



# Impact of COVID-19 on Child Care Programming and Practices

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Child Care Equity Study

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## CHILD CARE PROVIDERS SHARE THE IMPACT OF THE PANDEMIC ON THEIR PROGRAMS

Child care programs have remained critical to the health and wellbeing of working parents and their children throughout the COVID-19 pandemic. Some programs stayed open even during the early months of the pandemic to care for the children of essential workers. Others closed their doors but stayed engaged with families by providing virtual activities and instruction. During the first year of the pandemic, the majority of child care programs that had closed reopened, and directors refitted programs to meet new public health realities. Through in-depth interviews with the directors or owners of licensed child care centers and licensed family child care homes, researchers at the University of Chicago and Illinois Action for Children (IAFC) captured the experiences of 76 Illinois child care providers during the first year of the COVID-19 pandemic. This report highlights how providers faced the uncertainty and challenges of the pandemic, and how they continued to provide an essential service to children and families. In this report, we discuss the programmatic changes providers made to adapt to new public health regulations and school closures and how these changes impacted their business and the children and families in their care.

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## THE PANDEMIC CONTEXT IN ILLINOIS

### Illinois Issues a Stay-At-Home Order in March 2020

Governor Pritzker responded to the public health crisis by issuing an emergency Executive Order for Illinois residents to stay at home unless they were participating in essential work or essential activities, effective March 21, 2020.<sup>1</sup> The State recognized the critical role of child care to enable parents and caregivers who were essential workers to continue working. Thus, although child care centers were required to close, they could apply for an emergency license to operate at a reduced capacity to serve children of essential workers. Emergency child care centers could serve 10 or fewer children in one room, were not permitted to move children between rooms and were required to follow strict health and safety standards. Family child care homes and license-exempt home providers were not required to close or apply for an emergency license but did have to operate at a reduced capacity. Still, many home-based providers made the decision to close due to safety and health concerns. All Pre-K-12 schools were required to shift to remote learning under the stay-at-home order, leaving many child care providers to care for school-age children and support their remote learning.<sup>1</sup>

### Child Care Programs Re-open in June 2020

On May 29, 2020, Governor Pritzker announced Restore Illinois,<sup>2</sup> a five-phase plan for Illinois to safely reopen businesses, including child care programs. The plan allowed all child care programs to reopen in June 2020 under new Illinois Department of Child and Family Services (DCFS) licensing guidelines that were designed to prevent COVID-19 transmission.

### Providers Operate Under New Public Health and Child Care Licensing Guidelines

Child care providers that reopened in June 2020 and onward were required to develop and submit a Reopening Plan that included procedures to reduce the transmission of COVID-19 and that complied with public health guidelines. The table on the following page summarizes the guidance described in *Restore Illinois Licensed Day Care Guidance and License Exempt School-Age Guidance*.

<sup>1</sup> Executive Order 2020-10 (Covid-19 Executive Order No. 8). March 20, 2020.  
<https://coronavirus.illinois.gov/resources/executive-orders/display.executive-order-number-10.2020.html>

<sup>2</sup> For more information on Restore Illinois, visit the Illinois State of Illinois Coronavirus Response website:  
<https://coronavirus.illinois.gov/restore-illinois/introduction.html>

## Illinois Department of Children and Family Services Guidance for Licensed and License-Exempt Day Cares<sup>3</sup>

<b>Grouping children and staff</b>	<ul style="list-style-type: none"> <li>• Children must remain with the same group each day while in care.</li> <li>• Groups must not be combined at any time, including on playgrounds.</li> <li>• The same staff should be assigned to the same group of children each day.</li> </ul>
<b>Temperature and symptom checks</b>	<ul style="list-style-type: none"> <li>• Staff, children, parents, and visitors will have their temperatures taken and recorded upon arrival if they are entering the facility.</li> <li>• Staff should ask the parent/guardian to confirm that the child does not have COVID-19 related symptoms.</li> <li>• Staff should make a visual inspection of the child for signs of illness (e.g., flushed cheeks, rapid breathing, difficulty breathing, fatigue, or extreme fussiness).</li> </ul>
<b>Cleaning and sanitation procedures</b>	<ul style="list-style-type: none"> <li>• Child care programs should clean and sanitize regularly throughout the day. All high touch surfaces should be cleaned every two hours, and computer components and telephones should be wiped down before each use.</li> <li>• All rooms should be cleaned and sanitized between use by different groups and between day care and night care shifts.</li> <li>• No soft or plush toys shall be permitted.</li> </ul>
<b>Personal protective equipment (PPE)</b>	<ul style="list-style-type: none"> <li>• Children, employees, and other individuals who are over age two and able to medically tolerate a face covering are required to wear one.</li> </ul>
<b>Drop-off/pick-up</b>	<ul style="list-style-type: none"> <li>• Programs can stagger arrival and drop-off times and/or have child care providers come outside the facility to pick up the children.</li> </ul>
<b>Hygiene and health practices</b>	<ul style="list-style-type: none"> <li>• Children and staff should wash their hands before and after playground use.</li> <li>• Children and staff should change shoes upon arrival.</li> <li>• Directors and staff who are designated as “floaters” must wash their hands, use hand sanitizer, and change PPE when switching between rooms.</li> </ul>
<b>Play and naptime</b>	<ul style="list-style-type: none"> <li>• Playground toys should not be shared between classrooms.</li> <li>• The use of shared water play, including pools, should be postponed.</li> <li>• During nap/sleep time, children’s cots or cribs should be separated by either 6 feet or a non-permeable barrier.</li> </ul>

With the June reopening announcement, providers who remained open during the stay-at-home period were no longer restricted to serving only essential workers and could expand, though not fully restore, their capacity to levels that did not require additional staff members, a measure designed to prevent additional virus spread. Centers were allowed to operate at about 30% reduced capacity, licensed child care homes could increase their capacity to as many as 10 children if allowed by their child care license, and group child care homes could return to their full capacity but had to maintain separate groups of children with no more than 10 children per group. Family, friend, and neighbor providers were required to return to caring for just three children. Still, with the expansion, many providers struggled to fill their open slots because parents were unemployed or not yet ready to return to formal care.<sup>4,5</sup>

<sup>3</sup> Restore Illinois Licensed Day Care Guidance and License Exempt School-Age Guidance, Illinois Department of Children and Family Services, Released December 20, 2020.

<sup>4</sup> In the Voices of Parents: Mothers Navigating the COVID-19 Pandemic Part 1. November 2020. Illinois Action for Children. Retrieved from: <https://www.actforchildren.org/about/research-data/reports>.

<sup>5</sup> In the Voices of Parents: Mothers Navigating the COVID-19 Pandemic Part 2. May 2021. Illinois Action for Children. Retrieved from: <https://www.actforchildren.org/about/research-data/reports>.

## Illinois's 2022 Child Care Landscape

Public health regulations for child care programs have eased in 2022 as COVID-19 hospitalizations in Illinois decline and more Illinoisians get vaccinated. Licensed child care capacity has returned to pre-pandemic numbers, allowing providers to increase enrollment. However, child care programs continue to face challenges with low enrollment. One year into the pandemic (March 2021), the number of Cook County families receiving child care assistance was 71% of pre-COVID levels.<sup>6</sup> Based on stories that we gathered from our interviews and IAFC's work in the field, providers suspect that parents are relying more on license-exempt family, friend, and neighbor care after having to make that switch from licensed child care early in the pandemic.

DCFS guidelines for licensed child care programs required staff to be fully vaccinated against COVID-19 by January 3, 2022, or be tested at least weekly for COVID-19.<sup>7</sup> There are less stringent recommendations in place regarding mixing of staff and groups of children/classrooms for vaccinated staff as of January 2022.<sup>6</sup> Child care programs can decide whether and how to combine groups of children, keeping in mind that the lowest risk of COVID-19 transmission is when groups of children are not combined, and staff do not move between the groups of children. However, unvaccinated staff are required to be assigned to the same group of children each day.

Illinois schools returned to in-person instruction for the 2021-22 school year, but child care providers still found themselves stepping in to care for school-age children for several reasons. They provided care when children were presenting symptoms and were turned away from schools or when schools and classrooms closed due to COVID-19 cases. School closures for non-COVID-related reasons (such as snow storms) became more common since schools had become equipped and familiar with switching to remote learning when needed.

The State has recognized the increased need to support the child care workforce using federal relief dollars from the American Rescue Plan Act. Previously, this funding had been used to provide Child Care Restoration Grants and the Child Care Workforce Bonus Programs. Most recently, the State implemented the Strengthen and Grow Child Care Grants with four rounds of funding scheduled for 2022-2023. These grants provide funding to support child care programs and invest in the workforce.<sup>8</sup> Programs are required to spend at least 50% of their quarterly award on new investments to recognize, reward, and adequately compensate their workforce.

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## RESEARCH QUESTIONS

**In this research report, we address two key research questions:**

- 1. How did child care providers' operational practices change as a result of the pandemic?**
- 2. What are the implications of the changes providers made during the pandemic to the future of their programs?**

<sup>6</sup> Report on Child Care in Cook County during the COVID-19 Pandemic, 2021. January 2021. Illinois Action for Children. Retrieved from: <https://www.actforchildren.org/about/research-data/reports>.

<sup>7</sup> Restore Illinois Licensed Day Care Guidance and License Exempt School-Age Guidance, Illinois Department of Children and Family Services, Updated January 31, 2022.

<sup>8</sup> For more information on the Strengthen and Grow Child Care Grants visit: <https://www.ilgateways.com/financial-opportunities/strengthen-and-grow-child-care-grants>



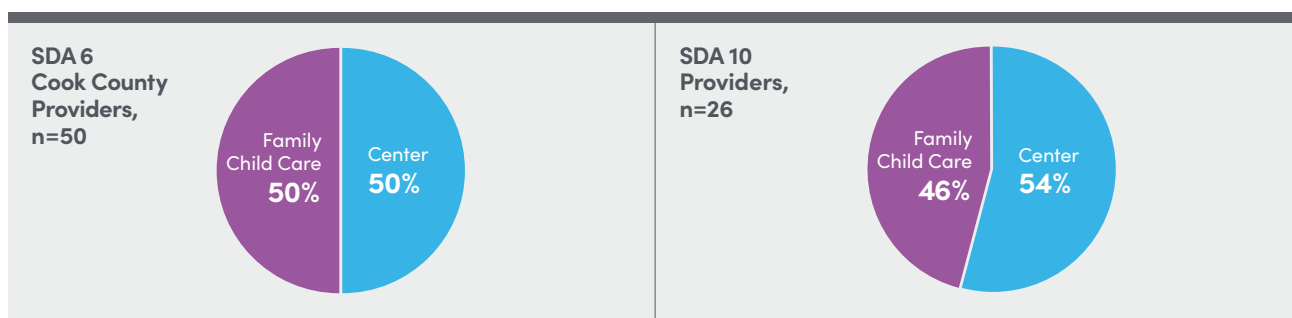
## RESEARCH STUDY

### Who we interviewed

Providers were chosen for the study using a targeted sampling strategy to achieve representation in each of the following factors: provider region and location, whether they were open vs. closed during the stay-at-home order (SAHO), centers vs. licensed home care providers, for-profit status, program size, quality rating, and level of subsidized care provided. All programs represented in the sample served at least some families enrolled in the child care assistance program (CCAP) prior to the pandemic.

We interviewed licensed child care program directors and owners serving families with diverse caregiving needs. In total, 39 child care center directors and 37 family child care (FCC) owners participated in the study.<sup>9</sup> The interviews were conducted in English (69) and Spanish (7) according to the preference of the participant. The programs were in two Service District Areas (SDAs) of Illinois: SDA 6 Cook County (25 centers, 25 FCCs) and SDA 10, a six-county region that includes Iroquois, Macon, Piatt, Champaign, Vermilion, and Douglas Counties (14 centers, 12 FCC). In Cook County, the sample included programs located across the south, west, and north sides including both the city and surrounding suburbs of Chicago. The sample included programs in four of the six counties represented by SDA 10. Most SDA 10 providers interviewed were in Champaign County (n=18). Among the 39 child care centers in the sample, 15 of them had a for profit business status.

40 directors/owners cared for the children of essential workers during the SAHO, and all but one of the remaining 36 programs that had temporarily closed during the SAHO had reopened by the time of our interview.<sup>10</sup>

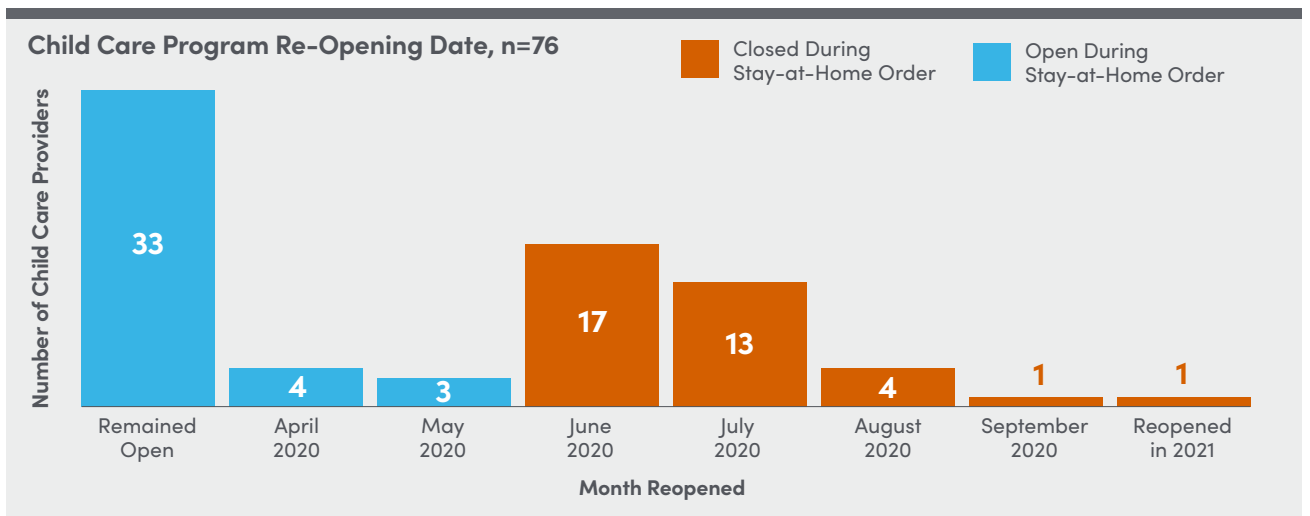


	Child Care Centers (n=39)			Family Child Care Homes (n=37)		
	Cook County (n=25)	SDA 10 (n=14)	Total	Cook County (n=25)	SDA 10 (n=12)	Total
<b>Reopening Status</b>						
Closed during SAHO	14	7	21	13	2	15
Open during SAHO	11	7	18	12	10	22
<b>Location</b>						
Cook: Southside	6	N/A	6	13	N/A	13
Cook: Westside	7	N/A	7	5	N/A	5
Cook: Northside	12	N/A	12	7	N/A	7
SDA 10: Urban	N/A	7	7	N/A	7	7
SDA 10: Rural	N/A	7	7	N/A	5	5
<b>Program Size<sup>a</sup></b>						
Small/Medium	17	8	25	N/A		
Large	8	6	14	N/A		
Child Care Home	N/A			19	12	31
Group Home	N/A			6	6	0

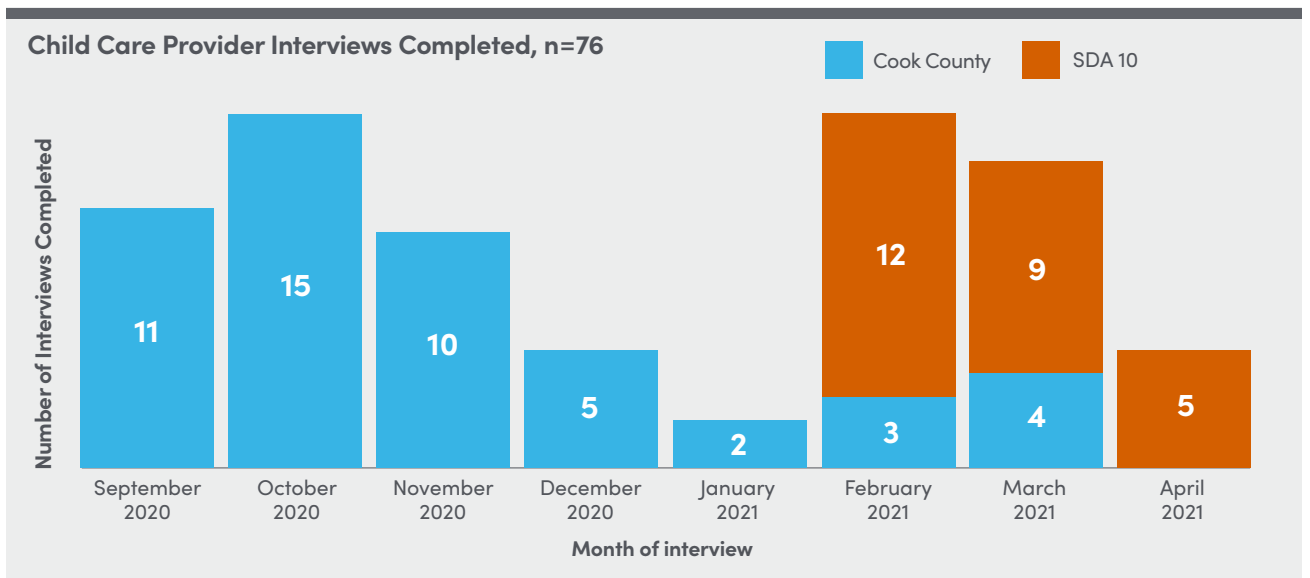
<sup>a</sup> Small: 1-49 children; Medium: 50-99 children; Large: ≥100 children

<sup>9</sup> Due to recording errors, 2 of the 76 interviews were unusable, resulting in a total sample of 74 programs.

<sup>10</sup> Center directors who remained open in March (after a mandatory 2-week shut down) or reopened in April or May were required to apply for an emergency license to provide care. Home-based providers were not required to apply for an emergency license to provide care.



The interviews were fielded in two phases: The Cook County interviews took place between September 2020 and March 2021, and the SDA 10 interviews took place from February to April 2021. By the time that we interviewed them, almost all programs had received at least some COVID-related government assistance, typically taking advantage of the CCAP attendance waiver, one or more cycles of the Child Care Restoration Grant, and in the case of providers caring for the children of essential workers, the emergency child care stipend. The experiences described by the participants were shaped by the timing of the interview. Interviews with Cook County participants took place at the early stages of the pandemic; providers not only had a shorter window on which to report their experiences but they also had not had as much time to learn about the relief programs or adjust to operating their program during the pandemic.



## The Information we gathered

Each of the 76 program directors/owners participated in a brief, 10-minute phone survey, followed by an in-depth interview, typically lasting 60 minutes. The interviews were conducted via the video, online Zoom platform. Interviews focused on the experiences of program directors/owners as they navigated the pandemic, including how their program's operational practices and curricula changed in response to enrollment declines, staff changes, safety concerns, and new public health measures. We also gathered additional information about the experiences of directors/owners with a range of federal and state COVID relief programs; this information is reported in a separate report, *COVID-19 Relief to the Child Care Industry: Perspectives from Child Care Directors and Owners Seeking Support*.

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## RESEARCH QUESTION 1: CHANGES TO PROGRAMMING AND OPERATIONAL PRACTICES

Child care providers changed their daily operations and activities to adjust to the public health guidelines, to keep children and staff safe, and to respond to the need for child care for school-age children during school closures. We discuss these findings under three major themes: 1) structural changes in child care programs and classrooms, 2) safety practices and 3) remote engagement and learning.

The classroom environment changed as providers altered the physical space and incorporated school-age students who were learning remotely. Additionally, several child care programs offered their own virtual activities and online learning (referred to as remote engagement) for children in their care – this was a new endeavor for many providers, and not all could offer these services. The program adaptations that providers made to respond to COVID-19 created additional work for staff and new expenses at a time when revenue was down due to low enrollment.

Providers, staff, and children adopted new safety rules such as social distancing and mask-wearing. This was not without challenges. The new guidelines restricted providers' abilities to regularly connect with parents and children's interactions with each other. Many providers reported that they and their staff had concerns about safety and the risk of contracting COVID, especially during the first few months of the pandemic. Because of this, staff safety and following safety guidelines were priorities for providers even though the new rules were sometimes in tension with caregiving beliefs and practices such as allowing children to share toys.

### 1. Structural changes in child care programs and classrooms

Providers' daily operations were impacted by public health guidelines including changing pick-up and drop-off procedures, adjusting staffing practices to prevent classroom mixing and limiting children's contact with one another. Providers described these public health regulations as time consuming and requiring undue staff time. Furthermore, many providers were concerned about the impact social distancing had on children's play, planned activities and providers' relationships with parents.

#### 1.1 Financial challenges due to enrollment declines

Drops in enrollment often corresponded with revenue declines and providers struggled financially, often expressing uncertainty about the viability of their business. Some had to resort to using their own savings or income to pay for business expenses, such as this SDA 10 center provider: **"The owner pretty much paid for everything out of her own pocket. She was buying masks for the kids and the parents to put on when you come in."** Some providers expressed frustration about the capacity limits. One center provider in Cook County who was interviewed prior to the lifting of capacity restrictions expressed her desire to return to caring for more children: **"Give us our kids back. Let us open up fully, not be under any restrictions."** Despite this, some providers felt that having fewer children in the classroom improved program quality because they could do their job better.

#### 1.2 Pick-up and drop-off procedures impacted parent-provider relationships

All providers were required to modify child pick-up and drop-off procedures to comply with public health guidelines. Notably, families were no longer allowed to enter child care classrooms. Although some preferred the new procedures, others were concerned about the fewer interactions between parents and child program staff. Some reported that this made staff feel safer and more in control of their classrooms. Providers set additional rules such as not allowing anyone other than staff and children into the building or allowing parents only in the foyer/entrance area or hallways. To further limit contact and group gatherings, providers set different entry and exit points for parents and children and set different arrival times for children.

Every day at drop-off, providers screened children for COVID-19 symptoms and conducted temperatures checks. Some providers went outside to parents' cars to pick-up and drop-off children to avoid parents entering the building. Many providers required everyone who entered the building to wash their hands and use hand sanitizer—one provider said they used a portable basin for this. Other providers' rules included restricting



parents from bringing car seats, strollers, and outside food into the building. At pick-up, providers and staff helped children get ready by putting on the children's coats and changing their shoes since parents were no longer able to do this.

Child care providers dealt with complaints from parents about the public health regulations which caused tension in their relationships with some parents. Masking and hand washing were the most common rules that parents protested. A SDA 10 center provider said some parents would enter the building without wearing masks, **"We've had anti-masker parents and things like that. And so, we've had to address 'you can't come into the building without a mask' and things like that."** A home provider required new parents who were interested in enrolling their children to complete a COVID-19 safety screening process because they wanted to know the family would be a good fit and not compromise their safety.

**"We don't need less staff, even though we have less kids because of how all the processes have changed and you know processing families in everyday, taking temps, and sanitation, all that kind of stuff."**

*- Cook County center provider*

Some providers said the new drop-off and pick-up procedures made the process quicker and easier for parents because they didn't have to drop their children off in the classroom, they can drop them off at the door. The new procedures made things easier for a SDA 10 center provider, **"...we have found that that separation and that drop off is so much easier on the children, on the parents, on us."**

Parents had less opportunities to be part of the classroom community and to see how their children were doing in the classroom. To keep parents engaged, a child care provider installed a bulletin board in the foyer area that displayed children's crafts and information on classroom activities. Child care providers said they could not check-in with parents and provide them with support and resources like they used to. It was more difficult for providers to learn about the children's home life as one SDA 10 center provider described, **"I would say that not being able to have a daily face-to-face with the parent has been very difficult in the classroom, just being able to talk about their day and their activities and things that are going on which is something we were very used to doing. You know and knowing exactly what was going on at home and what's going on here and having those daily conversations. I think that that has made a huge difference."**

### **1.3 Staffing changes to address regulations around mixing classrooms**

The new guidelines prohibited classrooms to mix. Previously, providers were able to mix children from different classrooms in the mornings and afternoons because children would get picked up and dropped off at different times. As a result, staff members' shifts could start and end at different times. A teacher with the earliest shift would care for multiple children from different classrooms in the morning until their teacher arrived. Similarly, providers would combine classrooms in the afternoons, and fewer teachers were needed. As a result of COVID restrictions, this changed, and child care staff and children had to stay with the same group all day. This resulted in increased labor expenses and logistically challenging changes to staff schedules to ensure all classrooms were adequately staffed. One provider had to ask their part-time staff to work more hours. Many providers said they had teachers start their shifts earlier because teachers were needed when the children from their classrooms arrived.

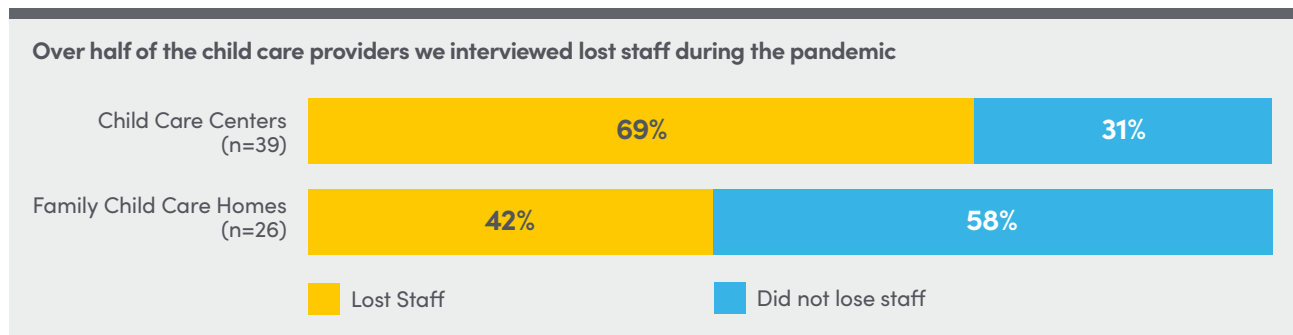
**“We have to be very careful about our hours that we work. We’re still under regulations that require that we can’t combine our classes and things like that, so we must have more staffing here than before because we could combine some ages and stagger or staffing. So, we just have to be really careful about what our hours are, and covering our classrooms the way that we’re supposed to...”**

– SDA 10 center provider

Child care staff were isolated because they could not go into other classrooms. A Cook County center provider purchased walkie talkies for staff in different classrooms to communicate with one another, **“we were able to purchase our own walkie talkies, which is—we have no phone or any PA systems in the school—and teachers are not allowed to have their cell phones in the classroom. So, having walkie talkies has been the best thing because it’s great communication for anything that goes on here...”**

### 1.4 Staffing challenges

Implementing the new pick-up and drop-off procedures, restrictions on classroom mixing, cleaning, and sanitizing required more staff time. Over half of providers who had staff before the pandemic lost staff during the pandemic and had difficulty hiring new, qualified staff. A few providers mentioned that cleaning took teachers’ time away from interacting with children. Staff were pulled into new roles for pick-up and drop-off, such as greeting children at the door and walking children to and from their classrooms. These additional responsibilities put a strain on staff.



### 1.5 Reconfiguring and modifying space for COVID safety

Child care providers modified how they used the space and classrooms in their center or home to follow the public health guidelines and maintain social distancing. Since staff were required to clean toys more frequently and children were not allowed to share toys, staff had to closely monitor which toys children played with. Staff put away toys and turned shelves to face the wall to keep toys out of reach of children. Children had to ask to use certain toys instead of just taking them off a shelf.

Providers used their space in creative ways to maximize function and keep everyone safe. Providers wanted children to spend more time outside to decrease the risk of COVID-19 transmission, so they made updates to their outdoor spaces and bought new equipment. Some providers bought new indoor furniture such as individual desks and smaller tables so that children could sit further apart such as one Cook County home provider describes, **“I used to have large tables where I could allocate eight kids, now I can’t have eight kids in one table, I had to buy individual desks.”** Child care centers decreased the use of shared spaces such as a multi-purpose room, playground, and gym because it was a lot of work to clean and sanitize after every use,

**“in the playground and the gym, we’ve had to do a lot of sanitizing between all of the classrooms. So, we’ve had to limit that a little bit more as well.”** Home providers used more rooms in their homes than before COVID and rearranged their furniture to create more space. One home provider had to figure out new sleeping arrangements to keep children socially distant. Another home provider cared for fewer children, so social distancing was not difficult.

Mealtimes looked different because children had to sit apart. Children ate at different times to have enough space to distance themselves. One provider was concerned that this would make children feel isolated. Meals were packaged individually, and providers no longer served family-style or self-serve.

### **1.6 Group play and educational activities were eliminated or changed**

The public health guidelines limited physical interaction among child care staff and children, group activities and sharing. Because classrooms could not be combined, children in different classrooms no longer played with each other or spent time in shared spaces such as the gym or playground. Children could not share toys and materials, which changed the nature of the activities and hindered providers from fully using their play curriculum. A SDA 10 family child care provider shared how the pandemic impacted their curriculum, **“Yes, we used to have play curriculum, where believe it or not, you learn from play. There’s not much play you can do when you’re quarantined inside. It’s not like they’re not learning; we’re still inside learning.”** One SDA 10 center provider felt that her program’s quality was negatively impacted because children could not play together and learn through play as freely as before.

**“Our sensory table now is not a sensory table because again, there’s too many hands in that, we’ve been doing a lot of Ziploc bags full of sensory stuff so that they can still get that that feel, and that that sensory stuff, I guess, but not to the same degree.”**

*– Cook County family child care provider*

Providers modified group activities into individual activities by buying children their own supplies so they could complete activities individually (e.g., Play-Doh, paintbrushes, pots and plants, and cooking/food supplies). Many activities were eliminated if they were too difficult to carry out under the new guidelines such as dress up, rug time, and sensory and sand tables.

Unfortunately, children missed out on extra-curricular activities and classes (e.g., language and music classes and swimming lessons) that were cancelled for COVID safety. Many providers who would previously take children to the park or field trips struggled because this was no longer an option. Increased spending on cleaning supplies and other materials led some providers to cut back on extra-curricular activities. Despite this, at least one provider did not believe the program quality was affected, **“No I mean, I would say like we talked about, we eliminated some of our extracurriculars, which stinks. You know, the sanitation at night, the janitorial. I mean, that was such a luxury to have. But I don’t think it’s making our program worse. It’s just different.”**

## 2. Safety practices

Mask wearing, social distancing, and constant cleaning were the primary ways providers tried to keep everyone safe. Although staff were thankful for and supportive of the safety precautions, after a while, they started to feel tedious. Some providers said that at times it was very challenging to teach children to practice health and safety guidelines while others were surprised by the resiliency of children to adapt. In this section, we discuss the health and safety practices that were adopted by providers, as well as the effects that they were perceived to have on staff and children.

### 2.1 New protections for staff health and safety

Most providers said they were keeping their staff safe by following and enforcing the COVID safety guidelines. Specifically, providers said wearing and offering PPE, social distancing, sanitizing high-touch surfaces, conducting health screens, and new drop-off and pick-up procedures were keeping everyone safe, as one Cook County center provider explained, **“And then keeping teachers safe, it’s making sure that they’re keeping children safe, making sure that children are washing their hands, that children are wearing their mask, using tissues appropriately, throwing stuff away, washing their hands; because that keeps the teachers safe.”** Providers purchased PPE for staff and children. This added an extra and unexpected expense for providers that many found difficult on their business. Most providers reported receiving some PPE donations from child care resource and referral agencies, Illinois Action for Children and Child Care Resource Center. Some providers also received donations from parents.

**“I bought a whole bunch of washcloths and that’s what they use for their hand towels and when they, they’re done with it, they put it in the bucket. And I just wash every day. Paper towels got expensive.”**

*– SDA 10 family child care provider*

Some providers implemented their own hygiene and PPE rules to increase safety. For example, some had staff change their clothes when they came into the building, others required children and staff to switch into shoes worn only at the child care facility or home. Children were not allowed to bring personal items such as backpacks. To promote social distancing, providers took different approaches. One provider had more teachers working at a time to have smaller groups of children. Several providers changed the format of staff meetings. They held staff meetings virtually on Zoom, outdoors, or in a large space. Providers limited the number of staff in the break room, hallways, and kitchen and repurposed empty classrooms and outdoor areas as staff break areas.

Most of the interviews were conducted before wide-scale access to the COVID-19 vaccine in Illinois; the providers we interviewed may not have yet had the opportunity to get vaccinated. A few providers talked about practices they established to protect high-risk staff. These safety practices included closing the program when the stay-at-home order was instated, allowing high-risk staff to return to work when they felt comfortable or allowing them to work remotely. A home provider did not enroll new children during the emergency period to protect their 75-year-old assistant, who was also their mother.

#### Staff safety training

Providers felt it was important that staff were on board with the new safety procedures and felt safe in their work environment. Most providers delivered their own COVID safety trainings for staff or had their staff attend online trainings and webinars hosted by government agencies. Providers shared online resources from government agencies and non-government organizations. Some providers relied exclusively on these online resources while others used information they found online to develop their own trainings. A few providers hired

health professionals to train and support their staff. Health and safety practices were an ongoing conversation at some child care programs. Providers used staff meetings to review safety procedures, answer staff questions, share ideas about implementing new procedures, or check-in about how staff were doing. Overall, providers felt their staff were doing a good job of implementing safety procedures.

### **Teaching children about health and safety practices**

Providers found creative ways to teach children about COVID-19 and public health guidelines. They used books about health and hygiene practices, made posters, and found additional resources online. Providers thought that presenting information in this way helped children understand the changes they were seeing and experiencing, such as mask-wearing, social distancing, constant hand washing, and general COVID-19 prevention.

### **2.2 Some providers were able to offer additional support to their staff**

Providers tried to support their staff's well-being. One provider would occasionally treat staff to coffee, breakfast, or lunch to show appreciation. Some providers had the resources to offer emotional and behavioral supports such as conducting regular check-ins with staff, letting staff take time off for mental health days, and mental health trainings for staff to talk about how they were feeling about returning to work. Some providers were also able to offer their staff hazard pay in the form of a small raise for all staff members. Alternatively, if offering hazard pay was not possible, some programs gave staff extra sick days. Unfortunately, not all providers were able to provide their staff with additional resources because their businesses were under financial strain.

### **2.3 Home-based providers struggled with health and safety concerns**

A unique challenge that home-based providers faced was the inability to separate their home and work environments. One home provider said she expected to eventually get sick because she spent time around children and did not have control over contracting COVID. Home providers were concerned about exposing their family members to COVID and wondered whether the families they served were abiding by COVID guidelines. This created stress and anxiety.

### **2.4 Children adapted well to safety guidelines but learning and development may be affected**

Many providers reported that enforcing public health guidelines with children was not as difficult as they expected. Children struggled more with social distancing rules compared to wearing masks, although, there were some providers who described challenges with enforcing masking rules among children.

**"...it's actually driving me crazy because children are now in in their own little space—their own little box. So now, now they're being taught if somebody is too close to you, get them away instead of you inviting them into your space because you're caring, now it's—here's your box, everybody gets in your box... It just doesn't work like that."**

*– Cook County center provider*

### **Social Distancing**

Social distancing rules kept children from playing as freely with their friends. A Cook County center provider told us that when children were told that they couldn't play close to their friends, they didn't understand and got upset. Not only could the children not play together, but teachers could not physically comfort children when they got upset. A Cook County family child care provider described this conflict as a tension between the

way child care providers are trained and the way the pandemic changed our thoughts about physical touch: **“if you’re trained to take care of kids you have to have that closeness, that ability to love, so this is what the pandemic did to us, and we just have to follow the safety measures, as parents, as providers, to make sure the child is safe and that the space is appropriate for him.”**

A Cook County center provider thought social distancing rules sent mixed messages to children about how to treat others. She said that it’s hard to teach empathy when everyone is supposed to stay apart: **“you try to teach empathy... Now, it’s like, here’s an elbow, and you stay over there. That’s not teaching them, and it’s actually driving me crazy because children are now in in their own little space—their own little box. So now, now they’re being taught if somebody is too close to you, get them away instead of you inviting them into your space because you’re caring.”**

### **Mask Wearing**

Teachers and parents were worried about introducing masks to children and getting children accustomed to masked teachers. One Cook County center director had her teachers wear masks while teaching remotely so that children would get used to seeing masks on faces. Many providers thought that children handled wearing masks well, even better than adults. Providers also found that children were resilient and quickly adapted to the new rules.

**“They’re very resilient, to tell you the truth, the children are resilient. They know they walk in the now, we don’t even tell them to use the hand soap. They walk in and the pump, you know their hands soap, at the front door, and then they go into a classroom, and they wash their hands. The first thing they do is wash their hands, so knowing that they have to cough in their sleeve—even if they have a mask on... you would think they’ve been doing it for a long time because just to them, it was easy going.”**

*– Cook County center provider*

One provider thought that children whose parents did not require them to wear masks had a harder time wearing them in the child care facility than the children whose parents did require them to wear masks. Younger children, ages two to five, had a harder time wearing masks than older children. One home provider did not have her children wear masks because she thought they were too young. A number of providers expressed frustration for needing to constantly remind children to keep masks over their noses and mouths.

Many providers were worried about the negative effects of mask wearing on children’s development and learning. A Cook County center provider believed speech and language development were hindered by masks, **“...children they react to your face, you know, and I’m a pretty expressive person and so like children can tell I’m happy... And now my whole face is almost covered right. So, and then we were also speaking the other day about how like children learn to speak kind of by watching you speak, and now they can’t see our mouth, right? That’s kind of a hindrance that were a little concerned about. And we’re kind of wondering just in theory you know like will speech be delayed, more so than we thought it would be since of the COVID.”**

Another provider described that communicating and teaching children while wearing masks was difficult and lessened the quality of the program.



### 3. Remote engagement and remote learning of school-age children

Providers offered remote engagement to support families while children were at home because their child care programs were closed. When K-12 schools were operating remotely, many school-age children were taken care of by child care providers. In the process, they adopted many changes in their program, facilities, and staff configuration.

#### 3.1 Remote engagement offered by child care providers

Many of the providers we interviewed provided some type of remote or online engagement to stay connected with children and families. This included calling parents and children, group video calls, synchronous and asynchronous online lessons, and sharing educational activities that parents could complete with their children at home. Providers used various applications to make video calls such as Skype, Facetime, Zoom, and Facebook Messenger. Several providers used social media to connect with families and share educational resources. Having educational resources available online allowed parents the flexibility to create their own schedule with their children at home. Providers reported that remote engagement helped parents who were having a difficult time finding things to do with their children while child care programs were closed. Providers charged full or reduced fees for remote engagement and some parents paid service fees even if it was not required by the providers.

#### 3.2 Challenges with remote engagement

Despite the benefits of remote engagement, child care providers and parents experienced challenges. Some parents in low-income households did not have access to computers to participate in virtual calls and online sessions. Other parents and grandparents did not know how to use the technology to participate. A Cook County family child care provider recounted families' challenges, **"...sometimes I get families who tell me, 'I don't even know how to turn on a computer.'"**

Several providers did not have the capacity to offer remote engagement. A Cook County center provider said they were only able to conduct parent phone calls because, **"We couldn't figure it out."** Child care staff had to learn to implement remote engagement and use new technology platforms. A center provider said this transition was not easy and required a lot of training, **"They did you know, group Zoom or Google Duo or Facetime, whatever platform was easiest for the teacher, [...] I am one of the youngest members of my school so that was also a hard thing for most of them, transitioning into this. You know how it was a lot of training involved with that."** Purchasing software for remote engagement activities added an expense for some providers.

Parents with multiple children did not always have multiple devices available to participate in remote engagement and juggled the schedules. Parents and child care providers had a hard time getting children to focus during online lessons and calls. Often, children could not stay focused during video calls because they were still young. Despite providers' efforts, attendance to online lessons and calls was often low.

#### 3.3 Providers stepped up to care for school-age children

The challenges providers experienced were exacerbated by the need to accommodate school-age children during school closures. Providers who cared for remote-learning K-12 students made significant changes to their physical space, staffing, operations, and curriculum. In addition to modifying classroom space and investing in faster broadband and other technology changes, providers lengthened and rearranged the daily schedules because remote learners arrived earlier than other children and had unique lunch and break times. These changes were sometimes in direct conflict with state regulations regarding screen time and meal procedures. Although not trained to do so, staff took on the new responsibility of assisting school-age children with many technological challenges that accompanied remote learning, and they helped with schoolwork and communicated with teachers and parents. Remote learning of K-12 children came with new staffing challenges and new expenses, but also became an important source of revenue for many providers. [See text box on the following page.]

## How Providers Modified their Programs to Respond to Remote K-12 Learning

### Physical Accommodation

Providers made changes to how they used the space in their child care facilities or homes. They rearranged the layout of rooms so that students could sit with children in the same grade or the same school and be separated from younger children. The space was reconfigured so children could be proximate to outlets to charge their devices. Some providers dedicated one classroom only for remote learners, which required staff reassignments. Some providers reported that they had to add outlets for children to plug devices. Making physical accommodations to cramped quarters sometimes interfered with social distancing and student learning. As one SDA 10 center provider put it: *“we’ve gotten to the point where we’re like we try to put all the same kids that are in the same class. Or at least the same grade, and the same area of the classroom but then we wind up not social distancing them, because we need to be able to get to each one of them to answer their questions or help them right on their tablets.”* Home providers used more rooms to space children apart in their homes which was overwhelming for one provider in Cook County, *“I don’t even have a place to go. I didn’t even have a place to relax. I didn’t have a place to—I have them everywhere in my home.”*

### Scheduling Changes

Providers made changes to their program’s schedules to accommodate the children’s remote learning schedules and lunch and break times. Extensions to operating hours occurred when remote learners arrived earlier than the other children, and providers had to help them get ready to log into their online classrooms and start working. School-age children’s lunchtimes were often incompatible with the usual program mealtimes, and K-12 children coming from different schools had to follow the lunchtimes of their regular schools. *“They’re on different schedules, school schedules. I have three different lunch times now.”* Providers juggling different lunch and break times sometimes experienced conflicts with state guidance: *“If we’re caught serving lunch past one o’clock, we could get in trouble. If we serve lunch before 11 o’clock, we could get in trouble. Some of these schools, their lunch break time is from time 10:40 till 11 o’clock, so how are we doing lunch then? The schools are not working with us.”*

### New Staff Responsibilities and New Stressors

Providers and staff took on additional responsibilities—serving as teacher aides, IT assistants, and school social workers—to meet the needs of remote learning students. They assisted students with logging into their online classrooms, troubleshooting technical issues, communicating with teachers and parents about schoolwork, charging student devices, and helping with class lessons and homework—although they did not always feel prepared to do this. Younger children needed more support to use their devices and complete assignments. As one Cook County family child care provider noted, *“You have to be hands-on [with students.] If she doesn’t know a word, we have to sound the word out. If she doesn’t know how to do a math, I have to help her with math. So, it’s like I’m the teacher.”* Commenting on her exhaustion and stress, another Cook County family child care provider remarked: *“I am stressed so, so much, because of the e-learning.”* One provider felt the State should have increased the reimbursement rates for subsidized care of remote learning students to compensate providers for the additional responsibilities they took on.

### New Expense and New Revenue

Providers hired additional staff to monitor and support K-12 classrooms, bought extra chargers for children, upgraded internet services since students needed strong Wi-Fi, and even bought desks for students to do their school work. These additional expenses were partly balanced by the additional revenue that school-age children provided, and in some cases, programs were only able to stay open because of the financial benefits of shifting to all-day school-age care. As one Cook County center provider noted: *“I’d rather that the kids be in school than here, but financially speaking it has kept me afloat.”*

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## RESEARCH QUESTION 2: LOOKING AHEAD AND LESSONS LEARNED

### 1. Providers have positive attitudes about the safety guidelines

Overall, most providers reported feeling like they did their best to make the required and necessary program changes. Providers expressed that implementing the new public health guidelines mitigated COVID-19 transmission. Furthermore, providers saw the value in continuing to implement the guidelines because fewer children got sick from colds or the flu in the past year. They attributed decreased flu and cold cases to handwashing, mask-wearing, health screens, and thorough cleaning and sanitizing protocols. A few providers, including a Cook County center provider, thought program quality improved because of the increased attention to personal hygiene, **“I think it’s increased the quality of care because I can honestly say I’ve been doing child care for 20 years, 22 years, we haven’t had colds since we had to wear masks. I’ve had a teacher who said this is the first year she’s never been sick because of the masking.”**

**“I think I’d like to keep these operational changes in place because like I said it’s working for me. It’s working. You know, I haven’t had any snotty noses. I haven’t had anybody having to be rushed out or picked up due to a fever or due to that. So, the extra is really paying off you know it’s work but is definitely paying off in the end. And the children are healthier, and I can see that.”**

*- Cook County family child care provider*

Some providers accepted the new practices and guidelines as the new standards, while others reported wanting the guidelines to be eased.

### 2. What program changes will providers keep?

More frequent handwashing, cleaning and sanitizing, and temperature checks were practices that most providers said they would like to keep. Several providers mentioned that they already had thorough cleaning and sanitizing procedures pre-COVID, making it easy to continue following cleaning procedures after the pandemic ends. Most providers said they would not require mask-wearing or would continue to offer masks but not require children to wear masks or only require them during flu season.

Social distancing guidelines resulted in the elimination of many activities (e.g., group activities, sharing toys, field trips, and being physically affectionate with children) that providers said they would like to resume. Most providers were eager to return to pre-pandemic classroom sizes and capacity and to combining classrooms to make staffing easier. Alternatively, one provider said having smaller classrooms improved the program and will keep this change.

Providers had mixed feelings about whether they would revert to pre-COVID pick-up and drop-off procedures if the guidelines changed. Providers would like to see more parent and family engagement by allowing them to enter the building and classrooms. This would benefit parents because they would be able to see what their children have been doing in the classroom and communicate with teachers. Additionally, parents would be able to receive socioemotional support and resources from providers more easily. Some providers said they would like to continue with the new drop-off and pick-up procedures because it helped with workflow and with children who typically cry or cling to their parents at drop-off. Providers implemented new virtual options for parents that they said they will keep, including tours of the program, parent meetings, and parent-teacher conferences.

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## CONCLUSION

Child care providers in Illinois had to shift their practices, curriculum, and interactions with parents and families to continue providing care safely during the pandemic. Generally, child care providers, their staff, and the children in their care adapted well to the new public health guidelines. Additionally, providers believed the guidelines mitigated COVID-19 transmission and had a beneficial result of reducing cold and flu cases among children. However, the new guidelines and procedures they were required to follow were time consuming for staff and resulted in providers restructuring staff time and roles. Moreover, the new guidelines were issued during a time of staff shortages in many programs. Public health guidelines that called for social distancing and limited contact between children and providers were difficult to reconcile with providers' caregiving beliefs and their early childhood education training. Providers raised concerns about the impact of social distancing on children's pro-social skills and the effects of masks on language and speech development. They were eager to return to their play curriculums in which children more freely interact with each other and share toys.

When K-12 schools closed and offered remote learning, child care providers took on the role of caring for school-age children – no other industry was expected to increase COVID-19 exposure by taking on this role. Providers who were caring for school-age children during school closures needed more support and many providers felt that their efforts in this area were not adequately acknowledged or supported by the State. Support for providers could have included funds for device chargers, desks, and internet upgrades; improved communication between schoolteachers, parents, and providers; information technology (IT) support to troubleshoot students' issues; and increased reimbursement rates for school-age children.

Changes to program operations, modifications to the physical space, and daily use of PPE and cleaning and sanitizing supplies increased providers' expenses. Furthermore, increased staff time to implement safety guidelines while enrollment was low was yet another additional expense. Illinois supported providers through programs funded by federal and state stimulus dollars. These supports were much appreciated by providers but nevertheless insufficient to address the severity of financial challenges they faced. Child care programs' financial well-being requires stable public funding, even after the pandemic, as programs recover, and the industry stabilizes. The introduction of the Strengthen and Grow Child Care Grants is one encouraging initiative to increase funding to Illinois child care providers moving forward.<sup>11</sup> Moreover, Illinois is actively invested in new efforts to support providers and increase the availability of affordable, quality child care for all families.

<sup>11</sup> For more information on the Strengthen and Grow Child Care Grants visit:  
<https://www.ilgateways.com/financial-opportunities/strengthen-and-grow-child-care-grants>



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