A Simple Fee-For-Service SAS® Application Used in a Government Public Health Office

Jay Gravink, Kaiser Permanente of Southern California

ABSTRACT

In an age when tax payers demand higher value for their tax dollar, the County of Los Angeles-Department of Health Services-Office of AIDS Programs and Policy (OAPP) needed to find a way to hold itself and associated public entities more accountable for each public health dollar spent on the rather expensive HIV/AIDS prevention/intervention service known as "HIV Counseling and Testing." Understanding both business and public health objectives, using *The Little SAS Book: A Primer* (Delwiche and Slaughter, 1995) and the SAS® System, I was able to write a rather elementary fee-for-service billing/ invoicing application that has saved tax payers untold dollars, while increasing public health service accountability. This SAS® application has helped OAPP shift its operational paradigm from a typical reactive government management model to a more pro-active "data driven" business model. This application has intersected public health epidemiology with responsible management of tax dollars.

INTRODUCTION

Behind every good SAS® application is a problem about to be solved. I solve data problems in the health care industry, and SAS® has been one of my most valued data driven decision making tools since the early 1990's. The problem at hand was how to dole out grant money in a fashion that would be fair and equitable to twenty-six public health clinics, mandated to provide HIV Counseling and Testing services to patients. The purpose of this paper is to tell the story behind one application in the Los Angeles County Department of Health Services and one employee who found a way, through intelligent SAS® programming, to allocate grant money to local public health clinics via an internal fee-for-service protocol.

BACKGROUND

HIV disease has been a politically emotional topic since the early 1980's, but funding for research and prevention of the disease was somewhat slow to begin. As death tolls began to rise and the disease continued to spread, those populations most adversely affected became politically organized around this public health crisis. Pressure was placed on all levels of government to "Do something about AIDS," and as a result, federal, state and local governments eventually allocated copious amounts of funding for biological and social/behavioral research. In many cases, large amounts of federal tax money was granted to local governments without any meaningful strings attached as to how the tax dollars should be spent.

In the early 1980's, the United States Congress pledged several hundred million dollars to the federal Centers for Disease Control and Prevention (CDC) in Atlanta, GA, for the purpose of conducting voluntary HIV seroprevalence studies in all 50 states and in some United State's territories over a period of years. The CDC funded each state and territory to conduct this research and prevention activity. Further, large metropolitan areas in the United States such as Los Angeles, Houston, Denver and New York City, to name a few, were funded separately from their home states because of the assumed positive relationship between high population density, "high risk" behavior and high rates of HIV infection. Two primary "High Risk" behaviors that are known to increase one's risk of becoming infected with the virus that causes HIV disease are (1) unprotected sexual activity where body fluids are exchanged between two or more partners and (2) drug use involving shared injection paraphernalia where blood is exchanged between two or more partners.

Within the Los Angeles County government, OAPP utilized the above mentioned CDC grant funding to conduct HIV seroprevalence studies in approximately 100 clinics where "high risk" populations were evaluated and treated. For the most part, OAPP had formal contractual agreements or less formal "letters of agreement" in place, concerning the number of patients that each clinic was expected to see, as well as remuneration agreements for the prescribed research activities. The problem addressed in this paper concerns twenty-six Los Angeles County Department of Health Services (DHS) clinics and the absence of an agreement that was monitored for quality.

For a number of years, at great expense, OAPP paid the salaries and benefits of one or two County of Los Angeles employees to work in each of the above mentioned twenty-six public health clinics in exchange for the HIV seroprevalence studies, including data collection, to take place. In addition, OAPP provided computers and ongoing maintenance of those computers to many clinics, which were to be used to bring the staff of each clinic into the information age.

I became employed at the OAPP in April 1995, and soon realized that the quality and quantity of the HIV seroprevalence research and HIV prevention data at the twenty-six DHS clinics was very poor compared to the general quality and quantity of the research data being submitted by many other of the seventy-five research sites which operated under more formal agreements. In some cases, OAPP was funding two employees to conduct the research, but the clinic was only submitting 10 records per month, and even then, the data was often incomplete or internally inconsistent. I conducted site visits and found that for the most part, clinic employees who were on the payroll of OAPP, were no where to be found. Instead of conducting HIV prevention and seroprevalence research, or at least supervising the activities, our clinic employees had been assigned as personal assistants to clinic managers and/or district health officers. Further, the computers provided for each clinic were locked up, only to be used by the clinic managers and/or the district health officers.

It was at this time that I knew an internal fee-for-service protocol had to be put in place for these twenty-six clinics in order to ensure their accountability in terms of research data quantity and quality. In other words, instead of funding employees and computers, hoping the HIV prevention and research activities would take place, under the fee-for-service protocol, OAPP would only pay for the data received and much more site visit clinic monitoring activity would have to take place. My challenge would be to write an automated claims and billing application that would interface with the current data collection format in order to invoice each claim submitted by each clinic on a monthly basis.

THE DATA COLLECTION TOOL AND FORMAT

This labor intensive HIV Seroprevalence research and prevention activity involved (1) a twenty to thirty minute one-on-one pretest counseling session where a trained counselor would educate the patient about general HIV risks while collecting that patient's demographic and personal HIV risk information on part "A" of a three part scantron (No. 2 pencil only) data form, (2) If the patient consented, blood was drawn for an HIV test and part "B" (The lab slip) of the three part form was completed and sent to the lab with the blood specimen. (3) From five to sixty days after the pretest counseling session and blood draw, the patient could return to the clinic for their HIV test result, which also included a review of

the pretest counseling HIV risk and education session. At that time, part "C" of the scantron form (Posttest counseling Information) was completed and mailed to OAPP to be scanned in by OAPP employees. During this process, outside referrals might be made to patients, and if they failed to return for their HIV test results, the clinic might send a postcard or call the patient to ask them to return.

The primary "high risk" target populations for this prevention and research activity included attendees of county sexually transmitted disease (STD) clinics and county clinic patients with suspected or confirmed Tuberculosis (TB) infection. It was believed by CDC and OAPP epidemiologists that if HIV disease started to spread rapidly in Los Angeles County, these closely monitored "high risk" populations would be among the first to become infected, giving the health department a chance to prepare. Other target populations in other Los Angeles County clinics conducting this prevention activity included injection drug users in methadone treatment programs, sex crime suspects appearing in court, adolescents attending primary health care clinics, women of child bearing age attending prenatal clinics and homeless people seeking medical services.

Over the years, it was my observation that OAPP management was slightly more professional and strict in terms of enforcement of research protocol with outside contracted agencies than they were with their sister County of Los Angeles Health Department agencies and clinics. Being responsible for building one data warehouse out of all clinic data and for conducting sound data analysis, I could not be concerned about who had negotiated which political agreement with whom. I just knew that I was responsible for creating one reliable database from which I and others could make sound public health decisions about the progression and prevention of HIV disease in Los Angeles County.

Most of OAPP's risk averse management were quite happy to live with this duality of enforcing different rules at different agencies for the same research study. One man however, John Schunhoff, M.D., the OAPP director for a number of years, and one woman, Cynthia Harding, M.P.H., the OAPP M.I.S. director, (both moved onto to other duties well before this was implemented) understood that for public health clinics to begin to care about the quality and quantity of their HIV seroprevalence research and prevention work, a fee-for-service protocol would have to be instituted. They also understood data validity and reliability issues, and the effect of those concepts on statistical analysis outcomes. If one data warehouse was going to be made up of data from 125 public health clinics, each clinics had to follow the same data collection rules.

Of course, negotiations with our LA County public health clinics were difficult. The clinics wanted the free ride to continue, but fortunately, some leaders outside of OAPP within the health department understood the need for more accountability. Internal fee-for-service would be the law of the land starting July 1, 1997, and I had to write what would turn out to be an insurance claims/reimbursement application to operate with the new reimbursement protocol.

From a SAS® programming point of view, the final reimbursement fee-for-service schedule turned out to much more complex than was needed, but I knew it could easily be programmed in SAS®. Figure 1 shows part of the fee schedule that was finally negotiated between OAPP and DHS management. The difference in a "High Risk" and a "Low Risk" patient is their self-reported sexual and drug using activity. The whole idea that HIV prevention studies should be reimbursed at a different rate for "High Risk" and "Low Risk" patients was born at the State Office of AIDS in Sacramento. Figure 1 shows the total possible difference in reimbursement between a "Low Risk" HIV negative and a "High Risk" HIV negative patient is $20.00. Might you, if you were a clinic manager always in need of funds, and unhappy about the new internal fee-for-service protocol, tell your research staff to do everything possible to check at least one "high risk" behavior on each data collection form in order to raise more money for your clinic?

Figure 1: **FEE-FOR-SERVICE SCHEDULE (Partial)**

	Low Risk No Result	High Risk No Result	Low Risk HIV-	High Risk HIV-	Low Risk HIV+	High Risk HIV+
Pre-Test	$20	$30	$20	$30	$30	$30
Posttest	$0	$0	$13	$18	$33	$33
Referral	$0	$0	$0	$5	$15	$15
No Show Follow-up call or post card	$0	$0	$3	$3	$0	$0
Lab	$0	$0	$10	$10	$55	$55
TOTAL:	$20	$30	$46	$66	$133	$133

In reality, the data was and likely is today, skewed by the financial incentive for clinic staff to make every patient appear to be "High Risk" on the data form. Lab charges truly are higher to test and confirm HIV positive blood, so that part of the design made sense. Otherwise, the reimbursement charges might have looked like Figure 2 which does not supply an incentive for the clinic staff to exaggerate any patient's HIV risk.

Figure 2:

	No Result - Patient declines HIV test	HIV-	HIV+ & HIV Inclusive
Pre-Test	$15	$15	$15
Test	$0	$10	$10
Posttest	$0	$15	$15
Referral	$0	$0	$15
No Show Follow-up call or post card	$0	$3	$3
Lab	$0	$10	$55
TOTAL:	$15	$53	$113

THE DATA COLLECTION TOOL AND DATA FORMAT

Part-A of the federal risk assessment data collection scantron form, completed by the pretest counselor, included three sections. Section one included housekeeping information such as database record identification number (supplied by the CDC), project area, site type, site number, pretest counselor ID number and the date of patient visit. Part two included demographic information such as gender, race/ethnicity, age, state, county,

and zip code. Part three included the following nominal level HIV behavioral risk indicators:

SINCE 1978 HAVE YOU:
____Had sex with a Male
____Sex with a female
____Used injecting drugs
____Had sex while using non-injecting drugs
____Had sex for drugs or money
____Been given an STD diagnosis

SEXUAL RELATIONS SINCE 1978 WITH:
____An injection drug user
____A man who had sex with another man
____A person with HIV/AIDS
____A person with other HIV/AIDS risk

____Is patient a child of a woman with HIV/AIDS
____Does patient have hemophilia
____Has patient been a blood recipient since 1978
____Has patient had a health care exposure since 1978
____Has patient been a victim of sexual assault since 1978
____No acknowledged risk (if none of the above are checked)

Before the start of the federal HIV seroprevalence and prevention studies, the CDC contracted with Conceptual Software® in Houston, Texas to write an integrated series of programs in Professional Data Analysis System, Inc. (PRODAS®) programming language. All data was scanned into the PRODAS® database through a PRODAS® application written for the CDC. It was called "CTS," (Counseling and Testing System). The scanning application included code to clean the data as scantron forms were scanned into the PRODAS® database. If 'date of this visit' was left blank on the scantron form for example, the software would not accept any of the data from that scantron form. This ensured clean data in the PRODAS® database. Also, as each record was saved to the PRODAS® database, the variable MODE (possible mode of HIV transmission) was automatically assigned using the above HIV risk data. MODE=01 for example, was assigned to a record if the data indicated a male patient who had sex with another male since 1978. MODE=02 indicated a record where a male who had sex with another male since 1978, had also used injection drugs since 1978. It was these various combinations of each patient's risk assignment which made it possible to easily assign "High Risk" and "Low Risk" to each record in the SAS® database that I created from the PRODAS® database using a Conceptual Software® data format translation package called, DBMS/COPY®.

A "TURNOVER FRIENDLY" APPLICATION

What's a "turnover friendly" SAS® application? It is a program that, after one has left employment with a company, another SAS® programmer with a similar skill set can understand and alter without having to ask the original programmer to translate. People change jobs quite often in today's job market. Its only fair to write computer application code that balances programming language efficiency with code that is easy to understand. How is the "turnover friendly" SAS® application accomplished? In part, through annotations (comments) within the SAS® application code. The beginning of my fee-for-service application read as follows:

(Top of Page)

```
/*
PROGRAM BY:     JAY GRAVINK
                RESEARCH ANALYST III
                DHS-OFFICE OF AIDS PROGRAMS
                COUNTY OF LOS ANGELES, CA

CREATION DATE:  11/15/97-12/31/97, LAB added 4/15/98

PROGRAM NAME:   C:\INVOICE.SAS

LANGUAGE/VER:   SAS 6.11 FOR WINDOWS 3.X

DESCRIPTION:    This program will invoice HIV counseling &
                testing data in LAC by month.
                                                        */
   options nocenter nofmterr ps=51 ls=156;
   libname library 'C:\invoice';
   data a;
   set library.inv0498;
*_____________________________________________________;
*DONE is a variable which allows the program to invoice only ;
*one logical situation at a time. Once a record is invoiced by ;
*the program it cannot be changed later in the billing process.;
*_____________________________________________________ ;

    DONE='0';
*_____________________________________________________;
*The following subsetting if statement allows;
*the application to create invoices for      ;
*specific sites.                             ;
*_____________________________________________;

    *If sitenum > '123';
*_____________________________________________;
*The following assigns HI or LO risk to each;
*record. RISK is based on the CDC variable  ;
*called MODE. See the CDC CTS manual for    ;
*further information about MODE.            ;
*_____________________________________________;

      If (mode = '01'  |
          mode = '02'  |
          mode = '03'  |
          mode = '04'  |
          mode = '05'  |
          mode = '06'  |
          mode = '07'  |
          mode = '08'  ) then RISK = 'HI';
   else if
         (mode = '09'  |
          mode = '10'  |
          mode = '11'  |
          mode = '12'  |
          mode = '13'  |
          mode = '14'  ) then RISK ='LO';
                         else RISK   ='!!';
```

The next challenge for my application programming skills was to assign the fee schedule (Figure 1) to all probable service and HIV test status combinations. The application contains forty-five coding combinations that yield different reimbursement amounts for each patient. All forty-five of the combinations are linked together as one "IF-THEN DO-END-ELSE-IF" statement. The following are three examples of combinations of service and reimbursement code.

```
*=============================================;
*                  NO RESULT                  ;
*=============================================;
```

```
*                                                    ;
* 1. Low risk- No test result in database, so no post ;
*    test, referral, no-show follow-up or lab money  ;
*    possible. $20 for pretest counseling only.      ;
*                                                    ;

      IF (id > '0000000000'
            &   DONE = '0'
            &   risk  =  'LO'
            &   result = ' ' | result  = '3')
            THEN DO;
      DONE    = '1'  ;
      PRE_C   = 20   ;
      POST_C  =  0   ;
      REFERAL =  0   ;
      NOSHOW  =  0   ;
      LAB     =  0   ;   END;

*                                                    ;
* 2. High risk- No test result in database, so no post ;
*    test, referral, no-show follow-up or lab money  ;
*    possible. $30 for pretest counseling only.      ;
*                                                    ;

      else IF(id > '0000000000'
            &   DONE = '0'
            &   risk  =  'HI'
            &   result = ' ' | result  - '3')
            THEN DO;
      DONE    = '1'  ;
      PRE_C   = 30   ;
      POST_C  =  0   ;
      REFERAL =  0   ;
      NOSHOW  =  0   ;
      LAB     =  0   ;   END;

*============================================;
*       LOW/HIGH RISK - HIV+                 ;
*============================================;

*                                                    ;
* 3. Low/High risk- HIV+, No post test counseling    ;
*    No-Show follow up code blank, so $30 for pretest;
     counseling and $55 for the lab only.           ;
*                                                    ;

      else IF(((id > '0000000000'
            & DONE = '0'
            & (risk   =  'HI' | risk = 'LO')
            & result =  '1'
            & (post   =  ' '  | post = '0')
            & Client_C = '   ')))
      THEN DO;
      DONE    = '1'  ;
      PRE_C   = 30   ;
      POST_C  =  0   ;
      REFERAL =  0   ;
      NOSHOW  =  0   ;
      LAB     = 55   ;   END;


*============================================;
*       NOT INVOICED                         ;
*============================================;

*                                                    ;
* 43. DONE = 0 (IT WAS NOT INVOICED)                 ;
*                                                    ;

else IF (id > '0000000000' &  DONE   = 0)
    THEN DO;
DONE    = 'X'
PRE_C   =  0
POST_C  =  0
REFERAL =  0
NOSHOW  =  0
LAB     =  0;   END;
```

After all of the service and reimbursement logical combinations were programmed, programming for effective reports were next. The following variable, TOTAL, was created at this point. TOTAL would appear on the last column on the right hand side of the page where each record would display a dollar total.

```
TOTAL = (PRE_C + POST_C + REFERAL + NOSHOW + LAB);
```

Time for VALUE labels and formatting: Value labels allow the programmer to use words on the final printed report instead of codes that are unfamiliar to most of the audience who will read the report.

```
proc format;
VALUE $sitefmt   '   '    = 'No Site Number!'
                 '101'    = '101-STD-Central'
                 '102'    = '102-STD-South'
                 '107'    = '107-STD-Hlwd/WIL'
                 '108'    = '108-STD-Tucker'   ;
                 (....And so on for all site numbers)

VALUE $postfmt   ' '      = 'no report'
                 '0'      = 'no'
                 '1'      = 'yes, req. result'
                 '2'      = 'yes, w/follow up'
                 '3'      = 'yes, w/new visit'
                 '4'      = 'yes,  other';

VALUE  $rsltfmt  ' '      = 'No Result'
                 '0'      = '-          '
                 '1'      = '+          '
                 '2'      = 'Inconclu   '
                 '3'      = 'No Test    ';
```

The following code is the sorting and output code for the record-by-record printed invoice using PROC PRINT: Please see **Figure 4** (last page of this paper) for an example of this record by record output.

```
proc sort; by sitenum  dt_visit;

proc print; by sitenum;
SUM TOTAL     ;
SUM PRE_C     ;
SUM POST_C    ;
SUM  REFERAL  ;
SUM  NOSHOW   ;
SUM  LAB      ;
VAR done id dt_visit precoun RISK RESULT post dt_post
postcoun client_c PRE-C REFERAL NOSHOW LAB total;
```

The following assigns the formats built above to the actual variables.

```
FORMAT result $rsltfmt. sitenum $sitefmt. post $postfmt.
          PRE_C POST_C REFERAL NOSHOW LAB total
          DOLLAR8. ;

TITLE 'APRIL 1998 P R E L I M I N A R Y FEE-FOR-SERVICE
INVOICE';
run;
```

==========

The following is the alternate output code for a summary page of all services and reimbursements for all clinics, totaled both horizontally and vertically so that clinic totals and service totals can easily be compared. Please see **Figure 3** (last page of this paper) for an example of this summary output.

```
proc means noprint; by sitenum;
var PRE-C POST_C REFERAL NOSHOW HC_TOTAL LAB
TOTAL;

OUTPUT OUT=totals
SUM (PRE_C POST_C REFERAL NOSHOW HC_TOTAL LAB)
= PRE_C POST_C REFERAL NOSHOW HC_TOTAL LAB
SUM (total) = TOTAL;

PROC PRINT;
SUM  _freq_;
SUM  PRE_C;
SUM  POST_C;
SUM  REFERAL;
SUM  NOSHOW;
SUM  HC_TOTAL;
SUM  LAB;
SUM  TOTAL;

TITLE1  'County of Los Angeles';
TITLE2  'Office of AIDS Programs and Policy';
TITTLE  ' ';
TITTLE  'April 1998  P R E L I M I N A R Y  Invoice summary';
TITTLE  '  ';

FOOTNOTE  'KEY';
FOOTNOTE  '  ';
FOOTNOTE  '_FREQ_    =Number of pretest counseling
                      sessions';
FOOTNOTE4  'PRE_C    =HIV pretest counseling
                      reimbursement totals';
FOOTNOTE5  'POST_C   =HIV posttest counseling
                      reimbursement totals';
FOOTNOTE6  'REFERAL  =Referral reimbursement totals';
FOOTNOTE7  'NOSHOW   =Reimbursement totals for patients
                      who tested but did not return for
                      test results';
FOOTNOTE8 'HC_TOTAL  = Health Center Reimbursement
                      totals';
FOOTNOTE9  'LAB      =Public Health Lab Reimbursement
                      totals';
FOOTNOTE10'TOTAL     =Total reimbursement for LAC
                      Health Centers and LAB costs.;

FORMAT sitenum $sitefmt PRE_C  POST_C  REFERAL
        NOSHOW  HC_TOTAL LAB  TOTAL  DOLLAR8.;
run;
```

==========

CONCLUSION

SAS® programming language, the SAS® system and my computer application development skills have played an important role as the basis for the development of strategic automated applications to turn public health research data into useful information for better financial planning and general sound decision making.

Government has a reputation for being quite slow and quite inefficient in its response to public health concerns. Often, as in the case of HIV disease, money has been thrown at public health emergencies without a viable strategic plan for holding any entity accountable for the way in which the money is spent. Data is often collected without a realistic plan to use it effectively. In this example, as a government employee and a United States tax payer, I took it upon myself to raise the standards at one government office. The federal CDC granted OAPP copious amounts of money over the years to provide public health prevention services along with a research/data collection component. OAPP passed the money down to some of its sister agencies who were not held accountable for their use of government funds until this fee-for-service idea and this application made the fee-for-service idea possible. This scenario created an opportunity for me to make a difference. With data already being collected for a research study, I was able to create a SAS claims and payment application that forced public health clinics to be more accountable for their spending of public funds.

REFERENCES

Delwiche, Lora D. and Slaughter, Susan J, *The Little SAS Book: A Primer*, Cary, NC, SAS Institute Inc., 1995. 228 pp.

ACKNOWLEDGMENTS

"It is always nice to hear a splash after dropping a rock in a well," as my friend TREZ E. in Texas recently said. I wrote and implemented the above application two years ago while working for the County of Los Angeles, and never received an ounce of acknowledgment until I was recently asked to be a contributor to the 7th Annual Western Users of SAS® Software conference. I would like to thank George C.J. Fernandez, Department of Applied Economics and Statistics at the University of Nevada in Reno, for granting me this opportunity to share my application and ideas of high public service integrity with a respected audience of application development professionals. Also, I must acknowledge Casey Cantrell at UCLA, who taught me many of the SAS® basics that I have used in order to be successful at the art of SAS® programming and applications development. Lastly, Andrew C. Ellis, I could not have fought the good fight without your support.

Your comments and questions are valued and encouraged. Please contact the author at:

Jay Gravink, M.A.
Kaiser Permanente of Southern California
"Community Medical Services"
393 E. Walnut St., 7th Floor
Pasadena, CA 91188

Work Phone: 626-405-3652
Fax: 626-405-6456
Email: Jay.x.Gravink@kp.org

Figure 3:

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
OFFICE OF AIDS PROGRAMS AND POLICY

APRIL 1998 PRELIMINARY FEE-FOR-SERVICE INVOICE

OBS	SITENUM	_FREQ_	PRE_C	POST_C	REFERAL	NOSHOW	HC_TOTAL	LAB	TOTAL
1	101-STD-CENTRAL	181	$4,630	$1,505	$15	$3	$6,153	$1,635	$7,788
2	102-STD-SOUTH	336	$8,050	$1,029	$0	$0	$9,079	$2,210	$11,289
3	107-STD-HLWD/WL	176	$4,530	$1,188	$0	$0	$5,718	$1,360	$7,078
4	108-STD-TUCKER	283	$6,320	$1,329	$0	$0	$7,649	$2,140	$9,789
25	604-HIV-A.VALLEY	15	$420	$242	$0	$3	$665	$150	$815
		2174	$51,560	$14,320	$20	$357	$66,257	$16,860	$83,117

KEY:

FREQ = Number of pretest counseling sessions. (Number of scantronPart-A records in database)
PRE_C = HIV pretest counseling reimbursement totals.
POST_C = HIV posttest reimbursement totals.
REFERAL = Referral reimbursement totals.
NOSHOW = Reimbursement totals for follow-up of clients who tested, but did not return for results.
HC_TOTAL=Health Center reimbursement totals.
LAB = Public Health lab reimbursement totals.
TOTAL = Total reimbursement for LAC Health Centers and LAC Public Health Lab.

Figure 4:

APRIL 1998 PRELIMINARY FEE-FOR-SERVICE INVOICE

Site identifying number = 101-STD-CENTRAL

OBS	DONE	ID	DT_VISIT	PRECOUN	RISK	RESULT	POST	DT_POST	POSTCOUN	CLIENT_C	PRE_C	POST_C	REFERAL	NOSHOW	LAB	TOTAL
1	1	10103400000	4/1/98	2031	HI	" - "	yes, req. result	4/15/98	2031		$30	$18	$0	$0	$10	$58
2	1	10103500000	4/1/98	2061	LO	" - "	yes, other	5/4/98	2061		$20	$13	$0	$0	$10	$43
3	1	10103600000	4/1/98	2037	LO	" - "	no			101	$20	$0	$0	$3	$10	$33
4	1	10103700000	4/1/98	2064	LO	" - "	yes, req. result	4/14/98	2064		$20	$13	$0	$0	$10	$43
5	1	10103800000	4/2/98	2001	HI	" + "	yes, req. result	4/27/98	2031	303	$30	$33	$15	$0	$55	$133
181	1	10118700000	4/30/98	2037	LO	" - "	no			101	$20	$0	$0	$3	$10	$33
SITENUM											$4,630	$1,505	$15	$3	$1,635	$7,788