Meaningful Use Criteria - Inpatient

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Agenda

Terminology

ARRA/HITECH

Meaningful Use Defined / Health Outcomes Policies

Stages / Rollout of ARRA Program

Demonstrating Meaningful Use for Eligible Hospitals
  •  Core Objectives
  •  Menu Set Objectives
  •  Clinical Quality Measures

Security Requirements

Certification
Terminology / Acronyms

ONC HIT - Office of the National Coordinator for Health Information Technology

CMS – Centers for Medicare & Medicaid Services

HITECH Act - Health Information Technology for Economic and Clinical Health Act

PQRI – Physician Quality Reporting Initiative

EP/EH – Eligible Provider / Eligible Hospital

ONC ATCB – ONC Authorized Testing & Certification Body

HITSP – Health Information Technology Standards Panel

NIST – National Institute of Standards & Technology
ARRA/HITECH

ARRA

American Recovery and Reinvestment Act of 2009
Economic Stimulus Program
Multiple program components

HITECH Act

Intended to promote adoption of electronic health records
Provides for financial incentives to eligible hospitals and providers using electronic health records
Final Rule outlines initial set of standards, implementation, specifications and certification criteria for EHRs
Separate final rule establishes certification programs for health information technology
ONC/CMS/HHS
Meaningful Use Defined

An EP /EH shall be considered a meaningful user of EHR technology if they meet the following 3 requirements:

1. Demonstrate use of certified EHR technology in a meaningful manner (core objectives and menu set objectives)

2. Demonstrate that EHR technology is connected in a manner that provides for the electronic exchange of health information

3. Using certified EHR technology, submit information on clinical quality measures (CQM)
Meaningful Use Health Outcomes Policies

Improve quality, safety, efficiency [of healthcare], and reduce health disparities

Engage patients and families in their care

Improve care coordination

Improving population and public health

Ensure adequate privacy and security protections for PHI
Meaningful Use Stages / Program Rollout

**Stage 1**  
*2011*
- Electronic capture of health information in a structured format
- Implement clinical decision support tools
- Engage patients & families in their care
- Reporting of quality measures and public health information

**Stage 2**  
*2013*
- Expand on Stage 1 requirements
- CPOE – transmission (likely EBOS)
- Continuous quality improvement
- Information exchange

**Stage 3**  
*2015*
- Improved health outcomes
- Decision support for national priorities
- Patient self-mgmt
- Population health
Demonstrating Meaningful Use

Core Objectives
14
All are required

Menu Set
5/10
Select 5
Flexibility
More difficult to attain

CQMs
15
All are required
2 - Emergency department turnaround times
7 - Stroke measures
6 - Venous thromboembolism (VTE) measures
Demonstrating Meaningful Use

Numerator: # Compliance
Denominator: Total population
Threshold: Expected minimum compliance rate
Exclusions: Excluded encounters
Self attestation: Some measures are Y/N
Demonstrating Meaningful Use

Unique Patient

“To further describe the concept of ‘unique patient’ - If a patient is seen by an EP or admitted to an eligible hospital’s or CAH’s inpatient or emergency department more than once during the EHR reporting period then for purposes of measurement they only count once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.”
Core Objectives

All are required
Core Objectives

Subject: CPOE – Computerized Provider Order Entry

Description: Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines

Denominator: The number of unique patients with at least one medication in their medication list who were admitted to an EH/ED during the reporting period

Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE

Threshold: >30%

Exclusions: None for EH
Core Objectives

Subject: Implement drug-drug and drug-allergy interaction checks

Description: The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: Record demographics

Description: Record demographics, including preferred language, gender, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH

Denominator: Number of unique patients seen by the EP or admitted to EH/ED during the EHR reporting period

Numerator: The number of patients in the denominator who have all the elements of demographics recorded as structured data

Threshold: >50%

Exclusions: None
Core Objectives

Subject: Problem List

Description: Maintain an up-to-date problem list of current and active diagnoses

Denominator: The number of unique patients admitted to EH/ED during reporting period

Numerator: The number of patients in the denominator who have at least one entry (or “no known”) recorded as structured data in their problem list

Threshold: >80%

Exclusions: None
Core Objectives

Subject: Medication List

Description: Maintain an active medication list

Denominator: Number of unique patients seen by the EP or admitted to EH/ED during the EHR reporting period

Numerator: The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data

Threshold: >80%

Exclusions: None
Core Objectives

Subject: Allergies

Description: Maintain an active medication allergy list

Denominator: Number of unique patients seen by the EP or admitted to EH/ED during the EHR reporting period

Numerator: The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list

Threshold: >80%

Exclusions: None
Core Objectives

Subject: Vital Signs

Description: Record and chart changes in vital signs, including height, weight, BP; calculate and display BMI; plot and display growth charts for children 2-20 years, including BMI

Denominator: Number of unique patients age 2 or over seen by the EP or admitted to EH/ED during the EHR reporting period

Numerator: The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data

Threshold: >50%

Exclusions: None for EH
Core Objectives

Subject: Smoking status

Description: Record smoking status for patients 13 years old or older

Denominator: Number of unique patients age 13 or older seen by the EP or admitted to EH/ED during the EHR reporting period.

Numerator: The number of patients in the denominator with smoking status recorded as structured data

Threshold: >50%

Exclusions: EP/EH/CAH who see no patients age 13 years or older
Core Objectives

Subject: Clinical Decision Support

Description: Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance that rule (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: Quality Measures

Description: Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States

For 2011, an eligible hospital or CAH would provide the aggregate level data for the numerator, denominator, and exclusions through attestation (Y/N)

For 2012, an eligible hospital or CAH would electronically submit the measures Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: Electronic Copy of Health Information

Description: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.

Denominator: The number of patients of the EP or EH/ED who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

Numerator: The number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Threshold: > 50%

Exclusions: EP/EH has no such requests from patients.
Core Objectives

Subject: Electronic Copy of Discharge Instructions

Description: Provide patients with an electronic copy of their discharge instructions and procedures at discharge, upon request

Denominator: Number of patients discharged from an EH/ED who request an electronic copy of their discharge instructions and procedures during the EHR reporting period

Numerator: The number of patients in the denominator who are provided an electronic copy of discharge instructions

Threshold: >50%

Exclusions: EP/EH has no such requests from patients
Core Objectives

Subject: Exchange Key Clinical Information Electronically

Description: Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically; perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: Privacy and Security Protections

Description: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities; conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives
5 of 10 required
Menu Set Objectives

Subject: Drug Formulary Checks

Description: The EH has enabled this functionality and has access to at least one internal or external drug formulary for the entire reporting period (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives

Subject: Advance Directives

Description: Record advance directives for patients age 65 or older

Denominator: Number of unique patients age 65 or older admitted to an EH during the EHR reporting period

Numerator: The number of patients in the denominator with an indication of an advanced directive entered using structured data

Threshold: >50%

Exclusions: EP/EH/CAH who see no patients age 65 years or older
Menu Set Objectives

Subject: Lab results

Description: Incorporate clinical lab test results into certified EHR technology as structured data

Denominator: Number of lab tests ordered during the EHR reporting period by the EP or authorized providers of the EH for patients admitted to an EH/ED whose results are expressed in a positive or negative affirmation or as a number

Numerator: The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data

Threshold: >40%

Exclusions: None for EH
Menu Set Objectives

Subject: Patient lists

Description: Generate at least one list of patients with a specific condition (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives

Subject: Patient-Specific Education Resources

Description: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate

Denominator: Number of unique patients seen by the EP or admitted to EH/ED during the EHR reporting period

Numerator: The number of patients in the denominator who are provided an patient education specific resources

Threshold: >10%

Exclusions: None
Menu Set Objectives

Subject: Medication Reconciliation

Description: The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation

Denominator: Number of transitions of care during the EHR reporting period for which the EP or EH/ED was the receiving party of the transition

Numerator: The number of transitions of care in the denominator where medication reconciliation was performed

Threshold: >50%

Exclusions: None
Menu Set Objectives

Subject: Summary Care Record

Description: The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral

Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP or EH/ED was the transferring or referring provider

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided

Threshold: >50%

Exclusions: None for EH
Menu Set Objectives

Subject: Immunization Registries

Description: Perform at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: none of the immunization registries to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically; no immunizations administered during reporting period
Menu Set Objectives

Subject: Reportable Lab Results

Description: Perform at least one test of certified EHR technology’s capacity to provide electronic submission of reportable lab results to public health agencies (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: none of the public health agencies to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically
Menu Set Objectives

Subject: Syndromic Surveillance

Description: Perform at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: none of the public health agencies to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically
Clinical Quality Measures

All are required
Clinical Quality Measures (EH)

**ED-1**

*CMS*

**Inclusions**

Any ED Patient from the facility’s emergency department admitted as an inpatient

**Exclusions**

No exclusions

**ED-1**

*CMS*

Median time from ED arrival to time of departure from the ED for patients admitted to the facility from the ED

Calculated in minutes

Aggregated

1. Observation patients
2. Psychiatric/Mental Health patients
3. Non-Observation / Mental Disorder Patients
## Clinical Quality Measures (EH)

### ED-2

**CMS**

Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

Calculated in minutes

Aggregated

1. Psychiatric/Mental Health patients
2. Non-Observation / Mental Disorder Patients

### Inclusions

Any ED Patient from the facility’s emergency department admitted as an inpatient

### Exclusions

No exclusions
**STK-2**  
*Joint Commission*

**Inclusions**
- Discharges with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"

**Exclusions**
- Age < 18  
- Length of Stay >120 Days  
- Comfort Measures Only  
- Clinical Trial  
- Elective Carotid Intervention  
- Discharged/transferred to another hospital for inpatient care  
- Left AMA or discontinued care  
- Expired  
- Discharged/transferred to a federal healthcare facility  
- Discharged/transferred to hospice  
- Documented Reason For Not Prescribing Antithrombolytic Therapy at Discharge

**Clinical Quality Measures (EH)**

*Joint Commission*

**Ischemic stroke patients prescribed antithrombolytic therapy at hospital discharge**

Question: Was the patient prescribed antithrombolytic therapy at discharge? If not, why?
STK-3

Joint Commission

Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.

Question: Was the patient prescribed anticoagulation therapy at discharge? If not, why?

Inclusions

Ischemic stroke patients with documented atrial fibrillation/flutter

Exclusions

Age < 18
Length of Stay >120 Days
Comfort Measures Only
Clinical Trial
Elective Carotid Intervention
Discharged/transferred to another hospital for inpatient care
Left AMA or discontinued care
Expired
Discharged/transferred to a federal healthcare facility
Discharged/transferred to hospice
Documented Reason For Not Prescribing Anticoagulation Therapy at Discharge
### STK-4

**Joint Commission**

Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.

**Inclusions**

Acute ischemic stroke patients whose time of arrival is within 2 hours (< =120 minutes) of time last known well.

**Exclusions**

- Age < 18
- Length of Stay >120 Days
- Clinical Trial
- Elective Carotid Intervention
- Time last known well to arrival in the ED >2 hours
- Documented Reason For Not Initiating IV Thrombolytic

**Question:** Was IV thrombolytic therapy initiated within 3 hours of time last known well? If not, why?
**STK-5**
*Joint Commission*

<table>
<thead>
<tr>
<th>Inclusions</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2</td>
<td>Age &lt; 18</td>
</tr>
<tr>
<td>Question: Why was antithrombotic therapy not initiated by the end of hospital day 2?</td>
<td>Length of Stay &gt;120 Days</td>
</tr>
<tr>
<td>Discharges with a Principal Diagnosis Code for ischemic stroke as defined by value set &quot;Joint Commission Ischemic Stroke Value Set&quot;</td>
<td>Patients discharged before the end of hospital Day 2</td>
</tr>
<tr>
<td></td>
<td>Clinical Trial</td>
</tr>
<tr>
<td></td>
<td>Elective Carotid Intervention</td>
</tr>
<tr>
<td></td>
<td>IV or IA t-PA administered within 24 hrs prior to arrival</td>
</tr>
<tr>
<td></td>
<td>Documented Reason For Not Administering Antithrombolytic Therapy by end of hospital day 2</td>
</tr>
</tbody>
</table>
Clinical Quality Measures (EH)

**STK-6**

*Joint Commission*

Ischemic stroke patients with LDL ≥ 100 mg/dL, or LDL not measured, or, who were on a lipid lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge

Question: Was statin prescribed at discharge? Was LDL-c measured 30 days prior to admit? Was patient on lipid-lowering medication prior to admit?

**Inclusions**

Ischemic stroke patients with an LDL >= 100 mg/dL,

OR

LDL not measured,

OR

who were on a lipid-lowering medication prior to hospital arrival

**Exclusions**

Age < 18
Length of Stay > 120 Days
Comfort measures only
Clinical Trial
Elective Carotid Intervention
No evidence of atherosclerosis
Discharged/transferred to another hospital for inpatient care
Left AMA or discontinued care
Expired
Discharged/transferred to a federal healthcare facility
Discharged/transferred to hospice
Documented Reason For Not Prescribing statin at discharge
Clinical Quality Measures (EH)

**STK-8**

*Joint Commission*

Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following:
- activation of emergency medical system,
- need for follow-up after discharge,
- medications prescribed at discharge,
- risk factors for stroke,
- warning signs & symptoms of stroke

**Inclusions**

Ischemic stroke or hemorrhagic stroke patients discharged home

**Exclusions**

- Age < 18
- Length of Stay >120 Days
- Comfort measures only
- Clinical Trial
- Elective Carotid Intervention
## Clinical Quality Measures (EH)

<table>
<thead>
<tr>
<th>STK-10</th>
<th>Joint Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services</td>
<td></td>
</tr>
</tbody>
</table>

### Inclusions
- Ischemic or hemorrhagic stroke patients

### Exclusions
- Age < 18
- Length of Stay >120 Days
- Comfort measures only
- Clinical Trial
- Elective Carotid Intervention
- Discharged/transferred to another hospital for inpatient care
- Left AMA or discontinued care
- Expired
- Discharged/transferred to a federal healthcare facility
- Discharged/transferred to hospice
**Clinical Quality Measures (EH)**

**VTE-1**  
*Joint Commission*

This measure assesses the number of patients who received VTE prophylaxis (or have documentation why no VTE prophylaxis was given) the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.

**Inclusions**

- All inpatients

**Exclusions**

- Age < 18
- Length of stay < 2 days
- Length of stay > 120 Days
- Comfort measures only
- Clinical trial
- Direct admits to ICU, or transferred to ICU on hospital day 1 or 2
- Principal dx code of mental disorder, hemorrhagic or ischemic stroke, VTE
- Service delivery location of obstetrics

**Question:** Why was VTE prophylaxis not given?
Clinical Quality Measures (EH)

**VTE-2 (ICU)**
*Joint Commission*

This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).

Question: Why was VTE prophylaxis not given?

**Inclusions**

| All patients |

**Exclusions**

- Age < 18
- Length of stay < 2 days
- Length of stay >120 days
- Comfort measures only documented on day of or day after hospital arrival
- Clinical trial
- ICU LOS < one day without VTE prophylaxis administered and [without] documentation for no VTE prophylaxis
- Principal diagnosis of obstetrics
- Principal diagnosis of VTE
This measure assesses the number of patients with confirmed VTE who received an overlap of parenteral or subcutaneous anticoagulation and warfarin therapy.

For patients who received less than five days of overlap therapy, they must be discharged on both medications.

Question: Was overlap therapy prescribed at discharge?

Inclusions:
- Patients with confirmed VTE who received warfarin

Exclusions:
- Age < 18
- Length of stay >120 days
- Comfort measures only
- Clinical trial
- Patients without warfarin therapy during hospitalization
- Patients without warfarin therapy prescribed at discharge
- Patients without VTE confirmed by diagnostic testing
This measure assesses the number of patients diagnosed with confirmed VTE who received IV unfractionated heparin therapy (UFH) therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.

Inclusions:
Patients with confirmed VTE receiving IV UFH therapy

Exclusions:
- Age < 18
- Length of Stay > 120 Days
- Comfort measures only
- Clinical Trial
- Patients without UFH therapy
- Patients without VTE confirmed by diagnostic testing
VTE-5

Joint Commission

This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring and information about the potential for adverse drug reactions/interactions.

Question: Was warfarin therapy prescribed at discharge?

Inclusions

Patients with confirmed VTE discharged on warfarin therapy

Patients with confirmed VTE who received warfarin

Discharged to home

Discharged to home with home health

Discharged to home hospice

Exclusions

Age < 18
Length of Stay > 120 Days
Comfort measures only
Clinical Trial
Patients without warfarin prescribed at discharge
Patients without VTE confirmed by diagnostic testing
Clinical Quality Measures (EH)

VTE-6

This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

Why was VTE prophylaxis not initiated?

Inclusions

Patients who developed confirmed VTE during hospitalization

Exclusions

Age < 18
Length of Stay > 120 Days
Comfort measures only
Clinical Trial
Security Requirements

All are required

No data submission
Security Requirements

Access Control
• Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.

Emergency Access
• Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.

Automatic Log-Off
• Terminate an electronic session after a predetermined time of inactivity.
Security Requirements

Audit Log

1. Record Actions. Record actions related to electronic health information in accordance with the standard.

2. Generate audit log. Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in the standard.

Authentication

• Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
Security Requirements

Integrity

1. Create a message digest in accordance with the standard specified in 170.210(c).

2. Verify in accordance with the standard specified in 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.

3. Detection. Detect the alteration of audit logs.

(Optional) Accounting of Disclosures

• Record disclosures made for treatment, payment, and healthcare operations in accordance with the standards.
Security Requirements

§170.302 (t) Authentication
• Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

§170.302 (u) General encryption
• Encrypt and decrypt electronic health information in accordance with the standard.

§170.302 (v) Encryption When Exchanging Electronic Health Information
• Encrypt and decrypt electronic health information when exchanged in accordance with the standard.
Certification
Certification

Gap Analysis
• Perform a gap analysis against the certification test scripts

Close Gaps
• Ongoing development project to assure compliance with all certification requirements

Application
• Submission of certification application and self attestation materials

Inspection
• Software review against certification test scripts
ONC-ATCB
EH Certification Timeline

CCHIT named as an Authorized Testing & Certification Body (ATCB) by the Office of the National Coordinator (ONC)

Healthland to apply for Stage 1 Meaningful Use certification with CCHIT

EHR testing period by CCHIT with Healthland

CCHIT launches new ONC-ATCB EHR certification program

Healthland expects receipt of ONC-ATCB certification, enabling clients to submit attestation of meaningful use for Medicare incentive payments

August 30, 2010

September 20, 2010

Q4 2010

Q4 2010

Q4 2010

Q4 2010
Continuing Education Requirements - Presentations

In order to qualify for contact hours you must:

• Register your attendance by signing in and signing out of each of your selected courses. A sign in and sign out sheet will be available in each class.

• Complete a course evaluation form prior to leaving the class. Forms will be provided at the start of each session and must be left with the instructor prior to leaving.

• Within two weeks of the conclusion of Connect 10, you will receive verification of successful completion.
Thank you for attending