Federal Tobacco Legislation Offset
- Litigating Releasing Parties Offset
- Claims Over Offset

There are up to 10 adjustments that tobacco companies are allowed and these adjustments are likely to affect our state because these calculations are determined by the Independent Auditor

and adjusted before distributed to each individual state. These amounts are determined sometime in January in preparation for the April 15 payment to each Settling State. Keep in mind whatever the payments total, our state receives a predetermined percentage of .82%

*Two main adjustments that may reduce MSA payments would be:*

- Volume adjustment: depending on the # of cigarettes shipped into the domestic market, compared to the 1997 level of 475B may decrease or increase. Under this adjustment, if fewer cigarettes are sold in the US, which is a goal of the MSA, MSA payments will be decreased.
- NPM adjustment: if an independent economic consultant determines that the PM's experience a loss of domestic market share of greater than 2%, as measured by the 1997 baseline, as a result of the MSA, a reduction to some states may occur. States can protect themselves from this potential adjustment if they pass and diligently enforce a "qualifying statute".

#### Variations in Projected Payments

| <i>Year</i> | <i>NAAG Projected Payment</i> | <i>Payment Received</i> |
|-------------|-------------------------------|-------------------------|
| 2003        | \$68,839,575.47               | \$60,067,457.27         |
| 2004        | \$57,997,749.17               | \$52,688,976.05         |
| 2005        | \$57,997,749.17               | \$52,774,223.89         |
| 2006        | \$57,997,749.17               | \$43,446,984.69         |

Many of you have asked why there has been such a variation between amounts projected in 1998.

Every payment received by the State is likely to be affected by the MSA adjustments. When the MSA was executed in November of 1998, the NAAG made rough projections of the amounts that would be paid to the settling states over time, but these projections did not include any possible adjustments. The information necessary for calculations did not exist in 1998.

Payments received are unlikely to match the payments projected in 1998 – demonstrated in the chart outlining projections and the amounts actually received, and these amounts also do not reflect any deductions the State makes before distribution to the programs (i.e. Debt Service Fund) or recouped payments from negotiations with PMs.

*Contributing factors MSA payment reductions for Arkansas*

- Disputed payments
- Diligent Enforcement

*Disputed Payments*

- Generally relate to non-payment by Subsequent Participating Manufacturers (SPMs)
- Current primary dispute relates to an NPM adjustment for the 2003 sales year, and the 2004 payment to settling states
- PMs argue that an NPM adjustment should have been made to 2004 payment
- Several PMs made payments into a disputed payment account in 2006
- This subsequently reduced 2006 MSA disbursements to the Settling States

To address the question about the participating companies who withheld portions of their payment with claims of market shares losses to NPM's – there is actually a total of 54 PMs which include the original PMs and SPMs. As with all disputes over payment issues since 1998, the AG's office has been working with other settling states to resolve disputes through negotiation. Our state has also filed a Motion for Declaratory Order requesting a determination and order that the state diligently enforced its qualifying statute in 2003. This would entitle Arkansas to recoup Arkansas' share of the funds withheld this year.

Our Attorney General's office has gone through this process in the past, and this may be a fight for us every year but as you will see on the next few slides there are mechanisms in place to help ensure or increase our chances of recouping those funds.

#### *Diligent Enforcement*

- Act 1165 of 1999
- Requires that each tobacco manufacturer selling cigarettes in the State either be a PM or as an NPM, deposit monies into escrow
- All monies are to be held in escrow no longer than 25 years
- Used to satisfy any health-related judgment or settlement
- Failure to comply may result in the Attorney General filing a lawsuit

#### *Act 1073 of 2003*

- Enhanced the terms of Act 1165 of 1999
- Non-compliant NPM brands will be removed from the Approved-for-Sale Tobacco Products Directory

Act 1073 of 2003 is a statute that merely assists the State in meeting its obligation - this statute addresses the issue of NPM brands who do not make payments into escrow. These companies who are non-compliant are removed from the Approved –for-sale Tobacco Products directory.

#### *Act 384 of 2005*

- Also known as the Allocable Share Amendment
- Purpose of this legislation was to require NPMs to maintain an adequate fund against which the State may satisfy health-related judgments or settlements
- Requires more competitive pricing amongst NPMs
- Makes them account for every cigarette sold
- Limits targeting sales to youth and poor

The actual purpose of 384 of 2005 was to require NPMs to maintain an adequate fund against possible litigation for health-related judgments.

The Allocable Share Amendment, the most recent legislation from this past session, while this wasn't its main purpose, it closed the loophole for NPMs that were not paying their fair share into the MSA. The amendment also causes the NPMs to raise their cigarette prices so that they have more competitive prices, and therefore are not competing against PMs in the Arkansas market.

If prices are more competitive, this lessens the chances for those companies to target youth and making cigarettes less affordable to some populations.

In February 2005, the Arkansas General Assembly passed Act 384 of 2005. This Act amended the manner in which releases from escrow are to be calculated. Under the Act 384 of 2005, each Non-Participating Manufacturer (“NPM”) must now maintain in escrow funds for each cigarette sold in the State of Arkansas. The purpose of this change was to create a viable fund against which the State may collect health-related judgments or settlements against the NPM. Although not necessarily the goal of the Act, by closing the loophole created within the original escrow release provision, it will also require NPMs to raise costs, thereby reducing their ability to target children and others that are more sensitive to the costs of cigarettes.

### *Conclusion*

- Our state is unique in using its MSA funds for healthcare
- Our Attorney General’s office is apprised and consistent on the issues as they arise
- As cigarette consumption decreases, so will the payments
- From a public health standpoint, we are improving the health of our citizens!

## **VI. Program Briefings/SWOT Analysis**

### **Arkansas Bioscience Institute (ABI)**

**Dr. Larry Cornett**

ABI receives 22.8% of the available finds each year. ABI is comprised of five institutions from around Arkansas. A Partnership of Scientists from Arkansas Children’s Hospital, Arkansas State University, University of Arkansas at Fayetteville, University of Arkansas Division of Agriculture and the University of Arkansas for Medical Sciences

Oversight for ABI includes the ABI Board, ABI Advisory Committees, ABI Scientific Coord. Committee and RAND Health.

### *Research Areas Mandated in Act:*

- Agricultural Research
- Bioengineering Research
- Tobacco-related Research
- Nutritional Research
- Other Related Research

### *Research Activities:*

- Recruitment of New Scientists/Researchers
- Support Investigator-initiated Research Projects
- Support Essential Core Instrumentation Facilities

ABI funding is used to leverage additional grants, extramural funding has grown steadily since FY02, when it was about 20 million dollars, and it has risen to slightly over 30 million dollars in FY05.

There has been a steady growth in publications and papers written by ABI scientists, close to 300 in FY05.

Recruitment of scientists, the average is 8-10 are recruited to come to places like UAMS and ACH, ASU and so forth. We are bringing new scientific talent into the state.

#### *ABI Strengths*

- Scientific talent: Experienced, well-funded scientists, including those recently recruited to Arkansas
- Infrastructure: Enhances State's research infrastructure already in place
- Resources: Has resources to stimulate collaborative research between scientists from multiple institutions
- Governance: Knowledgeable and committed governing Board and Advisory Committees
- Strategy: Strategic investments are increasing research capacity, catalyzing research, and strengthening research competencies

#### *ABI Weaknesses*

- "Cultural" differences between ABI institutions
- Funding cannot be carried forward beyond the biennium; long-term ABI research has short-term funding stream
- Not all ABI institutions are at the same point in length of research experience; newer research programs have less extramural funding to rely on during declining tobacco funding

#### *ABI Opportunities*

- Continued/increased extramural funding
- Stimulation of inter-campus collaborations to increase competitiveness for large federal grants
- Facilitation of commercialization opportunities

#### *ABI Threats*

- Declining core funding from tobacco settlement
- Flat or declining funding for NIH and other federal agencies that support biomedical research
- Raids on research funding

#### *ABI Funding from the Tobacco Settlement Plan has Benefited Arkansas*

- Leverages tobacco settlement funding with federal grants (~\$3 federal: \$1 tobacco settlement)
- Stimulates multi-institutional collaborative research projects
- Enables member institutions to recruit talented research-oriented faculty
- Supports the creation and development of biotechnology companies located in Arkansas

#### Questions

Dr. Atiq- If there is a funding decrease, would one of the recommendations be to cut out one of the institutions such as ASU and focus more on the institutions that have a track record?

Dr. Larry Cornett- I don't think that would be a good decision to make, because ASU brings a type of research to the ABI that is not duplicated by the other institution they are developing strong programs in agricultural research that relate to medicine. There is great interest on the part of the NIH, which is the primary source of extramural funding for the ABI, to really develop inter-disciplinary teams of scientists to stimulate collaborative research.

Dr. Wheeler-Higher education has focused over the past 10-15 years on leveraging research resources and this is a perfect example of that. The state has invested millions of dollars in Northeast Arkansas and there has been a wealth of researchers that have been attracted to ASU. Because of the Tobacco Settlement funds there are doctoral programs that would have never been created in the state if it had not been for the ABI fund.

Dr. John Ahlen- The ABI funds have allowed at all the campuses, infrastructure, equipment and top rate talent to be recruited. Prior to ABI there were not many good mechanisms that allowed people in higher education and research to think horizontally across campuses.

### **Arkansas Minority Health Commission (AMHC)**

**Tracy Gatlin**

#### *Strengths*

- Dedicated staff committed to improving health of Arkansans.
- Trusted by the community.
  - o Personal services to callers
  - o Resources to help churches and organizations set up health fairs
- Only mandated state wide organization that targets minorities.
  - o Act 912
- Seeking to improve awareness of minority needs among health care providers.
  - o 2007 Diversity Conference
- Already addressing decreased funding issues within agency.
  - o External contract amounts reduced
  - o Media now being handled in-house
  - o Rigorous cost-saving measures
- Ability to collect sponsorships.
  - o Southern Ain't Fried Sundays
  - o MESH
- Multiple partnerships and collaborations with other agencies and organizations

#### *Weaknesses*

- Only minority agency responsible for attempting to eliminate health disparities among minorities.
- Limited funding and staff to accomplish all objectives and opportunities.
  - o Low entry-level pay affects staff retention
- Financial collaborations with other agencies are sometimes one-sided
- Sometimes mistakenly confused with other entities
  - o EX: DOH/DHHS/UAPB Minority Sub-grant

- Large burden of responsibility associated with less attention to these minority health issues by other health organizations.
- Currently we do not charge for services or publicity related items
  - Literature, MHT tapes, t-shirts, etc...
- Underutilization of potential community resources.
  - Volunteers
  - Media services such as PSA's
- Effectiveness of programs may not be appreciated.
  - Effects of health initiatives are often not able to be seen or measured for years.

### *Opportunities*

- Large group of untapped agencies and organizations remain for possible sponsorships.
  - Both within the state and nationally
- Funding opportunities exist to address the issue of health disparities.
- AMHC programs are well known within the state and outside of Arkansas.
  - AREHD Study
  - Minority Health Today Show
  - Southern Ain't Fried Sundays
  - Website: [arminorityhealth.com](http://arminorityhealth.com)
- Ability to begin charging fees for collateral items.
  - Copies of MHT episodes
  - T-shirts
  - Mugs
  - Pedometers, etc...
- More utilization of community resources.
  - Volunteers
  - PSA's
  - Local businesses, organizations, schools and churches

### *Threats*

- Decreased funding.
  - Monies are not being allocated for special programs including Phase II of the AREHD Study.
  - Low entry level pay affects ability to hire and retain qualified staff.
  - Other agencies seeking additional revenue sources may target funds of smaller agencies
- Limited perceptions by legislators of effectiveness of preventive health programs.
  - Effects of health programs often are not measurable for a period of years.
- Lack of attention to minority issues by other agencies.
  - More burden on AMHC
- Political climate
  - New legislators may be unfamiliar with the agency or the scope of its work
- Worsening health in Arkansas, especially in minorities.
  - HTN, Diabetes, and obesity
- Changing standards and expectations by evaluators cannot be supported in a small agency without an increased staff.
  - More finance, media and accounting functions

Questions:

Dr. Ahlen-Can you explain the one sided financial collaborations with other agencies?

Tracy Gatlin-We get a lot of calls and a lot requests from people seeking support for a lot of different things, we have been able to assist with a lot of those, but when we are looking for sponsorships they can not always come back and contribute in kind.

Dr. Atiq- Can you please tell me of the strengths, which do you believe to be the Minority Health Commissions strongest strength?

Tracy Gatlin- Well, this is my opinion, for the overall agency I would say our staff is our strongest strength. We have staff that go out and go way beyond what is the normal call of their job description, however as it relates to the decreased funding issue which is the point of all of this I think we have a big chance, a big opportunity with the whole ability to collect sponsorships now.

Dr. Atiq- What is the strongest strength in terms of the program, of the objective, of the work that you do? What strength comes to your mind if I ask you to tell me in one line what is the Arkansas Minority Health Commission, what has it done? What is it supposed to do?

Tracy Gatlin- I think it would boil back down to our staff, when I started working out there I was not knowledgeable in relation to minority and health disparities but I have seen so many things and I have witnessed our staff going out making such an impact among the different communities and the different individuals just on a one on one basis when we are at the different health fairs in the different communities. I am going to say our strongest strength is our staff. Our staff really works to help.

Dr. Atiq- Of that good staff, where is it that they are most effective?

Tracy Gatlin-Our ability to help with other organizations, other churches, other communities I think in pulling together more community resources as far as health fairs go, bringing more awareness within communities to the health.

Dr. Atiq-One weaknesses you said that AMAH has is that it's sometimes mistakenly confused with other entities, what is the Minority Health Commission planning to do to address that?

Tracy Gatlin-I really don't think I can answer that question, I'm sorry.

Dr. Atiq- Effectiveness of programs may not be appreciated but that is very important for funding, which program do you think is really good which is not being appreciated?

Tracy Gatlin- Well I would be speaking for someone if I said it was not being appreciated but the Eating and Moving for Life Program is a very, very good program, but it works in the most simplest of ways, but to me those are the ways that work the best. It's not real scientific, it teaches people how to shop healthier, it teaches people how to realize that they don't have to have gym memberships to be able to get physical activity and it brings people together to learn all of these things and to have demonstrations on how to do these things. To me it is a common

sense simple approach, but it is not always looked at in the best way but it's a very good program.

Dr. Wheeler- One threat you have mentioned is the changing standards and expectations will you give a couple of examples on your perspective on what has changed.

Tracy Gatlin-We are a very small agency, we have about eight staff people, we have to start people at a low entry rate of pay, the evaluators often think we need to have someone who has a masters in accounting to do our accounting, and that is not feasible.

Dr. Wheeler-Have the expectations of the evaluators changed? To me this statement says that they come in one year and tell you to do this thing and the next year they tell you to do something else and the following year they have changed courses again, have they always set these expectations that you all feel are unrealistic based on the funding levels?

Tracy Gatlin-Honestly, Ms. Smith our Executive Director could be better to answer this question than I could, I think when they first started they were a little on the unrealistic side but they did not fully understand everything. As they have learned and we have learned what they want we have come more to a middle ground, but there are still rough spots that we hit.

Dr. Halverson-I just wanted to say that in relationship to opportunities, much of the work that the commission is doing is very positive in particular in raising awareness of minority health issues. I would suggest that one opportunity would be to have a greater emphasis in collaborating with other agencies throughout the state, both public and private agencies. I think that capitalizing on this strength that you have, the passion for minority health issues and interest in diversity, you could provide an important service in many of the organizations in the state and that is a important value added.

## **College of Public Health (COPH)**

**Dr. Jim Raczynski**

### *Strengths- General*

- Unusual, highly mission-driven focus of the COPH (resulting from opportunity presented by tobacco funding with no existing concentration of faculty with existing public health interests) with aligned:
  - Faculty
  - Centers (Center for the Study of Obesity; Center for the Study of Tobacco; Center for the Study of Maternal and Child Health Issues)
  - Teaching, research and service programs
- Very strong and talented, collaborative faculty, mostly new to UAMS and excited to be in Arkansas
- Strong and effective leadership among faculty, chairs, center directors, and program directors
- High level of awareness among elected officials and residents in Arkansas of poor health of population and of high prevalence of risk factors (obesity, tobacco use), probably resulting from:
  - Activities surrounding decisions about use of tobacco funds
  - Public health focus of Governor Huckabee's initiatives
  - Other efforts -- e.g., Act 1220 of 2003, BMI data, etc.

- College programs have only recently evolved or have yet to emerge, allowing for evolution without having to deal with inertia from long-standing programs (“a sense of being agile”)
- Located in a small state with a less complicated environment and easier access to decision-makers than in many states, allowing development of programs that probably could not be developed in other states or at least could not be developed without greater effort
- A small state where a small College can truly have an impact on the public’s health
- Only school of public health in the state, minimizing competition for students, programs and resources
- Close relationship with DHHS Division of Health, enabling:
  - Leveraging of resources (financial when synergies exist, intellectual)
  - Enhanced opportunities for the COPH to impact on the health of Arkansans
- A sense of “uniqueness” among faculty, staff and students, and increasing national recognition of uniqueness of the COPH
- Increasing national recognition of Arkansas as a leader in public health initiatives (resulting from many sources)
- Strong collaborations with some other on-campus UAMS programs, adding interdisciplinary perspectives and fostering leveraging of resources, such as:
  - COM and COPH Departments of Biostatistics
  - Center for Addictions Research (CAR)
  - Planned COM/COPH Center for Translational Epidemiology
  - Collaborations with Division of Pharmaceutical Evaluation and Policy
  - COPH secondary appointments for faculty with primary appointments in all other UAMS colleges
- Strong support at national level from ASPH for advocacy and coordinated program development between schools of public health
- Close proximity of UALR, allowing ready development of educational, research and service collaborations

#### *Strengths-Educational*

- Close connections with DOH leadership overall and those involved in workforce development, allowing:
  - Continuity of CE and graduate program development
  - Integration of practice-based experiences into educational programs
- Great student diversity (race, age)
- Unique combined degree programs (4-year combined MD/MPH, JD/MPH, PharmD/MPH program, developing MSW/MPH, planned LLM in public health law)
- Large number of public health practice partners, providing high quality preceptorships and integrative projects

#### *Strengths-Research*

- Strong research faculty with many having an extremely strong record of research and extramural funding
- Strong recognition of importance of collaboration, involvement of an interdisciplinary team, and translational research

- Beginning collaborations with AHECs, providing statewide infrastructure for tobacco and obesity initiatives

#### *Strengths-Service*

- Extensive collaborations with public health practice community across state, allowing ample opportunities for service

#### *Weaknesses-General*

- Significant space constraints without a clear plan to meet inevitable acute and chronic needs
- A small college that inherently must focus and develop priorities rather than cover the broad scope of public health
- Insufficient ethnic diversity (Latino) among faculty
- Insufficient racial diversity, particularly among upper-level, primary faculty
- Constraints on foundation development opportunities
- No pool of graduates from whom to solicit financial support and support for student preceptorships and integrative projects

#### *Weaknesses-Educational*

- Paucity of support for student scholarships and stipends
- Insufficient classroom space in COPH-allocated space (should improve with construction of education building)
- No space for students in doctoral programs
- Need for a centralized UAMS plan for newer distance-learning technologies and sufficient resources
- Need to increase ethnic (Latino) diversity of students

#### *Weaknesses-Research*

- Only an evolving intra-college infrastructure to support research
- A very slowly evolving university infrastructure for supporting efficiency in research

#### *Weaknesses-Service*

- Insufficient faculty time to meet service needs in face of needs for development of extramural research and educational programs

#### *Opportunities- General*

- Unexplored or undeveloped opportunities to partner with UALR and perhaps other universities to develop collaborative programs, e.g.,
  - Planned Center for Public Health Law with UALR Law School
  - Developing opportunities in health communications research with School of Communications faculty
- Strong COPH ties with Clinton School with opportunities for collaboration (e.g., joint Center for Community Change Methods)
- Opportunities to build stronger relationships with other state agencies than DOH, other organizations and other communities

- Sense of excitement among Arkansans for public health approaches, building opportunities for:
  - Development
  - Student education and recruitment
  - Community partnerships for research, education, and service

#### *Opportunities- Educational*

- Continuing unmet need for public health educational programs resulting from lack of access to higher educational programs, aging of public health workforce, and evolution of public health practice and research
- Opportunities to recruit students across Arkansas with adequate support of distance accessible programs
- Unexplored or undeveloped opportunities for collaborative educational programs with other institutions
  - Planned LLM with UALR Law School (as part of Center for Public Health Law)
  - Planned combined MSW/MPH program with UALR
  - Combined MA (or MS) in health communications and MPH program
  - Combined MPA/MPH program
  - Opportunities with Business School
  - 5-year BA/MPH or BS/MPH program with undergraduate institutions
- National movements toward credentialing MPH graduates and licensing health departments may create an increased visibility of public health careers and number of applicants
- Strong support from existing combined MPH programs (MD/MPH, JD/MPH, PharmD/MPH) for recruiting an increased number of students

#### *Opportunities- Research*

- Virtual paucity of population-based research programs, minimizing potential for contamination and confounding
- UAMS state-wide programs (e.g., AHECs, Centers on Aging), allowing partnerships and collaborative opportunities

#### *Opportunities- Service*

- Believed high level of support for prevention, resulting from awareness of poor health of Arkansans and high prevalence of risk factors
- Opportunities to partner to a greater extent with existing UAMS programs
- Strong interest from UALR in developing collaborative Center for Public Health Law, offering service opportunities

#### *Threats- General*

- Risk of losing tobacco funding
- Space constraints creating burdens on research and educational programs
- Change in Governor, DHHS, and/or DOH leadership that might threaten close relationship with DOH

### *Threats -Educational*

- Efforts to organize a school of public health in Memphis, resulting in competition for students

### *Threats-Research*

- Decreases in research funding and/or shifts in funding priorities
- Regulatory and accounting burdens increasing demands on faculty research effort and limiting productivity and substantial non-direct costs for compliance

### *Threats-Service*

- Threats to collaboration in DOH, other agencies, organizations, arising from leadership and/or changes in leadership and putting limits on opportunities to support service programs

Questions: no questions

## **Delta Area Health Education Center (Delta AHEC)**

**Dr. Becky Hall**

UAMS is part of the University of Arkansas Systems and is the state's only comprehensive academic health center. AHEC is a national program designed to provide health care training to rural and underserved areas. UAMS operates the 7 Arkansas AHECs. Each AHEC serves multiple counties as an extension of the University. UAMS Delta serves 7 counties in Eastern Arkansas with offices in Helena and West Memphis and staff in Lake Village

### *Strengths*

- The new 31,000 sq. ft building
- A member of the UAMS regional programs/AHEC family
- Community Outreach Programs in seven counties
- Health and Wellness
- Fundraising efforts
- Educated, well-trained, DEDICATED staff
- Community support
- Collaboration with other UAMS programs
- Relationship with area junior colleges, schools, community based organizations, ADH, churches
- Renewed interest in the Delta has resulted in more visibility through the Delta Bridge Project and the DRA

We held an Open House for the fitness center on June 1 and opened for business on June 5. To date we have 674 members. This includes walking track, aerobics, tai chi, yoga, etc classes. We are not just a gym, but a wellness facility. I have a couple of stories to share, a lady started exercise 2 months ago doing tai chi and walking track because her liver enzymes were elevated. She went to the doctor last week and her enzymes are now normal. A lady and her teenage son both weighed over 350. They have been coming into the center since June 5 and she has lost 10 lbs and her son 12 lbs.

A lady has been coming since June 5, she was trying to reduce her weight in order to have a heart transplant, our staff has been working with her twice a day then she went to the doctor and her heart function has improved so much that she is no longer on the transplant list

We are helping a lady that has had 5 heart bypasses and has diabetes. Staff has designed a special program for her and she is working out 5 times a week

We are working with a man that is unemployed because of his back pain. He can't have surgery until he loses 30 lbs.; he has been coming in for 7 days and has already lost 5 lbs. most of our clients who are overweight are also seeing our nutritionist and those with diabetes are being seen in the diabetes clinic.

Having the UAMS network as our foundation is a tremendous support. They provide financial, IT, evaluation, networking, and other support. Serving seven counties means that most of our programs have to be delivered at distant sites. We take programs out to the community where they are most accessible to the public. The health and wellness education programs we provide a unique and a niche that no one else is filling. We go into schools, churches, business and other COB organizations

#### *Weaknesses*

- Name recognition
- Reaching the most needy/hardest to reach
- Lack of funding for programs and much needed additional staff
- New grant restrictions from UAMS
- Support from the medical community is lukewarm.
- Lack of participation in CME/CE from medical community
- No residency program

Name recognition is much better. The medical community did not want the senior health clinic they were fearful of a family practice residency program/and or CHC because they fear reduction in their patient load. Lake Village hospital no longer will be able to house our delta AEHC staff...expansion at the hospital means no office space.

UAMS AHEC-SW provides Continuing Medical Education, also known as CMEs, every week to keep health care professionals up-to-date with new diseases and treatments including the latest pharmacological therapies. CMEs cover a wide range of topics important for health professionals including legal and ethical guidelines. Some of the major CME conferences this year include Sports Medicine, HIV, Bioterrorism, and Care for Older Adults. UAMS AHEC-SW has provided CMEs in Texarkana since 1976.

#### *Opportunities*

- New Facility
- Community support and partnerships are increasing
- New opportunities to change resistance to the AHEC
- Increased space provides opportunity to serve more people
- Opportunity to educate more people about health issues
- New building offers increased visibility and access to a greater variety of clients
- So many people, from all walks of life, are excited about the new facility and the programs that will be offered

The UAMS AHEC-SW Family Clinic is a full-service clinic for the entire family with benefits of up-to-date medical training of residents plus experience of UAMS faculty physicians. This is the same combination that makes teaching hospitals the best in health care services.

Our clinic is the largest Family Medicine Clinic in the region. The UAMS AHEC-SW Faculty Clinic is staffed with veteran faculty family medical physicians and a Family Nurse Practitioner. The Faculty members who see patients in the clinic are Sandra Bedwell, Nurse Practitioner, Dr Michael Downs, Dr Donald Duncan, Dr Russell Mayo, Dr Shanna Spence, Dr Jerry Stringfellow, and Dr Andrea York.

*Threats*

- Loss of HETC funding
- Decrease in tobacco funding
- Too MUCH participation
- Too LITTLE participation
- Sustaining Fitness Center memberships month to month
- Loss of COPH tobacco interventionist
- Can we change the health behavior of the people of the Delta by 2010?

The Texarkana Regional Center on Aging educates senior adults and their families on issues directly affecting the elderly.

Resources include a library of books, tapes and pamphlets and staff is available for patient counseling. The center also specializes in geriatric training for students.

TRCOA is a partnership of UAMS AHEC-SW, Donald W. Reynolds Center on Aging, and CHRITUS St. Michael Senior Health Center.

Questions:

Dr. Atiq- How many Physicians do you have in Helena?

Becky Hall- Twenty five or so.

Dr. Atiq- Do you have any ideas as to why the support is lukewarm from the physicians?

Beck Hall- When we started talking about a residency program and the Senior Health Clinic they perceived that as a threat. They are afraid we are competition.

**Donald Reynolds Center on Aging (AAI)**

**Dr. Claudia Beverly**

Demographics of Older Arkansans

|   | U.S.               | Arkansas                       |
|---|--------------------|--------------------------------|
| Population per Capita $\geq 65$ 1<br><ul style="list-style-type: none"> <li>• 2000</li> <li>• 2025</li> </ul> | 12.4%<br>20%       | 14% (377,000)<br>24% (731,000) |
| Poverty <sup>2</sup>  | 13%                | 18%                            |
| Mortality <sup>3, 4</sup>   | 5023.4 per 100,000 | 5313.1 per 100,000             |

1. US Census Bureau 2000  
 2. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).  
 3. [http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54\\_13.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_13.pdf)  
 4. <http://www.healtharkansas.com/stats/mort2003/MORT510.HTM>

The top two causes of Death:

- o Heart diseases 32.4%
- o Cancer 20.4%

Obesity, smoking, and physical inactivity are the most important contributors to morbidity and mortality in general, and to heart disease and cancer.

### *Strengths*

- Multiple partners and collaborations
  - o Area Agency on Aging
  - o Local/regional/community Hospitals
  - o AHECs
  - o Local Universities and Colleges
- Education and health care services that focus on state's leading causes of death
- DWRIOA/UAMS – ranked in the top ten according to U.S. News and World Report
- Successful recruitment of geriatricians, GNP's, Social Workers, and other health professionals
- Engaged in community capacity building
- Multiple external evaluations all with favorable results
- History of influencing policy

### *Weaknesses*

- Unstable funding
- Difficulty recruiting geriatric workforce
- Regional geographic catchment areas are unequally distributed
- AAI identity and branding confusion
- Program is only five years old and has not yet reached its full potential
- Lack of dollars for evaluation and research

### *Opportunities*

- To develop an integrated and comprehensive statewide healthcare and social services program to meet the needs of older Arkansans.
- To become a national model
- replication of the AAI Model to other states
- To increase standards of care of older Americans – improve their quality of life
- To improve the health status of older Arkansas' - from being ranked one of the worst in the nation
- Arkansas is a statewide laboratory for scientific inquiry.
- To prepare an expert geriatric workforce
- Formal
- Informal
- Implement a healthy life course perspective by collaborating with
- UAMS' COPH, College of Nursing, ACHI, College of Medicine and Department of Health and Human Services
- Target public and private sectors for raising funds/grants
- Partner with the Division on Aging, DHHS and the AAA's to develop a comprehensive, integrated healthcare and social services statewide program
- Influence policy at the state and national level
- Use the AAI infrastructure, including the partnerships, to lead a statewide effort to develop a comprehensive strategic plan for older Arkansans

- To tap into local/regional resources
- Use the community capacity that we have built to:
- Strengthen programming
- To raise private funds
- Attract more qualified staff
- Develop more and stronger collaborations

#### *Threats*

- Lack of adequate funding could cause sites to close
- Change in the ownership of hospitals
- Change in senior health clinic reimbursements from CMS
- Lack of adequately trained geriatric workforce

#### Questions:

Dr. Atiq- How many patients does each clinic average?

Dr. Beverly- The clinics have not been able to give us the number of patients because they have to count them by hand. Outpatient visits, collectively we had over 36,000 statewide.

Dr. Atiq- 36,000 visits which could also be multiple visits by a person, would there be a way to find out how many people you really attract?

Dr. Beverly- We can ask the clinics to count those numbers, we have not had much success at this point but we can try to push that issue with our partners. There are a few clinics that are on electronic health records, others have to count by hand.

Dr. Atiq- Are they not on electronic records?

Dr. Beverly- No, just two of our sites. Texarkana and Jonesboro, we wish they all were.

Dr. Atiq- That sounds a little strange, because for even our offices may not have electronic health records but everywhere at least the scheduling is done electronically and from there you can get demographic data.

Dr. Halverson- On the comment of improving the quality of life for older Arkansans, I wonder if you thought about how you are going to measure that.

Dr. Beverly- Only recently we have been partnering with the College of Public Health and we have started putting some of our evaluation and research ideas together, but one of the things about older adults and the quality of life is that they equate that a lot with being in the least restrictive environment.

#### **Medicaid Expansion (DHHS)**

**Joni Jones**

I want to update everyone status of the Medicaid expansion, there are for parts to the expansion, we began with hospital benefit coverage, we did increase the number of benefit days from 20 to 24, and we reduced the co pay on the first day of hospitalization from 22% of the cost to 10% of the cost. We immediately followed that with an expansion of the pregnant woman's program,

increasing the eligibility for that program from 133% to 200% of the federal poverty level. The following year the ARSenior program received an expanded benefit package. The fourth part to this is the expansion to the services for the 19-64 year old group; we have had some difficulties getting that started.

#### *Strengths*

- Ability to match Tobacco Funds with Federal Medicaid dollars at a 3:1 ratio
- Providing previously uninsured low-income Arkansans access to health care
- Increasing the number of Pregnant Women with access to pre-natal care thereby improving the health of both mother and child
- Increasing the number of covered hospital days and decreasing co-pay requirements
- Managing the expansion programs with very low administrative costs

#### *Weaknesses*

- Limited program outreach to date (RAND)
- Indications of some underutilization of benefit package for ARSeniors (RAND)
- Excessive delay in obtaining CMS approval for waiver to provide services to individuals 19 – 64

#### *Opportunities*

- Implementation of the Arkansas Safety-Net Waiver Program
- Expansion of ARSeniors Program to 100% FPL

#### *Threats*

- Sustainability of New Programs in future years
- Financial Impact of the Medicare Part-D Clawback Requirement

No questions

### **Tobacco Prevention Education Program (TPEP)**

**Dr. Jennifer Dillaha**

#### *Mission & Goals*

To reduce disease, disability and death related to tobacco in Arkansas citizens by:

- Preventing youth initiation
- Decreasing exposure to secondhand smoke
- Eliminating disparities among diverse populations
- Providing cessation services and resources

#### *Strengths*

- Research-based comprehensive tobacco control program in place that includes all of the CDC components
  - Strong local coalition base
  - Successful cessation program
  - Successful enforcement program
  - Strong media & public relations campaign
  - Strong statewide youth coalition
  - Successful school-based program
- Recent passage of the Clean Indoor Air Act
- Strong collaborative relationship with non-profit partners – ACS, AHA & ALA
- Ability to carry over funds

- Positive evaluation indicators
  - Decline in youth smoking
  - Decline in pregnant women smoking
  - Decline in tobacco sales to minors

#### *Weaknesses*

- Funding level for the nine components are below the CDC recommended level
- Funding goes to programs that are not within the scope of tobacco prevention & cessation
- Funding mechanism relies on borrowing against future MSA payments
- Vacant positions including Branch Chief & Media Program Support Manager

#### *Opportunities*

- Educate the legislators on the need for an effective a comprehensive tobacco prevention program and the successes already obtained through the local coalitions and media campaign
- Require grantees to secure matching funds
- Implement the sustainability plan in preparation for the next legislative session
- Supplement funding through other sources
- Collaborate with the Coordinated School Health Program to include school-based tobacco prevention & education component elements in their program plans

#### *Threats*

- Perpetual attempts to redirect funds
- Continual decrease of MSA funding
  - FY 07 – Able to carry over funds so there was minimal decreases in funding for some of the components
  - FY 08 – Budget is projected to be \$12 million (decrease from \$15.5 million working budget)

#### Questions:

General Lefler- I think the spit tobacco should be taxed severely.

Dr. Dillaha- Right now non cigarette products are taxed at 32% of the wholesale price, of course increasing the cost has demonstrated to be very effective in decreasing usage, particularly initiation among youth that would be a consideration.

Chiquita Munir - Do you think we may have the opportunity in the next legislative session to educate and encourage legislators to increase the cigarette tax?

Dr. Dillaha- I am always hopeful that our legislators will make good decisions. The best chance of them making good decisions is by us working closely with them to make sure they have a full understanding of the situation and that they know their facts and figures.

#### VII. Meeting Adjournment

##### Adjournment

The meeting was adjourned at 4:00

The next meeting is scheduled for July 19, 2006

Arkansas Real Estate Commission

612 South Summit Street