First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 25-0522.01 Alana Rosen x2606 **SENATE BILL 25-017**

SENATE SPONSORSHIP

Cutter,

HOUSE SPONSORSHIP

(None),

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

101 **CONCERNING MEASURES TO SUPPORT EARLY CHILDHOOD HEALTH BY**
102 **INTEGRATING EARLY CHILDHOOD HEALTH-CARE SYSTEMS INTO**
103 **COMMUNITIES.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill creates the child care health consultation program (consultation program) in the department of early childhood (department) to expand access to child care health consultants (consultants) and to support whole-child health and well-being in licensed and license-exempt child care and learning settings.

The department shall:

- Contract with an implementation partner (consultant partner) to facilitate the implementation and administration of the consultation program;
- Create a model of child care health consultation (model of care) to provide standards and guidelines to ensure the consultation program is implemented effectively;
- Develop with the consultant partner a statewide professional development plan to support consultants in meeting the expectations outlined in the model of care; and
- Develop a statewide data collection and information system to collect and analyze implementation data and selected consultation program outcomes to identify areas for improvement, promote accountability, and provide insights on how to improve consultation program outcomes to benefit young children and their families.

The department shall submit a report on the consultation program to the joint budget committee by October 1, 2027, and by each October 1 thereafter.

The bill creates the pediatric primary care practice program (primary care program) in the department. The purpose of the primary care program is to provide funding and support to a pediatric primary care medical practice (medical practice) to integrate into the medical practice a professional who specializes in whole-child and whole-family health and well-being.

The department shall contract with an implementation partner (primary care partner) to create and implement the primary care program. The primary care partner shall create and implement a team-based, research-informed pediatric primary care practice evidence-based model (evidence-based model). The evidence-based model must be a comprehensive approach to guide pediatric care medical practices to deliver services to children from birth to 3 years of age and their families.

The primary care partner shall:

- Establish an application and selection process with the department for select medical practices to participate in the primary care program;
- Review applications from medical practices and select applicants to participate in the primary care program;
- Work with selected applicants to complete assessments on the applicants' community health-care systems, health and well-being practices, and related concerns; and
- Train and support the medical practices selected to participate in the primary care program to maintain fidelity to the evidence-based model.

The executive director of the department may adopt rules to carry

out the purposes of the consultation program and the primary care program.

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1 *Be it enacted by the General Assembly of the State of Colorado:*
2 **SECTION 1.** In Colorado Revised Statutes, **add** part 10 to article
3 3 of title 26.5 as follows:
4 PART 10
5 CHILD CARE HEALTH
6 CONSULTATION PROGRAM
7 **26.5-3-1001. Definitions.** AS USED IN THIS PART 10, UNLESS THE
8 CONTEXT OTHERWISE REQUIRES:
9 (1) "CHILD CARE HEALTH CONSULTANT" MEANS A MEDICAL
10 PROFESSIONAL WHO IS EXPERIENCED IN MATERNAL AND CHILD HEALTH
11 CARE, CREDENTIALED PURSUANT TO THE DEPARTMENT'S PROFESSIONAL
12 DEVELOPMENT INFORMATION SYSTEM, AND PARTICIPATES IN THE CHILD
13 CARE HEALTH CONSULTATION PROGRAM.
14 (2) "CHILD CARE HEALTH CONSULTATION PROGRAM" OR
15 "PROGRAM" MEANS THE CHILD CARE HEALTH CONSULTATION PROGRAM,
16 A VOLUNTARY STATEWIDE PROGRAM CREATED IN SECTION 26.5-3-1002
17 (1).
18 (3) "IMPLEMENTATION PARTNER" MEANS A STATE PUBLIC OR
19 PRIVATE ENTITY THAT HAS EXPERIENCE IMPLEMENTING AND OPERATING
20 NATIONALLY SUPPORTED, EVIDENCE-BASED MODELS OF CHILD CARE
21 HEALTH CONSULTATION.
22 (4) "MODEL OF CHILD CARE HEALTH CONSULTATION" OR "MODEL"
23 MEANS THE MODEL OF CHILD CARE HEALTH CONSULTATION CREATED IN
24 SECTION 26.5-3-1003 (2).
25 (5) "PLAN" MEANS THE STATEWIDE PROFESSIONAL DEVELOPMENT

1 PLAN CREATED IN SECTION 26.5-3-1004 (1).

2 (6) "STATEWIDE DATA COLLECTION AND INFORMATION SYSTEM"
3 OR "INFORMATION SYSTEM" MEANS THE STATEWIDE DATA COLLECTION
4 AND INFORMATION SYSTEM CREATED IN SECTION 26.5-3-1005 (1)(a).

5 **26.5-3-1002. Child care health consultation program - created**
6 **- purpose - rules.** (1) (a) ON OR BEFORE JULY 1, 2026, THE DEPARTMENT
7 SHALL CREATE THE CHILD CARE HEALTH CONSULTATION PROGRAM TO
8 EXPAND ACCESS TO CHILD CARE HEALTH CONSULTANTS AND TO SUPPORT
9 WHOLE-CHILD HEALTH AND WELL-BEING IN LICENSED AND
10 LICENSE-EXEMPT CHILD CARE AND LEARNING SETTINGS TO ENSURE
11 CHILDREN HAVE ACCESS TO LEARNING AND SUPPORTS. THROUGH THE
12 PROGRAM, CHILD CARE HEALTH CONSULTANTS COMBINE THEIR
13 KNOWLEDGE OF EARLY CHILDHOOD HEALTH CARE AND EDUCATION TO
14 HELP LICENSED AND LICENSE-EXEMPT CHILD CARE AND LEARNING
15 SETTINGS IMPLEMENT BEST PRACTICES TO CREATE HEALTHY AND SAFE
16 LEARNING ENVIRONMENTS FOR CHILDREN.

17 (b) THE PURPOSE OF THE PROGRAM IS TO:

18 (I) INCREASE THE NUMBER AND DIVERSITY OF QUALIFIED AND
19 APPROPRIATELY TRAINED CHILD CARE HEALTH CONSULTANTS IN THE
20 STATE WHO CAN CONSULT WITH PROVIDERS WHO WORK WITH YOUNG
21 CHILDREN AND FAMILIES IN LICENSED AND LICENSE-EXEMPT CHILD CARE
22 AND LEARNING SETTINGS;

23 (II) PROVIDE SUPPORT AND GUIDANCE TO PROVIDERS TO ADDRESS
24 THE HEALTH AND WELL-BEING NEEDS OF CHILDREN AND FAMILIES SERVED
25 IN LICENSED AND LICENSE-EXEMPT CHILD CARE AND LEARNING SETTINGS;

26 (III) DEVELOP A MODEL OF CHILD CARE HEALTH CONSULTATION
27 THAT IS ROOTED IN DIVERSITY, EQUITY, AND INCLUSION, AND PROVIDES

1 GUIDANCE TO CHILD CARE HEALTH CONSULTANTS ON THE QUALIFICATIONS
2 AND PROFESSIONAL COMPETENCIES NEEDED TO PARTICIPATE IN THE
3 PROGRAM AND THE EXPECTATIONS OF THE PROGRAM. THE MODEL MUST
4 INCLUDE THE PROGRAM'S EXPECTED OUTCOMES AND LONG-TERM GOAL OF
5 LIMITING ADMINISTRATIVE AND FINANCIAL BURDENS SO PROVIDERS HAVE
6 ACCESS TO CHILD CARE HEALTH CONSULTANTS.
7 (IV) DEVELOP AND MAINTAIN A STATEWIDE PROFESSIONAL
8 DEVELOPMENT PLAN THAT ASSISTS CHILD CARE HEALTH CONSULTANTS IN
9 MEETING THE REQUIREMENTS SET FORTH IN THE MODEL.
10 (2) (a) THE DEPARTMENT SHALL CONTRACT WITH AN
11 IMPLEMENTATION PARTNER TO FACILITATE THE IMPLEMENTATION AND
12 ADMINISTRATION OF THE PROGRAM. THE DEPARTMENT SHALL SELECT AN
13 IMPLEMENTATION PARTNER THAT HAS, AT A MINIMUM, EXPERIENCE AND
14 EXPERTISE WITH EVIDENCE-BASED CHILD CARE HEALTH CONSULTATION
15 PROGRAMS. THE IMPLEMENTATION PARTNER MUST, AT A MINIMUM,
16 PROVIDE TRAINING AND SUPPORT TO CHILD CARE HEALTH CONSULTANTS
17 IN THE PROGRAM TO ACHIEVE THE GOALS OF THE PROGRAM.
18 (b) IN DEVELOPING THE PROGRAM, THE DEPARTMENT SHALL WORK
19 IN CONSULTATION WITH:
20 (I) THE EARLY CHILDHOOD LEARNING AND KNOWLEDGE CENTER
21 ADMINISTERED BY THE OFFICE OF HEAD START WITHIN THE UNITED
22 STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADMINISTRATION
23 FOR CHILDREN AND FAMILIES AS SET FORTH IN 42 U.S.C. SEC. 9831 ET
24 SEQ.;
25 (II) NATIONALLY RECOGNIZED ENTITIES THAT SUPPORT THE
26 IMPLEMENTATION OF SUSTAINABLE SYSTEMS OR PROGRAMS THAT FOCUS
27 ON PROMOTING HEALTH AND WELL-BEING OUTCOMES FOR YOUNG

1 CHILDREN; AND
2 (III) KEY STAKEHOLDERS IN THE STATE, INCLUDING:
3 (A) CHILD CARE HEALTH CONSULTANTS;
4 (B) NONPROFIT ORGANIZATIONS WITH EXPERTISE IN EARLY
5 CHILDHOOD WHOLE-CHILD HEALTH;
6 (C) ORGANIZATIONS REPRESENTING PARENTS OF CHILDREN WHO
7 WOULD BENEFIT FROM CHILD CARE HEALTH CONSULTATIONS;
8 (D) HOSPITALS AND OTHER HEALTH-CARE PROVIDER
9 ORGANIZATIONS WITH EXPERTISE IN WORKING WITH CHILDREN FACING
10 SPECIAL HEALTH-CARE NEEDS OR CHALLENGES THAT IMPEDE OPTIMAL
11 GROWTH AND DEVELOPMENT;
12 (E) EARLY CHILD CARE AND EDUCATION PROVIDERS; AND
13 (F) CLINICIANS WITH EXPERTISE IN PEDIATRIC HEALTH.
14 (3) THE EXECUTIVE DIRECTOR MAY ADOPT RULES TO CARRY OUT
15 THE PURPOSES OF THIS PART 10.
16 **26.5-3-1003. Model of child care health consultation -**
17 **standards - guidelines - statewide qualifications and competencies.**
18 (1) (a) TO BE A CHILD CARE HEALTH CONSULTANT IN THE PROGRAM, AN
19 INDIVIDUAL MUST MEET THE FOLLOWING QUALIFICATIONS:
20 (I) BE IN GOOD STANDING AS A:
21 (A) NURSE WHO IS LICENSED PURSUANT TO ARTICLE 255 OF TITLE
22 12 AND HAS KNOWLEDGE AND EXPERIENCE IN PEDIATRICS OR MATERNAL
23 AND CHILD HEALTH; OR
24 (B) PHYSICIAN WHO IS LICENSED PURSUANT TO ARTICLE 240 OF
25 TITLE 12 AND HAS KNOWLEDGE AND EXPERIENCE IN PEDIATRICS OR
26 MATERNAL AND CHILD HEALTH; AND
27 (II) SUCCESSFULLY COMPLETE A MANDATORY TRAINING PROGRAM

1 AS REQUIRED BY THE DEPARTMENT.
2 (b) THE DEPARTMENT SHALL ENSURE EACH CHILD CARE HEALTH
3 CONSULTANT WHO PARTICIPATES IN THE PROGRAM MEETS THE
4 QUALIFICATIONS AND PROFESSIONAL COMPETENCIES DESCRIBED IN
5 SUBSECTION (1)(a) OF THIS SECTION. CHILD CARE HEALTH CONSULTANTS
6 WHO PARTICIPATE IN THE PROGRAM MUST USE THE DEPARTMENT'S
7 PROFESSIONAL DEVELOPMENT INFORMATION SYSTEM TO ENTER THEIR
8 QUALIFICATION AND PROFESSIONAL COMPETENCY INFORMATION.
9 (2) ON OR BEFORE JANUARY 1, 2027, THE DEPARTMENT SHALL
10 CREATE, IN CONSULTATION WITH THE STAKEHOLDERS DESCRIBED IN
11 SECTION 26.5-3-1002 (2)(b), A MODEL OF CHILD CARE HEALTH
12 CONSULTATION. THE PURPOSE OF THE MODEL IS TO PROVIDE STANDARDS
13 AND GUIDELINES TO ENSURE THE PROGRAM IS IMPLEMENTED EFFECTIVELY,
14 WITH PRIMARY CONSIDERATION GIVEN TO EVIDENCE-BASED SERVICES. THE
15 STANDARDS AND GUIDELINES MUST INCLUDE, AT A MINIMUM, THE
16 FOLLOWING:
17 (a) JOB QUALIFICATIONS FOR CHILD CARE HEALTH CONSULTANTS,
18 AS DESCRIBED IN SUBSECTION (1)(a) OF THIS SECTION;
19 (b) JOB EXPECTATIONS FOR CHILD CARE HEALTH CONSULTANTS;
20 (c) EXPECTED PROGRAM OUTCOMES;
21 (d) GUIDANCE ON THE RATIOS OF CHILD CARE HEALTH
22 CONSULTANTS TO CHILDREN IN LICENSED AND LICENSE-EXEMPT CHILD
23 CARE AND LEARNING SETTINGS;
24 (e) REQUIRED COMPETENCIES FOR CHILD CARE HEALTH
25 CONSULTANTS IN THE PROGRAM AND THE APPROPRIATE
26 COMPETENCY-BASED TRAINING TO ACHIEVE THE REQUIRED
27 COMPETENCIES;

1 (f) EXPECTATIONS FOR A PROGRAM STRUCTURE THAT MEETS THE
2 NEEDS OF LOCAL COMMUNITIES;
3 (g) A PROCESS FOR THE COMPETITIVE SELECTION, PLACEMENT,
4 AND PUBLIC FUNDING OF CHILD CARE HEALTH CONSULTANTS;
5 (h) GUIDANCE ON THE SCOPE AND FREQUENCY OF SERVICES CHILD
6 CARE HEALTH CONSULTANTS MAY PROVIDE TO PROVIDERS WHO WORK
7 WITH YOUNG CHILDREN AND FAMILIES, INCLUDING:
8 (I) TRAINING, INCLUDING, BUT NOT LIMITED TO, TRAINING ON
9 HEALTH AND SAFETY;
10 (II) DELEGATION AND ONGOING SUPERVISION OF MEDICATION
11 ADMINISTRATION AND HEALTH PROCEDURES;
12 (III) REFERRALS TO OTHER SERVICES;
13 (IV) COACHING;
14 (V) PREVENTIONS TO SUPPORT THE HEALTH AND WELL-BEING OF
15 CHILDREN; AND
16 (VI) OTHER APPROPRIATE CONSULTATIVE SERVICES THAT SUPPORT
17 AND ENHANCE WHOLE-CHILD HEALTH AND WELL-BEING;
18 (i) METHODS TO INCREASE THE NUMBER OF BILINGUAL OR
19 MULTILINGUAL CHILD CARE HEALTH CONSULTANTS AND TO ENSURE
20 CULTURAL COMPETENCY OF CHILD CARE HEALTH CONSULTANTS;
21 (j) METHODS TO ENSURE THE CHILD CARE HEALTH CONSULTANTS
22 PARTICIPATING IN THE PROGRAM REPRESENT THE DIVERSITY OF THE STATE,
23 INCLUDING LINGUISTIC, CULTURAL, AND GEOGRAPHIC DIVERSITY, SO CHILD
24 CARE HEALTH CONSULTANTS ARE ABLE TO CONNECT WITH PROVIDERS AND
25 THE YOUNG CHILDREN AND FAMILIES SERVED BY THE PROGRAM;
26 (k) GUIDANCE ON HOW TO WORK IN AND WITH A VARIETY OF CHILD
27 CARE ENVIRONMENTS AND PROVIDERS IN ORDER TO MEET THE DIVERSE

1 NEEDS OF YOUNG CHILDREN AND FAMILIES;

2 (l) A PROCESS FOR CHILD CARE HEALTH CONSULTANTS TO
3 EDUCATE AND WORK WITH DIVERSE EARLY CHILDHOOD PROFESSIONALS,
4 INCLUDING, BUT NOT LIMITED TO, EARLY CHILDHOOD EDUCATION
5 TEACHERS AND PROVIDERS, ELEMENTARY SCHOOL TEACHERS AND
6 ADMINISTRATORS, CHILD WELFARE CASEWORKERS, PUBLIC HEALTH
7 PROFESSIONALS, AND HEALTH-CARE PROFESSIONALS ON BEST PRACTICES
8 TO CREATE HEALTHY AND SAFE LEARNING ENVIRONMENTS;

9 (m) GUIDANCE FOR CHILD CARE HEALTH CONSULTANTS TO
10 EDUCATE EARLY CHILDHOOD PROFESSIONALS, AS DESCRIBED IN
11 SUBSECTION (2)(l) OF THIS SECTION, ABOUT THE PROGRAM; AND

12 (n) AN OUTLINE OF THE ACHIEVEMENT OUTCOME GOALS FOR THE
13 PROGRAM AND FOR CHILD CARE HEALTH CONSULTANTS, INCLUDING:

14 (I) INCREASE STAFF KNOWLEDGE, CONFIDENCE, AND
15 EFFECTIVENESS OF IMPROVING HEALTH AND WELL-BEING OUTCOMES FOR
16 CHILDREN IN LICENSED AND LICENSE-EXEMPT CHILD CARE AND LEARNING
17 SETTINGS;

18 (II) INCREASE CAREGIVER ACCESS TO TRAINING AND RESOURCES
19 TO SUPPORT CHILDREN WITH SPECIAL NEEDS, DISABILITIES, AND
20 DEVELOPMENTAL DELAYS;

21 (III) INCREASE THE COMPLIANCE OF A LICENSED OR
22 LICENSE-EXEMPT CHILD CARE AND LEARNING SETTING WITH BEST
23 PRACTICES STANDARDS AND HEALTH AND SAFETY REQUIREMENTS
24 ESTABLISHED BY THE DEPARTMENT PURSUANT TO PART 3 OF ARTICLE 5 OF
25 THIS TITLE 26.5;

26 (IV) STRENGTHEN ENVIRONMENTAL HEALTH PRACTICES;

27 (V) SUPPORT AND IMPROVE THE QUALITY OF HEALTH AND SAFETY

1 POLICIES AND PRACTICES WITHIN LICENSED AND LICENSE-EXEMPT CHILD
2 CARE AND LEARNING SETTINGS;
3 (VI) INCREASE THE NUMBER OF CHILDREN WHO RECEIVE ORAL,
4 DEVELOPMENTAL, VISION, AND HEARING SCREENINGS AND REFERRALS;
5 (VII) IMPROVE ACCESS FOR CHILDREN TO MEDICAL HOMES, AS
6 DEFINED IN SECTION 25.5-1-103; ENROLLMENT IN HEALTH INSURANCE;
7 AND UP-TO-DATE IMMUNIZATIONS;
8 (VIII) IMPROVE FAMILIES' ACCESS TO RESOURCES THAT SUPPORT
9 THE HEALTHY DEVELOPMENT OF CHILDREN; AND
10 (IX) INCREASE INCLUSION OF CHILDREN WITH SPECIAL
11 HEALTH-CARE NEEDS IN LICENSED AND LICENSE-EXEMPT CHILD CARE AND
12 LEARNING SETTINGS.
13 **26.5-3-1004. Statewide professional development plan - child**
14 **care health consultants.** (1) ON OR BEFORE JANUARY 1, 2027, THE
15 DEPARTMENT AND THE IMPLEMENTATION PARTNER SHALL DEVELOP A
16 STATEWIDE PROFESSIONAL DEVELOPMENT PLAN TO SUPPORT CHILD CARE
17 HEALTH CONSULTANTS IN MEETING THE EXPECTATIONS OUTLINED IN THE
18 MODEL OF CHILD CARE HEALTH CONSULTATION. IN DEVELOPING THE PLAN,
19 THE DEPARTMENT AND IMPLEMENTATION PARTNER SHALL WORK
20 COLLABORATIVELY, TO THE EXTENT PRACTICABLE, WITH THE
21 STAKEHOLDERS DESCRIBED IN SECTION 26.5-3-1002 (2)(b).
22 (2) THE PLAN MUST INCLUDE:
23 (a) TRAINING TO MEET THE COMPETENCIES OUTLINED IN THE
24 MODEL; AND
25 (b) GUIDANCE ON HOW TO PROVIDE ONGOING SUPPORT TO CHILD
26 CARE HEALTH CONSULTANTS, SUPERVISORS OF CHILD CARE HEALTH
27 CONSULTANTS, AND OTHER EXPERTS.

1 **26.5-3-1005. Data collection - evaluation - reporting.**
2 (1) (a) ON OR BEFORE JANUARY 1, 2027, SUBJECT TO AVAILABLE
3 APPROPRIATIONS, THE DEPARTMENT SHALL DEVELOP A STATEWIDE DATA
4 COLLECTION AND INFORMATION SYSTEM TO COLLECT AND ANALYZE
5 IMPLEMENTATION DATA AND SELECTED PROGRAM OUTCOMES TO IDENTIFY
6 AREAS FOR IMPROVEMENT, PROMOTE ACCOUNTABILITY, AND PROVIDE
7 INSIGHTS ON HOW TO IMPROVE PROGRAM OUTCOMES TO BENEFIT YOUNG
8 CHILDREN AND FAMILIES.
9 (b) THE INFORMATION SYSTEM AND ANY RELATED PROCESSES
10 MUST PLACE THE LEAST BURDEN POSSIBLE ON THE CHILD CARE HEALTH
11 CONSULTANTS IN THE PROGRAM. IN SELECTING THE IMPLEMENTATION
12 DATA AND OUTCOMES, THE DEPARTMENT MUST INCORPORATE
13 VARIABILITY ACROSS DIVERSE SETTINGS AND POPULATIONS.
14 (2) (a) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), BY
15 OCTOBER 1, 2027, AND BY EACH OCTOBER 1 THEREAFTER, THE
16 DEPARTMENT SHALL SUBMIT A COMPILED REPORT TO THE JOINT BUDGET
17 COMMITTEE. THE REPORT MUST INCLUDE THE FOLLOWING INFORMATION:
18 (I) A GAP ANALYSIS OF:
19 (A) THE NUMBER OF CHILD CARE HEALTH CONSULTANTS
20 PARTICIPATING IN THE PROGRAM;
21 (B) THE TYPES OF LICENSED AND LICENSE-EXEMPT CHILD CARE
22 AND LEARNING SETTINGS IN WHICH CHILD CARE HEALTH CONSULTANTS
23 PRACTICE AND THE NEEDS OF THE LICENSED AND LICENSE-EXEMPT CHILD
24 CARE AND LEARNING SETTINGS THAT HAVE NOT BEEN ADDRESSED BY THE
25 EXISTING CHILD CARE CONSULTANTS' PRACTICE; AND
26 (C) INSTANCES WHEN A LICENSED OR LICENSE-EXEMPT CHILD CARE
27 OR LEARNING SETTING IS UNABLE TO SERVE A CHILD DUE TO THE

1 FINANCIAL BURDEN ON THE LICENSED OR LICENSE-EXEMPT CHILD CARE OR
2 LEARNING SETTING AND WHEN THERE IS NOT A CHILD CARE HEALTH
3 CONSULTANT AVAILABLE IN THE GEOGRAPHIC REGION; AND
4 (II) PROGRAM ADJUSTMENTS NEEDED TO ENSURE ALL ELIGIBLE
5 LICENSED AND LICENSE-EXEMPT CHILD CARE AND LEARNING SETTINGS
6 HAVE EQUITABLE ACCESS TO THE PROGRAM.
7 (b) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), BEGINNING
8 IN JANUARY 2028, AND EVERY TWO YEARS THEREAFTER, THE
9 DEPARTMENT SHALL INCLUDE AS PART OF ITS "SMART ACT" HEARING,
10 REQUIRED BY SECTION 2-7-203, THE COMPILED REPORT DESCRIBED IN
11 SUBSECTION (2)(a) OF THIS SECTION.
12 (3) (a) ON OR BEFORE JULY 1, 2032, THE DEPARTMENT SHALL
13 CONTRACT WITH AN INDEPENDENT THIRD PARTY TO CONDUCT AN
14 EVALUATION OF THE PROGRAM TO DETERMINE WHETHER THE PROGRAM
15 OUTCOMES WERE MET AND WHETHER THE PROGRAM HAD A MEASURABLE
16 EFFECT ON THE HEALTH AND WELL-BEING OF YOUNG CHILDREN AND THEIR
17 FAMILIES ACROSS THE STATE.
18 (b) IN JANUARY 2033, DURING THE"SMART ACT" HEARING
19 REQUIRED PURSUANT TO SECTION 2-7-203, THE DEPARTMENT SHALL
20 PRESENT THE RESULTS OF THE EVALUATION DESCRIBED IN SUBSECTION
21 (3)(a) OF THIS SECTION.
22 **26.5-3-1006. Funding.** (1) THE DEPARTMENT, IN PARTNERSHIP
23 WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE
24 DIVISION OF INSURANCE IN THE DEPARTMENT OF REGULATORY AGENCIES,
25 SHALL EXPLORE FUNDING SOURCES TO IMPROVE ACCESS TO THE PROGRAM,
26 INCLUDING POTENTIAL FUNDING OPTIONS THROUGH THE CHILDREN'S BASIC
27 HEALTH PLAN, SET FORTH IN ARTICLE 8 OF TITLE 25.5, AND THE STATE

1 MEDICAL ASSISTANCE PROGRAM, SET FORTH IN ARTICLES 4 TO 6 OF TITLE
2 25.5.
3 (2) ON OR BEFORE JANUARY 1, 2027, THE DEPARTMENT SHALL
4 REPORT TO THE JOINT BUDGET COMMITTEE ANY IDENTIFIED FUNDING
5 SOURCES.
6 (3) THE DEPARTMENT MAY SEEK, ACCEPT, AND EXPEND GIFTS,
7 GRANTS, OR DONATIONS FROM PRIVATE OR PUBLIC SOURCES FOR THE
8 PURPOSES OF THIS PART 10.
9 **SECTION 2.** In Colorado Revised Statutes, **add** part 11 to article
10 3 of title 26.5 as follows:
11 PART 11
12 PEDIATRIC PRIMARY
13 CARE PRACTICE PROGRAM
14 **26.5-3-1101. Definitions.** AS USED IN THIS PART 11, UNLESS THE
15 CONTEXT OTHERWISE REQUIRES:
16 (1) "IMPLEMENTATION PARTNER" MEANS A STATE PUBLIC OR
17 PRIVATE ENTITY THAT HAS EXPERIENCE IMPLEMENTING AND OPERATING
18 NATIONALLY SUPPORTED EVIDENCE-BASED, RESEARCH-INFORMED
19 PEDIATRIC PRIMARY CARE PROGRAMS.
20 (2) "PEDIATRIC PRIMARY CARE PRACTICE EVIDENCE-BASED
21 MODEL" OR "EVIDENCE-BASED MODEL" MEANS THE TEAM-BASED,
22 RESEARCH-INFORMED PEDIATRIC PRIMARY CARE PRACTICE
23 EVIDENCE-BASED MODEL CREATED IN SECTION 26.5-3-1102 (2).
24 (3) "PEDIATRIC PRIMARY CARE PRACTICE PROGRAM" OR
25 "PROGRAM" MEANS THE PEDIATRIC PRIMARY CARE PRACTICE PROGRAM
26 CREATED IN SECTION 26.5-3-1102 (1).
27 **26.5-3-1102. Pediatric primary care practice program -**

1 **created - model - rules.** (1) (a) ON OR BEFORE AUGUST 15, 2025, THE
2 PEDIATRIC PRIMARY CARE PRACTICE PROGRAM IS CREATED IN THE
3 DEPARTMENT. THE PURPOSE OF THE PROGRAM IS TO PROVIDE FUNDING
4 AND SUPPORT TO A PEDIATRIC PRIMARY CARE MEDICAL PRACTICE TO
5 INTEGRATE INTO THE MEDICAL PRACTICE A PROFESSIONAL WHO
6 SPECIALIZES IN WHOLE-CHILD AND WHOLE-FAMILY HEALTH AND
7 WELL-BEING.
8 (b) THE DEPARTMENT SHALL CONTRACT WITH AN
9 IMPLEMENTATION PARTNER TO CREATE, IMPLEMENT, AND ADMINISTER THE
10 PROGRAM. THE IMPLEMENTATION PARTNER SHALL DEMONSTRATE
11 EXPERIENCE AND EXPERTISE IN:
12 (I) PLACING PROFESSIONALS WHO SPECIALIZE IN WHOLE-CHILD
13 AND WHOLE-FAMILY HEALTH AND WELL-BEING WITH PEDIATRIC PRIMARY
14 CARE MEDICAL PRACTICES;
15 (II) IDENTIFYING THE CONCERNS OF FAMILIES AND HEALTH-CARE
16 PROFESSIONALS ABOUT CHILD DEVELOPMENT AND FAMILY NEEDS; AND
17 (III) OFFERING SUPPORT STRATEGIES, GUIDANCE, AND COMMUNITY
18 RESOURCES TO FAMILIES.
19 (2) (a) THE IMPLEMENTATION PARTNER SHALL CREATE AND
20 IMPLEMENT A TEAM-BASED, RESEARCH-INFORMED PEDIATRIC PRIMARY
21 CARE PRACTICE EVIDENCE-BASED MODEL. THE EVIDENCE-BASED MODEL
22 MUST BE A COMPREHENSIVE APPROACH TO GUIDE PEDIATRIC PRIMARY
23 CARE MEDICAL PRACTICES TO DELIVER SERVICES TO CHILDREN FROM
24 BIRTH TO THREE YEARS OF AGE AND THEIR FAMILIES. THE
25 EVIDENCE-BASED MODEL MUST DEMONSTRATE IMPROVEMENTS IN
26 PHYSICAL HEALTH, BEHAVIORAL HEALTH, DEVELOPMENTAL OUTCOMES,
27 AND SOCIAL OUTCOMES FOR CHILDREN FROM BIRTH TO THREE YEARS OF

1 AGE AND THEIR FAMILIES.

2 (b) IN ADDITION TO CREATING AND IMPLEMENTING THE
3 EVIDENCE-BASED MODEL DESCRIBED IN SUBSECTION (2)(a) OF THIS
4 SECTION, THE IMPLEMENTATION PARTNER SHALL:

5 (I) WITH THE DEPARTMENT, ESTABLISH AN APPLICATION AND
6 SELECTION PROCESS FOR PEDIATRIC PRIMARY CARE MEDICAL PRACTICES
7 TO PARTICIPATE IN THE PROGRAM;

8 (II) REVIEW APPLICATIONS FROM PEDIATRIC PRIMARY CARE
9 MEDICAL PRACTICES AND SELECT ELIGIBLE MEDICAL PRACTICES TO
10 PARTICIPATE IN THE PROGRAM;

11 (III) WORK WITH PEDIATRIC PRIMARY CARE MEDICAL PRACTICES
12 SELECTED FOR THE PROGRAM TO COMPLETE ASSESSMENTS ON THE
13 MEDICAL PRACTICES' COMMUNITY HEALTH-CARE SYSTEMS, HEALTH AND
14 WELL-BEING PRACTICES, AND RELATED CONCERNS, WHEN NECESSARY OR
15 AS REQUIRED BY THE EVIDENCE-BASED MODEL; AND

16 (IV) TRAIN AND SUPPORT THE PEDIATRIC PRIMARY CARE MEDICAL
17 PRACTICES SELECTED FOR THE PROGRAM TO MAINTAIN FIDELITY TO THE
18 EVIDENCE-BASED MODEL.

19 (3) (a) TO BE ELIGIBLE FOR THE PROGRAM, A PEDIATRIC PRIMARY
20 CARE MEDICAL PRACTICE MUST INCORPORATE THE EVIDENCE-BASED
21 MODEL INTO THE MEDICAL PRACTICE. THE DEPARTMENT AND THE
22 IMPLEMENTATION PARTNER SHALL PRIORITIZE THE SELECTION OF
23 PEDIATRIC PRIMARY CARE MEDICAL PRACTICES THAT OFFER CHILDREN
24 FROM BIRTH TO THREE YEARS OF AGE AND THEIR FAMILIES THE FOLLOWING
25 SERVICES:

26 (I) AN EVALUATION OF THE RELATIONSHIP BETWEEN THE CHILD
27 AND THE CAREGIVER THROUGH ASSESSMENTS, INTERVENTIONS, AND

1 REFERRALS;

2 (II) CHILD DEVELOPMENT, SOCIAL-EMOTIONAL, AND BEHAVIORAL

3 HEALTH SCREENINGS;

4 (III) SCREENINGS THAT IDENTIFY FAMILY RISK FACTORS AND

5 NEEDS, INCLUDING PERINATAL AND POSTPARTUM MOOD DISORDERS,

6 SOCIAL DETERMINANTS OF HEALTH, AND OTHER RISK FACTORS;

7 (IV) ACCESS TO SHORT-TERM BEHAVIORAL HEALTH

8 CONSULTATIONS; AND

9 (V) ONGOING, PREVENTATIVE TEAM-BASED WELL-CHILD VISITS.

10 (b) A PEDIATRIC PRIMARY CARE MEDICAL PRACTICE SELECTED FOR

11 THE PROGRAM SHALL PARTNER WITH PROFESSIONALS WHO SPECIALIZE IN

12 WHOLE-CHILD AND WHOLE-FAMILY HEALTH AND WELL-BEING AND WHO

13 USE DATA AND OUTCOMES TO DEMONSTRATE ADHERENCE TO THE

14 EVIDENCE-BASED MODEL.

15 (4) THE DEPARTMENT MAY ADOPT RULES TO CARRY OUT THE

16 PURPOSES OF THIS PART 11.

17 **26.5-3-1103. Funding.** (1) THE DEPARTMENT, IN PARTNERSHIP

18 WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE

19 BEHAVIORAL HEALTH ADMINISTRATION IN THE DEPARTMENT OF HUMAN

20 SERVICES, SHALL EXPLORE FUNDING SOURCES TO IMPROVE ACCESS TO THE

21 PROGRAM, INCLUDING POTENTIAL FUNDING OPTIONS THROUGH THE

22 CHILDREN'S BASIC HEALTH PLAN, SET FORTH IN ARTICLE 8 OF TITLE 25.5,

23 AND THE STATE MEDICAL ASSISTANCE PROGRAM, SET FORTH IN ARTICLES

24 4 TO 6 OF TITLE 25.5.

25 (2) ON OR BEFORE JANUARY 1, 2026, THE DEPARTMENT SHALL

26 REPORT TO THE JOINT BUDGET COMMITTEE ANY IDENTIFIED FUNDING

27 SOURCES FOR THIS PART 11.

1 (3) THE DEPARTMENT MAY SEEK, ACCEPT, AND EXPEND GIFTS,
2 GRANTS, OR DONATIONS FROM PRIVATE OR PUBLIC SOURCES FOR THE
3 PURPOSES OF THIS PART 11.
4 **SECTION 3. Act subject to petition - effective date.** This act
5 takes effect at 12:01 a.m. on the day following the expiration of the
6 ninety-day period after final adjournment of the general assembly; except
7 that, if a referendum petition is filed pursuant to section 1 (3) of article V
8 of the state constitution against this act or an item, section, or part of this
9 act within such period, then the act, item, section, or part will not take
10 effect unless approved by the people at the general election to be held in
11 November 2026 and, in such case, will take effect on the date of the
12 official declaration of the vote thereon by the governor.