



# HEALTH ANALYSIS

## **Navy and Marine Corps Public Health Center**

Return on Investment Analysis of Health Experts  
onLine at Portsmouth (HELP)

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PREVENTION AND PROTECTION START HERE

## BLUF

The Health Experts onLine at Portsmouth (HELP) program at Naval Medical Center Portsmouth delivered measurable, positive returns on investment (ROI) between June 2014 and December 2015. Incorporating only tangible savings, HELP produced an 80% ROI based on prevented medical evacuations; the addition of intangible savings such as reduced lost productivity increased the ROI to 250%.

## Background

Health Experts onLine at Portsmouth (HELP) is a web-based teleconsultation system launched in June of 2014 to facilitate communication between specialists at Naval Medical Center Portsmouth (NMCP) and providers assigned to both the fleet forces and primary care clinics across the eastern United States, Europe, and the Middle East. HELP currently has more than 1,500 registered users who can utilize the system for three purposes:

1. To expedite patient movement.
2. To request and share patient medical documents.
3. To consult with specialties that are not locally accessible.

The Health Analysis (HA) department at the Navy Marine Corps Public Health Center (NMCPHC) was tasked to take an in-depth look at the third purpose: costs and savings associated with providers using HELP to communicate with specialists at NMCP between June 2014 and December 2015. Specialist consultations through the HELP system purport to improve access to care for patients who otherwise might be referred to the civilian network or medically evacuated (MEDEVACed) to NMCP for specialized care. If HELP-facilitated communications help avoid civilian referrals or MEDEVACs, the associated costs of that care should be reduced. Due to data limitations, this evaluation focuses only on the cost savings associated with consults deemed to prevent MEDEVACs; it does not include potential costs savings from recapturing purchased care.

## Methods

We evaluated cost savings associated with prevented MEDEVACs by analyzing both tangible savings (prevented costs of flights, per diems, and consults) and intangible savings (reduced lost productivity time). We compared these savings to the costs of maintaining and utilizing the HELP system: startup costs, administrative costs, and provider time costs. Note: we use the term “MEDEVAC” to mean any patient transfer required for medical reasons, regardless of whether the case originated from a location in the continental United States (CONUS), outside of the continental United States (OCONUS), or from a ship.

We used patient and provider data from the HELP database to evaluate clinical consult cases. Prior to this analysis, a panel of three physicians associated with HELP reviewed each consult to determine whether a case qualified as a prevented MEDEVAC. All three physicians had to agree for a case to be considered a prevented MEDEVAC. To exclude any bias, our clinicians conducted an independent review of the previously identified prevented MEDEVAC cases. Our clinicians agreed with the previous panel of reviewers more than 80% of the time, so we moved forward with the cases identified in the initial review.



We used the Comprehensive Ambulatory Professional Encounter Record (CAPER) table from the Military Health System (MHS) Management and Analysis Reporting Tool (M2) and the Defense Eligibility and Enrollment Records System (DEERS) table from the MHS Data Repository (MDR) to estimate costs associated with provider time, patient time, and direct care medical encounters.

## Costs of the HELP Program

There are two main cost drivers for the HELP system: startup/administrative costs and provider time costs.

### Startup/Administrative Costs

HELP administrators provided estimates of the startup and administrative costs associated with the program, including both travel and staff. We calculated the administrators' time based on the physician salary calculations (see below).

### Provider Time Costs

For the majority of the consults, providers specified their time spent by associating an Evaluation and Management (E&M) code with the consult and/or providing a time range within the text of the consult. For these consults, we took the median value of the range (for example, 7.5 minutes if the claimed time spent was 5-10 minutes) as the provider's time spent. For the few cases wherein the time range included in the text did not match the E&M code reported for the consult, we estimated the provider time using the associated E&M code. If there was neither an E&M Code nor a time range provided in the text, we used the word count of the consult to estimate the time spent. We averaged 20 consults of each length and determined average word count ranges. Based on these averages, we determined a word count threshold to estimate the time spent on each consult.

We calculated the cost of providers' time using their base Department of Defense (DoD) cost and additional specialty pay dependent on provider type. Estimates of a provider's DoD base cost DoD include:

1. Base pay (dependent on rank and years served)<sup>1,2</sup>
2. Basic Allowance for Housing (BAH) or Overseas Housing Allowance (OHA) (dependent on location, number of dependents, and rank)<sup>1,2</sup>
3. Basic Allowance for Subsistence (BAS) (dependent on officer or enlisted status)<sup>1,2</sup>
4. Retirement (calculated as 32.4% of base pay for 2014 and 31.3% of base pay for 2015)<sup>3</sup>
5. Training costs<sup>3</sup>
6. Health care costs<sup>3</sup>
7. Medicare-Eligible Retiree Health Care (MERHC)<sup>3</sup>

For simplicity, we estimated years served by subtracting the start year in the provider's DEERS records from the calendar year of the consult of interest (2014; 2015). To calculate BAH, we assumed dependents for all married providers and no dependents for all single providers. Note: OHA was not available for patients or providers in Guantanamo Bay, Korea, or London. We estimated the OHA for those locations as an average of the OHA for Sigonella, Rota, Naples, and Bahrain.



Health providers receive additional pay based on profession and specialty. We included these supplements to base salary to compute the overall costs of provider time.

For physicians, we included:

1. Physician Variable Special Pay (based on years served)<sup>4</sup>
2. Physician Additional Special Pay (\$15,000)<sup>4</sup>
3. Physician Incentive Special Pay (based on specialty; dependent upon board certification)<sup>4</sup>
4. Physician Multi-Year Special Pay (based on specialty, years served, and length of contract; dependent upon board certification)<sup>4</sup>
5. Physician Board Certification Pay (based on years served; dependent upon board certification).<sup>4</sup>

Physicians who are recent residency graduates do not immediately obtain board certification, and we cannot determine from the data when they become certified. We therefore assumed that physicians who had served three years or less at the time of the consult were not board certified. Physicians who are not board certified receive only Variable Special Pay and Additional Special Pay. For most specialties the Incentive Special Pay is higher for those who have signed contracts for additional years of service (and, therefore, are also eligible for MSP); to err on the side of overestimating costs, we used the ISP rate for those who had signed additional contracts. Further, because we do not have access to the contract renewal period each provider signed, we averaged the MSP for each contract length (2 years, 3 years, and 4 years) to estimate the contribution of the retention bonus to providers' salaries.

Non-physician providers have different salary features. Nurses, on top of their base DoD cost, also get:

1. Incentive Special Pay (based on length of contract)<sup>4</sup>
2. Non-Physician Board Certification Pay (NPBCP) (based on years of service).<sup>4</sup>

Those in the Medical Service Corps (physician assistants, psychologists, podiatrists, physical therapists, etc.) also receive additional pay based on their occupation.

In addition to their base salary, physician assistants and psychologists earn:

1. Incentive Pay (\$5,000)<sup>4</sup>
2. Retention Bonus (based on length of contract)<sup>4</sup>
3. NPBCP (based on years served)<sup>4</sup>

Finally, for physical therapists and podiatrists, we included NPBCP to supplement their base cost to the DOD.<sup>4</sup>

Non-physician providers typically obtain board certification immediately. Therefore, we assumed all were board certified and, as such, eligible for NPBCP. For both those serving in the Nurse Corps and those serving in the Medical Service Corps, we ignored any accession bonus for which they might have been eligible. Furthermore, for those providers who receive pay based on the length of the contract they sign, we again determined the applicable rate by averaging the annual rate for each contract length. For nurse's ISP we estimated \$12,500 per year, and for physician assistants/psychologists' retention bonuses we estimated an annual amount of \$15,000.



Once we estimated providers' total annual cost to the DoD, we computed the total cost per minute of their time. We multiplied the minute cost by the total number of minutes spent on each consult to determine the provider cost for each case. We summed the total of the administrative/startup costs and the provider time costs to estimate the total costs associated with the HELP program (Appendix Tables A1, A2, A3, and A4).

## Tangible Savings associated with the HELP Program

We evaluated three main sources of tangible savings from prevented MEDEVACs associated with communications via HELP: prevented flight costs, prevented per diem allowances, and prevented costs of direct care consults at NMCP.

### Prevented Flight Costs

For each consult that resulted in a prevented MEDEVAC, we evaluated the savings from avoided transportation costs for both the patient and a companion (all active duty patients must travel with a military companion). Prevented flight costs for medical transfers from most stationary MTFs were estimated using average costs in the Defense Travel System (DTS) for two round-trip tickets from the airport closest to the patient's location to the Norfolk International Airport (the airport closest to NMCP). Because civilian flights are not available for transfers from NH Guantanamo Bay, these are typically conducted through International SOS, a TRICARE contractor, or via military aircraft. We obtained an estimate of \$21,158 for the prevented costs associated with the transfer of both the patient and the companion from NH Guantanamo Bay to NMCP.<sup>5</sup> We further assumed that both the companion and the patient would take a Space-A (space available) military flight for the return to Guantanamo. As the Space-A flight would run with or without the patient/companion, we assumed a \$0 net cost for this flight.

MEDEVACs from deployed ships are more complicated from a cost perspective. The patient and the companion must first be flown from the ship to the nearest MTF, using organic assets such as helicopters or the C-2 COD (Carrier On-board Delivery) fixed wing aircraft. Based on discussions with staff at Commander Naval Surface Forces Atlantic, we estimated the cost of a MEDEVAC flight from the ship to the nearest MTF to be \$5,000. In areas of operation other than the Virginia Capes (for which the closest MTF is NMCP), the patient and companion must still be flown to NMCP once they are ashore, usually via commercial air. Because our data does not include a referring ship's location at the time of the MEDEVAC, we averaged the costs of round trip flights from MTFs in Europe and the Middle East to NMCP. Upon return post-care, the patient and companion would either meet the ship at its next port or catch a no-cost ride on routine logistics flight via helicopter or COD. Therefore, we assumed no net cost for the return trip from the nearest port or logistics head to the ship.

If the patient was a dependent, we only accounted for savings for one round-trip ticket as we assumed that no military companion would accompany him/her.

### Prevented Per Diem Costs

When patients undergo MEDEVAC, they must be authorized for 30 days of fully funded temporary additional duty (TAD) away from their permanent station.<sup>6</sup> Per discussions with HELP administrators, we assumed the companion would be away from his/her duty station for an average of 7 days. If the patients and companions underwent MEDEVAC, both would receive per diem allowances for lodging, meals and incidentals in Portsmouth. To estimate the savings associated with prevented per diem allowances, we used the 2014 and 2015 DoD per diem rates in Portsmouth, VA (\$150 and \$148, respectively).<sup>7,8</sup> For non-active duty patients, we included only the 30-day per diem rates for the patient.



## Prevented NMCP Consults

Patients undergoing MEDEVAC to NMCP would be treated there. If this transfer was prevented, the cost of the direct care consult was also prevented. We used similar consults at NMCP to estimate the savings of avoiding the direct care consult associated with a MEDEVAC. Similar consults were defined as those for patients with similar diagnoses to the HELP consult cases, no comorbidities (no additional diagnosis codes), same gender, and similar age (plus or minus 10 years). We relaxed some of these criteria when similar cases were not available; these instances are marked in the Appendix Tables B1 and B2.

## Intangible Savings associated with the HELP Program

Preventing MEDEVACs results not only in tangible savings, but also intangible savings — those that do not directly affect the bottom line but still impact the organization. We estimated savings from reduced lost productivity to account for soft savings. When a patient and the military companion are away from their duty station, their regularly assigned tasks are either not completed or they are picked up as additional duty by others with regularly assigned duties. We estimated the potential costs of time away from duty using the overall cost to the DoD for 30 days and 7 days, respectively. We estimated the overall cost to the DoD using the seven components of the base cost previously used to determine provider's costs: base pay, BAH/OHA, BAS, retirement, training costs, health care costs, and MERHC. We ignored any additional pay based on specific occupation for the patients because the occupations were so varied in nature, although this likely underestimates their overall cost.

Since the MEDEVAC did not occur, we had to make assumptions in order to estimate the reduced lost productivity associated with a companion. Per discussion with HELP administrators, we assumed:

1. The companion had a rank of E-5.
2. The companion had been serving eight years (the average time served for E-5 patients who had HELP cases).
3. The companion had no dependents (allowing us to be more conservative in our savings estimates).

## Return on Investment Metrics

We calculated two return on investment (ROI) metrics. Both include all costs associated with the HELP program (provider time costs and startup/administrative costs), but one includes only tangible savings and the other includes all savings.

### ROI (including only tangible savings)

$$\frac{\text{Tangible Savings} - \text{Costs}}{\text{Costs}} * 100\%$$

### ROI (including only tangible savings)

$$\frac{(\text{Tangible Savings} + \text{Intangible Savings}) - \text{Costs}}{\text{Costs}} * 100\%$$



## Results

Between June 2014 and December 2015, 559 consult cases occurred in the HELP system. Of the 559 total consult cases, 50 consults prevented MEDEVACs (10 in 2014; 40 in 2015).

### Costs of the HELP Program

#### Startup and Administrative Costs

Table 1 shows the breakdown of the startup and administrative costs by calendar year. The total cost for HELP support staffing (including the medical director, associate medical director, and programmer) plus other startup costs summed to \$325,792 for the study period.

**Table 1. Startup and Administrative Costs for HELP System (June 2014 - December 2015)**

Year 1: June 2014 - December 2014	
Startup Travel	\$10,099
Programmer (hired July 2014 at \$50,000 per year for .5 FTE)	\$25,249
HELP Medical Director (2 hours/day)	\$42,511
HELP Associate Medical Director (1.5 hours/day)	\$34,545
<b>Total Cost, CY 2014</b>	<b>\$112,404</b>
Year 2: January 2015 - December 2015	
0.5 FTE Programmer (July 2014 - September 2014)	\$37,500
Programmer (hired October 2015 at \$100,000 per year for 1.0 FTE)	\$25,000
HELP Medical Director (2 hours/day)	\$72,710
HELP Associate Medical Director (1.5 hours/day)	\$78,178
<b>Total Cost, CY 2015</b>	<b>\$213,388</b>
<b>Total Cost</b>	<b>\$325,792</b>

Health Analysis Department, Navy and Marine Corps Public Health Center.

Source: Military Health System (MHS) Data Repository (MDR), Defense Eligibility and Enrollment Records System (DEERS), April, 2016.

All costs converted to 2015 dollars.

#### Provider Time Costs

Providers spent an average of 53 minutes per case on each of the 559 consult cases. We assumed that requesting providers (those who initiated the consult) spent 30 minutes per case, so consulting providers (those responding to the consult request) averaged about 23 minutes per case.

For the period between June 2014 and December 2015, the 559 cases resulted in a total provider cost of \$57,009; the average cost per case was \$102 (Table 2).



**Table 2. Provider Time Costs for Consults, June 2014 - December 2015**

	Average Per Encounter	Total
Consult Length (min)	52.8	29,504.5
Provider Time Cost (\$)	101.98	57,008.55

Health Analysis Department, Navy and Marine Corps Public Health Center.

Source: Military Health System (MHS) Data Repository (MDR), Defense Eligibility and Enrollment Records System (DEERS), April, 2016.

All costs converted to 2015 dollars.

### Total HELP Program Costs

The HELP program totaled \$382,800 in startup costs, administrative costs, and provider time costs between June 2014 and December 2015.

### Tangible Savings associated with the HELP Program

#### Prevented Flight Costs

Of the 50 prevented MEDEVACs, 29 cases came from 10 land-based MTFs and 21 cases came from the fleet forces. Forty-one of these cases were for active duty patients; in those 41 cases both the patient and a military companion would have been transferred to NMCP. Table 2 details the locations from which the prevented MEDEVACs would have originated. More than 40% of these cases originated with the fleet forces, and an additional 25% came from providers and patients stationed in Italy (either NH Naples or NH Sigonella).

**Table 3. Patient Round Trip Transfer Costs**

Location	Number of Cases	Round Trip Cost (\$)
NHC Annapolis	2	\$407.19
BHC Bahrain	2	\$2,255.83
BHC MCAS SC	1	\$951.84
NH Camp Lejeune	2	\$973.21
NHC Corpus Christi	1	\$797.15
NH Pensacola	2	\$348.94
NH Naples	8	\$1,627.62
NH Rota	2	\$7,553.56 <sup>a</sup>
NH Sigonella	5	\$2,728.40
NH Guantanamo Bay	4	\$21,158.00 <sup>b</sup>
Fleet Forces	21	\$8,541.03 <sup>c</sup>

Health Analysis Department, Navy and Marine Corps Public Health Center.

Unless otherwise indicated, prices from MTFs came from the Defense Travel System

<sup>a</sup>No round trip tickets were available from NH Rota, so we doubled the average price of a ticket from ORF to the airport nearest Rota.

<sup>b</sup>Estimate for International SOS flight from NH Guantanamo Bay

<sup>c</sup>Includes \$5,000 estimate of flight from ship and average round trip ticket from international locations

All costs converted to 2015 dollars.



Including the cost of flights for all patients regardless of beneficiary status and the cost of flights for military companions for active duty patients, the 50 prevented MEDEVACs resulted in a cost savings of \$420,115 (Table 4).

#### Prevented Per Diem Costs

Assuming that each MEDEVAC would include 30 days of per diem allowance for the patient, the 50 prevented MEDEVACs resulted in savings of \$223,048 for the patient's per diem. Including seven days of per diem allowance for the military companion increased this savings by \$39,683 to reach a total savings of \$262,730.

#### Prevented Direct Care Consult Costs

We used the median cost of a similar encounter to determine what the cost would have been had each of these patients been seen at NMCP for the condition diagnosed during their HELP consult. Across the 50 cases, the average cost of the direct care encounter would have been \$212, resulting in an overall savings of \$10,616.

#### Total Tangible Savings

Summing the savings from the prevented flight, the saved per diem costs, and the prevented direct care consult costs, we estimated a tangible savings from the 50 prevented MEDEVACs for June 2014-December 2015 of \$693,461.

#### Intangible Savings associated with the HELP Program

When we incorporated the full cost (salary and benefits) to the DoD for 30 days for each active duty patient with a prevented MEDEVAC, the savings from reduced lost productivity totaled \$540,511. Including the savings from seven days of the E-5 companion's lost duty time raised this amount by more than \$100,000. In total, preventing 50 MEDEVACs resulted in intangible savings from reduced lost productivity of \$644,168. Note that these savings do not affect the bottom line—the service members' salaries will be paid regardless of whether they are at their duty station or at NMCP. However, when the service members are not at their duty station fulfilling their assigned occupational duties, the taxpayers are not getting the service for which they are paying. Savings between June 2014 and December 2015 total \$1,337,628 when including both tangible and intangible (Table 4).

**Table 4. Total Savings from Prevented Medevacs, June 2014 - December 2015**

Tangible Savings (\$)	
Prevented flight savings	420,114.51
Per diem cost savings	262,730.44
Prevented consult savings	10,615.78
<b>Total Tangible Savings</b>	<b>693,460.74</b>
Intangible Savings (\$)	
Reduced lost productivity savings	644,167.71
<b>Total Savings</b>	<b>1,337,628.44</b>

Health Analysis Department, Navy and Marine Corps Public Health Center.

Source: Military Health System (MHS) Data Repository (MDR), Defense Eligibility and Enrollment Records System (DEERS); MHS Management Analysis and Reporting Tool (M2), Comprehensive Ambulatory/Professional Encounter (CAPER) Data, April, 2016.

All costs converted to 2015 dollars.



## Return on Investment Metrics

When including only tangible savings, the HELP program has an ROI of about 80%, meaning for every \$1.00 spent, the DoD saves \$0.80. However, when including both tangible and intangible savings, the ROI jumps to 250% (Table 5). Between June 2014 and December 2015, for each \$1.00 the DoD spent to support the HELP program, it prevented an additional \$1.70 in lost productivity.

**Table 5. Return on Investment for Health Experts onLine at Portsmouth (HELP), June 2014 - December 2015**

Including Tangible Savings (\$)	
Total Costs	382,800.28
Total Savings	693,460.74
ROI	81.15%
Including Tangible and Intangible Savings	
Total Costs	382,800.28
Total Savings	1,337,628.44
ROI	249.43%

Health Analysis Department, Navy and Marine Corps Public Health Center.

Source: Military Health System (MHS) Data Repository (MDR), Defense Eligibility and Enrollment Records System (DEERS); MHS Management Analysis and Reporting Tool (M2), Comprehensive Ambulatory/Professional Encounter (CAPER) Data, April, 2016.

All costs converted to 2015 dollars.

## Conclusions

During the period of this analysis, Health Experts onLine at Portsmouth prevented 50 MEDEVACs, avoiding \$693,461 of tangible costs and another \$644,168 in lost productivity costs. Regardless of whether the ROI metric incorporates only the tangible savings or also includes intangible savings, the HELP program delivers measurable, positive returns on the initial investment. This analysis accounted only for return on investment as a direct result of preventing MEDEVACs. Additional intangible benefits associated with preventing MEDEVACs may exist. For example, avoiding a direct care consult at NMCP opens that slot to other patients—increasing access to care and potentially enabling additional recapture from the civilian network. In summary, the HELP program produces considerable savings (both tangible and intangible) for small costs.

## Limitations

A number of assumptions were required to estimate some of the costs and benefits associated with this analysis. For example, we had to infer what constituted a prevented MEDEVAC based on subjective assessment by the HELP panel on whether or not a MEDEVAC would have occurred absent the HELP consult. We accepted these cases as prevented MEDEVACs because a review of a subset of cases by HA physicians resulted in a greater than 80% match, but it is impossible to know for certain if the physician would have requested a MEDEVAC. Additionally, for prevented MEDEVACs from deployed ships, we did not know where the ship was physically located at the time of the consult request (i.e., actually underway or moored in home port). We averaged the costs of flights from international MTFs to NMCP to estimate what the



flight cost from the closest MTF to NMCP after the patient underwent MEDEVAC from the ship to shore. Amending the HELP consult process to include specific questions for location of a ship if deployed and whether or not the provider requests a MEDEVAC or a purchased care referral could improve data collection and avoid these limitations for future studies.

Because the data did not support a determination of whether a patient would have been sent to the purchased care environment for an encounter had the HELP system not been available, we did not account for savings from prevented purchased care. Future analysis evaluating the benefits from prevented purchased care would provide further insight into the overall program ROI.

We did not include a comparison of the price of care at NMCP versus the patient's location. In some instances, even if the HELP consult prevented a MEDEVAC, the patients were sometimes still treated at their local hospitals or clinics. If it cost more to treat the patient in the local facility than it would have in Portsmouth, then this would reduce the savings associated with the prevented transfer. Further, we estimate direct care encounter costs using overall clinic expenses from a prior timeframe adjusted for inflation, so the costs assigned to each encounter are just estimates of what the cost might have been.

## Contact Information

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For more information about the Health Analysis Department, please visit our website at: [www.med.navy.mil/sites/nmcphc/health-analysis](http://www.med.navy.mil/sites/nmcphc/health-analysis)

## Appendix

Appendix A and B include detailed tables for each HELP consult. They are included in the accompanying Excel file.

## References

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