



OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

PERSONNEL AND  
READINESS

AUG 28 2019

The Honorable James M. Inhofe  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

The enclosed initial report is in response to section 578 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115-232), which requests the Secretary of Defense provide a report on the pilot program for military families: prevention of child abuse and training on safe childcare practices.

This initial report addresses how the Defense Health Agency (DHA) will assume management and expand an existing Under Secretary of Defense for Personnel and Readiness and Military Community and Family Policy program. HealthySteps, the evidence-based, interdisciplinary pediatric primary care program, ensures infants receive nurturing parenting for healthy development. The Naval Health Research Center and DHA will conduct an Institutional Review Board that evaluates the effectiveness of the pilot for promoting the high-quality delivery of evidence-based practices and program. Five pilot sites selected include: Joint Base Lewis-McChord, Naval Base San Diego, Keesler AFB, Ft. Bragg/Pope Air Field, and a fifth site to be identified.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the Chairman of the House Armed Services Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "James N. Stewart", is written over a large, stylized, light-colored scribble or watermark.

James N. Stewart  
Assistant Secretary of Defense for Manpower  
and Reserve Affairs, Performing the Duties  
of the Under Secretary of Defense for  
Personnel and Readiness

Enclosure:  
As stated

cc:  
The Honorable Jack Reed  
Ranking Member



PERSONNEL AND  
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

AUG 28 2019

The Honorable Adam Smith  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

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Sincerely,

James N. Stewart  
Assistant Secretary of Defense for Manpower  
and Reserve Affairs, Performing the Duties  
of the Under Secretary of Defense for  
Personnel and Readiness

Enclosure:  
As stated

cc:  
The Honorable William M. "Mac" Thornberry  
Ranking Member

# **Report to Congressional Armed Services Committees**



## **Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare**

**Requested by: Section 578, of the John S. McCain National Defense  
Authorization Act for Fiscal Year 2019 (Public Law 115–232)**

**The estimated cost of this report or study for the  
Department of Defense (DoD) is approximately \$10,103,000  
in Fiscal Years 2019 - 2022. This includes \$5,610,000 in  
expenses and \$4,493,000 in DoD labor.  
Generated on 2019Jun24 RefID: 4-D7C1773**

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## ▪ EXECUTIVE SUMMARY

Section 578 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Public Law 115–232) directs the Secretary of Defense, through the Defense Health Agency (DHA), to implement a 2-year pilot program to reduce child abuse and neglect (CAN) and fatalities due to abuse or neglect in covered households (households of beneficiaries), to identify and assess risk factors for child abuse, and to facilitate connections between covered households and community resources.

The Department of Defense (DoD), through the DHA, is expanding the existing *HealthySteps* pilot program to meet this congressional requirement. The Office of the Assistant Secretary of Defense for Health Affairs, in collaboration with the Office of Military Community and Family Policy (MC&FP), launched the *HealthySteps* pilot in December 2017 at Naval Base San Diego (NBSD), CA and Joint Base Lewis McChord, WA. *HealthySteps*, a program of *Zero to Three*, is an evidence-based, interdisciplinary pediatric primary care program that promotes positive parenting and healthy development for babies and toddlers. DHA will use the *HealthySteps* model in the pediatric clinics at three additional installations: Fort Bragg, NC; Keesler Air Force Base (AFB), MS; and a fifth site to be identified to meet the requirement for DoD in section 578 of the NDAA for FY 2019.

## ▪ INTRODUCTION

This report responds to section 578 of the NDAA for FY 2019 (Public Law 115–232), the Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare, which directs the Secretary of Defense to submit an initial report to the Committees on Armed Services of the Senate and House of Representatives. This initial report follows an interim report submitted on March 25, 2019, and provides a plan for the elements required by section 578. The report includes the installations selected for the pilot program and why; installations selected as comparison installations; and how the pilot is carried out, including strategy and metrics for evaluating effectiveness of the pilot.

Section 578 of the NDAA for FY 2019 requires the Secretary of Defense implement a pilot program targeting the reduction of child abuse and fatalities due to abuse or neglect in covered households. The pilot program must include the following elements:

1. Postnatal services, including screening, and referrals to community services.
2. Approaches to screening, identification, and referral that empirically improve outcomes.
3. Services and resources designed for a covered household.
4. Home visits to provide support, screening, and referral services as needed.
5. Special arrangements for home visits if a parent is deployed.
6. Electronic directory of community resources.
7. Electronic integrated data system to track usage of services as well as evaluate the outcomes of the pilot.

## ▪ BACKGROUND

Ensuring military children receive the best possible start in life and throughout their development strengthens not only the military community and its readiness, but the Nation. Research shows military children are incredibly resilient, but military life can introduce unique challenges (Chandra et al., 2010; Flake et al., 2009; Lester et. al., 2010; Department of Defense, 2010b). Deployment can contribute to problematic behaviors (Chartrand et al., 2008, Hosek, 2011). Additionally, the more months of deployment a military family endures, the higher the frequency of depressive/anxiety symptoms for military spouses. Overall stress for military spouses continues to increase the longer a Service member is deployed (Defense Manpower Data Center, 2015). While research shows these negative effects may dissipate after reintegration (Lester et al., 2013), more can be done during and around a deployment to provide support. Introducing additional supportive services for families in communities with frequent deployments may help mitigate some of these negative effects.

While a military family may not make its way into an installation family center or log-in to Military OneSource, one place every new family goes is the pediatrician's office for well-child appointments. Families show a higher level of receptiveness for supporting services when offered within their pediatricians' office as opposed to their child's school (Molleda & Prado, 2017). Integrating family programs into pediatric primary care would offer proactive support to military families in a non-stigmatizing, clinically-accessible space.

*HealthySteps* is an evidence-based, interdisciplinary pediatric primary care program that ensures babies and toddlers receive nurturing parenting to promote healthy development. The program interweaves the medical support of the pediatrician's office with the resource and service support of the family center, and is easily adapted to a wide variety of settings. As military families move every 2 to 3 years, *HealthySteps* can provide a proactive, supportive resource that helps to provide continuity of services. *HealthySteps* can deliver universal early identification of and access to effective interventions for developmental delays, improved age-appropriate parent-child interactions and child social-emotional development; reductions in severe physical discipline, emergency room utilization, and delays in school readiness; and support for parental depression, domestic violence, and substance abuse. A 2007 evaluation of *HealthySteps* found a sustained positive impact on parenting practices beyond the duration of the intervention. (Minkovitz et al., 2007)

The *HealthySteps* model works by adding a child development professional, called a *HealthySteps* Specialist, to the pediatric service care team. The *HealthySteps* Specialist becomes an integral part of the medical home who partners with families during well-child visits, coordinates needed screenings, and problem-solves with parents for common and complex challenges. *HealthySteps* Specialists are trained to provide tailored guidance and referrals, support between visits, and care coordination and home visits when needed. The role and credentials of a *HealthySteps* Specialist are kept flexible so each pediatric team can select the type of specialist that best fits the needs of the staff and families. Typically, the *HealthySteps* Specialist is a nurse, social worker, home visitor, or psychologist. The core components of the *HealthySteps* model are:

- Team-based well child visits

- Child development, social-emotional, and behavior screening
- Family protective/risk factor and social determinants of health screening
- Access to *HealthySteps* Specialist support between visits (office, home, phone, text, email, etc.)
- Connections to community resources
- Care coordination/systems navigation
- Positive parenting guidance and information
- Early learning resources

Evidence of the effectiveness of the *HealthySteps* model is noted in, “Outcomes from National Evaluation of *HealthySteps* (2003),” a study conducted by the Johns Hopkins Bloomberg School of Public Health Women’s and Children’s Health Policy Center:

<p><b>Child Visits, Vaccines &amp; Screenings</b></p> <ul style="list-style-type: none"> <li>✓ 1.5 to 2.4x as likely to receive a well-child visit on time</li> <li>✓ 1.6x more likely to receive vaccinations on time</li> <li>✓ 1.4x more likely to be up-to-date on vaccines by 2 years</li> <li>✓ 8x as likely to receive a developmental assessment at 30 months</li> </ul>	<p><b>Breastfeeding &amp; Early Nutrition</b></p> <ul style="list-style-type: none"> <li>✓ Mothers 16% more likely to report feeling supported to breastfeed</li> <li>✓ 22% less likely to give newborns water</li> <li>✓ 16% less likely to introduce cereal by 2-4 months of age (ie too early)</li> </ul>	<p><b>Maternal Depression</b></p> <ul style="list-style-type: none"> <li>✓ Mothers 1.6x as likely to discuss depressive symptoms</li> <li>✓ Mothers 1.4x as likely to have a referral, including for maternal depression</li> <li>✓ More likely to discuss postpartum depression with mothers</li> </ul>	<p><b>Child Safety</b></p> <ul style="list-style-type: none"> <li>✓ Children 23% less likely to visit ED for injury-related causes</li> <li>✓ Mothers 24% less likely to place sleeping newborns on their stomachs to reducing SIDS risk</li> <li>✓ Parents scored higher on injury control index</li> </ul>
<p><b>Early Literacy &amp; School Readiness</b></p> <ul style="list-style-type: none"> <li>✓ Mothers 22% more likely to show picture books to infants daily</li> <li>✓ 12% more likely to have read to their infant in previous week</li> <li>✓ Beyond 5 y.o., still more likely to report child had read books in previous week</li> </ul>	<p><b>Parenting Skills &amp; Engagement</b></p> <ul style="list-style-type: none"> <li>✓ Parents more likely to notice behavioral cues and provide age-appropriate nurturing.</li> <li>✓ 22% less likely to use harsh punishment (yelling, threatening)</li> <li>✓ 27% less likely to use severe discipline (face slap, spank with object)</li> </ul>	<p><b>Family Health &amp; Wellbeing</b></p> <ul style="list-style-type: none"> <li>✓ Mothers more likely to raise domestic abuse with a provider</li> <li>✓ Children whose mothers had adverse childhoods have protected social-emotional development</li> <li>✓ Families receive more anticipatory guidance that matches their needs</li> </ul>	<p><b>Quality of Care And Connections</b></p> <ul style="list-style-type: none"> <li>✓ Greater care continuity and knowledge among residents</li> <li>✓ 1.4x as likely to have non-medical referral, including behavior, hearing, child abuse/neglect, and early intervention</li> <li>✓ 4x as likely to receive information on community resources</li> </ul>

Within a military environment, the *HealthySteps* model is being tailored to take into account factors specific to the military community including deployments, frequent relocation, and injury in combat, among others. This tailored model for the military provides linkages to specific resources found within the military community from financial counselors at the family center to home visitors with the New Parent Support Program (NPSP) to connections with the Exceptional Family Member Program (EFMP). The *HealthySteps* model implemented in a military setting can provide holistic support to a military family and ensure the full benefit of the military support system can be brought to bear for a family in need.

## • INSTALLATIONS SELECTED

Historically, the Department's program for CAN and related fatalities is provided by the MC&FP, located within the Office of the Under Secretary of Defense for Personnel and Readiness, and the Services' Family Advocacy Programs (FAP) and their prevention program, NPSP. Section 578 states the Secretary may not carry out the pilot program through the FAP. Therefore, DHA will assume management of the *HealthySteps* pilot program and add additional sites to meet the five site requirement in the statute. Currently, the *HealthySteps* pilot is operating at NBSD and Joint Base Lewis-McChord (JBLM). Ft. Bragg, NC; and Keesler AFB, MS, have recently agreed to implement *HealthySteps* in their pediatric clinics. The fifth pilot site is to be identified. The pilot program will run for two years with evaluation occurring pre- and post- pilot. The complete timeline of the project can be found in Appendix A.

### 1. Pilot Program Sites

Four sites meet criteria for pilot locations and reflect a range of characteristics. Five comparison installations are selected for purposes of assessing the outcomes of the pilot. All installations have a hospital or clinic. Each site listed below meets specified variables, as follows:

- Fort Bragg and Pope Air Field, NC – Womack Army Medical Center: Rural location; large population; high incidence of CAN; hospital with a birthing center, joint installation U.S. Army and U.S. Air Force (USAF).
- JBLM, WA – Madigan Army Medical Center: Urban location; large population; high incidence of CAN; hospital with a birthing center; joint installation U.S. Army and USAF.
- NBSD, CA – Naval Medical Center San Diego: Urban location; large population; high incidence of CAN; hospital with a birthing center; installation serving U.S. Navy (USN) and U.S. Marine Corps (USMC).
- Keesler AFB, MS – 81st Medical Group: Rural location; small population; mid-level incidence of CAN; hospital with a birthing center, installation serving USAF and USN.
- A fifth site to be identified.

These four pilot sites represent a range of characteristics, as required, and include population size, rural versus urban setting, incidence of CAN, presence of a hospital versus clinic, to include birthing centers as well as the population being served (i.e., single or more services versus joint installation).



## 2. Pilot Program Comparison Sites

The comparison installations also range in characteristics as described below. Comparison installations include:

- Ft. Hood, TX – Carl R. Darnall Army Medical Center: Rural location; large population; high incidence of CAN; hospital with a birthing center; installation serves U.S. Army.
- Camp Pendleton, CA – Naval Hospital Camp Pendleton: Urban location; large population; high incidence of CAN; hospital with a birthing center, installation serves USMC.
- Joint Base Charleston, SC – 628th Medical Group: Urban location; small population; high incidence of CAN; clinic without a birthing center; joint installation (U.S. Army, USAF, USN, USMC).
- Seymour Johnson AFB, SC – 4th Medical Group: Rural location; small population; mid-level incidence of CAN; clinic without a birthing center; installation services USAF.
- Ft. Jackson, SC – Rural location; small population; low incidence of CAN, clinic without a birthing center; installation serves U.S. Army.

Appendix B displays a comparison chart of all criteria by pilot site and comparison installation.

### ▪ **DHA STRATEGY FOR PILOT IMPLEMENTATION AND EVALUATION**

A cohort of program managers and ombudsmen from all Services reviewed and gave feedback for the pilot program design. The DoD's Child Development Center (CDC) subject matter experts serve as intermediaries to installation-level military family groups. Consultation is summarized:

- Strong Services Program Managers' support exists for the pilot program and connection to installation level family groups about family needs and community resources.
- At typical U.S. Army installations, approximately 90 percent of the primary users of CDCs are the youngest age group of infants and their parents who are single or dual military spouses.
- Military families not living on installations could connect with their military medical treatment facility (MTF)-embedded specialists for assessments, safe childcare practices, home visits, and on-line community resources from Military OneSource's directory.
- The USMC has new Child and Youth Program nurse positions, a source of connection for the pilot specialists and a channel to community resources.
- The U.S. Coast Guard (USCG) ombudsmen's appointed unit spouses are conduits to families, build networks to push information to units and families, and learn about needs of USCG families for tailored support. The next step is to meet with family groups at

selected pilot program sites regarding family needs and community resources for covered households.

### 1. Postnatal Services, Screening, and Referrals to Community Services

Postnatal services are provided in the military treatment facilities or, where no birthing center or family medicine clinic are present, by referral to TRICARE for services in the community. Within 30 days after a birth by a beneficiary, the child developmental specialist will contact new parents and encourage participation in the voluntary pilot program. Parents who live off-installation will be provided screening to identify family needs and potential risk factors and make referrals to appropriate community services. An electronic directory of community resources supports child developmental specialists and parents to connect to services. Installation level military family groups will assist in validation of the appropriateness of community resources. An electronic data management system tracks referral of beneficiaries and usage of services, resources, and interactions.

### 2. Approaches to Screening, Identification, and Referral that Empirically Improve Outcomes

The pilot program is based on multiple, scientific approaches to screening, identification, and referral that empirically improve outcomes for parents and infants, to include the following: collaborating with parents to evaluate children's developmental status and behavior problems; a parenting stress index; screening instruments for family history; a patient health questionnaire mood scale; and a screening for depression in primary care (validated by Aroll, Khin & Kerse, 2003).

### 3. Services and Resources

The DoD *HealthySteps* model provides tailored services and resources for military parents with on and off-base linkages to specific resources; for example, State Part C Coordinators for children from birth to age three with a developmental disability or Early Intervention Services (EIS), where available on installations. Women, Infants, and Children provides a special supplemental nutrition program on installations for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women and to infants and children up to age five who are found to be at nutritional risk. Military communities provide financial counselors at the family centers, home visitors with the NPSP, and connections with the EFMP during relocation. DoD pilot program specialists will compare the information gained from screening, plus identification of family needs and potential risk factors, against the library of parent educational material to provide a personal, family specific package with resources and facilitate connections to community service. The *HealthySteps* model implemented in a military setting can provide holistic support to a military family and ensure the full benefit of the military support system can be brought to bear for a family in need.

### 4. Home Visits

To avoid duplication of resources, the current *HealthySteps* pilot program leverages the NPSP home visiting function when home visits are requested or agreed to by a family. The Department will continue using the NPSP as one home visiting referral source. NPSP nurses and other home

visitors are trained in the *HealthySteps* model. The Department is open to engaging with other evidence-based home visiting models as referral sources, such as Family Connects (Durham Connects) for home visiting services at Womack, since Family Connects is based in North Carolina.

### 5. Home Visits and Deployed Parents

Homefront parents whose spouses are deployed can connect electronically during home or hospital visits via Military OneSource resources for telephonic connections to deployed spouses with the child developmental specialists. For example, Military OneSource provides telephone cards to the child development specialists for use by military families that cover the cost of electronic communication with the deployed sponsors. If a parent is deployed at the time of birth, the first in-home visit incorporates both parents. Another home visit is offered on the return of the deployed parents and includes both parents, if determined in the best interest of the family.

### 6. Electronic Directory of Community Resources

MC&FP has leveraged Military OneSource to house educational materials for all areas outlined in section 578 (see Appendix C for an example). Resources are available 24/7/365 to inform and educate parents, child development specialists, pediatricians, family practice physicians, nurses, and pilot program team members by logging into the website ([www.militaryonesource.com](http://www.militaryonesource.com)), looking up the “Community Resource Finder,” and filtering resources for parents with young children. An informal, comparative study of website materials for the Centers for Disease Control and American Academy of Pediatrics indicated all topic areas were covered and contained similar content.

### 7. Electronic Integrated Data System

A DHA Clinical Support Division electronic integrated data system development team leveraged the expertise of the NBSD and JBLM *HealthySteps* program coordinators and the USN and U.S. Army’s EIS/Educational and Developmental Intervention Services program managers at clinics for children from birth to age three with developmental disabilities. A pilot program data dictionary and workflow diagrams have been developed, and subject matter expert validation requires 60 days.

A pilot program electronic integrated data system would support section 578 assessment criteria, to include: referrals to eligible beneficiaries to services and resources; tracking usage of services and resources and interactions between specialists and covered households, and allowing evaluation of the implementation, outcomes, and effectiveness of the pilot program. Examples of data system support in two key areas include: notification to each covered household of the services provided by the pilot within 30 days of pilot implementation and contact with covered households with newborns no later than 30 days after a birth to encourage participation in the pilot program.

Currently, the DHA Special Needs Program Management Information System (SNPMIS) is migrating to a new platform. SNPMIS should encompass the pilot program's electronic integrated data system, as beneficiary demographics, assessments, decision points for services, and processes are highly similar. Neither SNPMIS nor the pilot program electronic data integration system requires data entries into the electronic medical record, but data would be housed on Armed Forces Health Longitudinal Technology Application-Health Artifact and Image Management Solution and Military Health System (MHS) GENESIS. Both SNIPMS and the pilot program system require technical product development, end user training, and implementation at MTFs. The Department is prioritizing funds, anticipated to be available in the next 6 to 9 months, required for technical development, testing, training, and implementation of SNIPMS.

### 8. Assessment and Metrics for Evaluating Effectiveness

Understanding the effectiveness of the pilot is an essential part of promoting the high-quality delivery of evidence-based practices and program. It is also critical to determining the applicability to the remainder of the enterprise. We have partnered with the Naval Health Research Center to conduct an Institutional Review Board (IRB) study of this pilot.

The program evaluation will provide the following data as required by section 578:

- Success in contacting covered households for participation in the pilot
- The percentage of covered households that elect to participate in the program
- The extent to which covered households participating in the pilot program are connected to services and resources under the pilot program
- The extent to which covered households participating in the pilot programs use services and resources under the pilot program
- Compliance of pilot program personnel with pilot program protocols (i.e., fidelity to the model)

As required by section 578, the pilot will include no fewer than five assessments throughout the two year pilot period at the following intervals: baseline/pre-pilot, 6-months, 12-months, 18-months, and post-pilot.

### **SUMMARY**

Expansion of the existing DoD *HealthySteps* pilot meets the requirements of section 578 and offers the best intervention for MHS beneficiaries because of its proven track record at existing sites such as NBSD and JBLM. *HealthySteps* is an evidence-based program that embeds a child development specialist into the pediatric service team. This specialist is well connected to installation and off-installation resources for the family to include the NPSP home visiting program. This avoids duplication of resources and leverages existing programs.

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## Appendix B: Comparison Chart of Criteria by Pilot Sites and Comparison Installations

Section 578 of the NDAA for FY 2019, Pilot Sites and Comparison Installations												
Pilot Site	Location		Population		Incidence of CAN			Facility			Installation	
	Urban/Rural		Large/Small		High	Med	Low	Hosp.	Clinic	BC	Jt.	1 or >
Ft. Bragg		Y	Y		Y			Y		Y	Y	
JBLM	Y		Y		Y			Y		Y	Y	
NBSD	Y		Y		Y			Y		Y		2
Keesler AFB		Y		Y		Y		Y		Y		2
A fifth site to be identified												-
Comparison Installations												
Ft. Hood		Y	Y		Y			Y		Y		1
Camp Pendleton	Y		Y		Y			Y		Y		1
Joint Base Charleston	Y			Y	Y				Y	N	Y	
Seymour Johnson AFB		Y		Y		Y			Y	N		1
Ft. Jackson		Y		Y			Y		Y	N		1

Legend. AFB=Air Force Base; BC=Birthing Center; Ft.=Fort; Hosp.=Hospital; Jt.=Joint; JBLM=Joint Base Lewis-McChord; N=No; NBSD=Naval Base San Diego; Y=Yes



# Appendix C: Military OneSource Educational Material Sample: Safe Sleep

## Putting Baby Safely to Sleep:

Tools for nurses, family physicians, obstetricians and pediatricians



This guidance provides useful ideas and resources for sharing important messages with new and expectant parents about putting baby safely to sleep.

### Your role

Engage new and expectant parents, provide them with information, direct them to resources that educate them about safe infant sleep environments and practices, and empower them to cope with infant sleep-related challenges.

### The opportunities

- Ask parents about infant sleep challenges during medical appointments and hospital stays, and whether they have questions about the **National Institutes of Health's recommended infant sleep guidelines**. Do you have a patient who has just returned from deployment? Discuss the risks associated with fatigue while caring for an infant.
- Share safe sleep information with your patients. Use American **Academy of Pediatrics safe sleep information**, First Candle's downloadable brochure, "**Room Sharing is Safer Than Bed Sharing**,"\* and articles on safe sleep practices on **Military OneSource**.
- Encounter parents that might need extra support? Encourage them to contact their **local New Parent Support Program** by searching "New Parent Support Program" on **MilitaryINSTALLATIONS**.
- Share our archived blogs. Tell them about the archived blog series, "**Sleep Like a Baby: The Keys to Infant Slumber**," designed especially for military parents.
- Participate in free **American Academy of Pediatrics online training** about creating safe sleep environments.

### Key messages for new and expectant parents:

- Sleep is often one of the most significant challenges for new parents.
- One of the most important decisions a new parent makes is where and how they place a baby to sleep.
- Ensuring your baby is in a safe sleep environment involves closely monitoring your own personal level of alertness while caring for your infant.
- Safe sleep can save lives.

### Key online resources:

- <http://www.militaryonesource.mil/parenting/safe-sleep-practices>
- <https://www.theparentreview.com/DoD/>
- <http://www.zerotothree.org/child-development/from-baby-to-big-kid/>
- <https://text4baby.org/>
- <http://www.extension.org/pages/22110/just-in-time-parenting-newsletters>

\*The American Academy of Pediatrics and First Candle are private organizations. The Department of Defense does not control or endorse the content of these sites.



Providing policy, tools and resources to further enhance the quality of life of service members and their families.

## Appendix D: Key Outcomes and Data Sources Table

Elements and Key Outcomes	Data Sources
Success in contacting covered households for participation in the pilot	Electronic Integrated Data System
The percentage of covered households that elect to participate in the pilot program	Electronic Integrated Data System
The extent to which covered households participating in the pilot program are connected to services and resources under the pilot program	Electronic Integrated Data System
The extent to which covered households participate in the pilot program use services and resources under the pilot program.	Electronic Integrated Data System
The compliance of pilot program personnel with pilot program protocols	Electronic Integrated Data System
<b>Pilot Program</b>	
<b>H.R. 5515, Sec 578</b>	<b>Key Study Outcomes and Data Sources</b>
Key Outcomes are derived from Pilot Program requirements specified in section 578. Purpose: (a)(1)(A),(B) and (C) and Elements: (6)(C )(i) to (xiv)	Data Source(s) and Items Measured
<b>(A) Provide information regarding safe childcare practices to covered households</b>	
(x) Other positive parenting skills and practices.	National Parent Survey (Minkovitz et al., 2007) - Items: ●Parental responses to and perceptions of child misbehavior (e.g., slap in the face/spank with object)
(i) General maternal and infant health exam (xi) The importance of participating in ongoing healthcare for an infant (iii) Feeding and bathing.	National Parent Survey (Minkovitz et al., 2007) - Items: ●Parental knowledge of child development and nutrition
(ii) Safe sleeping environments (x) Other positive parenting skills and practices.	National Parent Survey (Minkovitz et al., 2007)- Items: ●Promotion of child development and safety (e.g., bedtime routine)
(vi) Self-care.	Parenting Stress Index - Items: ●Parenting Stress
(iii) Feeding and bathing.	Self-Report and Medical Record

<b>(B) Identify and assess risk factors for child abuse in covered households</b>	
(C)(i) General Maternal and infant health exam. (xi) The importance of participating in ongoing healthcare for an infant.	Medical Record
(C)(xi) The importance of participating in ongoing healthcare for an infant.	Medical Record
(C)(i), (x) Other positive parenting skills and practices, and (C)(xi).	Medical Record
<b>(B) Identify and assess risk factors for child abuse in covered households</b>	
(6) Elements. The pilot program shall include the following elements.	
(C)(xii) Finding, qualifying for, and participating in available community resources with respect to infant care, childcare, parenting support, and home visits. (C)(xiii) Planning for parenting or guardianship of children during deployment and reintegration.	<ul style="list-style-type: none"> <li>● Consultation with Military Family Groups at pilot sites and comparison installations' CDCs</li> <li>● Parental self-report for Family Member Care Plan, social support, and community resources</li> </ul>
(C)(vii) Postpartum depression, substance abuse, or domestic violence.	Disclosure acknowledgements provided for: PHQ-9 Primary Care screener items Family History Screener
<b>(C) Facilitate connections between covered households and community resources</b>	
(C)(i) General Maternal and infant health exam.	Perceived satisfaction with providers and healthcare ● Questions developed to address MTF context and perceived support
(C)(xi) The importance of participating in ongoing healthcare for an infant	Healthcare experiences ● Medical Record, Self-Report, Pediatric Care, Emergency Department and Urgent Care visits
(C)(xii) Finding, qualifying for, and participating in available community resources with respect to infant care, childcare, parenting support, and home visits.	Utilization of military support programs to address: ● Rates of referral and receipt of services from programs such as NPSP, non-medical counseling, FAP, and Military OneSource among others

## **Appendix E: List of Acronyms**

AFB	Air Force Base
CAN	Child Abuse and Neglect
CDC	Child Development Center
DHA	Defense Health Agency
DoD	Department of Defense
EFMP	Exceptional Family Member Program
EIS	Early Intervention Services
FAP	Family Advocacy Program
Ft.	Fort
FY	Fiscal Year
IRB	Institutional Review Board
JBLM	Joint Base Lewis-McChord
MC&FP	Military Community and Family Policy
MHS	Military Health System
MTF	Military Medical Treatment Facility
NBSD	Naval Base San Diego
NDAA	National Defense Authorization Act
SNPMIS	Special Needs Program Management Information System
USAF	U.S. Air Force
USCG	U.S. Coast Guard
USMC	U.S. Marine Corps
USN	U.S. Navy