Winter 2016

American Board of Family Medicine, Inc.

THE PHOENIX

A Diplomates' Newsletter

A Message from the President

James C. Puffer, M.D.

In preparing my message for this newsletter, I looked back over the first several issues that we published after our decision to resurrect this form of communication in 2005 to keep you updated on Maintenance of Certification for Family Physicians (MC-FP). As we transitioned together into MC-FP from our old recertification paradigm, I made several promises to you in each of those issues. I assured you that 1) we wanted to develop meaningful, continuous, long-term relationships with each of you as we worked together to help you deliver the highest quality of care to your patients; 2) we would listen carefully to the feedback that you provided to us and act on it accordingly to make completion of your requirements as efficient as possible; and 3) we would endeavor to evolve MC-FP in keeping with the best evidence of assessment, measurement, and quality improvement science.

In keeping with these promises, I have several important improvements in MC-FP to announce. These include no longer requiring completion of the clinical simulation component of the Self-Assessment Modules (SAMs) for MC-FP Part II credit, transitioning everyone to the MC-FP point system, adding a new Continuous Knowledge Self-Assessment process to the Part II menu, and instituting a major discount in fees for Diplomates over the age of 70.

Unlinking the Clinical Simulation from the Knowledge Assessment in the SAMs

We have just completed an exhaustive review of all of the evaluations that you provided after completion of your Performance in Practice Modules (PPMs) for Part IV and the Self-Assessment Modules for Part II. I shared the preliminary results from the very positive feedback that you provided with respect to the PPMs in the Phoenix last winter. These data have now been fully analyzed and a peer-reviewed manuscript has been accepted for publication this year. Our research staff has just finished a thorough analysis of the SAM data. Unlike the PPM data however, these data were somewhat more concerning.

While you provided very positive feedback with respect to the 60-question knowledge assessment portion of the SAMs, your assessment of the utility of the clinical simulation component was less favorable. Not only were the quantitative evaluations significantly lower, the qualitative analysis of over 5 million open-ended feedback comments from 325,000 completed SAMs also revealed several important concerns with respect to technical and navigation issues in the simulations. In an effort to determine whether Diplomate familiarity and periodic technical improvements had affected your ratings over time, we analyzed a second data set from almost 100,000 SAMs completed more recently in 2013 and 2014.

The findings were essentially unchanged. You consistently rated the knowledge assessments more favorably than the clinical simulations. The majority of the negative comments about the clinical simulations revolved around four major issues: difficulty in ordering or scheduling tasks; inadequate recognition of questions or language by the simulator; limited medication, treatment and diagnostic options; and the lack of "realness" in the simulation environment. We provided these data to our Board of Directors for review at their April 2015 and October 2015 meetings. Between those two meetings, our Clinical Simulation Team, led by Senior Vice President Michael Hagen, undertook the task of making several technical improvements to the clinical simulation interface.

While these changes resulted in improvement in the clinical simulation evaluations during this brief period of time, our Directors endorsed unlinking the clinical simulation and knowledge assessment components of each SAM, thereby making the clinical simulations optional effective this year. Accordingly, the mandatory Part II requirement that at least one SAM be completed during each stage of MC-FP will be modified this year to mandate that at least one knowledge assessment, to be renamed Knowledge Self-Assessment (KSA), be completed in each stage in addition to at least one Part IV activity. In order to avoid the confusion of the multiple permutations of Part II and Part IV activities that could be combined to meet your stage requirements, we will also be transitioning all Diplomates to a point system to simplify how you meet your stage requirements.

Transitioning all Diplomates to the MC-FP Point System

Those of you that have entered continuous MC-FP (those initially certifying or maintaining their certification in 2011 and thereafter) are by now very familiar with this system. For those that are not, it simply requires that you accumulate 50 MC-FP points in each stage with completion of at least one Part IV activity and one Part II activity. That mandatory Part II activity will now be a KSA instead of a SAM (knowledge assessment plus clinical simulation); the SAM terminology will no longer be used. Most Part IV activities (but not all) are valued at 20 points; the KSAs will now be worth 10 points each and the clinical simulations, to be renamed Clinical Self-Assessment (CSA), will be valued at 5 points. After completing at least one Part IV activity and one KSA, you will be able to mix and match any additional Part IV activities, KSAs or

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CSAs to reach the 50 point requirement.

As you might suspect, these major changes for the MC-FP Part II requirement and conversion of all Diplomates to the MC-FP point system will require significant re-programming of our website and your portfolios. We have provided an article in this issue that discusses the transition noted above in greater detail. We will hope to have all of these changes in place by July 1 of this year.

Development of a New Continuous Knowledge Self-Assessment for Part II

Three major events occurring over the past eight months have significantly influenced our plans to revise our Part II Platform for Maintenance of Certification for Family Physicians (MC-FP) beginning this year. The first was the testing summit held by the American Board of Pediatrics (ABP) that we attended late last spring. A number of assessment experts brought the meeting participants up to date with best practices in the clinical assessment arena; a single, high-stakes examination was not at the top of their list. The consensus opinion that had developed by the end of the summit was that frequent, smaller scale assessment was a much more accurate way to measure knowledge and ability.

The second event was a presentation by the American Board of Anesthesiology (ABA) at the American Board of Medical Specialties (ABMS) meeting held in Chicago in June. They provided results from their MOCA (Maintenance of Certification-Anesthesiology) Minute format that they have used for the past few years as their Part II platform. This format has been overwhelmingly popular with their Diplomates, and it essentially sends out a couple of questions—which their diplomates have one minute each to answer—per week. After they submit their answer, they receive immediate feedback on whether they answered the question correctly and the rationale for the correct answer. The ABA has gathered very useful information on the knowledge gaps of its Diplomates, and they have shared this information with their professional society for purposes of CME development. This activity has been so successful that they are now embarking on a pilot that has been approved by the ABMS Committee on Continuous Certification (CCC) to use this same format to make summative decisions on the knowledge of their Diplomates for Part III.

The third event occurred in October when a blue-ribbon task force created by the American Board of Internal Medicine (ABIM) released its white paper on Assessment 2020. This separate group of experts independently came up with similar recommendations with regard to assessing medical knowledge: multiple, frequent assessments over time are much better than a single, high-stakes examination.

Armed with this information, we sent several members of our staff to the 2015 MOC Summit in late July hosted by the ABA and ABMS to learn more about the ABA's experience with continuous longitudinal assessment. Thirteen other ABMS Member Boards were in attendance and most were very interested in learning how this format could be used to replace their high-stakes maintenance of certification (MOC) examinations. We know that several are considering moving in this direction, most notably the ABA and the ABP. However, after reviewing all of the information from the meeting, we do not believe this format is quite ready for prime time for use by the ABFM in Part III yet. The major obstacles in doing so are security, creation of sufficient secure assessment items, and uncertainty about the psychometric methodology that will underlie summative decision making.

Accordingly, our Board of Directors recently approved an alternative Part II activity that would use the MOCA Minute format and which we would use to provide targeted feedback to our Diplomates about their specific knowledge gaps as well as the probability that they would pass the MC-FP examination. This offering will allow Diplomates to choose completing KSAs or this alternative activity, which will be named Continuous Knowledge Self-Assessment (CKSA), to meet their MC-FP Part II requirements. We are planning to make this option available in early 2017. Over the course of the following three years, we hope to use data gathered from those Diplomates choosing this Part II offering to assess the feasibility of using this format to replace the current Part III examination.

Discounting the Cost of MC-FP for Diplomates over Seventy Years of Age

I have mentioned previously the significant number of Diplomates who continue to participate in MC-FP well into their 70s, 80s and 90s despite the fact that they are no longer practicing. As a matter of fact, I recently talked to a 96-year old Charter Diplomate, Dr. Edward Hill (he took the very first certification examination in 1970), who finally decided to retire and allow his certification to lapse! In recognition of the dedication and commitment that these Diplomates have made to our specialty, we will offer them a 50% discount on their MC-FP fees if they wish to continue to maintain their certification.

Before closing, I would be remiss in not directing your attention to two other important articles in this issue. The first describes our selection as one of 39 health care collaborative networks selected to participate in the federal Transforming Clinical Practice Initiative (TCPI). This initiative was designed to help physicians transform their practices to enhance care coordination and expand information-sharing. We will collaborate with the American Academy of Family Physicians (AAFP) on this effort and will receive as much as $538,000 to help offer the tools, information, and network support needed to assist physicians as they improve the quality of care they provide, increase patients' access to information, and ensure more judicious use of health care dollars. Our registry, which was discussed in great detail in our last issue of the newsletter, will be an integral part of our strategy to strengthen quality of care and develop comprehensive quality improvement strategies for those participating in these networks.

The final, but not least important article, describes the increasing rate of physician burnout and our specific efforts to

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Self-Assessment Modules (SAMs) to Become Two Separate Activities

In an effort to make MC-FP more customizable and effective for individual physicians, starting this summer the current Self-Assessment Module, known as a "SAM," will be divided into two separate activities. The SAM is currently comprised of two parts including a 60-question knowledge assessment and a patient clinical simulation. Once the SAM is divided into two activities physicians will be able to choose whether to complete the 60-question Knowledge Self-Assessment (KSA) and/or the Clinical Self-Assessment (CSA) simulation for MC-FP Part II credit.

In order to make the MC-FP requirements easier to understand for all physicians and to allow for adding various MC-FP activities in the future all physicians will transition to an MC-FP points plan this summer. This change will make completing the MC-FP requirements more flexible for each physician and simpler to understand.

How will this change affect the 3-year stage requirements?
The current minimum Part II requirement for each stage is completion of at least one (1) Self-Assessment Module (SAM), and that will now be replaced by completing a minimum of one (1) Knowledge Self-Assessment (KSA) activity. Completing the Clinical Self-Assessment (CSA) will still provide credit towards the maintenance of certification process, but the 60-question Knowledge Self-Assessment will now be the minimum requirement for MC-FP Part II The remaining requirements will consist of completing a minimum of one Part IV activity and additional Part II or Part IV activities to reach a total of 50 MC-FP points during the 3-year Stage.

For physicians whose initial certification examination or most recent successful recertification exam was prior to 2011 and who are on the 10-year certification pathway, the stage requirements can be successfully completed in various ways. Below are a few examples:

Options	Part II**		Part IV	MC-FP Points
	Knowledge Self-Assessment (10 MC-FP pts)	Clinical Self-Assessment (5 MC-FP pts)	PPM, MIMM, etc. (20 pts)	Additional Part II or Part IV Activities to Total
Option 1*	2 KSA	2 CSA	1 Part IV	50 MC-FP Points
Option 2	3 KSA	0 CSA	1 Part IV	50 MC-FP Points
Option 3	1 KSA	0 CSA	2 Part IV	50 MC-FP Points

*Option 1 reflects completing the 3-year Stage with two (2) SAMs and one (1) PPM.
**Part II requirement also includes completing continuing medical education activities equaling 300 CME hours in the last six years prior to the examination year. Part II SAMs, KSAs and CSAs, as well as Part IV activities that have CME credits, can be applied toward the CME requirement.

How will this change affect the 7-year certification requirements?
The current minimum requirement for Part II in the 7-year cycle is at least three (3) Self-Assessment Modules, and that will now be replaced by completing a minimum of three (3) Knowledge Self-Assessment (KSA) activities. Completing the Clinical Self-Assessment (CSA) will still provide credit towards the maintenance of certification process, but the 60-question Knowledge Self-Assessment will now be the minimum requirement for the Part II activities. The remaining requirements will consist of completing a minimum of one (1) Part IV activity and additional Part II or Part IV activities to reach aminimum of 110 MC-FP points in the seven years.

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understand how prevalent this phenomenon is in board-certified family physicians. The findings from the data that we collect will inform our decisions on how we can further enhance MC-FP to create added value and less burden for practicing family physicians in keeping with our promises that we have made to you.

In closing, let me extend my sincere thanks to each of you who has provided information to help us with the decisions that I have announced in this message; your invaluable input allows us to continually improve the MC-FP process.

Self-Assessment Modules (SAMs) to Become Two Separate Activities

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For physicians whose initial certification examination or most recent successful recertification exam was prior to 2011 and who chose to remain on the 7-year path, requirements can be successfully completed in various ways. Below are a few examples:

Options	Part II**		Part IV	MC-FP Points
	Knowledge Self-Assessment (10 MC-FP pts)	Clinical Self-Assessment (5 MC-FP pts)	PPM, MIMM, etc. (20 pts)	Additional Part II or Part IV Activities to Total
Option 1*	6 KSA	6 CSA	1 Part IV	110 MC-FP Points
Option 2	9 KSA	0 CSA	1 Part IV	110 MC-FP Points
Option 3	3 KSA	0 CSA	4 Part IV	110 MC-FP Points

*Option 1 reflects completing the 7-year cycle as most have done to date with six (6) SAMs and one (1) PPM.
**Part II requirement also includes completing continuing medical education activities equaling 300 CME hours in the last six years prior to the examination year. Part II SAMs, KSAs, and CSAs, as well as Part IV activities, include CME credits which can be applied toward the Part II CME requirement.

How will this change the Continuous MC-FP 3-year stage requirements?
The current minimum Part II requirement for each stage is completing at least one (1) Self-Assessment Module, and that will now be replaced by completing a minimum of one Knowledge Self-Assessment (KSA) activity. Completing the Clinical Self-Assessment (CSA) will still provide credit towards the maintenance of certification process, but the 60-question Knowledge Self-Assessment will now be the minimum requirement for the Part II activities. The remaining requirements will consist of completing a Part IV activity and additional Part II or Part IV activities to reach a total of 50 MC-FP points in the three years.

For physicians whose initial certification examination or most recent successful recertification exam was in 2011 or after, your stage can be successfully completed in the following way:

Options	Part II			Part IV	MC-FP Points
	Knowledge Self-Assessment (10 MC-FP pts)	Clinical Self-Assessment (5 MC-FP pts)	CME (minimum 50% Division 1)	PPM, MIMM, etc. (20 pts)	Additional Part II or Part IV Activities to Total
Option 1	Minimum 1 KSA	No Minimum CSA	150 Credits	Minimum 1 Part IV	50 MC-FP Points

Currently the SAM is completed for 15 MC-FP points under the Continuous MC-FP process. What will the point values be for the Knowledge Self-Assessment (KSA) and the Clinical Self-Assessment (CSA) simulation?
The KSA will be worth 10 MC-FP points, and the CSA will be worth 5 MC-FP points.

What if I have already started or completed a Self-Assessment Module (SAM) in my current Stage requirements?
Completed SAMs in the current stage will count toward your MC-FP requirements. Any SAM in progress will need to be completed in full (both the knowledge assessment and clinical simulation) to receive MC-FP credit. A completed SAM will count toward the minimum KSA requirement and equal 15 MC-FP Points.

Will there still be a SAM once the module is divided?
No, the Self-Assessment Module as it has been known with the 60-question knowledge assessment and the clinical simulation together as one activity will no longer be a SAM. The two individual parts, the Knowledge Self-Assessment (KSA) and the Clinical Self-Assessment (CSA) simulation, will be completed individually as separate activities. At that time, only the SAMs in progress will remain available to be completed. No new SAMs will be able to be started.

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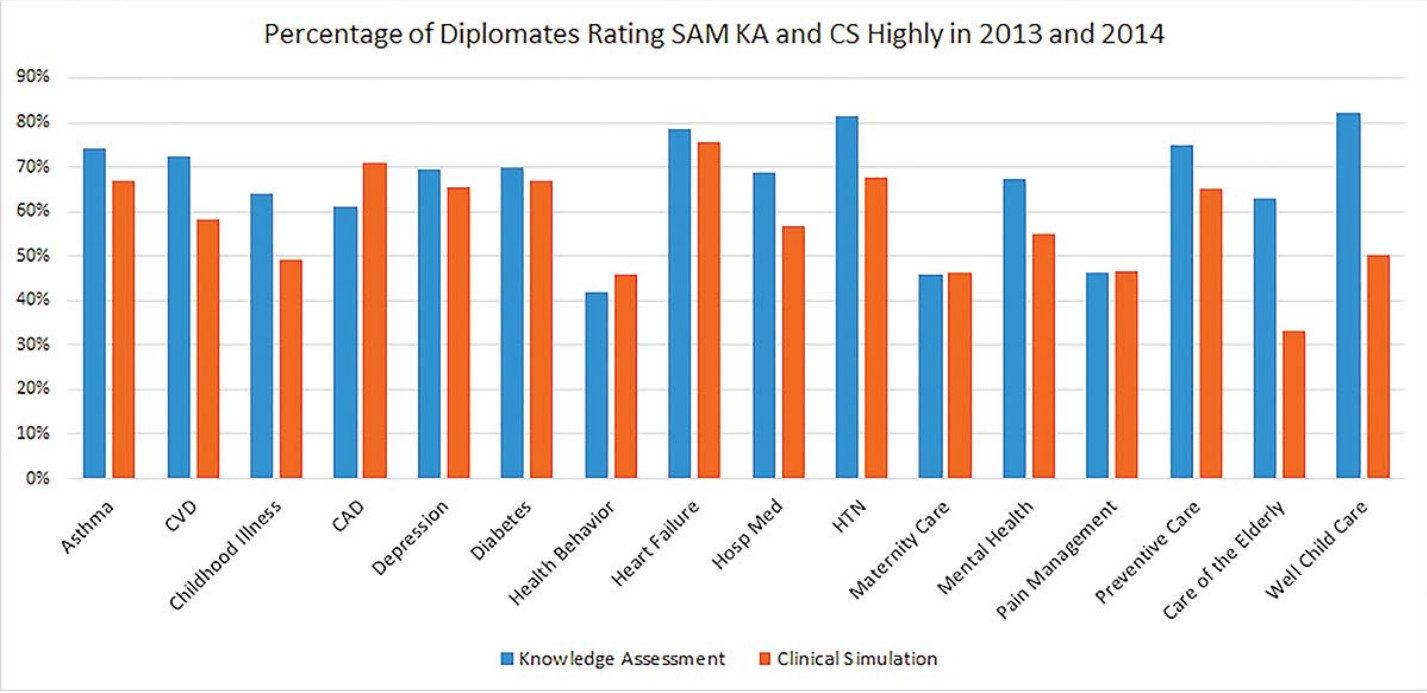
SAM Feedback Analysis Update

As Dr. Puffer mentioned in the 2014 Winter *Phoenix*, the research department has been analyzing over a decade's worth of feedback data from the SAMs and PPMs. Early results of the PPM analysis were reported in the 2014 Winter *Phoenix*, and a peer-reviewed manuscript will be published in 2016. As for the SAMs, the first round of results were presented to the ABFM Board of Directors in October 2014. These results were based on data from the start of MC-FP in 2004 to early 2013. From over 325,000 SAMs, our Diplomates provided over 5 million open-ended feedback comments! Our qualitative team developed a unique methodology to manage such a large qualitative dataset and were able to reduce feedback to approximately 440,000 meaningful comments. The first pass at the data showed that Diplomates rated the SAMs highly, and the qualitative feedback supported these numeric ratings. For example, comments of a positive nature (e.g., thanks, I learned a lot, very useful) outnumbered negative statements (e.g., waste of time, stinks) two to one. We also found that the clinical simulation (CS) portion was consistently rated lower than the knowledge assessment (KA) portion in most SAMs. In looking at the open-ended comments, these low CS ratings were mostly due to navigation issues, technical issues, and a lack of realness in the simulation. In addition, Diplomates expressed frustration with the CS when the learning objective and/or the end point was not clear. A final report from this round of analyses was provided to the Board at its April 2015 meeting.

As the first data set did not include the year of SAM completion and many of the issues with the CS may have resolved with improved internet connectivity and periodic improvements to the SAMs, we wondered whether the same issues were present in more recent years. To that end, we began analyzing a second set of data including all SAM feedback from 2013 and 2014, which included nearly 100,000 SAMs. Using the numeric ratings, we found the same pattern with the KA being rated consistently higher than the CS except in CAD and Health Behavior (see figure). In open ended comments, the same CS technical problems were reported as in the earlier data set. Specific issues that accounted for more than 60% of the CS comments included:

- difficulty in ordering or scheduling tasks
- not recognizing questions or language
- limited medication / treatment / diagnosis options
- lack of realness in the CS environment

We are preparing manuscripts for publication about the unique methods applied to this large data set and about the SAM feedback results.



ABFM Helping Diplomates Navigate Practice and Payment Changes

The ABFM and AAFP are collaborating on the Family Medicine Support and Alignment Network (SAN) to help family physicians take advantage of the Transforming Clinical Practice Initiative. This initiative is designed to give you resources to facilitate change so that your practice is prepared for Medicare and Medicaid payment changes, but more importantly, to help make your practice even more effective for your patients. Family physicians who join a Practice Transformation Network (PTN) under this initiative will be eligible for MC-FP Part IV credit, CME courses under development by the AAFP, and services to help improve their practices. PTNs are looking to enroll family physicians. You can find out more about this on the AAFP website here: http://www.aafp.org/practice-management/transformation/tcpi.html; the ABFM website here: https://www.theabfm.org/primeregistry/; or the HealthCare Communities website: http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx.

The ABFM is tripling the value of the grant from the Centers for Medicare & Medicaid Services, committing $6 million to supporting board-certified family physicians who join a PTN by enrolling them in the PRIME Registry free for three years. The registry is designed to allow practices to:

- Extract data from their EHR
- Assess and manage quality for patients and populations
- Participate in Maintenance of Certification
- Report for PQRS and Meaningful Use (available 2016)

To get the registry support for free, enroll in a PTN and be sure to sign up for the Family Medicine Support and Alignment Network (SAN) Community.

If you are an ABFM board-certified family physician, this will put you in the queue to be enrolled in the PRIME Registry for free. We plan to start enrolling practices in the PRIME Registry Spring 2016, and you'll be securing your place in the first 6,000 who can access it at no cost. If you work with other primary care clinicians, they can join the registry for $33/month. The PRIME Registry will work with 85 different EHRs.

Join our Family Medicine SAN Community on Healthcare Communities at: http://www.healthcarecommunities.org/Communities/TCPIAvailableCommunities.aspx to learn more or email Dr. Elizabeth Bishop at ebishop@theabfm.org.

IOM Puffer/American Board of Family Medicine Fellow Gerardo Moreno, MD, MSHS

The American Board of Family Medicine (ABFM) is pleased to announce the selection of Gerardo Moreno, MD, MSHS, James C. Puffer, MD/ABFM Fellow, as one of the National Academy of Medicine's (NAM) five Anniversary Fellows for 2015. Dr. Moreno is an assistant professor in the Department of Family Medicine at the University of California, Los Angeles.

The five fellows were chosen based on their professional qualifications, reputations as scholars, professional accomplishments, and relevance of current field expertise to the work of the NAM and the Institute of Medicine (IOM), the health and medicine division of the National Academies of Sciences.

Dr. Moreno is a federally funded clinician investigator with formal training and expertise in community-based participatory research (CBPR) and health services outcomes research. He is the 2015-2017 James Puffer M.D./ABFM Anniversary Fellow at the IOM and a recipient of a National Institute of Aging (NIA-NIH) Paul B. Beeson Career Development Award in Aging (K23). Dr. Moreno is co-director of the UCLA MyMeds program and is co-PI for the evaluation of this PCMH practice-based clinical pharmacist and health IT medication management program. He is also co-investigator of an NIH funded research project that investigates medication adherence among patients with chronic conditions and language barriers.

Dr. Moreno will be awarded a research stipend of $25,000 and will continue his primary academic post at UCLA while working over a 2-year period in the Academies' health and science policy work.

Read more about the fellows chosen and their work with the National Academy of Medicine at: http://www.eurekalert.org/pub_releases/2015-10/naos-nao_1101915.php.

ABFM to Study Need for Resources to Combat Physician Burnout

The topic of physician burnout has come to the forefront of conversation in recent years, with a reported rise in prevalence from 45.5% in 2011 to 54.4% in 2014. Rates of burnout appear to vary by specialty, with the highest rates among front-line physicians, including family physicians. Unlike other professionals, in which higher levels of education are protective against burnout, physicians report being significantly more exhausted by work than other professionals or the population at large. Burnout among physicians tends to follow a U-shaped relationship, with younger and older doctors suffering less burnout than mid-career doctors.

Why is the topic garnering so much attention now? It's likely because the heavily studied phenomenon of physician burnout is associated with a variety of worrisome consequences, including an increase in unhappy family lives, fewer collegial personal and professional relationships, greater likelihood to cut back work hours and/or leave current clinical practice (with its impact on access and continuity), higher rates of dysfunctional care teams, loss of empathy, delivery of suboptimal care, and an increase in medical errors. With more than 1 in 2 physicians reporting at least one symptom of burnout, it is imperative to address this for the sake of our patients, health systems and communities, as well as for our own health.

When considering the drivers of burnout, it is not a surprise that the rates are on the rise. A RAND study commissioned by the AMA in 2012 showed that a leading "satisfier" for physicians was having enough face-to-face time with patients. Yet, administrative work has reached 40% of time for many primary care physicians, leading to increased busyness of practice, greater amounts of non-visit care, more data entry activity, and increasing requirements to demonstrate the delivery of higher quality care at lower cost. Increasing health system or corporate ownership of physician practices has also contributed to feelings of powerlessness, with a sense that physicians lack control and autonomy over their work.

The components of burnout: emotional exhaustion, depersonalization, and low sense of personal accomplishment can be managed and reversed, with individual interventions aimed at increasing self care, mindfulness and stress reduction. In one study conducted by the Mayo Clinic, personal self-help interventions substantially reduced overall burnout, emotional exhaustion and depersonalization compared to nonparticipants, whose scores declined on all measures across the study period. Organizational and online approaches (e.g. www.stepsforward.org) to better understanding and coping with burnout are becoming more available. At the same time, individual change alone, while necessary, is insufficient. Physician practices and health systems also have a significant responsibility to understand and address the workplace factors that contribute to burnout.

Like others in the medical community, the ABFM is interested in better understanding the phenomenon of burnout among our Diplomates. The ABFM has collected data during examination registration for over 30 years. The ABFM Board of Directors has used these data to track scope of practice and also to assess the need to develop tools to help its Diplomates. For example, in the 1990s, the questionnaire included questions on how many Diplomates owned personal computers with access to the internet. This information helped the ABFM move to an online MC-FP process. Beginning in 2016, the ABFM will be querying a sample of Diplomates about their level of burnout and will use this information to similarly help the board determine the need to help its Diplomates address this growing problem and reduce its consequences to the health of our families and populations.

Dr. Elizabeth Baxley
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Research & Development Committee Chair
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Recognition of Diplomates Over the Age of 70

The Board is recognizing the long-standing dedication of our Diplomates over the age of 70 who wish to maintain their certification status. Beginning with payments required for 2016, those Diplomates age 70 and over who are maintaining their certificates will have their MC-FP process payments cut in half. Changes inside the physician portfolio will take a few months to implement, but once complete, the payment options will be appropriately reflected in each physician's portfolio.

Self-Assessment Modules (SAMs) to Become Two Separate Activities

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How will this impact the cost of the MC-FP process?
First, the overall cost for MC-FP will not increase due to the change in dividing the SAM into two activities. Second, to simplify MC-FP fees, all payment plans will now transition into annual payments. This transition means that for those physicians paying for MC-FP as they go, those who have not prepaid in full, will pay for the MC-FP process on an annual basis. Finally, MC-FP fees will now be listed as a requirement for easier access and tracking of fee payment information in the ABFM Physician Portfolio.

When will the changes to the SAM take effect?
Changes to the SAM are being developed now and are estimated to be in place this summer. A launch date and additional details will be communicated as soon as a launch date is confirmed.

What do I do in the meantime until the changes to the SAM are implemented?
You can continue to participate in the MC-FP process as usual. If you would like to complete your Stage requirements you can continue completing the SAM and Part IV activities available. If you would like to wait and only complete the knowledge self-assessment (KSA) without having to do the clinical simulation, you may wait until later this summer to do the KSA. The implementation of these changes will not change any deadlines to the MC-FP process, so please plan to complete activities at the best time for you throughout the year(s).