under Process B the opportunity to continue to do so. You will be hearing more about these when they come online in January 2005.

From Family Physician in Kenya

Q Today I received documents from the ABFP about the new MC-FP program for family physicians. I applaud the Board's attempt to assure competence and quality in our specialty. However, I have some personal concerns. I am a board-certified (and recertified) family physician who maintains an active medical license in Kentucky, even as I work as a full-time missionary doctor in rural Kenya. What mechanisms will the ABFP have to help me stay current when I am out of the United States most of the time? I have been able to secure the required number of CME hours through various distance courses. I have been eligible to keep my certification each time I have recertified by following Process B. What will this new process of Maintenance of Certification mean to me? Are there mechanisms to accommodate my situation? Thank you for your attention to this question. I am certain that I am not the only American family physician who is in this situation.

A Thank you very much for your letter. You will be able to keep abreast by participating in MC-FP via the Web from Kenya. The Self-Assessment Modules (SAMs) can be taken online, and you will receive credit toward your 300-hour CME requirement for the time spent completing these modules. We will have unique components for Part IV (eg, patient safety) for those who do not have continuity patients. You will be able to continue to recertify just as you have done in the past using Process B. There is an increasing amount of CME available on the Web and much of it is free. Visit FamilyPractice.com at http://www.familypractice.com to see some of their offerings.

From a Hospital Family Practice Department

Q Basically, our questions are of necessity and expense. Frankly speaking, many of us are struggling to find ways of cutting expenses. Personally, I think the idea has merit, but I really do not know whether I can afford any more expenses. My department members concur that the MC-FP program may be valuable, but question whether this is the time to add new burdens to those already facing them.

A We are fully cognizant of the pressures confronting family physicians. We have designed the MC-FP so that it would take no more time than our current recertification process. The only difference is that we will be asking you to participate in selected components on a regular basis (namely, the Self-Assessment Modules in Part II). The amount of time that you spend completing these modules, and the Performance in Practice Modules in Part IV, will be credited toward your 300-hour CME requirement, and you will be able to do these from a computer in your home or office. This will offset some of the cost and time that you would have spent to obtain CME under the current recertification process.

We anticipate that the cost associated with delivering MC-FP over the Web will be more than offset by the savings realized by CME offsets for completing Parts II and IV, and avoiding travel, hotel costs, and lost opportunity income from practice associated with taking the recertification examination at a limited number of written test centers on a single day. By 2005, we will be offering the examination by computer at more than 200 sites and on multiples dates. When you figure these savings, you will find that your cost of participating in MC-FP is less than the cost of recertifying using the current process.

This year the recertification fee was $850, which is $100 less than what any other specialty board charges and is almost half of the average charged by all other boards. That works out to about $121 per year over the 7-year recertification cycle, or about $0.33 per day. When viewed in this manner, I hope you would agree that we have been not only cognizant of the issue of cost but also responsible in providing a certificate which provides considerable added value. In an effort to underscore that the fee covers the entire recertification process, when we begin MC-FP in January, we will offer the opportunity to "pay as you go." We do believe that MC-FP will be a value-added activity for you and your colleagues. Clear evidence exists that, in the future, physician reimbursement is going to be tied to quality. The Center for Medicare Services is readying a pilot program to base reimbursement on performance measured against quality indicators. The private insurers will not be far behind. We expect that participation in MC-FP will satisfy these requirements, as well as those that are being discussed by several state licensure boards regarding relicensing examinations by specialty.

From the Society of Teachers of Family Medicine

THE SOCIETY OF TEACHERS OF FAMILY MEDICINE PRESENTS ITS 2003 STFM BEST RESEARCH PAPER AWARD TO DAVID MEHR, MD, MS

At its annual conference in September 2003, the Society of Teachers of Family Medicine presented its 2003 Best Research Paper award to David R. Mehr, MD,

MS, and his colleagues: Ellen Binder, MD; Robin Kruse, PhD; Steven Zweig, MD, MSPH; Richard Madsen, PhD; Lori Popejoy, MSN, RN; and Ralph D'Agostino, PhD. The paper, "Predicting Mortality in Nursing Home Residents with Lower Respiratory Tract Infection: The Missouri LRI Study," was published in the *Journal of the American Medical Association* in November 2001.[1] Dr. Mehr, an associate professor at the University of Missouri-Columbia, presented the paper at the Research Award Winners session at the annual conference.

The Missouri LRI Study identified a new predictive model for 30-day mortality risk among nursing home residents with lower respiratory tract infections (LRIs). The 8 variables in the model are absolute lymphocyte count, level of independence in activities of daily living, body mass index, presence of mood deterioration within the previous 90 days, pulse, serum urea nitrogen level, sex, and white blood cell count. These variables, when assigned a point value and summed, accurately stratified nursing home residents with LRIs into quintiles of mortality risk. In the study's validation sample, 30-day mortality ranged from 1.8% in the low-risk quintile of patients (with scores of 4 or lower) to 54.2% in the very high risk quintile (with scores of 11 or higher). If the rule is validated outside Missouri, it will be a particularly valuable tool for identifying relatively low risk nursing home residents who might not need hospitalization.

As with many important research findings, the motivation for the study arose from questions in clinical practice. Dr. Mehr practiced family medicine and geriatrics in a variety of community and nursing home settings through the 1980s, and he wondered about the best way to treat pneumonia in nursing home residents. "There was a major disconnect between the literature and clinical practice," Dr. Mehr said. "Experts recommended hospitalizing all nursing home residents with pneumonia and treating them with parenteral antibiotics. Actual practice commonly included treatment in the nursing home with oral antibiotics." As he studied the area in more depth as a geriatric medicine fellow in the late 1980s, he found that most studies were retrospective or not focused on the nursing home, whereas pneumonia and other LRIs are the leading cause of mortality. His time as a full-time clinician was invaluable in developing the Missouri LRI Study. "I had a clear focus on staying practical," Dr. Mehr said. For example, the research team decided to expand the study beyond pneumonia to LRIs in general, because the clinical distinction among pneumonia, bronchitis, and tracheobronchitis often difficult.

Although the design focused on practicality, Dr. Mehr still reports he had many challenges in the study's development. Because approximately two thirds of potential subjects would be cognitively impaired, informed consent was a potential barrier, "and those were the folks we most wanted to study," Dr. Mehr added. He worked with his medical center's institutional review board to develop a clinical protocol that was consistent with the standard of care, thus not requiring written consent of the patients. The challenge then became recruitment of nursing homes and physicians who would agree to the protocol. In the end, 36 nursing homes in central Missouri and St Louis became involved, and the project identified 1,044 individual residents with 1,406 LRI episodes.

The analysis posed its own challenges and surprises. The initial list of variables was huge, encompassing 25 categories of factors. A process of bivariable and multivariable analysis narrowed the model to the 8 specific criteria in the final model. "Creating a useful clinical model turned out to be a bigger challenge than I ever anticipated," said Dr. Mehr. "I thought I knew a lot about modeling at the start, but I didn't know anything!" He and his team were eventually able to identify the areas of overlap and eliminate some variables. Cognitive status, for example, is not included in the final model. "It unquestionably relates to ADL status, which is in the final model," observed Dr. Mehr. He also said the importance of mood deterioration in the previous 90 days (as reported by nursing home staff) was surprising to the research team and might be a broader indicator of general decline. The practical decision to include other LRIs in addition to pneumonia led to another somewhat surprising finding—that the presence of pneumonia on a chest radiograph was not a significant predictor of mortality.

While individual clinical decisions involving LRIs in the nursing home depend on many factors, Dr. Mehr feels this study adds another tool that health care providers, their patients, and families can use to make a more informed decision. "Understanding what indicates high risk is important, and this helps us recognize that treatment in the nursing home with oral antibiotics is acceptable and reasonable in most cases," which, he said, is more in line with what happens in other countries. His interest in international variations in nursing home LRI care led to a productive relationship with a group of Dutch physicians and researchers. He eventually spent a year in The Netherlands learning their approach to LRIs and advanced dementia. "The international collaboration that flowed out of this was hugely illuminating in terms of end-of-life care issues," he said. "This whole experience reinforced how crucial it is to decide on goals of care ahead of time." If patient and family preferences regarding hospitalization and aggressiveness of care are known

before an LRI episode occurs, Dr. Mehr believes that the study's prediction rule would make treatment decisions more straightforward. As a future research direction, he is interested in following up on another part of this study that identified communication barriers between nursing home staff and physicians; these barriers can account for unnecessary and often hazardous hospitalization. "Ultimately, we could probably treat at least three quarters of these cases in the nursing home," he said.

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Reference

1. Mehr DR, Binder EF, Kruse RL, et al. Predicting mortality in nursing home residents with lower respiratory tract infection: The Missouri LRI Study. *JAMA*. 2001;286:2427-2436.

MARK YOUR CALENDARS FOR THE UPCOMING STFM CONFERENCES

25th Anniversary Conference on Patient Education

November 20-23, 2003
Hyatt Regency San Antonio Riverwalk, San Antonio, Texas

30th Anniversary Predoctoral Education Conference

January 29-February 1, 2004
Hotel InterContinental, New Orleans, Louisiana

24th Annual Conference on Families and Health

February 25-28, 2004
Amelia Island Resort, Amelia Island, Florida

37th Annual Spring Conference

May 12-16, 2004
Westin Harbour Castle, Toronto, Ontario, Canada

Visit http://www.stfm.org for more information on any of the above conferences.