Baby University
Selected Evaluation Findings, August 2015-October 2017

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Prepared for
Baby University

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Introduction

Baby University (Baby U) is a partnership between the city of Chattanooga, Blue Cross Blue Shield of Tennessee, and Signal Centers, Inc., to provide intensive case management services to expectant mothers. Since August of 2015, Baby U’s mission has been to coach families to effectively prepare children for lifelong success through early childhood intervention. This report describes the first 26 months of the Baby U program by analyzing instruments that evaluate the program’s outcomes.

Baby University Program Model

Signal Centers serves as lead agency for the administration of Baby U. Signal Centers accomplishes its goals through Baby U specialists who act with a consortium of collaborative partners working with families in the East Lake, East Side, and Alton Park communities. Signal Centers provides intensive case management, oversight, fiscal monitoring, and serves as the convener of the partnership. The vision is for Baby U to become a model for helping families across Hamilton County and Chattanooga access appropriate services, navigate those services, and prepare children for lifelong success.

The original Baby U program design targeted pregnant women, teens, or families with newborns to age 2 who resided in the East Lake and East Side areas of Chattanooga. As the program matured and funding increased, the program was expanded in 2016 to include the Alton Park neighborhood as well as homeless moms, teen parents, and parents of children with disabilities who may be outside the immediate target communities. The program was further expanded in 2017 to include a component to engage fathers.

Baby U specialists support mothers in having healthy pregnancies and providing quality early learning environments where children can safely achieve their developmental milestones. Teen parent outcomes also include staying in school, graduating high school on time, and delaying additional pregnancies until after graduation.

Specialists partner with parents through evidence-based interventions including strengths-based coaching, motivational interviewing, stages of change, and the Strengthening Families Five Protective Factors, to build family resiliency and promote strong child outcomes. Specialists provide education and resource linkage around quality prenatal care, developmental assessment and intervention when needed, and general health, wellness, and safety needs. Developmentally appropriate

Success Story

A Baby U mom who has maintained all home visits, doctors’ appointments, participated in every Baby U event, and donated no-longer needed items to other families has regained full custody of three of her children this month. The specialist and other social service agencies collaborated to increase family’s stability by connecting them to community resources, developing a home safety plan, promoting early childhood development and academic enrichment, discussing social-emotional behavior support strategies, and helping secure necessities to prepare the three older children for transition back into the home.
parent-child interactions are modeled, and strategies are provided to stimulate early cognitive development. This helps children achieve developmental milestones including literacy and communication, math and logic, fine and gross motor skills, and social-emotional development. Baby U specialists also work to build social connections for parents and increase their sense of community support and decrease isolation. Specialists also collaborate with parents to help them achieve life goals such as completing high school, enrolling in higher education, or obtaining new or improved employment.

Community partnerships enable specialists to provide access to concrete needs including technology, transportation, books, toys, food, car seats, safe sleep environments, and emergency assistance. These partnerships also enable specialists to provide services that support the social and emotional needs of families including connection to subsidy programs, child development screenings and early intervention referrals, free and low-cost access to early childhood education, home- and center-based services for children with special needs, mental health services, in-home parent mentoring and coaching, prenatal care, substance abuse interventions, and community cafés to connect parents.

Baby U specialists conduct initial intakes at potential participants’ homes. Case management consists of biweekly contact with each newly enrolled parent. This frequent contact is made possible by the specialists’ small caseload size of 25 parents per specialist. Parents work closely with specialists to develop goals focused on areas such as parent and child education, employment, child care, housing, and increasing the family’s health and safety.

Baby U specialists work with families to identify goals/needs and monitor progress toward attaining these goals. Specialists and parents jointly monitor progress and determine when the goals are achieved. Parents’ progress toward the goals forms the basis for their transition through a tiered graduation system. As parents achieve their goals around health, safety, and enhanced stability, they progress to the next tier until graduation from Baby U. Graduates are encouraged to volunteer with the program and mentor newly-enrolled parents.

**Methodology**

This report includes results of the analysis of several instruments. During their visits to participating families, Baby U specialists administer several assessment tools aimed at collecting information on families’ self-sufficiency, parenting skills, home health and safety, and children’s development. This report includes results of the analysis of these instruments: the Arizona Self-Sufficiency Matrix, the Ages and Stages Questionnaire®, the Parent’s Assessment of Protective Factors, and a Health and Home Safety Survey. Each of the four assessments is administered at enrollment and at regular intervals thereafter.

In addition, The University of Tennessee Social Work Office of Research and Public Service conducted a parent satisfaction survey to assess parents’ perspectives on the program and experiences with their
specialists. This survey was first administered in spring of 2017 to parents who had been with the program for at least three months; Spanish-speaking parents were interviewed in person by a Baby U staff member who was not their specialist due to language and literacy barriers, whereas English-speaking parents completed and returned the survey by mail.

Together, these measures provide an accurate picture of families’ life situations, changes over the period of enrollment in Baby U, and the families’ perceptions of their Baby U experience. To summarize, this report includes statistical analysis of parent demographics and of data from the four assessments and the satisfaction survey.
Parent Characteristics

Demographics

The demographic data summaries include the 124 active cases and 30 program graduates as of October 31, 2017.

Race and Ethnicity: African Americans made up the largest percentage of parents (87 participants or 56.5%), followed by Latina/Latino parents (43 participants or 28%) and Caucasians (16 participants or 10%) (Figure 1).

Figure 1: Racial Composition

Number of Adults and Children Per Family: There were 60 families with one adult, 68 families with two adults, 18 families with three adults, six families with four adults, and two families with five adults. Nine families included no children (the mothers-to-be were pregnant but had not yet given birth); 38 families had one child; 52 families had two children; 32 families had three children; 11 families had four children; seven families had five children; and five families had six or more children (Figures 2 and 3).
Figure 2: Number of Adults per Family

Figure 3: Number of Children per Family
Pregnancy and Birth Data

The status of 79 participants (51%) was “pregnant” at enrollment (Figure 4). Twenty-nine participants (19%) were teen parents (Figures 5 and 6). Additional data were collected on teen parents: 18 teen parents (62%) were pregnant at enrollment, and for 16 of them, this was their first pregnancy. As of October 31, there were 67 births, including 16 births to teen moms, with an additional 12 due as of November 2017. Birth weight equal to or greater than 5 pounds 8 ounces is considered healthy and used in the state of Tennessee as a cutoff for low birth weight. Eight babies were born weighing less than that amount; two of these babies were twins, who tend to weigh less at birth than do single births, even at full-term.1 Median birth weight was 104 ounces (Figure 7).

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Figure 6: Teen Parent Pregnancy Status at Enrollment

- Pregnant at enrollment
- Not pregnant at enrollment
- Pregnant for first time at enrollment
- Pregnant at enrollment; not first pregnancy

Figure 7: Baby U Births at Healthy Weight (At Least 5 Pounds 8 Ounces)

- No
- Yes

8
59
Outcomes

Healthy Birth Outcomes

Data on healthy birth outcomes for Baby U (2015-2017) were compared with data for the state of Tennessee and Hamilton County from 2015 (source: tn.gov) and with data for Baby U’s target neighborhood ZIP codes (average 2012-15, source: Hamilton County Health Department). Among Baby U parents, 100% received prenatal care; there were no infant mortality cases; and the proportion of infants with low birth weight was smaller than in the target ZIP codes (Figures 8 and 9).

Figure 8: Healthy Birth Outcomes by Location: Prenatal Care

Figure 9: Healthy Birth Outcomes by Location: Low Birth Weight and Infant Mortality
Employment, Education, and Other Outcomes

In addition to their focus on healthy birth outcomes, Baby U specialists have provided support to help families reach self-sufficiency by achieving related milestones like graduating high school, enrolling in higher education, and obtaining new or better jobs. Baby U specialists have collaborated with parents to achieve these self-sufficiency milestones by developing and tracking definite goals such as staying in school or obtaining a GED, improving credit scores, writing resumes, or obtaining transportation or child care when needed. Since 2015, Baby U families have successfully achieved more than 100 such goals, greatly contributing to increasing their self-sufficiency. Baby U specialists have been particularly successful in their efforts to empower teen moms to stay in school and graduate high school. While nationally only 53% of teen moms receive a high-school diploma,2 100% of Baby U’s teen moms have graduated or are on track to graduate with their peers (Figure 10).

Figure 10: Teen Moms On-Track to Graduate High School

Success Story
A single mom looking for work was immediately hired as a housekeeper at a gym close to home and her children’s school. The gym has been working well with her available hours. The gym has even provided mom with a free gym membership for herself and her two girls, and mom has begun attending dance classes; she especially enjoys Zumba.

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Assessment Outcomes

The assessment data analysis includes active cases, program graduates, and at least 48 closed cases (as of October 31, 2017). This report includes statistical analysis of the following assessment data:

- Ages and Stages Questionnaire (ASQ-3),
- Self-Sufficiency Matrix (SSM),
- Parents’ Assessment of Protective Factors (PAPF),
- Health and Safety Survey (H&S), and
- Parent Satisfaction Survey.

ASQ-3 questionnaire copyright © Paul H. Brookes Publishing Co., Inc. All rights reserved. The remaining assessments are included in the Appendix.

**Ages and Stages Questionnaire:** ASQ-3 pinpoints developmental progress of children between 2 and 66 months old in five key areas: communication, gross motor, fine motor, problem solving, and personal-social skills. The ASQ-3 results in a score for each area, and these are compared to cutoff points on the scoring sheet. Scores above the cutoff suggest the child is “on track” developmentally; scores near the cutoff points call for discussion and “monitoring;” and scores beneath the cutoff points indicate “a need for further assessment.”

Each child is assessed at the time of the family’s Baby U enrollment and then at prescribed intervals afterwards depending on age. The percentages of children on track have been compared for the first ASQ-3 assessment and the most recent ASQ-3 assessment; a total of 180 children were assessed at least once, and a total of 103 children were assessed at least twice. There were increases in all four areas, with the biggest increase in the on-track percentage occurring in the area of problem solving skills, the only area where the increase was statistically significant (Figure 11).

*Figure 11: Increase in Percentage of Children On-Track by ASQ-3 Area from the First to the Most Recent ASQ-3 Assessment*

<table>
<thead>
<tr>
<th>Area</th>
<th>First Assessment</th>
<th>Most Recent Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving</td>
<td>88.3%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>88.3%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Personal-Social</td>
<td>90.5%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Communication</td>
<td>91.1%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>91.1%</td>
<td>92.2%</td>
</tr>
</tbody>
</table>
Self-Sufficiency Matrix: The SSM is a tool that enables practitioners, policymakers, and researchers in public healthcare, social services, and related work fields to assess the degree of self-sufficiency of their parents. The instrument used by Baby U has 18 domains. For each domain, there is a 5-point scale, the midpoint of which, “3,” means that the parent reached the basic level of self-sufficiency in this particular domain; the lowest rating, “1,” indicates that the parent is in crisis and not self-sufficient in that domain, and the highest rating, “5,” indicates that the parent is fully self-sufficient and stable in that domain. One of the Baby U goals is to achieve long-term stability for participating families. This would be indicated by the decreased number of domains rated 1 and 2 and increased number of domains rated 3, 4, and especially 5.

SSM is administered at intake and subsequently every 2-6 months. In this report, the percentages of people who scored 3 or above at the first SSM assessment and at the latest available SSM assessment are compared. There were 131 people with at least two SSM assessments by October 31, 2017.

Figures 12 and 13 illustrate increases in the combined percentages of participants who rated various SSM domains as 3, 4, and 5 from the first to the most recent SSM assessments.

While certain domains are universal, others are important only insofar as they represent goals of the mothers assessed. For example, Figure 12 shows that in the employment domain, the percentage of people who scored at 3 or above increased from 29.1% to 62.8%, whereas in the child care domain, the percentage of people who scored at 3 or above increased from 73% to 83%. However, these domains are not considered for those mothers in the Baby U population who intend to stay at home with their children and are therefore not seeking employment or child care.

All the increases in the combined proportions of the respondents who scored 3, 4, and 5 were statistically significant for all domains shown in Figure 12 except adult education.

Figure 13 shows that in the community involvement domain, the percentage of people who scored at 3 or above increased from 75.8% to 90.8%. All the increases in the combined proportions of the respondents who scored 3, 4, and 5 were statistically significant for all domains shown in Figure 13 except health care coverage and substance abuse.

Figure 14 illustrates the spread of the number of SSM domains rated as 1 or 2 (in-crisis or unstable). For example, in the latest SSM assessment, 55% of the participants have rated one or zero domains as in-crisis or unstable. This is an improvement compared to the first assessment, when only 17.6% of participants had one or zero domains as in-crisis or unstable. At the same time, there was a decrease in the number of participants who rated as many as eight to 13 domains as in-crisis or unstable (from 14.5% to
4.6%). The change in the distribution of proportions of people with different numbers of domains in crisis was statistically significant. In particular, the significant increase in the proportion of participants with no domains or only one domain in-crisis can be attributed to the decrease in the proportions of participants with five to seven and eight or more domains in crisis.

Figure 12: Increase in Combined Percentage of Participants Who Rated SSM Domains as 3, 4, or 5 from the First to the Most Recent SSM Assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>First Assessment</th>
<th>Most Recent Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>29.1%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Food</td>
<td>31.3%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Adult Education</td>
<td>44.4%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Income</td>
<td>56.3%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Mobility</td>
<td>70.6%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Housing</td>
<td>71.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Child Care*</td>
<td>73.0%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Family/Social Relations</td>
<td>73.8%</td>
<td>91.6%</td>
</tr>
</tbody>
</table>

Figure 13: Increase in Combined Percentage of Participants Who Rated the SSM Domains as 3, 4, or 5 from the First to the Most Recent SSM Assessment (continued)

<table>
<thead>
<tr>
<th>Domain</th>
<th>First Assessment</th>
<th>Most Recent Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Involvement</td>
<td>75.8%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Life Skills</td>
<td>86.2%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Parenting Skills</td>
<td>89.8%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Safety</td>
<td>92.2%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Disabilities</td>
<td>92.9%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>93.0%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Health Care Coverage</td>
<td>97.7%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>98.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Parents’ Assessment of Protective Factors: The PAPF is a list of 36 statements across four domains, which assesses indicators related to protective factors believed to prevent child abuse: parental resilience, social connections, concrete supports, and social and emotional competence of children. A 5-point Likert-type scale, with responses ranging from 0: “This is not at all like me or what I believe” to 4: “This is very much like me or what I believe,” is used to assess the presence, strength, and growth of parents’ beliefs and behaviors that are indicative of the protective factors—conditions or attributes of individuals, families, communities, or the larger society that both mitigate risk factors of abuse and actively enhance well-being. The maximum score is 4.0 on each of the four protective factors subscales. The PAPF is administered at intake and quarterly thereafter. There were 82 people with at least two PAPF assessments by June 30, 2017. Beginning in July 2017, a different instrument (the Protective Factors Survey) was substituted. As the two instruments are not directly comparable, this report focuses solely on the PAPF since that was the tool used for almost the entire report period.

Because of the high proportion of participants who scored high (3.0 or above) on the first assessment, Figure 15 compares the percentage of participants who scored 4 on each of the four subscales. For the parental resilience factor, the percentage of those who scored 4 increased from the first to the most current PAPF assessment from 43.9% to 62.2%; for the social connections factor, from 32.9% to 50%; for the concrete support factor, from 36.6% to 53.7%; and for the social-emotional competence of children, from 57.5% to 67.9%. The increases in the proportions of participants with maximum scores were statistically significant for all subscales except social and emotional competence of children (which approached significance).

The total PAPF score is the average of responses to the PAPF’s 36 statements. A total score from 3.0 to 3.99 is considered “High,” whereas 4 is the maximum possible score. The percentage of participants who scored 4 increased from 19.5% to 42.7%. The combined percentage of participants with high and maximum (3-4) total scores increased from 91.5% to 92.7% from the first PAPF assessment to the most
current PAPF assessment. Figure 16 illustrates the distribution of total scores. The median total score has increased from 3.7 to 3.9 from the first PAPF assessment to the most current PAPF assessment. The increase was statistically significant (Figure 17).

Figure 15: Increase in Percentage of Parents with Maximum Score on Protective Factors Subscales from the First to the Most Recent PAPF Assessment

<table>
<thead>
<tr>
<th>Social Connections</th>
<th>32.9%</th>
<th>50.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concrete Support</td>
<td>36.6%</td>
<td>53.7%</td>
</tr>
<tr>
<td>Parental Resilience</td>
<td>43.9%</td>
<td>62.2%</td>
</tr>
<tr>
<td>Social and Emotional Competence of Children</td>
<td>57.5%</td>
<td>67.9%</td>
</tr>
</tbody>
</table>

Figure 16: Distribution of Total PAPF Scores from the First to the Most Recent PAPF Assessment

First assessment of PAPF  
Most recent assessment of PAPF

- Percent with total score 4.0 (Maximum)  
  - First assessment: 19.5%  
  - Most recent assessment: 42.7%
- Percent with total score 3.0-3.99 (High)  
  - First assessment: 72.0%  
  - Most recent assessment: 50.0%
- Percent with total score below 3 (Low/Moderate)  
  - First assessment: 8.5%  
  - Most recent assessment: 7.3%
Health and Safety Checklist: The Health and Safety Checklist covers the most common areas of concern and risk in households with young children. The instrument used by Baby U has seven domains, each including multiple questions with the answer options, “Yes,” “No,” and “Not Applicable.” The Health and Safety Checklist is administered at intake and quarterly thereafter. Figure 18 summarizes the differences by domain in the average scale score (calculated by dividing the “Yes” responses by the combined number of “Yes” and “No” responses for each scale domain) from the first assessment to the most current assessment. The total Health and Safety Checklist score is calculated the same way.

There were 108 people with at least two Health and Safety Checklist assessments by October 31, 2017. It should be noted that the Health and Safety Checklist has been revised by Baby U periodically to assess new child-safety domains, in accordance with funder requests; to reconcile the old and the new versions, only the questions that are consistent between versions have been included in calculating the scale domain scores and the total score.

Figure 18 shows that the average scale scores have increased. All the increases were statistically significant. The mean total Health and Safety score increased from .87 to .93 from the first to the most current Health and Safety assessments. This increase was statistically significant (Figure 19).
Figure 18: Increase in Health and Safety Subscale Mean Scores from the First to the Most Recent HSS Assessment

Figure 19: Increase in Mean Health and Safety Total Score from the First to the Most Recent HSS Assessment
Parent Satisfaction Survey

One hundred surveys were provided in person or via mail to current Baby U parents. The surveys consisted of nine Likert-type questions with responses ranging from “Strongly Disagree” to “Strongly Agree.” A total of 30 Baby U parents responded to the survey. Results are summarized in Figure 20.

Out of 30 respondents:

- 29 strongly agreed with the statement that their specialist was a good match for them.
- 29 strongly agreed with the statement that they would recommend Baby U to a friend or relative.
- 29 strongly agreed with the statement that they could get in contact with their specialist when needed.
- 29 strongly agreed with the statement that they were satisfied with services at Baby U.
- 28 strongly agreed with the statement that they understood what was expected from them in order to continue in the program.
- 25 strongly agreed with the statement that they were able to reach their goals as planned.
- 23 strongly agreed with the statement that Baby U incentives were useful and valuable to them.
- 21 strongly agreed with the statement that participating in Baby U helped them be more involved in the community.
- 18 strongly agreed with the statement that the other mothers were very supportive.

The staff at Baby U is working on strategies to increase community involvement and provide ways for parents to interact and support each other to reduce feelings of isolation, such as support groups, alumni mentors, and family-focused community events.

Success Story

The father is the sole provider and mom is the caregiver for five children, ages ranging from 2 months to 13 years old. Mom reached out to the Baby U specialist for help finding English and GED classes as well as summer programs for her oldest child. Mom aspires to enhance her understanding of English to better communicate with her children and the school system.
Positive Case Study

Now a program graduate, a Baby U parent enrolled as a pregnant single mother who already had two children. With the assistance of her Baby U specialist, she had a healthy, full-term pregnancy and gave birth to a baby at a healthy weight of 7 pounds 2 ounces. Over the course of her experience with Baby U, her self-sufficiency grew by leaps and bounds. Over the course of the five SSM assessments she received, she transformed her life, going from having 13 domains in-crisis or at risk (out of 18 SSM domains) and only four domains in which she was stable and thriving at the first assessment to having only one domain in-crisis or at risk and 13 thriving domains by the fifth assessment. She also obtained a solid foundation in the protective factors through her Baby U experiences, increasing her scores from low 3s to perfect 4s across all four subscales of the PAPF assessment over her time in Baby U. This parent demonstrates the effectiveness of the Baby U program in empowering mothers to have healthy pregnancies and births, to increase their self-sufficiency, and to strengthen their families with protective factors.
Figure 20: Results of Parent Satisfaction Survey

<table>
<thead>
<tr>
<th>Statement</th>
<th>STRONGLY AGREE</th>
<th>OTHER RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>My specialist and I are a good match</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can get in contact with my specialist when needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this program to a friend/relative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with services at Baby University</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand what is expected of me in order to continue in the program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to reach my goals as I planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentives are useful/valuable to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in Baby University has helped me be more involved in my community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The other mothers in Baby U are very supportive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

Over the 26 months of the period covered by this report, Baby U specialists have empowered and supported at-risk mothers to meet their concrete needs, as well as to significantly increase their self-sufficiency and the health and safety of their children. With the assistance of their specialists, Baby U families have achieved healthier pregnancies and births, more on-track child development, higher levels of protective factors for family well-being, healthier homes, and greater self-sufficiency. Baby U parents also express a high degree of satisfaction with their experiences with the program and their relationships with their specialists. Going forward, the program will continue to build on its demonstrated successes while further developing parents’ involvement in their communities.

Success Story

A teen mom (age 15, sophomore in high school) has been maintaining daily contact with her Baby U specialist. She attended all prenatal appointments and had a healthy baby girl weighing 7 pounds. Mom is exclusively breastfeeding and taking her daughter to all well-baby checkups. Due to the frequent communication with her specialist, she has decided to begin using birth control. Mom has enrolled her daughter in child care close to home, has returned to school, and plans to be valedictorian of her graduating class.
Appendix: Assessment Instruments

Ages and Stages Questionnaire
Arizona Self-Sufficiency Matrix
Parents’ Assessment of Protective Factors
Health and Safety Checklist
Baby U Parent Satisfaction Survey
Ages and Stages Questionnaire

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Arizona Self-Sufficiency Matrix
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