OVERVIEW

The following tabs are available for all providers to share the pieces that are unique and important to their field of practice within early intervention.
I'm
The content collected here will be shared with the team at the state level as they want to know from you the nuances of providing services as each provider type.

We will always communicate with you around when we pull this content to share with the CDEC team!

-Mari & Meredith

If you are not already a part of the Facebook group, please join us here: https://www.facebook.com/share/g/18v3efTPZ3/

This is where information is being shared, ideas are being generated, and general support is happening. We'd love to have you!

Medicaid Considerations

Please post any nuances to Medicaid billing here. This includes information you'd like the state to consider when considering cost containment strategies

-support disciplines (like lcsws) that could potentially bill medicaid with the credentialing process. The process could also help apply with rae's that serve rural/underserved communities for providers to serve through telehealth

As CDEC collaborates with HCPF, we could look at credentialing LPCs/LCSWs with medicaid and utilizing the 6-visit offering that is funded by HCPF to off-set some of the cost of keeping SE/DI on a plan.

For children that have significant needs they are often accessing services through multiple service delivery methods. For example, I have children that receive services through a medical model and bill medicaid, and then also receive EI services billed through state funding. I want to ensure that those families still have the ability to receive services through multiple modalities when needed. YES - I have had families who see a clinic based OT billing their Medicaid and then also get OT through EI… which of course, EI provider could not bill Medicaid as well.

- I would make another point that this puts EI at risk on budget as we can't bill medicaid and insurance if another provider already is. I think it is confusing for families and children to have multiple providers and parents should choose to take EI or not. If they want to private pay for other therapies then fine but let EI keep the funding as should be. Im seeing a child now who gets 6 different therapies a week all at her daycare. She isn't getting benefit to her daycare time with 3 times speech, 2 OT and 2 PT and family isn't present to follow through.

CDEC and HCPF assistance with billing accurately for independent contractors and EI Brokers

Information and guidance on the operational framework of the TEAM EI CO concerning OT, PT, SLP, and other disciplines. It is important to clarify who will be responsible for coaching families on outcomes outside their specific areas of expertise, which may not be accommodated within the current PAR structure. This situation could lead to providers having to divide their time between Medicaid-funded services and the time they need to bill to the state, potentially resulting in a greater expenditure of state funds, rather than enabling all team members to bill under distinct PARs.

If a child has Medicaid, I know EI Colorado doesn't want it to look like those Children are getting more services than a child without Medicaid, but why try to limit to one provider if they would benefit from say OT and ST weekly? If EI Colorado isn't paying for the service and a child needs multiple services - I would hope it wouldn't be limited.

If a child has Medicaid and the family and PT wants to do 5 units a week or 75 minutes that should be allowed on the IFSP. It can make a big difference in reimbursement.

How do we allow for services that can bill medicaid in specific circumstances, but can't bill medicaid in other circumstances?

Please post any nuances to Medicaid billing here. This includes information you'd like the state to consider when considering cost containment strategies

When we talk about co-treats with Medicaid we need to remember that Medicaid will not pay two providers in one visit.

Also, we need to look at medical necessity. The family can't continue with services just because they want to. The child will need to have a delay otherwise Medicaid will pull back the money from the provider that is treating when there is not medical necessity.

OT Thoughts

Please post any nuances to being an OT provider here. This includes information you'd like the state to consider when considering cost containment strategies

Identification of Children for EI

- Parents and physicians need more education on how development and learning intersect.
    - Too many parents and physicians focus only on discrete developmental skills (number of steps, stacking blocks, etc.) without consideration of how subtle language, social, and cognitive development impact group learning readiness.
    - ASQ encourages this as only discrete skills are emphasized.
    - EI qualification thresholds should be more sensitive to learning readiness. For example, it might take only a 10-15% delay in language, cognition, and socialization for a child to struggle in group learning.
    - Deferring support for children who are drifting from developmental competency costs more in the long run. When we wait for children to be "disabled enough," we are facing a much bigger problem than if we support children at the onset of challenges.
    - Given that 90% of brain development occurs in the first 5 years of life, every day matters.
- Developmental milestones may indicate good development but are not necessarily predictors of group learning readiness.
    - Childhood disability has changed post-COVID. We now see more behavioral and mental health impacts versus a physical "developmental delay".
    - Children may pass developmental screenings yet struggle significantly in group learning because of dysregulation.
- Developmental support needs to be more visible and accessible for a range of diverse family contexts.
    - We have parents who are diagnosed with serious mental health disorders, neurodiverse, English-language learners, and living in poverty.
    - How do we create an EI system that adequately serves diverse families?
- Early childhood education centers (ECECs) need consistent access to developmental specialists to help teachers, administrators, and parents interpret children's development and share information with parents.
    - Families are increasingly diverse and dual-income.
    - When EI was conceived, children were cared for at home by their parents.
    - Now, most children spend 40-50 hours in ECEC/group child care contexts.
    - We must be nimble and pivot service delivery to account for children's reality.

Intake Process for EI

- The intake process should adopt more of a patient-navigator model. Focus on finding the children most likely to benefit from the EI model and offering choices to families who do not qualify for EI or whose needs might exceed the EI Model.
    - This could be accomplished through a decision-making tree, an infographic with pros and cons of each setting, or other mechanisms.

Please post any nuances to being an OT provider here. This includes information you'd like the state to consider when considering cost containment strategies

- What seems most important is supporting children early through an appropriate machanism, be that EI or other practice settings.
    - When families do not qualify for EI, are they being referred elsewhere to settings with more options to qualify children (home health, outpatient, etc)?
    - We need improved surveillance of young children's development during the early childhood years. Parents, physicians, and ECEC staff are not finding children with subtle developmental delays that impact group learning adequately. A study by McManus et al. (2020) found that only 18% of eligible children were referred to EI from a major pediatric practice in the Denver Metro area. White children from middle to upper-class families with physical delays were most likely to be referred, representing a disparity between White and non-WHite families of means.
        - McManus, B. M., Richardson, Z., Schenkman, M., Murphy, N. J., Everhart, R. M., Hambidge, S., & Morrato, E. (2020). Child characteristics and early intervention referral and receipt of services: a retrospective cohort study. *BMC Pediatrics*, *20*(1), 84–84. https://doi.org/10.1186/s12887-020-1965-x

EI Intervention

- Inefficiencies in delivering EI services arise from poor family support strategies, the prevalence of families requesting EI services in ECECs, and systemic challenges among practice settings and across disciplines.
- Providers and ECECs want a more streamlined process for hosting EI providers within ECECs and more involvement from parents when children are served in the ECEC context.
    - Providers are reporting that as much as 80% of their caseload is seen in ECECs. Some report having no contact with families to coordinate care.
    - ECEC report 7-8 different EI providers coming to their center each day. This is very inefficient and disruptive ot center operations, and providers have a range of skills in working in classrooms.
    - Can we consider assigning EI providers to ECEC with multiple children? Fyffe (2024) offers an example of this through the Occupational Therapy Embedded in Early Childhood (OTEEC) Partnership Model.
        - Fyffe, L. (2024). Occupational therapy embedded in early childhood education (OTEEC): Developing a population-focused, place-based approach to early intervention through occupational therapy and early childhood education center partnerships. *Journal of Occupational Therapy, Schools & Early Intervention*, 1–21. https://doi.org/10.1080/19411243.2024.2442915

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- Providers want more resources to address familial health, especially parental mental health.
    - Can we normalize assessing parent mental health as an aspect of EI evaluation? Undiagnosed/treated parental mental health impacts children's development and progress within a parent coaching model.
    - Individual providers are finding ways to justify remaining involved with a child when there is a delay in accessing other disciplines, especially when parent mental health is a factor.
- Could there be a workforce incentive for providers accepting evening and weekend appointments?
    - Because families are working multiple jobs, we see more families requesting evening and weekend appointments. These families tend to be lower SES/BIPOC. These children sit on the waiting list longer because fewer providers offer weekend/evening appointments.
        - Can we offer an incentive for providers to accept evening/weekend appointments?
- Do we understand why families choose multiple treatment contexts (i.e., Ei for OT, outpatient for PT, etc.)? How can we better coordinate care across multiple practice settings?

EI Transition

- Providers think it is important to recognize the diverse needs of children and the different developmental trajectories they may take.
- Families who need full-time care but have a child with an IEP may decline the IEP to secure a preschool/ECEC slot with full-time care.
- Providers want options for families who cannot enroll their child in district preschool yet still need support.
- Extended EI is important for many families, and OT wants this option to remain in place.

Concerns with Team-Based EI (TBEI)

- TBEI needs to be explained to providers in a positive, strength-oriented manner. We are fortunate that so much work was done to build out TBEI given our current situation- providers need to understand what TBEI is and is not.
    - Providers need assurances that they are acting legally, ethically, and within their scope.
    - TBEI needs to be framed as "an option" for children who are appropriate for this model.
    - Providers need assurances that they will have paid, dedicated collaboration time with other professionals.

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- Providers need examples of how this model has been successful in other States and countries.

PT Thoughts

Please post any nuances to being a PT provider here. This includes information you'd like the state to consider when considering cost containment strategies

SLP Thoughts

Please post any nuances to being an SLP provider here. This includes information you'd like the state to consider when considering cost containment strategies

I think I collaborate with almost every type of discipline - ASL teachers, nutrition, AT consultant, DI, SE….I think having reduced ability to add these services to IFSPs would really, really impact my ability to feel like a competent SLP. We sometimes have enough knowledge of one of these areas to get by (i.e some early signs) but are reliant on more skilled colleagues when there is a greater need (i.e. permanent hearing loss).

(could also fall under "Medicaid" tab) - Reducing the SLP Medicaid stipend will negatively impact both providers as well as low-income families. If providers are being reimbursed at a significantly lower rate for Medicaid-funded families, they will be less likely to pick up these families, creating a longer waitlist for those who are funded by Medicaid. Providers who currently have a high caseload of Medicaid-funded families will have their income significantly impacted, possibly to a point where they will need to find work elsewhere, impacting provider retention, and potentially causing even longer waitlists for all families due to reduced number of providers available. In addition, Medicaid reimburses SLPs for an hour of therapy at a significantly lower rate than they reimburse OTs and PTs, since SLPs use an un-timed code. The Medicaid stipend is necessary to account for this large discrepancy in reimbursement rates.

SE Thoughts

Please post any nuances to being a social-emotional provider here. This includes information you'd like the state to consider when considering cost containment strategies

The state offered grants for providers to be trained to support the mental health of families (infant family specialist) because this is a needed service. The majority of my families are needing the social emotional approach to DI. The state has seen this is a need which is why the grants and retention grants have been offered so why would they reduce a service that was targeted as a specified need?

Often there are SE-based needs within a household that are sustaining behaviors or needs that have been picked up in EI. Social Emotional providers are able to capture both specific behavioral needs while also supporting the parent/caregiver within the household. This includes elements such as trauma (attachment-based, birth loss, natural disasters, medical trauma, etc.), but also support in intergenerational parenting within one household, etc. Without these stabilizing supports, other interventions are happening in a vacuum.

Licensed mental Health providers can bill insurance.

The only intervention endorsed by the American academy of pediatrics for adhd in children under 4 is parent coaching. This is a service that many SE providers can offer

SE providers are often well versed in family psychosocial dynamics. SEs are uniquely qualified to support families when they are presented with birth trauma, grief over diagnoses, and challenging behaviors. This is especially true in the face of generational trauma. It's hard to take in new information when you feel like you are drowning. SEs can help buoy parents so they are better able to support their children

SE providers navigate parental mental health struggles and crises, by making referrals and knowing what referrals to make for parents who need higher level support (inpatient, substance abuse treatment, clinic based therapy, medication management etc). SE therapists are often a mental health lifeline.

Many families are at very high risk of perinatal mood disorders (PPD/PPA) after a traumatic birth, NICU stay, or significant medical diagnosis for their infant. SE providers are often the only provider in home supporting and checking on attachment, bonding and mental and physical health of the parent. Without that in home support many families would fall through the cracks and not get the support they need, and infant outcomes would suffer.

It would be best practice if SE services were only provided by a licensed mental health therapist. This is a highly skilled service and requires the same amount of education as (ST, OT and PT) yet EI allows other disciplines that do not have the education, training or licensure to provide this service. It is concerning from a liability standpoint but also minimizes and devalues the education and professional licensure of mental health professionals.

DI Thoughts

Please post any nuances to being a DI provider here. This includes information you'd like the state to consider when considering cost containment strategies

As an ECSE, this past month has really caused me to reflect on how my training and expertise is or is not valued by the state. It seems that CDEC was ready to significantly impact the livelihood of a multitude of providers with 6 days notice. My caseload would have been reduced by 70%. It's wonderful that there seems to be a solution for 25-26, but that doesn't really change the reality that we the department charged with supporting EI and EI providers fundamentally does not understand the work we do. It is disheartening. The state talks about provider retention, but it feels like only some providers and I'm really wondering what my next move should be career-wise because EI doesn't feel safe.

The above statement is very valid. It would be great if collaboration with providers could be ongoing and part of the CDEC's regular practice.

Providers who can bill medicaid often work for home health agencies that require new assessments every 3-4 weeks and other regular paperwork. DI's do not have that requirement and are able to go to a session and devote the entire session to working on goals or whatever the family's current concerns are. This factor would allow us to have more time for the family in a primary provider model.

DI's often create visual supports and other teaching tools specific to the family's needs that are not reimbursed. We are also not reimbursed for time that we write reports or research topics that may also be unique to us because we aren't working in a larger agency.

Other providers do not have the in-depth training in the areas of early cognitive development and behaviors as the collective group of all of the teachers. There isn't another provider who can focus on preschool readiness in the same way as a teacher.

It might be beneficial to review the Personnel Standards for DI and then be able to speak to why a teacher is uniquely qualified to provide the things listed.

I believe an ECSE can be especially helpful to families when a child is transitioning into Part B services and preparing for life in a preschool classroom.

Developmental Interventionists are ideal for the primary service model since we have general knowledge of all areas and strategies for all areas of development. We are often great at learning those skills like joint engagement and regulation that helps the SLP, PT or OT do their job as well.

ECSE's are in a unique position to work with children who have needs in multiple areas. We are trained to see the child holistically, and come from a play based and routines based perspective. We have specific skills in scaffolding learning, and teaching parents how to scaffold their child's learning to the next step.

Currently, it is a struggle to find mentor teachers for candidates in ECSE programs, especially for the Birth-3 practicum and especially over the summer semester. The proposed changes and

even the primary provider model have the potential to negatively impact the future workforce in Early Intervention.

Teachers work on social relatedness, school readiness, attention and emotional regulation which are essential to being in a classroom setting. Teachers help children with social skills, relationships with peers and teachers and having tools needed to navigate a half day without their parent. They also focus on cognitive skills like memory, following structured activities and conceptual learning. These areas might be touched on by other providers, but are not explicitly taught and monitored in the same way as a teacher. Our job is to help these little ones grow and develop and be ready for preschool and if they do not have support from teachers they will not be ready. This will increase the burden on school districts to make up for areas that were allowed in EI, but not provided.

It seems like teachers are taking the brunt of the responsibility to help balance the budget because we are the providers targeted who cannot bill medicaid. Instead of lessening needed services for children, we could explore other areas such as making sure anyone who can bill medicaid is, and possibly finding ways for ECSE's to be able to bill for SE or cognitive services.

It would be great to be able to explore Family Centered Models of service delivery to ensure that the child's needs are prioritized over medicaid allowances.

Added 3/29/25: Early Intervention providers are a self-selected population of those who are committed to make a positive impact for children and their families. Providers do not enter this field simply to make money nor are they volunteers. Rather, providing services is our passion AND our livelihood. The abrupt announcement of severe cost saving measures in late February demonstrated a callous disregard for not only children and families but also for providers. EI and CDEC then laid blame on evaluators and providers over qualifying children and overspending rather than taking responsibility for their own spending, lack of planning, and lack of foresight. A JBC member created a model that laid out anticipated increases in referrals following the pandemic. Why did EI and CDEC not do this? Were there no cost saving measures to consider within the EI and CDEC offices rather than solely cutting direct services? Perhaps reducing training and outside consulting costs. The immediate budget crisis has been resolved by the JBC. An ongoing concern is how the primary provider approach is being implemented. I support the transdisciplinary teaming as an accepted practice that I have participated in for years. As far as the Colorado EI model, transdisciplinary teaming is an extension of the EI approach of coaching and collaborating with parents presented in our initial training. My concern is how the primary provider model will be implemented. It has been said that some children with higher needs may warrant more than one service provider. What criteria will be used to determine this? If a primary provider is agreed upon, some families may need more than one visit per week by that provider. Will this individualization be allowed? I am equally concerned how the primary provider approach will impact providers. It is ironic that this model is being funded through Workforce to support recruitment and retention while disregarding the impact on the EI

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workforce, the providers. Many providers are independent contractors who do not receive vacation or sick leave and are not compensated when families cancel appointments. The impact of this is providers tightly scheduling appointments to provide services and maintain an adequate income. How will the complex scheduling of the teaming appointments be managed in a way that providers can fill their schedule and receive fair compensation? The initial primary provider videos do not address these practicalities. Both parents and providers deserve better.

Nutrition Thoughts

Please post any nuances to being a Nutrition provider here. This includes information you'd like the state to consider when considering cost containment strategies

Registered Dietitians play a crucial and often under-recognized role in Early Intervention. Nutrition is not an isolated concern - it impacts every domain of development, from communication and motor skills to behavior and cognition. When nutrition is compromised, progress in other domains can be delayed.

Dietitians in EI support children with feeding difficulties, food allergies, growth concerns, gastrointestinal issues, and more. We work together with feeding therapists to ensure a child's nutritional needs are met, which often leads to better outcomes. Without dietitians, many families may not receive the guidance they need to navigate feeding difficulties or medically complex nutrition concerns.

Additionally, It's not ethical (or legal) for non-nutrition providers to give medical nutrition therapy as it's a highly nuanced field, and acts of harm can be unintentionally committed even by the most well-intentioned therapists.

As Dietitians we get to help families and providers with so much peace of mind. We are able to decipher between a small child who has a consistent growth pattern and a child who's growth pattern is not meeting standards. When a child is not growing or meeting their nutritional needs, it can not only affect their developmental milestones, but it can drastically affect cognitive and brain development as well as health outcomes. A child who is not meeting their nutritional needs is more likely to be admitted to the hospital more or have more pediatrician visits due to poor immune health.

I take special pride in being a part of the Early Intervention team of providers as I have witnessed toddlers who are chronically constipated, struggling with sleep, weight and some really hard behaviors see a 180 in therapy when we help the family resolve the constipation. Families whole lives can be affected by an infant screaming with reflux, not sleeping, not latching properly and without a dietitian to help with breastfeeding, infant formula assessment, gastrointestinal assessment and feeding routine evaluation, that family may lose precious months of sleep, delays in motor milestones as well as some of these infants develop such sensitive emetic reflexes they vomit up large percentages of their meals and growth issues can be eminent.

We also provide unique skills that would be out of other therapist's scope to evaluate the nutritional status of a severely selective eater due to potential sensory processing disorder, autism spectrum disorder, severe food intolerances or other cognitive delays. It provides family and other feeding therapists a sense of relief to be able to have a dietitian to help establish meal content and routines that give families ease that their child is getting enough while they work on more slow developing skills of building in a wider variety and texture (which dietitians can also support).

No other therapy or provider should be giving Enteral Nutrition feeding advice to these families, so the kiddos who are getting feeding therapy via Early Intervention should also be getting some consults via a Dietitian as we are the clinicians best suited legally to manipulate a feeding rate,

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volume and assess Nutritional quality of the feedings. This is such a HUGE aspect in Early Intervention as we get a lot of referrals to help support feeding therapists with weaning a child from a tube. This is not a service easily found in clinics or available inpatient care. Most families find themselves having to guess and we can provide reassurance and a safe environment to help families meet their feeding goals on the IFSP.

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Audiology/Hearing Thoughts

Please post any nuances to being an Audiology or Hearing Support provider here. This includes information you'd like the state to consider when considering cost containment strategies

AT Consultant Thoughts

Please post any nuances to being an AT Consultant here. This includes information you'd like the state to consider when considering cost containment strategies

I don't know how the budget currently works to support the purchase of AT Devices. I know there is another group at work that is developing more of a protocol on what can be purchased and what cannot in the area of AT devices. I'm concerned about how items will be purchased for a child… was this figured into the projections of increased caseload?

I am concerned that if a child has ST one time per week and AT for 60 minutes 1 x month. Will one of the ST visits have to be eliminated in order to provide the AT time for that week? It seems certain services that often occur less frequently (nutrition, AT) should be able to occur in a week without having to eliminate a session for another service in the same week.

How do we ensure that AT consultants continue to have the option of co-treating with other service providers? If an AT is an SLP by training but also asked to bring a stander, walker, or gait trainer, then they should be co-treating with the PT to help ensure the AT equipment it set up appropriately. Or if an AT is a PT by training but also asked to bring a speech-generating device, then they should be co-treating with an SLP to trial SGDs and set up appropriately.

How do we ensure that AT Consultants have the flexibility to support the child, family, and team members? If AT consultants are limited to 1x/month, they are not able to immediately meet and troubleshoot if there is a problem when a new device is dropped off?

How do we accommodate for the extra time spent by AT consultants picking up equipment, setting up equipment, and dropping off equipment? AT Consultants spend time setting a chair or gait trainer. AT Consultants customize vocabulary on speech-generating devices and write AAC funding reports, as well as following up with doctors to get paperwork signed. AT consultants also spend extra time driving between clients and may be in multiple brokers because it is a specialized service. As an AT Consultant, I don't have the option to do telehealth if I I need to bring equipment to trial with children or be in person to model and problem solve with the team. I have spoken with other therapists who do not want to become AT Consultants because of the extra time commitment that is unpaid.

How do we ensure we do not lose the specialized training and knowledge that AT Consultants (and dietitians, and TVIs, and hearing providers, and ECSEs, etc.) bring to our teams? AT Consultants (like many of the other therapists) have specialized training and knowledge. For example, as an AAC Consultant I know about the different hardware/devices that are currently available; I know about the different communication apps/software available; I know about the different language systems available and on what communication apps and/or hardware/devices; I know how to modify different apps and language systems to meet a child's specific needs (including vision and hearing differences); I know about alternate access methods and how to modify different access methods to meet a child's specific needs; I know about the funding hierarchy and how to work with the SGD manufacturers to go through private insurance and/or Medicaid to fund devices; I know how to write a very strong AAC eval; I know how to brainstorm alternate funding methods when insurance/medicaid is not an option; I know how to train other people on how to use the device in everyday life, as well as how to customize

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the device to meet a child's needs. Each specialty in EI brings so much knowledge of their field. We need to make sure these skills aren't lost to budget cuts or forgotten in TEAM EI CO.

Vision Thoughts

Please post any nuances to being a Vision provider here. This includes information you'd like the state to consider when considering cost containment strategies

Psychology Thoughts

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Service Coordinator Thoughts

Please post any nuances to being a service provider here. This includes information you'd like the state to consider when considering cost containment strategies

I'm writing this as a provider - not a service coordinator. Service coordinators ARE in fact making changes to plans currently even while the state is saying no services will change. They're talking families into less services, to selecting a primary provider model (when we haven't been trained in our EIB yet) and to reducing minutes. Some of this is just based on their personalities, some of this is based on our EI Director giving unclear direction on what to do. EI Colorado needs to re-iterate to directors and service coordinators - do not change how we've been doing things right now until we know for certain which cost containment strategies will in fact happen.

Rural/Underserved Community Thoughts

Please post any nuances to being a provider in or rural or underserved Colorado regions here. This includes information you'd like the state to consider when considering cost containment strategies

I understand the elimination of travel affects all providers (non Medicaid and Medicaid) the same and so it's an impact on all providers which can make it seem like a fair cost savings. And it sounds like this cost containment is already a done deal. Each community and area has its strengths and challenges and when you apply blanket solutions for the whole state - it's going to impact different areas in unique ways. The picture of having a long bench with three children standing on it to peer over a fence to watch a baseball game is one that comes to mind. They all have the same bench to stand on so it's equal… but two children are shorter and can't see over the fence. That is what happens to rural and frontier areas when these policies are made based on how things work in metropolitan areas. We have very few providers in the NE CO frontier and rural areas. At this time I know of 5 providers that provide in-person services across 9 counties. We have accessed many telehealth providers which has been incredible. And we have a couple providers who live in the front range who come out to the NE CO area and utilize a hybrid model. For our children who have vision and hearing diagnoses we utilize front range providers who drive out to the nine counties. I know telehealth can be accessed for many services and supports, but others are simply not as effective. The cost of time and mileage will just be passed on to providers who are still willing to travel. EI Colorado continues to tell us out here that telehealth is just as effective, it's a coaching model, we don't need to be in-person and that it's evidence based. I don't doubt the outcomes are reached in a similar manner but there are relationship aspects to coaching as well and there is a culture, particularly in the rural and frontier communities that places a high value on some in-person contact.

More families have been traveling to the metro area to receive therapy than ever before seeking in-person services.

We have PCPs who won't refer if they think a family is only going to receive telehealth services. Education will need to be done in this arena.

For rural and frontier areas, early intervention providers are often the only providers or therapists that are able to work with the families. There is a lack of pediatric interventionists, nutrition and certainly vision and hearing providers in our small communities. Consider that there are not other programs for therapy generally in our small towns (with some exceptions.)... and so what EI offers should be rich and deep.

Not having travel, not having some small reimbursement for no-shows for treatments and IFSP meetings will certainly be hard to recruit someone into as a provider. Those of us who are invested will likely continue, but it's hard to recruit someone into that.

Not having travel/mileage will make it difficult to recruit and keep providers with specialized skills that cannot be done over telehealth. As an AT Consultant, I don't have the option to do telehealth because I need to bring equipment to trial with children.

Please post any nuances to being a provider in or rural or underserved Colorado regions here. This includes information you'd like the state to consider when considering cost containment strategies

EI providers often collaborate with preschools, childcare centers, home visiting programs, and healthcare professionals to support young children. With service reductions, these community partners may struggle to address developmental concerns.

Childcare centers and preschools may have more children with unidentified or untreated developmental delays, increasing challenges in classroom management and requiring additional support that may not be available.

Rural school districts, which already have limited special education resources, may see an increase in students requiring intensive intervention later due to missed EI opportunities.

Without consistent EI services, families may feel isolated and unsupported, particularly in rural areas where alternative resources are scarce. Parents may struggle with increased emotional stress, as they attempt to manage their child's developmental needs without professional support.

Families may relocate to urban areas in search of better services, further depleting rural communities of young families and reducing local economic growth.

EI already requires a high level of specialization, flexibility, and compassion. Without competitive compensation or supports, rural EI roles are less attractive to professionals.

While we recognize that telehealth is an effective and evidence-based service delivery method, many families and referral partners (like pediatricians and childcare providers) still view in-person services as the gold standard. Some families may not have reliable internet, private space, or the confidence to engage in virtual services. Community partners may hesitate to refer families for telehealth, believing virtual visits are less personal or effective. As a result, local, in-person EI providers remain essential, especially during times of policy transition. Without mileage reimbursement, providers may limit their service radius.

Please post any nuances to being a provider in or rural or underserved Colorado regions here. This includes information you'd like the state to consider when considering cost containment strategies

Thank you in advance for considering keeping mileage reimbursement in the budget. ECSEs and DIs play a vital role in all of Colorado, but with special attention to our rural Colorado. ECSE/DI often fills gaps when SLPs, OTs, PTs, and SEs are unavailable. As contractors, we are usually not reimbursed for mandatory meetings, lesson prep, and other responsibilities. While we are deeply committed to the children and families we serve, budget cuts affecting mileage reimbursement could create further hardship. Travel is a necessary part of service delivery in these communities. This burden can be compounded when providers drive long distances *50+miles for a single visit (*example only; some families could be more that 100+ from the CCB) only to experience a no-show, another budget consideration. This results in wasted time, fuel costs, and lost opportunities to serve other children.

Having mileage reimbursement helps to ease **some** of the financial strain of travel. It also ensures that providers can continue to serve rural communities effectively in person and without added financial stress. However, it's important to note that mileage reimbursement only covers the cost of gas, not wear and tear on vehicles, tires, or maintenance, which are additional costs that providers must absorb. *(While $.65/mile is little compared to the ever-rising gas prices currently at $3.19/gallon, at least it is something.) As a small sample of March so far, with only eight families seen 2 times/week this month, I have driven over 700 miles so far.* **Again, thank you for the consideration.**

Catch-All

If you have thoughts that do not fit into the other categories, please share them here!

- What steps are being taken to recruit and retain providers, if the work force initiatives are the first on the chopping block?
- Why are they not requesting more funding to improve provider retention, if this has been an ongoing issue?
- If a bilingual provider is saving the state money because no interpreter is needed, why are these sessions (or meetings for SCs) not reimbursed at a higher rate?

When families enter EI they are repeatedly told that everything is family driven, they are at the forefront, etc…so I can see how they would be confused or feel surprised if all of a sudden discharge is being strongly suggested, without them bringing it up first. I think there should be some thought put into the language used if there will be clearer guidelines for discharge, or if it is something we as providers need to be more cognizant of when children are approaching age expected skills. As a provider, I don't know what options a family would have through their broker (I also contract with several brokers, so the options could vary) so if we had some options to present, perhaps we could discuss discharge with more confidence and more frequently.

It has been SO encouraging to see caregivers and families get involved and want information about advocacy, who to contact, etc. Could there be a family group, list serv, or some way to provide a summary of this information to all families who enter the program, so they can feel proactive and get involved if they would like to?

Seems like all the brokers have different language around telehealth and offering it as an option to families - maybe some consistent messaging about use of telehealth would help families consider it as an option?

The cost of the referral and intake staff/care navigators is too high! Local programs can provide this service in a more effective way at a lower cost. Instead of having families call the local program to make a referral to the state, the care navigators can call the families to get consent and schedule the evaluation. The family is then contacted by the local evaluating entity to complete the evaluation. After that, the care navigators call the families again to discuss their options for communicating with EI and then send them back to the local program to be assigned a service coordinator who will develop the IFSP. LOOK AT THE TIME FRAME; it can take families WEEKS to get a service coordinator assigned due to the back and forth, and look at how many families "fall through the cracks."

As I recall, CCB's were given the option to do the intake and eval - many opted out.

CDEC should be "in network" with private insurance on top of trust dollars so that the contacting brokers can bill all insurance types including TRICARE. Or at least HELP the brokers figure out how to get in network.

SLP Stipend for Medicaid funded services should be cut

If you have thoughts that do not fit into the other categories, please share them here!

Alternate opinion - many SLPs won't pick up Medicaid funded children because reimbursement is poor, and the stipend is one of the few reasons some people choose to work with Medicaid children

EI Colorado and the CDEC really have their work cut out for them to repair trust with referral sources, families, providers, service coordinators and directors. It will be worth the effort to package the final product of what can truly be offered in EI clearly in a variety of formats to referral sources and families.

If EI CO goes with a 1 session per week model, there has to be a waiver process that is quick and responsive to making allowances for a child with unique needs.

At some point the Workforce Retention and Recruitment group needs to show if they made a difference. At first I applauded the direct funds to providers as bonuses - now I wonder if that was wise at all? Did it make a difference? Did providers remain longer because of those? The changes they made did they actually improve retention and recruitment rates?
Bonuses - nice for sure - were they effective at retention?
SLP Stipend - likely a positive
No Show Rate - 1 unit - unsure if it was effective
Travel - hadn't been decided
Team EI CO - was it really to help providers? How did this come out of this committee?
Unfortunately - we don't know the impact of what was done in this committee. And if positive movement was made - where? Which areas? And unfortunately, now the efforts have likely been undone.

I've been a provider 30+ years - even clear back to the day of each CCB (now EIB) writing grants for what their specific community needed. I don't think Colorado would be willing to go back to this much local control. But, it was a wonderful thing. Each community has such awareness of what they need, what they don't need and how they could best utilize resources. Maybe there's a way to incorporate some of this local involvement in making decisions in a direct manner?

From a parent: What skills or resources will my child miss or lose out on if they don't have all of the different therapists providing different services, information, training, and skills? How will know what is needed if I don't have different therapists sharing information and guiding me while I teach my child?

Please share with us the mentality of allowing SLPA's to see kids under the supervision of an SLP when we have capable ECSE aka DI's who could fill that role. As an ECSE we were required to take masters level classes in all 5 areas of development focusing on Birth to 5 . Language Acquisition in young children, Speech and Language disorders to name a few.

Even though things are supposed to be happening as per usual, there are 2 call outs for DI on our provider request log. SLPAs are often entering their names for these services even though

If you have thoughts that do not fit into the other categories, please share them here!

our area has plenty of DI providers. At this point, I am actively looking for other work. I don't trust EI Colorado or CDEC and feel that taking a wait and see approach is foolish. This doesn't seem like a great way to foster provider retention which is supposed to be a priority.

I would like to examine the underlying data. What do the provider/brokerage demographics entail? Specifically, how many DI's, ST's, OT's, PT's, SC's, etc., are there? Furthermore, how many of these professionals are contracted versus employed by a broker? It is challenging to assess the actual impact without concrete numbers to provide perspective.

After listening to the JBC, I found it disheartening that there wasn't a reliable metric to measure the anticipated caseload growth in the coming years. How is this possible? While I understand that predicting growth with absolute certainty is impossible, there should always have been a method to gather these projections.

Nevertheless, I remain optimistic that with the right data and metrics, we can better understand and prepare for future growth.

I did not realize the provider calls had changed times for 4.2.25; so I apologize for the message after the fact. It looks like CHP+ and private insurance billing was on the agenda for today. My concerns around insurance are provider retention. Many of us are individual contractors whom do not have time to take on lengthy insurance battles. Therefore, many will leave EI if forced to start doing both additional instances. Would it be possible for the state to contract with a billing company that the providers could choose to use (and pay for the service)? EI should also consider bringing in trainers for billing those insurances on a webinar platform to assist providers in effectively moving forward. As providers, we are in this work for the kids and don't have a lot of extra time to painstakingly shuffle through each insurance to figure out how to apply to be a provider and each billing platform. So by providing the training and the option to pay someone reputable to bill for us, the EI program would have the optimal chances of provider retention if they make everyone bill private insurances. Also how does this apply to those insurances who pay into the trust? All of those situations are complicated and hard to navigate as businesses of one, which many of us are.

One area to look at is payment to all those servicing children. In my area basically everyone gets paid the same rate. If they were in another sector education, healthcare etc some would be paid less than others based off need, current job market etc.

Put the evaluations back in the hands locally so can coordinate those with IFSP and reduce time families have to service. This also provides more cohesive experience and allows the providers involved to make better recommendations for services and times.

Want more consistency from state on how items should be done. For example the Global outcomes and what is required, all the areas are getting muddled together, some use family assessment and other dont. Then writing service time can be discussed if more beneficial to write weekly or twice a month or better compliance and flexibility if writing a lump sum of visits. Then you aren't out of compliance if child needs to vary in frequency

TEAM EI CO

Information and guidance on the operational framework of the TEAM EI CO concerning OT, PT, SLP, and other disciplines. It is important to clarify who will be responsible for coaching families on outcomes outside their specific areas of expertise, which may not be accommodated within the current PAR structure. This situation could lead to providers having to divide their time between Medicaid-funded services and the time they need to bill to the state, potentially resulting in a greater expenditure of state funds, rather than enabling all team members to bill under distinct PARs.

It's going to be very challenging for the department to try to market and package TEAM EI CO as a potentially better way of service delivery to reduce the number of professional people in a child and family's life now that it is completely seen by families and providers as merely a cost saving effort only.

How are providers going to be paid for cross training and consultation time with each other?

If the IFSP service page says OT 1 x week x 60 minutes and that page is like a physician's script - then that service should occur 1 x week x 60 minutes - every week (except for illness, etc, of course). How is it okay to not do OT 1 time one week so for example the AT consultant can see them or the RD, etc.?

How will providers be taught how to team? How will brokers deal with employed therapists vs. contractors when referrals are to be distributed in a team, to ensure contracted therapists are getting enough children to make a living? I do not see how this will work with a mix of contracted providers and employed providers. Also, as a full time provider, I am uninterested in taking on additional duties such as assigning referrals or spending likely unpaid time discussing a family that will not even end up on my caseload.

How much money has been spent on rolling out the primary provider model?

The timing of everything is so unfortunate-If EI plans to move to a Primary Provider model this looks so similar to what they just suggested and back tracked on-Credibility will be ruined with families, community, doctors etc. It was already going to be an extremely hard sell, but now it seems improbable. Primary provider model has not historically been effective and most families and providers are opposed to this model. It only works in certain situations, with children who need very low level support and not with contract workers (which many providers are and want to continue to be). Imagine being a parent of a medically fragile infant and being told your Speech therapist will provide "coaching/support"' in place of the PT, OT and SE therapist. Most families will move on from EI I would imagine.

Are the same folks at the state who made the horrible error in judgement in late February and turned the program upside down also the ones pushing the primary provider model?

(from OT) Concerns with Team-Based EI (TBEI)

- TBEI needs to be explained to providers in a positive, strength-oriented manner. We are fortunate that so much work was done to build out TBEI given our current situation- providers need to understand what TBEI is and is not.
    - Providers need assurances that they are acting legally, ethically, and within their scope.
    - TBEI needs to be framed as “an option” for children who are appropriate for this model.
    - Providers need assurances that they will have paid, dedicated collaboration time with other professionals.
    - Providers need examples of how this model has been successful in other States and countries.
- Concerns about therapy assistants working in the TEAM model under the licenses of other providers. Assistants are great at what they do within their training, but I am concerned that the TEAM model requires more extensive training and knowledge and would it be appropriate for assistants to do this work.

Evaluations and Eligibility

There is talk about the over identification of children. Perhaps this is the case? But, I see often that this is just said, assumed, not studied or data collected to make sure this is happening. I am a provider and an evaluation entity owner. The one issue that has been raised as a potential cost savings is that perhaps children are identified by having a delay in fine motor only. I have not found that to be the case at all in our evaluation entity geographic area. I use the IDA and DAYC and just by switching to another tool, we don't know that fine motor delay identification would change? Too many strategies are just tried out without data being really gathered or known for sure. Our state really needs to study the data before making a decision on changing tools. As evaluation entities we had a group that originally identified the IDA as being a preferred tool due to the social emotional areas being more extensive? Now that we've actually used the DAYC - I don't think that just because we said 3 years ago we think the IDA would be better that we would make the same decision today. I know I would prefer to stay with the DAYC to complete evaluations.

There seems to be 2 standards. Evaluation Entities are asked to provide central locations, to accommodate families that desire an in-person evaluation saying that families should have that in-person service if that is their request. For ongoing services EI Colorado has separate messaging - that if a family declines telehealth then they're refusing EI.

Many times a child on paper looks like he qualified in fine motor. But the evaluator may see some red flags in the other areas snd then the fact that the child qualified in Fine motor circumvents the Evaluator from having to use informed opinion.

I know we try really hard not to use informed opinion when ever possible. We do share with the parents that at the IFSP dev, this is a good time to share that fine motor is not their primary concern but ____ is.

-When the data is looked at, is there a greater number of children qualifying for EI per year since pre COVID?

-Is there a greater percentage of children who are evaluated that qualify when compared to the previous evaluation process? Are more children getting evaluated?

- -With the use of the DayC, is a higher percentage of children qualifying by area (eg, fine motor, communication) or by age group (eg, infants) than they did before the DayC was used?

-Is there a way to look at the number of kids who would have qualified, had standard scores with the DAYC been used as the measure to qualify instead of age equivalents?

I will not be able to be on evaluation session next week so hope this gets passed on. I see point suggesting that virtual evals lead to higher number qualifying. Do we have any data to reflect this? As an evaluator I disagree. It is the same set of questions and often I get more information from seeing them exploring their home environment that coming to a room with strangers. There are just as many children that one could say performs better virtually as in person. If they are shy may need more parent report in person as they won't try the activity or use their voice but do when at home with parents. We let families know what to have handy prior to the evaluation and I often feel virtual was a better representation.

We need to stop letting families request in home evaluations. There are in person at a location or virtual which can cover anyone. The only exception would be area where dont have internet access or a car prohibiting them from participating either way. Going to homes is more expense in time and mileage for evaluators.

4/15

If you look at the 23/24 performance of each CCB.

Under Indicators 5 and 6. The State calculates how many children should be in EI services and then looks at the actual percent of kids receiving services. So the data shows that based on the state's own calculations- we have too few kiddos that we should be serving. Here's an example.

helped the family:				
A. Know their rights	92.00%	**97.98%**	96.96%	96.88%
B. Effectively communicate their children's needs	94.00%	**95.96%**	95.89%	97.28%
C. Help their children develop and learn	94.00%	**97.98%**	96.17%	97.12%
Additional reporting information below which does *not* affect your programs determination				
INDICATOR 5: Percent of infants and toddlers birth to 1 with IFSPs that are expected to be served in this catchment area compared to the number of children birth to 1 in this catchment area.	2.15%	**0.86%**	0.92%	0.81%
INDICATOR 6: Percent of infants and toddlers birth to 3 with IFSPs that are expected to be served in this catchment area compared to the number of children birth to 3 in this catchment area.	4.90%	**4.53%**	4.11%	3.73%
State Summary of EIB Program Performance in FFY:	Programs are awarded up to an additional 5 points for receiving a score of 90% or greater for compliance indicators. A&I Avenues received a total 33 out of 55 possible points.			
EIB Comments:				

Tab 18

Tab 19