Discriminative and Evaluative Properties of the Activities-specific Balance Confidence (ABC) Scale

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Background. Balance confidence is an important indicator of functional mobility and independence in older adults. Preliminary psychometric evidence for the Activities-specific Balance Confidence (ABC) Scale is promising, with a series of four studies adding information on the discriminative and evaluative properties of this tool.

Methods. The original validation sample was reinterviewed one year later. In the second study, the ABC was administered to 475 older adults ranging from home care clients to highly functioning individuals in community exercise programs. The third study compared 31 residents of retirement homes given a 10-week balance control exercise program and fall education with 32 residents who received only fall education. The fourth study examined balance confidence preoperatively and postoperatively for 27 patients undergoing hip or knee replacement.

Results. ABC scores remained stable over 12 months in higher functioning elders, but deteriorated in retirement home residents over 26 weeks. Ten weeks of balance training significantly improved balance confidence, as did hip or knee replacement with standard physical therapy. ABC scores lower than 50 indicated a low level of physical functioning characteristic of home care clients. ABC scores above 50 and lower than 80 indicated a moderate level of functioning characteristic of elders in retirement homes and persons with chronic health conditions. ABC scores above 80 are indicative of highly functioning, usually physically active older adults, and are achievable through exercise and rehabilitative therapies.

Conclusions. Balance confidence is amenable to change and able to distinguish between elders at various levels of functional mobility. These results provide comparative benchmarks for researchers and clinicians working with different groups of older adults.

Fear of falling appears to increase with age and to be more common among older women (1). Fear of falling may represent an independent contributor to functional decline (2) and has been associated with frailty, decreased mobility and social activities, depressed mood, and lower life satisfaction (1). Self-imposed activity restriction, in turn, can precipitate balance deterioration (3). Fear of falling may be amenable to therapeutic change, and together with balance training, should be targeted for intervention (2,3).

There are two multi-item measures modeled after Bandura’s efficacy framework that operationalize fear of falling as a continuum of balance confidence (0 to 100%) in various situations (4,5). Both the 10-item Falls Efficacy Scale (FES) and the 16-item Activities-specific Balance Confidence (ABC) Scale have good psychometric properties (4,5); the latter has a wider continuum of item difficulty and is more suitable for moderate to high functioning older adults (3,5). For instance, simple shopping is the only activity on the FES performed outside the home. In contrast, the ABC examines balance confidence in progressively more challenging situations ranging from mobility inside the home to walking outside to a parked car, across a parking lot, up and down a ramp, in a crowded mall, getting on or off an escalator, and lastly, walking on icy sidewalks. Psychometric evidence for the ABC published to date includes: test-retest reliability over a 2-week period, high internal consistency, convergent and discriminant validity, the ability to discriminate between fallers and nonfallers and low versus high mobility groups (5), and correspondence with balance performance measures (3).

Normative comparisons and responsiveness to change data are needed to guide both researchers and clinicians using the ABC scale for discriminative, predictive, and/or evaluative purposes. Accordingly, this article reports the results of four studies using the ABC scale with diverse populations of older adults. In the first study, the original validation sample (3,5) was reinterviewed a year later to examine score stability and the ABC’s predictive ability to identify fallers and near fallers. In the second study, the ABC was administered to older adults participating in a variety of research projects and community exercise programs to establish norms. In the third and fourth studies, the ABC was a primary outcome measure used in a fall prevention program with retirement home residents, and in a clinical examination of the recovery process of patients undergoing hip or knee replacement, respectively.
Study 1

METHODS

One year following the ABC validation study (3,5), repeated attempts were made to contact each of the 60 subjects in the original sample. Nine people could not be reached, five refused, four had died, and five were hospitalized. The structured interview included readministration of the ABC scale and detailed descriptions of any fall or near fall incidents experienced over the previous 12 months. Falls were defined as “ending up on the floor or ground unintentionally” (6), while near falls were defined as “close calls such as tripping, slipping or colliding with something or someone” (7,8). Persons were classified as “low” mobility if they reported needing personal assistance (apart from transportation) to leave their homes (5).

RESULTS

Table 1 presents the baseline characteristics of respondents (n = 37) and nonrespondents (n = 23) from the original cohort, as well as one-year follow-up scores. Half of the low mobility group was lost to follow-up; all nine individuals known to have died or be hospitalized came from this group. As can be seen in Table 1, the nonrespondents overall and within both the mobility groups had lower ABC scores. Over the one-year period, ABC scores remained fairly stable, increasing slightly but not significantly. Interviews with the 37 respondents revealed that 20 had not experienced any health-related changes over the year; individuals reporting such changes were evenly split between the high (n = 9) and low (n = 8) mobility groups. A repeated measures ANOVA showed a significant between-group difference (F = 97.7, p < .000), with high mobility persons having higher ABC scores at both baseline and follow-up.

Fall and near fall information was classified independently by two researchers (6) with over 90% interrater agreement. Having experienced at least one fall in the 12 months prior to baseline was predictive of falling over the subsequent 12 months (76% of fallers at Time 1 also reported a fall at Time 2, χ² = 6.4, p < .01). With respect to within-group change, those who fell over the 12-month period (n = 17) were also more likely to have started using a new walking device (χ² = 12.96, p < .01).

In contrast, a number of subject characteristics were predictive of near fall incidents at one year. Nine people or 24% of the sample experienced a close call or near fall incident, with six people reporting more than one event. Balance was often recovered by grabbing something or someone (60%) or sitting down (13%). Individuals reporting a near fall (as compared to those who did not) were significantly older (mean age = 80 vs 73, t = 2.48, p < .05), had more health problems (mean = 5 vs 3, t = 3.06, p < .01), were more likely to receive formal assistance (67% vs 18%, χ² = 7.3, p < .01), to be classified as “low” mobility (100% vs 21%, χ² = 20.9, p < .000), to use a walking aid (100% vs 36%, χ² = 16.1, p < .01), and to have lower ABC scores at baseline (mean = 37 vs 75, t = 4.54, p < .001), as well as at follow-up (mean = 40.8 vs 77.6, t = 4.50, p < .001).

Study 2

METHODS

The ABC scale was administered to 475 older adults as part of a psychometric investigation of two new exercise outcome measures (9). Subjects were involved in a variety of research projects and community programs, most of which were exercise-oriented (Table 2). All participants were administered a detailed background questionnaire (including demographic, health, and activity items), as well as the ABC and the two new scales (9). Physical assessments such as the Timed Up and Go or TUG (10) and paced walk test (11) were conducted on some of the research groups. Both entry and follow-up assessments were taken for new attendees in a number of exercise programs/research projects (Table 2).

RESULTS

Table 2 reports cross-sectional comparisons; groups are rank ordered according to average ABC scores. The group of home care clients had the lowest ABC scores, were the oldest group, and had the highest number of health problems. The TUG score for this group (mean = 21.6, SD = 4.5, range 14–29) substantiated their mobility restriction (10). The TUG score of the home-based group can be contrasted to that of the highly functioning Centre group (TUG mean = 9.3, SD = 1.6, range 7–12). TUG scores obtained for these two groups were significantly correlated with ABC scores (r = -.92, p < .000) and with age (r = .68, p < .000). Gait speed (fast-paced walk), obtained on the Centre group, correlated moderately with ABC scores (r = .47, p < .003).

Next, the groups were collapsed to examine factors
related to ABC scores for the entire sample of 475. Age was moderately correlated with ABC score ($r =-.29$, $p < .000$), as was the total number of health problems ($r =-.30$, $p < .000$). As shown in Table 3, males scored significantly higher than females overall. Education was also related to ABC scores. Tukey $B$ revealed that the significant difference was between persons who had less than a high school education compared to all higher levels of education. All health variables were significant in univariate analyses.

Given the large sample size, we were able to compare persons with no health problems ($n = 82$; mean age = 59, $SD = 17$) to subgroups with selected health conditions. The group with no health problems had an average ABC score of 91 ($SD = 13$), compared to 25 people with diabetes (mean ABC = 70, $SD = 32$; mean age = 69, $SD = 7$), 56 people with heart trouble (mean ABC = 77, $SD = 27$; mean age = 72, $SD = 7$), 93 people with foot problems (mean ABC = 79, $SD = 22$; mean age = 65, $SD = 13$), 69 with vision problems (mean ABC = 79, $SD = 22$; mean age = 64, $SD = 15$); and 20 people with bladder problems (mean ABC = 76, $SD = 23$; mean age = 64, $SD = 10$). Persons with arthritis ($n = 170$), osteoporosis ($n = 55$), and chronic obstructive pulmonary disease ($n = 43$) had average ABC scores in the low 80s with substantial within-group variability.

As shown in Table 3, older adults who perceived themselves as being very physically active (a majority of this sample) scored much higher on the ABC (mean = 89.4) than persons who said they were not at all physically active (mean = 73.7). Perceived importance of routine physical activity was also related to balance confidence. We asked a subsample ($n = 104$) the question, "To what extent does exercising (walking, gardening, classes) improve your balance confidence?" Over 50% said "very much so," and 26% said "moderately."

A stepwise regression analysis was run on 268 subjects examining all the variables in Table 3, plus age and total number of health problems. Both entry and removal criteria were applied, and partial regression coefficients were adjusted statistically for other variables in the equation. Five variables emerged in the final model accounting for 40% of the variance ($F = 35.56, p < .000$). The best predictor of balance confidence (ABC scores) was perceived health (Beta = 12.5, $R^2$ change = .21), followed by current level of physical activity (Beta = 8.2, $R^2$ change = .31). Three demographic characteristics also were significant: age (Beta = .47, $R^2$ change = .35), education (Beta = 2.6, $R^2$ change = .38), and gender (Beta = 7.2, $R^2$ change = .40).

Change in balance confidence was examined for new
Of the five exercise groups with baseline and follow-up data shown in Table 2, the 3-month wellness clinic (which included walking, balance, and strength training twice a week) was the most relatively beneficial concerning improvements in balance confidence. Almost 40% of group participants improved their ABC scores by 5% or more. The clinic coordinator reported that many of their attendees were previously sedentary. In contrast, ABC scores did not change for as many participants in either the 2-month aquatics class or the 3-week walk group. Instructors reported that many of their participants had previously taken a pool class or regularly walked on their own, respectively.

Study 3

Methods

Study protocol.—Older adults from five retirement homes were recruited to take part in a fall prevention program. While each facility already offered recreation/activity programs, these were primarily social in nature and did not contain exercises challenging balance control. The aim of the study was to compare the effects of education alone against the effects of education plus exercise intervention on balance enhancement, balance confidence, and falling (13). All 63 volunteers received two 90-minute fall education sessions in their respective facility. Group presentations were delivered through a standardized slide show covering both risk factors and prevention strategies, such as the importance of exercise, medication monitoring, and environmental modifications (14,15).

Two of the retirement homes (total of 32 subjects) also received two general wellness education sessions spaced one week apart and delivered on-site by a local seniors organization. Information on nutrition, medication, and general benefits of exercise was presented in a standardized format, followed by discussion. This group—receiving both fall education and general wellness education—constituted the comparison or education-only condition.

Three of the five residences (total of 31 subjects) participated in the fall education plus exercise intervention. In two settings, volunteers received an on-site, 10-week (two sessions per week; progressing to 45 minutes in duration) land-based exercise class specifically tailored to enhance postural control. In the third setting, an equivalent water-based exercise class was conducted in the on-site pool. Examples of specific exercises to challenge balance control (both on land and in the pool) included stride walking, lunging, knee lifts, and marching.

All subjects were assessed by the same research assistant (blind to the study hypotheses) at three time points: Time 1, or baseline; Time 2, or post-intervention follow-up 11 weeks later; and Time 3, the maintenance follow-up 26 weeks after baseline. The 11-week reassessment was conducted in early December following the falls education (for everyone) and the exercise intervention. The 26-week re-assessment in March followed the health education sessions (for the comparison condition) and a period of no intervention for the exercise condition.
Subjects.—The total sample of 63 ranged in age from 60 to 94 (mean age = 80.4, SD = 8); 89% were female; 60% had not completed high school. Most had health problems, including: hypertension or heart trouble (70%), arthritis (60%), vision (48%), and nocturia (75%). On average, subjects took four medications (SD = 2.4, range 0–11). Most had a walking device. ABC scores for the total sample ranged from 14 to 98 (mean = 63.6; SD = 24.6). Scores on the Performance Mobility Assessment (16) (mean = 14.9, SD = 5.4, range 2–24), and on the Timed Up and Go (10) or TUG test (mean = 8.9, range 9–47) similarly indicated this sample was at a fairly low level of functional mobility. The groups assigned to the two conditions were comparable (no significant differences) at baseline on all the above variables, except for education. A greater proportion of the comparison group (81% vs 35%) had not completed high school (p < .01).

RESULTS

ABC scores were highly correlated with both mobility performance test scores (r = .78, p < .0001) and TUG scores (r = -.59, p < .0001). Data for all three assessment periods were obtained on 87% of the intervention group (r = .78, p < .0001). Tukey B indicated no significant group difference for ABC mean scores at baseline (mean = 62.4; SD = 26; 95% CI: 51.73) than the intervention group (n = 27, mean = 70.7; SD = 17, 95% CI: 64.77), confidence intervals overlapped.

Figure 1 shows the ABC scores and 95% confidence intervals for the two study conditions at each time period. Repeated measures ANOVA showed a significant Time by Group effect (F = 10.03, p < .0001). Tukey B indicated no significant group difference for ABC mean scores at baseline, but significant differences at both Time 2 and Time 3. Computation of effect size revealed a 35% improvement in balance confidence scores for the exercise intervention group over the 26 weeks, with much of the improvement (26%) occurring immediately following the 10-week exercise program. In contrast, balance confidence in the comparison group declined by 50% over the 26-week period (a 12% decline occurring by the 11th week and a further 38% between the 11th and the 26th week). The performance results on the balance and mobility tests, reported elsewhere (13), mirrored the confidence results.

Study 4

METHODS

Study protocol.—Osteoarthritic patients age 50+ scheduled for their first hip or knee replacement at a Baltimore hospital were assessed preoperatively, and at 6 weeks and 6 months postoperatively as part of a clinical study examining psychosocial factors in the recovery process. All patients received daily physical therapy while in the hospital and were discharged with exercise prescriptions. Preoperative assessments included a depression scale (17), a functional questionnaire developed for this population (18), and a visual analog scale of pain intensity. Gait speed (19) at a normal pace was assessed at both preoperative and at the 6-week postoperative clinic visit. The 6-month telephone follow-up precluded readministration of all measures. Pain ratings, use of pain medications and walking aids, and ABC ratings were obtained at all three time points.

Subjects.—The 27 subjects (mean age = 69.4, SD = 7, range 58–80) with complete data for the three assessment phases consisted of 10 hip and 17 knee replacement patients. The sample was English speaking, primarily White (85%), and female (74%); about half had a high school education. With respect to preoperative functioning, all subjects reported pain during walking; 81% took pain medications. A walking aid was used by 48% of the sample. Average normal walking speed (mean = .6, SD = 2, range 1.15–1.0 meters/sec) indicated a mobility impaired sample (19). Functional ratings (mean = 58.2, SD = 13, range 36–82) were very similar to previous studies with this patient group (18). The average score on the depression scale was 22.2 (SD = 7.8, range 12–40); scores over 16 indicate a greater probability of clinical depression (17). Half the sample (n = 14) classified their activity as "very restricted." ABC scores at baseline ranged from 9 to 97 (mean = 71.9, SD = 14.7).

RESULTS

At baseline or prior to surgery, ABC scores were related to gait speed (r = .65, p < .001), functional ratings (r = .49, p < .01), pain intensity ratings (r = -.35, p < .07), and depression scores (r = -.33, p < .09). Patients who rated their activity level as "restricted" scored much lower on the ABC scale (mean = 64 vs 81), t = 2.89, p < .01. At 6 weeks postoperative, ABC scores decreased slightly from baseline levels (mean = 68.1, SD = 16.6, range 34–99). Gait speed remained relatively unchanged, and again was strongly associated with ABC scores (r = .60, p < .001). Self-reported maximum walking distance (without resting) was also related to ABC scores (r = .44, p < .02).

At 6 months postoperative, ABC scores increased markedly (mean = 83.2, SD = 14.8, range 48–100). Repeated measures ANOVA revealed significant change across time


Taken together, the results from these four studies can be used to guide both researchers and clinicians using the ABC scale with older adults in either preventive or rehabilitative interventions. The first and third studies provided information on the stability of balance confidence scores. While we expected the high mobility subgroup of the original cohort to be very confident a year later, the low mobility group able to be recontacted also showed stable scores. These latter individuals were likely more robust than their counterparts—they had higher ABC scores and were no more likely than the high mobility respondents to report health-related changes over the 12-month period. The fact that half the low mobility group was lost to follow-up, together with the finding that everyone known to have died or been hospitalized came from this group, suggests that persons with poor mobility and low confidence may be at much greater risk for decline. Study 1 also provides further support for the strong association between mobility classification and ABC scores found with the original cohort (5).

In Study 1, we were unable to obtain physical performance measures at follow-up, nor could we consider the role of seasonal effects on balance confidence. In harsh winter climates, snow and ice are highly likely to affect seniors’ balance confidence. On the ABC, five items pertain directly to outdoor situations, while another four items (getting around a crowded mall and using escalators) imply that the person has to leave their home. Study 3 obtained both balance confidence and balance performance measures at three time periods—fall, early winter, and late winter. The results from the comparison (education only) group showed that both balance confidence, along with physical mobility, deteriorated over 3 months, and deteriorated further over a subsequent 3 months in a moderately functioning sample of retirement home residents. Reluctance to go outside during winter months is likely responsible for both physical decline through further reduced activity levels and fear of falling. A program of balance control exercises, however, was able to overcome seasonal effects resulting in improved balance and mobility performance, as well as enhanced confidence over the same periods.

Studies 2 to 4 provided further support for the correspondence between ABC scores and various measures of mobility and balance performance, in addition to self-paced walking and static postural performance assessed in the original study (3). Most importantly, these four studies provide evidence of the discriminative and evaluative properties of the ABC scale. The home care clientele in Study 2 had very similar scores (mean ABC = 36) to the “low” mobility group comprising home care and day care users (mean ABC = 38) in the original study (3, 5). Gait speed (< .5 m/s) in the original study (3) and TUG scores (> 20) in the comparable group in Study 2 verify the mobility limitations of these samples. When working with such subjects, researchers and clinicians can expect to find total ABC scores averaging less than 50 on the 0 to 100% continuum, with individual variability ranging from about 10 to 60.

The next level of functional mobility may be represented by the sample of retirement home residents in Study 3. Although this sample was similar in age (both mean and range) to the home care samples in Study 2 and the original study (3), overall their functional mobility and ABC scores (mean = 64, range 14–98) were higher. As mentioned above, the nonexercise group’s balance confidence (and performance) declined over the 26-week study period, despite the fact that this group received fall and wellness education. It could be that the education was not of sufficient duration, that subsequent behavioral changes did not follow as a result, or that seasonal effects had a stronger influence. The lower education level of the comparison group may also have explained their somewhat lower ABC scores at baseline, as Study 2 showed an association between having less than a high school education and lower balance confidence. What is noteworthy is that 10 weeks of balance control exercises plus falls education with retirement home volunteers did produce significant improvements in both balance confidence and balance performance. The continued improvement in balance confidence over the subsequent 15-week follow-up is likely due to the fact that many of these individuals reportedly continued to do the exercises on their own. The falls education may have contributed to this.

Most of the retirement home sample had chronic health problems, took multiple medications, and used walking devices. Health, measured by a variety of indicators, is strongly related to balance confidence scores as illustrated by the large sample in Study 2. ABC scores were able to discriminate between persons with no chronic health conditions (who tended to score above 90, with little variability) and individuals with various health problems. When working with older adults with specific health conditions, it should be kept in mind that the majority of the Study 2 sample were regular exercisers. Both severity of the condition and comorbidity, probably account for the large variability found in ABC scores when looking at single health conditions.

It is interesting to compare the arthritic group from Study 2 to the more severe osteoarthritic patients scheduled for first hip or knee replacements in Study 4. Although similar in age, average ABC scores were lower for the latter group. Within-group variability was evident, and ABC scores were able to discriminate between patients who rated their activities as being quite restricted and those who did not. Gait speed, functional, and pain intensity ratings were also related to balance confidence. What was particularly interesting for this sample undergoing hip or knee replacement...
surgery and receiving standard rehabilitation postsurgery, was that little improvement (in either gait speed or balance confidence) took place in the 6 weeks following surgery. It appears that both physical and psychological recovery takes more time for this patient population. By 6 months, use of walking aids and pain medications declined. Balance confidence ratings correspondingly increased by 59% from preoperative levels. At 6 months following hip or knee replacement and rehabilitation, the average ABC score was 83, with almost half the sample scoring 80% or above.

A score of 80 is comparable to many of the higher functioning older adults seen in Study 2 and the "high" mobility cohort in the original study (3,5). It is noteworthy that the Alumni group, comprising retired faculty exercising together on a regular basis for 10 years, had an average balance confidence score of 97 with little within-group variability. Regardless of the outcome of interest, exercise programs will be relatively beneficial depending on each individual's baseline level and participation rate (9,12). In our follow-up comparisons of various community exercise programs, it was not uncommon to find "new attendees" had previously participated in other exercise classes or exercised on their own. Individuals who score in the mid-80s or better on the ABC tend to be highly functioning and already physically active and are unlikely to show further improvement in balance confidence. For such robust older adults, maintenance of functioning will be the primary objective.

For individuals scoring below 80 on the ABC, there is room for improvement on balance confidence, although incremental improvement is likely to be greater for persons scoring below 70 as demonstrated by three of the studies reported herein. Further investigation should continue with respect to the relative efficacy of different intervention strategies (surgery, physiological and occupational therapy, hip protectors, falls education, and general exercise vs balance specific training—both land and water based) for the enhancement of balance performance and confidence. Although Study 1 is suggestive, further research using prospective fall reporting methods is necessary to examine the predictive abilities of balance confidence scores. The present series of studies demonstrates that balance confidence is amenable to change and able to distinguish between older people at different levels of functional mobility. These results should assist clinicians and researchers in benchmarking their particular target group.

On a final note, the ABC is suitable for the assessment of balance confidence with most noninstitutionalized older adults. While the FES is a good instrument to assess balance confidence with most noninstitutionalized older adults, maintenance of functioning will be the primary objective. For individuals scoring below 80 on the ABC, there is room for improvement on balance confidence, although incremental improvement is likely to be greater for persons scoring below 70 as demonstrated by three of the studies reported herein. Further investigation should continue with respect to the relative efficacy of different intervention strategies (surgery, physiological and occupational therapy, hip protectors, falls education, and general exercise vs balance specific training—both land and water based) for the enhancement of balance performance and confidence. Although Study 1 is suggestive, further research using prospective fall reporting methods is necessary to examine the predictive abilities of balance confidence scores. The present series of studies demonstrates that balance confidence is amenable to change and able to distinguish between older people at different levels of functional mobility. These results should assist clinicians and researchers in benchmarking their particular target group.

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