CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Health and Mental Health Needs of Children in US Military Families

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abstract

Children in US military families share common experiences and unique challenges, including parental deployment and frequent relocation. Although some of the stressors of military life have been associated with higher rates of mental health disorders and increased health care use among family members, there are various factors and interventions that have been found to promote resilience. Military children often live on or near military installations, where they may attend Department of Defense–sponsored child care programs and schools and receive medical care through military treatment facilities. However, many families live in remote communities without access to these services. Because of this wide geographic distribution, military children are cared for in both military and civilian medical practices. This clinical report provides a background to military culture and offers practical guidance to assist civilian and military pediatricians caring for military children.

INTRODUCTION

Children who are military connected have unique needs and experiences compared with peers of the same age. These experiences often include frequent moves, prolonged separations, and deployments of family members. Although these challenges may be familiar to military and civilian health care providers working at military treatment facilities, up to 50% of children who are military connected receive care in the civilian sector.[1–3] The American Academy of Pediatrics (AAP) clinical report "Health and Mental Health Needs of Children in US Military Families" was published in 2013 to assist pediatric health care providers who care for military children who have been affected by deployment.[4] In that report, the cycle of deployment was described as well as the common reactions to deployment and the effects of wartime deployment on children at different developmental stages. Age-based recommendations were provided to assist family members, and additional resources were provided to assist pediatricians.

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Since the publication of the last AAP clinical report, military families continue to be significantly challenged by deployments and various stressors associated with military life. Many children in military families live in settings remote from a military community, and civilian health care providers are faced with caring for military children in their practices. This updated clinical report is intended to provide a background of the military culture, to serve as a tool to help navigate the military health care system, and to provide resources that may assist families and the broader health care community, especially during periods of transition and relocation.

DEMOGRAPHICS

The Department of Defense (DOD) remains the nation's largest government agency and employer; 1.3 million men and women serve on active duty, 818 000 in the National Guard and Reserve and more than 2 million military retirees.[5,6] Active duty personnel are members of the US Armed Forces who serve in a full-time duty status. Approximately 88% of active duty forces are stationed in the continental United States and US territories, whereas the remainder are stationed at installations throughout the world but primarily in East Asia (5%) and Europe (5.1%).[5] According to the DOD, military personnel are composed of 17.7% officers with an average age of 34.6 years and 82.3% enlisted personnel with an average age of 27.1 years.[5,7] Most enlisted personnel have a high school diploma, and 8% have a bachelor's degree or higher; the majority of officers (85%) have a bachelor's degree or higher.[5]

Approximately 58% of the 2.2 million members serving on active duty and the National Guard and Reserve have families, and 40% have at least 2 children.[1,3] There are an estimated 1.7 million children of active duty and reserve military personnel, of whom 37.8% are 0 to 5 years of age, 31.6% are 6 to 11 years of age, and 23.8% are 12 to 18 years of age.[5] When including active duty personnel, reserve personnel, and veterans, it is estimated that there are 4 million children who are military connected, with the largest group age ≤5 years.[7]

MILITARY CULTURE

The military is a well-defined institution with a distinct hierarchy and organizational structure. Service members come from ethnically and geographically diverse backgrounds and join the military for a variety of reasons, including the propensity to serve, educational benefits, and financial motivations.[8] Redmond et al[9] described the military workplace culture as a unique environment with unifying characteristics, including discipline, self-sacrifice, cohesiveness, and emphasis on core values. Military service is associated with numerous traditions and common experiences that engender a sense of camaraderie among members who have proudly served.

Military personnel are a relatively young workforce, are more likely to marry young, and have a high proportion of children that are of preschool age.[10] Military personnel are generally paid favorably in comparison with their civilian equivalents; however, additional stressors of the military lifestyle, such as relocation, results in spousal underemployment and unemployment.[11] Military life is often defined by prolonged separation and frequent moves, with many simultaneous stressors in a short time.[10]

Children growing up in military families often share common experiences with each other, such as living on base or post, attending DOD schools, frequent moves, and prolonged separations from a parent. These experiences create a common bond and camaraderie among peers. This sense of identity may be influential in later career choices because children of veterans are more likely than their civilian peers to enlist.[12]

Conversely, military children may feel heightened pressure to conform, behave, and wear their parent's military rank.[1] Davis et al[2] reported that early research portrayed the military family as authoritarian with children who were behaviorally challenged; however, subsequent research has revealed no psychosocial differences from nonmilitary families. Padden and Agazio[13] described 4 major stressors for military children: relocation, family separation, adaptation to danger, and a unique military culture. Socioeconomic challenges include financial stressors among junior enlisted personnel[14] and rates of food insecurity similar to the national average.[15]

RELOCATION

One of the most common aspects of military life is frequent relocation. Active duty personnel receive orders to their respective duty stations for a tour of duty, which is generally 2 to 3 years in length. These orders may be designated as accompanied or unaccompanied, in which the former authorizes dependents' travel and sponsorship at the new duty station and the latter does not. Unaccompanied orders are generally 1 to 2 years in length and are often a result of the nature of the assignment or a dependent family member having medical needs that exceed the capabilities of the local military medical treatment facility.

Military families are geographically mobile, moving at a rate 2.4 times more frequent than that of their civilian counterparts.[7,10,16] Military children may experience a move every 2 to 4 years and can transition

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between schools up to 9 times by the age of 18 years.[1,17] Because of the frequent mobility, there is often a lack of continuity of health care[1] and limited employment opportunities for nonmilitary spouses.[10]

In a large population study of military youth, there were increased mental health encounters if a geographic move occurred in the past year.[18] This study also revealed that adolescents who were affected had increased psychiatric hospitalizations and emergency department visits. Because families often move away from extended family support, they often refer to the military community as a surrogate family that provides a support network.

Although children of reservists are typically geographically more stable than their active duty counterparts, they often live in nonmilitary communities without resources or knowledge specific to the military.[1] They may feel isolated from the community,[10] and services may not be as readily available.[2] Veteran families may also feel isolated and have challenges when transitioning to civilian communities,[10] where familiar military programs may not exist and there may no longer be access to many of the benefits that were associated with active duty service.[12]

Although moves may be stressful, Clever and Segal[10] asserted that some research has demonstrated increased resilience in military children, including decreased school problems and enhanced development of positive attitudes about moves.[19] Protective factors may include effective support systems, such as living in a military community and military programs designed to address relocation challenges, which may include family newcomer orientations, command sponsorship programs, and programs intended to assist children in connecting with peers at the prospective duty station before the move.

DEPLOYMENT

One of the characteristics of military life that is well known to the public is deployment. Research has found that more than 2 million children of military families have had a parent deployed since 2001.[1] Service members may be deployed to areas throughout the world in support of combat operations or peacekeeping missions for periods ranging from several weeks to more than a year. During this time, family members often remain at home to adapt to life without the military service member or temporarily move to areas where they may have support from extended family members.

The deployment cycle, as described by Pincus et al,[20] consists of 5 stages (predeployment, deployment, sustainment, redeployment, and postdeployment) that each present various emotional challenges to family members. Recommendations to assist family members during each of these stages have been offered by various authors[4,13,20] and serve as a valuable framework for pediatricians caring for children affected by deployment.

Impact of Deployment

Multiple studies have explored the effects of deployment on families and children who are military connected. The stressors associated with deployment, including prolonged family separation, potential injury or death of a service member, and traumatic experiences, can have a cumulative negative effect on the entire family unit. Aranda et al[21] found that 1 in 4 military children have an emotional-behavioral challenge associated with deployment. One study revealed an 11% increase in mental and behavioral health outpatient visits in children 3 to 8 years of age during parental deployment.[22] An additional study evaluating the effect of deployment on children 5 to 12 years of age showed increased child psychosocial morbidity with parental stress and decreased morbidity with military supports.[3]

A 2014 systematic review explored literature examining the impact of parental deployment–related mental health problems on children's outcomes.[23] Of the 42 studies reviewed, the authors found that outcomes were negatively affected by caregiver stress and mental health, and there was evidence of increased child maltreatment and substance abuse. The authors found that family communication was a protective factor, and interventions should be aimed at addressing these challenges. Another 2015 systematic review revealed that a child's age and development, parental mental health and coping abilities, available resources, and resilience factors influenced coping abilities in children affected by military deployment.[24]

Mustillo et al[25] evaluated the timing and duration of deployment on children ages 10 years and younger and whether deployment was associated with any particular type of emotional-behavioral disorder. The authors identified increased anxiety in children ages 3 to 5 years if there was a recent long deployment. For older children ages 6 to 10 years, there was evidence of a long-term impact of parental deployment at the time of their birth, including more peer problems and behavioral problems. This study and others suggested differential effects on the basis of developmental age.[4,26] In a telephone survey involving children 11 to 17 years of age and their home caregivers, increased length of deployment and poor mental health of the caregiver who was not deployed was associated with more challenges for children in dealing with the deployment.[27] Another study of 6- to 12-year-old children and their civilian parent who was not deployed demonstrated increased depression and externalizing symptoms associated with parental

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distress and cumulative length of parental combat deployment as well as increased anxiety symptoms.[28] The aforementioned research was focused on the immediate effects of wartime deployment, and more longitudinal studies are needed to assess the long-term effects.[29]

Deployment Interventions

Given the challenges associated with deployment, numerous programs have been established to assist service members and their families. Nelson et al[7] described several family-based intervention programs that have been established to increase resilience, combat stress, and improve family functioning: Families OverComing Under Stress,[30] After Deployment: Adaptive Parenting Tools,[31] and the STRoNG Intervention for families with young children.[32] Additional programs that may assist families with younger children in preparing for the stress of the deployment cycle include Sesame Workshop's Talk, Listen, Connect initiative[33] and child-parent psychotherapy–based interventions.[34]

Health Care Use

Research has revealed various challenges associated with deployment, including a decline in academics, increased behavioral problems during deployment, increased emergency and specialist visits, and somatic symptoms.[1,35] A systematic review of 26 studies found an association between increased deployment-related stress and mental health problems in parents and young children as well as increased use of mental health resources.[36] One of these studies demonstrated an increase in outpatient and well-child visits during deployment for children of married parents, which may be attributed to the effect of deployment-related stress on the spouse who was not deployed.[37] Conversely, the authors found decreased visits for children of single parents, which may be attributed to a decreased effect of deployment on a nonparent caregiver or lack of familiarity navigating the health care system. Another study showed an increase in specialist visits and antidepressant and/or anxiolytic medication use among children during deployment. Additionally, a shift from military treatment facilities to civilian facilities during deployment was observed, which may be indicative of a temporary family relocation while the active duty service member was deployed.[38] Finally, research has shown a 7% increase in outpatient visits for children younger than 2 years during the deployment of a parent[37] as well as an increased effect of deployment on children if it occurred during the developmental or attachment period.[39]

Abuse and/or Neglect

Deployment and relocation stressors are concerning for an increased risk of child maltreatment.[40] Cozza et al[41] demonstrated an increased risk of neglect among deployed families compared with families that were never deployed, and a systematic review found an increased risk of child maltreatment, including neglect and physical abuse.[36] Furthermore, there is an increased risk at the time of redeployment,[1] making it important to continue to provide resources once a service member who was deployed returns.

Various programs are available to assist families with abuse prevention, and there are also resources available if abuse has occurred, including the Family Advocacy Program (FAP).[42] FAP professionals interact with families in a variety of ways, including parent workshops and support programs, and conduct investigations when allegations of abuse are made. Because civilian providers may not be aware of the FAP, they may report concerns about child maltreatment to local child protective services without also notifying the local FAP office. Wood et al[40] found that only 42% of cases of medically diagnosed maltreatment were reported to the FAP, compared with 90% reported to child protective services, meaning that many families do not receive timely and appropriate military-specific services.

The DOD has various programs to support families with young children. The New Parent Support Program is an FAP that uses licensed clinicians, nurses, and home-visiting specialists to serve families with young children. A variety of services are available through this program, including home visits, parenting classes, and linkages to community and DOD resources. More information on this valuable program may be found at http://www.militaryonesource.mil/-/the-new-parent-support-program.[43]

RESILIENCE

Despite many of the inherent challenges of military life, multiple studies indicate increased resilience among children who are military connected. Easterbrooks et al[44] noted that most research on military children is focused on deficits rather than the strengths and supports that promote resilience. The authors cite several studies that describe positive outcomes, including enhanced family bonding during deployment, resilience through shared experiences, and enhanced social connections. Aranda et al[21] found that although school-aged children had increased psychosocial morbidity during parental wartime deployment, they had lower baseline psychosocial symptoms than those of civilian peers. Resilience is key in all phases of deployment, and effective support networks may improve coping skills.[2] There is usually

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not a difference in psychological symptoms in military children during nondeployed seasons, although there may be a "dose effect" with repeated deployments.[21]

Research has examined factors that promote resilience. Parental mental health and parental adjustment to deployment may impact a child's resilience[11]; therefore, it is important to consider the family dynamic when caring for military children. A longitudinal study across the deployment cycle found that socialization with other military children during a deployment was a protective factor that led to better functioning.[45] An ecological model[46] that includes various systems of influence on an individual, such as family and community, has been suggested as a framework to identify the effects of military deployment and separations on children,[26,47] and effective interventions to promote resilience should be designed and tailored at each level.

CHILD CARE AND EDUCATION

Child Care System

The DOD runs the nation's largest employee-sponsored child care system, which consists of 900 child development centers, 300 school-age care program sites, 4500 family child care homes, and subsidized civilian child care.[48] Child development centers are located on most military installations throughout the world and provide child care to children from ages 6 weeks to 5 years. School-age care programs are available for children ages 5 to 12 years and are typically located at schools or youth centers. Additional child care services may be provided in other settings, including on- or off-base child care homes, providing more flexible hours and servicing a wider age range. Services at DOD-sponsored child care sites are income based, and some families may receive subsidies for civilian child care if space is unavailable through military care centers and if they meet specific income qualifications.[48]

Despite the immensity of the child care system, a 2008 study by the RAND Corporation revealed that only a small fraction of the military population was reached by these programs.[49] In this study, only 7% of military members were served by child development centers, and fewer than half of families with children younger than 6 years of age were using DOD-sponsored child care. Child development centers were found to be costlier and less flexible than other options, such as family child care homes. An increased awareness of the various child care options can assist families who are seeking child care arrangements, and additional information may be found at http://www.militaryonesource.mil/-/military-child-care-programs.[50]

Education System

Approximately 13% of children with an active duty parent attend a Department of Defense Education Activity (DODEA) school.[7] DODEA operates 166 schools for 72 000 children enrolled in kindergarten through 12th grade; is located in 7 states, 11 countries, and 2 territories; and also provides support for 1.2 million students who are military connected in public schools in the United States.[51,52] DODEA schools are accredited by the Commission on Accreditation and School Improvement and use a comprehensive curriculum and standardized assessments, including the National Assessment of Educational Progress.[52]

Although continuity of education through DODEA provides many advantages for transient military children, the vast majority of military children attend civilian schools. Astor et al[53] referenced research that revealed that the average military student attends 9 schools between kindergarten and 12th grade.[54] The authors remarked that civilian schools may be less familiar with the needs of military children. Because of increased risks of academic challenges and social problems,[55] it is recommended that military children are provided a supportive environment, which can serve as a protective factor. To facilitate the challenges civilian schools may encounter with military issues, there is a partnership grant with DODEA and public schools to assist civilian schools[11] with children who are military connected. School liaison officers serve as a valuable resource and are available near military installations worldwide (http://www.dodea.edu/Partnership/schoolLiaisonOfficers.cfm).[56]

MILITARY HEALTH SYSTEM

The Military Health System is a global health care delivery system dedicated to supporting the nation's military mission.[57] It is a single-payer umbrella system[2] that serves 9.4 million beneficiaries at an annual cost of approximately $50 billion.[57,58] The Assistant Secretary of Defense for Health Affairs oversees the Defense Health Agency, which manages regional Tricare contracts and the centralized Military Health System while integrating direct and purchased health care systems.[59] Each service branch is responsible for ensuring medical readiness of its operational forces and provides direct health care to beneficiaries at 54 inpatient hospitals and 377 ambulatory clinics throughout the world.[57]

There are multiple Tricare plans available. Eligibility is dependent on service status and enrollment in the Defense Enrollment Eligibility Reporting System. All health care plans are in compliance with the coverage requirements for the Affordable Care Act.[60] The most recent changes to Tricare occurred

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on January 1, 2018, with several changes to health plans, coverage limits, and regional contractors.[61] Most dependents of active duty members are enrolled in the Tricare Prime program if they live in Prime Service Areas, usually near a military treatment facility.[62] This is a managed care option in which beneficiaries receive direct care at military facilities or from network providers and generally do not pay out of pocket.[58] Tricare Select (Formerly Tricare Standard and Extra) is a fee-for-service plan with deductibles and cost sharing that is available to beneficiaries who do not meet eligibility for Prime or choose not to enroll in Prime and generally receive purchased care through network providers outside of military treatment facilities.[58,63]

There are different Tricare regions throughout the United States administered by a managed care support contractor.[64] Tricare-authorized providers can work directly with the managed care support contractor for claims processing and any management assistance. Additional information for providers can be found at www.tricare.mil/Providers.[64]

MILITARY CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Approximately 220 000 active duty and reserve military personnel have a family member with special needs,[65] including 20% of children who are military connected.[66] In fiscal year 2015, 1.79 million children ages 6 months to 21 years were enrolled in the Military Health System, 17.3% of whom had noncomplex chronic needs and 5.6% of whom had complex chronic needs.[57]

Although subspecialty care may be available at military treatment facilities, children with special health care needs often receive services through civilian network providers, who may be unfamiliar with the military system. In a survey of military family support providers, the most common challenges included navigating systems, child behavioral problems, parental stress and child care, relocation, and the therapy and/or insurance referral process.[65,67] To assist parents of children with special needs, the Office of Community Support for Military Families with Special Needs published the DOD *Special Needs Tool Kit: Birth to 18*.[68] This resource provides valuable information for families navigating early intervention programs and special education services, relocating, accessing Tricare benefits, and connecting to support services.

In addition, the Office of Special Needs provides an early intervention and special education directory to assist families with transitions during relocation to different communities, which is available through the Military OneSource Web site (www.militaryonesource.mil).[69] For military children located overseas who qualify for early intervention services, Educational and Developmental Intervention Services provides comprehensive developmental services, including early childhood special education, speech therapy, occupational therapy, physical therapy, social work, and child psychology. For children ages 3 to 21 years who qualify for special education services, DODEA schools provide special education services while collaborating with Educational and Developmental Intervention Services for medically related services in the school setting.

Exceptional Family Member Program

The Exceptional Family Member Program (EFMP) is a DOD program that provides services for families with special health care or educational needs. There are currently more than 128 000 military family members enrolled in the EFMP,[47,70] with approximately two-thirds of these being children and youth.[65] Any active duty family member with a chronic medical condition or special education need should be enrolled in the EFMP. In a survey of EFMP family support providers across all branches, the largest proportion of disabilities cited included autism spectrum disorders and attention-deficit/hyperactivity disorder.[23,65]

For children of an active duty service member with a chronic medical condition, a DD Form 2792 documenting medical diagnoses and therapeutic needs is required from their pediatrician and should be taken by the family to their respective EFMP service coordinator to complete the enrollment process. The educational form (DD Form 2792-1) should be completed by an early intervention program or school special education program provider if the child is receiving Individuals with Disabilities Education Act Part C or Part B services, respectively. An EFMP quick reference guide is available on the Military OneSource Web site (www.militaryonesource.mil) and may be used to guide families and providers when enrolling in the EFMP. Enrollment in the EFMP is mandatory for dependents of active duty members and ensures that medical and educational needs can be met when service members are considered for various duty stations.

Overseas Screening

Overseas suitability screening (OSS) is a process that active duty service members and their family members undergo once they are identified for an overseas assignment. Because of limited medical service capabilities in overseas environments, OSS reviewers take these factors into consideration when making a determination. Families undergoing this process should bring required OSS and EFMP paperwork to their provider for completion and return these to their screening coordinator.

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If a determination is made by the receiving overseas medical facility that the patient's medical needs exceed local capability and capacity or if the environment may exacerbate a medical condition, then the service member may receive unaccompanied orders to the overseas location or may be reconsidered for an alternative duty assignment in an area with the required services to preserve family cohesiveness and avoid unnecessary costs for early returns because of lack of available services.

EXTENDED CARE HEALTH OPTION

The Tricare Extended Care Health Option (ECHO) program is a supplemental benefit for active duty family members with a qualifying condition, such as autism spectrum disorders, intellectual disability, serious physical disabilities, and neuromuscular developmental conditions.[71] It is a monthly cost share based on the sponsor's rank that ranges from $25 to $250 per month, with an annual coverage limit of $36 000.[71] Services covered by ECHO may include durable medical equipment, in-home medical services, rehabilitative services, respite care, and transportation.[71] ECHO eligibility is contingent on enrollment in the EFMP.

AUTISM CARE DEMONSTRATION

Military children with autism spectrum disorders are eligible for applied behavioral analysis (ABA) therapy through the Tricare Autism Care Demonstration (ACD).[72] Eligibility for dependents of active duty members and some activated reservists is contingent on EFMP and ECHO enrollment, whereas dependents of retirees are eligible for ACD services without EFMP and ECHO enrollment. Once a diagnosis of autism is received, a referral for ABA therapy is placed to the regional Tricare contractor, who will then authorize an initial 6 months of ABA therapy.[67] The ACD provides services totaling $195 million in yearly expenditures,[57] with cost shares and copayments dependent on the family's Tricare health plan.[72]

Military families with children with autism spectrum disorders face challenges, including delays in reestablishing therapeutic services and lack of provider continuity because of relocation.[57,73] Given the unique burdens of military families, recommendations are to identify autism spectrum disorders in children early, have a tiered menu of services available, and consider telehealth options for parent training.[74,75] In addition, early identification and improving access to early intervention may be cost-effective measures to ensure sustainability of the military autism benefit.[76]

SUGGESTIONS FOR PEDIATRICIANS CARING FOR MILITARY CHILDREN

Cultural Competency

Most US medical students will care for a patient who is military connected in their career. Prospective military physicians who receive medical training through the F. Edward Hébert School of Medicine at the Uniformed Services University of the Health Sciences or civilian medical schools through the Health Professions Scholarship Program are exposed early in their careers to military medicine through clerkships and research opportunities. Furthermore, military residency programs have served a vital role in training military physicians to serve our nation in operational settings and military treatment facilities throughout the world.

Although military physicians are familiar with military culture and the military medical system, their civilian colleagues may not have received similar training opportunities. Gleeson and Hemmer[77] have recommended competency training in medical schools, including military history taking, providing opportunities for clinical rotations through military treatment facilities, and encouraging medical students who are military connected to share their experiences in medical schools. Graduate medical education as well as printed and online information may serve as effective routes for increased cultural competency.[74]

Research indicates that 56% of providers outside of military treatment facilities do not ask for the military status of families,[78] and recommendations have been made for community capacity building through increased cultural awareness, asking families about military status, and implementation of clinical practice measures aimed at improving coordination of care between health care systems.[79] To assist providers, the Department of Veterans Affairs has created the Veterans Affairs Community Provider Toolkit,[80] which provides additional information on military culture.

Screening

Given the increased stressors associated with the military lifestyle and the associated behavioral risks, incorporating a behavioral screening tool can assist the pediatrician in the office setting. The Pediatric Symptom Checklist was used in 1 study during parental deployment and revealed increased internalizing behaviors, externalizing behaviors, and school problems.[21] The AAP, in a recent clinical report, recommends behavioral and emotional screening as a routine component in pediatric practice, and references multiple resources available on its Web site (http://www2.aap.org/commpeds/dochs/mentalhealth/KeyResources.html).[81]

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Although broad-scale behavioral screening tools are effective, a mechanism to identify military children in practice would be a helpful adjunct. Chandra and London[29] recommend routinely identifying children who are military connected in practices as well as taking a military history at intake.[23] A school identifier has been proposed to assist in school-district resourcing for military students,[11] and schools may serve as a primary resource for pediatricians to identify issues that may influence the academic, social, and behavioral health of children in military families. The Have You Ever Served in the Military? campaign by the American Academy of Nursing designed a pocket card to assist clinicians caring for veterans.[82] An expanded American Academy of Nursing initiative, I Serve 2, has been launched to identify military children in practice by asking the question, "Do you have a parent who has or is serving in the military?" and to provide a modified pocket guide to assist clinicians caring for military children.[1] Furthermore, Hisle-Gorman et al[39] have also suggested not only asking families about their military status but also directly asking about deployment schedules and parental health as well as gaining familiarization with local support systems for military families.

Advocacy

Efforts to advocate for military children can occur at many levels. Lester and Flake[47] note that military children are influenced by many factors, and understanding these systems from an ecological framework may influence outcomes. In addition to the individual- and family-based interactions discussed in this report, advocacy efforts can occur at the community and national level. There have been several large-scale legislative actions and national campaigns in support of military children and their families, including the Military Family Act of 1985 and Joining Forces.[2] April has been designated as the Month of the Military Child, during which time awareness is brought to the forefront. The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development and the HSC Foundation sponsored a conference in April 2014 to raise awareness for children with special health care needs who are military connected and provided an excellent summary of the latest challenges and research surrounding the military child.[66] (conference summary can be found at: https://www.nichd.nih.gov/news/resources/spotlight/120214-military-families). Aronson et al[65] have stressed that health care professionals, schools, and communities should proactively reach out to military families.

Psychosocial support resources are also available to assist families that may be affected by disasters or grief and bereavement. Two AAP clinical reports are available to assist pediatricians: "Providing Psychosocial Support to Children and Families in the Aftermath of Disasters and Crises"[83] and "Supporting the Grieving Child and Family."[84]

Navigating the Military Health System

This clinical report provides a review of the current literature and identifies some of the programs available for children with connections to the military. One of the key ways providers can assist military families is through effectively navigating the military health care system and coordinating with community agencies and local support networks. The following list provides general recommendations that may provide additional assistance to providers caring for children who are military connected.

RECOMMENDATIONS

Screening

1. Establish a clinical process to identify children who are military connected and document it in the electronic medical record.
2. Take a thorough military history, including parental deployment history, relocation, and parental mental health.
3. Integrate an evidence-based behavioral and emotional rating scale in your practice to identify children who are at risk.

Deployment

1. Gain familiarization with the deployment cycle and common reactions to deployment.
2. Provide a linkage to community-based resources for families of service members who are deployed, including mental health services and evidence-based intervention programs that promote resilience:
   a. Families OverComing Under Stress (http://focusproject.org),
   b. After Deployment: Adaptive Parenting Tools (ADAPT): http://www.cehd.umn.edu/fsos/research/adapt/default.asp,[31]
   c. STRoNG Intervention for families with young children,[32] and
   d. Sesame Workshop's Talk, Listen, Connect initiative: http://www.sesameworkshop.org/what-we-do/our-initiatives/military-families/.[33]

Relocation

1. Help new families in the local community connect with local military resources and community agencies.
2. Prepare families for an upcoming move through online resources for spouses at Military

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OneSource[85] (militaryonesource.mil/for-spouses) and for children at Military Kids Connect (militarykidsconnect.dcoe.mil/).

3. Work with local schools to implement a program identifying military children and provide resources to assist with transitions.

Special Needs

1. For children with special health care needs, complete EFMP paperwork and ask the family member to turn in the completed copy to their local EFMP office. The EFMP Quick Reference Guide, which includes the DD Form 2792 to be completed by the medical provider, may be found on the Military OneSource Web site at: http://download.militaryonesource.mil/12038/MOS/ResourceGuides/EFMP-QuickReferenceGuide.pdf.[86]
2. Provide families with contact information for the ECHO program to assist with any additional coverage that may not be afforded by the Tricare benefit.
3. Additional resources that are valuable in assisting families with children with special needs include:
   a. the EFMP special needs tool kit,[68] (http://download.militaryonesource.mil/12038/EFMP/PTK_SCORs/ParentToolkit_Apr2014.pdf), and
   b. Specialized Training of Military Parents (http://stompproject.blogspot.com).

Tricare

1. For providers interested in becoming a Tricare-approved provider, refer to the Tricare Web site for additional information at https://tricare.mil/Providers.[64]
2. For assistance with navigating Tricare, contact information for regional contractors can be found at https://tricare.mil/Providers.[64]
3. Generally, prior authorization or referrals are not required of Tricare beneficiaries for initial outpatient mental health care with providers who are Tricare authorized.[87] Pediatricians can assist families connecting with an authorized Tricare provider by referring them to www.tricare.mil/findaprovider.[88]
4. Please refer to the following for additional Tricare information:
   a. Tricare Prime (https://tricare.mil/Plans/HealthPlans/Prime),[62]
   b. Tricare Select (https://tricare.mil/Plans/HealthPlans/TS),[63] and
   c. Tricare Mental Health Care (https://tricare.mil/mentalhealth).[89]

Overseas Screening

1. Pediatricians can work with overseas screening coordinators by completing any requested forms and providing an up-to-date assessment of a patient's medical needs.
2. Overseas hospitals frequently publish possible disqualifying conditions on their Web sites, which can help families be prepared and manage expectations.
3. In the case of an overseas screening denial, pediatricians can clarify any concerns with the overseas screening office and provide any additional documentation as needed to facilitate a thorough review of the case.

Additional Resources

1. Comprehensive resources for pediatricians and families:
   a. Military OneSource (www.militaryonesource.mil) and
   b. The National Military Family Association (www.militaryfamily.org).
2. New parent support:
   a. The New Parent Support Program (http://www.militaryonesource.mil/-/the-new-parent-support-program)[43] and
   b. Zero to Three (https://www.zerotothree.org/resources/series/honoring-our-babies-and-toddlers#the-resources).
3. Education:
   a. the Military Child Education Coalition (www.militarychild.org) and
   b. DODEA (www.dodea.edu).
4. Child care: Military Child Care (www.militarychildcare.com);
5. Autism:
   a. Operation Autism (www.operationautismonline.org) and
   b. Autism Care Demonstration: https://tricare.mil/Plans/SpecialPrograms/ACD/GettingCare.[90]
6. Advocacy:
   a. AAP Section on Uniformed Services (https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Uniformed-Services/Pages/default.aspx) and
   b. Clearinghouse for Military Family Readiness (www.militaryfamilies.psu.edu).

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ABA: applied behavioral analysis
ACD: Autism Care Demonstration
DOD: Department of Defense
DODEA: Department of Defense Education Activity
ECHO: Extended Care Health Option
EFMP: Exceptional Family Member Program
FAP: Family Advocacy Program
OSS: overseas suitability screening

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