

# A Comparative Cost Analysis of an Integrated Military Telemental Health-Care Service

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## ABSTRACT

The National Naval Medical Center, Bethesda, Maryland, integrated telemental health care into its primary behavioral health-care outreach service in 1998. To date, there have been over 1800 telemental health visits, and the service encounters approximately 100 visits per month at this time. The objective of this study was to compare and contrast the costs to the beneficiary, the medical system, and the military organization as a whole via one of the four methods currently employed to access mental health care from remotely located military medical clinics. The four methods include local access via the military's civilian health maintenance organization (HMO) network, patient travel to the military treatment facility, military mental health specialists' travel to the remote clinic (circuit riding) and TeleMental Healthcare (TMH). Interactive video conferencing, phone, electronic mail, and facsimile were used to provide telemental health care from a military treatment facility to a remote military medical clinic. The costs of health-care services, equipment, patient travel, lost work time, and communications were tabulated and evaluated. While the purpose of providing telemental health-care services was to improve access to mental health care for our beneficiaries at remote military medical clinics, it became apparent that this could be done at comparable or reduced costs.

## INTRODUCTION

THE NATIONAL NAVAL MEDICAL CENTER (NNMC) consists of the medical center proper located in Bethesda, Maryland, and several branch medical clinics (BMCs) located in Maryland, Virginia, West Virginia, Pennsylvania, New Jersey, and the District of Columbia. Staffing at branch medical clinics varies from site to site, and may include combinations of internists, family practitioners, general medical officers, flight surgeons, physician assistants, and independent duty corpsmen. No locations have mental health-care providers as part of

the branch medical clinic staff. Most sites have Fleet and Family Support Centers staffed with social workers who generally address issues of domestic violence and partner relational and occupational problems that are typically referred to as "V-codes" secondary to their coding in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).<sup>1</sup> Tertiary military facilities, such as NNMC, are also regional referral centers for 'stand-alone' medical clinics. These Navy, Army, and Air Force clinics do not fall under a tertiary facility but are part of the military's regional health maintenance organization (HMO). These clinics may be staffed

by social workers, psychologists, and occasionally psychiatrists who are credentialed to treat the full range of mental health disorders.

Although most beneficiaries present to their primary care providers for mental health-related issues, many are either referred to the local civilian community or travel to one of the tertiary military treatment facilities (MTF). In an effort to improve access to mental health care, the Department of Psychiatry created the primary behavioral health-care (PBH) division in 1998. The division supplied circuit-riding psychiatric services directly to two branch medical clinics and indirectly to four others. Additionally, circuit-riding psychiatric services were supplied to two 'stand-alone' Naval Medical Clinics (NMCs) that did not have organic psychiatric resources.

In the summer of 1998, an effort was made to integrate telemental health-care services into the primary behavioral health-care service. This initiative was based on the experience and success that was realized in providing mental health-care services to ships at sea as well as shore-based medical facilities in late 1997 and early 1998, via interactive videoconferencing. It was felt that providing telemental health services would be an effective and affordable alternative to the other ways of accessing mental health services at remote clinics. Currently, NNMC provides direct primary or augmented mental health support to eight remotely located medical clinics. Two remote clinics are supported with a circuit-riding psychiatrist and six remote clinics are supported via telemental health, five within the United States and one overseas. Of the clinics located in the United States, one is approximately 1 hour, two fall between 1 and 2 hours and the remaining two fall between 2 and 3 hours drive from the National Naval Medical Center. One remotely located site, Carlisle Barracks, located in Carlisle, Pennsylvania, was chosen for the purposes of this cost analysis because it was the first telemental health-care (TMH) site established as part of the primary behavioral health-care service. Additionally, the post is located within minutes of the Navy Inventory Control Point, at Mechanicsburg, Pennsylvania, and serves a diverse military population. Medical clinics located at both of these sites routinely referred

patients to the local community as well as military treatment facilities located in Maryland and Washington, D.C.

The purpose of this paper is to compare and contrast the costs to the beneficiary, the medical system, and the military organization as a whole via one of the four methods currently employed to access mental health care from remotely located military medical clinics. Those four methods include local access via the military's civilian HMO network, patient travel to the military treatment facility, military mental health specialist's travel to the remote clinic, and TMH.

## MATERIALS AND METHODS

### *Materials*

The PBH service at NNMC utilizes a Polycom Viewstation MP, with dual 32-inch Sony Trinitron color televisions, a Sony VHS model SLV-789HF videocassette recorder, and a Sony model VID-P110 video presentation stand. Four ISDN lines are available for use with a maximum bandwidth of 512 kbps. Patient intake evaluations, medication follow-up appointments, and treatment team meetings are conducted at a bandwidth of 384 kbps; group psychotherapy is conducted at 256 kbps. Commercial telephone ISDN services are utilized.

The remote site uses a Dell Pentium III computer, a 21-inch Dell Trinitron monitor, Picture Tel 550 PCI video/audio codec board, Harman/Cardon model HK195 speakers, and a Canon VC-C4 camera. Three commercial ISDN lines are available for use with a maximum bandwidth of 384 kbps.

### *Methods*

The remote telemental health clinic has established hours, 0800–1200, e.g., each Wednesday, with treatment team planning from 0800–0830 on the first and third Wednesdays of the month. The remote site is responsible for all appointment scheduling; patients seen are told when to follow up and schedule these appointments as if they were being seen by a provider at the remote site. Urgent evaluations or follow-up appointments can be made by ei-

ther the patient or the remote site providers by letting the telemental health practitioner know via phone, electronic mail, or pager.

*Network costs:* Charges for each Current Procedural Terminology (CPT)<sup>2</sup> code is based on the current Champus Maximum Allowable Charge (CMAC) for a physician (class 01) in the 17013 zip code area (Pennsylvania except for the Philadelphia Metro Area).<sup>3</sup> The number of new evaluations (4) and follow-up appointments (4 medication only, 9 medication/psychotherapy, and 8 group) are based on the average number of patients seen each month (25) for the past 12 months. Since December, 2000, 2 patients from this site participate in videoconferencing based group psychotherapy each week (2 patients for a total of 8 visits/month), CPT code 90853. The follow-up CPT code of 90805, medication management with psychotherapy, was used more extensively than 90862, medication management without psychotherapy, because nearly all, if not all military psychiatrist at the hub site utilize an integrated pharmaco/psychotherapy, 20- to 30-minute follow-up model. Medication sessions lasting 20 minutes or less were coded as 90862; those medication sessions greater than 20 minutes as 90805.

*Military provider costs:* Provider costs per hour is based on a psychiatrist earning \$120K per year, working an average of 48 weeks each year, 5 days a week, at 10 hours per day. The number of hours is based on 1.25 hours per new evaluation, 0.5 hours per follow up, a 1.5-hour group session four times per month, 0.5 hours two times a month for multidisciplinary treatment team planning, and for circuit riding 4.5 hours of provider time lost per round trip at four trips per month. Travel is based on one visit each week, one-way travel distance of 115 miles and current reimbursement rate of \$0.345 per mile.<sup>4</sup>

*Telemental health-care costs:* Transmission costs are based on quotes from the medical centers' current commercial communication vendor. Monthly line maintenance charges at the hub site are \$15.88 per line; the remote site assumes no additional monthly line charge for these lines. The transmission costs of \$0.09 per minute per 128-kbps line is the Government Service Administration-contracted price for all

calls originating from the hub site to locations in the United States. Group therapy costs were based on four 90-minute sessions per month at a bandwidth of 256 kbps; new, follow-up and treatment team meetings were based on 5 hours, 6.5 hours, and 1 hour per month, respectively, at a bandwidth of 384 kbps. Videoconferencing equipment maintenance service is based on a quote of \$1000 per year/per unit for guaranteed overnight repair when shipped overnight to the factory. An estimated 72-hour turnaround time was felt to be acceptable for the remote sites, while the hub site could put existing administrative units online temporarily for patient care in the event of equipment failure. The maintenance service cost was based on the full cost of the remote unit and dividing the cost of the hub unit six ways (the current number of clinics currently served by the hub site). Replacement cost (life-cycle planning) is based on full replacement every 3 years of the remote videoconferencing unit, monitor, and NT1 terminals (\$8000) and one-sixth of the cost of the hub unit, monitors, terminals, and projection stand (\$2500). Where applicable, costs reflect those on the Government Services Administration contract.

*Hospitalization costs:* Costs were based on figures published in the Tricare/Champus health care summary by primary diagnosis, based on care received from October, 1999, through September, 2000.<sup>5</sup> The average Government cost per day for inpatient mental health professional and hospital services in this region was \$481.80. The average length of inpatient mental health stay was 6.73 days.<sup>6</sup> There were approximately eight hospitalizations in 2000 at this remote site. Additionally, the on-site and consultant staff estimated, based on clinical evaluation of patients at presentation, that four hospitalizations in the year 2000 were avoided due to the ready access of specialty consultation and coordinated treatment team planning available via telemental health. This would result in an estimated 12 hospitalizations per year or 1.0 per month based on local HMO network provider access availability. The average wait time prior to the use of TMH, in 1998, was 6–8 weeks for a network provider. Because telemental health wait time depends primarily on the patient's clinical presentation, access time

has ranged from minutes to 3 weeks. Thus, the estimated hospitalization rate utilizing the system was 8 per year or 0.67 patients per month. However, to reduce potential error, a conservative rate of 0.8 patients per month was used for purposes of this analysis. The average waiting time at a military treatment facility, the closest to this remote site being NNMC, averages 1–3 weeks. However, due to the practicality of this option, i.e., the patient's drive to the hub, winter weather, etc., no benefit in access would be expected at this remote location. Thus, the estimated rate of hospitalizations per month, when relying on the patient traveling to the MTF, would be 1.0 per month. Circuit-riding wait time was estimated, based on experience at other remote sites, to be 1–3 weeks. Because circuit riding was not used at this particular site, an assumption of its effectiveness at improving access, and thus hospitalization avoidance, was made (based on circuit-riding experiences at other sites) falling halfway between 8 hospitalizations when telemental health is available and 12 hospitalizations where it is not available. Thus, one might expect 10 hospitalizations per year or 0.83 per month. However, to reduce potential error a conservative rate of 0.9 was used for this analysis.

*Operational unit/patient costs:* Operational unit costs are those costs due to lost work time for active duty patients and their travel costs. The average pay grade for active duty patients seen was E5, equating to an estimated salary of \$1800.00 per month.<sup>7</sup> Military pay grades are based on rank, time in service, marital/dependent status, and include E1–E9, WO1–WO4, and O1–O10, enlisted, warrant officer, and officer pay grades, respectively. Costs per day were based on 22 workdays per month with an 8-hour workday. It was estimated that an on-post appointment would take an average of 1.6 hours, or 0.2 of each work day, and an off-post appointment and average of 3.2 hours, or 0.4 of each work day. Of the average of 25 follow-up visits per month, 12 were active-duty patients. While the remaining 13 patients were dependents of active-duty service members, it is common for active-duty members to take time off from work to accompany their dependents to medical/mental health appointments. How-

ever, these lost work days were not included in this estimate.

Patient travel costs are estimated based on the current mileage reimbursement rate for local travel established by the government, \$0.345 per mile.<sup>8</sup> Although travel costs for active duty are reimbursable, those to his or her family are not. This can create a significant financial burden on the military family, and is thus included in the subtotal and total costs to the beneficiary.

*Total organizational costs:* Total organizational (Department of Defense) costs encompass and were broken down into three areas based on their practical significance to the patient (beneficiary), the medical system (treatment facility/medical department), and the military work center (operational unit).

## RESULTS

The total monthly estimated costs of each method of remote mental health-care delivery were itemized (see Table 1). The resultant ranking, from most expensive to least expensive was as follows: the patient drives to the hub site (MTF) for care, \$6986.72; the patient is seen by local HMO network providers, \$5510.39; a circuit-riding provider travels weekly to the remote site, \$5421.67; and telemental healthcare \$4599.73. It is clear that each method of remote mental health-care delivery had unique features that significantly affected total costs.

The most expensive method of health-care delivery overall, having the patient drive to the hub site where specialty mental health-care is available, was most influenced by the costs of travel, \$1983.75, and lost work time, \$785.45; 40% of total organizational costs. Lost work time accounted for 11%, reimbursable travel costs of active duty members 14%, and cost burden placed directly on the family household for dependent travel 15%. This option is however, the most inexpensive for the medical department, \$4217.51.

The second most expensive method of mental health-care delivery overall, being seen by local HMO network providers, was most influenced by the reimbursement rate as based

TABLE 1. ITEMIZED AND TOTAL MONTHLY MENTAL HEALTH CARE COST PER METHOD OF CARE DELIVERY<sup>a</sup>

<i>Method of care delivery:</i>	<i>Local network</i>	<i>Pt drives to Hub</i>	<i>Circuit riding</i>	<i>TeleMental health</i>
<b>HMO Network Costs:</b>				
Visit Type/Charge Per Visit/CPT	# Visits	#Visits	# Visits	# Visits
NEW/\$145/90801	4	\$579.68	0	\$0.00
FU Med Only/\$52/90862	4	\$207.12	0	\$0.00
FU Med-Therapy/\$72/90805	9	\$649.89	0	\$0.00
GROUP/\$34/90853	8	\$274.72	0	\$0.00
<b>Total:</b>		<b>\$1,711.41</b>		<b>\$0.00</b>
<b>Military Provider Costs:</b>				
Labor (Psychiatrist)				
Hours <sup>b</sup>	0	19.5	37.5	19.5
Cost/Hour <sup>c</sup>	\$50	\$50	\$50	\$50
<b>Total:</b>		<b>\$0.00</b>	<b>\$975.00</b>	<b>\$1,875.00</b>
Travel				
Travel Distance (miles) <sup>d</sup>	0	0	230	0
Cost per Mile <sup>e</sup>	\$0.35	\$0.35	\$0.35	\$0.35
Provider Visits per Month	0	0	4	4
<b>Total:</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$317.40</b>
<b>Telemental Health Costs:</b>				
Transmission Costs:				
Line cost/min/128kbs line	\$0.00	\$0.00	\$0.00	\$0.09
Usage/Month (min) @256kpbs (group)	0	0	0	360
Usage/Month (min) @384kpbs (other)	0	0	0	750
<b>Total:</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
Line Charges/Month	\$0.00	\$0.00	\$0.00	\$15.88
Number of lines	NA	NA	NA	4
<b>Total:</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$63.52</b>
Maintenance Service <sup>f</sup>				
<b>Total:</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$97.22</b>
VTC Replacement Cost/Month <sup>g</sup>				
<b>Total:</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$291.67</b>
<b>Hospitalization Costs (Access):</b>				
Est. Number of Pts Hospitalized/Month	1.00	1.00	0.90	0.80
Average Length of Stay <sup>h</sup>	6.73	6.73	6.73	6.73
Average Cost per day <sup>i</sup>	\$481.80	\$481.80	\$481.80	\$481.80
<b>Total:</b>		<b>\$3,242.51</b>	<b>\$3,242.51</b>	<b>\$2,918.26</b>
<b>Operational Unit/Patient Costs:</b>				
Active Duty Work Lost (Ave Paygrade E5)				
Average Time Lost per Appt (Days)	0.4	0.8	0.2	0.2
Active Duty Patients/Month	12	12	12	12
Average Active Duty Patient Cost/Day <sup>j</sup>	\$81.82	\$81.82	\$81.82	\$81.82
<b>Total:</b>		<b>\$427.09</b>	<b>\$785.45</b>	<b>\$181.64</b>
Patient Travel (\$0.345/mile) <sup>e</sup>				
Miles/Round Trip	15	230	15	15
Travel Cost: AD Patients (12)	\$62.10	\$952.20	\$62.10	\$62.10
Travel Cost: Dep. Patients (13)	\$67.28	\$1,031.55	\$67.28	\$67.28
<b>Total:</b>		<b>\$129.38</b>	<b>\$1,983.75</b>	<b>\$129.38</b>
<b>Sub-Total Costs:</b>				
Medical Dollars	\$4,953.92	\$4,217.51	\$5,110.66	\$4,288.72
Beneficiary Dollars (dependent travel)	\$67.28	\$1,031.55	\$67.28	\$67.28
Operational Dollars (lost work & AD travel)	\$489.19	\$1,737.65	\$243.74	\$243.74
<b>Total Organizational Costs:</b>	<b>\$5,510.39</b>	<b>\$6,986.72</b>	<b>\$5,421.67</b>	<b>\$4,599.73</b>

<sup>a</sup>Costs itemized here are specific to Carlisle Barracks, PA; remote site costs will vary depending on local conditions

<sup>b</sup>Equivalent number of hours needed to provide care for 4 New visits, 4 FU Medication Only visits, 9 FU Medication/Therapy visits and 4 Groups visits; also includes multidisciplinary treatment meetings, and provider travel time where applicable.

<sup>c</sup>Based on annual salary of \$120,000.00 and working 48 weeks per year, five days a week, ten hours a day.

<sup>d</sup>Actual Mileage

<sup>e</sup>Government mileage reimbursement rate as of April 2001

<sup>f</sup>Includes full costs of remote site equipment and 1/6th of hub site costs as six remote sites currently share use of the hub site equipment.

<sup>g</sup>Life cycle planning; full costs of remote site equipment and 1/6th of hub site equipment, as above.

<sup>h,i</sup>Tricare/Champus Health Summary by Primary Diagnosis based on care received October 1999 to September 2000

<sup>j</sup>Includes basic pay and allowances.

on the Champus Maximum Allowable Charge (CMAC) for the respective Current Procedural Terminology (CPT) code applied to this particular remote location, \$1711.41.

The third most expensive method of mental health-care delivery overall, provider circuit riding, was most influenced by military provider cost. Eighteen military provider labor hours are lost secondary to travel time, \$900.00, and travel cost reimbursement, \$317.40. Lost labor hours account for 17% and travel 6% of total organizational costs. Savings due to on post access (\$245.45) and decreased hospitalization (\$324.25) reduced over all organizational cost compared to local network access by \$569.70 or 10%.

The least expensive method of mental health-care delivery, TMH, equaled the lowest military provider costs and operational unit/patient costs and the lowest estimated hospitalization costs. Savings due to hospitalization costs (\$648.50), or 14% of total costs, is based on the flexibility and resultant short time to specialty access, available only via telemental health. As mentioned above, times from patient encounter with a primary care provider or remote mental health provider to time seen by mental health specialist (psychiatrist) have been as short as 5–10 minutes in appropriate cases. Additional costs of TMH include equipment life-cycle replacement planning (\$291.67, 6% total costs) maintenance (\$97.22, 2% total costs), and communication costs (\$267.30, 6% total costs).

## DISCUSSION

The mission of the Primary Behavioral Healthcare Service at NNMC is “to improve quality, access and continuity of mental health-care delivery to our beneficiaries, as near to the point of entry into our health-care system as feasible, through the forward deployment of appropriate behavioral health-care consultation-liaison, treatment, and psycho-educational assets.” This is accomplished by providing circuit-riding and TMH services to complement existing on-site mental health resources and the local HMO provider network.

While the goal of integrating emerging tele-

mental health technologies into the primary behavioral health-care service was one of improving access, it became apparent that it could also be done at comparable, if not reduced costs. While telemental health adds \$719.71 in medical cost per this example, these medical dollars are effectively “paid back” for, with savings in medical dollars over the local network (provider and hospital costs) and circuit-riding (provider travel and hospital costs) alternatives. While the medical cost “pay back” for the patient driving to the hub site is less than (\$648.50 in hospital costs) that invested in telemental health, it is anticipated that this small difference in medical cost would be quickly realized owing to improved patient compliance with a treatment plan that does not involve driving 230 miles. The latter example also does not take into account the significant savings of lost work time and travel expenses to the organization, which clearly yields telemental health as the cost-minimizing solution.

Interestingly, the military service’s responsibility for employment, housing, and health-care costs is similar to another successful cost-effective application of telemental/telemedicine services, the civilian penal system. The penal system is fiscally responsible for all aspects the beneficiaries quality of life to include housing, subsistence, and health care. More important, however, can be the necessity to move detainees from one location to another to access health care, an evolution that may require significant time and expense. Another similarity between the systems is that they are both contingency organizations and incur overhead costs regardless of their “beneficiary” population at any one time. Thus, while overhead costs are not changing at the tertiary military treatment facility, maximizing specialist provider time and remote patient access can improve overall operating efficiency of the tertiary facility while enhancing care at the remote site. Access to specialty care, i.e., psychiatrist, at the tertiary facility will be affected as resources are shifted to remote locations. However, the hub site, NNMC, is only losing 0.1 full time equivalents (half day a week) of psychiatric care out of approximately 12.0 full time equivalents (FTEs) available. This is considered small compared to the improvement in services offered to the pa-

tients and staff at the remote site. Additionally, hub sites are generally located in metropolitan areas where access to psychiatric providers is significantly better. Another easily overlooked but significant benefit to tele-access is parking. Typically, many tertiary medical facilities located in urban and suburban areas face parking problems due, it appears, to the continued migration of beneficiaries to suburban and rural areas where mass transportation solutions unsuccessfully vie with the 'convenience' of privately owned vehicular transportation. Thus, telemental health, like other forms of telemedicine, may reduce traffic congestion at the tertiary facility and improve access and lost appointment time due to parking difficulties. Administrative costs at the hub site remain unchanged, because the number of specialists is not changing. The administrative costs at the remote site were, for the most part, insignificant because the added provider is "there" less than a day a week and is absorbed into a system that generally supports several other on-site providers.

Additional savings or improvements may be realized through combinations of the health-care delivery methods described but were not considered for the purposes of this costs analysis. Also, the costs delineated here are specific to the remote site described, Carlisle Barracks, and may be higher or lower at other remote locations.

The costs for travel of our dependent beneficiary population were included because these costs can be significant for many military families. It is, but is one factor amongst many that are less tangible in the "overall quality of life" in the military. For example it is not uncommon for a dependent beneficiary to put off treatment due to child-care costs, feelings that local civilian providers will not understand the stressors inherent in military family life, one-vehicle families, single-parent households during military deployments, and limited incomes, particularly for junior enlisted and officer personnel. The delay in care could be hypothesized to result in greater morbidity. Additionally, to prevent over-utilization secondary to improved access, patients are required to access specialty mental-health care via their primary care or remote mental health provider.

The importance of these issues is recognized and appreciated even more so in an all-volunteer military force. Recruiting and maintaining personnel on active duty requires that the member feels that not only is he or she being looked after but also those family members, who frequently are left keeping the home fires burning while the service member is deployed around the world. Telemental health can significantly improve access where it is poor, and thus reduce the psychological stress of our beneficiaries.

Although this paper focuses on comparison cost analysis of various modalities of providing mental health care to remote populations, it does not attempt to compare outcomes data or analysis of the effectiveness of each modality. This is a key question because, if providing care via telemental health technologies is less effective, then the costs of additional sessions may quickly render telemental health the most expensive option. Zaylor conducted a retrospective review of the Global Assessment of Function in patients seen via telepsychiatry at 128 kbps and a face-to-face control group and noted no significant differences.<sup>9</sup> Patient satisfaction surveys by this author comparing the population described here and that of the outpatient mental health clinic at a tertiary medical facility demonstrated ready acceptance of TMH. Remote providers have been equally pleased with the service and the increased collaboration through regular tele-treatment team planning meetings.

In summary, while several estimates were made in this comparative cost analysis of one military TMH practice, it is evident that utilization of telemental health technologies is comparable in costs to other methods of mental health care delivery. The benefits of TMH are realized at many levels through direct care or care to active duty personnel and their family members.

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