

Evaluation of the Michigan Healthy Eating and Physical Activity Strategic Plan: 2011-2012 Implementation Plan Accomplishments Summary



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2011-2012 Implementation Plan Accomplishments Summary

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EXECUTIVE SUMMARY

The prevalence of obesity in both Michigan and the United States has risen steadily since the year 2000. Compared to healthy weight adults, obese individuals are at greater risk for developing chronic illnesses such as cardiovascular disease, asthma, diabetes and arthritis. In addition to the negative implications overweight and obesity have on people's health and quality of life, they have tremendous potential to affect state government spending as well. Across the state, significant disparities in overweight and obesity prevalence exist with regard to individuals' racial/ethnic background, socioeconomic status, and education level. Further, barriers related to breastfeeding, physical activity participation and adequate fruit and vegetable consumption also influence the overall health of Michigan residents.

To combat the multiple and interdependent factors that influence obesity, particularly behavioral and environmental factors, the Michigan Healthy Weight Partnership developed *The Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (the Strategic Plan). The Strategic Plan is a CDC-funded state-based initiative within the national Nutrition, Physical Activity, and Obesity (NPAO) program and was developed as a guide to move Michigan citizens toward healthier eating and physical activity behavior patterns. Evaluation of the Strategic Plan is critical for determining the effectiveness of its conceptualization, implementation, and capacity to produce intended outcomes. The overall evaluation includes assessment of the Strategic Plan's annual implementation plans. Using a mixed-methods, multi-level approach, the evaluation examined the initiative's progress toward meeting its overarching goals in year one.

The Strategic Plan goals are to:

1. Increase the portion of Michigan's population who are at a healthy weight;
2. Reduce inequities that contribute to health disparities in overweight and obese individuals;
3. Increase physical activity;
4. Increase healthy eating;
5. Increase breastfeeding.

In order to meet these goals, several programs and activities were undertaken as part of the one-year Implementation Plan. These programs included the Healthy Lifestyle Campaign: Childhood Obesity; Building Healthy Communities; Faith-Based Nutrition and Physical Activity Programs; Nutrition and Physical Activity Self-Assessment for Childcare (NAP SACC); Head Start Program: Agency-Wide Policy and Environmental Change; Head Start Program: Television Viewing Reduction Program; Healthy Kids, Healthy Michigan: Policy Change Initiative; Breastfeeding Initiative. Programs undertaken as part of the one-year Implementation Plan were instrumental in creating progress toward each of the CDC's six pillars of obesity prevention.

INTRODUCTION

The prevalence of obesity in both Michigan and the United States has risen steadily since the year 2000. In 2009, 31.3% of adults in Michigan were considered obese, while an additional 34.2% of the adult population was overweight.¹ Research has identified associations between individuals' weight and both their mental and physical well-being. Compared to healthy weight adults, obese individuals are at greater risk for developing chronic illnesses such as cardiovascular disease, asthma, diabetes and arthritis. In addition to the negative implications overweight and obesity have on people's health and quality of life, they have tremendous potential to affect state government spending as well. If obesity prevalence continues to rise at its current rate, Michigan is projected to spend approximately \$12.5 billion on costs related to health care by the year 2018.²

Significant disparities in overweight and obesity prevalence also exist with regard to individuals' racial/ethnic background, socioeconomic status, and education level. In 2011, Blacks (41.0%) were shown to have a significantly higher prevalence of obesity than their White counterparts. Hispanics had a high prevalence of obesity (36.7%) as well. On the other hand, those who graduated from college were less likely to be obese than those without a college degree.¹ Further, barriers related to breastfeeding, physical activity participation and adequate fruit and vegetable consumption also influence the overall health of Michigan residents.

To combat the multiple and interdependent factors that influence obesity, particularly behavioral and environmental factors, the Michigan Healthy Weight Partnership developed *The Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (the Strategic Plan).³ The Strategic Plan was developed as a guide to move Michigan citizens toward healthier eating and physical activity behavior patterns. The Strategic Plan is designed to target multiple levels of the social ecology in order to positively impact individual health behavior. It is not meant to duplicate other initiatives throughout the state; rather, it intends to assist in the alignment of the state's priorities regarding improved physical activity and nutrition.

Evaluation of the Strategic Plan is critical for determining the effectiveness of its conceptualization, implementation, and capacity to produce intended outcomes. The overarching evaluation plan was developed by the Michigan Public Health Institute (MPHI) in collaboration with the Michigan Department of Community Health (MDCH). It was developed to provide insight and direction to MDCH with regard to the Strategic Plan and its capacity to promote healthy eating, physical activity, and policy and practices that empower individuals to achieve and maintain a healthy weight. The overall evaluation includes assessment of the Strategic Plan's annual implementation plans. The focus of this

¹ Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS). Available at www.cdc.gov/brfss/

² The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses, Kenneth E. Thorpe, Ph.D. Nov 2009; A collaborative report from United Health Foundation, the American Public Health Association and Partnership for Prevention; Available at <http://www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf>

³ Michigan Department of Community Health. *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020*. Available at http://www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf

report is to summarize the work completed under the year one implementation plan. Specifically, the following discussion includes priority activities and collaborations of programs already funded by MDCH that address obesity and its risk factors. Using a mixed-methods, multi-level approach, the evaluation examined the initiative's progress toward meeting its overarching goals in year one.

BACKGROUND

Obesity Strategic Plan

The Strategic Plan is a CDC-funded state-based initiative within the national Nutrition, Physical Activity, and Obesity (NPAO) program. The national program originated in 1999 with the hope of building states' capacities to better prevent obesity and associated negative health outcomes. The Strategic Plan aims to serve as a guide for community stakeholders to focus obesity reduction efforts within six target areas, thus, allowing the state to maximize resources and draw on the strengths of collaborative problem-solving processes. To designate sufficient time for the measurement of relevant outcomes, the Strategic Plan will be implemented over the course of 10 years. Further, plan implementation occurs as an iterative process, receiving active revision and further development at 18 month intervals. The Strategic Plan is based on the Social-Ecological Model,⁴ which suggests that the creation of lasting behavior change is most likely when interventions address individuals as well as their social, physical and environmental contexts. This involves the development of policies and environmental changes that better support positive health behaviors to transform community norms.

Members of the Healthy Weight Partnership, who represent state, local, public and private organizations and have expertise in nutrition, physical activity, breastfeeding, and other chronic conditions, participated in the planning process for the Strategic Plan. Key sources of data, references, and other resources were compiled to inform this planning process. Related existing plans in Michigan were also pooled to guide the design of the Strategic Plan and to distinguish opportunities for collaboration, integration, and resource sharing among programs. Other national guidance documents, particularly those issued by the CDC,^{5,6} also helped inform the development of the Strategic Plan and its goals and objectives. The logic model, presented in Figure 1, presents a detailed breakdown of the inputs and activities that went into facilitating the Strategic Plan in year one. The Strategic Plan goals are to:

1. Increase the portion of Michigan's population who are at a healthy weight;
2. Reduce inequities that contribute to health disparities in overweight and obese individuals;
3. Increase physical activity;
4. Increase healthy eating;
5. Increase breastfeeding.

⁴ Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 10, 282-298.

⁵ Mattessich, P. Evaluation of State Nutrition, Physical Activity, and Obesity Plans. Centers for Disease Control and Prevention (CDC). Available at www.cdc.gov/obesity/downloads/EvaluationofStateNPAOPlans.pdf

⁶ Centers for Disease Control and Prevention (CDC). (2008). State Nutrition, Physical Activity and Obesity (NPAO) Program Technical Assistance Manual. Available at <http://www.cdc.gov/obesity/downloads/StateNPAOProgramTechnicalAssistanceManual.pdf>

Figure 1. First Implementation Plan Logic Model

INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
<ul style="list-style-type: none"> • MI Healthy Eating and Physical Activity 10 year Strategic Plan ↓ • MI Healthy Eating and Physical Activity Year One Implementation Plan ↓ • NPAO supported programs: <ul style="list-style-type: none"> • Building Healthy Communities • Breastfeeding Initiative • Childcare Initiative • Healthy Kids Healthy Michigan • Faith Based Projects • Program-specific workplans and evaluation plans • Existing data and data sources • MI Health Tools • CDC technical assistance manuals and related guidance documents • NPAO program staff • MPHI evaluation staff • Healthy Weight Partnership and other stakeholders • Results of the Michigan Obesity Summit • Workplans stemming (8) from the Michigan Obesity Summit 	<p style="text-align: center;"><u>Implementation</u></p> <ul style="list-style-type: none"> • Ongoing implementation and activities of individual programs • Ongoing data collection and monitoring by programs • Quarterly program reporting • Participating Healthy Weight Partners adopt Year One Implementation Plan <p style="text-align: center;"><u>Evaluation</u></p> <ul style="list-style-type: none"> • Regular meetings between MPHI and NPAO program manager and other staff • MPHI reviews implementation plan and evaluation indicators • MPHI reviews program-specific workplans and evaluation plans • MPHI synthesizes data and tracks programs' progress through existing data sources • MPHI determines additional, key process and content evaluation questions 	<ul style="list-style-type: none"> • Year one implementation plan logic model ↓ • Evaluation plan for year one implementation plan: <ul style="list-style-type: none"> • Regarding existing programs • Regarding process and content of overall implementation plan • Processes for obtaining data • HWP fiscal meeting presentation • Annual CDC report • Year one evaluation report summarizing: <ul style="list-style-type: none"> • Baseline data and implementation plan outcomes • Process and content findings for overall implementation plan 	<p style="text-align: center;"><u>Implementation</u></p> <ul style="list-style-type: none"> • Year one implementation plan objectives incorporated in NPAO supported (see Inputs) program specific workplans and evaluation plans ↓ • Programs meet program-specific objectives • Year One Implementation Plan actions completed for NPAO supported (see Inputs) ↓ • Programs meet overall objectives of Year One Implementation Plan and state Strategic Plan • Increased number, reach, and quality of efforts to support physical activity, healthy eating, and breastfeeding: <ul style="list-style-type: none"> • Policies • Environments • Social and behavioral programs • Increased awareness of Year One Implementation Plan and State Strategic Plan <p style="text-align: center;"><u>Evaluation</u></p> <ul style="list-style-type: none"> • Improved strategies for monitoring Implementation and Strategic Plan process and content • Improved strategies for monitoring changes in the social and physical environment in addition to changes in health outcomes • Increased environments, programs and policies that support physical activity, healthy eating, and breastfeeding • Feedback and findings incorporated into next year's Implementation Plan

Most of the work of the Healthy Weight Partnership in developing the Strategic Plan was accomplished prior to the tenure of Michigan's new Governor and Executive Leadership. Since entering office in January 2011, Michigan's Governor Snyder and appointed Director of MDCH, have adopted obesity as a key health benchmark on which to "move the needle." Towards this aim, over 500 stakeholders from across Michigan joined MDCH in a summit entitled *Michigan Call to Action to Reduce and Prevent Obesity* on Wednesday, Sept. 21, 2011. Out of this summit, a series of specific action items were put forward by multiple small workgroups as well as the 4 x 4 concept. The recommendations and 4 x 4 elements are quite consistent with the Strategic Plan. Moving forward, Michigan has the opportunity to incorporate the priorities of a new administration to energize and provide renewed focus to Michigan's efforts to promote healthy weight goals. The broadening of engaged stakeholder groups should lead to greater reach within the State of Michigan over the coming decade.

Implementation Plan

The Annual Implementation Plan serves as a guide for the activities and collaborations that will occur during the year to accomplish the objectives of the State's Ten-Year Strategic Plan. The purpose of the Michigan Healthy Eating and Physical Activity Implementation Plan: 2011-2012 is to provide a snapshot of the priority activities and collaborations that will occur this year to accomplish the objectives of the state's obesity prevention plan, Michigan's Healthy Eating and Physical Activity Plan: 2010-2020.

The 2011-2012 Implementation Plan is organized around the three goals related to improving the health status of the population found in the 10-year Strategic Plan: 1.) increasing physical activity, 2.) increasing healthy eating, and 3.) increasing breastfeeding. As with the 10 year plan, the actions within the Implementation Plan are related to eliminating health disparities and improving the health of the population and population subgroups.

In the one-year Implementation Plan, the goal, background, objective, and strategies come directly from the ten-year Strategic Plan. The Implementation Plan provides an overview of programs funded by the NPAO CDC grant, as well as other obesity-related programs in the state. Implementation and evaluation details are provided for programs funded by the NPAO Program. The plan also highlights activities partners are conducting to contribute to the ten-year state strategic plan. The following discussion includes summaries of the specific programs included within the Implementation Plan, program objectives, and accomplishments.

PROGRAM SUMMARIES AND ACCOMPLISHMENTS

Healthy Lifestyle Campaign: Childhood Obesity

The *Healthy Lifestyle Campaign: Childhood Obesity* program promotes and supports the implementation of Michigan's 54321GO! message for child obesity prevention. The goal is to provide consistent and unified information to Michigan families through various organizations, such as child care centers, schools, community groups, community gardens, health providers, health departments/centers, local planning groups and coalitions, and many more.

Objective: Conduct culturally appropriate campaigns to increase awareness of the importance of physical activity and healthy eating.

Strategies: The 54321GO! campaign included activities to advance support for statewide implementation, including supporting local campaigns, promoting appropriate policy areas, educating schools and community leaders, and developing and disseminating promotional materials as well as devising a system for other groups to utilize materials.

Accomplishments: The three school districts (13 schools total) who successfully implemented the Michigan Nutrition Standards during the 2010-2011 school year incorporated a variety of outreach activities to stakeholders, including prominent use of 54321GO! MDCH provided a number of 54321GO! materials to districts to assist in communicating with stakeholders. The promotional efforts undertaken through the campaign were specifically noted as a contributing factor to the heightened awareness of healthy behaviors. Evaluation activities elicited the following highlights regarding the 54321GO! campaign:

- A parent described how the campaign was part of increased awareness among students: "It has to do with the children and the different things they have been exposed to, everything from 54321GO! and the fruits, veggies, and dairy. Less than 2 hours of TV/computer time—they can understand it."
- A teacher attributed increased awareness that has led to greater self-efficacy among children to have healthy behaviors to the campaign.
- To celebrate students' birthdays, one classroom started —GO! Celebrations. During—GO! Celebrations, students had a half hour to play games and be physically active in the gym instead of celebrating with food.
- Interviewees reported that the 54321GO! message was widely embraced and well-recognized by students, especially at the elementary and middle school levels.

Building Healthy Communities

The Building Health Communities (BHC) Project works with local health departments (LHDs) to implement and evaluate evidence-based policy and environmental change interventions to increase access to places for healthful eating and physical activity and reducing tobacco exposure. Through BHC, LHDs are provided mini-grant funding, training, and technical assistance. Community coalitions establish diverse local partnerships to support BHC program success and sustainability.

Objective: In 2011, 12 LHDs serving 35 counties were funded to conduct strategic planning, including:

- Form or engage an existing health coalition of multidisciplinary partners.
- Complete an environmental assessment to determine the assets, resources and needs of the community.
- Create a strategic action plan to increase healthy eating and physical activity and reduce tobacco use through evidence-based policy and environmental change strategies.

Strategies: Communities were presented with the specific strategies to address unhealthy eating, physical inactivity, and tobacco use. These strategies and the objectives to which they apply are as follows:

1. Reduce unhealthy eating by increasing fruit and vegetable access, availability and consumption by implementing:
 - Local food policy councils
 - Farmers' markets
 - Community gardens
 - Emergency food sites
2. Increase physical activity by improving safety, access and availability for daily recreation and transportation by:
 - Enhancement of parks in communities
 - Creation of new trails and enhancing current trails
 - Pedestrian and bicycle safety facilities
3. Increase tobacco-free environments by:
 - Creating policies for tobacco-free environments

If implemented, the short-term outcomes of these strategies are expected to be changes in community capacity, policy, the built environment, community awareness, and self-efficacy. Long-term outcomes may include changes in physical activity and tobacco use of community residents; and a reduction in overweight and obesity prevalence, Type II diabetes, cardiovascular disease, cancer, and other chronic diseases.

Accomplishments: During the 2011-2012 project period, the 12 grantees had several accomplishments. These accomplishments occurred at multiple levels of the social ecology and included changes to legislation, local resolutions and systems change, physical activity and nutrition environment as well as

the formation of new community coalitions. Overall, BHC programs reached 20 communities and an estimated 518,474 residents.

Physical Activity Initiatives- Of the ordinances LHDs enacted through BHC project efforts, four out of five were specifically informed by the Complete Streets mission. This national movement works to ensure that roadways are designed and operated to enable safe access along and across a street for users of all ages and abilities (including pedestrians, bicyclists, transit users, and those with disabilities). Specific ordinances were passed in the City of Manistee, Ypsilanti, the Village of Manchester, and Lansing Township. The City of Norway also passed a Complete Street resolution and Houghton County developed the non-motorized plan to incorporate Complete Streets design consideration and practices as a routine part of infrastructure, planning, and implementation.

Environmental changes accomplished through BHC also included two park projects. One park installed new playground equipment; the other installed additional playground equipment for children with physical and cognitive disabilities along with fencing to enclose the park from the parking lot. In addition to improving access to physical activity, the parks are tobacco-free.

BHC coalitions added 150 feet of bike trail and 5 miles of forest trail to two existing trail networks. An additional 2.32 miles of bike trail development also allowed for these disparate trail systems to connect. Coalitions completed enhancements on five trails including smoke-free signage and physical amenities such as benches and pedestrian bridge safety fencing. To further support physical activity access, 28 new bike racks were installed at points of interest and wayfaring signage were also added to trails in 3 communities.

Nutrition Initiatives: One nutrition-related ordinance was enacted in Oakland County. The City of Pontiac revised their Master Plan to include a policy allowing for the outdoor sale of produce with a temporary permit. The cost of the permit, which is valid for 6 months, was also reduced from \$1,200 to \$200. In addition to local legislation, communities formed food policy councils through the work of local Building Healthy Communities Coalitions. Three councils in Southern Clinton, Washtenaw, and Ottawa counties work to transform problems within the local food system by bringing priority policy initiatives to the Board of Commissioners, mapping services related to food security and developing recommendations for efficiencies, among many other initiatives.

Healthy eating initiatives also included the establishment of two new farmers' markets and the expansion of two existing markets. To accommodate residents receiving government assistance and credit card users, these markets incorporated electronic benefit transfer technology. In addition to offering Project Fresh coupons to senior citizens, SNAP-Ed funds supported nutrition education and taste samplings at the market as well. Environmental changes resulting from BHC also included the formation of three new community gardens, which are also tobacco free zones, as well as increased marketing of fresh produce at one community's corner stores.

Faith-Based Nutrition and Physical Activity Programs

The goal of the Faith-Based Nutrition and Physical Activity Project (FBNPAP) is to address health disparities within the African American community through the provision of programming and support for healthy eating and physical activity. The effort is in its third year and continues to work with 25 churches to implement policy and environmental supports, and social behavioral programs for healthy eating and physical activity. These supports and programs include creating a sustainable network of trained leaders capable and willing to implement mini-markets (farmers' markets) and physical activity programs in their community.

Objective: In 2012, FBNPAP programs aimed to strengthen and support state, local, and community partners working in communities with underserved, low-resource African American populations. Objectives also included increasing the availability of healthy food opportunities by supporting the development of farmers' markets, community gardens, and church policies supporting the provision of healthy foods at church events.

Strategies: Faith-based programming was implemented in collaboration with existing partners as well as newly recruited churches. Participating churches were also slated to implement a physical activity program, create a sustainable network of trained leaders to implement mini-markets within the community, and establish a mini-market mentorship program between new and experienced churches. Mini-markets were to be implemented weekly.

Accomplishments: Surveys administered to participating churches informed the evaluation findings and program accomplishments:

- The program served over 2,400 individuals
- Approximately 1,700 people attended mini-markets
- There were approximately 700 physical activity participants

Participating churches maximized reach and impact by fostering collaborative partnerships and leveraging resources. Seventy-five percent of surveyed churches partnered with other community organizations and churches to bolster and sustain their programming. These partners include: The Women of Excellence, Fishermen Ministries, Blue Cross Blue Shield, and Eastern Market vendors. Further, nearly half leveraged additional resources from these partnerships, such as educational materials and expertise, financial support, and produce.

The program produced successful outcomes related to physical activity, healthy eating, and environmental change. Eighty-five percent of coordinators surveyed were satisfied/very satisfied with the impact of the physical activity programming on their target population, and nearly 80% were satisfied/very satisfied with the impact of the mini-markets on their population. Seventy-six percent of the churches surveyed have policies in place with guidelines for healthy church-wide meal preparation and/or healthy meal options, representing structural change resulting from the programming.

Nutrition and Physical Activity Self-Assessment for Childcare (NAP SACC)

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) intervention includes best practices for the promotion of regular physical activity and proper nutrition. The intervention consists of 5 key components that are completed sequentially: (1) self-assessment, (2) action planning, (3) continuing education workshops, (4) technical assistance, and (5) re-assessment. The process is designed to facilitate continuous quality improvement.

Objective: The key objectives of NAP SACC in Head Start Centers were to expand the number of child care centers implementing nutrition standards and to enhance physical activity opportunities in child care settings.

Activities: In 2012, MDCH aimed to expand the NAP SACC intervention to 10 new Early Childhood Education centers in Michigan, with continued work in 56 existing centers. Participating centers included the following settings: Head Start, licensed child care centers, Telamon Michigan Migrant Head Start, and other settings focused on children aged 0-5.

Accomplishments: In partnership with the National Kidney Foundation of Michigan (NKFM), MDCH engaged 11 new child care sites, exceeding the goal of ten centers, while continuing work with existing sites. The new sites included Macomb Head Start sites (5) and Detroit home-based and center-based facilities (6). All new centers completed self-assessments, developed action plans, and started the process of making policy and environmental changes related to obesity prevention. Programming in these 11 centers impacted a total of 468 children: 77 children in Wayne County and 391 children in Macomb County.

All sites improved their self-assessment scores from pre- to post-test (see figures 2 and 3). On average, Head Start sites in Macomb County improved their scores by 9.2 points. In Detroit (a mix of home- and center-based sites), scores improved by 24.2 points, notably more than the Macomb sites. The small size of the Detroit sites may have contributed to more favorable positive environmental change in centers. Fewer regulations within home-based and non-Head Start settings may have had a similar impact on observed outcomes.

Figure 2. Macomb County Sites' Self-Assessment Scores

Site Name	Pre-assessment	Post-assessment	Overall Improvement
Pearl Lean (Head Start)	127	132	+5
Walsh (Head Start)	129	144	+15
Dooley (Head Start)	119	129	+10
Mt. Calvary (Head Start)	123	125	+2
Dort (Head Start)	126	140	+14
Average	124.8	134	+9.2

Figure 3. Detroit Sites' Self-Assessment Scores

Site Name	Pre-assessment	Post-assessment	Overall Improvement
Brainiacs Clubhouse (center-based)	115	137	+22
House of Joy (home-based)	134	157	+24
Infant and Tots (home-based)	113	136	+23
Little People (home-based)	112	136	+24
Gwen's Heavens Angels (home-based)	119	141	+22
Village of Shining Stars (center-based)	75	105	+30
Average	111.3	135.3	+24.2

While successful environmental changes to reduce screen time were not identified, key changes to centers within the areas of improved physical activity and nutrition include the following:

Physical activity:

- Displayed USDA physical activity posters in classrooms as well as books, curriculum tools, and recipe resources;
- Increased availability of gym;
- Installed new, fixed play equipment;
- Increased teacher-led as well as free active play time during the day;
- Developed and implemented a written physical activity policy;
- Researched new funding mechanisms and fundraising techniques to purchase new playground equipment.

Nutrition:

- Increased provision of self-serve water breaks;
- Increased provision of lean meats;
- Increased provision of whole grains during teacher purchased snacks;
- Improved cultural diversity of food served;

- Reduced seasoning, such as salt and butter, added to vegetables;
- Increased healthy seasoning, such as herbs, added to foods;
- Provided educational materials to parents regarding healthy snacks for children;
- Displayed USDA nutrition posters in classrooms;
- Implemented standardized nutrition curriculum, “Grow it, try it, like it” over the summer;
- Made revisions to child care centers’ menus based on review and recommendations of a registered dietitian;
- Implemented the Regie’s Rainbow Adventure™ program;
- Implemented regular fruit and vegetable samplings.

In addition to the structural changes that were made, child care providers also noted positive behavior and knowledge changes among children, parents, and center staff following NAP SACC implementation, especially related to making healthier food choices. While the program was generally well-received by center staff and parents, some providers noted the difficulty of making structural changes to larger child care environments particularly around food service limitations.

Head Start Program: Agency-Wide Policy and Environmental Change

Objective: The goal of the Agency-Wide Policy and Environmental Change program was to build upon the NAP SACC work done the preceding year by developing higher level agency-wide physical activity policy changes in 27 Wayne County Head Start centers. At baseline, one agency-wide policy change (serving 1% milk) was implemented at all of the centers. The objective for the 2012 implementation year was to expand the number of child care centers implementing nutrition standards.

Accomplishments: For the 2011-2012 school year, Wayne County Head Start participated in the NAP SACC program on a grantee level with direct involvement at the delegate level. Nutrition education, identified as a need by the grantee, was provided to the 12 nutrition staff from all 5 delegate agencies and all Head Start teachers. This activity impacted 3,723 children in the 27 sites. All teaching staff at the sites also received paper-based training regarding incorporating nutritional messages when talking with preschoolers and the benefits of talking with children about healthy eating.

Head Start Program: Television Viewing Reduction Program

Objective: The goal of the Head Start Program: Television Viewing Reduction program was to expand by 5 the number of centers implementing Regie’s Rainbow Adventure™ to reduce television viewing among low-income African American children. The intervention was also implemented with current partners. At baseline, the TV Viewing Reduction curriculum had been implemented in 82 Early Childhood Education centers.

Strategies: NKFM implemented four new campaigns, two of which were in Head Start programs. NKFM also worked to continue offering the intervention in an existing 100 centers; use culturally appropriate curriculum to reduce television viewing; use social marketing approaches to select intervention and appropriate messages for the target audience; and evaluate the intervention (including mean reduction in television viewing time).

Accomplishments: Of the 154 early childhood sites that implemented Regie’s Rainbow Adventure™, which includes the television viewing reduction component, 50 were new implementing partners. To date, the 154 sites that have implemented Regie’s Rainbow Adventure™ have impacted 11,638 children and their families.

Healthy Kids, Healthy Michigan: Policy Change Initiative

Healthy Kids, Healthy Michigan (HKHM) is a coalition dedicated to reducing childhood obesity in Michigan through strategic policy initiatives while working with state government leaders. HKHM is comprised of executive-level decision makers from over 120 organizations statewide dedicated to addressing childhood obesity and improving the health of Michigan’s youth. Coalition members represent government, public and private sectors, school districts, health care and non-profit organizations.

Objective: The goal of HKHM in 2012 was to increase (by two) the number of state and local policies, rules, or regulations that support childhood obesity prevention statewide. Specifically, the Policy Change Initiative aimed to increase the number of policy changes to support physical education, physical activity, and healthy eating.

Accomplishments: Thirty-one Schools Implementing Nutrition Standards (SINS) trainings (88.75 hours) were held for state and local advocates, grantees, and other school district partners, with total participation of 1,066 individuals. Near the conclusion of the project, MDCH conducted five regional trainings to disseminate the Nutrition Standards Toolkit and lessons learned from the SINS project; these trainings reached a total of 362 people. Training evaluation forms were received from 235 participants (65% response rate). Food service professionals (n=82, 35%) and teachers (n=36, 15%) comprised the largest number of evaluation survey respondents. A majority of respondents indicated their agreement with the necessity of nutrition standards to improve students’ health (n=210, 89%). Nearly half of respondents indicated their intention to implement nutrition standards (n=106, n=45%), while 35%

(n=82) were already implementing them. Respondents also reported planning on implementing nutrition standards in venues including school meals and a la carte.

Three school districts (13 schools total), out of a total possible of 549 public school districts in Michigan (0.5%), implemented the Michigan Nutrition Standards in all venues providing foods and beverages during the 2010-2011 school year.

School districts incorporated a variety of promotional strategies including prominent use of 54321GO!, a childhood obesity prevention message and marketing campaign adopted by Healthy Kids, Healthy Michigan. The total number of schools that could have been reached was 855; actual school reach was 15%. Individual reach was 12,526. This number included the numbers of students, administrators, and teachers within demonstration school districts, as well as estimated parents reached and Michigan Nutrition Standards Toolkit Training Participants.

Breastfeeding Initiative

Objective: The goal of the Breastfeeding Initiative was to support the work of the Michigan Breastfeeding Network (BFN) and its members to increase and strengthen the number of breastfeeding coalitions across the State. Through these actions, the Breastfeeding Initiative aimed to increase the number of legislative, policy and environmental changes to support breastfeeding.

The initiative also worked in collaboration with the Women Infants and Children (WIC) program to promote breastfeeding initiatives throughout Michigan. The objective was to support the development of state-wide infrastructure to promote and support breastfeeding activities.

Strategies: Several workgroup and coalition meetings were convened to support structural and environmental changes.

Accomplishments: The robust work of the groups described above facilitated the promotion of breastfeeding initiatives. Highlights and accomplishments from 2011-2012 are as follows:

Breastfeeding Policy Workgroup: A key accomplishment of the workgroup included the development of an issue brief entitled, "Obesity Prevention Starts in Infancy." The workgroup also addressed:

- The creation of a grid on lactation services/equipment covered by Medicaid and private health insurance plans.
- Proposing changes to the Bureau of Children and Adult Licensing rules including: the general plan for feeding infants, feeding infants on cue, preparing, feeding, and storing human milk, and on site accommodation for breastfeeding mothers.
- The *We Care for Breastfed Babies Webinar* took place on June 27th (2012) during which insurance coverage for breast pumps and education under the Affordable Care Act was discussed.

Capital Area Breastfeeding Coalition (CABC): The CABC also initiated activities to support structural changes including meeting with the Director of MDCH to discuss legislation and Medicaid coverage of

pumps. The coalition also hosted a tent at the East Lansing Art Festival for breastfeeding mothers, which included space for children to play, mothers to breastfeed, and changing tables. A resource guide was distributed that includes information on lactation consultants, free breastfeeding support, resources at county health departments, books, websites, blogs, breast pump rental and sales, and a maternal-infant outreach program. Two hundred guides were distributed at the festival and later mailed to local doctors' offices. Information provided through the resource guide was supplemented by the development of a website for CABC: <http://www.mibreastfedbaby.org/>.

MDCH Breastfeeding Support and Collaboration Workgroup: Through their collaborative efforts, this workgroup reviewed and discussed breastfeeding initiatives of several other states and groups to keep pace with evolving evidence and inform efforts within Michigan. Topics reviewed included stopping in-hospital infant formula giveaways, mothers' rights to breastfeed in public/excuses from jury duty, exclusive breastfeeding rates in hospitals, and Medicaid coverage of lactation services. Coordination among the work group, the Michigan Infant Health Program, Medicaid, and WIC also helped ensure that clients can get breast pumps and related support as well as receive better coordinated services.

Michigan Breastfeeding Network (BFN): The network participated in several events in collaboration with the Policy Workgroup to produce the *Obesity Prevention Starts in Infancy* issue brief. BFN discussion also included updates regarding the status of several bills: the protection of a mother's right to breastfeed in public and a bill to exempt nursing mothers from jury duty. Resources including Workplace Lactation Toolkits (available on the BFN website) were also discussed.

PROGRESS TOWARD THE CDC'S SIX PILLARS OF OBESITY PREVENTION

Looking across the programs included in the First Year Implementation Plan, activities occurred within each of the following CDC pillars of obesity prevention (also see Figure 4 below):

- Physical Activity
 - Increase Physical Activity (Pillar 1)
 - Decrease Television Viewing (Pillar 2)
- Healthy Eating
 - Increase Consumption of Fruits and Vegetables (Pillar 3)
 - Decrease Consumption of Sugar-Sweetened Beverages (Pillar 4)
 - Decrease Consumption of High Energy Dense Foods (Pillar 5)
- Breastfeeding
 - Increase Breast Feeding Initiation, Duration, and Exclusivity (Pillar 6)

Figure 4. Implementation Plan Alignment with CDC Pillars of Obesity Prevention

Programs Incorporated within Implementation Plan	CDC Pillars of Obesity Prevention					
	1	2	3	4	5	6
<i>Healthy Lifestyle Campaign: Childhood Obesity</i>	x	-	x	x	x	-
<i>Building Healthy Communities</i>	x	-	x	-	-	-
<i>Faith Based Nutrition and Physical Activity Programs</i>	x	-	x	x	x	-
<i>Nutrition and Physical Activity Self-Assessment for Childcare (NAP SACC) in Head Start Centers</i>	x	x	x	x	x	-
<i>Head Start Program: Agency-Wide Policy and Environmental Change</i>	x	x	x	x	x	-
<i>Head Start Program: Television Viewing Reduction Program</i>	-	x	-	-	-	-
<i>Healthy Kids, Healthy Michigan: Policy Change Initiative</i>	x		x	x	x	-
<i>Breastfeeding Initiative</i>	-	-	-	-	-	x

Physical Activity

Activities related to increasing physical activity (pillar 1) were among the most common type incorporated in the first implementation plan. While six out of the eight programs included in the implementation plan aimed to increase physical activity, only four aimed to decrease television viewing (pillar 2). Programs utilized strategies to increase physical activity in multiple settings and among diverse age groups. Further, these efforts occurred at multiple levels of the social ecology including the individual, interpersonal, organizational, community, and societal level. Television reduction efforts occurred primarily in child care settings and addressed the interpersonal and organizational levels of the social ecology. Physical activity-related progress also addressed several obesity disparities by increasing access to safe and affordable physical activity and active transportation opportunities for low-income populations.

Healthy Eating

Along with increasing physical activity, implementation plan programs most commonly incorporated activities aimed at increasing the consumption of fruits and vegetables (pillar 3). While the primary focus of healthy eating activities was related to pillar 3, four programs incorporated activities related to decreasing the consumption of sugar sweetened beverages and decreasing the consumption of high energy dense foods (pillars 4 and 5). Similar to television reduction efforts, activities related pillars 3 and 5 targeted children or took place primarily in child care or education centers. Efforts to reduce the consumption of sugar sweetened beverages and energy dense foods could be expanded in sectors outside of the early education sector to include broader age groups. Program efforts of the Healthy Lifestyle Campaign and the NAP SACC intervention addressed multiple levels of the social ecology. In particular, the broad reach of the NAP SACC program, delivered in collaboration with NKFM, initiated environmental and policy changes influencing the individual, interpersonal, organizational, community, and societal levels. Further, Healthy Eating initiatives incorporated in the Implementation Plan addressed health disparities. Policy and environmental changes support increased access to safe and affordable fresh produce among low-income populations.

Breastfeeding

Among the CDC obesity prevention pillars, pillar 6, relating to increasing breastfeeding initiation, duration, and exclusivity, was only incorporated in the Breastfeeding Initiative. Similar to the domains of physical activity and healthy eating, breastfeeding efforts addressed social, environmental, and physical contexts to achieve population impact through addressing policy. The work of the Initiative targeted issues around Medicaid and private health insurance coverage of lactation services and equipment, hospital infant formula giveaways, mothers' rights to breastfeed in public, and exemption from jury duty for lactating mothers.

SURVEILLANCE UPDATE

Overweight and Obesity

Adults: Overweight and obesity is a significant health concern that puts many Michiganders at an increased risk of several diseases and health conditions, including high blood pressure, diabetes, stroke, and high cholesterol. The 2011 Michigan Behavioral Risk Factor Survey (MiBRFS) estimated that 31.3% of adults in the state were obese, or had a body mass index (BMI) greater than or equal to 30, and an additional 34.2% were estimated to be overweight, or had a BMI between 25.0 and 29.9.⁷ Michigan was one of only twelve states that reported an estimated obesity prevalence greater than 30%, which is higher than the median U.S. prevalence of 27.8%. Furthermore, Michigan ranked 5th in the country for the highest prevalence of obesity. On the other hand, Michigan’s prevalence of overweight individuals is lower than the U.S. average of 35.7%.

The estimated prevalence of obesity among adults is not equal across all subsections of the population (Table 1). Many social, economic, and environmental factors may contribute to these weight disparities in Michigan and should be addressed in efforts to reduce the prevalence of overweight and obesity. For example, Black, non-Hispanic adults reported the highest prevalence of obesity (41.0%) when compared to other races and ethnicities. In addition, disabled adults were more likely (42.3%) to be classified as obese than non-disabled adults (27.1%). The prevalence of obesity also increased with age, but did begin to decline again starting with the 65-74 year old age group.

Children: Children in Michigan are also at significant risk of being overweight or obese. According to the 2011 Michigan Youth Risk Behavior Survey (MiYRBS), an estimated 15.3% of 9th-12th graders in the state were overweight and an additional 12.1% were obese.⁸ Black students were more likely (23.5%) to be

Table 1: Obesity among Michigan Adults⁷	
Demographic Characteristics	%
Total	31.3%
Age	
18-24	17.3%
25-34	31.3%
35-44	33.3%
45-54	34.7%
55-64	38.0%
65-74	34.0%
75+	24.2%
Gender	
Male	31.9%
Female	30.7%
Race/Ethnicity	
White non-Hispanic	29.7%
Black non-Hispanic	41.0%
Other non-Hispanic	24.8%
Hispanic	36.7%
Household Income	
< \$20,000	36.6%
\$20,000 - \$34,999	32.4%
\$35,000 - \$49,999	28.6%
\$50,000 - \$74,999	32.6%
≥ \$75,000	28.2%
Health Insurance	
Insured	30.6%
Uninsured	34.8%
Disability	
Disabled	42.3%
Not disabled	27.1%

⁷ Michigan Department of Community Health (MDCH). Michigan Behavioral Risk Factor Surveillance System (MiBRFSS). Available at www.michigan.gov/brfs

⁸ Michigan Department of Education. Michigan Youth Risk Behavior Survey (MiYRBS). Available at www.michigan.gov/yrebs.

overweight than Hispanic (16.2%) or White (12.8%) students. On the other hand, Hispanic (17.2%) students were more likely to be obese than either Black (13.7%) or White (11.5%) students.

According to the 2011 Michigan Pediatric Nutrition Surveillance System, an estimated 16.6% of children between the ages of 2 and 5 who were enrolled in the Women, Infants, and Children (WIC) program were overweight and an additional 13.3% were obese.⁹

Nutrition

Adults: Adequate fruit and vegetable consumption may help reduce the risk of cancer and other chronic health conditions. Unfortunately, many Michigan adults are not consuming the recommended five or more servings of fruits and vegetables each day (Table 2). According to the 2011 MiBRFS, only an estimated 17.8% of Michigan adults met the recommended guidelines, assuming adults consumed 1 serving each time they had a fruit or vegetable. Women were more likely (21.9%) to consume an adequate number than men (13.5%). In addition, fruit and vegetable consumption increased as annual household income rose. Adults between the ages of 18 and 34, and over the age of 74, were more likely to meet the recommendations than were adults between the ages of 35 and 74. Disability status did not seem to affect the percentage of individuals eating at least five servings of fruits and vegetables per day.

Children: Similar to Michigan adults, few children are consuming the recommended five or more servings of fruits and vegetables each day (assuming children consumed 1 serving each time they had a fruit or vegetable). The recent survey estimated that only 18.7% of 9th-12th graders consumed at least five servings of fruits and vegetables per day in the 7 days preceding the administration of the MiYRBS. Unlike adults, the percentage of male (18.5%) and female (19.0%) students meeting the recommendation was relatively equal. Black (21.6%) students consumed at least five servings of fruits

Table 2: Adequate Fruit and Vegetable Consumption among Michigan Adults¹⁰	
Demographic Characteristics	%
Total	17.8%
Age	
18-24	20.7%
25-34	21.8%
35-44	13.9%
45-54	16.8%
55-64	17.6%
65-74	14.6%
75+	20.9%
Gender	
Male	13.5%
Female	21.9%
Race/Ethnicity	
White non-Hispanic	17.2%
Black non-Hispanic	20.4%
Other non-Hispanic	19.9%
Hispanic	18.8%
Household Income	
< \$20,000	16.5%
\$20,000 - \$34,999	14.4%
\$35,000 - \$49,999	16.4%
\$50,000 - \$74,999	18.4%
≥ \$75,000	22.5%
Health Insurance	
Insured	18.4%
Uninsured	14.7%
Disability	
Disabled	17.2%
Not disabled	18.2%

⁹ Michigan Department of Community Health (MDCH). Michigan PedNSS Reports. Available at http://www.michigan.gov/documents/mdch/2011.state.PedNSS_381738_7.pdf

¹⁰ Michigan Department of Community Health (MDCH). Michigan Behavioral Risk Factor Surveillance System (MiBRFSS). Available at www.michigan.gov/brfs

and vegetables each day more frequently than either White (17.6%) or Hispanic (17.7%) students.¹¹

Physical Activity

Adults: The U.S. Department of Health and Human Services recommends that adults participate in moderate physical activity for at least 150 minutes per week, vigorous physical activity for at least 75 minutes per week, or an equivalent combination of moderate and vigorous physical activities and also participate in muscle and strengthening activities on two or more days per week. Regular physical activity can reduce the risk of several diseases, including cardiovascular disease and diabetes, and can help control weight.

Despite the benefits of regular physical activity, the 2011 BRFSS estimated that 23.6% of Michigan adults did not participate in any leisure-time physical activity during the month preceding the survey administration.¹² Leisure-time physical activity could include running, calisthenics, golf, gardening, or walking, among other activities. Michigan currently exceeds the Healthy People 2020 target of having fewer than 32.6% of adults not taking part in leisure-time physical activity; however, several factors appear to be limiting Michiganders ability to participate in physical activity (Table 3). For example, those with lower annual household incomes and those with a disability were less likely to participate in leisure-time physical activity. In addition, older adults were less likely to participate in leisure-time physical activity than were younger adults.

In 2011, only 19.7% of Michigan adults met the recommended guidelines for both physical activity and muscle strengthening.¹² Adults were more likely to participate in the recommended amount of aerobic physical activity (53.5%) than they were to participate in muscle strengthening activities on two or more days per week (28.8%). Michigan exceeds the Healthy People 2020 target of 47.9% for aerobic physical activity and the target of 24.1% for muscle strengthening. However, Michigan does not meet the Healthy People 2020 target of 20.1% for both activities combined.

Table 3: Michigan Adults Not Participating in Leisure-Time Physical Activity¹²

Demographic Characteristics	%
Total	23.6%
Age	
18-24	15.8%
25-34	16.9%
35-44	21.4%
45-54	27.0%
55-64	25.5%
65-74	28.6%
75+	34.4%
Gender	
Male	22.1%
Female	25.0%
Race/Ethnicity	
White non-Hispanic	22.2%
Black non-Hispanic	30.1%
Other non-Hispanic	24.5%
Hispanic	28.9%
Household Income	
< \$20,000	32.4%
\$20,000 - \$34,999	29.0%
\$35,000 - \$49,999	19.5%
\$50,000 - \$74,999	18.6%
≥ \$75,000	15.8%
Health Insurance	
Insured	22.9%
Uninsured	27.2%
Disability	
Disabled	34.5%
Not disabled	19.5%

¹¹ Michigan Department of Education. Michigan Youth Risk Behavior Survey (MiYRBS). Available at www.michigan.gov/yrbs.

¹² Michigan Department of Community Health (MDCH). Michigan Behavioral Risk Factor Surveillance System (MiBRFSS). Available at www.michigan.gov/brfs

Men (21.6%) were more likely to meet or exceed the recommendations than women (17.9%). As age increased, Michigan adults were less likely to participate in adequate amounts of physical activity. Those with a disability (15.3%) were also less likely to meet the recommendations than those without a disability (21.5%). On the other hand, as income increased, adults were more likely to participate in adequate amounts of physical activity.

Table 4: Adequate Physical Activity among Michigan Adults¹³	
Demographic Characteristics	%
Total	19.7%
Age	
18-24	25.8%
25-34	21.5%
35-44	19.5%
45-54	18.4%
55-64	17.8%
65-74	17.6%
75+	16.5%
Gender	
Male	21.6%
Female	17.9%
Race/Ethnicity	
White non-Hispanic	19.6%
Black non-Hispanic	19.1%
Other non-Hispanic	23.3%
Hispanic	22.2%
Household Income	
< \$20,000	15.1%
\$20,000 - \$34,999	16.1%
\$35,000 - \$49,999	18.4%
\$50,000 - \$74,999	20.5%
≥ \$75,000	26.1%
Health Insurance	
Insured	19.9%
Uninsured	17.9%
Disability	
Disabled	15.3%
Not disabled	21.5%

Children: Children were more likely than adults to participate in adequate amounts of physical activity. According to the 2011 MiYRBS, 49.4% of students in grades 9 through 12 were physically active for at least 60 minutes per day on five or more of the seven days preceding survey administration.¹⁴ In addition, 33.9% of surveyed students participated in a physical education class on one or more days during an average school week and 26.7% attended physical education class daily. Males were more likely to be physically active for at least 60 minutes (57.9% versus 40.8%), participate in a physical education class on one or more days during an average school week (42.8% versus 24.5%), and attend physical education class daily (34.5% versus 18.7%) than female students. Younger students were more likely to be physically active than older students. For example, 55.5% of 9th graders participated in at least 60 minutes of physical activity per day on five or more days during the week and only 40.0% of 12th graders were physically active for the same amount of time. This grade level trend continued for the percentage of students participating in physical education class on one or more days during the average school week and for those attending physical education class daily.

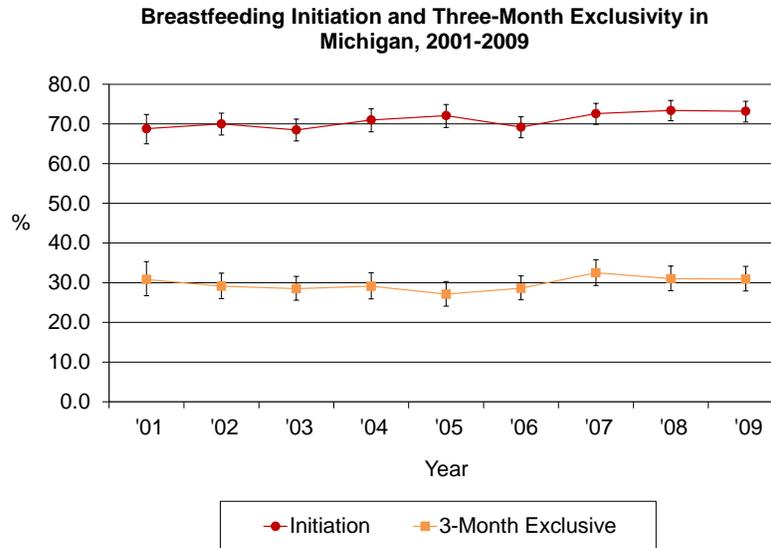
¹³ Michigan Department of Community Health (MDCH). Michigan Behavioral Risk Factor Surveillance System (MiBRFSS). Available at www.michigan.gov/brfs

¹⁴ Michigan Department of Education. Michigan Youth Risk Behavior Survey (MiYRBS). Available at www.michigan.gov/yrbs.

Breastfeeding

The prevalence of breastfeeding initiation among Michigan women who had a live birth increased slightly between 2001 and 2009 based on results from the Michigan Pregnancy Risk Assessment Monitoring System (Chart 1).¹⁵ Unfortunately, the prevalence of mothers who breastfed exclusively for at least three months remained relatively stable at approximately 30%.

Chart 1: Breastfeeding Initiation and Three-Month Exclusivity in Michigan, 2001-2009



For the years 2006 to 2009, combined, Asian-Pacific Islanders showed the highest prevalence (89.1%) of breastfeeding initiation. They were the only racial/ethnic group to exceed the Healthy People 2020 target of 81.9%. White mothers (74%) and Hispanic mothers (75%) were more likely to initiate breastfeeding than Black mothers (58.8%); however, they all fell short of the Healthy People 2020 target. In terms of breastfeeding exclusively for three months, none of the mothers met the Healthy People 2020 target of 46.2% of mothers. In 2009, the prevalence of breastfeeding initiation was significantly higher (90.1%) among college graduates than among mothers with less than a college degree (55.0%-77.2%). Only mothers with at least a college degree (52.3%) met the Healthy People 2020 target (46.2%) for three-month breastfeeding exclusivity. According to the Michigan Pregnancy Risk Assessment Monitoring System, the prevalence of breastfeeding initiation in 2009 was independent of the mother's pre-pregnancy weight status. This was also observed for three-month exclusivity.

¹⁵ Michigan Department of Community Health (MDCH). Michigan Pregnancy Risk Assessment Monitoring System (MiPRAMS). Available at www.michigan.gov/PRAMS