LEARNING, REFLECTION, and MOVING FORWARD

June 15, 2022

Presented To: Jaime Kalenik, FIRST 5 LA

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Introduction

The pandemic affected everyone. The virus hit hard. People lost loved ones. Some families lost many. There was fear, confusion, and illness. Some illnesses were relatively mild, others acute, and some debilitating and long-term (Long-COVID). There was great uncertainty about COVID-19's impacts on other areas of well-being, not just health. There were supply shortages and business and work shutdowns. There were times when store shelves for personal protective equipment, disinfectants, hand sanitizer, and the like were bare. At the peak of shutdowns some areas of the county looked like ghost towns—e.g., normally noisy congested streets of Los Angeles had silence and no moving cars. When people had to go out for groceries or the like, ages two and up wore face masks and sat, stood, or walked six feet apart from one another. Some also wore gloves, face shields, goggles, or other protective clothing and wiped down the grocery bags and their contents with something sanitizing when they arrived home.

At the beginning of 2020, the questions were unending: Will there be vaccines for this virus? Will there be treatments and cures? Are there any long-term or permanent effects for those who get the virus and seemingly recover? What effects will being in isolation for such a long time have on my child—on her/his social, emotional, and intellectual development? How can I work from home or externally and supervise my child's online classes at the same time? What do I do with online learning and a 3-year-old, a 4-year old, and a 14-year old? What arrangements will I have to make if someone in the family gets COVID-19? What income can I count on now that my work is closed? How do I feed my family with no income? Will we lose our house, our apartment? I am experiencing a lot of worry, anxiety, and stress: what can I do to reduce it? Where can I get reliable, truthful, useful, and timely information to protect my family?

March and April 2020, shortly after the state's Governor issued a Stay at Home Order in an effort to slow the fast rise in COVID-19 cases, there was an organic gathering of people

concerned about COVID-19 and early care and education (ECE). Three people, each from different institutions, had earlier begun exploring how they might maximize resources and work more effectively and differently together. In time, others from different institutions were invited, referred, or in other ways showed up to become a part of this emerging group. At their level of work within the different institutions, many members already knew one another, but some didn't. All but one was well-experienced in ECE.

May 14, 2020, the group held a special meeting with the Chief Science Officer, Los Angeles (LA) County Department of Public Health (DPH), to learn more about COVID-19 in the county. The intention was to see what they could do by working collectively, cooperatively, and collaboratively with a focus on COVID-19 related problems and ECE in LA County. Feeling that they did not have the luxury of time, the group moved quickly to not lose windows of opportunity. The group was the Los Angeles County Early Care and Education COVID-19 Response Team (Response Team or RT).

No one was appointed, no one was assigned, and no one was paid for participation. The focus of these volunteers was the virus' impacts on ECE providers, parents, and system. It soon became clear that without adequate, quality, ECE services, persons designated as first responders and other essential workers in the county would not be free to do their jobs. ECE workers were, in effect, "essential" for the county's first responders and others. Viewing from the early days of this rapidly unfolding epidemic and then pandemic, RT initially thought that their work might require several months of intense, urgent, emergency efforts. It has now turned into more than two years at the point of this writing.

RT members stepped forward to help in the ways that they could, just like so many others. At the time, people in neighborhoods were bringing hot meals, bags of groceries, offers of rides and errands, or contributing cash to family, friends, and neighbors in harm's way of COVID-19. Neighbors said things like, "Here's my number. Let me and my family know if we can be of help." Local business people collected bags of groceries from within ordinary communities to deliver to local food banks. When public schools shut down, schools provided meals to entire families ensconced in lines of cars that sometimes stretched around the block. This was a collective response. Individuals were collectively responsible for everyone.

A desire to help was part of what initially brought RT members together. Some RT members spoke of being deeply affected by the fact that many in the field of ECE would be placed at high risk of exposure to the virus given the face-to-face hands-on nature of ECE work. This was especially the case if ECE workers continued working throughout the pandemic: some workers had opportunities to close and work virtually; others did not, and remained open throughout the shutdown. Those who remained open had daily face-to-face engagement with children and children's family members coming into the care space from the wider outside. One RT member talked about personally experiencing great anxiety over these kinds of potential harms to providers, children, and parents who were on the front line of exposure, sometimes without the necessary personal protective equipment (PPE) and materials and protocols needed to be as safe as possible in the pandemic.

Something personal for a different RT member was the family story that the pandemic of 100 years ago had taken the life of their grandparent. This made the fight against COVID-19 even more personal for this ECE professional. RT interviewees all spoke about concerns for others as well as for their own lives: they, too, had elders and extended family members, newborns, pre-school-age and older children, and other loved ones.

These human-to-human feelings of care, though commonly not topics in a document about learning and reflection and how a group has done its job, is an important substrate of the RT story. It is a kind of human-glue, a human-to-human connection, that links all involved. It tends to manifest when very different people find themselves facing a common crisis together. RT focused on the human beings that were being placed in harm's way, especially those person's serving as essential workers to the essential workers. The centering of human beings was part of the glue that infused RT's work, held members accountable, and facilitated team cohesiveness.

Other indicators of this humanity-glue emerge from the minutes of RT's weekly virtual meetings: Certain members kept an almost drumbeat focus on the urgency of the situation and COVID-19's threat to human life and livelihood. There was respect from and for each team member, a willingness to listen and learn from one another, and speaking and problem-solving

in terms of one another's strengths. Members built upon one another's ideas and contributions. These things, too, strengthened RT's cohesiveness.

There were also at least three additional factors shaping RT. These were like unseen members of the 19-person RT: The first was the influence of isolation. Staying at home for such a long period of time cultivated a felt need to somehow connect and interact with other people, and to do something meaningful in the situation. The second factor was a willing environment. The COVID-19 threat was so scary and potentially so disruptive and damaging that lots of decision-makers were open to trying new things. Operating within the context of the pandemic, very little was, or even could be, business-as-usual. The third unseen member of the RT was that everyone was forced into experiencing change. No exceptions. Things changing and one not being able to assume business-as-usual became a norm.

All of these humanity-themes and factors appear in various forms in the personal stories shared not only by RT members, but also by providers and parents (see latter half of this report). Humanity-themes have played a role and will continue to play a role, hopefully, in any movement out of the emergency phase of the pandemic and into the transition and building phases for an "equitable recovery" (a term that appears in RT minutes).

Response Team (RT) Members

Who were these people that came together weekly, and later bi-weekly, over the course of more than two years during the pandemic? The following 19 individuals have served as members of RT and are associated with nine different institutions. Fifteen (15) of these 19 individuals participated in RT interviews for this report and/or shared documents.

NAME	INSTITUTION	POSITION
Becca Patton	First 5 LA	Director, Early Care and Education Team
Christina Acosta	Pomona USD	Child Development Program Supervisor
Christina Hernandez	LA Mayor's Office	LA Early Childhood Equity Project Coordinator
Colin Legerton	LA County Office of Education	Head Start Communications Specialist

Cristina Alvarado	Child Care Alliance of LA	Executive Director
Dean Tagawa	LAUSD	Executive Director, Early Childhood Education Division
Debra Colman	Office for the Advancement of Early Care and Education (Department of Public Health)	Director
Ed Sudario	Child 360	VP of External Relations
Ilyssa Foxx	Child Care Alliance of LA	Quality Start Los Angeles Program Manager
Jamie Kalenik	First 5 LA	Program Officer, Early Care and Education Team
Keesha Woods	LA County Office of Education	Executive Director, Head Start and Early Learning
Lindsey Hanlon	LA County Office of Education	Grants Consultant, Head Start and Early Learning
Luis Bautista	LA County Office of Education	Administrative Supervisor, Head Start and Early Learning
Marcy Banuelos	First 5 LA	Administrative Coordinator, Early Care and Education
Marcy Manker	First 5 LA	Senior Program Officer, Early Care and Education
Michael Olenick	Child Care Resource Center	President & CEO
Patrick MacFarlane	Child Care Resource Center	Government Relations Manager
Ranae Amezquita	LAUSD	Early Childhood Education Director
Steve Zimmer*	LA Mayor's Office	Senior Education Advisor

* This member has moved to a position at the state level.

What Has Been RT's Work?

> *"The response team [RT] was able to mobilize our efforts quickly due to our clear understanding of the "why." We knew why providers needed us to get systems in place and supplies into their hands quickly. We knew that the key to first responders to be able to go to work was having access to child care. We knew that providers were highly challenged with accessing PPE supplies due to shelves being bare at their local stores. All of this information was known to all of us which allowed us to act quickly on behalf of our unsung heroes of early care and education."*
>
> (An RT Member)

Theoretically, the full field of outreach for RT was all childcare providers in Los Angeles (LA) County, and to a lesser extent, essential workers needing childcare, as explained by one RT member. From interviews with RT members, there were three broad foci. RT members did not speak in terms of goals or objectives. The feeling was that these terms were too confining, limited, and specific. RT took a broader and more fluid approach. Its primary foci were that:

- ECE workers are kept safe
- essential workers have access to ECE for their children
- there is preservation of the county's ECE infrastructure

Some RT members further identified more specific, hoped-for, outcomes for *providers*. These were that providers, as much as possible given the conditions of the pandemic:

- had clarity on how to be safe during this pandemic
- felt supported, and didn't feel alone
- felt that they had people working on their behalf
- had knowledge and practices for keeping children safe, developing, educationally stimulated, and learning

In practice, RT's efforts were more than providers knowing how to be safe or that they felt supported. From its beginning, RT operated largely in crisis mode. As stated in the earlier quote, RT was flexible and worked hard to put into providers' hands the materials that were necessary to be safe and do their care- and education work. For example, in 2020, at a time when there were major shortages of all varieties of needed supplies, RT began working on the supply issue. Though it took time given the many delays in the supply chain—this was a time of shutdowns and closures—RT was eventually able to secure, warehouse, and distribute multiple

rounds of large quantities of supplies to providers across the county. Supplies included items like: masks for adults and children, hand sanitizer, wipes, diapers, cleaning supplies, gloves, non-contact thermometers, and other items. As of the time of this writing, there have been 6.5 rounds of distributions.

In interviews, several RT members offered more specifics about what they saw as RT aims for *parents*. These were that parents, as best as possible given the circumstances:

- felt that their children were safe
- felt free to do their first-responder and/or other essential work and maintain family stability without risking the safety of their children
- felt that their children were also in environments where they could develop, be educationally stimulated, and learn

RT Activities: A One-Stop Shop

The weekly meeting minutes, individual interviews, and documents show that RT gave continuous attention to, and actively worked on, the preceding foci and aims. RT did so from multiple angles. For example, RT worked on a host of ECE access issues. For instance, these included: setting-up an enhanced referral system and a 1- 888 toll free phone number for easier and swift access to ECE services. RT helped with prioritizing hospital staff (i.e. essential workers) for accessing ECE, and sought and secured funding for stipends for low-wage hospital workers to do the same. RT worked to help open care and education services with LA City Parks and Recreation. RT arranged for some of the expert coaching and training that was needed for pop-up care in struggling areas of the county. RT also collaborated on submitting an emergency plan to the state.

One continuing activity has been RT actively seeking out, overseeing, and distributing resources to providers. The diversity of resources has been wider than those items previously mentioned. This diversity of resources has included donations from funders, donated and reduced-cost supplies, trauma-informed and other learning materials, furniture, books, and toys. One part of the outreach to funders yielded $150,000 for vouchers and $150,000 for general support. Raising money from philanthropy completely outside the usual funding stream, created the opportunity to provide low-wage hospital workers $100 per shift for six

months to use for child care. Two donor organizations created individual learning kits for children. Reaching out to key existing organizations such as the eight county-wide Resource & Referral Centers (R&Rs), RT was able to collaboratively set up a system for distributing* these diverse supplies to providers. The R&Rs cover the entire county of Los Angeles. Hence, closely working with this pre-existing system enabled RT to reach more providers. In one instance, one RT member stepped forward and paid for the warehousing of large supplies when other means for storage were not available. By May, 2022, supplies in total numbered over 16 million items.

Information was a key element of protection from the virus and its impacts. RT regularly provided a variety of expert health and safety communications. It did this through fliers, hotlines, question-lines, emails, webinars, billboards, and attempting to access provider networks that served different cultural and language communities (e.g., Mandarin speakers, etc.). There were also Community Calls (18 such calls as of January 14, 2022)*, website updates, a phone bank, and Facebook posts.

RT made efforts to receive feedback, questions, and inputs from providers and others through these different channels of communication. Surveys were another method used by RT to find out what was happening at the community level. Additional on-the-ground insights emerged from the questions and concerns that providers and parents raised in their interactions with R&Rs, and queries to the Department of Public Health (DPH).

RT members routinely received relevant updates from across the county at the weekly and later bi-weekly virtual meetings. Members were then able to pass this information along to other agencies, including their home agencies. Something that DPH was planning concerning COVID-19 vaccinations, for instance, could be shared with the Mayor's Office, the R&Rs, or any one of numerous ECE agencies. This early sharing gave opportunities for increased planning, preparation, and inter-institutional participation. At the weekly meetings, RT partners sometimes invited fellow RT members to help with planning for upcoming events or rollouts (e.g., how best to organize for the vaccination effort for young children).

* Further details concerning this point will be discussed later in this document.

RT partnered with different agencies on a variety of projects. One of a number of examples was partnering with the Mayor's Office and a community college to support the College Promise Works program. In an attempt to get ahead of the issue of vaccine hesitancy, College Promise hired and trained community college students to call providers and give out accurate information and answer questions concerning vaccinations. RT also worked to prioritize ECE providers to receive vaccinations once they were made available. RT members worked with Children's Hospital, as well as sought to get providers to the County mega-vaccination sites.

In various venues RT advised, advocated, and proposed policies on behalf of the ECE community. Examples of policy issues that RT worked on included: hazard pay, that existing programs receive full state allocations, funding child care and education for essential work, streamlining enrollment requirements, extending hold harmless, and vouchers for those receiving unemployment. RT advised both the County and City of Los Angeles on structures for grants, and advocated for funds to be used in support of child care providers. Some grantees received funds to support their child care businesses.

Much of what RT did during this two-year period was in partnership and collaboration with the various member institutions/agencies as well as with external agencies. The work was virtual, given that throughout the county and state people were largely working from home. The work was detailed and sometimes intense. It involved a lot of day-to-day communications, planning, decision-making, implementing actions, and responding within a changing environment.

The mix and level of RT activity cannot be easily captured, especially not in the small space of this document. Interested persons can find far greater information in the detailed weekly and bi-weekly RT meeting minutes, and the near week-to-week timeline of RT activities. These two sources, as well as other documents (e.g., identification and tally of all items distributed), can be accessed in the RT archives housed at First 5 LA.

For any one of RT's efforts or accomplishments, there were a host of smaller tasks that had to be completed in order to make that one larger task happen. Many of RT's efforts might best be described as projects; these were projects happening within the context of continuing

disruptions and uncertainties of the pandemic and other people's responses. Like everyone else during the pandemic, RT and those assisting were learning as they were doing. Four examples illustrate some of the many smaller or intervening issues and questions that RT navigated in efforts toward achieving some particular outcome.

Example 1: Community Calls

"A community call is what the RT calls its webinars (the first couple were actually big Verizon conference calls instead of Zoom meetings). The format is usually 30 minutes of presentation and 30 minutes of Q&A. The content is aimed primarily at childcare providers, but in the beginning was for a broader audience including parents needing childcare. Presentations have ranged from updates from the Department of Public Health and information about supply distribution, to mental health resources and LAUSD distance learning processes." (An RT member)

Community Calls, of which there is an official record of 18 between April 2020 and January 2022, presented information to provider- and parent communities. They also created a means to hear from, get feedback from, and answer questions from call attendees. Often, multiple agencies were available to present information or answer questions on the call. Recordings of Community Calls and printouts of the questions that providers and others asked are in the RT archive.

Questions were most often about concrete, practical, real-life, daily challenges that providers or parents encountered in navigating the pandemic. This included guidelines and new rules. For instance, questions asked by providers elicited expert responses like: "Two (2) surgical masks should be used in lieu of a single high-grade mask: K95, KN95 or KF94." Providers asked myriad questions that sometimes reflected a high level of concern or confusion. A few examples of provider questions are:

- *"Are we still submitting unusual incidents for each COVID case?"*
- *"Are vaccines required by ECE? Head Start is requiring them by Jan 31."*
- *"Does shortened isolation apply to pre-K students, considering they nap without masks? Does it apply to toddlers that don't mask due to age?"*

- *"Can you please go over home kits? Are we allowed or not allowed to test children with these on campus if it is the parents administering it? Or do these kits need to be administered by parents at home?"*
- *"Parents are both negative. One-year-old child continues to test positive. What is this protocol? Do we admit the child?"*
- *"During nap/resting time children under 5 do not wear mask so is everyone present then exposed or do you have comments on this?"*
- *If a child under 5 has traveled internationally, what is the recommendation?* [this question was paraphrased]

Experts presented on the Community Calls and/or were available to answer at least some of the questions at the time of the Community Call. RT made efforts to get answers back to providers: e.g., on the next Community Call, through group emails, and trying to keep information current on the website.

Example 2: Website

RT's partner that managed the website *Child Care Heroes* provided a report for the period December 2020 – June 2021. Summarizing and paraphrasing:

> *The total number of users was 179,074. The website was visited 263,240 times and had 333,316 page-views. Per session, the average number of pages visited were 1.27 and persons visiting the site did so an average of 1.48 times.*
>
> *The order of the most visited pages in English was: home page, educators landing page, and learning activities. Learning activities held visitors' attention the longest. Pages that gave guidance and that had information about vaccines received the next longest attention. The Spanish site had fewer visitors, but had "comparable average times on pages to the English site for the guidance pages and vaccine page."*
>
> *The* Child Care Heroes *site was shared by Facebook users 982 times, and the complete reach of Facebook content was 863,349.*
>
> (December 2020 – June 2021, *Child Care Heroes* Final Analytics Report*,* June 30, 2021 Viva Social Impact Partners)

RT is presently working on updating and further refining the website. Aspects to learn more about go beyond numbers and include questions of quality and usefulness. They seek to

answer questions like: "What do any of these numbers truly mean for intended users?" How frequently was any website content updated? Not just what was taught, but what did website visitors actually learn from their visits to this site? Was what they learned helpful? How easy was it for providers and parents to apply what they learned given the circumstances they were facing? Does anything else need to be added to the website?

Example 3: Distributing Supplies

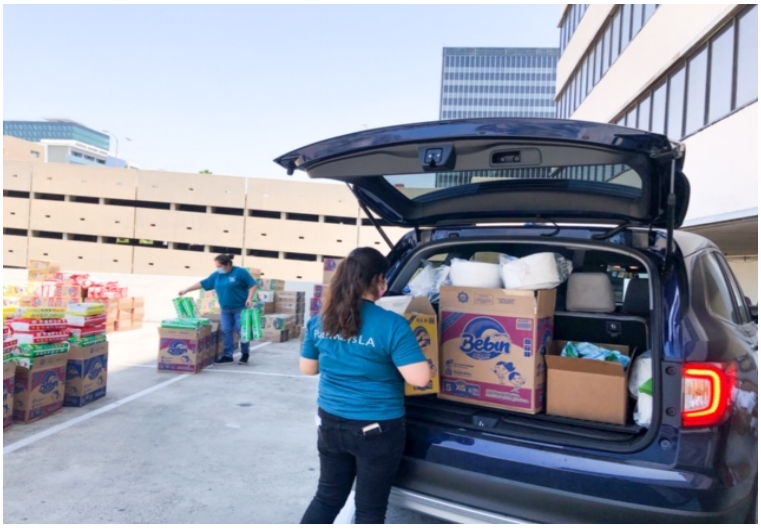
At latest count, RT played a role in acquiring, warehousing, and distributing 16,407,867 individual items. Distributions were done in 6.5 rounds, as of this writing. To give several examples of size, at one point between 2020 and January 2022, the official count of several items by category included 2,885,200 diapers; 1,212,150 adult face masks; 2,198,850 child face masks; 74,096 bottles of hand sanitizer, etc. While the *Los Angeles Times* (January 22, 2022, A1, 10) was reporting that home testing kits were coming very slowly to child care, documents show that LA County R&Rs were distributing these home testing kits in January 2022 and later in February. (See the RT archive for current official tallies and the sources of contributions of home testing kits.) Though much needed, securing and distributing these and other items (e.g., gloves, no-touch thermometers, cleaning wipes, liquid hand soap, disinfectant, baby wipes, etc.) over the course of two-years had many logistical challenges.

Digging into the logistics a bit deeper helps one to appreciate the amount of work it took to address the many levels and types of complications involved in getting these supplies into the hands of providers: First, it took efforts to net the various donations coming from different sources (e.g., city, county, state, private companies, foundations, etc.). Then, assuming that these were sometimes very large quantities of items being donated or purchased at any one time, where are these items to be stored once they are available? If these large quantities are to be stored in a warehouse, where does one find a warehouse? What are the requirements, including length of time, contracts, etc.? How will large and small amounts of supplies be moved from one place to another? If the movement of large quantities of supplies is by truck, where does one get the trucks, drivers, and how many? If by car, whose cars? Are there any insurance or liability issues? In a large county like LA, what locations in different parts

of the county will be best for distributing items? What staff will be needed and available onsite to implement the distributions? When will all this take place? What will be COVID-19 safety methods for distribution? And, throughout, what will all of this cost?

One Resource and Referral Center (R&R) described the end part of distributing large quantities of needed supplies to individual providers. The following description provided during an interview is edited and paraphrased:

> *At [*this R&R*], those who received the PPEs (personal protective equipment) were mostly Family Child Care (FCC) providers who typically may have limited access to additional resources. The larger Child Care Centers have multiple access avenues. The group of FCC providers already have fluid relationship with [the name of this R&R] and have a strong history of being responsive. For example, these providers attend workshops, seek information, and have relationships with [this R&R's] staff.*



Courtesy of Los Angeles County Early Care and Education COVID-19 Response Team (RT).
Distribution activities at a site.

> *This R&R sent out an email notice to all providers in their network. Many providers responded. The R&R first tried distribution as a mass event. This resulted in long lines around the building. Next time the R&R used appointments for picking up supplies. There were appointment hours with a 15-minute window between provider pick up. No contact occurred. The provider makes a request and the goodie bag is prepared and left in the front of the office for pick up. When the provider arrives, the provider calls the front desk to be let in to receive their supplies.*
>
> *R&R staff made the supply bags, and took the orders. Distribution occurred during normal business hours. Items distributed over the course of multiple rounds of distributions included: home test kits, N95 masks, hand sanitizers (size 8 oz. and 16 oz.), and medium/large non-Latex gloves, etc. Early on during the time of shortages, providers inquired repeatedly for supplies prior to the first distribution.*

Example 4: Vaccinations

RT was working in a complex and fluid environment. Members had to be aware of and respond to the actions of other decision-makers, as well as to so many other conditions. The following story of RT and vaccinations for ECE providers illustrates some of this environmental fluidity, impacts of the decisions of others, and spaces in which RT navigated.

The COVID-19 pandemic forced the closure of many child care facilities. By May of 2020, only 21% of the centers and 59% of the family child care homes were open. Many ended up closing for good, but for those who wanted to continue serving children in their care, the COVID-19 vaccine became a critical part of this process.

When the vaccine first rolled out, child care providers were not on the priority list. We advocated for them to be added, and they were included in the teacher group. At the end of February 2021, we began to set up weekend vaccine clinics at Children's Hospital Los Angeles (CHLA). The Resource and Referral agencies first had to sign up providers 65 years and over. A couple of weeks later, we expanded to all child care providers as long as they had an appointment through their R&R (we made the appointments and shared them with CHLA).

Other community groups followed the same process, until the Governor expressed concern that people seeking vaccines were not following the roll-out order (i.e. older folks first, followed by first responders, nurses, teachers, child care providers, etc.). As a result, the Governor implemented a system of codes. Vaccine providers could reserve a certain time/place and they would be assigned codes. When a recipient visited the indicated website, the idea was that only those who had a code could sign up to get a vaccine for that designated site.

We asked child care providers to sign up for CHLA on the identified days/times. Later, mega-sites run by the Department of Public Health (DPH) set aside Saturday mornings for child care providers with a code. The Child Care Alliance was sent thousands of codes from the State, and we had to allocate these to all the Resource and Referral Centers (R&Rs) in the county, Los Angeles County Office of Education, and the provider union (SEIU).

As we rolled out the vaccines, we started receiving notifications that the codes worked for some and not others. Mostly they didn't work. This caused frustration amongst providers as well as some "giving up" on trying to receive a vaccination. As we contacted child care providers to assess vaccine interest, we learned that there was resistance and trust issues in certain communities, especially brown and black communities who have had past negative experiences with government. We then targeted some of the areas by sending out mobile vaccine vans on specific dates – no codes! This produced some results but the level of vaccination rates within targeted communities remained low.

(An RT member)

LEARNING and REFLECTION

Context, Context, and Context

All that we do happens within a context. Context gives meaning. It includes not only the physical world, but also social-emotional-cognitive-philosophical and other ways that we organize and interpret events. There is no way of interpreting actions in the absence of some form of context. Too, the same behavior in different contexts will often be interpreted very differently. In taking the time to look back, learn, and reflect on RT's work to date, two enormous issues stand out as critical aspects of the context. They influence the meaning of what RT has done to date, and what RT might do in moving forward.

The first issue is obvious: RT was operating in a pandemic—as was everyone else. In hindsight there is sometimes a temptation to ask questions like: Why did RT do "A" and not "B" or "C"? Given the context at the time, questions like these may not wholly apply. The context was fluid. Everyone was working in a once in a lifetime, illness-causing, deadly set of circumstances. There was chaos, fear, and trauma—often going unnoticed at the time. It was a time of unknowns, uncertainties, and all hands-on-deck. And, everyone was doing their best.

This is not to excuse or rationalize, but it is to state the reality of the context for many people at the time, including RT. Could RT's work have been performed better? As several RT members themselves have said: "Yes, there is always room for improvements." Could RT's work have been performed worse? Most definitely. Simply doing nothing would have produced far worse outcomes. Given the many efforts by RT to provide important information, materials/supplies, and other supports over more than two years, RT efforts contributed to saving and protecting lives.

The second issue of context is inequalities and inequities. Because of historical, systemic, and institutional inequities in the society at-large, and the nature and economic structures of ECE, some people were far more exposed to COVID-19 and its damages than others. These were the providers themselves. Add to this the fact that the providers of ECE in the county (and the state and nationally) were among those populations that, pre-COVID-19, based on income and race/ethnicity were already at high disadvantage in virtually all areas of well-being in the society.

The ethnic and racial breakdown for ECE providers in LA County is largely Latina and other women of color:

> *"In LA County, 56.1% of providers identify their ethnicity as Hispanic or Latino, and 43.9% of providers identify their ethnicity as Neither Hispanic nor Latino. When asked to identify their race after their ethnicity, providers identify as: 56% White, 22.3% Black or African American, 7.4% Asian American, 1.5% American Indian, 1.3% Other Pacific Islander, 0.2% Native Hawaiian, 0.1% Alaska Native, or 11.2% as Two or more races."*
>
> (Resource manager for an RT member)

In terms of income, a recent statewide study of early care and education in California found that:

> *"…the median hourly wage in 2019 for a California child care worker was $13.43, whereas preschool teachers earned $16.83. Meanwhile, a kindergarten teacher earned $41.86 per hour—just above the California living wage for a single parent with one child…. In addition to poor wages, many early educators lack access to benefits such as health care or retirement savings…."* ("'The Forgotten Ones'—the Economic Well-Being of Early Educators During COVID-19: Findings from the 2020 California Early Care and Education Workforce Study," Research Brief, February 2022, p. 9)

Income in this field is low. So low, in fact, that in the state (California) substantial percentages of early care and education workers are forced to supplement their income with public assistance (Figure 1).

Low-income and persons of color have been among those populations especially in earlier periods of this pandemic at greatest risk of contracting COVID, falling ill, and dying. Too, they are less likely than white counterparts to receive lifesaving medicines and treatments for COVID-19 (*Los Angeles Times*, "COVID Drugs Expose Equity Issue," February 5, 2022, A1, 6). These populations experience myriad other forms of inequities throughout the systems of health, education, housing, assets, and the like (*The State of Black America and COVID-19*, 2022[1]; *A Poor People's Pandemic Report: Mapping the Intersection of Poverty, Race, and COVID-19*, April 2022[2]). Issues of inequities are dominant themes in the story of COVID-19. One RT member referred to "the brutality of the disparity of impact," associated with COVID-19. Though not so much in what RT discussed, the topic of inequalities and inequities, especially

[1] https://blackcoalitionagainstcovid.org/the-state-of-black-america-and-covid-19/

[2] https://www.poorpeoplescampaign.org/wp-content/uploads/2022/04/ExecutiveSummary_7.pdf

income inequities and access to a living wage, clearly emerged in the interviews with providers (see the latter half of this report).

Figure 1

Assistance Program Use By Early Educators in California, 2020

Public Assistance	FCC Provider	Center Teaching Staff
One or more	41.9%	31.6%
Medicaid (child)	26.2%	29.22%
Medicaid (self)	18.1%	12.1%
SNAP	9.1%	8.1%
Food pantry	8.1%	8.4%
Child care subsidy	5.9%	5.5%

Source: This figure is reconstructed from *Figure 2. Early Educator Participation in Public Assistance Programs in California, 2020*, "'The Forgotten Ones'—the Economic Well-Being of Early Educators During COVID-19: Findings from the 2020 California Early Care and Education Workforce Study," *Research Brief*, February 2022, p. 12.

These and other aspects of context have implications for future work by RT and/or its successors. Such contextual factors are critical components that will need to be addressed in moving forward and for building something healthy, flourishing, equitable, and sustainable for the people and the field of ECE.

RT Learning and Reflection: Selected Issues

Looking back to learn from what has happened is wisdom. In the case of COVID-19, looking back creates opportunities for learning how to heal from the trauma and other damage resulting from the pandemic. Looking back with a reflective, fearless, critical, and open mind also creates opportunities to see what facilitated and what hindered the work, what didn't work, and why. It holds the potential for depth of insight about what should be valued and retained, and what may need to be re-designed or newly built for moving forward in ways that nurture health, well-being, and equity.

The following section centers learnings related to RT's work. (Other learnings from providers and parents appear in a later section). Consider the RT learnings presented here in this section as incomplete: There are more lessons to add. Many of those lessons can and should come from RT members discussing among themselves and from those persons and groups whom RT sought to serve.

1. Providers in circumstances of most need were often not reached; some were "chronically left out," as one RT member stated. Contributing factors included: e.g., some providers did not have social media or email; some spoke languages other than English (e.g., Cantonese, Mandarin, Spanish, Armenian, etc.); and RT's lack of knowledge about how best to reach certain communities, etc. This means that some of the children in circumstances of most need, as well as their parents, too, were not reached. This is an observation from RT members themselves, and is something that should be given immediate attention. That immediate attention should have the same push and sense of urgency (all-hands-on-deck) that has characterized much of RT activities to date. Rigorously addressing this significant shortfall is independent of what RT may decide about its future. This is a NOW problem that was also referenced in interviews with providers and parents. A related comment from one RT member was: "Do not just look at demographics. We need to do deeper dives: There are poor people everywhere."

2. RT was working to manage the ECE portion of a county-wide crisis. The initial years of the pandemic did great damage to individuals, families, children, provider businesses, and the ECE system. All that damage, including the trauma, needs to be assessed and addressed. It is another, perhaps deeper, level of the COVID-19 crisis.

3. RT functioned within larger contexts where agencies and institutions often have a history of working in silos. Purportedly, there was even prior friction between some agencies/institutions that were represented on RT. Each RT member stepped out of

their silo and brought their best, free, and willing self to the circle of collaboration. In this way, it was possible for very different agencies and organizations to collaborate, work well together, build trust and relationships, plan, implement, and accomplish desirable results. In and of itself, this is advancement.

Several questions to consider going forward: 1. How can such openness, trust, willingness, cooperation, and focus on a common good be sustained? 2. What can RT do to contribute to something similar in terms of relationship building between RT and an organic group representing ECE providers?

4. *Who* RT members are was important: In telling how they became involved with RT, they presented as "people-people:" they were caring, willing to give of themselves, and personally invested in doing something to help the situation. Some expressed actual worry and anxiety about the health and well-being of providers, especially those providers that had to remain open during the pandemic when so many others had the relative safety of being closed. It seemed in some way that these RT members were questioning the extent to which our society was not too troubled about placing ECE workers in harm's way—a human glue kind of question.

   RT members came into the group with resources and positions of influence. They were among LA County's experts in ECE. They had seats and voices at decision-making tables in the county. They had a wide variety of skill-sets, relevant contemporary and historical knowledge, first hand and analytical experience with the field of early childhood, up-to-date COVID-19 and related information, access to ongoing planning within and across different agencies, access to resources including technology (e.g., media platforms), and an open mind. They had both private and public contacts with persons, groups, institutions, and government agencies that had resources. High up enough within their respective agencies, RT members had connections, access to information, and an understanding of how systems work. They could anticipate what was and what might be needed. All of this worked in ways to synergistically enhance their collective problem-solving.

Question: How can all this power be focused and/or refocused in various intentional ways to shape a healthy (in all meanings of the word), equitable, and sustainable ECE system for moving into the future?

5. *How* a group does the work of collaboration can be both satisfying to its members and produce collective output that is greater than the sum of the individual inputs. In RT's case, members of the group operated with no hidden agendas, no egos, no one leader. They worked as equals, though taking on a variety of different roles. They operated from a spirit of good will and collective cooperation. The approach was more about, what can I contribute, as opposed to what can I get, and what can I give up, for example, in terms of institutional ideas about regulations, how money is spent, etc. They maintained an urgent focus on specific tasks and projects, learned from one another, and built trust in the group.

   Reflecting on their experiences, RT members used words and phrases like: velocity, dexterity, tolerant of different ideas, a means to cross-walk between institutions, exposure to new knowledge about various participating institutions, offering-up team members and their time, no psychological fear of failure, doing our absolute best, reduced bureaucracy, and no slackers—we would bring back to the group what we said we would do.

To quote several RT members:

- *"We all need to feel that we have a community during a crisis; we (RT) became a community for one another."*
- *"…so early on to have so many different players/stakeholders in one work group. It gave us more of a full scope and the effort was what is most needed."*
- *"The LA County COVID-19 response team is an example of government collaboration during a crisis. We saw multiple agencies and departments across several levels of government come together with community-based non-profits and philanthropy to meet the needs of community during the pandemic."*

- *"We are not afraid to bump into one another—we speak up, openly, honestly, and work all <u>together</u> as a team."*
- *"This work was hard, quick, varied, and we felt like we were really doing something good and important; we did our best."*
- "*The Response Team has been very different from all other committees that I have been on. It is not a chore, but an opportunity to do something important."*

Question: How can RT help facilitate these kinds of coming together for other sectors involved in ECE, for instance, providers and parents?

6. It was not merely egos and hidden agendas that were excluded from RT meetings. It was also certain institutional- and cultural ways of doing things, philosophical orientations, and sensitive issues that had the potential to divide, weaken, or slow down the group. This meant members leaving outside the meeting things like: "In my institution, we always have to …." or ideas that there has to be full bureaucratic approval of something before exploring it, planning it, or trying to implement it.

7. Time management was different. There was no time to wait for designing and testing a prototype before going to scale, for instance. RT's approach was more like: observe, learn, go for it, assess, tweak in real time, and if necessary try again or try an alternate approach. Though at times the speed did pose challenges, there were efforts at trying to closely observe, learn, and net some amount of timely feedback so corrections could be made. Even though there was an effort to move swiftly, meeting minutes and other documents show that there was a lot of communication, thought, and planning behind the scenes.

8. A commitment to paying attention and aligning with the realities of a situation has been productive for RT. It made it possible to find mistakes early and to get out in front of some issues. For instance, some things that RT tried didn't work initially (e.g., using codes as a means to move providers up on the eligibility list for

vaccinations given their level of potential exposure to the virus). After what some RT members described as a fiasco with the codes, they switched to other means. RT also pushed back on the agendas of others, for example, making the case that providing testing, vaccinations, etc. only during workday hours made it difficult for providers that had to work during those hours.

9. Having a variety of venues (e.g., website, Community calls, social media, emails, etc.) through which providers and parents could access information has been constructive. Accurate and timely information based on science was high on the list of what providers and parents found valuable and said that they wanted/needed.

10. Having the member composition, structure, and functioning that it had, RT's existence introduced greater efficiency. It reduced the need for so many meetings by serving like a one-stop shop for receiving and sharing data, information, and planning. RT's weekly virtual meetings kept members current and in the loop of what was happening across various institutions and agencies in the county. Information, directly from key sources, could within hours be brought back by RT members to their respective home institutions and professional networks. This is one of several issues to consider when inviting others to serve on a team like RT.

11. RT's weekly (and later bi-weekly) virtual meetings were not only spaces for collaborative problem-solving, but provided an un-politicized, non-polarized, open space in which to discuss and work. It was more like a space with a clean slate and fresh air. This gave freedom. Working in the interstices between institutions, and where one institution's boundaries ended and another institution's boundaries began, made it possible for faster, unbureaucratic, decision-making. During interviews, RT members made frequent remarks concerning RT being able to get things done. This was experienced by team members as a positive. It was a good

motivator: members felt that their actions were making headway and they could see fruits of RT's labor.

12. RT gained a lot of inter-agency problem-solving experience working on real-life, on-the-ground, problems. RT often worked from the very beginning of an effort through to the end outcomes. This continuity yielded a much clearer picture of some of the problems and the potential for obstacles. Consider extending this continuity to include at the end point how the efforts actually impact the individuals within the groups that RT is intending to serve. The second half of this report includes some examples of those individuals that RT has been attempting to serve. How can those individuals and RT come together even more closely? To what extent is/can RT make a meaningful difference in the lives and livelihoods of the people in the latter half of this report?

13. Transportation and low-income may need much more consideration by RT. Financially struggling providers may or may not have a car, gas money, available time, or easy access to other transportation. This may restrict their opportunities to pick up needed supplies from what may be for them a distant R&R site—LA is a very large county.

14. Isolation during the pandemic was a silent member of RT. Many RT members as of the time of interview had yet to meet one another in person, for instance. The RT experience made some members feel that they were not alone as they worked from their "shelter in place." The fact that RT members found ways to connect with one another and develop strong, cooperative, working relationships under the conditions of isolation suggests that maybe they can do so under other conditions, as well. For example, what's to stop RT members from finding new ways of reaching out, connecting- and collaborating with providers and parents (and indirectly the

children), especially those that are in circumstances of great need. What would it take to do so?

15. RT's work had to be done by videoconferencing, phone, text, emails, webinars, social media, and other technologies. How does one get at least the basics of some of these technologies (and training for how to use these technologies) into the hands of providers and parents that are in most-needy circumstances? How does one improve their access to and acquisition of updated information, opportunities, resources, financial supports, and supplies?

16. In the midst of a deadly pandemic that was very scary and uncertain, some RT members spoke of experiencing joy in their work. They spoke of pride, laughter, friendship, trust, amazement, and a sense of belonging to something that was doing good. One of many ways to think of this is that these members were experiencing a kind of ongoing mental health treatment in the middle of a deadly pandemic. They had a lightness and happiness when they talked about RT's work. Members expressed that they felt a part of the group. For these members, there was a strong sense of belonging and work well done, even though they recognized that there was so much more to work on and always room for improvement.

    Providers and parents could potentially benefit greatly (including in terms of mental health) from ongoing experiences such as these. Their interviews show that they do reach out to help one another. But, in a group, where can they virtually go to reach out, connect, problem-solve, and experiment with having access to resources for implementing their solutions for support and collective concerns? RT may be able to help with this, especially in terms of resources to support this.

17. COVID-19's impacts also made even more clear the need for a wide variety of fundamental economic, structural, and valuing changes for the ECE system and its providers. So many in the society at-large depended on, or leaned heavily upon, this

largely under-paid, under-appreciated, under-valued system, career, and its people. Question: What is in place or should be in place for providers and parents to be similarly able to lean on and depend on as a safety net?

18. In addition to RT's hard work, so many other things facilitated their efforts. Some of these included: access to and use of technology; reaching out to contacts; creating a means and a place for receiving and sharing information; having access to resources and supplies, and a mechanism (e.g., the R&Rs) for distributing those supplies; an active official direct contact high up and inside DPH; the values practiced when collaborating with one another, etc.

    What can RT do to provide these same or similar opportunities to providers, and parents, to come together on a regular basis, examine their situations, map what they need and when, and have access to decision-makers and resources? Could it be that it is through the current RT that they can access some of these kinds of experiences?

    This is part of a larger fundamental question about how RT can bring the <u>natural</u> other half of solutions into the circle for identification, discussion, and attempts at solutions. This natural other half is the on-the-ground portion that is directly experiencing the realities and living with the consequences in the present context of providing frontline services. How does one support the organic creation of something like an RT that consists of providers, or parents, or both?

In an effort to follow our own research team's recommendations concerning viewing from systems-level perspectives and viewing from first-hand, on-the-ground perspectives, we've added the following sections as part of Learning and Reflections. The purpose is to hear from frontline providers and parents in their own words about some of their experiences. What are some of their observations and assessments on the frontline in the midst of this pandemic?

PROVIDER and PARENT INTERVIEWS

Methodology

As shown in Table 1, 20 providers were interviewed. Seventeen (17) came from providers that responded to an email invitation sent to all providers in the RT database. Eighty-one (81) providers responded with their first name, email address, type of ECE facility, and zip code in which they worked. Thirty-one (31) were selected, each from a different zip code and representing the different types of ECE (family child care home, child care center, or friends/family/neighbor care). Of the 31 initially approached by the research team, 17 completed an interview. Three (3) additional providers were selected by convenience sampling. In total, 20 providers completed the structured interview (see Appendix). Four (4) additional providers that were nannies (a convenience sample) separately received only informal interviews. Nanny data are included in the texts about providers.

Parents were selected by convenience sample (N=16). The requirement was that they had at least one child age 5 or under during the period March 2020 - February 2022. Providers and parents were interviewed by phone between February - March, 2022. (See Appendix for interview instruments.) Provider and parent interviews averaged 50-60 minutes in length.

Interviewees were read a confidentiality statement that also included the purpose of the interview. Throughout, the interviewer reminded interviewees of their rights to stop at any time, not answer a question, etc., without them being negatively impacted in any way. Interviewers frequently asked would it be OK if the interviewer quoted them and/or told the stories that the interviewees shared. Interviewers read back to the interviewee anything that they thought they may wish to quote. Interviewers told interviewees that if they gave permission, their stories without identifiers might be shared with the general public.

The interview forms had id numbers and no names. Only at the end of the interview did the interviewer ask if the interviewee wished to receive a "Thank You" note in appreciation of their participation. If they said yes—all said yes, but one--the interviewer used a completely different form and asked the interviewee for a full name and address to send the note. The personal data were captured on this completely separate sheet with no identifiers connecting it to an interviewee's questionnaire. The two documents were then stored separately. Though

never told beforehand about a $30 cash card, a $30 cash card was included with the Thank You note along with a personal handwritten message of thanks.

ECE Providers

Table 1
Provider (N = 20)[3] Demographics
(Data Collected February – March 2022 in Los Angeles County)

GENDER 20 Female 0 Male

ETHNICITY[4]

Black	Latinx/Hispanic/ Mexican American	White	Asian	Middle Eastern
2	9	6	1	1

SELF-DESCRIBED INCOME LEVEL OF PROVIDER'S NEIGHBORHOOD

Low/ Poor	Working Class	Working-Middle Class	Middle Class	Upper Middle Class	High Income
2	2	1	8	5	1

AGES OF CHILDREN SERVED[5]

0 - 5	6 – 11	12 – 14
19	3	1

TYPE OF PROVIDER[6]

Child Care Center	Family Child Care Home	Family/Friends/Neighbor	Other[7]
8	8	0	5

[3] Providers in this table do not include the four nannies that were given a different type of interview (one of which was in Spanish) and whose data are included in later text.
[4] One provider chose not to answer this question and the next question about income level of neighborhood.
[5] Some providers had to take in older children sometimes because of school closures.
[6] One provider indicated that she did both Child Care Center and Family Child Care Home.
[7] Other: three Head Start providers, one LAUSD preschool provider; one interviewee also did nanny work.

Provider Stories

Provider-Story A
A Family Child Care Home (FCCH) provider discussed caring for the children of a single mother of six (ranging in age from 3-years to 18-years). This mother got COVID-19, was hospitalized, and placed on a ventilator for 3 months. While the mother was hospitalized, the provider's family took food, clothes, shoes and whatever else was needed to the family of the sick mother. When the mother returned home from the hospital, she suffered from Long- COVID-19. She had permanent lung damage and difficulty walking. The provider continued to be involved in helping to support the family as much as possible. The provider also attended the funerals of one of the children's parents who died from COVID, and also attended the funeral of one of the parent's family member who died from COVID-19. According to the provider, "We wanted them to know that 'you are not alone.'"

Provider-Story B
A Child Care Center Provider recalls, "During COVID-19, we were all traumatized. I saw students losing their parents, [their] family members from COVID-19 and other illnesses. We need to focus on the children's mental health. It is emotionally stressful times for them. [During COVID-19] I would ask a child in the morning: 'how do you feel?' A child would say, 'Grandma passed,' then this little kid will go sit in a corner, alone. I can see [that] they are disturbed. These children are not okay. It is really draining. One parent lost her husband, her child lost his father: the child would say, 'I want my father back.' You can feel the emotional impact. I had to talk to children and their families. They would call me—we need to answer calls [parents' calls] because we don't know how [we] may have a positive impact on a family and child."

Provider-Story C
A Family Child Care provider had to close for 6 months because she contracted COVID-19 from one of the babies she cared for. When low-income parents found out, the provider explained: "Poor [low-income] women on food stamps gave my family food when we were all sick with COVID-19." After she reopened, her low-income families gave diapers, cleaning supplies, and other supplies to help. The provider had to borrow money to keep her home that was also her business. She lost a brother and aunt to COVID-19, five people in her household got COVID-19. "We are in the line of fire for them [essential workers]. We [also] need help."

Provider-Story D
"When the Pandemic started we needed supplies, gloves, masks—it took 6-8 months to get aid. We could not close because we [would] not get paid. …Parents had to work so I stayed open. We risked our lives [because] I have underlying conditions. Some parents would not pay attention [to guidelines]: they brought kids sick with fevers of 103 (an 11-month old). The parents told me the baby tested negative [for COVID-19]. All of that family had COVID-19."

Provider-Story E
"We had to close down because I got sick, [so did] my mother and my child with COVID-19. When I reopened, because it was difficult to get parents to practice the health guidelines, I had

to get a pro-bono lawyer to draft a 'Provider/Parent Contract' for me. It made me feel more comfortable about parents [following] guidelines they signed onto. This invisible disease [has] a domino effect, we don't know who will get sick and die. I knew a young athlete who got COVID-19 and died. My mom got sick, my child's college savings fund was lost, and I [nearly] lost my home. I worry about this."

Provider-Story F
A childcare provider talked about not being aware that funding was available to help childcare providers stay open. This caregiver did not receive any government funding. In order to comply with COVID-19 social distancing policies, she lost some of the children in her care. She talked about the constant worry and fear of having to shut down her childcare business. For this provider, navigating her childcare business during COVID-19 was difficult. She felt it was "unknown territory " for those who were providing COVID-19 information, and she had to trust that she was doing her best in "uncharted territory."

Provider Story-G
A caregiver describes how she navigated COVID-19 health care practices and her understanding of early childhood development in her family day care business. She recognized the need for young children to learn important emotional cues through exploring and monitoring the facial features of those around them. Therefore, she decided that she, her staff, and children would not wear masks. Understanding that young children need to be comforted through touch, she also decided not to enforce the social distancing policy, and stuck to her previous routine. She said that all her parents were always aware of her non-masking, non-distancing, and touching policies. Parents contributed cleaning, and sanitation supplies to her family day care facility. Understanding that her staff made a commitment to work during the COVID-19 Pandemic, after receiving funding she used it to give her staff bonuses. She had only one positive COVID-19 case, and closed down until she could re-open. She said, she was, "committed to keeping the day care intact knowing that she had working parents who depended on her."

Table 2 identifies circumstances that providers experienced. Though providers were largely aware that some financial assistance was available (Table 2), only half that number applied for this assistance. Their qualitative responses (later in this section) indicate some of the problems they encountered when trying to get financial help. High on the list of what they did receive were supplies and information, something that RT emphasized. A little over half received some benefits through employment. All had health insurance, which they later described as a life saver and very important for their families. Though all had experienced stress and anxiety, the averages over time at the point of the interview were not exceptionally high. They reported that their stress/anxiety levels increased when there were surges of the virus, and decreased when virus cases were on the decline.

Table 2
Provider (N = 20) Experiences During COVID-19
(Data Collected February – March 2022 in Los Angeles County)

Number of Providers Indicating "Yes"

16 Awareness of financial assistance

8 If "Yes" concerning awareness of financial assistance, did apply

11 Received any form of assistance[8]

- 7 Money
- 15 Supplies
- 0 Vouchers
- 5 Stipends
- 13 Information
- 7 Other: (grant; resources, masks, cleaning supplies; N/A; Pampers, milk, disinfectants, baby wipes, thermometers, masks; diapers, PPE, food daily)

16 Closed within last two years

15 If closed, re-opened[9]

10 Used own money for COVID related items for business

11 Received some benefits through employment

20 Health insurance

20 Experienced stress/anxiety: Stress/anxiety level = **4.63**[10]

Very Low Stress/Anxiety **Very High Stress/Anxiety**

1 2 3 4 5 6 7 8 9 10

[8] Respondents may have understood "Assistance" to mean finances, given that more providers indicated that they received supplies and information than "received any form of assistance."
[9] One provider did not re-open. Reasons given were: opened September 2021 but closed again shortly after due to no director and not enough staff.
[10] Providers often described having different levels of stress/anxiety at different times during the pandemic. The different levels for the individual provider were averaged, and that average was used to give the individual provider one number used in this table to represent stress/anxiety. They reported that having health insurance reduced their stress/anxiety; so did having accurate, scientific, COVID-19 information.

Table 3
Provider (N = 20) Problems Encountered During COVID-19
(Data Collected February – March 2022 in Los Angeles County)

Have any of the following been problems for your childcaring business/activities?

Number of Providers Indicating "Yes"	
5	Parents/Guardians unable to pay
13	Staffing difficulties (recruiting or keeping)
7	Unsure about or unable to implement health safety standards
16	Children absent from childcare
11	Your own personal illness/well-being/stress/anxiety
6	Unstable scheduling due to COVID-19
8	Loss of stable income
2	Long-Term COVID symptoms within your own family
4	Had to care for family members who were experiencing COVID symptoms
8	People distrusting vaccines/medical system
0	Vaccine scarcity/unavailability
7	Forced to close because own children were home due to school closures
10	COVID-19 vaccine hesitancy/fears/uncertainty
3	Other:

a. [Parents] "Don't want to be vaccinated because they want to do what they want to do."

b. "Staff got COVID; some staff had immigration issues."

c. "Parents were challenging health guidelines: Sent protocols, Zoom meeting. 75% came back in summer. By end of summer 100% came back."

Table 3 lists a number of problems that providers were likely to have encountered during the pandemic. In the order of their frequency, half or more of the 20 providers encountered problems with: children absent from childcare; staffing difficulties (recruiting or keeping); own personal illness/well-being/stress/anxiety; and COVID-19 vaccine hesitancy/fears/uncertainty. No provider identified vaccine scarcity/unavailability as a problem at the time of the interview.

Provider Assessments of COVID-19 Impacts on Children

a. Less of a sense of community overall for children and families for fear of COVID-19 infection
b. 4- and 5-year-olds seemed to suffer more than younger children from fear of getting sick with COVID-19. For example, once things started opening up and children could play together more, a 4-year old got very upset when a younger child went to play on yard equipment. The 4-year-old started saying, "No you can't go on that, it has COVID-19 all over it!" Staff had to assure the 4-year-old that it was safe before s/he would play freely.
c. Children's social, physical, and emotional health and development are being affected. Children don't go to play dates, parks, or just outside because some parents are fearful and stressed thinking that the child will get sick. Born in the COVID-19 era, some children haven't been socialized into their larger family or larger society. Children seem to be more fearful.
d. Drastic changes in behavior for some children: rude, aggressive, rather play alone, lack social interaction, less verbally communicative than before COVID-19
e. Masks, distancing, barriers were the norm in the environment for children born during COVID-19. Some children didn't know how to play with other children, sat alone in corners, didn't make social attachment to their child care providers like before the pandemic.
f. Children couldn't hug, touch, share toys, comfort each other. Since COVID-19, it seems harder for children to share.
g. Some children are grieving and traumatized by the pandemic. They need mental health attention.
h. Some children (born during COVID-19) were isolated and never saw or played with another child. For example, one child sat across from a baby but didn't interact. When the teacher explains that this is a baby, the child insisted it was not a baby; the doll was a baby, not the real baby. It took 30 full minutes to get the child to interact with the real baby.
i. Young children are much more aware today than during pre-COVID-19 that a person can get sick and die, because family members got sick and died. They are sensitive to the word *sick*. "Sick equals COVID-19 to them."

j. Trauma by COVID-19, especially among providers and the children and families they served in low-income areas, came from things like COVID-19 related deaths, loss of jobs, loss of income, Long-COVID, and food scarcity.
k. We see developmental problems, e.g., child could not jump or move alone because s/he never played outdoors or with other children, delays in communication skills
l. Some children don't show as much affection as they did before COVID-19.

The Added Care That Providers Gave

a. Called families to check on them to make sure they were okay
b. Made homework packets or baskets filled with crayons, scissors, paper, glue and little objects the children could hold in their hands during Zoom sessions, and delivered them to the families
c. Talked to parents about what programs were available to help them: e.g., food, formula, diapers, and distributions for PPE, rent or mortgage payment programs, COVID-19 vaccines and testing sites
d. Scheduled appointments with parents so they could FaceTime with children to read them stories, talk to the children, so they could feel safe and know someone cares about them
e. "What I did was hug the children [2-year-olds] because they need hugs."
f. Drive by birthdays, promotions, end of year celebrations for kids during height of pandemic
g. Had parents sign pledge to create "Social Pod" with childcare so children could play freely with the children in the Pod. Mask in public places, quarantine after air flights, socialize outdoors with immediate family. The idea was lowering their risk for contracting or infecting other children in the Pod.
h. Sometimes didn't charge low-income parents who had been laid off their jobs during COVID-19 and couldn't pay
i. Instead of artificial barriers to separate children in play areas, one provider used natural materials, such as flowers, leaves, and sea shells arranged in ways that separated play areas and were non-intrusive for the children.
j. Assessing different skills or learning bench marks of children over Zoom: e.g., eating skills--had parents let child help make a sandwich, then eat the sandwich
k. When doing online learning, some children had meltdowns—the teacher taught the children breathing techniques to calm themselves down, and asked the other little kids to help calm their friend. "The children were so compassionate."
l. Minimized mask use, distancing, and tried to keep daily routines normalized so that children could learn facial cues; this learning could not occur with facial masking
m. Taught toddlers to wear masks by modeling, and taught learning skills around masking. All of the teacher's 3-year-olds learned quickly and understood that they needed to wear their masks. If the children dropped their masks on the ground, they would come and ask for a clean one. Masking, distancing, and washing hands was normalized.

n. Spent their own money on Gift Cards and other things and mailed to families and children because families lost jobs, children got COVID-19, they had family members who died. "I did things that would help them to know they weren't alone, and these things also helped children's development."
o. Provider gave stipend money to staff as a thank you for all they did during the COVID-19 pandemic
p. Created outdoor classrooms for children to minimize chances of contracting COVID-19

Challenges

a. Parents "lied" about themselves or their children having tested negative for COVID-19 and brought sick children to childcare providers. Providers felt that many parents did not want to abide by COVID-19 guidelines and as a result put everyone at risk. Providers in this situation did not feel safe.
b. Providers got infected with COVID-19 from toddlers with COVID-19.
c. Providers had to close down family child care home because they had COVID-19 or were caring for family members with COVID-19 and almost lost their homes because they couldn't pay mortgage during the closures.
d. Difficulty for some providers applying for funding because of language barriers combined with the complexity of some of the forms, and meeting eligibility requirements (some FCCH Providers were not eligible for funding): e.g., one Spanish-speaking provider asked her daughter to fill-out forms for the business, the daughter tried but gave up because the forms were too hard to fill-out
e. Staffing shortages, staff not willing to risk getting COVID-19 resigned, and some even changed professions (not working in Child Care) because they did not want to take the vaccine
f. Alterations that child care providers made to meet regulations for COVID-19 health and safety guidelines were expensive. If they were unable to get funding, they borrowed or went into debt to make alterations to their businesses.
g. Transitioning to Zoom classes for children and teachers, teachers and children unfamiliar with Zoom technology, children couldn't focus, providers felt anxiety over the increased amount of paperwork
h. Distance learning meant more work for teachers, but coming back to classroom and trying to adhere to COVID-19 health guidelines meant constantly cleaning and worrying about safety of the children
i. Long waits for getting COVID-19 related supplies and learning materials
j. Anxiety about running a Child Care business in uncharted territory during COVID-19 pandemic
k. Low enrollment and absent children because parents did not want to adhere to the social distancing mandate and other COVID-19 pandemic rules that providers had to implement
l. Applying for funding was "hit or miss" in the beginning because providers weren't sure they could qualify. Many discussed the Small Business Bureau (SBA) as asking

for so much information, and often duplicate information that they had already supplied. Providers thought the bureaucracy was overwhelming, especially when they were "stressed and fearful" to begin with.

m. Some parents were challenging health guidelines. We sent them COVID-19 protocols and had Zoom meetings to get them to comply.

Feeling Safe

a. Information (COVID-19 guidelines) and resources made providers feel more secure/safe with providing child care services for "essential workers"
b. Knowing that guidelines were there as back-up when parents were not co-operating and didn't want to test, wear masks, distance, wash hands, wanted to bring babies in with 102 temperature, etc. Just referred parents to the Guidelines
c. Supplies: masks, hand wipes, diapers, formula, and food were given to us and we gave to our families. It made them feel safer because the government was helping them during COVID-19
d. "Really helpful to get information, educational materials, PPE, sanitizing supplies, guidelines [these] really cut the COVID rates. Parents were able to see that by following the guidelines they could also help bring the COVID-19 rates down. The children want to come to school; the parents want them to come to school, so they follow the guidelines. And our modeling really helped."
e. "I feel safer because of it [information, resources, and health advice]. Our community is safer because we had reliable information."
f. "It made a big difference." This provider was able to stay up-to-date on her mortgage, utilities, and create an outdoor classroom because she felt it was healthier for her and the children to spend half the day outside.
g. Felt safer because they were "guided by science."
h. "It helped, [we] had no transmission [COVID-19] in our schools because we were testing, families were not sending children to school sick. [We] had the DPH as back-up, it was like, this is what I am told, I have to do this. [we] appreciated the helpline. I called on a weekend and they called back, they were very reliable."
i. "Very important, …what helped was cash stipend to buy [COVID-19] related supplies because we could get the appropriate PPE. [The pandemic was] financially ruinous, it [assistance] made a huge difference."
j. "We are definitely safer, because of DPH and COVID-19 Response Team collaborated with ECE."
k. We felt safer, information gives us opportunity to make informed decisions about being safe, especially for the children."
l. "We are safer, we took many precautions that DPH guidelines gave us. We reduced enrollment numbers, we social distanced. Families trusted us to be safe. I was in direct communication with parents."

Health Insurance

a. "We need coverage [insurance] for COVID-19 related sickness for employees and their families."
b. "It is a blessing to have insurance…"
c. "We felt secure and confident because [we had insurance]."
d. "Happy to have insurance"
e. "If we had not had insurance we would have had a rough time."
f. "Nice to know that I have it [health insurance], I have underlying conditions. What would I have done if I'd gotten sick [without insurance]?"

Worry Most About

a. Everything has changed; it will take time for things to be normal. I am worried about early child education because parents aren't comfortable sending kids to school.
b. After first mandatory shut-down, enrollment dropped tremendously. Providers worried about getting kids back in child care, etc. LAUSD schools closed for 1½ years while teachers taught kindergarteners by Zoom.
c. Government mandated COVID-19 vaccinations
d. Getting COVID-19
e. That they, their families, and their children would get COVID-19. Example: "I don't want to get sick, my child has underlying conditions. I pray that we don't get COVID-19. I cry. I worry so much. Parents don't tell the truth so they can work and bring sick children [to child care]."
f. Someone would get sick and not recover
g. They [providers] would get COVID-19 and die
h. They would lose their home that was also their child care business location
i. Their families and the children and families they served through their child care business
j. Learning loss, and opportunities for children to learn. "Zoom and hands-on are different, [I] worried about the social, physical, emotional, [and] cognitive development of children who could not attend school."

What Would Have Happened Without Help?

a. "By now (end of February 2022) we would have been dealing with a worsened situation. We needed structure, everyone following the same information."
b. "It would have been devastating, a lot of deaths among my students, family members, [and] staff if we had not received these things."
c. "There would have been a lot of people with COVID-19. We would have been very stressed."
d. "It was good to have solid, scientific guidelines. How could we have functioned with confusing, contradictory information? People would have been arguing over information."

e. "Our classes would have shut down if we had not received the things we needed during the COVID-19 pandemic. The Head Start office supplied us with a resource book. We used it to tell the families how to get medical care, food, mental health support, immigration information. We call it our 'Bible.'"
f. "It would have been difficult, a challenge. There would have been uncertainty."
g. "Everyone would have gotten sick, I would have had to close down."
h. "I would be closing if they had not helped, with six children, if they had not helped. I don't know what I would do without my job. Thanks for programs, information, educational materials; it made it easy for us (providers) and parents."
i. "[There would be] more people with COVID-19. We teach the children to wash hands, mask, but at home they don't wash their hands."
j. "We may not have been able to stay open, [and] there was a much greater chance of contracting sickness [COVID-19]."
k. "We would have closed down. I would have been hiding like a 'hermit crab.' We would have a lot of fear."
l. "I would not have opened if I hadn't the resources and information. The guidelines made a difference, very strategic."
m. "It would have been a disaster. We need science-based information about what to do. It would have a significant difference to not have this information."
n. "[With] no resources, funding or guidance, it would have been difficult. We would have had to use our own funds for PPE, cleaning materials etc., difficult financially. We may have had to close."
o. LAUSD teachers' union played a large part in setting the parameters for safely opening schools.

In brief summary, providers experienced a lot of physical- and emotional health threats and problems. They had tremendous financial difficulties and threats of losing their business and home. This was more the case for Family Child Care Home (FCCH) providers. Also, it was more difficult for FCCH providers to access funding: reasons given included lack of knowledge about financial opportunities, language barriers, complexity of forms, and meeting eligibility requirements. Childcare centers seemed to have better access, know-how, fewer problems filling out forms and meeting eligibility requirements. As reflected in the stories and comments, many providers (and parents in the next section) helped one another.

> "*Education is an act of love and courage. We were not able to be physically with the children, but our love for our students and families remained. We had the courage to continue to provide services to our children and families during the COVID-19 pandemic, the only thing missing was the touch. Because of COVID-19, we embraced the love for each other as humans*."
>
> (A provider at a child care center)

Parents

As was the case for providers, all parent respondents were female (Table 4). The majority of the parents interviewed live in "low-income/poor" to "working-class" neighborhoods and rely upon multiple types of care and education. Family, friends, neighbors, and others were an import component in their care arrangement.

Table 4
Parent (N = 16) Demographics
(Data Collected February – March 2022 in Los Angeles County)

GENDER 16 Female 0 Male

ETHNICITY[11]

Black	Latinx/ Chicana	White	Pakistani
8	6	0	1

INCOME LEVEL OF PARENT'S HOME NEIGHBORHOOD

Low/ Poor	Working-Class	Working-Middle-Class	Middle-Class	Upper Middle-Class	High Income	Other[12]
4	2	5	2	2	0	1

AGES OF CHILDREN[13]

0 - 5	6 – 11	12 – 14	15+
14	6	2	1

TYPE(S) OF PROVIDERS USED BY PARENT[14]

Child Care Center	Family Child Care Home	Family/Friends/Neighbor	Other[15]
11	4	5	2

[11] One parent chose not to answer this question.
[12] One parent lived in student housing.
[13] Some parents had multiple children.
[14] Some parents used child care during weekends or other non-conventional work hours, hence used multiple types of providers.
[15] "Other" included nanny and parent.

Table 5
Parent (N = 16) Experiences
(Data Collected February – March 2022 in Los Angeles County)

Number of Parents Indicating "Yes"

16	Received information, resources, health advice or other assistance regarding COVID-19
15	Feel safe[16] because of what you received
16	Health insurance
14	Have stories to share publicly about the pandemic

Level of comfort about their child care arrangement

Not Comfortable **Very Comfortable**

1 2 3 4 5 6 7 8 9 10

Comfort Level = **7.25**

Level of stress/anxiety:

Very Low Stress/Anxiety **Very High Stress/Anxiety**

1 2 3 4 5 6 7 8 9 10

Stress/anxiety level = **7.44**[17]

[16] Parents did not necessarily feel *safe* with the information they received, but felt more equipped to make informed decisions to protect themselves and their children.

[17] Parents often described experiencing different levels of stress/anxiety at different times during the pandemic. For this table the different levels for the individual parent were averaged, and that average was used to give the individual parent one number representing their stress/anxiety. They reported that their levels of stress/anxiety went up when there were surges of the virus, and went down when the virus seemed to be retreating. Parents also emphasized that having health insurance was critically important for reducing their levels of stress/anxiety, in that health insurance provided an important safety net and sense of security.

Table 5 shows that all parents had health insurance at the time of the interview. Too, all had received some form of information, resources, health advice or other form of assistance concerning COVID-19. Based on the provider interviews, we might expect that some of the information received by parents about COVID-19 may have come through their providers. Parents in these interviews reported a fairly high comfort level with their child care arrangement(s). They also reported a fairly high level of anxiety/stress. Some of the issues captured in Table 5 are further clarified in the parents' stories that follow.

Parent Stories

Parent-Story A

One mother delivered her first child during the COVID-19 pandemic. She talked about feeling comfortable being a first-time mother because she and her husband lived in the same community with her family. But, her comfort level dropped tremendously after she and her husband moved to Southern California and away from her support community. She struggled in isolation with no family or community to support her because of COVID-19. She experienced heightened levels of anxiety and fear of death due to possible contraction of COVID-19. She worried because her child and husband had underlying health issues. She had her child in university-sponsored day care, but was uncomfortable and anxious about how strict (not strict) the providers were in implementing the COVID-19 health guidelines. She also distrusted the way other parents were implementing safety precautions because she felt they did not take the pandemic as seriously as she did.

She was so terrified of her family getting COVID-19 that she took her child out of childcare after only a short time. Eventually, the entire family was infected with COVID-19. She realized that COVID-19 socially and developmentally impacted her and her child. They missed out on bonding opportunities like *Mommy and Me* classes, and peer play days for her child's interpersonal skills development.

Parent-Story B

A single mother of two children (ages 4 and 6) lived in a one-bedroom apartment. The mother contracted COVID-19 and was forced to isolate from the children in the bedroom for 5 days. She had no one who could come help her with the kids. She ordered food for herself and the children daily from "Door Dash." She worried every time she had to leave the bedroom to go to the bathroom. She had to thoroughly disinfect everything each time, for fear that the kids could touch anything in the bathroom. She monitored the children's behavior using cameras in the apartment and communicated with them using FaceTime. Nightly prayers were said together. The mother said, "It was a bittersweet experience hearing my 6-year-old read to the 4-year-old."

Parent-Story C
"In the beginning of the pandemic, I was very stressed because of the misinformation, contradictions, and uncertainty. There was no food, and scarcity of essential needs. Also, people during the pandemic don't make as much wages. [My] job cut hours, then cut what I was paid. I was already part-time but they cut me from 4 days a week to 2 days a week, … they gave no "heads up." Try making childcare affordable. Make things more accessible to people who can't afford to pay for childcare so they can work. It is difficult to get help. I received information about a local community Head Start in the mail, but when I contacted them they couldn't help me because my 3-year-old daughter is special needs."

Parent-Story D
A new mother gave birth during the COVID-19 Pandemic. She had not planned to breastfeed her infant, but decided to breastfeed to support the infant's immune system. She thought this would help keep her infant safe, so she breastfed longer than she felt comfortable doing. However, doing this contributed to her fragile mental health. Feeling isolated from family, feeling trapped, and feeling her worth reduced to providing milk at the infant's whim, were all contributing factors to her fragile mental state. In an emotional crisis, she left her partner, and almost turned down a new employment opportunity. She had a family member in the mental health field, so she with her infant went to this family member seeking guidance and an opportunity to gather herself.

Parent-Story E
This parent's 5-year-old contracted COVID-19 from school. The parent felt that medical professionals were misleading the public with the new guidelines decreasing the isolation period from 10 to 5 days. Then saying it's okay to send children to school 5 days after a positive COVID-19 antigen test. She said, "I didn't agree with that because my child was still antigen testing positive 7 days after the first positive test. I took all my children out of school, now they distance learn. They [authorities including medical professionals] need to be truthful and keep this a public health issue, not worry about pleasing everyone, and just keep people safe."

Parent-Story F
Distrusting some medical procedures during the pandemic, this parent shared the following: "If you go to the hospital, everyone needs to make choices for their own bodies. If you can, don't let medical procedures be forced on you." For example, one of her loved ones [hospitalized with COVID-19] was put on a ventilator during the pandemic. This loved one eventually died. "We should know how our body works, and make informed decisions about medical procedures being offered; many people died after they were put on ventilators," she explained.

COVID-19 Related Impacts on Their Children and Themselves (Parents)

a. Children learned about viruses, how to protect themselves, and what a pandemic looks like
b. Children born during COVID-19 show less interest in social interactions and have some preference for isolated play when put in a group

c. Children under 3-years-old are not meeting social development milestones. Some of those 4-year-old and above are showing emotional wellness issues: e.g., anxiety, fears of not wearing masks, hyper-vigilance around safety precautions, worry about getting sick
d. Parents are grieving lost opportunities for engaging in group activities with their young children, like participating in *Mommy and Me* classes, and regular social interactions
e. There has been an absence/loss of family support systems for parents and children, such as grandparents and family members who would be alternative care givers, and that families normally rely on for stability
f. Parents are experiencing anxiety over COVID-19 and new variants
g. Overall, parents indicate that their mental health has suffered

Key Things Parents Did

a. Some mothers breastfed and others got vaccinations while breastfeeding to ensure their children's immune systems were boosted and infants' immune systems were supported by antigens in mother's milk
b. Took their young children out of school and did distance learning until there is a safe COVID-19 vaccine for children under 5-years-old.
c. Made health care choices on their own after **seeking out** reliable information

Comfort Levels with Childcare

a. Working parents felt more comfortable with childcare located at their place of employment
b. Did not trust that other parents with children in child care facility would follow health care protocols or recognize the seriousness of the pandemic
c. Had the highest comfort levels when they had a nanny, parent, or family member (<u>if consistent</u>) taking care of children in the home

Distrust of COVID-19 Information Messaging

a. Parents did not feel safe with the information they received but felt more equipped to make informed decisions to protect themselves and their children
b. Parents who were healthcare providers or who had close connections with a healthcare provider had more trust in personal capacity to keep children safe
c. Parents felt the information they were receiving was often contradictory and confusing. They sometimes felt that misinformation from those in authority caused the general public to distrust some of the information they were receiving.
d. Especially troubling to some parents was the information around safety and efficacy of vaccines, and the contradictory information about children and the vulnerability of children, especially younger children, to the COVID-19 virus. As one parent put it:

"They [authorities] were saying, 'kids can't contract the disease, then kids need to be vaccinated.' It was confusing."

Worry Most About

a. Surges in new COVID-19 variants
b. Over whether child care centers/family day care would close due to parent's exposure to COVID-19, disrupting parent's work routines and children's need for consistency
c. Fear of dying from COVID-19, inability to protect children, getting elders ill
d. Feared children with compromised immune systems would fall ill and possibly die
e. Worried about government mandated vaccines and vaccine side-effects
f. Most anxiety over misinformation, uncertainty about the disease, shortages of food and basic necessities, losing jobs, and pay cuts
g. Safety and efficacy of the COVID-19 vaccines

Challenges

a. Providers' over-reactions to "common cold" symptoms. Parents had to get doctor's notes, or keep children out of school for extended periods of time
b. Information did not always address how to protect children, but was more tailored for adults
c. Not being able to afford reliable, consistent childcare during the pandemic. For example, one parent, who works and goes to college, relies on family to care for her 3-year-old with special needs, because she can't afford childcare. She explains, she has someone to take care of her child "only when [family are] available, [it is] inconsistent."
d. Getting COVID-19 related PPE, food, sanitizing and disinfecting products at the height of the pandemic
e. Loss of income and pay cuts

How Helpful Was the Information Received?

Parent interviewees felt that the information they did receive was helpful, especially information about testing and vaccines. They all felt the information they received helped them to make *informed* decisions about how to keep themselves and their children and families safe. However, they also felt that the often contradictory and sometimes misinformation messaging from those in positions of authority caused them and others to distrust some of the information they were receiving.

Health Insurance

Parents were "relieved," "comforted," and "at ease" because they had health insurance. They felt having insurance was essential in case of medical necessity.

MOVING FORWARD

Ideas for moving forward appear in various parts of this report. They can be found in the Learning and Reflection section of this report, as well as in the comments that RT members, providers, and parents have made up to this point. When specifically asked about what they need and would like to talk with decision-makers about, providers and parents made the following comments.

Provider Suggestions for Moving Forward/What Providers Need

a. More funding for buying educational materials, the budget is not enough
b. "Hourly rate for teachers is low. Because of our professional ethics we were willing to expose ourselves, we worked hard to keep children learning. We are 'essential workers' for the first time this is validated that we are 'essential workers,' for children and their families. Show this [by] paying us a higher wage."
c. Need to be clear, consistent with information about COVID-19 and be more organized in distributing materials, supplies, guidelines
d. Need to give more mental health days--maybe 1 or 2 times a month. "It is overwhelming what's going on during this pandemic."
e. Some Child Care providers felt they should not be classified as "essential workers" (like Target or Walmart employees), they are *teachers*
f. Funding assistance for providing training for COVID-19 related issues
g. "Child care providers are essential, we need financial programs, higher wages, and more resources made available to help us continuously, not just during a crisis"
h. Need to supply more formula, diapers, to give to parents; parents could not afford these items because they have to buy food for their families
i. Licensing needs to help us take care of these children. Make it easier. There are too many forms. They are too removed from children and society.
j. We need mental health support, would recommend therapist to come to school. We need parent and student workshops to learn how to deal with this situation [pandemic] emotionally, socially. People need some kind of reassurance that they will be okay.
k. "We [early education teachers] need encouragement not to give up, we are doing work for the next generations."
l. "Incidental fees: CPR training, fingerprinting, should be paid upfront for Child Care Providers, we shouldn't have all the paperwork to get reimbursed."
m. "Child care should be supplemented by the government, if we want good, quality child care."
n. "Small [child care] businesses need to be eligible for loans, emergency loans. The government should know that small business is [the] backbone of this economy. They need to give us grants, aid. Private providers don't get the help that state sponsored providers get. We are in the line of fire."

o. "Going forward there needs to be more clarity about protocols. [There] needs to be one central place that gives reliable, scientific information."
p. "DPH should be on all COVID-19 Response Team calls with scientific information collaborating with ECE. Because, in the beginning, we got contradictory information. We lost time and energy on distancing [didn't know to distance]."
q. "Early Education funding needs to be provided by the government. Give us [ECE teachers] more money and we will give you better child care, better service, you will be building provider's self-esteem."

Parent Suggestions for Moving Forward/What Parents Need

a. "Make childcare affordable. Make things more accessible to people who can't afford childcare."
b. "…conflicting, confusing, contradictory information makes us lose faith in CDC, NIH, and DPH. They need to be truthful and keep this a public health issue, not worry about pleasing everyone, and just keep people safe."
c. The DPH should send daily alerts to all our phones. While they sent alerts about vaccines, they needed to send up-to-date information on COVID-19 guidelines straight to all of our phones to keep us safe and informed
d. Assistance for childcare because children's [early development] is being stunted
e. Get people free home testing kits quicker
f. Help people get resources

The Writers of This Report Recommend

We have included more ideas to consider in the previous section, "Learning and Reflections." Please see that section. In addition, several closing remarks seem warranted about moving forward. At the top of the list, it is essential to create and implement ways to reach those ECE providers and families that are in situations of most need. Providers in these situations may not even be on RT's radar. This is unfinished business. It is an important step for moving forward—when RT can create ways to serve the ones in situations of most need, that will also strengthen future work by RT and/or its successors.

It is the work-spirit, access to resources, and experience of having successfully worked together collaboratively across institutions for more than two years that should be preserved. This preservation would be helpful whether or not RT is continued, modified, or changed to some sort of Transition Team, Building Team, or something else. Don't lose the contacts, trust, and access to knowledge that have been built. These will be needed again. There are any

number of crises on the horizon and this current crisis is far from over, in that it is embedding and deepening. Use all your talents and advantages to see and prepare.

Be ready. Stay ready. Collaboratively put together an emergency plan of action in preparation for the next crisis (it may be a virus, an earthquake, a fire, or something else unforeseen). Keep that plan current. Conduct mock practices, like practicing fire drills. Providers and parents need to be included in all aspects of developing this plan. They have had first-hand experience of what will likely be needed. They will also need to know what to expect from the different institutions and systems and how to work those institutions and systems during emergencies and crises.

Streamline access. Build on what you have learned from the COVID-19 experience. For example, in preparation for and during the next emergency, providers and parents will need quick and adequate financial supports, technology equipment and training, supplies, transportation, fast access to health services, etc. Work out these kinds of issues in advance. Put something in place before the emergency, and while these issues are at the forefront.

Now or soon will be a time for transitioning out of the emergency aspects of COVID-19. Consider a Team PHASE 2 that involves transition and building. Foci can include the fallout of what everyone has been through (e.g., trauma, child developmental delays, providers leaving the career, providers financially ruined, families stressed emotionally and financially, etc.). Again, include providers and parents equally in this transition planning and building. It could be that providers and parents have their own Teams. (There are suggestions along these lines in the Learning and Reflection section of this report.)

See the connectedness between ECE and all the critical things in our society that rely on its health, safety, and effectiveness.

Reassess. What are all the voices that need to be at the table for moving forward. This may include psychologists, social workers, child development specialists, R&R staff, parent educators as well as providers and parents. As parents and providers have said, people in Los Angeles County need help. Children need help: Providers and parents will be among the first to see some of the hidden impacts of the pandemic on children's intellectual, physical, social-

emotional, moral, and other early child development issues. ECE workers, too, need help as do parents, families, and communities.

In an "equitable recovery," ECE workers need to be adequately represented in discussions and at decision-making tables. As one RT member expressed: "Have all the different entities and levels of the problem communicate." Draw upon the village to identify problems and find solutions.

Recognize, acknowledge, and fully compensate early care and education workers for any work related to something like RT. Consider their financial hardships and frequent lack of opportunities (e.g., access to and training to use technology, material resources, time constraints, transportation challenges, etc.).

Establish some type of easily accessible pipeline from providers and parents to RT or other Teams. Among other things, use this pipeline to check/verify who is being reached (e.g., during the distribution of resources) and who is not. Providers and parents will likely have ideas for how to do this.

The ECE sector and all of its workforce need to be economically and educationally healthy, stable, and vibrant. This is to everyone's benefit, independent of there being a crisis or not. This sector is a significant part of society's foundation for healthy social, emotional, intellectual and other learning, growth, and development for our next generations.