Moving the Life Course Work Forward:
Recommendations from the Life Course Town Hall Meetings

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As a result of a collaborative partnership of more than 5 years that encompassed several projects of joint work focused on women’s health, CityMatCH and AMCHP received funding for FY 2010-2011 to host two town hall-style meetings (in September 2010 and February 2011) for key MCH leaders and practitioners interested in and currently developing life course-focused programming. These Town Hall Events explored applying the life course perspective, social determinants of health, and health equity concepts to everyday MCH practice, and promoted in-depth discussions about the three essential elements of the MCHB Concept Paper: knowledge base, program and policy strategies, and political will. The voices of participants are the essential part of this document and the authors appreciate the thoughtful, insightful, and innovative approaches and ideas that were shared in these two meetings. CityMatCH and AMCHP would also like to acknowledge Christina (Kiko) Malin for co-facilitating the first Town Hall Meeting. This work was supported by Maternal and Child Health Bureau, HRSA Grant U01MC00001 (AMCHP), Grants # 5 U65 DP724969-05 (CityMatCH) and #U65CCU324963-05 (AMCHP) from the Centers for Disease Control and Prevention.

About the Organizations
CityMatCH and The Association of Maternal & Child Health Programs (AMCHP) represent local and state governmental public health leadership in maternal and child health. CityMatCH is dedicated to improving the health and well-being of urban women, children, and families by strengthening the public health organizations and leaders in their communities. AMCHP is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.
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Introduction

Since the publication of “Racial and Ethnic Disparities in Birth Outcomes: A Life Course Perspective” in the Maternal and Child Health Journal (Lu, Halfon 2003), there has been growing interest and substantial investment in the application of the life course perspective to the practice of maternal and child health at the local, state and federal levels. Many health jurisdictions and State Title V (Maternal and Child Health) programs around the country have worked with Drs. Lu and Halfon and other practitioners familiar with this theoretical framework, hosting day-long symposia for staff and community partners to learn more about the theory, identify how the life course perspective (LCP) is already in use in their settings, and develop locality-specific strategies for applying the theory to practice settings.

The Life Course Perspective (LCP) encourages us to focus beyond the individual and individual behavior change and look more broadly at how the complex interplay of biological, behavioral, psychological, environmental, and social protective and risk factors contributes to health outcomes across the life-span. The LCP also draws attention to critical periods of development and early life events, positing that inequities in birth outcomes, such as low birth weight and infant mortality, result from differences in protective and risk factors between groups of women over the course of their lives. Furthermore, the LCP reinforces the work of several MCH scholars in suggesting that cumulative risk, such as accumulation of and adaptation to chronic stress (sometimes described as weathering or “wear and tear”), requires greater attention in the design, delivery and implementation of MCH programs.

In October 2010, in celebration of the 75th Anniversary of Title V, the Maternal and Child Health Bureau released a Concept Paper – “Rethinking MCH: The Life Course Model as an Organizing Framework” (Fine, Kotelchuck 2010) – designed to influence the development of the new MCHB Strategic Plan. This Concept Paper explores “how life course theory might be used as a strategic planning framework, guiding the work of MCHB, its grantees, and partners over the next five years.” Through an examination of life course theory and examples of life course application, the paper addresses four core life course concepts – timeline, timing, environment, and equity (T2E2) – and suggests that in order to create a strategic agenda for change, MCHB will need to work in three broad areas: knowledge base, program and policy strategies, and political will.

The release of this Concept Paper, and the publication of existing and emerging research demonstrating that social, political, and physical environments are major determinants of family health and health inequities, encouraged MCH programs around the country to identify new opportunities to introduce and implement innovations in the field. At the same time, AMCHP and CityMatCH recognized that state and local health departments accustomed to operating with a primary focus on prenatal care and categorical service delivery, might be challenged to incorporate this approach into their daily work.

To this end, AMCHP and CityMatCH teamed up to host two Life Course Town Hall Meetings at their respective membership meetings in September 2010 and February 2011. This report provides a brief overview of those Town Hall meetings, reviews the key themes and recommendations identified by Town Hall participants, and offers food for thought to federal agencies exploring their next steps as well as states and localities seeking to either begin or continue their efforts at integrating the life course perspective into their communities and work.

“Moving the Life Course Work Forward” blends the voices of participants from the two Town Hall Meetings to give a complete picture of MCH professionals’ responses, reactions, and suggestions. This report captures the ideas of the organizations’ members and what they believe is needed while MCHB, the Centers for Disease Control and Prevention (CDC), other federal agencies and the MCH community “move forward” with this work. Both meetings — one focused primarily on the practical application of life course theory to MCH settings (CityMatCH), and the other focused on providing further reflection to the knowledge base, program and policy strategies, and political will (AMCHP) — were designed to answer the question: How do you take the life course theory and put it into action and practice? With knowledge base, we looked at issues of concept and practice, with program and policy strategies we focused on translating the life course concepts into concrete programs and policies, and with political will we addressed strategies for building engagement and “buy-in.”
Key Themes and Recommendations
Several key themes emerged from the Town Hall Meetings that give direction to what is needed to facilitate a broader and well-informed integration of the concepts of life course perspective, social determinants of health, and health equity into day-to-day and strategic long-term MCH work. It is interesting to note that many of these key themes have been echoed at other meetings and in different settings in which MCH practitioners are grappling with the opportunities offered through this paradigm shift in the field over the past several years.

The key themes have been framed in terms of “members’ needs” and “recommendations for next steps.” Each one is described in greater detail in the following sections:

1. Create a common language about life course,
2. Establish a shared outcomes framework with a centralized database of life course measures and standardized criteria for use at national, state, and local levels,
3. Design coordinated, comprehensive educational strategies for people at all levels about life course (policy makers, medical and public health practitioners, families, youth, advocates, etc.),
4. Develop and maintain a clearinghouse of ideas, evidence-based programs, and innovative efforts of the practical application of life course,
5. Establish and support Learning Communities to foster the ongoing exchange and development of ideas and innovation,
6. Identify strategies for aligning funding for the design, implementation, and evaluation of life course-related activities.

Create a common language about Life Course
The life course perspective encourages us to view health more holistically across the lifespan, emphasizing the importance of critical periods in development and the cumulative effects of both risk and protective factors. It builds on recent theoretical work suggesting that social, economic, and neighborhood environments have a profound impact on individual and community health. To many practitioners in the field, these ideas make a lot of sense, but communicating them remains a challenge.

Creating a common language to communicate clearly about life course will require moving beyond “jargon” by finding a vocabulary of words, terms, phrases, and metaphors that resonates with the community, families, policy makers, non-traditional partners (such as business, finance, transportation, housing) other disciplines (such as chronic disease), MCH and public health practitioners, students, and beyond. We will need this common language and/or messaging to be able to communicate effectively with different constituencies about these concepts; to encourage and support others in taking ownership of these ideas; to develop a Memoranda of Understanding; to design broad MCH goals and objectives; to conduct needs assessments; and to describe new directions in grant guidances for potential funding.

One challenge will be creating this common language, but we can begin by looking at the tools that have been developed to date to explain life course. These include the CityMatCH Life Course Game, the Alameda County Road Show (designed to explain life course to community members and community partners who are not identified with “health”), and the stories that are told by MCH practitioners who are implementing life course-focused projects in their settings. In particular, it will be useful to identify the words and terminology that really mean something to MCH practitioners and community members (e.g., do the terms “risk” and “protective” factors make sense to everyone? If we talk about “weathering” or “wear and tear,” does that communicate a clear message? When we explain that just focusing on “the prenatal period” cannot reverse a lifetime of what may have been an “accumulation of risk factors,” does this make sense to people?) Let’s begin by developing a language that includes words and terminology that are familiar and easy to understand, tell a story, and bring the concepts of life course to life.

Establish a shared outcomes framework with a centralized database of life course measures and standardized criteria for use at national, state and local levels
It is widely agreed that if we are going to move forward with the incorporation of life course, social determinants of health, and health equity in our day-to-day work in MCH, methodology will be key. We will need to work with our federal partners such as CDC and MCHB to define and identify meaningful measures, a set of indicators,
and what success will look like. Many practitioners have suggested that we establish a shared outcomes framework that will allow us to develop a centralized database with standardized criteria, to be used by organizations and individuals at the national, state and local levels. Once we have an idea of what some of these shared outcome measures could be, it will be important to review existing surveys such as the National Health and Nutrition Examination Survey (NHANES), Behavior Risk Factor Surveillance System (BRFSS), and review Special Projects of Regional and National Significance (SPRANS) grants to see what indicators already exist, as well as incorporate life course measures into these existing data collection tools and into the data collection efforts of other federal agencies, such as the Departments of Education, Labor, and the Treasury. Furthermore, efforts need to be made to identify indicators and data collection tools that can amass data specific to local health jurisdictions in addition to state and national data sets.

Longitudinal data would be of the most value to our work in this emerging field. Several new longitudinal studies are in the process of being launched (the National Children’s Study), and Los Angeles County has been working for several years with data from their Los Angeles Moms and Babies Study (LAMBS). It would be useful to learn from researchers working with these databases and build on existing multigenerational studies to glean life course-related data and add life course-relevant questions to the ongoing research. Furthermore, we need to define and clarify meaningful measures for risk and protective factors and translate those factors into indicators that can be measured and tracked. For example, how will local health jurisdictions measure the impact of adopting a life course framework in their programs and policies? How do we quantify the value added of addressing social determinants of health in different sectors across time in an effort to improve health outcomes? Practitioners agree that considerable assistance is needed from epidemiologists and statisticians to design databases that enable MCH programs and policy makers to answer these questions and track the evolution of this work.

Furthermore, as the concept of Life Course gains great traction, it will be necessary to develop effective approaches to data sharing and data linkages to track local, state and federal indicators. It has been suggested that we begin by developing data-sharing agreements that identify partners and potential data that could be shared to capture life course measures and practices. Finally, as we begin to transform the way we both view and conduct MCH programs and services, it will be necessary to have accountability measures, performance measures, and documentation for cost benefit analysis.

Design coordinated, comprehensive educational and training strategies about life course for people at all levels (policy makers, medical and public health practitioners, families, youth, advocates, etc.)

As states, local health jurisdictions, and federal partners begin the work of introducing life course concepts, it seems there are several levels at which education and/or training will need to take place. First of all, it will be important to identify essential life course talking points and practical elements of a general orientation for staff, community partners, policy makers, community residents, and others. Several health jurisdictions in California (Los Angeles County, Alameda County, and Contra Costa County) have started this process and have designed presentations, speaker’s bureau presentations, a web-based life course toolbox, and community-oriented educational sessions to bring the life course message to staff and community partners. There is a clear need for standardized educational programming that is engaging, clear, and adaptable for use with different types of groups in various settings.

Attention should also be given to the development of life course competencies for current and future MCH practitioners and leaders. In addition, we must also focus attention on educational strategies for the general public. It has been suggested that we consider designing a media campaign to inform and educate the general public about the larger issues of life course, perhaps with a focus on the social determinants of health and health equity concepts. It would be important to package these ideas and develop the core messages in terms that are concise and strategic. The 2008 release of the California Newsreel Series “Unnatural Causes: Is Inequality Making Us Sick?” offers practitioners a useful, highly informative, and easily understandable tool to make this type of large scale and broad based media campaign possible.
Develop and maintain a **clearinghouse** of ideas, evidence-based programs, and innovative efforts for the **practical application** of life course

Town Hall Meeting participants unanimously requested the ongoing development of websites and resource hubs/centers that could serve as a clearinghouse for ideas, strategies, and activities for the practical application of life course in practice, policy, education and training, and research. In addition to the tools that are currently under development by CityMatCH, MCHB, the CDC, and the Maternal and Child Health Life Course Research Network, participants indicated the need for a toolkit specific to life course integration, incorporation, and implementation in state and local settings. They offered specific ideas for what this toolkit could include:

1) A presentation on life course that focuses on the basics in an easy to understand language,
2) Specific suggestions of activities and approaches for implementing life course-related programs, policies, research, etc.,
3) Success stories with specific examples of how MCH programs are incorporating life course into their plans,
4) Contact information for resources,
5) Bibliography of life course articles and related resources,
6) Step-by-step guide for how to measure/evaluate life course activities, and
7) Opportunities for dialogue and discussion with colleagues.

In addition to this toolkit, Town Hall participants indicated they needed information and statistics that could be used to engage non-traditional partners and help them understand how they and their clients would benefit from this broader look at the social, political, economic environment, as well as the influence of social factors and the importance of health equity. It was also suggested that this type of information be used with all new partners, including those in law enforcement, safety, business, juvenile justice, economic development, education, faith-based communities, etc., as well as policymakers, legislators, internal staff, and above all, diverse populations.

The question of how to apply the concepts of life course to all MCH populations (not just women who are pregnant and parenting) was one that was posed repeatedly by Town Hall Meeting participants. In particular, participants stated it would be useful to have resources and ideas that focus more attention on adolescents from a life course perspective. Examples of this, perhaps from a perspective of preconception health, would be a valuable addition to a clearinghouse, along with a clarification of the ways in which the life course perspective fits in with the work of Children and Youth with Special Health Care Needs. Any examples of best practices in this arena in particular would be welcome, as well as practical suggestions for how MCH programs serving different populations could begin to explore and eventually incorporate the life course perspective into their day-to-day work.

**Establish and support Learning Communities to foster the ongoing exchange and development of ideas and innovation**

To continue to evolve our ideas and innovative strategies about the integration of the life course perspective into MCH work, Town Hall Meeting participants identified the need for a community of learners and leaders to continue to explore possibilities, address problems, share ideas, cultivate model programs, stimulate innovation, and share successes. For many, the creation of learning communities is an essential step in leadership development for MCH practitioners. Furthermore, these dynamic and engaging collaborative communities will be valuable in helping to build the infrastructure necessary to sustain the ongoing incorporation of the life course concepts into their work.

Regional Learning Communities could offer participants opportunities to learn from one another and build their skills and professional strengths in addressing the challenges and complexities of new endeavors. For example, several Town Hall Meeting participants talked about the need to learn from those who have been successful in forging new partnerships with other categorical programs, such as chronic disease, to initiate a life course partnership. Learning Communities would also utilize the expertise of MCH leaders to convene educational conversations about life course theory in an environment that fostered discussion, dialogue, and exploration of possibilities without the pressure to have the "right" answer.
or know the exact specifications of a new program.

Along these lines, it was suggested that our federal partners provide a “road map” that could be tailored to specific jurisdictions and localities and offer details of specific steps that could be taken, as well as concrete examples of models that are being utilized with some success. It was also suggested that this “road map” could include some examples of structures for cross-agency partnerships that are already in place to serve as models for planning, collaboration, and eventual program implementation.

Given the potential for new partnerships suggested by the framework of the life course perspective (e.g., community members, as well as representatives from business, economic development, social services, law enforcement, city planning, transportation, etc.), it will be important to recognize that these collaborative efforts may require different formats, processes, and approaches. Giving voice to those states and localities that have already started this process would be of substantial benefit to MCH leaders and practitioners as they move forward.

As mentioned above, several local health departments and state MCH programs have taken specific steps to incorporate aspects of the life course perspective into their work. Some have started by changing the internal functioning of their programs (through education and training of staff, redirecting programmatic efforts, redefining program goals and objectives), while others have been working closely with new and non-traditional MCH partners to form community collaborations designed to bring greater attention to the broad concepts of social determinants of health, life course, and health equity.

Participants at both Town Hall Meetings expressed enthusiastic interest in hearing from these programs, specifically about what they are doing, how they moved from point A to point B, what their challenges were, what they would do differently, and what they would recommend to others.

Identify strategies for aligning funding for the design, implementation, and evaluation of life course-related activities

There is a growing and urgent need to align monetary resources for life course-related work and local, state, federal, and private grant funding that is flexible, supports sharing funds across programs, encourages collaboration with traditional and non-traditional partners, and enables funded programs to work on improving outcomes that are measured over time (e.g., looking beyond a one-to-two year trajectory in an effort to demonstrate meaningful change). We need to be doing a better job across all levels of government to remove the silos and increase collaboration. It is clear that it will be difficult for States and local entities to follow suit without leadership from the federal level in this arena. If the federal agencies encourage and allow this paradigm shift in resource alignment, not only will states and local entities benefit, our constituents, women, children, and families will as well.

Town Hall Meeting participants suggested that we identify strategies to blend funding streams within categorical programs to create a dedicated position focused on life course-related activities. Participants were enthusiastic about the possibility of being able to work with federal partners, such as Congress, CDC, and MCHB, to create funding streams that were less categorical, had less of a “silo” approach, provided opportunities for leveraging with other partners, and enabled program staff to organize the work “horizontally” so that there could be a longitudinal strategy for funding.

There was also discussion about the value added of creating a business model based on the concept of Return On Investment (ROI). This would require taking the “long view” and recognizing that the work we are proposing to embark upon with regard to life course is broadly about changing the health of this and future generations. With that in mind, it will be imperative to identify those private foundations using innovative approaches to social determinants of health who are funding programs based on a life course approach, and clarify how they are measuring “success,” what outcomes they are seeking, and how they can share their efforts and insights with our federal partners.

The CDC and MCHB have the ability to set the stage for multi-sector collaboration as well as broader implementation or incorporation of life course concepts into State and Local work. By including specific instructions in grant guidance that requires cross-departmental, multi-sector approaches using the life course theory, these key federal partners and other funders are not only encouraging that type of multi-sector work, but are also acknowledging that these efforts will allow us to address disparities in health and birth outcomes that have continued to persist in MCH populations for generations.
Town Hall Participants to Federal Partners: Lead by Example

Participants at both Town Hall Meetings were clear that they are looking for leadership, direction, and guidance from federal partners such as the CDC and MCHB as we move the life course work forward. They applauded the strategic planning currently taking place at MCHB and welcomed the opportunities being offered to communities by CDC through the Community Transformation Grants.

Participants had a short list of suggestions for federal partners as the process for defining and clarifying what life course work will look like unfolds. In particular, they made some of the following suggestions:

1) Model interagency collaboration at the federal level with regard to programming, funding, and direction;
2) Identify resources to assist states and local health jurisdictions as they evaluate these new program directions, produce data, and write for publication;
3) Provide support for the development of relevant life course indicators for the MCH Needs Assessment;
4) Identify possible opportunities for expansion that promotes collaboration across funding streams;
5) Encourage and promote “cross talk” between agencies and programs (chronic disease, education, finance, housing, etc.) to facilitate interdepartmental collaboration;
6) Work with federal partners to design approaches that will make funding less categorical and more blended;
7) Encourage and enable pilot testing of life course programs, projects, and ideas through Healthy Start;
8) Articulate a direction similar to that in the Children and Youth with Special Health Care Needs 6 point agenda.

Conclusion

The challenge for all of us working at all levels in the field of maternal and child health today is to identify the best possible approach for moving forward with the integration and incorporation of the life course perspective, in light of where we are and what we have available to us now. Building on the considerable work that has already been accomplished, the specific recommendations identified by Town Hall Meeting participants, and the current efforts on the part of MCHB and the CDC to clarify and provide a starting place for enhancements and new directions that might be explored, we have within our reach the ability to move forward with the life course perspective. LCP can improve the health and well being of families, women, children, adolescents and children with special health care needs in ways that make sense to us, resonate with concepts of social determinants of health, and put us on a path to health equity for all.
Appendix A

Rethinking MCH: The Life Course Model as an Organizing Framework

Rethinking MCH: The Life Course Model as an Organizing Framework – Knowledge Base

There is general agreement among those working on MCH life course strategies that the knowledge base around both concept and practice needs to be further strengthened. Among the key areas to be addressed are:

1. Developing new standards and measures that capture key life course concepts (i.e., timeline, timing, environment and equity);
2. Developing new methodological approaches for ongoing monitoring of longitudinal impact; and
3. Incorporating life course theory concepts into training and continuing education programs to move the MCH field forward.

Rethinking MCH: The Life Course Model as an Organizing Framework – Program and Policy Strategies

Translating life course theory into concrete programs and policies is perhaps the most difficult of the life course challenges. Multiple interventions and policies at a variety of levels across multiple time periods are needed. While many individual MCH programs and policies can and do improve the health of individuals served, more needs to be done to address alarming new trends in chronic diseases and disorders, and to reverse longstanding disparities in health and well-being.

1. A thoughtful, integrated set of MCH and federal programs and policy strategies could provide an opportunity to improve health and well-being across the life course and across the population. Life course theory implies we need to go beyond programs and policies which are aimed at individual diseases and disorders in order to promote and optimize health across generations and communities.
2. Life Course Theory suggests the need to consciously build a program and policy “pipeline for healthy development” – a continuum of services and supports that promote optimal health and development from birth throughout the life-span, from one generation to the next.
3. What is needed is the integration of services and supports that are longitudinal (over time), vertical (within the health sector), and horizontal (across health and other sectors).
4. Also needed are programs and policies that address the root causes of disparities in health by helping to reshape the conditions in which people live, work, play, and develop.

Rethinking MCH: The Life Course Model as an Organizing Framework – Political Will

Building political will (i.e., engagement and buy-in) for a life course approach among a broad base of stakeholders. To build political will, at least five groups need to be engaged:

1. MCHB’s and CDC’s staff (and that of HRSA);
2. The broader MCH “family” (i.e., grantees, and partner organizations);
3. Other health and non-health Federal agencies;
4. Non-traditional stakeholders (e.g., the business community, the environmental community, etc.); and
5. Local community stakeholders (e.g., the larger MCH population itself). Building political will require balancing the immediacy and more limited focus of specific legislative mandates with a broader, cross-cutting, and longitudinal life course vision.

Political will doesn’t just happen; it must be nurtured and developed through activities such as preparing and training leaders, engaging communities, social marketing and media campaigns, and professional education.

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1 Concept Paper, U.S. Department of Health and Human Services, Health Resources and Service Administration, Maternal and Child Health Bureau.
Appendix B
Original Advertisements for the Town Hall Meetings

Life Course Town Hall Meeting (CityMatCH, September 2010)
Sometime in 2012, as part of the 75th Anniversary Celebration of Title V, the Maternal and Child Health Bureau will release a new strategic direction document focused on life course, social determinants of health, and health equity. This document promises to offer a path for federal and state agencies to improve maternal and child health using these three important frameworks. For those serving at the local level, it is our time to move beyond theoretical constructs and to act upon the ideas being shared in the field. For the last several years, CityMatCH has been fostering the translation of life course theory into practice in local health agencies. Join us and our state MCH partner, the Association of Maternal and Child Health Programs (AMCHP), for this next step in our work. Discuss with us how life course practice can “trickle up” from local MCH agencies to the state and federal levels. Participate in our Town Hall Meeting as we get down to the roots of action.

Life Course Town Hall Meeting (AMCHP, February 2011)
Join us for a lively, interactive conversation about the life course perspective and MCH programs. This session will feature national experts who are working to integrate the life course perspective across MCH health practice. Interested in learning more about this emerging issue and how you can link it to your work at the national, state or local levels? Participate in this exciting session.
Appendix C
AMCHP Life Course Town Hall Summary Results

What is needed related to “knowledge base”?

• Look to multigenerational studies (New England Family Study, Framingham Study, Nurses Study, Black Women's Health Study, etc.) for existing data, and add life course-themed interviews with living participants to complement the multi-generational data.
• Establish a common outcomes framework (cross disciplinary and agencies), with measures around sentinel events.
• Incorporate new measures into existing data collection tools (NHANES, BRFSS, Department of Education).
• Create a centralized database of life course measures with standardized criteria for use at national, state, and local levels.
• Education at all levels around life course.
• Examine gaps between services.
• Identify missed opportunities and begin addressing these.
• Creating a media campaign to educate the general public around life course.
• Develop multi-modal means of disseminating information and workforce development to better understand and use life course via the web, download hard copies, listen to a talk, etc.
• Fund research and disseminate best practices/evidence-based methods.
• Use and communicate data to do real time tracking that allows for adjusting strategies and programs.
• Develop toolkits/tools to talk with partners in law, business, juvenile justice, policymakers, legislators, families, internal staff, education, faith-based communities, and diverse populations.
• Create mechanisms that allow state and local agencies to use data specific to their locality.
• Identify relevant positive and negative sentinel events, work backwards and forwards to identify risk and protective factors for those events, then translate those factors into traceable measures (a la Nashville, could turn into tool to trigger intervention).
• Develop and implement effective data-sharing agreements.
• Establish common language of life course for communicating with partners and collecting data.
• Adapt existing systems to identify partners and potential shared data around existing life course measures and practices.
• Develop effective data sharing and data linkages that track local, state, federal indicators.
• Include families at all levels - what is important to families? How are they understanding and receiving our information? National orgs can broker an info exchange.
• Improve and integrate diverse science and database systems.
• Create strategies that are scientifically based to drive local action (from longitudinal dimension to cross-sectioned action).
• Apply our proven MCH capacity for systems thinking to embrace the breadth of need.
• Develop relevant, relatable and understandable terms that “Emily’s Mom (CYSHCN)” can understand and use at all levels from the individual up.
• Create a road map outlining the specific details of models that are reshaped or applied to local practice using concrete examples at all levels.

What is needed in regard to “program and policy” strategies?

• Educate consumers about wellness as they have responsibility for the health choices that they make.
• Learn from the community level.
• Harmonize funding across federal, state and local levels.
• Federal: Simplify ability to integrate and create less “silied” streams. Organize horizontally so that there is a longitudinal strategy for funding.
• State/local: Blend funding streams or create one person who works on multiple related programs to connect across life course.
• Foundations: Look to foundations using innovative approaches around life course and move that up to Federal level.
• Identify non-traditional partnerships (and incentivize partnerships) and find mutually beneficial goals and outcomes (at state and community level).
• Put the whole model into a communication strategy with common language to guide work (e.g., use language and concepts in MOUs, goals, and needs assessments in communication across agencies and with partners).
• AMCHP, CityMatCH, and federal partners should fund life course learning collaboratives.
• Develop resource by federal agencies that support life course theory across agencies and outline roles for each agency/partner.
• Flexible grant funding that supports shared funding, collaboration, and outcomes over time (consistent with life course theory)
• Work with nontraditional partners, including businesses to support life course approaches.
• Grant guidance to require cross-departmental/agency approaches to life course theory.
• Categorical funding is a struggle.
• Need to look at the Feds to set the stage for collaboration.
• Start with adolescent health and education sectors coming together and setting the example in communities and states.
• We need a list of measures for life course? What are the indicators we should be using? What does success look like? And for whom?

What is needed regarding “political will”? 

• Decouple from preconception health.
• Need living communities of learners & leaders.
• Need to package this to develop core, strategic, and concise messages for all levels (simplified relevant measures) and measures.
• Need accountability measures, performance measures, and cost benefit analyses.
• Need learning and leadership development (to build infrastructure).
• Need to capture current successes and lessons learned. Who is doing this? What were their challenges? What would they change? What would they recommend to others?
• Need to forge new partnerships with chronic disease and other professional silos to work together on lifespan.
• Need to create a consistent language and message for life course.
• Need to create a return on investment /marketing/ business model that incorporates delayed gratification (even intergenerational).

• Engage the community/consumer. Get the community voice at the table of our programs so we are giving them what they actually need, versus what we think they need.
• Create basic, standard nomenclature to be used.
• Clearly identify stakeholders to be part of the movement and create language we all can cling to, understand.
• Telling stories could be one way to create common language and understanding.
• We need to partner and collaborate across sectors. We cannot do this alone. We need the department of education, department of justice, department of labor, and the department of defense on board and part of this work.
• Begin with a step-by-step approach.

• Need to create strong connection/relationship within HRSA and with other government agencies (e.g. CDC, HHS, etc.) for a shared understanding around life course.
• Need to align monetary resources with life course and MCH.
• Need coordinated, consistent, and comprehensive educational strategies to teach kids early about their health trajectories from well-trained educators, technology applications, and pediatric providers (e.g. text book chapters, curriculums, etc.).
• Use MCH leaders to convene life course theory educational conversations that demonstrate the value of the theory (e.g. Teri Gross interviews with Dr. Michael Lu, Chamber of Commerce lecture series, life course theory language into legislation, YouTube channel, etc).
• “Sell” life course theory by playing off the nation’s social conscience (e.g. identify ways big business can incorporate life course into their operating philosophies similar to Green products).