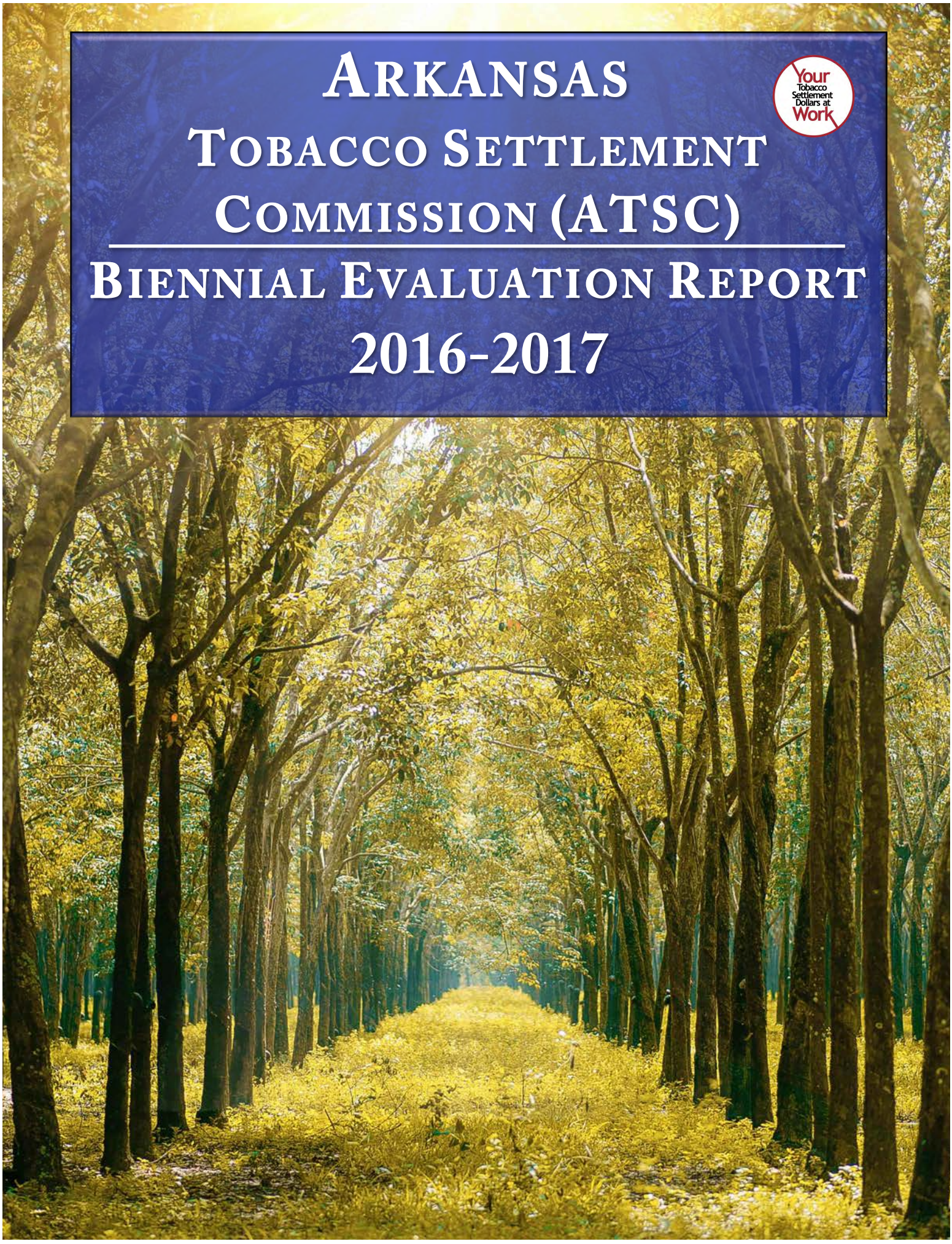
Arkansas Tobacco Settlement Commission (ATSC)

Biennial Evaluation Report 2016-2017

Your Tobacco Settlement Dollars at Work



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Education

27,547

TPCP and **UAMS-COA** provided **educational opportunities to healthcare professionals** each year. In 2016-17, these programs reached 27,547 professionals.

COPH had 126 Graduates

84% of COPH graduates planned to stay in Arkansas and work in public health.

273,447 Community Education Encounters

MHI, TPCP, UAMS-COA, and **UAMS East Regional Campus** recorded 273,447 **community education** encounters in the biennium. In total, educational programs and events **reached 72 of 75 counties.**

Of all community education encounters, more than **81,000 were youth** encounters through programs provided by **MHI, TPCP**, and **UAMS East Regional Campus**.

SOS PRESENTS Project Prevent YOUTH TOBACCO & NICOTINE PREVENTION

More than 3,800 youth were engaged in tobacco control activities through **TPCP's** Project Prevent Youth Coalition.

Service

50,959 Vulnerable Arkansans Covered by TS-MEP Services

TS-MEP increased coverage by 14% from 2015 levels.

49,445 Health Clinic Encounters

UAMS-COA reported **49,445 health clinic encounters** throughout the state.

49,055 Screenings

In 2016-2017, **MHI** and **UAMS East Regional Campus** provided **49,055 health screenings**.

UAMS East Regional Campus celebrated Grand Opening of medical center in 2017.

TPCP implemented 448 new smoke-free/tobacco-free policies, protecting the health of thousands of Arkansans across the state.

Collective Impact

2016-2017

Arkansas Biosciences Institute (ABI); College of Public Health (COPH); Minority Health Initiative (MHI); Tobacco Prevention and Cessation Program (TPCP); Tobacco Settlement Medicaid Expansion Program (TS-MEP); UAMS Centers on Aging (UAMS-COA); UAMS East Regional Campus

Research

ABI and **COPH** produced 1,601 research **publications** and offered 1,503 research **presentations**.

1,601 Publications

1,503 Presentations

ABI focuses on five research areas.

- Agricultural
- Nutritional
- Tobacco-Related
- Bioengineering
- Other related areas of research

In 2017, **COPH** received **$7 million** for five years of funding for the **Arkansas Center for Health Disparities**. The funds will support research, faculty infrastructure, and postdoctoral mentoring and development.

ABI Fall Research Symposium, 2017

98% of COPH faculty contracts and grants had an Arkansas focus.

Economic Impact

$120.3 Million Leveraged

UAMS East Regional Campus provided **prescription assistance** for an average of 855 clients and 1,007 prescriptions per year for a total cost savings of **$1,331,877.**

During the biennium, **ABI, COPH**, **TS-MEP, UAMS-COA,** and **UAMS East Regional Campus**—together—**leveraged** approximately **$120.3 million** in external funds, for an average of **$2.02 return for every ATSC $1**.

UAMS-COA reported $740,000 in volunteer hours and non-cash donations.

$2.02 Return for every ATSC $1.

ABI supported an average of 299 full-time employees per year.

About The Report

Purpose

The purpose of the biennial report is to present progress assessed for the calendar years 2016 and 2017 for each of the seven programs funded under the Arkansas Tobacco Settlement Commission (ATSC). Progress is shown through activities related to program indicators that were created by program directors, in consultation with the evaluation team, and approved by the ATSC. Program activities are evaluated each quarter, and this biennial report serves as the culmination of activities recorded across the previous eight quarterly reporting periods.

Structure

The biennial report consists of six main parts: (1) an infographic illustrating the *collective impact* of the seven programs in 2016-2017; (2) a brief on the report's purpose and structure; (3) an overview of the ATSC and the flow of funding to health programs; (4) a look at ATSC-funded program efforts that are contributing to a culture of health; (5) individual program progress for 2016-2017; and (6) a conclusion accompanied by references. The program progress section offers seven subsections highlighting each program. These subsections will include (a) an infographic that highlights key accomplishments under a central theme; and (b) overall program goals, long-term and short-term objectives, indicators and their associated activity, comments by program evaluators, and testimonials from program recipients and providers.

About ATSC

The mission of the Arkansas Tobacco Settlement Commission (ATSC) is to provide oversight and assessment of the performance of the seven programs funded by the Tobacco Settlement Proceeds Act of 2000. The Act mandates the distribution of Master Settlement Agreement funds. The seven health programs that receive funding work to enhance the health and well-being of Arkansans through various projects, programs, and outreach. The seven programs are as follows:

Arkansas Biosciences Institute (ABI)
Robert McGehee, Jr., PhD, Director of ABI
Leslie Humphries, Program Coordinator

Fay W. Boozman College of Public Health (COPH)
Jim Raczynski, PhD, FAHA, COPH Dean
Liz Gates, JD, MPH, Assistant Dean for Special Projects

Arkansas Minority Health Initiative (MHI)
ShaRhonda Love, MPH, Director of MHI
Louise Scott, Senior Grant Coordinator

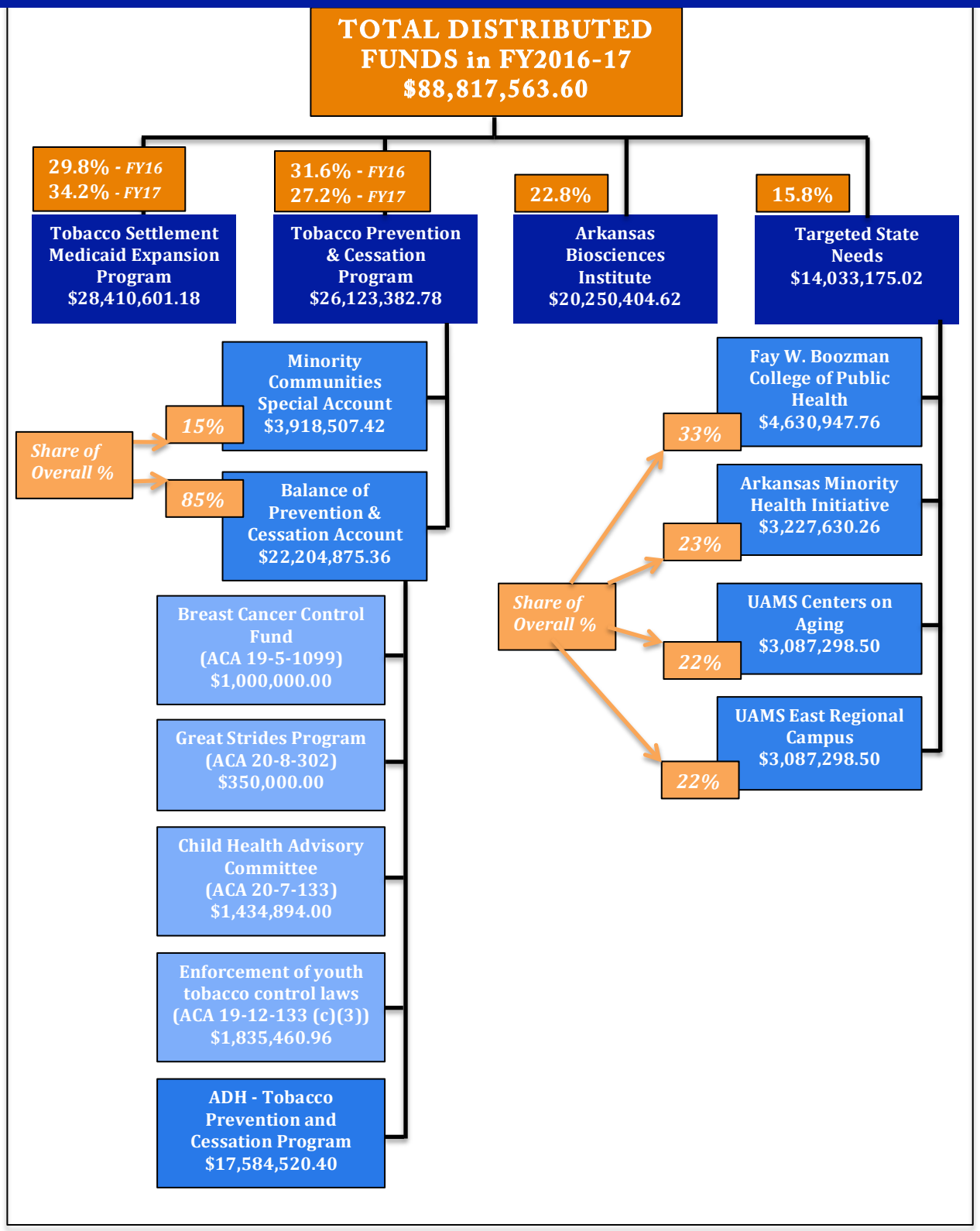
Tobacco Prevention and Cessation Program (TPCP)
Debbie Rushing, Branch Chief

Tobacco Settlement Medicaid Expansion Program (TS-MEP)
Mary Franklin, Director, DHS Division of County Operations

UAMS Centers on Aging (UAMS-COA)
Claudia Beverly, PhD, RN, FAAN Director (Outgoing)
Jeanne Wei, MD, PhD, Director (Incoming)
Amy Leigh Overton-McCoy, PhD, GNP-BC, Associate Director

UAMS East Regional Campus
Becky Hall, EdD, Director
Stephanie Loveless, MPH, Associate Director

ATSC Funding Flow



The flow chart on the previous page illustrates the distribution of ATSC funds for fiscal years 2016 and 2017. Act 894 of 2015 modified the Tobacco Settlement Proceeds Act of 2000, changing the fund allocation percentages for the Tobacco Prevention and Cessation Program (TPCP) and the Tobacco Settlement Medicaid Expansion Program (TS-MEP); changes are noted on previous page. As shown, ATSC funds are divided among four accounts: TS-MEP, TPCP, the Arkansas Biosciences Institute, and Targeted State Needs programs. The TPCP is separated into a special account for Minority Communities and the remaining balance stays in the Prevention and Cessation account, which is divided between the Breast Cancer Control Fund, the Great Strides Program, the Child Health Advocacy Committee, enforcement of youth tobacco control laws, and the Arkansas Department of Health Tobacco Prevention and Cessation Program. The Targeted State Needs account is divided among four programs: the College of Public Health; the Arkansas Minority Health Initiative; the UAMS Centers on Aging; and UAMS East Regional Campus. Note that although funding flow is represented by fiscal years (July 1-June 30), the program accomplishments highlighted in the report cover the 2016-2017 calendar years. Next we take a closer look at ATSC-funded program efforts that contribute to a culture of health.

INTRODUCTION: EFFORTS THAT CONTRIBUTE TO A CULTURE OF HEALTH

The seven programs funded under the ATSC are designed to enhance the health and well-being of Arkansans. In the introduction to this biennial report, we explore how efforts of ATSC-funded programs contribute to overall health and well-being by looking through the lens of the *Culture of Health* model (Robert Wood Johnson Foundation & RAND Corporation, 2018). Below, we provide an overview the Culture of Health model, followed by examples of program efforts that align with the model—ultimately contributing to the programs' overall mission to enhance the health and well-being of Arkansans. After this discussion, we transition to the remainder of the biennial report that highlights individual program progress and accomplishments.

OVERVIEW OF CULTURE OF HEALTH

Using rigorous research and contributions from more than 1,000 experts, community members, and leaders worldwide, the Robert Wood Johnson Foundation (RWJF) along with RAND Corporation (RAND) has developed a Culture of Health (CoH) model to catalyze a nationwide movement toward improved health, well-being, and equity (RWJF & RAND, 2018). According to RWJF and RAND (2018), creating a CoH is critical to addressing national health crises, citing $3 trillion in annual health expenditures, $226 billion in annual loss of productivity, and more than one third of children being overweight or obese. Given such complex challenges, a CoH recognizes that achieving good health and well-being is contingent upon the integration of health with economic, social, physical, and environmental factors; and, accordingly, all sectors are charged to work together in addressing complex challenges to facilitate a CoH.

The U.S. has $3 trillion in annual health expenditures.

Equity is emphasized in the model as it grounds efforts towards improved health and well-being. Equity is fostered when people have equal opportunities to make good health choices

and pursue healthy lifestyles, irrespective of their circumstances or environment. Overall, the CoH model assists community members and organizations in discovering relevant points of entry toward meeting specific health and well-being needs, while acting with equity in mind. These efforts on the community level will contribute to a larger, national CoH movement.

The CoH model is guided by ten principles that illustrate the integrative nature of health pursuits and help to operationalize the CoH concept. The ten principles are as follows:

1. Good **health flourishes across** geographic, demographic, and social **sectors**;
2. Attaining the **best health possible** is valued by our **entire society**;
3. Individuals and families have the **means and the opportunity to make choices** that lead to the healthiest lives possible;
4. Business, government, individuals, and organizations **work together** to build healthy communities and lifestyles;

5. **No one is excluded**;
6. **Everyone has access** to affordable, quality healthcare because it is essential to maintain, or reclaim, health;
7. Healthcare is **efficient and equitable**;
8. The **economy is less burdened** by excessive and unwarranted healthcare spending;
9. Keeping everyone as healthy as possible **guides** public and private **decision-making**; and

10. Americans understand that **we are all in this together**.

These ten principles inform the structure of the CoH *Action Framework*, which offers four action areas that propel progress: (1) *making health a shared value*, (2) *fostering cross-sector collaboration,* (3) *creating healthier, more equitable communities*, and (4) *strengthening integration of health services and systems*. Robert Wood Johnson Foundation and RAND (2018) suggested that when communities make progress within these action areas, they could expect an *outcome of improved population health, well-being, and equity*. See Figure 1 on the following page for a visualization of the Action Framework.

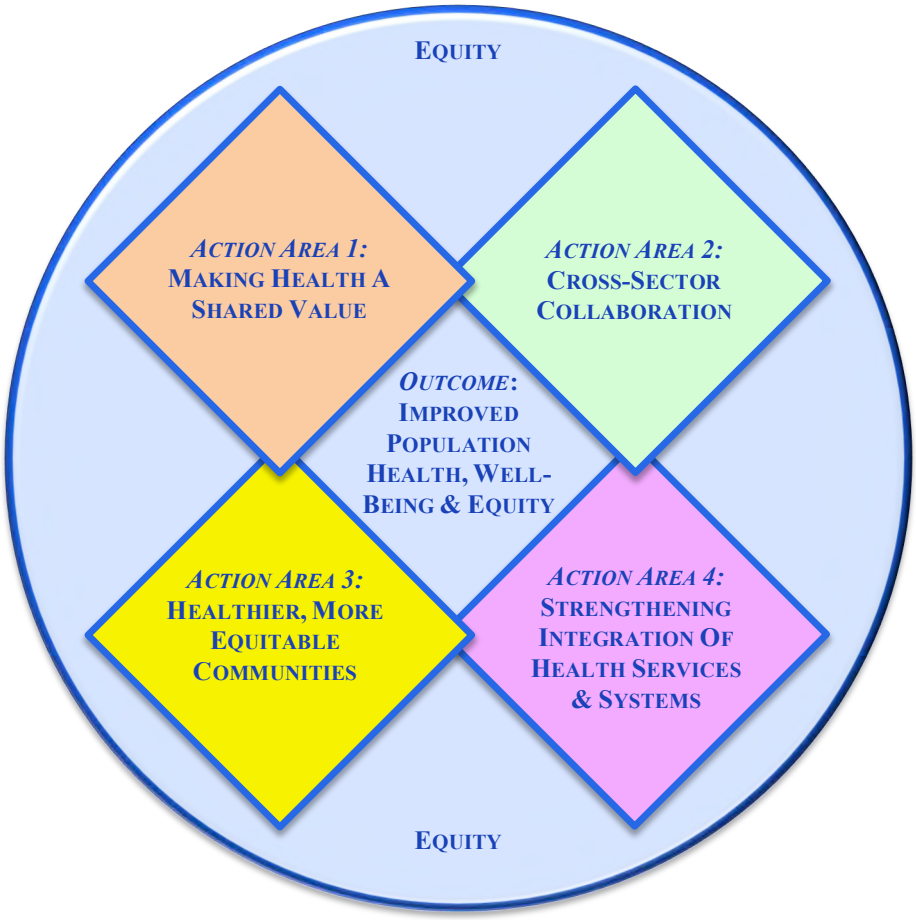


Figure 1. Culture of Health Action Framework

Within each action area, RWJF and RAND identify a number of measurable *drivers* that help public health practitioners prioritize goals and accelerate change. In Action Area 1, for example, there are three drivers: mindset and expectations, sense of community, and civic engagement. Using civic engagement to explain further how drivers contribute to an action area, we see in the CoH model that civic engagement emphasizes volunteer participation and the active role of community members in addressing vital community health and well-being needs. This volunteer activity and engagement in community health activities increase social cohesion and the notion of health as a shared value. The Action Framework is discussed in more detail in the following section as we highlight examples of program efforts that align with the framework.

Program Efforts Aligned with Culture of Health Framework

In exploring efforts of ATSC-funded programs and their contributions to a Culture of Health, we outline each of the four action areas within the Action Framework, citing examples of program efforts that align with each action area. We then cover examples of program efforts that point to outcomes of improved population health, well-being, and equity.

Action Area 1: Making Health a Shared Value

Making health a shared value hinges on our social connections and the importance of everyone (individuals, families, and communities) taking a role in improving the health and well-being of all people, ultimately contributing to a CoH (RWJF & RAND, 2018). Through personal decision making and public policy efforts, communities can create a shared value that is focused on health. The examples presented below focus on policy efforts by ATSC-funded programs as well as efforts that support two of the drivers under this action area—*civic engagement* and *sense of community*.

Prioritizing health through policy. ATSC-funded programs prioritize health through policy in a number of ways. The following examples show some of the policy efforts during the biennium. These efforts involve 1) partnership with local communities to enact smoke-free/tobacco-free policies, 2) adoption of a statewide initiative to protect vulnerable populations, and 3) production of research that points to the importance of adopting specific health policies.

Tobacco Prevention and Cessation Program (TPCP): In 2016, the city of Wooster implemented comprehensive smoke-free policies in accordance with the Americans for Nonsmokers' Rights, designating all public places in the city as smoke-free. The role of TPCP was fundamental in bringing about this policy. Mary Krisell, a program coordinator at Lifeway International—a partner of TPCP—had this to say


Mary Krisell

about the effort to make Wooster smoke-free, "Working with the city of Wooster was a great honor. I think it was important first to build relations with the Mayor and his councilmen while educating them on the importance of becoming a smoke-free city. Public health policy has a profound impact on health status. Through policy change, we can reduce exposure to secondhand smoke, which in turn will help our communities become healthier. I believe with Wooster taking a stand against tobacco, it will be a great influence on other communities around the state. Through educating other communities we can change the social norm in Arkansas." Wooster's policy was one of hundreds of new smoke-free/tobacco-free policies that TPCP and their partners helped implement across the state during the biennium.

Wooster Park

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Tobacco Settlement Medicaid Expansion

Tobacco Settlement Medicaid Expansion Programs (TS-MEP): Another important policy brought forth in the biennium was the passage of HB1033 in 2017, which allocated funds to support developmentally disabled Arkansans who are currently on a waiting list to receive vital services like living assistance, job-related support, and training to enhance self-sufficiency. Josh Wilson, Director of Operations at Independent Case Management, relayed the importance of this policy, "This is a tremendous step in the right direction….I applaud the [policy] efforts to support people with intellectual and development disabilities. We must continue pleading with our officials to end this waitlist so people with disabilities have the option to live and thrive in the community of their choice." The TS-MEP expects the funding from this policy to serve 500 individuals currently waiting for services.

Josh Wilson

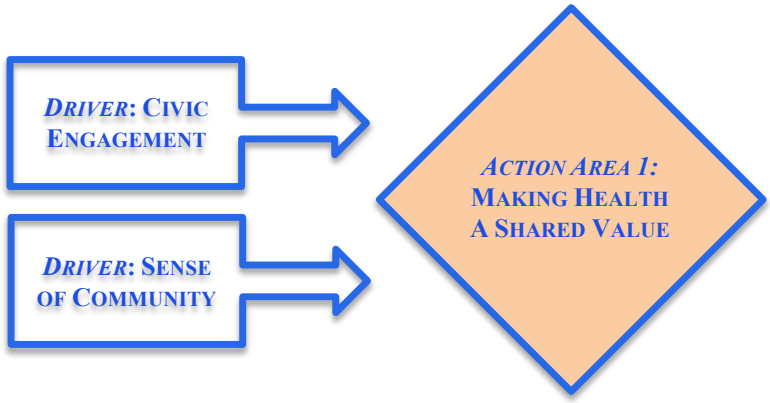
UAMS Fay W. Boozman College of Public Health

Fay W. Boozman College of Public Health (COPH): The research of Pebbles Fagan, PhD, Director of the Center for the Study of Tobacco at the COPH, clarified the utility of policies that target tobacco use. Fagan recently published a monograph focusing on why some population groups are more likely to

Pebbles Fagan

smoke than others as well as what strategies may help smokers quit. The monograph was the "first comprehensive document to focus on tobacco-related health disparities since the publication of the 1998 US Surgeon General's report on tobacco and minorities," Fagan said. Explaining some implications from the research, Fagan stated, "Overall, tobacco use has declined, and we have evidence that shows which practices have effectively influenced this trend. This includes such things as cigarette taxes that increase the cost of the product…and statewide policies that prohibit smoking in the workplace, restaurants, and bars."

Drivers: Civic engagement and sense of community. In this subsection, we look at efforts by UAMS Centers on Aging (UAMS-COA) as exemplars of two drivers of making health a shared value, *civic engagement* and *sense of community*. Civic engagement activities advance the public good, while activities that build a sense of community facilitate strong social connections within communities (RWJF & RAND, 2018). Though not mentioned below, the efforts of other ATSC-funded programs—particularly the Minority Health Initiative, Tobacco Prevention and Cessation Program, and UAMS East Regional Campus—help to cultivate civic engagement and a sense of community to build overall health and well-being towards a CoH.



UAMS-Centers on Aging (UAMS-COA): One component of civic engagement in the framework is *volunteer participation*. UAMS-COA actively engages a base of volunteers who participate in health education and outreach activities for older Arkansans. Over the course of the biennium, UAMS-COA valued volunteer hours at $80,601, and volunteer participation increased by 36% from 2016 to 2017. This increase results in greater civic engagement—enhancing social cohesion and promoting health as a shared value.

Volunteer participation increased by 36%.

UAMS-COA: Community education and outreach by UAMS-COA cultivate a sense of community by enhancing feelings of connectedness. One example of these efforts can be seen in the interpersonal approach by Edward Ellis, a social worker who routinely offers educational outreach in west central Arkansas. Before an educational session begins, Edward makes certain to greet each attendee as an individual, inquiring about personal matters like family, friends, and pets. He takes the time to get to know everyone and to ensure participants feel welcome and valued. With his thoughtful approach, Edward creates trust, connectedness, and a sense of belonging among participants—building an overall sense of community. Research shows that feelings of connection prompt individuals to be proactive in improving their own health and the health of others in their community (Carman et al., 2015). Reflecting on his experience in providing outreach to older Arkansans, Edward imparted, "Our seniors have so much to offer to each other and the community that it is a truly rewarding joy for me to serve them. These programs assist our seniors in maintaining an improved quality of life through their later years."

Community Education with Edward Ellis at West Central COA in Van Buren

Action Area 2: Fostering Cross-Sector Collaboration

Action Area 2: **Cross-Sector Collaboration**

Fostering cross-sector collaboration (CSC) centers on the idea that no single entity can solve complex public problems; rather, addressing complex problems and creating sustainable solutions requires a network of responsible leaders from across sectors, including health, education, nonprofit, government, corporate, faith-based, and other grassroots and community groups (Bryson, Crosby, & Stone, 2006, 2015; RWJF & RAND, 2018). Robert Wood Johnson Foundation and RAND (2018) explained that CSC efforts that work towards improved health call for individuals from all sectors to recognize the implications of health and well-being within their profession, and to see the benefit of shared investments, policies, and partnerships that uplift community well-being. Through

quality partnerships and investment in collaboration, effective CSC is fostered—which supports an overall CoH. The following examples illustrate CSC by four ATSC-funded programs.

Quality partnerships and investment in collaboration. All ATSC-funded programs at one time or another utilize partners across various sectors to impact health, well-being, and equity in the state. A prime example of this was the effort to construct and open a clinic in the city of Helena under the UAMS East Regional Campus. Other partnerships during the biennium resulted in (a) ongoing community collaborations to bring health education or preventative health screenings to people in need, or (b) ongoing research collaborations that crossed institutional and state lines while also partnering with local schools to enhance science education. All of these efforts required investment in collaboration, and ATSC dollars—along with leveraged funds as well as other contributions by partners and supporters—were critical in cultivating sustainable cross-sector collaborations for health improvement.

UAMS University of Arkansas for Medical Sciences East Regional Campus

UAMS East Regional Campus: In October 2017, UAMS East Regional Campus celebrated the Grand Opening of the UAMS Family Medical Center in Helena. Many partners played a role in getting the clinic off the ground and also in supporting services upon the clinic opening. Partners included the Helena Health Foundation, City of Helena, community extension agencies, Farm Bureaus, the local college and hospital, and the UAMS endowment. Since opening, the clinic has served an average of 40 patients per day. UAMS Interim Chancellor Stephanie Gardner, Pharm.D, Ed.D., stated, "All of these multiple partnerships were necessary to complete the valuable and varied collaborative community health improvement activities." UAMS East Regional Campus, in Helena, can now offer clinical services alongside long-standing community outreach programs that enhance health and education in a medically underserved region.

Ribbon-Cutting Ceremony at UAMS Family Medical Center in Helena

AMHC Arkansas Minority Health Commission

Arkansas Minority Health Initiative (MHI): Each year, MHI partners with grassroots, nonprofit, government, and faith-based organizations to bring health education and screenings to communities across the state,

Stephens Community Health Fair

particularly targeting minority populations. Over the biennium, MHI partnered with 75 organizations to provide outreach that impacted individuals in 62 of 75 counties, covering the vast majority of minority populations in the state.

Tobacco Prevention and Cessation Program (TPCP): In July of 2017, the TPCP held its Sub-Grantee Kickoff event that brought together approximately 125 participants from across the state, representing multiple community-based organizations and TPCP partners. One presenter, Stephanie Strutner, Executive Director of Allies for Substance Abuse Prevention, shared how passionate she is about collaborations to bolster public health, "I am most encouraged by seeing many people from different sectors coming together to address the same community goals and their ability to bring about significant health improvement opportunities through collaboration." Collaborations by sub-grantees are many and varied. During the Sub-Grantee Kickoff, Mary Krisell of Lifeway International, a sub-grantee, reflected about previous opportunities to work across sectors (to reach out to K12 students), "Last year I was able to provide leadership training to Conway Public School students, who then were able to share their knowledge about tobacco prevention to younger students in the Mayflower School District. My being able to provide leadership training to Conway students was very rewarding and so well received by the younger students in Mayflower that it makes me realize how important it is to provide leadership skills training and the opportunity for students to teach other students, which is truly a significant opportunity to change young lives and improve overall adolescent health and well-being."


Stephanie Strutner

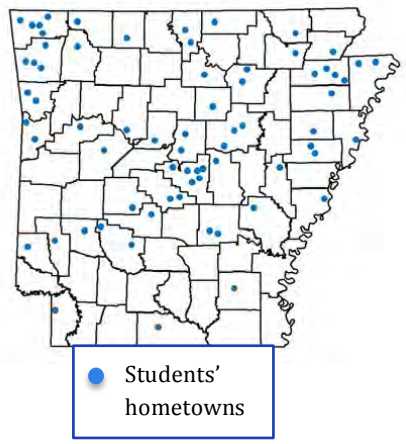
Arkansas Biosciences Institute (ABI): ABI routinely collaborates across their five-member institutions to produce research in five different areas; some of these collaborations reach across state lines with other research institutions. Also, some of these inter-institutional and interstate partnerships embrace collaborations across sectors to K12 education or community groups. We see an example of this CSC through the work of the Plant Imaging Consortium (PIC) that brings together investigators in areas like plant biology, computational biology, and radio imaging

from various ABI member institutions. The goal of the PIC, which includes investigators from Arkansas and Missouri, has been to combine areas of expertise to create a better understanding of how plants respond to stress. So far, the collaboration has brought about discoveries that can help protect and improve crops in a changing agricultural environment. ABI researcher Fiona Goggin discussed the partnerships outside of ABI member institutions, "We created new collaborations with Missouri…and also brought in participants from Little Rock and Monticello….we were working on building that network of plant scientists." These partnerships also provided funding for outreach to students "to expose them to science and, perhaps, encourage them to be future collaborators," said Goggin. "We created a program to partner with high school teachers, to do plant science experiments in the classroom that reached almost 2,000 students." The PIC and their partners also regularly contribute to public events like Fayetteville's Annual Insect Festival, which brings around 3,000 students and adults from across Arkansas.

Plant Imaging Consortium
A new perspective on plants

Arkansas Biosciences Institute

ABI: As part of its overall mission, ABI is charged to collaborate with other institutions when possible. In 2016-2017, an average of 30% of all research projects under ABI were collaborative in nature. Some of these projects drew partners from across sectors, like the example of the Plant Imaging Consortium (PIC). In addition to the PIC, ABI employs partnerships with local schools around the state throughout the year. During the biennium, 397 college and high schools students from 43 of 75 counties engaged in ABI-related research. The map indicates where these student collaborators call home.



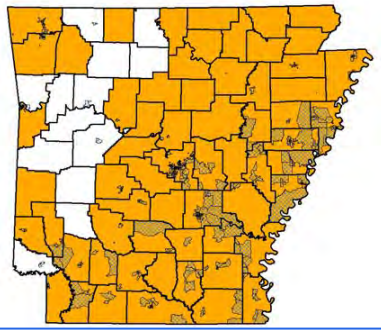
Action Area 3: Creating Healthier, More Equitable Communities

Creating healthier, more equitable communities is rooted in the notion that every community deserves a chance to thrive, and efforts towards this end generally contribute to safe, healthy spaces in which community members live, work, learn, and play (RWJF & RAND, 2018). In a Culture of Health, everyone has access to basic opportunities in their socio-economic environment—like quality education and employment, and everyone has adequate conditions within their built environments. Also, policy and governance drive progress in this action area, just as it does in Action Area 1—making health a shared vision. The following section demonstrates select examples of ATSC-funded programs that have addressed health disparities in access to vital services and education, and highlights efforts that align with two drivers under this action area, *built environment and physical conditions* and *policy and governance*.

Addressing health disparities. All ATSC-funded programs address health disparities and gaps in access to health services, health education, and research. For the sake of brevity, we look at two program examples that targeted health disparities during the biennium: the Arkansas Minority Health Initiative that has a mission is to address disparities among minority populations, and the Tobacco Settlement Medicaid Expansion Program whose mission is to support vital health services for vulnerable populations (i.e., pregnant women, seniors, hospital patients requiring extended stays, and developmentally disabled populations).

Arkansas Minority Health Initiative (MHI): As mentioned in Action Area 2, MHI partnered with dozens of organizations that provided health education and screenings that impacted individuals in 62 of 75 counties during the biennium. MHI is mandated through ATSC to target "disorders disproportionately critical to minority groups" by partnering with multiple organizations and community groups, providing access to health education and services that increase awareness and prevent adverse health outcomes, and by encouraging healthier lifestyles overall. In 2016-2017, MHI and its community partners provided education to more than 60,000 Arkansans, and approximately 40,000 health screenings were administered across the state. When an individual's screening results were abnormal, the individual was provided with

further information or services to assist them in addressing their screening results. Also, MHI programs and events, overall, did well in targeting certain minority populations. The map illustrates the 62 counties where individuals were impacted by screenings and educational events that were held in the biennium. Areas shaded in blue represent Census Block Groups (CBGs) in the fourth quartile for percent minority population (i.e., non-white populations). These CBGs have a minority population of 43% or higher. In all, MHI events reached counties that cover 98.7% of the CBGs with the highest minority populations.



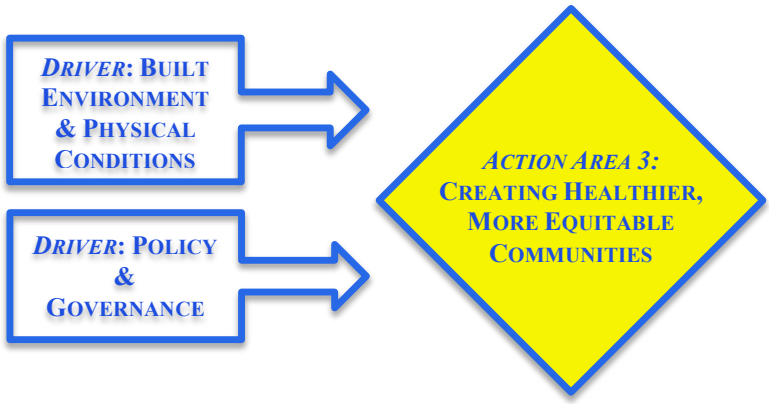
Counties reached by MHI screenings & events
Census Block Groups in the 4th quartile for minority population

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Tobacco Settlement Medicaid Expansion

Tobacco Settlement Medicaid Expansion Program (TS-MEP): While TS-MEP provides fundamental health services to various vulnerable populations in the state, this example is focused on a recipient in the pregnant women population. Stephanie Rozanski, a college student and young mother living in northwest Arkansas, relayed her story, "I lost my job at six months pregnant because of pregnancy-related nausea and sickness, and lost my work provided health insurance. . . . I wasn't able to find work anywhere and could not afford continuing healthcare insurance coverage payments. Expanded benefits from Medicaid literally saved my life. . . . As I battled extreme nausea and sickness throughout my pregnancy, I required prescription medication to keep enough food down to support my unborn child's nutritional needs. Because I had expanded Medicaid coverage, I received the professional prenatal care with check-ups and monitoring for myself and my unborn child, and the prescription medications necessary for our survival. . . . Expanded Medicaid benefits covered my medications and…supplies essential in my recovery [after delivery]. I am forever grateful…to return to work and school, and to know that I can now provide a bright future for my daughter as a healthy mother."

Stephanie Rozanski and daughter, Sunny

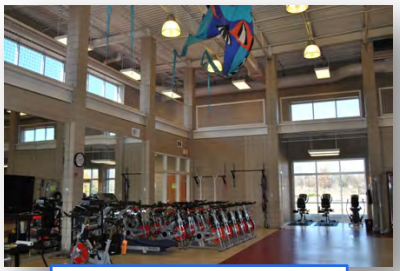
Drivers: Built environment and physical conditions, policy and governance. In this subsection, we look at two drivers, *built environment and physical conditions* and *policy and governance.* The first three examples attend to conditions of the built environment as we highlight two services provided by UAMS East Regional Campus and also highlight research by Fay W. Boozman College of Public Health. The fourth example under Action Area 3 covers a policy effort as we return to the example of the Wooster smoke-free policy mentioned under Action Area 1.



UAMS East Regional Campus: Robert Wood Johnson Foundation and RAND (2018) remind us of the utility of libraries in enhancing health and well-being as libraries offer access to resources and information related to health as well as providing safe spaces for interaction among community members, which bolsters social cohesion. Each year, students, health professionals, and consumers from the community have access to medical library services through UAMS East Regional Campus. During the biennium, more than 20,000 people utilized the library services.

More than 20,000 people utilized library services.

UAMS East Regional Campus: Access to safe spaces for physical activity is a vital component of a healthy built environment where community members can thrive. Each quarter, UAMS East Regional Campus provides opportunities for physical activity through programs in the community and through its onsite facilities, like the fitness center and walking track in Helena. UAMS East Regional Campus records the number of people it encounters at each community program or within its fitness center (encounters on the walking track are typically not documented unless associated with a specific exercise program). In all, between 2016 and 2017,



Fitness Center in Helena

encounters at the Helena fitness center totaled more than 56,000, while community-based physical activity encounters totaled more than 76,000.

Fay W. Boozman College of Public Health (COPH): During the biennium, students and faculty at COPH focused their research on conditions of the built environment; students explored issues related to food insecurity while faculty explored issues of housing insecurity. In 2016, one capstone project aimed to help communities understand the various elements of a local food system and the interactions of those elements in the local environment while assessing existing food systems and setting priorities for system change. Partnering with Conway Public Schools, a Preceptorship Project incorporated local foods into Conway schools through a Farm to School service-learning project that implemented nutrition education and a curriculum for food services staff, teachers, and principals that was focused on farm to table resources. Also in 2017, two Master of Public Health students had culminating experiences related to food insecurity. One project looked at an initiative to combat patient food insecurity at a health and wellness center in Little Rock, while another project provided a case study of food insecurity in a college community. Some faculty research in 2017 also aimed to address conditions of the built environment, particularly focused on housing issues. Two related projects were centered on the homelessness of pregnant women and their babies, one study looking at impacts of homelessness on health and the other on the identification of support for pregnant women who are housing insecure.

Tobacco Prevention and Cessation Program (TPCP): As mentioned in Action Area 1, the city of Wooster with the help of TPCP implemented a comprehensive smoke-free policy. This policy not only helps to create a shared vision of health but also protects vulnerable populations from the dangers of secondhand smoke and helps to ensure clean and safe spaces for recreation in Wooster. After the policy was implemented, the Mayor of Wooster, Terry Robinson shared, “Losing my mom to lung cancer left a lasting impression on me. I have never wanted to try smoking, not even a single cigarette. Our City Council agrees that it’s important for all public

places to be clean and healthy. No one should have to breathe secondhand smoke or have cigarette butts on their playground. We were happy to support the Farmers' and Crafters' Market request to be smoke-free, but we knew we would need a city ordinance. Having the template provided by Mary Krisell and Stamp Out Smoking helped guide us to create the specific language we needed for the Wooster ordinance….Now, in any public space in Wooster, smoking is prohibited."

Wooster Mayor poses with Xandra Sharpe at Wooster City Park

Action Area 4: Strengthening Integration of Health Services and Systems

Strengthening integration of health services and systems is contingent upon combining medical care, public health services, and social services to uplift overall community health—and contribute to a CoH (RWJF & RAND, 2018). This integration of care advances health outcomes and decreases medical and other health-related expenditures. Three program efforts that aimed to integrate health services and systems during the biennium are highlighted below. UAMS East Regional Campus's new medical clinic, UAMS Centers on Aging integrated approach to clinical care and community education, and MHI's efforts to empower young girls are all highlighted.

UAMS University of Arkansas for Medical Sciences
East Regional Campus

UAMS East Regional Campus: The opening of the UAMS Family Medical Center in Helena immediately bolstered the integration of health services and systems in the greater Helena area within a medically underserved region. Now, clinical services are offered alongside community education and outreach programs. UAMS Interim Chancellor Stephanie Gardner spoke of the facility's overall mission to improve the health of Arkansans through patient care, education, research, and community outreach.

Stephanie Gardner speaks to attendees at Grand Opening

"UAMS East Regional Campus is critical to our ability to accomplish the goals of our mission at UAMS. Better healthcare service provision to meet the needs of people who live here—and future residency opportunities for primary care providers—support the concept of patient-centered healthcare homes. UAMS East Regional Campus is one of only two regional programs of this nature in the entire United States, and is praised as a model for other programs in the nation."

UAMS Centers on Aging (UAMS-COA): UAMS has eight Centers on Aging around the state, each with a clinical component. In 2016-2017, UAMS-COA assisted in more than 49,000 Senior Health Clinic encounters. In addition to clinical services, UAMS-COA offers a variety of evidence-based community education events throughout the years. Over the course of the biennium, UAMS-COA counted nearly 129,000 community education encounters. Education programs include, but are not limited to, Virtual Dementia Experience; Healthy Eating and Tasting; Older, Wiser, and Livelier Seniors; and the Diabetic Empowerment Education Program (DEEP). Kasandra Williams-Guilbeau, Community Outreach Educator from the Texarkana Regional COA, provides regular education modules like DEEP. During a DEEP session, participants are actively engaged and highly motivated to find ways to improve nutrition and diabetes management abilities. Williams-Guilbeau, spoke with us after a DEEP session in Texarkana and emphasized the importance of health education as part of UAMS-COA's efforts, "We could prevent so many health problems if we could reach our community members with education about healthy nutrition before diseases such as diabetes occur."

Location of eight UAMS Centers on Aging


Kasandra Williams-Guilbeau at a DEEP session in Texarkana

Arkansas Minority Health Initiative (MHI): An MHI community partner, Delta Community Based Services, offers community services, character building, education enrichment, as well as empowerment programming for girls. In 2016, the annual "At-Promise" Girls conference exposed nearly 250 girls, age 12-18, to peer-to-peer

networking opportunities as well as mentors through experience sharing and relationship-building. Breakout sessions consisted of mental health, tobacco prevention, drug addiction, body mass index screenings, and living a healthy lifestyle. These partnerships with MHI help girls to understand the relevance of health services outside of traditional clinical care and empower girls to continue building relationships with peers and mentors while educating themselves on health and well-being topics.

2016 "At-Promise" Girls conference

Fay W. Boozman College of Public Health (COPH): The COPH offers a doctoral degree in Health Systems and Services Research. The program strengthens students' theoretical and methodological understanding that is necessary to carry out independent research on health systems. The goal of this research is to find pathways toward improved performance of health systems via evidence-based policy and management. A rigorous curriculum is focused on strategies relevant to research on the organization, financing, and delivery of health services. After completing the program, graduates find opportunities in research centers based in universities or independent research institutes, health policy organizations, philanthropic groups and consulting firms, and advocacy and professional organizations at the state and national level.

Outcome: Improved Population Health, Well-being, and Equity

Outcome: **Improved Population Health, Well-Being, and Equity**

The outcomes of goals achieved under the four action areas result in *improved population health, well-being, and equity*. Progress towards this outcome requires persistence and time, shifts in cultural norms and expectations, expanded knowledge and innovation, and cross-sector partnerships (RWJF & RAND, 2018). All ATSC-funded program efforts contribute to reaching the outcome of improved population health, well-being, and equity in Arkansas. The examples that follow underscore efforts that point to achieved outcomes, categorized by three measures recognized by RWJF and RAND as contributing to the effectiveness of CoH outcomes (2018). The three

measures are *individual and community well-being, managed chronic disease and reduced toxic stress,* and *reduced healthcare costs.*

Individual and community well-being. Individual well-being encompasses many factors that impact a person's view of health and well-being, including fundamental needs (e.g., education and housing) and physical and emotional needs (e.g., mental health and feelings of safety). While ATSC-funded programs are not designed to measure a person's view of health and well-being, many programs are designed to provide education and services to individuals who are willing to be proactive about health. Some programs have recorded a significant increase in participation at community education and exercise programs, particularly the **UAMS-COA**. This increase in participation may indicate that older Arkansans and their families are doing more to take part in improving their health. In addition, the **TPCP**, has measured decreases in risky health behaviors like smoking use in certain populations, which may indicate a shift in mindsets about personal and community health within these population groups. Also, research funded by the Minority Research Center on Tobacco and Addictions, through TPCP's minority communities account, recently found that tobacco education prevention and policy has had a positive influence on smoking prevalence in Arkansas (Morris & Harris, 2018), supporting the idea that education and policy positively affects well-being.

Under UAMS-COA, community education encounters increased by 82% and exercise encounters increased by 240.7%.

TPCP reported that youth smoking prevalence decreased by 17.8% and young adult smoking prevalence decreased by 28%.

Community well-being encompasses health, education, resilience and stability, and adaptation to changing environments. Achieving community well-being requires consideration of diverse populations, particularly marginalized populations. The **MHI** also has expanded its outreach to Marshallese populations in northwest Arkansas, effectively providing vital education and services to those who otherwise may have fallen through the cracks. Outreach included a community forum with Dr. Sheldon Riklon, one of two Marshallese physicians in the world, health promotion media with a focus on chronic disease, and an updated Marshallese Acculturation

MHI expanded outreach efforts to Marshallese populations in northwest Arkansas.

Booklet detailing community resources. With this new opportunity, the Marshallese may embrace new views and opportunities to improve their health and well-being. Overall, ATSC-funded programs helped bring about positive outcomes in individual and community well-being.

Managed chronic disease and reduced toxic stress. To achieve good health and well-being outcomes, those in healthcare and in other sectors must work together in the prevention and treatment of chronic health conditions and toxic stress. Some ATSC-funded programs are charged with directly addressing chronic disease and stress, like **UAMS East Regional Campus** that has documented a decrease in the percentage of abnormal health screenings from 2016 to 2017, which may point to an improvement in Delta residents' ability to manage chronic conditions like diabetes and heart disease. Other ATSC-funded programs, chiefly the **COPH** and **ABI**, regularly produce research that informs the management of chronic disease and stress. Data reported by these programs provide a platform from which public health and community leaders can design and implement efforts that facilitate the management of disease and stress. COPH also directly impacts chronic diseases through research interventions. Overall, ATSC-funded programs aided Arkansans in managing chronic diseases and stress.

UAMS East Regional Campus reported a drop in the percentage of abnormal health screenings from 39% in 2016 to 36% in 2017.

COPH and ABI produce research focused on chronic diseases like obesity and cancer.

Reduced healthcare costs. As health and well-being improve, healthcare costs fall. While it may be difficult to estimate how much costs could decrease in Arkansas as health and well-being improve, we do know that eliminating health disparities among Arkansas minority populations could result in a cost reduction of $518.6 million in direct medical care expenditures. The **MHI,** under the purview of Arkansas Minority Health Commission that commissioned the study on expenditures related to minority health disparities, directly addresses the burden of minority health disparities and medical care expenditures through raising awareness and providing health education and screenings to minority groups.

MHI directly addresses the burden of health disparities and medical care expenditures.

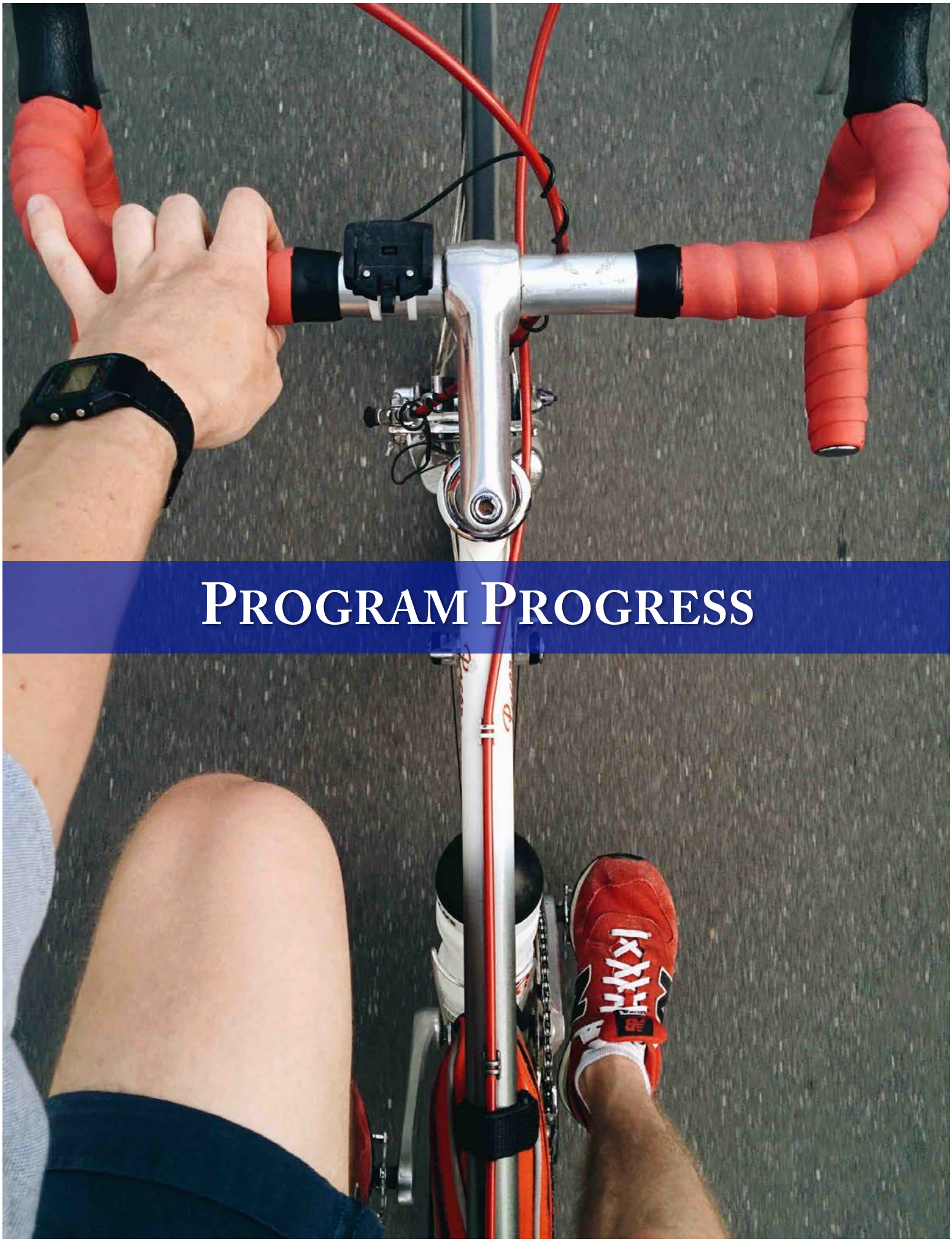
Rates of preventable hospital stays are a good indicator of how well communities are doing in reducing healthcare costs. Over the last three years, preventable hospital stays in Arkansas have dropped by 13.9%, in part because more people have access to health coverage through the Affordable Care Act (County Health Rakings, 2018). This coverage allows citizens to access primary care physicians in lieu of seeking emergency care or other hospital services. In addition to an increase in insurance coverage, Arkansans have seen an increase in expanded Medicaid services and access to clinics, which helps reduce rates of hospitalization. The **TS-MEP** increased coverage to pregnant women, seniors, and patients requiring extended hospital stays over the biennium. TS-MEP also began providing services to individuals with developmental disabilities. **UAMS East Regional Campus**, with the opening of the UAMS Family Medical Center in Helena, greatly impacted healthcare access in Helena and surrounding areas. Since opening, the center has served an average of 40 patients per day. Overall, ATSC-funded programs contributed to a reduction of healthcare costs.

TS-MEP increased coverage by 14% during the biennium.

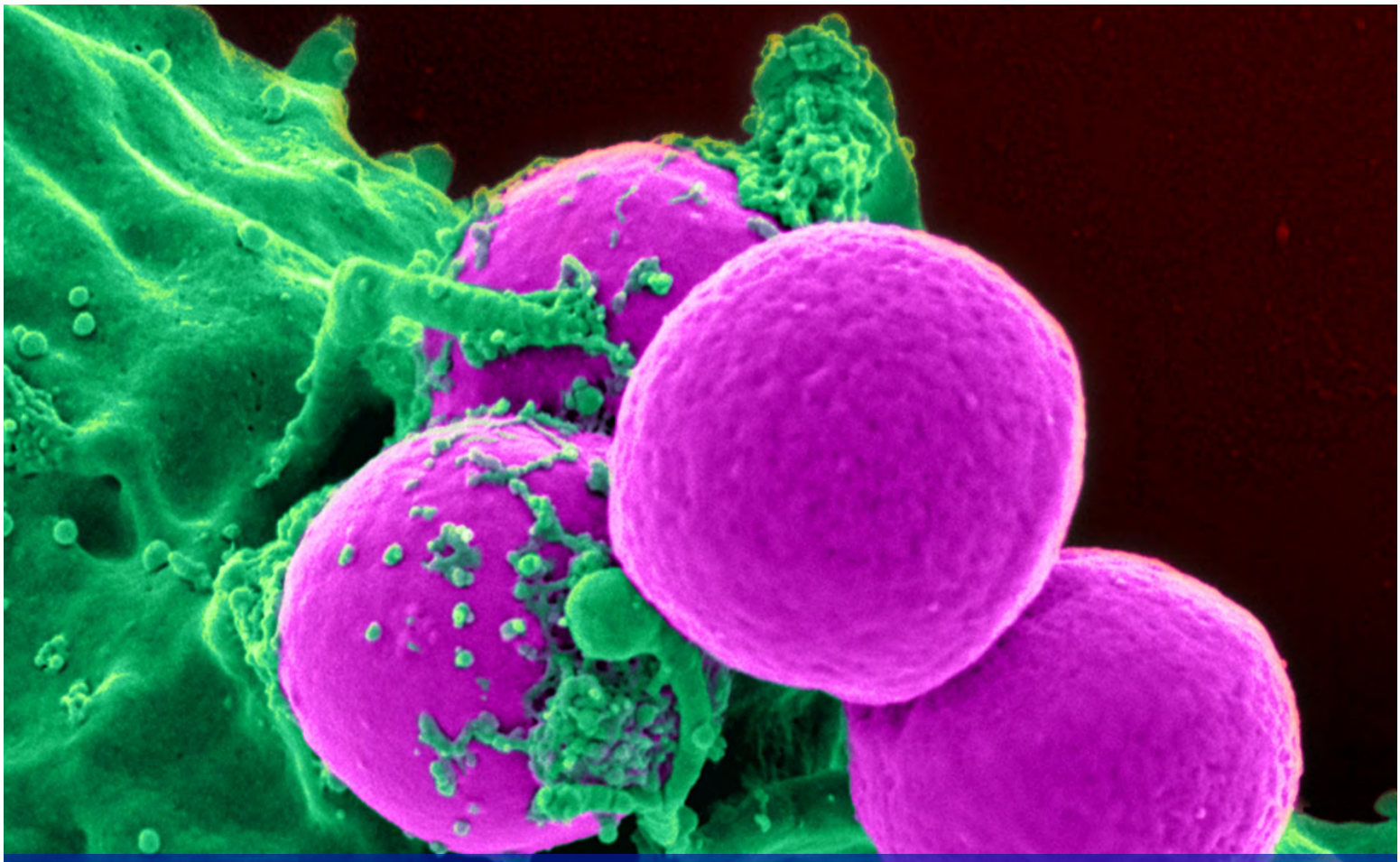
UAMS East Regional Campus improved access with new medical center.

Summary of Efforts that Contribute to a Culture of Health

Throughout the introduction of this report, we have seen how ATSC-funded programs contribute to a Culture of Health by (1) working to make health a shared value through policy, civic engagement, and building a sense of community; (2) collaborating across sectors to foster quality partnerships and investments in collaboration; (3) creating healthier, more equitable communities through addressing the built environment and physical conditions, and enacting new policies that support the overall well-being of communities; and (4) strengthening the integration of health services and systems by combining medical care with public health and social services. Programs also strive to serve vulnerable and marginalized populations, to exclude no one, and to reduce health disparities. These collective efforts contribute to outcomes of improved health, well-being, and equity—and help to build a Culture of Health in Arkansas. (See pages 6-7 of this report for a graphical representation of the "collective impact" of program efforts—categorized by efforts in education, service, research, and economic gains.) The following section provides a comprehensive look at ATSC-funded program progress and accomplishments according to ATSC-approved goals and indicators.



Program Progress

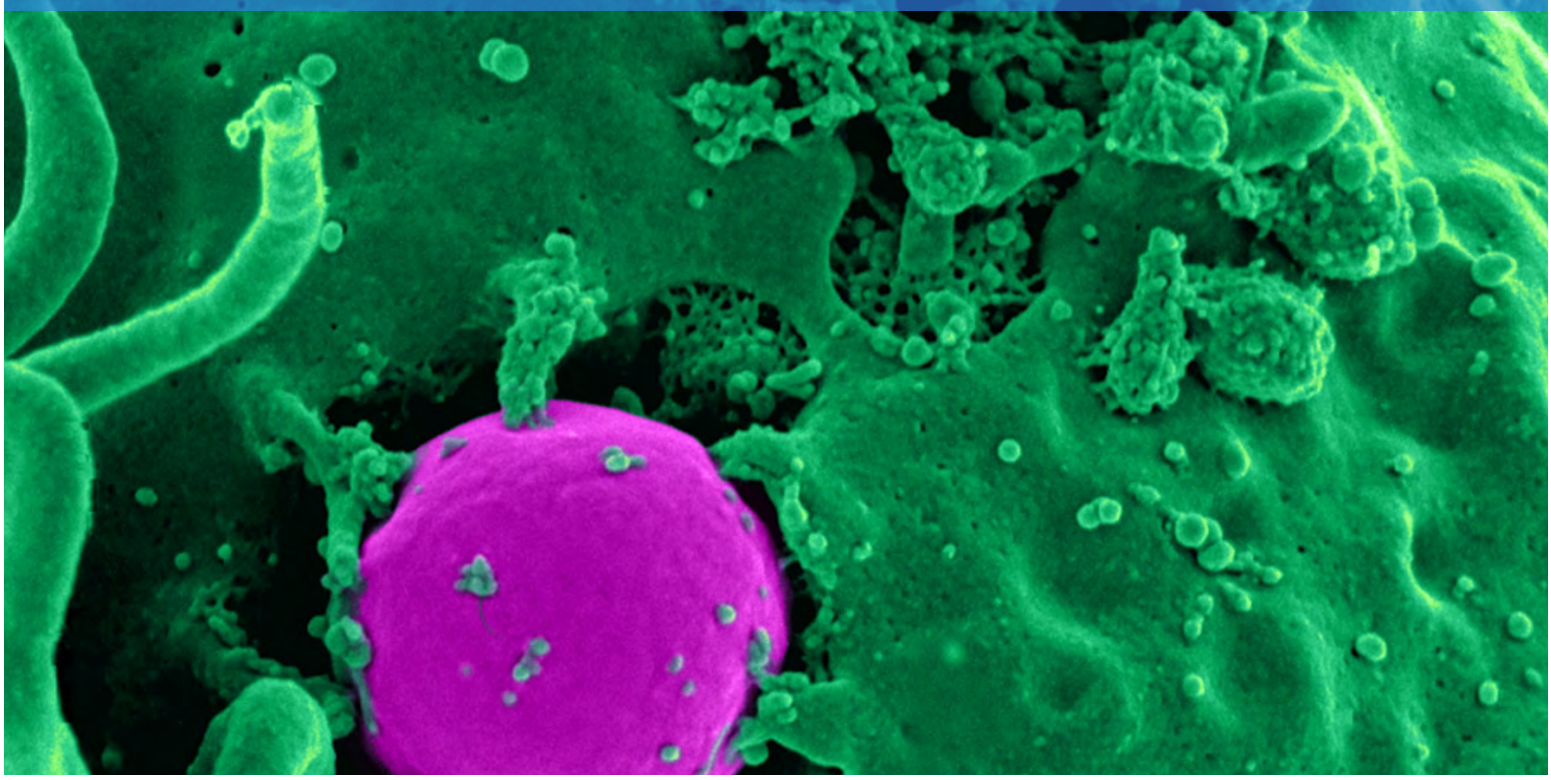


Arkansas Biosciences Institute (ABI)

Robert McGehee, Jr., PhD, Director

Leslie Humphries, Program Coordinator

UCA ATSC Evaluator: Betty Hubbard, EdD, MCHES



THE KNOWLEDGE CAPITALISTS

ARKANSAS BIOSCIENCES INSTITUTE (ABI)

Arkansas Biosciences Institute

THE PRODUCTION OF KNOWLEDGE

ABI focuses on five research areas.

Arkansas Children's Research Institute · Arkansas State University · University of Arkansas · University of Arkansas for Medical Sciences

- Agricultural
- Nutritional
- Tobacco-Related
- Bioengineering
- Other related areas of research

Average of 181 new and ongoing research projects per year.

1,290 Publications

1,352 Presentations

ABI Fall Research Symposium, 2017

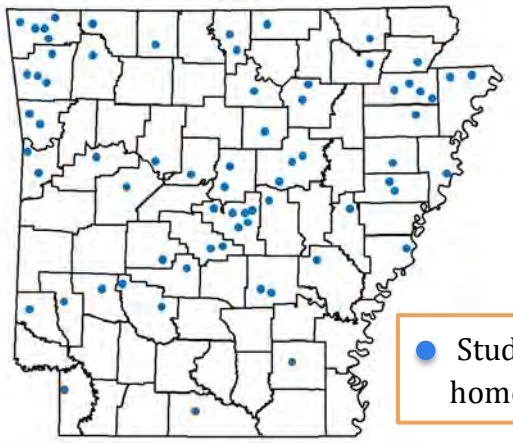
ECONOMIC IMPACT

$82 Million Leveraged

ABI leveraged $82 million in extramural funds, an average of **$4.08 for every $1** in ATSC funding.

Supported 299 full-time employees per year.

In FY16 & FY17, **397** college and high school **students** from 43 counties engaged in ABI-related research. This map indicates where these students call home.



● Students' hometowns

ABI Evaluator Summary & Comments

Program Description: Arkansas Biosciences Institute, the agricultural and biomedical research program of the Tobacco Settlement Proceeds Act, is a partnership of scientists from Arkansas Children's Hospital Research Institute, Arkansas State University, the University of Arkansas-Division of Agriculture, the University of Arkansas, Fayetteville, and the University of Arkansas for Medical Sciences. ABI supports long-term agricultural and biomedical research at its five member institutions and focuses on fostering collaborative research that connects investigators from various disciplines across institutions. ABI uses this operational approach to directly address the goals as outlined in the Tobacco Settlement Proceeds Act; these goals are to conduct:

- **Agricultural research** with medical implications;
- **Bioengineering research** that expands genetic knowledge and creates new potential applications in the agricultural-medical fields;
- **Tobacco-related research** that identifies and applies behavioral, diagnostic, and therapeutic knowledge to address the high level of tobacco-related illnesses in Arkansas;
- **Nutritional and other research** that is aimed at preventing and treating cancer, congenital and hereditary conditions, or other related conditions;
- **Other areas of developing research** that are related or complementary to primary ABI-supported programs.

Economic Impact: During the biennium, ABI received approximately 23% of ATSC funding, equivalent to $20.4 million. By using these funds, and through collaborative efforts, ABI leveraged an additional $82 million to support or produce the following:

1. An average of 181 new and ongoing research projects each fiscal year;
2. An average of 299 FTE jobs each year;

3. 1,290 publications;
4. 1,352 presentations;
5. 46 patents that were filed or provisional with nine patents awarded;
6. Two start up enterprises; and
7. 199 media contacts.

The full measure of economic impact includes the tangible activities listed above but also extends to lives that have been improved or saved through research conducted, disseminated, and applied for the benefit of Arkansans.

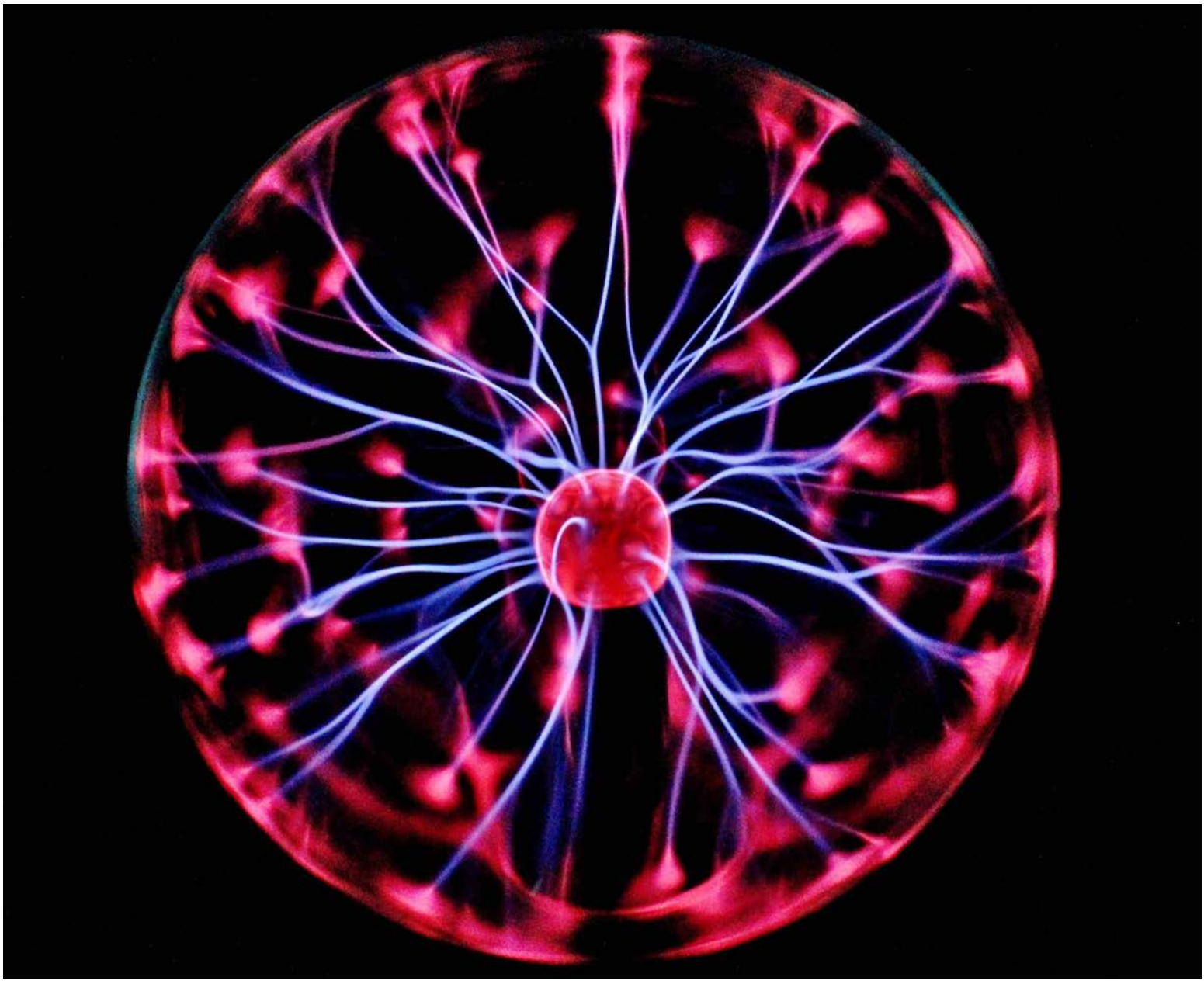
CHALLENGES: As research funding on the national level shrinks, the number and scope of research projects related to ABI also contracts. Over time, these contractions adversely impact ABI research investigators at the five member institutions. Because the research supported by ABI is long-term and large-scale, investigators rely heavily on several different funding sources, not just ABI funding.

OPPORTUNITIES: ABI-supported research investigators continue to look for collaborative opportunities. With most of the large research challenges that the investigators attempt to address—like obesity, heart disease, and cancer—it takes a team of diverse disciplines to tackle such complex issues. ABI-supported research investigators have had successes in larger research awards from the National Institutes of Health, the US Department of Agriculture, and the National Science Foundation when they have presented a collaborative approach.

EVALUATOR COMMENTS
Attendance at the 2017 Fall Research Symposium was a highlight for this evaluator. The event is conducted yearly, presenting an opportunity for participants to attend oral presentations that provide an overview of research conducted by selected ABI investigators. The research reports are wide-ranging and demonstrate the many ways in which funding from the Tobacco Proceeds

Act is being used to advance and support health-related programs for Arkansans. In addition to the oral presentations, students display and explain their research projects. The symposium advances its objectives through multiple opportunities for discussion and collaboration between presenters as well as those in attendance.

Despite the decline in government funding that has occurred over the past biennium, ABI continues to meet or perform above almost all benchmarks for indicators. The continued growth in leveraged funds and consistent productivity of ABI investigators is particularly impressive. Given the ongoing success of ABI, researchers should continue their efforts to achieve the short-term and long-term objectives of this program.



ABI Performance Indicators and Progress

Overall Program Goal: To develop new tobacco-related medical and agricultural research initiatives to improve the access to new technologies, improve the health of Arkansans, and stabilize the economic security of Arkansas.

LONG-TERM OBJECTIVE
The institute's research results should translate into commercial, alternate technological, and other applications wherever appropriate in order that the research results may be applied to the planning, implementation and evaluation of any health related programs in the state. The institute is also to obtain federal and philanthropic grant funding.

2016 INDICATORS	*2017 INDICATORS*
Indicator: The five member institutions will continue to rely on funding from extramural sources with the goal of increasing leverage funding from a baseline of $3.15 for every $1.00 in ABI funding.	**Indicator**: The five member institutions will continue to rely on funding from extramural sources with the goal of increasing leverage funding from a baseline of $3.15 for every $1.00 in ABI funding.
Activity: ABI-supported research investigators' extramural funding totaled more than $40.5 million. This amount represented a $3.99 direct return on every ABI dollar received. The indicator was met.	**Activity**: ABI-supported research investigators generated $41.7 million in extramural grant awards, representing a $4.17 direct return leveraged for each ABI dollar received. The indicator was met.
Indicator: ABI-funded research will lead to the development of intellectual property, as measured by the number of patents filed and received.	**Indicator**: ABI-funded research will lead to the development of intellectual property, as measured by the number of patents filed and received.
Activity: Twenty-eight patents were filed or given provisional status. Five patents were fully awarded. The indicator was met.	**Activity**: Eighteen patents were filed or given provisional status. Four patents were awarded. The indicator was met.
Indicator: ABI-funded research will result in new technologies that generate business opportunities, as measured by the number of start-up enterprises and public-private partnerships with ABI and member institutions to conduct research.	**Indicator:** ABI-funded research will result in new technologies that generate business opportunities, as measured by the number of start-up enterprises and public-private partnerships with ABI and member institutions to conduct research.

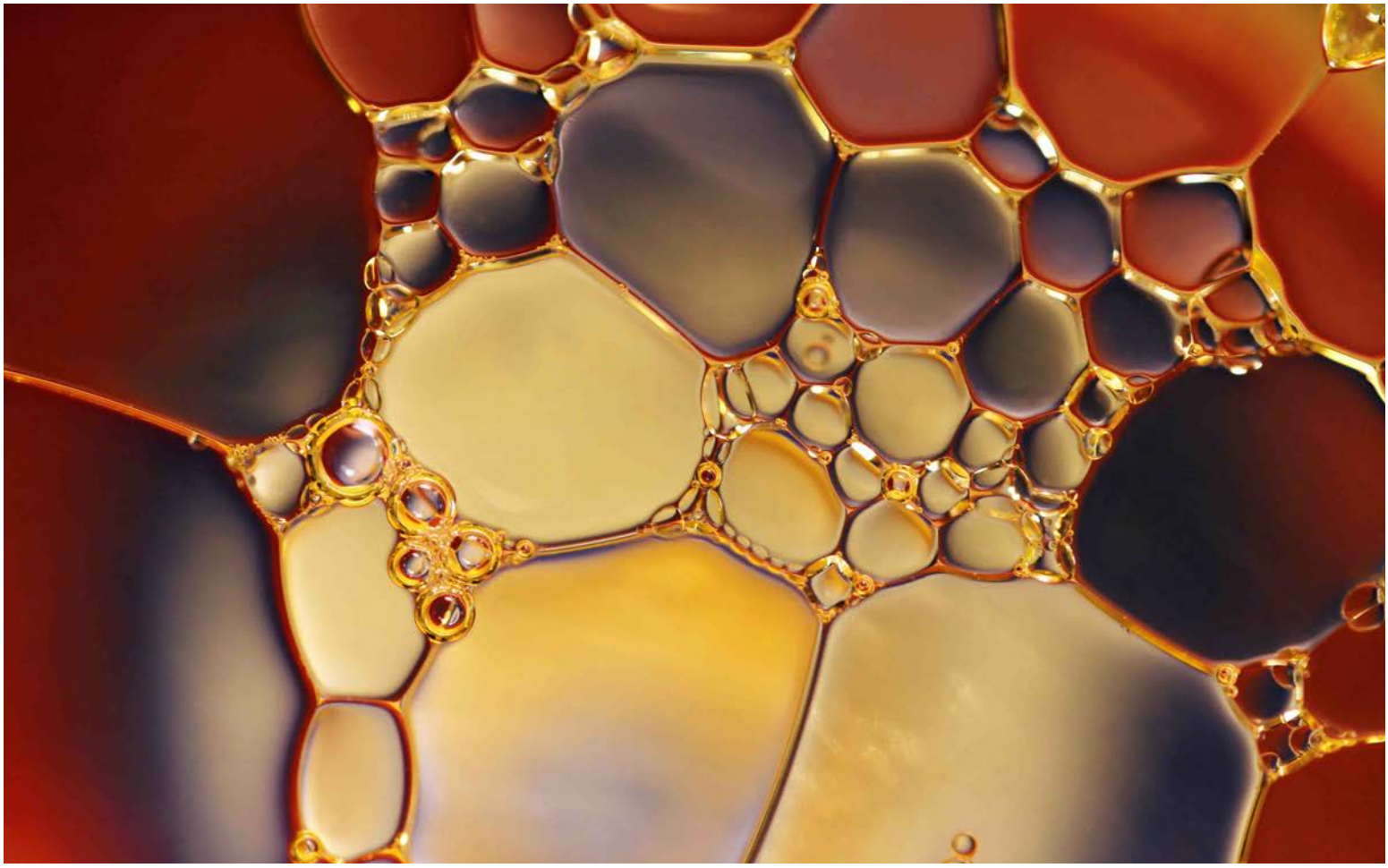
Activity: ABI researchers helped to foster one new start-up enterprise. The indicator was met.	**Activity:** ABI researchers helped to initiate one new start-up enterprise. The indicator was met.
Indicator: ABI will promote its activities through various media outlets to broaden the scope of impact of its research.	**Indicator**: ABI will promote its activities through various media outlets to broaden the scope of impact of its research.
Activity: Ninety-six distinct media contacts were made by ABI. The indicator was met.	**Activity:** There were 130 media contacts regarding ABI-supported research projects provided through media outlets (e.g., newspaper articles, news conferences, press releases, and television/radio). The indicator was met.

SHORT-TERM OBJECTIVE

The Arkansas Biosciences Institute shall initiate new research programs for the purpose of conducting, as specified in § 19-12-115, agricultural research with medical implications, bioengineering research, tobacco-related research, nutritional research focusing on cancer prevention or treatment, and other research approved by the board.

2016 INDICATORS	*2017 INDICATORS*
Indicator: ABI will allocate funding to its five member institutions to support research, while also monitoring that funded research activities are conducted on time, within scope, and with no overruns.	**Indicator**: ABI will allocate funding to its five member institutions to support research, while also monitoring that funded research activities are conducted on time, within scope, and with no overruns.
Activity: ABI reported 174 new and ongoing research projects across all five research areas. The indicator was met.	**Activity**: For this fiscal year, there were 188 new and ongoing research projects covering all five areas of research. The indicator was met.
Indicator: ABI and its member institutions will systematically disseminate research results, and ensure that at least 290 publications and 370 presentations are delivered each year. These include presentations and publications of results, curricula, and interventions developed using the grant funding, symposia held by investigators, and the creation of new research tools and methodologies that will advance science in the future.	**Indicator**: ABI and its member institutions will systematically disseminate research results, and ensure that at least 290 publications and 370 presentations are delivered each year. These include presentations and publications of results, curricula, and interventions developed using the grant funding, symposia held by investigators, and the creation of new research tools and methodologies that will advance science in the future.
Activity: ABI investigators reported 689 publications, 692 presentations, and five new/improved research methods/tools. The	**Activity**: ABI investigators reported 601 publications and 660 presentations. In addition, there were five new/improved research

indicator was met.	methods/tools reported. The indicator was met.
Indicator: Employment supported by ABI and extramural funding will increase from a baseline of 300 full-time equivalent (FTE).	**Indicator:** Employment supported by ABI and extramural funding will increase from a baseline of 300 full-time equivalent (FTE).
Activity: There were 309 full-time equivalent jobs in Arkansas that were directly supported with ABI and extramural research funding. The indicator was met.	**Activity:** There were 289 full-time equivalent jobs in Arkansas supported with ABI and extramural research funding. The number of full-time employees fell short of the benchmark by 11 positions. While the indicator, technically, was not met, ABI continues to support hundreds of research-related positions.
Indicator: ABI will facilitate and increase research collaboration among member institutions, as measured by both ABI and extramural funding of research projects that involve researchers at more than one member institution.	**Indicator**: ABI will facilitate and increase research collaboration among member institutions, as measured by both ABI and extramural funding of research projects that involve researchers at more than one member institution.
Activity: Of the 174 new and ongoing ABI-supported research projects, 32% were collaborative with other ABI institutions. The indicator was met.	**Activity:** There were 188 new and ongoing research projects at the five institutions; 28% of these projects were collaborative research efforts conducted with other researchers within ABI institutions. The indicator was met.



ABI Testimonial

Plant Science Research in Arkansas, Fiona Goggin

"One of the first grants I got when I was a younger faculty member was from ABI to study antioxidants in tomatoes," said Fiona Goggin, PhD, Professor of Entomology at the Dale Bumpers College of Agricultural, Food, and Life Sciences at the University of Arkansas System's Division of Agriculture. Goggin studies plant-insect interactions, and how to better defend crops against damaging insects.

"More recently, I had an ABI grant that I wrapped up last year to study fatty acids metabolism in tomatoes," Goggin continued. Fatty acids are important both to the health of the plants, particularly in terms of insect resistance, and to the nutritional quality of the produce for consumption.

"In a nutshell, we use imaging technologies to study plant defenses so that we could then figure out how to improve those plant defenses," said Goggin. "And we created new collaborations with Missouri to do that, because Missouri has strengths in radio imaging that aren't present in Arkansas. So we brought together participants so that we had access to facilities in Missouri, Missouri researchers had access to facilities in Arkansas, and we created new collaborations."

"We also have seed grant programs. So it wasn't just University of Arkansas, Fayetteville and ASU in Jonesboro that were participating, we also brought in participants from Little Rock and Monticello. So again, we were working on building that network of plant scientists."

"ABI has allowed us to do some work that was in its early stages," Goggin explained. "So we couldn't just go out and get a federal grant for it, but it has since helped with work that I have gotten funded by the USDA."

Fay W. Boozman College of Public Health (COPH)

Jim Raczynski, PhD, FAHA, COPH Dean

Liz Gates, JD, MPH, Assistant Dean for Special Projects

UCA ATSC Evaluator: Ron Bramlett, PhD

Cultivating Homegrown Public Health Practitioners

College of Public Health (COPH)

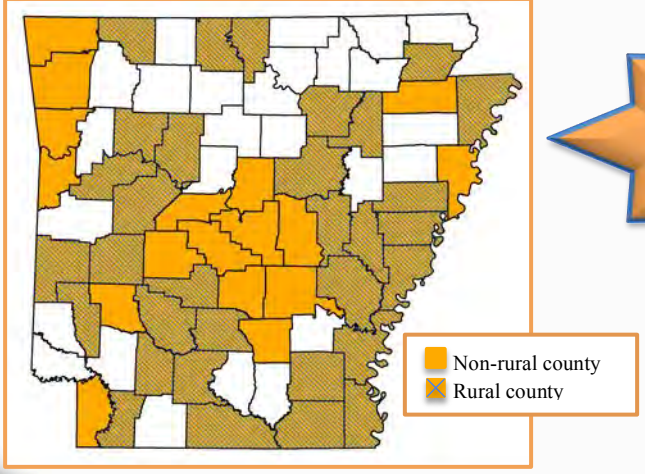
UAMS Fay W. Boozman College of Public Health

Cultivating Practitioners

126 Graduates

In 2016-2017, a large majority of COPH graduates, **84%, plan to stay in Arkansas** and work in public health. Pictured above are the 2016 Honor Graduates.

COPH draws students from across the state. In 2016-2017, students represented 49 of 75 counties, 32 of these counties are rural. In all, **22% of COPH students came from a rural county.**



Faculty Research

397 Publications & Presentations

98% of faculty contracts and grants had an Arkansas focus.

In 2017, COPH received **$7 million** for another five years of funding for the **Arkansas Center for Health Disparities**. The funds will support research, faculty infrastructure, and postdoctoral mentoring and development.

Economic Impact

$10.7 Million Leveraged

COPH leveraged $2.31 for every $1 in ATSC funding.

COPH Evaluator Summary & Comments

Program Description: The Fay W. Boozman College of Public Health (COPH) educates a public health workforce and advances the health of the public by investigating the causes, treatments, and prevention of human health problems. Preventing chronic disease and promoting positive health behavior is the most effective way to improve the health of all people. The College's mission of improving the health of all Arkansans is realized through teaching and research as well as service to elected officials, agencies, organizations, and communities. Examples of the complex health issues addressed include: improving the multiple dimensions of access to healthcare; reducing the preventable causes of chronic disease; controlling infectious diseases; reducing environmental hazards, violence, substance abuse, and injury; and promoting preparedness for health issues resulting from terrorist acts, natural disasters, and newly emerging infectious diseases.

Economic Impact: The COPH received 5.2% of the Tobacco Settlement Program funds during the biennium—$2,328,532 in FY 2016 and $2,302,416 in FY 2017. The College leverages these monies to generate funding in the form of grants and contracts, and other funding in the form of tuition and fees, investment revenue, and gifts. In FY 2016, the ratio of gross extramural research funding to Tobacco Settlement Program funds was 2.32:1, totaling more than $5.4 million. In FY 2017, COPH received nearly $5.3 million in grants and contracts, a 2.3:1 ratio of extramural funds to tobacco funds. The Tobacco Settlement Funds are coupled with extramural and other funding to improve public health through the following activities: conducting research that involves students from all areas of the state, providing courses and presentations to deliver current information, and serving as consultants and partners within the state to positively affect the health of Arkansans.

COPH leveraged $2.31 for every $1 in ATSC funding.

Challenges: The financial situation at UAMS resulted in cuts in various ways for the COPH. These included non-personnel cost savings, delaying faculty searches and institutional financial commitment towards those searches, and contemplation of personnel cuts during this

time period. The delay in faculty searches also means that the search for the Director for the Center for Obesity and the Governor Sydney S. McMath Endowed Chair in Obesity Prevention is delayed indefinitely.

OPPORTUNITIES:

- In 2016, two of the grants awarded totaled over $2.5 million and will allow researchers the opportunity to explore the relationship between genetic variants and arterial blood pressure—which has not been tested before in any population in the United States—and to study faith-based interventions for depression among a rural population in Arkansas.
- In late September of 2017, the COPH received the Notice of Award for another five years of funding for the Arkansas Center for Health Disparities. The funding, from the National Institute on Minority Health and Health Disparities, is over $7 million for five years and will allow for research funding for the Center and three additional research projects per year. The funds will also be used to develop infrastructure for faculty and for postdoctoral mentoring and development. As a result, the COPH will have additional opportunities for developing faculty, research, and pilot projects that will increase and enhance the College's ability to apply for additional federal funding.

- Students in the Master of Health Administration program worked towards obtaining an administrative fellowship after graduation. During the October-December 2017 time period, four students received these prestigious fellowships at Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana; CHI St. Vincent in Little Rock, Arkansas; the University of Kansas Health System in Kansas City, Kansas; and Johns Hopkins Medicine in Baltimore, Maryland.
- Students at UAMS are required to take part in Interprofessional Education (IPE) activities to ensure they are well prepared to work as a team to improve patient care experience and the health of the populations they serve as well as to reduce the cost of care. The IPE curriculum includes working as a group to develop a project proposal that addresses a problem that relates to the Triple Aim of healthcare reform: improving health and

healthcare delivery as well as lowering healthcare costs. In December 2017, each of the top three project teams included at least one student from the COPH representing the public health aspect of the healthcare issue to be addressed.

EVALUATOR COMMENTS

The Fay W. Boozman College of Public Health continues activities that work toward its long-term objective: elevate the overall ranking of the health status of Arkansans. The faculty of the COPH serves the citizens of the state by providing education, research, and service. Their topics of research and teaching are far-reaching and relevant to the health needs of Arkansans. Examples of the topics of projects in which COPH faculty are involved include, but are not limited to, eliminating health disparities, hospital management issues, cardiovascular disease, obesity, tobacco prevention and cessation, breast cancer, and HIV/AIDS. The students enrolled in the programs offered by the COPH also contribute to the well-being of Arkansans through various preceptorships, culminating experiences, and capstone experiences.

Highlighted here are three examples of how recent graduates are contributing to the health of Arkansans by taking key leadership positions in Arkansas. Suzanne Bierman JD, MPH, serves as the Vice President of Data & Policy at the Arkansas Hospital Association, which manages and oversees the activities of the Association related to policy and data analysis and development. The Vice President of Data & Policy is responsible for identifying opportunities for improving data and policy analyses to support quality improvement and advocacy efforts and to inform strategic planning efforts. Bierman also interprets and translates research and policy findings into practical tools and products for distribution to members and other stakeholders. The Vice President of Data & Policy reports to the President and CEO and is a member of the Senior Leadership Team.

Jennifer Wessel, JD, MPH, is a senior policy analyst and data privacy officer at the Arkansas Center for Health Improvement. Wessel serves as a project lead on research projects and health policy analyses related to health system transformation and health information. She is also

responsible for the coordination of information privacy and security compliance activities, including impact and risk assessments, vendor due diligence, data management and protection, and staff education.

Dr. Appathurai Balamurugan, MD, DrPH, MPH, FAAFP, serves as the State Chronic Disease Director and the Medical Director for the Chronic Disease Branch at the Arkansas Department of Health. In this capacity, Balamurugan provides medical oversight and leadership to chronic disease programs such as heart disease, stroke, diabetes, cancer, nutrition, and physical activity across the state through the Arkansas Department of Health's 94 Local Health Units.

Importantly, COPH has met its indicators for the 2016-2017 biennial period.

COPH Performance Indicators and Progress

Overall Program Goal: To improve the health and promote the well-being of individuals, families, and communities in Arkansas through education, research, and service.

LONG-TERM OBJECTIVE
To elevate the overall ranking of the health status of Arkansans.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Through consultations, partnerships and dissemination of knowledge, the COPH serves as an educational resource for Arkansans (e.g., general public, public health practitioners and researchers, and policymakers) with the potential to affect public health practice and policy – and population health.	**Indicator**: Through consultations, partnerships and dissemination of knowledge, the COPH serves as an educational resource for Arkansans (e.g., general public, public health practitioners and researchers, and policymakers) with the potential to affect public health practice and policy – and population health.
Activity: COPH faculty engaged in a variety of activities including the following: presenting to professional and lay audiences; consulting and serving on expert panels, task forces, committees and boards of directors; and partnering with public health practitioners or community organizations that have health-related missions. The measurement for this indicator is that the faculty and staff engage in at least 20 activities per quarter. During 2016, faculty participated in an average of 28.5 activities per quarter. Eighty-six percent of these activities were classified as ongoing, 7% monthly, and 7% met quarterly. The indicator was met.	**Activity**: COPH faculty engaged in a variety of activities including the following: presenting to professional and lay audiences; consulting and serving on expert panels, task forces, committees and boards of directors; and partnering with public health practitioners or community organizations that have health-related missions. The measurement for this indicator is that the faculty and staff engage in at least 20 activities per quarter. During 2017, COPH faculty participated in an average of 38 activities per quarter. Overall, 84% of activities were classified as ongoing, while 8% were monthly, 6% were quarterly, and the remaining three activities (2%) took place bi-monthly, bi-annually, and annually. The indicator was met.
Indicator: Faculty productivity is maintained at a level of 2 publications in peer-reviewed journals to 1 FTE for primary research faculty.	**Indicator**: Faculty productivity is maintained at a level of 2 publications in peer-reviewed journals to 1 FTE for primary research faculty.

Activity: During 2016, 51 faculty members reported 135 publications in professional outlets and/or presentations at professional conferences, a ratio of 2.65:1 publications/presentations per faculty member. The indicator was met.	**Activity**: During 2017, 60 faculty members reported 262 publications in professional outlets and/or presentations at professional conferences, a ratio of 4.4 publications/presentations per faculty member. The indicator was met.
Indicator: Research conducted by COPH faculty and students contributes to public health practice, public health research, and the health and well-being of Arkansans.	**Indicator:** Research conducted by COPH faculty and students contributes to public health practice, public health research, and the health and well-being of Arkansans.
Activity: In 2016, 31 faculty members participated as the principal investigator, co-principal investigator, or consultant for 51 grants and contracts. Twenty-six preceptorships were conducted by students enrolled in the Master of Public Health (MPH) program. Thirty-four students in the MPH program participated in culminating experiences and two students in the Doctor of Public Health program conducted a capstone experience. The indicator was met.	**Activity:** In 2017, 31 faculty members participated as the principal investigator, co-principal investigator, or consultant for 75 grants and contracts. Thirty-three preceptorships were conducted by students enrolled in the Master of Public Health (MPH) program. Twenty-five students in the MPH program participated in culminating experiences and two students in the Doctor of Public Health program conducted a capstone experience. The indicator was met.
Indicator: COPH faculty, staff, and students are engaged in research that is based in Arkansas.	**Indicator**: COPH faculty, staff, and students are engaged in research that is based in Arkansas.
Activity: During 2016, 50 of the 51 (98%) faculty grants/contracts and 24 of the 26 (92%) student preceptorships and culminating projects were conducted in Arkansas or had an Arkansas focus. The indicator was met.	**Activity:** During 2017, 44 of the 45 (98%) faculty grants/contracts and 27 of 27 (100%) student preceptorships and culminating projects were conducted in Arkansas or had an Arkansas focus, and involved a wide range of health-related topics and populations. The indicator was met.
Indicator: The COPH makes courses and presentations available statewide.	**Indicator:** The COPH makes courses and presentations available statewide.
Activity: Twenty-four distance-accessible courses were offered by the COPH during 2016: nine in the spring semester, six in the summer semester, and nine in the fall semester. Additionally, the COPH, which is a co-sponsor of the Arkansas Department of Health Grand Rounds, provided 30 presentations in 2016: 13 during the first quarter, nine during the second quarter, and eight during the last quarter. The indicator was met.	**Activity:** Thirty-three distance-accessible courses were offered by the COPH during 2017: 13 in the spring semester, six in the summer semester, and 14 in the fall semester. Additionally, the COPH provided 35 presentations in 2017: 16 during the first quarter, 11 during the second quarter, and eight during the last quarter. The indicator was met.
Indicator: Twenty percent of enrolled students come from rural areas of Arkansas.	**Indicator:** Twenty percent of enrolled students come from rural areas of Arkansas.
Activity: During the spring 2016 semester, 38 (24%) of the 160 Arkansans who enrolled were from rural areas. Thirty-four (25%) of 137 Arkansans enrolled during the summer 2016	**Activity:** During the spring 2017 semester, 17 (12%) of the 144 Arkansans who enrolled were from rural areas. Thirty (26%) of 115 Arkansans enrolled during the summer of 2017 semester were

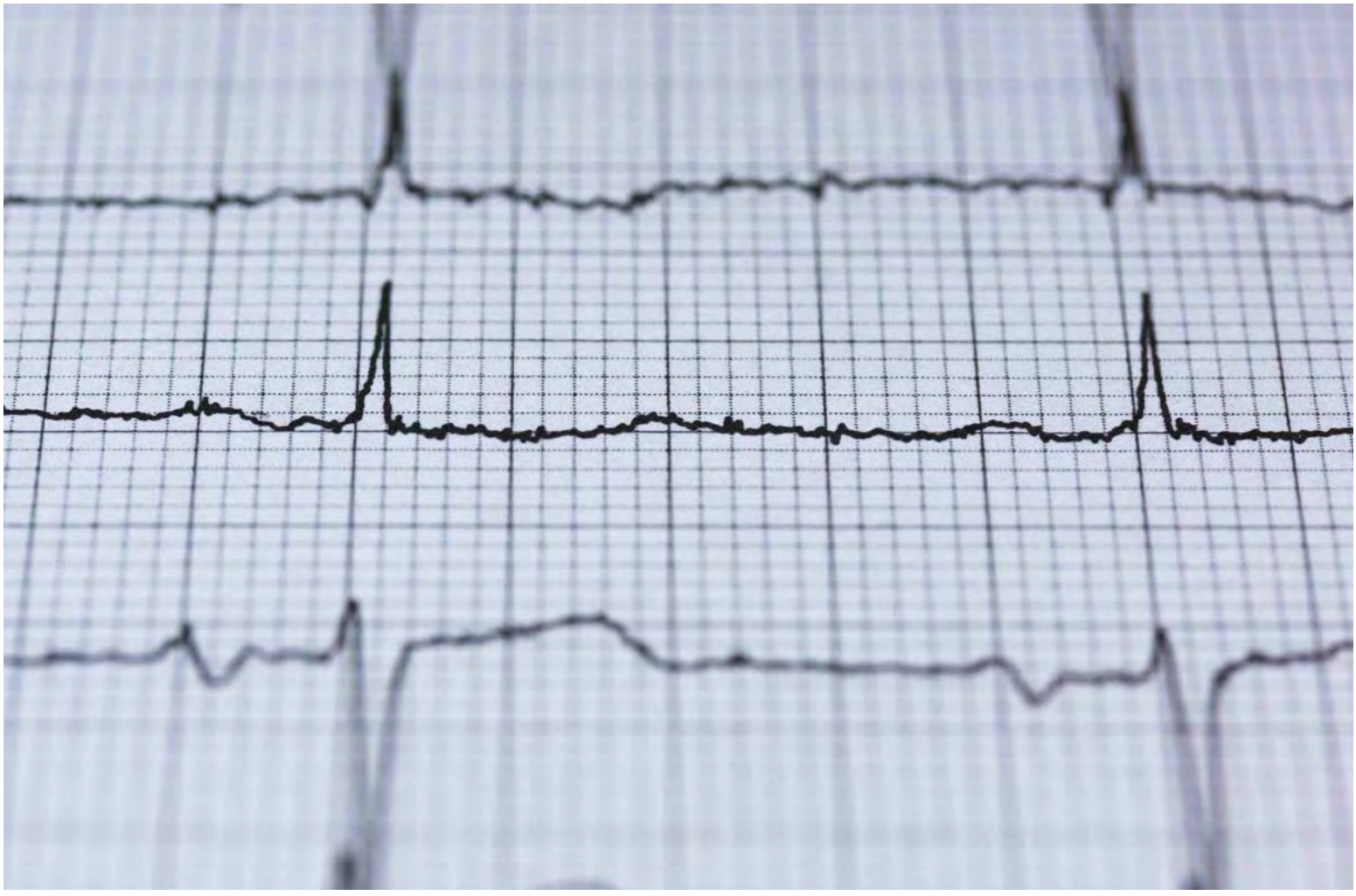
semester were from rural areas, and 34 (20%) of 168 students enrolled for the fall 2016 semester were from rural areas. On average between semesters, 22% of Arkansans enrolled in the program were from rural areas. The rural designation is determined by the Federal Office of Management and Budget based upon the 2010 census. The indicator was met.	from rural areas, and 42 (26%) of 160 Arkansans enrolled for the fall 2017 semester were from rural areas. On average between semesters, 21% of Arkansans enrolled in the program were from rural areas. The rural designation is determined by the Federal Office of Management and Budget based upon the 2010 census. The indicator was met.
Indicator: Graduates' race/ethnicity demographics for whites, African American and Hispanic/Latinos are reflective of Arkansas race/ethnicity demographics.	**Indicator:** Graduates' race/ethnicity demographics for whites, African American and Hispanic/Latinos are reflective of Arkansas race/ethnicity demographics.
Activity: Sixty-six students received degrees or certificates from COPH. Twenty-nine students (44%) were Caucasian, 17 students (26%) were African American, 10 students (15%) were Asian, two students (3%) were Hispanic, two students (3%) were of more than one race/ethnic group, and six students (9%) did not report race/ethnicity. The percentages for White and Hispanic students were lower than the demographics in the state; however, the percentage of Asian and African American students exceeded the state demographic profiles. The indicator was met.	**Activity:** Sixty students received degrees or certificates from COPH. Thirty-one students (52%) were Caucasian, 12 students (20%) were African American, 10 students (16%) were Asian, one student (2%) was Hispanic, three students (5%) were of more than one race/ethnic group, and three students (5%) did not report race/ethnicity. The percentages for White and Hispanic students were lower than the demographics in the state; however, the percentage of Asian and African American students exceeded the state demographic profiles. The indicator was met.
Indicator: The majority of alumni stay in Arkansas and work in public health.	**Indicator:** The majority of alumni stay in Arkansas and work in public health.
Activity: Of the 66 students who graduated during 2016, 52 (79%) planned to stay in the state and work in public health. Fourteen (21%) of the students' future plans were unknown. The indicator was met.	**Activity:** Of the 60 graduates from 2017, 53 (88%) planned to stay in the state and work in public health. Seven (12%) of the students' future plans were unknown. The indicator was met.

SHORT-TERM OBJECTIVE

To obtain federal and philanthropic grant funding.

2016 INDICATORS	*2017 INDICATORS*
Indicator: The COPH maintains a level of leveraged (extramural) funding in relation to unrestricted funding that exceeds that of comparable accredited schools of public health.	**Indicator (a) (January – June)**: The COPH maintains a level of leveraged (extramural) funding in relation to unrestricted funding that exceeds that of comparable accredited schools of public health.

Activity: The data for the previous fiscal year required to evaluate this indicator were unavailable. Therefore, no conclusions could be drawn regarding progress toward the achievement of this short-term objective. The financial information that was provided by COPH indicated a 2.32:1 ratio of extramural funds to tobacco funds, a slight decrease between FY15 and FY16. This decrease was attributed to the completion of several contracts.	**Activity (a)**: The fiscal data for July 1, 2016 through June 30, 2017 showed that $2,302,416 was awarded to COPH from ATSC. Grants and contracts to COPH totaled $5,298,029. The financial information that was provided by COPH indicated a 2.3:1 ratio of extramural funds to tobacco funds. The indicator was met.
	Indicator (b) (July – December): The COPH shall maintain a 1.5:1 ratio of total annual fiscal year extramural award funding to annual fiscal year tobacco settlement dollars. **Activity (b)**: Based on the data through June 30, 2017, the program is on track to maintain a 1.5:1 ratio on extramural award funding to annual tobacco settlement dollars. The indicator is in progress.



COPH Testimonial

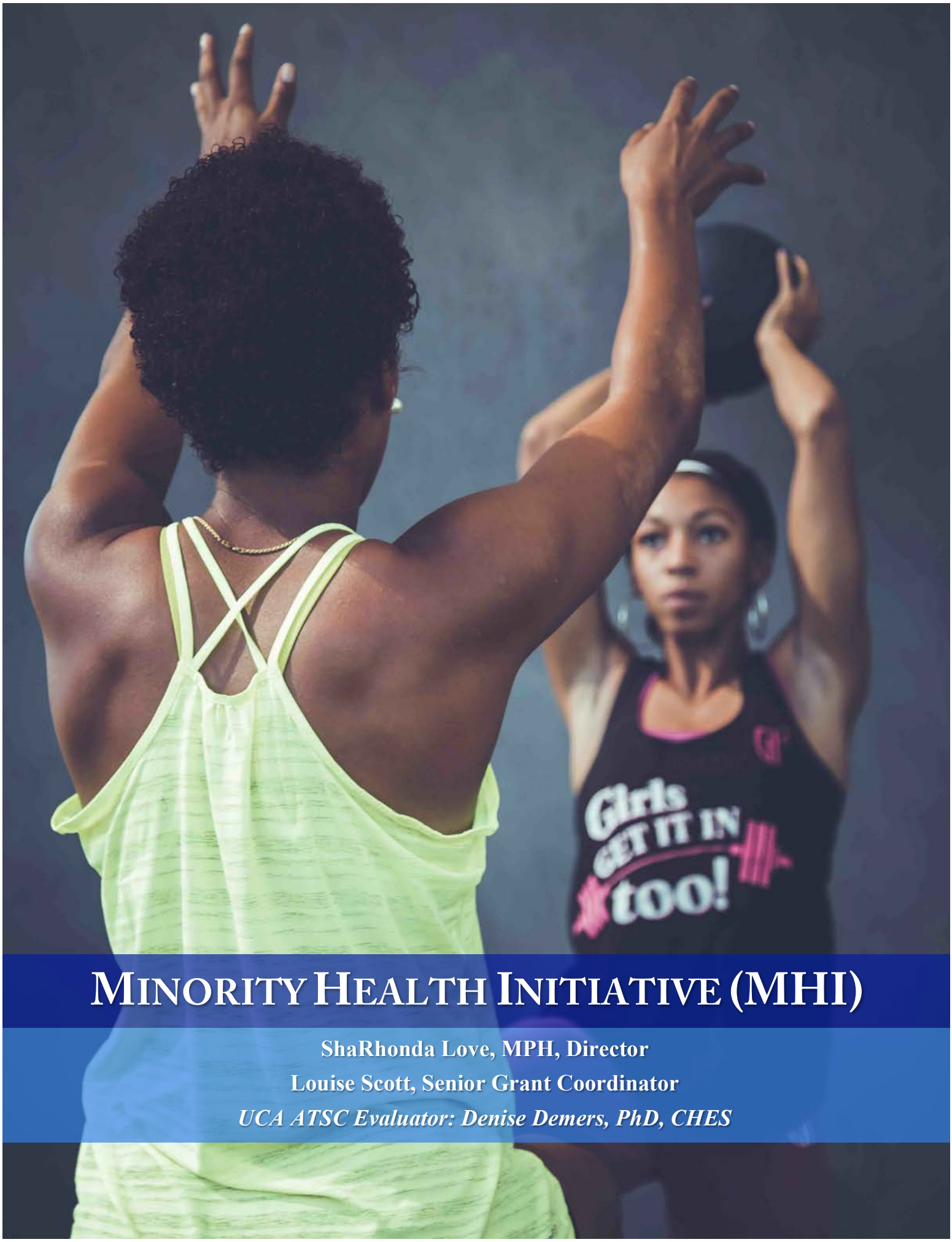
Hsueh-Fen Chen, PhD

Two Medicare "pay for performance" programs have contributed to declining financial performance by Mississippi Delta hospitals and widening the gap in financial performance between Mississippi Delta hospitals and other hospitals in the nation, according to a study published in the peer-reviewed journal, *Medical Care*, by UAMS faculty.

The Hospital Readmissions Reduction Program (HRRP) and Hospital Value-based Purchasing Program (HVBP) are having a disproportionate financial impact on Delta hospitals, according to Hsueh-Fen Chen, PhD, Associate Professor at the Fay W. Boozman College of Public Health, and lead author on the study. The two programs provide financial incentives for hospitals to deliver higher-quality, higher-value care. The HRRP reduces Medicare reimbursements to hospitals with higher than average readmission rates for selected conditions. The HVBP adjusts payments based on a set of quality indicators.

The Delta region is among the most socioeconomically disadvantaged areas in the country and has a high proportion of minority populations. The region includes 252 counties in eight states, including Arkansas. Dr. Chen and her colleagues compared operating margin (profitability from patient care) and total margin (profitability from patient and non-patient care) between Delta hospitals and non-Delta hospitals from 2008 to 2014 that were covered before and after implementation of the HRRP and HVBP in 2013. After implementation of HRRP and HVBP, the gap in financial performance became significantly wider.

"Delta hospitals serve as healthcare safety nets and are essential for healthcare delivery for the Delta," said Dr. Chen. "While quality of care is improved nationwide, Delta hospitals are likely to get left behind and to continue to receive penalties because they have fewer resources to improve quality of care due to poor financial performance." Dr. Chen and coauthors conclude that these findings show that altering the HRRP and HVBP is necessary and urgent to ensure that the resources are not removed from the communities that need them most.



MINORITY HEALTH INITIATIVE (MHI)

ShaRhonda Love, MPH, Director

Louise Scott, Senior Grant Coordinator

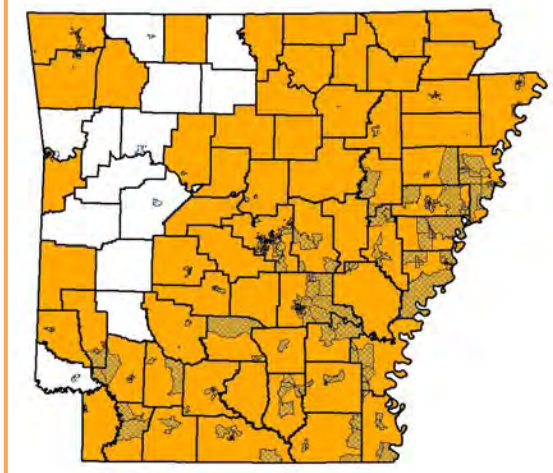
UCA ATSC Evaluator: Denise Demers, PhD, CHES

Health Equity As Our Charge

Minority Health Initiative (MHI)

Arkansas Minority Health Commission

Targeting Health Disparities



Counties reached by MHI screenings & events
Census Block Groups in the 4th quartile for minority population

The MHI and its partners provide **educational events and health screenings** throughout the state. This map illustrates the 62 counties where individuals were impacted by these events in 2016-2017, highlighted in orange. The areas shaded in blue represent Census Block Groups (CBGs) in the fourth quartile for percent minority population. In all, **MHI events reached counties that cover 98.7% of the CBGs with the highest minority populations**.

61,000 People Educated

44,000 Health Screenings

Economic Impact

A study commissioned by the Arkansas Minority Health Commission showed that **eliminating health disparities** for Arkansas minorities would result in **a reduction of direct medical care expenditures of $518.6 million**. The work of MHI directly addresses the burden of minority health disparities and medical care expenditures.

Partnered with 75 grassroots organizations.

Expanded outreach efforts to Marshallese populations in northwest Arkansas.

$518.6 Million Potential Cost Reduction

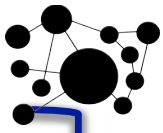
MHI Evaluator Summary & Comments

Program Description: The Arkansas Minority Health Initiative (MHI) was established in 2001 through *Initiated Act I* to administer the Targeted State Needs for screening, monitoring, and treating hypertension, strokes, and other disorders disproportionately critical to minority groups in Arkansas by 1) increasing awareness, 2) providing screening or access to screening, 3) developing intervention strategies (including educational programs) and 4) developing/maintaining a database. To achieve this goal, the Arkansas Minority Health Commission's focus addresses existing disparities in minority communities, educating these communities on diseases that disproportionately impact them, encouraging healthier lifestyles, promoting awareness of services and accessibility within our current healthcare system, and collaborating with community partners.

Economic Impact: In 2016 and 2017, MHI received 3.6% of ATSC funds. This equated to $3,277,630.26 received. Every five years, the Minority Health Commission produces an economic impact study that estimates the direct medical care savings to the state if minority health disparities were to be eliminated. The most recent report was released in April of 2014, and it was estimated that $518.6 million could be saved in direct medical care expenditures if disparities were eliminated. Conversations with the new Arkansas Surgeon General and the Stephens Group regarding medical savings resulted in a desire to decrease healthcare inequalities by just 10%. If these healthcare inequalities for Arkansas minorities were reduced by 10%, it would yield $51.8 million in savings. If the prevention of premature death were taken into account, that figure would increase to $220 million. The work of MHI directly addresses the burden of minority health disparities and direct medical care expenditures in Arkansas. Lastly, it should be noted that MHI strives to be good stewards of the monies it receives, and this evaluator sees that they are spending their allotted funds wisely.

CHALLENGES: Heart disease remains the number one cause of death in Arkansas. Likewise, cardiovascular disease rates in Arkansas are in the top five in the nation. Risk factors include poor nutritional choices, a lack of physical activity, smoking, and hypertension, all of which are prevalent in Arkansas. While MHI continues to increase awareness of deadly diseases, including heart disease, by offering many screening opportunities as well as educational events, there remains many challenges to lowering the incidence of such an extensive disease. Robert Wood Johnson Foundation's *County Health Rankings* report reminds us of the challenge to address health by looking at health behaviors, clinical care, social and economic factors, and the physical environment. MHI does a fantastic job of meeting this challenge and offering events that are convenient to the state's population, but reaching more people is always a barrier they will face.

OPPORTUNITIES: MHI makes great use of partnerships to provide programs, community forums, and health summits in attempts to increase awareness and screenings, and thus reduce death and disability due to tobacco, chronic, and other lifestyle-related illnesses.



Partnered with 75 grassroots organizations.

EVALUATOR COMMENTS

During this biennium, MHI has consistently added more events, distributed more educational packets, and partnered with more faith-based or grassroots/nonprofit organizations. Thus, the amount of awareness continues to increase, and the number of screenings offered continues to be in the thousands. MHI is a leader in offering education and screenings to the underprivileged, low-income, and diverse populations that may not otherwise have the opportunity to access vital health information and services. In 2017, MHI added social media as a means to communicate with the public, which has increased their reach to thousands more Arkansans. Additionally, MHI expanded its educational outreach to include the Marshallese populations in northwest Arkansas with the campaign #yourhealthourpriority. This evaluator believes that MHI is doing an effective job with the monies given to them as they strive to increase awareness for risky behaviors and deadly diseases like heart disease, stroke, and other diseases that disproportionately impact the minority population in Arkansas.

MHI Performance Indicators and Progress

Overall Program Goal: To improve the health care systems in Arkansas and access to healthcare delivery systems, thereby resolving critical deficiencies that negatively impact the health of the citizens of the state.

LONG-TERM OBJECTIVE
Reduce death / disability due to tobacco, chronic, and other lifestyle related illnesses of Arkansans.

2016 INDICATORS	*2017 INDICATORS*
Indicator: To increase stroke awareness by one percent annually among minority Arkansans as measured by previous comparison beginning in FY 2015.	**Indicator**: To increase stroke awareness by one percent annually among minority Arkansans through screenings and educational events as measured by previous comparison beginning in FY 2015.
Activity: Throughout 2016, MHI provided approximately 22,000 health screenings and educated more than 30,000 individuals in all four congressional districts. Additionally, they continued to partner with grassroots/nonprofit and faith-based organizations to provide screenings, educational information, and events to impact the health of Arkansans, specifically regarding stroke awareness. MHI provided over 5,853 blood pressure screenings, 1,134 of which were abnormal, at which time they provided information and advised the individuals for follow-up with their primary care physician. The indicator is in progress.	**Activity**: In 2017, MHI provided more than 22,000 health screenings and educated more than 31,000 Arkansans. Approximately 72% of total screenings in 2017 were related to heart disease and stroke. Concerning stroke awareness, they provided 5,410 blood pressure screenings to minority citizens. During the 3rd quarter, 41.9% of the minority population was given health screenings. This is a great accomplishment. Data from the BRFSS indicate that 13% of respondents from Arkansas had been told by a healthcare provider that they had a blood circulation problem (an increase of 3% from the previous year). Regarding cholesterol, a risk factor for heart disease and stroke, 79% of Arkansans have had their blood cholesterol checked (an increase of 2% from the previous year). Also 75% of the respondents shared that their cholesterol had been checked within the last year (an increase of 3.4% from the previous year). The indicator was met.

Indicator: To increase hypertension awareness by one percent annually among minority Arkansans as measured by previous comparison beginning in FY 2015.	**Indicator**: To increase hypertension awareness by one percent annually among minority Arkansans through screenings and educational events as measured by previous comparison beginning in FY 2015.
Activity: During 2016, MHI provided numerous screenings. Those affecting hypertension include blood pressure (5,853), height/weight (2,399), BMI (1,589), cholesterol (1,564), and glucose (2,877); and these screenings, consequently, raise awareness for hypertension and its associated risk factors. The indicator is in progress.	**Activity**: During 2017, MHI provided more than 15,900 screenings that impact heart disease and stroke. Of those, 7,634 were blood pressure and heart rate screenings, 1,636 were cholesterol screenings, and 2,657 were glucose screenings. MHI provided more than 4,000 screenings for height/weight and BMI. MHI has also increased awareness through partnership with the COPH Hypertension Research Project. *Take Control* is a community research project to control high blood pressure and target adults age 18-64 who live or work in Desha County. Participants received basic information to follow-up with their doctor as well as follow-up instructions. They were provided a list of doctors if they did not have one, and uninsured participants who needed assistance with prescriptions were provided contact information for someone who could assist them. Participants also received information on lifestyle change such as healthy eating and physical activity. Further, data from the BRFSS show that 41.9% of Arkansas respondents indicated they had been told by a health professional they had high blood pressure (an increase of 2.9 % from 2016). Also, 54.4% of the respondents had been advised on how to reduce or prevent high blood pressure (a 3.4% increase), and 72.4% of respondents knew what their blood pressure measurements should be. Additionally, MHI requires collaborative partners to distribute health education literature on hypertension. Over 60 health education messages aired on three television stations in central and northwest Arkansas encouraging individuals to "Know Your Number". The indicator is in progress.
Indicator: To increase heart disease awareness by one percent annually among minority Arkansans as measured by previous comparison beginning in FY 2015.	**Indicator:** To increase heart disease awareness by one percent annually among minority Arkansans through screenings and educational events as measured by previous comparison beginning in FY 2015.

Activity: Admirably, MHI continued to partner with several grassroots/nonprofit or faith-based organizations providing screenings, awareness, and educational packets and information. MHI provided over 17,000 screenings related to heart disease, including screenings for height/weight, BMI, cholesterol, glucose, and blood pressure. Moreover, MHI distributed over 3,740 educational packets containing heart disease and healthy lifestyle information. The indicator is in progress.	**Activity:** Heart disease remains the top cause of death for Arkansans. During 2017, MHI conducted multiple screenings that raise awareness for this disease. Screenings pertinent to heart disease include height/weight, BMI, cholesterol, glucose, and blood pressure (BP). Throughout the year, over 70 outreach initiatives, approximately 22,000 health screenings, and health education literature that focused on prevention were provided to more than 31,000 individuals. Data from BRFSS reveal that 54.4% of respondents had been advised on how to reduce or prevent high BP (an increase of 3.4% from the previous year). Also 47.9% of respondents had been told about the role of diet in reducing or preventing BP. The indicator was met.
Indicator: To increase diabetes awareness by one percent annually among minority Arkansans as measured by previous comparison beginning in FY 2015.	**Indicator**: To increase diabetes awareness by one percent annually among minority Arkansans through screenings and educational events as measured by previous comparison beginning in FY 2015.
Activity: MHI provided many educational and health screening events throughout the year. In 2016, MHI provided 2,877 glucose screenings. Further, educational and information packets that were distributed contained information about healthy lifestyles, specifically heart disease and smoking cessation, which are two strong risk factors for diabetes. The indicator is in progress.	**Activity:** In 2017, MHI provided educational events and screening opportunities for minority Arkansans. Glucose level is most associated with diabetes risk, and this year, MHI provided 2,657 glucose screenings, thus increasing diabetes awareness. Data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that 86% of Arkansans that have not been tested for diabetes stated that they knew where to go to get tested (an increase of 1% from the previous year). The MHI provided health and education literature through sponsorships, partnerships, and other organizations and individuals. The indicator was met.

SHORT-TERM OBJECTIVE

Prioritize the list of health problems and planned interventions for minority populations and increase the number of Arkansans screened and treated for tobacco, chronic, and lifestyle-related illnesses.

2016 INDICATORS	*2017 INDICATORS*
Indicator: MHI will conduct ongoing needs assessments to determine the most critical minority health needs to target, including implementation of a comprehensive survey of racial and ethnic minority disparities in health and healthcare every five years.	**Indicator**: MHI will conduct ongoing needs assessments to determine the most critical minority health needs to target, including implementation of a comprehensive survey of racial and ethnic minority disparities in health and healthcare every five years.
Activity: Every five years, data are collected through survey methods to inform MHI concerning the health of the nation, and in particular, the state of Arkansas (CDC and BRFSS). The next survey will be completed in FY 2019. To date, MHI works off current data, which show that if the MHI continues to commission the Economic Cost of Health Inequalities in Arkansas report, we can better understand and estimate the economic impact of racial and ethnic disparities in Arkansas. The most recent report found that eliminating health disparities for Arkansas minorities would result in a reduction of direct medical care expenditures of $518.6 million. The indicator is in progress.	**Activity**: Every five years, data are collected through survey methods to inform MHI concerning the health of the nation, and in particular, the state of Arkansas (CDC and BRFSS). The next survey will be completed in FY 2019. To date, MHI works off current data, which show that if the MHI continues to commission the Economic Cost of Health Inequalities in Arkansas report, we can better understand and estimate the economic impact of racial and ethnic disparities in Arkansas. The most recent report found that eliminating health disparities for Arkansas minorities would result in a reduction of direct medical care expenditures of $518.6 million. The indicator is in progress.
Indicator: MHI will increase awareness and provide access to screenings for disorders disproportionately critical to minorities as well as to any citizen within the state regardless of racial/ethnic group.	**Indicator**: MHI will increase awareness and provide access to screenings for disorders disproportionately critical to minorities as well as to any citizen within the state regardless of racial/ethnic group.
Activity: Throughout 2016, MHI did a great job of increasing awareness and providing access to screenings as they collaborated with multiple grassroots, nonprofit, and faith-based organizations. Over 30,000 people were given the opportunity to attend activities and be screened for specific health risk factors. Additionally, if the individuals received an abnormal reading, they were given information to contact their primary care physician, as well as educational information. The indicator is in progress.	**Activity**: MHI works to increase awareness and provide access to screenings as they collaborated with an increasing number of grassroots, nonprofit, and faith-based organizations each quarter. Over, 31,000 individuals were given access to outreach initiatives. Additionally, initiatives impacted individuals who reside in 62 or 75 counties, and three statewide initiatives were implemented, representing all four congressional districts. This year MHI also took on a new endeavor to advocate for screenings for Marshallese populations within the state. MHI continues to increase awareness throughout the state. The indicator was met.
Indicator: MHI will develop and implement at least one pilot project every five years to identify effective strategies to reduce health disparities among Arkansans.	**Indicator:** MHI will develop and implement at least one pilot project every five years to identify effective strategies to reduce health disparities among Arkansans.

Activity: Camp iRock, the most recent pilot project, concluded in 2015. Since that time MHI has held follow-up activities with the young women who participated, many of which (78%) now state that they have a positive body image. Noteworthy accomplishments include 56% of participants reporting they were ready to change how they eat and 67% reporting being ready to change what they do to be active. Seventy-eight percent were confident in their ability to make changes to be healthier. Most participants reported healthy eating behaviors such as not eating when bored (89%), not eating when sad or worried (100%), not hiding food (89%), not sneaking food (78%), and eating out once a week or less (89%). In all, there was a loss of 12 pounds during the week-long camp. Adding those accomplishments together, MHI has succeeded in creating one effective strategy to reduce health disparities among young women in Arkansas. The indicator was met.	**Activity:** The Camp iRock Reunion was April 29, 2017. The reunion was a culmination of the camp, and all participants were invited. A focus group was conducted to determine ideas for development of future camps. There were 19 campers in attendance, with data collection of height/weight, BMI, and blood pressure. Research is being conducted for an adolescent nutrition and fitness camp that will allow community partners to facilitate camps in their community. The camp will mirror Camp iRock and include these goal areas: self-confidence, healthy eating behaviors, nutrition, and physical activity. The indicator is in progress.

MHI Testimonials

Stephens Community Health Fair:

The MHI collaborated with Pastor Wilfred Cross (Mt. Pleasant AME) for a community health outreach initiative in Stephens, Arkansas (Ouachita County). According to the 2013 US Census, less than 900 people reside in Stephens. Also, Ouachita County ranks poorly (62 of 75 counties in Arkansas) in overall Health Outcomes, according to Robert Wood Johnson's County Health Rankings.

Ninety-three individuals attended the event, representing faith-based, community, and health organizations from Columbia, Jefferson, Lafayette, Ouachita, Nevada, Mississippi, and Pulaski counties. Of those who reported their age, 66% were age 50 and over. A total of 640 screenings were documented, most of which (73%) were related to heart disease and stroke (blood pressure, glucose, cholesterol, heart rate, weight, BMI, and EKG). Many attendees (72%) obtained three or more preventive screenings. Individuals who received abnormal results were able to talk with an Advanced Practice Nurse. Also, 75 of the 93 attendees obtained an EKG, and a cardiologist from CHI St. Vincent discussed results with individuals who were screened. Those who received abnormal results were provided information for CABUN Rural Health and Ouachita Medical Center for follow-up.

White River Medical Center Health Fair:

Free screenings, immunizations, nutrition tips, and fresh food samples were just a portion of the day's offerings at the WRMC Health Fair. The event was well attended by the community. Jerrika, a WRMC Marketing Specialist, relayed her experience with the hospital, "I have only worked for the hospital since February, but I am in love with my job, coworkers, and our patients. It is a joy to be employed where healthcare professionals have such a charismatic attitude." It is this type of character and charisma that meet participants at MHI-sponsored health events across the state.

Tobacco Prevention and Cessation Program (TPCP)

Debbie Rushing, Branch Chief

UCA ATSC Evaluator: Janet Wilson, PhD

Protecting Your Health

Tobacco Prevention and Cessation Program (TPCP)

Moving the Needle

Youth smoking prevalence reduced to 15.7% from 19.1%, a decrease of 17.8%.
(YRBSS 2015)

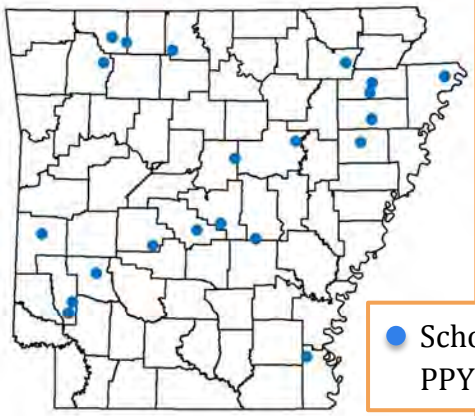
Implementation of 448 new smoke-free/tobacco-free policies in 2016 and 2017.

Young adult smoking prevalence decreased to 21.3% from 29.6%, a decrease of 28%.
(BRFSS 2016)

In 2017, TPCP offered 29 educational sessions for tobacco retail owners and clerks with 858 attendees.

Youth Engagement

More than 3,800 youth engaged in tobacco control activities through the Project Prevent Youth Coalition (PPYC). The map shows where PPYC Advisors are located across Arkansas.



Training Providers

The goal to train 410 health providers by June 2017 was exceeded by 286% as 1,584 providers were trained.

Economic Impact

$1.5 Million in Savings

TPCP collaborated with Local Public Housing Authorities in the adoption of federal smoke-free multi-unit housing (MUH) policies. In 2017, policies were implemented in three MUHs covering **243 units and 535 residents**. The significance of these policies is the cost savings recognized by smoke-free facilities. National estimates suggest a 2-7 fold increased cost of maintaining smoking apartments versus smoke-free apartments, or about **$1.5 million in savings in Arkansas**.

TPCP Evaluator Summary & Comments

Program Description: The Arkansas Department of Health (ADH) Tobacco Prevention and Cessation Program (TPCP) includes community and school education tobacco prevention programs, enforcement of youth tobacco control laws, tobacco cessation programs, health communications, and awareness campaigns. The TPCP also sponsors statewide tobacco control programs that involve youth to increase local coalition activities, tobacco-related disease prevention programs, minority initiatives and monitoring, and evaluation. TPCP follows the Centers for Disease Control and Prevention (CDC) *Best Practices for Tobacco Control 2014* as a guide for program development. Outcomes achieved by Arkansas's TPCP include a reduction in disease, disability, and death related to tobacco use by preventing initial use of tobacco by young people, promoting quitting, eliminating exposure to secondhand smoke, and educating Arkansans about the deleterious health effects of tobacco use.

Economic Impact: In FY 2016, the Tobacco Prevention and Cessation Program Account received 31.6% (or $14,112,312.40) of the Tobacco Settlement Program funds. As directed by the Tobacco Settlement Proceeds Act, 15% of those funds (or $2,116,846.86) are deposited into the Minority Communities Special Account. The remaining 85% (or $11,995,465.54) was utilized by TPCP and partners in FY 2016. Tobacco Prevention and Cessation Program Account funds distribution percentage was reduced, however, in FY 2017 by 4.4%. Act 894 of 2015 modified the FY 2016 distribution, directing the transfer of approximately $2,000,000 from the Tobacco Prevention and Cessation Program Account to the Medicaid Expansion Program Account on July 1, 2016. Thus, in FY 2017, the Tobacco Prevention and Cessation Program Account received only 27.2% (or $12,011,070.38) of the Tobacco Settlement Program funds; the Minority Communities Special Account received 15% or $1,801,660.56 and TPCP and their partners received 85% or $10,209,409.82.

Even working with a smaller budget, TPCP has been able to support programming and legislation that has a positive economic impact on the state. One example is the collaborative effort to assist Local Public Housing Authorities (PHAs) in the adoption of federal smoke-free

multi-unit housing policies. In 2017, policies were implemented in three multi-unit facilities covering 243 units and approximately 535 residents. The significance of these policies is the cost savings recognized by smoke-free facilities. Savings arise out of fewer maintenance costs for heating and air units and building maintenance through painting or flooring replacement, better air quality so fewer breathing challenges, and safety increases due to fewer fires from unattended smoking devices. While there are no specific Arkansas estimates, national estimates suggested a 2-fold to 7-fold increased cost of maintaining smoking apartments versus smoke-free apartments or about $1.5 million in savings in Arkansas.

CHALLENGES:

- In 2016, the TPCP program experienced a replacement in the Branch Chief position. Fortunately, the Associate Branch Chief at that time, Debbie Rushing, was promoted to the new position thus minimizing the disruption that comes with a change in leadership. Additionally, a new University of Central Arkansas program evaluator was brought in June 1, 2017.
- During the past two years, hiring freezes and uncertainty in funding levels have led to challenges for TPCP in recruiting and maintaining staff. Operating with a less than full staff impacts program implementation efforts. Partner agency position vacancies are also challenging since they impact the ability to complete programming. For example, in 2017 Project Prevent Youth Coalition (PPYC) recruitment numbers of advisors and youth engagement numbers were lower in the final quarter than expected due to a position vacancy. That position has since been filled, so we expect a return to higher recruitment and youth engagement numbers.
- The Youth Risk Behavior Surveillance System (YRBSS) data indicate success in dropping the Arkansas youth (high school age) tobacco use (cigarette, smokeless, and cigar) prevalence rate (the rate of 26.2% is well below the goal of 29.6%). However, tobacco use (cigarette and smokeless) prevalence by young adults (18-24 year olds) has not met the indicator goal of 25.8%. The Behavioral Risk Factor Surveillance Systems

(BRFSS) data indicate the tobacco use prevalence rate for young adults (18-24) decreased to 30.2% (from a starting point of 32.3%). TPCP and partner agencies are challenged to continue this trend. A potential legislative change supported by TPCP that may assist in targeting this particular group of smokers is increasing the smoking age to 21. In the 2017 legislative session, TPCP supported the T21 Bill that would have raised the legal age of smoking to 21. This Bill, however, failed by nine votes. Research indicates that Chicago has seen positive impacts from raising their age of purchase to 21.

OPPORTUNITIES: A major area of opportunity for TPCP over the previous two years can be found in the use and support of social media outlets to reach Arkansans about the harms of tobacco consumption. A few examples of social media campaigns are provided below:

- In August 2016, the Arkansas Community Foundation published a magazine called *Engage*. The magazine contained numerous articles providing information regarding tobacco control, as well as the support of and need for comprehensive smoke-free indoor air.
- In November 2017, the *Arkansas Democrat-Gazette* published a story in reference to the Tobacco Industry Corrective Statements. The Department of Justice initiated a lawsuit against the tobacco industry for violating civil racketeering laws. After 11 years of appeals, tobacco companies were required to run advertisements regarding the damaging health effects of smoking—the first of which began running November 26, 2017. Within Arkansas, these advertisements will be run in the *Little Rock Sun*, a weekly paper that targets African American readers.
- In December 2017, a focus group was utilized to test messaging that was developed from conversations with previous tobacco users who quit cold turkey (i.e., without assistance) and current tobacco users. There were three cold turkey campaigns tested. All three campaigns were highly rated, but the "Proud Quitter" campaign provided the strongest motivation, according to the focus group participants. The "Stop. Start." campaign was also perceived as effective and highly motivating. TPCP will proceed with production on both campaigns during 2018.

TPCP employees continue to interact and collaborate with others outside of Arkansas to become better informed about the challenges of and best practices for reducing tobacco consumption. Two examples are as follows:

- In 2016, TPCP participated in the Association of State and Territorial Health Officials (ASTHO) Smoke-Free Housing Virtual Learning Community webinar series. This was a six-month training program to increase a state's capacity to more effectively coordinate statewide smoke-free housing initiatives to reduce secondhand smoke exposure.
- In 2017, an abstract was accepted for a poster presentation at the Society for Research on Nicotine and Tobacco 2018 annual conference.

TPCP continues to foster strong relationships with partner agencies and sub-grantees. Two recent examples follow:

- In 2017, sub-grantees worked to promote the Great American Smoke-Out (GASO). To assist in these tobacco control efforts, Mayors of Conway, Russellville, and Dardanelle issued proclamations of support for GASO.
- The annual Project Prevent Youth Coalition (PPYC) Conference was hosted on October 31, 2017 at Heifer Village in Little Rock. The theme was "Escaping Big Tobacco… Prevention is Key!" There were 149 students and 17 advisors in attendance. The conference covered all of the Taking Down Tobacco trainings as well as a tobacco-control escape room. Although the PPYC Coordinator position was vacant during the coordination of this conference, Arkansas Children's Hospital Community Outreach team hosted and implemented the event successfully.

EVALUATOR COMMENTS

During this biennium period, the Tobacco Prevention and Cessation Program has seen much success in meeting the goals of stated indicators, especially those related to decreasing tobacco use in youth, including youth in tobacco control activities, implementing new smoke-free/tobacco-free policies in communities across Arkansas, and decreasing sales to minor

violations through educational sessions for tobacco retail owners and/or clerks. There is optimism that the tobacco use prevalence rate among young adults (18-24) and disparate populations (LGBT, Hispanics, African Americans, and Pregnant Women) may be decreased through such activities as social media campaigns and potential legislation related to increased age to purchase tobacco. Whether we see the passage of new legislation, TPCP will continue its pursuit of best practices for tobacco control.

It is important to recognize, however, that TPCP participates in programming that goes far beyond what is captured in the 10 indicators below. Thus, a major goal that was achieved at the December 2017 meeting of the Arkansas Tobacco Settlement Commission was the approval of 36 new or updated indicators. Beginning with the January-March 2018 quarter, TPCP will be reporting on indicators that better capture the nine program components dictated by the Tobacco Settlement Proceeds Act, provide for the evaluation of School-Based Health Clinics and their use of the Vital Signs protocol (2As and R - Ask, Advise, and Refer) as established by Act 1220, and include activities which are supported by the Minority Communities Special Account administered at the University of Arkansas at Pine Bluff.

TPCP Performance Indicators and Progress

Overall Program Goal: To reduce the initiation of tobacco use and the resulting negative health and economic impact.

LONG-TERM OBJECTIVE
Survey data will demonstrate a reduction in numbers of Arkansans who smoke and/or use tobacco.

2016 INDICATORS	*2017 INDICATORS*
Indicator: By March 2020, decrease the tobacco use prevalence (cigarette, smokeless, and cigar) in youth by 7% (a decrease from 32% to 29.6%) and tobacco use prevalence (cigarette and smokeless) in young adults (18-24) by 7% (a decrease from 27.7% to 25.8%). [Data Source: Youth Risk Behavior Surveillance System (YRBSS) 2013 & Behavioral Risk Factor Surveillance System (BRFSS) 2013].	**Indicator**: By March 2020, decrease the tobacco use prevalence (cigarette, smokeless, and cigar) in youth by 7% (a decrease from 32% to 29.6%) and tobacco use prevalence (cigarette and smokeless) in young adults (18-24) by 7% (a decrease from 27.7% to 25.8%). [Data Source: Youth Risk Behavior Surveillance System (YRBSS) 2013 & Behavioral Risk Factor Surveillance System (BRFSS) 2013].
Activity: The YRBSS 2015 data indicate the youth (high school age) tobacco use prevalence rate is 26.2% (well below the goal of 29.6%). BRFSS 2016 data indicate the tobacco use prevalence rate for young adults (18-24) decreased to 30.2% (from a starting point of 32.3%). The indicator was met for youth, but not for young adults.	**Activity**: New data will be available in 2018. However, as noted in the Activity report for 2016, TPCP has met the reduction in the tobacco use prevalence rate goal for youth. The indicator is in progress.
Indicator: By March 2020, decrease tobacco use among disparate populations (LGBT, Hispanics, African American, and Pregnant Women) by 2 percentage point change (Data Source: LGBT Survey, BRFSS, Vital Statistics Data).	**Indicator**: By March 2020, decrease tobacco use among disparate populations (LGBT, Hispanics, African American, and Pregnant Women) by 2 percentage point change (Data Source: LGBT Survey, BRFSS, Vital Statistics Data).
Activity: TPCP is making progress towards these goals, with the exception of the tobacco use rate for Hispanics and African Americans. The LGBT survey will be completed in 2017, pending funding. The Hispanic tobacco use prevalence rate increased from 17.7% to 21.4%, and the rate for African	**Activity**: Baseline and goal tobacco use prevalence rates have been clarified. The LGBT baseline survey was conducted in 2014 using a purposive sample of 281. Clarified goals include reducing LGBT smoking prevalence from 37% to 35% and smokeless tobacco from 24% to 22%. Due to lack

Americans increased from 23.0% to 28.9%, according to the BRFSS 2015 report. The pregnancy tobacco use prevalence rate is 14.9%, according to the new data collection methodology that utilizes electronic medical records (EMR). The indicator is in progress.	of funding, the LGBT survey was not conducted again in 2017. Utilizing the Adult Tobacco Survey (2016), the goal reduction in Hispanic smoking prevalence is from 13% to 11% and African American smoking prevalence from 21.3% to 19.3%. Utilizing the Vital Statistics report for 2013, the goal reduction in smoking prevalence for pregnant women is from 13.1% to 11.1%. Progress towards indicator goals will be provided in 2018.
Indicator: By March 2020, decrease smoking prevalence among youth by 10.5% (a decrease from 19.1% to 17.1%) and among adults (18 to 24 year olds) by 7.7% (a decrease from 23.9% to 22.1%) (Data Source: 2015 YRBSS, 2013 BRFSS).	**Indicator:** By March 2020, decrease smoking prevalence among youth by 10.5% (a decrease from 19.1% to 17.1%) and among adults (18 to 24 year olds) by 7.7% (a decrease from 23.9% to 22.1%) (Data Source: 2015 YRBSS, 2013 BRFSS).
Activity: According to the YRBSS 2015, youth smoking prevalence has been reduced to 15.7% (well below the goal of 17.1%). The BRFSS 2016 data indicate smoking prevalence for young adults (18-24 year olds) has decreased from 29.6% to 21.3%. The indicator was met.	**Activity:** New data will be available in 2018. However, as noted in the Activity report for 2016, TPCP has met the reduction in the smoking prevalence goal for youth and young adults. The indicator is in progress.

SHORT-TERM OBJECTIVE

Communities shall establish local tobacco prevention initiatives.

2016 INDICATORS	*2017 INDICATORS*
Indicator (a) (January – June): By March 2016, 96 new smoke-free/tobacco-free policies will be implemented across Arkansas (Data Source: TPCP Policy Tracker).	
Activity: The goal of 96 new policies being implemented was exceeded with the establishment of 445 new policies. These included policies at various workplaces, parks/festivals/farmers' markets, faith-based organizations, schools, multi-unit housing complexes, and one comprehensive city policy. The indicator was met.	
Indicator (b) (July – December): By June 2017, 100 new smoke-free/tobacco-free policies will be implemented across Arkansas (Data Source: TPCP Policy Tracker).	**Indicator**: By June 2017, 100 new smoke-free/tobacco-free policies will be implemented across Arkansas (Data Source: TPCP Policy Tracker).

Activity: From July 2016 through December 2016, 39 new smoke-free/tobacco-free policies were implemented. The indicator is in progress.	**Activity**: This goal was exceeded with the establishment of 157 new smoke-free/tobacco-free policies by June 2017. TPCP contributed to the development of 83 policies at various workplaces, parks/festivals, faith-based institutions, schools, and multi-unit housing complexes, while the Minority Initiative Sub-Recipient Grant Office (MISRGO) contributed to 74 policies. During July-December 2017, an additional 71 new policies were implemented (33 by TPCP and 38 by MISRGO). The indicator was met.
Indicator (a) (January – June): By March 2016, decrease sales to minor violations from 11% to 9% (Data Source: FY 2014 Arkansas Tobacco Control). **Activity:** This goal was met with a 6.27% non-compliance rate. Although the indicator goal of 9% was achieved, TPCP recommends continued monitoring of sales to minor violations as ACT 1235 rules and regulations are implemented throughout the state. The indicator was met.	
Indicator (b) (July – December): By June 2017, decrease sales to minor violations from 11% to 9% (Data Source: FY 2014 Arkansas Tobacco Control). **Activity:** The current non-compliance rate is 5%, well below the targeted 9%. The indicator was met.	**Indicator**: By June 2017, decrease sales to minor violations from 11% to 9% (Data Source: FY 2014 Arkansas Tobacco Control). **Activity:** By the final quarter of 2017, the non-compliance rate of sales to minors increased to 7.2%, which remains below the goal of 9%. Additionally, during 2017, there were 29 educational sessions for tobacco retail owners and/or clerks with 858 attendees. The indicator was met.
Indicator (a) (January – June): By March 2016, increase by 20% the proportion of youth and young adults up to age 24 who engage in tobacco control activities to include point of sale, counter marketing efforts, and other advocacy activities to increase tobacco free social norms (Data Source: Youth Prevention Program Participation FY 2014). **Activity:** The target goal was the engagement of 205 youth and young adults in tobacco control activities. During this time, 789 youth and young adults were involved in tobacco control activities. The indicator was met.	

Indicator (b) (July – December): By June 2017, increase by 25% the proportion of youth and young adults up to age 24 who engage in tobacco control activities to include point of sale, counter marketing efforts, and other advocacy activities to increase tobacco free social norms (Data Source: Youth Prevention Program Participation FY 2014).	**Indicator:** By June 2017, increase by 25% the proportion of youth and young adults up to age 24 who engage in tobacco control activities to include point of sale, counter marketing efforts, and other advocacy activities to increase tobacco free social norms (Data Source: Youth Prevention Program Participation FY 2014).
Activity: The target goal was the engagement of 257 youth and young adults in tobacco control activities. During this time, 1,035 youth and young adults were involved in tobacco control activities. The indicator was met.	**Activity:** With the goal of an additional 257 youth engaged during January-June, Project Prevent Youth Coalition (PPYC) connected with 1,714 students through statewide coalition meetings, *My Reason to Write*, Taking Down Tobacco presentations, Health and Safety Day at the zoo, Big Pitch Film Festival, and engagement through the Remind mobile app. Additional PPYC activities included recruiting nearly 200 new members and offering presentations to 340 teachers, school administrators, and partners to broaden PPYC's reach. During July-December, 150 underserved youth were reached by PPYC through the Derek Lewis Foundation summer program, and 149 students and 17 advisors participated in the annual PPYC statewide conference entitled, "Escaping Big Tobacco... Prevention is Key". The indicator was met.
Indicator (a) (January – June): By March 2016, increase Arkansas' quit rates for the Arkansas Tobacco Quitline from 27.7% to 29.7% (Data Source: ATQ FY 2014 Evaluation Report, 7-month follow-up of multiple calls with NRT quit rate).	
Activity: The FY15 quit rate was 28.8%. While this was a change in the right direction, it is slightly below the indicator goal of 29.7%. The indicator was not met.	
Indicator (b) (July – December): By June 2017, increase Arkansas' quit rates for the Arkansas Tobacco Quitline from 28.9% to 29.7% (Data Source: ATQ FY 2014 Evaluation Report, 7-month follow-up of multiple calls with NRT quit rate).	**Indicator:** By June 2017, increase Arkansas' quit rates for the Arkansas Tobacco Quitline from 28.9% to 29.7% (Data Source: ATQ FY 2014 Evaluation Report, 7-month follow-up of multiple calls with NRT quit rate).
Activity: The FY15 quit rate was 28.8%. This rate decreased to 27.9% in FY16. The indicator was met.	**Activity:** There are no new indicator data. The FY16 quit rate was 27.9%. Legislative funding for support of the analysis of Quitline data was not renewed during 2017, thus updated quit rates will not be available. The indicator is in progress.

Indicator (a) (January – June): By March 2016, increase the number of callers to the Arkansas Tobacco Quitline from 245 to 294 for Hispanics; 2,596 to 3,115 for African American; 476 to 571 for LGBT (Data Source: ATQ Yearly Demographic Report, 2014).	
Activity: In FY16, there were 175 Hispanic, 1,686 African American, and 327 LGBT calls to the Arkansas Tobacco Quitline. Calls to quitlines are down across the country. The indicator was not met.	
Indicator (b) (July – December): By June 2017, increase the number of callers to the Arkansas Tobacco Quitline to 300 for Hispanics; 3,200 for African American; 500 for LGBT, and 150 for pregnant women (Data Source: ATQ Yearly Demographic Report, 2014).	**Indicator:** By June 2017, increase the number of callers to the Arkansas Tobacco Quitline to 300 for Hispanics; 3,200 for African American; 500 for LGBT, and 150 for pregnant women (Data Source: ATQ Yearly Demographic Report, 2014).
Activity: TPCP is making progress towards the goal with the following calls to the Arkansas Tobacco Quitline: 88 Hispanics, 785 African Americans, 172 LGBT, and 58 pregnant women. The indicator is in progress.	**Activity:** By December 2017, calls to the Arkansas Tobacco Quitline were reported as the following: 182 Hispanics, 1,644 African Americans, 359 LGBT, and 105 pregnant women. The indicator was not met.
Indicator (a) (January – June): By June 2017, decrease the overall rate of pregnant women reporting tobacco use during pregnancy from 13.1% to 12.1% (Data Source: 2013 Vital Statistics Data).	
Activity: Due to a change in the methodology used to gather data on the overall rate of pregnant women reporting tobacco use during pregnancy (from self-reported to physician-reported), it is recommended that the baseline rate be changed to 14.9%. Thus, no measure of the original indicator is provided.	
Indicator (b) (July – December): By June 2017, decrease the overall rate of pregnant women reporting tobacco use during pregnancy from 14.9% to 13.9% (Data Source: 2014 Vital Statistics Data).	**Indicator:** By June 2017, decrease the overall rate of pregnant women reporting tobacco use during pregnancy from 14.9% to 13.9% (Data Source: 2014 Vital Statistics Data).
Activity: The 2015 Vital Statistics indicated the smoking prevalence for pregnant women has decreased from 14.9% to 14.4%. The indicator is in progress.	**Activity:** No new data to report. This short-term indicator duplicates the second long-term indicator (which sets a 2% reduction of smoking prevalence among pregnant women from 14.9% to 12.9%).

	Because of duplication, we proposed the deletion of this indicator when we sought approval in December for updated and new indicators. This deletion was approved by the Commission.
Indicator (a) (January – June): By March 2016, increase number of healthcare providers, traditional and nontraditional, from 3,116 to 3,500 who have been reached by the STOP program (Data Source: FY 2014 End of Year Summary Report for STOP from Alere).	
Activity: This indicator calls for an increase of 384 healthcare providers who have been reached by the STOP program. During this time, 347 healthcare providers attended the UAMS continuing medical education trainings, 31 people attended Tobacco Treatment trainings and/or Dimensions Training, and 60 school nurses attended trainings on school-based wellness (for a total 438 providers). The indicator was met.	
Indicator (b) (July – December): By June 2017, increase number of healthcare providers, traditional and nontraditional, by 410 who have been reached by TPCP trainings (Data Source: FY2014 End of Year Summary Report).	**Indicator:** By June 2017, increase number of healthcare providers, traditional and nontraditional, by 410 who have been reached by TPCP trainings (Data Source: FY 2014 End of Year Summary Report).
Activity: During this time, 176 healthcare providers were trained. The indicator is in progress.	**Activity:** The number of healthcare providers trained in 2017 far exceeded the goal of 410. There were 1,584 healthcare providers trained, including those working in the areas of nursing, medical practice, registered dieticians, allied health, mental health, and substance abuse. The indicator was met.

TPCP Testimonials

Newport Tobacco-free Parks:

In the summer of 2016, the City of Newport voted down tobacco-free parks. Not letting this decision deter them from their goal, the Jackson County Community Health Coalition went back to the table to create an action plan to secure a tobacco-free park policy for the community. Coalition members successfully carried out the action plan. In October of 2017, the City of Newport passed a city ordinance for tobacco-free parks. A city official in Newport relayed this message, "We realize our County Health Rankings are low and in order to improve we must make changes in our community. We appreciate the coalition members' efforts to take these first steps to work toward a healthier community and set the example for our youth."

2017 Sub-grantee Kickoff Event

Stephanie Strutner, MPH, CPSII, Executive Director of Allies for Substance Abuse Prevention: After completing her 2-hour presentation on substance abuse prevention, Stephanie shared how passionate she is about public health in her community and across the country, "I am most encouraged by seeing many people from different sectors coming together to address the same community goals and their ability to bring about significant health improvement opportunities through collaboration."

Patrick W. Hunter, Tobacco Education Coordinator for the North Arkansas Partnership for Health Education: "My previous professional career as a law enforcement officer was very rewarding, but I am even more proud now to be able to know that through working with the Tobacco Prevention and Cessation Program that we have the opportunity to help adolescents understand the importance of their decisions concerning substance abuse and the power to positively improve their lives."

Tobacco Settlement Medicaid Expansion Program (TS-MEP)

Mary Franklin, Director, DHS Division of County Operations

UCA ATSC Evaluator: Joseph Howard, PhD

Vital Support Services

Tobacco Settlement Medicaid Expansion Program (TS-MEP)

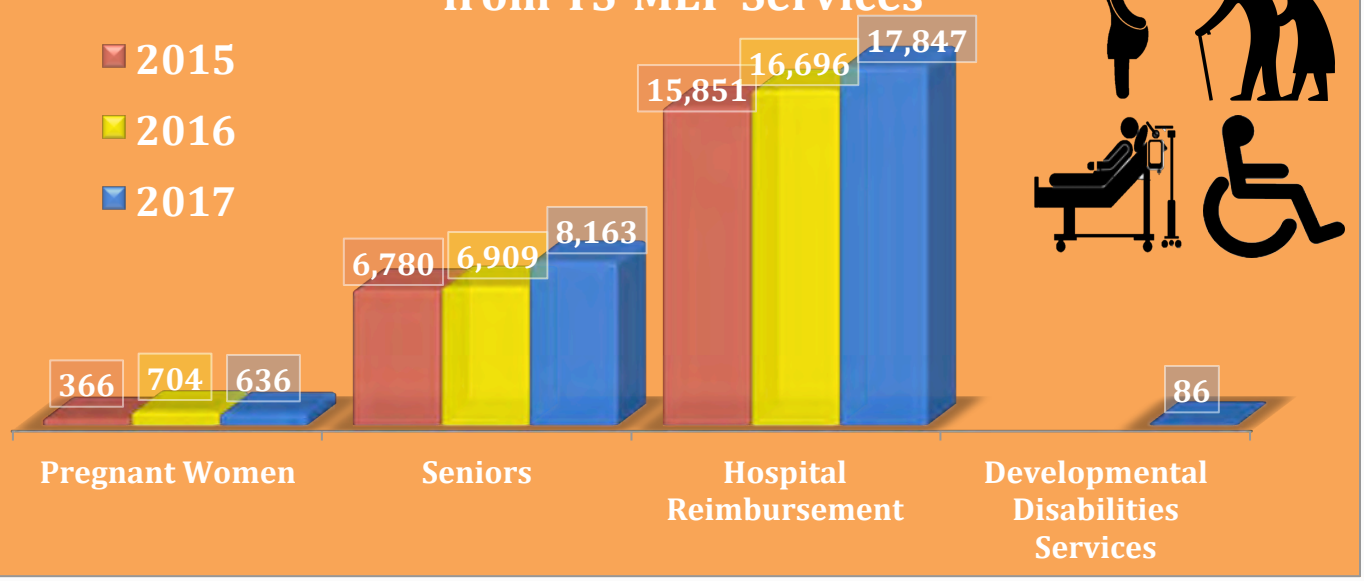
Arkansas Department of Human Services
Tobacco Settlement Medicaid Expansion

Serving Vulnerable Populations

Over the course of the biennium, TS-MEP increased coverage by 14% from 2015 levels.

50,955 Arkansans Covered in 2016-17

Number of Arkansans Benefitting from TS-MEP Services



New Population

In 2016, DHS proposed to add the individuals with **developmental disabilities** as a new coverage group. In early 2017, legislation passed and DHS began providing services for this population in July 2017. It is expected that this new funding **will serve 500 individuals** currently waiting for these services.

Economic Impact

Total claims paid for TS-MEP populations for 2016-2017 was nearly $36.5 million. These funds were used to leverage **federal Medicaid matching dollars** of **$20.1 million**.

TS-MEP Evaluator Summary & Comments

Program Description: The Tobacco Settlement Medicaid Expansion Program (TS-MEP) is a separate and distinct component of the Arkansas Medicaid Program that improves the health of Arkansans by expanding healthcare coverage and benefits to targeted populations. The program works to expand Medicaid coverage and benefits in four populations:

- Population one expands Medicaid coverage and benefits to pregnant women with incomes ranging from 138–200% of the Federal Poverty Level (FPL);
- Population two expands inpatient and outpatient hospital reimbursements and benefits to adults age 19-64;
- Population three expands non-institutional coverage and benefits to seniors age 65 and over;
- Population four expands medical assistance, home and community-based services, and employment supports for eligible (a) adults with intellectual and developmental disabilities and (b) children with intellectual and developmental disabilities.

The Tobacco Settlement funds are also used to pay the state share required to leverage federal Medicaid matching funds.

Economic Impact: For the past biennium, the TS-MEP received 29.8% (in FY16) and 34.2% (in FY17) of the Tobacco Settlement funds. Act 894 of 2015 modified the FY16 fund distribution, directing the transfer of approximately $2,000,000 from the Tobacco Prevention and Cessation Program Account to the TS-MEP Account on July 1, 2016, for the start of FY17. From January 2016 to December 2017, total claims paid for the TS-MEP populations were nearly $36.5 million. The Tobacco Settlement funds are also used to pay the state share required to leverage federal Medicaid matching funds. This amounted to more than $20.1 million in federal matching Medicaid funds.

CHALLENGES: As a result of the implementation of the Arkansas Works program, traditional Medicaid expenditures have decreased. Many Medicaid-eligible adults age 19-64 years old are covered by the Arkansas Works program and receive their coverage through Qualified Health Plans in the individual insurance market. Arkansas Medicaid pays the monthly insurance premiums for the majority of these individuals. For the TS-MEP populations, Pregnant Women Expansion was expected to significantly decline as individuals are provided health coverage outside of TS-MEP. As of now, successful performance has been measured by growth in the number of participants in the TS-MEP initiatives. Arkansas Department of Human Services (DHS) may need to continue to explore new performance measurements for the TS-MEP initiatives as individuals are transitioning into new coverage groups.

OPPORTUNITIES: The discontinuation of TS-MEP initiative ARHealthNetworks provides the opportunity to support the other three TS-MEP populations as well as the state's overall Medicaid efforts. The Department of Human Services (DHS) has had the legislative authority for over ten years to use any savings in the TS-MEP programs to provide funding for the traditional Medicaid. These savings are not used to provide any funding for the Arkansas Works program. As the state of Arkansas continues to explore opportunities for Medicaid reform, new possibilities for using TS-MEP funds may emerge. During the past biennium, DHS proposed to add the individuals with developmental disabilities as a new coverage group. In early 2017, Act 50 of the 91st General Assembly removed the discontinued population (ARHealthNetworks) and added the Developmental Disabilities Services, Community and Employment Supports (CES Waiver) as the new population four group. DHS began providing services for this population in July 2017, and it is expected that this new funding will serve 500 individuals currently waiting for these services.

EVALUATOR COMMENTS
During the biennium, TS-MEP has been affected by the significant changes in the healthcare system. As noted, one of the covered populations (ARHealthNetworks) has been eliminated and replaced with a new population (DDS, CES waiver). Another population, Pregnant Women

Expansion (PWE), was expected to see a significant reduction in the number of participants. The PWE has seen a drop in the number of participants from the previous biennium but has been fairly consistent in the number of women served each year during this biennium. The Hospital Benefit Coverage and the ARSeniors program both have seen an increase in the number of people served over the previous biennium. While there are no immediate plans to change the Pregnant Women Expansion, Hospital Benefit Coverage, and ARSeniors programs, there have been discussions with the director of the TS-MEP to revisit the performance measurements to reflect current changes in the programs.

TS-MEP Performance Indicators and Progress

Overall Program Goal: To expand access to healthcare through targeted Medicaid expansions, thereby improving the health of eligible Arkansans.

LONG-TERM OBJECTIVE
Demonstrate improved health and reduce long-term health costs of Medicaid eligible persons participating in the expanded programs.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Demonstrate improved health and reduced long-term health costs of Medicaid eligible persons participating in the expanded programs.	**Indicator**: Demonstrate improved health and reduced long-term health costs of Medicaid eligible persons participating in the expanded programs.
Activity: With the implementation of the Arkansas Works program, more individuals will have health coverage beyond the TS-MEP initiatives. Therefore, the TS-MEP long-term impact will be limited compared to the influences outside of the TS-MEP. From January 2016 to December 2016, TS-MEP provided expanded access to health benefits and services for 24,309 eligible pregnant women, seniors, and qualified adults. This is an increase from 22,997 persons served in 2015. The indicator was met.	**Activity**: From January 2017 to December 2017, TS-MEP provided expanded access to health benefits and services for 26,646 eligible pregnant women, seniors, qualified adults, and persons with developmental disabilities. This is an increase from 24,309 persons served in 2016. The indicator was met.

SHORT-TERM OBJECTIVE
The Arkansas Department of Human Services will demonstrate an increase in the number of new Medicaid eligible persons participating in the expanded programs.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Increase the number of pregnant women with incomes ranging from 138-200% of the FPL enrolled in the Pregnant Women Expansion.	**Indicator**: Increase the number of pregnant women with incomes ranging from 138-200% of the FPL enrolled in the Pregnant Women Expansion.
Activity: Between January 2016 and December 2016, there were 704 participants in the TS-MEP initiative Pregnant Women Expansion program. This program provides prenatal health services for pregnant women with incomes ranging from 138–200% FPL. The TS-MEP funds for the Pregnant Expansion program totaled $921,706 in 2016. With the implementation of Arkansas Works and other healthcare options provided through the federally facilitated marketplace for this population, a significant decline in the number of participants in the TS-MEP Pregnant Women Expansion program was anticipated. However, there was a significant increase from the 366 women served in 2015. The indicator was met.	**Activity**: Between January 2017 and December 2017, there were 636 participants in the TS-MEP initiative Pregnant Women Expansion program. The TS-MEP funds for the Pregnant Expansion program totaled $929,232 in 2017. There was a decrease from the 704 women served in 2016. TS-MEP continues to provide vital services to hundreds of pregnant women each year. However, because of the decrease in the number of participants, the indicator was not met.
Indicator: Increase the average number of adults aged 19-64 years receiving inpatient and outpatient hospital reimbursements and benefits through the Hospital Benefit Coverage.	**Indicator**: Increase the average number of adults aged 19-64 years receiving inpatient and outpatient hospital reimbursements and benefits through the Hospital Benefit Coverage.
Activity: From January 2016 to December 2016, the TS-MEP initiative Hospital Benefit Coverage increased inpatient and outpatient hospital reimbursements and benefits to 16,696 adults age 19-64, up from 15,851 in 2015, by increasing the number of benefit days from 20 to 24 and decreasing the co-pay on the first day of hospitalization from 22% to 10%. In 2016, TS-MEP funds for the Hospital Benefit Coverage totaled $5,221,348. The indicator was met.	**Activity**: From January 2017 to December 2017, the TS-MEP initiative Hospital Benefit Coverage provided inpatient and outpatient hospital reimbursements and benefits to 17,847 adults age 19-64, up from 16,696 in 2016, In 2017, TS-MEP funds for the Hospital Benefit Coverage totaled $3,992,446. The indicator was met.
Indicator: Increase the average number of persons enrolled in the ARSeniors program, which expands non-institutional coverage and benefits for seniors age 65 and over.	**Indicator:** Increase the average number of persons enrolled in the ARSeniors program, which expands non-institutional coverage and benefits for seniors age 65 and over.
Activity: The ARSeniors program expanded Medicaid coverage to 6,909 seniors between January 2016 and December 2016. In 2015, 6,780 seniors were covered through the ARSeniors program. Qualified Medicare Beneficiary	**Activity:** The ARSeniors program increased Medicaid coverage to 8,163 seniors between January 2017 and December 2017. In 2016, 6,909 seniors were covered through the ARSeniors program. TS-MEP funds for the ARSeniors

recipients below 80% FPL automatically qualify for ARSeniors coverage. Medicaid benefits that are not covered by Medicare are available to ARSeniors. Examples of these benefits are non-emergency medical transportation and personal care services. TS-MEP funds for the ARSeniors program totaled $12,168,588 in 2016. The indicator was met.	program totaled $14,339,218 in 2017. The indicator was met.
Indicator: Increase the average number of persons enrolled in the ARHealthNetworks program, which provides a limited benefit package to low-income employed adults in the age range of 19-64.	**Indicator (January – June)**: Increase the average number of persons enrolled in the ARHealthNetworks program, which provides a limited benefit package to low-income employed adults in the age range of 19-64. *(Note: The deletion of this indicator was approved by the Commission in June 2017.)*
Activity: The ARHealthNetworks program was discontinued on December 31, 2013, due to implementation of Arkansas Works, previously known as the Arkansas Health Care Independence Program/Private Option. This population is now offered more comprehensive healthcare coverage options through the Arkansas Works program. Individuals with incomes equal to or less than 138% of the FPL are eligible for Arkansas Works program and those with incomes above 138% FPL can access the federally facilitated marketplace to determine their eligibility for federally subsidized private insurance plans. Arkansas Works eligible individuals with exceptional healthcare needs and determined medically frail are enrolled in the traditional Medicaid program.	**Activity:** See 2016 indicator activity.
	Indicator (July – December): Increase the average number of persons enrolled in the Developmental Disabilities Services, Community and Employment Supports (CES Waiver) and note the number of adults and children receiving services each quarter by county. *(Note: The addition of this indicator was approved by the Commission in June 2017.)*
	Activity: During this time period, the process to serve this population began. Based on the waitlist numerical order, the process of eligibility redeterminations was initiated for the first 500 individuals from July 2017 to October 2017. From

	October 2017 to December 2017, 191 individuals were allocated waiver slots with 86 of these individuals provided services through TS-MEP funds. During this quarter, TS-MEP funds for the CES waiver program totaled $158,831. The indicator is in progress.

TS-MEP Testimonial

Stephanie Rozanski, TS-MEP recipient

Stephanie Rozanski is a college student and new mother living in northwest Arkansas, and she explains how access to expanded Medicaid benefits positively impacted her life and the life of her daughter.

"I lost my job at six months pregnant because of pregnancy-related nausea and sickness, and lost my work provided health insurance. I tried to find another job, but for potential employers considering hiring me, I didn't seem very appealing as an employee. I was pregnant, would soon be on maternity leave, and had been too sick to keep my previous job. I wasn't able to find work anywhere and could not afford continuing healthcare insurance coverage payments. Expanded benefits from Medicaid literally saved my life.

I live in a very rural area with limited access to healthcare providers and there is a dilemma with OB-GYNs preferring not to accept new patients with medical concerns after their second trimester of pregnancy, even if they have full coverage insurance. As I battled extreme nausea and sickness throughout my pregnancy, I required prescription medication to keep enough food down to support my unborn child's nutritional needs. Because I had expanded Medicaid coverage, I received the professional prenatal care with check-ups and monitoring for myself and my unborn child, and the prescription medications necessary for our survival.

When it was time for my daughter to be born, she became lodged in a bad position for natural delivery, and I was forced to have an emergency surgical delivery. We were discharged the following day, but had to return to the hospital with a serious infection at the surgical incision site. I was temporarily totally disabled for three months, basically helpless and on strong antibiotics. Expanded Medicaid benefits covered my medications and the disinfection solutions and bandaging supplies essential in my recovery. I am forever grateful that expanded Medicaid benefits gave me the ability to return to work and school, and to know that I can now provide a bright future for my daughter as a healthy mother. Thank you."

UAMS Centers On Aging (UAMS-COA)

Claudia Beverly, PhD, RN, FAAN Director (Outgoing)

Jeanne Wei, MD, PhD, Director (Incoming)

Amy Leigh Overton-McCoy, PhD, GNP-BC, Associate Director

UCA ATSC Evaluator: Ed Powers, PhD

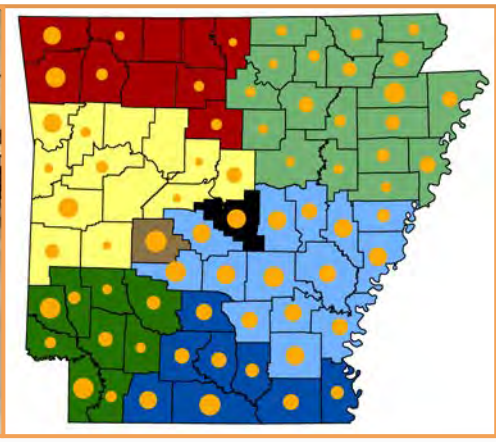
Aging Never Looked So Good

UAMS Centers on Aging (UAMS-COA)

UAMS Donald W. Reynolds Institute on Aging

Lifelong Learning

UAMS-COA **increased community education encounters by 81.2%** between 2016 and 2017, for a total of **128,777 encounters**. The picture shows participants of a "Cooking Side by Side" class held at the Texarkana Regional COA.



- Community Education Encounters per county in FY16 – *Larger dots represent more encounters*
- Northwest Regional service area
- Northeast Regional service area
- West Central Regional service area
- Oaklawn Regional service area
- UAMS service area
- South Central Regional service area
- Texarkana Regional service area
- South Arkansas Regional service area

Quality Care

25,525 education encounters with healthcare professionals and students.

49,445 Health Clinic Encounters

UAMS-COA **increased exercise encounters by 240.7%** between 2016 and 2017.

25,536 Exercise Encounters

Economic Impact

$6.9 Million Leveraged

UAMS-COA leveraged more than $6.9 million in extramural funds, which equates to

$2.25 for every ATSC $1.

$740,000 in volunteer hours and non-cash donations.

UAMS-COA Evaluator Summary & Comments

Program Description: The purpose of the UAMS Centers on Aging (UAMS-COA) is to address one of the most pressing policy issues facing this country: how to care for the burgeoning number of older adults in rural community settings. The overall goal is to improve the quality of life for older adults and their families through two primary missions: an infrastructure that provides quality interdisciplinary clinical care and innovative education programs.

Economic Impact: It is difficult to make precise estimates of the total economic impact of UAMS-COA activities. However, in an era of high medical costs, it is safe to say that any health improvement among the vulnerable older population is likely to have a positive return on investment. UAMS-COA receives slightly more than 3% of ATSC funds annually. This relatively small funding stream provides a broad range of services to the state including:

25,525 education encounters with healthcare professionals and students.

- Training healthcare providers to respond to the unique needs of seniors;
- Directing older Arkansans to appropriate clinical services;
- Elevating community awareness about aging;
- Providing health enrichment activities for older Arkansans;
- Distributing senior health services to underserved portions of the state, and
- Attracting grant funding to improve geriatric healthcare approaches.

Each of these services can be associated with positive economic gains primarily through more efficient and effective management of chronic conditions associated with older populations. UAMS-COA training promotes awareness of best practices for confronting health issues within a geriatric population. Ideally, refined practice saves money by helping to prevent disease conditions from reaching critical and costlier modes. Excellent examples of this during 2016-2017 are campaigns by UAMS-COA to raise awareness about diabetes and to improve dementia diagnosis and treatment.

Another example of positive economic value is the effort by UAMS-COA to increase the number of qualified home caregivers in the state through cooperation with the Schmieding Center for Senior Health and Education. This cooperative alliance with Schmieding is enhancing the workforce with timely skills training in the emerging market of senior care. The Schmieding alliance is also making it feasible for many older adults to continue living in their own homes instead of moving prematurely to costlier nursing or assisted-living facilities. UAMS-COA is currently working to produce more precise estimates of the annual savings represented by these initiatives.

Overall, programs and services provided by UAMS-COA enhance the quality of life for older adults in Arkansas by prioritizing geriatric healthcare and by providing opportunities for seniors to continue being active. Quality of life and access to senior healthcare are important determinants in retirement decision-making. UAMS-COA is positioned to help Arkansas enhance senior health and advance its current low position in national rankings of desirable states to retire (Bernardo, 2017). The ability to support seniors through the end of their lives is likely to become a more pressing economic concern in future years as larger cohorts of baby boomers reach retirement age.

CHALLENGES:

- Staffing continues to be the most critical challenge faced by UAMS-COA. Most of the Centers on Aging are located in regions of the state where it is difficult to find and keep specialized healthcare workers. The challenge is further exacerbated by the fact that the demand for healthcare workers nationwide is growing relative to the capacity to supply such personnel (Supiano & Alessi, 2014). In addition, the leadership of UAMS-COA is in transition as the agency's founding director, Dr. Claudia Beverly, retired in 2017.
- Educational programming is expected to be more of a challenge in coming years because of the increased size and diversity of the population age 65-plus and also because of the uneven distribution of this population in the state. It is a colossal project to identify effective educational models that meet the increasingly diverse needs of an expanding and awkwardly distributed population of seniors.

- Another fundamental challenge faced by UAMS-COA is funding. Most agency activities depend heavily on foundation grants and awards from other external sources. While these large multi-year grants have been instrumental in supporting programming, many of them will expire in coming years. Further, the UAMS system is experiencing budgetary difficulties that threaten to alter some of the funding streams that impact COAs. While the administrative budget of the agency is fully funded through ATSC, future adjustments may need to be made to accommodate UAMS system changes. In order to maintain its prior levels of success, UAMS-COA may need to place added emphasis on cultivating external funding in a highly competitive environment.

OPPORTUNITIES: In June 2017, Dr. Claudia Beverly retired from her position as the founding director of UAMS-COA (formerly the Arkansas Aging Initiative). Transitions in leadership are challenging but such changes can also provide opportunities to revisit the mission and objectives of the agency and to explore new organizational structures and service delivery models. There are a number of society-wide technological and systemic changes that have taken place since the Centers on Aging were originally established. New leadership models might help to leverage societal changes in favor of better services for Arkansas seniors. The core personnel of UAMS-COA appear to be energetic and capable enough to manage this leadership transition and continue advancing positive health options for older Arkansans.

EVALUATOR COMMENTS

UAMS-COA is meeting core objectives and surpassing expectations on all critical indicators. The evidence indicates that UAMS-COA continues to adhere to its mission and meet the vital needs of a large number of seniors throughout the state. As the proportion of adults 65 years or older continues to grow in Arkansas, core functions of UAMS-COA should become even more important to the state.

Changes in the executive leadership of UAMS-COA present an opportunity to re-evaluate objectives and service delivery models in ways that provide more comprehensive services to

senior adults in Arkansas. However, there is substantial confidence in the new leadership and this confidence is expected to carry the agency through the challenges with meeting the needs of seniors in the 21st century.

A number of evaluation indicators were adjusted during this biennial cycle to help better assess UAMS-COA activity. Most importantly, an indicator related to the staffing of Senior Health Clinics was deleted because changes in the structure of the nation's healthcare delivery system minimized influence over Senior Health Clinics. It was determined that UAMS-COA should not be held accountable for clinic staffing decisions. A second adjustment was made to update the external funding indicator for UAMS-COA. The revised external funding indicator is more focused on the ability to leverage ATSC funds into expanded opportunities for Arkansas seniors. There is now a clear goal of finding additional resources for seniors that, at minimum, match ATSC's investment. A third adjustment was made to broaden the objective of channeling seniors into necessary health clinic engagement. Since the hospital partnership model has become outdated, UAMS-COA is now counting its relationships with a more expansive range of local healthcare practitioners in encouraging senior health clinic visits. Finally, a new indicator was added to help promote more intentional strategic planning. UAMS-COA directors will now meet annually to discuss and analyze problems facing Arkansas seniors. Each COA will now develop a clearer annual agenda of priorities and will identify ways to make a measurable impact on the communities they serve.

UAMS-COA Performance Indicators and Progress

Overall Program Goal: To improve the health of older Arkansans through interdisciplinary geriatric care and innovative education programs, and to influence health policy affecting older adults.

LONG-TERM OBJECTIVE
Improve the health status and decrease death rates of elderly Arkansans as well as obtain federal and philanthropic grant funding.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Provide multiple exercise activities to maximize the number of exercise encounters for older adults throughout the state.	**Indicator**: Provide multiple exercise activities to maximize the number of exercise encounters for older adults throughout the state.
Activity: UAMS-COA counted 5,795 exercise encounters with senior Arkansans in 2016. The indicator was met.	**Activity**: UAMS-COA counted 19,741 exercise encounters with senior Arkansans in 2017. Each exercise activity provided through UAMS-COA is evidence-based and customized to meet the needs of older Arkansans. The indicator was met.
Indicator: Implement at least two educational offerings (annually) for evidence-based disease management programs.	**Indicator**: Implement at least two educational offerings (annually) for evidence-based disease management programs.
Activity: UAMS-COA offers numerous evidence-based educational modules throughout the state. Some of the activities offered during the last two years include the Virtual Dementia Experience; Healthy Eating and Tasting (HEAT); Older, Wiser, Livelier Seniors (OWLS); and Diabetic Empowerment Education Program (DEEP). The indicator was met, exceeding expectations.	**Activity**: UAMS-COA offers numerous evidence-based educational modules throughout the state. Some of the activities offered during the last two years include the Virtual Dementia Experience; Healthy Eating and Tasting (HEAT); Older, Wiser, Livelier Seniors (OWLS), and Diabetic Empowerment Education Program (DEEP). The indicator was met, exceeding expectations.
Indicator: Increase the amount of external funding to support programs by the end of FY 2015.	**Indicator (a) (January – June)**: Increase the amount of external funding to support programs by the end of FY 2015.

Activity: UAMS-COA received approximately $2,747,305 in funding from grants during 2016. In addition, the Oaklawn COA received $1,100,674 from the Oaklawn Foundation. Finally, COAs value volunteer hours and other non-cash donations received during 2016 at approximately $278,000. The indicator was met.	**Activity (a):** UAMS-COA received approximately $1,040,320 in funding from grants during the first six months of 2017. In addition, the Oaklawn COA received more than $550,000 from the Oaklawn Foundation. Finally, COAs value volunteer hours and other non-cash donations received during this period at approximately $206,834. The indicator was met.
	Indicator (b) (July – December): On an annual basis, UAMS Centers on Aging will obtain external funding to support programs in amounts equivalent to ATSC funding for that year.
	Activity (b): UAMS-COA received $1,033,231 in grant funding during the last two quarters of the biennium. During the same period, the agency received $487,460 from the Oaklawn Foundation to support initiatives at the Oaklawn COA. Finally, an additional $259,555 in non-cash donations was secured during the period to help support essential operations of the COAs. The total cash funding received by UAMS-COA during these two quarters amounts to $1,520,691 (two times more than the $791,190 in ATSC funding received by the agency during the same period). The indicator was met, exceeding expectations.

SHORT-TERM OBJECTIVE

Prioritize the list of health problems and planned interventions for elderly Arkansans and increase the number of Arkansans participating in health improvement programs.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Assist partner hospitals in maintaining the maximum number of Senior Health Clinic encounters through a continued positive relationship.	**Indicator (a) (January – June)**: Assist partner hospitals in maintaining the maximum number of Senior Health Clinic encounters through a continued positive relationship.
Activity: UAMS-COA assisted in 25,672 Senior Health Clinic encounters during this calendar year. The indicator was met.	**Activity (a):** UAMS-COA assisted in 13,621 Senior Health Clinic encounters during the first two quarters of the biennium. The indicator was met.

	Indicator (b) (July – December): Assist local healthcare providers in maintaining the maximum number of Senior Health Clinic encounters through a continued positive relationship. **Activity (b)**: UAMS-COA assisted local healthcare providers (not limited to partner hospitals) in brokering 10,152 Senior Health Clinic encounters during the final two quarters of this biennium. The indicator was met.
Indicator: Partner hospitals will maintain a minimum of three provider Full Time Employees (FTEs) for Senior Health Clinics including a geriatrician, advanced practice nurse, and social worker.	**Indicator (January – June)**: Partner hospitals will maintain a minimum of three provider Full Time Employees (FTEs) for Senior Health Clinics including a geriatrician, advanced practice nurse, and social worker. *(Note: The deletion of this indicator was approved by the Commission in June.)*
Activity: UAMS-COA has worked diligently to ensure that all Senior Health Clinics are staffed sufficiently. However, the goal of three FTEs per clinic was not maintained during the period. There are a number of external contingencies that prevent UAMS-COA from meeting this goal, the most important being that UAMS-COA has no direct involvement in hiring or paying Senior Health Clinic personnel. The indicator was not met.	**Activity**: UAMS-COA was only able to meet this goal in two locations: Center on Aging-Northeast and Texarkana Regional Center On Aging-Wadley. However, UAMS-COA has no direct control over clinic staffing and the indicator has been deleted (effective July 2017).
Indicator: Provide education programming to healthcare practitioners and students of the healthcare disciplines to provide specialized training in geriatrics.	**Indicator:** Provide education programming to healthcare practitioners and students of the healthcare disciplines to provide specialized training in geriatrics.
Activity: UAMS-COA recorded 10,954 educational contacts with healthcare professionals, paraprofessionals, and students during the calendar year. The indicator was met.	**Activity:** UAMS-COA recorded 14,571 educational contacts with healthcare professionals, paraprofessionals, and students during the calendar year. The indicator was met.
Indicator: Provide educational opportunities for the community annually.	**Indicator:** Provide educational opportunities for the community annually.
Activity: UAMS-COA conducted a variety of community education events throughout Arkansas resulting in 45,799 encounters during the year. The indicator was met.	**Activity:** During 2017, UAMS-COA generated 82,978 educational encounters in community education events throughout Arkansas. The indicator was met.
	Indicator (July – December): On an annual basis, the UAMS Centers on Aging will develop a list of health problems that should be prioritized and education-related interventions that will be implemented for older Arkansans.

	(Note: The addition of this indicator was approved by the Commission in June 2017.) **Activity:** UAMS-COA is working on a better process for identifying and prioritizing healthcare concerns in the state. This process is being developed with the recognition that critical health concerns in one region of the state may differ from those in other regions. Each COA is being charged to identify the key health concerns of its region and develop education-related interventions that are appropriate and practical for the area. The first iteration of this process should be complete by the end of June 2018 with plans to repeat the process annually into the future. This indicator is incomplete as of December 2017, but progress is being made toward its completion.

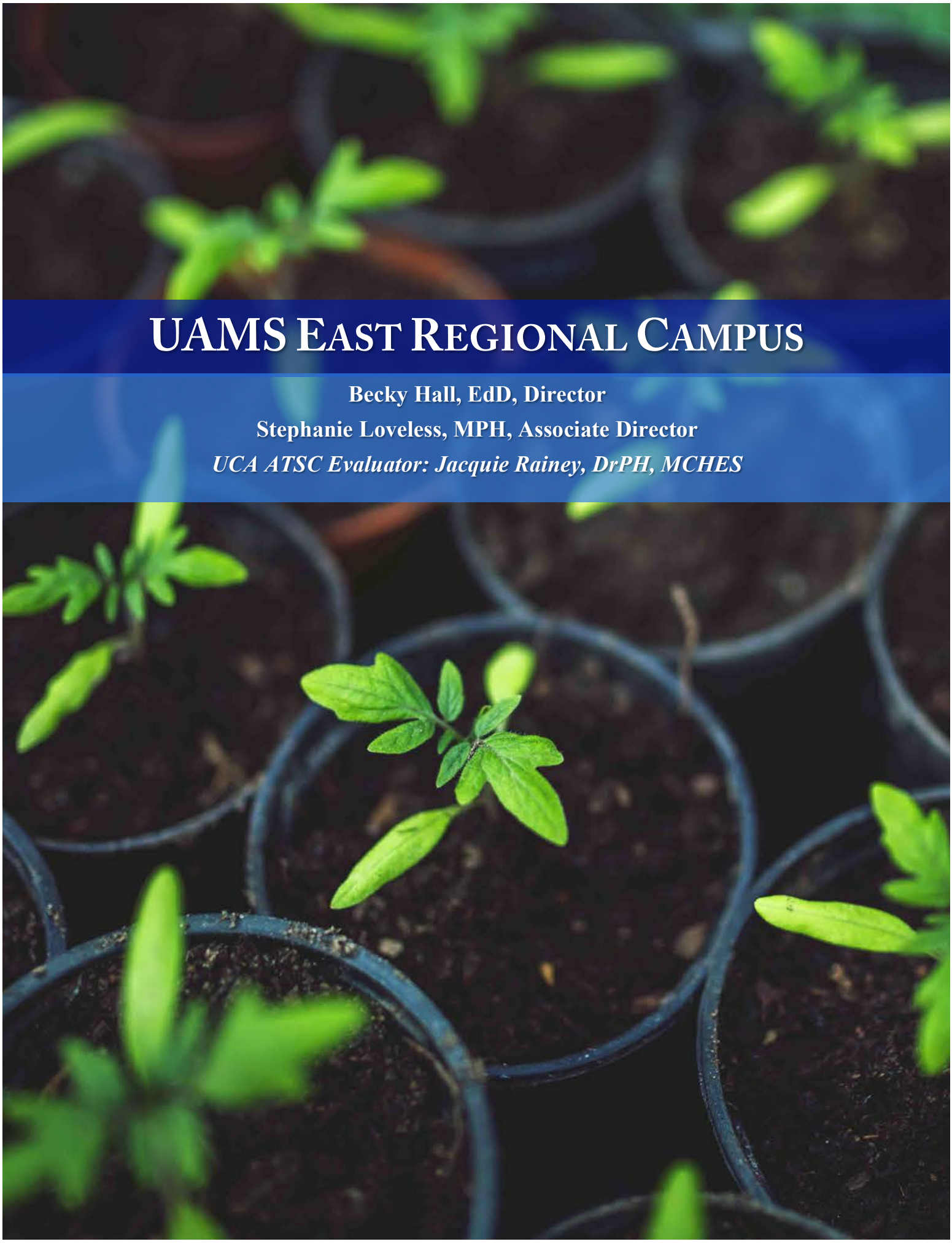
UAMS-COA Testimonial

Edward Ellis, UAMS-COA Outreach

Edward Ellis is a social worker and hospice caregiver who routinely provides education to older adults around the state. Today, Ellis visits a senior citizen center in Van Buren as part of a UAMS-COA outreach program.

A chorus of warm welcomes meets Edward upon entering the senior center. He greets each person as an individual, recalling their first names with ease and inquiring about their family, friends, and pets. Edward's presentation is set to follow Beanbag Baseball, and he reassures the teams that he will not begin the educational presentation on "Maintaining Healthy Aging Skin" until the game is finished. Edward provides an easy-to-read handout and covers multiple topics like skin cancer awareness, pressure sores, shingles, as well as how nutrition, hydrating, and exercise support skin health. Edward completes his presentation in time for the next scheduled Bingo game.

Edward reflects on his experience in Van Buren, "It's an honor for me to be able to share health education information about topics that matter to our senior community members. Our seniors have so much to offer to each other and the community that it is a truly rewarding joy for me to serve them as a resource through the Centers On Aging programs. These programs assist our seniors in maintaining an improved quality of life through their later years."



UAMS East Regional Campus

Becky Hall, EdD, Director

Stephanie Loveless, MPH, Associate Director

UCA ATSC Evaluator: Jacquie Rainey, DrPH, MCHES

Developments From The Delta

UAMS East Regional Campus

UAMS University of Arkansas for Medical Sciences East Regional Campus

Youth Development

A total of **67,360 youth participated in health education programs** in 2016-2017. Youth programs under UAMS East Regional Campus are evidence-based.

10,460 students participated in pre-health professionals recruitment activities.

Clinic Opening

One of the biggest accomplishments for UAMS East Regional Campus was the opening of the **UAMS Family Medical Center in Helena**. The clinic has served an average of **40 patients per day** since opening.

Serving Community

5,055 Health Screenings

132,636 Exercise Encounters

12,510 Adult Education Encounters

20,187 used Library Services

Economic Impact

UAMS East Regional Campus provided **prescription assistance** for an average of 855 clients and 1,007 prescriptions per year for a total cost savings of

$1,331,877.

UAMS East Regional Campus

Evaluator Summary & Comments

Program Description: University of Arkansas Medical Sciences East Regional Campus provides healthcare outreach services to seven counties including St. Francis, Lee, Phillips, Chicot, Desha, Monroe, and Crittenden counties. UAMS East Regional Campus, formerly known as the Delta Area Health Education Center (AHEC) and UAMS East, was established in 1990 with the purpose of providing health education to underserved populations in the Arkansas Delta region. The counties and populations served by UAMS East Regional Campus are some of the unhealthiest in the state with limited access to healthcare services being one of the challenges. As a result of limited access and health challenges, UAMS East Regional Campus has become a full service health education center with a focus on wellness and prevention for this region. The program has shown a steady increase in encounters with the resident population and produced a positive impact on the health and wellness of the region. Programs to address local health needs of residents are being implemented in partnership with more than 100 different agencies. The overall mission of UAMS East Regional Campus is to improve the health of the Delta's population. Goals include increasing the number of communities and clients served and increasing access to a primary care provider in underserved counties.

Economic Impact: UAMS East Regional Campus received approximately 3.5% of the Tobacco Settlement Program funds at $1,552,354 in FY 2016 and $1,534,944 in FY 2017. Additional funds were secured by UAMS in the form of grants, contracts, gifts, and fees for service. Partners for various projects included but are not limited to the Delta Crisis Center, the Greater Delta Alliance for support of the "Cooking Matters" classes and diabetes education, and the Helena Health Foundation provided funding to supply all students in kindergarten through 6th grade in Phillips County with dental supplies. Additionally, they provide funding to support nicotine replacement for participants who attend the smoking cessation classes and emergency medicine vouchers for patients in need.

"Cooking Matters" class, Desha County

Disease prevention and education are critical parts to reaching the goals of the Triple Aim of healthcare reform: improving health and healthcare delivery as well as lowering healthcare costs. UAMS East Regional offices do this by exposing youth to the potential of healthcare careers and supporting the continuing education of healthcare professionals. This work will help to create a more health literate community while reducing disparities and providing income improvement in the Delta. Additionally, UAMS East's programs work at improving health literacy through education of youth, their families, and the community. The knowledge and skills these programs develop will foster individuals' abilities to practice healthy behaviors and to seek appropriate healthcare. Providing opportunities for residents to engage in a healthy lifestyle and to be mindful of their risk factors through screenings enables residents to participate in their own healthcare and take greater responsibility for their health and that of their families.

CHALLENGES: The change in focus to establish and open the clinic is the biggest challenge that UAMS East Regional Campus faced during this biennial period. Hiring and training qualified staff remains an issue for the future. Additionally, a major challenge will be to maintain a robust community-wide health promotion program that meets the needs for primary prevention in the Delta region.

OPPORTUNITIES:

- The Delta Crisis Center will begin to offer direct client services at the East Central Arkansas Community Correction Center in January 2018.
- UAMS East Regional Campus will partner with the Arkansas Department of Health's Chronic Disease Prevention and Control program and the Kettering Foundation to host community conversations on diabetes.
- Plans are on track to begin the process of applying for a rural residency training program. This process will take several years to complete with a projection of the first class beginning in 2020-2021.

EVALUATOR COMMENTS

One of the biggest accomplishments for UAMS East Regional Campus was the opening of the UAMS Family Medical Center in Helena. The Medical Center provides access to quality healthcare in a region that is medically underserved. In addition to clinical services, the medical center will provide numerous patient activation services designed to help patients manage their health. Once the UAMS East Regional Campus has adjusted to the demands of operating a clinic, a thorough evaluation of the remaining indicators, and the programs used to meet those indicators, will need to be conducted. Resources that had been used to provide community-based screening and education programs were redirected to meet the needs for the establishment of the clinic. Opening the clinic required the addition of eight new staff and the conversion of 3,500 feet of space. This change required eliminating six positions that all worked at providing outreach services. Currently, there is one staff member and one contract employee providing outreach services in the Helena office, one employee at the West Memphis office that provides all services, and one full-time and one contract employee at Lake Village. Additionally, two of the remaining positions have taken on additional clinical activities. These changes mean that many outreach programs were offered less frequently or were eliminated. The redirection of resources and funds are the reason that three of the indicators were not met for 2017.

UAMS East Regional Campus continues to partner with other organizations to extend their reach into the community. These sustained partnerships expand the number of services that they can offer and thereby enhance their impact on the community. With the reallocation of resources to the clinic, these partnerships are even more critical to being able to provide the primary prevention programs needed to address the socio-behavioral determinants of health. The multi-faceted approach of education and screening as well as providing opportunities to practice health promoting behaviors, along with healthcare services, employed by UAMS East Regional Campus is the most effective means to improving the quality of life of the residents in the Delta. UAMS East Regional Campus has been very productive during this biennial period. It is recommended that the program continue to provide health education and disease prevention in the communities it serves. The challenge for the next few years will be to find a balance between healthcare delivery and disease prevention and health promotion.

UAMS East Regional Campus Performance Indicators and Progress

Overall Program Goal: To recruit and retain health care professionals and to provide community-based health care and education to improve the health of the people residing in the Delta region.

LONG-TERM OBJECTIVE
Increase the number of health professionals practicing in the UAMS East Regional Campus service areas.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Increase the number of students participating in UAMS East Regional Campus pre-health professions recruitment activities.	**Indicator**: Increase the number of students participating in UAMS East Regional Campus pre-health professions recruitment activities.
Activity: Pre-health professions programs included: "A Day in the Life" for high school students, "Club Scrub" for junior high students, and "CHAMPS" for middle school students. A total of 2,995 youth participated in one of these programs. Health career fairs are another venue to introduce youth to the health professions. Health career information was disseminated to 3,229 people. A total of 6,224 student encounters was recorded by the recruiter in 2016, up from 4,386 encounters in 2015. The indicator was met.	**Activity**: A total of 4,236 encounters with youth interested in pursuing a healthcare career was recorded for this year. Although the recruiter was very active this year, there was a decrease in the number of student encounters from 2016 to 2017. The indicator was not met.
Indicator: Continue to provide assistance to health professions students and residents, including RN to BSN and BSN to MSN students, medical students and other interns.	**Indicator**: Continue to provide assistance to health professions students and residents, including RN to BSN and BSN to MSN students, medical students and other interns.
Activity: Assistance was provided to 44 nursing students and two health education students. The indicator was met.	**Activity**: Assistance was provided to 33 nursing students in 2017. The program is continuing to provide assistance to RN/BSN students and students in the MSN track. The indicator was met.

SHORT-TERM OBJECTIVE
Increase the number of communities and clients served through UAMS East Regional Campus programs.

2016 INDICATORS	*2017 INDICATORS*
Indicator: Increase or maintain the number of clients receiving health screenings, referrals to primary care physicians, and education on chronic disease prevention and management.	**Indicator**: Increase or maintain the number of clients receiving health screenings, referrals to primary care physicians, and education on chronic disease prevention and management.
Activity: Biometric screenings for health markers were conducted for 2,764 participants. Of those screened, 39% were determined to have an abnormal result and the person was provided additional counseling and a referral to a local healthcare provider. The number of screenings decreased slightly from 2015, so the indicator was not met.	**Activity**: The total number of screenings provided in 2017 was 2,291 with 835 (36%) of these being referred for follow-up due to an abnormal result. Screenings were provided throughout the region at various venues and events such as the Forrest City Fishing Rodeo, the Marianna Food Pantry, PSA tests at Superior Uniform Group in Eudora, and the Chicot County Courthouse. In 2017 there was a 17% decrease in the number of screenings performed from the previous year. See Table 1 for a comparison of the abnormal results from the most commonly screened risk factors. Since there was a decrease in the number of screenings conducted this indicator was not met.
Indicator: Maintain a robust health education promotion and prevention program for area youth and adults.	**Indicator**: Maintain a robust health education promotion and prevention program for area youth and adults.
Activity: Health education and promotion programs were provided to youth in all seven Delta counties. A total of 33,755 youth participated in programs such as "Project Alert" to prevent substance abuse, "Farm to You" to explore nutritional health, and "Kids for Health", "Reducing the Risk", and "Making Proud Choices"—all evidence-based health education programs. Programs for adults included topics related to stroke awareness, healthy eating, violence prevention, and getting enough exercise. There were 9,107 participants in 2016. The total number of encounters in health education programs was 42,856. The indicator was met.	**Activity**: For 2017, the number of youth educated was comparable at 33,605. Therefore this aspect of the indicator was met. The number of adults who participated in health education programs decreased by 63%, down to 3,403. Programs included: CPR certification and Basic Life support, baby safety showers and car seat installation, parenting classes, support groups for breast cancer and Autism, "Cook Smart, Eat Smart", "Cooking Matters", and the group lifestyle program. Participants in one of the lifestyle programs lost a combined 99.9 pounds in this 16-week program. The total number of Delta residents who participated in health education programs was

	down by 14%, to a total of 37,008. Although there was an overall decrease in participation, a robust health education program was maintained; therefore, the indicator was met.
Indicator: Increase the number of clients participating in exercise programs offered by UAMS East Regional Campus.	**Indicator:** Increase the number of clients participating in exercise programs offered by UAMS East Regional Campus.
Activity: UAMS East at Helena operates a fitness facility that is available to the community. Fitness center encounters were 29,191 while other community-based physical activity encounters totaled 42,417. The indicator was met.	**Activity:** Fitness center encounters were 26,989, an 8% decrease from the previous year. Other activities offered outside of the fitness center that promote exercise and physical activity include programs such as PEPPI, Silver Sneakers, Zumba, Easy Does it, Adult Boot Camp, Yoga, and fitness walks/runs. The number of physical activity encounters outside of the fitness center was 34,039. This is a 19% decrease from the previous year. The total number of encounters of people engaging in physical activity decreased from 2016 to 2017, so the indicator was not met.
Indicator: Provide crisis assistance to rape victims as needed.	**Indicator**: Provide crisis assistance to rape victims as needed.
Activity: There were 124 calls or texts to the hotline this year. Additionally, 15 clients were provided services and three educational programs were delivered to 230 people. The indicator was met.	**Activity:** This year there were 47 calls or texts to the hotline. The number of clients served increased by 100% to 30 clients. Educational programs were provided to 622 people, for a 170% increase from the previous year. Education programs were delivered at the East Central Arkansas Community Correction Center in West Memphis, Central High School in Helena, and Lee County schools. In cooperation with the Helena Police Chief, the Crisis Center staff worked to implement a Sexual Assault Response Team and a Sexual Assault Nurse Examiner in Helena-West Helena. The indicator was met.
Indicator: Increase or maintain the number of clients in Chicot and Phillips counties receiving prescription assistance.	**Indicator:** Increase or maintain the number of clients in Chicot and Phillips counties receiving prescription assistance.
Activity: The number of clients served was 814 for a total of 1,038 prescriptions at a cost savings of $687,594. The indicator was met.	**Activity:** In 2017, there was a 10% increase in the number of clients served (895). The total number of prescriptions secured decreased to 976 and the cost savings decreased to $644,283. Since the number of clients served increased, the indicator was met.

Indicator: Provide medical library services to consumers, students, and health professionals.	**Indicator:** Provide medical library services to consumers, students, and health professionals.
Activity: The library provided services to 10,190 consumers, 352 students, and 355 health professionals. The indicator was met.	**Activity:** The library provided services to 8,948 consumers, 230 students, and 112 health professionals. The number of services provided from 2016 to 2017 decreased for all three target groups. This indicator is to provide services to these groups, so the indicator was met even though the number of services provided declined.
Indicator: Plan and implement a Rural Residency Training Track for Family Medicine in Helena, in partnership with UAMS South Central's residency program.	**Indicator:** Plan and implement a Rural Residency Training Track for Family Medicine in Helena, in partnership with UAMS South Central's residency program.
Activity: The indicator was on hold pending the opening of the clinic.	**Activity:** The indicator was on hold pending the opening of the clinic.
Indicator: Provide targeted clinical care in Helena.	**Indicator:** Provide targeted clinical care in Helena.
Activity: Throughout this year, construction plans were designed for the renovation of the Helena office and negotiations with a primary care physician were undertaken to staff the clinic. The indicator was on hold pending the opening of the clinic.	**Activity:** Renovations of the Helena campus were completed to change existing office space into eight exam rooms, a lab area, two waiting rooms, a reception area, and a nursing station. Negotiations were conducted with a physician who joined the staff in October. Additional staff members that were hired included three nurses, two access coordinators, a financial counselor, a phlebotomist, and a medical assistant. The grand opening of the UAMS Family Medical Center was held in November. In addition to primary healthcare, the clinic offers patient-centered services such as smoking cessation, weight loss, diabetes education, chronic disease self-management, and the services of a registered dietician. Since opening in October, the clinic has been serving an average of 40 patients per day. Since the clinic is now providing services, the indicator was met.
Indicator: Provide diabetes education to community members and increase the proportion of patients in the diabetes clinic who maintain an A1C below seven.	**Indicator:** Provide diabetes education to community members and increase the proportion of patients in the diabetes clinic who maintain an A1C below seven.
Activity: There were 34 HbA1c tests provided to community members of which 18 (53%) were at seven or above. There were 164 participants in the diabetes education program. The indicator was met.	**Activity:** In 2017, there were 379 participants in the diabetes education programs for a 131% increase over 2016. The participants in the UAMS East Regional Campus Diabetes Prevention Program have lost an average of 3.5% of their body weight and have increased the amount of their

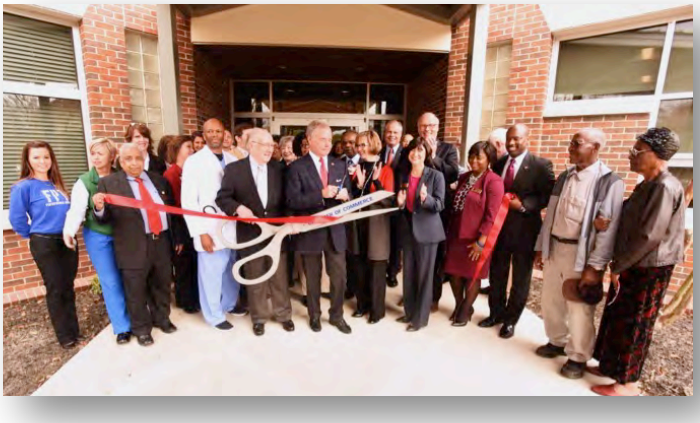
	physical activity per week. There were 110 HbA1c tests provided to participants with only 31 (28%) reported as being elevated to seven or above. This 47% reduction in the number of elevated HbA1c results shows that the indicator was met.

Table 1. Abnormal screenings results per year.

	High Blood Pressure	High Cholesterol	High Glucose	High BMI
2016 2017	327 298	340 272	78 89	258 116

UAMS East Regional Campus Testimonials

UAMS Family Medical Center in Helena, Grand Opening:



The transformation from offices to clinic space is an impressive development and was well supported by a large cross-section of the "Friends of UAMS" community who were present for the grand opening ceremony of the Helena clinic.

State Representative Chris Richey shared, "It's impossible to separate jobs, a healthier community workforce, and economic benefit. Becky Hall [UAMS East Regional Campus Director] got my attention and the need for this facility when I saw the health disparity data. Knowing that the ten-year life expectancy difference between Phillips and Benton counties is improving because of these types of efforts truly shows how important this project is for the Delta. We are really looking towards a better future. Because of the job that Becky and her team are doing, quality of life overall is improved and we know that this positively impacts business in the area."

UAMS Interim Chancellor Stephanie Gardner, Pharm.D., Ed.D., offered this reflection, "UAMS East Regional Campus is critical to our ability to accomplish the goals of our mission at UAMS. Better healthcare service provision to meet the needs of people that live here—and future residency opportunities for primary care providers—support the concept of patient-centered healthcare homes. UAMS East is one of only two regional programs of this nature in the entire U.S., and is praised as a model for other programs. Through the collaboration of the Helena Health Foundation, City of Helena, county extension agencies, Farm Bureaus, the local college, the hospital, and the UAMS endowment, we are able to provide services such as the M.A.S.H. program, local emergency care, prescription assistance, healthcare provider scholarships, and improved community health education and outreach programs. All of these partnerships were necessary to complete the valuable and varied collaborative community health improvement activities."

CONCLUSION

During the biennium, the work of ATSC-funded programs—individually and collectively—have enhanced overall health and well-being of Arkansans. In this report, we have shown (1) collective program efforts in areas of education, service, research, and economic impact; (2) how these efforts drive action towards building a Culture of Health; and (3) individual program progress and accomplishments according to ATSC-approved indicators. In concluding this report, we revisit the economic impact of ATSC funds in the state, review challenges and opportunities across programs, summarize comments from evaluators, and return to our Culture of Health discussion, particularly reflecting on efforts towards advancing equity.

Revisiting Economic Impacts

ATSC-funded programs made a significant economic impact on the state using Tobacco Settlement dollars in 2016-2017. Programs leveraged more than $120 million and promoted health programs and policies that generated millions more in cost savings for the state. ATSC funds also supported hundreds of jobs and contributed to new start-up enterprises. Also, healthcare costs in the state have been impacted by program efforts that lead to preventable hospital stays. In total, programs used funds responsibly to produce health-related research, provide broad ranging health services, address specific health disparities, promote health literacy, and partner with other organizations—all to advance the health and well-being of Arkansans.

Programs leveraged more than $120 million and generated millions more in cost savings.

Reviewing Challenges and Opportunities

ATSC-funded programs noted several challenges in the biennium, namely shrinking funding streams from external sources, which led to spending cuts and hiring freezes for some. Programs reported the need to maintain and create new relationships with external partners to support bringing in additional funds. In addition to the challenge of shrinking funds, some programs experienced leadership changes, which brought about new opportunities to reevaluate program goals, strategies, and indicators. In the face of this particular challenge, programs did well in remaining resilient through leadership transitions. Other difficulties encountered by

programs were related to finding and keeping staff in rural, underserved areas as well as addressing prevalent chronic conditions like heart disease. Despite the many challenges, programs were effective in adjusting course as necessary and finding new opportunities for success where applicable.

In addition to challenges faced by ATSC-funded programs, many opportunities arose during the biennium. Chiefly, these opportunities included collaboration with outside partners to produce research and implement health programs and projects across the state. Some programs also utilized new outreach strategies through social media outlets, particularly targeting underserved and minority populations. Other programs capitalized on opportunities to provide expanded medical coverage or clinical services to populations in need, while also laying the groundwork for additional client services and rural residency training in the years to come. Further, two programs experienced leadership changes that brought opportunities to reassess goals, strategies, and indicators. All of these opportunities contributed to the enhancement of health and well-being of Arkansans.

Programs provided expanded medical coverage and clinical services to those in need.

Summation of Evaluator Comments

Evaluators at the University of Central Arkansas reviewed program progress and accomplishments for each program, and provided summary comments on efforts in 2016-2017. These evaluator comments highlighted (1) the importance of leveraging tobacco funds, (2) the impact of continued research productivity, (3) the challenge and opportunity presented by leadership transitions, (4) the effect of continued and new support for underprivileged and underserved populations, (5) the development of new program indicators to assess progress, and (6) the overall effectiveness of program activities—noting that most program indicators were met or making significant progress towards goals. In all, 88% of indicators were met or in progress during the biennium (see Table 2). Of the remaining indicators, some proved obsolete or ineffective at capturing progress and were, therefore, eliminated or updated before the end of the biennium. A select few indicators that were not met were neither eliminated or updated during this biennium, but will be reassessed in 2018 based on new or changing program needs. For example, UAMS East Regional Campus will reassess its indicators given the addition of the medical center in Helena and the resulting realignment of services.

Program	Year	Total Indicators	Indicators Met	Indicators in Progress	Indicators Unmet or Needs Adjustment	Overall Progress
ABI	2016	8	8	--	--	94% met
	2017	8	7	--	1	
COPH	2016	9	7	1	1	94% met or in progress
	2017	9	8	1	--	
MHI	2016	7	1	6	--	100% met or in progress
	2017	7	4	3	--	
TPCP	2016	10	5	3.5	1.5	83% met or in progress
	2017	10	4	4	2	
TS-MEP	2016	5	4	--	1	80% met or in progress
	2017	5	3	1	1	
UAMS-COA	2016	7	6	--	1	87% met or in progress
	2017	8	6	1	1	
UAMS East Regional Campus	2016	11	8	2	1	82% met or in progress
	2017	11	7	1	3	
TOTAL		***115***	***78***	***23.5***	***13.5***	***88% met or in progress***

Table 2. Program Indicator Progress.

Returning to Culture of Health

ATSC-funded programs put forth robust efforts—through education, service, research, and economic impact—towards making health a shared vision, partnering across sectors, creating healthier and more equitable communities, and strengthening integration of health services and systems. Programs also focused much of their work on vulnerable populations, helping to reduce health disparities in the state. The result of these program efforts was improved health, well-being, and equity—the benchmark for crafting a Culture of Health. Next we wrap up the conclusion by reflecting on the advancement towards equity.

Reflection on the advancement towards equity. As we assessed ATSC-funded programs' contribution to a Culture of Health, we noted that efforts towards equity may be influencing actual declines in health disparity across the state. When we compared County Health Rankings (CHR) data for 2015 (before the biennium) and 2018 (after the biennium), we saw a tightening in the range between minimum and maximum rates of certain health outcomes across Arkansas counties. Between 2015 and 2018, the state minimum and state maximum range for "percentage of adults reporting poor or fair health" tightened by 11 percentage points (CHR,

2015, 2018), which indicates that there is less disparity between the healthiest and unhealthiest among us—at least as it relates to *self-perceived* health status. This tightening of minimum and maximum rates across counties also applies to other health outcome measures: "poor physical health days" (tightened by 4.4 percentage points) and "poor mental health days" (tightened by 6.8 percentage points) (CHR, 2015, 2018). However, while health disparities may be declining in Arkansas, the overall self-perceived health status of Arkansans—on average—was worse in 2018 than it was in 2015. To illustrate this point: in 2015, 19% of adults across all counties reported poor or fair health, and in 2018 this state average was 24%. In this case (and in most cases where the range of values tightened), there was a significant increase in the minimum value reported; in 2015, the minimum value for poor or fair health was 12%, and in 2018 it was 18%. Even though the maximum value in this measure decreased significantly as well, from 36% to 31%, the increase in the minimum value—along with other reported rates across counties—resulted in an increased state average.

In sum, reducing health disparity—alone—does not guarantee improved health status for all. This reflection reminds us of the importance of cultivating a Culture of Health—embracing concerted, cross-collaborative efforts to remedy complex health problems and to attend to holistic health and well-being of individuals and communities. The efforts of ATSC-funded programs, while broad and impactful in the state, are only one piece of the puzzle in constructing a Culture of Health in Arkansas. It takes all of us, inside and outside health sectors, to improve population health, well-being, and equity.

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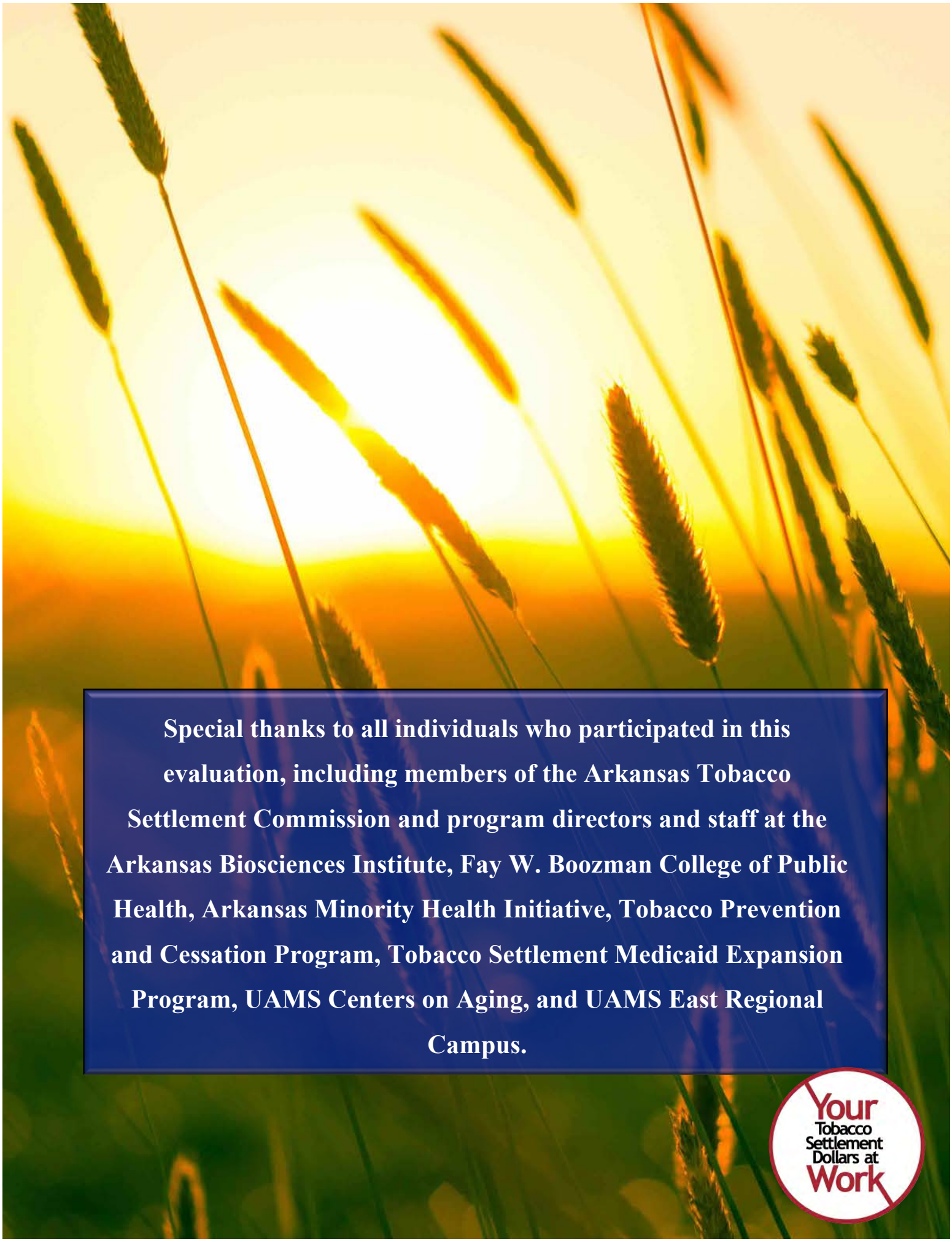

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Your Tobacco Settlement Dollars at Work