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# 1998 National Estimates of the Number of Boarder Babies, Abandoned Infants and Discarded Infants

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## EXECUTIVE SUMMARY

This study, entitled *1998 National Estimates of the Number of Boarder Babies, Abandoned Infants and Discarded Infants<sup>1</sup>*, notes an estimated 13,400 boarder babies nationwide. Compared to data from a similar 1991 study, these numbers represent a 38 percent increase in the boarder baby population between 1991 and 1998.

Both studies asked State child welfare agencies to identify jurisdictions that might have had boarder babies. This resulted in contacting 865 hospitals in 101 jurisdictions in 1991 and 926 hospitals in 113 jurisdictions in 1998. Pediatric discharge staff at each hospital provided estimates of the numbers of boarder babies and abandoned infants in the previous year. They also provided data on characteristics and length of stay of those boarder babies and abandoned infants in the hospital on the day they were contacted.

Although the number of boarder babies had increased by 1998, there was a considerable change in the geographic distribution of these infants. In 1991, three jurisdictions accounted for 47 percent of the boarder baby population – New York City, New York; Cook County (Chicago), Illinois; and Los Angeles County, California. By 1998, the number of boarder babies in these jurisdictions had declined by 21 percent, while the boarder baby population in the rest of the nation had increased by 90 percent. Hospital staff who noted a decline in the boarder baby population most frequently attributed the decline to improved efforts on the part of child welfare agencies and hospitals to more promptly identify alternative placements for these children.

When the characteristics of boarder babies in 1991 and 1998 are compared, some positive changes are noted. The mean length of stay for boarder babies beyond the point of medical discharge declined from 22 days in 1991 to 9 days in 1998. The percentage of boarder babies residing in hospitals for more than 21 days declined from 24 percent to 12

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<sup>1</sup> Study definitions are as follows. Boarder babies are infants, under the age of 12 months, who remain in the hospital beyond medical discharge. Abandoned Infants are infants, under the age of 12 months, who have not yet been medically discharged but who are unlikely to leave the hospital in the custody of their biological parent(s). Discarded infants (live births) are infants, under the age of 12 months, found in a public or other inappropriate place absent anyone's care or supervision.

percent. Also, the percentage of these infants who were born prematurely declined from 47 percent to 35 percent, and the percent with a low birthweight declined from 57 percent to 33 percent. Drug exposure decreased over time, yet remained a common characteristic among boarder babies: 79 percent in 1991 and 65 in 1998.

The per diem cost for boarder baby care rose 17 percent from \$476 in 1991 to \$570 in 1998. Although the cost per day increased, the decreases in mean and median length of stay beyond medical discharge led to decreases in the costs of care for each boarder baby. The average cost of care per boarder baby decreased from \$10,472 (for 22 days) in 1991 to \$5,130 (for 9 days) in 1998. The average annual cost of boarder baby care decreased from \$101.6 million in 1991 to \$68.7 million in 1998.

Hospitals in those jurisdictions with a boarder baby problem also were queried about the estimated number of abandoned infants in their hospital during the past year as well the number residing in the hospital on the day they were contacted. In 1998, there were 17,400 abandoned infants identified in these jurisdictions—an increase of 46 percent since 1991.

Unlike the boarder babies, there was no change in the average length of stay for abandoned infants. The mean was 34 days in both 1991 and 1998. Decreases occurred in the percentage of abandoned infants with medical conditions (57 percent in 1991 versus 45 percent in 1998), in the percentage of infants who were drug exposed (78 percent in 1991 and 72 percent in 1998), and in the percentage of infants with low birthweights (76 percent in 1991 versus 71 percent in 1998). No changes occurred in the percentage of abandoned infants born prematurely (70 percent in both 1991 and 1998).

Estimates of the discarded infant population were derived from a search of the Lexis-Nexis newspaper database for 1992 and 1997. The search identified 65 discarded infants in 1992 and 105 infants in 1997. It is uncertain whether the observed differences represent an increase in the numbers of discarded infants or an increase in the reporting of such cases.



## CHAPTER I INTRODUCTION

### A. Background and Purpose of the Study

In 1988, Congress passed P.L. 100-505, The Abandoned Infants Assistance Act, in response to the boarder baby problem identified in the 1980s. The legislation was intended to assist States in addressing the problem of an increasing number of infants residing in hospitals whose parents were unable or unwilling to provide care at the time the infants were medically ready to be discharged from the hospital. The law was enacted in response to concerns that infants who were medically ready for discharge were remaining in hospitals for days, and sometimes months, while child welfare agencies endeavored to find alternative placements for these infants or provide the in-home services necessary to permit the infant to remain in the care of a biological parent(s) safely.

These infants, who are frequently referred to as "boarder babies," created new demands on the already scarce resources available to child welfare agencies and hospitals, particularly in poor, urban areas. Many of these infants were reported to be born to mothers who had been using crack/cocaine during their pregnancy, and some were also reported to have tested positive for the HIV virus. In addition, many of those infants were born prematurely, had low birthweights, or had medical problems that required specialized care. Not only were children who remained in the hospital beyond the point of medical need deprived of the opportunity to grow and develop in a nurturing environment, but medically unnecessary hospital care for those children also resulted in additional costs and a drain on limited medical resources when care in a non-institutional setting would have been more appropriate.

The Act authorized funding for grants to public and nonprofit private entities for developing, implementing and operating programs to demonstrate methods of serving abandoned infants and young children. In addition, the law required the Department of Health and Human Services (HHS) to conduct a study that included national estimates of the number of infants abandoned in hospitals and the annual cost of their care. In December, 1991, the

Administration for Children, Youth and Families (ACYF) awarded a contract to James Bell Associates (JBA) to conduct this study.

The 1991 study (DHHS, 1994) identified an estimated 9,700 boarder babies in the United States. More than three-quarters of the boarder babies were found to be drug-exposed. One-half of the boarder babies were born prematurely, and 57 percent of the infants had low birthweights. The boarder babies remained in the hospital beyond medical discharge for an average of 24 days, or a median of 7 days.<sup>2</sup> The estimated annual cost of care for boarder babies ranged from \$23.1 million to \$101.6 million.

An estimated 11,900 abandoned infants were identified in the 1991 study. Eighty-seven percent of the abandoned infants were found to be drug-exposed. Seventy percent of the abandoned infants were born prematurely, and 66 percent of the infants had low birthweights. The average length of stay in the hospital for abandoned infants was 34 days.

In December 1991, Congress reauthorized and expanded the Act to include services to medically fragile and perinatally drug-affected and HIV-exposed infants and their families.<sup>3</sup> In October 1996, P.L. 104-193 again reauthorized the Abandoned Infants Assistance Act through 2001.

In September, 1997, ACYF awarded JBA a contract to conduct a follow-up study on boarder baby and abandoned infant problems. During the 1990s, changes in population characteristics as well as the availability of services were believed to have affected the boarder baby and abandoned infant populations. Declines in these populations were anticipated, given nationwide declines in crack/cocaine use,<sup>4</sup> increased availability of services through Abandoned

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<sup>2</sup>Medical discharge—a physician’s certification that the patient is medically ready to leave the hospital—is a necessary preliminary to, but is not the same as, hospital discharge, or being released from the hospital.

<sup>3</sup>The Abandoned Infants Assistance Act, P.L. 102-236.

<sup>4</sup>Preliminary findings from the 1996 National Household Survey on Drug Abuse (DHHS, 1997) indicated that the number of cocaine users declined by 4.3 million between 1985 and 1992; numbers of users did not change significantly after 1992. Given the overall decline in cocaine use, a decline in use among women of child-bearing age was anticipated.



Infants Assistance (AIA) grantees, or changes in State and local child welfare agency resources and placement policies.

The purpose of the follow-up study was to:

- Develop more current estimates of the number of boarder babies and the cost of their care, and the number of abandoned infants;
- Examine changes in the nature and extent of the problem for each of the populations between 1991 and 1998; and
- Provide an estimate of the change in the number of discarded infants (i.e., those abandoned in public places other than a hospital) between the two study periods.

This report presents these estimates and also provides an update on the demographic characteristics and medical conditions of boarder babies and abandoned infants including drug exposure and HIV status, and it explores the length of time these infants remained in the hospital both before and after medical discharge. Outcomes, including discharge to biological parent(s) or relative(s), and placement in foster care or an adoptive home, are also examined.

## **B. Study Approach**

A brief description of the definitions employed in the study and the study methodology is required before addressing the issues concerning the number of boarder babies, their costs and their characteristics; the number and characteristics of abandoned infants; and the number of discarded infants.

### **1. Study Definitions**

The terms “boarder babies” and “abandoned infants” are sometimes used interchangeably. However, while boarder babies and abandoned infants may have many common characteristics, there are important differences in terms of the costs of their care and the funding sources used to cover their costs. For the purposes of the study, operational definitions for the populations to be served by the legislation were developed. The study definitions are as follows:

- **Boarder Babies:** Infants, under the age of 12 months, **who remain in the hospital beyond the date of medical discharge.** They may eventually be claimed by their families or abandoned and/or placed in alternative care. (These may include infants who were discharged from the hospital and then returned to the hospital when drug-related or other symptoms endangered their health.)
- **Abandoned Infants:** Infants, under the age of 12 months, who have not yet been medically discharged but who are unlikely to leave the hospital in the custody of their biological parent(s). This includes infants whose parents are unwilling or unable to provide care and/or who the child welfare agency determines cannot safely remain in the care of their biological parent(s).

In other words, boarder babies create an additional strain on hospital resources by remaining in care when there are no longer medical reasons for them to stay. Both boarder babies and abandoned infants affect the child welfare system—increasing the number of Child Protective Services (CPS) investigations, the need for additional services and the need for foster parents.

In addition, this study attempted to identify infants who were “discarded”—left in a public place other than a hospital. This population was not included in the 1991 study, but in recent years there has been significant media attention to this issue. In this study, estimates of the number of discarded infants in 1992 and 1997 were developed.<sup>5</sup> The study definition of **discarded infants** is as follows:

- Were 12 months old or younger;
- Were found in a public place or other inappropriate place without anyone’s care or supervision; and
- Were a live birth or were found deceased and the cause of death appeared to be related to abandonment (e.g., exposure, dehydration, etc.).

## 2. Study Methodology

The data collection methodology for the 1998 study of boarder babies and abandoned infants was similar to the 1991 study. However, a different method was used to obtain data on discarded infants. A description of the data collection methodology for boarder babies and

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<sup>5</sup>The data collection period for discarded infants is somewhat different than that for the boarder baby and abandoned infant populations. Data collection periods for each component are described in sections 2a and b.

abandoned infants is followed by a description of the data collection methodology for discarded infants.

**a. Boarder Babies and Abandoned Infants**

Prior to the 1991 study, no comprehensive effort to identify the number of boarder babies residing in hospitals in the United States had been undertaken. Limited research (CWLA, 1992), as well as media reports, had identified the existence of the boarder baby phenomenon in selected cities, but the full extent of the problem was unknown. To identify the extent of the problem, the 1991 study began by contacting the child welfare agencies in all 50 States and the District of Columbia and asking them to identify any counties or cities in their State that were experiencing a boarder baby problem. This information was supplemented by telephone calls to local child welfare agencies, health departments and hospitals in large urban areas, as well as by a search for newspaper articles on the boarder baby crisis. As a result of these efforts, 101 jurisdictions were identified as possibly having boarder babies. In 1998, calls were again made to State child welfare offices regarding the boarder baby and abandoned infant problem. Through this effort, 12 jurisdictions were added to the initial list of 101 jurisdictions,<sup>6</sup> 2 of which were in States that did not identify a boarder baby problem in 1991 (Oklahoma and Hawaii).

Using *The American Hospital Association Guide*, all hospitals in the study jurisdictions that had a newborn nursery or pediatric unit were identified. This resulted in a list of 926 hospitals in 1998 and 865 hospitals in 1991. A total of 824 (89 percent) of the 1998 hospitals and 853 (99 percent) of the 1991 hospitals agreed to participate in one or more aspects of the study. Conversations were typically held with hospital discharge planners who were either nurses or social workers. Discussions covered the following topics:

- The number of boarder babies residing in the hospital at the time of the telephone discussion (referred to as the census day) and a brief description of their characteristics;

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<sup>6</sup>See the Appendix for a complete list of jurisdictions.

- An estimate of the number of boarder babies who had resided in their hospital during the past year;
- The number and characteristics of infants currently residing in the hospital for medical reasons who were expected to be released to the custody of someone other than their biological parent(s);
- The estimated annual number of infants who left the hospital at the time of medical discharge in the custody of someone other than their biological parent(s); and
- Hospital policies and procedures relating to drug and HIV testing.

For those hospitals that indicated that they had one or more boarder babies residing in the hospital on the census day,<sup>7</sup> a second telephone call was made to a hospital finance administrator who was knowledgeable about cost and reimbursement policies. In 1998, 113 hospitals were contacted, of which 68 (60 percent) agreed to provide some information on cost and reimbursement mechanisms; in 1991, 120 hospitals were contacted, and 97 (81 percent) agreed to provide some cost information. These conversations focused on average daily costs of care for boarder babies and the sources of reimbursement for their care.

This report limited its data collection to infants and young children under 12 months of age. It includes infants who remained in the hospital since birth, and newborns who were discharged to their homes after birth but returned later because of a serious medical condition.

Data from responding hospitals were tabulated to provide national estimates of the number and characteristics of boarder babies and abandoned infants, and the costs of care for boarder babies in the hospital beyond the point of medical discharge. Adjustments to the data were made to correct for non-responding hospitals. It is important to note, however, that the data provided in this report represent an underestimate of the true number of boarder babies and abandoned infants for the following reasons:

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<sup>7</sup>In 1998, a census day refers to any weekday from May 1998 through February 1999, and for the 1991 study, a census day refers to any weekday from December 1991 through June 1992. Although these counts cover somewhat different time periods, there is no reason to expect that seasonal variations would affect the number of boarder babies in a hospital during the study time frames to any notable extent. Therefore, no adjustments for seasonal differences were made.

- State child welfare agencies may have been unaware of or reluctant to acknowledge the existence of a boarder baby/abandoned infant problem. Although the newspaper searches and direct contacts with local child welfare agencies and health departments partially ameliorated this problem, it is likely that some jurisdictions with minimal problems were unintentionally omitted from the study.
- Hospital staff often appeared reluctant to admit to a boarder baby problem. Possible reasons for their reluctance included: (1) fear of jeopardizing Medicaid reimbursement, since Medicaid generally does not cover medically unnecessary hospital days; (2) differences in medical opinion regarding an infant's readiness for medical discharge, including the subjective nature of the decision; and (3) concerns about a negative image for hospitals with a boarder baby problem.

Further, because the data on abandoned infants were collected only from hospitals with boarder babies, the count of abandoned infants is not a national estimate. To address this weakness, the hospitals contacted for the study would have had to have been supplemented with hospitals that were likely to have abandoned infants, but no boarder babies. Such an effort could easily have doubled the number of hospitals contacted.

Another weakness in the data collection methodology was the difficulty in assessing the reliability of information—especially on the estimated annual number of children and cost data—obtained through telephone conversations. As a result, readers are cautioned to view these data as estimates of the nature and scope of the problem and the changes that occurred since 1991.

Despite these limitations, the findings presented in the following chapters reflect the most complete national-level data on boarder babies and abandoned infants available to date.

#### **b. Discarded Infants**

Numbers of discarded infants were identified through a Lexis-Nexis news database search for the periods of November 12, 1991 to November 11, 1992, and November 12, 1996 to November 11, 1997. The initial search provided headline citations using the following key

words: boarder, abandon, discard, baby, babies, infant and newborn.<sup>8</sup> Excluding international cases, the search produced 628 citations in 1997, and 230 citations in 1992. Citations provided news source titles, headlines, authors, publishers, publication dates, number of words per article, and in some instances, publication locations. Some cases garnered considerable attention, resulting in numerous articles being written describing the same infant. These records were not "double-counted;" duplication was detected using information about the infant or family name, demographics, location, date of incident or article, and/or other circumstances of abandonment.

### **C. Organization of this Report**

Chapter II presents the annual estimated numbers of boarder babies, abandoned infants and discarded infants. Chapter III presents comparisons of boarder baby characteristics data as well as the cost of care for boarder babies between 1991 and 1998. Abandoned infant characteristics data are presented in the fourth chapter. Chapter V provides a summary and conclusion of the study findings.

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<sup>8</sup>The search string was as follows: boarder OR abandon\* OR discard\* WITHIN 3 words of baby OR babies OR infant OR newborn. The search captured articles published from January 1, 1991 to November 13, 1997.

## CHAPTER II

### ANNUAL ESTIMATED NUMBERS OF BOARDER BABIES, ABANDONED INFANTS AND DISCARDED INFANTS

As described in Chapter I, the 1991 study on boarder babies and abandoned infants was the first effort by the Children's Bureau to quantify the extent of the boarder baby problem on a national level. One purpose of the 1998 study was to update national estimates of boarder babies and abandoned infants and to develop, for the first time, estimates of the numbers of discarded infants. This chapter presents findings on the numbers of infants found in 1998 and analyses of the changes that occurred since 1991.

Estimated counts of boarder babies, abandoned infants and discarded infants all rose from 1991 to 1998. Exhibit II-1 shows the numbers of infants and the percent increases. The boarder baby population rose 38 percent; the abandoned infant population rose at a higher rate—46 percent; and numbers of discarded infants rose 62 percent.

**Exhibit II-1  
Annual National Estimates**

	1991	1998	Percent Increase
Boarder Babies	9,700	13,400	38%
Abandoned Infants	11,900	17,400	46%
Discarded Infants	65	105	62%

The increase in the number of boarder babies is somewhat surprising. Recently, there have been fewer reports in the media about the boarder baby problem, and anecdotal information from hospitals that previously reported high numbers of boarder babies has indicated a decline in the problem. Reductions in the number of boarder babies and abandoned infants also might have been expected, given the decline reported in crack/cocaine use. In addition, by the time of the follow-up study, several responses to the boarder baby problem had been in place for several years. Approaches included an increased use of kinship care instead of traditional foster care, and the development of programs such as those supported by

the Abandoned Infants Assistance Program (AIA). Since fiscal year 1990, the AIA discretionary funds have been used to provide health, education and social services to medically fragile, perinatally drug-, alcohol-, or HIV-exposed infants and their families at more than 40 sites (Maza, 1999).

In regard to discarded infants, the information in this study sheds light on the scope of a highly publicized problem. Relative to the boarder baby and abandoned infant counts, the discarded infant population appears small. Although the number of discarded infants rose 62 percent from 1991 to 1998, 105 infants are less than one percent of either the boarder baby or abandoned infant populations identified in 1998.<sup>9</sup> More details regarding the three study population counts are presented below.

#### **A. National Estimates of the Numbers of Boarder Babies**

The number of boarder babies rose nationally from 9,700 in 1991 to 13,400 in 1998, a 38 percent increase. However, a closer examination of the data reveals that the number of boarder babies decreased in some jurisdictions and increased in others. As shown in Exhibit II-2, in both 1991 and 1998, New York City, Cook County (Chicago), Illinois and Los Angeles County, California had the largest estimated number of boarder babies annually. However, in 1991 these three jurisdictions accounted for 47 percent of the boarder babies identified in the study, while they accounted for only 27 percent of the boarder babies in 1998. All other jurisdictions had an estimated 5,124 babies in 1991 and 9,719 boarder babies in 1998, representing a 90 percent increase in the number of boarder babies outside the three jurisdictions with the largest numbers of boarder babies. Both New York City and Cook County experienced considerable declines in their estimated boarder baby population (27 percent and 28 percent respectively). Some other jurisdictions with large numbers of boarder babies in 1991 also had experienced notable declines by 1998. In Wayne County (Detroit), Michigan, the estimated number of boarder babies declined 62 percent between the two study periods, from 707 in 1991 to 266 in 1998. Similarly, the number of boarder babies declined 59 percent in Washington, D.C., from 138 in 1991 to 57 in 1998.

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<sup>9</sup>Further, since the discarded infant counts are based on a newspaper search, it is possible that the increase is related to increased reporting of these events.



**Exhibit II-2**  
**Number of Boarder Babies in the Three Jurisdictions**  
**with the Largest Boarder Baby Populations in 1991 and 1998<sup>10</sup>**

Jurisdiction	Number and Percent of Boarder Babies				Percent Change 1991 vs. 1998
	1991		1998		
New York City, NY	2,141	22%	1,571	12%	-27%
Cook County (Chicago), IL	1,661	17%	1,194	9%	-28%
Los Angeles County, CA	812	8%	889	7%	10%
<b>THREE-JURISDICTION TOTAL</b>	<b>4,614</b>	<b>47%</b>	<b>3,654</b>	<b>27%</b>	<b>-21%</b>
All Other Jurisdictions	5,124	53%	9,719	73%	90%
<b>TOTAL</b>	<b>9,738</b>	<b>100%</b>	<b>13,373</b>	<b>100%</b>	<b>38%<sup>11</sup></b>

At the same time, other urban jurisdictions noted considerable increases in the estimated number of boarder babies between the study periods. For example, after New York City, Cook County and Los Angeles County, the jurisdictions with the highest estimated number of boarder babies in 1998 were: Essex County (Newark), New Jersey; Harris County (Houston), Texas; King County (Seattle), Washington; St. Louis City/County, Missouri; and Baltimore City/County, Maryland. Exhibit II-3 shows the estimated number of boarder babies in 1991 and 1998 and the percentage increases in these jurisdictions.

**Exhibit II-3**  
**Other Jurisdictions with Large Boarder Baby Populations in 1998**

Jurisdiction	Number and Percent of Boarder Babies				Percent Change 1991 vs. 1998
	1991		1998		
Essex County (Newark), NJ	270	3%	798	6%	196%
Harris County (Houston), TX	73	1%	548	4%	651%
King County (Seattle), WA	77	1%	367	3%	377%
St. Louis City/County, MO	99	1%	279	2%	182%
Baltimore City/County, MD	81	1%	273	2%	237%

<sup>10</sup>Figures are rounded to the second decimal point throughout this report.

<sup>11</sup>The national percent change is based on rounding the estimated national totals of babies to 9,700 for 1991 and to 13,400 for 1998.

Several factors may account for geographic shifts in boarder babies. One explanation is that the large urban centers that experienced high concentrations of boarder babies in the late 1980s and early 1990s have now responded to their earlier crises and have developed the policies and resources to address the problem. Anecdotally, there is a suggestion that geographic changes in drug utilization may also affect the dispersal of the boarder baby problem. Drugs, such as methamphetamine, are "locally manufactured" and may become more prevalent in smaller cities and rural areas not dependent on typical drug traffic routes.

Telephone survey participants provided their explanations for changes in the number of boarder babies. Of the 170 respondents who were in their jobs long enough to discuss changes in population over time in their hospital, 60 believed numbers had increased, 70 thought numbers had decreased, and 40 believed numbers remained about the same. Reasons offered for decreased numbers were:

- Child welfare agencies and hospitals had become more aggressive about promptly finding homes for the infants (46 respondents). Discharge planners, for example, reported that they contacted CPS as soon as they had reason to believe that an infant might not safely go home with a parent rather than waiting, as in the past, to contact CPS until the infant was about to be medically released. Others felt CPS had become faster and/or more resourceful in finding placements and in picking up the infants on time.
- Fewer drugs were seen among hospital patients (15 respondents).
- Hospital census counts were down (13 respondents).
- Community demographics had changed (7 respondents).

When participants indicated increases in boarder baby counts, they offered the following explanations.

- Hospital census counts had increased (38 respondents).
- Drugs were more present and/or there was better drug screening of mothers and infants (16 respondents).
- CPS was taking longer to place infants or they faced a lack of homes for medically fragile infants (12 respondents).
- Hospital populations had changed (10 respondents).

Given the increases in numbers and the change in the distribution of boarder babies, it would be expected that more hospitals are caring for boarder babies. In 1991, 59 percent of the hospitals studied reported having one or more boarder babies in the past year; in 1998, this rose to 76 percent of hospitals reporting at least one boarder baby in the past year. However, the proportion of boarder babies residing in public and in large hospitals over a year remained the same. In both 1991 and 1998, about one-fifth of the hospitals that housed boarder babies were public hospitals. More than two-thirds of the hospitals reporting boarder babies were large (250 beds or more): 73 percent in 1991 and 79 percent in 1998.

**B. National Estimates of the Numbers of Abandoned Infants**

Abandoned infant counts rose from 11,900 in 1991 to 17,400 in 1998. This was a 46 percent increase and was a larger percent increase than was found for boarder babies (38 percent). As was true with boarder babies, the jurisdictions with the largest number of abandoned infants in both 1991 and 1998 were New York City, Cook County (Chicago), Illinois and Los Angeles County, California. However, unlike the boarder baby population, which showed declines in numbers in these three jurisdictions between 1991 and 1998, there was an 11 percent increase in the abandoned infant population (see Exhibit II-4). However, there was an even greater increase in the number of abandoned infants identified in jurisdictions other than New York City, Cook County and Los Angeles County. In these other jurisdictions, the estimated percentage of boarder babies increased by 64 percent, from 7,856 in 1991 to 12,915 in 1998.

**Exhibit II-4  
Number of Abandoned Infants in the Three Jurisdictions  
with the Largest Abandoned Infant Populations in 1991 and 1998**

Jurisdiction	Number and Percent of Abandoned Infants				Percent Change 1991 vs. 1998
	1991		1998		
New York City, NY	2,211	19 %	1,244	7 %	-44 %
Cook County (Chicago), IL	701	6 %	1,127	7 %	61 %
Los Angeles County, CA	1,117	9 %	2,090	12 %	87 %
<b>THREE-JURISDICTION TOTAL</b>	<b>4,029</b>	<b>34 %</b>	<b>4,461</b>	<b>26 %</b>	<b>11 %</b>
All Other Jurisdictions	7,856	66 %	12,915	74 %	64 %
<b>TOTAL</b>	<b>11,885</b>	<b>100 %</b>	<b>17,376</b>	<b>100 %</b>	<b>46 %</b>

Abandoned infant populations, like boarder babies, both increased nationally and became more widely dispersed. Abandoned infants may be viewed as “potential boarder babies” whose living arrangements were resolved prior to the time of medical discharge. These findings support the hypothesis that an improved response by child welfare agencies and hospitals, rather than a decline in drug use or related problems, may account for changes in boarder baby and abandoned infant populations.

Similar to boarder baby findings, more hospitals were serving abandoned infants in 1998 than in 1991 (83 percent and 67 percent, respectively). The proportion of abandoned infants residing in public and in large hospitals was similar to the proportion of boarder babies. In 1991, 26 percent, and in 1998, 23 percent of all abandoned infants were found in public hospitals. In 1991, 80 percent, and in 1998, 74 percent of all abandoned infants resided in large hospitals (250 or more beds).

**C. National Estimates of the Numbers of Discarded Infants**

A Lexis-Nexis news database search resulted in identifying 65 discarded infants in 1992 and 105 in 1997, a 62 percent increase (Exhibit II-5). Although increases were noted for infants found alive and those found deceased, the larger increase was among those found deceased. Exhibit II-5 presents numbers of infants found alive and those found deceased for the 1992 and 1997 time periods. Cases in which homicide was certain were not included. Of those who were found deceased, however, the count includes infants for whom a live birth was questionable and/or for whom a cause of death was not determined. Since most articles were published immediately following an incident, autopsy results were not necessarily available to be reported in an article. In other cases, autopsies were inconclusive.

**Exhibit II-5  
Number of Discarded Infants and Percent Increase Between 1992 and 1997**

	1992	1997
Number of Infants Found Alive	57	72
Number of Infants Found Deceased	8	33
<b>TOTAL</b>	<b>65</b>	<b>105</b>

Because the numbers in both time periods are small, it is difficult to determine whether the percentage increase represents a true increase, a change in the scope of the Lexis-Nexis database or a change in the frequency with which newspapers covered the stories. There is at least some evidence that the differences may not entirely reflect a true increase in discarded infants. First, media coverage of these cases may have increased. In 1997, there were three very high-profile stories: (1) the University of Delaware couple who discarded their newborn in a trash bin outside a New Jersey motel; (2) the New Jersey high school student who delivered a baby at her prom; and, (3) the infant found alive in a bathroom at Disney World. It is possible that these nationally covered stories have prompted greater media attention to similar local occurrences, and thus, increased reporting.

Second, the Lexis-Nexis news database contained more data sources (approximately 4,000) in 1997 than in 1992 (approximately 3,600 news sources). Lexis-Nexis purchases data from various news source and database vendors. Over time, their contracts with vendors change, as do the database contents.

Perhaps the more important finding is the relatively small number of discarded infants in either time period when compared to the numbers of boarder babies and abandoned infants. This observation is not intended to trivialize the issues concerning discarded infants; however, it is important to note that for each discarded infant identified in 1997, there were 128 boarder babies and 166 abandoned infants.

## CHAPTER III

### CHARACTERISTICS OF BOARDER BABIES AND COST OF THEIR CARE

As described in the study methodology (Chapter I), additional information was acquired regarding infants who were being served on the census day. In 1991, there were 300 boarder babies on the census day. In 1998, there were 210 census day boarder babies.<sup>12</sup> This chapter presents findings on these boarder babies with regard to their characteristics and medical conditions, drug and HIV testing and exposure, discharge plans, and length of stay in the hospital. Finally, costs of care for boarder babies are presented. In some instances, data about a specific child were unavailable. Numbers, represented by "n" in the graphs, indicate the number of infants for which information on that variable was available. Where graphics are not presented, the relevant "n" is provided in the text.

#### A. Characteristics of Boarder Babies

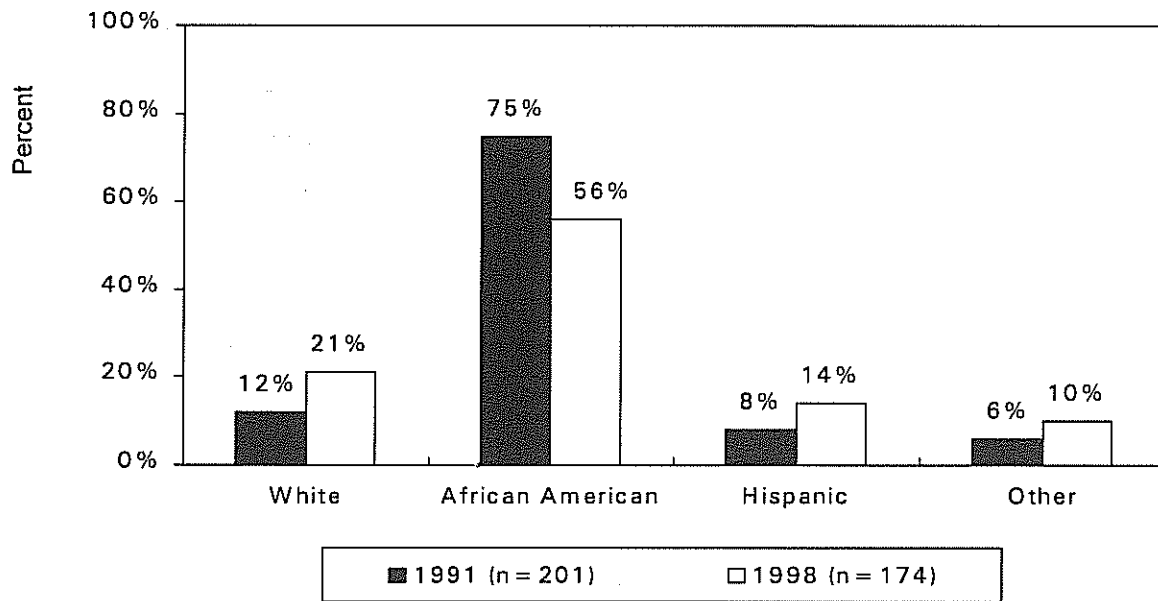
Basic demographic data were requested for the census day boarder babies. In both study years, the sex of the infants was similar: 48 percent of 200 infants in 1991, and 52 percent of 155 infants in 1998 were female. Exhibit III-1 presents the distribution of boarder babies in 1991 and 1998 by race/ethnicity. The majority of infants in both study years were African American, although African American children constituted a smaller percentage of boarder babies in 1998 than in 1991 (56 percent versus 75 percent).

It is difficult to determine the reason for the change in the racial/ethnic composition of the boarder baby problem. It is possible that increased efforts by the child welfare agencies and hospitals in the large cities reduced the number of African American boarder babies. Similarly, the increase in white boarder babies may reflect the movement of the problem to smaller cities and suburbs where the proportion of African Americans is smaller.

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<sup>12</sup>The census day is the day of the telephone contact between the hospital and JBA. Respondents provided data on the characteristics of boarder babies and abandoned infants in their care on the date of contact. These data were not used for the purpose of deriving annual estimates. Annual estimates were provided separately by each respondent. The fact that there were fewer boarder babies on the census day in 1998 than in 1991 is not indicative of a decline in the number of babies reported annually. As discussed later, the decline in the length of stay for boarder babies likely contributed to fewer boarder babies being reported in a count on any single day.

**Exhibit III-1  
Percent of Boarder Babies by Race/Ethnicity**



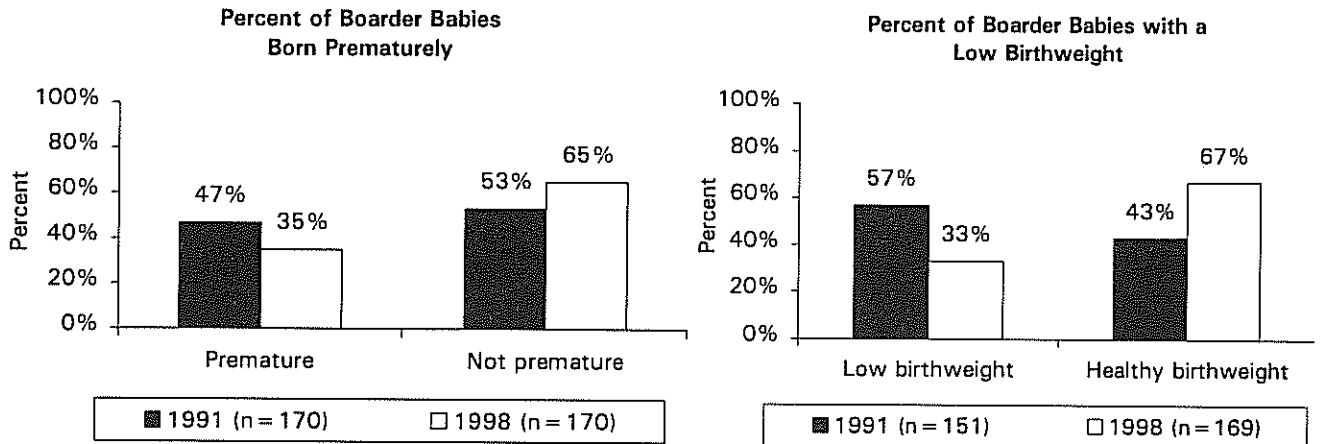
**1. Medical Conditions**

Discharge planners provided information on infants' prematurity, low birthweight and other medical conditions<sup>13</sup>. In 1991, 47 percent of the census day boarder babies were born prematurely; this figure dropped to 35 percent in 1998 (see Exhibit III-2). There was also a decrease in boarder babies with a low birthweight: 57 percent in 1991 to 33 percent in 1998.

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<sup>13</sup> "Other medical conditions" excludes drug and HIV exposure, which are discussed in Section 2.

**Exhibit III-2  
Medical Conditions of Boarder Babies**



In 1991, discharge planners reported that 36 percent of the census day boarder babies had one or more medical conditions (other than drug or HIV exposure, prematurity or a low birthweight). In 1998, this figure decreased to 28 percent. The types of conditions infants suffered included respiratory problems, heart defects, congenital syphilis or other sexually transmitted diseases, physical deformities, or injuries from domestic violence. In the latter case, newborns may have been initially discharged to their parent(s), but were readmitted to a hospital while still very young as a result of abuse/neglect at home. In some instances, these boarder babies had conditions that required equipment such as an apnea monitor or a ventilator that a parent or caretaker needed to operate. For some mothers who might have managed to care for a healthy infant, the added burdens of caring for a medically fragile infant may have been overwhelming. When the infant's medical needs resulted in a hospital admission, the parent (or the child welfare agency) may have decided the infant should not return home.<sup>14</sup>

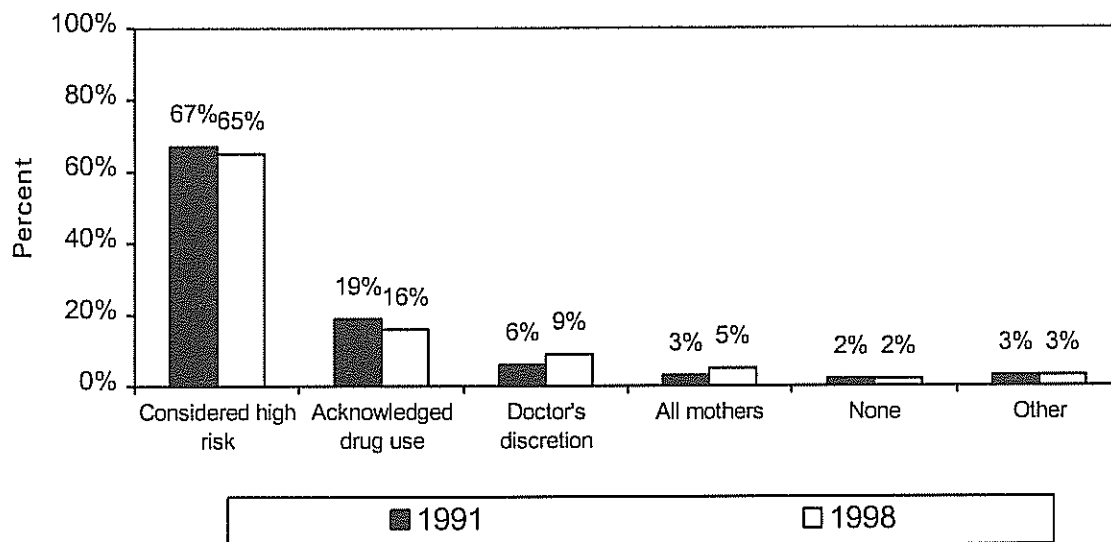
<sup>14</sup>Although this study only included infants up to one year of age, some respondents noted that they had older babies who returned to the hospital and subsequently became boarder babies.



## 2. Drug and HIV Testing and Exposure

Discussions with discharge planners included hospital policies on drug and HIV testing as well as drug and HIV test results for boarder babies. Exhibit III-3 presents responses to a question about hospital policies regarding which mothers were tested for drugs. The most frequently cited policy was to test mothers who were considered "high risk." Typically, this included mothers who: were suspected of or known to have abused drugs; did not receive prenatal care; were teenage mothers; had premature deliveries; had previous CPS involvement; were homeless; had a known psychiatric history; had displayed unusual or inappropriate behavior; had a history of violence; and/or lacked resources. Less common were policies calling for testing only those mothers who acknowledged drug use during pregnancy, testing at the doctor's discretion, testing all mothers, or not testing mothers for drugs (some hospitals, for example, were children's hospitals which would not treat mothers). When asked about drug testing procedures for infants, the most frequent response was that infants were tested if their mothers were considered high risk (65 percent and 54 percent in 1991 and 1998, respectively). Other reasons for testing infants were mothers who acknowledged drug use, mothers who tested positive for drugs; and infants who exhibited withdrawal symptoms.

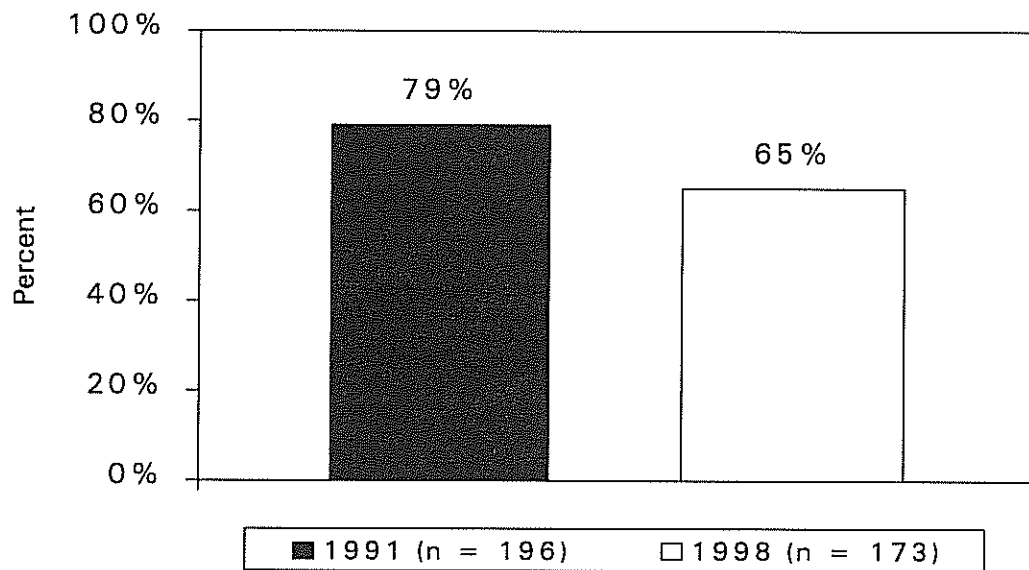
**Exhibit III-3**  
**Hospital Drug Testing Procedures for Mothers**



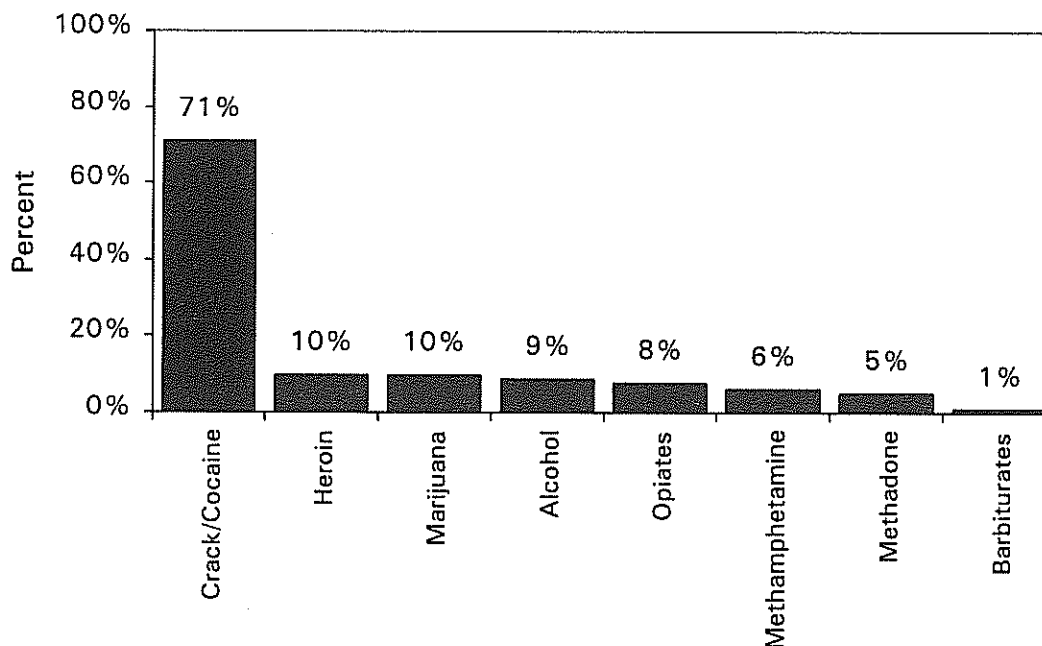
These responses are similar to the ones provided in the 1991 study. They suggest that there are still no uniform standards as to when to test mothers or infants for drugs. Instead, hospitals and doctors assess whether one or more factors may suggest that there is a high risk of drug use. Consequently, data on the percentage of infants with positive drug tests may underrepresent the true extent of the problem. The lack of consistent testing criteria may also skew the data on positive drug tests by race, since some criteria for testing (e.g., lack of prenatal care, receipt of Medicaid) may result in more frequent testing of minority mothers and infants than of white mothers and infants.

In 1991, 65 percent of the infants were tested for drug exposure; 82 percent were tested in 1998. Of the infants who were drug tested and for whom data were available, 79 percent and 65 percent of the infants tested positive for drug exposure in 1991 and 1998, respectively (see Exhibit III-4). In 1998, respondents were able to identify which drugs were present; they could report more than one drug for each infant. As shown in Exhibit III-5, crack/cocaine was most prevalent (71 percent). Other drugs found were heroin, marijuana, alcohol, opiates, methamphetamine, methadone and barbiturates.

**Exhibit III-4**  
**Percent of Infants Who Tested Positive for Drug Exposure**

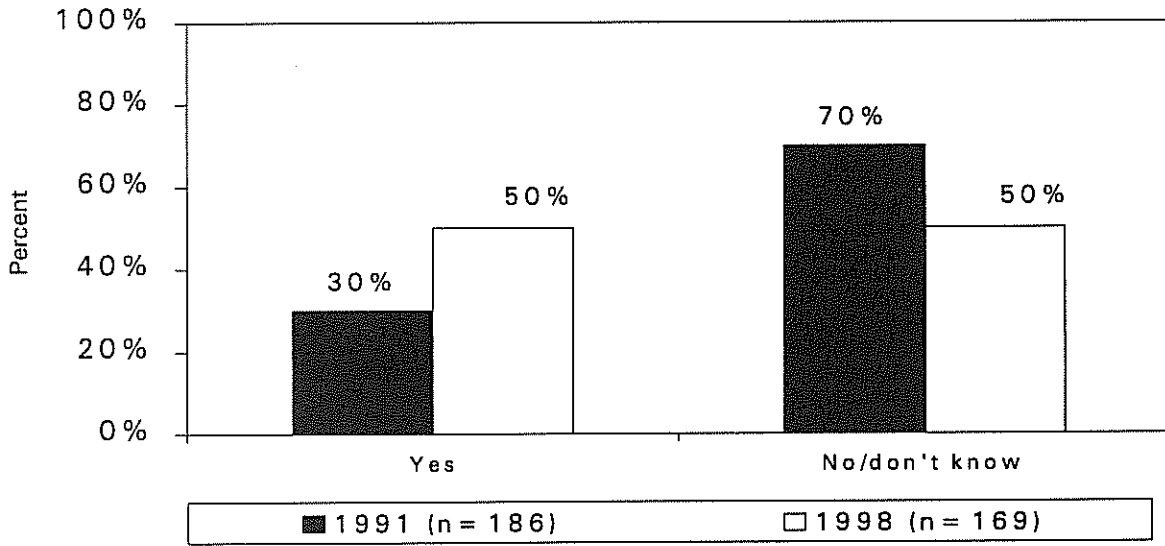


**Exhibit III-5**  
**Percent of Census Day Boarder Babies with Drugs Present in 1998**  
**(n = 106 infants)**

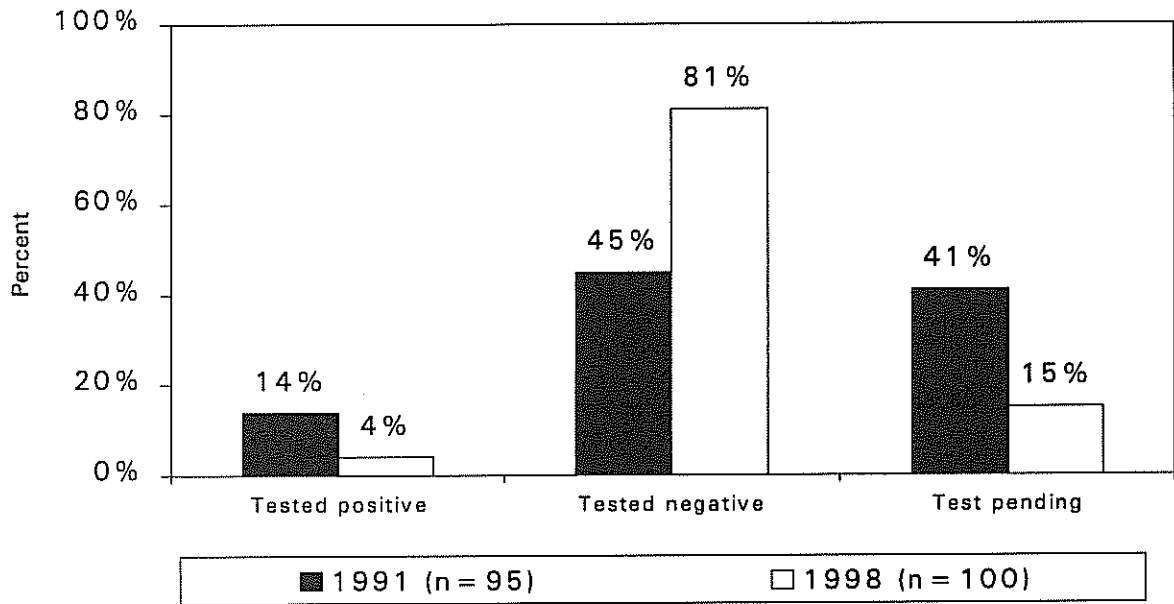


As shown in Exhibits III-6 and III-7, the findings on HIV testing show considerable change since the 1991 study in terms of both the number tested and the number whose results were negative. Testing for HIV rose from 30 to 50 percent between 1991 and 1998, as shown in Exhibit III-6. Among those tested, the percent of boarder babies found to be HIV positive was smaller in 1998 than in 1991 (4 percent versus 14 percent) (see Exhibit III-7).

**Exhibit III-6  
Percent Tested for HIV**



**Exhibit III-7  
Results of HIV Testing**



### 3. Reasons for Alternative Care and Discharge Plans for Boarder Babies

Discharge planners discussed three related issues regarding the status of infants as “boarder” babies: (1) reasons infants needed alternative care; (2) reasons for the infants’ continued stay in the hospital; and (3) discharge or placement plans for the infants. Exhibits III-8 and III-9 present reasons why alternative care was needed for the boarder babies in 1998 as perceived by the discharge planner. The first exhibit presents responses to questions about the parents’ ability or willingness to provide care for the infant; the second graph presents responses regarding CPS involvement in each case. While there was a common perception that infants became boarder babies as a result of maternal abandonment, Exhibit III-8 shows that the mother’s identity was always known, and that mothers were typically **willing but unable** to provide care for the infant (68 percent). Only one-fifth of the mothers were considered to be unwilling to care for their infants. Eight percent were willing to at least temporarily place the child in foster care or the care of a relative. Reasons parents may have been unable to care for an infant could have included parental drug involvement, lack of resources, inability to reliably operate medical equipment or meet the special health needs of a medically fragile infant, and homelessness.

**Exhibit III-8**  
**Parent-Related Reasons for Alternative Care for Boarder Babies**

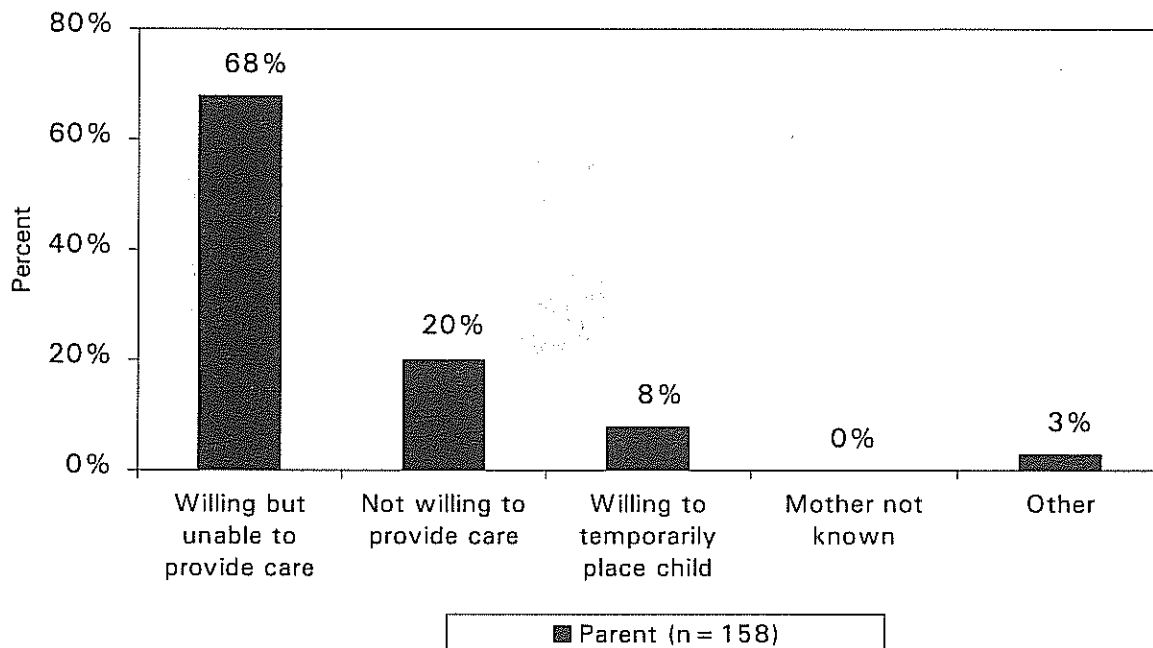


Exhibit III-9 focuses on the status of CPS involvement. CPS was involved in 84 percent of the boarder baby cases. In nearly one-half the cases (48 percent), CPS had determined that is was unsafe to allow the infant to be discharged to the parent(s). CPS had not completed its investigation in another 27 percent of the cases.

**Exhibit III-9**  
**Status of CPS Involvement with Boarder Babies**  
(n = 169)

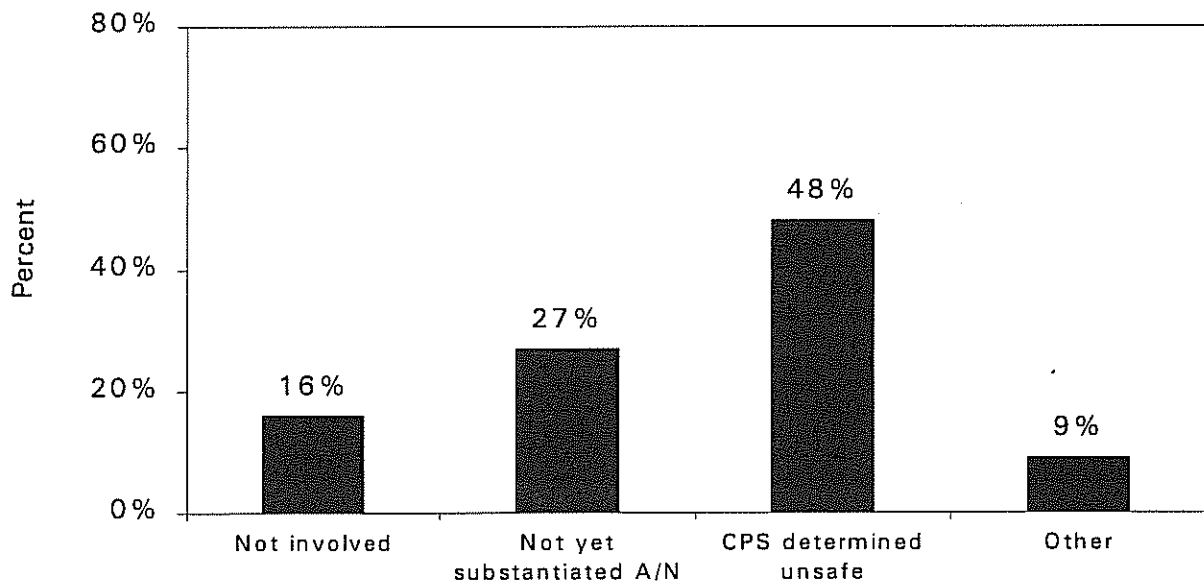
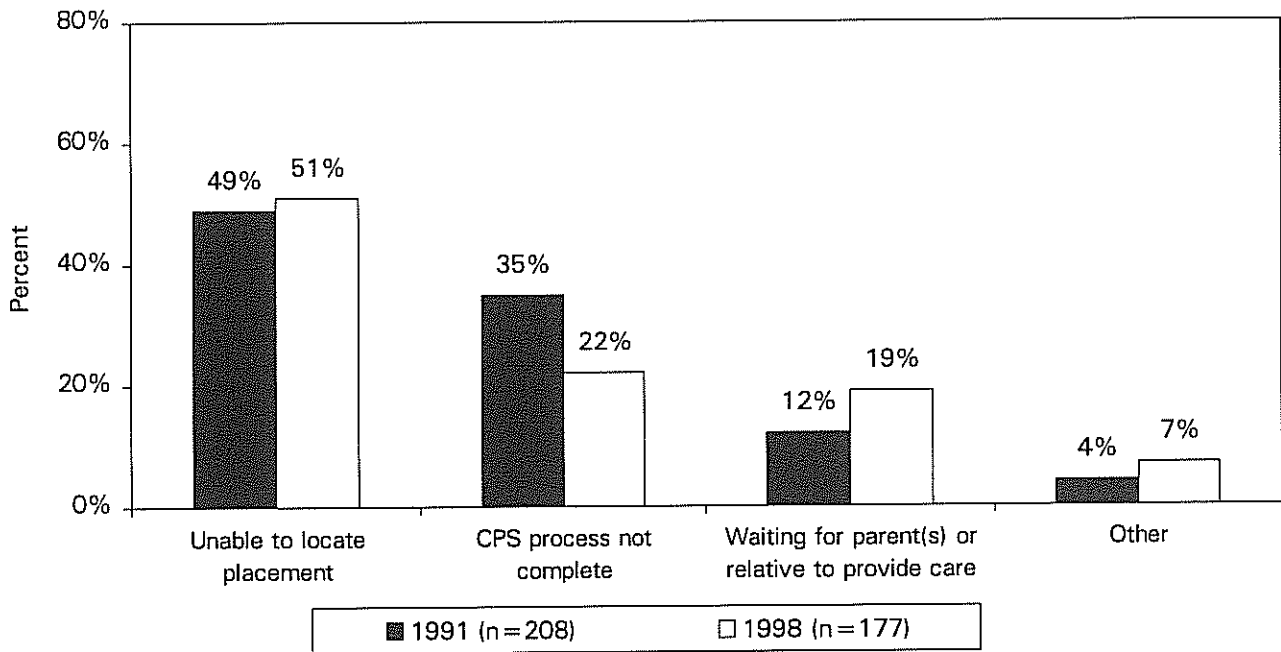


Exhibit III-10 presents the reasons infants remained in the hospital after medical discharge. An inability to locate an appropriate placement was the most common reason for boarder babies' continued stays in both 1991 and 1998 (49 percent and 51 percent, respectively). However, CPS appears to have reduced the number of cases in which delays in completing investigations resulted in infants remaining in the hospital after medical discharge. Incomplete investigations occurred more often in 1991 (35 percent of cases) than in 1998 (22 percent of cases). The findings also suggest that in an increasing number of cases, CPS provided the time and/or support necessary for the infant to remain in the care of a parent or relative (12 percent in 1991 and 19 percent in 1998).

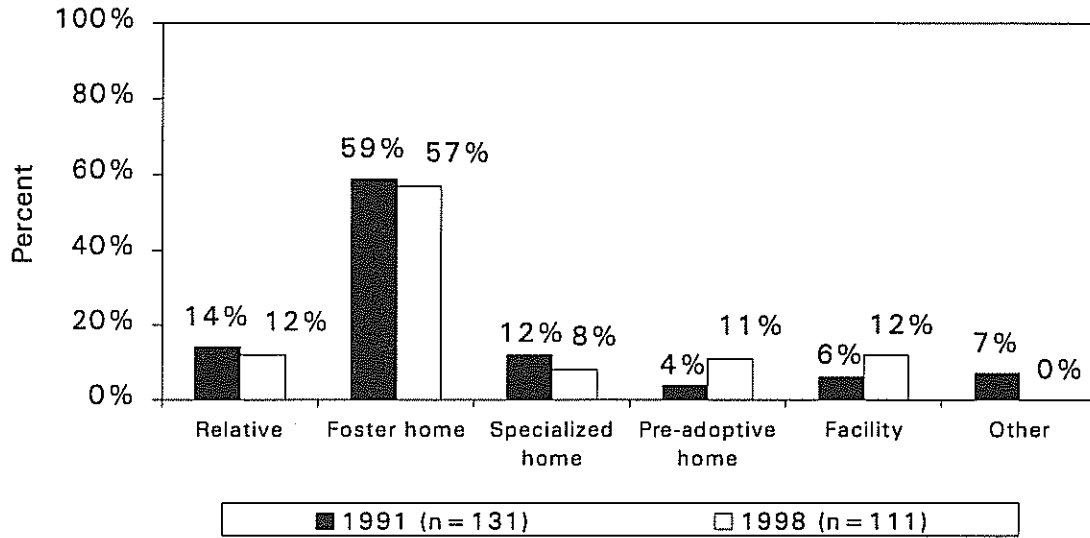
**Exhibit III-10**  
**Reasons for Boarder Babies' Continued Stay in the Hospital**



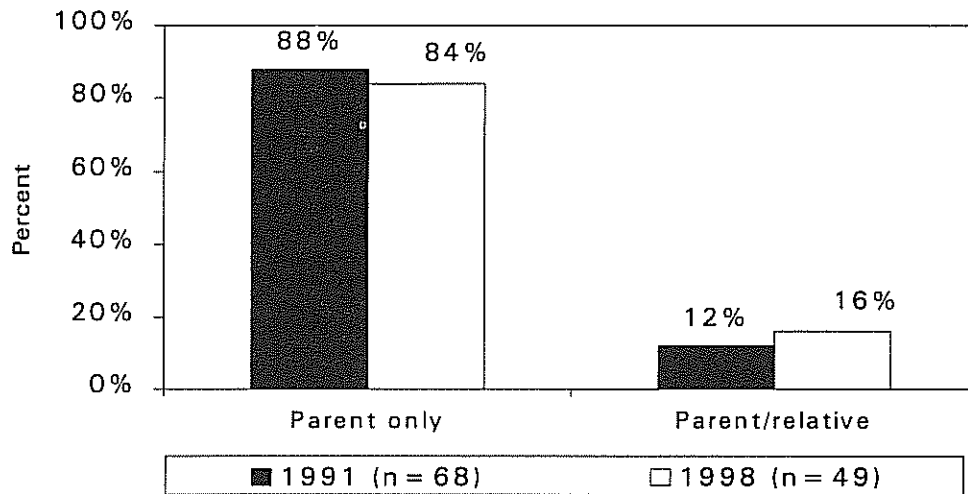
In 1991, 66 percent of the infants were expected to have an out-of-home placement; in 1998, this figure was 70 percent. For those infants requiring placement, Exhibit III-11 identifies the types of placements expected. As shown in the Exhibit, there was little change between 1991 and 1998 in the types of placements used. The most common placement was foster care (59 and 57 percent in 1991 and 1998). Other placements included relatives (with no biological parent in the home), specialized foster care, preadoptive homes, and congregate care facilities.

For those infants expected to be returned home, Exhibit III-12 shows that in both 1991 and 1998, the majority of infants would be released to the biological parent only (88 and 84 percent). Other infants were expected to be discharged to their parent(s), but with the requirement that another relative also be in the home.

**Exhibit III-11**  
**Expected Discharge Plans for Boarder Babies—Out-of-Home Placement**



**Exhibit III-12**  
**Expected Discharge Plans for Boarder Babies—Home to Biological Parent**



**4. Length of Stay in the Hospital**

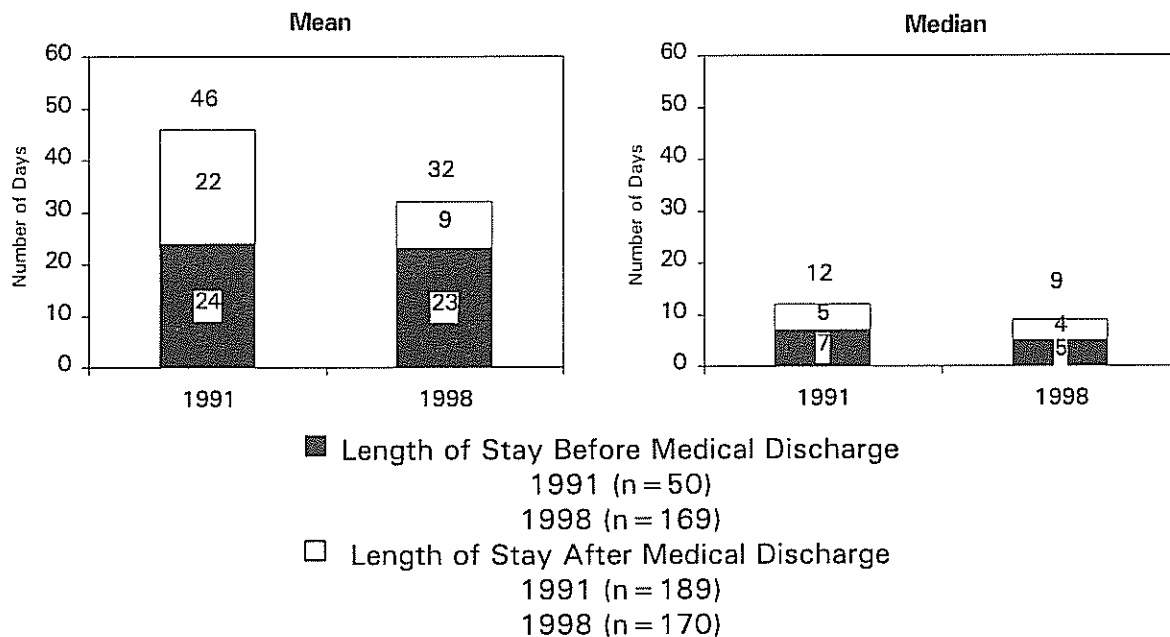
The length of time boarder babies remain in the hospital can be divided into two separate time periods: the length of stay prior to becoming medically ready for discharge, and the period of time beginning when an infant is medically ready to leave the hospital and ending the day the infant leaves. Unfortunately, since data were obtained for infants who were still in the hospital, the true length of stay cannot be determined. Instead, data were obtained for the time between medical discharge and the date the study team contacted the



hospital. Clearly, these findings should be viewed as an underestimate of the true length of stay. However, since the same methodology was also used in 1991, it is possible to determine, at least partially, how length of stay has changed over time. Exhibit III-13 presents boarder babies' mean and median lengths of stay. The mean length of stay **prior** to medical discharge did not vary between 1991 and 1998 (24 and 23 days, respectively); however, the mean length of stay **after** medical discharge decreased from 22 to 9 days. The median length of stay changed from 5 to 4 days **after** medical discharge. In 1991, 24 percent of the boarder babies remained in the hospital for three weeks or longer after medical discharge. By 1998, only 12 percent remained in the hospital for this length of time. No infants stayed longer than 100 days in 1998, whereas 5 percent stayed longer than 100 days in 1991.

To summarize, the length of stay after medical discharge had shifted to shorter hospital stays in 1998 than in 1991. These findings suggest that the major change in length of stay after medical discharge occurred among those infants who had previously remained in the hospital for the longest periods of time. This pattern can be seen more clearly in Exhibit III-14. In 1991, 24 percent of the boarder babies were in care three weeks or more. By 1998, only 12 percent remained in care three weeks or longer.

**Exhibit III-13  
Mean and Median Length of Stay Before and After Medical Discharge**



**Exhibit III-14**  
**Percent of Cases By Length of Stay Beyond Medical Discharge**

<b>Length of Stay</b>	<b>1991 % of Cases (n = 189)</b>	<b>1998 % of Cases (n = 170)</b>
Less than 3 Days	33	38
3 to 5 Days	19	24
6 to 10 Days	12	9
11 to 20 Days	12	17
<b><i>Subtotal: Less than 3 weeks</i></b>	<b><i>76%</i></b>	<b><i>88%</i></b>
21 to 50 Days	11	9
50 to 100 Days	8	3
More than 100 Days	5	0
<b><i>Subtotal: 3 weeks or longer</i></b>	<b><i>24%</i></b>	<b><i>12%</i></b>
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>

**B. Cost of Care for Boarder Babies**

Estimates of the costs of care for boarder babies are extremely difficult to develop. Many hospitals were reluctant to provide data on their actual costs, and those that were willing to provide information often used disparate and incompatible methods for categorizing costs. Nevertheless, per diem cost data were obtained from 81 percent of the hospitals in 1991 and 61 percent of the hospitals in 1998 that had one or more boarder babies on the census day.

Costs provided by individual hospitals varied along several dimensions. These included the following:

- **Hospital Unit Housing a Boarder Baby:** Charges varied depending upon whether boarder babies were housed in the nursery, neo-natal intensive care unit (NICU), or pediatric units. Two-thirds of the 1991 hospitals and 84 percent of the 1998 hospitals could identify the unit in which the boarder babies were typically housed and could provide daily rates for care in that unit. For hospitals which were uncertain about the unit typically housing boarder babies, an assumption was made that the boarder babies would be housed in the lowest-cost unit available in that hospital. Rates for that unit, typically the regular newborn nursery, were obtained from these hospitals.

- **Level of Care:** Charges also varied depending on the level of care provided in a unit. Some hospitals noted that boarder babies were typically housed in a “special care” or “step-up” unit within a nursery rather than in the well-baby unit where the mother would care for and feed the infant. Most hospitals that housed infants in the NICU provided the lowest level of care available in that unit (i.e., a step-down unit). For hospitals that did not specify the level of care provided, assumptions were made that the boarder babies were either in a “step-up” unit in the nursery or a “step-down” unit of the NICU.
- **Type of Cost Estimate:** Three types of daily rates were provided by the hospitals:
  - 1) A *base rate* of direct and indirect costs of minimum care without ancillary charges (provided by 76 percent of 1991 hospitals and 28 percent of 1998 hospitals);
  - 2) *Inclusive rates* that covered ancillary charges (provided by 16 percent of 1991 hospitals and 46 percent of 1998 hospitals); and
  - 3) *“Direct rates only”* based on minimum direct costs only (provided by 8 percent of 1991 hospitals and 16 percent of 1998 hospitals).

Hospitals that provided per diem rates with direct and indirect costs typically indicated that indirect costs were approximately equal to direct costs. Therefore, costs at the direct-rates sites were doubled to approximate the base rates for those hospitals that did not include indirect costs. It was not possible, however, to estimate ancillary costs. Thus, the rates used in this study represent an underestimate of the total costs involved in caring for boarder babies.

### 1. Estimated Costs of Care for Boarder Babies

Cost estimates were derived by weighting the rates provided by individual hospitals in proportion to the number of boarder babies residing in each facility. Hospitals that provided inclusive rates were not used in the following estimation—only those hospitals that provided direct and indirect costs were used. Exhibit III-15 provides a breakdown of the range of rates and the average daily rate per child in 1991 and 1998 in each of the six jurisdictions that had the most boarder babies in 1991 on the census day. In 1991, rates ranged from \$263 to \$843, and in 1998, they ranged from \$294 to \$697. The national average rate increased 20 percent, from \$460 in 1991 to \$551 in 1998.

**Exhibit III-15**  
**Estimated Daily Hospital (Base) Costs of Boarder Babies**  
**for Selected Jurisdictions<sup>15</sup>**

Jurisdiction	Estimated Daily Hospital Cost Per Boarder Baby (\$) <sup>16</sup>		Percent Increase
	1991	1998	
Los Angeles County, CA	536	604	13
Washington, DC	843	Not available <sup>17</sup>	----
Cook County (Chicago), IL	538	697	30
Wayne County (Detroit), MI	416	564	36
Essex County (Newark), NJ	263	294	12
New York City, NY	296	623	111
All Other Jurisdictions	500	523	5
<b>National Weighted Average<sup>18</sup></b>	<b>\$460</b>	<b>\$551</b>	<b>20%</b>

To calculate national annual costs of boarder baby care, a per diem rate, averaging base and inclusive rates (weighted by numbers of boarder babies in each hospital), was developed. The average per diem rate for boarder babies was \$476 in 1991 and \$570 in 1998. These figures were used with length-of-stay figures to determine national cost estimates for boarder baby care. "Low" estimates were developed using the median length of stay, and "high" estimates were developed using the mean length of stay, as shown in the formulas below:

- **Low Estimate:** Daily Rate x Median Length of Stay
- **High Estimate:** Daily Rate x Mean Length of Stay

The low and high estimates are shown in Exhibit III-16. Even though the rates increased from 1991 to 1998, the high estimates (using mean length of stay) appear to have decreased from 1991 to 1998. This is due to the shorter mean length of stay (LOS) of boarder babies (from 22 to 9 days).

<sup>15</sup> The costs are adjusted for nonresponding hospitals.

<sup>16</sup> Estimates are based on weighting hospital rates in proportion to the number of boarder babies in that facility on the census day.

<sup>17</sup> Insufficient data were available for the one boarder baby reported in a Washington, D.C. hospital in 1998. The national increase in costs was applied to the Washington, D.C. infant in calculating the national weighted average.

<sup>18</sup> Hospital costs for each jurisdiction were multiplied by the number of boarder babies in each jurisdiction to create a national weighted average cost of care for boarder babies.

**Exhibit III-16  
Costs for Serving Each Boarder Baby**

<b>Year</b>	<b>Low Estimate (Using Median LOS)</b>	<b>High Estimate (Using Mean LOS)</b>
1991	\$2,380	\$10,472
1998	\$2,280	\$5,130

To calculate the annual costs of care for boarder babies, the costs of care for each boarder baby were multiplied by the number of infants served annually (9,700 in 1991 and 13,400 in 1998) (see Exhibit III-17).

**Exhibit III-17  
Annual Costs of Care for Boarder Babies**

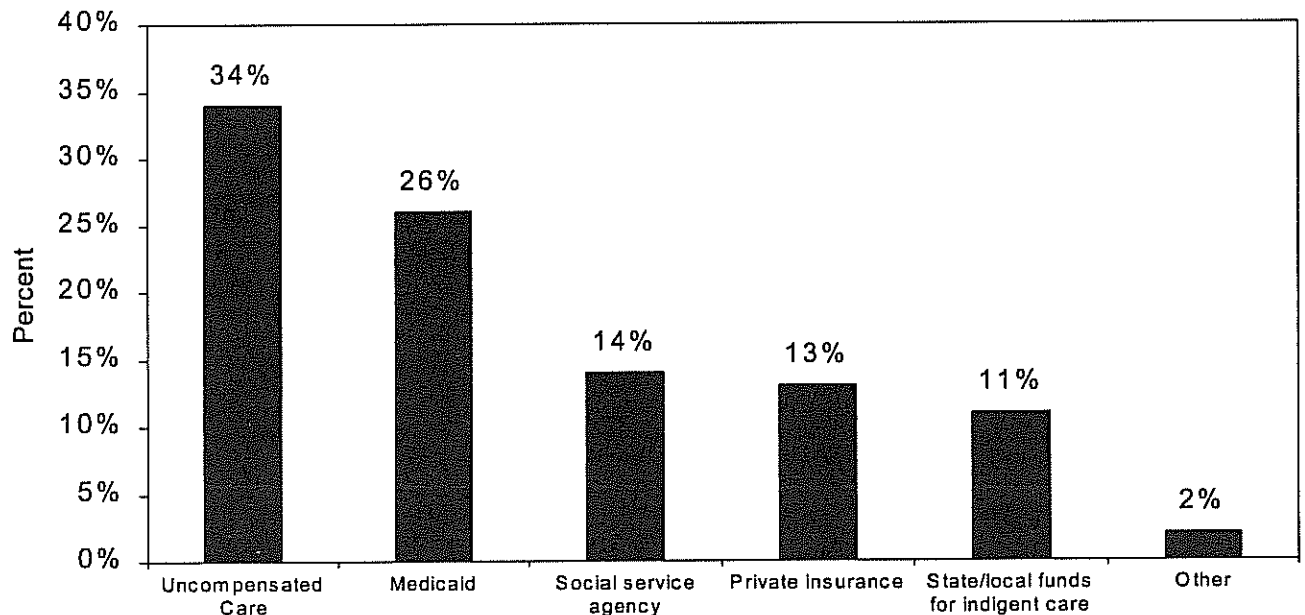
<b>Year</b>	<b>Low Estimate (Using Median LOS)</b>	<b>High Estimate (Using Mean LOS)</b>
1991	\$23.1 million	\$101.6 million
1998	\$30.6 million	\$68.7 million

The annual costs of boarder baby care increased (by 32 percent) from 1991 to 1998, given the median (or low) estimates. The high range of annual costs appears to have decreased by 32 percent; again, this was due to the 13-day decrease in average length of stay for each boarder baby served. Given the lack of data on the complete length of stay, these figures underestimate the cost of boarder baby care.

## 2. Payment Sources for Boarder Baby Days

Hospitals found it challenging to identify and secure funds for the cost for care of boarder babies beyond the point of medical discharge. In 1991, payment sources most often cited were: uncompensated care, some Medicaid coverage (for a limited number of boarder baby days), social service or adoption agencies, and alternative approaches. Exhibit III-18 provides detailed information on payment sources cited for boarder baby care in 1998 in 35 hospitals. More than one payment source was usually mentioned.

**Exhibit III-18**  
**Payment Sources for Boarder Baby Care in 1998**  
(n = 93)



Uncompensated care was reported by more than one-third of the hospitals, meaning that hospitals were not reimbursed for the costs of boarder baby days. More than one-quarter of the hospitals reported receiving Medicaid funds. Other payment sources were social service agencies (including public and private child welfare and adoption agencies), private insurance, State/local funds for indigent care, and other sources (e.g., charity funds).

**C. Summary**

In summary, there have been some changes in the characteristics of boarder babies since 1991. A smaller percentage of boarder babies are African American; smaller percentages of infants tested positive for drugs or the HIV virus; and the average length of stay declined from 22 to 9 days after medical discharge. Daily charges for boarder baby care increased by 20 percent since 1991, offsetting some of the reduction in costs that was realized by the reduction in the average length of stay. The cost of boarder baby care remains problematic, with hospitals most frequently reporting that the cost of care is uncompensated or is paid for by Medicaid.

## CHAPTER IV

### CHARACTERISTICS OF ABANDONED INFANTS

In addition to the gathering of data on the number and characteristics of boarder babies, discussions were held with hospital staff regarding infants who were not yet ready for medical discharge, but whose eventual discharge was unlikely to be to the custody of their biological parents. In some cases, these abandoned infants had no parent who was willing or able to provide care. In other cases, an eventual release to the custody of a birth parent was unlikely because the child welfare agency had determined that the parent or parents could not care for their infant safely.

As explained in the study methodology section (Chapter I), State child welfare agencies were contacted to identify jurisdictions that might have had a boarder baby (and in 1998, an abandoned infant) problem. Only those jurisdictions identified as having a boarder baby problem were included in this study. Thus, the estimated numbers of abandoned infants documented in this report do not represent a national estimate; rather, they provide an estimation of the scope of the abandoned infant problem in those jurisdictions that were experiencing boarder baby problems as well.

Abandoned infants residing in hospitals that had boarder babies were included in this study for several reasons. First, some of these infants, in time, may have become boarder babies. Although these infants still required medical care on the day of the telephone call to the hospital, these infants ultimately may have remained in the hospital longer than medically necessary while appropriate placements were sought. Second, even those infants who did not remain in the hospital beyond medical discharge would have required the services of the child welfare agency. At a minimum, they may have required a CPS investigation and support services to a parent or relative. Most would have required costly out-of-home placements. Therefore, assessing the extent of the abandoned infant problem is important in identifying the full scope of the problem facing child welfare agencies. Costs and resources are needed by CPS to conduct investigations and provide alternative placement settings for both boarder babies and abandoned infants.



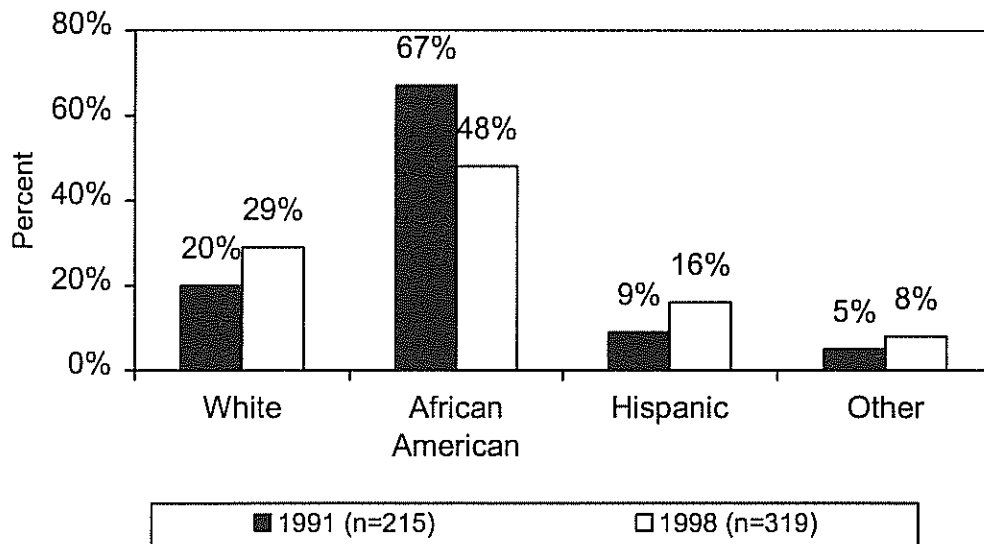
Whether or not an infant can be medically discharged may be a somewhat subjective decision. Some physicians, for example, consider the appropriateness of the parents' home or the identification of a placement alternative as a criterion for readiness for discharge. Finally, lack of reimbursement for medically unnecessary hospital days may lead some hospitals to fail to identify infants as medically ready for discharge. Therefore, it is possible that some of the infants identified by hospitals as abandoned were, in fact, boarder babies.

As with boarder babies, census day data on abandoned infants' characteristics were collected from hospital discharge planners. In 1991, there were 301 abandoned infants; in 1998, there were 382 census day abandoned infants. This chapter presents findings on abandoned infants with regard to their characteristics and medical conditions, drug and HIV testing and exposure, discharge plans, and length of stay in the hospital.

#### **A. Characteristics of Abandoned Infants**

Basic demographic data were requested for the census day abandoned infants. In both study years, 51 percent of the infants for whom data were available were female. Exhibit IV-1 presents the distribution of abandoned infants by race/ethnicity in 1991 and 1998. Similar to the boarder babies, the majority of infants in both study years were African American, and African American children constituted a smaller percentage of abandoned infants in 1998 than in 1991 (48 percent versus 67 percent).

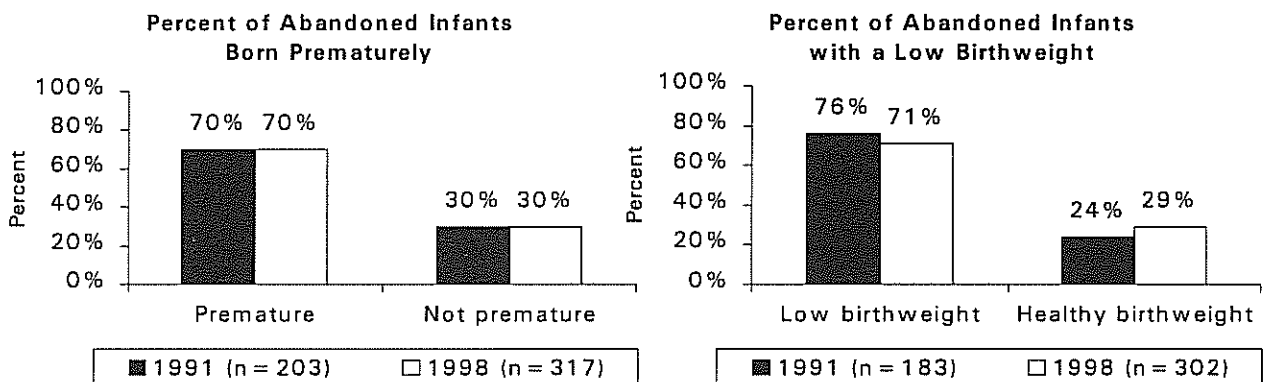
**Exhibit IV-1  
Percent of Abandoned Infants by Race/Ethnicity**



**1. Medical Conditions**

Discharge planners responded to questions about infants' prematurity, low birthweights and other medical conditions (see Exhibit IV-2). In both 1991 and 1998, 70 percent of the abandoned infants were born prematurely. Seventy-six percent of the abandoned infants in 1991 and 71 percent in 1998 were born with a low birthweight. Further, staff reported that 57 percent of the 1991 infants had "other medical conditions" compared to 45 percent in 1998.

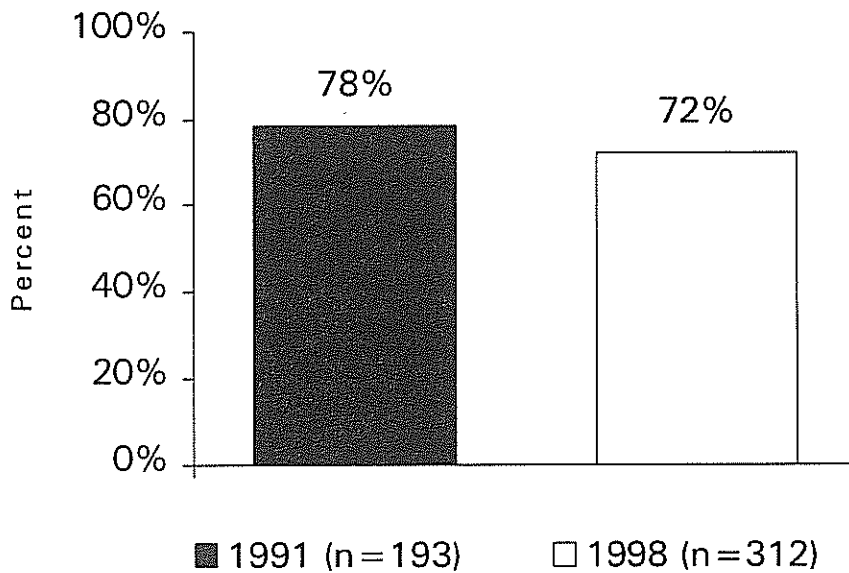
**Exhibit IV-2  
Medical Conditions of Abandoned Infants**



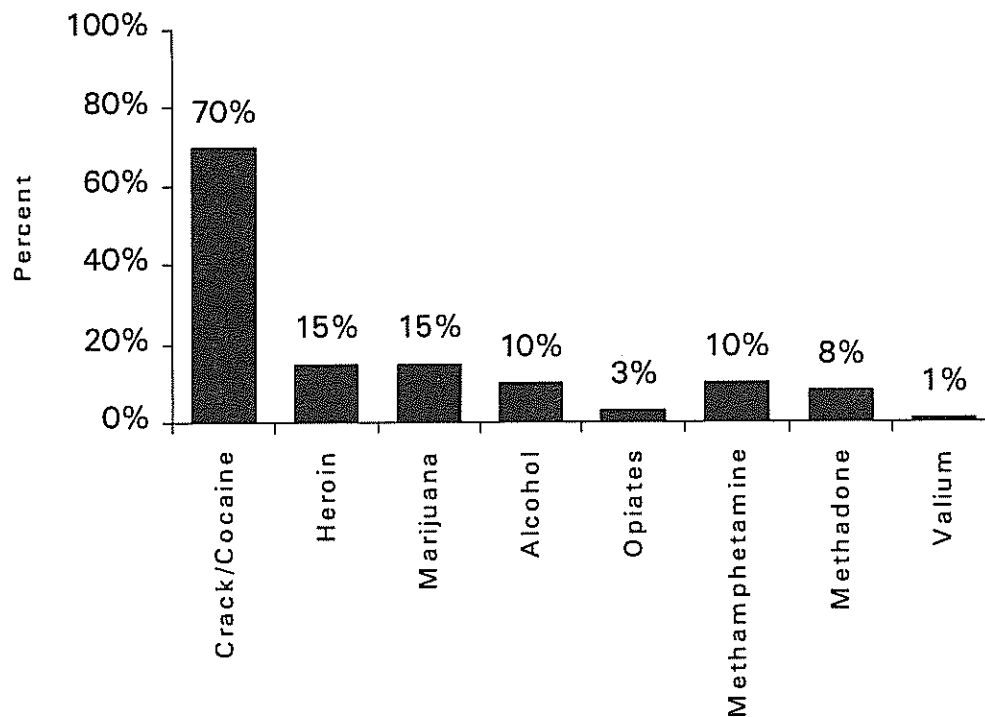
## 2. Drug and HIV Testing and Exposure

Drug testing of census day abandoned infants revealed positive drug exposure for 78 percent of the 1991 infants and for 72 percent of the 1998 infants (see Exhibit IV-3). In 1998, respondents identified the drugs present in 217 infants; they could report more than one drug present in each infant. As found with the boarder babies, crack/cocaine was most prevalent (70 percent) (see Exhibit IV-4). Other drugs found were heroin, marijuana, alcohol, methamphetamine, methadone, opiates and Valium.

**Exhibit IV-3**  
**Percent of Infants Who Tested Positive for Drug Exposure**

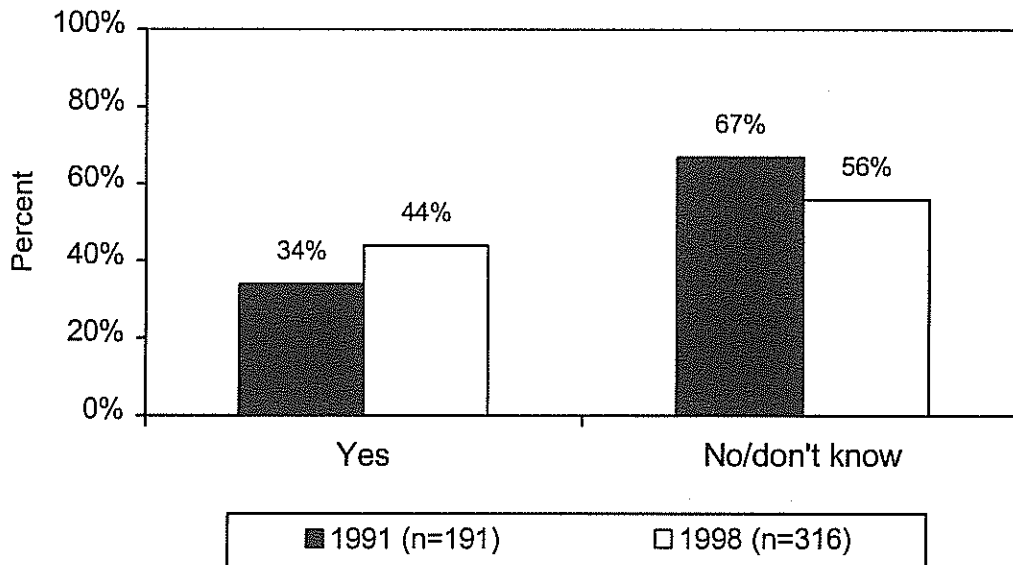


**Exhibit IV-4**  
**Percent of Census Day Infants with Drugs Present in 1998**  
**(n = 217)**

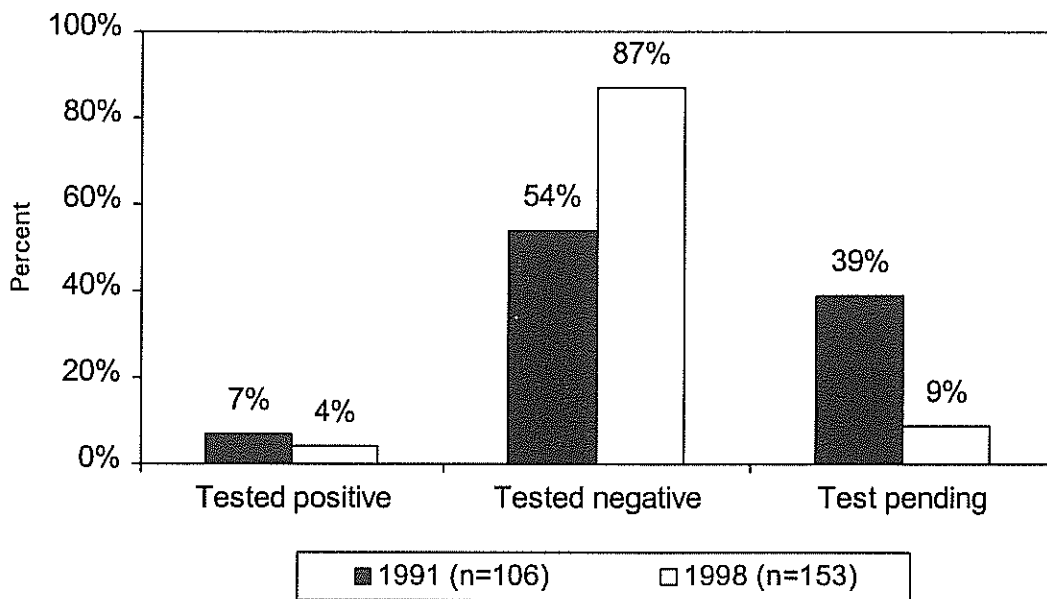


Exhibits IV-5 and IV-6 present findings on HIV testing. Testing for HIV occurred in 34 percent of the cases in 1991 and in 44 percent of the cases in 1998 (see Exhibit IV-5). Among those tested, (65 in 1991 and 139 in 1998), the percentage of abandoned infants found HIV positive were 7 and 4 percent (see Exhibit IV-6). The higher percentage of negative HIV tests in 1998 (87 percent) compared to 1991 (54 percent) may have been partly due to increased testing.

**Exhibit IV-5  
Percent Tested for HIV**



**Exhibit IV-6  
Results of HIV Testing**



### 3. Comparison of Boarder Baby and Abandoned Infant Health Characteristics

Exhibit IV-7 presents the differences between boarder babies and abandoned infants in health characteristics. As shown in this Exhibit, abandoned infants were twice as likely as boarder babies to be premature or to have low birthweights, were considerably more likely to have a serious medical condition, and were slightly more likely to have been drug exposed. The differences may have related to the fact that infants with more medical problems had greater medically necessary lengths of stay, thereby providing a longer period of time for CPS to complete an investigation and, when necessary, locate an alternative placement. In contrast, it is not surprising that "healthy" infants met medical discharge criteria more quickly and therefore were identified as boarder babies.

**Exhibit IV-7**  
**Differences in Characteristics of Boarder Babies and Abandoned Infants**

	Percent Premature	Percent with Low Birthweight	Percent with Medical Conditions	Percent Drug Exposed
Boarder Babies	35%	33%	28%	65%
Abandoned Infants	70%	71%	45%	72%

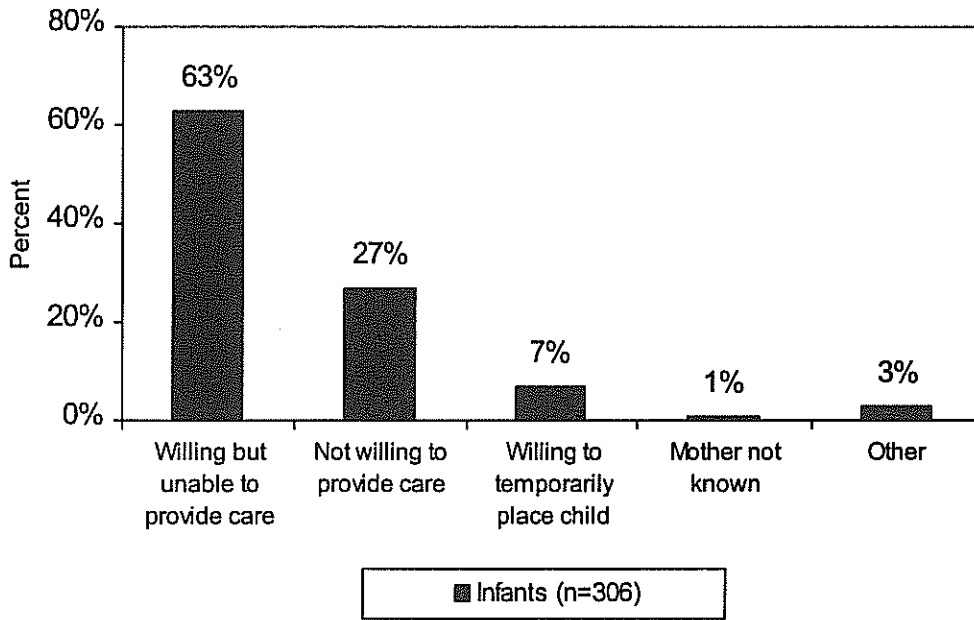
### 4. Discharge Plans for Abandoned Infants and Reasons for Alternative Care

Hospital staff were asked about the status of discharge plans for abandoned infants in the hospital on the census day. At the time of the study contact, abandoned infants included babies whose release to a birth parent was questionable but had not necessarily been ruled out. In most instances, a CPS investigation had not been completed. When asked about reasons for alternative care for these infants, staff in 1998 cited parental ability or willingness to provide care for the infant (see Exhibit IV-8) and the child welfare agency's involvement (see Exhibit IV-9).<sup>19</sup> As found with boarder babies, most often parents were willing but unable to provide care for their infants (63 percent), and about one-quarter (27 percent) were not willing and/or able to provide care. As was true with boarder babies, the child welfare agency was involved in most cases. In 55 percent of the cases, the agency determined that it was not safe to allow the infant to be released to the parent(s), and in one-third of the cases, the agency had not yet completed its investigation.

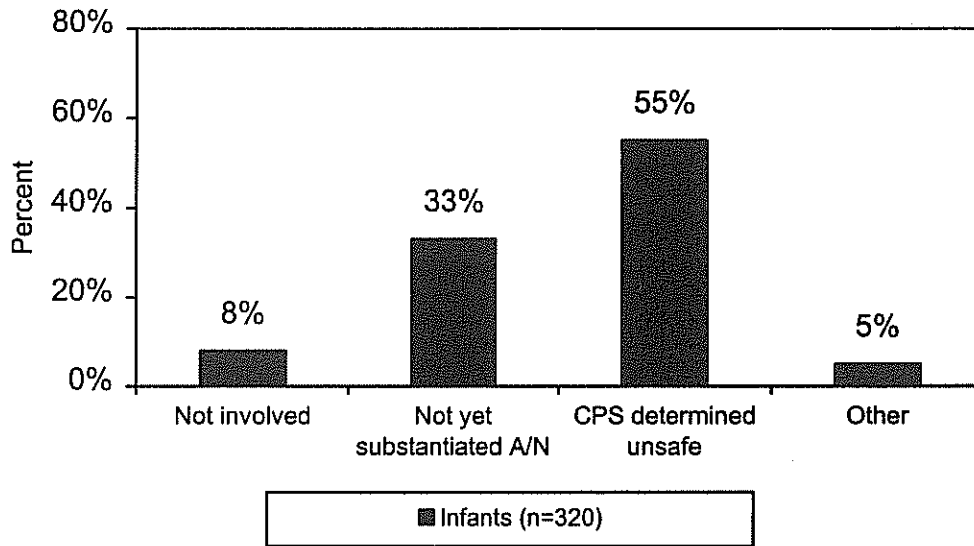
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<sup>19</sup> Comparable information was not obtained in 1991 data; only 1998 data are reported here.

**Exhibit IV-8  
Parental Ability to Care for Infant**

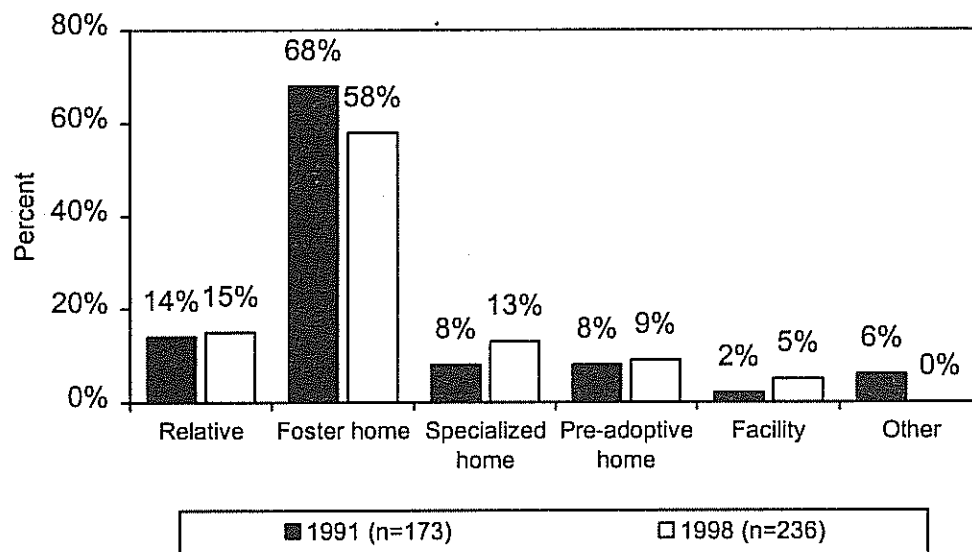


**Exhibit IV-9  
Status of CPS Involvement with Abandoned Infants**



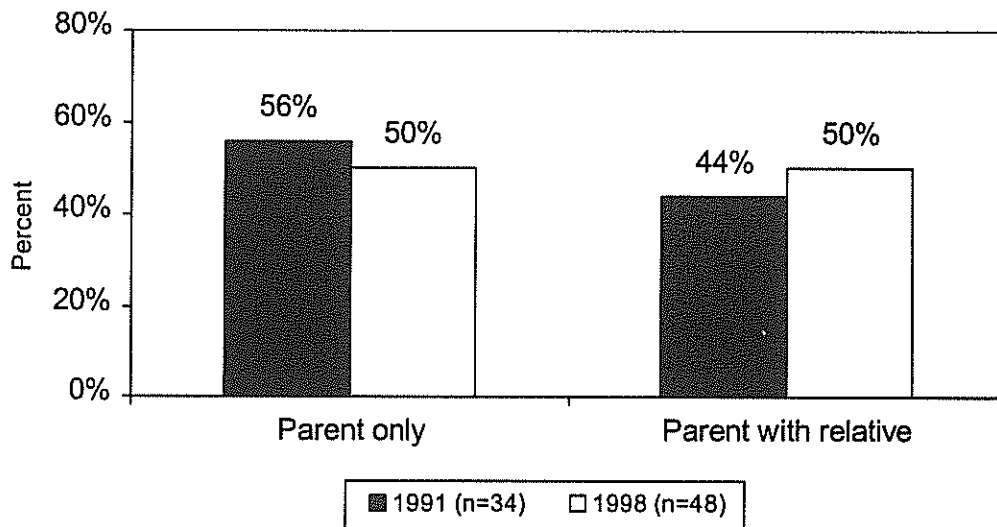
In 1991, 85 percent of the infants were expected to have an out-of-home placement; in 1998 this figure was 84 percent. Exhibits IV-10 and IV-11 present findings on expected discharge plans for abandoned infants. As shown in Exhibit IV-10, for those expected to have out-of-home placements, the most common expected placement was foster family care (68 percent in 1991 and 58 percent in 1998). Other placements reported included relatives, specialized foster homes, pre-adoptive homes and congregate care facilities. Of those infants expected to be returned home (see Exhibit IV-11), about one-half would be released to the parent only, and the other half would be allowed to go home with the biological parents only if another relative were also in the home.

**Exhibit IV-10**  
**Expected Discharge Plans for Abandoned Infants—Out-of-Home Placement**





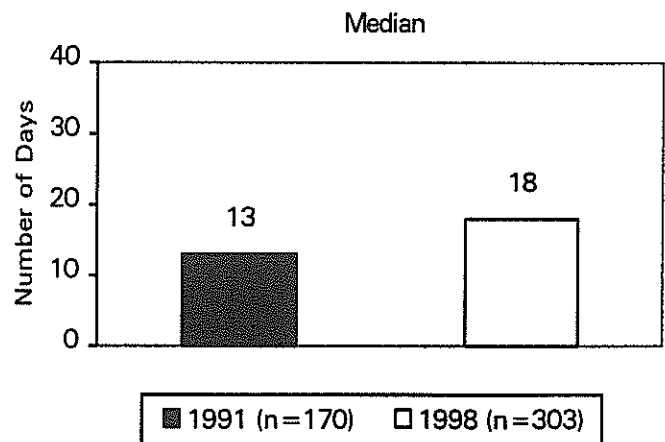
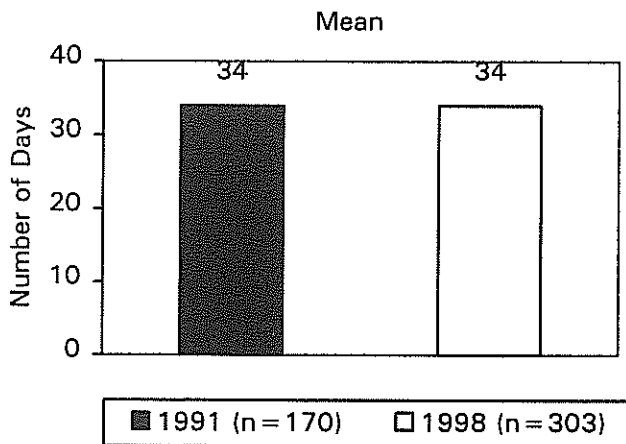
**Exhibit IV-11**  
**Expected Discharge Plans for Abandoned Infants—Home to Biological Parent**



**5. Length of Stay in the Hospital**

Exhibit IV-12 provides information on the number of days that abandoned infants had been residing in the hospital. This was the length of stay from birth or admittance to the hospital until the day of the study’s telephone contact. The mean length of stay remained constant from 1991 to 1998: 34 days. The median length of stay, however, increased from 13 to 18 days between 1991 and 1998. This difference indicates a slight increase in the length of stay for abandoned infants.

**Exhibit IV-12**  
**Length of Stay**



The length of stay for abandoned infants was longer than the length of stay for boarder babies prior to medical discharge in both study years. This difference may have been related to the differences between abandoned infants and boarder babies in prematurity, low birthweight, and the presence of other medical conditions.

In summary, while much attention has been focused on the boarder baby problem, it is important that the abandoned infant problem not be overlooked. As noted above, abandoned infants are even more likely than are boarder babies to have serious medical problems (see Exhibit IV-7), and a greater percentage (84 percent versus 70 percent) are expected to require some type of out-of-home care (see pages 25 and 42).

## CHAPTER V

### SUMMARY AND CONCLUSIONS

The purpose of this study was to examine the changes that have occurred in the number and characteristics of the boarder baby and abandoned infant populations since 1991. In addition, efforts were made to document the number of discarded infants in 1992 and 1997.

The findings of this study suggest that several key changes have occurred since the first national estimates of the boarder baby problem were developed in 1991. On some dimensions, the problems have worsened, while in other areas, some positive changes can be noted.

The most important area of concern is that the numbers of both boarder babies and abandoned infants have increased nationwide. This study estimates that there were 13,400 boarder babies and 17,400 abandoned infants in 1998. This represents a 38 percent increase in the boarder baby population (from 9,700 infants in 1991) and a 46 percent increase in the abandoned infant population (from 11,900 in 1991).

Equally important is the change in the distribution of the populations across the country. In 1991, three urban centers accounted for 47 percent of the boarder baby population, while the remainder of the population was distributed across 98 jurisdictions. In contrast, by 1998, there had been a 21 percent decline in boarder babies in the three aforementioned urban centers, while the boarder baby population in the rest of the nation had increased 90 percent. In jurisdictions that experienced a decline, hospital staff most frequently attributed the decline to improved efforts on the part of child welfare agencies and hospitals to more promptly identify alternative placements for these children. It appears that those jurisdictions that experienced a significant boarder baby crisis actively took steps to address the problem. While this explains the decline in the boarder baby problem in many of the large urban areas, the question remains as to why the problems increased in smaller cities and suburbs. This study cannot provide a concrete answer to this question; however, hospital staff noted changes in the characteristics of the

populations they served, most notably an increase in poverty and drug use. In other words, the boarder baby problem simply may be following the pattern of other social problems that capture national attention—they begin in major urban centers but eventually spread to the suburbs and other areas.

Although crack/cocaine was the drug of choice in both the 1991 and 1998 studies, some staff noted that they were seeing a surge in the use of methamphetamines or “crystal meth.” They noted that unlike cocaine or heroin, whose users are dependent on the flow of drugs from major suppliers, the new so-called “designer” drugs are manufactured locally in people’s basements, garages and trailers, thus providing an easily accessible drug supply in even the most rural areas. If this trend continues, it is likely that the abandoned infant and boarder baby problems will also continue to spread to more suburban and rural areas.

While the changes in the number and distribution of abandoned infants follow a somewhat similar pattern as for boarder babies, the rate of increase between 1991 and 1998 is even more pronounced—there was a 46 percent increase in the number of abandoned infants, from 11,900 to 17,400. Furthermore, in the three jurisdictions that collectively experienced a 21 percent decline in the number of boarder babies, there was an 11 percent increase in the number of abandoned infants. These findings support the hospital staffs’ comments suggesting that social problems have not declined; rather, the system for rapidly identifying alternative care settings for these infants has improved. In other words, the number of infants requiring child welfare services has increased, as evidenced by the increase in the abandoned infant population. In some urban centers, the resources to meet these needs have improved, thus reducing the number of boarder babies without addressing the more fundamental social issues that create the abandoned infant problem.

On a positive note, the mean length of stay for boarder babies beyond the point of medical discharge declined from 22 days in 1991 to 9 days in 1998. The percentage of boarder babies residing in hospitals for more than 21 days declined from 24 percent to 12 percent.

Data on characteristics of boarder babies also show some positive change. Although African American infants are still disproportionately represented in the boarder baby population, the percentage of African American boarder babies declined from 75 percent to 56 percent between 1991 and 1998.

The 1991 study noted that hospital policies relating to drug testing were inconsistent, with hospitals and physicians exercising considerable discretion in establishing and utilizing criteria for testing. In both 1991 and 1998, mothers or infants who were considered "high risk" were tested, with criteria for risk often linked to socio-economic status. A lack of objectivity in testing criteria created subsequent biases in examining characteristics of those who tested positive.

Although policies on testing for both drugs and HIV status had not changed, the number tested for drugs and HIV had increased. In 1998, 82 percent of the boarder babies were tested for drug exposure, compared to 65 percent in 1991. Of the infants known to have been tested for drug exposure, the percentage of boarder babies identified as drug-exposed declined from 79 percent in 1991 to 65 percent in 1998. Similarly, HIV testing increased from 30 percent to 50 percent, and the number testing positive declined from 14 percent to 4 percent.

Improvements also can be noted in the health status of these infants. The percent born prematurely declined from 47 percent to 35 percent, and low birthweights declined from 57 percent to 33 percent. A similar decline was found in serious medical conditions, from 36 percent to 28 percent.

Findings on the costs of care for boarder babies were mixed. The average per diem cost increased 17 percent between 1991 and 1998—from \$476 to \$570. To some extent this was offset by the decline in the average number of boarder baby days from 22 to 9. If the average daily rate is multiplied by the average number of days of care beyond medical discharge during the year, then the estimated cost of care per boarder baby in 1998 is \$5,130 (compared to \$10,472 in 1991). If the median length of stay is multiplied by the average daily rate, then the estimated cost of care per boarder baby decreased from

\$2,380 in 1991 to \$2,280 in 1998. Annually, estimated costs of care (using median rather than mean length of stay) for boarder babies ranged from \$23.1 million to \$101.6 million in 1991 and ranged from \$30.6 million to \$68.7 million in 1998.

Finally, there is the question of discarded infants. It is difficult to interpret the findings about the number of discarded infants. The use of newspaper reports as the primary resource for identifying the number of discarded infants is a less-than-perfect method. The increase between 1992 and 1997 (65 and 105, respectively) may represent changes in the extent of reporting or in the number of newspapers included in the Lexis-Nexis data base.

When the number of discarded infants is compared to the number of boarder babies and abandoned infants, the problem appears rather small; however, it is a serious problem in terms of the number of infant deaths. When the boarder baby problem first emerged, there was considerable media attention to the problem. As the problem in large urban areas has declined, attention to the problems of boarder babies and abandoned infants has receded and media attention has shifted to discarded infants. Yet the findings of this study demonstrate that the boarder baby problem and the abandoned infant problem have not only grown in numbers but have spread to more communities. In light of these findings, it is important that the discarded infant population be viewed as simply the most visible component of a larger and more serious problem. As these findings also demonstrate, the role of the child welfare agency in addressing this problem is critical. In many larger cities, the child welfare agency, in coordination with hospital staff, has been able to reduce the problem of infants remaining in hospitals beyond the point of medical necessity. However, the underlying problem of needing either additional in-home support services or finding appropriate alternative living arrangements for infants whose parents cannot provide care continues to increase.

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## APPENDIX



**APPENDIX  
STATES AND JURISDICTIONS INCLUDED IN TELEPHONE SURVEYS**

AL	Jefferson Mobile Montgomery	IN	Allen Lake Marian	NY	Albany Erie New York City Onondaga Westchester
AK	Anchorage Fairbanks	KS	Sedgwick Shawnee Wyandotte	NC	Durham Forsyth Mecklenberg Orange Pitt Wake
AZ	Maricopa Pima	KY	Fayette Jefferson		
CA	Alameda Fresno Los Angeles Orange Riverside* Sacramento San Diego San Francisco San Mateo Santa Clara	LA	Orleans	OH	Cuyahoga
		MD	Baltimore	OK*	Oklahoma* Tulsa*
		MA	Hampden Plymouth Suffolk	OR	Multnomah
		MI	Wayne	PA	Allegheny Erie Philadelphia Westmoreland
CT	Fairfield New Haven	MN	Hennepin Ramsey		
DC	District of Columbia	MS	Harrison Hinds	RI	Providence
FL	Brevard* Broward Dade Duval Hillsborough Leon* Manatee* Orange Palm Beach Pinellas Sarasota* Seminole* Volusia*	MO	Jackson St. Louis	SC	Richland
		NE	Douglas Lancaster	TN	Davidson Shelby
		NV	Clark Washoe	TX	Bexar Dallas El Paso Harris Nueces Tarrant Travis
		NH	Grafton Hillsborough		
		NJ	Essex Hudson Mercer* Middlesex Monmouth Union*	VA	Accomac/Norfolk Albemarle/Charlottesville Fairfax Henrico/Richmond Roanoke
GA	Bibb Chatham Fulton Muscogee Richmond				
HI*	Honolulu*	NM	Bernalillo Dona Ana	WA	King
IL	Cook			WI	Milwaukee
				WV	Monongalia

\* Added in 1998





