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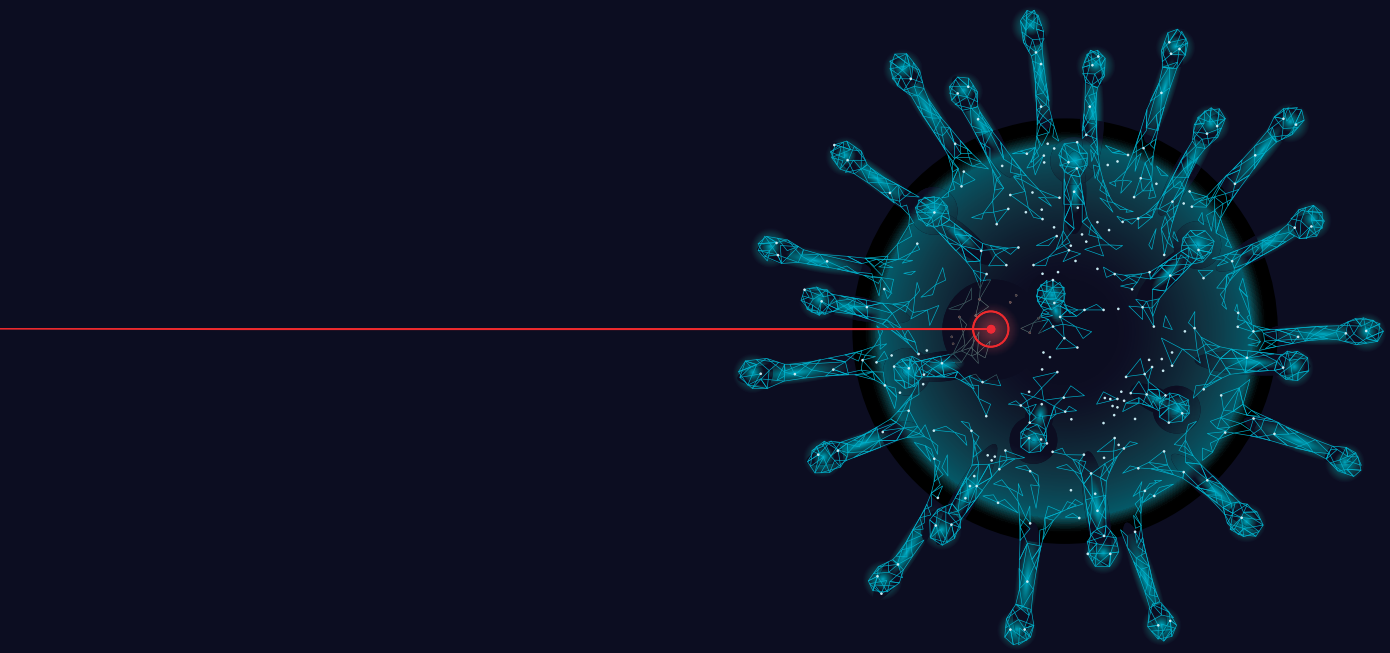
The Impact of COVID-19 on Pennsylvania Child Care



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About the Institute of State and Regional Affairs (ISRA)

ISRA has been a vital resource in Pennsylvania since it was established in 1973. As a Penn State research and services unit in the state's capital region, the Institute serves to foster understanding and progress in the areas of public policy and administration; community, regional and state planning; information management and analytics; research and evaluation; and economic development. ISRA has a strong, unrivaled commitment to applied social science research and public service focused on Pennsylvania's communities. To learn more about ISRA, visit our websites at isra.hbg.psu.edu.

Overview of Study Findings

The operational and financial impacts of COVID-19 on Pennsylvania child care providers and staff have been significant. Most child care programs closed, at least temporarily, in the initial weeks of the pandemic, eliminating income even while costs continued to accrue. Statewide, 86% of providers reported closing at some point, although the true rate of closure could be as high as 93% due to the unknown status of unresponsive providers. Throughout the closure, nearly all providers did not charge tuition, which had substantial financial impacts. Many child care providers need to make payments on expenses that continue to accrue during the COVID-19 pandemic. In order to reopen, many providers have or plan to extend their debt to cover the lag between payroll expense and the return of revenues.

Between mid-March and June 2020, most child care providers closed for some period of time. Those that remained open, or closed and reopened, operated with fewer children present than in usual operations. Providers were able to partially reduce costs in response to reduced demand or closure. Personnel costs, which are the largest share of provider costs, were decreased by furloughing staff at many programs. Facility costs, which are the second-greatest cost category, could not easily be altered. Lease and mortgage payments, utility bills, real estate taxes, and insurance premiums came due, despite the lack of revenue. A small center serving under 30 students, facility expenses alone exceeded $1,200 per month. Statewide, the financial impact of facility expenses which accrued during the state shutdown exceeded $56.6 million.

To pay for obligations such as facility expense during the shutdown, providers used all available cash reserves, if available. Others extended their debt, sometimes using high-interest credit cards, or requested deferment. In either case, new debt will add to their expenses going forward, requiring additional revenue to remain in operation. The lack of revenue has also left providers without the liquidity needed to cover payroll as they reopen, further necessitating the use of debt alternatives. Making payroll during the reopening phase is a major concern for many providers. As attendance increases upon program reopening, tuition and subsidy revenues often lag behind expenses. Payroll is the largest of these expenses, and providers worry that they will have insufficient cash to rehire and pay teachers during the weeks following reopening. At the median program, statewide, a two-week payroll is approximately $1,400.

As of June 29, 2020, 125 providers that were operational at the onset of the pandemic have announced permanent closure. This corresponds with the percent of providers from the statewide survey which indicated they did not plan to reopen. Based on provider reports, without immediate assistance to offset ongoing costs associated with implementing COVID-19 guidelines and reduced enrollments, it is expected at least 4%

of child care providers (280) will close permanently, with another 1,000 at risk of closure.

Staff and providers are still preparing to implement the Centers for Disease Control (CDC) guidance, including masking and social distancing with young children. As providers reopened, they have experienced increased costs to comply with COVID-19 health and safety protocols. Additional personnel resources required will have the greatest cost implications. Providers report modified drop-off and pick-up procedures that involve program personnel stationed near or outside the front door at opening and closing times to limit contact of family members. Cleaning time is also adding to personnel costs, as teachers and other program staff are working extra hours to sanitize classrooms and equipment. Materials and resources such as cleaning supplies and personal protection equipment will also meaningfully affect costs. The estimated net impact will be an increase of slightly more than $22 per child per week. The large combined costs of the COVID-19 response have left providers reassessing whether they can afford to continue operation, or will need to close.

Results of this study find that, at a minimum, providers require financial assistance for facility expense during the shutdown, sufficient liquidity to cover one two-week floating payroll, and assistance to implement COVID-19 health and safety guidelines. The combined costs of facility expense over fourteen weeks, a one two-week payroll, and two-months of implementing COVID-19 guidelines is approximately $209.4 million. While the COVID cost estimate is only for an eleven-week period spanning the start of reopening to Labor Day, it will facilitate initial implementation of health and safety protocols. The cost of implementing COVID-19 guidelines will continue.

Providers are also operating below capacity and expect to be doing so for at least several months, which has increased per-child costs of operation. For some of the largest programs, reductions in staff can partially offset the loss in revenue. In the scenario with small to moderate decreases in attendance; however, most programs could not reduce the number of staff and still maintain the child-to-staff ratios specified in code. The effect of under-enrollment is significant. Operating at 83% of capacity would increase per-child costs by 27% (median) for all provider types and sizes. For child care centers, operating at 50% capacity will increase per-child costs by almost two-thirds (61%). Family provider have less opportunity to reduce expenditures and the cost of care is nearly double (97%) then compared to full enrollment. In addition to the one-time investments needed as part of reopening, providers will need financial assistance to offset reductions in enrollments. It is unknown how long a period of low enrollment will continue. When the school year begins, the statewide financial toll of enrolling only five out of six children served prior to COVID-19 is estimated to be $115.7 million in increased costs per child that continue to accrue each month while operating at reduced enrollment.

Study Description

The COVID-19 pandemic is an unexpected and rapidly changing event, which has shocked and strained critical services and basic operations within the commonwealth. The crisis unfolding now demands that state leaders have access to reliable and timely information about how child care services are responding. In partnership with the Pennsylvania Office of Child Development and Early Learning (OCDEL) and the PA Key, the Institute of State and Regional Affairs (ISRA) at Penn State Harrisburg conducted a study initially designed to answer four questions:

1. How have child care providers responded to COVID-19, and what are the financial costs?
2. How many child care providers will remain operational without revenue in the next few months?
3. What level of investment is needed for continued operation of child care after restrictions on public movement are lifted?
4. What level of investment is needed to ensure that child care services are accessible to families during a transition period of low demand?

The study, led by Philip Sirinides, included a detailed cost analysis, a representative statewide survey of child care providers, and in-depth interviews with child care providers and workers. The study protocols, recruiting materials, consent form, and final instruments were submitted to Penn State University's Office for Research Protections and were subsequently approved as "exempt research" under study number 00015031.

During April 2020, protocols for data collection from study participants were developed. External reviewers with expertise in child care were consulted, resulting in some revision of prompts for clarity and relevance. Topics of data collection included: operations, impacts on families and staff, revenue and expenses, plans of the future, capacity, and sources of information on COVID-19.

Study Sites for Qualitative and Cost Analyses

This study utilizes and builds on a recently completed 2020 Cost of Care Study which included detailed site visits and a statewide representative survey. In April 2020, ISRA attempted to recruit all 30 providers which participated in the prior study. Twenty-four agreed to continue participation. Seven sites were added, all of which were able to operate because they were a family child care home or had received a waiver. It was important that study include sites that were open to investigate operations and identify costs associated with reopening. These seven additional providers were contacted via email, as they were on a published list of programs operating with a waiver. The new sites comprised a convenience sample of providers that were operating while also preserving the variability of key provider attributes of sites from the prior study.

The final site sample (*See Table 1*) included 31 providers, 24 of which were participants in the original 2020 Cost of Care Study. At the time of the interview 14 providers were open (three of which were virtual only), seven were permitted to reopen but remained closed, and 10 providers remained closed. The sample had coverage across provider type (11 Family Homes, 9 Group/Small Centers, and 11 Large Centers) as well as Keystone STAR levels (12 at STAR 1, 5 at STAR 2, 7 at STAR 3, and 7 at STAR 4). Sites were located in 25 Pennsylvania counties (*see Figure 1*). To incentivize responses, a $25 electronic gift card was offered to all participants who participated in the study.

Table 1: COVID Impact Study Sites

	Unable to operate *		Able to operate	
	Closed	Virtual only	Closed	Open
Cost of Care sites				
CCC	3	1	0	4
FCCH	0	0	5	2
GCCH	6	1	0	2
New sites				
CCC	0	1	0	2
FCCH	0	0	3	1
GCCH	0	0	0	0
Total	9	3	8	11

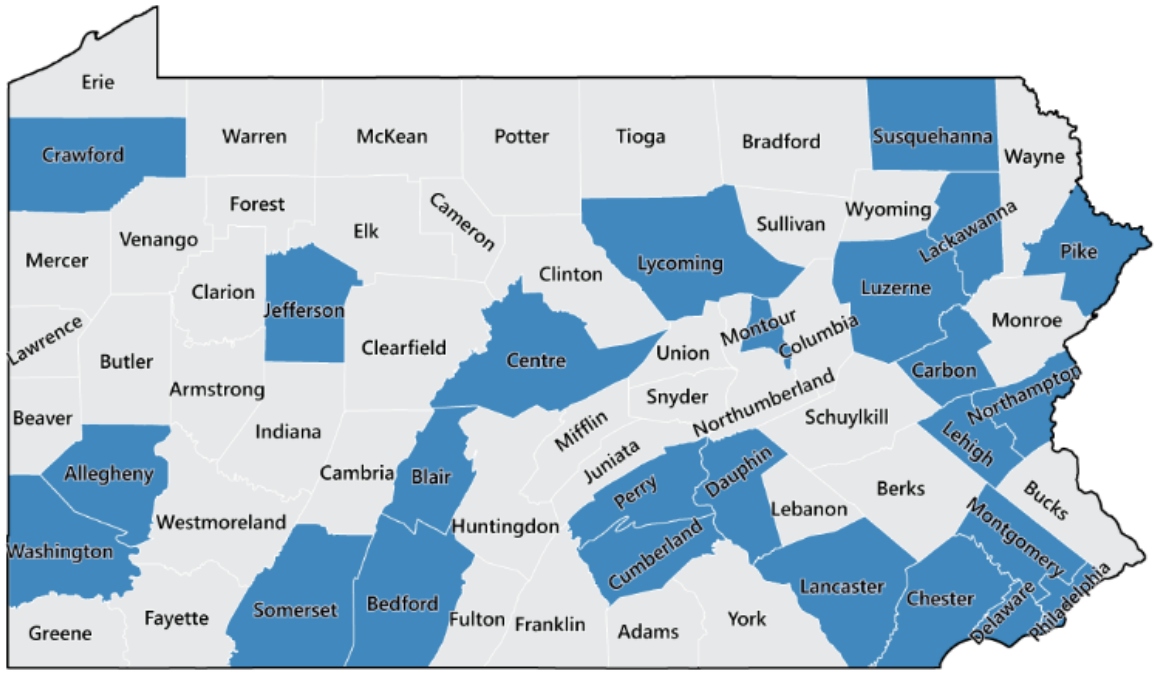
Notes: Child Care Center (CCC); Family Child Care Home (FCCH); Group Child Care Home (GCCH).
* During the red phase of Governor Wolf's COVID-19 recovery plan, regulated child care programs were required to remain closed unless 1) they were licensed as a family child care home 2) a group child care home operating in a residence 3) a child care center or group child care home operating outside a residence that had received a waiver to provide care for children of employees of life-sustaining businesses. All regulated providers were permitted to re-open in the yellow phase of the recovery plan if certain health and safety guidelines were met.

Cost study sites with employees were also asked to forward an invitation to staff members, inviting them to participate in the study. Seventeen of the child care providers who completed an interview agreed to share the recruitment flyer and study information with their staff. Interested child care workers were asked to complete a brief Qualtrics form to collect basic contact information. A total of 40 child care workers completed the form. Ten staff members were selected randomly by child care facility to be interviewed. Interviewed staff were asked how their job was affected (including hours, pay, and role, remote work), reasons for any changes, expectations for the future, and concerns about returning.

A total of 41 virtual semi-structured interviews with child care providers and workers were conducted between April 28 and May 22, 2020 using Zoom Video Communications web conferencing software. The goal of the interviews was to generate new information on the financial and operational impacts of COVID-19 on regulated

child care in Pennsylvania. Thirty-one interviews were completed with child care providers, and ten interviews were completed with child care workers in various roles.

Figure 1: Child Care Providers Included in Qualitative and Cost Analyses



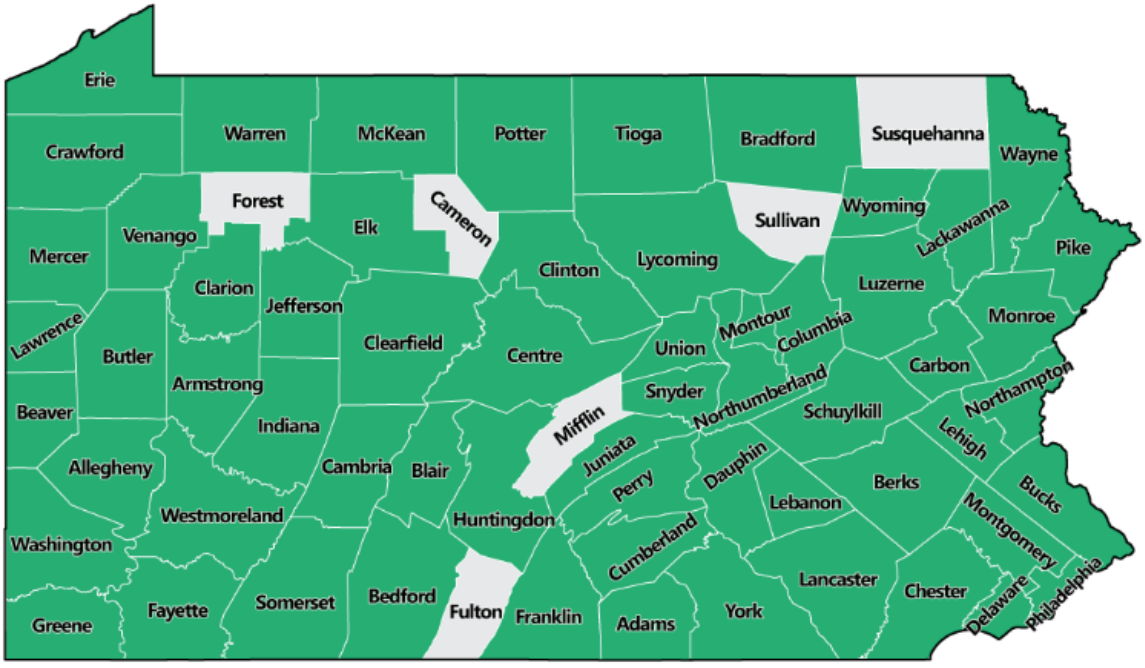
The semi-structured interviews were conducted by an ISRA staff member experienced with qualitative methods and interviewing. Prior to the start of each interview, the participants reviewed a consent form, that was sent via email, and were given an opportunity to ask questions. Interview participants were able to connect to the web conference via computer or telephone. The interviews were audio recorded using the web conferencing software. Participants who connected via computer were asked to turn off their web cam to facilitate audio recording only. The interviews lasted approximately 30-45 minutes for child care providers and 10-20 minutes for child care workers. Transcripts were created from interview audio files. They were reviewed and analyzed for key themes that emerged by questions posed during the semi-structured interviews.

In coordination with the site-level protocol, a survey instrument was also developed to collect data from a large representative sample of Pennsylvania's regulated child care providers. The survey included both fixed-choice and open-ended questions, and collected a range of indicators related to experiences of providers in response to COVID-19, and specific changes to revenues, expenses, enrollment, staffing, and operating procedures. Several precautions were taken to avoid problems related to self-reported data. To the extent possible, questions were carefully worded to not suggest that one response was "correct" or more appropriate than others. The survey focused

on changes in operations and finances and included questions on: the facility's operational status, employment of staff, number of children attending and/or paying tuition, communication with families, plans to reopen, and any planned changes that will be made to staff, enrollment, facilities, costs, etc. Open-ended questions were also included to explore selected topics in more depth. As with site-level protocols, external reviewers with expertise in child care were consulted to ensure clarity and relevance of each of the survey questions. The instrument was then programmed using Qualtrics web survey software. Qualtrics' Online Survey Platform allows for complex question patterns and automatic skipping when appropriate to create a seamless flow from one question to the next for respondents.

The sample for the statewide provider survey was also coordinated with the prior 2020 Cost of Care Study. Due to smaller proportions of group and family providers with high STAR levels, a stratified sampling approach by STAR level and provider type was used to oversample smaller segments of the provider population. In addition to provider type and STAR level, equal proportions of providers in rural and non-rural counties were selected for the sample. Finally, additional stratification was used within STAR 1 providers to ensure equal proportion were selected both with and without Child Care Works (CCW) subsidy agreements. This resulted in providers having selection probabilities that varied by multiple attributes. Sample weights were created as the inverse of the selection probability and used in all statistical analyses.

Figure 2: Statewide Provider Survey



Surveys were self-administered through Qualtrics Online Survey Platform, and responses were collected through Penn State's Qualtrics web survey account between

April 30 and June 2, 2020. Each potential respondent was sent an initial invitation email and two reminder emails to request participation in the survey. Participants were also given the option to opt-out of future survey invitations by selecting a link in the invitation email.

Of the 1,000 records in the starting sample, 62 were returned as undeliverable. Another three respondents refused to participate. The study received over a 50% response rate and over 90% completion rate from respondents. The final dataset includes data from 479 respondents. Of those that responded, 324 (67.7%) were child care centers, 99 (20.6%) were family child care homes, and 56 (11.7%) were group child care homes. Survey participants were located in 61 Pennsylvania counties.

All survey data were recorded in Qualtrics and stored on a secure server that required two-factor authentication for access. Data were extracted, deidentified, and verified for accuracy of variable coding by running frequency distributions to check for out-of-range values. All final data were reviewed by the senior staff of ISRA.

Inferences and Study Limitations

Despite making multiple attempts to contact all providers selected to participate, the project team did not receive a completed survey or complete an interview with every possible respondent. Because the answers from these non-respondents could be different from those who did participate, non-response bias exists.

Although not a limitation of the study, it is important to clarify the inferences which can be made based on site-level data. Site-level data were used for both the cost analyses and qualitative component of the study. While the providers in this sample are representative of a broad range of geographies, views, and conditions, the composition of the site sample may not generalize to the population in terms of proportional representation for all attributes. The reason is the site sample was purposefully constructed to reflect combinations of provider attributes related to cost of care and operational status at the time of data collection. Salient provider attributes include type, state quality rating (i.e. Keystone STARS), participation in the subsidy program, and rurality. It is thus appropriate, for example, to interpret the median per child cost of care based on this collection of site-specific analyses. There would be less evidentiary support from this sample, however, to support subgroup analyses such as the difference in costs between provider types. This study can reliably estimate the financial impact as a statewide median economic cost.

Also, although not a limitation of the cost analyses, the recommendations made are based on a proxy measure of the number of children who normally would be cared for when operating at full enrollment. Current data does not exist on the pre-COVID number of child enrollments and the number of personnel employed at individual sites. Neither is data on facility size consistently recorded. Absent these data, proxy measures based on

site licensed capacity were used. It is assumed that license capacity is equivalent to typical full-time enrollment. Pennsylvania leaders and the provider community would greatly benefit from the regular collection of enrollment and personnel data by care level in the future.

The Operational Impacts of COVID-19 on Child Care Providers

The *Operational Impacts* section of this report includes findings related to closures, changes to revenues, expenditures, and staff, and final plans for reopening. Primary data come from the interviews and statewide survey. The *Financial Impact* section uses site-level ingredient data to estimate site- and statewide- costs associated with four specific areas of impact.

Closure of Child Care Facilities

Statewide, 85.5% of child care providers reported closing at some point as a result of COVID-19. Almost all child care centers (97.1%) reported closing, as compared to 79.5% of group child care homes and 50.5% of family child care homes (*See Table 2*). It should be noted that the survey was conducted during a tumultuous time when the COVID-19 pandemic was affecting people around the world. Many businesses were closed during this time, and Pennsylvania residents were asked to stay at home. This may have had a negative effect on the response rate. Some child care providers may not have had readily available access to email to receive and respond to our invitations. Also, because providers were dealing with many challenges regarding center closures, staffing issues, moving to remote instruction, and responding to concerns from families they serve, they may not have had time to participate. Based on an extreme assumption that all survey non-respondents had closed, the overall rate of closure may have been as high as 93.1%.

Of the child care providers that closed at some point, more than two-thirds closed during the week of March 15 – March 21, 2020. Nearly all (92.3%) providers that closed at some point closed before March 22, 2020. Child care centers, and group child car homes operating outside of a residence, were initially required to close unless they acquired a waiver to serve essential workers. A small number of the providers indicated that they operated in school buildings. As a result, when the Pennsylvania Department of Education closed schools at the end of the day on March 13, they also had to cease operations. The other reason shared for closing their child care facilities was a loss of demand for services. Providers stated that since many of their families were working from home, they no longer needed child care.

One family child care home provider stated in an interview that her last day open was April 10. When asked why her child care closed so long after the pandemic began, the provider shared that she no longer felt she had enough information to keep her children and families safe and healthy due to COVID-19, so it was best to close.

Table 2: Closure of Child Care Facilities

	CCC	FCCH	GCCH	All
Closure				
Did your facility close as a result of COVID-19?	97.1%	50.5%	79.5%	85.5%
Are you currently closed? *	87.6%	81.5%	63.3%	84.3%
On what day did you close because of COVID-19?				
03/01/20 – 03/07/20	1.0%	0.0%	0.0%	0.8%
03/08/20 – 03/14/20	24.8%	21.3%	19.0%	23.8%
03/15/20 – 03/21/20	70.3%	53.2%	64.3%	67.7%
03/22/20 – 03/28/20	0.6%	19.1%	4.8%	3.3%
03/29/20 – 04/04/20	0.3%	2.1%	11.9%	1.8%
Other	2.9%	4.3%	0.0%	2.8%
On what day did you reopen? (of 26% open)				
03/15/20 – 03/28/20	17.9%	33.3%	25.0%	21.9%
03/29/20 – 04/11/20	15.4%	44.4%	18.8%	20.3%
04/12/20 – 04/25/20	10.3%	0.0%	6.3%	7.8%
04/26/20 – 05/09/20	20.5%	11.1%	25.0%	20.3%
05/10/20 – 05/23/20	33.3%	11.1%	25.0%	28.1%
05/24/20 –	2.6%	0.0%	0.0%	1.6%
Enrollment totals & changes (average reported)				
Number of children served before closing	66.5	6.8	13.7	53.5
Number of children currently served (*26% open)*	19.4	4.8	5.3	10.0

Note: Child Care Center (CCC); Family Child Care Home (FCCH); Group Child Care Home (GCCH);
*Survey responses were collected between April 30 and June 2, 2020.

Most respondents who had closed at some point remained closed at the time of the survey. Nearly two-thirds of group child care homes (63.3%) who had closed indicated that they were not operating. In comparison, 81.5% of family child care homes that had closed were still closed, and 87.6% of child care centers that had closed at some point remained closed. The average number of children being served before the closure varied across the three provider types, with the highest number being served at child care centers (66.5 children), as compared to 13.7 children on average at group child care homes and 6.8 at family child care homes. The survey did not ask respondents to identify how many children were receiving full-time or part-time care.

There was a great deal of variation in re-open date and percent of children who returned. Generally, family child care homes re-opened the earliest, with 77.7% reporting that they re-opened before April 12, 2020. In contrast, 56.9% of child care centers and 50.0% of group child care homes re-opened April 24, 2020, *or later*.

Significantly decreased attendance numbers were seen by providers who re-opened with a waiver or because of a change in county status (i.e. red to yellow phase). In fact, most centers and groups indicated only one-quarter to one-half of their children attending once they re-opened. Of the facilities that were open at the time of the survey,

child care centers were serving an average of 19.4 children per facility, while group child care homes were serving 5.3 children and family child care homes were serving 4.8 children. None of the re-opened providers reported families unenrolling in their programs during this time, only reduced attendance.

The main reason providers decided to re-open was when their county moved to Governor Wolf's yellow phase, which lifted the stay-at-home order. In addition to the reduced enrollments measured by the statewide survey, some interviewed providers reported having families inquire about changing from full-time to part-time care. Reasons included that family members were laid off and did not want to incur full-time child care costs, holding a spot in the child care facility, easing children back into the child care setting, and not needing full-time care since one adult was still working from home.

Throughout the COVID-19 shutdown, staff typically continued to reach out to families via email, text, Facebook, or by sending activities, stories, or lessons. Most staff were doing these tasks unpaid. Three of the providers interviewed were offering complete virtual learning. These included packets of materials provided to families, interactive lessons, recordings, and virtual face to face meetings with each student to check in and monitor their progress. Additionally, these providers were offering support for families during this challenging time. While many providers were not offering a complete online program, they were in touch with their families and children through text, email, video calls and social media. Programs offering virtual learning saw a small number of families unenroll who were not interested in paying for the virtual program.

Revenues

All providers interviewed had lost some level of income and ranged from $500/week up to $1 million lost over 2-3 months since closure.

> "If I don't open back up, I'm looking at a huge financial burden!"

The previous statement concisely summarizes the opinion of most child care providers when interviewed about how their revenue had been affected during the COVID-19 pandemic. Most providers reported that their current level of revenue loss would either stay the same or get worse in the coming weeks. In the statewide survey, less than 5% of child care providers report that the pandemic had not impacted revenue. Statewide, 83.4% of providers lost more than a quarter of their revenue.

Table 3: How has your revenue changed since the start of the Stay-at-Home order?

	CCC	FCCH	GCCH	All
Changes to revenue				
I have lost all of my revenue	22.7%	18.4%	34.5%	23.3%
I have lost more than half, but not all revenue	37.4%	24.3%	26.2%	33.3%
I have lost between a quarter and half revenue	25.5%	33.4%	22.4%	26.8%
I have lost less than a quarter of my revenue	11.5%	10.0%	16.1%	11.7%
My revenue has stayed the same	2.9%	13.9%	0.4%	4.8%
My revenue has increased	0.0%	0.0%	0.4%	0.0%
Changes to tuition/hours				
Have you changed your tuition? *(Yes)*	12.3%	4.0%	0.0%	6.1%
Have you changed your hours/days? *(Yes)*	31.6%	23.8%	41.4%	30.3%
Efforts to replace lost revenue				
Replaced some revenue	44.9%	13.8%	16.8%	34.4%
Sought replacement, unsuccessful	25.8%	31.1%	38.7%	28.6%
Have not sought to replace revenue	29.3%	55.1%	44.5%	37.1%

Almost all child care providers were not charging tuition during their closure. In some cases, providers did receive some revenue. Most often, these providers were offering virtual programs and charging a partial tuition to families. A small number of providers shared that even though they were not charging tuition during the closure, a small number of families still offered to pay because the adult family members remained employed and knew that the provider was incurring expenses.

Several of the providers interviewed reported that they continued to receive child care subsidies and PA Pre-K Counts funding during the closure which helped immensely. The Head Start Supplemental Assistance Program (HSSAP) was also paid during the closure, although none of the providers interviewed offered this programming. Some providers noted receiving USDA food program funds during this time also provided some relief. Many interviewees highlighted the major difference between providers that continued to receive CCW subsidy payments from the commonwealth and those that did not. Many providers who were continuing to receive CCW subsidy payments noted that they were in a better financial position since they knew they had some revenue during the shutdown. One provider even called these funds, “a blessing.” However, providers that were not receiving Child Care Works subsidies seemed to face some of the biggest challenges with recouping lost revenue.

> “For providers that don't have a large population of subsidized clients, not because they wouldn't take them, just because that's where they're at, that's problematic.”

The statewide survey found that very few providers (6.1%) changed their tuition since the start of the Stay-at-Home order. Five times more common (30.3%), however, was

some change to hours/days of operation. Although not asked on the survey, several providers interviewed have waived their minimum days per week of attendance. These providers indicated that many families wanted to ease their children back into the routine, so they were only interested in 1-2 days per week of care to start.

With enrollment-based tuition being the main source of revenue, providers sought alternatives in a variety of ways, including applying for the Payroll Protection Plan (PPP), disaster loans and emergency grants through the Small Business Administration (SBA), Pandemic Unemployment Assistance (PUA), grants from private foundations, and receiving donations from some of their child care families (*See Table 3*). More child care centers reported that they have sought means of replacing lost revenue (70.7%) and also have received means of replacing lost revenue (44.9%) than both family child care homes (44.9% and 13.8%, respectively) and group child care homes (55.5% and 16.8%, respectively).

Providers gathered information on applying for programs to help with revenue losses mainly from emails from the commonwealth, most notably OCDEL. Providers also mentioned reaching out to their banks, lending institutions, insurance companies, and financial advisors for assistance on how to recoup losses. A few providers shared that they relied on social media groups and speaking with other child care providers to determine what options were available to help with revenue losses.

Expenditures

Loss of revenue has created considerable challenges, mainly because, providers cannot efficiently reduce expenditures (*See Tables 4 and 17*). Providers most-commonly reported having to pay rent/mortgage, utilities, insurance, and credit card bills while they are or were closed. More child care centers reported having to pay salaries (54.7%) than group child care homes (35.0%) and family child care homes (25.1%). Some family child care owners take a salary, although most elect to retain the profit from operations.

Table 4: Which of the following expenditures must be paid while you are/were closed?

	CCC	FCCH	GCCH	All
Facility (Rent/Lease/Mortgage)	88.7%	91.1%	85.7%	88.7%
Utilities	81.6%	89.6%	99.3%	84.5%
Insurance	72.8%	71.1%	73.8%	72.7%
Salaries	54.7%	25.1%	35.0%	48.9%
Staff benefits	43.6%	0.0%	14.1%	35.0%
Equipment previously ordered	37.4%	22.1%	21.6%	33.8%
Credit card bills	62.0%	76.8%	81.8%	66.0%
Other Loan(s) (business, vehicle, etc.)	39.2%	48.2%	59.7%	42.6%

Survey respondents who indicated that they had to pay for utilities while closed were asked how their utility bills had changed during the close-down period (*See Table 5*). More than half of child care centers reported having their utility bills decrease a little

(53.1%) or a lot (10.4%) as compared to just 17.4% of family child care homes that said that their utility bills had decreased a little and no providers said they had decreased a lot. For group child care homes, 25.8% said that their utility bills had decreased a little and 3.0% that said that these bills have decreased a lot. It is unclear why some family providers (29%) reported an increase in utility bills, or if it was business related.

Regardless of whether their businesses had closed, all respondents were asked about their insurance costs, credit card payments, and other loan expenses. More family child care homes indicated that they pay their insurance monthly (75.7%) than both group child care homes (52.1%) and child care centers (50.2%). In comparison, 29.5% of group child care homes and 25.4% of child care centers pay their insurance annually, as compared to 16.7% of family child care homes.

Table 5: Utility and Insurance expenses

	CCC	FCCH	GCCH	All
How have your utility bills changed since the Stay-at-Home order was implemented?				
They have increased	0.5%	29.3%	13.1%	5.9%
They have stayed the same	36.0%	53.3%	58.0%	41.0%
They have decreased a little	53.1%	17.4%	25.8%	45.0%
They have decreased a lot	10.4%	0.0%	3.0%	8.1%
How much was the following bill in the most recent month (average reported)				
Credit card(s)	$9,324	$2,237	$1,499	$6,917
Other loan(s)	$6,189	$2,112	$2,189	$4,782
How often do you pay the insurance amount noted above?				
Monthly	50.2%	75.7%	52.1%	53.9%
Quarterly	14.7%	1.9%	16.4%	13.2%
Semi-annually	3.9%	5.6%	0.0%	3.6%
Annually	25.4%	16.7%	29.5%	24.8%
Other	5.8%	0.0%	2.0%	4.5%

Facility expenses continued even as providers were closed. Among sites in the cost study, mortgage and rent payments at the median were $1,404 per facility with some larger centers paying over $14,000 a month for lease of space. This was by far the highest monthly expense, next to salaries, that some providers had to determine how to continue to pay while closed. A small number of providers noted that they asked for a deferment or forbearance on these major expenses.

The survey found that credit card bills for the most recent month were higher for child care centers ($9,324 on average) than family child care homes ($2,237) and group child care homes ($1,499). The same was true for other loans, including business and vehicle loans, where child care centers had a monthly bill of $6,189 on average, as compared to $2,112 for family child care homes and $2,189 for group child care homes. Because of regulatory limits on capacity, the ratio of combined debt payment (credit card and other

loans as reflected on prior month bills) per child served was more than double for family home providers ($725 per child) than it was for centers and groups ($300 per child). Calculation of debt to child ratio assumes full time equivalency of 6 children for family child care homes, 12 children for group child care homes, and 52 children for child care centers. The difference between group and center providers in monthly debt payment to child served was less than $10. For reference, the 2018 average daily market rate for non-school age full time care by a family child care home was $29.26. The estimated amount of monthly business loans per child is comparable to the monthly median per child market rate for full time child care. Statewide data suggest that family providers are using monthly credit cards and loans to pay for most expenses.

Providers were then asked how they plan to pay for expenses (S*ee Table 6*). Half of family child care homes indicated that they will use personal savings to do so (56.6%) as compared to 39.8% of group child care homes and just 19.2% of child care centers. More child care centers plan to use a company savings account (39.9%) than family child care homes (2.5%) and group child care homes (21.8%). It is noteworthy that 15.2% of providers reported not knowing how they would pay for some of the expenditures. An additional 2.8% said that they would not pay for some of the expenditures.

Table 6: How will you pay/have you paid for these expenditures?

	CCC	FCCH	GCCH	All
Company savings account	39.9%	2.5%	21.8%	33.3%
Personal savings account	19.2%	56.6%	39.8%	26.1%
Spouse / Partner / family income	7.30%	37.6%	19.7%	12.4%
Other lead agency funds	14.7%	7.5%	3.3%	12.6%
SBA disaster relief loan	26.9%	6.7%	4.3%	21.9%
Tuition payments from families	19.2%	7.5%	12.3%	17.0%
Credit card	18.2%	20.6%	16.1%	18.2%
Other loan	10.3%	6.3%	1.4%	8.9%
Other	24.8%	7.4%	11.3%	21.2%
Don't know	15.9%	9.4%	16.8%	15.2%
I do not plan to pay these expenditures	2.7%	6.1%	0.0%	2.8%

A family provider interviewed expressed her fears about lost revenue.

> "So, the only way this business is staying afloat is out of my personal savings. So, if something does not change soon, not to sound dramatic, but it's going to be very detrimental."

Most providers interviewed were paying expenses from savings/cash on hand, subsidy payments from the state, or the PPP funding that many of the providers applied for and received. Providers did note that the PPP funding, while extremely helpful, was only able to be used for certain expenses. Other ways providers continued to pay expenses

included income from partial tuition (especially if open), SBA grants, and credit cards. Family child care home providers shared that they relied on income from a spouse as well as cutting costs in their home to help during the shutdown. Almost all providers planned to pay their bills, and pay on time, as best as they could.

Staffing

To provide additional detail about staffing-related expenses and decisions, survey respondents were asked how many paid staff they employed in various roles before the start of the COVID-19 pandemic. These questions were not asked of family child care homes.

Table 7: Prior to the COVID-19 Pandemic, how many of the following paid positions did your organization have?

	CCC		GCCH		All	
	FT	PT	FT	PT	FT	PT
Director	1.45	0.10	1.04	0.02	1.10	0.07
Assistant Director	0.58	0.08	0.14	0.10	0.41	0.07
Lead Teacher	4.43	0.59	0.61	0.22	3.07	0.42
Assistant Teacher	3.41	1.73	0.30	0.35	2.34	1.21
Classroom Aid	0.48	0.64	0.34	0.33	0.36	0.47
Support Staff	0.53	0.31	0.17	0.16	0.38	0.23

Respondents were then asked to indicate whether they had to suspend employment, lay off, or reduce wages and/or hours for their staff because of the COVID-19 pandemic. Respondents could select all response options that applied for each staff role.

Table 8: As a result of the COVID-19 Pandemic, have you had to do any of the following?

	Layoff	Suspend	Reduce	None
Director	14%	39%	16%	35%
Assistant Director	19%	44%	12%	27%
Lead Teacher	22%	53%	12%	21%
Assistant Teacher	22%	52%	11%	21%
Classroom Aid	26%	47%	10%	26%
Support Staff	21%	45%	10%	26%

Notes: CCC and GCCH only

Finally, respondents were asked if they expected to rehire all, some, or none of the staff that had been laid off. Respondents could again select all response options that applied for each staff role.

Table 9: Do you expect to rehire the following laid off staff?

	All	Some	None	Not sure
Director	73%	15%	2%	10%
Assistant Director	67%	13%	17%	4%
Lead Teacher	60%	17%	8%	15%
Assistant Teacher	55%	17%	6%	21%
Classroom Aid	53%	10%	10%	27%
Support Staff	56%	11%	17%	17%

Notes: CCC and GCCH only

To gain additional perspective on the financial impact on providers and their employees, sites that were interviewed were asked about their staffing decisions. Twenty-one had full-time or part-time staff that had worked at their facilities. Only four reported paying their staff during their closure, and most of these providers were larger centers that were open. Several providers continued to pay their staff reduced hours even during the closure which could then supplement unemployment compensation. Eight indicated that all their staff was furloughed and had applied for unemployment. Staff numbers at the providers who furloughed their entire staff ranged from 4-40.

In addition to families, several providers reported that some of their staff would be reluctant to return to child care work due to risk of infection. Statewide, 24.1% of providers expect staff to leave for a different profession following the disruption. Nearly half of child care centers and groups child care homes (45.2%) did not know whether they will operate with a reduced number of staff when they reopen.

Table 10: Child care provider views about returning staff

	Yes	No	Not Sure
Do you expect to operate with a reduced number of teachers?	28.4%	26.5%	45.2%
Do you expect any of your teachers/staff to be reluctant to return to child care work due to risk of infection?	57.2%	21.7%	21.1%
Do you expect any teachers/staff to leave for a different profession following this disruption?	24.1%	32.6%	43.3%

Notes: CCC and GCCH only

Most providers interviewed expected to rehire all furloughed staff. However, several noted that it would likely need to be a rolling rehire based on demand. Providers realized most families would be slow to return to a child care setting, so they would need to adjust their rehire plan based on enrollments. A small number of providers noted that they planned to bring all their staff back part-time and then move to full-time hours as more children began attending.

Interviewed providers noted that they had staff with underlying health conditions, older staff members, staff with family members that were immuno-compromised, and staff

who recently had babies and did not want to bring a newborn back to the child care facility during the pandemic. Providers that did not feel their staff would be reluctant to return noted their staff's love of children and especially their work with young children. One provider expressed the following:

> "My staff love what they do. They love the students. They are really in this because of their love for teaching."

While none of the providers interviewed knew with certainty they had staff who were planning to leave, they had fears. Most noted their fear that all the changes to procedures and policies to mitigate with the risk of infection would cause staff to leave the field. One provider explained,

> "I think some people will be able to handle it, I think others... I think it will just be too much for them to deal with."

In addition to interviewing providers, ten child care staff were interviewed as part of the study. Staff from various positions including teachers, aides, floaters, and janitorial/cooking staff were interviewed. Staff reported working in a child care setting from 6 months to 26 years with an average of approximately 8 years in the field.

Four of the staff were currently furloughed and receiving or waiting to receive unemployment compensation. Two staff were being paid for partial hours even though the facility was closed, and then applied for unemployment to supplement their income. These two staff were from the same facility and noted that they were able to receive partial pay since their facility continued to receive CCW subsidy payments. The remaining interviewed staff were currently working virtually, or at a site that was open due to a waiver and receiving full pay. In fact, two of the child care workers shared that they were receiving extra pay for working at their waiver sites.

Even though several staff were not receiving pay, they were reaching out to their children and families. Communicating via group chat, Facebook, email, and text were all ways staff were continuing to connect. Many staff shared how much they missed working. One child care worker announced,

> "I'm ready to go back. I miss the kids. I miss the atmosphere. I miss talking to the parents."

Another staff member who was teaching remotely shared her feelings when she stated,

> "The children fuel my inspiration for the day. I think that it has me just really, truly seeing how much the day in and day out interactions I have with students were beneficial."

Only one of the staff members interviewed reported considering changing jobs and leaving the child care field due to the COVID-19 pandemic. This staff member noted that

she had two young children that attend the child care where she works, and she was concerned for their health when she returns to work. The other interviewed staff indicated that they did not want to leave the child care field. One staff member working at a waiver site shared that she felt the pandemic made her realize how vital child care is to so many working families.

> "I like what I do. And I think working with the kids now, it gives me a greater appreciation for all those people who are essential workers and definitely need the care. It makes me feel more important in what I do."

Another staff member working at a site which received a waiver to operate summed up her love of the early childhood education field this way,

> "I've known my whole life that I wanted to work with kids. And I just fell in love with the field and I knew from that point that this is where I plan to be until I'm retired."

Staff expressed several concerns about returning to child care work. Masking (of both children and adults), social distancing, and COVID-19 transmission were concerns shared. Several staff were frustrated with the drastic changes that needed to be put in place for child care facilities to re-open. One staff member shared her frustration,

> "I honestly don't think that the government or anyone who hasn't worked in daycare understands it."

Another staff member re-iterated this feeling when she stated,

> "I feel like they're a bunch of men that don't know anything and it's insulting. I think that's what bothers me the most is when they talk about what we're supposed to do, the first thing in your brain is, man, they never worked in a daycare."

While staff understood the need for increased health and safety measures when their facilities re-opened, they also discussed concerns for the impact of new policies and procedures on the children. One staff member indicated,

> "I'm worried just about how children are going to be receptive to the regulations that are going to be in place. The young children that I work with that is one of the main ways they learn language, seeing facial expressions. If they can't see our facial expressions, I worry about how that's going to impact them."

Additionally, staff shared concerns about the stress that they felt would accompany the re-opening of their facilities. Fears about the virus and the associated stress of ensuring that staff and children were safe was noted by several child care workers. One staff member expressed,

> "I think the pressure on us is going to be huge. Huge. I think it is going to double. Triple. We clean, we are on top of things, we've done handwashing, we do everything that we're supposed to do all this time, even before COVID. Now I think that being neurotic about it is going to make our job extremely stressful."

Reopening of Child Care Facilities

In addition to current and planned changes to staffing, extensive data were collected about whether and how providers expected to resume operations when the stay-at-home order was lifted (*See Table 11*). Those who planned to resume operations were also asked questions related to their operational plans going forward. Four out of five (80.6%) providers plan to resume operations when the stay-at-home order was lifted. An additional 15.3% were undecided whether they would resume operations when the order was lifted.

As of June 29, 2020, 125 providers have announced permanent closure. This corresponds with the percent of providers from the statewide survey which indicated they did not plan to reopen. Based on provider reports, without immediate assistance to offset ongoing costs associated with implementing COVID-19 guidelines and reduced enrollments, it is expected that at least 4% (280) of providers will close permanently.

Providers were asked whether they expected to take several different actions to pay off loans, or salvage some of the losses sustained during the shutdown. About one-in-six group child care homes (16.1%) plan to reduce teacher or staff wages, as compared to 14.4% of child care centers and 6.5% of family child care homes. In addition, one-third of child care centers (33.0%), and one-fourth of family child care homes (27.9%) expect to increase rates, as compared to just 16.9% of group child care homes. One-third or more of all respondents across all provider types indicated that they did not know whether they would have to reduce teacher or staff wages or increase rates.

Providers were asked about payment plans and repayment methods. Over one third (36.8%) expect that they will have to pay bills late. In addition, one quarter (25.6%) do not know whether they will have to pay bills late. Over one third (35.0%) have asked for or plan to ask for a delayed payment schedule for expenditures. In contrast, nearly two thirds (63.7%) have applied for new loans or grants because of COVID-19 related revenue loss.

About half of providers (49.8%) expect to delay or cancel planned quality improvements. Similarly, nearly half (45.2%) indicated they plan to offer less enrichment, such as activities or field trips. About one-third expect they will have to cancel services or subscriptions from other businesses (33%), increase rates (31.1%), and or pursue higher STARS levels to increase awards and Child Care Works subsidy add-ons (30.9%).

Table 11: Actions associated with reopening child care facilities

	CCC	FCCH	GCCH	All
Do you expect to resume operations when the Stay-at-Home order is lifted?				
Yes	80.0%	79.8%	87.4%	80.6%
No	4.2%	4.7%	2.4%	4.1%
Don't Know	15.8%	15.6%	10.2%	15.3%
Have you applied for any new loans or grants as a result of revenue loss due to COVID?				
Yes	75.6%	29.0%	59.5%	63.7%
No	24.4%	71.1%	40.5%	36.3%
Have you or do you plan to ask for a delayed payment schedule for any expenditures?				
Yes	32.6%	31.3%	55.3%	35.0%
No	41.5%	46.4%	26.5%	40.7%
Don't Know	25.9%	22.3%	18.2%	24.2%
Do you expect that you will have to pay bills late?				
Yes	35.8%	37.1%	41.9%	36.8%
No	39.2%	38.8%	26.3%	37.6%
Don't Know	25.0%	24.0%	31.8%	25.6%
*Do you expect that you will have to take any of the following actions to pay off loans or recover from losses sustained during the shutdown? **				
Delay or cancel planned quality improvements	50.1%	50.1%	45.8%	49.8%
Offer less enrichment (e.g. activities or field trips)	45.8%	46.8%	36.2%	45.2%
Cancel services or subscriptions	33.4%	32.8%	28.6%	33.0%
Increase rates	33.0%	27.9%	16.9%	31.1%
Pursue higher STARS to increase awards/add-on	28.7%	36.3%	47.8%	30.9%
Reduce teacher / staff wages	14.4%	6.5%	16.1%	13.7%

Notes: *Percentages reflect 'Yes" responses; 'No' responses ranged from 22% to 50%; 'Don't Know' responses ranged from 26% to 36%

To gain qualitative perspective on reopening, interviewed providers were asked how they planned to reduce costs. Cancelling quality improvements or upgrades to their facilities, cancelling field trips, and activities such as music or gymnastics classes were the main avenues providers expected to pursue to lower expenses. Several providers indicated that they were already planning an annual rate increase for their families, so they would not plan to increase rates further. One provider re-iterated this point,

> "I would hate to raise rates because the parents aren't making money and they need to go back to work. They're not going to be able to pay higher rates."

The survey results indicated that reducing staff wages had significantly less support than any other option. Consistent with this finding, providers who were interviewed did not

want to consider reducing staff wages as a strategy for recouping some of their losses. Many providers acknowledged the already low wages in the field, and did not want to risk losing staff at this time. For example, one provider responded,

> "I morally would not do that to them. And if I ever did, I would be out of employees that day."

Returning to results from the statewide survey, providers were asked about anticipated demand for services upon reopening (*See Table 12*). More than half of respondents (50.4%) reported knowing of families that would not return when the stay-at-home order was lifted, with the percentage in centers much higher than family and group providers. Additionally, 81.1% of providers expect that families would be slow to return, resulting in an uncertain picture of potential revenue following the stay-at-home order. Respondents were also asked to indicate why they expect families to be slow to return. Most providers (91.6%) cited concerns about the pandemic, while 76.8% believe families will be unemployed and/or unable to afford it. Most providers (78.2%) were concerned some families would not return when the stay-at-home order was lifted. This resulted in 80.4% of respondents expecting to run below capacity when the stay-at-home order was lifted.

Table 12: Anticipated changes in demand for child care services

	CCC	FCCH	GCCH	All
Do you expect to run below capacity when the Stay-at-Home is lifted?				
Yes	82.5%	59.9%	86.7%	80.4%
No	4.1%	17.6%	5.3%	5.7%
Don't Know	13.5%	22.5%	8.0%	14.0%
Do you expect that any families will be slow to return?				
Yes	84.1%	54.7%	86.7%	81.1%
No	5.6%	17.6%	5.3%	6.9%
Don't Know	10.3%	27.7%	8.0%	12.0%
Why do you expect families will be slow to return? (Select all that apply)				
They have concerns about the virus	94.0%	77.3%	80.6%	91.6%
They will be unemployed and/or unable to afford it	80.6%	34.8%	73.8%	76.8%
They will continue working from home	78.4%	43.4%	73.8%	75.5%
Other	9.5%	8.5%	0.0%	8.6%
Are you concerned that families will not return at all?				
Yes	79.8%	65.5%	79.8%	78.2%
No	15.7%	31.0%	6.1%	16.5%
Don't Know	4.5%	3.5%	14.1%	5.2%
Do you know of any families that will not return?				
Yes	57.5%	23.0%	20.7%	50.4%
No	8.2%	19.8%	8.8%	9.5%
Don't Know	34.4%	57.2%	70.5%	40.1%

In the interviewed sample, almost all providers expected to run below capacity when they re-opened. Only two providers noted that they were not concerned due to large waiting lists and felt they could fill spots if needed. Several providers reported that they were concerned about low numbers when re-opening and how that would affect staffing. Providers shared that they may consider reducing hours for staff for a time so all staff members could at least work part-time.

While most providers indicated that they did not know of any families not returning when they re-opened, there were several that were expecting some families not to return. Aging out of the program, financial difficulties, moving out of the area, and concerns about returning their children to a child care setting were all reasons families were not planning to return when their child care provider re-opened. A small number of providers interviewed early in the project noted that they had not discussed re-opening with their families since it was too early to provide a re-opening plan. One stated,

> "I haven't put any pressure on the parents asking them if they're going to return. Right now, I'm just taking it really month by month."

Most providers felt that families would be slow to return once they re-opened. Concerns and fears about COVID-19 and continuing to work from home were the main reasons families shared with their child care providers for not returning. Some providers noted that families working remotely would like to send their children to child care to ease their workload at home, but had concerns about the pandemic and did not want to take a chance that their children would contract COVID-19.

Child care providers did not express concerns about families changing providers if they did not open quickly enough. Providers noted the strong relationships they had established with families and children and the high-quality programs they provided as reasons for not changing to another provider. One family child care home provider shared her feelings about why her families would not find care elsewhere when she stated,

> "They're loyal to me, and they care about me, and they care about my family."

Another provider from a larger center expressed similar sentiments.

> "Our families really appreciate the care that we give to their children. They're pretty satisfied, so I don't think they're intentionally going to look to leave."

Providers discussed a variety of policy and procedure changes they would need to follow when re-opening their child care facilities. Temperature checks, sanitizing, family members not entering the building, staggering nap or lunch times, and creative room

arrangements to encourage social distancing were mentioned. Providers realized these changes were going to be in place for a while. One provider stated,

> "This is the new norm for at least a year."

Masking and social distancing were noted as areas providers were most concerned with when planning their re-opening. In addition to these concerns, providers were frustrated they were having trouble finding and purchasing personal protective equipment (PPE) for their facilities. Providers were also hearing concerns about these areas from their staff as well. One provider expressed her frustrations,

> "I know that the suggestions that they're putting forth are completely ridiculous. As far as my situation is concerned, I have four children age four to one. I can guarantee they will not be wearing masks."

Another provider shared her concerns about social distancing and how that would impact the children and her staff.

> "I think the social/emotional part of it needs to really be brought into it because when they come back, it's not only the children, it's the families and the relationships I think that are very important between me and them, between my teachers and them. I mean, though we have tried to keep that going, being able to give a hug is not able to happen. And I think it's going to be a bit of a challenge."

Providers reported additional staff and staff hours would be needed to implement health and safety protocols.

> "When we would take the kids out in the mornings and the afternoons, we would have someone stay behind to clean. We always have an additional staff person. It made it that much easier to keep up with the cleaning and that affects the ratio. "

Another provider similarly stated,

> "I feel like I might need someone here just to be like a hawk. Literally, just a hawk to watch every child, if they touch their mouth, if they touch their nose they are going to need to go wash their hands, so I might need to hire someone, not even to be in with the ratios, they're not even going to count with the ratios, they're just the person standing by ready to clean and then open the door. "

Many directors (and staff) interviewed also discussed implications for loss of teaching time. A large amount of teacher time during normal operations would be spent on cleaning and COVID-19 safety.

> "We're going to have to appoint somebody as a COVID-19 safety officer to make sure that people are following the procedures."

The marginal increase in costs associated with COVID-19 are presented in the following section, along with findings on facility expense during shutdown, personnel costs for first payroll needed to reopen, implementing COVID-19 health and safety guidelines, and cost implications of an extended period of reduced enrollment.

The Financial Impact of COVID-19 on Child Care Providers

This report provides site- and statewide- costs associated with four specific areas of impact. Two criteria were applied to identify targeted areas of financial impact: 1) Is there evidence the financial impact was experience by all child care providers? and 2) Is there available data to calculate the cost with reasonable precision? The study does not include costs associated with financial impacts that were experienced by only some providers. Neither does this study report costs that cannot be reliably calculated using available data.

There were four areas of financial impact for which common costs could be determined for individual providers. These include: the facility expense during statewide shutdown; the liquidity needed for one two-week payroll; the additional costs to implement COVID-19 health and safety guidelines; and the financial strain associated with operating at reduced enrollments (represented as a percent increase in cost of remaining children enrolled). It should be noted that many providers experienced negative financial impacts which are not reflected in this set of four impact areas. Indeed, the sum of these four costs does not represent 100% of the financial impacts for most, if not all, providers. These are only the known costs that can be reliably calculated.

Table 13 provides key provider attribute values used for calculating costs and recommended grant amounts. Child care centers (CCC) were separated into deciles based on capacity size. The average number of children served is represented as the number of full-time enrollments based on a ten-hour day. For example, two children who receive care for five hours each are considered one ten-hour enrollment. The Full-Time Equivalency (FTE) of children served by each provider type/decile is the base value for estimates of staff and facility size. Methods for estimating staff and facility size are described below. For example, the average CCC3 provider serves 45 children in a 1760 square foot facility with one director and 5 full time staff. These are the estimates used for all 421 child care centers in Pennsylvania with licensed capacity for 39 to 49 children. FTE estimates were capped at 150 for CCC9 and 181 for CCC10 to align with typical enrollment counts at facilities with large space.

Table 13: Estimates of Children Served, Staff Size and Facility Size

	Provider Count	Licensed Capacity	FTE Estimate	FT Directors	FT Staff	Square feet
FCCH	1,412	6	6	1	0	432
GCCH	660	12	12	1	1	542
SAO	779	-	18	1	2	814
CCC1	410	8-26	18	1	2	814
CCC2	420	27-38	32	1	3	1,446
CCC3	421	39-49	45	1	5	2,034
CCC4	423	50-62	55	1	6	2,486
CCC5	415	63-77	70	1	7	3,164
CCC6	409	78-93	85	1	9	3,842
CCC7	401	94-113	100	1	11	4,520
CCC8	404	114-138	125	1	14	5,650
CCC9	402	139-180	150	1	17	6,000
CCC10	337	181-598	181	1	20	6,780

Notes: Family Child Care Home (FCCH), Group Child Care Home (GCCH), School Age Only (SOA), CCC Child Care Center (CCC). A multiplier of 1.8 was applied to estimate FCCH facility size

School-age-only providers often care for a large number of children for a few hours in the afternoon. The child served and square feet for SAO is unknown and was set to equal a smallest center. Eighteen full time children served (10-hour day) would be equivalent to 60 after-school children (3-hour day). If the number and duration of enrollments becomes available, this estimate should be updated with the median full-time equivalency of children for SOA providers.

All costs presented are median economic costs and represent the market value of a good or service and often parallel out-of-pocket expenditures. However, they are not the same measure as two providers may pay different amounts for a good/service with the same economic value. For example, a provider may pay above the market value to rent facility space. Similarly, programs operating out of a public school or a church may pay less in rent than for-profit operations because the facility expense is intentionally, subsidized by the property owner. Another example of the difference between economic cost and out-of-pocket expenditures might occur if some providers carry high-interest debt which must be serviced, even though the economic value of goods purchased using debt is of no greater value. A third example germane to the study can be seen in that the economic costs for family child care home providers will increase due to additional personnel time spent sanitizing, even though there is no cash expense for this time, as few family providers pay themselves hourly. Despite no out-of-pocket expense, there is an additional economic cost borne by the owner/operator, who may not wish to remain open if it requires markedly more labor hours without increased revenue.

An extensive discussion of the ingredients method and its application for calculating the economic cost of child care can be found in the 2020 Cost of Care Final Report

(Sirinides & Collins, 2020). The following sections describe the methods and assumptions used for cost analyses in the study, and present the results in four areas of cost, each supported by mixed methods findings. Finally, recommendations are given for child care provider grants and communication.

Facility Costs During Closure

Most child care programs incurred meaningful costs during COVID-19 closures, primarily for facility-related resources. Facility expenses represent approximately 10% of total program costs for providers. Unlike personnel, who could be furloughed during temporary closure, provider survey and interview data revealed pre-existing lease and mortgage obligations continued to accrue despite the lack of revenue. All survey participants who reported costs included payment on a lease or property loan. Utilities expenses were also ubiquitous. Analysis of site data yielded a median facility cost of $1,404 per month.

The estimated facility costs include owning or occupying a property, and the associated utilities, calculated using state-representative property and utilities prices per square foot. Because the state does not collect square footage for some provider types, licensed capacity data were used to estimate square footage. Records from the 2020 Cost of Care Study were analyzed and found that applying the minimum square footage per child (40 square feet) to facility capacity results in a slight underestimate of the actual space measured, especially for smaller providers such as family and group child care homes which are capped at six and twelve children respectively. For a family or group child care home, a multiplier of 1.8 was derived from the site data as the ratio of measured indoor square-foot dimensions to the space estimate based on capacity data.

Facility costs during the closure were calculated by applying weekly cost per square foot for elementary classroom space ($13.76) over a 14-week closure period. Although many providers were closed for much longer, this period was used to calculate facility expense during shutdown because nearly all providers had closed prior to or during the week of 3/15 (*See Table 2*) and by June 19 all but 6 counties were green, thus permitting operation.

By applying the resource data to the full census of licensed providers, the total facilities cost statewide is approximately $56.6 million for the 14-week period in which most facilities were closed. Table 14 provides estimated individual and statewide costs associated with one week and fourteen weeks of state shutdown.

Table 14: Facility costs during state shutdown

	Individual 1-week	Statewide 1-week	Individual 14-week	Statewide 14-week
FCCH	$114	$160,968	$1,600	$2,259,200
GCCH	$229	$151,140	$3,201	$2,112,660
SAO	$191	$148,789	$2,667	$2,077,593
CCC1	$191	$78,310	$2,667	$1,093,470
CCC2	$339	$142,380	$4,742	$1,991,640
CCC3	$476	$200,396	$6,668	$2,807,228
CCC4	$582	$246,186	$8,150	$3,447,450
CCC5	$741	$307,515	$10,373	$4,304,795
CCC6	$900	$368,100	$12,596	$5,151,764
CCC7	$1,058	$424,258	$14,818	$5,942,018
CCC8	$1,323	$534,492	$18,523	$7,483,292
CCC9	$1,588	$638,376	$22,228	$8,935,656
CCC10	$1,916	$645,692	$26,821	$9,038,677
Sum		$4,046,602		$56,645,443

Neccesary Liquidity for Two-Week Floating Payroll

Providers that closed or operated at less than full enrollment due to COVID-19 expressed concerns about being able to pay staff. Revenue from returning families would be expected only after initial payrolls needed to be paid. Covering these payrolls may require many providers to further add to their debt, thus incurring new financing expenses and making their continued operation more tenuous.

Providers need access to currency to make their initial payroll upon reopening. Some programs reported the availability of personal savings, while others were concerned about their ability to finance payroll until revenues returned to normal. The pay rate for teachers varies with qualifications. At the median, early childhood teachers in Pennsylvania who hold a bachelor's degree are paid about twice as much per hour as teachers with a high school diploma. Those programs staffed primarily with teachers having higher educational attainment would expect to need more to make payroll, while other programs may require less.

Personnel costs were calculated as the cost of a two-week payroll using statewide labor rates, OCDEL licensed capacity data, and a child-to-teacher ratio established by a weighted estimate of children by care level in subsidy-participating programs. Labor rates associated with child care workforce and directors were the most recent 2018 Bureau of Labor Statistics (BLS) adjusted to 2020 dollars using the Consumer Price Index. Table 15 presents data on the workforce size along with the median hourly wage including a 12% benefit for payroll taxes and some minimal paid sick time.

Table 15: BLS published labor force and median wage

	Employment	Median Hourly Wage	Median w/12% tax & sick time
Childcare Workers	25,370	$10.57	$11.84
Administrators, Childcare	2,730	$22.07	$24.72

Note: 2018 Bureau of Labor Statistics adjusted to 2020 dollars

To estimate the number of full-time staff, subsidy population data were analyzed to determine the minimum number classes by grouping children of the same care levels established by state regulation. The number of staff was then calculated assuming all classes were fully enrolled by adding tuition-paid enrollments to reach maximum class size. The overall ratio of teachers that is required to stay in ratio is 8.8. In other words, on average, at least one staff person is needed for every 8.8 children being served with maximum efficiency.

The estimated number of staff at a provider was calculated by dividing facility capacity by 8.8 and rounding up to the nearest integer. Within this total estimate, one staff member was assumed to be a director/operator. For example, a family child care home provider with capacity of six is expected to have one director only. A group child care home with a capacity of 12 children is expected to have one director and one full time worker. A center caring for 85 children is estimated to have one director and nine full time employees (*See Table 13*).

BLS median wage rates were applied to the estimated number of staff by role for a two-week pay period and 50-hour work week. More precise labor costs can be calculated using local wage data from the Bureau of Labor Statistics (BLS). The variation in labor costs (up to +/- 15%) using BLS would provide a more precise labor costs for local markets and would result in a similar statewide total cost. County multipliers for child care labor rates are provided in the appendix of the 2020 Cost of Care Study. For a center serving 55 children, the cash needed for two-week pay period is ($10,760). The estimated cost of statewide two-week payroll for child care staff exceeds $63.4 million (*See Table 18*).

COVID-19 Health and Safety Guidance

Implementing COVID-19 precautions in child care programs requires additional physical and personnel resources. To estimate the cost of these additional resources, directors, and owner/operators at 31 programs were interviewed about changes in their practices. Interview responses were supplemented by resource price data from the 2020 Cost of Care Study. Providers identified several resources required to implement the OCDEL COVID-19 guidance. Added personnel time is necessary for intensive cleaning of the facility and, at centers, for modified drop-off and pick-up procedures. Thermometers, masks, and other personal protection equipment are reusable physical resources

providers are purchasing. The necessary quantities of consumable cleaning supplies are also higher than in pre-COVID-19 operations.

The cost of implementing COVID-19 guidance was calculated using resource price data for ingredients from provider interviews and applied to a comprehensive set of ingredients observed during the 2019 site visits. Interviews were conducted in April and May 2020, at which time some providers were open, and others were closed. Directors or owner/operators from 31 programs provided details on the resources they were using to comply with COVID-19 guidance. These resources were paired with state-representative price data and applied to the 30 sites with complete ingredient data in the Cost of Care Study. A median across programs was calculated, resulting in a per-child marginal increase in cost to implement.

Additional personnel costs account for most of the cost increase. In fact, higher personnel costs explain about 70% of the increase in the cost of care. Family and group child care homes are spending an additional 30 to 60 minutes daily on cleaning at the end of each day. Child care centers are spending even more time, largely proportional to the number of classrooms. They are also extending teacher hours to implement low-contact drop-off and pick-up procedures. Such procedures are in place at family and group child care homes, though they do not result in extra personnel time, but rather re-direct the teacher and other children away from instruction and play time to facilitate drop-off.

Table 16: Per child weekly costs to implement COVID-19 guidelines

	Min	Q1	Median	Q3	Max
FCCH/GCCH	$14.76	$18.69	$22.89	$37.00	$47.63
CCC	$3.66	$12.54	$21.00	$34.38	$124.24

Notes: Assumes 100% enrollment, per child costs increase under reduced enrollment scenarios

Most programs will expect increases in cost of between $15 and $35 per child per week, but some further variation exists. Since added personnel costs explain much of the increase in total cost, variation in teacher pay rates and some economies of size will result in variation in the COVID-19 compliance costs. Differences in personnel pay rates are largely driven by two factors: teacher qualifications and the local economy. High-quality programs that employ state-certified teachers, for instance, will expect larger cost increases as those teachers work longer hours to clean and assist with drop-off. Similarly, providers in labor markets with higher average pay rates will experience higher cost increases. Small child care centers will also expect larger cost increases, due to a lack of economies of size. Most child centers are staffing a drop-off and pick-up position, regardless of the program size. Larger providers can divide this cost by a greater number of children than providers serving fewer.

Using the licensed capacity on record for each provider as an estimate of the number of children served, the increased cost of care in the COVID-19 context would total $7.89 million per week statewide due to the resources needed to comply with health precautions of this increase. To offset this cost until Labor Day (assuming providers were open eleven weeks from June 21 when most states where green), $89.3 million is required, although COVID-19 guidelines will remain in place for a longer period of time (*See Table 18*).

Under-Capacity Enrollment

Providers have reported operating their programs at enrollments much less than usual and are concerned that this under-enrollment may continue, leading to higher per-child costs. Providers have noted that achieving affordable and high-quality child care generally requires careful management of the child-to-teacher ratio. When enrollment declines moderately, the number of teachers may need to remain the same to comply with ratios established in regulation.

The cost of reduced enrollment was estimated using data from the 2020 Pennsylvania Cost of Care Study. Thirty programs were examined at the ingredient (i.e. specific resource) level. Adjustments were made to the number of personnel required as well as food and educational supply costs, which vary with enrollment. Personnel adjustments were based on state regulated child-to-teacher ratios by care level. The new set of annualized economic costs at each site was calculated and represented as the change in per-child costs of the remaining children for a set of enrollment scenarios.

There is insufficient evidence to predict the average or range of reduced enrollment resulting from COIVD-19. Integer ratios of six were selected as the set of illustrative scenarios to determine cost of enrollment reductions. The per child increase in costs of remaining children were calculated for scenarios in which a provider enrolled 5, 4, 3, 2 and 1 child out of every 6 children who could be served under full enrollment. These five levels of reduced enrollments were selected to demonstrate the impact under a few plausible scenarios. Family child care home providers are licensed to serve up to six children at a time, meaning all enrollment scenarios are covered for this provider type.

With personnel costs accounting for 80% of total provider costs, and facility expenses accounting for an additional 10% and being unalterable, the per-child cost of care increases. A reduction of just one child of every six increases costs by 19% at the median program. Small providers have less opportunity to reduce staff and maintain ratio than do larger programs, resulting in a disproportionate effect of reduced enrollment. Small child care centers and family and group child care home providers may have only one classroom or one classroom per care level. If 15-30% of children unenroll, the same number of teachers must be employed. At low levels of unenrollment, per-child costs increases are similar for large programs. When 30% or

more children unenroll, however, large programs can reduce the number of classrooms and teachers on staff, hence reducing their total costs. At enrollments of 50%, small child care centers and group and family child care homes experience nearly double the per-child cost. The same decrease in enrollment at large centers, however, may only result in 61% increase in cost per remaining child.

Table 17: Cost efficiencies and per child increases associated with levels of reduced enrollments

Enrollment		Efficiency of cost reductions		Cost increase per remaining child	
X / 6	Percent	FCCH/GCCH	CCC	FCCH/GCCH	CCC
6	100.00%	N/A	N/A	0.00%	0.00%
5	83.33%	0.83%	1.67%	19.00%	18.00%
4	66.67%	3.33%	14.00%	45.00%	29.00%
3	50.00%	4.50%	19.50%	91.00%	61.00%
2	33.33%	6.00%	32.67%	182.00%	102.00%
1	16.67%	7.67%	36.17%	454.00%	283.00%

Table 17 illustrates the financial challenge that reduced enrollments pose to all child care providers and the disproportionate effect it has based on size. It is not surprising that over the last ten years, the composition of the child care provider population has steadily moved toward fewer providers but with greater capacity.

When child enrollments decrease, providers face higher per-child costs. Facility costs remain the same in the short-term regardless of enrollment levels, thereby increasing per-child costs when the number of children decreases. Of even greater effect is the personnel costs, which account for 80% of total program costs. Moderate decreases in enrollment may not allow providers to reduce staff and maintain legal child-to-teacher ratios. As a result, total provider costs stay essentially the same even when the number of children over which those costs are divided drops. For a decrease in enrollment of one child of every six, most programs experience a per-child cost increase of 18-19%. When enrollments drop to half of capacity, costs nearly double, increasing by 91% per child for family and group child care home providers, and by 61% for child care centers.

Recommendations

Child Care Provider Grants

This study assesses the financial impacts of COVID-19 on child care providers in four areas, as well as the statewide total for each. Table 18 presents the total combined costs, which is the basis for recommended child care provider grants. It should be noted not all costs associate with COVID-19 are accounted for in the study. The costs described in the study only apply to all providers and can be calculated using available data.

Table 18: Statewide financial impacts of COVID-19 on child care providers

Facility expense during state shutdown	$ 56,645,443
2-week floating payroll to rehire and pay staff	$ 63,405,309
Implementing COVID-19 guidelines	$ 89,335,752
Slow reopening, assuming 83.3% enrollment	$ 115,731,403
Combined	*$ 325,117,907*

Although the combined cost for the four impact areas exceeds $325.1 million, Pennsylvania should prioritize grants to offset costs of the first three impact areas totaling $209.4 million. Table 19 provides additional detail on the average and statewide cost for each separately by provider grant category.

Table 19: Individual and statewide financial impact of COVID-19 by provider type and size

		Individual				Statewide			
		Facility Expense	Floating Payroll	COVID Practices	Slow Reopen	Facility Expense	Floating Payroll	COVID Practices	Slow Reopen
FCCH	1,412	$1,600	$2,472	$1,452	$1,881	$2,259,200	$3,490,464	$2,050,224	$2,655,972
GCCH	660	$3,201	$3,656	$2,904	$3,762	$2,112,660	$2,412,960	$1,916,640	$2,482,920
SAO	779	$2,667	$4,840	$4,356	$5,643	$2,077,593	$3,770,360	$3,393,324	$4,395,897
CCC1	410	$2,667	$4,840	$4,356	$5,643	$1,093,470	$1,984,400	$1,785,960	$2,313,630
CCC2	420	$4,742	$6,024	$7,744	$10,032	$1,991,640	$2,530,080	$3,252,480	$4,213,440
CCC3	421	$6,668	$8,392	$10,890	$14,108	$2,807,228	$3,533,032	$4,584,690	$5,939,468
CCC4	423	$8,150	$9,576	$13,310	$17,243	$3,447,450	$4,050,648	$5,630,130	$7,293,789
CCC5	415	$10,373	$10,760	$16,940	$21,945	$4,304,795	$4,465,400	$7,030,100	$9,107,175
CCC6	409	$12,596	$13,128	$20,570	$26,648	$5,151,764	$5,369,352	$8,413,130	$10,899,032
CCC7	401	$14,818	$15,496	$24,200	$31,350	$5,942,018	$6,213,896	$9,704,200	$12,571,350
CCC8	404	$18,523	$19,048	$30,250	$39,188	$7,483,292	$7,695,392	$12,221,000	$15,831,952
CCC9	402	$22,228	$22,600	$36,300	$47,025	$8,935,656	$9,085,200	$14,592,600	$18,904,050
CCC10	337	$26,821	$26,125	$43,802	$56,744	$9,038,677	$8,804,125	$14,761,274	$19,122,728
Total						$56,645,443	$63,405,309	$89,335,752	$115,731,403

Notes: Facility expense for 14-week state shutdown using state representative price. Floating payroll for two-week period. COVID practices and reduced enrollment (83.3%) during slow reopening costs represent 11-week period.

OCDEL continues to distribute CARES Act funds in two rounds of grants. In Round 1 (June), OCDEL determined award amounts as a single grant that included three sub payments: 1) a base payment determined by provider type and size, 2) a CCW payment based on the number of subsidy children who were enrolled pre-COVID-19, and 3) a child care desert payment, which was determined by provider category and whether the provider was located in a county identified as moderate or acute child care desert. Table 20 presents the total amount distributed in the first round by provider category, disaggregated by sub payment amount.

Table 20: Statewide Round 1 ELRC awards

	Base Payment	CCW Payment	Child Care Desert	ROUND 1
FCCH	$2,400,400	$528,200	$238,000	$3,166,600
GCCH	$1,320,000	$474,300	$225,000	$2,019,300
SAO	$2,103,300	$461,200	$0	$2,564,500
CCC1	$943,000	$454,600	$161,600	$1,559,200
CCC2	$966,000	$645,600	$160,900	$1,772,500
CCC3	$1,726,100	$662,600	$416,600	$2,805,300
CCC4	$1,808,700	$799,000	$358,300	$2,966,000
CCC5	$2,697,500	$883,200	$438,200	$4,018,900
CCC6	$2,734,300	$967,800	$735,200	$4,437,300
CCC7	$3,889,700	$1,017,800	$731,600	$5,639,100
CCC8	$4,041,200	$1,117,900	$523,000	$5,682,100
CCC9	$6,633,000	$1,155,800	$339,200	$8,128,000
CCC10	$5,560,500	$1,386,200	$212,200	$7,158,900
Total	$36,823,700	$10,554,200	$4,539,800	$51,917,700

Notes: Moderate child care desert: Adams, Armstrong, Cameron, Clarion, Clearfield, Clinton, Fayette, Franklin, Indiana, Jefferson, Lebanon, McKean, Northumberland, Snyder, Susquehanna, Wayne; Acute child care desert: Bedford, Elk, Forest, Fulton, Greene, Huntingdon, Juniata, Mifflin, Perry, Union, Wyoming

In July, OCDEL distributed a second round of base grants, but did not include CCW enrollments of child care desert funding factors. OCDEL has, in total, distributed approximately $104.3 million in two rounds of COVID-19 grants and intends to direct at least an additional $116 million in future rounds. Based on findings from this study, it is recommended that OCDEL layer additional funding on top of the base payments from Round 1 (June) and 2 (July). CCW payments and child care desert payments in Round 1 (June) should not be discounted because although both utilized CARES Act funding, the uses of the funds do not supplant the financial impacts determined by this study. Similarly, it would not be appropriate to discount award amounts because of other possible state funding such as Pennsylvania PreK Counts and HSSAP. Tables 21 and 22 present the recommended Round 3 grant amounts by category and state totals, respectively. Funds to address the first three out of four cost areas total $120.1 million. Additional funding is needed to ensure continued operation of providers under a conservative scenario of reduced enrollments.

Table 21: Individual Grant Totals by Provider Type and Size

	Round 1 (June)	Round 2 (July)	Current Awards	Target Amount	Round 3 (August)	Total Amount
FCCH	$1,700	$1,700	$3,400	$5,524	$2,124	$5,524
GCC	$2,000	$2,000	$4,000	$9,761	$5,761	$9,761
SAO	$2,700	$2,700	$5,400	$11,863	$6,463	$11,863
CCC1	$2,300	$2,600	$4,900	$11,863	$6,963	$11,863
CCC2	$2,300	$4,200	$6,500	$18,510	$12,010	$18,510
CCC3	$4,100	$5,600	$9,700	$25,950	$16,250	$25,950
CCC4	$4,100	$7,200	$11,300	$31,036	$19,736	$31,036
CCC5	$6,500	$9,000	$15,500	$38,073	$22,573	$38,073
CCC6	$6,500	$10,900	$17,400	$46,294	$28,894	$46,294
CCC7	$9,700	$13,300	$23,000	$54,514	$31,514	$54,514
CCC8	$9,700	$16,100	$25,800	$67,821	$42,021	$67,821
CCC9	$16,500	$20,100	$36,600	$81,128	$44,528	$81,128
CC10	$16,500	$30,700	$47,200	$96,775	$49,575	$96,775

Notes: Round 1 totals reflect base award only.

Table 22: Statewide Grant Totals by Provider Type and Size

	Round 1 (June)	Round 2 (July)	Current Awards	Target Amount	Round 3 (August)
FCCH	$2,400,400	$2,395,300	$4,795,700	$7,799,888	$3,004,188
GCC	$1,320,000	$1,322,000	$2,642,000	$6,442,260	$3,800,260
SAO	$2,103,300	$2,103,300	$4,206,600	$9,241,277	$5,034,677
CCC1	$943,000	$1,055,600	$1,998,600	$4,863,830	$2,865,230
CCC2	$966,000	$1,755,600	$2,721,600	$7,774,200	$5,052,600
CCC3	$1,726,100	$2,352,000	$4,078,100	$10,924,950	$6,846,850
CCC4	$1,808,700	$3,031,200	$4,839,900	$13,128,228	$8,288,328
CCC5	$2,697,500	$3,726,000	$6,423,500	$15,800,295	$9,376,795
CCC6	$2,734,300	$4,469,000	$7,203,300	$18,934,246	$11,730,946
CCC7	$3,889,700	$5,333,300	$9,223,000	$21,860,114	$12,637,114
CCC8	$4,041,200	$6,488,300	$10,529,500	$27,399,684	$16,870,184
CCC9	$6,633,000	$8,100,300	$14,733,300	$32,613,456	$17,880,156
CC10	$5,560,500	$10,345,900	$15,906,400	$32,604,076	$16,697,676
Sum	$36,823,700	$52,477,800	$89,301,500	$209,386,504	**$120,085,004**

Notes: Round 1 also included $4,539,800 in Child Care Works payments and $10,554,200 in child care desert payments; Round 2 payment equaled $53 million and included adjustments to Round 1.

Child Care Provider Communication

It is critical that OCDEL implement a strong communication strategy to keep providers informed about policy changes and opportunities for assistance. Additional qualitative findings are presented here to highlight the need for strong communication and inform the strategy.

Family providers were very vocal in expressing their frustrations that they were not being heard or that their issues were not being addressed during the pandemic. One family provider shared her feelings when she stated,

> "Family child care is not getting talked about, and it's not okay. The only thing we have right now is the PUA unemployment, the Pandemic Unemployment Assistance, which we're not expecting to see a penny from that until the middle of May, the beginning of June, and we have to try to make it all the way till then and I'm seven weeks without income. What do you do?"

Another provider summed up her thoughts when she stated,

> "Family homes need more direction than we get. You are in a different boat than other providers. A lot of the guidance is not directed towards your type of daycare."

Respondents were asked what sources of information they are using to make decisions. Most providers utilize the Centers for Disease Control (child care centers: 90.9%; family child care homes: 79.3%; group child care homes: 77.3%), press releases from the state (child care centers: 81.2%; family child care homes: 69.1%; group child care homes: 72.5%), and the news (child care centers: 48.1%; family child care homes: 54.9%; group child care homes: 54.3%). In addition, two-fifths of child care centers (39.2%) are relying on other programs in their areas to make decisions as compared to just 24.1% of family child care homes and 15.7% of group child care homes (*See Table 23*).

OCDEL and the CDC were most mentioned by providers when asked where they looked for information to make decisions about their facility. Other sources mentioned included: the state Department of Health (DOH), the Pennsylvania Department of Human Services (DHS), and the Pennsylvania Child Care Association (PACA).

Table 23: What sources of information are you using to make decisions? Select all that apply

	CCC	FCCH	GCCH	All
Centers for Disease Control (CDC)	90.9%	79.3%	79.3%	86.9%
Press releases from the State	81.2%	69.1%	69.1%	77.7%
The news	48.1%	54.9%	54.3%	50.3%
Other programs in the area	39.2%	24.1%	15.7%	33.3%
Word of mouth	11.7%	18.9%	18.9%	13.8%

Views of the information providers were receiving, especially from state agencies was mixed. Several providers noted disappointment in either the lack of communication or the constantly changing information, as well as the multitude of emails from various agencies. One provider expressed her frustration when she stated,

> "Guidance from OCDEL and DHS has been just not where it needs to be. At first, they were putting out pieces of information and it was just here and there, but they've issued no guidance. I know there are states that have issued like 27 page booklets on responding to this and what resources are available for families and for staff and how to think about going forward if you're going to reopen and what you need to consider and really none of that has been forthcoming from OCDEL. I've just been very disappointed."

On the other hand, another provider noted how pleased she was that so many webinars and meetings were being offered during the pandemic. The provider stated,

> "I'm very pleased with the way the state agencies have handled keeping in contact with us, offering the trainings, reaching out to us. They've been providing weekly meetings, asking people to voice our opinions, questions, and trying to help guide us."

Closing Remarks

The COVID-19 pandemic emphasized how essential child care is to working families and employers, in addition to highlighting the fragility of the child care system. Public awareness of these challenges and support for the dedicated directors and staff is critical for ensuring that the industry succeeds. Without assistance, the impacts of the COVID-19 pandemic will continue to be felt for months or possibly years as child care providers try to re-open, rebuild, and traverse their new normal. The intent of this study is to meet the requirements found in Act 24 of 2020, and provide a meaningful opportunity for state leaders to learn about the views, experiences, and challenges of child care providers in the commonwealth during the COVID-19 pandemic.