In the ethos of American culture, the words “substance abuse” conjure up images of bleary-eyed, out-of-control addicts living only for the next fix or drink. In reality, the face of the substance abuser looks like your coworker, neighbor, or friend—or perhaps your mother, father, sister, brother, son, or daughter. That’s because substance abuse is not an isolated phenomenon characteristic of a group of social misfits whose cravings have bankrupted their lives. Rather, substance abusers are usually functioning members of society, holding down jobs and raising families. Just as there are varying levels of wealth, there are degrees of substance abuse.

However, until recently there hasn’t been a diversity of treatment options. Traditionally, treatment plans have followed the 12-step model of total abstinence, but a new method of treatment called “harm reduction” has emerged. Harm reduction encompasses and encourages any behavioral change that reduces the harmful effects of substance abuse, even if it falls short of total abstinence.

“Abstinence remains the ultimate goal,” says UAB health behavior specialist and clinical psychologist Jalie A. Tucker, “but harm-reduction programs recognize that many behavior change attempts and treatment episodes may take place before stable abstinence is achieved—if it occurs at all.”

As she notes in her edited book, Changing Addictive Behavior: Bridging Clinical and Public Health Strategies, “Traditional views of substance abuse that are guided by a disease or addiction model have tied recovery to participation in intensive treatment or...” (continued on page 2)
mutual self-help groups like Alcoholics or Narcotics Anonymous.” These programs, she says, require persons seeking help to first accept society’s negative label of “alcoholic” or “addict” and adhere to an absolute abstinence policy. If they don’t, they’re viewed as being in denial and unwilling to change.

Zero Tolerance

Unlike the “zero tolerance” of drug use championed by 12-step programs and the government’s “War on Drugs,” Tucker maintains that it’s more productive to offer interventions tailored to the needs of people with problems that range from mild to moderate and severe. Most treatment programs are intensive and abstinence-oriented and are better suited for people with more serious problems. There are few services for the majority of substance abusers with mild to moderate problems, or for those who want to reduce the risks associated with substance abuse but are unable to abstain. The zero-tolerance position also intimidates many people who need help, especially when illicit drug use is involved, she says.

“On the one hand, we want substance abusers to enter treatment programs, yet we incarcerate them for using drugs,” says Tucker. “Substance users know there are real risks in coming forward and asking for help.”

Harm-reduction programs help substance abusers who are unable to abstain completely to reduce the harm or risk of harm associated with alcohol or drug use. For example, drinkers can avoid drinking and driving. Making interventions accessible and relaxing the abstinence requirement for participation removes known deterrents to seeking help, Tucker says.

Harm-reduction programs remain controversial in the United States, even though scientific evidence reveals their positive effects in reducing drug-related illness, says Tucker. For example, according to the National Institutes of Health (NIH), providing clean needles for IV drug abusers reduces the spread of HIV without escalating drug use, yet Congress prohibits spending federal funds to finance clean needle exchange programs.

The Roads Less Traveled

Some interventions, such as those that meet clients “where they are” with respect to motivation and resources for change, have been effective in treating persons with mild to moderate substance abuse problems but are not yet widely accessible in the United States. For persons with more serious problems, brief interventions help promote entry into intensive, specialized treatment.

Brief interventions involve assessment of a person’s substance use and related problems, followed by feedback and advice on behavior change that’s problem-specific. Such interventions typically consist of a few sessions and can be delivered through primary-care facilities and at worksites, schools, and other community settings.

“Cost-containment concerns in health care are helping to increase the availability of brief interventions,” Tucker says. “Their availability will broaden the range of services for substance abusers and will make services more accessible to persons who don’t want or need to enter specialized clinical treatment programs.”

However, Tucker points out, clinical treatment will remain essential for substance abusers with more serious problems.

Considerable progress has been made in the past 10 to 15 years in developing empirically guided interventions to match the diversity of substance-related problems. However, Tucker says, many frontline practitioners continue to use older approaches based on 12-step principles rather than treatment options derived from applied research on addictive behavior change. Developing better lines of communication between the research and practice communities is critical to improving services for substance abusers, she says.

Although some people enter treatment in order to quit using substances, the primary motive for help-seeking is to overcome functional problems created or aggravated by substance misuse. “Those individuals want to regain the ability to perform in their everyday lives—not necessarily to stop using drugs,” Tucker says.

She points out that considerable variability exists in drug use practices, levels of physical dependence, and the extent to which drug use impairs various “dimensions” or “domains” such as personal health or the ability to function at work and maintain interpersonal relationships.

“For example,” Tucker says, “one person may experience legal problems due to drinking, such as a drunk-driving arrest, without drinking excessively on a regular basis. Another person may drink heavily and develop tolerance and health problems without experiencing job or relationship difficulties. Yet another person may drink heavily with no ill health effects but may experience negative consequences at work and at home.”

Treatment goals for each of these people differ, according to Tucker. “The first
person needs to stop drinking and driving, but does not necessarily need to abstain. The second person probably needs to permanently abstain but will not require additional interventions once she quits. The third person requires help in improving areas of impaired function. However, the desired goal will depend on the range of problems the individual is experiencing because of drinking, as well as the degree of support from friends and family for the desired goal. In other words, if a person opts for abstinence but lives or socializes with people who don’t support that goal, then the chances for success are diminished.

Insisting that a person’s substance abuse is the root of all of their life problems also erects a barrier to treatment. “That approach assumes that if we get the drugs out of the person’s life, everything is going to be fine,” says Tucker. “That’s not necessarily true. For instance, a spouse may stop drinking, but that doesn’t mean the couple’s marital problems automatically go away. The newer treatment programs address these kinds of issues.”

**Continuously Funded Research**

Tucker’s research on recovery and help-seeking processes in problem drinkers has been funded continuously since 1992 by the National Institute on Alcohol Abuse and Alcoholism. Her current 5-year grant of $1.2 million funds her studies of the life situations that influence a person to seek help and the different ways that they resolve their problems with alcohol.

Her research goal is to enhance knowledge about substance abuse and treatment, so that interventions can be improved. She’s intrigued by the fact that many individuals stop abusing alcohol or drugs on their own without interventions.

“My studies investigate circumstances in the natural environment that influence recovery,” she says. “For example, the findings show that most problem drinkers experience improved functioning when they stop drinking abusively, whether on their own or with the help of interventions. However, improvements are more pronounced among persons who participate in professional interventions.

“Enhanced positive changes in social functioning and other health habits—including better diet, increased physical activity, and smoking cessation—are common and probably increase well-being and help sustain motivation for maintenance. The results of my research suggest that one primary benefit of interventions is that they help improve the chances of maintaining sobriety once a problem drinker has quit drinking abusively.”

Tucker is now working on a computerized telephone-based data collection system that lets problem drinkers—who want to quit drinking on their own—report daily on their progress. The system is tollfree, and each participant has a personal identification number (PIN) that keeps his or her reports confidential. Participants monitor their drinking and other activities for four months during the early recovery period, when the risk of relapse is high.

Once the system is developed, it can be used in brief motivational interventions for drinkers who have mild to moderate problems and who don’t want to enter specialized treatment programs. After participants receive initial assessments and brief interventions tailored to their problems, their alcohol intake and ability to cope can be monitored for as long it takes to resolve their drinking problems and form positive behavior patterns. The system allows for quick detection of a relapse or the development of other problems that would benefit from additional interventions. If further interventions are necessary, a participant’s level of care is adjusted or “stepped up” and may include entry into a clinical treatment program.

“Low threshold” programs of this sort offer proven interventions to a wide range of people in need of substance abuse services, Tucker says. The programs incorporate advances in computer and telecommunications systems to bring services to problem drinkers in the privacy of their homes and coordinate such “telehealth” programs with clinical care when needed.

“Telehealth programs are developing in many areas of health care,” says Tucker, “particularly in prevention and treating chronic health problems. Even though many technological, ethical, and consumer-related challenges remain to be worked out in this emerging health care market, telehealth programs hold promise for reducing cost of services for people with substance abuse problems, while increasing access to quality care.”
Epidemiology is often viewed as the straightforward investigation of the causes, transmission, and treatment of diseases. But modern epidemiology examines a complex mosaic of biologic, behavioral, and environmental factors that trigger disease or injury and affect outcomes. The field’s scope has greatly expanded, requiring sophisticated new research methodologies, according to UAB epidemiologist and international health expert Fabio Barbone.

Barbone’s own research interests are as diverse as modern epidemiology itself. Currently, his projects focus on topics ranging from medical errors in pharmaceutical prescriptions to pediatric injuries and the effects of psychotropic drugs on driver safety.

**Error Terror**

One of Barbone’s clinical epidemiology studies focuses on medical errors and adverse side effects of drugs—topics that are frequently in the news.

For example, a recent report by the Institute of Medicine (IOM) titled “To Err Is Human: Building a Safer Health System” concluded that medical errors and adverse drug side effects occur in 2.9 to 3.7 percent of all hospitalizations, resulting in anywhere from 44,000 to 90,000 inpatient deaths. The IOM report estimates that the cost of those errors—including lost income, lost household production, disability, and health-care costs—is between $17 billion and $29 billion.

“And that’s very likely to be the tip of the iceberg,” Barbone notes. “The problem is much broader when one considers the many out-of-hospital drug and medication errors, as well as the adverse effects that can occur even when people take medications properly. Since medications are prescribed frequently for nonhospitalized patients, there are many opportunities for harmful effects to occur.”

**Investigating Injuries in Children**

Barbone is also conducting international studies of childhood injuries. The results of one such research project will be published in an upcoming issue of the medical journal *Pediatrics*.

During the project, Barbone and fellow researchers studied 292 injured children who were treated at the Children’s Emergency Center in Udine, Italy. “We interviewed the mother or other caretakers of the children,” Barbone says, “and asked them what the children had been doing hour-by-hour during the 24-hour period immediately preceding the injury. Then we compared those findings to a 24-hour control period.

“We found that in the 24 hours preceding the injury, the children had slept less than usual during the night or had skipped normal daytime naps. Our findings show that interrupted sleep at night and skipping daytime naps are transient exposures that may increase the risk of injury among children.”

**Drugs and Driving Don’t Mix**

Driver safety is yet another focus of Barbone’s wide-ranging research. The results of his investigations into driver safety have been published in an article titled “Association of Road–Traffic Accidents with Benzodiazepine Use,” in the medical journal *The Lancet* (Vol. 352, No. 9137, 1331–1336).

“In the *Lancet* study,” Barbone says, “we examined traffic accident reports for residents of Tayside, in the United Kingdom (UK), as well as the records of prescriptions that had been filled for these people at different times prior to the traffic accidents. We had a complete history of medication use for each of the 20,000 people in the study.”

The UK was chosen as the study site, he says, because of that country’s national database known as the Medicines Monitoring Unit, or MEMO. “In the United States, in order to survey such a large number of people, we would have had to conduct face-to-face interviews or use telephone or mail surveys. In the UK, all the information we needed was available on the database.”

Barbone and his fellow researchers were motivated to undertake the driving study because of a European report suggest-
had significantly higher risks of being in road accidents than when they weren’t taking those drugs,” Barbone reports. “In a similar analysis, however, we did not find higher risks for accidents when individuals were taking antidepressants.

“A strength of this particular study is that prescriptions for psychotropic drugs redeemed at Tayside pharmacies were used as a measure of drug exposure, thus eliminating recall bias. A weakness of the study is that it included only accidents that occurred in Tayside and involved Tayside residents. As a result, the study may have underestimated the overall accident rate in this population.

“But the bottom line is this: Users of benzodiazepines should be advised not to drive.”

Return Engagement

Barbone, who joined the UAB faculty in January, is the author or coauthor of 57 published scientific articles indexed by Medline, the National Library of Medicine’s premier bibliographic database in the fields of medicine and public health. Although he is new to the faculty, Barbone’s no stranger to the School of Public Health. He earned his doctorate in epidemiology from UAB in 1989, after receiving a medical degree from the University of Trieste, Italy, in 1984. After graduating from UAB, Barbone worked for Arthur D. Little, Inc., in Cambridge, Massachusetts, analyzing the long-term use of drugs to control rheumatoid arthritis, multiple sclerosis, and other chronic immunologic disorders.

Later, he worked in the Department of Preventive Medicine at the School of Medicine of the University of Udine, Italy, where he conducted epidemiological studies of cancer and injury and served as a member of the scientific board of the Italian Commission for Pharmacological Research. He returned to UAB after spending a year as a visiting scientist at the University of Dundee, Scotland, working on the road-accident study.

Sedated Seniors

Barbone is now turning his attention to the study of elderly people with chronic adverse health conditions such as arthritis and diabetes. He is particularly interested in the use of medications by seniors and is in the process of analyzing data from an ongoing study of 12,000 elderly Americans.

“Among the issues I’m exploring,” Barbone says, “is whether the quality of these people’s lives improves or gets worse if they take prescribed medications, or even if they choose not to take drugs prescribed for their health conditions. There could be adverse consequences either way.

“For instance, take the case of an elderly person who gives up driving because his or her doctor warned about the sedating effects of a new medication. As a result of not getting out into the community as often, the quality of that person’s life diminishes rather than improving. Their world shrinks, which can lead to depression, perhaps even to suicide—or then again maybe not. That’s what I want to find out.”

Epidemiologists haven’t undertaken many studies of quality-of-life issues in the elderly because it’s difficult to control for the many variables in this population, Barbone says. Unfortunately, the case-crossover design—at least as it was used in his UK accident study—is often not appropriate for studying quality-of-life issues because the strength of that design lies in its ability to evaluate transient exposures. Elderly people frequently have chronic conditions necessitating long-term, rather than transient, drug treatment. But Barbone believes that case-crossover studies could be designed to study drug effects on elderly patients when they’re switched to new drug regimens.

“The problem of adverse effects of drugs, even when properly taken, will continue to escalate because people are now living longer. Longer lifespans increase the risk of developing serious illnesses. Many older patients are eventually treated concurrently with a large numbers of drugs,” he says. “Epidemiologists have to design new methodologies to study these problems.”

When those innovations occur, it’s a safe bet that Barbone will be in the forefront.
Public health professionals in Alabama, Indiana, and New Mexico can now learn while they earn. Through a dynamic distance-learning program presented entirely on the World Wide Web, these professionals can earn continuing medical education (CME) credits and a UAB “Certificate in Public Health Leadership” without taking valuable time off from work to attend classes.

The goal of the program is “to make continuing education management and leadership training available to public health workers with a maximum of personal convenience and a minimum of expense,” says Stuart A. Capper, who along with Michael Maetz developed and codirects the program. The distance-learning format allows students to save travel costs, avoid taking time away from work, and “attend” classes at their convenience, rather than at specified times.

**Rapidly Evolving Field**

The Public Health Leadership Certificate Program is composed of six distance-learning courses offered by the UAB School of Public Health through the MidSouth Program for Public Health Practice. Each class lasts 10 weeks, and students have 18 months to complete the entire six-course program and earn their certificates.

“The science, methods, and organizational environment for public health practice are constantly evolving,” Capper explains. “In fact, the entire field of public health is changing rapidly. Public health professionals have a real need for CME but face obstacles to furthering their education, including tuition costs and time spent away from the office. Most public health agencies can’t afford to give employees time off from work to attend traditional courses, particularly when the cost of travel is factored in. Professionals are needed where they are—on the job. We’re demonstrating that we can overcome these problems by producing and offering substantive courses entirely over the Internet. Our experience has been that we can use Internet methods to effectively teach the same number of people we can teach in a traditional classroom, which usually has 30 to 40 students. With more students than that, it’s hard for the professor to give each student the personal attention he or she deserves.”

The first course, appropriately enough, is titled “Learning to be a Distance Learner.” Capper explains, “We have to teach people how to use the Internet for learning, as well as how to solve technical problems they might encounter with their computers and modems or in accessing the Web.”

The other five courses included in the program are Managing Human Resources in Public Health Organizations, Health Information Systems for Public Health Professionals, Financial Management of Public Health Organizations, Executive Leadership in Public Health, and Strategic Management of Public Health Organizations.

**More Student Participation**

The courses incorporate workbook readings, streaming video lectures, asynchronous threaded “classroom” discussion among participants via the Internet, and e-mail consultations with the teacher. In addition, students frequently interact with leading public health professionals who have extensive experience in public health practice.

“I believe the level of student participation in the discussion aspects of Internet courses will be higher than in traditional classroom settings,” Capper says. “In general, most students in classroom situations listen but don’t talk. However, in an Internet class, a much higher percentage of students actively participate, because participation is the only way of making your presence known.”

“Since all of the students taking the online course are practicing public health professionals, we designed the curriculum to be as flexible as possible. Classes can be finished in 10 weeks, but we leave each individual course ‘open’ for up to three months, to accommodate students who may have fallen behind because of responsibilities on the job or at home. We want to give them every opportunity to complete the program.”

Capper says he anticipates an exceptionally high completion rate for the six courses in the initial program.
In an effort to become more community-based and responsive to the needs of clients, the Arkansas Department of Health (ADH) has undertaken a rigorous reorganization process. UAB health care organization and policy faculty Peter M. Ginter and W. Jack Duncan have served as consultants to the ADH during this process.

“They’re both excellent advisors,” says Gail Gannaway, one of many ADH leaders who worked with Ginter and Duncan on the new ASPIRE (Arkansas Strategic Planning Initiative Results in Excellence) program. “Instead of coming in and telling us pointblank how to do things, they have advised us on how to clarify and achieve our objectives and goals on our own.”

ASPIRE originated in 1996, when ADH’s then director Sandra Nichols, M.D., decided that the 83-year-old health department needed to be more “future focused” in light of the rapidly changing health-care environment. The ultimate goal was to ensure that ADH was appropriately serving the health needs of Arkansas’ 2.5 million citizens.

“One major initiative to come out of our strategic plan was to become more community-based,” Gannaway notes, “and to build coalitions within communities to help them develop solutions to their own local problems. It’s going to take a different kind of leadership to accomplish that. That’s one major insight we’ve gotten from Jack and Pete—the need for an increased emphasis on leadership versus management.

“Administratively, the health department was organized into service category bureaus,” says Gannaway. “We had 10 management areas, but they were controlled by our main office. Our decision-making was centralized and hierarchical. Many staff members in local units had dual lines of supervision. The service workers had professional supervision, as well as administrative supervision from management staff. Arkansas is one of the few states where the local units—the county health departments—are arms of the state department of health. We have 95 local health units scattered throughout the state, with a total of about 3,000 employees.

“Jack’s and Pete’s experience and knowledge as consultants have been invaluable,” says Gannaway. “They taught us how to do a situational analysis and compare where we were then to what we believe is our mission and vision for the future.

“The first thing we did was get input from our own employees,” Gannaway says. “More than 2,500 ADH employees participated by putting their views in writing.” From that pool of information, the reorganization leadership group wrote a report titled “Removing the Barriers to Excellence.” But even before the report was printed, change had started to take place.

In 1998, Nichols resigned to move into the private sector, and Fay Boozman, M.D., was appointed ADH director. “Dr. Boozman closely studied our strategic plan and fully embraced it,” Gannaway says. “His role has been crucial in realigning the department. We’ve facilitated many meetings discussing the reorganization issue, and we provided a fair amount of information on decentralized structures, but Dr. Boozman is the real force and passion behind the ‘total’ restructuring of the health department. He truly believes that improved health in Arkansas must occur at the local level. He also believes that decision-making, responsibility, and accountability lies with local administrators and employees.”

Since 1999, ADH employees have been calling their strategic plan Aspire2 “because we’re taking it to the next level,” Gannaway explains. “We’re really trying to change the ‘culture’ of our health department by empowering our employees to make decisions.

“Before, ADH was control-and-command oriented. Now we’re trying to move toward a team-based leadership system that will support employee decision-making at the local level. It’s imperative to make decisions at the point of service, and in order to do that we need educated, empowered employees.”

The Arkansas Department of Health plans to have the new organizational model in place by July 2001.

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### ARKANSAS DEPARTMENT OF HEALTH
**Interim Organization Chart**
**Effective May 1, 2000**

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[Image of organization chart]
In this presidential election year, Medicare reform and Medicare prescription drug coverage have been hot topics of debate. Polls indicate that both topics are of primary concern to voters, particularly older Americans. For that reason, the League of Women Voters and UAB’s Lister Hill Center for Health Policy recently held a public forum to discuss the pros and cons of Medicare reform.

UAB health policy expert Michael Morrisey, director of the Lister Hill Center, outlined why Medicare reform is needed, options for its reform, political viability, and the pluses and minuses of reform. He also discussed the issues surrounding prescription drug coverage.

**Overdue for Overhaul**

First of all, Morrisey points out that the Medicare system is overdue for an overhaul. The system is going broke, it is increasingly less like the insurance that people have during their working years, and its benefits are inadequate. The Medicare Trust Fund will be exhausted by the year 2023, he says. At that time, there will be almost 50 percent more retirees than there are today, and instead of nearly four workers for every retiree, there will be less than 2.5 then. Minor reforms can’t compensate for the enormous burden that the baby-boom generation will exert on the system. Moreover, to continue expanding benefits doesn’t make the cost problem any easier, Morrisey says.

Medicare is modeled after 1960s health insurance coverage programs. But, today, few people with employer-sponsored coverage have insurance plans that remotely resemble Medicare. Newly released numbers suggest that in 2000 only 8 percent of workers with health insurance coverage are insured through traditional plans, while 92 percent are insured via managed care. When these workers retire, they will find Medicare to be an alien system, Morrisey predicts.

Worse yet, he says, the current Medicare benefit package is inadequate—the number of days allowed for inpatient care are limited, there is almost no coverage for preventive care, long-term care is not covered, and, of course, there is no prescription drug coverage. More than 85 percent of seniors currently have medical coverage in addition to Medicare.

Morrisey says advocates have proposed a broad range of options for reform, ranging from “pure collectivization” to “pure privatization” with many options in between. Some are political non-starters. All have different implications for taxpayers and for beneficiaries. Most importantly, they take different views on the roles of government and health-care markets.

One option is pure collectivization. This approach would replace existing Medicare with a government run program such as the existing Veterans Affairs system. Beneficiaries would see only Medicare employed physicians and be cared for in Medicare-run hospitals. The rejection of Clinton’s health-care reform plans makes this approach highly unlikely.

Pure privatization is also unlikely. Under this plan, people would be given tax incentives to save for their health insurance needs after retirement. Morrisey says this plan is like a medical IRA. People would save while young and upon retirement they would use the money to buy private insurance. In his view this approach places too much faith in individual foresight and would curtail the government’s role too sharply for most Americans.

“Individualism” would convert Medicare to a catastrophic coverage plan. Medicare would only begin paying for medical care after the beneficiary had incurred a certain amount of out-of-pocket health care expenditures. “This is health insurance in its purest form” says
Morrisey, “it covers high cost and modest probability events. However, few Americans buy this type of coverage. The limited success of Medical Savings Accounts makes this approach a long-shot.”

The final three options are more viable, he says. A “Defined Contribution” approach to Medicare reform is similar to an education voucher system, in which seniors would receive a fixed amount of money from Medicare to purchase a private health insurance plan. A strength of this plan is that it clearly defines and limits how much taxpayers would be contributing to the Medicare program. Recipients also would have wide choice. They could purchase traditional coverage or some form of managed care. However, if the premium were greater than the voucher, they would have to make up the difference themselves. One problem with this approach is that the size of the voucher would be tied to the health status of the senior. “Our ability to risk adjust is still pretty rudimentary,” says Morrisey.

The “Premium Support” plan is the other serious new approach to reform. Under premium support, Medicare would define a new set of core benefits that all plans offering Medicare coverage would have to provide. Within each local market, insurers would compete to be the low bidder. Medicare beneficiaries could choose to enroll in this plan at no out-of-pocket premium or they could choose another approved plan, perhaps with expanded benefits, and pay an additional premium.

Under either of these options, seniors would be much more likely to be enrolled in managed care plans than they are today. The issues of relative cost, coverage, out-of-pocket payments, and quality of care all depend upon the details, and those have yet to be spelled out.

The most likely approach to reform, according to Morrisey, is “incrementalism.” This approach keeps Medicare pretty much in its current form, but institutes small reforms. These include lowering payments to physicians and hospitals, increasing cost sharing by seniors, changing the way Medicare-HMOs are paid, and selectively adding benefits. “While this may seem like the safest course,” he says, “it has its own serious limitations. The big problem is the cost of all those retiring baby-boomers. Reducing provider payments means that ultimately it will be difficult to find a provider willing to accept Medicare. Increasing cost sharing means that seniors pay a larger and larger part of the bill. Adding benefits means that costs rise.”

“Our ability to risk adjust is still pretty rudimentary,” says Morrisey. “Every senior gets a little end coverage is more attractive politically,” says Morrisey. “Every senior gets a little back-end coverage would really big drug bills would get help. “Front-end coverage is more attractive politically,” says Morrisey. “Every senior gets a little something. But back-end coverage would prevent seniors from being crushed by the burden of large drug bills.”

Third, what type of coverage should be offered—front-end or back-end? “Front-end” coverage means that every senior would receive help for drug expenditures. “Back-end” means that only those with really big drug bills would get help. “Front-end coverage is more attractive politically,” says Morrisey. “Every senior gets a little something. But back-end coverage would prevent seniors from being crushed by the burden of large drug bills.”

Finally, who pays? With both political parties proposing tax cuts, Morrisey says, taxpayers are less likely to support higher taxes for more Medicare benefits. “On the other hand, in the late 1980s Congress made the mistake of asking seniors to pay for expanded benefits. Many of us recall the TV images of Congressman Rostenkowski’s limousine being pelted with fruit by unhappy seniors. Congress repealed the expansions the next year.”

Professor Emeritus Vernon E. Rose received the 2000 Smyth Award at the 2000 American Industrial Hygiene Conference in Orlando, Florida. The Smyth Award recognizes an individual who has made significant contributions to the industrial hygiene profession for the benefit of the public welfare.

UAB epidemiologist and Professor Emeritus Philip T. Cole, has received the Distinguished Academic Achievement Award from the University of Vermont. Cole was recognized for his important contributions and leadership in cancer epidemiology, particularly in the field of occupational and chemical carcinogenesis. He is a 1965 alumnus of the University of Vermont.

Martin Harper, Assistant Professor in the Department of Environmental Health Sciences, received the Harriotte Hurley Award for Analytical Accreditation Board member of the year at a reception sponsored by the American Industrial Hygiene Association Laboratory Quality Assurance Committee.
Leland Yee, M.P.H., 1999 (Epidemiology) presented a paper in May at the annual meeting of the European Association for the Study of the Liver in the Netherlands. He presented aspects of his work on the genetics of Hepatitis C virus infection, which he is currently working on with Richard Kaslow in the SPH and Dirk Jacob Van Leeuwen in the School of Medicine. Leland will begin working on his doctorate in January at the London School of Hygiene and Tropical Medicine, continuing his work with hepatitis C epidemiology and immunogenetics.

Margaret S. Davis, Ph.D., 1995 (Biostatistics), professor of mathematics at Floyd College in Cave Spring, Georgia, received the Wesley C. Walraven Award in May 2000. This is the highest faculty honor bestowed by the college and is in honor of its first dean.

Congratulations to Jessica Duke, M.P.H., 1998 (Maternal and Child Health), and her husband Scott Urbatsch on the birth of their son, Gabriel Herman Urbatsch. Gabriel was born August 23 and weighed 9 lbs., 2 oz. Jessica, Scott, and Gabriel are now living in Portland, Oregon.

Anastasia Seyer, M.P.H., 1998 (International Health/Epidemiology), married Nicholas Palmer in November 1999. She recently moved to Manchester, New Hampshire, where she works for Parexel International as an application specialist building and developing interactive voice response systems for clinical trials.

John Wulu, Jr., Ph.D., 1999 (Biostatistics), senior biostatistician/biometry and computing research head at Camcare Institute has been appointed to the American Heart Association Council on Epidemiology and Prevention Minorities Task Force for a one-year term, from July 2000 to June 2001. The AHA Minorities Task Force is responsible for reviewing policies, procedures and programs that have the effect of promoting epidemiology and prevention initiatives in minorities, making recommendations to the Council, providing a written report at least four weeks prior to the Executive Committee meeting, soliciting suggestions for structured programs for the AHA Scientific Sessions and the International Stroke Conference, and developing and implementing a written annual plan and budget to define strategies that will meet the goals of the Council’s Strategic Plan.

Jennifer Rye Brown, M.S.P.H., 1999 (Environmental Health), and husband David, celebrate son Caleb Ryan, who was born on September 3, weighing in at a whopping 11 lbs, 8 oz! Jennifer, David, and Caleb are living in Tacoma, Washington.

Alumni, Let Us Hear from You

Alumni, today’s Internet e-mail system makes it easy for us to stay in touch. So please take a few minutes to share any personal and professional news that you would like included in a future edition of the newsletter.

Send us an e-mail today at sphalumni@uab.edu. Don’t forget to include your name, the year you graduated, departmental degree(s) earned, your home address and telephone number, your work telephone number and e-mail address, as well as your position/title and the company or organization where you work.

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Pakistani Alumni Chapter Formed
School of Public Health alumni from Pakistan recently founded an SPH alumni chapter in their home country. Pakistani chapter members pictured here with Dean Eli Capilouto at SPH graduation ceremonies are Martha Sanchez (left) and Rehana Siddig.
The Board of Trustees of the University of Alabama System has designated the Kathleen Ellis Ryals Endowed Scholarship as a pure endowment—which means the scholarship funds must be maintained in perpetuity as stated by the donor—of UAB. The scholarship honors UAB School of Public Health friend Kathleen Ellis Ryals, who passed away in January 1999. Scholarships will be awarded to deserving School of Public Health students.

Mrs. Ryals was born Kathleen Virginia Ellis on July 23, 1909, in Lowndes County, Alabama, and graduated from Lowndes County High School in Fort Deposit, Alabama, in 1926. She attended Livingston Normal School for Teachers and taught school in Alabama for 10 years.

"Mrs. Ryals was committed to improving health care in the rural areas of Alabama. She was a dedicated teacher and community leader," said Dr. J. Michael Foster, dean of the School of Public Health at UAB.

"She lived a life of service to others, and we are honored to continue her legacy through the establishment of this scholarship," Foster said.

"We are grateful for the generosity of Mrs. Ryals and her family," said Dr. Robert O. Queen, chair of the UAB Board of Trustees. "This scholarship will help us to continue our mission of providing high-quality education and research in the field of public health.

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If you have any questions about giving to the UAB School of Public Health, please call Mark Haney, director of development, at (205) 934-7775.

Lynn Walter, an M.S.P.H. student in the Department of Environmental Health Science's industrial hygiene program, received a 2000-2001 American Industrial Hygiene Foundation scholarship.

National Health Group Recognizes SPH Alumnus

School of Public Health alumnus Allan Kennedy, a senior executive of the Baptist Health System, has achieved the highest level of certification in the American College of Healthcare Executives, an international professional society of nearly 30,000 health-care executives.

Kennedy has earned the distinction as board certified in health-care management and receives the designation of Fellow of the American College of Healthcare Executives (FACHE). He serves as senior vice president of Ambulatory Services for Baptist Health System, Inc., as well as president of both Baptist Health Centers, Inc., a network of primary-care practices, and Southern Medical Group, Inc., which provides physician staff for emergency rooms.

Kennedy received three degrees from UAB—a bachelor of science degree in biology and master's degrees in public health and business administration.

Before joining the staff of Baptist Health System in 1990, he was affiliated with the Volunteer Hospitals of America Physician Services, UAB's School of Optometry and the Jefferson County Health Department Office of Health Center Administration.
School of Public Health Wins Spirit Award

The UAB School of Public Health won the 2000 UAB Homecoming Spirit Award. “We also tied for first place with the School of Social and Behavioral Sciences for the 2000 UAB Homecoming Building Competition,” says Joan Ohn, SPH director of alumni relations and career services. “We also won in 1999, so this is two years in a row for us.” Homecoming awards are sponsored by the UAB National Alumni Society. “Spirit competitions raise awareness of UAB’s fall homecoming tradition,” Ohn says. “The added bonus for all of us—faculty, staff, and students—in the School is that we can work together on a ‘fun’ project that supports the university.”

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