Modeling the Cost of Early Intervention in Illinois:

Analysis and Recommendations

Prepared by Afton Partners for the Illinois Department of Human Services – Division of Early Childhood

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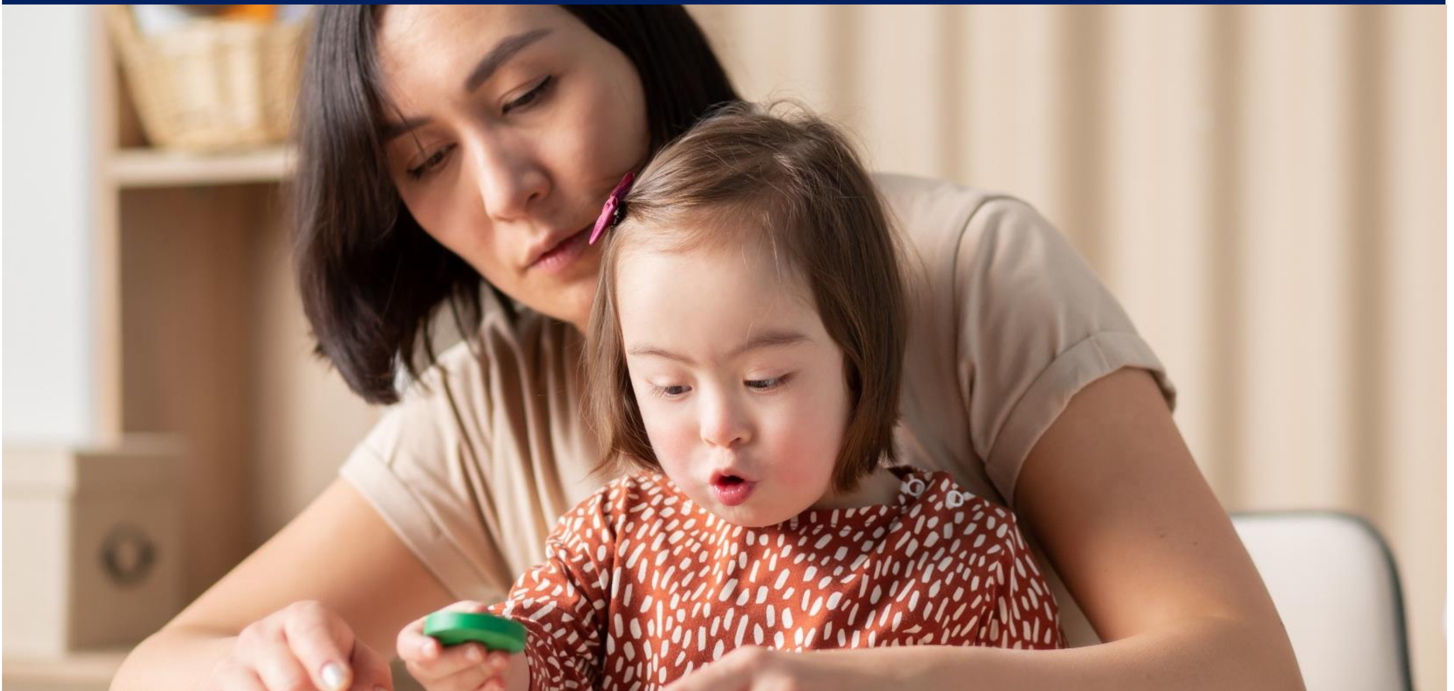

JB Pritzker, *Governor*

Dulce M. Quintero, *Secretary Designate*

20 December 2024

Greetings,

In February 2023, Governor JB Pritzker announced Smart Start Illinois. This multi-year initiative aims to ensure equitable access to early childhood services by eliminating preschool deserts, increasing funding for child care providers, expanding home visiting and Early Intervention supports, and more. Smart Start Illinois is the next step in achieving Governor Pritzker's vision for ensuring Illinois is the best state in the nation for families raising young children.

The IDHS Division of Early Childhood commissioned this cost model study to better understand the decline of Early Intervention providers in Illinois and to quantify what it will take to expand the supply of providers. The result is the cost model below, informed by surveys and focus groups with thousands of Illinois early childhood community members.

This model has given us a stronger sense of direction, and we acknowledge there is always more work to do. There are a few areas we need to examine. These include enhancing a person-centered approach to improving Early Intervention, addressing systemic challenges faced by Early Intervention providers, navigating Medicaid and private insurance billing, equitable implementation factors, and more. IDHS and the new Department of Early Childhood will work together to advance a thoughtful and appropriate recommendation for service improvement.

The State of Illinois remains committed to a practice of transparent, honest dialogue with families, providers, advocates, and others in the field. We share this cost model in that spirit, acknowledging the work that remains.

IDHS, in collaboration with the upcoming inaugural Secretary of the Illinois Department of Early Childhood, Dr. Teresa Ramos, will first focus on the development and design phase to find an equitable approach to improving the accessibility and timeliness of Early Intervention services.

In partnership,

Dulce M. Quintero
Secretary Designate
Illinois Department of Human Services

Contents

Executive Summary....3
Introduction....6
  Project Scope and Timeline....6
  IICEI Workforce Workgroup....7
Background....8
  Current State and Context....8
  Early Intervention Structure in Illinois....10
  Early Intervention Funding....11
Research and Findings....14
  Access to Services....14
  Input from Families and Early Intervention Practitioners....21
  Cost and Payment Reform Survey....32
  Time Use Study....38
Cost Model....47
  Salaries and Compensation....48
  Translating Cost Inputs into Cost Per Service....50
  Comparison of Costs to Current Rates....53
  CFCs and Service Coordination....54
  Statewide Costs....57
  Enhancement for Underserved Areas and Increased Children Served....57
  Pilot Programs....58
Payment Reform Recommendations....58
  Recommendation 1: Make progress toward aligning base pay and grants to real costs....59
  Recommendation 2: Consider layering on additional incentives to reach under-served communities and multilingual families....61
  Recommendation 3: Pilot other structural changes that need further exploration....63
Conclusion....65
Appendices....66
  Appendix A: IICEI Workforce Workgroup Membership....66
  Appendix B: Service Delay Regional Breakdowns by Race and Ethnicity....67
  Appendix C: Provider Focus Group Protocol & Attendance....69
  Appendix D: Family Focus Group Protocol....71

Appendix E: Illinois Early Intervention Cost Survey 72
Appendix F: Median EI Non-Personnel Costs by Specialty 86
Appendix G: Time Use Study for Early Intervention 87

Executive Summary

Early Intervention (EI) services play a crucial role in supporting young children in Illinois by serving infants and toddlers from birth to 36 months experiencing or at risk of developmental delays or disabilities and their families. EI is a federal entitlement program covering 16 core services including speech, physical, occupational, developmental, and other therapies, plus service coordination. The goals of EI services are to enhance child development, build family capacity, and minimize future need for special education services. Studies have shown that EI services can change a child's developmental trajectory, leading to better outcomes in various domains, and can reduce the need for future special education services.[1]

Illinois has made strides in its EI system, including a 10% rate increase to all EI service providers in State Fiscal Year (SFY) 2024, and is often recognized as a leader in the field.[2] However, in recent years, Illinois, like many other states, has struggled to meet the needs of all families and children in EI or those who could qualify for and benefit from the service. Since SFY 2018, EI caseloads in Illinois have risen 5.6%, while the workforce has shrunk by 6.6%. During the same time, service delays have almost doubled, with 8.8% of children and families experiencing service delays as of May 2024 (of over 24,000 children with active Individualized Family Service Plans that month). Intake delays, defined as cases where the child has not received an evaluation and service plan within 45 days, have increased from roughly 0% to 7.6%.

Recognizing the urgency of improving the family experience and reducing delays, the Illinois Department of Human Services (IDHS) commissioned Afton Partners (Afton) to develop a cost model to understand the full cost of the EI system and propose recommendations for payment reform to improve the family experience. The cost model is a flexible tool that can be used to estimate the cost to provide services in different scenarios. While a cost model can inform policy decisions by estimating the cost of those decisions, it cannot provide a holistic picture of what families want, the costs, benefits, and tradeoffs of a decision, or the judgement and insight of policymakers. A cost model is not a budget or funding allocation.

The purpose of this report is to describe the cost model as well as the revenue levers that can help to progress toward the modeled cost of services. These revenue levers can include the various sources of funding available to most states of Early Intervention: federal IDEA Part C, Medicaid, State General Revenue, county tax levies, state special education funds, private insurance, and private co-pay.

This work started as Illinois Governor JB Pritzker announced the intent to create a new Department of Early Childhood to create a simpler, better, fairer early childhood system for parents and families. The work was completed as PA 103-0594, the enacting legislation for the Illinois Department of Early Childhood (IDEC), was being passed by the Illinois General Assembly. As such, this report focuses on the current Early Intervention program and does not discuss future connection to other early childhood state programs and systems or the new capacity to reimagine early childhood in Illinois.

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[1] "The Importance of Early Intervention for Infants and Toddlers with Disabilities and their Families." *The National Early Childhood Technical Assistance,* July, 2011. https://ectacenter.org/~pdfs/pubs/importanceofearlyintervention.pdf.

[2] "2022 Prenatal-to-3 State Policy Roadmap." *Prenatal-to-3 Policy Impact Center,* n.d. https://pn3policy.org/pn-3-state-policy-roadmap-2022/us/early-intervention/.

This work to support the EI system contributes to Governor JB Pritzker's Smart Start Illinois initiative, which makes a commitment to reach young children and vulnerable families with early support. The Illinois Department of Human Services can use this report and cost model, alongside other research into other states' best practices, to continue implementation of Smart Start Early Intervention in Illinois.

Over the past year, Afton has conducted research, focus groups, and surveys to better understand the system challenges. This process has included over 1,300 engagements with EI practitioners and families. Findings from practitioners and families include:

- The EI system is struggling to recruit and retain practitioners who are often severely under-compensated for their field, with current rates at approximately half of what would be required to cover the full cost of delivering EI services. The lack of competitive wages, among other challenges, serve as a barrier for providers to work in EI.
- Direct service providers rely on fee-for-service billing that does not fully cover the overhead costs of delivering services, outside of the time spent directly providing therapy. On average, 36% of providers' time is billable, meaning that they spend nearly two hours preparing for, traveling to, and documenting appointments for each hour spent with the child. Additionally, approximately 20% of appointments are cancelled and not rescheduled. Current rates do not fully cover the costs associated with this non-billable time.
- Caseloads for service coordinators are too high, with an average caseload of 65 compared to Illinois' recommended caseload of 45,[3] which makes it difficult for families to access services and hinders the timeliness and accuracy of payment authorizations. Given the significant responsibilities,[4] service coordinator salaries are insufficient to attract and retain staff.
- Infants and toddlers outside of Cook and the Collar counties, and Black infants and toddlers, face disparities in access to services, both in receipt of services and in service delays.
- Families report frustration with service delays, long waitlists, and difficulty communicating with their service coordinators. However, those that are receiving services are generally very satisfied with the quality of their providers and the services their child has received.

After listening to practitioners and families, and using data from practitioners to construct the cost model, the following recommendations were developed to address the major concerns raised:

1. **To improve recruitment and retention, ultimately increasing families' access to services, rates for direct services and Child and Family Connections (CFC) Office grants should make progress towards aligning to the modeled cost of service delivery.** The state should consider available revenue levers to make progress toward this goal and should develop a multi-year implementation plan and strategy to bring rates and grants more in line with actual cost.

   a. Direct service payment rates need to be increased to move compensation closer to the labor market and rates need to cover the full cost and time required to provide services. Depending on the providers' discipline, the modeled cost of service delivery translates into a rate of between $127 and $199 for an hour of direct services, compared to current rates of $65 to $101 per hour of direct

[3] "Special Education - EI Child & Family Connections (25-444-84-2880-01)." *Illinois Department of Human Services,* April 26, 2024. https://www.dhs.state.il.us/page.aspx?item=160835

[4] "Illinois Early Intervention Provider Handbook." *Illinois Department of Human Services,* July 2022. https://providerconnections.org/wp-content/uploads/2022/05/Final-DRAFT-Provider-Handbook-R07-2022.pdf

services. Overall, direct service rates need to increase by an average of 95% over current rates to fully cover providers' costs and time. Statewide, this level of rate increase is estimated to cost approximately $150 million annually. The rates reflected in the cost model would bring Illinois' rates in line with EI rates in other states with a similar cost of living.

b. CFC grants should be modified to make progress towards reflecting the real costs of providing timely services, including adequate staffing, and set minimum Service Coordinator salaries that are competitive for roles with similar credentials. These changes would require the average grant size for a CFC to increase from approximately $2.3 million to approximately $3 million per year. The statewide cost of this increase is estimated at approximately $18.4 million annually, in addition to the $150 million for rate increase noted above.

c. In service of the above recommendation, the State should partner across agencies to maximize federal revenues, private insurance coverage, and Medicaid reimbursements for Early Intervention, now and as EI transitions to IDEC. This should include peer state analysis, evaluation of capacity throughout the field to complete billing, and development of a plan to strengthen that capacity. This work should be done in partnership with other state agencies and alongside efforts to strengthen Medicaid billing practices in other services.

2. **To support equitable access to EI services, the state should consider layering additional financial incentives to promote service delivery in underserved areas and to expand the multilingual provider workforce.** Service delays are disproportionately concentrated in rural areas with few providers; enhanced payment rates can encourage providers to travel longer distances to reach families in these areas. Additionally, because families typically prefer services provided in their home language, multilingual providers should be incentivized to offer these services through higher rates and/or recruitment bonuses or stipends. Payment changes should be coupled with training and support, such as reflective supervision,[5] to support providers in meeting families where they are. This approach should be developed and implemented in alignment with the forthcoming transition to the Illinois Department of Early Childhood, which is centering families with special needs and the providers that serve them.

3. **IDHS Division of Early Childhood (DEC) should pilot other structural changes that need further exploration to improve the attractiveness of the EI field,** including Grow Your Own[6] programs to provide a pathway for community members to join the EI field, alternative employment structures to support new providers through salaried roles, mentorship and coaching opportunities that allow for experienced EI providers to use their expertise to support other providers, benefits pools that allow EI providers to access health and retirement benefits, and improvements to billing to make

[5] Reflective Supervision is regular collaborative meetings between a professional that provides services to families and young children (clinical, intervention, early educator, etc.) and a trained Reflective Supervision provider. They meet to reflect and build skills, using the provider's thoughts, feelings, and values and how they apply within the context of providing services. (Kansas Association for Infant and Early Childhood Mental Health).

[6] Grow Your Own is an umbrella term that describes the many and dynamic, community-driven, equity-centered, holistic approaches designed to help communities support, strengthen, and sustain a well-qualified, experienced, and diverse ECE workforce by nurturing the talents that exist within it and removing barriers to entering and staying in the field. (National Early Care and Education Workforce Center).

the process easier for providers, including through technological innovations. This should be done in partnership with and through the IDEC Transition Advisory Committee Workgroups on Funding Design, Data, Insights, and Analysis, Workforce, and Intermediary Alignment.

As Illinois transitions toward the new Department of Early Childhood, there will be numerous opportunities to work across systems to improve services for children with developmental delays and their families. This includes opportunities to better coordinate across EI and Early Childhood Special Education, which serves children three and older. The two systems not only serve many of the same families, but also share many professionals who work in both systems during their careers. To more fully understand equity in timely access to EI services and to identify how rectify inequities through investments, policy changes, and other levers, the State should analyze service data across Early Intervention for infants and toddlers and Early Childhood Special Education for preschoolers and early elementary school students.

To make the changes necessary to meet the needs of all children and families, the State will need to make a significant investment in the EI workforce, addressing both immediate needs and planning for long-term changes that support high-quality, accessible services for Illinois' families.

Introduction

In State Fiscal Year (SFY) 2024, the Illinois Department of Human Services' Division of Early Childhood (IDHS-DEC) partnered with Afton Partners (Afton) to develop a cost model for Illinois' Early Intervention (EI) system and propose recommendations for payment reform. Over one year, the project team developed a cost model and recommendations informed by analyzing existing data, carrying out community engagement, and conducting a cost survey and time use study. The following report will detail the process and findings, share the results of the cost model, and propose recommendations for payment reform.

Project Scope and Timeline

Afton and the IDHS-DEC Early Intervention Bureau, with input from the Workforce Workgroup of the Illinois Interagency Council on Early Intervention (IICEI), established the following goals for the project:

- **Understand the full cost of the EI System,** including direct services, service coordination, and infrastructure through development of a cost model.
- **Develop recommendations for a payment structure** that will:
    - Improve the family experience and access to services,
    - Improve recruitment and retention of EI providers,
    - Incentivize activities that improve the family experience, including training, collaboration, and smooth transitions between services, and
    - Incentivize serving historically marginalized communities and populations.

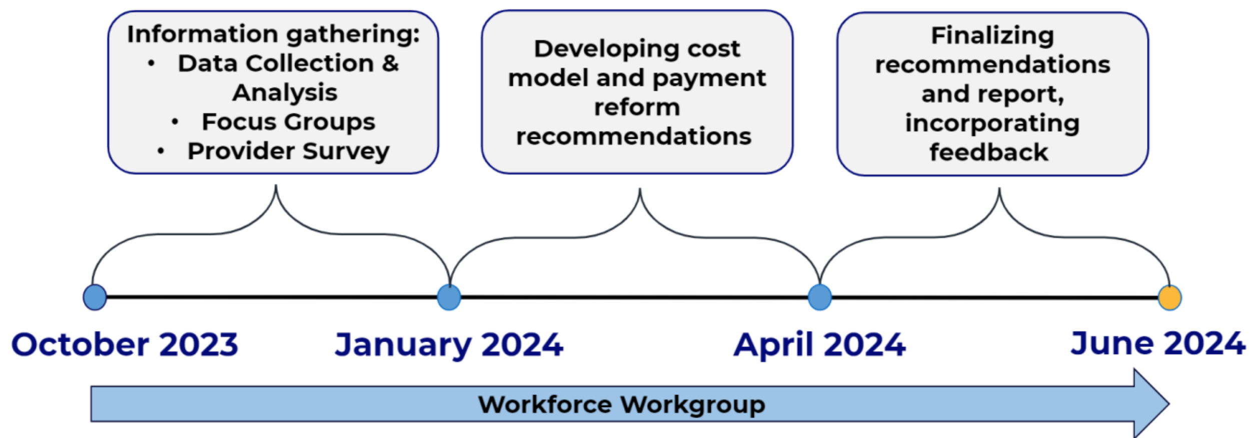
In addition to the goals, a set of guiding principles were developed with support from the Workforce Workgroup. These guidelines helped to center all contributors in the approach to the work and establish a shared foundation for decision-making:

- We are guided by the voices of providers, families, and children. Their experiences with the EI system make them experts.

- We seek out perspectives from communities with the most barriers to accessing sufficient, timely, and culturally and linguistically responsive EI services.
- We partner with trusted messengers to meet families and providers where they are. We provide translation, flexible meeting hours, simplified language, and other accommodations as needed.
- We ground decisions in research, evidence, and data.
- We embrace innovation while being actionable and realistic.
- Decisions are grounded in equity and focus on the needs and priorities of historically marginalized children, families, providers, and communities.

The project was completed in three phases detailed below in Figure 1:

Figure 1



IICEI Workforce Workgroup

The cost modeling and payment reform project has also been supported by the IICEI Workforce Workgroup. This group was convened to advise IDHS-DEC on workforce recruitment and retention strategies, including support and collaboration in developing payment reform recommendations. The group met monthly beginning in November 2023, with Afton leading sessions approximately every other month. The role of the group included:

**ECEC: Early Childhood Education and Care*

The Workforce Workgroup (Workgroup) co-chairs selected a group of EI professionals and system stakeholders that were representative of the field. This included various direct service providers, CFC staff, interpreters, advocates, and EI parents (full membership list is included in Appendix A).

The Workgroup meetings covered a variety of topics, including coming to a shared understanding of system challenges and discussing potential payment reform solutions. Their input and feedback were critical in developing payment reform recommendations.

Background

This project builds on many years of work that identified challenges with payment rates and mechanisms in the Early Intervention system. In 2019-21, the Early Childhood Education and Care Funding Commission's (Commission) Inclusion Working Group identified a number of challenges for families and providers, including gaps in service coordination and transitions across services, heavy administrative burden on providers, issues with timing of payments to CFCs and inconsistent provider payments, and difficulty finding services in rural and underserved areas.[7] The Commission's report noted that some of these challenges may stem, at least in part, from existing funding mechanisms. The Commission ultimately recommended further study and engagement with the field to develop more detailed recommendations.

Many of the challenges described in the Commission's report were only exacerbated by the Covid-19 pandemic and continue to persist. The following section gives a brief description of the existing system as context.

Current State and Context

Illinois has been recognized as a state leader in EI and has taken various steps to increase access and quality of the system. Notably, Illinois draws EI funding from multiple sources, including Medicaid, and has also expanded its eligibility criteria to include "at risk" infants and toddlers. Illinois's eligibility criteria are considered "moderate" compared to other states based on the number of risk factors it recognizes. However, across states, eligibility criteria are not strongly correlated with children served.[8] As of 2021, Illinois served approximately 4% of children under three based on a point-in-time count,[9] or 9.4% cumulatively over the course of a year, ranking 14th in the country based on percentage of children served.[10] There is not a national consensus on the percentage of children who need EI services, but many experts believe that more children can benefit than currently receive services. The states that

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[7] "Commission Report of Findings and Recommendations." *Illinois Commission on Equitable Early Childhood Education and Care Funding,* Spring 2021. https://oecd.illinois.gov/content/dam/soi/en/web/oecd/documents/early-childhood-funding-commission-full-report.pdf.

[8] Infant Toddler Coordinating Association, "Percentage of all children under the age of one receiving services by Eligibility," November 2023. https://www.ideainfanttoddler.org/pdf/2022-Child-Count-Data-Charts.pdf

[9] "Optimized Early Intervention." *Raising Illinois,* n.d. https://www.raisingillinois.org/high-quality-learning/optimized-early-intervention/.

[10] "2022 Prenatal-to-3 State Policy Roadmap." *Prenatal-to-3 Policy Impact Center,* n.d. https://pn3policy.org/pn-3-state-policy-roadmap-2022/us/early-intervention/

serve the highest percentage of children in EI are Massachusetts, which serves 10.4% of children based on a point-in-time count, and New Mexico, which serves 11.2% at a point in time.[11] Nationally, white children are more likely to access EI services than Black children.[12]

In Illinois there are disparities across the state in children's access to EI services, particularly for children in rural areas. Children in downstate Illinois make up 29% of children receiving EI services, which is similar to their percentage of the overall population of children under three, but they experience 37% of service delays. More than a quarter (27%) of ZIP codes in rural areas serve a much lower percentage of children in EI than the state average. Children in high-poverty ZIP codes are slightly less likely to receive EI services, although the correlation is weak.

With regards to racial disparities in access to EI, Black children are less likely to receive EI services: they make up 16% of the population under three and 14% of children receiving EI services. However, these disparities vary at the regional level. For instance, 30% of children under three in Chicago are Black, but Black children make up only 25% of children receiving EI services. Families of color have also reported disparities in their experiences with EI, such as having providers who share their language or cultural background. More information on these disparities is discussed in the "Research and Findings" section, and breakdowns of children served and service delays by race/ethnicity and region are provided in Appendix B.

Illinois is among a minority of states that charge family fees, although they were suspended during the pandemic. In July 2023, the state increased EI reimbursement rates by 10% through Smart Start Illinois State General Revenue funding and provided one-time bonus payments of up to $1,300 to EI Service Providers and Service Coordinators, funded through the American Rescue Plan Act (ARPA).[13]

Despite the forward momentum, Illinois, along with 12 other states, has been categorized as a state that "Needs Assistance" by the US Department of Education for failing to meet requirements for more than two consecutive years.[14] Illinois' Annual Performance Report for the period of July 2022 through June 2023 indicated that the state is not meeting various required standards, including the timely provision of services, early childhood outcomes, and planning for children transitioning to Early Childhood Special Education.[15]

The unmet indicators reflect access challenges for families and children and are closely tied to practitioner shortages. Since SFY 2018, caseloads in Illinois have risen more than 5%, while the workforce has shrunk more than 6%, resulting in increasing service delays for children and families. Furthermore, EI providers receive significantly lower wages than comparable roles in other settings such as private practices or schools. In 2023, Illinois providers had an average annual take home

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[11] U.S. Department of Education, "Number and percent of infants and toddlers receiving early intervention services under IDEA, Part C, by age and state," 2022-23. https://www.ed.gov/grants-and-programs/special-population-grants/students-with-disabilities/idea-section-618-data-products-static-files#partc-cc

[12] U.S. Department of Education, Office of Special Education Programs, "OSEP Fast Facts: Infants and Toddlers with Disabilities," June 24, 2020, https://sites.ed.gov/idea/osep-fast-facts-infants-and-toddlers-with-disabilities-20/.

[13] "Pritzker Administration Invests in Early Childhood with Early Intervention Incentive Payments." *Illinois Department of Human Services,* July 25, 2023. https://www2.illinois.gov/IISNews/26757-Pritzker_Administration_Invests_in_Early_Childhood_with_Early_Intervention_Incentive_Payments.pdf.

[14] "2023 Determination Letters on State Implementation of IDEA." *US Department of Education,* June 26, 2023. https://sites.ed.gov/idea/idea-files/2023-determination-letters-on-state-implementation-of-idea/

[15] "Annual Performance Report – Report Period: July 1,2022 – June 30, 2023." Provided by IDHS-DEC in July 2024.

pay ranging from $32,000 to $50,000 after taxes and expenses,[16] far below average wages for therapists and providers with similar credentials working outside the EI system. In Illinois, the average pre-tax annual salary for a Speech Language Pathologist was $87,910[17] and Occupational Therapists had an average pre-tax salary of $96,160.[18] Assuming a 30% reduction for taxes and deductions,[19] this still translates to at least $10,000 (or 20%) more per year than current-take home pay for EI providers.

Early Intervention Structure in Illinois

The Lead Agency for EI services is IDHS-DEC. Across the state, there are 25 Child and Family Connections (CFC) offices, each of which is responsible for coordinating EI services in their assigned region. CFC offices serve as the first stop for families needing EI services and employ Service Coordinators who are assigned to support families through the system.[20] Service Coordinators are responsible for scheduling intake, screenings, evaluations, and assessments; coordinating the development of Individualized Family Service Plans (IFSPs); assisting with provider selection; and developing transition plans, among other duties.[21]

IDHS-DEC has designated the EI Bureau to administer the EI program. The EI Bureau contracts with the following entities for additional support:[22]

- The Central Billing Office (CBO): processes claims for EI services, carries out the Medicaid reimbursement process, and administers the EI Insurance Billing Unit. The CBO also maintains the EI provider database.
- Early Intervention Clearinghouse: provides information and materials on Early Intervention, child development, health, and other related topics to families.
- EI Technical Assistance and Monitoring Program (EITAM): responsible for ensuring that state and federal regulations for service delivery are met. Reviews payees and CFC offices to ensure they follow policies and procedures through reporting and technical assistance.
- Provider Connections: responsible for credentialing and enrollment for providers; maintains and disseminates information and updates for providers.
- Early Intervention Training Program (EITP): provides professional development with the goal of developing a comprehensive system of personnel development for the EI system.

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[16] "Illinois General Assembly Approves Budged Increases for Early Intervention Program." *Zero to Three,* June 15, 2023. https://www.zerotothree.org/resource/illinois-general-assembly-approves-budget-increases-for-early-intervention-program/.

[17] "Occupational Employment and Wage Statistics." *US Bureau of Labor Statistics,* May 2023. https://www.bls.gov/oes/current/oes291127.htm#(2).

[18] "Occupational Employment and Wage Statistics." *US Bureau of Labor Statistics,* May 2023. https://www.bls.gov/oes/current/oes291122.htm#st.

[19] "IRS provides tax inflation adjustments for tax year 2024." *IRS,* November 9, 2023. https://www.irs.gov/newsroom/irs-provides-tax-inflation-adjustments-for-tax-year-2024; "Income Tax Rates." *Illinois Department of Revenue,* https://tax.illinois.gov/research/taxrates/income.html

[20] "Illinois Early Intervention Provider Handbook." *Illinois Department of Human Services,* July 2022. https://providerconnections.org/wp-content/uploads/2022/05/Final-DRAFT-Provider-Handbook-R07-2022.pdf

[21] "The Role of the Service Coordinator in Early Intervention." *Illinois Early Intervention Clearinghouse,* 2020. https://eiclearinghouse.org/blogs/service-coordinator/

[22] "Illinois Early Intervention Provider Handbook." *Illinois Department of Human Services,* July 2022. https://providerconnections.org/wp-content/uploads/2022/05/Final-DRAFT-Provider-Handbook-R07-2022.pdf; "Illinois Interagency Council on Early Intervention (IICEI) Overview & How To Apply." *Illinois Department of Human Services,* n.d. https://www.dhs.state.il.us/page.aspx?item=117789

- Illinois Interagency Council on Early Intervention (IICEI): A federally and state mandated council which advises and assists IDHS-DEC in development, implementation, and evaluation of the EI program. Includes parents of children with disabilities, advocates, and providers in addition to agency and CFC representatives.

Beginning in SFY 26 the EI program is expected to move to the new Illinois Department of Early Childhood.

Early Intervention Funding

EI programs across the country are typically funded by the Individuals with Disabilities Education Act (IDEA) Part C, Medicaid, State General Revenue, county tax levies, state special education funds, private insurance, and private co-pay. In Illinois, the majority of EI funding comes from Illinois' general revenue fund, followed by Medicaid reimbursement. IDEA Part C and family fees are relatively small revenue sources. In SFY 2025, 71% of total EI funding comes from the general revenue fund and 18% comes from Medicaid.[23] While EI funding varies widely across states, the Infant and Toddler Coordinators Association 2023 Finance Survey reports that state general revenue funds are the largest single source of funding for EI in the United States.[24] Cross state research has also shown that multiple states have drawn a higher percentage of funding from Medicaid than Illinois, including Massachusetts and New Mexico, which currently serve the highest percentage of children. [25] Based on the most recent monthly statistical report from May 2024, over 48% of children receiving EI services in Illinois have Medicaid and about 39% have private insurance.[26]

Family Fees

In Illinois, monthly family fees are part of the system of EI payments and fees, although service coordination, evaluations and assessments, and IFSPs are federally required to be free of charge. Family fees are on a sliding scale, calculated based on family income in relation to the Federal Poverty Level (FPL). [27] Since 2020, family fees have been temporarily suspended due to the Covid-19 pandemic.[28]

Provider Rates and Billing

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[23] Provided by IDHS-DEC in August 2024.

[24] "2023 ITCA Finance Survey Report." *Infant and Toddler Coordinators Association,* 2023. https://www.ideainfanttoddler.org/pdf/2023-ITCA-Finance-Survey-Results.pdf.

[25] "Legislative Report FY21" *Massachusetts Department of Public Health,* 2021. https://www.mass.gov/lists/public-reporting-for-early-intervention#idea-determinations-; "Annual Outcomes Report: Fiscal Year 2023" *New Mexico Early Childhood Education and Care Department,* April 2024. https://www.nmececd.org/wp-content/uploads/2024/07/Annual-Outcomes_April_16_2024_ECECD_Comms_rev1.pdf.

[26] "Early Intervention Monthly Statistical Report – May 2024." *Illinois Department of Human Services,* May 2024. https://www.dhs.state.il.us/page.aspx?item=164878

[27] "Overview of Early Intervention." *Illinois Department of Human Services,* n.d. https://www.dhs.state.il.us/page.aspx?item=50777#:~:text=The%20Part%20C%20Early%20Intervention%20Program%20in%20Illinois%20is%20federally,from%20HFS%20through%20Medicaid%20reimbursement.

[28] "Memo to Early Intervention Families re: Early Intervention (EI) Family Participation Fee Credit Process." *Illinois Department of Human Services,* January 27, 2022. https://providerconnections.org/wp-content/uploads/2022/02/01-27-22-EI-Family-Fees-Memo.pdf

Most services, including direct therapeutic services, evaluations, assessments, and IFSP development, are billed by the hour in 15-minute increments.[29] A few services, including hearing screenings, medical diagnostic evaluations, outpatient health consultation visits, and optometric exams, receive a flat fee per service.

Direct services are billed on a fee-for-service basis. This includes billing to private insurance as well as billing to other EI funding streams, such as Medicaid, federal, and state funds, through its Central Billing Office (CBO). If a child is covered by private insurance, the provider will bill the private insurance company, then seek additional reimbursement from CBO if the private insurance rate is less than the EI rate. If a child is covered by Medicaid, the services are billed directly to the CBO, which then seeks reimbursement from Medicaid. EI receives an enhanced Medicaid reimbursement rate that is higher than the standard Medicaid rate. For example, Speech Evaluations, Speech Therapy, and Physical Therapy have a standard Medicaid rate of $14.84 per 15-minute unit, but the EI rates pay $16.96 for onsite services and $21.16 for offsite services. All providers must enroll and sign provider agreements with IDHS-DEC, or work under the supervision of a provider who is enrolled (e.g., at a therapy agency).[30]

Many activities are not eligible for billing by direct service providers.[31] Administrative activities such as scheduling appointments, preparing for services, and documenting services are part of providers' overhead and cannot be billed for on their own, but must be covered by revenues from EI reimbursement rates as a cost of doing business. Direct service providers cannot bill for referring a family to other needed resources, attending a medical or other appointment with the family, discussing non-EI issues or concerns with the family, professional training, or canceled appointments.

Child and Family Connections Funding

Intake and service coordination are provided by CFC offices, which are directly funded by IDHS-DEC through a competitive grant process. Since SFY 2019, IDHS-DEC has increased funding for CFC offices from $37 million[32] to $56 million in SFY 2024.[33] Most CFC offices receive between $500,000 to $3 million grants, with some larger grants in more highly populated regions.[34] Some CFCs are also housed within larger medical centers or programs and receive additional revenue from private donations.

The main portion of a CFC's funding covers Service Coordination. This is calculated based on the highest combined average number of children with active IFSPs and intake in any one month in the previous fiscal year in that region. The combined number is divided by 45 to determine the number of funded

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[29] "Early Intervention Provider Information Notice-Rate Increase Effective July 1, 2023." *Illinois Department of Human Services,* June 13, 2023. https://eicbo.files.wordpress.com/2023/06/06-13-23-pin-fy24-rate-increase-.pdf
[30] "Illinois Early Intervention Provider Handbook." *Illinois Department of Human Services,* July 2022. https://providerconnections.org/wp-content/uploads/2022/05/Final-DRAFT-Provider-Handbook-R07-2022.pdf.
[31] "Illinois Early Intervention Provider Handbook." *Illinois Department of Human Services,* July 2022. https://providerconnections.org/wp-content/uploads/2022/05/Final-DRAFT-Provider-Handbook-R07-2022.pdf.
[32] "Special Education-Grants for Infants and Families - Early Intervention - Child and Family Connections." *Illinois Department of Human Services,* n.d. https://omb.illinois.gov/public/gata/csfa/Program.aspx?CSFA=2880.
[33] "Awards: Fiscal Year 24." *Illinois Department of Human Services,* n.d. https://omb.illinois.gov/public/gata/csfa/AwardList.aspx?CSFA=2880
[34] "Awards: Fiscal Year 24." *Illinois Department of Human Services,* n.d. https://omb.illinois.gov/public/gata/csfa/AwardList.aspx?CSFA=2880

Service Coordinators, with each position allocated $68,513 to cover wages and any related administrative or supporting costs. In addition to wages and benefits, these funds must also cover most other CFC staff, such as the CFC Manager and any administrative roles.[35]

CFCs receive some additional funds for operational funding and specific roles. Operational funding is set at 4% of the calculated service coordination base award amount. CFC offices also receive awards for specific roles based on the following calculations, using the highest combined average number of children with active IFSPs and intake in any one month over the previous fiscal year:[36]

- Local Interagency Council Coordination: $20 per case, or a minimum of $22,000 annually
- Parent Liaison Activities: $45 per case, or a minimum of $19,000 annually
- Developmental Pediatrics Consultation: $79.64 per case, or a minimum of $25,000 annually
- Infant Early Childhood Mental Health Consultation: $80 per case, or a minimum of $37,500 annually

Example grant calculations for CFCs of varying sizes are calculated below (amounts are rounded to the nearest thousand):

	Small CFC (300 Cases)	*Medium CFC (850 Cases)*	*Large CFC (2,000 Cases)*
Service Coordination *(Total Caseload/45 *68K)*	$453,000	$1.29 million	$3.02 million
Operational Funding *(4% * Service Coordination Funding)*	$18,000	$52,000	$121,000
Add-Ons for Specific Roles *(LIC Coordinator, Parent Liaison, developmental pediatrics consultation, mental health consultation)*	$104,000	$196,000	$320,000
Total Funding	***$575,000***	***$1.54 million***	***$3.46 million***

Recent Funding Increases

According to information provided by IDHS-DEC, in SFY 2024 the State received $18,695,363 in Part C funding plus an additional $2,400,000 of State Incentive Grant funds from the federal government due to EI's expanded eligibility for children who turn three over the summer and qualify for an Individual Education Plan (IEP).[37] Illinois' SFY 2024 budget allocated an additional $40 million in state general revenue funds to EI through the Governor's Smart Start initiative. This increase in funding was used, in part, to provide a 10% increase in provider rates, effective July 1, 2023.[38] While there have been smaller

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[35] "Special Education - EI Child & Family Connections (25-444-84-2880-01)." *Illinois Department of Human Services,* April 26, 2024. https://www.dhs.state.il.us/page.aspx?item=160835

[36] "Special Education - EI Child & Family Connections (25-444-84-2880-01)." *Illinois Department of Human Services,* April 26, 2024. https://www.dhs.state.il.us/page.aspx?item=160835

[37] Provided by IDHS-DEC in July 2024.

[38] "Pritzker Administration Invests in Early Childhood with Early Intervention Incentive Payments." *Illinois Department of Human Services,* July 25, 2023. https://www2.illinois.gov/IISNews/26757-Pritzker_Administration_Invests_in_Early_Childhood_with_Early_Intervention_Incentive_Payments.pdf.

increases, including in 2019, the 10% change is the most significant rate increase in the past 20 years.[39] However, Start Early Illinois, an early childhood advocacy organization, found that rates would need to be increased 30% just to account for inflation since 2004.[40] The EI system also changed CFC funding in SFY 2024, both by increasing award amounts and guaranteeing funding for the full year, which has made it easier for CFCs to plan for staffing and provides more stability. Previously, CFC funding amounts varied during the year based on fluctuations in caseload. In SFY 2025, the State has allocated an additional $6 million towards EI.

In 2023, Illinois also announced EI incentive payments, which provided one-time bonus payments of up to $1,300 to Service Providers and Service Coordinators who work with infants and toddlers. These bonuses are also included in the SFY 2024 budget and are funded through ARPA.[41]

Research and Findings

Access to Services

Key Findings

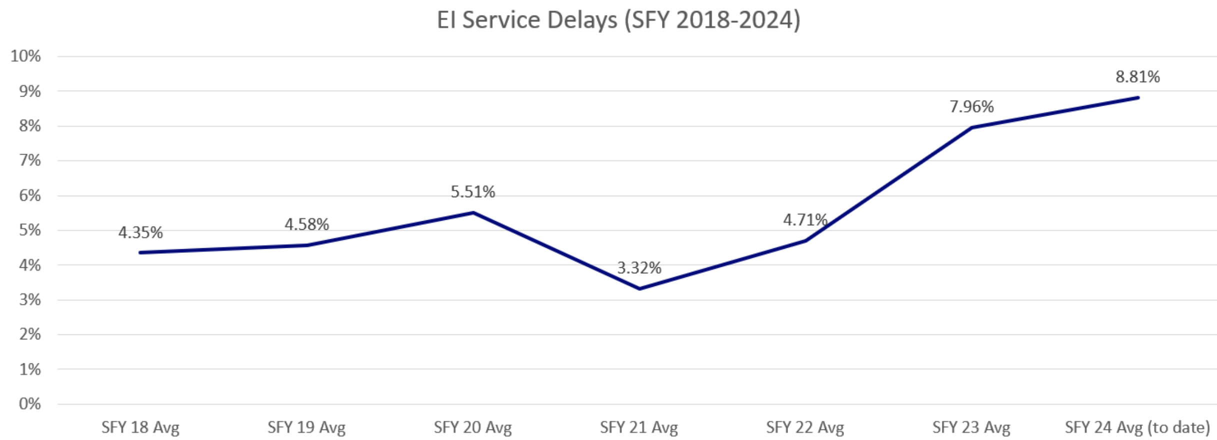
- Service delays have almost doubled since 2018, with an average of 8.8% of children and families experiencing service delays in SFY 2024 (through May 2024). Intake delays have increased from roughly 0% to 7.6%.
- Children in downstate Illinois, who make up 29% of children receiving EI services, experience 37% of the delays.
- Black and African American children are less likely to receive EI services than white children: Black children make up 16% of the population under 3, and 14% of the EI population. Black children are more likely to experience service delays, making up 18% of children experiencing delays.
- Virtual services differ widely across the state. Children in high poverty ZIP codes are nearly twice as likely to receive services virtually as those in low poverty ZIP codes, and the discrepancy is especially large in ZIP codes with the most children in deep poverty (under 50% FPL). Children in rural areas are less likely to receive services virtually than the state average.
- The number of active EI providers has declined by 6.6% since 2018, while active cases have increased by 5.6%.
- As of June 2023, the average caseload was approximately 65 cases per service coordinator, significantly above the recommended caseload of 45.

[39] "More Than Essential: Reimbursement Rates and the True Value of Human Services." *Illinois Partners for Human Service,* April 2021. https://issuu.com/lwrightilphs/docs/more_than_essential2021_rates_report_final_p_/16.
[40] "Lack of funding makes some Early Intervention professionals ponder career shifts." *Cook County Chronicle,* May 21, 2024. https://chronicleillinois.com/news/cook-county-news/lack-of-funding-makes-some-early-intervention-professionals-ponder-careeer-shifts/.
[41] Pritzker Administration Invests in Early Childhood with Early Intervention Incentive Payments." *Illinois Department of Human Services,* July 25, 2023. https://www2.illinois.gov/IISNews/26757-Pritzker_Administration_Invests_in_Early_Childhood_with_Early_Intervention_Incentive_Payments.pdf

Service Delays (Early Intervention Bureau)

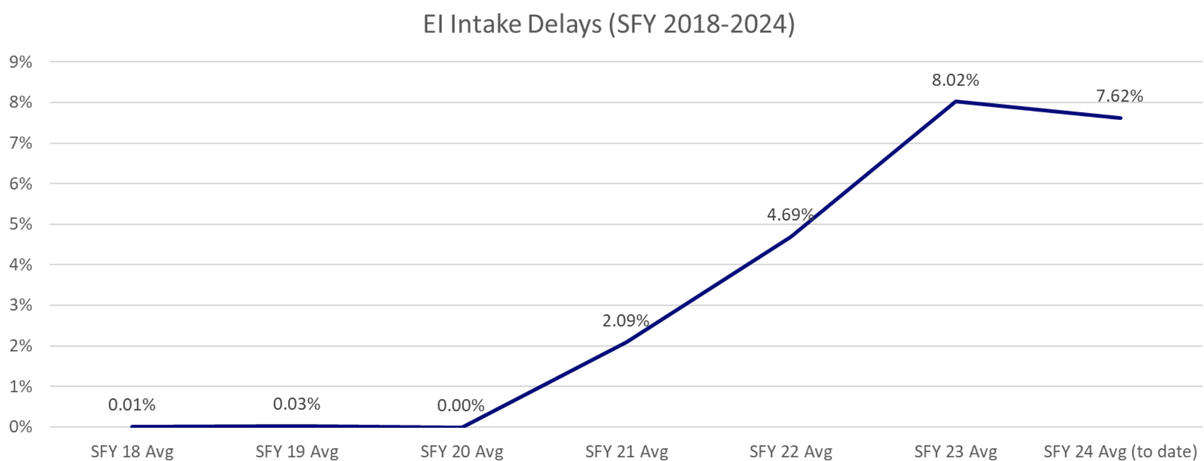
One of the growing challenges in Illinois' EI system is the increase in service delays. In Illinois' Annual Performance Report for SFY 2023, the indicators for timely provision of services and 45-day timeline for intake were not met. Service delays occur when a child is not receiving at least one service in their IFSP or is receiving services less frequently than their IFSP calls for, whether due to a provider or family reason. Service delays have doubled since 2018, with 8.8% of children and families experiencing service delays in SFY 2024 (through May 2024), as seen in Figure 2. Intake delays, which happen when a child does not receive their initial evaluation, assessment and IFSP within 45 days, were almost non-existent in 2018 and are now at 7.6%, as shown in Figure 3.

Figure 2



**SFY 24 Average includes the average percentage of service delays from July 2023 to May 2024.*

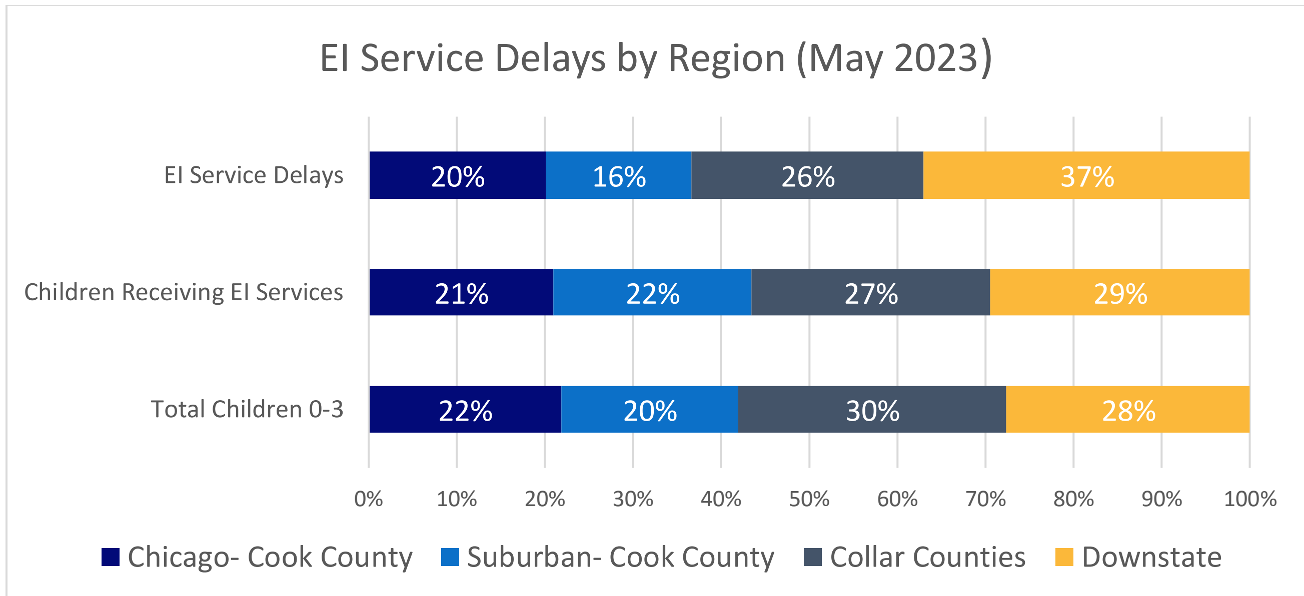
Figure 3



**SFY 24 Average includes the average percentage of intake delays from July 2023 to May 2024.*

Service delays are experienced differently by region and race and ethnicity, meaning that EI families are not receiving equal access to services (shown in Figure 4). Children in downstate Illinois, who make up 29% of children receiving EI services, experience 37% of the delays. Suburban Cook County, on the other hand, makes up 22% of children receiving EI but only experiences 16% of the delays.

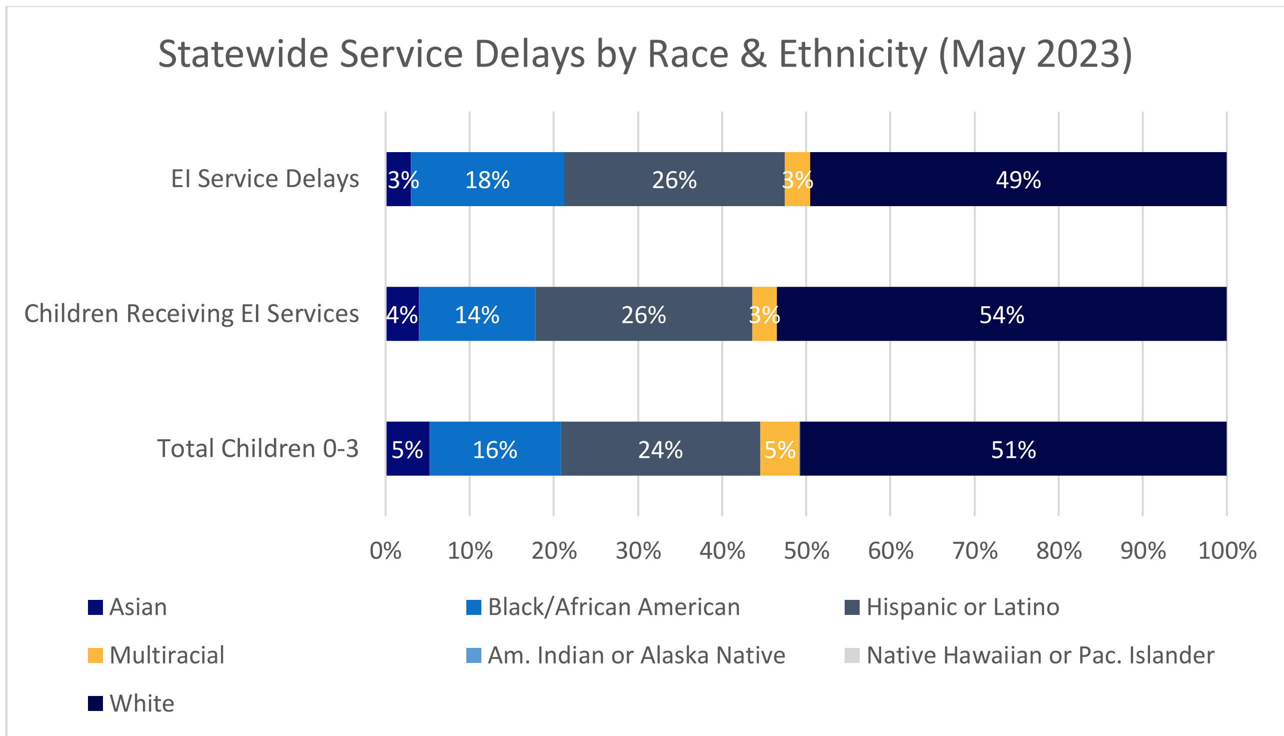
Figure 4



Service delays also disproportionately affect children of color (Figure 5). Statewide, Black children are less likely to be enrolled in EI and more likely to experience service delays. However, specific disparities vary by region. In suburban Cook County, 16% of children receiving EI services are Black, while 23% of children experiencing service delays are Black. Outside of Cook and the collar counties, 10% of children receiving EI services are Black, while 18% of children experiencing service delays are Black. On average across the state, Hispanic/Latino children experience proportionate delays, however this differs in the collar counties, where 29% of children receiving EI services are Hispanic/Latino and 35% of children experiencing service delays are Hispanic/Latino. Across the state, white children are more likely to be enrolled in EI.

In Chicago, disparities lie in EI participation, where Black and African American children are less likely to receive EI services and Hispanic/Latino children are more likely to receive EI services. However, children in Chicago receiving EI services are demographically similar to children experiencing delays, with no notable disproportionate service delays for any race or ethnicity. Charts showing all regional breakdowns by race and ethnicity can be found in Appendix B.

Figure 5



Service Setting (Early Intervention Claims Data – Central Billing Office)

Early Intervention services are required to be provided in the child's natural environment, such as their home or child care program.[42] In practice, services are provided in a variety of settings. During the pandemic, many providers began to deliver services through telehealth, known in EI as Live Video Visits (LVV). Some providers continue to provide virtual care, although during Afton's family focus groups a majority of families expressed dissatisfaction with virtual services and a preference for in-person visits. Some families across the state have had more difficulty finding providers who are willing to provide in-person care. The data below shows how geography and poverty status interact with LVV services based on analysis of a sample comprised of 30% of the claims paid by the CBO in SFY 2023. Data on claims includes information about the child's ZIP code, but not other demographic factors such as race or ethnicity, so the analysis of this data is focused on geography.

Children in high poverty ZIP codes, defined as ZIP codes where more than half of children 0-3 are under 200% FPL, are almost twice as likely to receive services virtually as children in low poverty ZIP codes, as shown in Figure 6. In high poverty ZIP codes, 20% of services are delivered virtually, compared to 11% in low poverty ZIP codes. The discrepancy is even larger in ZIP codes with the highest number of children in deep poverty. In ZIP codes where more than half of children are under 50% FPL, 35% of services are provided virtually, compared to the state average of 17%, as shown in Figure 7. These "deep poverty" ZIP codes are all located in predominantly Black areas of Chicago: Auburn Gresham, West Garfield Park,

[42] "34 CFR Part 303." *Office of Special Education and Rehabilitative Services, Department of Education*, Sept. 28, 2011. https://www.ecfr.gov/current/title-34/part-303

South Austin, and South Deering. Although only four ZIP codes meet these criteria for "deep poverty," this analysis is based on more than 10,000 claims for EI services provided in those ZIP codes.

Figure 6

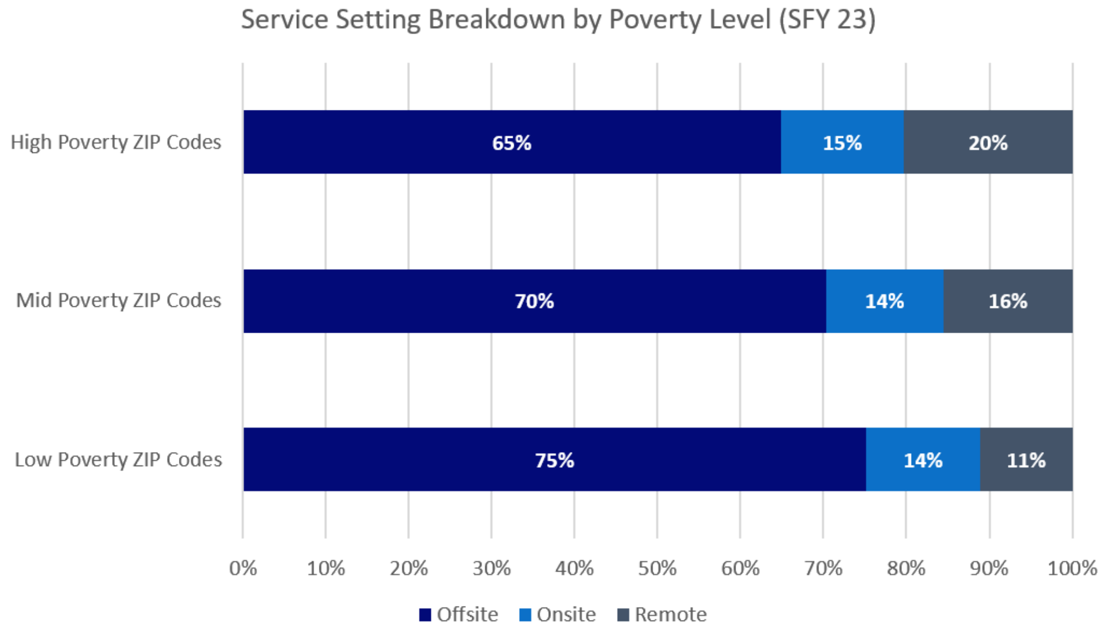
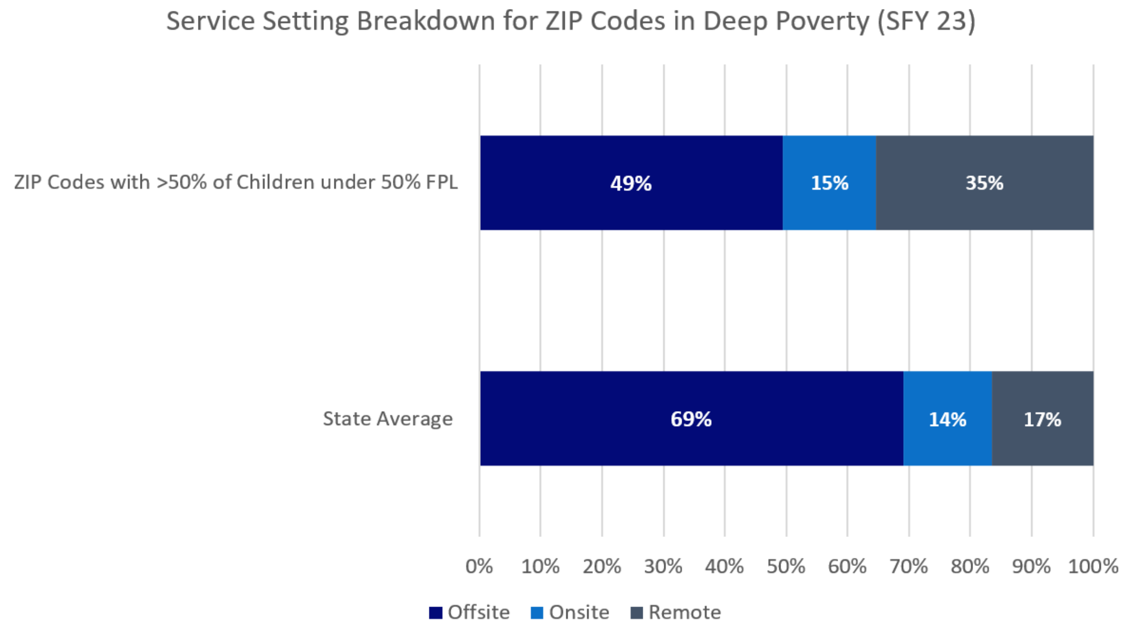


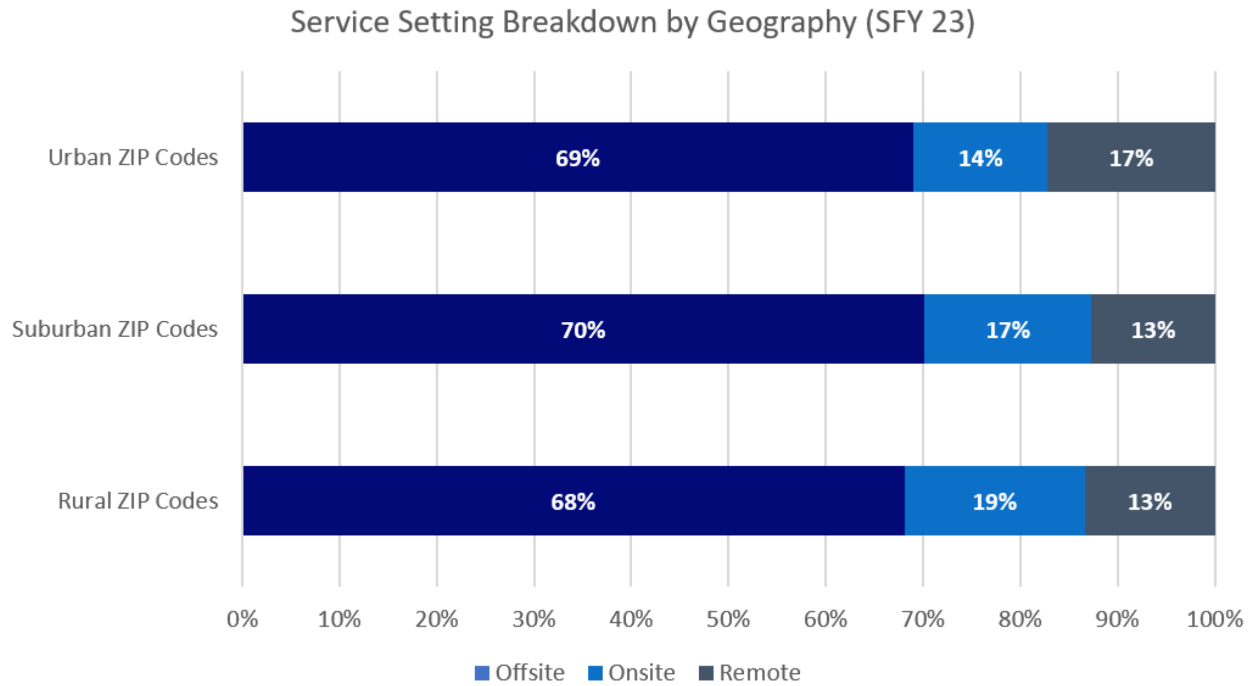
Figure 7



Virtual services have sometimes been proposed as a solution to EI access in rural areas, where there are fewer providers and travel times to in-person services are longer. However, families in rural areas are currently less likely to receive services virtually than the state average. In rural ZIP codes, 13% of services are delivered virtually, compared to 17% in urban ZIP codes, as shown in Figure 8. These discrepancies

could exist for a variety of reasons, including providers' willingness or availability to work in certain locations, families' access to reliable technology and internet, and family preference.

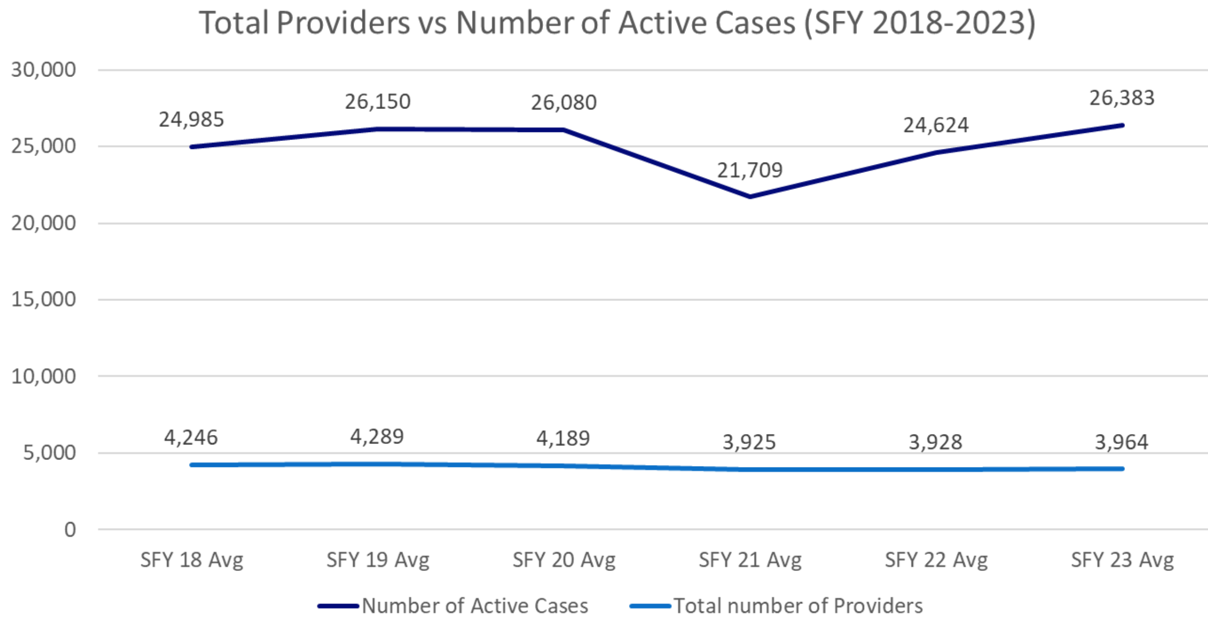
Figure 8



Active and Inactive Provider Information (Provider Connections)

One of the known challenges in EI systems across the country is the growing provider shortage. Figure 9 shows that the number of active providers in Illinois has declined by over 6% since 2020, while active cases have increased by more than 5%.

Figure 9



An average of 497 providers exited the Illinois EI system each year from 2018-2022, or 11.5% of the current total of active providers. Providers leaving the system have similar demographic characteristics as active providers by race/ethnicity and gender. The psychology, social work, speech, and physical therapy disciplines have seen especially steep declines in Illinois, as seen in Table 1.

Table 1

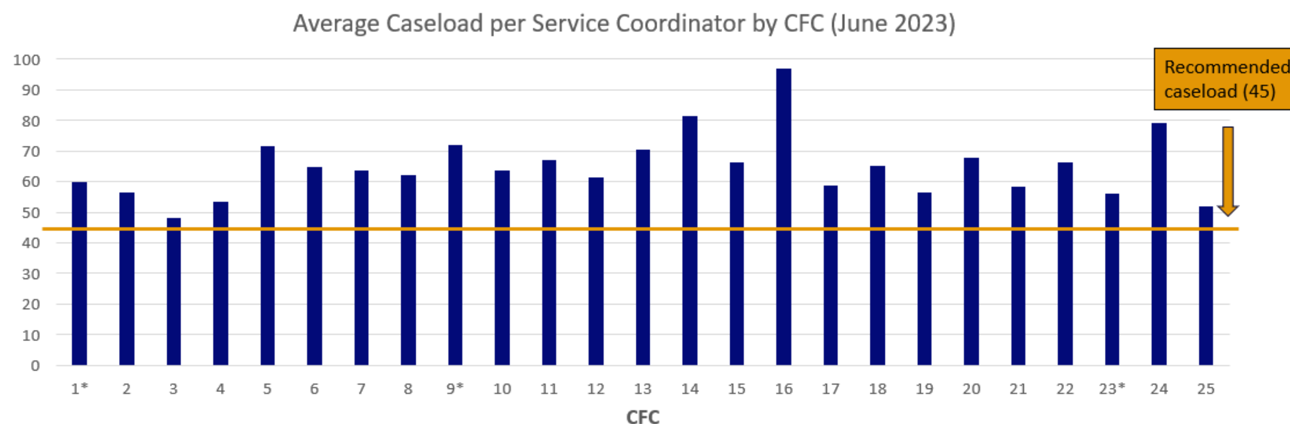
Provider Discipline	Number of Active Providers in 2018	Number of Active Providers in 2023	Percent Change
Psychology/Social Work	212	136	−36%
Physical Therapy	491	411	-16%
Speech Therapy	1335	1166	-13%
Developmental Therapy	879	848	-3.5%
Occupational Therapy	615	677	+10%

Service Coordination and Caseloads (Early Intervention Bureau)

Shortages in the EI system are also notable among Service Coordinators. If staffed adequately, Service Coordinators at CFC offices would carry a caseload of approximately 45 cases. Over the last five years, caseloads have been elevated and are currently slightly above pre-pandemic levels. As of June 2023, the average Illinois caseload was approximately 65 cases per Service Coordinator, significantly above the

recommended caseload of 45. The challenge of overburdened Service Coordinators is prevalent across the state, with the average caseload above the recommended target at every CFC, as shown in Figure 10.

Figure 10



**CFCs 1, 9, and 23 did not report data for June 2023. May 2023 numbers were used instead.*

Recent research indicates that there is a 13% Service Coordinator vacancy rate across CFCs in Illinois, and to reach the target caseload of 45 cases per service coordinator, CFCs would need to fill all vacancies and add an additional 130 positions.[43] Despite the noted shortage, hiring has been improving, with IDHS-DEC reporting a 10% increase in SCs in SFY24.

Input from Families and Early Intervention Practitioners

Between November 2023 and February 2024, Afton Partners conducted a series of focus groups to engage Early Intervention practitioners and families. Focus groups were divided into two categories, EI practitioner focus groups and EI family focus groups.

EI Practitioner Focus Groups

Purpose: EI practitioner focus groups were conducted to gain a better understanding of how practitioners were experiencing payment structures and practices in the field. Participants were specifically asked about:

- Major expenses
- Payment barriers and challenges
- How payment practices contribute to recruitment and retention challenges
- How cost and payment issues contribute to challenges with meeting families' needs

Process: Focus groups were held in November and December 2023, with nine sessions for various practitioner types, including:

- Southern Illinois practitioners (providers and CFC office staff)
- Developmental Therapists and Low Incidence providers

[43] "Early Intervention Recommendations Cross-State Research to Inform Early Intervention Service Coordination and Provider Services in Illinois." *Ted Burke,* April 20, 2024. https://providerconnections.org/wp-content/uploads/2024/04/Illinois-EI-Recommendations-04.20.24.pdf.

- Physical Therapists, Occupational Therapists, and Speech Language Pathologists
- Interpreters, translators, and bilingual providers
- CFC Managers
- Service Coordinators and CFC staff
- Former EI providers who have left the field

Focus groups were offered on both weekends and weekdays with daytime and evening hours to accommodate practitioners' varying schedules. Invitations were distributed by the Early Intervention Training Program and shared on social media. All sessions were conducted virtually, except for the session with Southern Illinois practitioners, which was conducted during an in-person training. To recognize and value participant's time, all attendees were offered a $25 gift card when they completed the session. The full focus group protocol and attendance is included in Appendix C.

Participant Engagement: 310 EI practitioners participated in focus groups. Practitioners represented a range of employment types, including independent contractors, agency employees and managers, and CFC staff.

Focus group participants joined from across the state, with significant representation from all four state regions. 17% of participants were from Chicago, 28% from suburban Cook County, 30% from the Collar Counties, and 25% from downstate. In addition, participants were generally racially and ethnically representative of the EI field, with providers of color well represented compared to EI practitioners overall. Specifically, 10% of focus group attendees identified as Black or African American compared to 8% of EI providers, and 10% of attendees identified as Hispanic or Latino, compared to 6% of providers.

Key Findings:

- EI providers expressed dissatisfaction with low compensation and overhead costs, including significant administrative burden.
    - Compensation in EI is far lower than in comparable roles.
    - Lack of benefits, uncompensated travel, and cancellations impact pay.
    - Providers experience high administrative burden, specifically from billing and authorizations.
- Interpreters, translators, and bilingual providers were growing increasingly frustrated with the EI payment system and often took on significant amounts of unpaid work to support non-English speaking families.
    - Interpreters and translators faced additional challenges with billing and authorizations.
    - Bilingual providers and interpreters often took on service coordination duties for non-English speaking families.
- CFC offices were dealing with difficulty recruiting and retaining Service Coordinators, increasing the burden across all employees.
    - Service Coordinators were experiencing burnout from low pay and high caseloads.
- CFC Managers felt that funding CFC offices based on Service Coordination fails to account for other costs, especially noting that additional personnel are needed for a successful program.
- Former EI professionals cited various reasons for leaving the field beyond the known challenge of low compensation.
    - Challenges included inconsistent pay and difficulty renewing credentials.

Direct Service Providers

EI providers expressed dissatisfaction with low compensation and overhead costs, including significant administrative burden. Among providers who attended focus groups, 90% believed that current reimbursement rates were too low. Providers explained that as therapists, they could work in different settings, such as schools or hospitals, or accept only private insurance, and receive higher or more consistent pay. Some providers reported working in EI part-time only so they could benefit from increased income and stability in other settings, such as schools or private practices. The focus group with former EI providers reinforced this theme, as some providers reported that they had switched to working privately or in schools.

Providers also noted many overhead costs to working in EI, with lack of benefits, lack of pay for transportation, and cancellations as top concerns.

- **Benefits:** Many providers commented that without health insurance from a spouse or family member, they would not be able to work in EI. For those who did not receive insurance through a spouse or family member, the cost of paying for their own health insurance without an employer contribution was a major burden.
- **Uncompensated Travel Time:** Providers who were offering in-person services often spent significant portions of their day traveling between appointments. The time they spent traveling reduced the amount of billable time they could otherwise be spending with a child. The lack of

compensation reinforces a system that incentivizes providers to only accept families that are in close proximity, which may be challenging or infeasible in sparsely populated parts of Illinois. This presents an equity issue, as areas with fewer providers nearby are often in low-income and rural areas. Despite this challenge, children living in rural areas are less likely to receive telehealth services than children in urban areas, which may indicate that virtual services are an imperfect solution due to lack of Internet access or provider or family preferences.

- **Cancellations:** Providers noted high rates of cancellations and no-shows, which impacted take-home pay. Providers felt that current reimbursement rates did not appropriately account for cancellations, and many noted that pay for cancellations was among their top priorities.
- **Administrative Burden:**
  - Providers spent significant time on insurance billing and communicating with the Central Billing Office, often to try to understand reimbursement denials. Other time-consuming administrative tasks included scheduling appointments and participating in yearly monitoring.
  - In addition to the amount of time providers spent on billing, they also dealt with inconsistent and delayed payments.

> "Even if we were to get paid fairly, I don't think it matters... if you don't get that check on a consistent, confirmed basis... I literally put mortgage bills on a credit card and have to pay 20% in interest because I did not get my expected check."- Occupational Therapist, CFC 15

Interpreters, Translators, and Bilingual Providers

Interpreters, translators, and bilingual providers were growing increasingly frustrated with EI payment systems and often took on significant amounts of unpaid work to support non-English speaking families. Specifically, interpreters and translators felt undervalued and disrespected in comparison to direct service providers. They expressed challenges with billing and authorizations, similar to direct service providers, but noted additional challenges for interpreters with receiving delayed authorizations for services, in comparison to providers.

> "I love what I do. I'm really good at what I do, but sometimes it takes a toll… I spend maybe two hours every week just with CBO, trying to figure out what I'm getting paid for and what was denied... And that is money that has been lost." - Interpreter, CFC 4 & 5

Interpreters, translators, and bilingual providers also faced additional costs due to their reliance on providers. Participants mentioned that they often spent time waiting for providers to arrive at the session, but they are not able to bill for their time until the provider arrives and begins the appointment.

Interpreters, translators, and bilingual providers often became a point of contact for families, spending significant time communicating via text or phone. For families that did not have Bilingual Service Coordinators, bilingual providers and interpreters often took on coordination responsibilities without compensation. Bilingual providers also spent time creating and adapting materials for non-English speaking families. Participants believed they should be compensated for these additional responsibilities associated with serving as a bilingual provider.

Translators noted that current pay structures are unusual in the field. For example, translation is typically paid at a per-word rate, but EI authorizations are typically provided for the same amount of time regardless of document length. Translators specifically noted that in addition to translating the language, they spend significant time trying to find and request documents in editable formats or pulling language from un-editable PDFs, which is uncompensated. Some translators reported that they had difficulty negotiating authorizations with their Service Coordinator for more time for particularly long or complex documents.

Service Coordinators

CFC offices faced difficulty recruiting and retaining Service Coordinators (SCs), increasing the burden across all employees in the EI field. CFC Managers noted high turnover for SCs, citing pay-related issues, lengthy hiring processes, and the inability to compete with other organizations offering higher salaries. Focus group attendees reported that starting salaries for SCs were between $33,000 to $42,000 per year, and while this was an increase from previous years, they felt that they would need to offer at least $50,000 to be competitive. Every SC that attended focus groups agreed that pay is too low, and the average suggestion for a fair wage was $30 per hour. Some SCs themselves explained that they do not view the role as a "career job" due to the low pay.

> "Service Coordinators are salaried, but I live at home with my parents and would never be able to move out on my salary. It's not a forever career job." – Service Coordinator, CFC 7

SCs also discussed the high stress levels of the job, specifically with managing high caseloads, which made it difficult to communicate with families and provide quality services. **The high caseloads also made it difficult to meet deadlines required by federal law, including intake time limits**. SCs mentioned that they struggled to take their allotted time off, and many felt that they were unable to have a break given that no one could substitute or take on their work when they were away. CFC Managers themselves noted that covering for time off was extremely challenging, and managers often take on cases to try to reduce the burden on other SCs.

The shortages and turnover of SCs not only impacted the quality of service provided to families but also impacted direct service providers, as they are reliant on SCs for authorizations. Incorrect or delayed authorizations resulted in providers receiving delayed payments or not receiving them at all.

> "There are times that we provide services that we will never get paid for. Sometimes it's an accident and an authorization wasn't entered correctly… I don't think it should be the responsibility of the Service Coordinator alone. I think that's a lot of pressure to be responsible for everybody's pay, essentially. You know, I just don't think it's appropriate to put that on someone who has a giant caseload." - Occupational Therapist, Northern Illinois

CFC Managers

CFC Managers felt that funding CFC offices based on Service Coordination fails to account for the other costs, especially noting that additional personnel are needed for a successful program. Managers reported that current funding is inadequate to cover all the costs, including personnel such as managers, assistant managers, administrative and support staff, along with additional consultants.

> “We’re funded so many dollars per Service Coordinator, which is based on our total active case rate, but there’s nothing in there that really identifies [that] every CFC has to have a manager. You have to have one, but there is no separate funding for their salaries. We have to have secretaries. We have to have administrators. Yet there’s no separate funding for that. So, all of those salaries come out of the Service Coordinator dollars.” – CFC Manager, Southern IL

The limited funding was used to cover the wages of full-time staff, which often meant that SCs and CFC managers covered multiple roles at once. A CFC Manager may also be the Local Interagency Council Coordinator and the Parent Liaison. Additional roles like Infant and Early Childhood Mental Health consultants were often reduced if the budget was not sufficient. These consolidations and reductions impacted the support that CFCs could give parents and families. While recent changes that removed the system of incentives and penalties have made funding more stable for CFC offices, payment based on service coordination continued to be insufficient.

Benefits for staff varied by CFC, with most offering health insurance, retirement, and paid time off, as well as flexible work hours and the option to work from home. While many CFCs offered health insurance, high premiums, in combination with low pay, were a barrier for employees. CFC managers used these benefits as a selling point to hire staff.

Former EI Professionals

During this process, a specific focus group was held for EI professionals who had left the field. **These former EI professionals cited various reasons for leaving the field beyond the known challenge of low compensation.**

- **Inconsistent Pay:** Many participants noted that it was not just the low pay, but the inconsistency in pay that led them to leave EI. They cited differing reasons for inconsistent compensation, including challenges with maintaining desired caseloads and high cancellation rates. The Covid-19 pandemic exacerbated those uncertainties.
- **Expiring Credentials:** Participants shared that renewing credentials was often a complicated and confusing process. In some cases, they did not realize their credentials were lapsing until after they had already expired.
- **Administrative Burden:** Along with previously mentioned challenges with billing, some also expressed that EI requirements and paperwork became increasingly burdensome over the years.

> “I work at a Title I school and make more than most districts. I think the earning potential in EI is probably better than what I make now, but again with so many cancellations and inconsistent income, potential income vs. real income, plus paying for my own benefits, [it] doesn't add up.” - Former EI Provider, Chicago Suburbs

Early Intervention Family Focus Groups

Purpose: Afton conducted family focus groups to reach parents and caregivers who currently or recently experienced the EI system. These focus groups sought to understand families’ thoughts and experiences in EI through discussions on the following topics:

- Access and barriers to receiving services
- Experiences with service coordination and CFC offices
- Quality of services and relationships with providers

Process: Five family focus groups were held in January and February 2024. Two sessions were open for any current or recent EI families, and specific sessions were also held for families in rural areas, those experiencing delays, and Spanish speaking families. Focus groups were offered on both weekends and weekdays with daytime and evening hours to accommodate families' varying schedules. Focus groups were also offered in Spanish, and American Sign Language (ASL) interpretation was offered as needed. The focus group protocol can be found in Appendix D.

Invitations were distributed through email and social media by partner organizations, including Raising Illinois, Birth to Five Illinois, and Community Organizing and Family Issues. To recognize and value participants' time, all attendees were offered a $25 gift card when they completed the session. Families who were unable to attend sessions were also offered the option to submit written responses by email or participate in an interview.

Participant Engagement: 107 participants attended EI family focus groups. Approximately 68% of families were currently receiving services, 22% were on a waitlist or experiencing delays, and 9% had recently exited the system.

Families from across the state attended focus groups, with collar county families over-represented and downstate and suburban Cook County families underrepresented, as shown in Figure 11. 17% of families reported that they resided in rural areas of Illinois. Approximately 8% of participants joined a Spanish-language focus group.

Figure 11

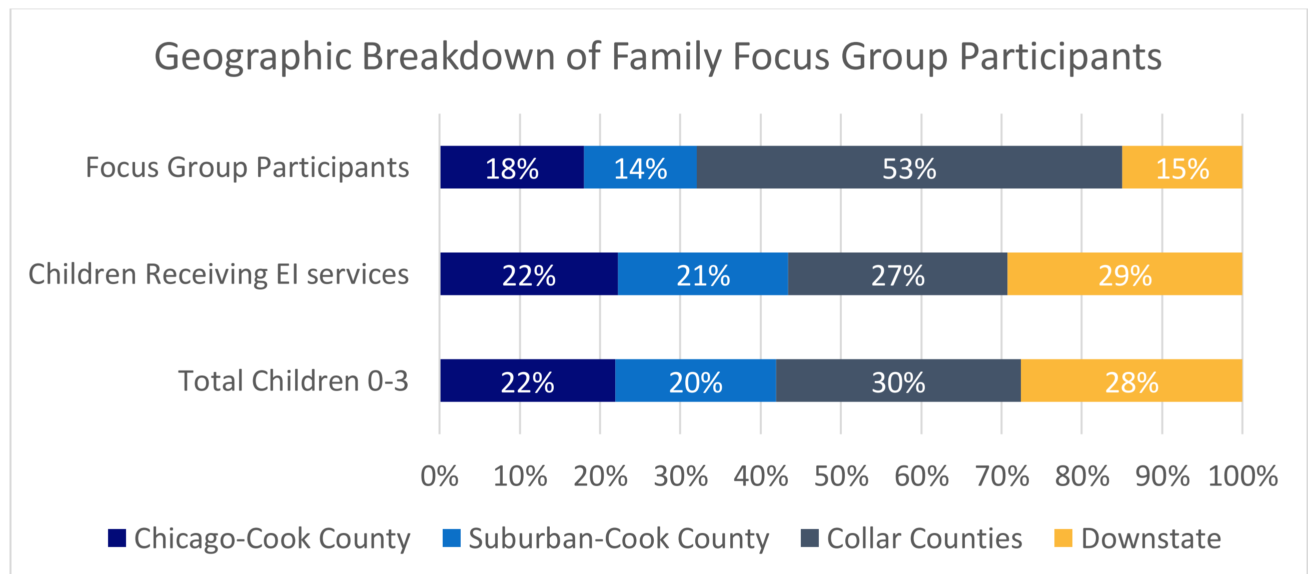
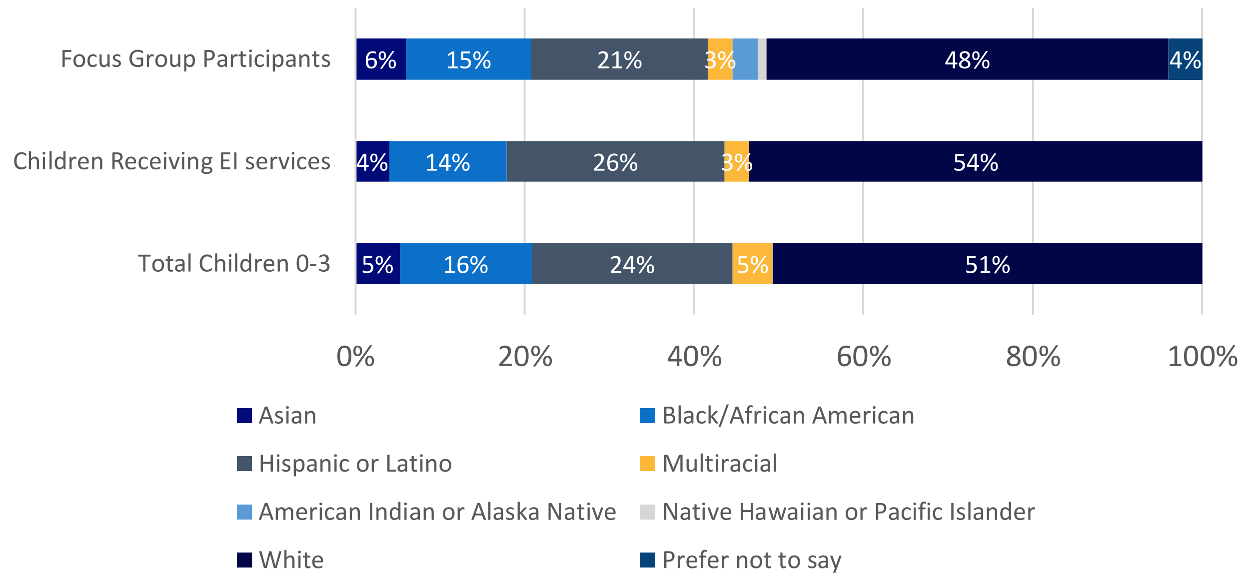


Figure 12



Key Findings

- Many families lacked awareness of Early Intervention services, and those who had experience with the system were at an advantage.
- Parents and caregivers were frustrated with service delays and long wait times.
- Families were generally happy with the quality of services they were receiving and had good relationships with their providers.
  - Those who had negative experiences cited lack of experience and professionalism as major challenges.
- Most parents and caregivers preferred in-person services and did not feel that Live Video Visits (LVV) met their needs.
- Relationships with Service Coordinators (SCs) greatly impacted families' experience.
- Families valued shared experiences and backgrounds with their service providers.

Access and Availability

Many families lacked awareness of Early Intervention services, and those who had experience with the system were at an advantage. Focus group participants who had a parent or relative who was involved with Early Intervention, education, or social work were more familiar with the EI system and were more likely to push for services for their child. Lack of awareness or knowledge of the EI system

contributed to longer wait times and service delays for families. Since many families did not come to EI with prior experience, this could result in unequal access to services.

> "I'm just lucky enough that in my last position I worked alongside EI. If this would have happened to me with my first daughter, I wouldn't have known any better. I would have accepted everything. And I would have trusted them. And I'm thankful that that wasn't the case this time because my daughter would be really, really delayed right now." — EI Parent, O'Fallon, IL

Most parents learned about EI through their pediatricians, while others heard about it from friends or family, or through their child care providers. Many participants felt that there was an unmet need for services in their communities due to lack of awareness or interest.

Parents and caregivers were frustrated with service delays and long wait times. Families across the state were dealing with frequent service delays, and as a result many had attempted to find providers themselves instead of waiting for their Service Coordinators to do so. When asked about what they would change in the system, increasing provider availability and reducing wait times were the most common responses from families. Participants expressed that they spent considerable amounts of time to both reach their coordinators and find therapists, and many described the experience as a full-time job.

> "Being a full time, stay at home parent helps because navigating EI services was my full-time job. My child had very mild needs compared to others, and I spent a lot of time asking questions… They hand you these packets and it's not easy reading. I can't imagine how you'd navigate if English isn't your first language, or you don't have a higher education level." – EI Parent, Frankfort, IL

Adding to the frustrations, many families felt that they did not receive timely communications or consistent updates when they were waiting for services. Some also discussed challenges with reaching their CFCs after receiving a referral, noting that they had to leave multiple messages before receiving a call back.

Consistent with service delay data, **participants in rural areas were more likely to experience delays.**

> "Because of where we live, EI is the only option, we'd have to drive an hour and a half away to get any private services. Those are the only options. We are eagerly awaiting preschool so he can get services." - EI Waitlist Parent, Stephenson County, IL

For families who were actively receiving services, most felt that they were accessible and valued the convenience and accessibility of receiving services in their homes and child care programs. Parents reported that this helped them keep appointments more regularly and that they appreciated that their children were receiving services in their natural environments.

Service Quality

Families were generally happy with the quality of services they were receiving and had good relationships with their providers. Most families described Early Intervention as having a positive impact on their child's development. Participants also noted that they, as caregivers, benefitted from

seeing their child's growth, receiving guidance from professionals, and learning how to better support their children. A majority of families felt that their providers were knowledgeable and experienced.

> "I love all of our providers... My husband and I call them the Dream Team. We feel very blessed…. It feels as though they are genuinely invested in our family and my daughter and I'm so grateful." - EI Parent, Normal, IL
>
> "My team is AMAZING. All three are moms, which I think helps... Since they come to our home, they are able to interact with my daughter and me and answer all my questions. I cannot think of anything needing improvement – they are knowledgeable, communicative, and amazing." - EI Parent, Skokie, IL

When asked what their top priority would be if they could change one thing about EI, many families said that they would like services to extend past three years old to allow children to continue to work with their therapists. Some families also expressed that they would like services to be more frequent or last longer.

Some families described negative experiences with providers, usually attributed to inconsistency in services, limited communication, or lack of professionalism. Others shared that some providers seemed inexperienced.

> "We have an OT [Occupational Therapist] right now who's very young and inexperienced, she'll tell you that herself. Her schooling was during Covid-19, and she didn't get a lot of hands-on [experience]." – EI Parent, O'Fallon, IL

Families discussed the need for more supervision for newer providers and providers with unprofessional behavior. Families who had negative experiences often were not sure how or with whom to address these challenges. Some mentioned that due to provider shortages, they had to continue to work with their provider.

> "I'm not satisfied with my Speech Therapist, but it took five months to get her so I'm afraid to go about getting a different one." – EI Parent, Peoria, IL

Parents and caregivers overwhelmingly preferred in-person services and did not feel that virtual services, known as LVV, met their needs. Many families had experienced LVV services, particularly during the Covid-19 pandemic; however, for most families, this was not their preferred option. Parents and caregivers noted that due to the children's young ages, it was difficult to keep them engaged through virtual services. Participants also explained that preparing and supporting children through virtual appointments was a larger burden and that they often felt unprepared or did not have the materials that the therapist was requesting. For families with other young children present, it was difficult to manage caregiving while participating in the session. In addition to the logistical challenges, many families felt that LVV services were simply not effective for their child, and they noticed more growth with in-person services. Families shared that their children often dreaded virtual visits while they enjoyed in-person visits.

"I was so desperate for an in-person provider as opposed to a LVV that I was willing to commute anywhere for an in-person visit. I didn't care where I had to take my daughter, as long as she got an in-person therapist… I did not have a good experience through Zoom. The personal connection is what I love the most." – EI Parent, Plano, IL

Although most families preferred in-person services, there were some who liked having the virtual option.

"I really appreciate having the meetings virtually, it's just easier scheduling-wise. Having five to six people in person in my home would be a little less comfortable for me." – EI Parent, Chicago, IL

Relationships with Service Coordinators greatly impacted families' Early Intervention experiences; however, family experiences with Service Coordinators are varied. Families who had positive relationships with their SCs reported that communications were clear and frequent, and that their SCs were helpful and timely in finding providers.

For many families, however, the service coordination experience was more challenging. Participants discussed having coordinators who were difficult to reach and slow in responding. They shared that it was clear when their coordinator was overloaded with cases because it impacted their communications.

"My Service Coordinator was a nice person, but it was obvious at times that her caseload was too heavy. She was getting our kids mixed up with other kids and there were meetings that should have been scheduled that were missed altogether… If somebody can make those loads a bit lighter just so communication flows better and more easily, that will improve the relationship." – EI Parent, Peoria, IL

Participants also discussed the challenges with turnover. Many parents and caregivers had been through multiple SCs within their short time in EI, often switching between SCs and CFC managers depending on CFC staffing. This turnover made it difficult for parents to know who to communicate with and to build relationships, impacting the consistency of communications and service delivery. Many families also noted that they had to be persistent in contacting their SC to ensure that there was progress on their case, or search for providers themselves. One parent shared:

"The truth is that my coordinator is very good, very, very attentive, but I think that they do have too many cases… I had told her that I was also searching [for a provider] and she told me the truth is that it's not your job, but if you find someone, tell me because I really can't cope." – EI Parent, Chicago, IL

Improving communications about their services, both during intake and case management process, was a top request from families.

Families valued shared experiences and backgrounds with their service providers. Many participants felt that it was important and beneficial to have shared experiences with the EI staff serving their family. Multiple mothers commented that having providers who are also mothers, especially if they had

children in EI, allowed for deeper connection and support. Parents felt that having providers or Service Coordinators who were also parents gave them a better understanding of their experiences.

> "No, the people that work in the CFC do not look like me or most of the people in the community. We're mostly Black and Latino/Hispanic and most people at the CFC are white or may identify as white. I think it impacts the experience, because it makes people feel some kind of way. And even most of the service providers are white, not Black… I think it helps, even, if they are culturally competent. I think my Service Coordinator would identify as white, but she had recently been through the process, so I think that's where a lot of empathy came from…" - EI Grandparent, Chicago suburbs

Families who receive services in languages other than English felt that home-language therapy was important for their child's development.

> "We had a Physical Therapist, but she moved to another state, so we no longer have her, but she was Colombian. And I did notice that she clicked more with my son and achieved more, because she was speaking in his language… I feel like it made him much more cooperative with therapy." – EI Parent, Chicago, IL

Despite a preference for therapy in their home language, many families were not able to receive services in their preferred language due to limited availability of linguistically diverse providers.

Cost and Payment Reform Survey

Purpose: In February 2024, Afton conducted an Early Intervention Cost and Payment Reform Survey for EI practitioners. The survey was intended to gather information on costs that EI providers incur to provide services and to gather further practitioner input on priorities for payment reforms. Cost data from independent providers and agency and practice managers were a primary source of data for developing the cost model. CFC cost data was obtained through grant reporting on budgets for all CFCs.

Process: Afton collaborated with the Early Intervention Training Program and Provider Connections to share the survey with active providers and CFC staff. The survey was also shared with participants from previous focus groups. The survey was open for four weeks, from February 19th to March 15th, 2024. The Afton team also offered assistance through a Help Request Form.

The survey included a unique set of questions for independent contractors, agency or practice managers, and CFC staff or other EI practitioners. Each section of the survey was reviewed by at least one practitioner from the corresponding category to ensure that questions were clear and easy to understand and captured the correct cost information.

Independent contractors and agency or practice managers were asked to respond to detailed cost information along with system priorities, while CFC staff and other EI providers responded only to the questions about system and payment reform priorities. The full EI Cost and Payment Reform Survey can be found in Appendix E.

Participant Engagement: A total of 707 EI practitioners responded to the survey, including partial and full responses. Respondents were primarily direct service providers, with limited participation from agency

and practice managers, CFC staff, and others (see Figure 13). Providers of various disciplines participated in the survey, with Speech Language Pathologists, Developmental Therapists, and Occupational Therapists having the highest numbers of responses (see Figure 14). If providers fulfilled multiple roles or disciplines, they were asked to select their main or primary position. Participants were generally ethnically and racially representative of the EI field. Approximately 79% of respondents identified as White, 8% as Hispanic or Latino, 7% as Black or African American, 3% as Asian, and 1% as American Indian or Alaska Native. 3% chose other and 7% preferred not to say. Respondents were able to choose more than one race or ethnicity.

Figure 13

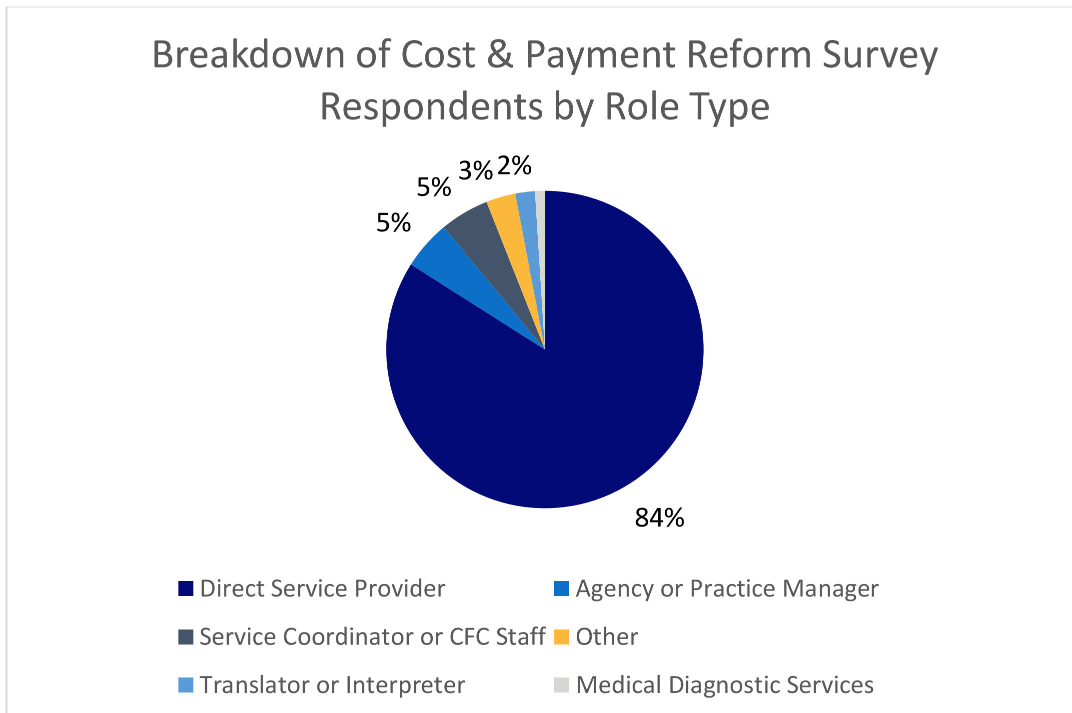
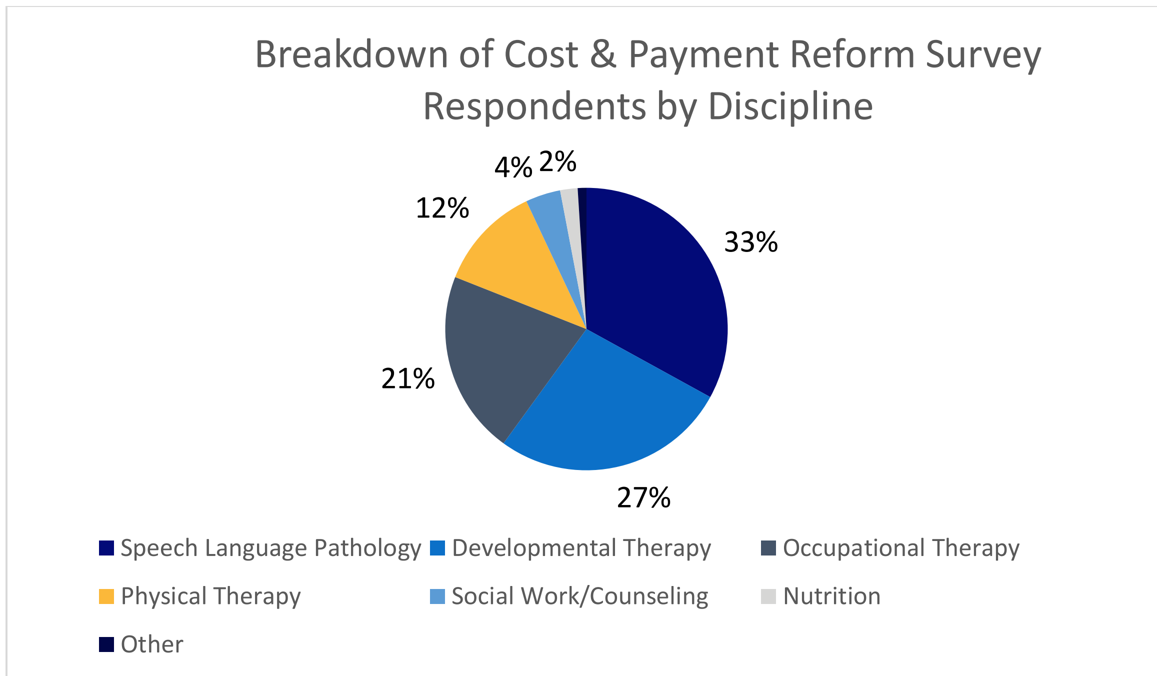


Figure 14



Payment Reform Solutions

The survey asked respondents to review a set of potential payment reform solutions and consider how much each option would increase or decrease their professional satisfaction and which solutions would have the greatest positive impact on children and families. (The full list of payment reform options presented for consideration is available in Appendix E.) Practitioners ranked the following as the solutions that would most increase their professional satisfaction:

All EI Practitioners	Direct Service Providers	Service Coordinators	Interpreters and Translators
• Raise rates for direct services. • Implement an annual cost of living increase for EI rates and CFC funding. • Pay practitioners for canceled or missed appointments.	• Raise rates for direct services. • Implement an annual cost of living increase for EI rates and CFC funding. • Pay practitioners for canceled or missed appointments.	• Reduce caseloads for Service Coordinators. • Implement annual cost of living increase for EI rates and CFC funding. • Pay higher rates to practitioners serving areas with shortages of EI practitioners.	• Implement an annual cost of living increase for EI rates and CFC funding. • Pay practitioners for canceled or missed appointments. • Pay practitioners for travel time for appointments that are especially far away and/or for transportation costs.

Practitioners selected these same top choices when considering what solutions would have the greatest positive impacts on children and families.

These preferences are in line with previous surveys conducted by the EI Grassroots Alliance and the EITP that indicate that increasing compensation is the top priority for providers. There was little variation in preferred solutions across different geographies and by race and ethnicity; however, there were some distinctions by practitioner type:

- Service Coordinators were 10% more likely than direct service providers to believe that "tiered pay structures for training and experience" would greatly increase their satisfaction.
- Developmental Therapists especially prioritized pay parity and were 46% more likely to believe that improving pay parity between disciplines would greatly increase their satisfaction compared to other providers.

Employment arrangement also impacted priorities, with agency managers valuing timeliness and accuracy of payments more than direct service providers. Agency employees were also less likely than independent contractors to believe that the state taking over insurance billing and paying higher rates in shortage areas would increase their satisfaction.

Revenue, Cost, and Income Findings

The survey aimed to gather detailed information on the costs associated with delivering services as an independent contractor and as an agency, differentiated by provider specialty and geographic location in Illinois.

Independent Contractors: 207 independent contractors or self-employed respondents submitted detailed revenue, cost, and income data. 47% of respondents worked in EI full-time and 53% worked part-time. Chicago providers were under-represented at 9% of responses, while suburban Cook County comprised 31%, collar counties comprised 33%, and downstate Illinois made up 27% of responses. Responses by provider disciplines are detailed in Table 2.

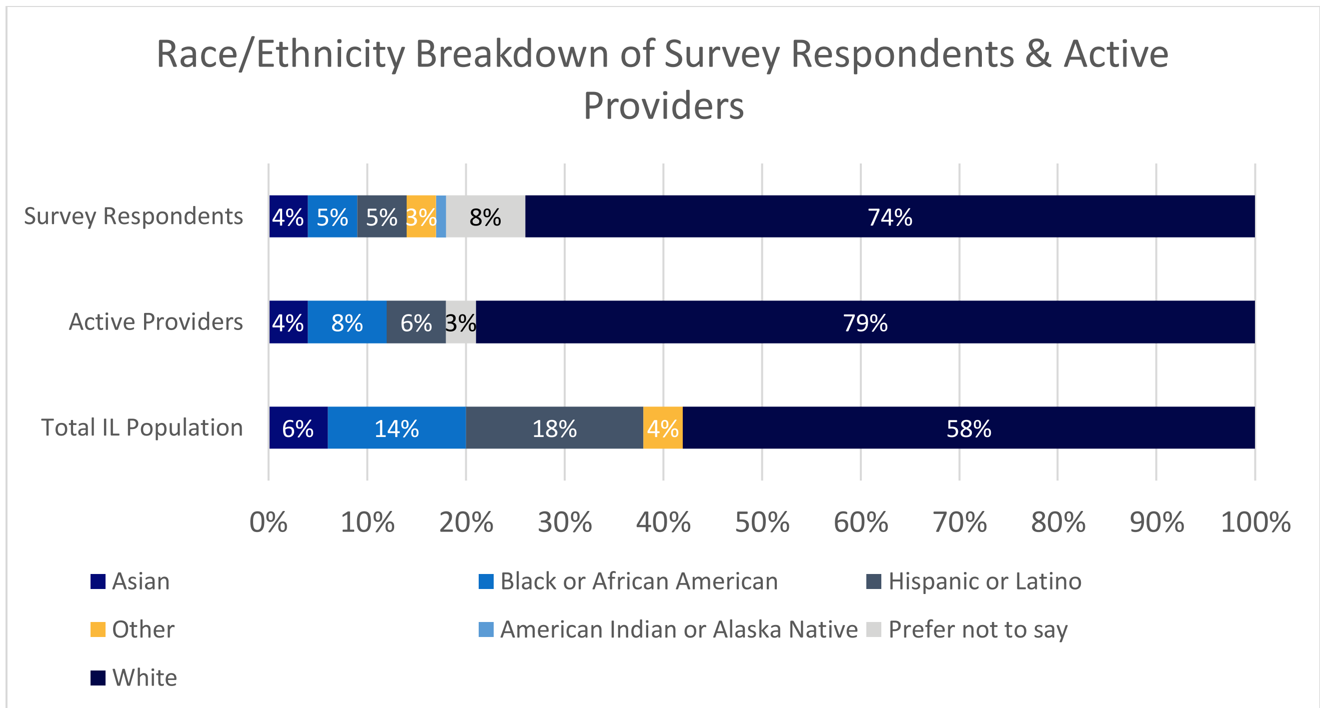
Table 2: Cost Survey Responses by Provider Discipline

Provider Discipline	Count	Percent
Developmental Therapy	62	30%
Occupational Therapy	44	21%
Speech Therapy	62	30%
Physical Therapy	20	10%
Psychology/Social Work	14	7%
Interpreter/Translator	5	2%

Participants were also representative of the racial and ethnic makeup of the current EI provider workforce. Figure 15Figure 15

shows the race and ethnicity makeup of survey respondents compared to active EI providers.

Figure 15



EI Agencies: Among the survey respondents, 18 identified themselves as agency/practice managers or direct service providers responsible for handling their agency's budget. Of these agencies, 44% were located in the collar counties of Illinois, 33% in the suburban areas within Cook County, 11% in Chicago, and the remaining 11% in the downstate area of Illinois.

Data Collection: Independent contractors and agencies were asked to report their total annual costs associated with a variety of operational expenses. These expenses included categories such as facilities, technology, transportation, supplies, marketing, administrative services, insurance, licensing fees, and professional development. All data was adjusted to reflect the cost of a full-time provider annually. Additionally, independent contractors were asked about their net income after accounting for taxes and expenses. Agencies were asked about their staffing patterns, including administrative staff, providers, and respective salaries and benefits.

Findings: The analysis of the survey data revealed the following key points:

- **Minimal Cost Variation**: There are minimal cost differences across provider disciplines and regions. This lack of variation, combined with an unequal distribution of responses across disciplines in all regions, made it impractical to differentiate costs without more data. Therefore, a decision was made not to differentiate non-personnel costs in the cost model based on discipline or region. As a result, median costs were calculated uniformly across all disciplines and regions but were differentiated between independent contractors and providers working at agencies. Tables showing data by region are provided in Appendix F.
- **Major Expenses:** The largest expenses for independent contractors were Transportation ($5,000), Facilities/Office Space ($3,000), and Technology and Software ($2,408). Similarly, for agencies, the largest non-personnel expenses were Transportation ($8,480), Technology and

Software ($7,250), and Facilities - Rent/Mortgage/Property Taxes ($7,670). Non-personnel costs for independent contractors and agencies are detailed in Table 3 and Table 4.

- **Agency Administrative Staff:** On average, agencies employed 1.7 full-time equivalent (FTE) administrative staff, including Directors/Assistant Directors (0.7 FTE), Administrative Assistants (0.4 FTE), and Billing Specialists (0.6 FTE). The average agency employed 8.2 FTE of direct service providers. There was substantial variation in size and staffing patterns across the 18 agencies who responded to the survey, ranging in size from 1.25 total staff to 33 total staff.
- **Net Income for Independent Contractors:** The net income data revealed that independent contractors had a full-time equivalent median annual revenue of $70,709 and median net income of $45,027 from providing EI services. Part-time incomes were adjusted to full-time equivalency to calculate these medians, meaning that they reflect what the equivalent annual income would be if the provider worked full-time in EI rather than part-time. This net income is substantially lower than typical earnings for similar roles in Illinois. For instance, the Bureau of Labor Statistics (BLS) reports that a Speech Language Pathologist in Illinois earns a median wage of $87,910 before taxes, and a Physical Therapist earns a median wage of $104,640 before taxes.

Table 3

EI Independent Contractor Costs:

Expense Category	Median Annual Cost ($)
Facilities/Office Space	$3,000
Technology and Software	$2,408
Transportation	$5,000
Service-Related Supplies	$1,100
Non-Service-Related Supplies	$600
Marketing and Advertising	$311
Administrative, Legal, and Financial Services	$1,200
Insurance	$360
Professional Licensing Fees	$325
Professional Development	$500

Table 4

EI Agency Non-Personnel Costs:

Expense Category	Median Annual Cost ($)
Facilities - Rent/Mortgage/Property Taxes	$7,670
Utilities - Electric, Water, Heating, Internet	$3,389
Maintenance and Repairs	$2,000
Training & Professional Development	$2,400
Technology and Software	$7,250
Transportation	$8,480

Service Related Supplies	$3,000
Non-Service Related Supplies	$1,750
Marketing and Advertising	$1,900
Administrative, Legal, and Financial Services	$4,000
Insurance	$2,250

Time Use Study

Purpose: Between February and March 2024, Afton conducted a time use study with EI direct service providers to better understand the full time spent on providing services, including billable and non-billable work. The study provided insight on the overhead costs of providing services, including time spent on preparation, travel, documentation, and cancelled appointments.

Process: Afton collaborated with the EITP to contact active providers and invite them to join the study. Afton also contacted providers who had previously participated in focus groups.

The study was held over four weeks and asked providers to submit daily time surveys for ten days during this period. The daily surveys provided categories of time usage in line with EI billing categories and other tasks described by providers during focus groups. The questions were reviewed by providers to ensure that tasks and categories would correctly capture time usage (the full survey instrument is provided in Appendix G). Before the study started, providers were asked to attend or watch a webinar recording to learn how to accurately input their time. The training was offered via two live sessions where providers could review the study requirements and tools and ask questions. The recording of the training was also shared with all participants. Time tracking resources, FAQs, and a help request form were also provided.

To compensate providers for their time, participants who completed the ten days of surveys received a $50 gift card. Afton also led reflection sessions after the completion of the study, and participants who joined a session or submitted a written reflection were eligible for three EI continuing education credits through the EITP.

Participant engagement: 237 providers participated in the study, with 207 completing the full ten-day requirement. This provided over 2,300 days of data. Participation by discipline is described in Table 5.

Table 5

Provider Discipline	Count	Percent
Developmental Therapy	68	29%
Occupational Therapy	36	15%
Speech Therapy	72	30%
Physical Therapy	34	14%
Psychology/Social Work	14	6%
Nutrition	3	1%
Interpreter/Translator	10	4%

Slightly over half, or 52%, of providers, were self-employed or independent contractors, and about 40% were employed by an agency, with the remaining 8% working under both employment arrangements or being agency owners. 58% of participants worked in EI part-time, and 39% were full-time EI providers. The collar counties were overrepresented (38%), and Chicago (21%), suburban Cook County (20%), and downstate Illinois (21%) had about equal participation.

Participants were also representative of the race and ethnicity makeup of the current EI provider workforce, with 83% of the participants identifying as white, 8% Hispanic or Latino, 7% Black or African American, and 3% Asian. 3% of participants chose other and 4% chose "prefer not to say". Participants could select more than one race or ethnicity.

Analysis Methodology and Definitions: Data analysis centered on understanding two interconnected components, provider caseloads and billable time. Provider caseloads included completed appointments, cancellation rates, and service delivery method (in-person or virtual/LVV). Each daily survey submitted by a provider was counted as one entry, and each entry was categorized as LVV if all services were provided virtually, hybrid if some services were provided virtually and some in person, offsite if in-person services included travel time, and onsite if in-person services were provided without travel time. While most EI services are provided "offsite," or in the child's natural environment, a small percentage of services are provided "onsite," or in a provider's office, potentially due to family preference.

The percentage of billable time was calculated by summing the hours a provider spent on "billlable tasks" and dividing it by the total hours worked within the day. Table 6 details which activities were defined as billable and non-billable:

Table 6

<table>
<tr><th>Provider Type</th><th>Direct Service Providers</th><th>Interpreters and Translators</th></tr>
<tr><td>Billable Tasks</td><td>• Providing services to children/families
• Conducting evaluation appointments
• Participating in IFSP meetings</td><td>• Interpreting during service or evaluation appointments
• Interpreting for IFSP meetings, conferences, or practitioner-family communications
• Translating documents/IFSPs</td></tr>
<tr><td>Non-Billable Tasks</td><td colspan="2">• Service preparation and planning
• Documentation and reporting
• Meetings and communications (excluding IFSP meetings)
• Travel and scheduling
• Professional Development
• General administrative planning</td></tr>
</table>

Participants were asked to self-report their full or part-time status, with 30 hours or more worked in EI counting as full-time. Part-time EI employees could vary from working just one hour per week in EI up to 30 hours, meaning that part-time data covers varying hours of work. Part-time providers may be providers who also provide therapy services outside of the EI system, hold another job, or do not work for pay during their hours outside of EI. Additionally, part-time providers were only asked to report on

days worked in EI. For example, a therapist who works at a private practice clinic three days a week, and provides EI services on two days, only reported time use for the two days in EI.

Key Findings

- On average, approximately 36% of EI providers' time was billable.
- The most time-consuming non-billable activities were travel, documentation, and communicating with other providers.
- Time spent on travel was about the same for all regions of the state, with some variation in travel time per appointment.
- The average cancellation/missed appointment rate across the state was 21%.
- There was no significant difference in percentage of billable time between different provider disciplines.
- Interpreters and translators had a higher average percentage of billable time at 47%.
- Self-employed providers had a slightly lower percentage of billable time at 34%, compared to agency providers at 39%.
- Onsite and virtual service providers had a slightly higher proportion of billable time in comparison to offsite service providers, but count sizes were low.

On average, **approximately 36% of EI providers' time was billable.** Full-time providers worked an average of 10.2 hours per day, completing 3.6 service appointments. Part-time providers worked an average of 6.6 hours per day, completing 2.0 service appointments. (Because part-time providers who completed the study were asked to report time on days in which they worked in EI, the average hours worked per day does not imply that part-time EI providers work 6.6 hours every day, but instead is an average for the days they did work in EI). Part-time providers had a slightly lower percentage of billable time at 34% compared to full-time providers, who had 40% billable time. The lower non-billable time for part-time providers can be attributed to tasks that take approximately the same amount of time to complete regardless of full or part-time status, including professional development, contributions to the EI field, communication outside of appointments, and addressing billing discrepancies.

A typical day for providers included the following tasks (note that break time is not included):

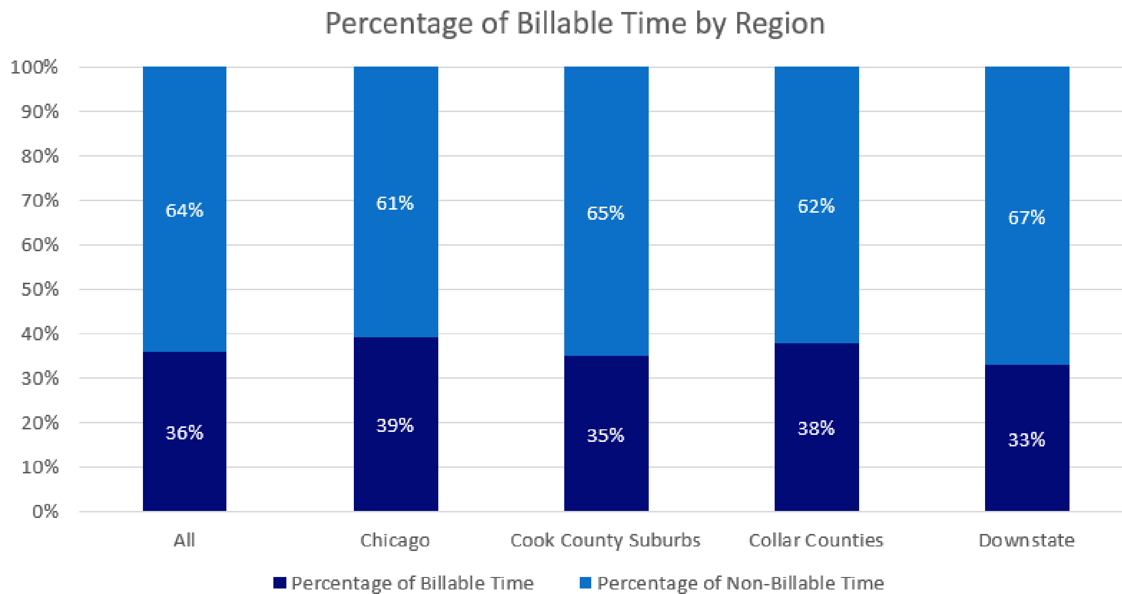
Full-time providers	Part-time providers
•4 hours on direct services •1 hour and 10 minutes on travel •1 hour and 10 minutes on documentation •1 hour communicating with other providers, including IFSP meetings •50 minutes on service preparation, planning, and research •40 minutes on general administrative planning and organization •30 minutes on billing	•2 hours and 20 minutes on direct services •45 minutes on travel •45 minutes on documentation •30 minutes on service preparation, planning, and research •30 minutes communicating with other providers, including IFSP meetings •30 minutes on general administrative planning and organization •20 minutes on billing

The most common type of day logged was a day where 40-50% of a provider's time was spent on billable tasks. However, it was also common for providers to work partial days (less than four hours) where more than 90% of their time was spent on non-billable activities. This aligns with anecdotal evidence from providers who explained that they often spend "catch-up" days working on the administrative portions of their job (for example, over the weekend).

Providers who do additional work outside of EI were asked to track only their EI activities. (These are considered part-time providers for data analysis purposes). If they spent time on administrative work across their whole practice, they were asked to record a portion of their time according to the percentage of their practice that is made up of EI services. For example, if a provider had a caseload that was equally divided between EI children and private pay clients, and she spent two hours on billing and paperwork, she was instructed to record one hour for EI-related administrative tasks, reflecting the 50% of her clients who are in EI.

Across the state, there was some variation in billable time by region. Notably, Chicago providers had a billable percentage six percentage points higher than downstate providers, who had the lowest percentage of billable time (see Figure 16).

Figure 16



Count: 2285 total daily entries (Chicago – 396, Cook County Suburbs – 479, Collar Counties – 888, Downstate – 522)

Despite initial assumptions that downstate providers would spend more time on travel, the time use study showed that **full-time providers across the state spent a similar amount of time on travel**. Table *7* shows that full-time providers spent an average of 1.1 hours traveling per day. However, full-time providers in downstate Illinois completed fewer EI appointments per day than the rest of the state, resulting in a slightly higher travel time per EI appointment. One potential explanation for the smaller caseloads in downstate Illinois could be that there are fewer children in the area who need services. For part-time providers, Chicago providers had a notably lower travel time in comparison to the rest of the state.

Table 7

Region	Completed Service Appointments		Total Travel Time (Hours)		Travel Time per Appointment (Hours)	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Chicago	4.3	1.8	1.1	0.5	0.3	0.2
Cook County Suburbs	4.0	2.0	1.1	0.8	0.3	0.4
Collar Counties	3.5	2.1	1.2	0.8	0.3	0.4
Downstate	2.8	1.8	1.1	0.6	0.4	0.4

While the time use study did not reveal significant differences in travel time between regions, providers who participated in the study suggested that multi-tasking during travel time may have impacted the reporting of travel time. When completing the study, providers were asked not to “double count” time, by reporting the same time used for two activities, such as travel and communicating with families. As a result, providers who used their travel time to communicate with families may have reported lower travel times. This was noted as particularly likely for providers traveling longer distances who had more uninterrupted time to speak with families.

The average cancellation/missed appointment rate across the state was 21%, with a slightly lower rate in the Cook County suburbs at 16%. Chicago had the highest cancellation rate at 23%. Cancellations were defined as any service appointment that was cancelled or not completed and not rescheduled within the same week. This rate of cancellations is in line with the anecdotal reports shared in focus groups.

The study did not show a significant difference in the percentage of billable time between different provider disciplines. Figure 17 shows that psychology and social work professionals had the lowest billable time at 33%, but low count sizes could impact the reliability of the data. While billable times were within a 5% range, Table 8 shows that there was more variation by discipline in hours worked and completed service appointments. Full-time Psychologists and Social Workers completed an average of 2.7 appointments per day compared to Occupational Therapists who completed an average of 4.3.

Figure 17

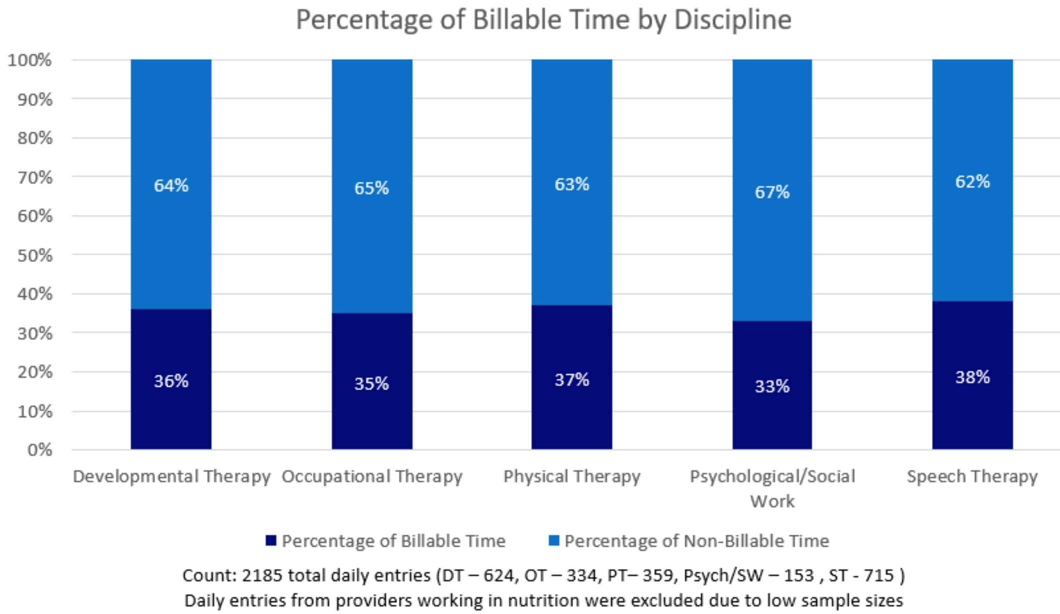


Table 8

Discipline	Total Hours Worked		Completed Service Appointments	
	Full-Time	Part-Time	Full-Time	Part-Time
Developmental Therapy	10.1	6.7	3.3	2.0
Occupational Therapy	11.1	5.6	4.3	1.7
Physical Therapy	10.0	6.6	3.1	2.1
Psychology/Social Work	10.2	6.1	2.7	1.7
Speech Therapy	9.8	7.1	4.1	2.2

Interpreters and translators had a higher average percentage of billable time, at 47%, compared to direct service providers at 36%. Count sizes for interpreters and translators were low, at 96 daily entries, potentially impacting the reliability of the data. Full-time interpreters and translators worked an average of 11.0 hours per day, providing interpretation for 3.5 appointments and spending 3.3 hours on translation. Part-time interpreters and translators worked an average of 3.5 hours per day, providing interpretation for 0.95 appointments per day and spending 0.96 hours on translation. Cancellation rates for interpreters were slightly higher than for direct service providers, with an average of 26%. The most time-consuming non-billable tasks for interpreters and translators included travel, billing, general administrative tasks, preparing and reviewing terms, and scheduling.

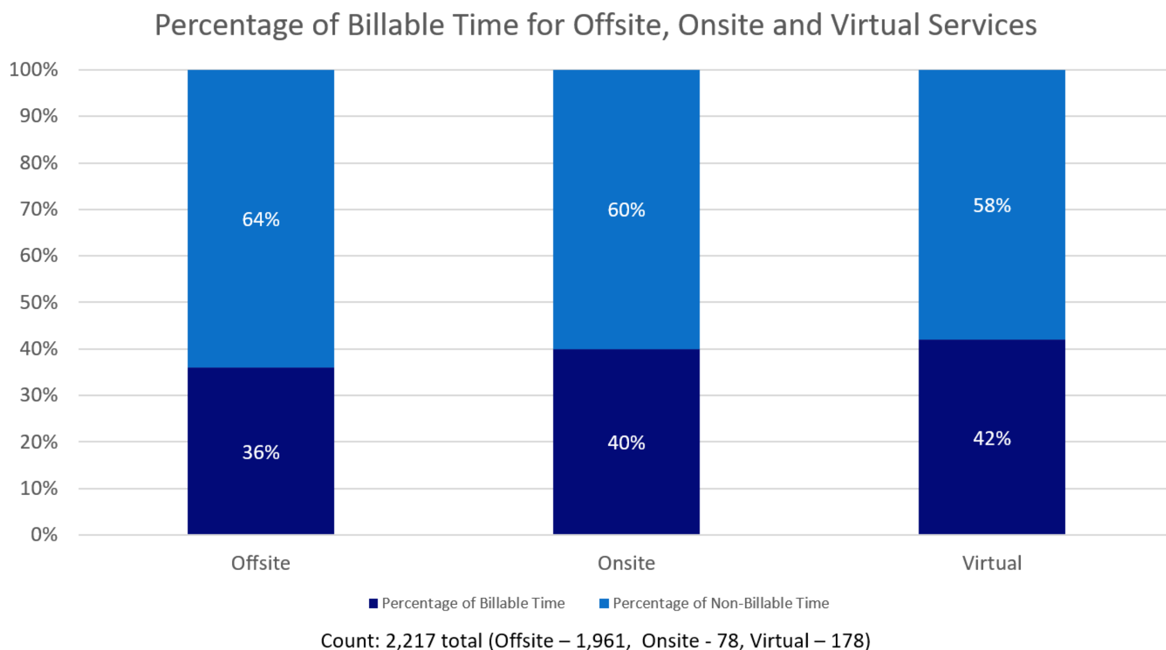
Self-employed providers saw a slightly lower billable time at 34%, compared to agency providers at 39%. Full-time providers employed by an agency completed an average of 4.0 appointments per day, which is slightly higher than self-employed providers, who completed an average of 3.3 appointments per day. For part-time providers, agency employees completed an average of 2.0 appointments per day, similar to self-employed providers, who completed 1.9 appointments per day. A key difference between

self-employed and agency-employed providers was time spent on completing and managing billing. Full-time self-employed providers spent an additional 30 minutes per day on this task. There was no noticeable difference in cancellation rates between self-employed and agency-employed providers.

Onsite and virtual service providers had a slightly higher proportion of billable time in comparison to offsite service providers, but count sizes were low (shown in Figure 18). While onsite and offsite service providers had similar billable times, Table *9* shows that onsite providers tended to work fewer hours per day and complete fewer appointments. Full-time providers who were fully virtual completed a similar number of appointments per day as offsite providers.

Initial expectations were that virtual and onsite providers would complete more appointments per day than their offsite counterparts due to the lack of travel time, but the data did not reflect that. Full-time providers, regardless of delivery method, spent an average of 5.9 hours on non-billable activities per day. In-person providers spent an average of 1.1 hours of that time on travel. LVV providers made up that time by spending slightly more time on other non-billable tasks including billing, documenting notes, scheduling appointments, general administrative planning and organization, engaging in training or supervision, attending case conferences, and professional development. Part-time in-person providers spent an average of 4.5 hours on non-billable tasks per day, compared to 3.9 hours for LVV providers. Of that time, in-person providers spent 0.8 hours on travel.

Figure 18



Count: 2,217 total (Offsite – 1,961, Onsite - 78, Virtual – 178)

Table 9

Setting	Completed Appointments per Day	
	Full-Time	Part-Time

Offsite	3.6	1.6
Onsite	2.7	2.1
Virtual	3.6	1.9

While the data above is analyzed on a per day basis, the data was also analyzed by time use over the complete ten days of the study. **While some tasks are not part of a providers' daily work, they are still important to their practice**. Specifically, Table 10 shows that tasks such as professional development, training and supervision, and contributions to the EI field were not apparent in daily averages but contributed to time spent over the ten-day period. Notably, part-time providers spent more time on these activities compared to full-time providers. A potential reason for this disparity could be that part-time providers have more time in their day to spend on these tasks.

Table 10

Task	Hours over 10-day period	
	Full-Time	**Part-Time**
Professional Development	1.4	1.9
Contributing to the EI Field	0.9	1.2
Engaging in Training or Supervision	1.0	0.9
Participating in Research or Interagency Projects	0.4	0.6
Total	**3.7**	**4.6**

Limitations:

Small sample sizes: While survey participants were generally representative of the EI field, as data was broken down and analyzed by subgroups or different characteristics, there were smaller counts for certain groups. Further exploration may be needed for the following provider disciplines and service types (see Table 11):

Table 11

Provider or Service Type	Number of Daily Entries
Nutrition	32
Interpreters/Translators	96
Psychological/Social Work	153
Onsite Services	78
Virtual Services	178

Multi-Tasking: Another potential limitation of the study findings was that time reported for each task may be underestimated due to multi-tasking. Since providers were asked not to "double count" their time, this may have impacted the way they reported their tasks. For example, a provider could complete

multiple tasks simultaneously, such as traveling to an appointment and communicating with a family, and this could skew the reported time spent on each task.

Survey Design:

- Each provider submitted multiple days of activity, meaning that daily entries are not independent events but share underlying similarities. This may limit generalizability. In particular, this limitation was considered when evaluating data for small sample sizes. For example, the data set might include more than 100 daily entries on a particular item, but these entries might come from only ten participants. Data was therefore combined across subgroups (such as provider discipline) whenever possible in order to generate more reliable estimates.
- The ten-day period within four weeks may not include providers' time worked on weekends or seasonal effects of time spent at different times of the year.
- Part-time providers were asked to report hours only on days they worked in EI, potentially skewing the average reported hours per day, as not all part-time schedules were consistent. For example, a part-time provider could work full days in EI on three days of the week and would not have reported their time for non-EI days, which could make their hours spent on EI look closer to full-time than they would if considered in the full context of their week.

Reflection Session: Participants had the opportunity to participate in a study reflection session to receive three continuing education credits. Reflection opportunities were offered through live Zoom sessions or through asynchronous written reflections. All participants, whether live or asynchronous, were asked to answer a series of questions reflecting on their own experiences, responding to shared findings, and reacting to potential payment reform options.

110 participants attended the live reflection sessions and 28 submitted written responses, meaning that about two-thirds of eligible participants received continuing education credit for participating in the study and reflection.

The reflection opportunity allowed providers to reflect on their experiences and learn about preliminary results from their participation. Participants expressed gratitude for the study and shared how the study impacted their perspectives.

> "I seem to average nine to 12 billable hours of time while putting in about 35 to 40 total hours of EI work per week, this was enlightening and terrifying at the same time since my income is less than half of what my PT colleagues in other settings make." - Physical Therapist, Kendall County, IL
>
> "I knew I felt like I was always working, but after really looking at it, I truly am. It is no wonder I am always exhausted." – Physical Therapist, St. Clair County, IL

The benefits of the reflections were twofold, in that they also provided Afton with the opportunity to check preliminary interpretations of the data and understand potential limitations of the study. Key takeaways from the reflections are shared below:

- **Participants felt validated by the results of the study.** They were surprised to learn how the tasks that seemed small added up during the week. They also appreciated understanding how

their time use compared with other providers and found the chance to discuss the findings and experiences valuable.

> "I never realized how much "extra" time I spent each day on EI activities that may only take a short time (answering emails, preparing materials, scheduling). When considered cumulatively, they can add an additional couple of hours of commitment each week." – Physical Therapist, Elmhurst, IL

- **Providers' felt that administrative tasks distracted from their highest priorities for their time.** Providers stated that their priority task was to provide direct services to families and support them through communication, preparation, and collaboration with other providers. Instead, many providers felt they spent too much time on billing and administrative work that detracted from their ability to work on priority tasks.
- **Providers noted that travel time seemed low** and discussed that this may be due to frequent multi-tasking, as many use long travel times to communicate with families or other providers.

Cost Model

To understand the full cost of the Early Intervention system, including direct services, service coordination, and infrastructure costs, a dynamic cost model was developed. This model can estimate the cost implications of changes to the system, such as differentiating rates or decreasing caseloads. Decisions were guided by field input, detailed in other sections of this report. The following outlines the assumptions and data used in determining the program's overall state cost.

The cost model is a flexible tool built in an Excel spreadsheet, allowing users to estimate the cost of providing services in various configurations and under different policy scenarios. Users can change inputs such as provider compensation and see the effect on costs. While it can inform policy decisions by estimating state-wide costs of various changes, it is not a replacement for the judgment, insight, and values of policymakers. A successful cost model relies on ongoing engagement with practitioners to ensure inputs are based on data that accurately reflects the costs faced by the EI field. The model uses average or median costs to represent a "typical" program, acknowledging that it will not reflect the exact experience of any one practitioner but can support an understanding of statewide costs.

The EI cost model is designed to inform the following questions:

What is the true cost of operating as an EI direct service provider?

- For self-employed and agencies (of various sizes)
- By discipline
- At different compensation levels

What billable rate covers the costs for direct service providers?

- By discipline
- By setting of service (offsite/onsite/LVV)

What is the true cost of operating a CFC?

- For different sizes of organizations
- At different compensation levels

How much would it cost the full EI system to make changes?

- Modified rates
- Modified CFC grants
- Increased services provided

It estimates costs for agencies, self-employed providers, and CFCs separately, as each entity has its own cost structure. Within each organization, costs are divided into personnel and non-personnel costs. Personnel costs include wages or compensation, payroll taxes, and benefits. Non-personnel costs include facilities, supplies, insurance, travel, and other "overhead" expenses (see Table 3 and Table 4 in the above section on the Cost and Payment Reform Survey results for a full list of non-personnel costs included in the model). Information about current spending in each of these categories was collected in the EI Cost and Payment Reform Survey.

Salaries and Compensation

Most EI providers in Illinois are self-employed: 45% are completely independent, and 25% work with an agency for administrative support only. The remainder are employed by private agencies.[44] The cost model treats these employment arrangements differently, assuming that self-employed providers must cover their own benefits and administrative costs in addition to their pay, while agencies bear the cost of support personnel such as directors and billing managers. In addition, many providers in Illinois work in EI in addition to other related systems, such as schools, hospitals, clinics, or private practice. For approximately half of EI providers, EI is one part of their overall income.[45]

The cost model estimates the cost of services *as if* the provider were working full-time in EI and had no other sources of income, for several reasons. First, this is the case for a significant share of EI providers. Second, income data from other sources, such as private pay patients, is unavailable and therefore cannot be estimated reliably as an income source in the model. Anecdotally, providers report income and work arrangements that vary widely across regions, career stage, specialty, provider preferences, and other factors. Finally, modeling the cost for a provider who works full-time in EI ensures that the

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[44] EITP, "2023 Illinois Early Intervention Workforce Survey," 2023, https://providerconnections.org/wp-content/uploads/2024/04/IL-EI-Workforce-Survey2023_Report.pdf

[45] EITP, "2023 Illinois Early Intervention Workforce Survey," 2023, https://providerconnections.org/wp-content/uploads/2024/04/IL-EI-Workforce-Survey2023_Report.pdf

estimated rates allow a provider to work in EI for as much time as she prefers and that low rates are not a barrier to providing more EI services. In engagement with providers, some shared that they would prefer to make EI a larger part of their work but feel constrained by the low rates and pressured to take on other roles or private pay clients to support their own families. Addressing service delays will require not just bringing more providers into the field, but encouraging existing providers to devote a larger share of their time to EI if they prefer to.

Compensation represents the largest single cost for any EI provider or CFC, and it presents unique challenges for modeling. Current compensation is influenced and limited by existing rates for direct services and grant amounts for CFCs. Feedback from the field indicated that current compensation is too low to attract and retain qualified practitioners and does not adequately cover the true cost of providing services. It would therefore be insufficient to use current compensation levels to determine the true cost of EI services and service coordination at a level necessary to provide access to high-quality EI services in Illinois. To address this, the cost model relies on external data sources to inform compensation for direct service providers, interpreters, and CFC staff. The primary external data source used is the Bureau of Labor Statistics (BLS) annual salaries by occupation**.** The BLS collects and reports annual salary data by occupation and geographic area. For example, annual salaries for Physical Therapists, Occupational Therapists, and Social Workers in Illinois are reported and updated annually. These salaries reflect the competitive wage in the labor market for a specific role or the compensation that a provider with specific credentials could earn in another setting, such as a hospital or school. The 2023 median salaries by occupation in Illinois for EI roles are shown in Table 12.

However, BLS salaries have limitations as a data source. The BLS dataset does not include roles like Developmental Therapist or Service Coordinator. Developmental Therapists, also known nationally as Special Instructors, are required to have a bachelor's degree in early childhood development, early childhood special education, or a related degree, comparable to role requirements for elementary special education teachers.[46] Feedback from the field indicated that Developmental Therapists most often leave EI for roles in schools, so Elementary School Special Education Teacher was chosen as a proxy. Although many Developmental Therapists move into roles as Preschool Teachers, the Elementary School Teacher salary was used to avoid further entrenching the existing pay disparities between preschool and elementary school educators. For Service Coordinators, the model includes an option to use the median annual salary in Illinois for a worker with a bachelor's degree.

The prevailing salary for a given profession reflects the labor market for that role, rather than the value to society, and may reflect existing inequities in how certain work is valued. To understand compensation in a broader context, BLS salary levels were also compared to median salaries for workers in Illinois with similar education levels and to the Massachusetts Institute of Technology (MIT) Living Wage for different family compositions, as shown in Table 12. The BLS salaries for each role are above the MIT Living Wage for a single adult, and most are similar to or higher than the average salary for the relevant education level.

[46] "DEC Position Statement: The Role of Special Instruction in Early Intervention." *Division for Early Childhood of the Council for Exceptional Children,* June 6, 2014.

BLS salaries were ultimately chosen as the primary data source used in cost estimates in this report because they are a consistent and reliable proxy for what EI providers could earn with similar credentials in other settings, such as schools or health care systems.

Table 12

Salary Information by Source and Occupation

Role	2023 Median BLS Salaries (Annual)
Audiologist	$89,390
Developmental Therapist*	$75,640
Occupational Therapist	$96,160
Physical Therapist	$104,640
Psychologist	$111,300
Social Worker	$63,590
Speech Language Pathologist	$87,910
Nutritionist	$64,370
Interpreter/Translator	$55,120
Education Level	**Median Salary by Education Level**
High School Graduate	$37,706
Associate degree or Some College	$44,840
Bachelor's Degree	$68,492
Advanced Degree	$87,244
Family Composition	**MIT Living Wage by Family Size**
One Adult, No Children	$47,549
One Adult, One Child	$82,430
Two Adults, One Child (Both Adults Working)	$46,010
Two Adults, One Child (One Adult Working)	$75,899
Two Adults, Two Children (One Adult Working)	$85,613
Two Adults, Two Children (Both Adults Working)	$57,990

**Developmental Therapist reflects the BLS salary for an elementary school special education teacher.*

In addition to salaries, the model also includes required payroll taxes (FICA, unemployment, and workers' compensation). Health insurance costs are reflected in a flat contribution for each employee based on data collected in the cost survey, and the model includes a 4% contribution toward retirement for all staff.

Translating Cost Inputs into Cost Per Service

To inform rates for direct services, cost inputs need to be translated into the cost to provide direct services. This is accomplished in two steps:

1. **Translation to Hourly Costs:** All costs are translated into hourly costs. Annual costs, such as health insurance and facilities costs, are divided by 2,080 working hours. The sum of all personnel and non-personnel costs yields a total cost per hour worked.

2. **Translation to Cost Per Service:** The percentage of billable time is used to translate hours worked into a cost per service. For example, if 36% of a provider's time is billable, then it takes 2.8 hours, on average, to provide one hour of billable services. The hourly cost thus needs to be multiplied by 2.8 to yield the cost per billable service.

Table 13 shows how these costs translate into a cost per billable service for a self-employed provider or interpreter, using BLS salaries, which vary by discipline. Table 13 is based on a billable rate of 34% for direct service providers and 47% for interpreters/translators.

Survey data revealed little variation in the cost of benefits or non-personnel expenses across disciplines and regions. Due to small sample sizes for any specific provider discipline or region, an average of all responses was used for benefits and non-personnel costs across all provider disciplines. The only difference across provider disciplines is therefore salary. However, responses were differentiated for self-employed providers and agencies due to their different cost structures.

Table 13

Hourly Costs for Self-Employed Providers, Salary Based on BLS Wages

Provider Discipline	Wages	Benefits and Taxes*	Non-Personnel Costs	Total Hourly Costs	Percentage of Billable Time	Cost Per Hour of Direct Service
Audiologist	$42.97	$11.53	$7.12	$61.62	34%	$181.23
Developmental Therapist	$36.37	$10.26	$7.12	$53.74	34%	$158.05
Occupational Therapist	$46.23	$12.16	$7.12	$65.51	34%	$192.67
Physical Therapist	$50.31	$12.95	$7.12	$70.37	34%	$206.98
Psychologist	$53.51	$13.56	$7.12	$74.19	34%	$218.21
Social Worker	$30.57	$9.14	$7.12	$46.82	34%	$137.72
Speech Language Pathologist	$42.27	$11.40	$7.12	$60.78	34%	$178.77
Nutritionist	$30.95	$9.21	$7.12	$47.28	34%	$139.05
Interpreter/Translator	$26.50	$8.35	$7.12	$41.97	47%	$89.30

**Includes health insurance, retirement, and federal self-employment tax*

For agencies, the cost of administrative personnel such as an Agency Manager, Administrative Assistant, or Billing Specialist was included. Salaries for these positions are adjusted in relation to the compensation for a direct service provider. For example, survey data showed that the Agency Director typically earned 13% more than an average direct service provider, so average direct service provider wages were increased by 13% to estimate the director's salary. The cost of these positions was prorated based on hours worked, since many agencies use part-time staff for these roles. The cost model automatically adjusts the number of administrative agency staff based on the size of the agency, using ratios of administrative staff to direct service staff reported in the cost survey. The total cost of these positions was translated into an hourly rate to combine with the hourly rate for a direct service provider. According to survey data, the average agency has 8.2 direct service providers and 1.7 administrative

staff. The cost per hour of direct service at agencies varies based on the number of staff, as larger agencies can spread fixed costs over a larger number of providers.

No interpreters or translators in our study reported working at an EI agency, so costs were only estimated for self-employed interpreters and translators.

Table 14

Overhead Costs for Average Agency

Note: The average agency has approximately 8.2 direct service providers and 1.7 administrative FTEs.

Cost Type	Hourly Cost
Personnel Costs	
Agency Director Salary	$34.05
Administrative Assistant Salary	$20.51
Billing Specialist Salary	$23.06
Combined Benefits & Taxes	$11.76
Total Administrative Personnel Costs	**$89.28**
Total Non-Personnel Costs per Hour	$21.20
Total Hourly Administrative and Overhead Cost	**$110.48**
Total Overhead Cost Per Direct Service FTE	**$9.65**

Table 15

Agency Costs by Provider Discipline, Salary Based on BLS

Based on an agency with one of each type of direct service provider

Provider Discipline	Personnel Only (Total)	Agency Hourly Cost/FTE, Including Overhead	% Billable Time	Offsite Billable Rate
Audiologist	$51.86	**$61.57**	39%	**$157.88**
Developmental Therapist	$44.42	**$54.14**	39%	**$138.82**
Occupational Therapist	$55.53	**$65.24**	39%	**$167.29**
Physical Therapist	$60.12	**$69.84**	39%	**$179.06**
Psychologist	$63.72	**$73.44**	39%	**$188.30**
Social Worker	$37.90	**$47.62**	39%	**$122.10**
Speech Language Pathologist	$51.07	**$60.79**	39%	**$155.86**
Nutritionist	$38.33	**$48.05**	39%	**$123.19**

At the same provider wage, a medium-sized agency has somewhat lower costs per hour of direct service than a self-employed provider. Even though the agency has the additional costs of administrative staff, their costs per hour worked are similar to self-employed providers because they are able to spread fixed costs over more providers. Agency-employed providers have a higher billable percentage of their time, largely because of reduced time spent on billing, which translates into a lower cost per hour of direct service.

For both self-employed provider and agencies, costs shown are for offsite services. Sample sizes for onsite services (delivered at a provider's office or clinic) and virtual services were insufficient to reliably estimate the differences in the percentage of billable time for providers working in these service settings. Rate setting for these services should consider how to continue to incentivize serving the child in their natural environment and meeting family preferences for virtual or in-person services.

Comparison of Costs to Current Rates

Under any scenario, the true cost of delivering EI services is far higher than current rates. Current rates are similar to the cost per hour worked, meaning that they currently compensate the provider fairly for the hour spent delivering the service itself, but not for the time required outside of the appointment to prepare, travel to the family, communicate with the family, document the visit, and so on. These overhead costs are essential to the nature of EI services, which are provided in a child's natural environment and therefore require additional preparation and travel time. Multiple funding streams are used to most effectively fund services in a way that both the State and families can afford. Table 16 shows a comparison of the true cost of services to current rates, using a blended percentage of rate between agencies and self-employed providers, and compensation based on BLS salary benchmarks. Table 17 shows Illinois' current reimbursement rates in comparison to other states, including those with similar living wages.

Table 16

Comparison of True Cost to Current Rates

Service	Current Rate Per Hour of Service	True Cost Per Hour of Service	Percentage Difference vs. Current Rates
Audiologist	$ 53.51*	$ 166.06	210%
Developmental Therapist	$ 66.80	$ 145.56	118%
Occupational Therapist	$ 84.64	$ 176.18	108%
Physical Therapist	$ 84.64	$ 188.85	123%
Psychologist	$ 100.72	$ 198.78	97%
Social Worker	$ 65.12	$ 127.57	96%
Speech Language Pathologist	$ 84.64	$ 163.89	94%
Nutritionist	$ 122.64	$ 128.75	5%
Interpreter / Translator	$ 63.04	$ 89.30	42%

**Audiologist rate is an average across all types of claims billed by audiologists*

Table 17

Comparison of Rates Per Hour of Service Across States[47]

[47] Rates for Ohio come from Ohio Early Intervention (https://ohioearlyintervention.org/storage/ocali-ims-sites/ocali-ims-oei/documents/Early-Intervention-Billing-Codes-Rates_100122.pdf).

State (Highest to Lowest Reimbursement)	Speech Language Pathologist	Occupational Therapist	Physical Therapist	Developmental Therapist/ Educator
VA	$150	$150	$150	$100
AZ	$133-$199	$133-$199	$133-$199	$96-$144
IN	$118	$133	$140	$86
CT	$120	$120	$120	$120
NJ	$112	$112	$112	$95
UT	$103-$108	$127-$130	$127-$130	$74-$78
NY*	$90-$111	$90-$111	$90-$111	$86-$106
KY	$89	$89	$89	$89
MO	$85	$85	$100	$75
IL	$85	$85	$85	$67
OH	$72	$87	$87	(none reported)

**New York provides rates for "basic" and "extended" services. Extended services are defined as one hour or more, comparable with the hourly rates presented for the rest of the states in this chart.*[48]

CFCs and Service Coordination

The cost model also includes an estimation of the cost to operate a Child and Family Connections (CFC) office. CFC grant reporting information was used to calculate average costs for personnel and non-personnel expenses. Since CFCs use a variety of titles to describe roles, roles were summarized and combined into general categories to allow for comparison; salaries represent an average across these categories. As discussed above, input from the field made clear that current salaries are insufficient to attract and retain qualified service coordinators and other related roles. Current salaries and staffing levels are thus an imperfect measure of true cost.

The cost model allows the user to choose to estimate the cost of operating a CFC if service coordinators were paid the median wage for a worker with a bachelor's degree in Illinois, which is $68,492. Under this scenario, Parent Liaisons, Intake/Transition Coordinators, and Administrative Assistants are assigned the median wage for workers with a high school diploma, which is $37,706, based on the minimum requirements for these roles seen in job postings. However, note that this is slightly below the current

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Rates for New York come from the New York State Department of Health (https://www.health.ny.gov/community/infants_children/early_intervention/docs/service_rates.pdf)
All other state rate information: "Early Intervention Recommendations Cross-State Research to Inform Early Intervention Service Coordination and Provider Services in Illinois." *Ted Burke,* April 20, 2024. https://providerconnections.org/wp-content/uploads/2024/04/Illinois-EI-Recommendations-04.20.24.pdf.

[48] "Section 69-4.30 - Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers" *New York State,* February 14, 2024. https://regs.health.ny.gov/content/section-69-430-computation-rates-early-intervention-services-provided-infants-and-children.

average salary for administrative or office staff based on CFCs' grant reporting, which is $41,536. Alternatively, the user can enter a custom wage level for service coordinators.

Salaries for leadership positions at the CFC, including Managers, Lead Service Coordinators, and Social-Emotional Consultants, are adjusted in relationship to service coordinators, based on their current average salary differential. For example, according to grant reporting, Program Managers currently earn 50% more than Service Coordinators, so their salary is set 50% higher than the Service Coordinator's salary under any scenario. This avoids wage compression by adjusting program leaders' salaries upward when other employees receive increased pay.

Table 18 shows the annualized salaries for CFC roles under different scenarios:

Table 18

Role	Current Salaries	Salaries Based on Education Level
Administrative and Office Support	$ 41,536	$ 37,706
Program Manager/Director	$ 71,847	$ 102,738
Service Coordinator	$ 47,261	$ 68,492
Lead Service Coordinator	$ 59,909	$ 85,615
Intake/Transition Coordinator	$ 31,559	$ 37,706
Parent Liaison	$ 36,753	$ 37,706
LIC Coordinator	$ 42,257	$ 68,492
Consultants' Hourly Rate		
Social Emotional Consultant	$ 45.32	$ 49.39
Developmental Pediatric Consultant	$ 89.07	$ 131.72
Other Specialized Support	$ 41.94	$ 60.92

Social-Emotional Consultants, Developmental Pediatric Consultants, and other similar roles are typically not full-time roles, but instead part-time roles paid on an hourly basis. Their higher hourly rates reflect the specialized nature of their support. Like leadership roles within the CFC, these rates are adjusted based on their current increase over Service Coordinators' pay to reflect existing wage differentials.

Staffing levels for CFCs are another important input to understanding their operating costs. Current staffing levels were used to calculate ratios of staff needed depending on the CFC's caseload. Input from CFC Managers indicated that current staffing levels may be insufficient, as grants do not currently cover needed positions beyond service coordinators and specialized consultants. Further engagement with CFC leaders is needed to better understand the staffing pattern that would best support children and families.

Table 19

Staffing Pattern for an Average-Sized CFC

Caseload	*847*

Indirect Service Positions	Full-Time Equivalent (FTE) Staff
Program Manager/Director	1.7
Administrative and Office Support	1.9
Total Indirect Service FTE	**3.7**
Direct Service Positions	
Intake/Transition Coordinator	0.4
Parent Liaison	0.6
Service Coordinator	19.6
Lead Service Coordinator	1.4
Social Emotional Consultant	0.6
LIC Coordinator	0.4
Developmental Pediatric Consultant	0.2
Other Specialized Support	0.3
Total Direct Service FTE	**23.5**

CFC costs were estimated using salaries based on Illinois's median wage for workers with a similar education level, to estimate the cost of bringing service coordinators and similar positions to salaries that would be competitive in the labor market for workers with similar credentials. This estimation, which is detailed in Table 20, shows that the true cost of operating a CFC at this increased compensation level is approximately $3 million for an average-sized CFC. For comparison, the current average CFC grant size is approximately $2.3 million. The statewide cost of providing grants that could support these increased salaries is approximately $18.4 million.

Non-personnel costs vary widely across CFCs. Additionally, some CFCs have a practice of paying out bonuses or similar incentive payments to their staff. The average amount of bonuses across all CFCs was 7% of salaries. Some CFCs also included an indirect or reserve line in their grants. These are included in the cost estimate for the average CFC to reflect current practice.

Table 20

Annual Operating Cost for an Average-Sized CFC, Salaries Based on Education Level

Personnel Costs	**Current Staffing**
Salaries for Indirect Service Positions	$252,103
Salaries for Direct Service Positions	$1,687,223
Incentive/Bonus Payments (7% of Salaries for Direct Service Staff)	$118,106
Benefits and Payroll Taxes	$533,996
Personnel Total Cost	**$2,591,428**
Non-Personnel Costs	
Travel	$32,923
Equipment	$4,119
Supplies	$47,033
Contractual Services*	$43,006

Occupancy (Rent and Utilities)	$87,810
Telecommunications	$27,876
Training and Education	$9,394
Other/Miscellaneous	$6,749
Total Non-Personnel Costs	**$258,910**
Indirect/Reserve (5%)	$142,517
CFC Total Cost	**$2,992,856**

**Contractual Services excludes direct service contractors such as Social-Emotional Consultants and Developmental Pediatric Consultants, who are included under personnel costs.*

Statewide Costs

On average, the true cost of delivering EI direct therapeutic services is 95% higher than current direct service rates. This implies that spending on EI direct services would need to approximately double to reach the true cost of services. The difference between current spending on direct services and projected spending on rates that reflect the true cost for direct services is estimated to be approximately $149.7 million. This estimate accounts for a projected 5% increase in services provided as more children and families are able to access services.

For CFCs, the average cost of operation at salary levels that reflect staffs' education and experience is estimated to be approximately $3 million for an average CFC, compared to the current average grant size of $2.3 million. The estimated cost to increase grant sizes to this level is approximately $18.4 million statewide.

In total, the true cost of delivering all EI services is estimated to be approximately $368 million, or approximately $168 million more than current spending. Statewide cost estimates are presented in Table 21. These estimates are shown as an approximation of the scale of investment that would be needed over time to bring the EI system in line with the true costs of delivering services and supporting families. Costs can and will change over time and in response to various policy decisions. Cost modeling should be continuously updated with input from the field and state leadership to reflect these changes.

Table 21

CFC Grants			
	Current Grants	$	56,397,067
	Enhanced Grants to Reflect True Cost	$	74,821,389
	Difference	*$*	*18,424,322*
Direct Service			
	Current Rates	$	143,540,908
	Enhanced Rates to Reflect True Cost	$	292,851,621
	Difference	*$*	*149,310,713*
Total Cost		**$**	**367,673,010**
	Total Difference	***$***	***167,735,035***

Enhancement for Underserved Areas and Increased Children Served

The cost model also allows the user to estimate the impact of increasing the number of children served and of enhanced rates for underserved areas. If increased rates, improved service coordination, and

other policy changes successfully increase the number of EI providers and allow more families to successfully connect with the EI system, the number of children served would be expected to increase. This dynamic effect can be reflected in the cost model.

Additionally, as described in the recommendations section below, further rate enhancements may better support increased service in areas that are currently experiencing high rates of delays. To estimate the impact of this change, the cost model allows the user to enter a percentage rate enhancement and the percentage of services it would be estimated to apply to (for example, a 20% enhancement for 10% of services). Further definition of qualifying underserved areas is needed to accurately estimate the percentage of services that might receive an enhanced rate.

Pilot Programs

The recommendations below describe several potential pilot programs that would allow IDHS-DEC to test out ideas for structural changes to the EI system. The cost model includes tools that can be used to estimate costs for each of the following pilots:

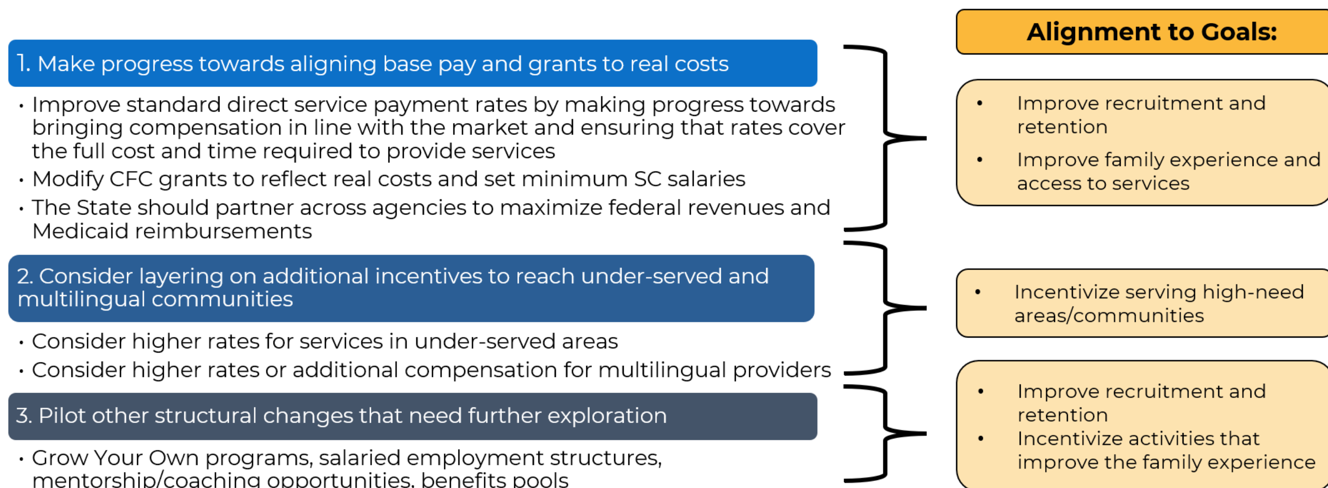
- **Grow Your Own Program**: The main components of this model include reimbursement for tuition and living expenses for program participants. In addition to the cost for participants, the model also includes the cost of mentorship, and distinguishes by discipline to allow for varying rates.
- **Salaried Employment Pilot**: This cost model estimates wages and benefits for new EI providers as well as experienced providers in a pilot program to provide salaried employment opportunities. Since participating providers would still bill for services, the model estimates the full cost of salaries and benefits, subtracts the amount that would be covered through reimbursements, and estimates the remaining gap that would be needed to run the program, as well as administrative costs. Wages are differentiated by discipline and can be adjusted as needed.
- **Mentorship and Coaching Program:** This program would provide compensation to experienced providers who would dedicate a portion of their week to supporting new EI providers. The model estimates the cost of providing compensation for both the mentorship support and training. It allows the user to decide if both mentors and mentees will be compensated and at what rate. It also includes materials and administration costs.

Payment Reform Recommendations

Payment reform recommendations respond to the challenges surfaced from the many forms of research and data collection shared above, including research, data analysis, input from families and practitioners, and results from the cost survey and time use study. The recommendations focus on addressing some of the most pressing challenges currently facing the EI system: recruitment and retention of EI practitioners to adequately provide the services to which qualifying families are entitled, and inequitable delivery of those services. These challenges have contributed to service delays for families across the state, which have been especially severe for children of color and families in rural areas. The following recommendations are based on the extensive research and community engagement, along with the support and input from the Workforce Workgroup of the IICEI. During this process, many issues beyond the scope of payment reform were also surfaced, and while they merit further discussion and planning,

the following recommendations focus specifically on changes that fit within the bounds of EI payment reform.

Figure 19



Recommendation 1: Make progress toward aligning base pay and grants to real costs.

Based on practitioner input and cost model findings, current pay and grants do not adequately cover the full cost of providing services. To improve both recruitment and retention of EI practitioners and support staff, and ultimately improve families' access to services, rates for direct services and CFC grants should make progress toward the modeled cost of service delivery. Since increasing rates and grants to meet true cost will require a significant increase in EI funding, the state should use a multi-year approach to align pay with true costs.

Recommendation 1a: Improve Direct Service Rates

EI rates are currently not competitive with the market and often lower than reimbursement rates in other states with similar cost of living. Increasing rates was the top desired change from providers according to the EITP 2023 Workforce Survey,[49] and 90% of providers agreed the reimbursement rates were insufficient during focus groups. Improving direct service reimbursement rates is critical for the State to improve both recruitment and retention.

To improve recruitment and retention, increased rates should make progress towards bringing compensation in line with the labor market. Reimbursement rates by provider discipline should be matched to BLS average salaries for professionals with the same credentials, providing a competitive rate for each discipline and encouraging more providers in the field to work and stay in EI. Increasing reimbursement rates to more closely align with the market would also support Illinois in reaching rates that are competitive with other states, as shown in Table 17. For example, Illinois' neighboring state of

[49] "2023 Illinois Early Intervention Workforce FY23 Survey." *Early Intervention Training Program,* 2023. https://providerconnections.org/wp-content/uploads/2024/04/IL-EI-Workforce-Survey2023_Report.pdf.

Indiana compensates its Occupational Therapists an additional $36 per hour and Physical Therapists an additional $56 per hour above Illinois rates.

Rates should make progress towards providing adequate compensation to cover the full cost of delivering services. Based on the time use study, approximately 36% of providers' time is billable, with the other 64% being non-billable. This means that reimbursement rates for the time spent on direct services need to cover the cost of related activities that are necessary to provide the full service. For example, if each hour-long service takes approximately 1 hour and 45 minutes of additional preparation, documentation, and travel time, the rate should cover the full 2 hours and 45 minutes of time it takes to deliver the service. In addition, rates should account for an approximately 20% cancellation rate as part of the non-billable time. Providing a rate that is sufficient to cover time spent outside of the direct service on preparation, travel, documentation, communication with families and other providers, cancellations, and administrative work ensures that providers in a fee-for-service model are compensated more closely to the full cost of delivering a service.

In addition to increasing rates across the board, the State should consider paying higher rates to experienced providers. In most jobs, employees can expect increasing compensation as they gain experience, and EI providers felt strongly that pay for experience is crucial for retention. While compensating providers for mentorship and supervision is one way to recognize their experience, increased compensation should also be considered for providers who want to remain in direct service. This should be viewed as an additional element of competitive compensation for EI providers.

Recommendation 1b: Improve CFC Grants

CFC grants should be based on the full staffing pattern of a CFC office. In the current system, CFC grants are based on service coordination, with supplemental amounts provided for a few part-time positions, but this does not align with true staffing patterns necessary to fulfill the role of a CFC. Based on CFC budget statements, all CFCs have a Manager, and most have at least one other administrative position. Larger CFCs often have Assistant Managers and more Administrative Assistant or Intake Coordinator positions. Most also offer a Lead Service Coordinator position, which provides some opportunity for growth for service coordinators. Input from CFC managers indicated that Lead Service Coordinators (or similar roles) play a key role in supervision, training, and support for service coordinators. Wages for these positions currently must come from the service coordination amount, which leaves Service Coordinator positions under-funded and under-staffed. This further reinforces the current cycle where Service Coordinators choose to leave the field due to low pay and high workloads, increasing the workload and burden on remaining staff.

To support the recruitment and retention of CFC staff, grants should provide sufficient funding to increase the number of Service Coordinator positions to meet recommended caseloads and account for turnover and paid time off. Further study and engagement with CFC leaders is needed to better understand the full range of staffing needs and how it varies by caseload and program size. The cost model can help to estimate the cost of all needed positions and non-personnel costs.

To further support recruitment and retention, CFC grants should set minimum salaries for Service Coordinators. Minimum salaries could be determined through a similar approach to the reimbursement rates to service providers, either using a comparable market wage or tying a wage floor to educational attainment. In Illinois, the average wage for an employee with a bachelor's degree, which is a

requirement for Service Coordinators, is $68,492. This would be a significant increase from the current average salary of $47,000. CFCs should be required to pay at least the minimum salary but could differentiate pay for staff based on additional characteristics such as multilingual status or experience. Grants should provide sufficient funding to raise salaries.

In addition to increasing funding, the State should continue to guarantee CFC funding for the full year. Setting funding levels annually, instead of varying amounts based on caseloads and incentive payments, allows CFC offices to hire and plan for their entire year. The State should also consider how to adjust for differences in caseload based on forward-looking rather than backward-looking measures. Currently, caseload calculations are based on previous months' caseload levels, but this may not account for population changes or changes in eligibility status. This can lead to a negative reinforcing cycle, where lower caseload leads to lower award amounts and staffing, which leads to delays that can suppress caseload while not providing adequate services. This consideration is especially critical as the State has recently expanded eligibility by including children who have experienced abuse and neglect (Public Act 102-926) and allowing children who turn three during the summer to continue with EI services until the start of school (Public Act 102-0209).[50] Using backward looking measures to calculate funding does not adequately fund CFCs to expand the reach of services to newly qualifying children.

Recommendation 1c: Maximize Federal Revenue, Private Insurance Coverage, & Medicaid Reimbursement

To support increases in direct service rates and CFC grants, the State should partner across agencies to maximize federal revenues, private insurance coverage, and Medicaid reimbursements for EI, now and as EI transitions to IDEC. Currently, a majority of public funds for EI in Illinois come from the General Revenue Fund, with IDEA Part C comprising 9% and Medicaid comprising 18% of public funds (not including private insurance payments). A survey of EI administrators nationwide found that federal sources, including Part C and Medicaid, comprise 36% of state's EI revenue, on average.[51] Massachusetts and New Mexico, which serve the highest percentages of children, rely more heavily on Medicaid funding, with Medicaid making up more than half of their public dollars spent on EI.[52] Further investigation, including peer state analysis, assistance needed to support any potential changes to billing, and development of a plan to strengthen that capacity is needed to understand how Illinois can better leverage Medicaid and other sources of funding to support sustainable investments in its EI system. This work should be done in partnership with other state agencies and alongside efforts to strengthen Medicaid billing practices in other services.

Recommendation 2: Consider layering on additional incentives to reach under-served communities and multilingual families.

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[50] "Illinois Early Intervention Extended Services." *Provider Connections,* 2021. https://providerconnections.org/wp-content/uploads/2021/11/EI-ES-Parent-Notice-Final-20211028.pdf.

[51] Infant Toddler Coordinating Association, "2023 ITCA Finance Survey Report," 2023. https://www.ideainfanttoddler.org/pdf/2023-ITCA-Finance-Survey-Results.pdf

[52] New Mexico Early Childhood Education & Care Department, "Annual Outcomes Report: Fiscal Year 2023," June 2023, https://www.nmececd.org/wp-content/uploads/2024/07/Annual-Outcomes_April_16_2024_ECECD_Comms_rev1.pdf; Massachusetts Department of Public Health, "Public Reporting for Early Intervention: Legislative Report FY21," https://www.mass.gov/lists/public-reporting-for-early-intervention#idea-determinations-.

To address the various equity challenges discussed in this report, including disproportionate service delays and the need for multilingual providers, the EI system should consider layering additional incentives on top of increased baseline compensation rates. This approach should be developed and implemented in alignment with the forthcoming transition to the Illinois Department of Early Childhood, which is centering families with special needs and the providers that serve them.

Under-Served Communities:

While improving direct service rates and CFC grants can address field-wide problems with recruitment, retention, and families' access to services, providers will still have an incentive to serve families who are closest to their own location as long as they receive the same rate for all services. Payment is one tool available to the EI system to address the higher investment of time needed to reach under-served communities – for example, through increased travel time to a rural area. Payment changes should be coupled with training and support, such as reflective supervision, to support providers in meeting families where they are.

To incentivize equitable access, the EI Bureau should consider providing higher rates for services in under-served areas. Service delay and waitlist data, along with other measures, can be used to pinpoint persistently under-served geographic areas. The State could consider the following additional measures to determine under-served areas:

- **Social Vulnerability Index (SVI)**: SVI takes into account both demographic and socio-economic factors including poverty, transportation, and housing to determine social vulnerability at the census tract level.[53]
- **Health Professional Shortage Areas (HPSAs)**: HPSAs are areas where there is a shortage of providers in a designated area based on the population.[54]

Enhanced rates can encourage travel and other investments of providers' time when serving children and families that the State has historically struggled to adequately serve. Rate enhancements should be based on stable characteristics to avoid continual fluctuations and reduce administrative complexity. Basing enhancements on a geographic region rather than specific characteristics of the child or family simplifies billing and minimizes changes needed when the family's situation changes. For example, it would be challenging to provide enhanced rates based on a family experiencing homelessness, as the rate to serve the child could change if the family finds housing. Any characteristics that lead to a rate enhancement should be simple to measure and track and must be recorded on service authorizations. In designing enhanced rates, the state should seek additional family and provider input to identify any unintended consequences.

Some states are currently providing higher pay to help address service shortages:[55]

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[53] "Place and Health." *Agency for Toxic Substances and Disease Registry,* n.d. https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

[54] "What Is Shortage Designation." *Health Resources and Services Administration,* n.d. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas.

[55] "Early Intervention Recommendations Cross-State Research to Inform Early Intervention Service Coordination and Provider Services in Illinois." *Ted Burke,* April 20, 2024. https://providerconnections.org/wp-content/uploads/2024/04/Illinois-EI-Recommendations-04.20.24.pdf.

- Colorado provides higher rates for geographic areas that have the lowest rates of contracted providers and lowest Service Coordinator salaries.
- Arizona uses a tiered payment system that varies rates by discipline and county for services delivered in the natural environment.
- Utah provides an add-on to hourly rates for offsite services based on geographic region of the state (Urban, Rural or Frontier).

Multilingual Families:

IDHS-DEC should also consider higher rates or additional compensation for multilingual providers. Families prefer services in their home language, and providers in the current system are often unable to meet that need. Supporting the recruitment and retention of additional multilingual providers and Service Coordinators through higher rates limits the need for two practitioners at visits (the service provider and the interpreter). To encourage home-language services, the EI system could offer a higher rate for services provided by a multilingual provider in a non-English language. Multilingual providers have also reported that there is additional preparation time required to create materials in a second language, often having to translate work and take on additional coordination work. Additional compensation would help to adequately compensate providers for their time while also encouraging the desired home-language services for children and families. To support recruitment, the state could consider sign-on bonuses or other stipend-based compensation to build the pool of multilingual providers and Service Coordinators in the EI system.

The State will need to consider various components for implementation, including establishing a system to determine language fluency and working with CFCs and the CBO to create a process for authorizations for services in a non-English language. It is important to provide this incentive specifically for services provided in a non-English language to encourage multilingual providers to serve families who have this need.

Recommendation 3: Pilot other structural changes that need further exploration.

While the changes above respond to immediate concerns around provider compensation, CFC grants, and equitable access to services, there are additional system challenges that would not be addressed through those changes. These challenges would require structural changes to the EI system, which have unknown consequences for providers and families. In some cases, implementation could be complex. Pilot programs are therefore an appropriate first step to understand the benefits, unintended consequences, and implementation needs involved.

Grow Your Own Program: Consider piloting a “Grow Your Own” program for both direct service providers and service coordinators. Families were clear that they appreciated and valued having practitioners who shared their backgrounds and experiences, and this program would help to create a pathway to bring practitioners with similar backgrounds into the system. Currently, providers in the EI system are predominantly white and female, and while there have been efforts to train employees in cultural competency, EI families of all demographics felt it was important to have providers that shared their cultural background. A “Grow Your Own” program could help to diversify the workforce and encourage community members and EI family members to explore careers in Early Intervention. Having more providers within a community could both support access to services, especially for families in areas with a lack of providers, and improve the quality of services, as families would be more likely to have

providers with similar backgrounds and experiences. This program could also provide pathways for growth for people currently involved in the EI system who are looking to further their career.

A “Grow Your Own” program should include scholarships for continuing education, funded internships, and stipends or salaries for qualified mentors. This pilot should include Service Coordinators as well as direct service providers. Participants should live in underserved areas. A commitment of at least three years of funding should be provided, since the education required to become an EI provider can take several years.

Salaried Employment Option for New EI Providers: IDHS-DEC could offer grants for EI teams that pair new providers with experienced providers in full-time salaried roles. EI practitioners expressed that it is often challenging to get started in the EI system, especially as an independent contractor. For new providers, navigating the various EI requirements and certifications, as well as understanding billing, can be a barrier to entry. In addition, many providers discussed the challenges of starting and maintaining a caseload, as it often takes time for new providers to develop relationships with service coordinators to begin receiving cases. Since pay in the fee-for-service model is tied to providing individual services, getting started in EI can mean unstable and insufficient pay due to lower caseloads. The combination of these challenges makes it difficult for new providers to join the field.

Providing an opportunity for new EI providers to enter the field through salaried employment, with support from an experienced provider, would resolve the challenge of unstable pay while also providing support in understanding the system. For the experienced provider who would provide support and training, this option would make use of their valuable expertise. This would also create career pathways and opportunities for growth for experienced providers who currently do not receive compensation for providing this kind of support. While the majority of EI providers valued the flexibility that comes with being self-employed, a substantial minority of experienced providers felt that the stability and teamwork of a salaried role would be appealing; this pilot would provide opportunities for salaried employment at each stage of an EI provider’s lifecycle.

The pilot grant should include funding for salaries for both the experienced providers, who would provide support for new providers part-time, as well as funding for salaries for new providers. This funding for new providers could decrease as the provider gains experience and builds a caseload (for example, the grant could provide 75% support in their first year, 50% in their second year, etc.) CFC offices and existing agencies could be appropriate implementation partners; however, more exploration is needed to determine the best approach for implementation.

This pilot would give the State an opportunity to test a different employment structure in the EI system. If successful, it could encourage the growth of more models for EI providers’ work structures beyond the current independent contractor model.

Mentoring and Coaching Program for Experienced Providers: In this pilot, the State would offer stipends to experienced providers to serve as mentors and coaches. This would allow the field to benefit from their expertise and increase collaboration among providers. It would also provide career growth opportunities for EI providers. The benefits of this approach include that providers could continue their current employment arrangement and opt-in to participate in this program. Using stipends would be a simpler method to compensating providers for this kind of work, while also encouraging the collaboration and mentorship that improves the quality of services for families. The state is currently

piloting a similar model through the Early Intervention Training Program's Reflective Supervision pilot, which provides training in reflective supervision and practice for providers and compensates them for their time. The state can continue to build on that model to develop a broader mentoring and coaching program for experienced providers.

Provider Benefits Pool: Many providers identified difficulty accessing health insurance and retirement benefits as a major barrier to remaining in the EI system. Some professional organizations offer pooled insurance plans to their members, known as Association Health Plans (although this option should be considered carefully, as some Association Health Plans are not subject to the Affordable Care Act's rules, such as guaranteeing coverage for pre-existing conditions).[56] Additionally, Illinois could explore a partnership with GetCoveredIllinois, its health insurance marketplace, to support EI providers in finding and affording appropriate plans. DC and Washington State have recently implemented additional subsidies for health insurance for child care providers through their marketplaces, providing one possible model.[57] Similarly, the State or EI professional organizations could provide navigation support to help providers find and set up retirement plans designed for self-employed or small business workers.

In addition to the suggested pilots, as EI services transitions to IDEC, the State should consider improvements to billing that would simplify the process for providers, including through technological innovations. This work should build on the EI Bureau's current progress on supporting billing practices through the implementation of its new data system. Billing and technology improvements should also be implemented in partnership with and through the IDEC Transition Advisory Committee Workgroups on Funding Design, Data, Insights, and Analysis, Workforce, and Intermediary Alignment.

Conclusion

Research, focus groups, and surveys with practitioners and families across the state highlight the challenges faced in Early Intervention today. This includes struggles to recruit and retain practitioners, challenges with covering the cost of delivering services, high caseloads, and inequities in service access and timely service delivery. The recommendations detailed in this report can help to address these challenges and improve equitable access to timely services.

Afton Partners extends its gratitude to the Illinois Department of Human Services' Division of Early Childhood and its Early Intervention Bureau, the Early Intervention Workforce Workgroup of the IICEI, and the many practitioners and families who gave their time to participate in this research.

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[56] "The Past and Future of Association Health Plans." *The Commonwealth Fund,* May 14, 2019. https://www.commonwealthfund.org/blog/2019/past-future-association-health-plans

[57] "Compensation Means More Than Wages." *National Association for the Education of Young Children,* May 2024. https://www.naeyc.org/sites/default/files/wysiwyg/user-73607/naeyc_benefits_brief.may_2024.pdf?utm_source=pocket_saves

Appendices

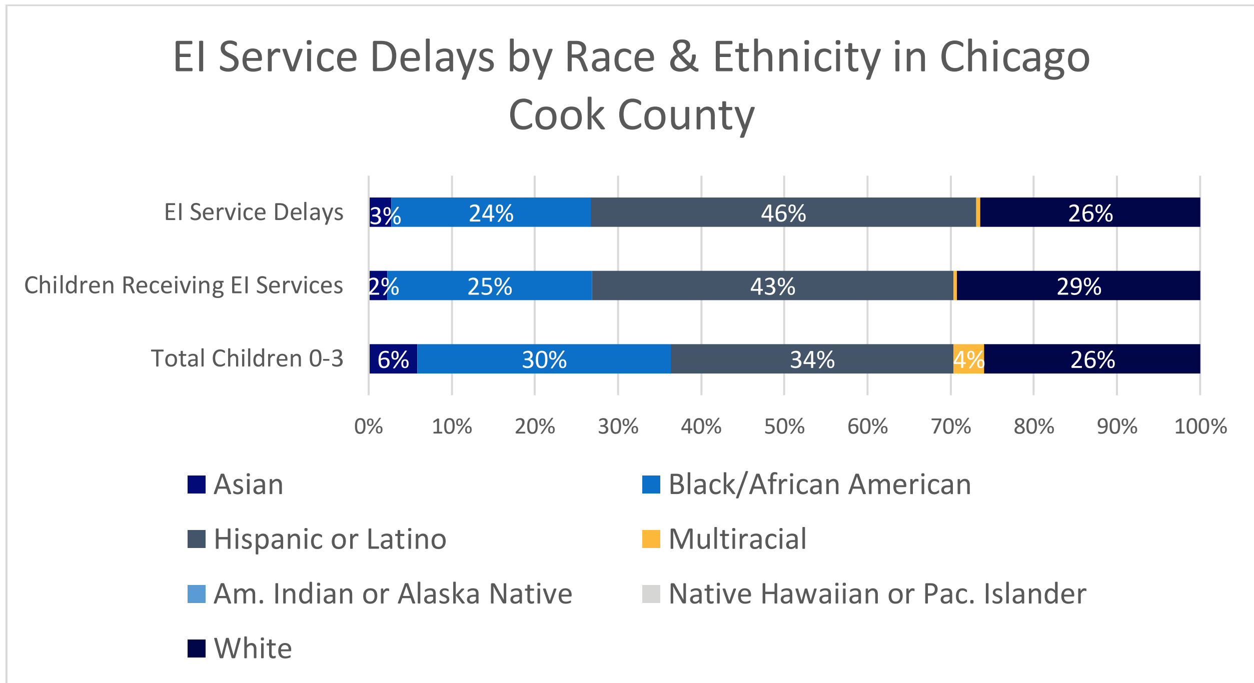
Appendix A: IICEI Workforce Workgroup Membership

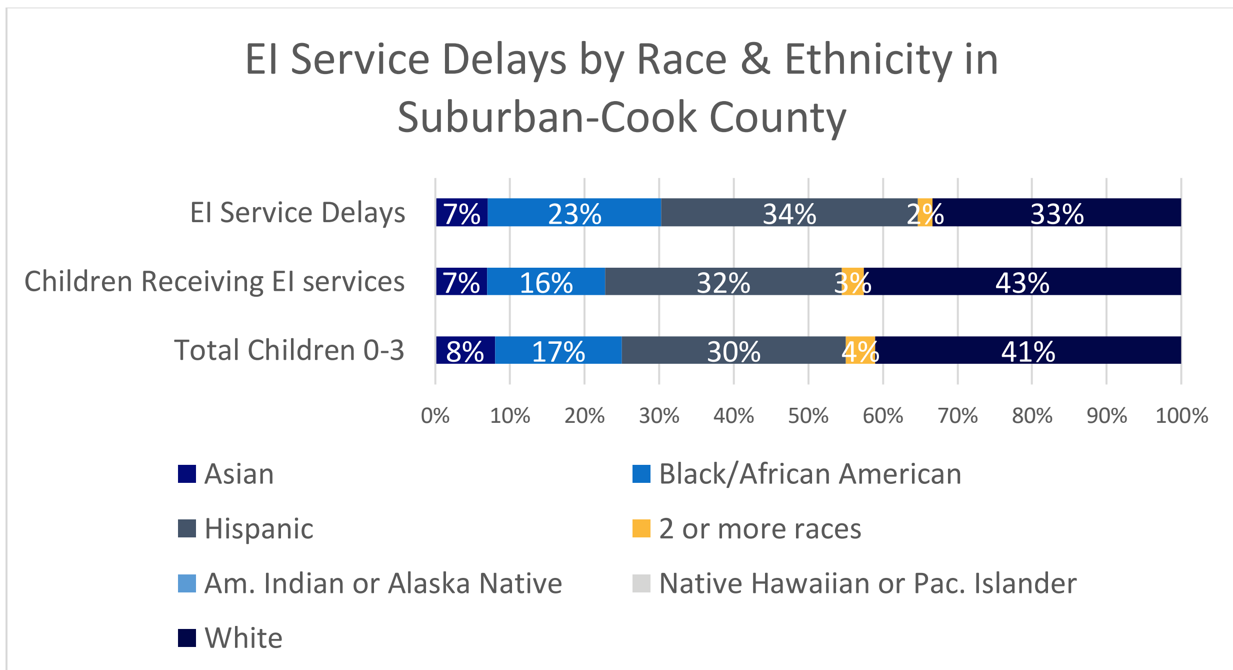
Name	Role	Discipline/Organization	CFC
Amanda Albright	Provider	SLP/ISHA	9, 11
Autumn Bruere	Provider	DTH	
Antonio Borjas	Provider	Interpreter	Cook
Michelle Clyne	Provider	DTV	5,6, 7, 8,9,10,11,12
Susan Connor	EI Partner	EITP	Statewide
Tracy Cooper	Provider	LCSW, IAIMH	1,8,9,11,12,15
Jen Crick	Provider	DT/IDTA	2, 25
Rob Derry	EI Partner	Provider Connections	Statewide
Chelsea Guillen*	EI Partner	Ombudsman/ EITP	Statewide
Kesha Harris	Parent		CFC 18 - Sangamon County
Katie Jacobs	EI Bureau	EI Bureau	Statewide
Zareen Kamal	Advocate	Start Early	Statewide
Jenny Masterson	Provider	PT	22
Rachel Mika	Provider	PT/IPTA	4, 5, 15
Carol Muhammad*	CFC	Program Manager	10
Stefanie O'Donnell	Provider	SLP, Advocate	5, 6
Talibah Moore**	Advocate	COFI, Raising Illinois	Southern IL
Monica Patrick	CFC	Program manager	9
Makenzie Pettit	Provider	SLP	14, 16
Amy Santos	Preservice	IICEI Preservice rep	
Lisa Seymour	Provider	OT	
Delreen Schmidt-Lenz	Provider	SW, SEC	20
Ellen Shwatal	Provider	DT/IDTA	4, 5
Ashley Stoffel	Preservice, Parent	OT, UIC OT program, ILOTA	9, 11
Nicole Van Hise	CFC	Program manager	22

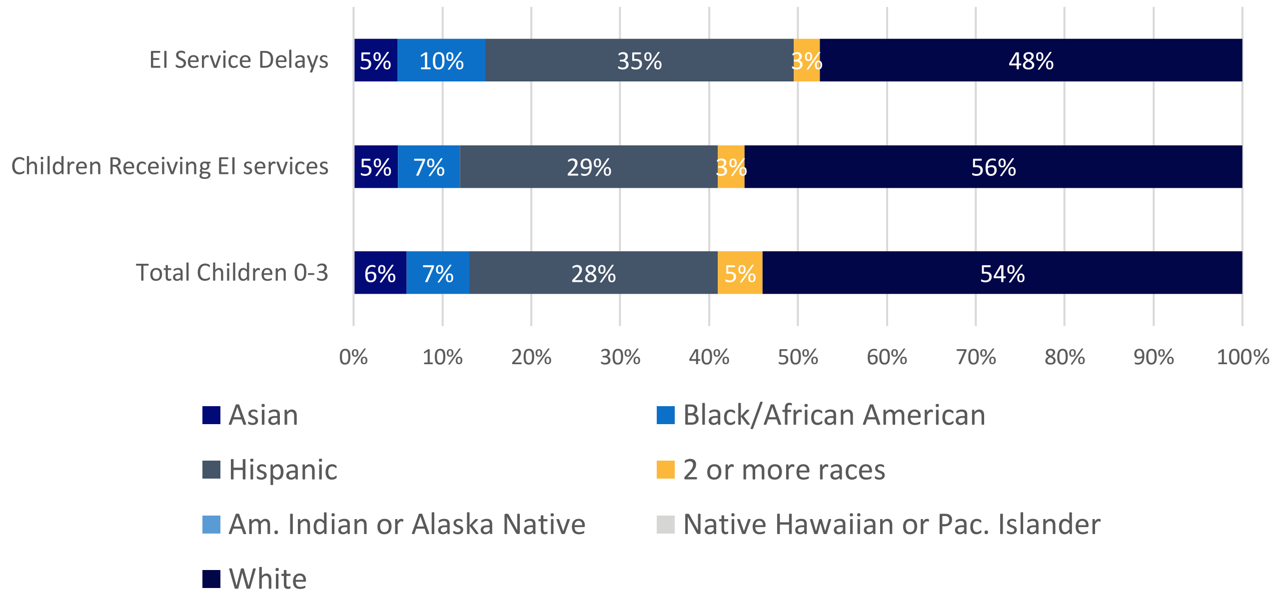
*Workforce Workgroup Co-Chairs. From October 2023 to April 2024, Christy Morrison served as a co-chair prior to Carol Muhammad.

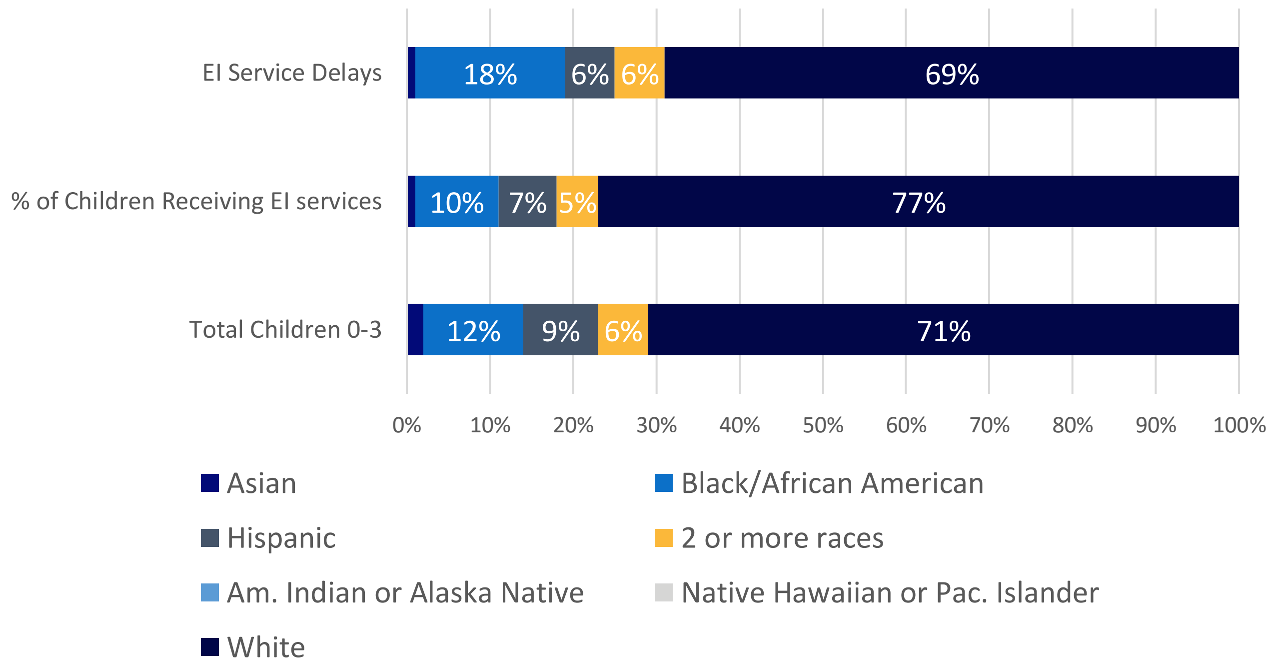
** Esther Beard served as the advocate member from COFI prior to Talibah Moore

Appendix B: Service Delay Regional Breakdowns by Race and Ethnicity






EI Service Delays by Race & Ethnicity in Collar Counties
EI Service Delays
Children Receiving EI services
Total Children 0-3
5%
10%
35%
3%
48%
5%
7%
29%
3%
56%
6%
7%
28%
5%
54%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Asian
Black/African American
Hispanic
2 or more races
Am. Indian or Alaska Native
Native Hawaiian or Pac. Islander
White


EI Service Delays by Race & Ethnicity in Downstate
EI Service Delays
% of Children Receiving EI services
Total Children 0-3
18%
6%
6%
69%
10%
7%
5%
77%
12%
9%
6%
71%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Asian
Black/African American
Hispanic
2 or more races
Am. Indian or Alaska Native
Native Hawaiian or Pac. Islander
White

Appendix C: Provider Focus Group Protocol & Attendance

Provider Focus Group Protocol
Note: Protocol was modified depending on the group of providers, including sessions for Speech Language Pathologists/Occupation Therapists/Physical Therapists, Developmental Therapists and low incidence providers, interpreters, translators and bilingual providers, CFC managers, CFC staff, and former EI providers.

1. What is a typical week like for you? What are the major tasks you complete in a week? How many hours per week do you work in EI? What do you spend the most time on?
   - If you work part-time in the EI system, explain why.
2. How much time do you spend on each child/family outside of the time you are working directly with the child?
3. About how many children do you work with in a typical week and approximately how many hours do you spend on each child (including time spent outside of direct services)? Do you think this is too many, too few, or about right?
4. Do you believe providers are receiving an appropriate salary for their work?
   - If not, what are the biggest barriers you experience in getting paid a fair salary?
   - What would be a fair, competitive salary or hourly rate for your work? Why?
5. If you could wave a magic wand and change one thing about the way that EI providers get paid, what would you change?
6. Have you experienced delays in payments or incorrect payments? If so, how frequently? What do you think caused these issues?
7. What are your largest sources of revenue – private insurance, EI billing, grants, other sources?
8. We've heard from providers that one of the biggest challenges they experience are cancellations or missed appointments. In the last month, how many times did a family cancel and for what reason (if known)?
9. Do you have a cancellation policy or procedure you follow when a cancellation happens? How do cancellations affect your work and/or pay?
10. What would you like to see changed to either reduce cancellations or reduce the negative impact on providers when families cancel?
11. Have you worked with families, either currently or in the past, who have extenuating circumstances or encounter severe barriers to receiving EI services? What were those barriers?
12. What current resources or supports are helpful to *you* when working with families/children that fit these categories?
13. If you had additional time or resources, are there specific activities or supports would help you meet family needs? (like spending more time talking to parents, more collaboration with other providers, increased training...)
14. The goal of this project is to make recommendations to improve EI payment structures and focus on equitably serving children and families, particularly those furthest from opportunity. Is there anything else we haven't talked about that you want to make sure we're considering to get closer to that goal?

Provider Focus Group Attendance

Group	Attendees
Southern IL Service Coordinators and Providers	28
Developmental Therapists and providers serving low incidence populations	45
Speech, Occupational, and Physical Therapists	84
Service Coordinators	45
Translators, Interpreters, and Bilingual providers	19
Open: Any provider or advocate	50
Former Providers/Providers who left the field	13
Open: Any provider or advocate	18
CFC Managers	8

* Additional conversations were held with Developmental Therapy Vision and Hearing Specialists and Medical Diagnosticians in March 2024 and CFC Managers in August 2024.

Appendix D: Family Focus Group Protocol

1. How did you find out about EI services in your community?
2. Tell us more about how your child was identified for EI services.
3. Was there ever a time where you were not able to receive services for your family?
4. Where does your child receive services?
5. About how long did it take you to receive services after completing an Individualized Family Service Plan?
6. Describe your relationship with your Service Coordinator. In what ways have they helped you and your family? What could they do to improve?
7. Describe your relationship with your service providers. In what ways have they helped you and your family? What could they do to improve?
8. Do any of the providers you've worked with have similar experiences to you? Does that impact your family's experience?
9. Thinking about your family, friends, and neighbors, how many of the children who need Early Intervention are receiving them? (All, some, very few?)
10. If your child receives more than one type of Early Intervention service, is one service easier to access in your community? Why do you think so?
11. Have you received services in different communities? Please share any similarities or differences.
12. If you travel to receive services, how long does it take you to get there? Could you access the location through public transportation?
13. Do you ever have to cancel or miss an appointment? What is the reason?
14. What would make it easier for you to attend appointments?
15. Do you feel as though your child's needs are being met through the Early Intervention program? Why or why not?
16. What do you like the most about the Early Intervention program? What has been most helpful to you and your child so far?
17. What is the biggest obstacle or challenge you have faced within the Early Intervention program? What would you like to see change or different?

Appendix E: Illinois Early Intervention Cost Survey

Introduction

1) Please select the year for which you will be providing data in this survey. Choose the year that you find easier for reporting, ideally the one for which you have already filed your taxes.*

( ) 2022
( ) 2023

2) For follow-up inquiries regarding your survey responses, please provide your email address. A reminder that this information as well as everything you provide in this survey will be confidential.*

About You

3) In the year you selected, which role did you primarily fulfill in the Illinois Early Intervention system? Select the role where you spent the most time. If you had multiple roles, choose the one that represents your main focus or the majority of your work hours during that year.

( ) Direct Service Provider
( ) Agency or Practice Manager
( ) Service Coordinator or CFC Staff
( ) Translator/Interpreter
( ) Medical Diagnostic Services
( ) Other - Write In: ____

4) If you were a direct service provider in the selected year, what was your primary specialty?*

( ) Translator
( ) Assistive Technology
( ) Aural Rehabilitation
( ) Bilingual and Sign Language Interpreting
( ) Board Certified Behavior Analyst
( ) Certified Occupational Therapy Assistant
( ) Deaf Mentor
( ) Developmental Therapy
( ) Developmental Therapy - Hearing
( ) Developmental Therapy - Orientation and Mobility
( ) Developmental Therapy - Vision
( ) Interpreter
( ) Licensed Audiology
( ) Licensed Clinical Professional Counselor
( ) Licensed Clinical Psychology
( ) Licensed Clinical Social Work
( ) Licensed Dietitian Nutritionist
( ) Licensed Marriage & Family Therapy
( ) Licensed Occupational Therapy
( ) Licensed Physical Therapy
( ) Licensed Physical Therapy Assistant
( ) Licensed Professional Counselor
( ) Licensed Social Work
( ) Licensed Speech Language Pathology
( ) Medical Diagnostic
( ) Ophthalmology
( ) Parent Liaison
( ) Physician Consultation
( ) Psychology Assistant

( ) Registered Nurse
( ) Service Coordinator
( ) Social Work Assistant
( ) Speech Language Pathology Assistant
( ) Other - Write In

5) In the selected year, which of the following employment arrangements applied to you in the Illinois EI system?*
( ) Self-Employed or Independent Contractor (Paid Directly by the Comptroller/Central Billing Office)
( ) Employed or Contracted by an Agency (Agency Handles Payments)
( ) Employee of a Child and Family Connections (CFC) Office
( ) Employed by a health care provider/hospital system

6) In the selected year, if you were employed by an agency within the Illinois EI system, were you responsible for managing the budget of this organization?*
( ) Yes
( ) No

7) In the selected year, if you were employed by a Child and Family Connections (CFC) office, did you manage the budget for this organization?*
( ) Yes
( ) No

8) In the selected year, what was your primary county of operation? If you were an independent contractor, select the county of your residence. If you worked for an agency or a CFC, select the county where your organization is located. If you don't live in Illinois, select "I operate outside of Illinois but provide services in the state".*
( ) I operate outside of Illinois but provide services in the state
( ) Adams
( ) Alexander
( ) Bond
( ) Boone
( ) Brown
( ) Bureau
( ) Calhoun
( ) Carroll
( ) Cass
( ) Champaign
( ) Christian
( ) Clark
( ) Clay
( ) Clinton
( ) Coles
( ) Cook
( ) Crawford
( ) Cumberland
( ) DeKalb
( ) DeWitt
( ) Douglas
( ) DuPage
( ) Edgar
( ) Edwards
( ) Effingham
( ) Fayette
( ) Ford
( ) Franklin
( ) Fulton
( ) Gallatin
( ) Greene
( ) Grundy
( ) Hamilton
( ) Hancock
( ) Hardin
( ) Henderson
( ) Henry
( ) Iroquois
( ) Jackson
( ) Jasper
( ) Jefferson
( ) Jersey
( ) Jo Daviess
( ) Johnson
( ) Kane
( ) Kankakee
( ) Kendall
( ) Knox
( ) Lake
( ) LaSalle
( ) Lawrence
( ) Lee
( ) Livingston
( ) Logan
( ) Macon
( ) Macoupin
( ) Madison
( ) Marion
( ) Marshall
( ) Mason
( ) Massac
( ) McDonough
( ) McHenry
( ) McLean
( ) Menard
( ) Mercer
( ) Monroe

( ) Montgomery
( ) Morgan
( ) Moultrie
( ) Ogle
( ) Peoria
( ) Perry
( ) Piatt
( ) Pike
( ) Pope
( ) Pulaski
( ) Putnam
( ) Randolph
( ) Richland
( ) Rock Island
( ) Saline
( ) Sangamon
( ) Schuyler
( ) Scott
( ) Shelby
( ) St. Clair
( ) Stark
( ) Stephenson
( ) Tazewell
( ) Union
( ) Vermilion
( ) Wabash
( ) Warren
( ) Washington
( ) Wayne
( ) White
( ) Whiteside
( ) Will
( ) Williamson
( ) Winnebago
( ) Woodford

9) Did you primarily work in the City of Chicago?*
( ) Yes
( ) No

10) During the year you selected, which Child and Family Connections (CFC) regions did you serve? Check all that apply

[ ] CFC 1
[ ] CFC 2
[ ] CFC 3
[ ] CFC 4
[ ] CFC 5
[ ] CFC 6
[ ] CFC 7
[ ] CFC 8
[ ] CFC 9
[ ] CFC 10
[ ] CFC 11
[ ] CFC 12
[ ] CFC 13
[ ] CFC 14
[ ] CFC 15
[ ] CFC 16
[ ] CFC 17
[ ] CFC 18
[ ] CFC 19
[ ] CFC 20
[ ] CFC 21
[ ] CFC 22
[ ] CFC 23
[ ] CFC 24
[ ] CFC 25

Views of the EI System - Part 1

In previous surveys and focus groups, EI professionals have identified challenges such as low compensation, lack of benefits, administrative burdens, and issues with canceled appointments. As we explore various ways to address these challenges, we are interested in understanding how different changes might impact children, families, and EI professionals.

Please rate each potential change based on how you believe it would affect the outcomes and experiences of children and families within the EI system.

Questions 11-26 were rated on the following scale:

( ) Greatly Negative Impact ( ) Somewhat Negative Impact ( ) No Impact ( ) Somewhat Positive Impact ( ) Greatly Positive Impact

11) Reduce caseloads for Service Coordinators.

12) Raise rates for direct services.

13) Implement an annual cost of living increase for EI rates and CFC funding.

14) Simplify billing processes.

15) Have the state take over insurance billing processes.

16) Improve timeliness and accuracy of payments.

17) Pay higher rates to practitioners serving areas with shortages of EI practitioners.

18) Pay higher rates to practitioners who can provide services in additional languages.

19) Pay practitioners for canceled or missed appointments.

20) Pay practitioners for travel time for appointments that are especially far away and/or for transportation costs.

21) Allow EI professionals to access a benefits pool for health insurance or retirement.

22) Pay practitioners for time spent on collaboration, reflective supervision, coaching, and/or mentoring new practitioners.

23) Offer sign-on bonuses for new practitioners.

24) Offer compensation for attending professional development.

25) Offer a tiered pay structure that recognizes additional training and experience.

26) Improve pay parity between disciplines.

Views on the EI System - Part 2

Building on our understanding of challenges in EI, we value your input on changes that could enhance your professional satisfaction.

Please rate each potential change based on how it would affect your satisfaction with working in the Early Intervention system.

Questions 27-43 were rated on the following scale:

( ) Greatly Negative Impact ( ) Somewhat Negative Impact ( ) No Impact ( ) Somewhat Positive Impact ( ) Greatly Positive Impact

27) Reduce caseloads for Service Coordinators.

28) Raise rates for direct services.

29) Implement an annual cost of living increase for EI rates and CFC funding.

30) Simplify billing processes.

31) Have the state take over insurance billing processes.

32) Improve timeliness and accuracy of payments.

33) Pay higher rates to practitioners serving areas with shortages of EI practitioners.

34) Pay higher rates to practitioners who can provide services in additional languages.

35) Pay practitioners for canceled or missed appointments.

36) Pay practitioners for travel time for appointments that are especially far away and/or for transportation costs.

37) Allow EI professionals to access a benefits pool for health insurance or retirement.

38) Pay practitioners for time spent on collaboration, reflective supervision, coaching, and/or mentoring new practitioners.

39) Offer sign-on bonuses for new practitioners.

40) Offer compensation for attending professional development.

41) Offer a tiered pay structure that recognizes additional training and experience.

42) Improve pay parity between disciplines.

43) Are there any additional changes you would recommend that would have a significant positive impact on children, families, and/or EI professionals? Please describe.

Self-Employed or Independent Contractors

For the following questions, please base your responses on the year you selected at the beginning of this survey.

EI Activities

Please consider the following definitions for full-time and part-time:
Full-time: working an average of 30 hours or more per week specifically on EI-related activities
Part-time: working less than 30 hours per week on average on EI-related activities

44) In the year you selected, did you work in EI as a full-time or part-time independent contractor?
( ) Full-time
( ) Part-time

45) If you worked part-time in EI, which of these best describes your reason(s)? Check all that apply
[ ] Part-time in EI and part-time in private practice
[ ] Prefer to work part-time in EI for family/other responsibilities
[ ] Payment rates too low for full-time
[ ] Insufficient referrals for a full-time caseload
[ ] Lack of benefits
[ ] Other - Write In: ____

46) Where did you typically provide EI services? Check all that apply
[ ] In child/family's homes
[ ] In a dedicated office or clinical space
[ ] Online (via telehealth platforms)
[ ] In community settings (e.g., schools, child care program)
[ ] Other - Write In: ____

47) How commonly did you provide Live Video Visit (LVV) services?
( ) Only LVV services
( ) Mostly LVVs
( ) About half LVVs
( ) Less than half LVVs
( ) Did not provide LVV services

For the following questions, choose one month from the year you selected (2022 or 2023).

48) How many total hours did you spend on EI services? Please include all time spent on EI-related activities, both billable and non-billable. This encompasses direct service delivery, preparation, travel, documentation, coordination, billing, and other non-billable tasks related to EI services.

49) How many children and families were you supporting?

50) How many initial evaluations for EI services did you participate in?

51) How many direct service appointments for EI did you complete?

52) How many scheduled direct service appointments for EI were canceled? Please include all appointments that were scheduled but did not take place, for any reason.

<u>Costs</u>

For the following questions, please refer to the year you chose at the start of this survey (2022 or 2023). If you have already filed your taxes for the chosen year, we recommend referring to your income tax return.

53) Annual Tax Payments: What was the total amount you paid in taxes last year for your EI practice? This includes federal income tax, state income tax, and self-employment tax.

54) Facilities/Office Space: What was the estimated annual cost for your home office, coworking space, or therapy space (e.g., space for physical therapists and occupational therapists) used for EI services? This includes rent or mortgage payments, property taxes, and any other relevant expenses.

55) Technology and Software: What was the estimated annual expenditure on technology for your EI practice, including hardware (computers and printers), HIPAA-compliant communication tools (cell phones and services), software, email services, and subscriptions to platforms like EMR, and telehealth services?

56) Transportation: What was your estimated annual cost of transportation for EI services, including mileage, gas, vehicle wear and tear, parking, and public transportation costs?

57) Service-Related Supplies: What was the estimated annual cost of service-related supplies for providing EI services, including assessment tools, books, toys, therapy supplies, and educational materials?

58) Non-Service-Related Supplies: What was your estimated annual expenditure on non-service-related supplies for your EI practice, such as office supplies like paper, ink, stationary, and cleaning products?

59) Marketing and Advertising: What was the estimated annual spend on marketing and advertising for your EI services, including digital marketing, website maintenance, online advertising, printed materials, and any promotional activities?

60) Administrative, Legal, and Financial Services: What was the estimated annual expenditure on administrative, legal, and financial services for your EI practice, including bookkeeping, legal consultations, accounting, or billing services?

61) Practice Insurance: What was the estimated annual cost of business, unemployment, liability, or medical malpractice insurance for your EI practice?

62) Professional Licensing Fees: What was the total annual cost of professional licensing fees related to your EI services?

63) Professional Development: How much did you invest annually in professional development specifically for your EI work, including costs for workshops, seminars, certification courses, and resources purchased for professional growth?

64) Health Insurance: Did you pay for health insurance?

( ) Yes
( ) No

65) Health Insurance: What was your annual cost for health insurance?

66) Retirement Savings Contribution: Did you make any payments towards retirement?

( ) Yes
( ) No

67) Retirement Savings Contribution: What was your annual contribution to retirement savings?

68) Health Insurance Source: How did you receive health insurance?

( ) Through a spouse/family member’s plan
( ) By purchasing an individual plan (for example, through Get Covered Illinois)
( ) Through a public plan such as Medicare or Medicaid
( ) Through a pooled or employer-based plan
( ) I do not have health insurance

( ) Other - Write In: ____

69) Satisfaction with Health Insurance Plan: How satisfied were you with your health insurance plan?

( ) Not Sure ( ) Very Dissatisfied ( ) Somewhat Dissatisfied ( ) Neutral ( ) Somewhat Satisfied ( ) Very Satisfied

Income

For the following questions, please refer to the year you chose at the start of this survey (2022 or 2023). If you have already filed your taxes for the chosen year, we recommend referring to your income tax return.

70) What was your total annual revenue from providing Early Intervention (EI) services in the selected year?

Please break down your revenue from providing EI services by the source. Indicate the percentage of your total revenue that each source contributed:

71) Private Insurance Reimbursements

72) Payments from the CBO (Central Billing Office)

73) CLTS (Children's Long-Term Support) payments

74) Grants or scholarships

75) Other

76) After accounting for taxes and expenses, what was your net income from providing EI services?

77) What percentage of your total income for the selected year came from EI services?

( ) 100%
( ) 75-99%
( ) 50-75%
( ) 25-50%
( ) 0-25%

78) How long did it typically take for you to receive system payment for EI services after submitting your billing information?

( ) Less than 2 weeks
( ) 2-4 weeks
( ) 4-6 weeks
( ) 6-8 weeks
( ) More than 8 weeks

79) How long did it typically take for you to receive insurance payments for EI services after submitting your billing information?

( ) Less than 2 weeks
( ) 2-4 weeks
( ) 4-6 weeks
( ) 6-8 weeks
( ) More than 8 weeks

80) How often did you receive incorrect payments or denied claims from the Comptroller for EI services?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always

81) How often do you not receive payment because of the 90 day filling limit?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always

Direct Service Practitioners

For the following questions, please base your responses on the year you selected at the beginning of this survey.

Staffing

For this survey, please use the following definitions to classify full-time and part-time staff:

Full-time: A staff member who works an average of 30 hours or more per week specifically on Early Intervention (EI)-related activities

Part-time: A staff member who works less than 30 hours per week on average on EI-related activities.

Please provide the number of full-time equivalent (FTE) employees for each of the following roles at your Early Intervention agency, along with the average salary for each role. Part-time employees should be calculated as a fraction of an FTE. For example, if you have one staff member working 30 hours per week (full-time) and another working 15 hours per week (part-time), this would be reported as 1.5 FTE in total.

82) Director

FTE Count: ____

Average Salary: ____

83) Assistant Director

FTE Count: ____

Average Salary: ____

84) Administrative Assistant(s)

FTE Count: ____

Average Salary: ____

85) Billing Specialist(s)/Manager(s)

FTE Count: ____

Average Salary: ____

86) Audiologist(s)

FTE Count: ____

Average Salary: ____

87) Developmental Therapist(s)

FTE Count: ____

Average Salary: ____

88) Occupational Therapist(s)

FTE Count: ____

Average Salary: ____

89) Physical Therapist(s)

FTE Count: ____

Average Salary: ____

90) Psychologist(s)

FTE Count: ____

Average Salary: ____

91) Social Worker(s)

FTE Count: ____

Average Salary: ____

92) Speech Language Pathologist(s)

FTE Count: ____

Average Salary: ____

93) Interpreters/Translators

FTE Count: ____

Average Salary: ____

94) Are there any other critical roles within your Early Intervention (EI) agency that we have not listed?

( ) Yes

( ) No

95) Role 1

Title: ____

FTE Count: ____

Average Salary: ____

96) Role 2

Title: ____

FTE Count: ____

Average Salary: ____

97) Role 3

Title: ____

FTE Count: ____

Average Salary: ____

Employee Benefits

For the following questions, please specify whether your organization offered each benefit, and indicate whether the benefit was available to all staff members or exclusively to full-time employees. Please base your responses on the year you selected at the beginning of this survey

98) Health Insurance (including dental and vision)

( ) Offered to all staff

( ) Offered to full-time employees only
( ) Not offered

99) Retirement Plan (e.g., 401(k), pension)

( ) Offered to all staff
( ) Offered to full-time employees only
( ) Not offered

100) Paid Time Off (e.g., vacation, sick leave)
( ) Offered to all staff
( ) Offered to full-time employees only
( ) Not offered

101) What was the average annual cost of health insurance per staff member, including dental and vision coverage?

102) What was the average annual cost to your organization for providing a retirement or pension plan per staff member?

103) What was the maximum number of Paid Time Off (PTO) days that your organization offered to any staff member?

Non-Personnel Expenses

For the following questions, please refer to the year you chose at the start of this survey (2022 or 2023).

104) Facilities: What was the estimated annual cost for your agency's facilities, including rent or mortgage payments and property taxes?

105) Utilities: What were the estimated annual utility expenses at your agency, including electricity, water, heating, internet services, and Wi-Fi?

106) Maintenance and Repairs: What was the estimated annual cost for maintenance and repairs of your agency's facilities and equipment?

107) Technology and Software: What was the estimated annual expenditure on technology for your agency, including hardware and software purchases, cell phone services, email services, and subscriptions to platforms like EMR, telehealth services, and HIPAA compliant communication tools?

108) Transportation and Travel: What was the estimated annual cost of travel for your agency, including mileage, gas, vehicle wear and tear, and other driving/traveling expenses?

109) Service-Related Supplies: What was the estimated annual cost for service-related supplies at your agency, including testing tools, therapy supplies, assessment tools, toys, and educational materials?

110) Non-Service-Related Supplies: What was the estimated annual spent on non-service-related supplies at your agency, such as office supplies, cleaning products, and personal protective equipment (PPE)?

111) Training and Professional Development: What was the estimated annual investment in training and professional development for staff at your agency? Include costs for workshops, seminars, certification courses, and resources purchased for professional growth.

112) Marketing, Advertising, and Communications: What was the estimated annual total cost for marketing and advertising at your agency? Include digital marketing, print materials, and communication expenses such as phone, text messaging, and video conferencing platforms.

113) Administrative, Legal, and Financial Services: What were the estimated annual expenses for administrative and legal services at your agency, including accounting, legal consultations, or billing services?

114) Insurance: What was the estimated annual total cost of insurance for your agency, covering liability, malpractice, professional liability, and worker's compensation insurance?

Revenues

For the following questions, please refer to the year you chose at the start of this survey (2022 or 2023).

115) In the selected year (2022 or 2023), what was the gross revenue generated by your agency specifically from Early Intervention services? Please provide the total amount before deducting any expenses or taxes.

116) What was the net revenue (after deducting all expenses and taxes) earned by your agency from Early Intervention services? Please enter a negative number if the expenses exceeded the revenue earned from these services.

117) What percentage of total revenue for your agency came from EI services?

Please break down your revenue from providing EI services by the source. Indicate the percentage of your total revenue that each source contributed:

118) Private insurance reimbursements

119) Payment from the EI system (through the Central Billing Office)

120) CLTS (Children's Long-Term Support) payments

121) Grants or scholarships

122) Other

Demographics

165) How do you identify your race? (Select all that apply)

[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White
[ ] Other
[ ] Prefer not to say

166) How do you identify your ethnicity?

( ) Hispanic or Latino
( ) Not Hispanic or Latino
( ) Prefer not to say

167) How do you identify your gender?

( ) Male
( ) Female
( ) Non-binary/Third gender
( ) Prefer not to say

168) What is your age group?

( ) Under 25
( ) 25-34
( ) 35-44
( ) 45-54
( ) 55-64
( ) 65 or older

169) How many years of experience do you have working in the EI field?

( ) Less than 1 year
( ) 1-3 years
( ) 4-6 years
( ) 7-10 years
( ) 11-15 years
( ) 16-20 years
( ) More than 20 years

170) Do you fluently understand any languages other than English? This includes listening and reading abilities. Please select all that apply.

[ ] Spanish
[ ] Mandarin
[ ] Hindi
[ ] Arabic
[ ] French
[ ] Russian
[ ] Portuguese
[ ] Bengali
[ ] German
[ ] Non-Bilingual
[ ] Other - Write In: ____________________________________

171) Do you fluently speak and write in any language other than English? Please select all that apply.

[ ] Spanish
[ ] Mandarin
[ ] Hindi
[ ] Arabic
[ ] French
[ ] Russian
[ ] Portuguese
[ ] Bengali
[ ] German
[ ] Other
[ ] No, I only speak English

Appendix F: Median EI Non-Personnel Costs by Specialty

Expense Category	Developmental Therapist	Occupational Therapist	Physical Therapist	Psychologist	Social Worker	Speech Therapist
Count of Respondents	***42***	***23***	***11***	***4***	***6***	***47***
Facilities/Office Space	$3,429	$2,400	$5,052	$1,500	$2,500	$5,000
Technology and Software	$2,244	$2,500	$2,743	$500	$1,600	$2,227
Transportation	$4,934	$6,000	$8,914	$5,000	$4,000	$5,000
Service-Related Supplies	$1,210	$1,500	$1,400	$600	$500	$1,100
Non-Service-Related Supplies	$633	$600	$634	$500	$1,000	$679
Marketing and Advertising	$256	$400	$2,011	$100	$1,893	$492
Administrative, Legal, and Financial Services	$1,100	$1,833	$4,387	$1,200	$520	$1,153
Insurance	$343	$500	$500	$325	$491	$340
Professional Licensing Fees	$372	$139	$250	$150	$296	$436
Professional Development	$331	$571	$1,123	$350	$900	$618

Appendix G: Time Use Study for Early Intervention

1) Is this your first daily submission for the Time Use Study?

( ) Yes
( ) No, I've already submitted other responses

2) For response tracking purposes, please write your email. This should be the same email you use for all 10 daily submissions.

3) To ensure accuracy, please re-enter your email address for verification purposes.

4) For which day are you submitting your time-use information?
*Please specify the day for which you are recording and submitting your time-use information. For example, if today is Wednesday, but you are submitting data for Monday, please indicate that you are reporting for Monday.

About You

[This section was only asked the first time a provider completed the survey.]

5) What is your employment arrangement?

( ) Self-Employed or Independent Contractor (Paid Directly by the Comptroller/Central Billing Office)
( ) Employed or Contracted by an Agency (Agency Handles Payments)
( ) Employee of a Child and Family Connections (CFC) Office
( ) Other - Write In: ____

6) Do you outsource any administrative tasks related to your work as an early intervention service provider? If yes, please select which administrative tasks you outsource from the list below. If you don't outsource, select "I don't outsource any administrative tasks".

[ ] I don't outsource any administrative tasks
[ ] Scheduling and appointment setting
[ ] Billing and invoicing
[ ] Documentation and record-keeping
[ ] Email and correspondence management
[ ] Financial management (e.g., bookkeeping, tax preparation)
[ ] Other

7) Please estimate the average number of hours per week dedicated to outsourced administrative activities by the external party.

8) Within the next three weeks, what will be your primary role/specialty in EI?*

( ) Assistive Technology
( ) Aural Rehabilitation
( ) Bilingual and Sign Language Interpreting
( ) Board Certified Behavior Analyst
( ) Certified Occupational Therapy Assistant
( ) Deaf Mentor
( ) Developmental Therapy
( ) Developmental Therapy – Hearing
( ) Developmental Therapy - Orientation and Mobility
( ) Developmental Therapy – Vision
( ) Licensed Audiology
( ) Licensed Clinical Professional Counselor
( ) Licensed Clinical Psychology
( ) Licensed Clinical Social Work
( ) Licensed Dietitian Nutritionist
( ) Licensed Marriage & Family Therapy
( ) Licensed Occupational Therapy
( ) Licensed Physical Therapy
( ) Licensed Physical Therapy Assistant
( ) Licensed Professional Counselor
( ) Licensed Social Work
( ) Licensed Speech Language Pathology
( ) Medical Diagnostic
( ) Ophthalmology
( ) Parent Liaison
( ) Physician Consultation
( ) Psychology Assistant
( ) Registered Nurse
( ) Social Work Assistant
( ) Speech Language Pathology Assistant
( ) Translator

9) Do you have a secondary role/specialty in EI?

( ) Yes
( ) No

10) Within the next three weeks, what will be your secondary role/specialty in EI?

( ) Assistive Technology
( ) Aural Rehabilitation
( ) Bilingual and Sign Language Interpreting
( ) Board Certified Behavior Analyst
( ) Certified Occupational Therapy Assistant
( ) Deaf Mentor
( ) Developmental Therapy
( ) Developmental Therapy – Hearing
( ) Developmental Therapy - Orientation and Mobility
( ) Developmental Therapy – Vision
( ) Licensed Audiology
( ) Licensed Clinical Professional Counselor
( ) Licensed Clinical Psychology
( ) Licensed Clinical Social Work
( ) Licensed Dietitian Nutritionist
( ) Licensed Marriage & Family Therapy
( ) Licensed Occupational Therapy
( ) Licensed Physical Therapy
( ) Licensed Physical Therapy Assistant
( ) Licensed Professional Counselor
( ) Licensed Social Work
( ) Licensed Speech Language Pathology
( ) Medical Diagnostic
( ) Ophthalmology
( ) Parent Liaison
( ) Physician Consultation
( ) Psychology Assistant
( ) Registered Nurse
( ) Social Work Assistant
( ) Speech Language Pathology Assistant
( ) Translator

11) Do you work in EI full-time or part-time? Full-time is defined as at least 30 hours per week.

( ) Full-time

( ) Part-time

12) What is your current caseload?

13) What county are you located in?

( ) Adams
( ) Alexander
( ) Bond
( ) Boone
( ) Brown
( ) Bureau
( ) Calhoun
( ) Carroll
( ) Cass
( ) Champaign
( ) Christian
( ) Clark
( ) Clay
( ) Clinton
( ) Coles
( ) Cook
( ) Crawford
( ) Cumberland
( ) DeKalb
( ) DeWitt
( ) Douglas
( ) DuPage
( ) Edgar
( ) Edwards
( ) Effingham
( ) Fayette
( ) Ford
( ) Franklin
( ) Fulton
( ) Gallatin
( ) Greene
( ) Grundy
( ) Hamilton
( ) Hancock
( ) Hardin
( ) Henderson
( ) Henry
( ) Iroquois
( ) Jackson
( ) Jasper
( ) Jefferson
( ) Jersey
( ) Jo Daviess
( ) Johnson
( ) Kane
( ) Kankakee
( ) Kendall
( ) Knox
( ) Lake
( ) LaSalle
( ) Lawrence
( ) Lee
( ) Livingston
( ) Logan
( ) Macon
( ) Macoupin
( ) Madison
( ) Marion
( ) Marshall
( ) Mason
( ) Massac
( ) McDonough
( ) McHenry
( ) McLean
( ) Menard
( ) Mercer
( ) Monroe
( ) Montgomery
( ) Morgan
( ) Moultrie
( ) Ogle
( ) Peoria
( ) Perry
( ) Piatt
( ) Pike
( ) Pope
( ) Pulaski
( ) Putnam
( ) Randolph
( ) Richland
( ) Rock Island
( ) Saline
( ) Sangamon
( ) Schuyler
( ) Scott
( ) Shelby
( ) St. Clair
( ) Stark
( ) Stephenson
( ) Tazewell
( ) Union
( ) Vermilion
( ) Wabash
( ) Warren
( ) Washington
( ) Wayne
( ) White
( ) Whiteside
( ) Will
( ) Williamson
( ) Winnebago
( ) Woodford

14) Are you located in the City of Chicago?

( ) Yes
( ) No

15) What CFCs are you currently serving?

[ ] CFC 1
[ ] CFC 2
[ ] CFC 3
[ ] CFC 4
[ ] CFC 5
[ ] CFC 6
[ ] CFC 7
[ ] CFC 8
[ ] CFC 9
[ ] CFC 10
[ ] CFC 11
[ ] CFC 12

[ ] CFC 13
[ ] CFC 14
[ ] CFC 15
[ ] CFC 16
[ ] CFC 17
[ ] CFC 18
[ ] CFC 19
[ ] CFC 20
[ ] CFC 21
[ ] CFC 22
[ ] CFC 23
[ ] CFC 24
[ ] CFC 25

16) How many years of experience do you have working in the EI field?

( ) Less than 1 year
( ) 1-3 years
( ) 4-6 years
( ) 7-10 years
( ) 11-15 years
( ) 16-20 years
( ) More than 20 years

Demographics

17) How do you identify your race? (Select all that apply)

[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White
[ ] Other
[ ] Prefer not to say

18) How do you identify your ethnicity?

( ) Hispanic or Latino
( ) Not Hispanic or Latino
( ) Prefer not to say

19) How do you identify your gender?

( ) Male
( ) Female
( ) Non-binary/Third gender
( ) Prefer not to say

20) What is your age group?

( ) Under 25
( ) 25-34
( ) 35-44
( ) 45-54
( ) 55-64
( ) 65 or older

21) Do you fluently understand any languages other than English? This includes listening and reading abilities. Please select all that apply.

[ ] No, I only fluently understand English
[ ] Spanish
[ ] Mandarin
[ ] Hindi
[ ] Arabic

[ ] French
[ ] Portuguese
[ ] German
[ ] Russian
[ ] Bengali
[ ] Other

22) Do you fluently speak and write in any language other than English? Please select all that apply.

[ ] No, I only speak and write fluently in English
[ ] Spanish
[ ] Mandarin
[ ] Hindi
[ ] Arabic
[ ] French
[ ] Russian
[ ] Portuguese
[ ] Bengali
[ ] German
[ ] Other

Appointments

23) Service Appointments: Within the last 24 hours, how many service appointments were you scheduled to complete today?

24) Service Appointments: Of the total service appointments you were scheduled for today, how many were not completed or canceled and were not rescheduled to take place within the same week?

25) Service Appointments: Of the total service appointments you were scheduled for today, how many did you complete?

26) Service Appointments: Of the total service appointments you completed today, how many were provided using Live Video Visits (LLV)?

27) Evaluations: Within the last 24 hours, how many evaluations were you scheduled to complete today?

28) Evaluations: Of the total evaluations you were scheduled for today, how many were not completed or canceled and were not rescheduled to take place within the same week?

29) Evaluations: Of the total evaluations you were scheduled for today, how many did you complete?

30) IFSP: Within the last 24 hours, how many IFSP meetings were you scheduled to complete today?

31) IFSP: Of the total IFSP meetings you were scheduled for today, how many were not completed or canceled and were not rescheduled to take place within the same week?

32) IFSP: Of the total IFSP meetings you were scheduled for today, how many did you complete?

33) IFSP: How many IFSP meetings were conducted using Live Video Visits (LLV)?

34) Group Therapy: Within the last 24 hours, how many group therapy sessions were you scheduled to complete today?

35) Group Therapy: Of the total group therapy sessions you were scheduled for today, how many were not completed or canceled and were not rescheduled to take place within the same week?

36) Group Therapy: Of the total group therapy sessions you were scheduled for today, how many did you complete?

37) Group Therapy: Of the total group therapy sessions you completed today, how many were provided using Live Video Visits (LLV)?*

38) Group Therapy: How many children/clients participated in the group therapy session?*

Time Tracking

Please record the time you spent today on various activities, using your best judgment to categorize each activity into the closest task listed below. For consistency, enter your time in quarterly increments of an hour.

- 15 minutes should be recorded as 0.25 hours
- 30 minutes should be recorded as 0.50 hours
- 45 minutes should be recorded as 0.75 hours
- 60 minutes should be recorded as 1.0 hour

For interpreters and translators: even if activities are not explicitly marked for you, they may still be relevant. Please include all applicable activities in your time reporting.

39) Direct Service Activities

If you did not spend time on a specific activity, leave the box blank.

________Provided services to children/families.
________Conducted evaluation appointments.
________For interpreters/translators: Interpreted during service or evaluation appointments.
________Awaiting client arrivals for scheduled appointments.

40) Service Preparation and Planning

If you did not spend time on a specific activity, leave the box blank.

________Prepared materials and planned for service/evaluation appointments.
________Researched resources for children/families.
________For interpreters/translators: Prepared and reviewed terminology.

41) Documentation and Reporting

If you did not spend time on a specific activity, leave the box blank.

________Documented notes from service/evaluation appointments.
________Fulfilled auditing and monitoring requirements.
________Completed and managed billing.
________Addressed billing discrepancies.
________Recorded other service-related documentation.
________For interpreters/translators: Translated documents/IFSPs; logged activities.

42) Meetings and Communications

If you did not spend time on a specific activity, leave the box blank.

________Participated in IFSP meetings.
________Attended case conferences/team meetings.
________Communicated with other practitioners/service coordinators/interpreters via email, text, or phone.
________Engaged in other family communications outside of appointments.
________Recorded other service-related documentation.
________For interpreters/translators: Interpreted for IFSP meetings, conferences, or practitioner-family communications.

43) Travel and Scheduling

If you did not spend time on a specific activity, leave the box blank.

________Travel time (to and from appointments)
________Scheduling (including follow-ups/reminders)
________For interpreters/translators: Interpreted during service or evaluation appointments.

44) Professional Development

If you did not spend time on a specific activity, leave the box blank.

________Pursued professional development opportunities.
________Engaged in training or supervision activities.
________For interpreters/translators: Interpreted during service or evaluation appointments.
________Contributed to the EI field (e.g., mentoring, professional organizations).
________Participated in research or interagency projects.

45) General administrative planning and organization (e.g., checking emails, answering phone calls)

46) Breaks or personal time during the workday

47) Other tasks not listed here

48) What tasks are included in this number?