MCHB/DRTE September, 2010 Webcast

Integrating the Life Course Model in MCH Training Programs

September 15, 2010

SUE LIN: Good afternoon, thank you for your patience while we handled our technical difficulties this afternoon. I'll just go over some quick technical information before we get the webcast started of the first of all, Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speakers' presentations, you do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the "Slide delay" control at the top of the messaging window. We recommend you change this setting to 12 seconds, as that seems to work best for most people. We encourage you to ask the speaker(s) questions at anytime during the presentation – simply type your question in the message window on the lower right side of the interface, select "Question for Speaker" from the drop down menu, and hit send. Please include your state or organization in your message so that we know where you are participating from. The questions will be relayed on to the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we will email you afterwards. Again, we encourage you to submit questions at any time during the broadcast.

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LAURA KAVANAGH: Good afternoon and welcome to the "Integrating the Life Course Model in MCH Training Programs" webcast which is sponsored by the MCH Training Program. I'm Laura Kavanagh. The director of the Division of research, training and education at the Maternal and Child Health. Thank you for your patience. I think it's an indication of your interest in the subject area that you've stuck with us through this. There also will be an archive of this available shortly so you can let any colleagues know who weren't able to stay with us during the technical difficulties. We're thrilled to have this esteemed panel of MCS training faculty members with us today. Several have conducted some of the research that has formed the development of Life Course theory and others are beginning to integrate the Life Course into education and training programs. The purpose of this webcast is to begin a dialogue about how we might begin to integrate the Life Course perspective into our MCH education and training programs. Let me provide a little background and context about why we're interested in integrating Life Course perspective into MCH Training. Our existing efforts haven't always been as effective as we had hoped such as disparities in the black/white infant mortality rate. We were looking at new proechs and how we've come to focus on the Life Course approach as the strategic direction. On October 10, 2010 we'll be celebrating the 75th anniversary of title five of the Social Security act. I hope that you'll be joining us for this celebration in Washington, D.C. As background for this meeting on October 20th, Dr. van Dyck, the bureau director asked doctor Milt Kotelchuck and Amy Stein to draft a concept paper to define Life Course theory and outline how MCHB might use it to start a new strategic direction. We'll hear more about the process and the paper from Dr. Kotelchuck. During the same period of time I began to talk about

Life Course as a direction for MCHB with our MCH Training Program and research programs. On the research end, the Maternal and Child Health is investing resources into new initiatives such as adjust-funded Maternal and Child Health resource network contributing to research in this area. From MCH Training groups of training programs such as the nutrition train programs. This webcast as I said earlier continues this dialogue. This afternoon Dr. Kotelchuck will provide an overview of the Life Course framework and the strategic vision. Dr. Stein will reflect on her work with the Institute of Medicine panel, the children's health and the nation's wealth which pointed to a new definition of child health that included a Life Course perspective and following Dr. Stein Dr. Haughton and Karen Edwards will speak. I'll provide introductions of our speakers. I'll do all four now and turn it over to Dr. Kotelchuck. He's visiting professor of pediatrics at Harvard medical school and at the Center for child and adolescent health policy at Massachusetts general hospital. Professor and chair of the Maternal and Child Health departments at the University of North Carolina in Chapel Hill. He has extensionive experience evaluating public health programs to improve birth outcomes and child health status. Next slide, please. His research interests include examination of the adequacy of racial disparities. Maternal morbidity. Child health services, child nutrition and health data policy. His current research interest focused on MCH Life Course model and the creation and utilization of the Massachusetts pregnancy to early life longitudinal data system and serves ot numerous national committees. Dr. Ruth Stein is a pediatrician for works in research and advocacy for children with chronic health conditions. She's at Children's Hospital. Her work has involved the development of a number of measures widely used in the assessment of outcomes for

children with disabilities and their families. She has over 150 publications and has edited two books relating to pediatric chronic illness. And healthcare for children. She serves on several boards and committees including the executive committees of the American p academy of pediatrics and the board of children, youth and families of the national academies of science and institutes of medicine. Next slide, please. Dr. Betsy Haughton is a professor in the Department of nutrition in the Knoxville where she's director of the MCH Training grant. Her special interests are public health nutrition practice including the public health nutrition workforce infrastructure, and collaborations with communities. She completed her doctor at Columbia university. Bachelors of science in food and nutrition at Douglas college. Dr. Karen Edwards has been a LEND program director eight years. She's director of training in the Division of developmental and behavioral pediatrics at the Cincinnati Medical Center and University of Cincinnati. She's been project director for a distance learning grant. A member of the board of directors of the association of university centers on disabilities. I'll turn it over to Dr. Milt Kotelchuck will who get us started.

MILT KOTELCHUCK: Thank you very much for inviting me. I just want to start by talking about the new strategic planning initiative of MCHB which Laura mentioned will be kicked off a new five-year strategic planning effort will be kicked off at the 75th anniversary Title V meeting. It will serve as a framework for the network and in case anyone is worried it's an inclusive process. You won't receive a document saying this is what the bureau is doing, this is a process that we're going to start then and everybody will be invited to participate. Because Life Course is an evolving model, we

need everybody's participation. This webinar is part of that larger strategic initiative and to engage the training programs. Next slide. Why do we need a new strategic approach? As Laura quickly said and others will, we're not doing as well as we ought to be doing m this country. Disparities exist. Key outcome measures are level. We're not as good as our European and east Asian countries in terms of child and infant health. When I look at things I think that sort of there are kind of clinical and public health approaches which really emphasize access to care, quality of health services, changing individuals' behaviors, working on very specific conditions. These types of things are all good but in a way they're out of balance in some sense with some of the deeper social, environmental root causes of some of the problems that we see in our health situations. There is a tremendous amount of new knowledge and Life Course as this really is, I think, the best science we have and you can really see that both in the perinatal area. Chronic illness and other areas are starting to come together with a new common kind of Life Course research approach. And Frankly, there is new political and programmatic students the change in presidency that has allowed movement for the first time in several years in the child health area. New initiatives being develop and new opportunities and new healthcare legislation that offers an opportunity. Frankly, it allows for reassertion of the children's bureau's Title V kind of legislative mandate. Finally last, but not least the old strategic plan is done. It's time to move on to new activities. Next slide. I want to particularly praise Dr. Peter van Dyck. He's really made a tremendous commitment to using the MCH Life Course theory as a strategic planning framework. Held multiple bureau and senior leadership meetings. State needs assessment conferences. Work groups trying to begin -- he's

trying to get this process going. Getting people to think about it. It just isn't something you say today we're doing this, tomorrow we do this. We have to all develop and work together as we're doing in today's things. As Laura said Amy Stein and I are writing a concept paper. I can't give you all the details in the talk but I'll give you a few highlights of it. And the bureau itself is already just not even waiting until we've moved into this era to start some new Life Course initiatives that Laura mentioned. The Life Course research network, a new web that they're developing, introducing new Life Course measures. Some of their research, etc. Next slide. I'm not quite sure how to best describe Life Course development. I want to do that for the next three or four slides. Really, I use Neil's definition, Life Course development provides a framework to understand how multiple determinants of health interact across the life span and across generations to produce health outcomes. Next slide. In reality, I think that what's motivating a Life Course movement are really two different streams that have kind of come together. One is the optimization goal. Not just everybody to do okay, but to actually thrive at the highest possible level. The second is to eliminate health disparities across populations and communities. Those two are really the core goals of the Life Course model. Next slide. I usually use this slide at the end of my talk to summarize things on the Life Course model but really the Life Course model in the end posits a new paradigm for the MCH field. It helps understand the source of disparities in birth outcomes by focusing not at the treatment during the pregnancy but what women bring into the pregnancy. It requires new longitudinal and holistic approaches to MCH programs, policies and research. It provides an integrated framework facilitating policy agenda and most interestingly it links the MCH community to adult

and elderly health and social service policy development. Next slide. I love this quote that I stole from Laura, actually. Written by a person similar to Laura over 50 years ago. I'll just read it. You can read it yourselves. MCH does not raise children, it raises adults. All of tomorrow's productive, mature citizens are located somewhere along the MCH continuum. At some point in their creation either being conceived, born or nurtured for years to come. There is very little genuine perception that mature people come from small beginnings. That they've had a perilous -- everybody at every age were at one time children and they bring to their mature tea and old age the strengths and scars of an entire lifetime. Next slide. Amy and I in trying to pull the essence of Life Course there is no single document that there is Life Course theory. There is a series of paper and we tried to pull together the central ideas in a way people could understand. This was our best reduction of our four key concepts. Today's experiences and exposures determine tomorrow's health. Health trajectories are particularly affected during critical or sensitive periods. The broader environment, biological, physical and social, place if you will. Strongly effect the capacity to be healthy. Inequity in health reflects more than genetics and personal choice. Next slide. If that wasn't clear enough we've reduced it to four ideas which go along with that time line. Timing, environment and equity and in the paper we write we actually elaborate in some length about them and their implications for strategic planning. Next slide, please. I added a few more points on the MCH Life Course that we didn't think were completely captured by those, but one that I want to emphasize a few of these for today. The social determinants or health equity models are complimentary. Life Course adds a temporal dimension not so noticeable in the other models but ultimately

they're really complimentary and synergistic. There are people who don't like this model and feel like it's too determinative. I just want to point out to people that we see this not as a static, fixed thing but as an interactive. This is an interactive exchange between a person and their environment. And finally, that really Life Course develops over the entire life span and that this is -- that, you know, all phases of life have to be valued equally, not just that childhood is the most important time but whenever you live is the most important time. Anyway, to continue. In -- next slide. In developing ideas about how to think about Life Course, as I noted, it's an evolving -- still evolving and the conference that serve ral of us organized, myself, Michael and others in 2008, we said we needed to work in five areas that needed to be addressed. This webinar is helping us think about education and training. Next slide, please. This was the slide from that and it just sort of laid out very quickly the kinds of things that we needed to do to get people involved in the development of educational activities. We need to engage students, staff and community groups if this was to an academic audience only but we have to engage our staff and community groups and develop faculty, create a pedagogy. You have to make a time and place for this. It doesn't just happen in five minutes. This is a real process, a reorientation of our thinking. Both for our long-term trainees, our short-term, medium-term and continuing education and staff folks. We need to link our training to on going research. Our practice is the leading -- some of the leading activities of the day. We have to meet the needs of agencies who need future and current staff with Life Course model skills and knowledge and we need to meet the needs of communities and our political supporters who want professionals who are trained and who think in this kind of a model. Next slide, please. Did I skip a

slide here? Sorry about that, folks. Sorry. To jump back to slide -- I hope I don't screw this up for you folks. Developing an agenda for change. We try to suggest in our paper what the bureau has to do that's three dimensions it has to really work on to implement a new strategic effort. These are strengthening, Life Course knowledge base and enhancing the Life Course programs and policy strategies and enhancing political will for its implementation and ultimately we have to provide training for MCH professionals in all three of those areas to be the participants and leaders in the development and implementation of the MCH Life Course. If you'll skip the next slide and you come to the next to the last slide, MCH Life Course and training needs. It's not a fast process. It will involve -- it asks us to have new skills and new knowledge. Skills like longitudinal analysis, multi-level analyses, more experience with policy, with collaboration, working in partnerships, advocacy. It also says to strengthen some of the areas we already do well, emphasis on prevention, systems development but there are no skills and certainly new knowledge to be taught in our training programs and we need to think about maybe new pedagogy methods to help people really appreciate the Life Course and what it does to people's health at times. We need new integration, which is to say the essence of the MCH Life Course is that we all are in this together. That there shouldn't be 13 separate training programs. Or whatever number we have at this moment. We need to integrate across all the training programs as we're doing in today's thing and we need new leaders. People who really appreciate the Life Course and have enthusiasm for it and can provide meaning to how to lead us into the future. So next slide. Our challenge is really ultimately to transform this new MCH Life Course theory, research and practice and enhance effective training programs to

prepare the future leaders of the MCH. My colleagues who will now talk about some of the specifics I would like to introduce Ruth Stein who will talk next. Thank you.

RUTH STEIN: Thank you, Milt. As Laura already mentioned, I participated as co-chair of a committee of the Institute of Medicine and national research counsel of the national academies in a study that looked at the definition of child health and tried to incorporate many of the thoughtful pieces of science that have been previously summarized in neurons to neighborhood which many of you are familiar with and came up with a report that I'll talk about briefly today, children's health, the nation's wealth. Next slide, please. You see the cover of this book which you may have seen before. And beyond that if we could go to the next slide, we'll see the definition of child health as we conceived of it. We discussed the fact that child health was defined as the extent to which individual children or groups of children are able or unable to develop and realize their potential, satisfy their needs and develop capacities that allow them to interact successfully with their biological, physical and social environments. As Milt has already mentioned, one of the things that is very much a part of the Life Course perspective is time and I think this definition in many ways is a dynamic one that moves through time. As it builds on the work of the World Health Organization and the conference definitions but it includes a couple very important new ideas. One is the view of health as a positive construct going beyond minimal health as a notion that you just don't have a disease. And it emphasizes development during childhood and its implications for long term outcomes. And implies an interaction between the developing child and his or her environment and it acknowledges that multiple

influences interact over time. If we could have the slide with the HP to 10 model, I think I may have forgotten to say please change the slide. Many of you are familiar with Healthy People 2010 model and with the model of how health occurs and it had a few central domains, behavior, social environment, biology and physical environment. And it also looked at policies and interventions and access to quality and health. We didn't want to disregard this important work but as we considered it -- next slide, please -- there were some very important things that we needed to think more dynamically about. One is the issue of risks and protective factors and we felt very strongly that risk and protective factors were somehow misleading terms because many things we know are both risks and protective factors. For example, whether a child has a family. It can be a risk factor or a protective factor how that family functions. So we preferred throughout the report to call those influences. In addition, we talked about the importance of transactional and interactive processes and next slide, please. We summarized the literature on risk factors and protective factors in six domains that are shown here. You'll recognize that biology, behavior, social environment and physical environment were part of the Healthy People 2010 model but we also incorporated notions of policies and services which are a little bit different from what we've said in the Healthy People 2010 model. We believe that all policies and all services may directly or indirectly affect health outcomes for children and ultimately for adults as well. This is because many, if not most services and policies do affect health even when they're directly not intended to do that. For example, policies that govern the built-in environment, a component of the physical environment may increase or limit the risk of injury and those that influences mining, traffic, taxes have direct and indirect

effects on children's health. A similar case can be made for the community that directly or indirectly affect children. This diagram is a representation of what things are like at one point in time and each circle consists of many sub domains that together form even more complex patterns of interaction and may have different levels of sailiency at different times of life. For example, it's generally thought that a family is a primary social environment of infants in a way that's quite different from its role with adolescents who, while still influenced by their family, may also be more involved with peers and community. All these influences affect child health in a transactional and interactive matter and are mediated or moderated by other influences in complex ways that are only now being understood. The influences overlap so the sum is not the result of all influences, but a result of their interactions and of how they affect one another and overall health. However, if we could go to the next slide, while child health is usually measured cross sectionally, that is not how it actually operates. Because the influences change over time. And you see on this particular diagram on one acts as time and on the other development. Health results from a dynamic interaction of these different factors in a model that is best represented as a kaleidoscope, which each turn, the patterns change altering health and incorporating previous patterns and elements, including the child's former health and it affects health into adulthood. Influences change in their relative importance during different stages of development and across time. Thus the relative size of each circle and its subcomponents within and their relative sail yens is dynamic. As in a kaleidoscope, however, the result is not random but determined by the previous pattern or setting and how much change is produced by the next alteration. So, too, the specific influences and combination of

influences on children's health change and interact over time and through development in a way that can be predicted if the prior state is understood. At some stages, these turns are rapid representing substantial developmental change and at other times less so. And each turn incorporates the previous elements and casts them in a new light affecting child's current and future health. And as Milt mentioned there also may be critical and sensitive periods where particular things are likely to have a very strong effect on future. So these implications are that the turns actually or the development and time changed pattern incorporate previous elements have critical and sensitive periods and overlap. So how do we apply this in developmental and behavioral pediatrics? Because it's very much a part of everything that we really do. We incorporate this model when we take a history of a child's behavior problems. We look at how different factors in the past may have influenced the child's health and development. In addition, while we can't study the whole model at any one point in time, all of the research questions of the fellows who have to do a substantial piece of research during the three years of training are definitely guided by this model. And in addition, it's a foundation for much of our advocacy work and very much a part of our teaching framework and I believe my colleagues will elaborate a little bit further. Some examples of how it's involved in each of these aspects of their own training program so I would like to introduce Dr. Betsy Haughton. Thank you very much.

KAREN EDWARDS: Thank you, Dr. Stein. And I would like to talk with you a little bit about how the MCH nutrition leadership education and training programs have begun to ex -- explore how we can use the Life Course model in our program. I'll focus on

the nutrition project's experiences I hope it will stimulate thinking across our projects. Next slide, please. What I'll do is first describe how we began to learn about the Life Course perspective social determinants of health and health equity models and then give some examples of ways we've identified to incorporate them in our work. It's important, however, to understand a little bit about what the training -- nutrition training programs are like. Next slide. There are six projects and while all have clinical and public health approaches, some are more clinically focused and others are more public health focused. All target obesity collection and treatment and cover the maternal, pediatric, adolescent populations and the families and communities in which they live. Some of the projects primarily offer short and medium term professional training and others offer primarily long-term degree based training. While we're a unidisciplinary set of projects our work includes collaborations to promote healthy weight by impacting not only behaviors but also the environments and policies that impact those behaviors. And finally, it's important to know that we began trying to understand about the models and their implications for training at the same time that MCHB itself was exploring them independently and prior to the evolution of what Dr. Kotelchuck has just presented as the MCH Life Course model. Then our overriding question that we asked was how can we use these models in both graduate and professional training? So we engaged in a staged process that included formative evaluation using a series of conference calls and email exchange and then process an outcome evaluations through a face-to-face meeting of the training program. Next slide, please. The primary focus of our formative evaluation was to design a process for how participants attending a one-day meeting could walk away from that meeting knowing what the three models are and

also how they could be incorporated in their work. The planning committee completed a literature review on the three models which resulted in a list of foundation readings and a summary table to be reviewed prior to the face-to-face meeting. Next slide. Here is the format of that summary table. It includes columns for each of the three models and rows for what each theory in and as Dr. Kotelchuck presented a moment ago, its implications for research, practice, policy and training and education and then also how the models overlap and are complimentary. This table provided us a succinct way to compare and contrast the models and their implications. For example, longitudinal measures and methods for economic analysis are often used for public health research grounded in social determinants of health. Policy approaches grounded in health equity emphasize social justice and human rights while those based on a Life Course perspective emphasize interventions during critical and sensitive time periods and as Dr. Stein just presented it's important that we think about how all of these compliment and are synergistic. The foundation readings and comparisons enabled by this table gave us all a common understanding and the background to begin to think about how to use the models in our work. But the specific examples about how to do this were identified at the face-to-face meeting held later that year. Next slide, please. At that meeting Dr. Kotelchuck gave a presentation on the three models and their implications for MCH and we broke into three groups of training program faculty, trainees, MCHB staff and other stakeholders to discuss how to incorporate the models in our projects. In university courses, in the curricula of degree-based training programs, in short and medium-term training and across our emphasis in clinical and public health nutrition. The results of the facilitated discussion

were recorded and analyzed qualitatively so we had a way to organize our thoughts into a meaningful framework. Next slide, please. Here is the first of two slides that I'll show you to demonstrate the four broad categories of ways we identified to incorporate the models and training. The first category is internal to the training programs and addresses practical experiences, course work and materials development along others. One example of how to do this is interdisciplinary community field practices experiences. Where trainees engage with community advocates, teachers, family, faith-based leaders, police and grocers to develop strategies for improving access to healthy foods and safe places to be physically active. Other examples are specifically including the three models in both graduate and undergraduate courses and also emphasizing cultural competence and its relationship to access to healthcare services. An analytical example is exploring how race, ethnicity, income and education impact eating behaviors and physical activity. There was a clear call for case studies that provide the opportunity for case studies and draw on the MCH Life Course model. The second broad category is how we, the training projects, can incorporate the model in our collaborations with other, including other healthcare providers, other training grants, state Title V programs and the media. One example here is incorporating nutrition case studies into other disciplines training such as primary care providers and adding the Life Course perspective in nutritional and professional training. Collaborations with advertising experts can target messages to time periods and tailored to priorities to impact social norms. Training grants can collaborate also by building on the different expertise of each other to promote faculty development, develop new research skills and deliver continuing education programs that integrate

the model. Next slide, please. The third broad category is how other agencies and groups can incorporate the models in their work. Specific ways identified for MCHB are to update the MCH time line history to include the Life Course model and to identify the models and grant guidance and performance measures and remember, we did this prior to MCHB identifying the MCH Life Course model for its strategic plan so I'm very confident that they are going to include those guidance and performance measures. Throughout the discussions, interdisciplinary collaborations and collaborations with parents, families and community stakeholders were emphasized. Examples here are community participatory research strategies that include community members as research partners, collaborations with other disciplines to develop parenting skills around obesity and child nutrition and partnering with organization such as AARP what their members need to know now about how to raise your grandchildren. The last broad category concerned the challenges of incorporating these models in our work. One challenge is the need for outcomes-based research to support theories and policies. Another is the uncertainty about how incorporation of these models is different and yet it's the same as what we were doing already. Still another concern is how to revise courses and curricula to accommodate the development of new skills such as the use of longitudinal datasets. What do you drop and how much can you add? I'd say that we learned a lot through this process particularly with regard to thinking about how the models are complimentary and synergistic. While some of this may not be new, being deliberative and including aspects of all the models really may be new. One key take home message is that faculty development is a need, which we began to address in our work and clearly MCHB is addressing through this webinar

and its other efforts. Internal to our programs, course work, field practice, development of new materials and continuing education and technical assistance are all areas in which the MCH Life Course model can be incorporated. However, we also can include it in how we collaborate with others in research and practice and advocate for prevention programs and policies that will really indeed impact the Life Course. Finally, the MCH Life Course model has implications for new research methodologies and evidence-based practice related to the Life Course. So on that note I'll close with a thanks to MCHB, staff, and other stakeholders who participated in this process from the planning phase to the face-to-face meeting in Alexandria. You have a picture of the group. We're continuing to collaborate and learning from each other in the field and other training grants. Thank you, I'm now going the pass the webinar on to Dr. Karen Edwards for her perspective on how to incorporate the models.

BETSY HAUGHTON: Thank you very much. I'm going to be addressing some of the practical aspects of incorporating Life Course theory, social determinants of health and health equity into the curriculum of MCH Training programs and I'll use the term Life Course with the abbreviation to refer to these concepts. Leaders and faculty have been hearing about Life Course and its place in our training program and I think we may have initially responded something like I've outlined on the slide. The first response might be our curriculum schedule is so full, where are we going to put this? And also everybody wants to know more and more about what exactly is Life Course? And then when we learn more about what it is we say well, oh, of course, this is really important and we already include some of it, quite a bit of it, in our training curriculum

because we think it's so important. And the associated value seems very familiar to us. And then the next step I think is that we start to think about how Life Course relates to MCH leadership development training and to our own particular training programs. So for instance nutrition, public health, adolescent health and we might also begin to think about who among our faculty are the experts who are going to teach this? So on the next few slides I'll provide some ways of framing up and thinking about Life Course as it relates to our own training programs. Next slide. All right, so how does Life Course relate to what we do in MCH Training? I created this slide by jux to posing the leadership that provide the curriculum on the right to -- I created these using the text of several recent publications concerning social determinants of health and Life Course perspective and if you have haven't used it, what it does, it creates a cloud of words from any text that you enter and in the resulting cloud, the size of the word is proportional to the frequency with which it is used in the text. So the word clouds give a visual impression of what is involved in each construct or theory and the relative prominence of each concept or term. Now, if you're familiar with the detailed objectives that are provided for each of the MCH leadership competencies you can see from examining the word clouds that there is a fair amount of crosswalking between Life Course and the MCH leadership competencies objectives. So to illustrate some of that compatibility I've marked a few of the MCH leadership competencies with purple arrows and the next slide we'll examine in a little more detail some of that crosswalking. If we start on this slide by examining the actual objectives that are included within leadership competencies three, which concerns ethics and professionalism. We know here highlighted in red that a lot of the language is really

directly related to terms that we saw in two of the word clouds. So for instance a discussion of justice, ethical implications of health disparities, culture and values of community in the development of policy, programs and practices that may affect them and then ethical implications of health disparities and strategies to address them. Next slide. Here similarly for MCH leadership competency 7, cultural competency we see cultural, socio-economic factors affecting access to services. And prevention, adherence and outcomes. Quite a bit of overlap or crosswalking. Next slide. For competency 11 working with communities and systems, language concerning collaboration, in communities, among organizations, identifying community stakeholders and their extent of engagement and collaboration. Next slide. Finally, looking at MCH leadership competency 12 policy and advocacy noting public policy processes, policies affecting MCH population groups, needs and impacts of current policy on MCH population group and including economic, political and social trends that effect MCH populations. Next slide. So we can see how just this quick sampling of objectives from the leadership competencies relate directly to Life Course. And next I would like to consider specific steps that individual programs can take through curriculum review to strengthen incorporation of these elements in curriculum and training experiences. So first step in planning might be providing faculty with the opportunity to learn more about Life Course and its specific elements and to review their own programs' curriculum to make plans for increasing the focus on Life Course. I believe that familiarity with Life Course theory and social determinants is pretty variable within a cross program. Most faculty and MCH programs are familiar with some of the elements and then others, many others, are quite knowledgeable and

even very passionate and devoted a lot of their life's work to many of these issues. So I think it's worthwhile to provide a structured opportunity for training faculty to develop sort of a shared vocabulary and a common understanding of key elements of Life Course and really to have an opportunity to review some of the evidence from recent publications and I've included a link where some of these can be found. I think this can easily take the form of faculty development workshops, curriculum committee meeting or a meeting of the training program faculty. By reviewing together the training program's current curriculum they're able to identify where Life Course is already incorporated and other opportunities to bring it in. And at the same time start to think about what are appropriate instructional methods. I think a previous speaker mentioned active learning, problem solving and experiential learning as ways to incorporate this. Next slide. Some of the very practical suggestions about how programs can use -- that programs can use to incorporate Life Course. For instance, it may well be valuable to provide a foundational session for training that includes an overview of key elements and how they're related to leadership development appeared to the particular training programs be it adolescent health, public health, nutrition, set ra. I think it's important for faculty to note where elements already exist in a curriculum. Here is another example on how social factors are impacting the social well-being of children. I think in very succinct, brief ways, considering of social determinants and illustration of health disparities can be incorporated into important existing offerings. For instance, when we discuss with trainees incidence of certain conditions or findings we should discuss how the incident, the serve -- trainees should examine whether diverse subjects were included and if not how that might limit the results. When

discussing etiology we can include consideration of social determinants such as when we're discussing obesity, for instance. We need to make sure to note the likely and unsafe neighborhood on the inability to exercise and the impact of supermarkets on the ability to buy and eat healthy food. Next slide. When doing case-based discussions, either actual cases or when building paper cases, we should be building in elements that require attention to social determinants. So for instance here is a case we use in a situation where a parent has stopped giving two medications prescribed by a previous MD for ADHD we might prompt the students to think about what are the possible reasons why a parent may have discontinued the medication and it could have been an adverse effect of the medication but perhaps it was a linguistic mismatch or issue of literacy level. Maybe a trusted family member has given advice against using the medication. Maybe there is a health belief mismatch, a financial issue or a parent who is so busy they have trouble getting to the pharmacy or can't find transportation to get to the pharmacy. So it's -- we can build these things in and have trainees discover them with our help. Next slide. Other examples abound when doing journal quotes we can choose articles that consider social determinants of health or discuss disparities. When we're training for cultural competency we should have trainees self-assess to consider difficult questions such as whether racial bias on the part of providers contributes to health disparities. Next slide. Many training programs encourage trainees to join professional organizations in their own disciplines and within these organizations trainees can often find special interest groups in policy and advocacy for MCH issues and we should encourage trainees to join them. Programs incorporate opportunities for trainees to learn about the big picture or

population health, whatever we call it. An important perspective for all leaders to have and this, for instance, might include, as we've done in our program, assignments and exercises that make extensive use of the data available from the national survey of children's health and the national survey of children with special healthcare needs, including looking at on that website how various groups have used that data strategically in an advocacy mode or policy application and actually have trainees review the many high-quality articles based on data from those surveys. Next slide. When we design family mentoring experiences and experiences with community-based organizations we should build in considerations of social determinants of health and actually provide examples of interview prompts for those kinds of questions. Next slide. In clinical supervision, we should have the expectation with trainees that they will attend to social determinants of health and for instance the social context review systems which I've used this training medical students, this was by -- this prompts medical students to include discussions about a patient's explanatory model for their situation. Patients sense of control over their environment. Social stresses and supports. Literacy level and changes in environment paying attention to immigration among others. As supervisors we should be role modeling attention to social determinants of health. For instance we can make sure to focus on attention to linguistic differences in assuring skillful translation. Next slide. When we mentor trainees in research we can call attention to recruitment and inclusion of diverse subjects and make sure to include community participation, including in the needs assessment and the design and dissemination of results. We can encourage trainees to embark on projects that include secondary analysis of datasets that include attention

to social determinants. Next slide. So in summary we should provide structured opportunities for training program faculty to learn more about Life Course theory, social determinants of health and health equity and to discuss parallels with leadership competencies. We can engage in curriculum review and faculty development and increase awareness of where Life Course is already being addressed and where it can be further incorporated into curriculum and experiences. I've provided a few examples of how Life Course can be built into training programs. I'm sure many of you could have provided many other examples but this gives a little snapshot and thank you for your attention.

LAURA KAVANAGH: Thank you so much, Dr. Edwards. I want to encourage participants to submit any questions. We have a few in the pipeline that I'll start but I encourage you to type into the text box any additional questions that you have for any of the speakers. If they are directed to a particular presenter, please let us know who you would like to address them to. I'll start off with one question that we've received. This is directed to Dr. Haughton. Given the work in collaboration of the nutrition training programs, would you recommend that other training networks go through a similar thought process of incorporating Life Course framework into their work?

>>I could answer that from a couple perspectives. We're a very close knit group and what it allowed us to do was to think about working with each other in new ways. And so I thought it was very, very helpful when we're thinking about how the different projects might have strengths in some areas and learning from each other. So that

perspective was extremely helpful. I think the other part of the process that was helpful was that -- I think it's something that Dr. Edwards really introduced is that some of us might feel comfortable in some of the models more so than others and what it allowed us to do is to say we're in this all together and how do we go about doing it? It gave us, from the approach we took, my impression it gave us an analytical framework by doing it by first identifying some things that were important coming up with a way to compare the models. Discussing how they were the same and different and then beginning to think about -- which we're continuing to do, very specific examples.

LAURA KAVANAGH: Thank you very much. I didn't mean to cut you off. Were you continuing?

>>No. I'm done.

LAURA KAVANAGH: This is a question to Dr. Kotelchuck. What evidence exists that demonstrates the advantages of this model over other models?

MILT KOTELCHUCK: Over other models? Well, I will be honest. You know, this is a theory and I would say that the science behind it, as Dr. Stein said, in a series of different publications it's unclear what the other model is. We have what we're doing now and what we're doing now isn't working as well as it could so is there evidence? I would say that there is a growing body of scientific evidence about the nature of Life Course and the impact of early experience, experiences on subsequent health as Dr.

Stein eloquently described. The challenge actually is not whether this science is better than another science. I think our challenge as as field is development programs and policies. Those are the hardest of our activities. When we're able to try out new kinds of programs, new ways of bringing -- I often talk in other talks about thinking about programs that have to do with horizontal, vertical, longitudinal integration. Think about how we can integrate our programs. It was a word in one of my slides that said we are one. We're single human beings and how do all these different developments in the world that all impact on us as individuals and our communities, how do we develop interventions that allow for change in such a complex world? That set of programs and policies, that becomes the basis for our science of whether it is true, is it really true that a Life Course model will actually make the difference that many of us hypothesis and that we can look at from our research suggesting this is the way things work? It's a complex answer. That's why I also believe, as we are going to suggest in our paper, that we need to continue developing the knowledge base. We have a good knowledge base, possibly the best science going, but it's not sufficient. And it is certainly not sufficiently tied into actual programs and practices. If those work, then if we can make a difference in the world through our programs and policies, then this model really works.

RUTH STEIN: This is Ruth. I wonder if I could add something to Milt's very eloquent answer. I think that the other real issue for me is that many times, because we haven't looked at the models in this very dynamic way, what we find is research findings that seem to contradict one another. But often it's because we haven't taken into

consideration some of the other factors that are affecting what is going on. And I think this broadens our horizon of what might be going on and sometimes that we may be finding different things in different studies because we're studying slightly different pieces of the puzzle.

LAURA KAVANAGH: Thank you. Ruth, can I give you another question from another person? Why do MCH Life Course concepts not include safety net programs?

LAURA KAVANAGH:I think they do. I think that safety net programs would be considered in our model to be services. And they very much are included. You know, all those kinds of things are definitely included.

MILT KOTELCHUCK: Can I add something to that? I think one of the reasons -- I wrote that in one of my slides, too, it is not a safety net that are proven. One easy way of visualizing Life Course is you draw a line that shows the life span and then you have arrows, the protective factors and the risk factors and it's a series of arrows. And that for some people give the illusion that they're holding up that line. And I just think we wanted to say the Life Course model is not just four programs, one program for infants, one program for children, safety net programs are very important. I'm a strong advocate of them but they aren't sufficient to be able to understand Life Course models. That is not a sufficient -- just developing programs that just keep people, you know, alive, this isn't meant to be an optimization program to optimize people's health. It's more than safety net programs. It includes them but it is more than that.

LAURA KAVANAGH: Thank you. This question I'm going to pose to all of the participants, anyone feel free to answer. The Life Course approach in other models reflect theory and practice central to a public health perspective. Do you have any suggestions for making this content engaging and relevant to faculty representing other disciplines? Anyone is welcome to take a crack.

BETSY HAUGHTON: This is Betsy. I think this is what the question is addressing but I'm going to give an example. Perhaps that would fit for Baylor College of Medicine which is very focused on the neonatal nutrition. A lot of what brings infants into that setting is impacted by multiple things that preceded it and at the same time those same infants go out and live in the community and they live in families where they may have different priorities and needs but some of the influences on them are the same as other children as well. So from my perspective, it is bridging that, which from a very clinical program and then thinking about okay, what happens to the infants when they leave the neonatal intensive care unit? What happens to them as they progress across their Life Course?

LAURA KAVANAGH: Thank you.

MILT KOTELCHUCK: This is Milt. I actually think this is a really very important question as I've gone out and my other colleagues have gone out talking about Life Course. It does come out sounding -- I'm a public health person so we emphasize the

public health aspects of this and I think some of the clinicians who hear us feel like we're not acknowledging and honoring their efforts in the same manner because we're emphasizing things that go beyond clinical practice often in our conversation. But I think the issue is not clinical or public health but how they interact and I think that one of the kinds of -- an example of something that might be a program or practice under a Life Course model might be having in a given region a call-in center to help physicians refer. They can't do -- they can't meet every need of the families that come to them when they take the social determinants but they have to link them to other -- to other professions and fields that they have to work with. MCHB and others could set up networks in which -- that provide services to clinicians to help them engage their clients with other social -- other service sectors that are in the community. We have to think a lot about things that are right on the cusp of what where clinical and public health overlap. That would be an important thing. My colleague gave a great example from neonatal but the point is to have these be synergistic. We have to think within clinical care. What can we do within clinical care to support a Life Course model? Do we have good handoffs from one age group to the next? Do we have good ability to link from our clinical practice to the larger social service? How can we make sure that we're not just sending our kids out back into kind of poverty and homes that have broken windows and various infections so they're coming back with the same condition? We cure their current health problem but we're really sending them back and they'll come back. That interaction is sort of what we need to think about in Life Course. Each clinical field needs to think how can it work in this area and it needs to

think how it can link to the other fields. It is not public health or clinical care but how we are going to all collectively work to ensure the health of the individual child.

RUTH STEIN: This is Ruth if I could add something. I'm a little missed by this question because it seems so intuitively obvious to me that clinical practice at least in pediatrics is very much already aligned with the kinds of things that this model is suggesting and that there has already been recognition on a very large scale of the need to take these other elements as givens in the care of patients and you see in clinical care and the emergency room where people are very often concerned with the kinds of things that Milt just mentioned in terms of making sure that whatever broad the child into the emergency room is not a recuring risk. You see that in the way we take histories in pediatrics and in the notion that the whole pediatric establishment has I think been sort of signing onto, which is that we need to take care of the mothers as well as the child. And that if a mother has maternal depression, it has an effect on the child. And many, many other areas where this is just a given part of our practice.

LAURA KAVANAGH: Thank you very much. This question actually is for me and all speakers. Might there be synergy or advantage for the MCH Training community to work across all of our disciplines in developing teaching materials that can be shared? And I would say there absolutely that would be something that we would encourage from the bureau, but how can we support those sorts of efforts? That would be my question to the speakers.

>> Well, go ahead.

BETSY HAUGHTON:This is Betsy again. That was actually one of the things in terms of collaboration with others. It was not only talking about collaboration within the nutrition training gants but collaboration with other of the leadership education and training grants and I think one way to do that is that there are some common issues that cross all of the programs, whether it has to do with parenting and how you deal in different situations with that and its impact on child health status or whether it has to do with healthy lifestyles such as eating and physical activity and having safe environments. So I think it makes a lot of sense for there to be cross collaboration across the different training grants.

KAREN EDWARDS: This is Karen. I think one of the common elements across training programs is looking at what sorts of instructional methodology can best address some of these training needs and so, you know, that I think is something that's cross cutting that is not necessarily discipline-specific nor training program specific, but more thinking about the kinds of instructional methodologies. I think, Betsy, you mentioned case-based discussions. And case-based problem solving and these are, you know, models and types of materials and strategies that certainly could be developed in a cross-disciplinary and cross-program manner.

>> I guess I could give an example. There are the leadership modules developed at Georgetown that can be used for multiple programs and it would seem -- a cross-

program is really about leadership. For me, for example, there are a lot of instructional technologies used in other training programs that I don't even know about so that to me would be a really nice type of way of building from each other. And even to develop modules that would be things that all the grants could go to, much like, for example, the Georgetown ones on leadership.

LAURA KAVANAGH: Are you referring to the Johns Hopkins models on leadership? I wanted to make sure.

>>Yes, the one that holly Grayson worked on.

LAURA KAVANAGH:Thank you all -- Milt, did you have an additional comment?

MILT KOTELCHUCK: No, I didn't. I support -- I completely support the development of case studies, modules, training modules by the bureau. I think, Laura, you just have to say I really would like to try this and to encourage people to write them, to bring us together when you have brought us together across the different training programs. And to try to just develop some models and, you know, it's -- I like to think of this whole area as we're a learning community and we're learning from each other and with each other but if you help give some support, a little financial support if I can put in a plug for many of the people, people will write them. If you ask for them, they will come.

LAURA KAVANAGH: I'm also struck by several of you mentioned the importance of faculty development and moving to this area as well. There might be opportunities for joint faculty development opportunities as well as curricula development in terms of case studies or leadership modules. Does that seem like a reasonable approach for faculty development or does it need to be more localized?

It can be both.

>>I think you mentioned some examples, actually, as we were chatting just before we went live, even in things like the game that's been developed, the Life Course game which I think I mentioned.

>>Right.

>>So there are things that are starting to appear. But if MCHB would encourage them to appear more quickly, that would be wonderful.

>>We'll do what we can.

BETSY HAUGHTON: Laura, just one last example of a way to think about doing that is the -- what was done with the diversity peer collaborative which brought different training grants together to talk about the issue in diversity recruitment and retention.

Perhaps the same idea in terms of learning to build things through an approach like that.

LAURA KAVANAGH: That's a great idea. Thank you, Betsy. Well, I thank our speakers so much for taking the time to join us. Your presentations were very thought provoking and I feel like they've moved us to a different level in our discourse about how to -- in our discourse about how to integrate Life Course into MCH education and training. Thank you so much. Thank you to our participants for your patience with us in this challenging webcast this time. You stuck with us. We really appreciate it and thank you so much for your thoughtful questions. If you think of an additional question after the webcast is complete, please be free to send me an email. L Kavanagh at HRSA.com or Sue LIN and we'll make sure it gets to one of our speakers or if it's directed to us we'll try to address it that way. I want to encourage everyone who participated to complete the evaluation that will appear in your box as you're signing off and is there anything else I've forgotten?

>>I think we've covered everything.

LAURA KAVANAGH:That takes care of all the questions we had in the queue as well. Thank you so much and have a good evening.