

# **Arkansas Tobacco Settlement Commission**

## **Meeting Minutes**

**Wednesday, July 19, 2006**

**APERS Conference Room**

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

Type of Meeting: Quarterly Meeting

Chairperson: Bill B. Lefler

Board Members Present:

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

Omar Atiq, M.D.

John Selig

Anthony Fletcher, M.D.

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

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

Jennifer Dillaha, M.D. (designee for Paul Halverson, DrPH)

Board Members Absent:

John Ahlen, Ph.D.

Staff Present:

Chiquita Munir

Karen Elrod

Invited Guests:

James Kahan, RAND

Donna Farley, RAND

Dr. Claudia Beverly, COA

Robin McAtee, COA

Judy Smith, AMHC

Suzanne McCarthy, ACHI

Warren Readnour, AG's Office

Linda Delaney, UAMS

John Engberg, RAND

Beck Hall, Delta AHEC

Dr. Larry Cornett, ABI

Leslie Humphries, ABI

Jim Raczynski, COPH

Willa Sanders, COPH

Heather Wechsler, Democrat Gazette

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

**General Lefler**

General Lefler called the meeting to order at 1:35 p.m. He welcomed observers, public, and the press.

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

**General Lefler**

Minutes of the June 21, 2006 meeting were reviewed by Commissioners.

General Lefler entertains a motion to vote.

Motion to Approve: John Selig

Seconded by: Karen Wheeler

Minutes from June 21, 2006 meeting were unanimously approved.

### **IV. Financial Update**

**Chiquita Munir**

Chiquita Munir updated the commission on the budget. This budget reflects the year end budget for FY06. The Commission has year-to-date spent \$456,753 for operating expenses and RAND payments (\$289,000 of this amount was for RAND). There has been no real difference in what we have spent and

what we are authorized to spend. The ATSC budget is \$130,343 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 committed to. We have a carry-over of \$832,666. The total funding level for FY07 is \$2,195,233. The ATSC total available funding for FY07 is \$3,027,899.

Questions:

John Selig- If the appropriations are not fixed then the funds keep building up?

Chiquita Munir- Yes.

John Selig- Has there been any discussion on fund balance using that particular line?

Chiquita Munir- I would like to present to you in the Directors report on how we could most efficiently use that money. RAND has made recommendations to earmark close to \$200,000 for technical support for programs. We will fund community grant programs if we get enough appropriations for travel. There is a need to hire someone in-house as an auditor who can audit community grant programs and who can audit the tobacco settlement funded programs, and that is what I am proposing in my next biennial request. I anticipate that our operating expenses may double; with at least \$500,000 funded to community grant programs.

General Lefler- The ATSC received a Legislative Audit report, the ATSC was found to be in good standing.

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. Director's Report**

**Chiquita Munir**

Director's Report:

In response to the recommendations that RAND has advanced, the Commission should consider a proactive response to strategically address issues related to ATSC and program performance.

### Mission:

To ensure the effective use of the Arkansas Tobacco Settlement

Goal 1:

Ensure Program Accountability (through the efficient/effective of Tobacco Settlement funds)

- A. Purchase new accounting system
- B. Consider individual program outcomes and strategic state needs when making programmatic decisions/recommendations. We need to base funding recommendations on performance of programs
- C. Retain use of external evaluator (RAND)

Goal 2:

Promote and maintain the strategic use of the tobacco settlement for health related programs

- A. Disseminate reports, statistical information and promotional materials to stakeholders
- B. Advocate continuous quality improvement of programs supported by tobacco settlement funds
- C. Develop an action plan that addresses significant reductions in tobacco settlement funds

Goal 3:

Maintain effective Commission oversight of programs supported by the Tobacco Settlement

- A. Develop Legislative Agenda that addresses effective and efficient use of tobacco settlement funding

B. Require collaborative activities between tobacco settlement programs and other related programs within the state

Questions-

Dee Cox- Can you give me an example of goal 3B?

Chiquita Munir- Currently the programs are doing an excellent job collaborating with each other, but it may be necessary for programs to do community outreach or develop collaborative efforts with other organizations outside of the ATSC.

John Selig- Which goals came from the strategic planning session?

Chiquita Munir- Goals 1 & 2 came from the strategic planning session.

John Selig- Including parts A, B and C?

Chiquita Munir- There were a few changes on goal 1, I added A-purchase new accounting system because we did not address that at the strategic planning session and that is a RAND recommendation.

John Selig- Under 1 C, I thought RAND recommended taking the evaluation internal at some point.

Chiquita Munir- We would retain RAND as our external evaluator; we would take over some of the activities. There are some things we can do internally that they do not have the ability to do.

James Kahan- The point there is that we feel that the Commission should move towards long term self sustainability and take on more of a role of self-evaluation, but you will always need some external evaluation. This is a gradual process that should start moving now.

Karen Wheeler- I was thinking in terms of the Legislative Agenda and the new accounting system it might be a good idea to start talking about an accountability person as well. If RAND is encouraging this I think we would have some support for that. I don't see how two staff members can take over evaluation, do auditing functions, and all of the other process required. I believe this is an opportunity.

Chiquita Munir- In my biennial request I requested a Management Project Analyst position to handle the accountability for the ATSC.

General Lefler entertains a motion to vote to accept the Directors Report as presented.

Dr. Atiq- I would like to hear the RAND report before we accept the Directors report in case we need to make some adjustments or fine tune it based on RAND's recommendations.

Dr. Atiq suggests that we move to accept the motion after we hear the presentation from RAND.

## **VI. RAND Evaluation & Recommendations (Draft Report Review)**

**Dr. James Kahan  
John Engberg**

This presentation is a culmination of two years of work by the RAND evaluation team and it is a project team effort. This is an overview of the Draft report that is oriented towards the actions that can be taken by the commission.

### ***Evaluation Results – July 2006***

#### ***Arkansas Tobacco Settlement Program***

#### **RAND Project Team**

**James Kahan, PI**

**John Engberg, Co-PI**

Overview of the 2006 RAND evaluation report

- Policy context: recent changes
- Process measures findings
  - »Achievement of Goals
  - »Governance, Quality, Financials, Contracts
  - »Responses to earlier RAND recommendations
- Outcome measures findings

- New recommendations and observations

#### Key Evaluation Questions

- Are the *funded programs on track* as specified in the Tobacco Settlement Proceeds Act of 2000?
  - »Are they fulfilling their missions?
- What *factors are contributing* to the programs' implementation successes or challenges?
  - »This year, we look at the processes of governance, quality, financial management, and contracting
- What *effects do the funded programs* have on improving the health of Arkansans?
  - »We learn more as time passes
- What changes should be made in the ATSC and its programs?

#### Chapters in the 2006 Evaluation Report

- Introduction and background
- Policy context in 2005-2006
- Process findings on each funded program
- Evaluation of smoking-related outcomes
- Evaluation of non-smoking outcomes
- Synthesis and recommendations

#### Good News: The Arkansas Indoor Clean Air Act

- Passed in special session of legislature, April 2006
- Prohibits smoking in most public enclosed areas
- Culmination of considerable political effort
  - »Local coalitions, champions of ATSC played a major role
- Anticipation, following many studies of similar acts, is that smoking will decrease, health will improve

#### Bad News: Is Tobacco Money Going Up in Smoke?

##### Appropriations and Funding

- Generally, appropriations for seven funded programs were close to proportions specified in the Initiated Act
- Amounts of appropriations are generally larger than funding from Settlement funds
  - »Therefore, programs can spend allocated amounts

**Planned and Received Tobacco Settlement Amounts,  
FY 2003-2007 (x 1000)**

<b>Fiscal Year</b>	<b>Arkansas' Planned Amount</b>	<b>Received by Arkansas</b>	<b>Percentage Adjustment</b>
<b>2003</b>	<b>\$73,692</b>	<b>\$62,180</b>	<b>-15.6%</b>
<b>2004</b>	<b>\$66,240</b>	<b>\$60,067</b>	<b>-9.3%</b>
<b>2005</b>	<b>\$66,240</b>	<b>\$51,500</b>	<b>-23.3%</b>
<b>2006</b>	<b>\$66,240</b>	<b>\$52,774</b>	<b>-20.3%</b>
<b>2007</b>	<b>\$66,240</b>	<b>\$48,446</b>	<b>-27.9%</b>

- Commission's appropriation was less than funding from Settlement interest

»Effect was to prevent Commission from spending according to plan

### Achievement of Goals

- Initiated Act Goals:* All programs except the MEP and MHI have achieved their initiation and short-term goals in the Act.
  - »MEP did get CMS approval for the AR-Adults program, but is still under spending on other programs
  - »MHI has not demonstrated achievement. Problems include evidence for increased awareness, no priority health lists for non-African-American minorities, no biographical database, and clearly showing how their screening efforts have a health effect
- Programmatic Goals:* Four of the seven programs have achieved all of their actions to be accomplished by 2006. The others achieved most of their goals.
  - »AAI fell short on professional education and the database for funding opportunities.
  - »MEP fell short in scope of AR-Seniors program.
  - »MHI did not complete application for survey funding. The scope of the Hypertension and Eating and Moving for Life initiatives was below objectives.

### Governance

- Diversity of programs is reflected in wide variety of governing boards they have
  - »Range is from close oversight (ABI, MHI) to considerable distance (COPH, Delta AHEC, AAI) to none (TPEP, MEP)
  - »Value in having somebody helping with strategic planning, fundraising
- Advisory boards mostly for community needs and interactions (TPEP, Delta AHEC, AAI)
  - »Considerable variation on involvement
  - »Programs with weak or no advisory boards (COPH, MHI, MEP) might consider forming such groups

### Quality Management

- QM processes define quality measures, collect information about quality, and analyze information to formulate and act upon quality improvement interventions
- The overall record of ATSC and the programs in this regard is weak
  - »Only COPH and ABI have formal quality management processes with monitoring capability
  - »TPEP and MEP (and AAI and Delta AHEC to a lesser extent) have tracking/monitoring capability for service delivery, contractors and grantees, but no self-quality-management
  - »ATSC itself should also have quality management process

### Financial Management

- Each program has a global financial management system in place; which one is dictated by where the program sits (State system, University systems)
- Component financial management varies
  - »TPEP, MEP monitor through separate accounts
  - »COPH, Delta AHEC monitor but not separately
  - »AAI, ABI do not monitor (by structure)
  - »MHI has initiated financial monitoring, but it is still fairly rudimentary.
- Programs would be well advised to use accounting resources for proactive and integrated strategic planning, such as locating external funding

### Contracting

- Most programs (COPH, Delta AHEC, AAI, ABI, MEP) do no contracting
- TPEP, MHI have contracts/subgrants for service delivery and personal service expertise

- »TPEP tracks financial records monthly, monitors quality, compares spending to reported activities
- »MHI tracks monthly to annually, some monitoring of quality, no comparison of spending to activity

#### Responses to Earlier RAND Recommendations

- Generally, programs and ATSC made serious efforts to adopt RAND recommendations
  - »Over half of recommendations fully implemented
  - »Sometimes, not under control of the program (e.g., meeting CDC minimums for tobacco reduction programming)
  - »Sometimes, still work in progress
- Here, we will touch on some important ones to give a flavor of reactions

#### Enlightening the Community

- TPEP Provided education, training and assistance for community coalitions, merchants, schools, others on practical, technical, and legal and enforcement issues.
- Delta AHEC Continuing engagement, education of local physicians
- ABI Increased awareness of ABI by increasing number of publications and media contacts
- MEP Working on greater support for outreach and education of beneficiaries

#### Leverage TS Funds

- COPH, ABI Increased grant funding significantly
- AAI Attempted to better leverage TS funds, but amounts raised to date have been quite small
- MEP Successfully worked with CMS to obtain Waiver for the Arkansas Safety Net Benefit program
- Delta AHEC Received <\$100K in grants; needs to expand that amount considerably. Wellness Center is an opportunity.

#### But Sometimes It Wasn't Done

- TPEP unable to obtain funding at CDC minimum levels
- COPH unable to continue discount for ADH employees
- MEP still under spending, although improvement in sight
- MHI did not adequately provide remedial training to improve skills and capacity of core staff
- MHI costs of treatment delivery still too high

#### The MHI Hypertension Treatment Program – Still Low Enrollment and High Spending

	<u>Hypertension</u>		<u>Eating &amp; Moving</u>	
	<u>2005</u>	<u>2006*</u>	<u>2005</u>	<u>2006*</u>
Number screened	4110	2,056	415	365
Number enrolled	100	53	345	269
Percent enrolled	2.4%	2.6%	83%	74%
Total costs	\$556,261	\$164,828	\$156,452	\$48,526
Costs per enrollee	\$5,563	\$3,109	\$453	\$180

#### Cross-Program Collaboration Is Growing

- TPEP, COPH, Delta AHEC, MHI, and AAI are most actively engaged
- MEP differs substantially from other programs.
- ABI individual institutions could consider collaborations, with other ATSC programs and more within ABI institutions.

## ATSC Commission and Staff

- Improved format of quarterly reports submitted by programs, to reflect systematic management indicators
- Developing financial reporting format to provide uniformity of reporting across programs
- Unable to provide technical support to the extent planned
- Planning for concrete expectations and longitudinal outcome measures from programs

## Overview of Presentation

- Overview of the 2006 RAND evaluation report
- Policy context: recent changes
- Process measures findings
- Outcome measures findings
  - »Smoking-related outcomes
  - »Other outcomes
- New recommendations and observations

## A Behavioral Model to Guide Analysis

### A Central Policy Question

Has the Tobacco Settlement spending had a beneficial effect on smoking behavior and health outcomes in Arkansas?

### Smoking Among Young People Has Declined Since Program Start

- High school and middle school students are smoking less since programming began
- Young adults, age 18 to 25, are smoking less than expected based on pre-program trends
- Pregnant women in their teens and 20s are smoking less than expected based on pre-program trends
- Compliance with laws prohibiting sales of tobacco products to minors dramatically improved

### Smoking Decreases for Young People in Arkansas

#### Trends in Store Violation Rates for Tobacco Sales to Minors

#### Overall Effects on Smoking for Adults in Arkansas

- Smoking rates for adults continue to follow baseline trend, with no accelerated decline
- Smoking among pregnant women older than 30 in Arkansas has not changed
- Baseline trend of declining cigarette sales has not accelerated since the start of Tobacco Settlement programs

### Trends in Percentages of Arkansas Adults Who Smoke

#### Lag Times Until Smoking Effects Were Found in Other States

<u>State</u>	<u>Program Approval</u>	<u>Full Program Implementation</u>	<u>Year for Which Impact Detected</u>
Minnesota	1985	1986	1990
California	1988	1990	1993
Massachusetts	1992	1994	1997
Arizona	1994	1997	1999
Arkansas	2000	2002	2005 (?)

Source: Reducing Tobacco Use: A Report of the Surgeon General.

## Chapter 7 Comprehensive Programs, 2000

### Oklahoma Tax Increase Makes Cigarette Sales Difficult To Interpret

### Findings for Program-Specific Effects on Smoking Outcomes

- Smoking prevalence among adults in the Delta region shows weak evidence of being less than baseline trends would predict and should be monitored in years to come
- Both smoking rates and TPEP spending vary by region
  - »Currently, TPEP spending does not appear to be targeted to high smoking regions
  - »TPEP recently has estimated smoking rates by region, which is a necessary step to appropriate targeting

#### Many Tobacco Related Health Outcomes Are Improving

- Stroke and AMI rates are significantly below their pre-Tobacco Settlement trends
- Asthma shows some evidence of a reduction in growth
- Pneumonia shows a more recent decline
- Of the five health measures, only Low Birth Weights does not appear to be declining
- All these results are preliminary and need to be compared to national and regional trends

#### Stroke And AMI Rates Are Now Significantly Below Prior Trend

#### Evaluation Issues For Non-Smoking Outcomes

- Are the service-providing community-based programs (MHI, AAI, Delta AHEC) collecting and analyzing participant outcome data effectively?
- Are the Medicaid expansions improving health outcomes for targeted populations?
- Are the academic programs (ABI, COPH) engaged in activities that are judged to be valuable by their scientific peers?

#### Service-providing Programs Lag in Outcomes Data Collection

- AAI's surveys of education program participants are flawed in design and implementation; the planned data system has not been implemented
- Delta AHEC does not have adequate expertise for data management or analysis on Diabetes Clinic outcomes; its education program outcomes data have not been analyzed.
- MHI has struggled to collect outcomes data; Eating and Moving for Life data are not yet usable and only some Hypertension data are usable.

#### Some Evidence of Health Benefits from Medicaid Expansions

- There are more short-stay admissions following the reduction in the co-pay for the first day of hospitalization
- There is weak evidence that avoidable hospitalizations have been reduced by the AR-Seniors program
- Eligible pregnant women are getting more pre-natal care

#### Percentage with 10+ Prenatal Care Visits

(Counties with High and Low Eligibility Rates)

#### Peer Review of ABI and COPH Activities

- Research and service activities of ABI and COPH will have greatest benefits to Arkansans over the long run
- Activities are too numerous and varied for RAND to evaluate in detail
- Two new measures of likely benefit
  - »Journal Impact Factor used to measure quality of published research
  - »Detailed review commissioned for Exemplary Projects

#### Journal Impact Factor Predicts the Likely Contribution of Research

- Journal Impact Factor (JIF) is equal to number of citations for average article in a journal
- Used as a prediction of an article's future impact on the scientific community

- Necessary to rank within topic since citation traditions vary by topic
- Not reliable for measuring quality of individual project or researcher but can be helpful in assessing quality of large body of work

Both ABI and COPH publish in highly ranked journals

Exemplary Project Review: Are Best Projects “Home Runs”?

- Evaluation does not have the resources to perform a detailed review of very many projects
- The payback from research comes from a few big winners
- ABI and COPH each nominated 4 projects that they considered exemplary
- RAND chose 2 from each and commissioned experts to examine whether projects met goals of Act

Selected Projects Spanned Range of Topics and Methods

- ABI projects
  - »Congenital Heart Defects and Nicotine (Hobbs, Children’s Hospital)
  - »Effect of Nicotine on Memory (Wenger, UAMS)
- COPH projects
  - »Evaluation of Implementation of Act 1220 on Childhood Obesity (Raczynski)
  - »Linking Disabled with Resources Necessary for Community Living (Stewart)

Reviews Were Positive, Citing Specific Expected Benefits

- Heart Defects: “results ... should facilitate ... risk assessment ... and millions of health dollars saved”
- Memory: “excellent model to ... impact ... product development, health sector benefits and broader economic benefits for the community”
- Obesity: “findings ... will help identify effective policies”
- Disabled: “offers great cost reduction in delivery of long-term care services”

Recommendations to the Commission

- Overall Recommendation: Continue to fund the seven programs while actively maintaining performance expectations for the programs
- In this briefing, we will present recommendations for the Commission’s attention regarding individual programs, and then go to more general observations.
  - »Recommendations addressed to individual programs are in the report, in their respective chapters.

Recommendations for Tobacco Prevention and Education

- The state should increase funding share for the TPEP to return it to compliance with the percentage share stated in the Initiated Act.
- The state should increase TS and other financial resources to bring total funding for tobacco control programs to at least the CDC-recommended minimum levels of funding.

Recommendation for Minority Health Initiative

- MHI should be re-assessed in six months. If, at that time, performance has not improved to the point where there is confidence that full functionality can be achieved, redirection of MHI funds should be considered.
  - »Although MHI has improved a little bit on all fronts, it is still not functioning adequately.
  - »Performance is complicated by state restrictions on staff job levels/titles.
  - »The AMHC has a valuable role in Arkansas, but perhaps is not the right organization to run the MHI.

Recommendation for Medicaid Expansion Programs

- Ensure that the expansion programs spend all of the TS funds available.

- »Under spending means Federal matching monies do not reach Arkansas
- »Consider shifting expansion program allocations if necessary

#### Recommendation for Tobacco Settlement Commission

- Continue to work toward establishing a complete reporting package
  - »Data that extend trends in the process indicators of service activity
  - »Financial statements in as standardized a format as possible
  - »Annual reports on progress toward long-term goals
- Aim towards eventually shifting role of external evaluator
  - »Long-term sustainability of ATSC
  - »More focus on outcomes
  - »Advise, assess Commission's own evaluation of programs

#### Cross-Cutting Recommendations

- Develop data collection and analysis plans and dedicate resources to implementing these plans
  - »Information not yet adequate to assess program effects
  - »Focus ATSC funds for technical support
- Intensify collaborative activity among the programs
  - »More of a good thing is a win-win solution
  - »Help with each others' problem solving
- All entities need a formal internal quality improvement process
  - »Identify quality information needs
  - »Collect quality information and analyze it
  - »Formulate actions and implement them

#### Recommendations for Long-Term Funding

- Aggressively seek funding to supplement TS funds
  - »MSA projections cannot be relied upon
  - »All programs need to do this
- Consider potential revisions to the current allocations
  - »Sustain best programs at full strength instead of proportional reductions
  - »Use TS funds to reward success instead of prime pumps
  - »Use TS funds to address newly identified needs of Arkansans
- Use TS funds to maximize value for money
  - »Grow capacity instead of providing services
  - »Leverage funds whenever possible
  - »Focus on public health rather than the sum of the health of individuals

#### Closing Thoughts

- Arkansas continues to be a national leader in the use of MSA funding to improve the health of its citizens.
- The value of the programs in expanding the state's public health infrastructure has been demonstrated.
- The value in terms of individual health measures is slower to emerge, but is beginning to be seen (e.g., trends on some smoking measures); more is to be expected given the experience of other states and nations.
- The ATSC as a credible source regarding the public health harms of tobacco use has probably helped sway popular opinion.
- We encourage the state to reaffirm its commitment to the vision and mission of the Initiated Act.

## **VII. Discussion**

General Lefler- My only regret is that the legislators did not hear this today. I thank you all publicly for your hard work and your presentation.

Dr. Atiq- Can we have questions intertwined with the Director's report and the RAND presentation?

General Lefler- Where do we address the quality management systems in our Director's report?

Chiquita Munir- In Goal 2B: Promote and maintain the strategic use of the tobacco settlement for health related programs. Part B states, advocate continuous quality improvement of programs supported by tobacco settlement funds and we should add the words *including the Tobacco Settlement Commission*.

John Selig- Addressing the funding and outreach issues, we have been very concerned at DHHS about not spending Medicaid expansion funds largely due to working on this waiver but there were also areas that we were not spending as much, like the senior programs. We are now at a point where we have the waiver and it is pretty clear that over the next five years we will spend that money. In fact we had hoped to extend the AR Seniors program to 100% of the federal poverty level but we don't think we can do that now. I am not sure we want to do any more outreach than we are or try to expand the programs. We could easily find ourselves three years into the program without enough money.

James Kahan- I have a number of reactions to that, first that you plan on spending it all is the most important thing and that is very good. I wouldn't raise my eyebrows at the notion that we shouldn't tell people that they can get certain money because we are already spending so much. I think in some sense there is a certain social obligation that we let people who are in need know that there are resources that can help them. If you run into the problem that it is strapping your budget because everybody who entitled to it is claiming it, that the risk you take. What our findings are is that not all the people who are eligible are aware that they are eligible. You have an obligation to tell the people who are eligible that they can get the money.

John Selig- If we tell them they are eligible and build up demand and then have to turn around and tell them that they are eligible but we can't actually put you on the program and we are going to have to eliminate the program because there are too many people who have signed up, have we really done a public service?

James Kahan- You raised a very difficult question, I would turn it around and say maybe it is those who are not aware are the ones most in need.

John Selig- I agree.

Donna Farley-Historically, what we have seen in people who were in this group is that they were not aware of what the benefits are.

John Selig- The programs in general has to be made available statewide, but our target outreach could be the high risk areas.

James Kahan- I talked earlier about collaboration and maybe here is an example of where there can be some collaboration. It occurred to me that working with the Centers on Aging and the AR Seniors program and getting the awareness data from a epidemiological project done by the COPH could help you better understand the best way to spend the Medicaid expansion money.

Dr. Atiq- But that would make an assumption that the people who were using the Aging Initiative were the people most in need.

Claudia Beverly- Very few percent of people who are using the senior health clinics are dual eligible. We have not tracked the information on education, but that would not impact Medicaid.

Judy Smith- I think that this is one of the most valid points that has evolved in any discussion that I have been in, in over nine years. It does not matter what the service is, it is a public service and the people who truly need it are generally the last to know about the benefit and the Medicaid expansion program is not targeting the senior only population. We know where the greatest needs are based on where the highest rates of morbidity and mortality are. It is traditional that the money hardly ever follows the greatest need. How do we then take those dollars and determine what chronic diseases we want to intervene with? Target the communities or sub communities with the highest rates and bring awareness and initiatives to those.

John Selig-With the Medicaid Expansion program, the way it is structured there is not a lot of ability to target the money.

Judy Smith- I would like to say that once we have our database in place and the system is operable we will be able to extract it, the evidence is clear that the people with excessive high blood pressure are all lowering their numbers. We have argued with RAND passively and aggressively about the way that RAND calculates the cost of the hypertension program. RAND has calculated the cost of each screening activity as well as the treatment and looked at it as a whole, whereas we know if you looked at the cost of the screening separate from the treatment, that the cost of the treatment is much more comparable to what it costs nationally. We are making a lot of improvement. The recommendation will be taken seriously, but given the fact that we are in the process of transitioning how we are implementing the hypertension program, I am not sure if six months is a fair expectation given that we don't even have a permanent contract.

James Kahan- We are not asking that you turn it around in six months, we are asking that you show that you can turn it around in six months. There is a big difference in those two. The demonstrated benefit of the hypertension treatment, on the one hand the people who had the highest blood pressure went down, on the other hand the people who had pre-hypertension went up even though they had treatment. We can say for some people it looks better and for some people it looks worse and we do not have a clear statistical statement because there aren't enough data and the data is not good enough. We would love to agree with you but we can't yet. That is what we mean by needing better data and needing better quality. It is possible that's true, but it is possible that it's not true.

Omar Atiq- What is it the commission can do to help the AMHC? It seems to me as it is the program is not performing to the standards that we chose. Something has to change and now we are in our fifth year and that is a fair amount of time. What is it we can do to try to turn it around?

Judy Smith- We are measured heavily on the treatment piece, but there are no indicators based on what we are doing with behavior modification and the other activities and it is a whole picture. However, we understand the necessity of focusing on the treatment piece because it is a service delivered program where you can show some true outcomes on an individual basis if the data were available. I am very interested in the statement that Dr. Kahan made that perhaps service delivery is not what we should be doing with the money. Treatment has been done by contract and we are changing how we are doing the contract and we are continuing to take every recommendation very seriously.

James Kahan- There are other things other than treatment. You don't have your priorities for anyone other than African Americans yet.

Judy Smith- We don't have the money for that.

James Kahan- It is what the initiated act told you to do.

Judy Smith- We are the only agency where the lack of money was not mentioned except for staff positions.

James Kahan- That's not true; AAI has a really severe problem with the lack of money they are faced with a possibility of having to close down some of the centers. Delta has a money squeeze they got the new building and unless they get more money they are going to have this beautiful building that is all they are going to have. COPH has to have two more doctoral programs; they have to find the money to do that. Everybody has a money problem. That is why I said if you take four words from this it's you need more money.

Judy Smith- Let me not be misquoted when I said we were the only agency that it was not mentioned that money was not a challenge for us. Money is a big challenge for us.

James Kahan- Money is a challenge for you too. Let me take it one other place, in terms of the evaluation, you have all these media contacts, you have all of these radio ads, do we know how many people are doing something as a result of that? You don't. There are other places where you do. You put out a website and you can talk about the number of hits that is evidence. Some of it you can do others you need to do more. You tell us about how many places you have talked, you tell us about how many places you've gone, all that is good, can you take it the next step and say who listened, what happened because of your talk. That is the next step you need to do in terms of data.

Dr. Fletcher- Do we have a model that might be used as a format as to how we solve some of these questions? Sometimes when you are a pioneer there are no answers as to how you solve a question until you work it through. Do we have a model as to how we might structure this program so that we are able to measure outcomes, so we are able to direct funding, and so we get more bang for the buck? How can we look at this and synthesize something to bring this together?

James Kahan- Un-leveraged service delivery is not the most efficient way to spend tobacco money. If every penny of a hypertensive treatment program comes out of tobacco money, maybe you can do better. Screening is a very good example, it is less important for the program to screen than for the program to use its resources for public outreach and get other people to screen and to document screening that takes place because of their outreach efforts. They can show that someone else started producing this because they convinced people that this was a good idea and maybe they even provided the training to get paraprofessionals to be able to do it right.

John Selig- What I heard you asking is if they knew of model programs that we might want to build on, if not where do we find the models?

John Engberg- We can look within our own programs to see some models. The COPH can sit down with the community based programs and find data sources and help define ways to measure impacts.

Dr. Atiq- Delta AHEC has improved. AAI may be improving, but it does not seem to be flowing with its peers.

John Engberg- I agree you would like to see the work that AAI doing is backed by the highest standards of knowledge about not only about geriatrics, but about how to transmit that knowledge through continuing education. We have had a lot of discussions with Dr. Beverly and the other folks that are doing the education side of AAI and they are doing surveys on the participants of these programs to see the impact that it's having. We didn't find that those surveys were adequate. We asked for information to the data and we have not obtained it.

James Kahan- There is in Arkansas an excellent geriatric institute, the Reynolds Center. The AAI's offices are located inside the Reynolds Center Building, it would be absolutely wonderful if there were an intimate and intricate, intertwined relationship between the tobacco funded part (AAI) and the rest of the center. It ain't there. In my opinion that is where the problem is. If we could get a close commitment and help from Reynolds in funding AAI then we would see the kind of growth we were expecting.

General Lefler entertains a motion to vote to accept the Directors Report with the changes.

Motion to Approve: Dr. Atiq

Seconded by: John Selig

Directors Report was unanimously approved.

General Lefler entertains a motion to vote to accept the recommendations of the RAND Corporation as enunciated in the report along with the concerns.

Motion to Approve: Dr. Atiq

Seconded by: John Selig

Recommendations of the RAND Corporation as enunciated in the report along with the concerns were unanimously approved.

Dr. Atiq entertains a motion to recommend continued funding for all programs as recommended by the RAND report along with the concerns and the time lines expressed.

Motion to Approve: General Lefler

Seconded by: Karen Wheeler

Recommendation to continue funding for all programs as recommended by the RAND report along with the concerns and the time lines expressed was unanimously approved.

## **VIII. Meeting Adjournment**

**General Lefler**

Adjournment

The meeting was adjourned at 3:30

The next meeting is scheduled for October 11, 2006

Location Cox Conference Room, 101 East Capitol Ave