

# **Dental Care in the Los Angeles Healthy Kids Program: Successes and Challenges**

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## EXECUTIVE SUMMARY

The Los Angeles Healthy Kids Program provides comprehensive health insurance, including dental coverage, to children in families with incomes below 300 percent of poverty who are ineligible for Medi-Cal and Healthy Families. This study draws upon results from qualitative and quantitative components of a five-year evaluation of the program, and presents new results from analysis of encounter data from SafeGuard Dental, the program's dental plan. Findings indicate that the Healthy Kids program has greatly improved coverage and access to dental care services for nearly 31,000 low-income, mostly immigrant, Latino children. Specifically, the program:

- ***Improved access to dental care.*** An evaluation household survey conducted in 2005 and 2007 with parents of Healthy Kids enrollees ages 2 to 5 found that Healthy Kids enrollment is associated with a nearly 28 percentage point increase in the likelihood of having a usual source of dental care, and a 9 percentage point decline in likelihood of having unmet need for dental care.
- ***Increased use of dental services.*** The household survey also found an increase in dental care use, consistent with the views expressed by the majority of parents in focus groups who reported that their children had received dental care services. According to encounter data, those children who had dental care used a large number of services.
- ***Satisfaction with dental care received.*** In focus groups, the majority of parents reported that they were able to access dental care for their children, and were satisfied with the quality of care delivered by their dental care provider.

Yet, as seen in many public insurance programs, this evaluation also finds that there is still a need for improvement in the dental care program. Specifically, this evaluation found:

- ***Delays in initiating dental care due to programmatic and administrative challenges.*** Evaluation case study interviews and focus groups found that some Healthy Kids enrollees were assigned to different dentists than those their parents had selected at enrollment, while others did not receive their dental coverage identification cards in a timely manner. Some enrollees also encountered long waits in obtaining dental care appointments.
- ***Inappropriate charges for dental services.*** Focus groups and case study interviews also revealed that some families were inappropriately charged copayments for covered dental care services not subject to cost sharing.

- ***Lower-than-optimal dental service utilization.*** Analyses of both survey and dental plan encounter data indicate that less than half of Healthy Kids enrollees received a dental care service in 2007. The low utilization rate observed from encounter data is in part due to underreporting of these data by primary dentists (who are paid via capitation).

As the Los Angeles Healthy Kids Program continues to provide health coverage and services to some of California's most vulnerable children, program and dental plan administrators should consider the following recommendations to improve dental service delivery to enrollees:

- ***Outreach efforts targeting Healthy Kids families should be strengthened*** to better educate more families about dental coverage and available services.
- ***Administrative procedures should be better coordinated*** between administrators of the Healthy Kids program and its dental service provider.
- ***Participating dental providers should receive more education about cost-sharing rules*** under the program, and dental plan administrators should more aggressively enforce cost-sharing rules if enrollees are inappropriately charged for dental services. Likewise, the dental service provider could intensify its efforts to further inform Healthy Kids families of the dental services that are covered by the program.
- ***Dental plan encounter data should be more closely monitored*** by dental and health plan administrators for completeness and quality.
- ***Dental service data collection and analysis should be improved*** through stronger oversight by health plan administrators.

## **INTRODUCTION**

Tooth decay is the most prevalent chronic childhood illness, and primary dental care is the most significant unmet children's health need. In California, oral disease among children is a major public health challenge, and particularly severe in Los Angeles County. The Los Angeles Healthy Kids program was implemented in 2003 to address unmet health care needs among children, and provide comprehensive, affordable health care coverage to uninsured children from families with incomes under 300 percent of the federal poverty level (FPL), who are not eligible for the Healthy Families or Medi-Cal programs. To address unmet dental care needs among its target population, the Healthy Kids coverage package was designed with a comprehensive dental benefit.

This study examines dental care access in the Los Angeles Healthy Kids program, synthesizing findings from several components of the Healthy Kids Program Evaluation—launched in 2004 to monitor the program's implementation and impact—and presents new results from analysis of encounter data from SafeGuard Dental, the program's dental carrier. Findings suggest that Healthy Kids has improved children's access to dental care and addressed unmet dental care needs, but that there remains a need for improvement in some aspects of the program.

## **BACKGROUND**

In 2000, the landmark U.S. Surgeon General's *Oral Health in America* report identified tooth decay as the most common chronic illness among children, affecting five times as many children as asthma, and contributing to nearly 51 million hours of missed school each year (U.S. Department of Health and Human Services 2000). Oral disease can affect children's growth,

speech development, nutrition, learning, and overall quality of life. The American Academy of Pediatric Dentistry (2009) recommends that all children have a dental care visit within six months of getting their first tooth and no later than their 1<sup>st</sup> birthday, and at least bi-annually thereafter through their 18<sup>th</sup> birthday.

However, many children do not receive adequate dental care due to access barriers such as family income, language and cultural barriers, and lack of dental insurance coverage. Numerous studies have documented the existence of income and racial/ethnic disparities in dental care access and oral health status. Low-income children (in families with incomes less than 200 percent FPL) are twice as likely as higher-income children to have tooth decay and unmet need for dental care; and low-income children without health insurance are twice as unlikely as their insured counterparts to receive preventive dental care (Kenny, Ko, and Ormond 2000; Kenny, McFeeters, and Yee 2005; Dye et al. 2007). Children of color, particularly Latino, African-American and American Indian/Alaskan Native children, are more likely to have unmet dental care needs and experience severe oral disease (Mouradian, Wehr, and Crall 2007). Additionally, children who are not U.S. citizens have been found to be twice as likely as children who are citizens to receive no preventive dental care (Kenny et al. 2005).

In California, oral disease among children represents a major public health challenge. A California Healthcare Foundation (2008) study found that 24 percent of California's six million children have never visited a dentist, and identified several demographic characteristics of children most likely to fall through the state's dental safety net (e.g., ages five and under, lack of dental insurance, low-income status, African American or Latino race/ethnicity, parents with limited English proficiency).

In Los Angeles County, childhood oral disease is particularly severe. According to the Governing Board of the Los Angeles Unified School District (2004), about 50,000 children a year report to nurses complaining of tooth pain. California's Dental Health Foundation (2006) reported that more than 60 percent of Los Angeles schoolchildren had dental decay by the time they were in kindergarten (compared to 50 percent statewide), and that nearly 70 percent of schoolchildren have a history of tooth decay (compared to 62 percent statewide).<sup>1</sup>

Dental insurance coverage has been documented to greatly improve access to and utilization of dental services (Wang, Norton, and Rozier 2007; Kenny et al. 2005). Specifically, public health insurance programs (e.g. Medicaid, SCHIP, etc.) have been shown to contribute to improved access to a usual source of dental care for children and reduce unmet dental care need (Kenny and Tebay 2003). Yet, many children remain without dental insurance. The Kaiser Family Foundation estimates that while nine million children lack health insurance coverage, more than 20 million children lack dental care insurance coverage (Paradise 2008). In California, over half of the 23 percent of children ages 2 to 11 who do not have dental insurance are eligible for, but not enrolled in, Medi-Cal or Healthy Families (the state's Medicaid and Children's Health Insurance Program, respectively).

The Los Angeles Healthy Kids program was implemented in 2003 to address the unmet health and dental care needs of children in families with incomes under 300 percent FPL, who are not eligible for the Healthy Families or Medi-Cal programs. Since its implementation, Healthy Kids has become the largest of California's twenty-six Children's Health Initiative (CHI) programs, currently serving over 31,000 low- to moderate-income, primarily Latino, and largely immigrant children ages 0 to 18.

## **IMPLEMENTATION OF DENTAL COVERAGE IN L.A. HEALTHY KIDS**

The Los Angeles Healthy Kids Program is funded through a combination of monies from First 5 LA, an organization established by California voters to invest tobacco tax revenues into programs for young children, and a group of not-for-profit providers, philanthropies, and other stakeholders operating as the Children's Health Initiative of Greater Los Angeles. The Healthy Kids benefit package is modeled after that offered by Healthy Families—California's CHIP program—and includes a comprehensive range of preventive, primary, acute and specialty services, including dental, vision and behavioral health care. Healthy Kids services are delivered through a managed care network administered by the L.A. Care Health Plan, a not-for-profit community health plan with extensive experience serving publicly insured families. Dental services are delivered through SafeGuard Dental, a private dental managed care organization, under a subcontract with L.A. Care.

L.A. Care receives a monthly capitation fee of approximately \$74 per member per month for health service delivery, of which a portion is paid to SafeGuard Dental to support dental service delivery on a per member per month basis. For the most part, dental services are provided at no charge to Healthy Kids enrollees. Families are required to contribute a \$5 co-payment for a small number of dental procedures, including root canals and crown placements. When families enroll in Healthy Kids, they select a primary dentist through L.A. Care, who then shares this information with SafeGuard Dental. SafeGuard records the primary dentist assignment, and issues a dental identification card and welcome materials to enrollees.

The SafeGuard Dental provider network consists of approximately 2,300 general dentists and approximately 560 pediatric dental specialists,<sup>2</sup> and is nearly identical to the network it makes

available to Healthy Families enrollees. In previous Healthy Kids evaluation case studies, dental plan administrators shared that the distribution of dentists across the county is quite even.

According to SafeGuard administrators, southern California is unique—both compared to the rest of California and to the nation, generally—in its large supply of general dentists, influencing the recruitment and payment of dentists into the plan’s network.<sup>3</sup> SafeGuard does not allow general dentists to “cherry pick” among plan products: dentists must agree to accept publicly-insured patients in order to gain access to the plan’s commercial products. General dentists receive a fixed capitation rate per month for each Healthy Kids enrollee that designates them as their primary dental provider; the plan also makes supplemental payments for certain encounters and dental procedures (e.g. crowns, sealants, pulpotomies, fluoride, etc). Though the total of these payments can be lower than commercial rates, general dentists interviewed for this evaluation’s case studies reported that they were willing to participate in Healthy Kids because they recognized the great need for dental care among the program’s target population, and wished to maintain a reasonable numbers of patients.

In contrast, like most parts of the country, southern California has an undersupply of pediatric specialty dentists. To ensure these providers’ participation in the SafeGuard network, dental plan administrators negotiate payment arrangements individually with each pediatric specialist based on several factors, such as the area in which they practice (Hill, Barreto et al. 2008).

## **EARLY EVALUATION RESULTS ON DENTAL CARE AND ACCESS**

The Healthy Kids Program Evaluation was launched in 2004 to monitor the program's implementation and impact on its target population, and includes multiple qualitative and quantitative components. During the first several years of the evaluation, case studies (conducted in 2004 and 2006) found that dental coverage under Healthy Kids showed signs of improving enrollee access to a usual source of dental care, and that dental services were in high demand. Key informants interviewed for case studies reported that dental care (along with preventive care) appeared to be the most popular benefit among enrollees, and that utilization was high, suggesting pent-up demand for dental services among enrollees who previously were uninsured (Hill, Barreto, et al. 2008; Hill, Courtot, and Wada 2005). Focus groups with parents of Healthy Kids, conducted in 2005 and 2007, reinforced these findings. The majority of parents described high levels of need for dental care among their children, reported seeking dental care, and said that they were satisfied with dental care their children received (Hill et al. 2006). This evaluation's household survey, also conducted in 2005 and 2007 with parents of enrollees ages 2 to 5, found that program enrollment was associated with a 28 percentage point increase in the likelihood of having a usual source of dental care, and a 9 percentage point decline in likelihood of having unmet need for dental care.

These early studies, however, also found that the delivery of care had not gone entirely smoothly, and identified specific challenges that undermined optimal delivery of dental services. According case study key informants, an information-sharing problem between L.A. Care and SafeGuard resulted in many families being assigned to primary dentists different from those they chose during the enrollment process. Dental plan administrators acknowledged that, during the

first two years of implementation, there was no system in place for electronically transmitting enrollees' primary dentist selections from L.A. Care to SafeGuard. Thus, dental plan administrators were left no option but to auto-assign children to dentists using an algorithm based on enrollees' zip codes, primary language, and distance from a dental provider. As a result, many Healthy Kids families experienced confusion as to where they could receive dental care which, according to informants, led to delays in obtaining dental care. The focus groups found that many parents were, indeed, confused by the fact that they had been assigned to different dentists than they had selected for their children; but that when they did contact SafeGuard to change their primary dentist assignment, the process was easy and accomplished immediately (Hill, Palmer, et al. 2008). By 2006, health and dental plan officials resolved this problem by creating a systematic process for sharing parents' primary dentist selections (Hill, Barreto, Courtot, and Wada 2005).

Case study interviews also revealed that some families delayed accessing dental care after not receiving their dental identification cards in a timely manner, and encountered long waits—sometimes up to three months—for appointments with dentists. These delays were particularly pronounced for parents of children with special health care needs, who often had difficulty finding specialists—who are already in short supply—to serve their children.

Another challenge identified in focus groups was that many parents reported being charged copayments by dentists when they obtained care for their children, despite program rules stating that no copayments are to be charged for routine visits. Some parents reported being charged \$5 for every dental visit, and a few said that they were charged as much as \$100 for certain procedures, such as fillings and crowns. Consequently, these parents voiced dissatisfaction with their children's dentists and felt compelled to select a different dental care provider (Hill, Palmer

et al. 2008). During the case studies, when asked about this improper practice, dental providers explained that, because California's numerous public insurance programs employ different cost sharing rules, they were sometimes confused about proper protocol and may have imposed charges in error (Hill, Palmer, et al. 2008). Discussions with SafeGuard administrators revealed that dental plan records do not reflect that such grievances were filed with any frequency, suggesting that many parents of Healthy Kids enrollees either don't know how to register, or are uncomfortable registering complaints with the dental plan.

Additionally, the household survey found that nearly 20 percent of children ages 2 to 5 needed dental care, but either did not receive or delayed care—a higher rate of unmet need than for any other studied medical services. Some of the access barriers to dental care identified in the survey included a lack of information about where to go to find a dentist, transportation problems, as well as an inability among some Healthy Kids families to schedule and keep appointments (Howell, Dubay, and Palmer 2008).

## **NEW ANALYSIS OF DENTAL UTILIZATION IN L.A. COUNTY**

A new source of data on Healthy Kids dental services utilization—encounter data from SafeGuard Dental—became available in 2008. Enrollment, encounter and payment data were obtained for two cohort-years (July 1, 2005, through June 30, 2006, and July 1, 2006, through June 30, 2007) of children ages 0 to 18, who were continuously enrolled in Healthy Kids for at least 12 months, with a gap in coverage no longer than 30 days. Though SafeGuard provided data for both 2005–2006 and 2006–2007, our analysis primarily focuses on the 2006–2007 cohort, as the data are more recent and patterns were similar for both years. The 2005–2006 utilization data are available in the report appendix.

Table 1 shows the number of children enrolled in Healthy Kids by age; the percent of children in each age group who had any general dentist, specialist, or any dental service reported in the claims/encounter records; and the average number of procedures per child for all children who had any reported service (“users”). Dental procedure codes were classified according to the American Dental Association’s Code on Dental Procedures and Terminology (CDT).

From July 2006 through June 2007, 37,246 children were continuously enrolled in Healthy Kids, with the large majority being ages 6 and older. Among these enrollees, 12,909 children—34.7 percent—received one or more dental procedures. This is a relatively low rate of use, considering that the American Dental Association recommends that each child receive two visits per year. Some of the low use may be due to under-reporting of dental services in the claims/encounter data, as discussed below.

While a smaller than desirable proportion of children received any dental care, children who did use dental care received a large number of services: an average of 8.5 dental procedures. Dental service utilization varied by age group, with children ages 3 to 5 having the highest utilization rate of 43.0 percent, and the highest number of dental procedures per child user at 9.6.

The most common type of dental service obtained by Healthy Kids enrollees (excluding office visits, which receive specific CDT codes but are not included in this analysis) over the two cohort-years (2005–2006 and 2006–2007) was diagnostic services (e.g. exams, x-rays) at 48.0 percent of all dental procedures (figure 1). The second most common type of dental service used was restorative procedures (e.g. fillings, crowns) at 11.8 percent. Analysis of procedure codes within age groups indicates that younger children (ages 0 to 2 and ages 3 to 5) received a larger percentage of restorative services at 21.3 percent and 22 percent, respectively, than their older counterparts (ages 6 to 11 and ages 12 to 17) at 10.3 percent and 8.9 percent, respectively (data

not shown). Predictably, general dentists provided many more preventive *and* treatment services than specialists. General dentists mostly provided diagnostic and preventive care—62.6 percent of their total services provided—while specialists mostly provided treatment services—68.3 percent of their total services provided (table 2).

## **DISCUSSION**

In order to draw accurate conclusions about the rate of Healthy Kids dental service utilization, presented above, we benchmarked SafeGuard dental encounter data with our parent survey and rates reported in other public insurance programs. The following utilization rates are all higher than the 34.7 percent we found for Healthy Kids based on SafeGuard’s claims/encounter data:

- According to the L.A. Healthy Kids evaluation household survey, 48.5 percent of parents of enrollees ages 2 to 5 reported accessing dental care (Howell, Dubay, and Palmer 2008).
- Nationally, 47.0 percent of children ages 4 to 18 enrolled in a Medicaid HMO plan received an annual dental visit in 2006 (National Committee for Quality Assurance 2009).
- Among Healthy Families enrollees ages 2 to 18, 59 percent had an annual dental visit in 2007, down from 62 percent in 2006. Annual dental visit rates were lower among the subset of Healthy Families enrollees assigned to SafeGuard Dental, who averaged 51 percent in 2007 and 54 percent in 2006 (California Managed Risk Medical Insurance Board Benefits and Quality Monitoring Division. 2009). These rates were determined using a hybrid HEDIS measure method of collection.
- In 2004, 52 percent of Denti-Cal (the fee-for-service dental segment of Medi-Cal) enrollees ages 4 to 18 who were continuously enrolled for 11 months received an annual dental visit (California HealthCare Foundation 2007). Reported elsewhere, 33 percent of children ages 0 to 5 and 47 percent enrollees ages 0 to 20 continuously enrolled in Medi-Cal from July 2004 to June 2005 received an annual dental visit (Phipps et al. 2008).
- Among 13 California Children’s Health Initiative and Healthy Kids programs that contract with the fee-for-service dental provider Delta Dental, an average of 67 percent of enrollees ages 2 to 18, who were continuously enrolled from January 2006 to December 2006, received an annual dental visit (Phipps et al. 2008).

All of these rates of public health insurance dental service utilization are lower than what is recommended for children, who should have regular preventive dental care. Consequently, it is apparent that all such programs, including Healthy Kids, need to increase outreach and education to both parents and participating providers, to increase the use of preventive care.

In addition, capitation of preventive dentists appears to lead to an underreporting of the use of dental care. The observed Healthy Kids dental utilization rate is lower than other programs and that reported by parent in our household survey, and is probably reflective of underreporting by general dentists who, paid on a capitated basis by SafeGuard Dental, have little financial or administrative incentive to regularly submit encounter data.

Underreporting of encounter data aside, however, we also conclude that the lower-than-optimal dental service utilization rate may also be due in part to the challenges in implementation described above. As detailed in this evaluation's case studies and focus groups, there are still some Healthy Kids families who are uninformed of the dental coverage offered by Healthy Kids, confused as to how to obtain dental care, or unaware of the importance of regular preventive care. For these families, more outreach is needed to increase their awareness and use of these critical services. From our survey, case studies and focus groups, we also learned about a range of barriers to access to dental care in Los Angeles County. The Healthy Kids program serves a large geographic area and nearly 31,000 children, making it the largest Children's Health Initiative program in the state. For families who said in focus groups that they lived a significant distance from their assigned dental provider, a lack of adequate transportation may contribute to poor dental care access. Families with other access issues (e.g. long waits for appointments,

misassignment to dental providers different from those they selected at enrollment, inappropriate charges of copayments), may have delayed or foregone dental care for their children.

This analysis contributes new findings about the types of services that Healthy Kids enrollees receive. We found that children who were able to access dental care received a wide range of dental services, the majority being diagnostic, but a significant number being restorative. As the prevalence of crowns, fillings, and other restorative procedures can indicate serious dental disease, this utilization pattern suggests pent-up demand for dental services, which is supported by case study findings.

Overall, our study finds that the L.A. Healthy Kids program has greatly improved coverage and access to dental care services for tens of thousands of poor, largely immigrant, Latino children. We also conclude that, as with many public insurance programs, the Los Angeles Healthy Kids program has been confronted with numerous challenges in meeting the dental care needs of program enrollees. To improve dental care delivery to Healthy Kids enrollees, we present the following recommendations for consideration:

- Outreach and education efforts targeting Healthy Kids families should be strengthened in order to educate more families about dental coverage, available services, and how to access dental care.
- Administrative procedures (e.g., primary care dentist assignment, dental plan membership card delivery, etc.) should be better coordinated between the health and dental plans.
- Participating dental providers should receive more education about cost-sharing rules for the program, and dental plan administrators should more aggressively enforce cost-sharing rules if enrollees are inappropriately charged for dental services. Likewise, the dental service provider should intensify its efforts to further inform Healthy Kids families about the dental services that are covered by the program.
- Dental plan encounter data should be more closely monitored by dental and health plan administrators for quality assurance purposes.

- Dental service data collection and analysis should be improved through stronger oversight by health plan administrators.

**TABLES AND FIGURES**

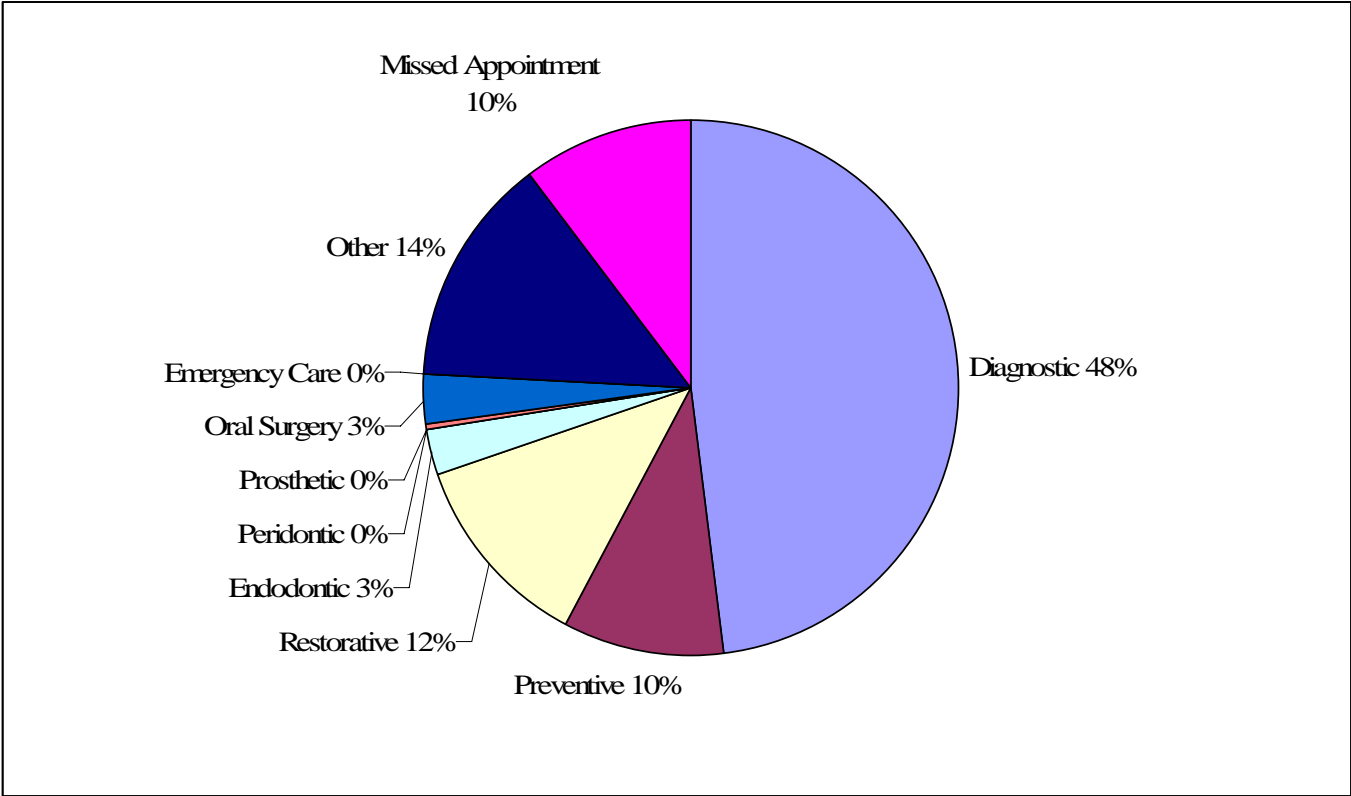
**Table 1: Dental Service Utilization in the LA Healthy Kids Program**

	July 2006 - June 2007					
	General Dentist Use		Specialist Use		Total Use	
	#	%	#	%	#	%
<b>Number of Eligible Children</b>						
Age < 3	631					
Age 3 to 5	4,627					
Age 6 and up	31,988					
Total Eligible Children	37,246					
<b>Children with Dental Services</b>						
Age < 3	66	10.5%	34	5.4%	91	14.4%
Age 3 to 5	1,689	36.5%	615	13.3%	1,988	43.0%
Age 6 and up	10,385	32.5%	1,149	3.6%	10,830	33.9%
Total Child Users	12,140	32.6%	1,798	4.8%	12,909	34.7%
<b>Average Number of Procedures per Child User</b>						
Age < 3	3.5		9.1		5.9	
Age 3 to 5	6.4		13.4		9.6	
Age 6 and up	7.8		7.7		8.3	
All Child Users	7.6		9.7		8.5	

**Table 2: Number of Dental Services Performed by Provider Type**

	July 2006 - June 2007					
	General Dentist		Specialist		Total Services by Type	
	#	%	#	%	#	%
Preventive Services	57,643	62.6%	5,505	31.7%	63,149	57.7%
Treatment Services	34,423	37.4%	11,883	68.3%	46,307	42.3%
Total Services Delivered	92,066	100.0%	17,388	100.0%	109,456	100.0%

**Figure 1: Dental Services Received by Child User Age Group, July 2005 – June 2007**



## Notes

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1. T. Anderson, “No. 1 Kids’ Epidemic: Bad Teeth,” *Los Angeles Daily News*, February 7, 2006.
2. Pediatric dentistry is one of nine dental specialties recognized by the American Dental Association. According to the American Academy of Pediatric Dentistry, pediatric dental specialists—or pedodontists—complete two to three years of additional clinical training to specialize in serving children. Pediatric dental specialists are also trained to care for patients with chronic illnesses and disabilities.
3. In 2004, California was among the states with the highest dentist-to-population ratio—74.36 dentists per 100,000 population versus the U.S. average of 59.4 dentists per 100,000 population. Notably, the state experienced a 20.9 percent increase in the number of dentists per 100,000 population between 1991 and 2004 (New York Center for Health Workforce Studies 2006).

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## Appendix

**Table A1: 2005 - 2006 Dental Utilization in LA Healthy Kids Program**

	July 2005 - June 2006					
	General Dentist Use		Specialist Use		Total Use	
	#	%	#	%	#	%
<b>Number of Eligible Children</b>						
Age < 3	840					
Age 3 to 5	5,104					
Age 6 and up	35,724					
Total Eligible Children	41,668					
<b>Children with Dental Services</b>						
Age < 3	61	7.3%	37	4.4%	61	7.3%
Age 3 to 5	1,582	31.0%	514	10.1%	1,846	36.2%
Age 6 and up	11,408	31.9%	1,097	3.1%	11,784	33.0%
Total Child Users	13,051	31.3%	1,648	4.0%	13,691	32.9%
<b>Average Number of Procedures per Child User</b>						
Age < 3	4.0		7.5		8.5	
Age 3 to 5	6.9		13.5		9.7	
Age 6 and up	8.6		7.5		9.0	
Average per All Child Users	8.4		9.4		9.1	

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**Table A2: 2005 - 2006 Number of Dental Services Performed by Provider Type**

	<b>July 2005 - June 2006</b>					
	<b>General Dentist</b>		<b>Specialist</b>		<b>Total Services by Type</b>	
	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
Preventive Services	68,874	63.2%	3,489	22.6%	72,364	58.1%
Treatment Services	40,186	36.8%	11,953	77.4%	52,140	41.9%
Total Services Delivered	109,060	100.0%	15,442	100.0%	124,504	100.0%