# Innovation Grants
# Care Coordination Agreements/Medicaid Savings

Joint Committee on Appropriations – May 11, 2021

South Dakota Department of Social Services

# Our Vision and Mission

Strong families – South Dakota's foundation and our future

## The South Dakota Department of Social Services

is dedicated to strengthening and supporting individuals and families by promoting cost effective and comprehensive services in connection with our partners that foster independent and healthy families.

# Innovation Grants

Primary & Prenatal Care Innovation Grant | DIVISION OF MEDICAL SERVICES

South Dakota Department of Social Services

# PROGRAM FACTS

YEAR 1 OF 3 | 2020

## INNOVATIONS BEING TESTED

Projects were initiated in January 2020, just before the onset of the pandemic.

### Center for Family Medicine

**Goal:** Provide patients with a health home approach for prenatal and postnatal care, and train family medicine resident physicians in innovative, evidence-based prenatal care models.

**Innovation being tested:** Health home model, technology, and transportation assistance to deliver patient education will result in improved health outcomes.

### Avera Health

**Goal:** Provide supports to pregnant women in their diabetes management through technology.

**Innovation being tested:** Non-traditional telehealth model, testing correlation between use of technology for management of gestational diabetes with improved birth outcomes.

### Native Women's Health Care

**Goal:** Help patients by linking prenatal services to behavioral health services via comprehensive care teams.

**Innovation being tested:** Use of comprehensive care teams to manage both physical and behavioral health will improve rates of substance use disorder (SUD) screening and treatment adherence.

## FACTS & FIGURES

### CENTER FOR FAMILY MEDICINE

*OUT OF 117 PROGRAM PARTICIPANTS...*

*$103,400 GRANT FUNDS PAID*

*Original Grant: $333,333*

- 8% were Native American
- appointment no-show rate was reduced by more than half with transportation supports
- 68% received early screening for gestational diabetes at year end

**KEY OUTCOMES**

Transportation assistance demonstrated positive results via decreased no-show pre- and post-natal appointments.

Increased use of telehealth was explored during the year, prompted largely by concerns around Covid-19.

### AVERA HEALTH

*OUT OF 106 PROGRAM PARTICIPANTS...*

*$90,410 GRANT FUNDS PAID*

*Original Grant: $330,000*

- the percent of infants admitted to the NICU decreased from 12% (Q1) to 3% by year end
- the percent of deliveries with major complications or comorbidities declined compared to baseline
- the percent of mothers needing a c-section decreased from 54% (Q1) to 34% by year end

**KEY OUTCOMES**

Covid-19 and associated challenges revealed that eGestational Diabetes services are critical, and that they can be sustained virtually in support of positive patient outcomes.

Difficulty was experienced in formalizing partnerships with an IHS facility.

### NATIVE WOMEN'S HEALTH CARE

*OUT OF 13 PROGRAM PARTICIPANTS...*

*$0 GRANT FUNDS PAID*

*Original Grant: $333,000*

- 62% received testing and treatment services for STDs by year end
- 100% received prenatal services
- 77% received early screening for gestational diabetes by year end

**KEY OUTCOMES**

The primary innovation is centered on coordinating patient care to support essential service delivery across three unique organizations, linking these providers' processes and data for the first time.

## Background

In 2019 the South Dakota Legislature in partnership with Governor Noem appropriated $1 million to the Department of Social Services (DSS) to pilot innovative projects focused on enhancing primary and prenatal care for Medicaid recipients. Following an application and review process, DSS awarded innovation grants in September 2019 to three organizations: Avera Health, the Center for Family Medicine, and Native Women's Health Care. Through the three grant projects, DSS expects to see improved access to care and positive health outcomes for women living in areas of the state served by the grant projects. Expected health outcomes include:

- improved rates of preventative primary care,
- improved rates of prenatal care visits,
- fewer infant hospitalizations for preventable conditions, and
- fewer c-section deliveries.

With the evidence gathered from the three projects, DSS will evaluate expanding the use of innovative service methods for statewide implementation within the Medicaid program.

## Recent Activities & Outcomes

### Avera Health

The *Before Baby* project helps pregnant women in South Dakota diagnosed with gestational diabetes by providing remote blood sugar monitoring, specialized test strips and video visits with a diabetic educator/dietitian. Patients are supported through an AveraNow mobile application.

***Innovation being tested:*** Non-traditional tele-health model testing correlation between use of technology for management of gestational diabetes with birth outcomes. Avera Health aims to work with Indian Health Service (IHS) to serve patients referred to Avera by IHS in targeted areas.

***Geographic area of focus:*** Huron (Beadle County), Aberdeen (Brown County), parts of Sioux Falls (Minnehaha and Lincoln Counties) Aurora, Brule, Buffalo, Charles Mix, Davison, Douglas, Gregory, Hanson, Hutchinson, Jerauld, Lyman, Miner, McCook, Sanborn, and minimum of one Indian Health Service site.

***Intended outcomes:***

- Improve access to OB care and treatment of gestational diabetes.
- Reduce the number of c-sections, birth complications, and infant/mother mortality.
- Increase rates of healthy birth weight babies and the number of babies who are delivered at full term.

***Programmatic updates:***

- Continued enrollment of patients in the program with successful adoption by Avera Aberdeen OB/GYN.
- Worked in consultation with Dr. Christine Hockett, an epidemiologist working with the Avera Center for Pediatric Research. Dr. Hockett has provided valuable insight into how to identify a useful control group.
- Finalized control population for comparison for both clinical and financial data. Initial clinical outcomes show similar outcomes when compared to traditional care for gestational diabetes. Additional patient enrollment will provide insight as to whether remote monitoring of gestational diabetes trends toward more favorable clinical outcomes when compared to traditional care.
- Avera finalized the HRS Software eGDM build and have scheduled team orientation and training to this new and innovative platform. This platform provides an app which allows for seamless transfer of data to the care team, video visits for both education, insulin starts, and face-to-face visits with Perinatal Nurse Practitioners. The program

also provides a tablet and Glucometer for patients who may not have a smart phone or other tablet.

- Despite multiple communications with IHS in Wagner, the project team has been unable to present this program to IHS Wagner administration for their consideration. Communication attempts with IHS Aberdeen have also been unsuccessful to date. Assistance from state program administrators is underway to support development of a relationship with other potential IHS facilities within South Dakota so that the program can be offered to their patients. Recently, the state assisted in establishing a connection with Lower Brule and the project team looks forward to furthering this partnership in the upcoming quarter.

***Lessons learned:***

- The HRS Software platform used for patient engagement in this project may be able to address language barriers with patients; this is being further evaluated.
- Patients who do not have access to internet or limited data usage within their home have inherent difficulty in accessing and utilizing the benefits of the HRS Software platform previously mentioned. The Avera team is encouraging those patients to download the eGDM apps at their local clinics or other "hot spots" so that they do not pull from their own data.

***Success stories:***

- Avera Aberdeen OB/GYN adopted use of the program.
- The Director of Women's Services in Aberdeen indicated to program staff that "they have had great success for our diabetic patients and think this program is wonderful…Your program has been very beneficial to our providers."
- Met weekly as an internal working group and successfully established a control group for enhanced data analysis.

**Project Goal 1: Increase access to innovative gestational diabetes management services.**

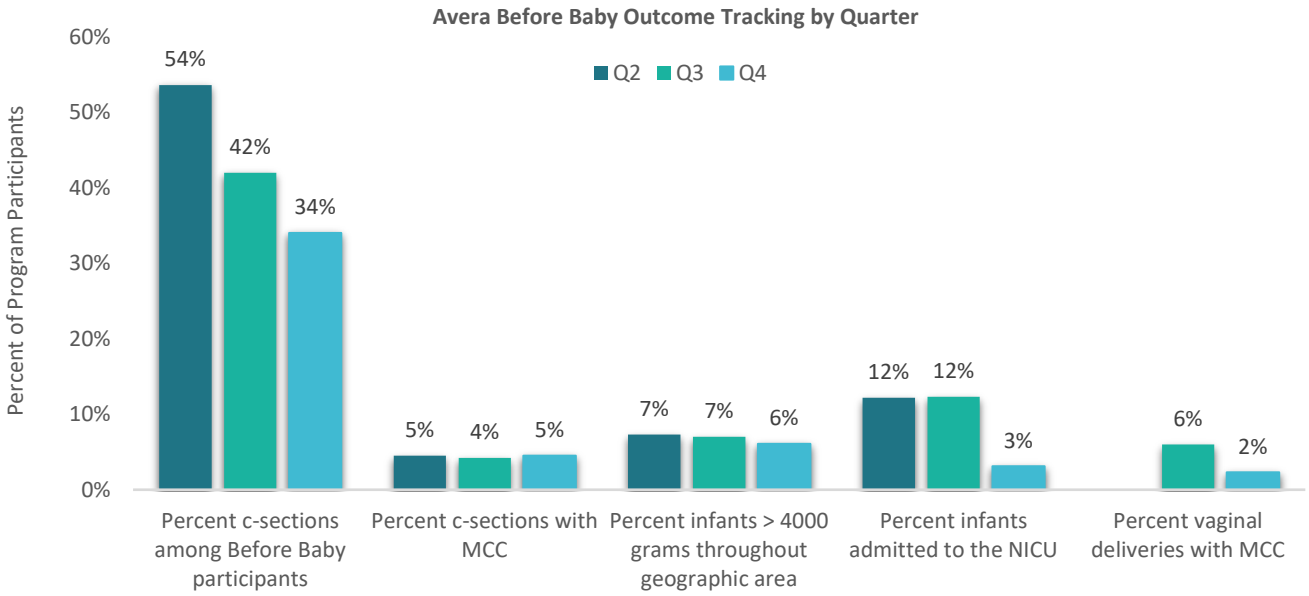
Baseline data from Avera's Before Baby program from the previous year showed 625 (17%) expectant mothers enrolled in the Before Baby project. To date, 106 women have been served by the program (since January 2020).

| | Avera Before Baby Program Enrollment by Quarter Compared to Baseline | | | | |
|---|---|---|---|---|---|
| | Baseline[1] | Q1-2020 | Q2-2020 | Q3-2020 | Q4-2020 |
| Number of expecting mothers enrolled in Before Baby | 625 | 20 | 75 | 78 | 29 |
| Percent of Medicaid eligible women enrolled in Before Baby | 17% | 10% | 19% | 5% | 18% |

[1] Baseline = 2019 aggregate data

**Project Goal 2: Decrease gestational diabetes complications to improve health outcomes for mothers and babies.**

Baseline data from Avera's Before Baby program from previous year is featured in the table below. Of the total women enrolled in Q1, none had delivered by the time that reporting period ended, thus all data reporting for outcomes began in Q2.




**Avera Before Baby Program Outcomes by Quarter Compared to Baseline**

| | Baseline | Q2-2020 | Q3-2020 | Q4-2020 |
|---|---|---|---|---|
| Number c-sections among Before Baby participants | 219 | 22 | 24 | 22 |
| Percent c-sections among Before Baby participants | 35% | 54% | 42% | 34% |
| Number c-sections with MCC[2] | 20 | 1 | 1 | 1 |
| Percent c-sections with MCC | 14% | 5% | 4% | 5% |
| Number infants > 4000 grams throughout geographic area | 9 | 3 | 4 | 4 |
| Percent infants > 4000 grams throughout geographic area | 1% | 7% | 7% | 6% |
| Number infants admitted to the NICU[3] | 51 | 5 | 7 | 2 |
| Percent infants admitted to the NICU | 8% | 12% | 12% | 3% |
| Number vaginal deliveries with MCC | 18 | 0 | 2 | 1 |
| Percent vaginal deliveries with MCC | 8% | 0% | 6% | 2% |

[2] Major Complication or Comorbidity
[3] Neonatal Intensive Care Unit

## Native Women's Health Care

Native Women's Health Care (NWHC) program's goal is to help patients by linking primary and prenatal services to behavioral health services, leveraging comprehensive care teams including primary care, behavioral health, and community health workers in support of care coordination. This innovation represents three independent organizations working together to develop processes and procedures that permit coordinated care and coordination of clinical resources to support that care. The time required to discern, plan, and ultimately implement these shared protocols, combined with the effects of COVID-19 and associated service delivery limitations, presented challenges.

***Innovation being tested:*** Use of comprehensive care team to manage both physical and behavioral health will improve rates of substance use disorder (SUD) screening and treatment adherence.

***Geographic area of focus:*** Rapid City Area

***Intended outcomes:***

- Improved adherence rates for SUD treatment, increased screening, preventive, and primary/prenatal care.
- Increase the number of qualified behavioral health staff.
- Increase in the number of women who are accessing prenatal services, wellness checks, and behavioral health services.

***Programmatic updates:***

- Strategic plan designed and implemented.
- Mandatory weekly meetings for Innovation grant activities inaugurated on Sept 1, 2020.
- Outlined Community Health Worker (CHW) PCC and RPMS integration for prenatal patients with NWHC and NHP.
- Designed and implemented program care plan utilizing Screening, Brief Intervention, and Referral to Treatment (SBIRT) approaches.
- Completion of HIPAA EDI in MedX.
- Marketing strategy developed and implemented.
- Risk assessment plan for all programs completed.
- Placement of cultural advocate at NWHC.

***Lessons learned:***

- COVID-19 service limitations continue to limit size and scope of activities for Innovation grant implementation. Grant participants also remain reluctant to engage with the diversion program per COVID- 19.

***Success stories:***

- Developed flowchart for staff reception for essential services integration.
- All Innovation grant participant programs have aligned work-flow processes for performance improvement of the overall grant.
- Diagnostic metrics on quarterly reports are now being looked at for performance improvement indicators for each program.

**Project Goal 2: Provide a medical home for OB and GYN services**

The table below shows the percent and number of patients who are receiving services or have a medical condition that impacts pregnancy. Thirteen (13) women have been served by the program since January 2020.

**Native Women's Health Care Program Outcomes by Quarter Compared to Baseline**

| | Baseline *(Pending[4])* | Q1-2020 | Q2-2020 | Q3-2020 | Q4-2020 |
|---|---|---|---|---|---|
| Percent High-risk mothers receiving SUD treatment | n.d. | 100% | 100% | 100% | 100% |
| Number of high-risk mothers receiving SUD treatment | n.d. | 3 | 4 | 4 | 13 |
| Percent women who are receiving testing and treatment services for sexually transmitted diseases | n.d. | 33% | 50% | 50% | 62% |
| Number of women who are receiving testing and treatment services for sexually transmitted diseases | n.d. | 1 | 2 | 2 | 8 |
| Percent patients that smoking during pregnancy and post-partum | n.d. | 33% | 50% | 50% | 62% |
| Number of patients that smoking during pregnancy and post-partum | n.d. | 1 | 2 | 2 | 8 |
| Percent women who use substance during pregnancy and post-partum | n.d. | 67% | 75% | 75% | 69% |
| Number of women who use substance during pregnancy and post-partum | n.d. | 2 | 3 | 3 | 9 |
| Percent women who receive early screening for gestational diabetes for patients with risk factors | n.d. | 100% | 100% | 100% | 77% |
| Number of women who receive early screening for gestational diabetes for patients with risk factors | n.d. | 3 | 4 | 4 | 10 |
| Percent C-section deliveries | n.d. | 67% | 50% | 50% | 23% |
| Number of C-section deliveries | n.d. | 2 | 2 | 2 | 3 |

[4] Pending resubmission of data from grantee.

**Project Goal 3: Increase number of qualified tribal behavioral health and community health workers.**

The table below shows the number and percent of women receiving various levels of services, delivered by the multidisciplinary care team. Pre- and post-natal services reflect medical care typically afforded to OB patients. Depression screen completion rates and receipt of outpatient behavioral health services (once services are delivered based on assessed need) are considered a measure of integrated behavioral health supports as part of patients' comprehensive care plans.

**Native Women's Health Care Program Outcomes by Quarter**

| | Baseline *(Pending[5])* | Q1-2020 | Q2-2020 | Q3-2020 | Q4-2020 |
|---|---|---|---|---|---|
| Percent pregnant women who are receiving prenatal services | n.d. | 100% | 100% | 100% | 100% |
| Number of pregnant women who are receiving prenatal services | n.d. | 3 | 4 | 4 | 13 |
| Percent of pregnant women who received all recommended prenatal visits | n.d. | 100% | 100% | 100% | 100% |
| Number of pregnant women who received all recommended prenatal visits | n.d. | 3 | 4 | 4 | 13 |
| Percent of women who received a post-partum visit | n.d. | 0% | 0% | 0% | 15% |
| Number of women who received a post-partum visit | n.d. | 0 | 0 | 0 | 2 |
| Percent of women who received a depression screen | n.d. | 100% | 100% | 100% | 100% |
| Number of women who received a depression screen | n.d. | 3 | 4 | 4 | 13 |

[5] Pending resubmission of baseline data from grantee.

## Center for Family Medicine

The program's goal is to provide patients with a birth center/pregnancy health home approach to provide full array of prenatal and postnatal care. The project will also train family medicine resident physicians in innovative, evidence-based prenatal care models. A total of 117 women have participated in the program since January 2020.

***Innovation being tested:*** Application of health home model and use of technology to deliver patient education results in improved health outcomes.

***Geographic area of focus:*** Sioux Falls, Pierre

***Intended Outcomes:***

- Improved screening services for those with increased risk for gestational diabetes and preeclampsia.
- Decreased rates of prenatal hospitalization and c-section, pre-term delivery, NICU stays, and other complications.
- Increased rates of contraception during the inter-conception period, patients breastfeeding, and interpregnancy interval.

***Programmatic updates:***

- Continued to leverage transportation cost assistance strategies (e.g., Lyft passes) to help patients keep appointments as scheduled, on time.
- Leveraging a risk assessment app to help support patient education.

***Lessons learned during Quarter 4, 2020:***

- Networking with other providers, care programs, and service agencies supporting the same population continues to be an important component of working collaboratively across a community to provide wraparound services to our clients.

***Success stories during Quarter 4, 2020:***

- Continue to see significant reductions in prenatal no-show visits due to transportation cost assistance.

**Program Goal 1: Improve Health Care Outcomes**

The figures below show the percent and number of program participants by indicator. For each indicator, data from program participants (Q1-Q4 2020) is presented alongside baseline data provided by the grantee as a percentage and actual count. Baseline data is derived from patients seen for an OB visit from 1/28/2018 – 1/1/2020. All participants is defined as the number of women participating in the program (intervention).

**Center for Family Medicine Program Outcomes for Non-Native Patients by Quarter**

| | Baseline | Q2-2020 | Q3-2020 | Q4-2020 |
|---|---|---|---|---|
| Percent patients that smoked during pregnancy and postpartum | 14% | 28% | 25% | 19% |
| Number patients that smoked during pregnancy and postpartum | 49 | 10 | 20 | 22 |
| Percent patients that used substances during pregnancy and post-partum | 3% | 14% | 13% | 10% |
| Number patients that used substances during pregnancy and post-partum | 10 | 5 | 10 | 12 |
| Percent of women who receive early screening of gestational diabetes for patients with risk factors | 32% | 70% | 71% | 68% |
| Number of women who receive early screening of gestational diabetes for patients with risk factors | 48 | 7 | 17 | 28 |

**Center for Family Medicine Program Outcomes for American Indian Patients by Quarter**

| | Baseline | Q2-2020 | Q3-2020 | Q4-2020 |
|---|---|---|---|---|
| Percent American Indian patients that smoked during pregnancy | 55% | 100% | 67% | 67% |
| Number American Indian patients that smoked during pregnancy | 20 | 1 | 6 | 6 |
| Percent American Indian patients that used substances during pregnancy and post-partum | 15% | 0% | 22% | 22% |
| Number American Indian patients that used substances during pregnancy and post-partum | 3 | 0 | 2 | 2 |
| Percent of American Indian women who receive early screening of gestational diabetes for patients with risk factors | 67% | 100% | 80% | 80% |
| Number of American Indian women who receive early screening of gestational diabetes for patients with risk factors | 6 | 1 | 4 | 4 |

# Care Coordination Agreements/Medicaid Savings Update

# Care Coordination Agreements – Background

## People can be eligible for IHS **and** also Medicaid eligible.

- When an American Indian is Medicaid eligible and gets services through an IHS facility, IHS bills Medicaid, and the federal government pays 100%.


100% Federal

- When an American Indian is Medicaid eligible and gets services outside IHS, the non-IHS provider bills Medicaid and the federal government pays about 58%, and the state pays the balance.


58% Federal 42% State

# Care Coordination Agreements – Background

- February 2016: Health and Human Services changed national **Medicaid funding policy** to cover more services for IHS eligibles with 100% federal funds.
  - More services now considered eligible through IHS.
  - Participation by individuals and providers must be voluntary.
  - Services outside IHS must be provided via written care coordination agreement.
  - IHS must maintain responsibility for the patient's care.
  - Provider must share medical records with IHS.
- Results in better coordination of care for the patient, improved discharge planning, and improved data sharing.

# Care Coordination Agreements – Background

- First care coordination agreements were signed in SFY 2018 starting with three large health systems (Avera, Sanford, Monument).
- Stakeholder group continued meeting and more hospitals were added along with community-based provider groups.
- Signed Community-Based Care Coordination Agreements
  - All six DSS/DOC - Psychiatric Residential Treatment (PRTF);
  - 14 DHS LTSS Nursing Homes; and
  - 15 Community Support providers have signed agreements - waiting for IHS to sign 13 of those.
- A full list of providers and the status of their care coordination agreements can be found online at: https://boardsandcommissions.sd.gov/bcuploads/CCA%20Table%20(11).pdf.

# Care Coordination Agreements - Reinvestment of Savings

- 100% of savings reinvested in the program with 70% of savings reinvested in provider rates.
- Addressed service gaps in the program:
  - Coverage of substance use disorder services for adults;
  - Additional mental health providers able to enroll;
  - Community Health Worker Program; and
  - Embedded three nurses and one mid-level practitioner at IHS facilities to improve care coordination.
- Shared savings with providers.
- $1 million in one-time general fund savings generated in SFY 2018 were invested in innovation grants.

# Care Coordination Agreements – Reinvestment of Savings

- Actual State Savings Generated SFY 2020
  - Recipients/Referrals: 4,578
  - General Fund Savings: $9.3 million

- SFY 2021 (YTD through March 2021)
  - Recipients/Referrals: 3,455
  - General Fund Savings: $7.4 million

# Care Coordination Agreements – Benefits/Outcomes

- IHS proposed, as an alternative to accepting shared savings payments directly, to embed state-employed nurses in IHS facilities to assist with referrals and care coordination.
- Nurses are embedded at Eagle Butte, Pine Ridge and Rosebud IHS hospitals.
- The IHS practitioner determines the patient's needs and course of care and nurses coordinate and manages the patient's care. All care, including diagnosis, treatment, and prescriptions, are recorded in the IHS facility medical records for the patient. All records are available to inform the IHS facility practitioner's ongoing management of the course of care for the IHS facility patient.
- Results in better case management and coordination for the patient, increased resources for three IHS hospitals, and savings to the State.

# Care Coordination Agreements – Benefits/Outcomes

## Nurses Referral Data

## Total number of referrals in place (April 2021): 83

### Nursing Facilities

| Facility | Active | New | Pending | Discharged |
|---|---|---|---|---|
| Ft. Thompson | 3 | 0 | 0 | 0 |
| Pine Ridge | 22 | 3 | 3 | 1 |
| Rosebud | 5 | 0 | 1 | 0 |
| Eagle Butte | 4 | 1 | 2 | 0 |
| Sisseton | 0 | 0 | 0 | 0 |
| Lower Brule | 0 | 0 | 0 | 0 |
| **Total:** | **34** | **4** | **6** | **1** |

### Psychiatric Residential Treatment Facilities

| Facility | Active | New | Pending | Discharged |
|---|---|---|---|---|
| Ft. Thompson | 3 | 0 | 0 | 0 |
| Pine Ridge | 8 | 0 | 0 | 4 |
| Rosebud | 5 | 2 | 0 | 0 |
| Eagle Butte | 0 | 0 | 0 | 0 |
| Sisseton | 3 | 0 | 0 | 0 |
| Lower Brule | 1 | 0 | 0 | 0 |
| **Total:** | **20** | **2** | **0** | **4** |

### Community Support Providers

| Facility | Active | New | Pending | Discharged |
|---|---|---|---|---|
| CCI | 23 | 0 | 0 | 0 |
| **Total:** | **23** | **0** | **0** | **0** |

# Care Coordination Agreements – Benefits/Outcomes

## Nurses Referral Data

## Total number of incomplete referrals (April 2021): 37

| *Affiliated IHS Facility* | *PRTFs* | *SNFs* |
|---|---|---|
| Ft. Thompson | 0 | 0 |
| Pine Ridge | 2 | 4 |
| Rosebud | 1 | 1 |
| Eagle Butte | 3 | 0 |
| Sisseton | 1 | 2 |
| Lower Brule | 1 | 0 |
| McLaughlin | 0 | 1 |
| Rapid City | 5 | 1 |
| No IHS Affiliation | 7 | 7 |
| Wanblee | 1 | 0 |
| **Total:** | **21** | **16** |

| *Reason for Incomplete Referral* | *Number* |
|---|---|
| No IHS affiliation | 12 |
| No CCA in place | 5 |
| Has not been seen at IHS within 1-2 years | 8 |
| No DSS nurse with patient's affiliated IHS facility | 8 |
| Affiliated IHS not currently completing PRTF referrals (EB) | 3 |
| Other | 1 |
| **Total:** | **37** |

# Care Coordination Agreements – Benefits/Outcomes

- In November 2020 Medical Services sent a survey to IHS and other community providers to gather feedback on Care Coordination Agreements and the use of DSS Nurses. The survey was sent to 39 individuals representing 24 organizations. Survey results:
  - 13 individuals from 11 agencies responded including three IHS facilities, two hospital systems, three Psychiatric Residential Treatment Facilities (PRTF), one Community Support Provider (CSP), and two nursing facilities.
  - Providers were asked on a scale of 0-100 how satisfied they were with Care Coordination Agreements; the average score was 73.
  - 77% of providers reported the Nurses have increased effectiveness of the Care Coordination Agreements and obtaining referrals.

# Care Coordination Agreements – Benefits/Outcomes

- Success Stories:
  - Patient from Pine Ridge transferred from the emergency department to Monument Health. Patient needed nursing facility care. Accepting nursing facility was found after an extensive search by Monument Health Rapid City staff – Avantara Lake Norden. Referral was obtained from IHS provider for nursing facility level of care to be provided at Lake Norden. To keep the provider engaged in the patient's care, records are being shared back with Pine Ridge Substance Use.
  - The above process was so successful that Avantara Lake Norden accepted a second difficult to place individual following referral from the IHS provider. This individual is a younger patient with a serious Traumatic Brain Injury (TBI) who will likely need nursing facility care for the remainder of his life. Records are being shared back with IHS.

# Care Coordination Agreements – Benefits/Outcomes

- Success Stories:
  - A youth from Pine Ridge was approved through the SD Medicaid process for inpatient Psychiatric Residential Treatment Facility. Then needed Substance Use Disorder services so a referral was coordinated to ensure both the SUD services and then a return to the Psychiatric Residential Treatment facility was coordinated.
  - Records across this care continuum have been shared back with Pine Ridge Substance Use which allows the patient's care team to remain aware of the patient's location, needs, and treatment plans and to facilitate aftercare on an outpatient basis once inpatient services are completed.

# Thank You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