



Replication Manual for Implementing Medical Foster Care Homes for Drug-Exposed, HIV+ and Medically Fragile Infants and Children

By

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I. INTRODUCTION

We chose topics that we believed would interest agency administrators, staff, families and others who may want to develop a foster care program for medically complex, drug exposed and HIV positive infants. Each topic was derived from qualitative analytic methods and appears as a section heading. Updated materials can easily be added to the loose leaf binder.

The Baby Moms program is organized as a special unit within a public welfare agency. A number of strategies with respect to caring for an HIV infected child in a surrogate placement have been adopted across the United States. Some public welfare agencies contract with private organizations to recruit and manage foster family homes in the private sector. There are also large non-profit, community-based, urban multi-program agencies such as Project Star in Boston. Each locale has unique demographics, preexisting agency relationships, and political considerations which influence choices about how best to provide services. If this program seems inappropriate for your area, you may still find that some components of the Baby Moms program can be adapted to your circumstances.

This manual is based on qualitative and quantitative data collected between 1987 and 1993. Notes from weekly Baby Moms staff meetings and monthly foster parent trainings were entered into a text database (askSam) and analyzed for salient themes and issues using the constant-comparative method (*Glaser & Strauss, 1967*). These issues and themes are discussed in each section of the manual to give the reader greater insight into the complexities confronted by staff and foster parents during the first six years of the program.

A two hour semistructured interview was done with each of the Baby Moms primary caregivers after they had been in the program for at least nine months. Observations of the caregiving by a Developmental Specialist during regularly scheduled assessment interviews in the Baby Moms' homes were also conducted.. Quantitative data describing personality factors of the Baby Moms foster parents and developmental dimensions of the infants and children have been gathered during the Maternal and Child Health Bureau grant period beginning in 1991. (This follows an assessment protocol that is described in Appendix A of this manual.) Updated materials and more recent data analyses will be sent to persons on the Baby Moms mailing list who have received a copy of this manual.

Modern foster family care originated with the Placing Out system of New York Children's Aid Society in the mid-nineteenth century. There have been criticisms of this approach to dealing with "vagrant" children since its inception because temporary separation from their biological parents often drifted into long-term placement and because there was little quality control of the foster family homes.

In the twentieth century, child welfare professionals have generally agreed that placement in a foster family home which has "normal" conditions is the best choice of substitute care for abused or neglected children whose behaviors or conditions do not require special services (Kadushin & Martin, 1988). Despite this professional consensus, criticism of the foster care system persists for its failure to provide continuity and stability to a group of children whose home environments are frequently chaotic. Passage of the Adoption Assistance and Child Welfare Act mandated national guidelines for assessment and monitoring a child's circumstance so that they don't get "lost" in the system and so that permanency planning will take place in a timely manner.

While not an ideal solution, it is widely acknowledged among professionals that there is an ongoing need for foster care homes (*Minuchin, 1992*). The National Center on Child Abuse and Neglect (NCCAN) reports that nearly one million children nationwide experienced "demonstrable harm" as a result of maltreatment in 1986, an increase of 51% from the 1980 rate (NCCAN, 1992), and others have found between 2 million and 4 million children abused by parents (*American Medical News, January 6, 1992*). Many of these children are placed in foster homes, or with relatives in "kinship care". Furthermore, in the past five years maternal drug use has contributed to an increase in the

number of children requiring foster care placements (*Ruff, H.A., Blank, S., and Barnett, H.L., 1990; GAO Report, June, 1990*).

As budgets have decreased and caseloads have grown, some public welfare agencies have contracted private organizations to recruit, train and monitor foster family homes. This places the Child Welfare Worker (CWW) more in the role of case manager and less a provider of direct services to children and families. The San Francisco Department of Social Services (SFDSS) both maintains its own foster parent system and also contracts private agencies to manage foster homes for children who require more intensive services. Historically, children with unusual medical needs were placed in special group home settings or in residential institutions. In the early eighties, the SFDSS implemented a Therapeutic Foster Home program within the Family and Children's Services Division creating a special unit for latency aged children with challenging behaviors. Foster parents recruited for this program had the special skills required to work with these children, received ongoing training in related subjects, and were paid a higher foster care board rate. The Baby Moms program was initially modeled after this SFDSS program.

A. THE URBAN CONTEXT

Although it has a history as a tourist Mecca, San Francisco is also a county troubled with substance abuse, homelessness and high rates of mental illness. It is recognized that geographic proximity of foster homes and biological parents promotes higher rates of reunification and shorter placement of children who are medically able for permanency planning (*Lerner, 1990*). There is, however, a limitation to the wider use of the foster family model in San Francisco, primarily because of the demographic shifts that have taken place in the City. Real estate values have skyrocketed in recent years squeezing out middle income families, many from African-American communities, and contributing to a widening gap between rich and poor. Minority and immigrant communities are growing. Between April 1980 and July 1987, the population increased at a 9.2 growth rate (County Office of Planning, January 1989). The 1990 census reports a total population of 723,959. In 1980 the African-American population of San Francisco was 84,857 — 12.5% of the City's population (Bureau of Census, 1980). In 1990, this figure had dropped to 76,343 — 10.5% of the population (Bureau of Census, 1991). Persons of Hispanic origin make up 13.9% of San Francisco and the Asian population constituted approximately 21% in 1980, rising to 28.4% by 1990. Nearly 75% of births between 1984 and 1986 were to minority residents. Currently, 50% of births to women 20 years of age and younger are to African-Americans. 12.7% of these children weigh less than 2500 grams. This is twice the low birth weight rate for the total population. The birth rate for women between 15 and 19 years of age increased from 35 per 100,000 in 1980 to 44 per 100,000 in 1986. Almost 21% of San Francisco's families are headed by a woman with no husband present. The average number of births to women receiving Aid to Families with Dependent Children (AFDC) in San Francisco is 2.4, more than double the national average.

B. THE ORGANIZATIONAL CONTEXT

Retaining direct management of the Baby Moms program within a public welfare agency such as the SFDSS rather than contracting with a private agency to recruit, train and manage the special foster homes creates unique interagency and intradepartmental issues. To better understand some of these tensions, consider the following example.

As a branch of government, a public agency is more concerned with the laws that define its operations and mandate its responsibilities than a private agency, which although regulated by these laws, often has more latitude when implementing service delivery programs. For this reason, some feel private human service organizations can deliver more effective services at lower costs. As new service needs emerge, private agencies will seek contracts from the public sector. By retaining the Baby Moms program within the public sector, the SFDSS came under criticism during the beginning phase of the program from private agencies that claimed services to infants or their families were not being delivered effectively. Racial factors exacerbated this private-public friction. Private agencies in minority communities criticized the SFDSS for not having sufficient numbers of minority foster homes and for lacking a staff that racially matched the Baby Moms clients—families from minority communities. It was assumed that such matching was necessary for effective delivery of services.

These criticisms were upsetting to the staff who were not only working with very sick infants but were also attempting to establish the new program in the community. The frictions continue today with many variations and have necessitated considerable staff and administrative time to respond to program critiques.

Intradepartmental issues also arose. In the last decade, public and private social service sectors have witnessed caseload increases as resources shift out of treatment and rehabilitation. Caseloads have grown as departmental budgets have been cut and staff reduced. The creation of a "special program unit" within the SFDSS' Family and Children's Services Division caused staff in other units to feel resentful. Because of lower caseload numbers, it appeared the Baby Moms staff worked less.

The new program also received press coverage, and luncheons attended by City officials honoring the Baby Moms foster parents and staff. This perceived "favoritism" led to backbiting and comments made by staff from other units about the comparative ease of the Baby Moms work relative to their caseloads. In fact, the Baby Moms staff worked longer hours, had infants significantly sicker than those in the caseloads of other departmental staff, and were available to the Baby Moms foster parents 24 hours a day. Other intradepartmental complications arose when a new

Mayor was elected in 1992. The Mayor appointed new Social Services Commissioners and a new General Manager who in turn hired new senior management level personnel. As often accompanies significant management changes, the staff in all units at the SFDSS had different performance expectations placed upon them by the new appointees.

C. THE PERSONAL CONTEXT

Many criteria are considered when selecting Baby Moms foster parents. According to research on the Baby Moms foster parents, individual personality traits significantly affected performance in the program:

Several CPI characteristics found in the unBM group seem worth commenting on for persons beginning new programs that do not yet have well established policies and procedures. The comparatively lower scores for this group in Achievement via Independence indicate they have difficulty working in situations that are vague, poorly defined and lacking in clear cut standards. Lower scores in Flexibility show a preference for what is known, well organized and with a steady pace. New programs are often conducting formative evaluation, developing policies and procedures, which requires participants to be flexible and to work independently. It raises an interesting question about how the current group of Baby Moms will continue to do now that the program is more stable and predictable. Will they begin to experience difficulties as they become impatient with a less flexible bureaucracy that requires them to conform with agency standards and would the persons who left in the initial stages of program development now function better in the more established Baby Moms? *(Cohon & Cooper, 1993, p. 124).*

Certain characteristics do interfere with a person's ability to meet program demands. Foster parents with a reflective, intellectualizing approach to problems, and those less likely to reach out didn't fare well in the Baby Moms program. They distanced themselves from staff, especially when emotions were involved. They also showed a tendency to rely less on others when resolving problems. This may have heightened staff concerns about these families. For example, when confronted by staff about problems, these families denied difficulties which from staff's point of view, inhibited resolution of problems and worsened the situation as the individuals withdrew further. Although these foster parents may not work well in an intensive caregiving situation like Baby Moms, a number of them can do very well in programs that are structured to match their coping styles.

Personality and coping styles among staff also play an important part in how staff functions in a program and how they interact with families. As indicated in a job analysis report from December 1989, a number of skills and abilities are essential to performing the Child Welfare Worker's (CWW) job in Baby Moms. A group of staff

voluntarily took the California Psychological Inventory (CPI) in early 1990. Of five Baby Moms staff completing the CPI, three were Alphas — those who "invest their values in the shared interpersonal world, and in adherence to norms. Alphas are doers, people who carry out the sanctioned mandates of the culture". The other two were Deltas — those who "center their cathexes on a private, internal world, and on a personal as opposed to a traditional or sanctioned system of values. Deltas are reflective idiosyncratic and detached". (*Gough, 1987, pp. 27-29*).

Staff respondents to the CPI were above average in actualizing the potential for their particular personality. Working within a large bureaucratic human services organization places demands on individual staff. An innovative, small, specialized program unit such as the Baby Moms requires frequent contact with foster parents, adding to the demands placed on the individuals involved. While the relatively small sample of five staff members doesn't permit one to draw significant conclusions about staff responses, it does demonstrate that individuals do view situations uniquely. Some staff members consistently focus on problems and the daunting task of the Baby Moms program. Others see this program providing a positive opportunity to work more closely with client families.

[Monica: highlight these next 2 sentences in manual.] Perhaps the important conclusion to draw from this information is that the personality styles of the staff and foster families should be taken into account when attempting to replicate the Baby Moms program elsewhere. Staff recruitment for a new program should include an effort by administrators to assess the individual characteristics and coping styles of staff applicants, perhaps using those with an ability to function independently during the initial stages of a program when it is necessary to work without established structures and policies. As the program evolves and policies are established, administrators may consider rotating staff with administrative and management strengths into the more mature developmental stages of the program. Similar considerations may influence the recruitment and selection of foster homes.

II. PROGRAM HISTORY

In the mid-1980s, escalating drug and alcohol use significantly increased the number of infants and children with special health care needs dependent on the system. A 1987 report titled, "Drug Exposed Babies in the San Francisco Bay Area," cites figures showing a 300% increase in this population between 1983 and 1986.

During this time at the San Francisco Department of Social Services (SFDSS), the primary reason for filing dependency petitions on newborns was listed as "Drug/Alcohol" meaning substance abuse alleged against the parent. This county does not support the idea that prenatal drug exposure alone indicates an inability to parent a child. The determining factor is whether or not it is in the best interest of the child to return the child to their birth family or to place the child with extended family. This decision is based on a thorough risk assessment of the biological family. A number of these infants entering the foster care system were also infected with the Human Immunodeficiency Virus (HIV), close to half of them might develop Acquired Immunodeficiency Syndrome (AIDS).

Children who have been neglected, abused, or exploited are referred to the SFDSS' Emergency Response Unit (ERU) whose goal is to keep these children with their biological family, preventing the need to ever remove a child from their parent(s). When "reasonable efforts" to maintain the family have failed, out-of-home placement may be required.

Foster care is a reality in our modern society. As noted above, drug use contributes to the rising numbers of children entering this system of surrogate care.

[Highlight next sentence in beginning of manual.] The SFDSS began the Baby Moms program in 1987 in response to the increasing number of infants with complex medical problems associated with drug exposure and/or HIV. The program was conceived in early 1987 by the Director of the Family & Children's Services Division (F&C) who took responsibility for overseeing the project during its start-up year.

A consulting Psychologist who had worked in the F&C Division for ten years was brought in to help design and implement the program. Rather than use group or institutional care, a specialized foster care model was developed to provide more opportunity for attachment between infants and primary caregivers.

[Highlight next sentence.] Reunification with biological parents or extended family is the primary goal of Baby Moms, but the challenges of working with high risk

families are a reality. To reduce the number of times an infant is moved, infants medically cleared for placement remain in their Baby Moms foster home until a permanent plan is developed.

Initially, foster parents recruited for Baby Moms were experienced foster parents with skills to care for very sick infants. At the outset, few people expressed an interest in becoming foster parents for the program. Many of those who did were from counties surrounding San Francisco, and were strongly recommended by professionals who had worked with them previously. These references, however, did not always guarantee a good "fit" between the foster parents and program needs. Many lessons were learned from this first group of foster parents and the present policies for application and foster parent selection are based on these early experiences.

A. PROGRAM STRUCTURE & ORGANIZATION

Baby Moms is a specialized foster care program designed to serve infants with medically complex conditions, often exposed to drugs in utero, and are experiencing severe withdrawal. They may test positive for HIV, or have symptomatic AIDS or other serious medical problems requiring specialized care. The program is made up of San Francisco Department of Social Services (SFDSS) staff and specially trained foster parents working in partnership to provide and coordinate necessary medical, emotional and supportive services the infants need in order to recover and move on to a permanent home. The program presently has 15 foster homes and eight part- and full-time staff members.

The Baby Moms program unit is part of the Family and Children's Services Division (F&C) with one Unit Supervisor who is responsible for Baby Moms as well as a second, specialized program unit, the Therapeutic Foster Home Program. Philosophically, the SFDSS administration believed that having the unit within the F&C Division and contracting necessary medical support would permit closer monitoring of the infants' medical and psychosocial status.

(Monica, This needs to reflect actual placement of charts.) The current (1993) staffing pattern for Baby Moms evolved over the course of the project. It has gone through three significant changes detailed in the organizational charts on pages 14, 15 and 16. The flowchart on page 16 illustrates the public-private partnership of the Baby Moms and the FISCIP programs.

One full-time Child Welfare Worker (CWW) was initially assigned to Baby Moms. A Program Coordinator scheduled trainings, handled foster parent applications, responded to press inquiries about the new program, and managed relations with numerous community programs serving the infants.

Initially, the Program Coordinator position was staffed by a full-time CWW. Reductions in the SFDSS staff made it necessary to seek an outside consultant and financial support for this position. A consulting Psychologist paid for with County funds was hired to assist with screening foster parent applicants and providing clinical support to Baby Moms caregivers in crisis situations.

During the first year, a part-time (25% FTE) Public Health Nurse (PHN) was assigned from the Department of Public Health (DPH), another San Francisco public agency. This position was paid for with Child Health Disability Prevention (CHDP) funds requiring this nurse to perform specific functions in order to be eligible for

CHDP reimbursement. This nurse regularly visited the Baby Moms homes to monitor the infants' health status and give advice to the foster parents about care. After one year, the nurse's attitude toward the home visits coupled with funding cutbacks in DPH combined to eliminate this position. Fortunately, program administrators sought and successfully obtained other funding from the state (Senate Bill 2056, Alquist) permitting the SFDSS to hire a Pediatric Nurse Specialist (PNS) to take over these responsibilities. (Page 14 illustrates the staffing of the Baby Moms program during the initial stage.) (*Monica, Charts pages*)

The SFDSS now funds full-time the PNS position, and 25% of that position is devoted to Baby Moms. A second CWW was brought into the program unit in March, 1988 to handle the growing caseload.

The SFDSS contracted with a Pediatrician as a consultant in the first year, and this position continues at approximately 5% FTE. During the second year, a part-time Clerk Typist was hired. A Case Aide was added to this program unit in April, 1990 at 40% FTE.

To document the effectiveness of the new program and to report information about the client population—children, biological parents and foster parents—staff developed data collection forms used from the start of the program. However, no funds were available within the SFDSS to analyze the data once collected. To meet this need, a Federal grant was requested and in 1990 the Maternal & Child Health Bureau (MCHB) funded the Fragile Infant Special Care Program (FISCP) for three years as a demonstration and improvement project to develop a computer database system for the Baby Moms program. (Staffing of the Baby Moms and FISCP programs for the duration of this grant is illustrated on page 15.)

The FISCP grant recipient was the SFDSS, a City/County public welfare agency which had the primary responsibility of administering this grant award. This was the first Federal grant of this type awarded to the SFDSS. Because of the complexity of the hiring process for City/County jobs, all of the personnel positions in this program were hired as contract staff.

Organizationally, the FISCP staff were within the F&C Division and operated as part of the Baby Moms program although staff reported to the FISCP Project Director who reported to the SFDSS' Director of the F&C Division.

The Baby Moms consulting Psychologist became the Project Director (60 % FTE) of the FISCP, and the consulting Pediatrician's position was paid for with MCHB grant funds.

Other FISCP staff included a full-time Project Coordinator (who had responsibilities different from those of the Baby Moms Program Coordinator), and a Developmental

Specialist to carry out periodic assessments of infants. Finally, a consulting Research Statistician was hired to perform statistical data analyses as needed. This MCHB project was funded until September 30, 1993.

During this MCHB project period, additional needs became evident: A more permanent Program Coordinator for Baby Moms to schedule trainings and coordinate recruitment of new foster parents; additional supportive work with the foster and biological parents in caregiving of these fragile infants; and ongoing developmental assessments to provide sufficient data to inform professionals and parents of the functional status of the children as they entered the school system.

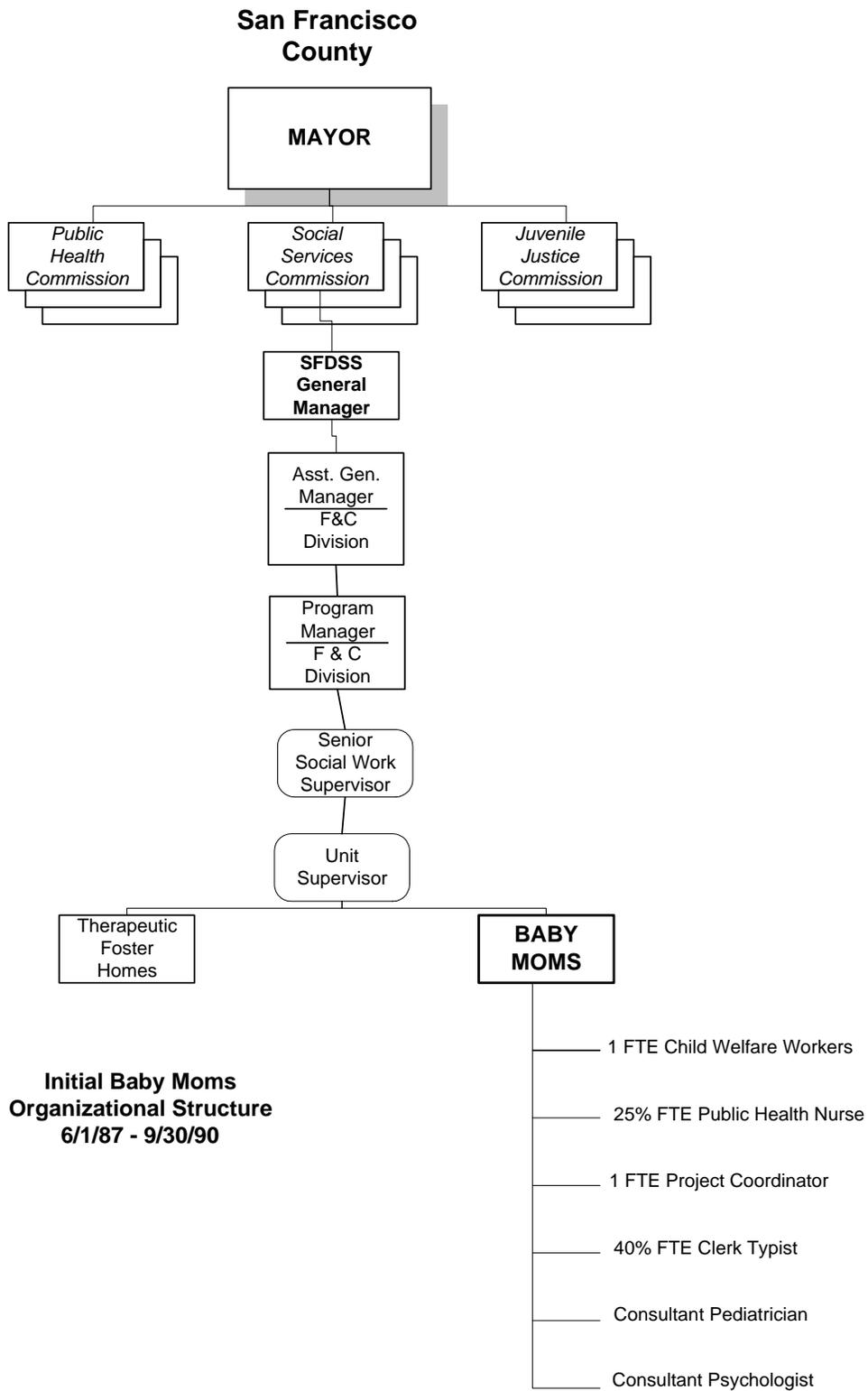
Simultaneously, management of the FISCOP personnel contracts by the SFDSS administration had placed an added burden on County staff at a time of shrinking resources and increased responsibility.

After consultation with the SFDSS administration, another grant addressing new needs was requested from the MCHB and the grant recipient was changed to Edgewood Children's Center, a private nonprofit agency with extensive experience in working with children. Edgewood was awarded a four year grant in October, 1993. The Project Director's time was reduced to 50% FTE, concentrating on data collection, data analysis and writing up findings.

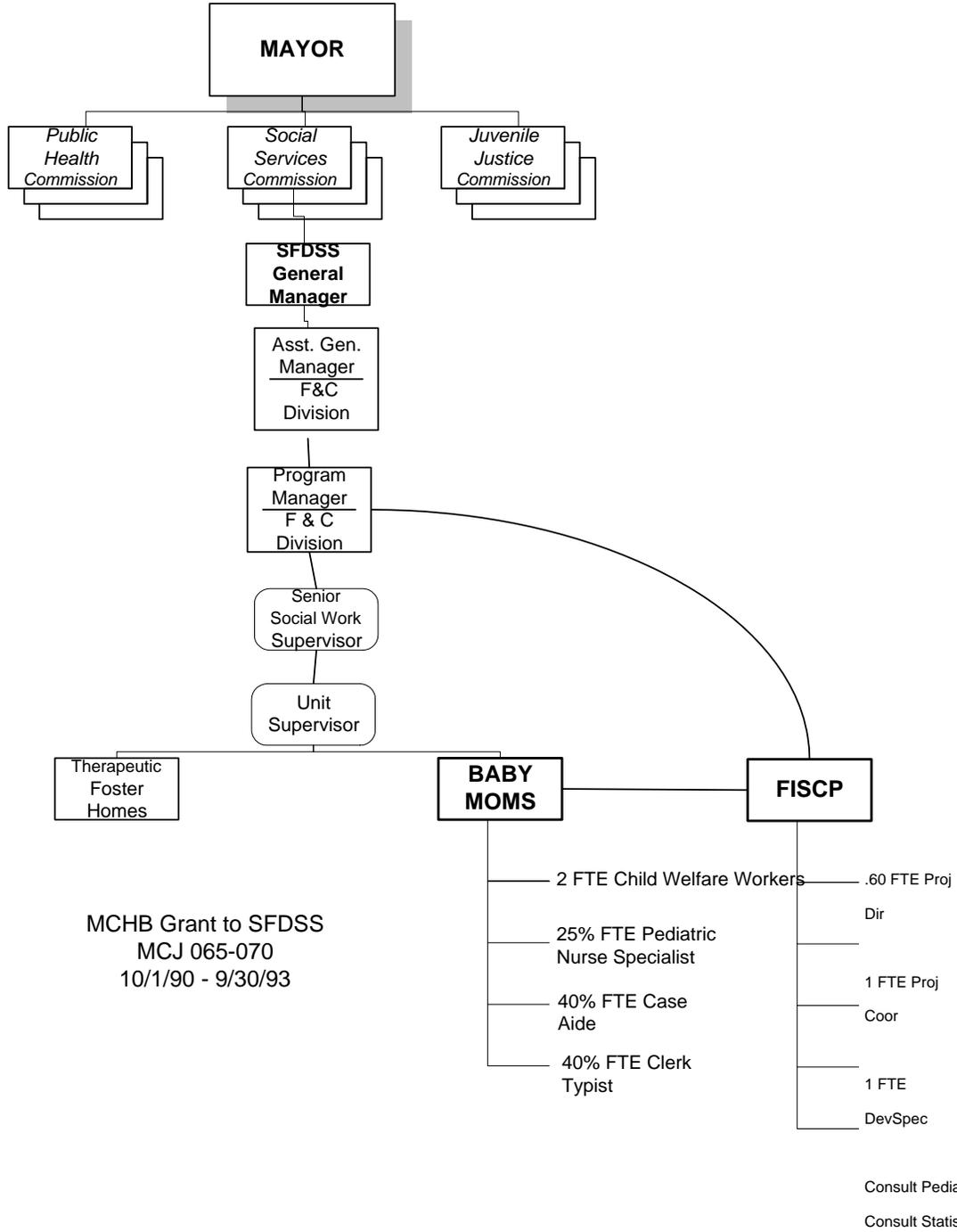
The Project Coordinator's role has expanded to include the responsibilities of the Baby Moms Program Coordinator and will divide time between locations at Edgewood and the SFDSS. The Developmental Specialist will begin to provide more supportive guidance to foster parents and biological parents in caring for the infants and also attend local Part H Interagency Coordinating Council meetings to give consultation to these teams on all Baby Moms infants being reviewed.

A part-time (50% FTE) Administrative Assistant will assume some of the Project Coordinator's functions. The consulting Pediatrician and consulting Research Statistician will continue to carry out their primary responsibilities as in the initial MCHB grant.

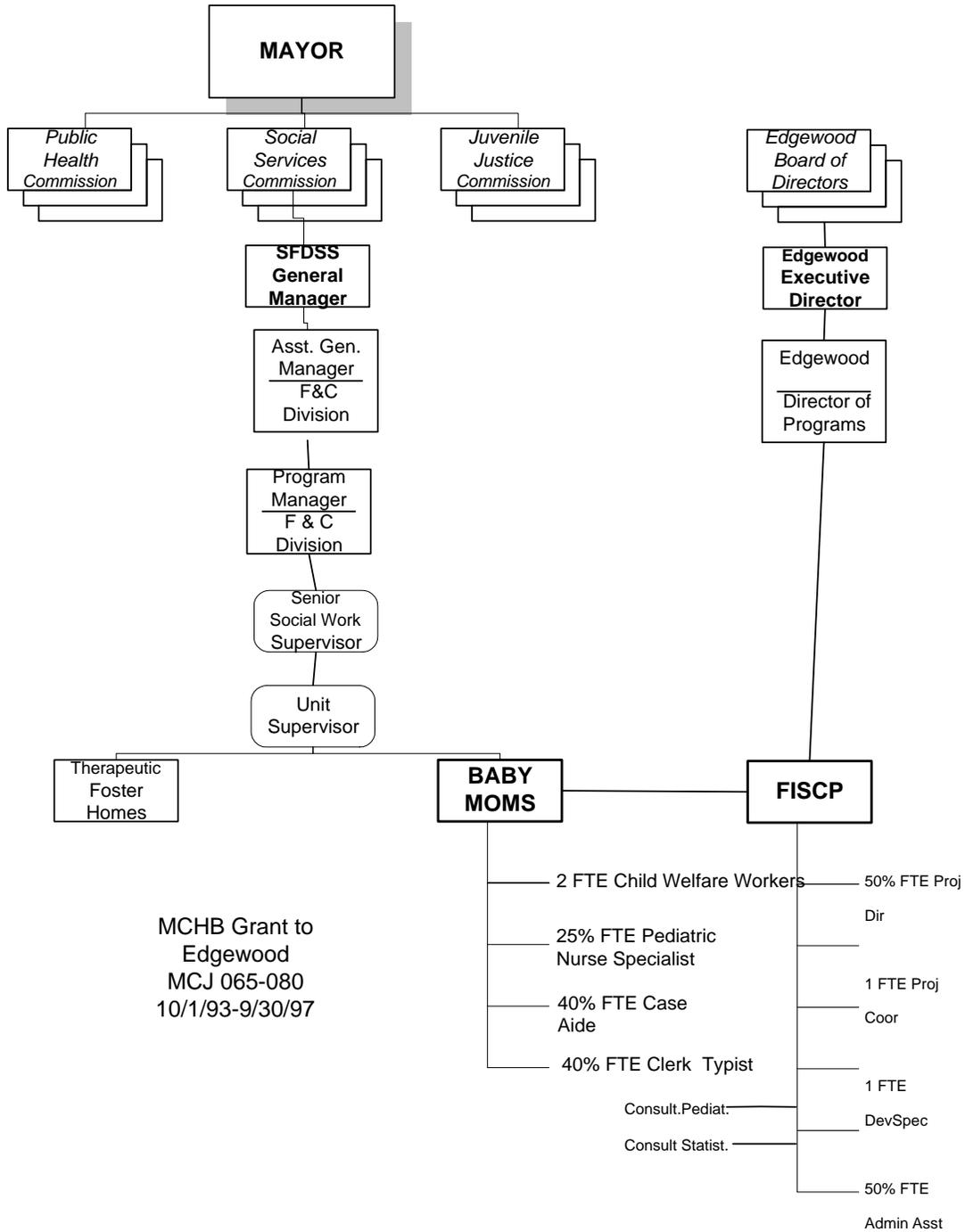
The mission of Edgewood's MCHB FISCOP is to support the SFDSS Baby Moms staff, foster parents, biological parents and infants while systematically collecting data that describe the program and its participants. By evaluating the program and all the players involved, the FISCOP hopes to enhance the lives of these children as they mature and also to contribute to the field of child welfare.



**San Francisco
County**



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County**



III. PROGRAM OPERATIONS

A. BABY MOMS PROGRAM: REFERRAL TO PERMANENCY

1. ELIGIBLE INFANTS

Infants age birth to 12 months who have been exposed to drugs and/or alcohol in utero, who are HIV positive, who have AIDS, or who have a serious medical problem as determined by the program's consulting Pediatrician in consultation with the Pediatric Nurse Specialist (PNS), are eligible for the Baby Moms program.

Infants with other medical problems may be placed in either the Baby Moms program or be designated as a medically fragile infants (MFI) and placed in the San Francisco Department of Social Services' (SFDSS) Shelter program. The severity of the medical problem determines whether the infant will be placed in the Baby Moms program (greater severity) or designated a MFI (less severe). At present, infants who are HIV positive and asymptomatic, all HIV positive symptomatic and/or technologically dependent are placed in the Baby Moms program.

◆LEVELS OF CARE

All children in Baby Moms require specialized home care. Levels of care are determined by medical review based on the child's needs, acuity, medical reports, staff visits and home assessment. Levels of care are reassessed at periodic intervals by the consulting Pediatrician in conjunction with the staff.

LEVEL I: Lower Risk

- At-risk infant who is growing/developing (previously Level II/III)
- Chronic medical conditions which have stabilized; currently few interventions
- HIV infected infant with typical problems of infancy

LEVEL II: Intermediate Risk

- Short-term home adjustment for a chronic intensive care nursery baby
- HIV infected child with symptomatic AIDS

◆LEVELS OF CARE cont.

LEVEL II: Intermediate Risk cont.

- Specialized procedures or management of moderate complexity (e.g. Broviac catheter for nutrition)

LEVEL III: High Risk

- Complicated AIDS child
- Ventilatory management
- Chronic disease in agonal stages
- Multiple complex procedures/management

◆ BASIC BOARD AND SPECIAL CARE SUPERVISION RATES

Level I Rate. The Level I rate is \$1,290 per month, which includes \$345 basic board rate and \$945 special care supervision rate.

Level II Rate. The Level II rate is \$1,500 per month, which includes \$345 basic board rate and \$1,155 special care supervision rate.

Level III Rate. The Level III rate is \$1,815, which includes \$345 basic board rate and \$1,470 special care supervision rate.

2. INFANT PLACEMENT PROCEDURE INTO BABY MOMS

Baby Moms was set up with a countywide referral and triage system to link staff of newborn nurseries at local hospitals with the program. Typically, hospital nursery staff identify potential Baby Moms cases and contact one of the SFDSS' Emergency Response Units (ERU) for assessment to determine the need for filing a dependency petition. Referrals of infants are sometimes made simultaneously to the PNS and the ERU by hospital staff, or in some instances by a SFDSS worker who is carrying the family's case

Once an infant who requires dependency is identified as having serious medical needs by hospital staff and/or the SFDSS worker, the child is referred to the Unit Supervisor or PNS of the Baby Moms program unit. The PNS calls the hospital social worker, who sees to it that the baby's primary doctor completes the Baby Moms Referral Form and forwards it to the PNS who then forwards it to the consulting Pediatrician. The PNS talks with the hospital nursing staff and/or visits the baby in the hospital and reviews the baby's chart. The PNS presents her views of the child to the consulting Pediatrician, who determines if the infant's medical needs require Baby Moms foster parenting. (A copy of the Baby Moms Referral form is in Appendix B.)

If an infant is not considered appropriate for placement in Baby Moms, the PNS informs the hospital social worker and the Baby Moms' Child Welfare Worker (CWW) immediately so that other plans can be made for the baby. According to one of the CWWs:

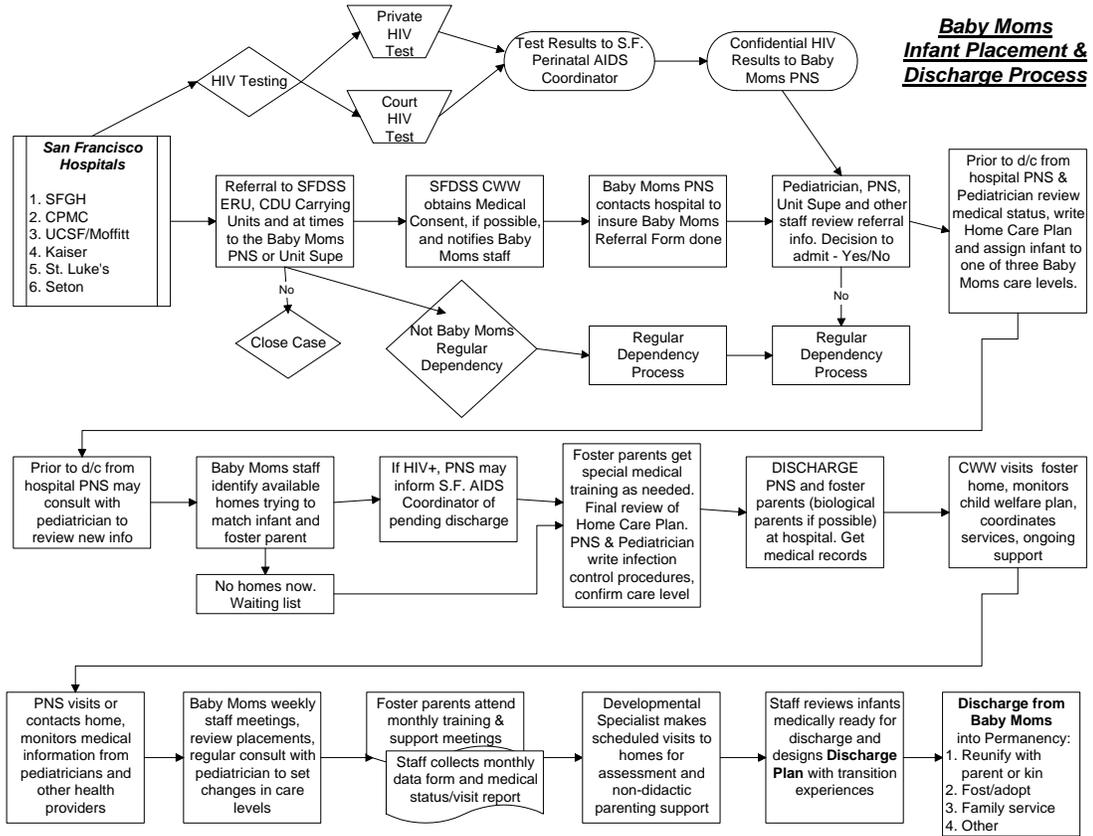
After a child is detained and the initial investigation is completed by the ERU, Baby Moms staff take over full case management responsibility. We don't turn this task over to another individual who then passes the case to yet another person once the child has been placed...we eliminate this middle man and the possibility of not being completely familiar with the needs of a particular child, the foster parents, and the biological family. This way we don't lose any time from one stage to another, and there is no loss of service. You can't pass the buck. We are responsible.

After an infant is accepted into Baby Moms, staff discusses that particular infant's needs and identifies the most appropriate available Baby Moms home for placement. According to one CWW, staff members look closely at the individual strengths of each foster parent before making a decision:

We look at things like whether or not there will be a lot of biological parent contact. Are there older children in the house (are they old enough not to present undue risk for a medically needy infant)? Can the foster parent handle the level of care demanded by this particular infant? Right now, about 50% of our present caseload are classified as very medically involved infants [*Levels II or III*]. This level of care requires experienced foster parents.

Prior to hospital discharge the PNS meets with the consulting Pediatrician to review the infant's status, develop a home care plan, and assign the infant to one of the three Levels of Care within the program. Baby Moms foster parents often go to the hospital and begin visiting the infant prior to discharge. In more severe cases the PNS will meet with the Baby Mom and hospital staff to review pertinent medical information and provide training to the foster parent in any special medical procedures required in the care (e.g. tube feedings, oxygen) prior to discharge. The hospital social worker may inform those birth parents, who are involved and interested, about the placement and arrange for all parties to meet at the hospital.

At the time of discharge from the hospital, the PNS and foster parent(s) are usually at the hospital. At this time the Baby Mom foster parent is given complete medical records and the home care plan.



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3. HIV TESTING

The Perinatal Coordinator of the Department of Public Health (DPH) stipulates that all infants who are "high risk" for HIV infection are to be tested as soon after birth as possible.

Consent for testing is obtained from the infant's parent. If the parent is absent or refuses consent, the Juvenile Court Judge is requested to give the consent. Definition of what constitutes "high risk" as well as the procedure for obtaining informed consent from the parent or consent from the Juvenile Court Judge is attached. (Copies of the Informed Consent form and Minute Order are in Appendix C.)

At present, test results take about two weeks from the time the blood is deposited at the laboratory. This time lag sometimes makes appropriate placement difficult, and efforts are being made to shorten the time. (Refer to Eligible Infants section on page 17.). In the case of a Baby Moms infant whose HIV status is unknown, precautions are taken by their foster parent as if the child were HIV positive until test results are known. This is the case for all foster homes caring for infants with uncertain HIV status (Refer to Infection Control section on page 56.)

4. INFANTS WHOSE HIV STATUS IS UNKNOWN AT THE TIME OF PLACEMENT

If the HIV status is unknown at the time of placement and the baby is not considered medically appropriate for Baby Moms by the consulting Pediatrician and PNS, the baby is placed in the Shelter program for medically fragile infants and/or regular foster care. Once test results are known, and if they are positive, the baby will be moved from their foster home into the Baby Moms program.

5. ONGOING CARE

The primary philosophy of the Baby Moms program is to provide these medically compromised infants with the best quality care in a home environment and to not move them until a well thought out permanent plan is in place or, in the case of terminally ill infants, until the child dies.

Once in placement the foster parents assume the major tasks of caring for the infants with support from program staff. There are regular visits with the infant and foster parent by the CWW and/or PNS with a minimum monthly face-to-face visit and, more frequently for ill infants regardless of caseload size. The frequency of these visits has varied during the project period depending upon the caseload size and paperwork requirements of the staff. The CWW monitors other services that the

infant may receive from therapists and at specialty clinics. Staff of Baby Moms and the MCHB funded FISCIP meet weekly to discuss program issues related to foster parents, infants, biological parents, discharge plans, monthly training, legal and legislative developments, community networking, recruitment of new foster parents, research and evaluation, special events as well as actual and pending/rumored organizational and administrative shifts. Staff meetings are chaired by the Unit Supervisor, and agenda items are referred to the Unit Supervisor by the Monday preceding the meeting.

Each Baby Mom foster parent is able to select their own local pediatrician with program staff's approval. Foster parents complete the Foster Parent Infant and Child Monthly Report describing the infant's status on a number of psychosocial functions, and included in this report are the findings from any pediatrician and/or physician specialists' visits and comments. The Baby Moms' consulting Pediatrician uses data from these forms as well as reports from staff to periodically review infants' medical status, to change the assigned Level of Care, and to update the care plan as indicated. The care plan includes the identification of any available or funded medical services that are to be provided to the child in the home, including but not limited to assistance from registered nurses, licensed therapists, and respite care workers. (A copy of the Foster Parent Infant and Child Monthly Report is in Appendix D.)

Foster parents attend monthly trainings, which are not only instructive but provide opportunities for supportive interaction and networking with other Baby Moms caregivers. (Refer to Training section beginning on page 50.)

6. DISCHARGE AND PERMANENT PLANS

Since the Baby Moms philosophy assumes that moving an infant disrupts the continuity of caregiving and is potentially harmful to the infant both physically and psychologically, an infant is discharged when two requirements are met: 1) the infant's medical problems no longer require specialized care and 2) a permanent plan is in place for the infant.

The CWW develops a permanent plan that involves reunification with the biological parent(s), placement with a relative, foster-adopt/adoption, or long-term placement. In most cases these plans involve careful transitions with multiple visits by the new caregivers to familiarize the child with their new caregivers and the new environment. There is a goal to involve biological family members with foster parents in training and support meetings to facilitate reunification efforts. The Unit Supervisor stresses that the reason for Baby Moms' high rate of reunification with biological family is due to the emphasis of the program itself:

Baby Moms was set up to place babies back into their biological family whenever possible. We don't do interim placements. We don't stop overseeing the care of our children until a long-term placement is found.

Baby Mom's PNS adds that the situation with infants who are HIV positive is a little different:

Because of the long-term nature of their medical care needs, some have stayed in a foster care home for over four years now. If they can be reunified with their biological family we do so. But usually, our foster parents make a commitment to these children for long-term care. We now know from research that some of these children will live to be nine and ten years old.

Several of the Baby Moms foster parents comment about the emotional strain of their infants moving into a permanent placement:

"I think these babies stay too long with us. After 7 or 8 months, it would be enough, but when they stay longer, it is very hard to give them up."

"My first child was very hard to give up. I've been to therapy, but I still worry about him every day. Does this happen with everyone and their first baby?"

"My first one, when I went to see her, it hurt good. I mean when that baby wanted her mother, it was the adoptive mother he sought. It hurt me, but it was for the baby's best interest."

◆REUNIFICATION

Even though it is the primary goal of staff to reunify the infant with parents and relatives, this is a challenging task because of the difficulties with which these families struggle. Baby Moms has found that one of the more important factors in the reunification process is the foster parents attitude and their effort to achieve this goal. The following "composite" conversation has been edited from several conversations with Baby Moms' foster parents about their views of and activities toward reunification:

☞ *Interviewer:* "You seem to be very good at fostering reunification, how do you do it?"

Baby Moms: "Just talk about their family, their roots, their problems. During the initial contact, I get them to relax. And they know that you care about them as well as their child. Once they open up and relax you can come at them harder. I say to them sometimes, 'You know that Social Services is too busy to take a lot of time with your child. **YOU** have to be the one who cares for your child.' And I tell them, 'You know you only have one hour to visit, and if you are 15 minutes late you won't get in.' I am very strict about appointment times, especially at first, and then will lighten up."

☞ *Interviewer:* "You seem to have a knack for making reunification work. Can you tell me about that?"

Baby Moms: "When we get a child, I ask for the relative's phone number. If they haven't seen the child, I take the child by their place at the kid's worst moment, so that they can see the child with all the tubes, etc. So they can meet the child and know that I will take care of him or her until they are well, but then it is the family's responsibility. The **BEST** place for any child is with the biological parent or relative. I let them know I'm here only temporarily through the crisis. I'm straightforward with them. I tell them that I will love, touch, kiss the kids until they can outgrow their troubles. And when the parents begin to contact me, I know they are beginning to care. You have to have patience with them and get them comfortable. I may talk about baseball or about them, but 80% about that child. I tell them that their child got through bad times, and that they can too. I tell the family 'This is your child, I can't raise it. You need to get your life together.' I know how smart these kids are, and I let the parents know this too."

☞ **Interviewer:** "You seem to have a strong belief that the best place for a child is with their biological family. Do you know how that belief was formed?"

Baby Moms: "I guess it was the way I was brought up. With a close-knit family...just family and relatives. Without a child knowing his family or roots, he is just a lost child. From having kids placed with relatives, I don't see any neglect, even in the rough areas. Every child whether Black, Korean or whatever, I truly believe they should be with their biological family. Even if they are not getting the type of lovin' you think that they should. It's important that you stay in contact with the parent and give the parent a break. I check up on them after the kids go home too. I'm always right around the corner. When we have a barbecue, I invite the parents, or the uncle or auntie. I keep in close contact with them. I give them baby clothes for their nieces or nephews."

☞ **Interviewer:** "What, if anything, do you do to help the child prepare for reunification?"

Baby Moms: "It all starts with the foster parent giving the child a strong self-esteem, instilling self discipline. I use time-out with them when they get older and toddle around. You know, no belt and no verbal abuse, just say it's time and take them to the time-out area."

?**Interviewer:** "Some foster parents are not as easy in their relationships with the biological families. Would you talk a bit about why this might be the case?"

Baby Mom: "Some foster parents take on the attitude that 'These are MY kids.', and I think maybe it could be their own guilt trip about things that never got fulfilled with their own kids. Maybe too it's that the money's not enough to pay me to make the time to work with these relative families. Or maybe it's that if the foster parent is doing well that if they work with the relative they will lose the child and that takes money out of their pockets. I really don't know these things. Just ideas and guesses."

◆PROTOCOL FOR THE DEATH OF A CHILD

When a child who may die is placed into a Baby Mom's home, the foster parent is provided with a written statement signed by the Assistant General Manager of the Family and Children's Services Division (F&C) indicating that this child is at risk of dying due to severe medical problems. The Baby Moms foster parent presents this to the medical team and police if death occurs. This alerts the authorities that the death was expected, influences the course of an investigation, and puts the authorities immediately in touch with the SFDSS' Special Investigator. When a child appears to have died, medical assistance is summoned via 911.

7. STAFF ROLES AND RESPONSIBILITIES

The 1993 staff consists of a part-time Unit Supervisor, two full-time CWWs, a part-time Pediatric Nurse Specialist, a part-time Program Coordinator, and part-time Case Aide and Clerk Typist. A Pediatrician and Psychologist consult with the program. (Refer to Organizational Chart on page 16.)

⇒**THE UNIT SUPERVISOR** (50% FTE): The Unit Supervisor in general, supervises the two CWWs, Program Coordinator, Case Aide and Clerk Typist. The Unit Supervisor chairs the staff meetings, reviews all referrals to the program, and reports to the Senior CWW Supervisor of F&C Division regarding the process of the program.

⇒**THE CHILD WELFARE WORKER** (2 FTEs): The CWW, in general, is responsible for all Reunification planning, working with the Juvenile Court, birth parents, Baby Moms foster parents, collateral contacts and child to develop a permanent placement for the child. The CWW is responsible for the protection of the child while under the SFDSS' care and supervision, and ensures the child gets services necessary to his or her well-being. When asked about their responsibilities, the CWWs give personal insights into their job:

Because we work with a smaller pool of foster parents instead of an entire foster care system, we know them much more intimately than we otherwise would. This results in a much more intense relationship. We are out there in the field a minimum of once a month to see them and the children. Our role is to be supportive of them. We go there to see how the kids are doing, but we hear about everything from the groceries to the husband. We are available 24 hours a day...they have our home numbers, they know our beeper numbers.

The other CWW adds:

And this kind of close contact is absolutely essential! The parents need this kind of backup and support. We must stay in touch and close contact. Some of the parents use our consulting Psychologist...then we get others who are very quiet and don't ask for much at all (although, there aren't many like this!) Then, there are those who call all the time. I actually prefer these parents because then I know what is going on with them!

Both CWWs emphasize the importance of being able to juggle friendship and the requirements of the job:

It's hard to go into a home and make suggestions and be their supportive friend at the same time. Then when we have to interject our observations and how things might be done better, they are resentful. Its a very complicated situation!

This CWW continues,:

Another issue mentioned by the CWWs centers on the role of Program Coordinator and the complex interaction that takes place with foster parents. In the past, Baby Moms coordinators were hired to recruit and support the foster parents with whatever they needed (donations of car seats, clothes, toys etc.), hold training sessions and group meetings and sometimes represent the needs of the foster parents to staff members, acting as an ombudsman or advocate. This is a natural outgrowth of the Program Coordinator's role of support. CWWs note that the Program Coordinator must maintain a sensitivity to the different level of interaction CWWs require with foster parents. "Too often, we would be portrayed as the bad guys by some of the foster parents, and the Coordinator got stuck in the middle.

CWW Job Analysis for Baby Moms
(Completed 12/89 by one of the CWWs)

Purpose/Objective: "Am working in the Baby Moms program as part of a team with one other CWW. Our objective is to work with families of children who are juvenile court dependents to attempt to stabilize their situations so that their children can be returned to them. Most of the children in these caseloads are considered medically fragile. We also supervise a limited number of siblings of medically fragile infants and also babies who have been placed with relatives and in fost/adopt placements. Additionally, we are to provide ongoing intensive support and guidance to the foster parents in Baby Moms caring for the babies."

Weekly Duties: "We participate in weekly staff meetings dealing with program objectives, plans for infants and abilities of foster parents. We also prepare court reports and attend court hearings; dictate court reports, case summaries and type reports when the word processing department is busy. We drive to visit foster homes; and accompany foster parents when possible to infants' medical appointments, consultations, etc. We supervise parents' and relatives' visits with their children. We evaluate and assess potential adoptive and fost/adopt homes by telephone and home visits. We provide all case management duties until a permanent placement has been found for the child (cases carried from ERU status through *PPH*). We're available 24 hours a day to foster parents to deal with medical emergencies and the death of infants. We investigate parent and relative situations and histories to determine their suitability to assume child's care."

Monthly Duties: "We screen incoming calls and inquiries from potential foster parents. We participate in training and support sessions for the foster parents including the planning and implementation of these. We supervise weekend visits for working relatives in the foster homes. We act as program liaisons to the community for recruitment purposes."

Requirements (Knowledge, Skills and Abilities): "Knowledge of Baby Moms program operations; medical terminology related to conditions of individual infants; awareness of the skills and capabilities of each foster parent selected for placement of an infant; ability to concisely describe the medical conditions of each child to determine the level of care required. Knowledge of family dynamics; ability to accurately and concisely present a history of the family, their functioning, reunification steps and goals for the infant's future. Knowledge of court procedures, laws related to minors and the skill to present credible testimony in court. Knowledge of community services and resources.

"Requires organizational and listening skills. Requires skills in dealing with people from all racial and socioeconomic levels. Requires skills in assessing

emergency situations and assisting with appropriate referrals, offering crisis and grief counseling, knowledge of emergency intervention services available.

“Requires knowledge of family dynamics to anticipate possible problems during visits; ability to present clear and accurate medical and developmental information about the infant to relatives; ability to diffuse potential conflicts between relatives and caregivers.

“Ability to summarize pertinent information, skill to use a typewriter and Sony dictation system. Also requires good telephone skills.

“Vehicle driving skills, a valid driver's license and map reading skills.”

⇒ ***THE PEDIATRIC NURSE SPECIALIST*** (25% FTE): The Pediatric Nurse Specialist, in general, assists the consulting Pediatrician in managing the infants' referral process, assesses infants' needs and interprets these to Baby Moms foster parents, assists the hospital in training the Baby Moms foster parent at discharge, trains staff regarding medical problems, plans and follows up on medical recommendations, records medical notes in the SFDSS case record, writes and institutes infection control procedures, and acts as a liaison with the DPH, hospitals and other community agencies.

⇒ ***THE PROGRAM COORDINATOR*** (50% FTE and this position is presently provided through the MCHB funded FISCP located at Edgewood.): The Program Coordinator, in general, oversees the recruitment and screening of applicants to Baby Moms, collects data, updates program statements, orientates new Baby Moms, and organizes all trainings.

⇒ ***THE CASE AIDE*** (40% FTE): The Case Aide, in general, assists the CWWs by transporting family members and supervising visits, maintains medical files of physician and foster parent monthly reports and follows through with foster and birth parents at the CWW's request.

⇒ ***THE CLERK TYPIST*** (40% FTE): The Clerk Typist, in general, provides administrative support to the Baby Moms staff.

The staff meets weekly. The agenda for these meetings varies and includes staffing of all infants in the program, including but not limited to Level of Care changes, discharge plans, medical status; staffing of all foster parents; needs assessment; admittance of new foster parents; SFDSS' Training for Foster and Adoptive Parents (T-FAP) in progress; support group and training planning; recruitment; special events; research development and evaluation; legal and legislative developments (i.e.

Assembly Bill 4411); resource library; media needs; staff organizational needs; community networking.

8. CONSULTANTS' ROLES AND RESPONSIBILITIES

⇒*THE PEDIATRICIAN* (Presently provided through the MCHB funded FISCP located at Edgewood): The consulting Pediatrician, in general, decides which babies are accepted into the program, orientates new Baby Moms, consults with and trains staff regarding medical problems and assigns the Level of Care for each infant.

⇒*THE PSYCHOLOGIST* (Presently provided through the MCHB funded FISCP located at Edgewood): The consulting Psychologist, in general, assists in development of program guidelines and policies, designs the research component, provides testing and evaluation of Baby Moms' families, provides needs assessment of Baby Moms. The consulting Psychologist meets regularly with staff and is available to foster parents to discuss any issues that may arise stemming from the care of these challenging infants.

9. STAFF STRESSORS AND COPING

One of the CWWs points out:

You do a juggling act when you go into a foster parent's home. Its an amazing transformation that takes place when you turn the car off and prepare yourself for a visit! We have to be very strong.

Another CWW adds:

There are unanticipated stresses too. When starting a new program such as Baby Moms within a public bureaucracy, administrators and staff should be prepared for the reaction of other units. The very nature of this type of service will warrant news media attention, and the staff members have been viewed by other employees as part of an elite group who get all the attention and don't really have to do much work. A lot of staff here thought what I did in the beginning was an easy job...they thought we only had a few cases each. And it's true that when we started our caseloads were lower than 'regular' family service caseloads. But today, we actually have more on our caseloads than the others!

What other social service workers don't realize is that Baby Moms staff are in constant contact with their families. This is cited as one of the leading stresses:

I've limited my families to calling me at home only during emergencies, yet it still gets intense. I come in every morning at 7:00 am, and my families know that. I get calls first thing, every day. Sometimes it gets to me, but I know that really they are just checking in and letting me know what's happening. It's really just a part of our job. They get depressed and overworked and tired. We need to boost their spirits and talk to them and give them positive strokes.

One CWW adds:

One of the worst stresses for me (and probably for all family services workers) is having to go into court and prove why you made the decision you did regarding the placement of a child.

As the AIDS epidemic continues to grow steadily among San Francisco's population, the CWWs predict a new kind of staff stressor emerging:

The biological parent that one ordinarily works with is changing. Now I'm seeing a baby with HIV virus and then on another visit you realize the mother has AIDS. One of my cases developed into full-blown AIDS and the mother died. The baby died later. This was very hard for me to deal with.

Staff believes they will have to deal more and more with the emotional roller coaster of supporting a terminally ill mother facing her own death, growing sicker and sicker every week, and simultaneously looking at the needs of her child and that home environment.

10. MANAGEMENT INFORMATION SYSTEM

◆HARD COPY MEDICAL FILES

Each child in the Baby Moms has a medical record containing all medical reports including all physician and dental reports, medical history reports, monthly foster parent reports and any specialty clinic evaluations or reports. A duplicate of this file is maintained in the Baby Mom's home. It is to be used in case of an emergency when the regular physician is not available and is sent with the baby into their permanent placement.

At the time of placement, two medical folders are made: one for the Baby Moms file at the SFDSS and one for the Baby Moms home.

◆COMPUTERIZED DATA STORAGE

The SFDSS maintains case records on children in a database system. These follow a standard format established by the State Department of Social Services (SDSS). In addition to these data, the MCHB funded FISCOP has developed a database that resides on an IBM-compatible personal computer using Paradox, a relational database. This database has standard demographic information about the infant, their medical history, and standard demographic information about the mother as well as her medical history obtained and recorded in the medical chart during the "birth" hospitalization. It also contains fields for the results of all the developmental assessments carried out by the Developmental Specialist. Minutes from all staff meetings and foster parent trainings are entered into a text database system, askSam.

11. FUNDING

◆TITLE IV-B

◆SPECIAL FUNDS

SENATE BILL 2076: California legislation, SB 2076, introduced by Senator Alquist required the SDSS to establish a pilot project in one California county for foster parents of HIV positive and/or infants with AIDS. San Francisco's

Baby Moms proposal was chosen by the SDSS and became the site for this pilot project which provided the following services:

- 1) Recruitment of foster parents who are willing to care for children two years of age and under who have tested positive for antibodies to HIV or who have been diagnosed as having AIDS.
- 2) Training and education for each new foster parent.
- 3) Support for foster parents participating in this pilot project, which shall include, but not be limited to, respite care and counseling.

The project began in July 1989 and continued for two years with funding of \$125,000 each year. These funds enabled the Baby Moms to pay for a part-time (50% FTE) Program Coordinator, a part-time (50% FTE) Pediatric Nurse Specialist as well as the consulting Pediatrician and consulting Psychologist. The SFDSS matched this grant with in-kind staff and other social services support contributions.

MCHB: The Maternal & Child Health Bureau's division for Children with Special Health Care Needs funded a proposal from the Baby Moms program beginning October 1, 1990. This grant award permitted Baby Moms to develop a computerized database, pay for the consulting Pediatrician and Psychologist, carry out developmental assessments of all infants in the Baby Moms foster homes and begin data analyses of qualitative and quantitative information describing the program and the foster parents.

OTHER CONTRIBUTIONS: Baby Moms was "adopted" by a home mortgage company's foundation and each year has received small donations derived from an annual run and other special fund-raising activities. This is renewed each year, but may not continue.

◆OTHER SOURCES FOR REIMBURSEMENT

MEDI-CAL

B. MCHB FUNDED FISCP

1. FISCP'S RELATION TO THE BABY MOMS PROGRAM

The core Baby Moms service program operates within the F&C Division of the SFDSS as described in the preceding section. The MCHB project staff attend the weekly Baby Moms staff meetings to collaboratively review cases and monitor ongoing operations. Project staff also attend the monthly Baby Moms foster parent training meetings. MCHB project staff are integrated into the SFDSS and operate within the F&C Division carrying out summative measures of infants' developmental status in accordance with established time frames and using data collection instruments that permit comparison with similar projects around the country. The Developmental Specialist conducts home-based assessments at regular intervals making use of both norm-referenced and criterion-referenced instruments (Refer to Appendix A.). The MCHB staff also carry out ongoing formative evaluation of program operations to refine and improve program design and services to infants and their families. Analysis of the data collected from the infants' assessments, and the results of the formative evaluation will be synthesized for use by others interested in developing similar projects.

Although the new MCHB funded project is housed at Edgewood Children's Center, which physically separates the two projects, the Project Coordinator will now work a significant amount of time to carry out the responsibilities of the Baby Moms Program Coordinator. This staff person will maintain a desk and phone at both locations. MCHB staff will continue to attend weekly Baby Moms staff meetings.

2. EVALUATION

All Baby Moms and FISCP project activities are documented to ensure that goals and objectives are met. Specially designed forms related to the performance of staff and foster parents on various dimensions (i.e. caregiving, relations with other professionals, relations with other foster parents) are regularly scored as are evaluations of the monthly training. (A copy of the Evaluation of Training form is in Appendix E.) The primary evaluation will look at the infants' development over time using medical reports, foster parent observations, norm-referenced (i.e. Bayley Scales, Infant Mullen's Scale of Early Learning, Vineland Adaptive Behavior Scales, Stanford-Binet) and criterion-referenced assessments (i.e. Security/Attachment Waters' Q-Sort, Temperament, Dyadic Interaction, Social Support). These measures are compared with infants' status at various points during the program, and where numbers permit, with a matched group of children in another foster care program.

Tracking of Baby Moms project activities by the MCHB staff includes information entered in the computer on both relational (Paradox) and text (askSam) databases. These software programs permit great flexibility by storing information in different formats to allow easy retrieval of demographic and assessment data on clients and on program activities (i.e. minutes of meetings, phone logs, correspondence, evaluation of training). Hard copy files of relevant information and meeting minutes are also maintained. Regular periodic review of both computer and hard copy data guides decisions about Baby Moms and MCHB program structure and policies. These reviews also demonstrate progress towards or areas for corrective action in meeting the goals and objectives of the MCHB project.

3. STAFF ROLES AND RESPONSIBILITIES

⇒ ***Project Director*** (50% FTE, paid as a consultant): In general administers the MCHB award, supervises all staff, oversees analyses of data, writes reports and give presentations of project findings and works to integrate the FISCP within ongoing operations of the two agencies, and developed a Memorandum of Understanding (MOU) between Edgewood and the SFDSS.

⇒ ***Project Coordinator*** (1 FTE): In general, carries out the tasks of the SFDSS Baby Moms Program Coordinator's position of recruitment and screening of new applicants, organizes all trainings and also supervises the FISCP Administrative Assistant, upgrades the database, obtains informed consent or minute orders.

⇒ ***Developmental Specialist*** (1 FTE): In general, implements the revised assessment protocol with all Baby Moms infants birth to three years of age, provides nondidactic anticipatory guidance for foster and biological caregivers, assists in writing and dissemination of findings.

⇒ ***Administrative Assistant*** (50% FTE): In general, assumes general office duties for the FISCP and carries out data entry.

4. CONSULTANTS' ROLES AND RESPONSIBILITIES

⇒ ***Pediatrician*** (5% FTE): Attends all Baby Moms staff meetings and regularly reviews infants' medical status and assigns an appropriate Level of Care, screens infants referred to Baby Moms and works with the PNS to design a home care plan.

⇒ ***Research Statistician*** (15% FTE): In general, carries out statistical analyses of data as requested by the Project Director and collaborates in writing articles and presentations.

⇒ ***Programmer***: Generally under the direction of the Project Director write programming language for medical "Passport" in Microsoft's Access database for infants and children to have comprehensive records in their possession when they go into permanent placement.

⇒ ***Child Development Psychologist***: Meet regularly with the Developmental Specialist to consult on developmental and parenting issues for each child, foster and biological family.

5. FUNDING

All funds for this project are provided by the Maternal & Child Health Bureau's division for Children with Special Health Care Needs in the U.S. Department of Health and Human Services. The present grant through Edgewood Children's Center is for four years. Edgewood does supply in-kind office space, telephone, and some supplies.

C. FOSTER PARENT SELECTION CRITERIA, SPECIAL TRAINING, APPLICATION PROCESS AND ORIENTATION

All applications are reviewed by the multidisciplinary staff and discussed in a team meeting before a decision is reached to accept an applicant into the Baby Moms program. Applicants for the Baby Moms program are judged on their emotional maturity, their ability to work as a team and understand and work with complex medical problems, to realistically plan finances, and to understand and work with various medical specialists and with a bureaucracy. Experience in working with fragile infants and medical training is preferred, but is not necessary. (Refer to Special Training section beginning on page 41.)

1. CRITERIA FOR SELECTION

State and County Licensing Requirements for foster homes must be met. These include:

- ✓No criminal record, specifically no convictions for a felony or multiple misdemeanors for anyone living in the home.

- ✓Participate in Model Approach to Partnerships in Parenting (MAPP), which in 1993 became known as Training for Foster and Adoptive Parents (T-FAP), a 7 week, 21 hour training program specifically designed to prepare foster and adoptive parents. Applicants are informed that going through T-FAP does not guarantee acceptance into the Baby Moms program. Candidates and their spouse or significant other must be available and attend the T-FAP training program which is held weekday evenings and on weekends.

- ✓Have a prelicensing home visit by staff from the SFDSS Licensing Unit to assess the living conditions, adequacy of space for caring for foster children, and commitment of the family.

- ✓Maintain a baby photo album, videos, "favorite" toys and clothing, books, etc. and to send these with their foster child to their permanent placement.

Baby Moms' Specific Requirements:

- ✓ Must be willing to accept an HIV infected child.
- ✓ Have a home visit by Baby Moms staff member(s) to describe program structure, requirements, answer particular questions from the applicant, and also give staff a chance to determine the family's understanding of the program and assess their degree of commitment and interest.
- ✓ Good health status for primary caregivers and others living in the home. Applicants must inform Baby Moms of any conditions of household members that might influence their ability to care for fragile infants such as restricted mobility, terminal illness, medications (potentially mind altering or not), any illness that may require regular hospitalizations or weekly time away from the home.
- ✓ Good stamina, defined as sufficient energy to care for fragile infants and the ability to function on little sleep for an extended period of time without negatively affecting the ongoing quality of care of the infant.
- ✓ Willingness to have biological and/or adoptive families visit in the foster home and to cooperate with reunification plans which may involve weekend and night visits.
- ✓ Willingness to have a maximum of only two babies under the age of two in the home at one time, unless a special circumstance exists for which staff has given approval.
- ✓ Having no other children in the home under the age of four unless it is an approved situation involving a Baby Moms child who has been approved to stay beyond their second birthday. This is to reduce the risk of exposure to colds and viruses to HIV positive infants from other youngsters, but to permit Baby Moms children with long-term illnesses such as AIDS to remain with their primary caregivers.
- ✓ Must utilize a pediatrician who meets all of the CHDP requirements for pediatric care.
- ✓ Willingness to undergo psychological assessment using standardized and criterion-referenced psychometric instruments. (Although part of the application process, this assessment is not intended to be the decisive factor in

accepting or rejecting an applicant, but rather is to understand coping mechanisms, interpersonal relationships, and certain personality dimensions.)

✓Have an insured, dependable automobile and a valid California driver's license.

✓Agree to work exclusively with the SFDSS' Baby Moms program.

✓Willingness to attend monthly training and support meetings.

✓The primary caregiver may have no other employment either in or outside the home because this is a paid, full-time occupation.

✓Possess certain knowledge of and/or have experience as follows:

- ◆Experience with infants and/or medical experience with very young children within the past 6 years. References required. Most prospective foster parents work in the Shelter program caring for MFIs prior to becoming a Baby Moms foster parent.

- ◆Basic knowledge of normal infant and child development.

- ◆Ability to understand and accurately complete monthly forms (i.e. monthly reporting forms, vouchers).

- ◆Sensitivity to cultural and ethnic diversity.

◆BABY MOMS FOSTER PARENTS' SUGGESTIONS FOR APPLICANT CRITERIA

When interviewed, Baby Moms foster parents offered their own advice on the qualities needed in being a Baby Moms foster parent(s) this program:

I think any newcomers to this type of program need to get hit with a dose of reality before even considering future possibilities in this type of foster care. All the training in the world can not prepare you for those sleepless nights, the crying, the restricted home life. But even more important for people to realize is the need for space in their environment. We've had three sons of our own, 30 - 40 foster care babies and 60 - 70 foster teenagers in our house in the last 12 years. I feel certain our good fortune to have a large house with separate

bedrooms has contributed to our success in foster parenting. People need space—especially with children!

It's not just that one has to be good at providing in-home care. I have learned to be a patient-rights advocate for my kids. We are in and out of the hospital for all kinds of reasons. Our doctors are good, yet I am not satisfied with the yes and no answers about the health of my children. From what I've seen, the other Baby Moms are like I am, they study the health condition of their children and they talk to each other and "bug" the physicians about any question they may have.

You have to be able to give the kind of love that makes this baby learn to trust. I know that if I have truly bonded with my baby then he will accept the next person to come along in his life. And this makes me proud. Proud that I can create trust that will last a lifetime.

2. SPECIAL TRAINING

For applicants who meet many of the criteria, but whose knowledge and/or experience is lacking, Baby Moms now offers specialized training to upgrade applicant skills and knowledge before entering the program. There are two categories of persons who may need this additional training support:

•***Little or no prior baby care or pediatric medical experience.*** Individuals with little or no prior baby care or pediatric medical experience are required to provide care to infants in the Shelter program for medically fragile infants for no less than six months. The length of time for being a Shelter foster parent is determined on a case by case basis. Once the experience with MFIs is successfully completed, and if both the applicant and the Baby Moms staff continue to work together, the individual will begin the Skills and Specific Subject training.

•***Prior pediatric medical experience.*** Applicants who have adequate pediatric medical experience are not required to first provide care to infants in the Shelter program, but they are required to attend the Skills and Specific Subject training.

◆**SKILLS TRAINING.** The applicant needs to be acquainted with but not completely proficient in the following skills and situations. The applicant may observe these procedures in the homes of other Baby Moms foster parents or hospital setting as arranged by the Mentor Foster Parent. If the applicant becomes a Baby Mom, it is the responsibility of the hospital

discharging an infant to ensure that the foster parent caring for that infant is adequately trained in carrying out any of these specialized procedures:

- 1) Tracheotomy (including suctioning)
- 2) Apnea monitor
- 3) Oxygen
- 4) Naso-gastric feeding and gastrostomy
- 5) Central line, Broviac
- 6) Seizure management
- 7) Infant and child CPR
- 8) Administering medications

◆ **SPECIFIC SUBJECT TRAINING.** The applicants will need to attend lectures and presentations on the following subjects.

- 1) HIV/AIDS (medication/drugs)
- 2) Intrauterine drug exposure (includes videos); withdrawal; at-risk infants—practical lessons and parent survival skills
- 3) Fetal Alcohol Effects and Syndrome
- 4) Prematurity; chronic lung disease
- 5) Normal infant development
- 6) What constitutes a major concern? When to call for help?

One foster parent, who was once a foster child, emphasized the importance of grooming potential foster parents for a very difficult task:

Screening is terribly important. This is not a job that just anybody could do—it's much more than medical training involved here. We began with teenage foster children when our children were small, then switched to babies and later still we took on medically fragile infants. This represents years of hard work. One can be trained, yes. But we need to realize that a gradual introduction to the actual hands-on care is best.

3. APPLICATION PROCESS

Initially the Program Coordinator was responsible for receiving phone inquiries and following up with applicants by sending information and maintaining contact with them. This process has varied as the Program Coordinator's position has been vacant or reduced from full- to part-time. Consequently roles have shifted as these responsibilities have been taken on by other staff such as the Unit Supervisor. (A copy of the application form is in Appendix F.)

Step 1. Prospective applicant phones in and is screened by the T-FAP Phone Intake Worker using forms: (a) T-FAP Inquiry Forms, and (b) Baby Mom's Checklist.

If the applicant appears licensable and seems to meet all the requirements of the Baby Moms program, both forms are stapled together and given to the Baby Moms Program Coordinator, and a packet which includes: (a) Cover letter, (b) General information on foster home licensing regulations, (c) Baby Moms statement, (d) Baby Moms application which includes the Maternal Attitude Scales is mailed to the applicant for further screening. The applicant is requested to return the completed Baby Moms application and Maternal Attitude Scales to the Baby Moms Program Coordinator.

Step 2. Program Coordinator reviews application, T-FAP inquiry form and checklist. For those applicants who do not meet the criteria, a denial letter is sent. Applicants who appear to be qualified, are invited by the Program Coordinator to an initial Group Screening Meeting. Spouses or significant others must also attend this meeting. The PNS attends and assists in evaluating the applicant's medical knowledge and experience. Aside from assessing new applicants, the screening meeting has a second purpose which is to discuss with the applicant their intentions regarding foster care should they not be accepted into the Baby Moms program.

If they are interested in foster care in general and, if licensed, would go on to foster other children then they can be referred to T-FAP. If their interest is solely in the Baby Moms, then another step must be taken prior to referral to T-FAP. Since T-FAP spaces are so valuable, no one should be referred to T-FAP unless they are willing to work in other programs or are more thoroughly evaluated by the Program Coordinator as to their acceptability for the Baby Moms. In this situation the Program Coordinator proceeds to Step 5.

Step 3. After the initial Group Screening Meeting, the Program Coordinator sends out one of two letters: (1) Denial letter or (2) Proceed letter. Those receiving the "proceed" letter, the procedure is as follows:

1. Two dummy cases are made—one for the Baby Moms file and one for the T-FAP trainers.
2. The T-FAP "dummy case" is given to the Homefinding Unit Supervisor who will assign the prospective foster parent to a T-FAP training; and
3. The Program Coordinator is alerted by the Homefinding Unit Supervisor regarding the date T-FAP training begins for each applicant.

Step 4. Between the 5th and 6th T-FAP meeting the Program Coordinator talks with the T-FAP trainers to find out the strengths and weaknesses of the applicant and the impressions and recommendations of the T-FAP trainers.

Step 5. Between the 5th and 9th T-FAP meeting the Unit Supervisor, CWW and/or the PNS interview the applicant and the applicant's spouse and/or significant other in the applicant's home in order to assess family dynamics and home environment. The PNS also evaluates medical knowledge and competence. If mutual interest continues, the applicant is referred for psychometric assessment by the consulting Psychologist.

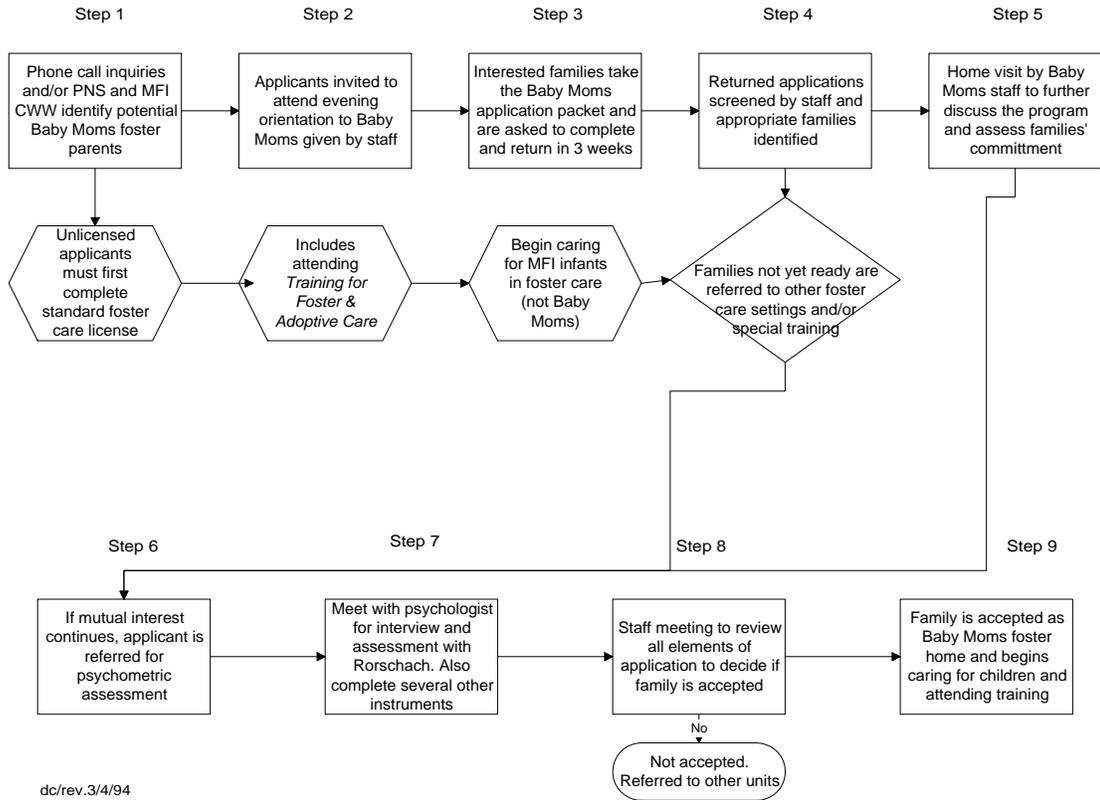
Step 6. Psychometric assessment is done by the consulting Psychologist. Assessment instruments include the Rorschach Technique, a Social Support Inventory, California Psychological Inventory, Moos Family Environment Scale.

Step 7. If the applicant continues with the process through Step 6, then, at or before the 12th week after beginning of T-FAP training, the Program Coordinator presents all information to the Baby Moms staff at the weekly multidisciplinary staff meeting. The T-FAP trainers for each applicant are invited to attend this meeting. The decision to accept or deny an application is made by the entire staff. Acceptance or denial letters are sent once the decision is made. Acceptance is based on a six month mutual evaluation period. Following the evaluation period all Baby Moms foster parents continue to have a twice yearly staff review of their performance. (See also Initial "Probationary" Period and Ongoing Evaluation section on page 47.) (A copy of the Foster Parent Rating Scale is in Appendix G.)

Step 8. The Program Coordinator then schedules an orientation for the newly accepted Baby Moms foster parents prior to the placement of a baby; alerts the T-FAP Unit Supervisor about the Baby Moms staff decision, and continues to maintain the Baby Moms dummy file.

Step 9. The Program Coordinator is responsible for arranging for the staff to complete a review of each Baby Mom every six months. (See also Initial "Probationary" Period and Ongoing Evaluation section on page 47.) (A copy of the Foster Parent Rating Scale is in Appendix G.)

**Baby Moms
Foster Home
Application Process**



dc/rev.3/4/94

4. ORIENTATION FOR APPLICANTS ACCEPTED INTO BABY MOMS

◆ **MENTOR FOSTER PARENT.** Every new Baby Moms foster parent is assigned a Baby Moms Mentor Foster Parent. The Mentor is responsible for arranging visits with other Baby Moms foster parents so that the new foster parent can observe the types of infants in the program and the care skills needed to nurture the infants. The Mentor Foster Parent is also available to answer questions and offer advice and support.

◆ ORIENTATION TRAINING

1. Administrative review of the program policies and procedures, usually presented by the Program Coordinator.
2. Infection control, medical follow-up procedures, usually presented by the PNS.
3. Overview of medical problems associated with infants accepted into the program usually covered by the consulting Pediatrician.
4. Reunification requirements, parental visits, Juvenile Court, partnership in parenting presented by CWWs.
5. Birth parents, drug problems and family situations.
6. Infant maternal attachment and bonding.

5. INITIAL “PROBATIONARY” PERIOD AND ONGOING EVALUATION

At the time of the foster parents' acceptance into the program, there is a six month mutual evaluation period to determine the appropriateness of staff and foster parents working together. At the end of this time, new Baby Moms foster parents are evaluated by staff using a Likert scale in the following five areas: Quality of caregiving, Quality of relations with other foster parents, Quality of relations with biological family members, Quality of relations with other agency professionals, and Participation in training. The results may be shared with the Baby Mom foster parent by the Unit Supervisor in conjunction with the CWW.

D. RESPITE CARE

Baby Moms are required to take 50 hours of respite care per month. Respite care hours must be used each month and cannot be accrued. This requirement provides Baby Moms foster parents a chance to get rest and hopefully to avoid burnout. Child care that is used when attending training or other group meetings is not considered part of respite care.

1. REIMBURSEMENT

Baby Moms are reimbursed for 50 hours of respite care each month at the rate of \$4 per hour for one baby and \$7 per hour for two babies. Baby Moms pay the respite care worker at the time of service and request reimbursement from the SFDSS. Child care is also reimbursed at the same rate as respite care. Reimbursement for respite care and child care is submitted using vouchers directly to the SFDSS' Income Maintenance Unit Supervisor. Respite care and child care hours are submitted on separate vouchers. Respite care hours for the first month are prorated from the date of placement. Respite care is allocated per month, not per child.

2. CHILD CARE (DIFFERENT FROM RESPITE)

Time spent in training and group meetings is not considered part of respite care. Child care is reimbursed for the following reasons:

- Required training.
- Group meetings.
- Special visits with physicians involved in research, unless the research project pays for expenses.
- Unusual circumstances which have prior approval.

3. FUNDING

Funding for Respite and Child Care comes from [WHERE???

4. RECRUITMENT OF RESPITE AND CHILD CARE WORKERS

Baby Moms may select and employ their own respite care workers. All respite care workers are screened by the Baby Moms foster parents and used at their discretion. All respite and child care workers must be over 18 years old, never convicted of a felony, have an up-to-date CPR certificate and be fingerprinted.

A predominant concern expressed by Baby Moms foster parents (especially single foster parents) focused on the ability to find and maintain medically skilled respite workers. Predictably, those foster parents with a large extended circle of family and/or friends did not express any feelings of frustration around respite care issues. These parents tended to employ their family members to provide respite care and extended total respite hours by making their own "family visit" arrangements (without pay).

One single foster parent suggested that perhaps more respite time could be allocated to single parents since they do, after all, spend more concentrated time with the children than those who can share the responsibility with a partner. Indeed, one married foster parent expressed a concern for these single parents and recalled that of the parents she has known who have experienced burnout with the Baby Moms program, several were single parents.

A Baby Mom couple who has been taking foster children for the past twenty years (while raising their own family) suggested that other foster parents could try what they have found to be a beneficial and cost-effective solution to obtaining extra help around the house or with the children:

We have learned that the church and community are excellent sources for finding people who are looking to learn a skill in exchange for their services. In our case, it happens to be a woman from Cuba with previous medical experience who needs to learn English and have a place to stay.

5. CONFIDENTIALITY ISSUES

For babies who are HIV positive or who have AIDS, it is not considered a breach of confidentiality to disclose this information to a respite or child care worker. The purpose of the confidentiality law is to ensure that the child is not discriminated against; however, respite and child care workers need to follow the same infection control guidelines as the primary caregiver and so should be informed.

E. TRAINING (Refer to Appendix H for a detailed training curriculum.)

The Baby Moms training curriculum is designed to integrate new information in a way that allows foster parents to discuss their own experience with their peers. In addition to monthly lectures and training, individualized training in medical procedures is arranged prior to placement of every medically fragile infant who may need these particular procedures regardless of how familiar a foster parent may be with a certain procedure. This individual training component follows a competency based model of mastery learning and certification is determined by hospital medical staff before an infant's discharge.

Group training sessions are of two types: support groups and formal instruction, and are often combined. The meetings are once a month for 2-1/2 hours. There are periodic meetings at which no formal instruction is presented, and foster parents have an opportunity to interact with staff and one another discussing what is on their minds, business matters and policies. Formal instruction of material occurs at least six times a year. Professionals from the community are brought in to teach the foster parents. The areas that are of continual importance and which form the core of training are as follows:

- Medical: HIV testing, HIV trends, AIDS symptomatology; infection control; common disorders of prematurity, such as respiratory distress syndrome, apnea, pneumonia, broncho-pulmonary dysplasia, acute cardiovascular disorders, central nervous system disorders, gastrointestinal disorders, anemia, sepsis; home care for oxygen dependency, gavage feeding, urinary catheters, colostomy, tracheostomy, gastrostomy; cardiopulmonary resuscitation; drug dependency, risk factors during pregnancy, fetal stresses, neonatal withdrawal symptoms, interventions in treatment, nutrition, speech and hearing disorders, physical and occupational therapy.

- Psychosocial: Issues of death, dying, grieving, separation, loss; developmental and behavioral concerns associated with drug withdrawal; developmental caregiving for infants recovering from intensive care; stress reduction.

1. EVALUATION OF TRAININGS

At the end of each training session, foster parents are asked to rate the speaker and presentation using a 4 point Likert scale from high to poor on the several aspects. Also, comments about strengths and weaknesses can be written in the space provided on the form. The forms are anonymous and are used to evaluate the usefulness of subject matter to the foster care provider and determine if speakers should be asked to return. (Refer to Appendix H for a detailed training curriculum.)

IV. PROGRAM POLICIES

A. INTRODUCTION

During its start-up period, Baby Moms operated primarily with traditional policy guidelines for the Family & Children's Services Division (F&C), but it quickly became evident that these did not sufficiently address the many unique aspects of this new program. Current Baby Moms policies are included here as a resource for those who may be starting a similar program in their own community. Obviously, each geographic region of the country has particular issues that must be addressed by creating specific policies. This is essentially how Baby Moms policies were developed over time. What is not revealed here is the many versions and drafts of policies that were debated by staff, written, rewritten, tested, rejected, revised and changed to meet the evolving needs of clients and interagency cooperative efforts. For example, one CWW notes:

When I first came into the program we were allowing only 2 children per foster care family. Now we find the HIV positive children are living longer than originally anticipated, and as they grow older, infants are allowed into the same home for the same kind of successful care—three children per foster family is not so unusual now.

The second CWW adds,

That's another thing that makes this program so different. We change and adapt to meet the needs of the kids, and the foster parents, rather than imposing strict policy mandates.

But the degree of flexibility in applying "policy mandates" has continually changed during the Baby Moms project period, fluctuating from less to more controlling as a function of numerous factors such as publicity, staff and individual foster parent relations, administrative and budget changes, legislative mandates, and the individual personality styles of staff. This reaffirms a well established view that policies are processes influencing the structure and function of the organization within which they are made, and as Vickers (1965) has written, "...the structure and function of these institutions and their mutual relationship are not static but are on the contrary in increasingly rapid change, partly as a result of policy making activity." Simply put, the Baby Moms policies written down here are today's, but probably won't be

tomorrow's, as will be the case with any human service organization's program's policies.

B. PROGRAM POLICIES

1. *Infant eligibility.* Infants must meet eligibility criteria and be medically reviewed by the consulting Pediatrician and staff prior to admission to Baby Moms. (Refer to Eligible Infants section on page 17.)

2. *Foster care board rates.* Board rates are determined by the Level of Care assigned by the consulting Pediatrician to each infant at the time of admission to Baby Moms. Levels of Care will be regularly reviewed by the Baby Moms staff and consulting Pediatrician, and infants' Levels changed according to the determination of amount of caregiving required to meet the unique medical and psychosocial needs of the particular child. (Refer to Levels of Care section on page 17.)

3. *Foster Parent Recruitment.* Efforts will be made to recruit persons who meet the criteria for acceptance established by program staff. (Refer to Foster Parent Selection Criteria, Special Training, Application Process and Orientation section beginning on page 38.) Recruitment strategies will be flexible to permit finding the greatest number of candidates, concentrating whenever possible on selecting persons who match the ethnic diversity of Baby Moms infants and who live in San Francisco in order to facilitate reunification and visits with the biological parent(s). Baby Moms Program Coordinator will work closely with the SFDSS Homefinding Unit to find appropriate candidates.

4. *Interaction with biological parents.* Birth parents and relatives must be allowed visiting privileges which may include weekend and night visits within the foster home. This is required because traveling is often contraindicated for a baby, a comfortable visiting atmosphere is conducive to reunification. Baby Moms often act as role models or parent educators for birth parents and relatives.

5. *Attendance at meetings, trainings and seminars.* Foster parents must attend the mandatory monthly meetings. Other educational seminars are optional, and foster parents are encouraged to attend, particularly for subjects related to a child in their care. Preauthorized reimbursement is occasionally available.

6. *Number and age of infants and other children in each home.* No more than two Baby Moms infants may be placed in a home at the same time. However, for those infants who remain medically fragile past their second birthday as is the case with a number of HIV positive children, current policy permits the placement of a third Baby Moms child in a home if the following conditions exist:

- No other suitable placement is available.
- The psychological and social needs of the children already in the home and the child to be placed will be met by this placement.

7. *Qualifications of child care and respite providers.* Child care personnel may be selected by the Baby Moms foster parent, but they must meet the SFDSS qualifications for anyone providing child care to a SFDSS dependent child which includes fingerprinting, a check of criminal records and CPR training.

8. *Developing transitional objects.* Foster parents are required to maintain a baby photo album, videos, "favorite" toys and clothing, books, etc. and to send these with the foster child to his or her permanent placement. Baby Moms are also urged to maintain their own copies of photos or remembrances of their foster children.

9. *Vacation.* The program does not pay for an annual vacation, although we encourage it. Arrangements are sometimes made between Baby Moms to "trade" babies during vacation time and foster parents make their own financial agreement. Babies can accompany foster parents on vacation if travel is approved by the baby's pediatrician, the CWW and by either the birth parent or the Juvenile Court Judge.

10. *Emergencies.* The Baby Moms' CWWs carry pagers and are available 24 hours a day to the foster parents. Urgent medical emergencies necessitate calling 911.

11. *Media.* The public's interest in this type of program, especially in its early stages, has been reflected in the media's requests for interviews, film footage, television appearances, etc. All press requests are directed to the Assistant General Manager. The Assistant General Manager decides the extent that a Baby Moms child will participate in the project, and in general coordinates media activity.

12. *Vacancies.* We expect to keep Baby Moms' homes filled; however, if a temporary vacancy occurs, we expect that the space be kept available to the program. The program will not pay while a space is vacant.

13. *Adoption.* If a Baby Moms' foster parent chooses to adopt an infant in their care, they will no longer be allowed to participate in the program. This policy was established to discourage participation in the Baby Moms program as a means of fast tracking the adoption process.

14. *Phone tree.* Baby Moms foster parents participate in the foster parent phone tree used to pass along program announcements from staff and from one another.

15. *Exclusive contract.* Foster parents must work exclusively with the SFDSS Baby Moms program.

16. *Record keeping.* Baby Moms will, as part of their duties, keep written records and notes of significant events on each baby as part of the care for the infant.

Medical Record: The Children Health Disability Prevention (CHDP) Medical and Dental report is completed by every doctor or nurse practitioner each time a baby is seen by medical professionals. The original is sent by the Baby Moms foster parent to the CWW and a copy is kept by the foster parent in the baby's medical record. This medical record is to be used in case of an emergency when the regular physician is not available and is to accompany the child into their permanent placement. (A copy of the CHDP Medical and Dental form is in Appendix I.)

Monthly Report: A Foster Parent Infant and Child Monthly Report Form must be filled out by the foster parent at the end of every month for each baby in care. This report is to be mailed to the CWW or turned in by the 10th of every month. These reports enable staff to follow the progress of the baby, make Level of Care changes, and are used extensively in the monthly staffing of each baby. They are also an important data element in the research component of the MCHB FISC project. (A copy of the Foster Parent Infant and Child Monthly Report form is in Appendix D.)

17. *Infection control.* When caring for babies, all participants in the Baby Moms should wear gloves under the following circumstances:

- When changing all diapers and handling soiled diapers, pads, linen or clothing.
- When cleaning up after vomiting.
- When cleaning up spills of body fluids.
- When handling blood.

While these requirements may be viewed by some as overly cautious and more stringent than those from the Center for Disease Control and the Department of Public Health's Perinatal Coordinator, the program's goal is to ensure maximum protection of our Baby Moms and to develop an atmosphere of alertness and caution when it comes to infection control. The consulting Pediatrician and PNS emphasize:

The foundation for good infection control is to observe strict hand washing at all times.

18. *Research.* Baby Moms are not required to participate in the MCHB FISCP data collection. They will be asked to read and have the choice to sign a Consent Form to participate in this research and evaluation effort. In the same vein, infants in the program do not automatically become part of the research. If a biological parent is available, the Baby Moms CWW or MCHB staff will meet with them to explain the purpose of the research and ask them to sign the consent form. If they do not, the infant will not be assessed by the Developmental Specialist. If efforts to locate the biological parent(s) are unsuccessful, the MCHB staff will present a Minute Order to the Juvenile Court Judge for signature for consent to have an infant participate.

Research is divided into two areas: MCHB's FISCP Research Project and community-based research projects.

MCHB Research: The Maternal and Child Health Bureau provided funding from 1990-1993 for an improvement and demonstration project. Among the goals of this grant was the development of a comprehensive database system to monitor infants' developmental progress.

Community-based Research Projects: The Baby Moms Program has agreed to allow babies who are HIV positive to participate in the University of California, San Francisco's (UCSF) study following infants and the study located at Children's Hospital in Oakland, California. The biological parent or Juvenile Court Judge must give legal consent prior to a child's participation. It is the strong belief of the SFDSS that babies who are enrolled in research studies must benefit from participating by gaining access to treatment and special services.

19. *Baby Moms as Parent Trainers.* Baby Moms are expected to be able to act as role models to birth parents, teach birth parents the home care procedures they are providing for the child and, when indicated, reassure the birth parents of the temporary nature of the care the Baby Moms is giving.

20. *Health status.* If the primary caregiver or other persons living in the home has an illness that requires hospitalization, or a significant number of hours away from the home each week, staff must be notified of the situation and kept fully informed of the extent of the problem. Child care to fill in for the primary caregiver must be provided by the primary caregiver with support from Baby Moms staff and, if necessary, another eligible care provider.

21. *HIV/AIDS.* Foster parents must be willing to accept an HIV infected child.

22. *Medical providers.* Baby Moms foster parents may select their own pediatrician to see their infants regularly in addition to any other specialty medical care that may be required. This choice must be approved by Baby Moms staff, and CHDP qualified providers must be utilized. Similar requirements are followed for the child's dental care.

23. *Transportation.* The Baby Moms foster parent must have an insured, dependable automobile and a valid California driver's license.

24. *Employment.* The primary Baby Moms caregiver can not have other employment either in or outside the home.

25. *Respite.* Because of the stressful nature of the job, foster parents are required to take 50 hours of paid respite each month, and this cannot be deferred or saved. (Refer to Respite and Child Care section beginning on page 48.)

V. FOSTER PARENT CAREGIVERS

Since the program began, 58 individuals and their mates including single persons, and gay and lesbian couples have applied to become Baby Moms. Of this number, 41 persons (70.7%)—17 couples and 7 single persons, were accepted as Baby Moms, and 17 persons (29.3%)—four couples and nine individuals, were declined. From the group initially accepted as Baby Moms, eleven persons (26.8%)—four couples and three single persons, created sufficient concern among staff that they were either directly asked or indirectly encouraged to leave the program, the latter frequently occurring after discussions with staff about their failure to comply with program policies. One couple about whom staff had no concerns chose to adopt the infants in their care and to leave the program, and they are not included in this analysis. Descriptive demographics for 36 primary caregivers are given for each group in the table below. As of October, 1992 the active Baby Moms have had an average of 11 years of prior experience as foster parents with a range from 3 years to 32 years. Nine of these families have cared for more than 5 foster infants and children, and 5 families have each cared for more than 16 foster children.

Table 1: Characteristics of Baby Moms, Former Baby Moms, and Applicants Not Accepted.

	Baby Moms	Former Baby Moms	Applicants Not Accp.
N	16	7	13
Age: M (SD)	43.5 (7.39)	44.0 (8.30)	39.8 (8.77)
Marital Status (%)			
Single	12.5	28.6	46.2
Married	62.5	28.6	23.1
Remarried	17.5	0.0	0.0
Divorced	6.25	42.9	30.8
Widowed	6.25	0.0	0.0
Ethnicity			
African-American	25	28.6	30.8
Caucasian	75	71.4	69.2
Education			
H.S. Diploma	31.25	28.6	15.4
Some College	50.0	57.1	53.8
College Graduate	12.5	14.3	23.1
Graduate Degree	6.25	0.0	7.7

Any effort to develop a "profile" of a group of people is significantly determined by the factors that bring individuals into the particular group under study. The unique challenges and demands posed by caring for this group of very medically complex infants present a significant "barrier" to most persons so from the outset it is apparent that the Baby Moms are an unusual group of persons. And there is a very high board rate for providing this care that may influence some individuals to apply for the Baby Moms. The application screening process and selection criteria further refines the mix (or lack of mix) of people who finally become Baby Moms. Given these factors, an attempt has been made to use standardized psychometric measures to develop a picture of the people who are Baby Moms foster parents. A detailed description of this research effort is found in a 1993 article titled *A First Look: Foster Parents of Medically Complex, Drug Exposed, and HIV positive Infants* which is included in this manual. (Refer to Appendix J.)

Briefly, results of the California Psychological Inventory (CPI) and Rorschach are quite convergent indicating that Baby Moms are an idiosyncratic, rather private and reflective group with above average realization of their potential. They are somewhat detached from typical social conventions, quite content to rely on their own rather than traditional values, but at the same time wanting to be viewed favorably by others. They view the world in a manner which differs significantly from that of most people. One significant variable noted on the CPI is the level of integration and realization of potential (V3) with Baby Moms having above average scores whereas persons judged not to be successful in the program had average scores. Other CPI variables worth noting include: Tolerance, Achievement via Independence, Psychological-Mindedness, and Flexibility. Baby Moms scored significantly higher in all these areas showing greater tolerance of other's beliefs and values, a strong drive to do well and to work in settings that encourage individual initiative and freedom, more interest in why people do what they do than in what they do, and a preference for change and variety. Conversely, persons who left the program scored higher in Communality indicating that they see themselves as quite average people fitting in easily with others in contrast to Baby Moms who view themselves as different. Baby Moms families have a high degree of internal commitment providing support for family members while minimizing conflict. They feel most satisfied with their intimate relations and their close circle of friends, but their involvement with their community and neighborhood or other organized groups is less important to them. Internal Control Index responses reinforce the view that Baby Moms are a group of persons relatively independent of social reinforcement or social pressure.

In addition to using standardized assessments, a semistructured interview modified from an earlier survey of Fanshel's (1960) was given to Baby Moms who had been in the program for at least one year (A copy of Form A of this modified survey is in Appendix K.). After preliminary modification, the questionnaire was piloted (Tufel, R., 1989), and revised to its current form. The final 36 page interview contains 18 sections covering basic demographic information and other topics such as foster parent recruitment, the role of foster parent, satisfaction from being a foster parent, difficulties in caring for fragile infants, relationship with the agency, board rates, training, reactions to separation and loss, caring for an HIV+/AIDS infant, and religion. This interview was done in the foster home with 16 of the primary Baby Moms caregivers by the MCHB FISCP Project Director, most interviews taking two hours. (There is also an interview Form B that may be used with a comparison group of foster parents in a nonspecialized program caring for drug-exposed infants. Form B is available by contacting the MCHB FISCP Project Coordinator).

Some general findings are reported here and as additional analyses are conducted, supplements will be sent and can be added to this manual. It is important to remember that the sample size is small and limits the ability to generalize findings, but nevertheless there are points of interest:

- When asked if foster parenting in general is good for foster children:
—94% (n=15) answered *Yes*, but only 19% thought that the general foster care system was *Good*, 37% thought it was *Fair* and 44% thought it was a *Poor* system.
- Responding to the question "Can foster parents make up for the loss or inadequacy of the biological parents?", the Baby Moms were divided in their views:
—53% answered *Yes*. —47% replied *No*.
- But when asked about their own personal ability to help a foster child, the Baby Moms responses were more optimistic:
—94% (n=15) answered *Yes* that they had been able to help a foster child.
- Asked about their recruitment activities, 94% of the Baby Moms foster parents have tried to recruit others for the program, and 31% reported that they also tried to dissuade someone from applying.

- In response to the question "How significant is being a Baby Mom to you?":
 - 19% (n=3) indicated it was the *Most Important* thing in their lives.
 - 63% (n=10) said that it was the *High Spot* in their lives.
 - 13 % (n=2) answered *Mildly Important* and 6% (n=1) that it was *Not Special*
- When asked about the satisfactions they derive from being a Baby Moms foster parent:
 - 75% said it was *Extremely Important* because they "enjoyed" having a baby in their home.
 - 69% stated it was *Extremely Important* because of their "fascination" with child development.
 - 63% indicated it was *Extremely Important* because they "like" working at home.
 - 56% responded that it was *Extremely Important* because they "like" affection from the foster child.
 - 50% said that it was *Extremely Important* because it allowed them to "put their religious beliefs into action" (no religion was specified). In a later question, 25% said that religion was *Most Important* in their lives and attended services weekly. 44% said religion was *Very Important*. But 53% *Rarely* attended services and 7% attend religious services only 3-4 times yearly. Thus, while religion is quite important to two thirds of the group, this doesn't necessarily translate into actually attending services. A number of persons who don't participate in organized religious activities did emphasize that they have "a belief in a higher power—a humanistic force" or acknowledge that they are "agnostic", reinforcing the view that a portion of the Baby Moms are independent thinkers.

Satisfactions expressed by Baby Moms appear to address their individual needs and are less externally directed. Responses that reflect more external "service" satisfactions received somewhat lower scores:

- 44% answered it was *Extremely Important* and 25% *Very Important* to helping disadvantaged children.
- 31% said it was *Extremely Important* and 44% *Very Important* to be serving the community.
- Only 6% answered that it was *Extremely Important* because they "liked their neighbors' respect"

Additionally,

- No one (0%) indicated that it was *Extremely Important* and only 12% that it was *Very Important* because it "kept them busy"
- Only 6% responded that it was *Extremely Important* because they "like being a homemaker".
- With respect to the financial reimbursement for being in the program,

—19% said it was *Extremely Important* , and 25% that it was *Very Important* that they were "adding to the family income".

There are several related questions to the financial reimbursement topic. In response to the question "Do you think that the board rate is satisfactory?", 85% said "*About Right*".

The next question on the interview was "How do you think other foster parents regard the board rate?", and 44% (n=7) answered that others felt it was too low.

When they were asked if other people thought that they were doing the job for the added income 15 of 16 respondents (94%) said that no one thought this to be the case. Although 44% of the respondents acknowledge that adding to the family income is a *Very Important* or *Extremely Important* reason for them to be doing the job, their responses to the question about others' view of their motivation show that they view others' perceptions of them as **not** being motivated by money.

- Each person was asked to think back to the year before they first became a foster parent (not necessarily a Baby Mom) and to comment if this had been a fairly typical year in their lives. 53% reported that the year had been typical and 47% that it was not. These are selected responses:

—"Had moved into our first home in California from back East, Had been in San Francisco for about one year. Had lost our first child to SIDS and had our second child. We wanted more children and really went into it wanting to adopt." This family has ten years of experience as foster parents.

—"Was dissatisfied with my job of almost 10 years. Felt that I should be doing something different. My brother, who had AIDS, and his wife and their three HIV positive children has disappeared, and our family still doesn't know where they are." This family are first time foster parents.

—"Eighteen months before had a surprise pregnancy that ended in a miscarriage and we realized that we had room in our hearts for other children and so we got licensed. We've had only two one month breaks since then." This family has 16 years of experience as foster parents.

—"It was the year after we'd gotten married. My husband had been a foster child and he wanted to repay society for what he had experienced. Before we were married we had discussed this." This family has 22 years of experience as foster parents.

—"Became a widow in 1972 and then worked for several years and traveled a bit. Was bored and watching television one day and saw this ad and called a number. My kids were grown. I was trying to figure out what to do with myself. This sounded meaningful and more interesting." Has 10 years experience in being a foster parent.

—"Oh, typical. Working in the hospital acute rehab unit for spinal cord injuries and was also involved in two prayer groups for children and persons with AIDS." This family is a first time foster family.

—"A lot of our friends have died of AIDS. It has been a very upsetting six years." This family is a first time foster family.

But having extensive experience doesn't necessarily mean that a family will be successful in the Baby Moms program. Following are two responses from families that were asked to leave Baby Moms:

—"It was a good year. Our daughter was three. When I started foster care it was, I thought, to help people who were having crises. Then I learned that these weren't crises. We've adopted children too. You know, in high school if I had to choose between a date and baby-sitting, I'd choose baby-sitting. My folks always took in people when there were problems - like if a house burned and I always grew up caring and sharing." This family has 26 years of experience as foster parents.

—"Nothing unusual. Was on the school board, President of the PTA, doing church work. My in-laws were foster parents for 15-16 years and we used to do respite for them. My mother-in-law told me that I had a knack for it and so we did it. I had something of a negative view before this of being a foster parent, mostly low-income people doing it, my own stereotype." This family has five years of experience as foster parents.

- A particularly salient issue for Baby Moms foster parents is that of separating from their infants when a permanent plan has been agreed upon. When asked to describe their reactions to a foster child's leaving their home:

—46% describe it as *Quite Upsetting* and 23% as *Feeling Bad* with 31% saying that they *Expected It* (i.e. feel all right about it).

It is clear that separating from their foster children is one of the most upsetting experiences for our foster parents, especially the newer ones. When the Baby Moms

foster parents have commented on these separations, they have been very articulate about their feelings:

—"It never goes away, it always flashes back."

—"It's almost easier if the infant has died because you are not worried about them, how they are being cared for, if they are being beaten or loved..."

—"For me having a new baby right away helps me handle the loss."

—"When S left, we looked around and cried a bit because we felt it in our hearts. But to see them go with a good family is a rewarding thing. My wife doesn't want to go by and visit—she was more hurt, and my son hasn't gotten too close to the other babies since."

Among those foster parents who have independently chosen to leave the program (not been encouraged to leave by staff), all of them have decided to adopt their foster children, an action they know will force them out of Baby Moms, rather than experience the separation and loss of permanently placing their child with someone else. This policy was established to avoid having people come into the program for the purpose of adopting and also because we don't want our foster parents to have to deal with too many child caregiving responsibilities.

Another interview question asked about the reactions of other people to the Baby Moms' foster parents' role. All of the respondents (100%) indicated that other people didn't "understand how they could separate from their foster child" and frequently asked how they could stand to separate from a child for whom they had cared. Comments made by Baby Moms foster parents when answering this question about their interactions with other people included:

"This is the most common one!"; "Everybody says this!"; "All the time!"; "Yes! Constantly."; "Yes, it's true. I ask myself."; "Always!"; " Yep. It's the number 1 question."

- When asked about AIDS in relation to their becoming a Baby Moms foster parent, the caregivers display good understanding of the risks involved and were primarily concerned about the potential loss of a child:

—88% answered that there is *Little/No* concern for infecting themselves; 81% for infecting family members; 94% *Little/No* concern for infecting friends or neighbors.

—Only 13% were *Very Concerned* and 69% were *Somewhat Concerned* about the "possible death of their foster child"

A. PARENT STRESSORS AND COPING

"Loss and separation from the foster child is the major stressor for Baby Moms foster parents", states the consulting Psychologist. "When the baby is successfully transitioned into another home, foster parents often continue to worry about the kind of care being provided—just as any parent would. Because of this concern and a very real separation anxiety, we have tried to keep Baby Moms families in touch with their babies once they have been placed in another home. They stay in contact with the new parents and find out for themselves how their baby is doing."

The consulting Psychologist passes along another method for maintaining the connection between foster parent and child. "Most of our Baby Moms foster parents enjoy maintaining the scrapbook on the child's early months—and in some cases the baby's first year or two. We strongly encourage the foster parents to maintain two such scrapbooks. Then, they pass one of them on to the new caregiver when the baby leaves and keep the other for themselves. This way, they know there will be a historical record of their love. It is a tangible link between the Baby Moms home the new home."

When death comes into the nursery of a Baby Mom home, the connection to family, church and support groups is even more important. One Baby Moms foster parent describes the supports that help cope with the feelings of loss and separation. This individual has raised three of her own children alone and now draws on the same emotional reservoir to nurture her two small foster babies:

I give them everything I've got and I don't think a lot about the future. But deep down it hurts, I know they are going to have to go. Every time a child leaves, it's painful, even though you know he is going to a good home. That's why you really need to have a strong support system. I have my children, my mother, my church. Sometimes you just have to be able to talk to someone about it."

Other foster parents cope by expressing their sadness through writing:

Shattered Dreams

"My babies are broken.
Won't someone please fix them?"

If they were teacups, I'd throw them away.
'Too much trouble, get new ones.', I'd say.

But these are my babies, precious and rare.
The only ones like them anywhere.

I've tried kisses and games,
But they're always the same.

My babies are broken.
Won't somebody please fix them?"

All the king's horses and all the king's men
Can't put your babies together again.

All the kings horses and all the king's men
Can't put your babies together again.

Having a Baby Moms infant in the home can also create strong emotions in the foster family's own children. One teenager expressed herself about the infant in her home through poetry:

A Foster Child

I thought I fit in, I was just like the rest.
I was loved and cared for, treated the best.

I walked across the street and held her hand,
My life was so perfect, like a fairyland.

I just don't understand why our colors aren't the same.
Then she told me, my real mom was to blame.

My mom was hooked on drugs, what could she do?
She needed my father, but he couldn't come through.

I'm HIV positive and a drug addicted baby,
Do they wonder about me, how I'm hurting, maybe.

My foster mom cares, I know she does,
But a blood to blood family is what a child loves.

Save our earth is the message, some people try,
But we must save the children, before we all die.

I can't understand why it has to be,
My mother is gone, I guess she didn't want me.

Although efforts are made during applicant screening to select families in which the sole source of income isn't dependent on the foster care reimbursement, this isn't

always the situation. As a result another very real stressor for some of the foster parents are the financial issues surrounding compensation during vacancy, i.e., when their foster children have been placed and they are awaiting a new baby. For one foster parent this was especially significant:

Being vacant is a major problem. This cannot be the only thing you do. I am leaving the program for this very reason. I will adopt two kids, both of whom are medically fragile, so that now in addition to providing the kind of care I'm committed to giving, I will be secure financially!

To help parents cope more effectively, the Baby Moms have asked to meet with the consulting Psychologist without other program staff. This is designed to provide opportunity to vent feelings and reactions to staff without rupturing the working relationship. In part, this request was an outgrowth of foster parents' feeling that their work wasn't being appreciated and that they were being treated in a somewhat bureaucratic manner by some staff. Such an impression is almost an inevitable even in specialized programs because of the multiple demands on staff and their own need to generalize issues to deal effectively with them. Monthly training and social meetings are designed to bring all of the parents together to share their concerns and learn how to better care for their children. (Refer to Training section beginning on page 50.) Most parents agree that socializing is a good idea, but a number of them expressed concern that after 4 years the group has splintered into several smaller groups, each having their own perspective on the program.

One foster parent suggested separating themselves from Baby Moms staff members, "So that the parents could really be honest with each other and talk about concerns and issues without the staff members getting hurt by what they may say." This is now being done for those foster parents who choose to for only one hour following the regular monthly training. Despite this comment, on the whole, the Baby Moms were happy with the staff at the SFDSS and complimented them on their ability to compromise and take into account the needs of the foster parent when making decisions. When asked about their satisfaction with the program 75% of the Baby Moms foster parents interviewed were *Much More* or *More* Satisfied than expected with the program. The foster parents are less unanimous about their satisfaction with the CWWs (these interviews took place between 1989 and 1992):

- 60% are *Very Satisfied* with the CWW staff.
- 13% are *Fairly Satisfied*.
- 20% are *Somewhat Dissatisfied*.
- 7% are *Very Dissatisfied*.

VI. INFANTS

Over 140 infants have been or are currently being cared for in the Baby Moms program since 1987. From the beginning, data have been collected on the infants through foster parent submission of the monthly reports describing each infant's medical and psychosocial functioning. All of the staff's time and effort was devoted to providing services in the beginning of the program's development and there were no resources available for refining the data collection instruments or devising a database system for recording and analyzing the information that was collected.

With the MCHB grant it became possible to provide detailed descriptive information about infants. 144 infants had been cared for in the Baby Moms program. Of this number, 68 (47%) were female and 76 (53%) were male. Ethnically, the infants are grouped as follows: 76 (52.8%) are African-American; 21 (14.6%) Caucasian; 8 (5.5%) Hispanic; 6 (4.2%) Native American; 2 (1.4%) Asian/Pacific Islander; and 31 (21.5%) Multiracial. This latter figure is quite typical for the population of infants and children in San Francisco, where rates for multiracial youth are reported in the 20-25% range for many youth service programs. Of some interest in the ethnic breakdown is the overrepresentation of African-American children which is consistent with national figures. The African-American population in San Francisco has declined from 84,857 representing 12.5% of the City/County population in 1980 to 76,343 constituting 10.5% of the population in 1990.

For the total number of infants served, 65 (45.1%) had positive tox screens at birth, 36 (25%) had negative screens and 43 (29.9%) were unknown. When looked at by birth weight 47 infants (37%) are over 2,500 grams; 40 (31%) are low birth weight (LBW) defined as less than 2,500 grams; 25 (20%) are very LBW defined as less than 1,500 grams; and 15 infants (12%) are extremely LBW defined as less than 800 grams. Infants presented with a variety of unique medical problems which were most often seen in combination with other problems (*Refer to Appendix ???--DON: Did you want to include the Primary Problem list? or what is this?*).

The infants HIV status shows that 19 (13.2%) are HIV positive; 16 (11.1%) sero-converted, that is they were born HIV positive but converted to negative during infancy; 34 (23.6%) were negative and 75 (52.1%) were HIV status unknown. Forty five (45) children were hospitalized after entering a Baby Moms foster home and data recording the number of days these children spent in hospital were reported for 38 of the infants as follows: HIV- n=4 spent a Mean number of 26.75 days; HIV sero-converted n= 5 spent a Mean number of 4.3 days; HIV+/AIDS infants spent a Mean number of 33.4 days and HIV status unknown n=24 spent a Mean number of 15.9

days in hospital. Although the sample sizes are small, there are significant differences in the Mean ranks for the number of days spent in hospital after being in Baby Moms between the HIV sero-converted group and the HIV negative group ($p=.05$) and also the HIV+/AIDS group ($p=.01$). There was also a difference noted between the HIV status unknown group and the HIV+/AIDS infants ($p=.06$).

At the time of this analysis 115 of the infants were permanently placed out of Baby Moms or had died—19 (16.5%) had been reunified with biological parent(s); 25 (21.7%) were living with relatives; 48 (41.7%) had been placed into fost-adopt which is long-term foster care with the intention of eventual adoption and, in fact, of these 48 infants initially placed in fost-adopt, 31 had been adopted; 5 (4.3%) infants were living with legal guardians; 8 (7%) were in long-term placement; 12 are now deceased; 1 had been transferred out of county and only 3 had been readmitted to foster care. The deceased figure includes children who passed away after they left the Baby Moms program and moved to their permanent placement. The three children who were readmitted to foster care are currently with their former Baby Moms foster parents. The other child has been adopted.

To provide readers with a better picture of the complex conditions of the infants, we have randomly selected Baby Moms infants meeting "severe conditions" criteria as defined by CIGNA [*define CIGNA here.*] which is birth weight of 1,000 to 2,499 grams and/or gestational age of 27-28 weeks:

Baby "A" (twin 1): 1,010 grams birth weight; 28 weeks gestational age (GA), "Infant of a drug abusing mother (IDAM); positive tox for methadone and cocaine; *Atlestatus*-right upper lobe, mild respiratory distress, Grade III IVH, post apnea and bradycardia, mild hyperbilirubinemia, rule out sepsis"

Baby "B": 1,380 grams birth weight ,32 weeks GA, "Serious inguinal hernia, necrotizing enterocolitis, HIV positive antibody, was on apnea monitor in hospital"

Baby "C": 1,799 grams birth weight; 32-33 weeks GA, " Prematurity; mild hyaline membrane disease; s/p transient respiratory. disease; sepsis; maternal drug abuse; positive tox for cocaine; IDAM with minimal symptoms; s/p oliguria hypocalcemia and hyponatremia; hyperbilirubinemia; candida (oral); erythema both knees"

Baby "D": 2,030 grams birth weight; 35-36 weeks GA, "Multiple congenital anomalies, cleft lip and palate, unbalanced translocation chromosome 20, dislocated hips, single left kidney"

Baby Moms infants meeting CIGNA's "extreme conditions" criteria of 1,000 grams, also have other complications as shown with the following examples:

Baby "E" (twin 2): 910 grams birth weight; 28 weeks GA, "Prematurity, respiratory distress syndrome, rule out sepsis, apnea of prematurity, Grade II ICH, cocaine exposure"

Baby "F": 623 grams birth weight; 25 weeks GA, "Discharged on oxygen; respiratory distress syndrome (bronch-pulmonary dysplasia) due to prematurity, long-term ventilator on high pressures, chronic thrush, anemia"

Baby "G": 750 grams birth weight; 28, 30 weeks GA, "Birth asphyxia, severe respiratory distress syndrome, pneumonia, apnea, h. flu sepsis, stage II retinopathy of prematurity, grade III IVH, mother's tox positive for cocaine"

Baby "H": 800 grams birth weight; 27 weeks GA, "Preterm delivery of female born to mom with history of crack use and premature rupture of membranes; poroencephalic cyst s/p brain, r/o sepsis, abscess s/p *serratice* meningitis, s/p wound infection, s/p apnea and bradycardia, s/p hydrocephalus, s/p anemia, seizure disorder".

The ethnic breakdown of the mothers of the Baby Moms infants is 81 (56.3%) African-American; 42 (29.1%) Caucasian; 8 (5.5%) Hispanic; 4 (2.8%) Native American; 4 (2.8%) Asian/Pacific Islander; and 5 (3.5%) Multiracial. Maternal toxicology screens show that 60 (42%) were Positive; 17 (12%) Negative and 67 (46%) were Unknown. Mother's HIV status shows that 36 (25%) were HIV positive; 32 (22.2%) HIV negative; and 76 (52.8%) were Unknown.

A. PRELIMINARY FINDINGS OF INFANT AND CHILD DEVELOPMENTAL ASSESSMENTS

The MCHB award has also permitted the Fragile Infant Special Care Program (FISCP) to perform developmental assessments of the infants in care. The FISCP follows a standard protocol administering the selected measures at specified times throughout a child's development (Refer to Appendix A.). Bayley Scales of Infant Development (BSID) means at 3 months for 12 Baby Moms infants who are HIV negative or sero-converted were 91.9 for the MDI and 92.5 for the PDI. The mean MDI is significantly lower than the PDI ($p < .05$, 1-tailed). At 9 months the 12 infants tested received a Mean MDI of 87.4 and a Mean PDI of 89.8. Both means are below the standardization Mean—for the MDI the p -value $< .001$ and the PDI $< .05$. We also used the BSID to test another group of drug exposed children in the Shelter program who had no serious medical complications and found no significant differences at 3 months. At 9 months there was a significant difference in the Mean Ranks for these groups using a Mann-Whitney U test with Baby Moms' score of Mean Rank 8.0 compared with the Mean Rank of 14.3 for 6 Shelter infants ($p < .02$, 2-tailed).

Only 6 of the Baby Moms infants were tested at both 3 and 9 months with the BSID. The Mean MDI score at 3 months was 94.7 and at 9 months this had dropped to a Mean MDI of 82.7 (N.S.). The Mean PDI at 3 months was 97.6 and at 9 months this had declined to a Mean PDI of 81.2 (Wilcoxon p -value $< .04$). (Note that in performing these analyses for this very small sample, we used an alpha of .10, rather than .05 to increase power, because we were also concerned about Type II errors.)

The Infant Mullen's Scales of Early Learning (Infant MSEL) resemble the BSID, but divide the gross MDI and PDI measures into more discrete domains of Gross Motor, Visual Receptive, Visual Expressive, Language Receptive and Language Expressive. Twelve (12) Baby Moms infants who were HIV negative or had sero-converted were administered the Infant MSEL at 14 months of age. Although all scores in the various domains were below the Mean, the only statistically significant differences were in Receptive Language with a Mean T-score of 38.7 ($p < .002$), and in Expressive Language with a Mean T-score of 35 ($p < .0001$). Because of the medical conditions of the infants in Baby Moms, necessary medical technology may have inhibited speech, but a review of individual medical records indicated that at the time of their evaluations all of these children did not have significant medical problems limiting speech.

At 6, 12, and 18 month corrected ages we also used the Early Language Milestone Scale (ELMS), a rapid method designed for physicians to assess language development in children 0-3. We decided to use this instrument to screen for

language problems and, when indicated, recommend early referral for a more extensive evaluation at a local speech and hearing center. At 6 months for 13 Baby Moms infants including three either HIV positive or status unknown, 12 consistently passed Receptive Language, Auditory Expressive Language, and Visual Performance. But at 12 months the results for 14 Baby Moms infants were notably different: Auditory Expressive Language 7=Fail (50%) and 7=Pass (50%); Auditory Receptive Language 10=Pass (71.4%) and 4=Fail (28.6%); Visual Performance 8=Pass (57.1%) and 6=Fail (42.9%). As an example, to pass Auditory Expressive at 12 months an infant needs to say "Mama" or "Dada" or babble. There are no significant scoring factors that would contribute to this rate of failure for the Baby Moms infants. Although a very small sample, the ELMS was also administered to 6 Shelter infants 12 months of age, and in all three areas the Pass/Fail rate was 5=Pass (83.3%) and 1=Fail (16.7%) indicating that the Baby Moms had a high rate of failure.

When using the ELMS at 18 months, there continued to be failures in all three areas for the 12 Baby Moms infants assessed at this age: Auditory Expressive Language 8=Pass (66.7%) and 4=Fail (33.3%); Auditory Receptive Language 7=Pass (58.3%) and 5=Fail (41.7%); and Visual Performance 4=Pass (33.3%) and 8=Fail (66.7%). As an example, to pass Visual Performance at 18 months a child is required to point to a desired object and also to respond to a one step command.

To date 14 Baby Moms infants who are HIV negative or sero-converted were assessed with the Vineland Adaptive Behavior Scales (VABS). The resulting Adaptive Behavior Domain scores were tested against the Standard score Means of the standardization sample. Consistent with the findings already described, the Baby Moms were significantly lower in the domain of Communication, Baby Moms Mean score of 87 and Standardization Mean score of 96.8 with $p < .007$. Baby Moms children were also significantly lower in Daily Living Skills Domain, BM Mean = 88.4 and Standardization Mean = 95.9 ($p = .009$). In the domains of Socialization and Motor Skills there were no significant differences, although Baby Moms scores were lower. The Composite Standard Score was also significantly lower for Baby Moms, BM Mean = 90.4 and Standardization Mean = 98.4 with $p < .04$. This Adaptive Behavior Composite score represents a comprehensive estimate of an individual's level of personal and social sufficiency.

The Waters' Attachment Q-Sort is a criterion-referenced measure that describes both a "secure" and a "dependent" type of attachment. In initial scoring of this instrument, Waters and his staff had very high interrater reliability, and they are soon releasing a diskette with standardization scores. Basically, none of the 12 HIV negative or seroconverted Baby Moms infants assessed at 18 months were perceived as being particularly "secure" or "dependent" when compared with Waters' interrater sample. But within our own sample of 12, ten of our infants were seen as more "secure" than "dependent" by the person doing the Q-Sort.

Infants' temperaments at corrected age three months were rated based on caregiver report with an adaptation of Rothbart's Infant Behavior Questionnaire (IBQ). The instrument used was modified to simplify the language by Josephine Brown with the author's review and agreement. The modified measure used a 5-point Likert scale ranging from 1=Never to 5=Always describing behaviors observed during the past week, and the results provide six dimensions of temperament. A small standardization group of 62 three-month-old infants was reported by Rothbart (1993) to yield the following Means and standard deviations based on a 7-point Likert scale: Smiling & Laughter Mean = 4.0 (SD = .96); Activity Level Mean = 3.7 (SD = .92); Distress to Limitations Mean = 3.7 (SD = .82); Fear Mean = 2.2 (SD = .72); Duration of Orienting Mean = 3.8 (SD = 1.3); and Soothability Mean = 4.3 (SD = .95). A group of 10 three-month-old Baby Moms infants, including three with HIV positive or HIV status unknown, was compared to this standardization sample with *t*-tests after using a linear transformation to convert their 5-point Likert scale scores to the 7-point scale reported by Rothbart: Smiling & Laughter Mean = 3.1 ($p < .05$); Activity Level Mean = 4.3 ($p < .01$); Distress to Limitations Mean = 3.6 (n.s.); Fear Mean = 3.1 ($p < .002$); Duration of Orienting Mean = 4.1 (n.s.); Soothability Mean = 6.2 ($p < .001$).

To provide a general, qualitative rating of caregiver-child interaction, the Developmental Specialist used Crnic and Greenberg's Affect-Interaction Rating Scale to rate the infant and caregiver separately for seven independent scales along a 1-5 point Likert scale. Caregivers and infants with corrected age of six months were observed during free play, a structured play activity and also a routine caregiving activity such as feeding or diapering. Caregivers appeared well organized and able to sustain an activity, seeking involvement with their child and showing sensitivity to their child's cues by responding to assist and facilitate them. Caregivers appeared to derive above average gratification from these interactions, and their children too were seen as having above average gratification, although slightly less than the adults. These scores may reflect the observer's closer identification with the caregiver role. When observed again at 12 months, the caregivers appeared more engaged and derived more satisfaction from the interaction as did their children, who also exhibited more ability to sustain a focus in completing an activity.

Achenbach's Child Behavior Checklist for 2 and 3 year olds provides scores on six empirically derived syndromes based on parent (i.e. caregiver) reports of behaviors that describe their child "now or within the past two months" using a three point scale with 2="very true" or "often true"; 1= "sometimes true"; and 0="not true". Caregiver reports for only seven Baby Moms children at age 2 show that in five of the six syndromes, the Baby Moms children are seen as doing well, that is they received scores in the nonclinical direction. Caregivers indicated that they sometimes displayed aggressive behavior, but not significantly.

B. SELECTED COMMENTS FROM FOSTER PARENTS' INFANT AND CHILD MONTHLY REPORTS

The Foster Parent Infant and Child Monthly Report form contains information about the caregiver's experiences with the infant during the past month and includes reports of medical or specialty clinic appointments, visits to the infant from family members and other factors about a child's functioning (A copy of the Foster Parent Infant and Child Monthly Report is in Appendix D.). One piece of information is the foster parents' techniques for calming "difficult" infants. We analyzed the frequencies of calming methods given in 1,020 reports for 113 infants selecting the two most frequently reported methods in each month. The results show that a combination of holding and verbal soothing is used most often at 41.3% (n=421 reports); physical contact only occurs next at 17.4% (n=177 reports) followed by using a physical environmental method (i.e. pacifier, blanket, rocking in cradle) at 9.2% (n=94 reports). Foster parents used a variety of techniques reporting a Mean of between 2.6 and 2.9 unique calming combinations with each child. Four groups of children were defined by their HIV status as follows: HIV negative (n=24); HIV negative having sero-converted from an initial positive finding (n=15); HIV+/AIDS (n=11) and HIV status unknown (n=63). We found that the total number of reports of calming methods used for each foster child differed for some of these groups. Pairwise differences following Kruskal-Wallis H-tests were significant at the .05 level for HIV negative sero-converters (Mean rank = 71.5) and HIV status negative (Mean rank = 48.8). The negative sero-converter group also differed at $P < .1$ from the HIV status unknown group (Mean rank = 55.8).

Another finding drawn from the foster parent monthly report suggests that reasons for this difference, although difficult to infer, might be due to factors associated with the child's HIV status and the caregivers response to this. Foster parents describe the most pleasing characteristics about their infants monthly, and their responses showed that they were most pleased by the child's personality/temperament (26.7%) followed by physical attributes (23%) and then social/interaction with the child (22.1%). We analyzed the total number of reports of pleasing characteristics for each child and again found a significant difference in the perceptions of the foster parents for the HIV status sero-converted group compared to the HIV negative and HIV status unknown groups. In both cases, a greater number of pleasing characteristics were reported for the sero-converted group. The HIV+/AIDS group is not significantly different from the sero-converted group. However, its Mean Rank is almost exactly the same as the HIV status unknown group. This comparison was probably not significant because of the small number of children in the two groups. The interpretation inferred from these differences is that the sero-converted group is perceived more favorably by foster parents because of a halo effect. That is, they no longer have an HIV status describing them as terminally ill.

C. Initial Conclusions About the Infants

Since this program was designed to address the needs of a group of foster children who have significant medical conditions, it was anticipated that differences would be found when using standardized assessment measures with them. These findings support this hypothesis. Baby Moms infants generally are below the Means using standard measures of intellectual and motor functioning, especially in the area of communication. Behaviorally, a very small group of Baby Moms children aged two years are seen by their primary caregivers as quite well behaved, but a bit aggressive at times, but overall the group does not have any measurable clinical behavioral syndromes.

Using more qualitative measures the group appears well attached to their caregivers, and the caregivers are actively engaged with the children, sensitive to their cues, and both groups derive a good deal of satisfaction from their interactions with each other. Temperamentally, Baby Moms infants at 3 months seem to smile less, are less active and orient for shorter times than a group of typical three month olds, although they are similar to the norm in showing fear to sudden stimuli, and in their ability to be soothed by their caregiver.

While we have entered data describing 144 infants, the data is partial in part because there was not the time or personnel or equipment available before the MCHB award to accomplish data collection in a reliable manner. This explains why you will see different totals entered for some variables where the data reported doesn't include all of the infants.

Child's Sex & Ethnicity

(n=144)

Female	47%
Male	53%

Cauc	14.6%
AfrAm	52.8%
Hispanic	5.5%
Pacls	1.4%
Multiracial	21.5%
NatAm	4.2%

Another figure of interest is the foster childrens' Multiracial representation of 21.5%, the second most represented group. In looking at other figures nationally, the category "Multiracial" doesn't appear that often, and this may be an example of what might be called a "San Francisco phenomenon", an artifact of the city's unique demographics which resembles the population of Noah's Ark.

Cocaine and the opiates still top the list of drugs found in infants of drug-abusing moms. For a lesser number of these infants a second drug was found in the tox panel and here methadone is the most frequently found suggesting that for some women participating in methadone treatment programs, other drug use continues.

Infant of drug-abusing Mom
(n=102)

Yes	92.2%
No	7.8%



Drug Type 1
(n=82)

None	18.3%
EtoH	7.3%
Cocaine	53.7%
Opiates	12.2%
Amphet	1.2%
PCP/Morph	1.2%
Methadone	4.9%
Other	1.2%

Drug Type 2
(n=26)

None	0%
EtoH	3.9%
Cocaine	23.1%
Opiates	26.9%
Amphet	3.9%
PCP/Morph	3.9%
Methadone	30.8%
Other	7.7%

This chart shows the frequency and severity of withdrawal in infants for whom this was recorded. Of the possible 118, 83.5% of 79 cases had withdrawal "present" and of this the severity was noted for 63 cases with 47.6% of this number having moderate to severe withdrawal.

Withdrawal Category

(n=79)

Present	83.5%
Absent	16.5%



Withdrawal Severity

(n=63)

None	19.1%
Mild	33.3%
Moderate	20.6%
Severe	27.0%

The range from 623 to 3,900 grams is roughly 1 pound 6 ounces to 8 pounds 10 ounces, that is extremely low birth weight (LBW) to average with the median below the 2,500 grams (5 pounds 8 ounces) figure usually accepted as the marker of LBW. For a 35- or 36 - week preemie, a 2,500 grams birth weight is appropriate for gestational age (AGA), but for a full-term infant (after 36 weeks) 2,500 grams is considered small for gestational age (SGA).

Birth Weight

(n=97)

Median	2,154 gm
Minimum	623 gm
Maximum	3,900 gm

Birth Weight Classifications

(n=127)

Over 2,500 grams	37%
LBW (<2,500 g.)	31%
Very LBW (<1,500 g.)	20%
Extremely LBW (<800 g.)	12%

Hospital Discharge Weight

(n=61)

Median	2,640 gm
Minimum	1,910 gm
Maximum	4,665 gm

APGAR @ 1

(n=89)

Median 6

APGAR @ 5

(n=90)

Median 8

Head Circumference at Birth

(n=91)

Median	33 cm
Minimum	21.7 cm
Maximum	49 cm

Median Apgar scores at one minute for 89 babies were reported at 6 and for 90 infants their 5 minute APGAR median was 8. Head circumference at birth

reported for 91 infants ranged from 21.7 cm (approximately 8.5 inches) to 49 cm (19.5 inches) in a child with macro-cephaly, and when taken together give a median head circumference of 33 cm (13.5 inches), the Mean for normal babies.

About half of the total of 36 infants for whom IVH was reported had these symptoms present with grades ranging from I to III and no grade IV bleeds reported.

Intra-Ventricular Hemorrhage
(n=36)

None	44.4%
Grade I	30.6%
Grade II	8.3%
Grade III	16.7%

From a reported n of 48, 70.8% had respiratory assistance in hospital and approximately 18 infants had chronic lung disease (broncho-pulmonary dysplasia). While in hospital 74% of 50 infants had cardiorespiratory monitors and the majority of these were discharged with apnea monitors into Baby Moms homes.

Respiratory Assistance in Hospital
(n=48)

None	29.2%
Oxygen	2.1%
Ventila	68.7%

Chronic Lung Disease
(n=34)

No	47.1%
Mild	8.8%
Moderate	8.8%
Severe	32.4%

Cardiorespiratory Monitor in Hosp
(n=50)

Yes	74%
No	26%

A number of our babies received antibiotics during their hospitalization as well as oxygen.

Days on Antibiotics In Hosp
(n=50)

Median	8.5
Minimum	0
Maximum	38



Days on Oxygen In Hosp
(n=35)

Median	9
Minimum	0
Maximum	140

The median number of days in hospital reported for 90 of the infants was 25 with a range from 2 to 234. This median figure would probably have been higher had it not been for the Baby Moms program which provided a placement for infants requiring medical care unavailable in the usual foster home setting. The median number of days spent in NICU for 9 infants was 5. This number of infants accords with the national average of 7% requiring admission to an NICU (*Phipps, C., Bateman, D., & Schwartz, R., 1991*).

Total Hospital Days
(n=90)

Median	25
Minimum	2
Maximum	234



NICU Days
(n=9)

Median	5
Minimum	0
Maximum	38

Semi ICU Days
(n=12)
(4=d/cNICU))

Median	17.5
Minimum	8
Maximum	59

NOW LET'S LOOK AT THE MOTHER'S OF THESE INFANTS FOR SOME SELECTED VARIABLES:

The Mean maternal age of 110 reported moms is 26.9 years ranging from a thirteen year old to a 44 year old. The predominant ethnic background reported for 81 mothers is African-American followed by Caucasian at 29.1%.

Mother's Age

(n=110)

Mean	26.9
Minimum	13
Maximum	44



Mother's Ethnicity

(n=144)

Cauc	29.1%
AfrAm	56.3%
Hispanic	5.5%
Paclsl	2.8%
Multiracial	3.5%
NatAm	2.8%

There were 89 mothers who had positive tox screens at delivery and/or who reported drug use during their pregnancy, and their drug use often involved more than one substance with two thirds of them having two drugs reported and another third having a third drug present. Since the effects of multiple drugs in the system act both additively and synergistically, this multiple use is one of the main reasons that “partialling out” for the effects of one substance on the newborn. A second significant confound in research efforts is the environmental influence since many of these moms have poor prenatal care and because of drug use have poor nutritional intake during pregnancy.

Mother Used Drugs During Pregnancy

(n=99)

Yes	93.9%
No	6.1%

Drug Type 1 (n=89)

None	6.7%
EtoH	20.2%
Cocaine	53.9%
Her/Opi	9.0%
Amphet	1.1%
PCP/Mor	2.3%
Marijua	0%
Methad	4.5%
Nicotine	0%
Other	2.3%

Drug Type 2 (n=62)

None	0%
EtoH	21%
Cocaine	25.8%
Her/Opi	24.2%
Amphet	1.6%
PCP/Mor	1.6%
Marijua	4.8%
Methad	9.7%
Nicotine	8.1%
Other	3.2%

Drug Type 3 (n=35)

None	0%
EtoH	8.6%
Cocaine	8.6%
Her/Opi	11.4%
Amphet	5.7%
PCP/Mor	0%
Marijua	11.4%
Methad	17.1%
Nicotine	17.1%
Other	20%

This chart gives a view of the extent of prenatal care for these moms, and three quarters of the 68 reported cases had no prenatal care. Out of a reported 93 delivery types almost one third (30,1%) were by Cesarean Section, an unusually high percentage. The median number of pregnancies for these women was 4 and the median number of actual deliveries was 2.

Prenatal Care
(n=68)

None	73.5%
1st Tri	2.9%
2nd Tri	8.8%
3rd Tri	14.7%

Type of Delivery
(n=93)

Vaginal	69.9%
C-Section	30.1%



Number of Pregnancies
(n=84)

Median	4
Minimum	1
Maximum	14

Number of Deliveries
(n=83)

Median	2
Minimum	0
Maximum	9

Here are some additional descriptive pieces of information about this group of mothers showing prior drug exposed children, having children already in the foster care system and other social factors. HIV status was unknown for approximately half of this group of 144.

Previous Drug-Exposed Child (n=33) **Previous Foster Child (n=55)**

Yes	51.5%	Yes	72.7%
No	48.5%	No	27.3%



Mother Incarcerated (n=34) **Mother Homeless (n=37)**

Yes	67.7%	Yes	97.3%
No	32.3%	No	2.7%



Mother's HIV Status (n=144)

Negative	22.2%
Positive	25.0%
Unknown	52.8%

The median number of days in Baby Moms was 309 ranging from a very short stay of 11 days in the case of a child that went to a skilled care facility to a maximum 1497 days. For our HIV+/AIDS babies who stay with us the median number of days is much higher at 616. Because of improved treatment and also, we like to believe, because of the quality of care they are receiving, the HIV positive babies still in our care are living longer and their median number of days in the program is 814 and rising.

Number of Days in Baby Moms When Exited Program
(n=86)

Median	309
Minimum	11
Maximum	1497



AIDS Infants # of Days at Death
(n=4)

Median	616
Minimum	41
Maximum	1479

HIV+/AIDS Infants Current # of
(n=6)

Median	814
Minimum	108
Maximum	1467

Upon leaving the program one third of the babies (38.2%) are reunited with a biological family member, a figure that is high for the overall rate of reunification for foster children. The majority (41.7%) are placed in fost-adopt which is a long-term placement with a foster family that has the intention of adopting the child. Nine of our babies have died in our care.

Disposition Upon Leaving Baby Moms

(n=115)

Reunified w/biological parent(s)	16.5%
Reunified w/other relative	21.7%
Fost-Adopt (not freed)	41.7%
Guardianship	4.3%
Long-term Placement	7.0%
Deceased	7.8%
Other (Transfer IC)	1.0%