

Building the Blueprint Foundational Planning and Partnerships-20250828_003223UTC-Meeting Recording

August 27, 2025, 11:00PM

1h 32m 11s

SC **Shaun Cross** 0:04

I've got a few more minutes.

KT **Katie Tolley** 0:14

Hello everybody.

Welcome to our next webinar. We're going to give it just a minute, see if a couple of more people will hop on here. But again, we've got a lot to cover today, so we'll get started here shortly.

While we're waiting here, if you guys would like to use the chat feature and share where you're joining us from, that was a whole lot of fun last time. We had people from all over the country as well as Canada and Australia.

We'll give it just a couple of more seconds, and then we'll get started.

Great. Well, welcome everyone. I am really excited to welcome you again to From Vision to Vitality, How to Launch a Clinic like Maddie's Place. I'm Katie Tolley and I am the Director of Advancement and Marketing here at Maddie's Place. And again, I'm excited to welcome you back to this second webinar in our series.

If you missed the first session a couple of weeks ago, you can find a link to that recording on our website. That's just maddiesplace.org. You just have to click on the Resources tab at the top of the page and select Want a Maddie's Place in Your Community.

And we've got a dedicated page there to this webinar series. So anything that we talk about, anything that we share or reference, you should be able to find there. Our goal, we just want to help other communities build similar clinics to be able to support infants and families impacted by prenatal substance exposure.

So over the course of the next couple of months, we'll be walking you through everything that we've learned about launching the first pediatric Transitional care facility facility of its kind in Washington state. We are thrilled that so many of you are joining us and have registered for this series.

This is our first time offering a program like this, and the response has really been more overwhelming and positive, more popular than we thought. So we're doing our

best to be responsive and adapt each of these webinars to really reflect the trends and the feedback.

And the experiences of every one of you that are participating. So we just want to make sure that each session is really relevant and as useful as possible for you all. So we really appreciate your flexibility as we sort of navigate this series. We're sort of building the plane while we fly it. So if you just.

Just pay attention to that, that web page that I mentioned, the how to build it or how to start a Manny's place in your community. What we've got listed there for upcoming webinars that may change as we sort of go through this, so.

Before we get started, I just want to touch on a few housekeeping items very similar to the previous webinar that we did. We've planned about 60 minutes of presentation and then we'll have about 15 to 30 minutes of Q&A, depending on how many questions you all have.

We used up all 30 minutes of that last time, so if you guys would like to chat back and forth with one another, you are welcome to drop a note in the chat. But if you've got a question for us, for Sean or for somebody on our team here at Maddie's Place, if you would please use.

The Q&A feature at the top. We received a lot of questions last session and many of those pertain to topics and things that we plan to address in upcoming webinars. So if you didn't receive a response directly from us last last time, just know that we will eventually get to those.

We're not ignoring you. We've read every single question and we we want to make sure that all of your questions are answered, so.

Just want to quickly introduce you to our team. Carly Shouten is our Communications and Social Media Coordinator and she'll be helping us monitor the Q&A today. And then you met Emma Jones, who is our Communications and Social Media Manager. She's also joining us today.

And just to remind everybody that we are recording this webinar, we plan to record all of these. So if you happen to miss one, don't worry about it. There will be a recording on our website and anybody that has registered for these should automatically get.

Something a link emailed to them. And again, any copies of slide decks, transcripts, any materials that we reference will also be on that web page. So now I'm pleased to introduce Sean Cross, the President and CEO of Maddie's Place. He's a long time leader in both the legal and non-profit sectors.

And has really dedicated his career to strengthening the Spokane community. After serving as Maddie's Place's founding board chair, he stepped into the role of CEO in 2022, where he continues to guide our mission of supporting infants and families. I'm going to turn it over to you, Sean. Welcome.

SC **Shaun Cross** 6:27

Hey, thanks, Katie. Well, it's great to have you all again. I was just commenting before we started this that it seems like yesterday that we had the last one, so it was 16 days ago. So time does truly fly when you're having fun. I wanted to have all the sort of boring.

Legal disclaimers up front and and and one is, you know, number one, I'm just a corporate lawyer here in Spokane, WA. I'm not a health care expert. I'm not an expert on substance use disorder or NASS or maternal infant health or health care generally. But I'm I'm learning. I have a pet parrot and he's really good at memorizing things. And I'm like a parrot over the last eight years. I've learned a lot about these subjects. So I'm like my parent parrot. I'm getting better at parroting what I'm learning. But there are most of you who are listening know way more.

About the health care issues that are involved than I do. So I really want to have a disclaimer on that. The other thing is, you know, we were really trying to help, but I want to make sure that I'm not giving any legal advice and that there's no attorney-client relationship that's being established through these webinars and through this process. There are situations whereas.

As you as the groups kind of get towards forming their organizations and that which you will need a lawyer and we're happy to provide templates and things like that that will make that job easier for whoever you hire or whatever, wherever you decide to go.

So that's it on the disclaimers on the goals again. And just to repeat that, you know, we have about six goals that we're really trying to get across with this series. First of all is just to increase awareness of this issue of prenatal substance exposure and neonatal abstinence syndrome.

And then also to just really encourage others that have a passion for these infants and for their parents to consider starting something like Maddie's Place in their own community. We really would be privileged to serve as a as a resource for you all in addition to that, I think.

That, you know, we're stronger with more numbers and is it's important, I think as I

look at this and in my involvement over the last eight years really that we build a political support nationally for this.

There's there's federal policy that's involved and there's obviously state policy and we need your help both at the state level and at the national level. The other thing and what's really been interesting just because of the interest that we've seen and how many people have registered for these.

Webinars and attended the webinars is we learned a lot of information since the last one and the first one I think you just had to register and we needed maybe your name and your e-mail address. But this last time we asked for a little bit more information, not only name and e-mail address, but your city and state and your

background, your skill set, and any federal political connections. And we really got a ton of information. We also received your consent to share that information with others that are interested in starting a Maddie's Place type clinic in their region, so we could start to see what sort of clusters formed.

So, you know, that ties in with really acting as a clearinghouse to connect all of you. And we know that, you know, this can feel very lonely. And I've felt that way for for about five years that you're the only one or only a couple people that are interested in this subject. And so I think it's really encouraging.

Encouraging and helpful to know that maybe you're here in Oklahoma as an example and you think that you're alone, but there's other five or six other people that are really, really interested. So we wanted to start to build out clusters of interest, what I'm calling new communities of hope and we're really.

Really super excited by what we've seen as far as your involvement and responses over the past couple weeks. So I want to kick it back to Katie, who's going to talk a little bit about what we have discovered as we've been going through all the information you've been sending us. So, Katie.

KT **Katie Tolley** 10:53

Wonderful. Well, like Sean mentioned, this time around to register for this webinar, we asked you a few more questions than we did the first time. And we had a chance to analyze all of that and really start to group people in the same state or the same region together. And through that, we have identified 29 potential cohorts from across the United States, Canada, and even Australia, people that have joined us. And so most of you, we had a couple of folks that we didn't have anybody

in your area, so if you haven't heard from us yet, uh we we will get to you. We will definitely be reaching out before the end of this

This week, if there isn't somebody in your state, we would love to connect you with somebody maybe in the region. But most folks should have received an e-mail like the one you're seeing on your screen now, just doing a quick introduction of folks, where you're from, what industry.

You're in if you had any federal political connections at all. And then I also included a link to a conversation starter. So you know, I think we just want to make sure that we're offering as much support as we can for next steps and so.

Just a helpful guide you might find for things like introductions and talking about shared visions, identifying the strengths and the needs of your cohort who you've already got in the group that's got really strong connections or skills, and then who else you might need to identify.

Next steps and then staying connected as well. So feel free to utilize that. Like I said, we grouped cohorts primarily by state and then for our friends in Canada and Australia, we grouped you by country cause there weren't quite as many of you.

So like Sean mentioned, you may have thought that you were alone, but for many of you, you've now got 5 to 10 other individuals that you know are interested in starting a Maddie's place as well. So our hope is that you're going to start to communicate with one another and see whether it would really make sense to start working together. Are there synergies in your group? How's the group chemistry?

Are you stronger together as you as you partner because of your diverse skill sets and contacts and and knowledge bases? So between now and our next webinar on September 24th, I know that that e-mail we sent said September 9th, but we're finding that we need a little bit more time in between these.

So we're going to push our cadence out probably every three to four weeks rather than every other week. So before our next webinar on September 24th, we really would encourage you to meet at least virtually if you can't be in person and then in order for us to really assess what's happening within each of these cohorts.

And really, to learn how to best support you and get prepared for our next webinar, it really would be helpful to have a summary of your meeting or meetings if you're going to meet multiple times on or before September 17th. That gives us a couple of days to really.

Figure out if we need to add anything to to the next webinar, if there are areas of interest that we're just not covering that you really need to know some information

on. And then we'll be following up with each cohort after this meeting with a form. We're going to try to make it real easy. You can just fill out and just give us some highlights.

From those meetings so that we can tailor, tailor our next session.

SC **Shaun Cross** 14:31

So thanks, Katie. So as we go to the next slide and we start to look at clusters. So what you're going to see is, is kind of what we've received from around the country as those are really, really interested.

And this exercise has shown us at least 10 primary clusters, which are groups of six or more individuals with diverse skill sets and many in healthcare and social services.

And the clusters we've identified so far include Oregon.

We have 7 individuals including a physician, a lawyer, a capital raising expert, one ARNP and three RNS and then Florida. We have 7 individuals identified including a physician with NIC unit NAS experience.

One hospitalist, 3 RNS, one CMA and a political consultant with state legislative connections in Tallahassee. Then just by sheer numbers, we have 10 that are interested in California, 9 in Pennsylvania.

Eight in Michigan and in Oklahoma, Idaho and Washington outside Spokane, and then seven in Virginia and six in Texas. So of the twenty 29 cohorts that we've identified, we see, you know, some hot spots.

In about 1010 states. So that's kind of what we've gleaned from the information and I just really appreciate everyone filling giving us that additional information. One thing that I didn't ask.

Or we didn't ask in the last registration that we're going to want as we go forward is now what are your state political connections? We didn't have a lot of federal political connections, which is fine. I had to ask the question just to make sure you're helping greatly politically.

Just with the breadth of what we're seeing nationally. So just because you don't have a federal political connection, that's fine. I just needed to ask that question. But similarly, as the groups form and that it's going to be helpful to know what other political connections the clusters and the groups may have or individuals may have either at the.

State level or at the local level, whether it be county or city, because those political connections in our experience here in Washington, Spokane County in the city of

Spokane have been absolutely critical. You know, we've gotten 8 million of our \$16 million from the state. We've gotten over 2 million.

Of our 16,000,000 from Spokane County and we just are in the process of getting 300,000 from the city of Spokane. So those political connections are something that we we need to know and that you need to know. If you don't have them, that's OK. The world's going to keep turning and we can still do clinics, but this is helpful information, so I appreciate that.

Now, I want to make it clear that even though, you know, we're talking about these cohorts and the clusters that we're seeing and where there's six individuals or more, does this mean that you can't form a NAS clinic if you have fewer than six individuals in your state? And the answer to that is.

Absolutely not. I mean, two folks really were responsible for starting Maddie's Place, Tricia Hughes and myself. And she's a nurse, didn't have any political connections. I'm a lawyer, had some political connections and knew a lot of people but had no health care background. But together, you know, we had enough firepower to. By the grace of God, get this thing off the ground. And I, you know, one thing I also wanted to mention again that I think I didn't have in my disclaimers that I'm not a health care person, all that sort of stuff. I also want to just repeatedly give, you know, let people know we don't have this all figured out yet. We don't have a permanent funding model.

Yet in the state of Washington, I think we're on the cusp and we're excited about that. And we think that the state legislature hopefully will put that model in place, what we're calling the Ohio model in the next legislative session starting in January. But I just want to let you know that we don't, we, you know, we're still on this journey too, but I think we had a.

Kind of a fork in the road. Do we wait until we've got everything figured out? We have a permanent funding model in place before we start to communicate with others around the country. And I think the answer to that was no, because they're just so many of of you on our social media platforms that have really said we want to do something like this in our state. So because it does take.

Years to to get this done. We wanted to at least give you the chance to get it started sooner rather than later, even though we're not at the end of the journey by any means ourselves. So you know, if you have one or two people or three people, you know we're going to try to make it together, make it so that you're not just by yourself.

And thankfully, we have so many that where there's clusters. And so I just wanted to mention that I've begun to have conversations with some folks in Florida and in Oregon, and one of the reasons, there's several reasons for that.

Oregon is obviously adjacent to Washington, but also the former chief medical officer for Hazelton Betty Ford is a good friend and has been following Maddie's place for a couple of years. He has two of his close friends, a lawyer and a person that's familiar with seed capital and financing.

That recently reached out to me and are actually in the process of this afternoon of driving from Portland to Spokane to meet with us tomorrow. So and then in addition to that we have I think five other people in in Oregon that are RNS or NICU unit experience.

That.

So that is definitely a cohort that will be forming. If you're in Oregon and you haven't received that e-mail yet from Katie, it's because I asked her to hold off until I meet with these individuals in person here at our clinic tomorrow. But we'll be getting out. Katie, if you can just make a mental note to make sure we get out that e-mail to the. The Oregon group tomorrow, that would be great. So and then why floor?

KT **Katie Tolley** 21:00

And I I do also want to mention, Sean, that for anybody that hasn't received an e-mail that has registered for this session, I think I had originally sent out cohort emails on Monday. And so anybody that has registered since then, I will be sure to go back through our registration list and get you.

connected in with the the larger groups that have already received an e-mail so.

SC **Shaun Cross** 21:24

Yeah, thank you very much. Thank you. And then on in regard to Florida, I had the pleasure of meeting Doctor Juliana Hellman of Melbourne, FL a year and a half ago. I think it was February of 2024. We've had several Zooms.

Doctor Hellman is a pediatrician in in Florida and is very familiar with the issue of of of NASA infants and what happens and what's happening in the NIC units in Florida. And is she has a partner, Nicole Baird, who has.

Political connections in Tallahassee. And so we've had an ongoing conversation that's been going on. And so that's another reason why I'm started to prioritize Florida. But that's not going to slow down what we do with other states or wherever you,

wherever you folks are. So anyway.

So kind of with that sort of background on what we're seeing in that, I wanted to go over again what is Maddie's place and I think this mission statement, it doesn't mean you have to have this mission statement. You can do whatever you want.

Focus on the infant. You can do different things, but every word in this mission statement really is kind of carved in stone in our organization and we really had a fair amount of debate about it. So I just wanted to chat a little bit more about it because I think it's

important, regardless of whether this is your mission statement or you have something similar, or whether you do something different, just how important it is to really have your team on the same page on what the mission is, exactly what are the goals. And because if you don't, then you're gonna run into problems down the road and it'll be.

Become divisive and so you want to kind of minimize that up front if you can. So what is our mission? Our mission is to provide medical care in a nurturing environment for substance exposed infants together with loving wrap around support for their caregivers.

Now let me let me go over this a little bit. So medical care, that means we're going to have to have or whoever does this is going to have to have a license probably from their state Department of Health in order to open a facility like this.

Nurturing environment. We've really went to great lengths to make this not feel and look like an institution. And for our parents that stay with our infants, this has been absolutely critical. So we do have a home like environment.

Two nurseries that are set up like really nice living rooms. It's low lighting, it's, you know, nice furniture and our staff is there together with our parents and then we have individual rooms for the parents.

Eight that go off of the main Nursery in one of our nurseries and then five individual rooms that go off sort of the living room in our second nursery. So it's a nurturing environment. These are substance exposed infants.

So one thing that that I am and need to be careful about, even as we're trying to get national data on this, is that there is a difference between substance exposed infants and NAS infants, and there's a difference between NAS infants and NAOS infants and WOS infants.

So the largest group is substance exposed. So that includes opioids. It includes synthetic opioids like fentanyl. It includes non opioids like meth and drugs, but it also

includes.

Alcohol and THC and marijuana and nicotine and any substance that can impact the neurodevelopment of an infant in utero. So that's kind of the universe. So when we're talking about, we think 1/3 of the.

The population of births have been substance exposed. Now of that universe, we've got NAS, which is neonatal abstinence syndrome, which includes infants that show the symptoms of their substance exposure in utero.

Indefinite ways and and if they're exposed to opioids, then they are also in WOS. So there are they're withdrawing from opioids. So neonatal Opioid withdrawal syndrome syndrome.

And so we have all these different categories and I think part of the difficulty with the data and with and with what everyone is doing is misunderstandings around the difference between substance exposed infants and NAS.

And neonatal Opioid withdrawal syndrome, NOWS. And I know we have a lot of experts that are on the line, you know, that can really get into greater detail on that, but we are admitting.

Any infant that has been substance exposed, and I think I mentioned at our last webinar that the average one of our infants has been exposed to 4 substances, not just to one. So often it's an Opioid like fentanyl and it's a non Opioid like meth and alcohol together and maybe.

Nicotine in addition, so together with loving wrap around support for their caregivers. So we are really trying to treat the dyad. We don't provide actual detox of to.

Adults or to the parents, but we're really trying to reach not only the infant, but the but the dyad, but the biological parent, primarily the biological mom. And and of the 150, we reached 150 infants. This last week we had a big celebration with 150 cupcakes.

You know, we've had just under 100 parents that have stayed with their infants while they're here and and the statistics that we're seeing that are so incredible is 95% of the biological parents that have stayed with us are still in recovery.

Today and we've been open almost three years and are in custody of their infant, didn't go into the foster care system, which is unheard of. And then and then third, they're housed because many of them were unhoused or most of them when they came to us.

And 75% have have been addicted to fentanyl. So we're dealing with a population

that is very difficult to get into recovery. And so when you see something like a 95% statistic, it's really getting people's attention. So that's our mission. So I just, I kind of beat that to death.

But it's been something that we struggled with because we really had a divergence of opinion in our leadership group between focus on the infant and the social side with the parents. And I think the power of what we're doing is bringing them all together at the same time, which the system is not, healthcare system is not currently doing right now.

Baby.

Being treated in the NIC unit with morphine while the mom is oftentimes still on the street. There's no bonding that's taking place at all. So again, this is the article that we think is a kind of a key article that has some key sections that we focus on. I actually sent our WSU study and some additional information.

To the three authors of this Johns Hopkins Harvard article yesterday. So I'm excited to see. You'll see that in the title to the article came out in some peer reviewed journal that has a, you know, a very complicated name.

That it's conceptualizing non pharmacological approaches. So we're licensed to provide morphine, but we've only had to give morphine to three out of 150 infants so far. The standard model in the hospitals is just the other way you give morphine first.

So it's non pharmacologic and you'll see just down there in the third line when their article was written in September of 2021 or when it was published, it was a theoretical article. So in writing them yesterday, I just wanted to let them know, hey, it's no longer theoretical. We're doing it here at this little clinic in Spokane.

So maybe the next next slide.

So again, it's a non pharmacological model. It's holistic care first, morphine only if you have to hands on care, a lot of staff not using much medical equipment. It's a home like setting, non clinical setting, non institutional setting. It's individualized care with wrap.

Around care for not only the infant, but for the parent. We have 7 in our peer support team, including our director of family advocacy and four of those members of actually five of those peer support individuals are in recovery themselves and four of them were former patients at Maddie's Place who have.

Have been in recovery for two plus years. So and then what we're also seeing is that we need to continue to provide ongoing support after our patients and after our

parents are discharged. Our average length of stay is 60 days, although we have one. One little guy here right now that's been here for over 120 days. So we've had as little as I think as eight days all the way up to over 120 days. But we're providing lots of support after discharge. We're providing whether it's housing support, whether it's food support, whether it's transportation.

Whether it's furniture for their apartment, whether you know it's dental assistance and that they need and everything is free. And so we're kind of turning it on your head where you go, well, who's your patient? Legally it's the infant, but.

Now as a pilot project, I'm saying no, it's the dyad, it's both both of our patients and we're treating both and well, what's the length of stay? Well, it's formally 60 days, but what we're finding is that we're connected to these people far after the time that they're discharged. So the dyadic model benefits for babies.

It's specialized trauma informed medical and developmental care to bring them through their withdrawal. It's to reduce their symptoms and improve comfort. But it's also, and this is really what that article, the Harvard Johns Hopkins article hits. It's really to promote bonding and attachment.

With their parent and to keep them together while they're both going through their recovery rather than separated, which is what the current standard of care sort of is. And then it's really to have improved long term developmental, emotional and health outcomes. When their parent is supported in recovery, there will be.

You know, longitudinal studies on what's happening at these clinics with with the infants right now. What we can see because of we're dealing with adults is the impact that it's having on the parents, but it's going to take a lot more research nationally to see what the longitudinal benefit.

Is with our infants and then obviously gaining stability from a safe, supportive environment that promotes growth and resilience for the parents. The model is really building confidence and skills in parenting while supported by the medical staff to really strengthen the attachment.

With their infant, which I've already mentioned is absolutely key, which we're seeing is really a protective factor against their own relapse and then just I think providing really non judgmental holistic support that addresses.

Both their recovery and all of their needs, accessing critical resources. I've mentioned housing, recovery programs, mental health services, community connections, really being a one stop place for all of them and then continuing that support after they are discharged. We're really trying to reduce.

Reduce all of their stress and to really, you know, be the opposite of the stigma that they've received, many of them from the current health care system where they believe they're treated as, you know, how could you do this? You're the worst mom ever. Not everybody's doing that, and I'm sure there's.

People that are that are watching this that are just unbelievably loving and wonderful and nonjudgmental in their in their dealings with these moms. But unfortunately that's not the experience of a lot of the moms that have come through here. They they say I've never been treated this way before and this is just amazing.

And So what we're really hoping is to improve long term recovery outcomes that is going to keep the family together, but not just the family just for the sake of itself, but a family that's in recovery. So pretty much really have covered.

All this, but we're trying to promote healing and bonding by bringing both the social side and the medical side together and bringing the infant and the mom primarily and the dad if available together. So what does this do from a systemic standpoint? Well, we're drastically reducing foster care places.

The 100 successes that we've seen with our parents, you know, those those kiddos would have would have likely gone into the foster care system. This is going to dramatically lower health care costs. Our model just for the treatment for the infant alone is about 1/3 what Medicaid.

Is currently paying our hospital NIC units and that doesn't take into consideration that the foster care system, the foster system savings that we'll see. So which is very, very significant like in the 10s of millions of dollars.

Already for what we've saved the foster care system in Washington state. And we're modeling that out and we're tracking more and more of the services that we're providing. So we can really articulate the value that we're providing versus what the system is paying now and the outcomes that the system is getting.

So we want to see improved maternal health outcomes and we want to break this intergenerational cycle. Obviously there's a huge genetic component to this. One of the reasons I'm excited about getting some of the Oregon folks on board is that Marvin Sepola is, you know, a recognized expert on the psychiatry of addiction and and breaking intergenerational.

Operational cycles and then so anyway and then we're really trying to push for better data for policy change and that's at the national level. And these webinars and the fact that you're all spread around the country is going to help us as I go back to DC probably in October, I was just there last month.

And a lot of folks are saying, OK, that's great, you're doing that in Washington. What about the rest of the country? So anyway, we need to almost create a national movement, to tell you the truth. So next slide.

So this gets probably really, really, really boring at this stage, and so I I apologize for that. But I wanted to focus a little bit on on what the law is in the state of Washington.

And and I want to do that because one of the challenges that you all are going to have in each one of the states is trying to fit what we're doing, our model, that dyad model into whatever.

Health care system you have in your state and so and so in our state and I think in in Ohio and in West Virginia, you know the the names are a little bit different, but they're very, very similar.

But we're called what's called a pediatric Transitional care facility. The law that created our structure was actually done clear back in 2017, and it was based on a clinic in Western Washington.

That just focuses on the just focuses on the infant and they were actually grandfathered in, so they didn't have to. We were the only clinic after eight years that's been able to navigate this legislative structure. The structure is going to need to be changed because it doesn't cover services.

To to the to the to the parent. But anyway, we will have links to all of this, right Katie, for everyone to access. And so I just I'm going to run through this just really, really, really, really quickly.

KT **Katie Tolley** 38:49

I was just sharing in the comments, these are already linked on our website. So Yep, Emma just dropped the the direct link in the chat.

SC **Shaun Cross** 38:59

OK, so um.

OK, so.

Excuse me.

OK, so this is this basically says we're an pediatric Transitional care services. It's an establishment that provides pediatric Transitional care services to drug exposed infants must demonstrate that it is capable of providing services for children who are no more than one year of age.

Have been exposed to drugs before birth and require 24 hour continuous residential care and skilled nursing services as a result of prenatal substance exposure and are referred to the establishment by the Department of Social and Health Services, regional hospitals and private parties. This is actually by law. This needs to be updated.

Because the Department of Social Health Services transferred its responsibilities for children to what's called the Department of Children, Youth and Families in 2018. So basically we get referrals from DCYF.

Which includes Child Protective Services and then we also get referrals from regional, from hospitals and also from private parties. So I want to move on to the, I think the intent is the next slide.

No, no, surprise, it's not. So this is basically saying the Secretary of Health must, in consultation with, and now it's the Department of Children, Youth and Families, adopt rules on pediatric Transitional care. The rules must.

Established requirements. Let's kind of scroll through this. So um.

I don't think I need to do this twice, but this this this particular provision gives sort of the structure that we have. So let's keep going. Let's go to the next one.

So then.

OK.

So, and I think we can skip on to the next one. So really, if you'll see links is point, it's .684 point or .68284 and 86. It's really, really just a very, very short statute. I want to get to the findings and intent.

And spend a little bit of time on that, because that is now. This is something I want to make sure you're all aware of. Hardly anybody knows about this. It's kind of buried in our statute, but it was actually really, really well written and well done.

And I think we're we're going to want to add some things as it relates to the families and the parents and the success that we're seeing with them. But this is, this is really, really is something that you can use As for when you're talking to your legislature or when you're doing presentations.

Why should the state adopt something like a Pediatric Transitional Care Facility Act?

Well, let's just start. The legislature finds that more than and this is, by the way, based on 2016 data. So this law was passed and these and the findings every time an act is passed by a state.

Legislature by Congress, there's a finding section and this is OK, why are we doing this? What's the purpose? What are we trying to address? The legislature finds that

more than 12,000 infants. Now we don't know where that number came from. This has really caused a great, really, really interesting because.

That would mean that we'd have 900 infants in Spokane, just on a per capita basis out of 6000. And the CDC would say that we only have 36 in Spokane per year. So our numbers are just all over. But anyway, each year have been prenatally exposed to opioids, opioids.

Methamphetamines and other drugs. Prenatal drug exposure frequently results in infants suffering from neonatal abstinence syndrome and it's accompanying withdrawal symptoms after birth. Withdrawal symptoms may include etc, etc, etc. Consequently, the legislature finds that drug exposed infants have unique medical needs and benefit from.

Specialized health care that addresses their withdrawal symptoms. Specialized care for infants experiencing neonatal abstinence syndrome is based on the individual needs of the infant and includes administration of intravenous fluids, drugs such as morphine, personalized hands on therapeutic care, et cetera, et cetera. General rocking. So go to the next paragraph if you would.

The Legislature further finds that drug exposed infants often require hospitalization, which burdens hospitals and hospital staff who either have to increase staffing levels or require current staff to take on additional duties to administer the specialized care needed by drug exposed infants. The Legislature further finds that drug.

Exposed infants and benefit from early and consistent family involvement in their care and families thrive when they are provided the opportunity, skills and training to help them participate in their child's care, the legislature further finds.

That infants with neonatal abstinence syndrome often can be treated in a non-hospital clinic setting where they receive appropriate medical and non-medical care for their symptoms. The legislature therefore intends to alternatives to continued hospitalization for drug exposed infants, including the continuation and development of pediatric Transitional care services that.

Provide short term medical care support, blah blah blah. That is a key section for you all. It can be expanded quite a bit to cover what we're seeing with the parents because these findings were intended to support the law that would have these Transitional facilities just for infants.

But it has a lot of the, you know, the main arguments for it. Ironically and paradoxically, when this was done in Washington state. And by the way, this is before when they talk about 12,000 infants in the state.

This is 2016. This is four years before the pandemic and years before fentanyl, at least in the state of Washington. And so the universe in Washington state has totally, completely changed. It's much, much worse than it was in 2016.

Way, way worse. So I don't know where they got their 12,000 numbers, but it's 10 times worse than that. So we have no clue how bad this is in our state. But these arguments are really, really, really the key arguments. The paradox and the irony is this.

When this law was drafted, eat, sleep, console was being adopted by the hospitals and it was looked at as a five to seven day kind of a time period that the baby would be going through withdrawal. What our WSU study showed is that.

Since 2022, the world has changed in Spokane and Washington state and Eat Sleep Consoles is not working in the hospitals. The methodology they were using was not working. Why is it not working? Because of polysubstance and fentanyl, which is a new phenomenon in the last few years.

In Spokane and Washington state. And so instead of five or six or seven days, these babies are staying an average of 26 days in the NIC unit currently in Spokane and in Washington state. And so and that's at 2000 to \$2500 per day that's being paid by Medicaid.

Secondly, what's happening is they're continuing to give the infants morphine while they're in the NIC unit and the mom, they're finding that that because of the power of fentanyl and the strength of that drug and the polysubstance use.

The mom, the biological mom, is no longer able to participate in each sleep console, which was what was initially intended. In fact, while the baby's in the isolette, the mom is still on the street. So we're paying the most money that we could pay out of Medicaid and getting the worst possible result because we're preventing bonding from taking.

taking place. So anyway, these are the arguments that you, you know, you want to start to become familiar with and build. Let's go on to the next, the next slide. So in every state, this is the way legislation works. In Washington, we have the RCWs, which is the Revised Code of Washington.

So that's the overarching law that the state created for the pediatric Transitional care facility structure. Then the law delegated to the Department of Health and now the Department of Children, Youth and Families to promulgate regulations.

Pursuant to the RCW's that would carry out the intent of that law. So the actual WAC or Washington Administrative Code regulations that govern us is 24246337081 which

is in front of you. So this gets into all sorts of details.

As to who we can admit, how we can admit this is going to have to be revised by our state legislature because we are a pilot project that came six years after these were drafted and they don't fit for what we're doing. So which has been sort of interesting from a legal risk.

Standpoint. So let's go on to, let's keep going on, Katie. So it gets into the staffing ratios. In our state, we have to have one registered nurse has to be present on duty at the facility at all times.

And so we have this interesting section B Romanet one that says we have one registered nurse or licensed practical nurse shall be present and on duty for every eight infants. I think some folks looked at this and said, oh wow, we need to have if we have 16 infants, which we've had three times.

Or we have more than 8 infants. We need to have two RN's on each shift. And if you look at the fine print, you'll see no, it's one registered nurse for every eight infants requiring morphine. And we have only had three out of 150 that have required morphine. So if you.

Not regularly giving morphine, you only need to have one nurse per shift rather than two. So our model has a benefit that no one was thinking about when all of this was drafted, but that cuts your costs as far as nursing staff literally in half.

So and then we have then they created this interesting thing called a trained caregiver and a trained caregiver. It goes on in another section to say this is a non licensed, uncredentialed individual who is just trained by by the facility by.

You know the pediatric care facility to handle the babies and - Feed the babies in certain ways and we call those infant care specialists. So we actually have I think 19 RN's, we have 3 providers, all ARNP's and we are actually 2 providers, 2 ARNP's. 19 RN's and 47 what we call infant care specialists. And this saves tremendously on your costs. And since we don't have a lot of equipment, that's one of the things that makes this so, so much less expensive than the way that we're doing it right now.

Now, so we need to have by statute and this is 5 subsection C1 trained caregiver or infant care specialist to every four infants. So that means if you had 16 infants by statute regulation, you'd only need to have four infant care specialists. We actually.

Our model right now currently and it continues to evolve. We have 6 infant care specialists rather than four for each shift. So one RN, six infant care specialists and then we're trying to get we have 46 trained volunteers and I think 30 that are being. Trained and in the queue, we're trying to get to the point where we'll have 4

volunteers, primarily cuddlers, that will be on each shift also. So that's one nurse, 6 trained caregivers, so that's seven, and then four cuddlers, that's 11.

So if you have 11 infants, you've literally got a pair of hands for every baby. So anyway, this gets into some of the details that really, you know, we don't need to wade into today, but it'll be made available for you. I just highlighted some of the sections that are important to us.

US. I think we can go on, Katie.

KT **Katie Tolley** 52:25

Well, Shaun, I think that brings us to Q&A.

SC **Shaun Cross** 52:28

Awesome. I didn't know where we were, so um.

KT **Katie Tolley** 52:31

Yeah, we're running. We've got a few extra minutes for for Q&A. So I don't see anything yet in that Q&A tab. So it must mean that you covered everybody's questions. So I'd encourage you, if you've got a question for Sean, please drop it in that Q&A tab.

SC **Shaun Cross** 52:34

Right, right.

I am.

KT **Katie Tolley** 52:51

In the meantime.

Oh, looks like maybe we've got some things in there. I'm just not. Couple of people said that they've dropped notes in there. Let me take a look. I don't. I wasn't seeing anything. Well, there we go.

OK, Sarah is wondering if they can use the slides from our PowerPoint to present to community members when she starts recruiting interests. Yes, I was just. I wasn't sure if you guys were seeing my e-mail flash on the screen. I'm trying to.

Gather a I've got a public link to this slide deck that I am happy to share. So I'll drop that in the chat here in just a moment and then I'll make sure it's also linked on our website as well. And then they're also wondering.

How you decide on location given the factors of available services to caregivers while trying to avoid a triggering community environment, city versus outskirts of town or farm like setting.

SC **Shaun Cross** 54:01

Wow. Well, that's a great, that's a great question. I yeah, I mean, I think it's, I think there's a lot of different factors you want to want to consider. I think you do want to have access to the services that this population needs, right? I mean.

And so I think it's we happen to be in the center of our of our medical community.

We're close to downtown. A lot of the resources for our population are within relatively short driving distance. We have one vehicle that was donated. We're in the process of getting another vehicle because we're transforming.

Supporting our parents around so much. So I think it's helpful to have resources around. Now on the other side of that, you want to have cost considerations too.

And so if you can be on the outskirts, I mean depending on how cost drops drops off for particularly for land and that I I think that is a factor you want to you want to consider you know we're you know Spokane's not that huge a place I mean we're but we are the second largest metro region.

State or the second largest city in the state. So I'm not sure if that addressed your question or not. Totally. What part of that did I miss, Katie?

KT **Katie Tolley** 55:27

I I think, I think you did well. I think there are benefits and and downfalls to both. I know for us we are in a residential, some places considered a residential area, but we are very, very close to.

Downtown and actually within walking distance of a couple of our partner providers.

So our parents, you know, we're very close to a bus line, which makes it easier for parents to come and go, you know, particularly those that have left our services or have graduated out of this program.

That.

Come back, they need to pick up diapers or wipes or clothing or mail or something like that. So that is definitely a benefit for us. The other thing that should be noted is families that are in our program that are rooming in that are resident parents usually typically aren't leaving without being.

Accompanied by one of our peer support members until they're farther along in their

recovery. So you know there's we're trying to reduce any opportunity for relapse there.

Pardon me, my computer's loading. Let me get back to our questions.

SC **Shaun Cross** 56:41

We.

KT **Katie Tolley** 56:49

And then Gabby is wondering what drives the length of stay for your infants? Since most are not being treated with morphine, do you anticipate Medicaid reimbursement could impact length of stay?

SC **Shaun Cross** 57:00

Yes, definitely. It's a great, great question. So right now our average length of stay is 60 days, but I think realistically we're going to have to kind of overtime move that down to closer to 30 days. We are asking that our legislature follow Ohio's model. And Ohio provides Medicaid reimbursement for our services for the infant for but for only 30 days. And they provide though a DCYF component which is non Medicaid where the Department of Children, Youth and Families in Ohio pays.

For 90 days for treatment of the parent. So in answer to your question, I think one of the reasons our length of stay is so long is because we have had capacity most of the time, even though we have hit that 16 full capacity.

Mark, three times now we've been able to work people through and create additional openings. So we haven't gotten to the place where we've really regularly had to turn people away, nor have we gotten to the place where we have to discharge people before we're comfortable with where they're going next.

The primary issue for us has been housing and securing adequate housing for our unhoused families when they leave. And so the baby may have finished its withdrawal within 30 days and we may hold on another 15 or 30.

Days while we're making sure that we've got a great place for the parent and the baby to go to. So it's a really, really good question. Our length of stay is 60, but as we move to Medicaid reimbursement, which we're hoping will start by summer of next year or in 2027, we're going to need to.

Have our patients go through more quickly. We're going to have to and that's one of the reasons we bought an acre next to us while we're looking at housing to assist

with that where we would have interim housing that would be another two to four months for families, not just for the for the infant.

And for primarily the mom, but for the rest of the family, which would be next door to us and we're looking at child care and other services, primary care, other services also, it's a great question. It's primarily driven by housing and the fact that up until now we've had.

We've had the latitude to keep people longer.

KT **Katie Tolley** 59:36

Great. Next question is from Maggie. They're wondering, are siblings allowed to visit or stay at Maddie's place? And what about other family members or caregivers?

SC **Shaun Cross** 59:47

Yeah. So great question. So really right at this time, and this primarily a space limitation, we made the decision early on that either the biological parent or the biological father could stay.

At the facility, 24/7, free room and board, but not both. That was primarily was driven largely by space, but there but there are other other reasons too. And so we just most of the time the parents are deciding who it will be or it's very clear that just one of them is really.

In recovery, the other biological parent may not be there yet, and so we just have had room for the infant and then for one of the biological parents. But we do have a visitation center. We've had 2000 visitations so far this year.

And so it's a whole separate part of our facility. We have 5 visitation rooms that's overseen by peer support. An infant care specialist brings up the infant that maybe grandparents want to see or siblings want to see or relatives want to see. And so we have 5 very nicely appointed rooms.

With some semblance of privacy that where visitation can take place and we just have regular business hours for our visitation 60, I think it's six days a week.

KT **Katie Tolley** 1:01:08

Six days a week, parents, caregivers, family members using that do not have to make an appointment. Umm So even if a parent is still actively using, we welcome them in to be able to visit with their infant in a safe and monitored visitation space. We ask anybody that visits.

No matter who they are to wash hands and we provide a protective scrub jacket for guests to wear just so we're not exposing baby to anything. And then our peer supports are offering supervision so that if baby starts to get dysregulated if. Visitors are, you know, breaking any rules or not being safe with the infant. We can step in and offer some guidance or end the visit if we need to. So Sean, I'm.

SC **Shaun Cross** 1:01:58

Right. And this is really, we're really founding this finding that this, excuse me, Katie, but this is really a huge this visitation center has become a way for us to reach a lot of parents who weren't ready to be in recovery for whatever reasons but want to visit their biological child and it gives us an opportunity to.

KT **Katie Tolley** 1:02:00

M.
No.

SC **Shaun Cross** 1:02:18

Start to provide support to them and meet them where they are. And we've actually reached 38 individuals whose babies stayed at Maddie's place, but who were not in recovery at the time. We've reached a whole bunch of people that are now in recovery, are now housed and now have custody of their infants.

And their CPS cases closed just because we allowed, you know, they were able to come in even while they were still using. And we it gave us a point of access to say, you know, can we help you with clothing? Can we help you with food? Can we help you drive you somewhere? It's just starting to love on these people, right? And they and really they're.

A lot of respond.

KT **Katie Tolley** 1:03:01

Great. I'm going to combine two questions. Let's see, where are the parents receiving their treatment for addiction, and how do you handle situations where parents relapse while in care?

SC **Shaun Cross** 1:03:15

So I've asked for the second part 1st and then I'm going to have Katie answer the

first part. So I think out of the 150 infants that we've had and the roughly 100 parents that have stayed here, I think we've had 14 of the parents that have relapsed. Nine of those parents have gone back into recovery and are still in recovery.

And you know, can be admitted back to the facility. They have to go back out and go through treatment again and then come back in. And Katie, you can probably name some of the partners that we work with is that we coordinate recovery with and then you can talk about the MAT program too.

KT **Katie Tolley** 1:03:51

Sure. So really, we are trying to help parents address literally any barrier that they may have to getting into and staying in recovery while they're here with us. And so we gosh, I was just pulling up our community partners list.

We're working on getting those updated on our website. So you can see that we are working with folks everywhere from, you know, recovery centers here locally, housing, you know, partners that that can provide housing support, childbirth and parenting assistance, job training and support.

um IOP, you know, intensive outpatient, outpatient and then group therapies. ESIT or early support for infants and toddlers, dental hygiene, behavioral health, mental health, gosh, therapy.

All sorts of of PCAP Parent Child Assistance Program. That program will continue to work with families until the infant or baby is I think up to age 3, so.

SC **Shaun Cross** 1:05:00

Right. But I think we have, I think we have several treatment facilities that we partner with, right. So it's not just one we have, we have several that we have really good relations with.

KT **Katie Tolley** 1:05:04

Mhm.

Yes.

We have, we have some that we've definitely found that we work better with that tend to be, you know, easier to work with for our for our parents that are here and yeah.

SC **Shaun Cross** 1:05:24

So let me let me ask you, Katie, maybe an obvious question. You know, for our parents that are here getting free room and board, but they're also going through their own treatment and own recovery during that initial stage of that, do they come back at nights and stay here at the facility or are they off-site while we're taking care of the baby for the first five or six days of their treatment?

KT **Katie Tolley** 1:05:43

Yeah, both, yes. So parents oftentimes will be gone throughout the day. You know, they're here staying overnight and then in the morning they're up. And you know, if they're on medically assisted treatment, we're making sure that everybody gets to the clinic.

Methadone clinic, if they don't have carries for a couple of days, you know, and we're making sure parents get to their group or therapy appointments and those can take several hours throughout the day. So while they are out and about doing what they need to do to support, you know, staying.

Recovery and and heal themselves. That's where our infant care specialists and our nursing staff and our volunteer cuddlers come in and they're doing care for the baby, taking care of the babies in our nurseries during the day.

SC **Shaun Cross** 1:06:30

We do track the time, so everyone logs in and logs out. We've actually, you know, mapped that. And I think it was the last time it was done. It was about 90% of a parent's time is spent on site here at Maddie's place and only 10% is outside the facility, but obviously for people that are.

KT **Katie Tolley** 1:06:33

Mhm.

SC **Shaun Cross** 1:06:50

Still an active recovery and treatment, you know we are not providing that. I mean we do the medically assisted treatment, we assist with that and then we're seeing that we're doing all sorts of other treatment after they get what we traditionally call their detox or treatment.

KT **Katie Tolley** 1:07:04

Yep. So to expand on that, Wendy had a question that relates to this asking about the legalities. What are the legalities that surround the agreement parents have to make in order to stay with their baby at Maddie's place?

SC **Shaun Cross** 1:07:16

Yeah. So about 50%, almost 50% of our babies that come here are placed by the Department of Children, Youth and Families. So they're in the they're in the those infants are in the court system. The parents are still using they're they're not in custody of their infants and so.

Really our state is sort of placing the infants here and we're dealing with DCYF, but about half, almost exactly half are voluntary placements where we have agreements and documentation and consent forms that are signed by the parent.

For their their infant's treatment here at Maddie's Place and we're happy to share those consent forms and those and all of those forms. And there's lots of different things that that need to be covered. For example, the parent consents that we will be making the decision when their infant will be discharged.

Charge. It's not just a question of the mom, you know, leaves here, maybe she relapses or whatever and says this is my child and I want custody of the child. She contractually, you know, puts puts Maddie's place in our medical director and our director of family advocacy in the decision-making role of when that infant will leave. And we've had.

Very little, very few problems with that. But there's other issues too. We want to obviously, you know, we have 340,000 followers on our social media platforms and you'll see a lot of infants on that. We receive a consent from the biological parent before any infant is ever, ever shown.

Obviously, which would be a HIPAA violation, but we also try to be sensitive on what we show as far as how close up and all that type of thing also. But all of the forms that allow us to do what we do here, whether it's clinically or whether it's on social media, are consented to by the.

Biological parent at the time they're admitted and we're happy to make all those forms. Those are that's, you know, stuff that that we can easily post and put online.

KT **Katie Tolley** 1:09:26

Wonderful.

And then how do you leverage partnerships to strengthen grant applications or attract donors?

SC **Shaun Cross** 1:09:38

Well, I you know, so before Katie joined us last year, you know, I I've been raising the money and and really we weren't really getting hardly anything from grant applications. It was.

You know, just, you know, a relatively small community. I've practiced law for 46 years and represented a lot of people in a lot of institutions and and stuff. And so most of it was just my personal relationships with individuals and meeting one-on-one with people.

During the first year, year and a half, it was by Zoom because of COVID. But it's mainly we haven't had a fan, a fundraiser, an annual fundraiser, all that typical stuff where you you're forced to buy a table and bring a bunch of your friends with checkbooks and that. I I really don't like that model to tell you the truth. And we haven't, we haven't, we haven't had to do that or.

Do that as far as grant applications, I think you know Katie and I are really learning as we go on this. We have had significant grants that we've received, but I think we're just at the at the very tip of this. I don't think we've really.

Really gotten into a lot of the large grants that we could be getting and particularly when you look at all the areas we're covering with which it's access to care, minority populations, maternal health, the drug crisis, which everyone is concerned about, health care, generally cost of health care, you know, I mean we.

Tick a lot of the boxes. Katie can also tell you there's software programs out there. One that we're using called Instrumental, which has an algorithm that will help you find private foundations around the country whose criteria match your key factors like.

Access to care, maternal health, infant health, infant mortality, SUD, all that sort of stuff. So there are programs that we can mention to you that will be helpful on grant writing. We've just hired a grant writing expert also to assist us this next quarter. So we're kind of we have a lot, a lot, a lot.

A big room to grow on that area.

KT **Katie Tolley** 1:11:53

Sean, I think you touched on this earlier. Heather's wondering, do you think a rural

setting is OK for this type of facility or would it be preferable to be in a bigger city with more hospitals to receive more referrals? They're concerned with the ability to maintain census if referrals aren't within the immediate city.

SC **Shaun Cross** 1:12:09

Yeah, I think it will. It will depend on your state. I think we found my recollection is and that we found a loophole in our state that if you were treating fewer than three patients, the regulatory burden was was or three or fewer was.

Much, much less. I know that on the construction we had to go through a construction review process and our state, you know, was very difficult to get this clinic up and running because they treated us like a hospital. So we had to have on the construction side to our firewalls and all this sort of stuff. We've got got them finally down to one hour firewalls or we would have.

Had to tear the facility down and start over. But we did find on the construction review that if you just were renting a house or owned a house that you could do one of these facilities if you had I think 3 or 4 or fewer patients. The issue is what what does your.

Do you need to have an RN? There are three shifts I think is is is the issue there. But yes, I think there is a place. I mean I think I really have a heart for small towns. I came grew up for 18 years in a town of about 2000 and and and.

Farm wheat country near here and it's just the need is so great in our rural communities. There's just so much poverty and drug use, at least that we're seeing in the rural areas in Eastern Washington. And I do think we need to find a way to kind of have these.

clinics. They'd be obviously smaller and much smaller cost, but we need to find a way to to have these clinics in rural settings.

KT **Katie Tolley** 1:13:58

Great. Let's see, Juliana is wondering, how do you facilitate recovery in the parent? Are the parents transitioning to methadone or subutex from illicit opioids?

SC **Shaun Cross** 1:14:09

You can go. You can do that one, Katie.

KT **Katie Tolley** 1:14:11

Yes, as much as we can. We definitely encourage parents. We we realize the power of, you know, methadone, Suboxone, subutex, things like that. I think more of our parents in this region and I'm not sure why I would love to to bring. I will consult with our.

Our social worker on this who's working with our parents, I don't think as many of them are using Subutex, which I think is the month-long injection. Most are either on methadone or Suboxone. But yes, we we definitely encourage, you know, parents to to utilize.

You know, treatments that we know are working and can support them in their recovery. The other thing I think that we noted last during the last webinar is, you know, we've talked a lot about substance exposure. We have infants here. We have treated infants here that are here because their parent is in recovery using.

You know, prescribed methadone or Suboxone. Infants can and will withdraw from those substances as well. So you know, there are parents, many of our parents that are here voluntarily that you know, 50% that are here voluntarily.

Are here because they recognize that even though they are in recovery, their infant is still going to experience some withdrawal symptoms from the the medications that they're using, so.

And then Ashley had a question. What's the best way to find reputable attorneys to guide us in our communities? So, Shaun, I think you're the expert in that arena.

SC **Shaun Cross** 1:15:45

Yes.

You know, you know, I yeah, I think if when the when, if there's in, you know individuals or clusters that have a question about, hey, what's a a good law firm or lawyer in my region, I I will try to feel those.

And help you with a with a few recommendations. I mean I think if you if you were looking at just incorporation and the tax exempt status and and that type of a thing, then you're generally going to be looking for a corporate lawyer.

To do that and and that's if you got if whoever wants to do their own thing. If people are interested in affiliating, you know possibly with Maddie's place, then if we do work together and end up affiliating, then you don't need a corporate lawyer because we've got that already covered with with the subsidiary that we would.

Form the LLC that we would form. So you would you would need a lawyer for that where I think everybody's going to need a lawyer whether they decide to affiliate

with Manny's place or not isn't is in the healthcare area because I think you know. You need, you need some health care expertise and it might, it might be an attorney. It may be that you're just very, very familiar with your health care system in your particular state. But I think the big.

The big challenges we had were trying to figure out where what what we were doing, where that fit. Is it a skilled nursing facility? Is it a residential treatment facility? Is it, is it, you know, do you get your license from the Department of Health? Is there a structure in your state that you can?

Fit our services within that is a really high level question. It doesn't necessarily mean you have to get a healthcare lawyer, but somebody has got to kind of wrestle with that question. We do have some Medicaid expertise here at Maddie's Place, our Director of Nursing and Clinical Operations.

Is very knowledgeable about Medicaid and can look at your state's situation pretty quickly, I think. And she may be talking to you all at a future webinar about that. So the Medicaid piece and the structure piece are, you know, really.

Really important questions on this. But having said that, if you want the name of a few lawyers or whatever, you know, I can have some people dig into that and get out some recommendations depending on what your location is, what your city is, and what your state is.

KT **Katie Tolley** 1:18:30

Thanks, Sean. So during our last webinar you were talking about, you know, whether if if people were going to create an organization like this, would they be, what kind of organization would they be? Libby's got a question more about.

What kind of treatment facility we are, sort of how we're classified there, wants to know what if you come at it from a residential treatment facility for the recovery of the addicted parents rather than medical treatment for the babies? From what they understand, babies in Denver are discharged from the hospital to the care of CPS foster.

Or kinship placement. But what if they could be released to this facility but it not have such extensive medical extents? So it's like a group home with babies and parents with recovery treatment. For example, they're thinking about a house with babies and moms included something small.

SC **Shaun Cross** 1:19:22

I get. I think that I I think that's a.

I think, I think that I think that is a brilliant and extremely creative potential solution. I I really that's a really cool question with a lot of content to it. I think that is a possible way of of approaching this.

The the the issue would be, you know you want to get the infant as quickly as you can and so I'm not sure if you if you went at it that way, how quickly you would get the you would get the infant.

And and the other thing is, but it might be a way to get to get your foot in the door and get started and then maybe you can while you're doing that, go to the legislature and get things changed so that you could also get the based on what's happening in other states like Washington and Ohio, so you could get them to add. The medical care of the infant too, because I do think with what I'm seeing, I think it should be a goal for all of us to ultimately try to get the infant and the parent as quickly to the date of birth as possible, because I think there is this limited window of opportunity.

Where you can really increase the percentage of recovery success. And so right now we are not getting the infants as soon as we'd like. Our in our study that WSU did with the 1st 71 infants, the average age on admission was 18.6 days.

And now we're seeing that the hospitals are holding on to these infants around 24 days in Spokane. So we occasionally, we just got a baby at five days here this past week, but we really, you know, and that's going to be legislation that, you know, should the hospitals be paid.

Under Medicaid for for 26 days when there's no comorbidities. If it's if they're just withdrawing, the infant's just withdrawing substances, then you know, should the hospitals only be paid for no more than seven days, something like that. But you know that's what we're gonna be talking.

About the state of Washington, I can tell you that, and we've already been raising it with public policy makers in our state capitals, so.

KT **Katie Tolley** 1:21:49

Wonderful. Some of you, we've answered your question in the chat. Jennifer's wondering, do you have any infants that were exposed to SSRIs? They've got a large population of families at at their workplace that have experienced that.

SC **Shaun Cross** 1:22:07

I, to tell you the truth, I don't know. Can you answer that question, Katie?

KT **Katie Tolley** 1:22:12

I believe we have, yes. Yeah. And and when we're we're talking, you know, Sean mentioned at the top of this, this webinar that, you know, we're really needing to shift our language or be mindful of the language that we're using around substance exposure versus NAS versus NOWS.

And so when we talk about substance exposure, we're talking about any substance that an infant could potentially withdraw from. And so that could be everything as, you know, mundane as caffeine to, you know, nicotine and alcohol, SSRI's, you know, illicit substances.

Now.

SC **Shaun Cross** 1:22:49

And this just so you know, just following up, Katie, just kind of making it into a discussion thing. But you know, the challenge is gonna be, I don't think that we're identifying all of the infants that are showing withdrawal symptoms under the NAFS criteria right now. I just, I just don't think we are.

But having said that, how are you going to identify those that don't show any withdrawal symptoms but have been exposed to substances that affected their neurodevelopment but won't show up until later? And so unless we have universal UA S or something like that for every baby that's.

Or in the state of Washington or in whatever state, you know, I mean that's, I think, I mean that's what I'm in favor of is that we need to have, whether it's the umbilical cord or whether it's universal UAS or whatever. I I think we're at a point in our society where.

We we can't wait until we see what's happening with these kids in school, in 6th grade and stuff. We've got to start catching this sooner.

KT **Katie Tolley** 1:23:54

OK.

Well, I just dropped a note in the chat. We're sort of wrapping up with our time here. I'm not seeing any additional questions. Oh, here we go. Let's try it one more time

here.

Oh, Wendy says babies in Pennsylvania are tested at birth.

SC **Shaun Cross** 1:24:14

That's awesome. So that's really that's a that's a that's a huge thing. It'd be interesting, you know, for those of you, you've got so we have so many healthcare people around the country. If you could let us know whether you know what's what's the requirements in your state.

KT **Katie Tolley** 1:24:15

Yeah.

SC **Shaun Cross** 1:24:32

Because it's not, it's suggested it's a recommendation by our public policy in the state of Washington, but it's not required and the hospitals don't do it in the state of Washington. So I'd be really curious to know.

You know what states are requiring UAS or umbilical cord tests for all births and also what, if any, impact you're seeing based on the data that's coming out of that.

KT **Katie Tolley** 1:25:03

Great. It sounds like maybe that is if they meet certain criteria. So that's that's interesting. And then Nicole, you were sharing that.

You have a house that was made for this 5 bedrooms, 4 baths, essentially 5 apartments where you are offering similar services. We would love to know more. So if you drop a link in the chat or shoot us a message, we'd love to talk more about what you've got.

Going on, a lot of times we we say, hey, we're one of only five in the country that we know of that are doing work like this with the dyad, you know, focused on this population. So yeah, if there are more resources out there that we don't know of, please, please share those with us.

SC **Shaun Cross** 1:25:41

Right.

Yeah, please let us, please let us know. Yeah. And also best practices. I mean, if someone's out there that we don't even know about that's doing this and they have

things that we need to know, you know that part of this is, is, is, is sharing information. And I know you have a ton of information out there that that we don't know about.

KT **Katie Tolley** 1:26:08

Yeah.

Wonderful. Folks are dropping, just dropping notes in the chat with more information.

SC **Shaun Cross** 1:26:18

Yeah, I just saw, I just saw that. I just saw that in Denver. The hospitals are all over the map as far as the criteria, what they use and what they do. I mean, it just seems to me we need to have a national standard. This is just crazy. We have a national drug crisis and the substance use, I mean, it's a disaster, I think, but anyway.

KT **Katie Tolley** 1:26:19

Oh, Ashley says in Denver.

Yeah.

SC **Shaun Cross** 1:26:38

Yeah, it just seems that we we we do it by county, by state, different hospitals do different things. We bad data in, bad data out, you know. So anyway we we need to you know one thing, last thing I wanted to you know mention and we'll wrap it up. You know we are trying to get Congress to.

Pass the Miracle Act, which would be a really good first start for all 50 states to find out, you know, what is the data around neonatal abstinence syndrome. And I'm going to, as I was one of the main writers of that legislation, we it was introduced last year. We're trying to get it introduced again.

This year and we're working on getting sponsors both in the Senate and in the House, but we need to expand it to all substance exposure rather I think than just NASS. I think we if we're going to do this, we might as well really do it. So anyway, but.

All of your support, encouragement, participation, involvement, you know, is really going to help us put pressure on Congress to do something about this sooner rather than later. So anyway, I think we're pretty much done, right, Katie?

KT **Katie Tolley** 1:27:51

Yeah, that's a that's a good segue into just want to thank everybody for for joining us the last hour and a half. Well, it sure goes fast when we've got so much to share so.

SC **Shaun Cross** 1:27:59

Yeah. Thank you so much. It's just really, really enjoy this and I hope you don't mind that we're kind of, I think we mentioned before that we feel like we're building the plane while we fly it. And so I know we had eight sessions webinar set up every two weeks, all of that, but really as we're seeing what's kind of happening in the clusters. And all this different stuff. We're starting to look at look at this in a different way. So appreciate your flexibility as we kind of navigate this. The goal is still to get as much information, share as much information, put you in contact with others, make this easier for you, put up, provide templates, do all that sort of stuff. But we are. You know, it's the next one I think is what, September 24th? So um.

KT **Katie Tolley** 1:28:42

Yes. So just, yeah, we we hope you guys are feeling as inspired and encouraged by all of this as we are and hope you'll join us for our next session. It's called Laying the Groundwork, Assessing Community Need and Building Credibility. That is scheduled for Wednesday, September 24th. That one we really, we plan to cover really how to assess your.

communities need. We're looking at data sources, you know, working with local hospitals and county health districts, you know, other related data if you don't have access to, you know, a WSU study like ours or something like that. And then really leveraging your professional expertise as,

Somebody that works in the NICU or a social worker, early learning space or, you know, foster parents, something like that. And also how to build credibility before you really have a track record. That's where we started is, you know, we had anecdotal data. We knew that there was a problem, but.

We didn't have a good way to prove it, so we hope you guys will join us for that. The hopefully. Oh, looks like Emma dropped the link to that next session in the chat, so be sure to register for that. Again, we do have.

SC **Shaun Cross** 1:29:53

And one thing I'll oh, I just want.

KT **Katie Tolley** 1:29:54

A different question, little bit different questions for you guys. So even if you did register for this one and you answered questions, we we hate to press you for all of that information, but it helps us get you connected and figure out where our strengths are, where we need to to help support you elsewhere.

SC **Shaun Cross** 1:30:09

And then one last thing too, remember we will be sending out. So for those that have received the emails and we've got the clusters and you've got the groups and everything, please try to meet virtually or otherwise prior to September 17th, which is a week before the next webinar.

Will be.

Sending out a form and hopefully you can provide some information and feedback to us as far as how those meetings went. Was a leader appointed? Are you leaning towards affiliation or independent or whatever you're thinking? So we'll get out a form by the end of this week.

Right, Katie, that'll kind of go to everyone and if you can get that back to us by September 17th, that would be really helpful because then we can cover some of what you provide us, some of that information for that. Also we'll be asking you.

KT **Katie Tolley** 1:30:50

Yep.

SC **Shaun Cross** 1:31:06

In that form, we can put it for state and local political connections, because we want you to start really talking about that and thinking about that. If you don't have any, that's OK. But if you do have them, and I sense there'll be a lot more people that have local and state connections than have federal connections, that would be, it'd be good to know that. So anyway, thank you all so.

So much just thrilled to have so many people around the country that have a heart for this issue and for this population and for these innocent infants and for their

parents. And we just really, really appreciate you a lot and look forward to the next one. So I hope you just have a wonderful. Evening and a wonderful rest of your week. Thanks so much. Have a great Labor Day.

 **Katie Tolley** 1:31:49
Take care.

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