This presentation has been prepared to provide some background information on the AMCHP Life Course Metrics Project and answer some frequently asked questions. For more information on the project or the call for public comment, please visit the following websites:


The life course metrics project was launched by AMCHP, with funding from the W.K. Kellogg Foundation, in the Fall of 2011. The project was a culmination of several factors happening around life course over the past few years, including strong interest from the AMCHP membership to have indicators available that could assist state MCH programs in assessing their efforts to take a life course approach to maternal and child health.

Some notable milestones include:

• 2010—Life Course Concept Paper by the MCH Bureau, HRSA (Kotelchuck and Fine)

• 2011—SSDI grant application guidance requested state/territorial programs address life course metrics – “begin to consider approaches for the development of a life course performance metrics that will assist in measuring progress in incorporating life course principles into their systems of care for their targeted MCH populations.”

• 2011—Kellogg Foundation grant funding to support AMCHP’s Life Course Metrics Project through September 2013
Important to note: The purpose of this project was NOT to create new measures for Title V or to force states and communities to use them. These indicators are meant to be a set of tools for needs assessment, program and policy planning, monitoring and evaluation of MCH outcomes, and engaging and educating partners, both within MCH and beyond.
The project began with the engagement of a national expert panel to do some
deep thinking on a framework for proposing a set of life course indicators. The
expert panel was convened in January of 2012 and met monthly via web
facilitated conference calls from January – June.

In June of 2012, the panel met in-person and came up with some final products.
Following the recruitment of state teams to work on indicator proposals, expert
panel members were invited back to facilitate knowledge transfer between the
two phases of the project.
Panel members included:
Wanda Barfield, Christina Bethell, Katherine Bradley, Carol Brady, Paula Braveman, Janet Brown, James Collins, Mike Curtis, Amy Fine, Jessica Foster, Reem Ghandour, Holly Grason, Flojaune Griffin, Neal Halfon, Arden Handler, Cynthia Harding, Maxine Hayes, Alisa Jones, Marilyn Kacica, Milt Kotelchuck, Lorraine Lathen, Cheri Pies (AMCHP contracted facilitator), Bill Sappenfield, Nan Streeter, and Mary Weber

Life Course Metrics National Expert Panel

Who was on the National Expert Panel?
• 25 thought leaders from academia and public health practice

What did they accomplish?
• Definition of ‘Life Course‘ for this project
• Framework to organize indicators
• Screening criteria for life course indicators

AMCHP
How is Life Course defined for this project?

Core principles of a life course approach

A life course approach is based on a theoretical model that takes into consideration the full spectrum of factors that impact an individual’s health, not just at one stage of life (e.g. adolescence), but through all stages of life (e.g. infancy, childhood, adolescence, childbearing age, elderly age).

Life course theory shines light on health and disease patterns – particularly health disparities – across populations and over time. Life course theory also points to broad family, social, economic and environmental factors as underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups.

This is the final working definition that the expert panel agreed upon. Also important to note is that the expert panel preferred to refer to the indicators as measuring or assessing a life course approach to MCH.
How is Life Course defined for this project?

A life course approach encourages a focus on health across the lifetime and includes the following components:

- A stages of life theory that takes into consideration factors that impact an individual’s health and development through all stages of life from preconception health into infancy, and through childhood, adolescence, and childbearing years into older age.
- The influence of family, environmental, biological, economic, behavioral, social and psychological impacts on health outcomes across the lifespan.
- There are critical or sensitive periods of risk that can particularly impact exposures and experiences during particular sensitive developmental periods in early life that may influence health and disease patterns and outcomes later in life.
- The potential cumulative effects of these influences on health outcomes, i.e. that health at any given state of life is a function of experiences at prior stages of life, and you cannot understand adult health without addressing child health.
- Health promotion and prevention interventions can be targeted at different stages in life.
- Connections exist between life stages, i.e., the relationship between adolescence and the two life stages that border it: childhood and adulthood.
- Efforts should be coordinated both across life stages and across the life span.

Part 2 of the working definition, which outlines the components of a life course approach to MCH.
The National Expert Panel developed a framework for organizing life course indicators that could assist states in thinking broadly about proposed indicators and beyond traditional performance measures. The National Expert Panel envisioned indicators spread across the four domains of services, risk, capacity, and outcomes and using language accessible to other disciplines and diverse partners. This organizing framework served as a platform for indicator proposals and initial evaluations of the proposed indicators.
This was the first take on a grid that could be used to propose and organize a set of life course indicators. Of note – there was no single framework that worked for everyone to organize a set of life course indicators; this is presented as one framework that helped move the state teams from ideas to proposing indicators.
State teams were recruited through a competitive Request for Applications. Of 14 state teams that applied, 7 were selected to participate. Bill Sappenfield, of University of South Florida, volunteered to facilitate the state team process from proposals through final indicator selection.
State teams were required to have members from these areas / disciplines to ensure not only that high quality indicators were proposed, but also that they are useful at the state and even community level for both program and policy planning and development. Team co-leadership was shared by a data expert and a program or policy expert.
These are the 7 teams that have been participating in the project since July 2012.
State teams were assigned a domain as described by the National Expert Panel to begin proposing indicators. At the same time, a call went out for public comment for proposed indicators, to ensure the project received input from external stakeholders in addition to the state team participants.
The final element of work that the expert panel began, and the state teams refined, was to establish a set of criteria by which the teams would be able to critically evaluate whether an indicator was truly a life course indicator. The overall set of criteria is broken out into two pieces – Data and Life Course.

The data criteria were heavily relied upon in the first round of screening and voting to reflect the project’s commitment to selecting measures from readily available, high quality data that can be examined at a state level, and ideally at local / community levels as well.
Criteria: Data

1. **Data Availability**: Can the indicator be calculated in state and local public health agencies?

2. **Quality**: Accuracy and reliability including consistency of data quality and reporting across jurisdiction.

3. **Simplicity**: Level of complexity in both calculating and explaining the indicator.

Availability: This includes: 1) whether the data set(s) is(are) available, 2) whether the data set requires data linkage for calculation and the ready availability of the linked data, 3) whether MCH program can readily get access to the data (what is the time frame in which this data is available), and 4) whether the data required is a mandatory module for inclusion or an optional module in the data set.

Quality: This includes things like sensitivity, positive predictive value, percent missing, and any other validation information that is available for the data source and the specific data elements.

Simplicity: This also includes the ease of ability to explain the meaning and the use of the indicator to professionals and the public. The need for simplicity must be maintained in balance with meaningfulness and usefulness as measure by other criteria.
The life course criteria focus on how the indicator interfaces with the life course approach to MCH, and makes the case for why this is not only a good indicator and a good MCH indicator, but also why it is a good life course indicator.
Criteria: Life Course

1. **Implications for equity**: How well the indicator reflects and has implications for equity-related measures such as social, psychosocial, and environmental conditions, poverty, disparities, and racism.

2. **Public health impact**: Impact of a positive change in the indicator due to program or policy interventions.

3. **Ability to leverage resources or realignment**: How well the indicator reflects programs, services, and policies that expand beyond the traditional MCH focus.
In addition to addressing each of these criteria in the final indicator write-ups, authors were also asked to select one or more life stages that the indicator should address to be considered a life course indicator. These life stages are similar to those found in the initial organizing grid, but not identical: Preconception health, Infancy, Adolescence, Childbearing years, Childhood, Other (specify). Teams also had the option to choose “Not applicable” if selecting life stages was not appropriate for the proposed indicator.
The most recently completed portions of the project included the state teams taking the indicators that made it through the first screening process, which was completed in December 2012, and writing up the full discussion of the indicator using the data and life course criteria outlined in the previous slides.

The write-ups were submitted to AMCHP, who then redistributed them to all teams for reading and scoring. The most recent project milestone was the final selection of indicators in an in-person meeting, and the opening of public comment on the final proposed set of indicators.
In total after de-duplication, the 413 proposed indicators were considered by the state teams, who screened, discussed, and voted on a set of 104 to move to the more detailed write-up.

Each team wrote 15-16 indicators. In two cases, indicators were so similar they were collapsed after the write-up phase, and so the state teams considered 102 indicators for the final set.

After the final scoring, discussion, and voting, the teams agreed on a final set of 59 indicators.
In the process of scoring and voting for a final set of indicators, a number of topics came up where the proposed indicator had so many limitations that it was not considered for a final write-up, but the teams felt the topic is so important that it should be maintained and shared. We created a “wish list” to capture items that fell into this category. Some of the limitations included not having adequate data to be measured currently, no ability to generate state level estimates, no ongoing source of data (an example would be a point in time survey with no plans to repeat), and finally, data that were being collected and reported but had limitations with regard to quality.
There have been several challenges to this process along the way to proposing a final set of 59 indicators. For example, the research on life course is still in the early stages, and it is not always called “life course,” and this was challenging when state teams were gathering information to show what evidence there was for a given issue’s impact on trajectories and intergenerational health.

The availability of data at the state and local levels limited what could be considered for a life course indicator – the operating assumption was that when the indicators are released as a final set, they could be used immediately; the wish list reflects some of the areas where data limitations were felt most strongly.

Availability and familiarity with non-traditional MCH data certainly pushed project staff and team participants out of their comfort zones.

The complexity of some of the proposed indicators posed a challenge for the simplicity criteria – a proposed indicator may have truly capture the life course implications for how an economic factor influences health, but if it was so complex to calculate and explain that no one could easily use it, it was not considered to be a “good” life course indicator.

As of now, there is no established schedule for updating the indicator set; however, project staff are working on a companion set of “tools for use” to be released with the final indicator set at the project’s conclusion.
On July 1, AMCHP launched a public comment period for the final set of 59 life course indicators. The public comment period will close on July 31, 2013. Currently available on the AMCHP website are the final indicator set, which includes for each indicator a brief description, formula, and data source, the list of indicators proposed but not included in the final set, and a wish list of indicators developed by the state teams. Members of the public are encouraged the review the documents available and submit their comments via an online survey tool.

Submitted comments will be used to develop and strengthen the narratives (or ‘write-ups’) that will be published in support of each individual indicator in the final set. Comments will also inform the development of tools for use and other ways AMCHP can assist partners in applying and using the indicators.
In addition to publishing a web-based resource of the indicators in September 2013, AMCHP will promote the indicator set widely, including hosting an explanatory webinar and other opportunities for discussion of the indicator set.
Updates and next steps

- Project documents and public comment information available on AMCHP website:

- Contact AMCHP staff:
  - Caroline Stampfel, [cstampfel@amchp.org](mailto:cstampfel@amchp.org)
  - Tegan Callahan, [tcallahan@amchp.org](mailto:tcallahan@amchp.org)
  - Andria Cornell, [acornell@amchp.org](mailto:acornell@amchp.org)