

FAQ

The Life Course Metrics Project

Q. Why doesn't the indicator set include some mortality indicators used by the MCH community - for example, infant mortality or pregnancy-related death?

A. State teams approached the mortality and injury-related measures with the preference of measuring prevention components of the measures. The two exceptions were for indicators that they felt were indicative of overall community issues (homicide rate and suicide rate) or highlighted a significant mental health issue (suicide rate).

The discussion on including infant mortality centered on whether the indicator added something to the final set that was not already captured. Although team members thought it was a broader marker for community wellbeing and equity, there was not strong support that it added more than some already included components, like preterm birth and small for gestational age. When it came to a vote, there were not sufficient votes from the state teams to support its inclusion.

For pregnancy-related death, the discussion centered on the fact that although every state can calculate a maternal mortality ratio, those with active maternal mortality reviews will likely look worse than those that do not because their case finding is better. Other points that were discussed include:

- Team members felt that the measure was not standardized; there were comments about how the National Center for Health Statistics is not using this measure until every state is using the new death certificate
- Others noted that maternal mortality is nearly always preventable
- For the life course perspective, there is something missing from pregnancy-related death as a measure, because loss of either parent could be detrimental, not just the mother

Ultimately, states voted not to include the indicator.

With regard to unintentional injury prevalence and mortality, the teams did not include indicators in this category. The teams took the approach of focusing on intentional injury in the form of substantiated child maltreatment, intimate partner violence, bullying, suicide and homicide. We are examining whether injury prevention indicators should be added back to the set, but as of now we have not included any new indicators related to injury.

Q. Why doesn't the indicator set include low birthweight? This is a classic measure used widely in the MCH field and literature.

A. State teams originally considered including low birthweight, but ultimately voted not to include it in favor of two other birth outcomes they felt were more closely tied to the life course and that further subdivided low birthweight: preterm birth and small for gestational age.

The discussion included the following points: Low birth weight was considered a good indicator, but the question was if it added something new or different to the set. When talking about

preterm birth versus low birthweight, team members felt that an indicator centered on gestational age would be preferred, particularly in light of CoIIN efforts, the ASTHO Healthy Babies Challenge, the March of Dimes campaigns and efforts, and improved ability to assess gestational age. Team members also debated whether low birthweight was still more reliable than a gestational age-based measure. Others noted that preterm birth is nested within low birthweight, leading the group to consider small and large for gestational age rather than low birthweight. Team members noted that from a policy perspective, small for gestational age can be hard to explain when compared to low birth weight. Ultimately, the group voted to include preterm birth and asked the AMCHP staff to explore adding a small for gestational age indicator in place of low birthweight.

While exploring the addition of small for gestational age, some methodological issues arose. The teams agreed that the ideal methodology would be to use a national standard for small for gestational age that is based on the best estimate of gestational age. However, there is no existing gestational age-based national standard to calculate percentiles; the most common methodologies use a national standard that estimates gestational age using the date of last menstrual period (LMP). To keep this indicator in the final set, as state teams asked, AMCHP staff framed the issue as follows: States that would like to use this indicator should create a standard internal state-based best estimate of gestational age. People who would like to calculate this indicator outside of a state and do cross-state comparisons or generate national estimates should use the existing national LMP-based standard. Partners in national organizations are encouraged to create a new national standard for future use.

Q. The indicator set appears focused on exposure to risk and less so on resiliency measures or community transformation. Why?

A. Although the classic life course perspective includes resiliency factors in addition to risk factors, in practice public health measurement is primarily disease and risk focused. From an epidemiology perspective, tracking disease prevalence and mortality has been the prevailing approach; most standard measures in epidemiology tend to be risk based. Some of this stems from practicality; since most of the population “survives,” tracking survival rates does not make as much sense as mortality rates. Also, true resiliency measures are not necessarily the opposite of risk measures; identifying factors that truly support or counterbalance risks is an area of the life course approach to MCH that still needs work. This gap in the field is reflected in what the team members felt were meaningful gaps in the indicator set.

There are a few examples of resiliency measures in the indicator set, including fourth grade proficiency, voter registration, receipt of immunizations and preventive care, which represent supportive measures for individuals and communities.

Q. Why don't the indicators have companion targets or goals associated with them?

A. From the start of the project, both the National Expert Panel and state team members struggled with the purpose of a set of life course indicators. Ultimately, the participants decided that the intention of putting out a set of life course indicators was NOT to create a new set of

performance measures. To underscore this point, no targets, benchmarks, or goals will be released with the final set.

To aid state-level users with assessment, program planning, monitoring and evaluation, policy development, and engaging partners, AMCHP has provided a national estimate, using the most recent data publicly available, for as many indicators as possible. In addition, more than 30 of the indicators align closely or exactly with Healthy People 2020 (HP 2020) focus areas, and users of the indicators could refer back to the HP 2020 targets if desired. Finally, each indicator narrative includes a list of potential modifiers that can be used to examine the data in different ways to determine what the “best” group looks like and could use this group for target setting.

Q. What are capacity measures, and how are they intended to be applied?

A. The concept of capacity is based on the idea that life course concepts require a level of community and organizational readiness in order to realign public health approaches through a life course lens. This reorientation may require educational efforts to ensure communities and organizations understand what it means to operationalize a life course approach. Capacity indicators examine community or organizational readiness to champion life course approaches and develop cross-and multi-sectoral partnerships to reach collective impact.

There were some challenges in creating capacity indicators. For example, the data and life course criteria used to assess each indicator were not necessarily supportive of indicators for capacity because they are fundamentally different from risks, outcomes, and services. However, both the National Expert Panel and the state team members felt strongly that a set of life course indicators should attempt to assess capacity. At times the state team members struggled with defining the difference between services and capacity indicators because there was some conceptual overlap. Because of the difficulties in teasing out what belonged to each category, the final set of indicators includes both of these types of indicators in a single domain. This is an area of opportunity for more conversation around what it means to have or build capacity for a life course approach within MCH.

Q. Are all of the indicators intended to be measured at a state level? It looks like some are being measured at a local or national level.

A. The priority in terms of considering the data availability for a life course indicator was whether the data were available at the state level. However, some of the indicators, particularly those centered on capacity, have a national-level measurement, which is the percent of states that have the capacity specified; on the state level the indicator is yes/no in terms of whether that capacity element is present at the state level.

Some of the indicators sourced from Census data are framed in terms of household or county. In the narrative for these indicators, the authors provide information about how to calculate these for the state. In some cases, a state-level estimate will really only be informative when compared to estimates generated at the community level, as in the case of the dissimilarity index that indicates the degree of residential segregation. A state-level estimate does not give

an accurate picture of how segregated some communities within the state actually are, but it provides a reasonable reference point for comparison.

Q. There are a lot of indicators in the final set. If programs don't have the capacity to calculate them all, where should they start?

A. When state teams voted on the final set of indicators, they also selected, through a nominal group process, a subset of indicators that we are naming the "Short List." The state teams felt that this set of 13 indicators best captured the breadth and robustness of the final set of 59 indicators, and also served as a communication tool with stakeholders outside of the MCH program. Programs with limited capacity could start with the Short List, available at <http://www.amchp.org/lifecourseindicators>.

The online tool also organizes indicators by Data Source (e.g. BRFSS), and the excel document that can be downloaded from <http://www.amchp.org/lifecourseindicators> allows users to search for similar measures in other indicator sets to maximize use and minimize burden or duplication in calculating the indicators.